

AIMSA Doctor Newsline

A helpful resource for the practice business



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Issue 31 Autumn 2015

Get your winter plans wrapped up early

With the days getting ever shorter, **Kathie Applebee** sets out a practice management survival plan to see you through the winter



As autumn segues into winter, there is a series of preparations to be made for running a practice during the dark and cold weather.

Many practices are struggling with capacity and staffing levels and there may be little scope for winter pressure adjustments.

However, as these are almost inevitably going to be needed, plans should be made for changing how to deal with rising demand for acute appointments and home visits.

Acute needs

Deferring non-urgent work raises the obvious issue of it still needing to be dealt with at a future date. While this is a significant problem, it is better to have patients complaining about lack of routine services than practice members toppling due to exhaustion.

Losing any team members to ill health at times of high demand is to be avoided at all costs, and these costs need to be calculated so that adequate risk assessments can be made.



For example, if the practice defers all IUCD fittings, minor surgery and other similar time-consuming advance bookings, it will lose income.

This has to be mapped against the costs of additional workload and the associated risks (such as errors and staff illness), and the funding of locums, assuming that the latter are available and are felt to provide good value for money.

Locums need to be used wisely, with on-the-day bookings and acute clinics the obvious settings for many practices.

Doing routine consultations with unfamiliar patients risks people returning at a later date to see the permanent GP and nurses. And it may also result in QOF reminders not being picked up and resolved if the practice systems are unfamiliar to temporary clinicians.

Review systems

Existing practice systems will need to be adapted to manage additional visiting workloads. If geographic visiting is not the norm, it should be considered, as well as nursing and care home rounds.

Autumn meetings with the staff at the latter institutions may help to ensure maximum understanding and compliance, and early calls regarding concerns rather than late afternoon exacerbations.

To help avoid practice team illness during this period, pursue an internal 'flu jab campaign and review infection control procedures throughout the practice.

It is worth reminding team members that hand disinfectant gels are usually only effective against bacterial infections, and that soap and hot water is needed at regular intervals for non-clinical staff as they move about the building. Receptionists should be cautioned against sharing pens, for example, and be encouraged to use gloves where appropriate.

Keep patients informed about pressures and staffing levels, and meet with the Patient Participation Group to enlist their help with such communications.

If the practice faces being overwhelmed, it needs to convey this to patients rather than simply struggling on, trying, and possibly failing, to provide a normal service.

Agree forms of wording, both verbal and written, which enable regret to be expressed but not apologising as such - practice members should not have to apologise for being unable to provide a routine service in abnormal conditions.

Infrastructure preparation

In addition to people issues, the infrastructure also requires attention. Heating systems should be serviced and emergency equipment, such as grit for pathways, ordered.

Procedures and rotas for grit spreading will also be required - it won't spread itself! Get external lights checked and gutters cleared, and check that summer growth has not caused trees to interfere with overhead cables.

Much ordering is now done on an immediate need basis so consider whether to increase stock levels of essential items to allow for delivery disruption.

Bad weather will also cause difficulties for staff in reaching the practice, and disrupt or delay home visits, and rural practices should do vehicle inventories so that those with 4x4 vehicles might help those without.

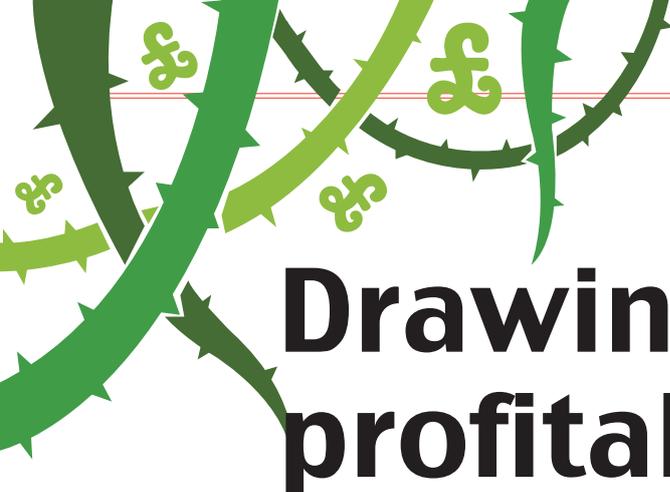
Note that staff providing transport for colleagues should notify their insurance companies in advance.

If the weather is benign until the spring, you will have wasted a couple of hours on unused plans. But planning is seldom wasted and it will help reduce the impact of a severe cold snap.

