

# AI SMA Doctor Newsl ine

— A helpful resource for the practice business —



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Issue 19 Autumn 2012

# Hello Goodbye

## What to say 'yes' and 'no' to when your partners change



All change! GPs' succession planning and partnership changes are bringing in huge numbers of inquiries to AISMA member firms.

**Luke Bennett\*** provides essential guidance to help you through the process

Every partnership will have to consider the retirement and replacement of a partner at some stage.

For large partnerships this could be annually but smaller stable partnerships may only have to deal with this issue once every 10 years or more - and the uncertainties can give rise to anxious times for the practice manager and all the partners.

Ideally the groundwork for successful succession planning will be in place even before a retirement is planned. A well run practice will be efficient and profitable, and therefore more attractive to new potential partners.

There will be an up-to-date partnership deed in place, setting out clearly the terms on which a retiring partner will be able to leave. It will cover such issues as notice periods, how properties and assets

are to be valued, and when capital and current account balances are to be paid.

Of course, it is easier to negotiate these issues before any partner has a specific retirement date in mind.

Consider if the practice has the appropriate mix of finance being provided either by the partners or by external borrowing. If a new partner is required to introduce a large capital balance then this may reduce the pool of candidates willing to join.

Once you know a retirement is planned then you need to decide whether to replace the partner with another or use this opportunity to look at the overall practice structure and perhaps replace the doctor with a salaried GP. Or you may want to consider increasing the use of locums.

If appointing a new partner then consider the overall skill mix of the remaining partners and use this as a guide in choosing a successor. If the retiring partner was the finance partner, for example, does one of the other partners have the skills to take this on or will you want your replacement to fulfil this role?

Choosing the right person as a replacement is obviously the most important aspect. An acceptable level of clinical skills will be a 'given' for all candidates. But a partner must be willing to think beyond just the medical needs of their own patients and be prepared to take an active part in the practice's management.

GP partnerships are complicated businesses and a doctor who has no interest in these aspects should not be appointed as a partner, although they may be very suitable as a salaried GP.

The financial aspects will clearly have a bearing on whether to replace your partner with another partner or a salaried GP.

Hopefully the practice's profitability will mean that partner profit shares exceed the salary payable to a salaried GP. Appointing a salaried GP would therefore boost profits for the continuing partners. Bear in mind though that a salaried GP will be contracted to work for an agreed number of hours per week. This means that tasks the retiring partner may have carried out in the evening or weekends may have to be picked up by the continuing partners, so increasing their workload.

Do not forget to factor into your calculations the cost of employer's superannuation and National Insurance contributions. If profit shares are too low, and a salaried GP would be earning more than the partners, then a more fundamental review of the practice will be required.

For example, can the practice cope by offering fewer sessions? Perhaps replacing an eight-session partner with a six-session salaried GP might be an option, enabling a higher profit share for the remaining partners.

If a suitable successor cannot be found, then the practice will have to rely on increased use of locums. This might be acceptable in the short-term and better than making a hurried decision and appointing the wrong person. But in the longer-term this could impact adversely on patient loyalty.

Prolonged use of locums can also diminish the practice's ability to score high QOF points and maximise enhanced service income, because locums will have less interest in these areas and will inevitably introduce inconsistencies in Read coding, prescribing and referral practices.

### Practical issues

Practical issues need to be considered too. Fortunately some of these can be addressed well in advance of any partnership change:

