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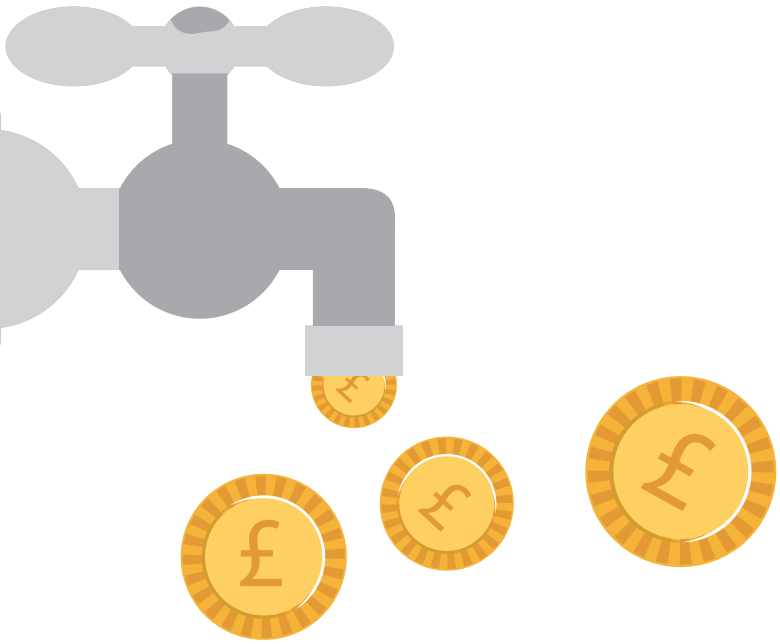
Issue 29 Spring 2015

Tips for keeping tabs on your threatened cashflow



Strong cashflow management will be even more vital for GP practices in the months ahead, warns **Andrew Pow***
Follow his tips to help you stay on top

Many GP practices are under increased financial pressure as we start the 2015-16 contract year. And not just because of the Review Body's 1.16% award:

- GMS practices with a Minimum Practice Income Guarantee (MPIG) will be in the second year of reduction;
- PMS contracts in many areas will see the first wave of cuts towards a GMS funding alignment; and
- QOF achievement pay will fall significantly.

Then there are local councils - they will be into the third year of managing the public health budget and, in a sector already under financial strain, you can expect cuts in prices paid for public health services.

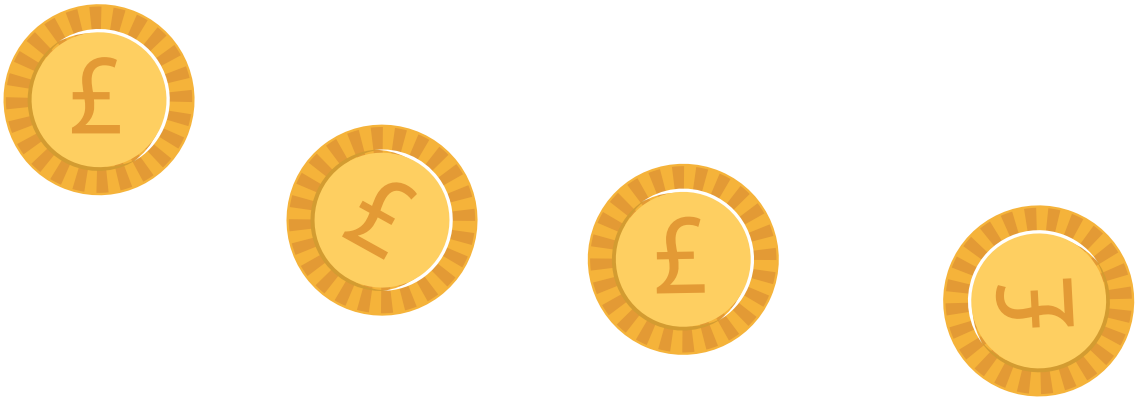
And on top of all this there is another wave of organisational change from this month. Hopefully this time there will be no repeat of the chaotic payment systems of two years ago.

So your management of cashflow will therefore become even more critical than in the past.

Making sure you are paid

Most practice managers will be fully aware of the chaotic payment system resulting from the organisational change in April 2013.

In some areas there is no respite to the organisational restructuring so we can expect more of the same as CCGs take on increased commissioning



roles and Commissioning Support Units are restructured.

