DOCTORS

An Industry Accounting and Auditing Guide

Fourth Edition

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Preface

The fourth edition of *Doctors – An Industry Accounting and Auditing Guide* is intended to provide broad background information on issues which relate to general medical practitioners for accountants with medical practice clients.

There have been significant changes since the third edition, following the introduction of the new general medical services contract in April 2004. In addition, there has been a significant update of the NHS Pension Scheme, effective from April 2008. Both of these subjects are covered in detail in this edition.

This book is intended to provide accountants with a background for understanding the financial environment in which medical practices function. However, readers need to be conscious that there is no longer a standard contracting environment as there was previously. England, Scotland, Wales and Northern Ireland have each developed variations on the delivery of health services and the structure for payment for those services. Furthermore, local Primary Care Organisations have more self autonomy to contract for specific services locally at locally set pricing.

This means that it is no longer possible to issue a book of this sort which comprehensively covers all areas throughout the UK. Therefore the intention of this edition is to provide a framework from which accountants can look in detail at the local variations in the areas in which they practice.

This edition covers tax issues of particular relevance to medical practices. This includes VAT in the context of medical practices and, particularly, dispensing practices. The financial aspects of running a dispensing practice are also considered.

Views are offered on the presentation of medical practice accounts to help accountants to consider how to establish their own in-house style in this regard.

For accountants new to this area of practice detailed checklists and pro-forma letters are supplied in the Appendices.

The challenges for general medical practices are increasing as time progresses and accountants need to keep abreast of current developments by ongoing background reading. This is a very interesting sector to work in but the requirement to maintain appropriate knowledge levels should not be underestimated, and this book provides a point of reference in this regard.
Preface

The views expressed in this book are those of the author and are based on the experiences of myself and colleagues in my practice. The book is intended as a guide and therefore does not fully or comprehensively cover all areas. Accountants practising in this sector will inevitably have differing views on certain aspects, particularly in terms of accounting presentation. The purpose of the book is to provide the reader with ideas and examples. It is not intended that the views expressed represent definitive advice.

I would like to thank my colleagues at Whittingham Riddell LLP for their support and encouragement to me and also their input in technical terms to the content of this edition. I am particularly grateful to Martin Reader and Rags Bram for their technical input and to Richard Tudor and Paul Adams for their diligent proofreading. In addition Michelle Thomson and Julie Ball have been an enormous help in tidying up my typing and interpreting my dictation. I would also like to thank my family for their patience and understanding during recent months when I have been immersed in my book-writing commitments.

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June 2008
Chapter 3 – The ownership of surgeries

Accountants acting for doctors will need to be able to advise surgery owning clients on the financial aspects of surgery ownership, including any relevant tax implications. Therefore, accountants working in this sector need to have a sound working knowledge of the topic.

GPs can receive financial support for much of the expenditure connected with the provision of their surgery premises, including rent paid to the owners of the building. Where practices own their own premises funding is also available in recognition of the use of those premises by the NHS.

This chapter looks at the various financial aspects of surgery ownership by GPs, the manner in which funding can be obtained for surgery premises and considers in some detail the provisions of the cost rent scheme.

It also deals with the refund of expenses relating to the ownership such as business rates, water rates, etc.

There are many practices which do not own their surgery premises. Reference is made in section 3.18 to the situation where GPs are occupying health centres owned by the PCO or the Strategic Health Authority. In addition, there are now many GP surgery premises which have been built as part of a Private Finance Initiative (PFI). These premises will be modern health centres, possibly occupied by other health services or built as community projects in association with local authority community requirements. The rental costs associated with such premises will be met through the notional rent allowance, see section 3.2.

Another arrangement is the Local Improvement Finance Trust (LIFT), which is a funding collaboration between the private and public sector. This initiative is used for high profile developments where high deprivation or urban regeneration need to be addressed.

The allied questions of surgery-owning partnerships (see 5.7) and taxation (see 8.10) are dealt with separately.

3.1 Principles and practice

The type and standard of accommodation provided by practices for their own use as surgery premises can come in many forms. On the one hand there might be the established building which has been owned by the practice for many years,
The ownership of surgeries

to the house in an urban area acquired for conversion to medical use, or, increasingly, at the top end of the scale the new purpose-built surgery, developed on a greenfield site at significant capital outlay. More recently government funded polyclinics are being proposed.

One common feature of all these surgery ownerships is that they will attract an allowance, in the form of the notional or cost rent allowance.