- Is the partnership deed up to date and signed by all partners?
- Where are the title deeds to any properties held, and which doctors are listed on the title deeds? If this has not been kept up to date, it may be necessary to contact retired partners to get their names removed from the deeds.
- Ensure there is clarity over the profit share being offered. Will the new partner have to work up to a parity share over a period of years? What percentage of a full partner share is to be offered during this period?
- What terms are being agreed for holiday, sickness, maternity and paternity leave?
- Is locum insurance in place, and whose responsibility is it to pay for this?
- Check that appropriate professional indemnity cover is in place.
- Will the partner be required to buy a share in the property, and if so at what time?
- What level of monthly drawings will be paid to the new partner? Is he/she responsible for paying their own income tax, or will this be paid for by the practice?
- When will the retiring partner be paid his capital and current account balances? If capital is payable to a retiring partner before a new partner has to introduce capital, how is this going to be funded in the interim?
- Is interest going to be paid to the retiring partner, and if so at what rate?
- Will the retiring partner keep a share of the notional rent until the sale of his property share is completed?
- Is there a danger that after the partner has retired the practice will have to pay balancing superannuation contributions, or repay seniority to the PCT? It may be necessary to estimate any sums owing and deduct this on an interim basis from any settlement due until the position can be finalised.
- Update all stationery, websites and other public material to reflect the partner changes.
- If the practice is VAT registered, it will be necessary to notify HM Revenue and Customs within 30 days of any change in partners.

Finally, remember to make use of your professional advisors. Your practice may not have had to deal with a partner change in recent years - but your accountants and solicitors should be very familiar with these issues, so make use of their expertise.

## OPINION

# Change is possible but do not forget the funding

Seamus Dawson, committee member, AISMA

The Royal College of General Practitioners recently launched a major consultation on the future of general practice across the UK. It aims to reach agreement on a vision of the future of general practice and the steps needed to provide better care for patients and a healthier population.

Suggestions made in the consultation include how general practice might operate in the future and how GPs can develop their skills, take on new roles and, most interestingly, work differently.

Rightly, the paper states that additional investment will be needed. However at this stage there is no attempt to quantify the level required or identify where this additional money will come from.

The question of funding is surely paramount to the future of general practice. Can GPs continue to provide an increasingly demanding service without additional finance?

From our discussions with GPs it is clear they are working longer hours, providing additional services and dealing with increased patient demand. All this while facing more criticism from politicians, the media and the public (complaints up 23% last year) and consistent reductions in primary care funding.

The RCGP paper seems to be stating that more of the same is anticipated over the next ten years. I can hear GPs asking: 'How can we continue to deliver if funding does not increase?'

In recent years GPs have consistently taken up the challenges thrown down by the Government to provide additional services as their core funding is steadily reduced. Most of these GPs, I have no doubt, will continue to adapt to changes in general practice but can we expect them to continue to do so without addressing the issue of funding?

The RCGP consultation suggests GPs will need to develop new ways of working together and discusses the formation of federations and the opportunities presented through commissioning. Broadening this discussion is to be welcomed as within this area there exist opportunities for GPs to reduce costs and/or open up new income streams.

A number of GPs and practices across the UK have already made advances in working together, and a number of successful federations exist. But a great majority of GPs are still working as independent practices looking to deliver more and more services to an increasingly demanding population.

The RCGP vision could assist these practices by including short term achievable goals and a series of stepping stones to assist them in working towards mutual goals and aims.

General practice, like most aspects of society, is evolving quickly. Remember the first iPhone was introduced only five years ago and has already had a significant impact on how we communicate and lead our lives. It is clear that we cannot underestimate the changes that general practice will continue to go through over the next ten years.

The RCGP is correct in calling for more training for both future and current GPs to help them maintain and improve the service they deliver and adapt to the changes ahead.

For GPs and those advising them the challenge is to embrace these changes and the opportunities they present. As Spencer Johnson in his book *Who Moved my Cheese?* stated: 'A change can lead to something worse or something better. How you react to it makes it worse or better for you.'

**AISMA Doctor Newsline** is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.  
www.aisma.org.uk

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# The top **legal** issues GPs ask about

Lawyer **Alison Oliver** considers the first five of the top 10 most common legal questions raised by GPs

## **1** We are thinking of merging with another practice: how should we go about it?

Lots of practices are thinking of merging to achieve greater economies of scale and increase the range of services they can offer patients.

The first step is to identify practices with a similar vision and culture who might be likely merger candidates. The next step is to agree heads of

terms, such as what services will be provided, what premises arrangements will be made for the merged practice, and how workload and profits will be shared. These heads of terms provide a framework for detailed negotiations.

We advise speaking to a solicitor at least six months before your anticipated merger date to ensure that all the necessary preparatory work can be done in time. PCT consent is needed to unify the



NHS contracts of the merging practices and this may prompt an attempt to re-negotiate other terms.