Practices must therefore make sure they have a simple system of recording when claims are submitted and match them up when income has come in.

Finding out who will be responsible for payments from April 2015 will also be essential to be able to chase them up when they are not received.

Beware the QOF reduction

Practices will not have seen the impact of the reduction of QOF points from 900 in 2013-14 to 559 in 2014-15 because the drop in aspiration funding has been matched by an increase in the Global Sum or PMS payment.

Firstly, some areas used to pay QOF advances in March or April with the balancing payment in June once the submissions had been approved. But this has now stopped and there is a national policy of paying the balance in one go towards the end of June.

Secondly, the payment will be much reduced from previous years. Practices that have relied on this annual large payment should prepare ahead for the reduced amount which will come in.

Paying suppliers

All suppliers will have payment terms setting out the length of time you are allowed to make the payment. Ensure you pay at the end of the period to make sure you retain the balance in your account for as long as possible.

If you can delay payments until after the monthly GMS or PMS income is received then this will help.

Paying drawings and staff

The two biggest payments in any month are paying the GPs and the staff. But NHS bodies have changed payment dates. For example in some areas PMS payments have moved from mid-month until the end of the month.

Practices will therefore have to review the date partners' drawings are paid to ensure they leave the practice account after the main monthly payment has arrived.

The same applies to the staff payments to a certain extent. Practices need to be mindful of the terms of employment contracts so any changes would need to be fully discussed with the staff.

Reviewing drawings and forecasting

Practices should be working closely with their AISMA accountant to review the level of drawings being taken. In some cases with the cuts in income this will need to result in a reduction in drawings.

Difficult times mean tough decisions. Forecasting ahead for any potential changes in income will become critical to ensure drawings are set at a prudent level.

Increasing income

It is clear that the core contract income is increasingly under pressure with more income being directed down the enhanced service route.

Federations are beginning to establish themselves across the country. Practices should ensure they work closely with their Federation and CCG to identify income streams that they may be able to bid for.

But new work must always be costed up to ensure the time needed to perform the additional requirements is properly remunerated.

Reducing costs

By far the biggest cost is staff costs. Practices are going to have to keep these under control by minimising overtime.

When someone leaves there should always be an appraisal of whether the replacement needs to be at the same level of pay or could be taken on at a lower rate.

A federated model of working may lead to practices sharing some staff costs to avoid duplication of duties. At the same time practices are all under pressure from patient demand so they must balance reducing the staff expense with the need to be able to provide the service.

Premises

The days of PCTs paying rent and rates payments direct to landlords and the council have gone. Practices are now required to make the payment direct to the landlord/council and then claim the reimbursement.

So work closely with the payment agency to ensure the time between the money going out of your bank and back in through reimbursements is reduced.

Practices who own their own premises should ensure they know the date of the next notional rent review. Ahead of this they should be taking steps to setting up the review with the District Valuer so that any new rent is applied as quickly as possible.

Interest rates also remain at an historic low level. And with inflation remaining low too they are unlikely to increase significantly in the near future.

Practices with borrowing should review the interest rates they are paying, particularly those who have refinanced since the banking crash.

More competitive borrowing rates are returning to the market place. So always look to see if you can get the best deal available. Fixing interest rates while they remain low may give you a protection for the future.

Pssst…speak to your neighbours

If you are struggling then there is a good chance your neighbouring practices will be too. Practices will need to work closer together in the future either through formal federations or more loose arrangements.

Often the best ideas and advice can be found on your doorstep and there may be more innovative solutions to the problems ahead that can be found by working together.

OPINION

Could private practice tempt more GPs?

Bob Senior, Chairman, AISMA

With the General Election fast approaching there is the usual uncertainty over how the current NHS plans might be affected if there is a change of government.

If that happens then we could see a different attitude to the involvement of the private sector in the NHS.

But there is unlikely to be any fundamental change in the desire to improve services to patients while reducing costs.

The present focus of moving to equitable funding per patient for both GMS and PMS contracts, accompanied by a reduction in contract transaction costs via the use of GP federations or networks, is likely to continue.

With the current GP recruitment crisis unlikely to be resolved any time soon we can expect to see a continuing trend towards increased federated working and practices looking to merge.

The latest ideas regarding the creation of multispecialty community providers and primary and acute care structures are still really a statement of intent but they again support the general direction of travel of increased working at scale.