And as winter will be back after next autumn, your plans can be all wrapped up and recycled for 2016-2017.

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Kathie Applebee, organisation psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice



Drawing lessons from profitability's well

Ouch! The thorny issue of drawings – or lack of them – raises a lot of concerns among GPs. **Keith Taylor*** gets to grips with some of the key factors

GP practices often struggle to cope with the calculation of regular drawings for their partners.

What you take out can be affected by a variety of factors, some under practice control and others subject to external constraints.

For instance:

- the practice may change the profit-sharing arrangements
- the partners may alter the number of sessions they do
- there may be a need for capital expenditure
- partners may leave and join, and
- there may be unexpected clawbacks of practice income.
- Or the Local Area Team may delay the payment for enhanced services and other income streams and there can be times when there are significant lumps of income or expenditure.

Irrespective of how you attempt to calculate partners' drawings there is fortunately a clear fail-safe. If the bank balance is significantly deteriorating then you may have overset drawings whereas if it is significantly increasing you may have under-calculated them.

Given that drawings are payments on account of annual earnings, the starting point must be the preparation of a profit forecast.

To do this, every line of the most recent profit and loss account must be examined to forecast what is likely to happen in the following year. For example new or phased out DESs and other issues have to be considered such as:

- Are there the skills to provide more lucrative services?
- Can you get involved in 'providing' either by your-

selves or in collaboration with other practices?

- Are you performing work that should be delegated to other members of the staff team?
- Can you create time to supplement your income with outside work or with new income streams?
- How will any contract changes affect you?

In a similar vein you should review all of your expenditure and determine what is likely to increase and what cost savings you can make.

For the purpose of illustration, let us assume that this exercise has been performed for a three partner practice and the profit forecast for the coming year is £360,000.

The next stage is to consider how the £360,000 is to be allocated among the partners, and in this respect you need to consider if there will be any partnership changes during the year or whether the profit sharing arrangements might change due to, say, a change in sessions.

If there is to be a partnership change, will a new partner 'buy-in' - and what does the Partnership Deed say about paying out a leaving partner?

Prior shares and charges have to be taken into account so that if, for example, seniority is drawn individually, this is reflected in the calculation of monthly drawings.

For the purpose of our illustration let us assume that seniority is prior shared and drawn by the individual partners, being £10,000, £8,000 and £5,000 respectively.

Traditionally the partners will have left behind earnings not drawn in order to finance the working capital of the practice. It is now necessary to consider whether this amount retained is sufficient for the forthcoming year.

To do this you must review the drug stock held, consider the time delays for receiving QOF or enhanced services, and review your policy as regards

the timing of payments to practice suppliers.

For the purpose of our illustration, let us assume that the figure arrived at is £21,000 - but bear in mind that this figure can vary from practice to practice.

In our example, assuming that the partners share profits equally, each partner could draw the excess of his or her balance on Current Account over £7,000 by way of what we can call an equalisation drawings.

There are other items that now need to be taken into account, which are liabilities that are not deemed to be practice expenses but personal to the partners, such as employee superannuation contributions and mortgage capital repayments.

Some practices still pay the income tax liabilities of the partners and it is at this stage these liabilities have to be provided for.

Again for the purpose of illustration let us assume that our example practice does not provide for the partners' income tax, repays £15,000 of the mortgage and pays the partners' employees superannuation contributions of £13,000, £12,700 and £12,300 respectively.

We are now in a position to calculate the partners' drawings as shown in the box below.

The conservative approach is to round down the figures shown and then divide by 12 to arrive at the monthly draw.

More prudent practices may decide to draw a lower amount. One might set the monthly drawings at £7,500 so that each partner draws £90,000 in the year, leaving the balance to be paid out when the accounts are prepared and the profitability confirmed. Hopefully, this might deal with any unexpected decline in profitability.

Had Dr C in the example been a new partner with a nil balance on his or her current account at the beginning of the year then he or she either puts £7,000 into the practice in order to buy-in, or restricts monthly drawings by say, £600 a month to achieve the same result. This would enable a leaving partner to be paid out.

Many practices wonder how they are going to manage to preserve drawings in the future.

As all of the above demonstrates, the simple answer is to maintain or improve profitability.

Drawings are just payments on account of profits earned and therefore all effort needs to be directed to the profitability of the practice.