However, even if PCT consent to a unified contract is not forthcoming, practices may be able to merge at an operational level and continue to operate separate contracts. Documentation is needed to set out the terms of the merger process and of the merged partnership.

## 2 I am a single-handed GP: can I take 24 hour retirement?

The NHS Pension Scheme allows GPs to retire for a minimum of 24 hours in order to trigger pension payments and then return to work. A single-handed contractor will need to recruit a partner to hold the practice contract for the period that he is retired otherwise the contract will terminate.

In the case of a GMS contract, regulatory notice requirements must be strictly observed when the new partner joins, when the incumbent retires and rejoins, and then - unless it is agreed that the new partner will stay on - again when the new partner leaves. In the case of a PMS agreement, the PCT's consent is needed to vary the agreement at each stage.

A partnership agreement is needed. The amount of detail this contains will depend on whether the partnership is temporary to facilitate the 24 hour retirement only, or a longer term arrangement whereby the new partner stays on to assist with the running of the practice.

## 3 Our senior partner is 65/70: can we force him to retire?

A compulsory retirement age constitutes direct age discrimination but may be justified provided that it serves a legitimate aim and provided that it is a proportionate means of achieving that aim.

For example, the aim of achieving a balanced workforce by providing partnership promotion opportunities for younger GPs may be potentially legitimate. However, if a practice has no difficulty in recruiting younger GPs, or if younger GPs show no interest in being promoted to partner, the compulsory retirement age may not be proportionate in the circumstances.

Practices should seek legal advice before including a compulsory retirement age in their partnership agreement and before seeking to enforce it, in order to avoid a costly discrimination claim.

## 4 We want to set up a clinic to provide flu vaccines/minor surgery/weight loss support/etc privately. What issues should we consider?

NHS practices are not permitted to accept payment from their NHS patients for treatment provided privately, except in the limited circumstances set out in the GMS/PMS Regulations. They can, however, provide private services to people who are not their NHS patients.

Practices providing services privately often set up a separate organisation to do this, sometimes in collaboration with other practices. Where private services are provided by a separate organisation, the rules on acceptance of fees from the practice's NHS patients could still apply and advice should be sought in order to avoid breaching the practice's NHS contract.

If the practice premises are used for providing private services, reimbursement of premises costs by the PCT may be abated if private income exceeds 10% of overall income.

Individual GPs must always act in their patients' best interests and inform patients if they have an interest in an organisation to which they are referring.

## 5 What happens if we do not register with the Care Quality Commission by the April 2013 deadline?

All GP practices must register with the CQC by April 2013. After that date, it will be a criminal offence for a practice to carry out a regulated activity without being registered.

The offence is punishable by, on summary conviction, a maximum fine of £50,000 and/or imprisonment of up to six months, and on conviction on indictment, an unlimited fine and/or imprisonment of up to 12 months. The CQC also has the power to shut down a provider.

*Alison Oliver, an associate in Ward Hadaway's healthcare practices team, specialises in GP partnership and contractual matters*

**See the rest of the top 10 legal issues in AISMA Doctor Newsline's next issue in January 2013**



# Say no to practice meetingszzzzzz

Putting a bit more effort into holding effective practice meetings will reap dividends.

**Dr Chris Hewitt** shows how

As a GP, you need to be good at working independently. After all, you spend much of your time in a consulting room with a succession of patients, not a hospital department or an open-plan office. But this does not mean working in isolation.

There are so many developments and decisions to be made in primary care – budgets, staffing, new services, protocols and procedures – that it is important to have a forum to meet colleagues and focus on the strategic direction of your practice.

But if your meetings are not effectively run – or worse do not happen at all – it is easy to feel detached from decision-making and for practice relationships to become fractured.

The following tips should help you ensure your practice meetings are not a frustrating waste of time.

## Strictly business

It is a good idea to hold a more formal practice meeting at least once each month to discuss administrative, management and partnership matters so everyone has an opportunity to contribute. I recommend clinical issues, such as patient complaints and adverse incidents, are addressed during a separate meeting.