Given the continuing growth in the population and the increasing proportion of elderly patients it is clear that the need for more clinical staff in their various guises still needs to be successfully addressed.

Finding more doctors and other clinical staff cannot be achieved overnight and the Government must now recognise that it needs to significantly increase the training provision.

And it must do its utmost to retain those staff after they qualify.

Although remuneration and workload are part of the problem they are not the only issue that needs resolving.

The Government urgently needs to address the levels of bureaucracy experienced by clinicians and refrain from berating them in the press.

And doctors in hospital should avoid giving the impression to trainees that doctors in primary care are in some way second grade.

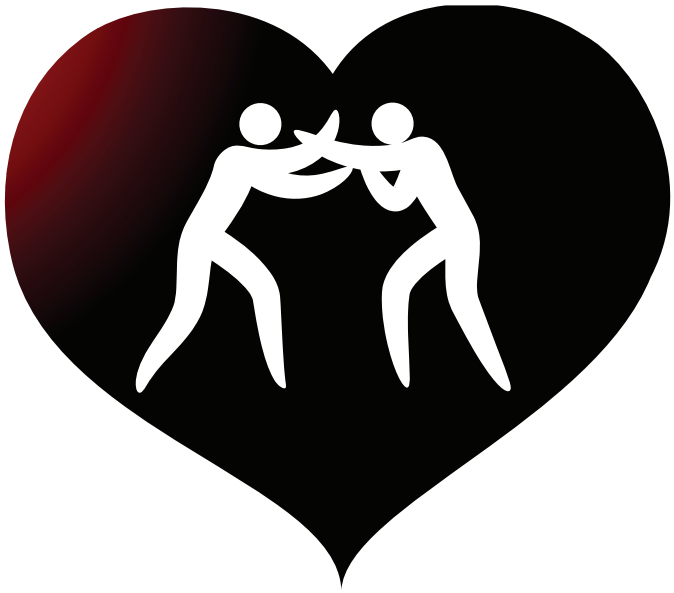
Unless the Government can get the recruitment and retention issues under control then we could see primary care fragmenting.

Could we, in some areas, see doctors turning the clock back and moving to private practice? Will we see far more GPs offering a preferential service to those patients that can afford to pay, potentially reducing even further the number of doctors available to others?

Only time will tell.

Co-commissioning and conflicts of interest

Alison Oliver has some timely advice following fears that the difficulty of managing conflicts of interest will undermine the effectiveness of GP-led commissioning



The *NHS Five Year Forward View* emphasises that giving CCGs more control over the commissioning of primary care is central to achieving the objective of more integrated out-of-hospital services.

But how will CCGs manage the conflicts of interest that will inevitably arise? And why co-commissioning?

Last May, when speaking at the National Clinical Commissioners Conference, NHS chief executive Simon Stevens said:

'If we want to better integrate care outside hospitals, and properly resource primary, community and mental health services – at a time when overall funding is inevitably constrained – we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed…That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations.'

Since April 2013 when the old PCTs were abolished, NHS England has been responsible for commissioning primary care while CCGs have been in charge of commissioning urgent and emergency care, elective hospital care and local community health services.

The *NHS Five Year Forward View* underlines the need to increase the provision of out-of-hospital care. But some policy influencers feel that CCGs have been hindered in their ability to commission integrated services locally because of their inability to make decisions about primary care commissioning.

What is co-commissioning?

Primary care co-commissioning is a way of enabling CCGs to play a bigger part in commissioning primary care.

NHS England remains ultimately accountable for commissioning primary care, but can share or delegate commissioning tasks with or to CCGs.

Following expressions of interest from CCGs, last November NHS England announced three different models for primary care co-commissioning, aiming to offer varying degrees of additional involvement for CCGs in primary care commissioning:

- Greater involvement – a flexible model whereby CCGs can work with their local NHS England area teams to participate in discussions about commissioning primary care but without taking any formal decision-making responsibility;
- Joint commissioning – where the CCG forms a joint committee with its area team to share responsibility for primary care commissioning; and
- Delegated arrangements – where the CCG takes on full delegated responsibility for primary care commissioning.

The system is entirely voluntary and CCGs were invited to submit applications in January. At the time

of writing, NHS England has announced that 65 CCGs have been approved to take on full delegated responsibility and applications for joint arrangements are still under consideration.