Whichever of these sources of finance is applicable, the income will be attributable to the practice. It should be included as part of the partnership profits for allocation between the partners. It should be treated as assessable to Schedule D tax, again divided in appropriate ratios between the partners. These allowances are paid to GPs by virtue of their contract of engagement with the NHS. The conditions and rules for payment are set down in the National Health Service (General Medical Services – Premises Costs) Directions 2004.

3.2 The notional rent allowance

The purpose of the notional rent allowance scheme is to reimburse practices for the rent, rates and other costs of providing practice accommodation by reference to the amount each practice pays or is deemed to pay for these services and facilities. Premises are only acceptable under the scheme where the PCO is satisfied that the accommodation provided is adequate and falls within certain parameters, including ease of access, treatment and consulting facilities, adequate waiting areas and security.

It is not unknown for partnerships to own two or more surgeries, or to have rented and owned accommodation being used simultaneously.

In the rare cases where a GP practices from his own house, and this is more normal in the case of sole practitioners, payment of any rent allowances and refunds in respect of rates and similar items will relate only to that part of the residence used for practice purposes. In such situations, the PCO will determine the amount of the notional rent payable as advised by the Valuation Office Agency (VOA), who will provide an assessment of the current rental value of that part of the premises used as practice accommodation. This applies whether the property in question is owned or leased.

Where surgery premises are occupied by the practice but fall outside the ambit of the cost rent scheme (see 3.3) a notional rent allowance will be paid to the GPs occupying the surgery. The amount of this allowance (both in respect of separate premises or those forming part of a residence) is determined following an assessment by the VOA as to the current market rent which might reasonably be expected to be paid for the accommodation. This amount, when agreed, is paid in full to the practice concerned, usually at monthly intervals.
These notional rent assessments are revalued at triennial intervals, again by the VOA. If a practice is not satisfied with the amount of the new assessment, it has a right of appeal. This is frequently exercised. It is recommended that practices use an experienced professional valuer to negotiate for them. Accountants working in this sector will build up a network of contacts so that they can make recommendations to help their clients. In practice, those surgeries which attract a notional rent allowance will normally be those which have been held and used by the practice for many years, together with those which have been developed under the cost rent scheme during more recent years and where the GPs have felt it to their advantage to opt for the notional rent basis at one of the triennial revaluation dates.

Accountants need to be aware of the potential for the abatement of notional rent payments. This will apply if any part of the premises are used for, or associated with, the provision of medical services to private patients or are let under arrangements with somebody other than a public authority. The abatement percentage is the proportion of the income from non-NHS patients to total income. There is a threshold of ten per cent private income below which no abatement will be made. This applies where the PCO has contributed to the cost of the building in a project whereby that contribution was made after 18 September 2003. The period of abatement will only last for ten years, after which time the full notional rent will again become payable.

3.3 The cost rent scheme

The cost rent scheme for the development of GP surgeries offers an investment opportunity unique in UK business life, inside or outside the National Health Service. The scheme offers, if used to its best advantage, the prospect of GPs acquiring a share in a valuable capital asset, without any significant capital outlay himself and with, effectively, an additional income to cover the interest charges on loans raised for the development. The cost rent scheme, introduced in the early 1970s, has already played a major role in providing new and improved surgery facilities for NHS patients. The use of the scheme has waned in recent years, beyond its high point of attraction in the mid-1980s, when practices were able to take advantage of this opportunity, and many projects which came to fruition at that time have brought tremendous financial advantages for those GPs fortunate enough to have shared in the development at that time. However, see also 3.8 below on negative equity.

Whilst the scheme still retains its inherent advantages, its take up has become less common in more recent years, primarily due to the difficulty which many practices encounter in obtaining funding from their PCO due to the imposition of cash limiting restrictions applying to this aspect of a PCO’s budget. It is by no means unusual to find practices have been asked to wait several years before...
funding will be available for their project and in virtually all cases PCOs have only a very limited amount of money available to be used for this purpose.

In addition, the effective reduction in cost rent limits in recent years has resulted in practices being less likely to recover the whole of their interest costs. What, then, are the financial benefits of the cost rent scheme which make it so attractive? These can be summarised as the:

- acquisition of a valuable asset over a period of years without significant capital outlay;
- interest and possibly an element of capital repayment being covered by receipt of the cost rent allowance;
- possibility of capital appreciation to retirement, and
- possibility of increasing levels of income over the years.

3.4 Establishment of cost limits

In order to qualify under this scheme, a project must fall within one of the following headings.

The:

- erection of entirely new premises;
- acquisition of a building for substantial modification, and
- extension or improvement of existing premises.