## The right time

This can be tricky: meetings before surgery have some advantages in that people are fresh and likely to arrive on time but it may interfere with school runs; after surgery, people are naturally keen to get home which means they may find it difficult to focus during the meeting.

The best solution is often to have some protected time during the day when a locum or assistant can provide cover.

While it may be an unwelcome intrusion into personal time, evenings or weekends might be a good



time for discussions when distractions need to be kept to a minimum – such as recruiting a new team member, discussing the partnership agreement or practice accounts.

It is tactful to acknowledge that a particular time is unlikely to be equally convenient for everyone and to rotate the scheduling of meetings so any inconvenience is fairly shared. A regular meeting always timed on one partner's half day, for example, is likely to cause ill-feeling.

## Follow an agenda

A nominated person (usually the practice manager) should ensure the minutes from previous meetings are circulated a week in advance and request agenda items at the same time.

In my experience meetings with lengthy agendas which take more than an hour to get through bring diminishing returns. It is important to prioritise the agenda items and to allocate sufficient time for important or complex matters, although if you suspect an agenda item is likely to be particularly contentious it may be better to arrange for this to be addressed in a separate meeting involving only the relevant parties.

**Have a chair**

Having someone to chair a meeting should ensure it is run efficiently and its objectives are achieved. Chairing is a particular skill (courses are available) which requires you to recognise when someone wishes to contribute; when to intervene to keep the discussion on topic; and most importantly, to be a good time-keeper.

It is a good idea to agree in advance who is the best person to chair a particular meeting, or rotate the chair.

**Take notes, agree actions**

Minutes and action points should be recorded by an experienced note-taker. Where discussion has been lively, it can also be helpful to review contemporaneously-made notes during the meeting to ensure there is consensus about what has just been agreed.

Where an action point is agreed, the notes should record this, as well as the person nominated for the task and someone to check it is done by a realistic deadline, and the time and resources allocated.

This will make it more likely that action is taken and there is a fair distribution of workload.

**Troubleshoot**

Practice meetings can sometimes be challenging as they can highlight different ways of working, clashing leadership styles and interpersonal issues within a practice.

Formal meetings with agreed rules of engagement (such as no swearing or interrupting the person speaking) and strong effective chairing go a long way to managing this but if your practice meetings repeatedly degenerate into bickering then this may indicate the need for mediation.

Local BMA and LMC offices can usually recommend good independent mediators - this is often worth the investment to avoid the time and costs to all parties of ineffective meetings and poor decision-making.

Regrettably, the common default 'solution' in many dysfunctional practices is to avoid meetings as much as possible and to make important decisions outside of meetings, ensuring a difficult situation becomes steadily worse.

*Dr Chris Hewitt is a practising GP and has worked in associate medical director and medical director roles at PCTs. He is an associate with Healthcare Performance which specialises in careers coaching, professional development and organisational trouble-shooting within the healthcare sector. ([www.healthcareperformance.co.uk](http://www.healthcareperformance.co.uk))*

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# Empower your practice with online business

The NHS spends a fortune on consultancy – but there are many areas where smart GPs and practice managers can ensure they keep the cost of specialist advice to a minimum, says **Kathie Applebee**

There is a booming market in business advisors, including a number tailored to meet the specific needs of general practice.

As each practice's requirements will be unique, only you can judge whether or not such services will be useful and good value for money.

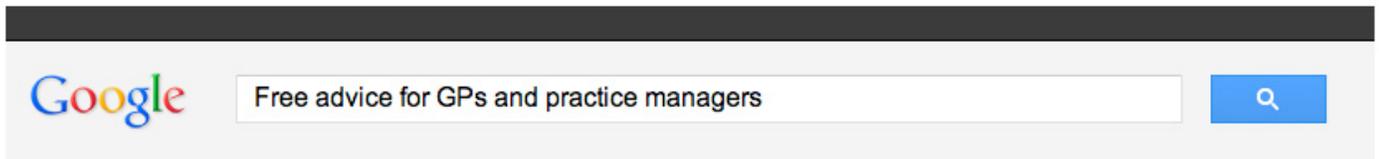
But before signing up it is worth exploring what is on offer either free of charge or as part of organisational membership with wider benefits.