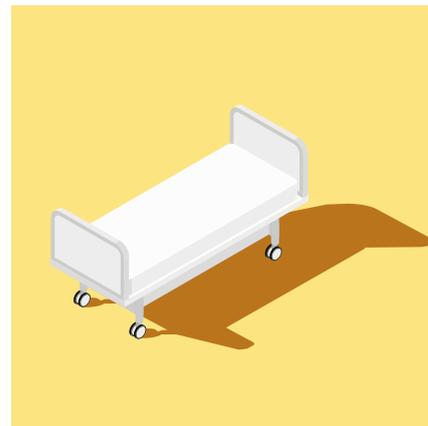
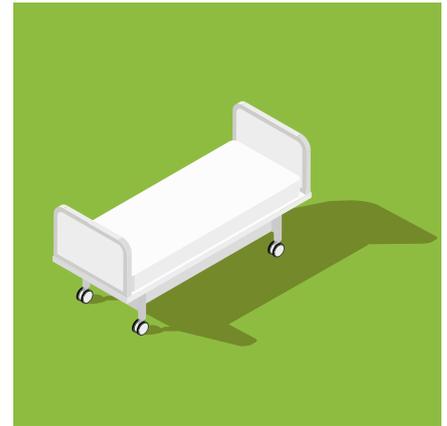
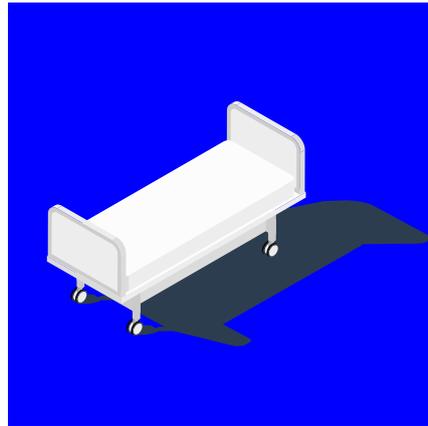
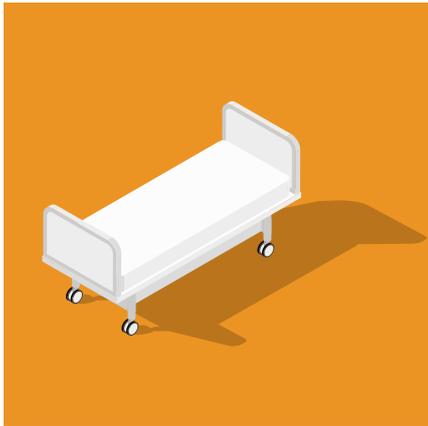
At the same time, the cash flow of the practice, particularly the timing of income and expenditure, needs to be controlled.

Remember that at the end of the day the bank balance will be the guide to whether you have properly set the correct level of drawings.

	Dr A £	Dr B £	Dr C £	Total £
Retained on current account at the beginning of the year	8,032	7,934	8,245	24,211
Forecast profit for coming year	122,333	120,333	117,334	360,000
(A)	130,365	128,267	125,579	384,211
Less:				
Seniority drawn	10,000	8,000	5,000	23,000
Retained for working capital	7,000	7,000	7,000	21,000
Equalisation drawings	1,032	934	1,245	3,211
Loan repayments	5,000	5,000	5,000	15,000
Employee Superannuation contributions	13,000	12,700	12,300	38,000
(B)	36,032	33,634	30,545	100,211
Amount available for drawings (A) – (B)	94,333	94,633	95,034	284,000

New models of care

The *NHS Five Year Forward View* outlines a number of proposed new models of care. **Alison Oliver** looks at the different models and what they might mean for general practices



A central theme of the *NHS Five Year Forward View* ('Forward View') is that the traditional divide between primary care, community services and hospitals is a barrier to the personalised and coordinated health services that patients need.

In an effort to break down these boundaries and also achieve greater integration between health services, social care and mental health services, the document published last year proposes a number of 'new models of care'.

These are:

- Primary and Acute Care Systems (PACS)
- Multispecialty Community Providers (MCPs)
- Urgent and emergency care networks
- Viable smaller hospitals
- Specialised care
- Modern maternity services, and
- Enhanced health in care homes

These new models are currently being piloted at a number of 'vanguard sites' around the country. The models that are likely to have the most direct impact on and relevance to general practice are the PACS and MCP models (see boxes on pages 6 and 7).

The PACS model perhaps represents more of a potential threat to general practice, enabling other providers, such as Foundation Trusts, to deliver list-based services, including GP services.