The essential feature of the scheme is that the initial cost rent allowance is based upon the total cost of developing the new surgery, or the cost of modification in other cases. To this total a percentage factor is applied, resulting in the term 'cost rent'. For instance, if the total cost of the project is £900,000 and there is a 7 per cent rate of cost rent in force at the time, the annual reimbursement (and additional income to the practice) will be £63,000.

Where the loan is not a fixed interest rate loan then the cost rent is reviewed annually in line with any movement in the Bank of England base interest rate so that the annual amount is recalculated based on the initial agreed level of borrowing. The calculation is also revisited if the loan is paid off or alternative borrowing arrangements are entered into by the practice. In addition, the practice has the option to elect to come out of the cost rent scheme. Generally, this would be to move across to the notional rent scheme where the practice felt that this might achieve a better financial outcome for them. It is not possible to move from the notional rent scheme to the cost rent scheme, and therefore the election to transfer from the cost rent scheme to the notional rent scheme is irrevocable.

The cost rent is paid to practices monthly on the last day of the month.
The determination of the total agreed cost of the project (which is not limitless) is by negotiation with the PCO, using cost rent limits in force at the time (see below). To that agreed total is applied the percentage rate in force at the time.

3.4.1 Calculating the total cost

As we have seen there are four major components in determining the cost of a development under the cost rent scheme.

The cost of acquiring the land

This would normally be included in the calculation of total cost on the basis of the actual cost to the practice. Where the Valuation Office Agency’s valuation is very much less and it is impossible to reconcile the two through negotiation, it is the VOA’s figure which will be used.

In practice, many such projects are developed using land already owned by some form of public body, which is also subject to the VOA’s valuation and in those cases it is unlikely that a conflict will arise.

The total building costs

The practice must obtain three written quotes for the building work and must agree with the PCO which one represents best value for money. The practice will already have agreed with the PCO the format of the building, ensuring that the minimum standards set out in the directions are achieved.

Professional and architects’ fees

Included in the total cost figure for the cost rent will be reasonable surveyors’ and architects’ fees and any reasonable legal costs arising out of the purchase of the site and the building or refurbishment. The gross cost, including VAT, will be the cost used in the calculation.

The cost of raising finance

The major component of the cost of raising finance will be the cost of bridging finance which, for a major project, possibly where the development lasts over several years, is likely to be significant. There can also be included under this heading any additional cost of raising finance, such as accountants’ and surveyors’ fees, although this again is subject to negotiation with the PCO.

Planning fees

The cost of any local authority and planning application fees which have necessarily been incurred.
Fitting out and equipment costs

The cost rent will also include the purchase or lease costs of adequately fitting out and equipping the new premises.

VAT and Stamp Duty Land Tax

The cost rent calculation will also cover any costs incurred with regard to VAT and Stamp Duty Land Tax associated with the project.

The total amount which the GP can spend on the development of his surgery is limited in a number of ways, including the total building costs. In practice, a major point of decision in these projects usually arrives when tenders are invited for building costs, which may transpire to be a great deal higher than originally estimated. By that time, the practice may well have expended an appreciable amount of money to date. Architects’ and surveyors’ fees will have been paid, the land may have been bought and planning permission obtained. The project may have passed the point of no return. If all else fails, and the GPs seek to go ahead with the project, they may be left in the position of having to finance this either through their own resources or by higher loan finance, whilst only obtaining cost rent reimbursement up to the prescribed limits.

3.5 Rates of reimbursement

The percentage factor which is applied is referred to as the ‘prescribed percentage’. The directions set out that this is:

- if the loan is a fixed rate loan, for the duration of the loan period, the 20 high year gilt rate used by Bank of England plus 1.5 per cent;
- if the loan is not a fixed interest rate loan, the Bank of England base interest rate plus 1 per cent, and
- if the practice is financing the building or refurbishment scheme wholly or mainly from its own resources then the percentage is that which the PCO determines as representing best value for money.

In some cases GPs will choose to finance their development through a fixed rate loan, but carrying the option to switch to a variable rate at some agreed future date. In these cases, the fixed rate of reimbursement will apply until the option is exercised, when the variable rate will come into operation. This rule allows GPs to enter such arrangements without the insecurity of knowing that if they do exercise the option at some future date, and at a time of high or rising interest rates, they will not be penalised through being required to pay a higher floating rate of interest to the finance house concerned while receiving a lower rate of fixed cost rent. It is frequently found that fixed rate borrowing is only available on such a project where other, and possibly unacceptable conditions are imposed.
Examples of this would be that the practice may be required to take out a succession of pension policies which they would not otherwise require and which would increase their total outgoings.