**Human resources (HR)**

Employment law is an area of concern for many employers and HR is the science of keeping on the right side of it.

A sound understanding of both not only reduces your liability for tribunal claims but should enable you to be confident in your dealings with employees whose standards do not meet your reasonable requirements.

It is possible to insure your practice against tribu-



Search

About 2,560,000 results

nals but these policies can be expensive and the small print needs extremely detailed scrutiny for the opt-out clauses.

Prevention is always the best form of cure and experts in this field reckon that a significant number of lost cases at tribunal are due to incorrect procedures: that is, how you approached the employee issue rather than what you actually did.

You can discipline and/or dismiss employees but you have to demonstrate that it was fair and done in accordance with best practice.

ACAS ([www.acas.org.uk](http://www.acas.org.uk)), the Advisory, Conciliation and Arbitration Service, is an excellent source of advice with a free helpline and a wide range of documentation to download and use.

For example, the ACAS Model Workplace interactive tool provides feedback on your adherence to sound employment practice. ACAS also offers good value training and an arbitration service, and provides the standards against which tribunals will measure your procedures.

Personal membership of a professional organisation such as the CIPD (The Chartered Institute of Personnel and Development) is another way of obtaining master documentation, protocols and advice as well as contributing to your defence by providing evidence of your knowledge of approved practice ([www.cipd.co.uk](http://www.cipd.co.uk)).

## Health and safety

As with ACAS, the Health and Safety Executive website ([www.hse.gov.uk](http://www.hse.gov.uk)) is the gold standard for obtaining all the key information about your business liabilities and required actions.

It is easy to use and provides a range of advice on areas such as your duty to manage asbestos<sup>i</sup> and legionella<sup>ii</sup>.

Much of health and safety is simply common sense and the need for risk assessments is covered here as well as on sites such as Business Link, the latter having a very comprehensive and clearly laid-out format<sup>iii</sup>. The latter also provides a link to the British Standards Institution website which provides details of the various business charter marks for which you can apply<sup>iv</sup>.

## CQC

The Care Quality Commission is a hot topic in general practice, with scary rumours abounding. Stick to the CQC website (for example, it offers a practice meetings' checklist<sup>v</sup>) for the core requirements and use the BMA guidance to interpret and implement this<sup>vi</sup>.

## Legal advice

Every practice needs a legal advisor at times but this is usually for specialist needs rather than general ones.

For the latter, web sites such as the Crown Prosecution Service offer useful advice on matters such as corporate and vicarious liability<sup>vii</sup>.

The BMA provides specialist information on GP contracts and partnerships while the RCGP also provides a range of useful advice: for example, on practice federations<sup>viii</sup>. For practice computer issues, turn to the user group for your chosen IT system.

Sources described here are either funded by the Government or are professional bodies which operate on behalf of their members. Although they may have commercial arms and activities, their advice is not only specialist and independent but also at the heart of the subject.

Taking second-hand advice from commercial suppliers may be appropriate when you feel that you have exhausted all other sources but, with so much expert help readily available, it need never be the first or only option.

*i.* <http://www.hse.gov.uk/asbestos/campaign/duty.htm>

*ii.* <http://www.hse.gov.uk/healthservices/legionella.htm>

*iii.* <http://www.businesslink.gov.uk/bdotg/action/layer?topicId=1073858799>

*iv.* <http://shop.bsigroup.com/BusinessLinks/BusinessLinkLP/>

*v.* <http://www.cqc.org.uk/register/find-out-more-about-registration-process#resources>

*vi.* <http://bma.org.uk/practical-support-at-work/doctors-as-managers/managing-your-practice/cqc-registration>

*vii.* [http://www.cps.gov.uk/legal/a\\_to\\_c/corporate\\_prosecutions/#a06](http://www.cps.gov.uk/legal/a_to_c/corporate_prosecutions/#a06)

*viii.* <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/primary-care-federations-toolkit.aspx>