The MCP model clearly envisages general practices playing a lead role in the provision of more integrated out of hospital care, either on their own, as part of GP federations or networks, or in partnership with others.

Legal considerations

There are various legal considerations for practices

to consider if embarking on involvement in new models of care. These include:

Relations with other parties

Who will the practice be working with and on what basis? Are the parties jointly responsible for delivering the care model or is there a lead party? Is the practice involved in its own right or through a GP federation or network? How will decisions be made? The respective rights and responsibilities of the parties should be clearly documented.

Organisational forms

There are various forms that collaboration between parties involved in delivering the models might take. These range from informal collaboration between organisations through to corporate joint ventures or full organisational mergers. Advice should be sought on the most appropriate organisational form for the project.

Contractual considerations

Under what form of contract will care be delivered? Will all the parties be jointly responsible for delivering care under an alliance contract, or will there be a lead contractor who sub-contracts different elements of the service to the other parties (prime contract)?

Is the contract compatible with the practice's GMS/PMS contract or will the practice be expected to relinquish its GMS/PMS contract? Advice should be taken on contract terms.

Premises

Will the new care model be delivered from existing premises of the parties or will new premises be developed or acquired? Will premises be transferred into the common ownership of a merged organisation or remain within the control of the practice?

If the practice's premises will be used for delivering new services, is the consent of a third party landlord or mortgagee needed, and will this affect the practice's entitlement to reimbursement under the Premises Costs Directions?

Do any new services being delivered from the premises fall within the permitted use of the surgery?

If using other parties' premises, you will need to ensure that the premises are fit for purpose and that you acquire the rights of occupation that you need in order to fulfil your contractual obligations.

Staffing

Staffing requirements will need to be identified and consideration given to how existing staff of the parties will be utilised.

PACS

This model allows single organisations to provide list-based GP and hospital services, together with mental health and community care services. Features include:

- Hospitals, in some circumstances (such as urban communities where general practice is under strain), being permitted to open GP surgeries with registered lists
- In a more extreme form, PACS being accountable for all the health needs of a registered list of patients

Examples of vanguard sites testing this model include:

- Northumberland Accountable Care Organisation – made up of lead partner, Northumbria Healthcare NHS Foundation Trust together with the CCG, Healthwatch, County Council, GP practices, Northumberland Tyne and Wear NHS Foundation Trust and North East Ambulance Service. The partners will work together to ensure that patient care is better coordinated and increasingly delivered in community settings. A key feature will be extended access to GPs so as to reduce emergency admissions.
- Salford Together – made up of a CCG, City Council and two foundation trusts, with support and engagement from a local GP provider consortium. The aim is to create an integrated care organisation to provide more coordinated health and care services under the leadership of Salford Royal NHS Foundation Trust.

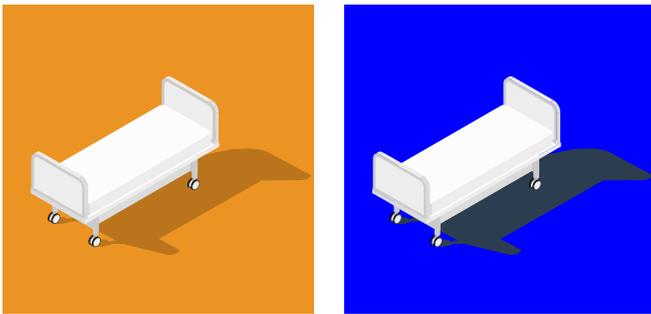
Advice should be sought to ensure compliance with the Transfer of Undertaking (Protection of Employment) Regulations and particular care must be taken if changing staff terms and conditions, seconding or sharing staff or making staff redundant.

Consideration should be given to ensuring access to the NHS Pension Scheme for staff, particularly those staff who are already members.

Integration of systems

Consideration should be given to how the policies, procedures and systems of the parties can be integrated to the extent necessary to enable the parties to deliver their obligations.

Particular consideration should be given to storing and accessing patient records with due regard to data protection and patient confidentiality obligations.



Clinical governance and liability

It will be important to put in place good systems of clinical governance and agree with other parties how obligations and liabilities will be apportioned.

CQC and other regulatory requirements

Consideration must be given to any changes that might be needed to CQC and other registrations to reflect participation in the new model.

Consultation/engagement

Where there are material changes in the way that services are delivered, parties should consider whether they are under an obligation to consult with stakeholders.

Merger control

Some forms of collaboration might be considered a merger which is subject to scrutiny by the Competition and Markets Authority (CMA). Advice should be taken at an early stage as to whether it is necessary to notify the CMA.