3.6 Financing the project

It is a misconception that the cost rent reimbursement is a refund of interest charges. This is not the case. If there was a situation where the doctors in the practice were of sufficient means to fund the project from their own resources, then they would still be eligible to receive the cost rent allowance but they would, of course, have no interest charges to pay because they would not need to fund the project through loan finance.

The practice will receive the cost rent reimbursement as based on the formula outlined above. From whom and how they borrow the money is entirely up to them. They will look at all the sources of finance currently available and select the one most suitable for their needs.

In most of these projects there are few GPs who have the resources to fund the project from their own free capital. In the vast majority of cases loans will be taken out, in many cases for 100 per cent of the total cost of the project, and the GPs will effectively have to finance this from the proceeds of the cost rent allowance or, if this is insufficient, from their own residual earnings.

The initial borrowing requirement will be to provide bridging finance during the development period. Practices are advised to open a separate loan account with their bank and to pay all charges appropriate to the project out of that account. This will result in an increasing overdraft, upon which the interest will be aggregated, ie ‘rolled up’ up to the date of final completion. Where funds are being advanced from an outside source, it will normally be possible to draw down instalments of the loan so that the bank bridging loan is kept at a relatively low level.

So far as the final source of borrowing is concerned, the problem facing the GP is not so much how to find the loan finance, as how to select the best option from the numerous ones which are available. Factors which should be taken into consideration when evaluating sources of finance are:

- the rate of interest available;
- conditions for repayment (20/25 year terms are normally available) and some practices choose not to repay by using an ‘evergreen’ loan;
- whether conditions are imposed concerning collateral life assurance or pension policies;
- whether capital repayment holidays will be available, and
- the option of variation from fixed/floating rates.
The ownership of surgeries

The lending institution must be able to satisfy itself that the practice will be able to service and repay the loan on the agreed terms. Where, for instance, the cost rent reimbursement appears to be lower than the total cost of servicing the loan, then the GPs will have to finance the shortfall from their own earnings. In a high earning practice this should cause few problems provided that the net cost is kept within reasonable bounds. Less remunerative practices may, for that reason, find greater difficulties in obtaining loan finance where the project is not completely viable on its own and they are in a less advantageous situation when negotiating over conditions to be imposed. Whatever the size of the practice, it is essential that any potential surplus or deficit is estimated at the outset. This will have to be taken into consideration by each individual GP when assessing his own financial position.

GPs may consider an endowment-linked mortgage. Whether this is appropriate is an investment decision and should be considered with an independent financial advisor. However, in accounting terms, particularly in a partnership, using an endowment policy as a means of repayment is difficult to handle. Problems arise where, at some future date, a surgery-owning partner seeks to leave the practice and it is necessary to value the accumulated premiums on the endowment policy. Conversely, a new partner buying in will find that he must take over a share of the existing loan, and again problems may arise over the valuation of the endowment policy.

Where such an endowment policy is taken out, it is common for this to be written on the life of the youngest partner.

Similarly, with collateral pension policies, these are really only effective where it is possible to obtain a full measure of tax relief on the pension premiums. This needs to be carefully considered in relation to NHS Pension Scheme funding, see Chapter 9.

In the majority of circumstances, it will be found that a normal repayment mortgage will be the most appropriate repayment strategy.

An alternative which many practices use is an evergreen loan. This is a loan for which there is no repayment schedule. This might be an appropriate loan where the practice considers that the value of the property going forward will be at least its initial build cost and that they prefer not to reduce borrowing from current income but to use that income for an alternative investment. Many banks are willing to enter into such arrangements with medical practices because they can see that the practice is well able to afford the ongoing interest instalments. This arrangement can make it much easier to recruit new partners into the property owning aspects of the premises because they have not got to bring in any external funding to fund any equity which older partners have achieved, through not only the increase in the value of the premises, but also the impact of the loan repayment over the term of the loan to date. Conversely, this will mean that a
retiring partner has less capital to be repaid than would be the case had the loan been on a repayment basis. This eases any cash flow issues associated with partnership retirement. The retiring partner might feel that there should be more value to be paid out but he needs to accept that in deciding to enter into an evergreen loan earlier in his working life he has had more income available to him for self investment than would be the case had some of his income been held back to contribute to the repayment of the loan.

There are many and varied packages of loan facilities available to GPs developing surgeries. Interest rates are competitive and bankers view medical practices as attractive customers to service.

3.6.1 What will it cost?

Naturally, a question that the GP is likely to ask is what the cost of the project will be.

When all the information is available it will be possible to consider this and to prepare a statement which will give some idea of any likely shortfall or surplus on the project. Only then will it be possible for GPs to evaluate whether they wish to go ahead with the project.

Figure 3.1 shows a simplified but typical situation which might arise.

**Figure 3.1 What will it cost?**

<table>
<thead>
<tr>
<th></th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost</td>
<td>1,450,000</td>
</tr>
<tr>
<td>Cost rent allowance (6.5% variable)</td>
<td>94,250</td>
</tr>
<tr>
<td><strong>Loan repayments:</strong></td>
<td></td>
</tr>
<tr>
<td>Annual interest (say 8%)</td>
<td>116,000</td>
</tr>
<tr>
<td>Total annual shortfall</td>
<td>21,750</td>
</tr>
<tr>
<td>Per partner – assuming 5 partners</td>
<td>4,350</td>
</tr>
</tbody>
</table>

1. Assuming building erected within cost rent limits.
2. The illustration ignores the effect of taxation.

This practice has a potential cost rent allowance of £94,250 but has been unable to borrow funds at 6.5 per cent and is obliged to do so at 8 per cent. The shortfall is therefore £21,750 pa or £4,350 per partner. In a high-earning practice one would not expect this to be an undue problem, particularly bearing in mind the potential for increases through the option to transfer to the notional rent basis in future years.
3.7 Third party development schemes

A sale and leaseback scheme was introduced in the 1980s, with the intention of catering for those practices which found themselves in difficulty when shares of the surgery were required to be bought and sold between partners, the sale and leaseback scheme has existed in various manifestations ever since.

As with any other similar development, the principle of the scheme is that the practice develops a surgery, going through all the processes required for the cost rent scheme and with the same limiting factors applying, then sells it to a third party, after which the practice becomes a tenant and reclaims the rent from the PCO.

Some practices have gone down this route and have been extremely satisfied. On the other hand, the scheme avoids the major fiscal advantages of the cost rent scheme proper, ie a regular and increasing source of income, with possibly capital appreciation on the value of the building.

If and when such a transfer is effected, there is no guarantee that the rent to be refunded will be equivalent to the charge made by the new owners. PCOs are now subject to significant budgetary restrictions and will only pay the rent reimbursement to the extent they are satisfied, in conjunction with the VOA, that this is a fair market rent for the property in question.

The scheme as originally formulated was invariably organised through the GPFC. In more recent years more schemes have been introduced by investors and by property developers. An industry has built up around this type of arrangement and in recent years many practices have sourced new surgeries through this type of PFI project.

Practices going down this route need to interview PFI providers and go and visit other practices who have engaged the PFIs who they are talking to. They need to be sure that they are working with the right people for them. The PFI will liaise with the PCO to ensure that the funding is secure to make the project viable for them. The fact that the PFI provider undertakes most of the organisation and negotiation for the project makes a PFI an attractive option for a practice. Where the previous surgery premises need to be sold, as part of the financing for the project, then PFI funders are willing to look at taking over any negative equity which may exist.

3.8 Negative equity

Many GPs own their own surgeries and these are often developed on the basis of a 100 per cent mortgage, so that in the early years of ownership there is little if any equity remaining in the building. Classically, equity has tended to build up over the years as a result of upward revaluations of the property and gradual repayments of the principal loan.
Many GPs have to live with the potential for negative equity, certainly in the early years of their ownership, due to high building costs which they may have been unable to recover in terms of cost rent income. Also it has regularly been found that the building value shortly after completion of the building work is less than the cost of development and in many cases also less than the amount outstanding on the surgery loan.

This gives a potential problem with regard to retiring partners who may find it beneficial not to join in such a development if it were to take place within a few years of their pending retirement. However, practices with a relatively high level of income and comprised of partners not nearing retirement, are able to weather this problem without too much difficulty. Provided there were no partnership changes pending and they were able to fund the cost of servicing the loan without undue difficulty, they could fairly confidently wait for a few years in the reasonable expectation that property values would increase over the relatively short term so that the negative equity would be extinguished.

In these cases, it is common for a clause to be inserted in the partnership agreement to the effect that a partner retiring or leaving the practice within a specified period would be protected, in that his share of the property would never be sold at less than cost. This gave those partners an assurance. It encouraged doctors in their fifties to join in the development in the knowledge that they would not find themselves with a substantial debt when they left the practice. They may well not have increased their equity but at least it could not fall into a negative equity position.

Doubts have been expressed over the legality of such clauses and the extent to which these may represent a hidden sale of goodwill (see 2.14).

This also raised problems for incoming partners which are addressed in section 3.9.