Competition law

Certain types of collaboration – including, for example, sharing commercially sensitive information – might breach competition rules and, again, advice should be sought.

Termination

In what circumstances might parties be able to terminate the arrangement, voluntarily cease to participate or be forced to leave the arrangement? What provisions apply in these circumstances?

The above are just some of the matters that should be considered if embarking on a venture of this type.

Alison Oliver is an associate solicitor with top 100 law firm Ward Hadaway. She has eight years' experience of advising GP practices on a range of legal issues, including partnership agreements and disputes, contractual matters and federating.

GP Federation Showcase

Ward Hadaway, together with AISMA members BW Medical Accountants and Scott McKenzie are hosting a showcase for GP federations and practices on 15 October 2015. The event, at Manchester Town Hall, is being chaired by Dr James Kingsland. Representatives from federations around the country (including a federation involved in one of the vanguard sites) will share their experiences. For more information or to book a place, go to <https://www.wardhadaway.com/events/national-gp-federation-showcase-2015/>

This briefing is for general guidance only. It represents our understanding of English Law and practice as at September 2015, but is not intended to be a comprehensive statement of the law. Readers are advised to seek special guidance from Ward Hadaway.

MCPs

This model envisages 'extended group practices' forming as federations, networks or single organisations to offer a wider range of care to registered patients. Features of this model might include larger group practices:

- Taking on delegated responsibility for managing the health service budget for registered patients
- Employing (or taking on as partners) consultants, nurses, therapists, pharmacists, psychologists, social workers and other staff
- Shifting a larger volume of outpatient services and ambulatory care into community settings.

Examples of vanguard sites testing this model include:

- Erewash MCP – a joint application was made by two foundation trusts, a GP provider company, an out-of-hours and 111 provider and a CCG. The MCP will focus on extending access to GP services, care planning for people with long term conditions and delivering services to people who can be treated for their conditions in a community setting.
- Vitality Partnership – a single GP 'super-practice' will expand the range of social, mental, community, enhanced and secondary care services on offer to patients by delivering community outpatient and diagnostic services from a number of primary care centres.

OPINION

Use your AISMA lifeline in these tough financial waters

Chris Howe, committee member, AISMA

‘Stability was practically assured’ - Aldous Huxley, Brave New World. Stability - the condition of being reliable or unlikely to change suddenly or greatly.

But two events recently were a forceful reminder that our world does not remain unchanged. The Chinese stock market crash, for instance, sent financial shock waves around the globe, and I recently watched a documentary on the Nepalese earthquake demonstrating nature’s power to destroy.

Looking back there have been several periods where GPs’ financial lives could be said to have been stable. However we do not appear to be in one at present.

GPs strive to give patients the impression of stability while behind the scenes someone is pulling the rug away from under their feet.

Last year GMS practices benefitting from the ‘correction factor’ saw the start of its removal. This year we see waves of PMS practices being reviewed with many losing significant amounts of income.

This income is to be recycled, but individual practices are never sure how much they might recover.

Sources of income have also multiplied with practices having to chase up payments from various providers and cope with the resulting cash-flow difficulties.

Of course in an ideal world, the perfect can plan for these changes and amend systems to cope with them. But when resources are already stretched it is not so easy.

Reduction of income exacerbates recruitment problems when the small pool of potential GP partners avoid practices where profits are under pressure.

This is worsened by the tide of older partners retiring perhaps earlier than in the past, prompted by work pressure and changes to the pension scheme and its taxation.

Recruiting salaried GPs as replacements is a popular option, but this then raises the working capital requirement for the ongoing smaller partner team.

Practices caught by too much of this instability may worry about their viability and consider merging with local colleagues. This is not easy and will require much work behind the scenes from an already busy team.

The Chinese stock market is said to have been fuelled by borrowed money, and hence the fallout, when it happens is large. Fortunately most GPs are prudent in their financial management, shying away from overdraft and borrowing unless it is absolutely necessary. Taking drawings prudently also helps to cushion financial shocks.

We see that GPs are having a very busy time at the moment keeping their ‘ship’ stable. Their AISMA accountants will be by their side as required to advise how to manage their finances through these rough seas.

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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Successful succession

....needs smart planning to help you out and ease the new generation in. **James Gransby**** has some useful tips



Succession. A number of people or things of a similar kind following one after the other.

This Oxford English Dictionary definition of succession seemed so appropriate that I thought it would make a good starting point.