To a large degree GPs have a real advantage over the conventional businessman who finds himself in a parallel situation. A GP can reasonably expect to receive a direct reimbursement for his ownership of the surgery, in the form of the notional or cost rent allowance. With an element of good fortune and depending on the date of development, this allowance may pay the whole of the interest on his bank loan and even some element of the capital repayment. This alone means that, even in a property recession, a GP is unlikely to have any undue problem in servicing this loan out of income.

3.8.1 Existing surgeries

Figure 3.2 below shows the position of a practice which has owned its surgery for some years, having been developed in 1999 at a total cost of £1.5 million. This was revalued on the retirement of Dr A in 2003 at £1.6 million and has been...
shown as such in successive balance sheets, being owned only by Drs B and C. They are receiving cost rent and servicing the loan interest out of this reimbursement. However, the senior partner, Dr B, announces his intention to retire at the end of December 2007 and to sell his share in the surgery to Dr D on the same date. The partners have obtained a professional valuation and found that the current value of the surgery is £850,000.

In view of the valuation and the outstanding loan Dr D does not feel able to buy a share of the property. Because of the requirement for him to take over obligation for part of the outstanding surgery loan he does not intend to go ahead with this purchase, so that the ownership will devolve only on Dr C, who himself is due to retire in some three or four years. Although there was no clause in the partnership deed, Dr C has agreed that Dr B would be paid out on the basis of the amount outstanding under the loan, which gave him nil equity.

Dr C therefore finds himself faced with an outstanding loan substantially in excess of the value of his surgery. While the interest is covered by the cost rent allowance, he would have to stand a considerable loss if he wished to sell the property and he has no funds to meet the annual loan repayment amounts.

**Figure 3.2 Negative equity: existing surgery**

<table>
<thead>
<tr>
<th></th>
<th>1999 £'000</th>
<th>2003 £'000</th>
<th>2007 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>At cost</td>
<td>1,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Valuations:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 December 2003</td>
<td>1,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 December 2007</td>
<td>850</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loan finance</td>
<td>1,500</td>
<td>1,400</td>
<td>1,200</td>
</tr>
<tr>
<td>Positive equity 2003</td>
<td></td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Negative equity 2007</td>
<td></td>
<td></td>
<td>(350)</td>
</tr>
</tbody>
</table>

This is a rather dramatic example but illustrates the problem of surgery ownership on partnership changes and the impact which valuations can have on the situation. Accountants need to be able to explain the accounting impact of valuations. They need to be able to offer suggestions to practices well before problems arise. An example might be that a practice should make it a requirement of an incoming partner that they buy into the surgery premises. This means that all partners are ‘in the same boat’, so to speak. New, younger partners, can take a long view of the likely outcome of buying into the practice, and providing that cost or notional rent funding is relative to the borrowing costs, then taking a long view on the equity value should produce a relatively low level of risk in such an investment.
The situation at each practice needs to be considered individually and the options explained to the GPs.

## 3.9 Basis of valuation

The basis for valuation of the surgery property should be set out in the partnership agreement. It is important that a professional valuer with experience of valuing medical surgery properties is instructed to carry out valuations of the surgery property. The surgery should be valued on the basis of its use as a GP surgery. Frequently this will be a requirement of its original planning consent or a covenant on the property at acquisition, if it was purchased from a public body.

The valuer will take into account the current use of the building, the available accommodation, the site and local property values and the cost or potential notional rent value. In addition they will follow the recommendations for valuing GP surgery properties set down by their professional body. The Royal Institution of Chartered Surveyors (RICS) has long established guidelines for its members.

This will ensure that the practice would not subsequently find that they had valued the surgery property at above its market value and that property value, albeit for only a portion of the property being transferred between a retiring and an incoming partner, had been the basis of a sale. If the property had been overvalued then the retiring partner could be deemed to be selling goodwill, by the amount of the over-valuation, and this is illegal for GP practices in respect of property values.

This is why a proper professional valuation should be obtained for all occasions when any share in the property is to be bought or sold or for any other valuation exercise.

### 3.9.1 The incoming partner

We have already seen (in section 3.8) the situation which may apply when an outgoing partner leaves the practice, with the benefit of an agreement to the effect that his share of the surgery will be deemed to have been sold to him at a value based upon original cost.

On most such occasions, an outgoing partner will be replaced by a new partner who has the opportunity of buying into the surgery at the earliest convenient date. For many reasons it has been considered standard practice for such a new partner to buy direct from the outgoing partner without involving the continuing partners.

This in itself can bring about problems. The new partner may not be prepared to buy in on the same valuation as that which the outgoing partner sold. For
example he may know that the outgoing partner has been paid out on the basis of his share of the original cost of the surgery at, say, £600,000, when the current valuation is £400,000.

3.10 Premises Improvement Grants

The NHS (General Medical Services – Premises Costs) Directions 2004 include details of the Premises Improvement Grant. This covers projects which might include the improvement to practice premises in the form of building an extension, or to bring into use rooms not previously used to support the delivery of medical services, or to enlarge the existing rooms. It could also include improving physical access and any alterations or additions in respect of compliance with the Disability Discrimination Act 1995. Further examples are improving lighting, ventilation and heating installation, extending telephone facilities and providing additional car parking space. The practice could be looking to adapt the premises to provide suitable accommodation to meet the needs of children, the elderly or infirm. The project could involve improvements to the current fabric of the premises, such as the installation of double glazing, security systems or fire precautions.

The directions stipulate certain types of expenditure which would not be covered by the Premises Improvement Grant. This would be any project where work has not been subject to prior agreement with the PCO and any cost elements of the project for which tax allowance is claimed. The cost of acquiring land, existing buildings or new buildings is not covered because this is not deemed to be eligible for an improvement grant and would be considered as part of the cost rent or notional rent arrangements.

Routine repair and maintenance of premises, furniture, etc, is not considered relevant expenditure for the Premises Improvement Grant. This also applies to restoration work in respect of structural damage or deterioration. The grant does not cover work in connection with the domestic quarters or residential accommodation of the doctors or staff, even if the expenditure concerned is a direct consequence of work on the surgery accommodation which might, in itself be eligible for the improvement grant. The grant is not available for an extension which is not attached to the main building although the attachment can be by a covered passageway, and if this was the case then the project would be eligible for consideration.

Before a proposal can go forward, the PCO needs to consult the Local Medical Committee and the Valuation Office Agency and also consider generally whether the project requires support in the context of the services delivered by the practice concerned. Where the premises are held on lease or licence, then the PCO needs to ensure the practice has adequate security of tenure and will be occupying the premises for an appropriate period.
The Directions contain information on the documentation which must be presented to the PCO, which includes plans, tender information, etc.

The grant which the PCO can pay can only be between 33 per cent and 66 per cent of the cost of the project. If the PCO wishes to support the project then it will agree a project plan with the practice. This would include a payments schedule.

Where the premises are held on lease or licence then the payments are conditional on the practice guaranteeing that the premises will remain in use for at least five years for projects up to £100,000 plus VAT or at least ten years for projects costing over £100,000 plus VAT. If the premises cease to be used for NHS services before the five or ten year period is complete, then the practice will have to repay a portion of the grant.

### 3.11 Grants relating to the relocation of a practice

Where a practice agrees to locate to modern leasehold premises approved by its PCO, it can make an application to the PCO for a mortgage redemption/deficit grant. This grant will cover all or a proportion of:

- a mortgage deficit arising after owner occupied premises are sold because the actual sale proceeds of the premises are not sufficient to clear the outstanding mortgage on the property, and
- mortgage redemption fees that the contractor may incur as a result of the sale or remortgage of the property.

The PCO will not agree to cover costs in this category where any proportion of the mortgage deficit has arisen through payment holidays or reduced loan payments which have not been reflected in the cost rent reimbursement. Nor will it cover any borrowings or redemption charges which are not connected with the original purchase of the land, building works or any subsequent improvement. The PCO needs to satisfy itself that the practice has properly negotiated with the lender the extent of any deficit or redemption charges and properly explored the options for the change of use of the property and identified a suitable developer and site for the new premises.

Whilst the grant will be paid to the practice, the PCO must ensure that the payment is paid on directly to the lender and who must provide suitable evidence of this to the PCO. Where a practice agrees to relocate premises approved by its PCO but is not in receipt of a mortgage redemption/deficit grant and takes out a mortgage to cover costs of a mortgage deficit or redemption fees relating to the earlier premises, then it can apply to the PCO for financial assistance in respect
The ownership of surgeries

of this loan. The PCO has to gain the similar assurances as for the redemption/deficit grant before it can agree to make payments with regard to the loan repayments.

3.12 Guaranteed minimum sale price payments

Where a practice agrees with its PCO to relocate to modern leasehold premises and the relocation will, in the opinion of the PCO, result in an improvement of the services to be provided to the patient and the PCO and the practice have agreed a guaranteed minimum sale price for the owner-occupied premises which are being sold, then the PCO will provide to the practice financial support if the property is subsequently sold for less than the guaranteed minimum sale price. However, the sale must not have been to the practice itself or to any former or present partner or shareholder or employee in the practice, or to a family member of a present or former partner, shareholder or employee in the practice, or the employer of a family member of a present or former partner or shareholder or employee in the practice.