The succession I am considering here is that of a GP who, having served the community for many years, now finds it time to hand their patients to a new custodian.

With careful preparation and planning, succession can not only be a means of exit but also a great opportunity for the next generation of GPs.

Succession takes many forms

The many different routes include:

1 Passing the contract on to another GP partner

Whether this is a single hander entering into partnership for the first time to effect an exit, or a GP partner relinquishing their partnership share, this is the familiar route, historically.

2 Merger

Figures released by NHS England under a freedom of information request suggest that practice mergers are becoming much more prevalent now.

This appears to be the way the Government intended, delivery of primary care at scale. Given the right ingredients, a merger can be a good option for many in the current environment.

Nationwide there are a number of GP practices consolidating and many GPs will be familiar with those acquisitive practices operating in their area.

3 Passing the contract to a private specialist company

The most notable here is Virgin Care. Once the move has been made to migrate from the GP partnership model there appears to be no easy route back in the future. Usually this option is considered if the first two options have been exhausted.

The above three options, structured appropriately, could enable the exiting partner an opportunity to

continue performing sessions on a reduced basis if this was desirable.

4 Allowing the contract to lapse (ie a single hander)

This would lead to either a dispersal of the patients to neighbouring practices, or the contract may go out to tender. This is usually the least desirable option and may even lead to a large redundancy figure to settle by the outgoing GP.

Exodus meets recruitment crisis

A BMA survey from April 2015, sampling 15,560 GPs, showed that one third of GPs are considering retirement in the next five years and one fifth of new trainees are heading abroad.

A glut of retiring partners looking to recruit from a smaller pool of potential successors means that only the most attractive of practices will be considered suitable to the next generation.

A new partner will need to be convinced that becoming a partner at your practice is a good idea.

Some considerations to incoming partners would include the patient list (size and demography), how solid the organisation is from an administration and clinical perspective (for example how many QOF points it is achieving), perhaps the age and condition of the building and certainly the profitability of the practice.

Other factors which make a practice more attractive, such as modern computer systems and perhaps the ability to offer flexible working hours during the changeover, could be the difference between finding a successor or not.

On the profitability front, taking note of the benchmarking available to AISMA accountants and taking action to remedy any profitability issues will be of utmost importance.

Incoming partners will need to be shown the opportunities for them, looking further than just the extra responsibilities and loss of employment security (or locum flexibility).

They will need to be shown that as a GP partner there is also influence over the organisational and clinical direction of the practice in a way that is not achievable without being a partner, coupled with the ability to increase earnings at the right practice.

GMS vs PMS contracts

It is important to recognise the differences each contract brings when it comes to passing on the contract.

Taking single handers first, it is currently the case that a single hander holding a GMS contract has the automatic right to take on an additional partner.

They still need to give 28 days notice to NHS England who will need to confirm the suitability, in writing, of the incoming partner. This is not usually an issue if the new partner is on the performers list and not subject to any sanctions.

A suitably drafted partnership agreement will be of utmost importance to set out the basis on which the contract is to be handed over, and to what timescale.

This is different for a single hander holding a PMS contract as the taking on of a new partner is deemed to be a variation of the contract, the PCO would need to approve the change and they are not obliged to agree to it. Working with the appropriate LMC is therefore imperative in this case.

Any retirement by a GP should be notified to NHS England with three months' notice in the case of a GMS contract, and up to six months for PMS.

If there is an existing partnership, whether GMS or PMS, the partnership agreement is a very powerful document when a partner retires.

It will determine the necessary notice period and what happens in other areas such as the distribution (or recovery) of a partner's capital account balance. It should also cover what happens in the event of a clawback of seniority for a GP if this occurs after retirement.

Action points

- Plan ahead - perhaps up to five years in advance of a succession event. Monitor the profile of patients and the capacity to service them.
- Make your practice attractive – deal with any profitability issues and maximise QOF points. Perhaps consider the effectiveness of branch surgeries as part of this process.
- Value the property - consider obtaining an up-to-date property valuation to recognise the cost that a potential new partner (or fellow partners) may incur on your retirement.
- Avoid tax traps - particularly for those partners who own a share in the property and wish to sell it on. Getting the timing wrong could mean a tax liability on any increase in property value at 28% instead of a much more favourable 10% rate.

Assisting with succession will be a topic that your AISMA accountant will be well prepared to deal with. There is also an AISMA guide available: 'Managing changes in the practice partnership', available from any AISMA member, which gives practical advice.