3.13 Grants for the costs of re-converting a former residential property

Where a practice has a proposal for re-converting practice premises which were previously the practice’s or a partner or shareholder in the practice’s owner-occupied residential property, back to residential use, and the property is no longer suitable for the delivery of modern primary medical services and the practice has agreed to move to suitable premises, then the PCO must consider any application for financial assistance in respect of the re-conversion costs.

This is likely to be a fairly unusual situation but details of the conditions applying are contained within the Directions.

3.14 Grants towards the costs of surrendering or assigning leases in vacating leasehold premises

Where a practice is moving or has moved to premises that are suitable for the delivery of modern primary medical services, it may make an application to the PCO for a grant towards the costs incurred (including legal costs) relating to the surrender of the lease or assignment of that lease in respect of the leasehold premises being vacated where those premises were considered not suitable for the delivery of modern primary medical services.
3.15 Stamp Duty Land Tax payable on agreeing a new lease

Where a practice agrees with its PCO to relocate or to occupy, in addition to its existing premises, modern leasehold practice premises approved by the PCO and the PCO considers that the result of this move will be an improvement in the range of quality and services to be delivered, then the PCO will consider an application for financial assistance in paying any Stamp Duty Land Tax (SDLT) costs incurred in establishing the lease.

3.16 Rents

Where a practice rents a surgery from a third party, ie a landlord, the rent paid will normally be reimbursed in full. However, in some cases GPs will not use the whole of the leased building for NHS purposes and in those cases a restriction will be applied so as to reflect the proportion of the rent which is not reimbursable. Where this applies, the District Valuer will visit the premises and assess the proportion qualifying for refund.

In some cases also, the District Valuer may consider the rent paid to be above the market rental value and in those cases a lower notional refund figure may be substituted. GPs do not therefore have a ‘carte blanche’ facility to pay out whatever they will in rent. The amount paid will always be based on the level of accommodation provided and market rental values.

In many cases, however, GPs will own their own surgeries. In those cases, they will receive either a notional or cost rent allowance, which are dealt with earlier in this chapter.

3.17 Rates

GPs can also claim a full refund of all rates and service/utility charges paid on behalf of their surgery, whether the building is owned or leased. This will include such items as:

- business rates;
- water rates;
- water (metered) charges;
- drainage rates;
- sewerage rates;
- collection and disposal of clinical waste, and
- utility and service charges.

Some of these items will only be paid by practices in certain areas. In some urban areas, a charge may be made by the local authority for disposal of trade
refuse. Where this occurs a refund should be claimed from the PCO. Rates will not be separately reimbursed where the rental paid includes a charge for rates.

Some practices will choose to make payments of business rates by monthly standing orders, normally by ten payments between the months of April to January inclusive. Care must be taken to ensure that these instalments are recovered on a regular basis, from the PCO.

In some areas, PCOs have agreed to make payments of this nature, normally for business and water rates, direct to the local authority or water company concerned, without any cash passing through the practice. This is attractive to practices, who do not have to concern themselves with making these payments and subsequently dealing with the claiming and receipt of refunds. However, it does mean that the accountant needs to ensure that these figures are included on both sides of the accounts, to achieve the grossing up principle. The mere fact that they are not passed physically through the accounts does not mean that they can be ignored (see 7.3.1).

There is an abatement mechanism which will apply to the reimbursement of the above expenditure where any part of the premises are occupied by any person other than the GP practice. In addition, a similar abatement applies as has been referred to in the context of the notional rent in section 3.2, where a practice has private patients or part of the property is occupied by a person who is not a public authority. Again, there is no abatement where the private income percentage is less than 10 per cent.

As with other entitlements in this area of funding, there are minimum standards required of the premises for which expenditure reimbursement claims are being made.

3.18 GPs in health centres

Those doctors practising from publicly-owned health centres, normally owned and administered by the local PCO, will find that no direct charge is made on them for rent and rates, in the sense that they do not actually pay a rent and rates charge and subsequently have to recover this from the PCO. Nevertheless, a charge is made and this is dealt with internally.

In those cases the figure for the rent and rates should be obtained and included as an item of expense and refund on both sides of the annual practice accounts. This serves the purpose of maximising expenses in case these accounts are required for production to the Review Body (see 2.4). Accountants preparing accounts for practices may encounter difficulty in obtaining such details from PCOs for inclusion in the accounts. If all else fails, the recommendation would be to include an estimate.