CCGs approved to take on delegated or joint responsibility for commissioning primary care were to take over these responsibilities on 1 April 2015.
In both delegated and joint arrangements, CCGs will be able to:

- Manage primary care contracts.
- Design new enhanced services and local incentive schemes.
- Establish new practices and approve practice mergers.
- Make decisions about discretionary payments such as returner/retainer schemes.

For the time being, co-commissioning only extends to primary medical services. But it is expected there will be discussions about extending this to include other primary care services in the future.

During the consultation, CCGs indicated that they did not think it was appropriate for them to take on 'pseudo-employer' responsibilities, so individual performance management and management of the performer lists will remain with NHS England.

What about conflicts of interest?

According to Monitor: 'A conflict will arise where an individual's ability to exercise judgement or act in their role in the commissioning of services is impaired or influenced by their interests in the provisions of services.'

Since CCGs' formation on 1 April 2013 there have been concerns about GPs on CCGs having conflicts of interest when making commissioning decisions in relation to services that their practices might deliver. These concerns are obviously heightened with this increased role for CCGs in primary care commissioning.

CCG committee members have an individual responsibility to declare interests and any conflict of interest that arise.

GP members are also under a professional duty not to allow their own interests to influence either their treatment of patients or decisions to award contracts or make purchases.

But all practice representatives - not just GP partners - need to be alert to their duty to declare their interests and conflicts of interest. While GP partners have a clear direct financial interest in their practices, practice managers and other practice staff have an interest too.

Members also need to declare indirect interests, for example if their spouse has an interest in a potential provider of services.

Interests need not be financial. For example, a CCG member could have a relative with a particular health condition which means they have a particular interest in directing resources to services aimed at helping patients with that condition.

I would advise individuals who are unsure whether an interest is relevant to err on the side of caution and declare it.

A useful gauge is the 'Paxman Test'. Ask yourself how it would look if an interest which you did not declare was discovered and you had to justify yourself to a journalist.

CCGs have a statutory obligation to manage conflicts of interest and in particular to:

- Maintain and publish a register of interests.
- Ensure members declare their interests.
- See that conflicts do not affect – or appear to affect – the integrity of an award of a contract.
- Keep records of procurement decisions and how conflicts between commissioner and provider interests were managed.

In addition, new NHS England statutory guidance gives various recommendations for CCG committees making decisions about services which might be provided by practices or GP federations:

- The chair and vice chair of the committee should be lay members.
- A majority should be held by a combination of lay members, executive members, GP representatives from out of the area and non-GP clinical representatives (such as nurses or hospital consultants).
- Meetings should be held in public unless there is a good reason for excluding them - for example for patient confidentiality reasons.
- Healthwatch and Health and Wellbeing Boards should have a standing invitation to attend meetings.
- Where members have a material interest, they should be excluded from the decision making and possibly not even participate in the discussion.
- Arrangements should be put in place to allow decisions to be taken where the committee has insufficient 'unconflicted' members to reach a quorum, for example, referring the decision on to another committee, arranging independent scrutiny of the decision or drafting in additional members for certain decisions.

In reality, CCGs might find it difficult to put these arrangements in place and some commentators are concerned that the difficulty of managing conflicts of interest will undermine the effectiveness of GP-led commissioning.

Alison Oliver is an associate solicitor with top 100 law firm Ward Hadaway, nationally recognised for its work in the healthcare sector

The 10 biggest managment failings in general practice

When management falls short then your practice wellbeing will suffer. **Kathie Applebee** highlights the major areas where it goes wrong

Practices have been businesses for many years - but not all are businesslike.

This may be because of a genuine preference to maintain a self-serving fiefdom but it could also be the result of management failings.

Management shortfalls are not necessarily the preserve of the practice manager. Unless the latter is in sole command of the practice, weaknesses may lie with the ways in which the practice principals choose to run their organisation.

Failing 1: Lack of management training

The clinicians of the practice are required to maintain their skills through regular updates and the same should apply to those in management roles. This should not just include the regular basics, such as employment law, but encompass management theory and practice.

Much of what happens in general practice is common to other businesses. There are staff to be managed and developed, money must be earned and tracked, premises and equipment need to be maintained, and systems have to be reviewed and improved.

Any competent manager should be able to manage a general practice, much as they would manage a school, a shoe shop or a production line.

There are unique technicalities to be learned, such as the details of QOF and enhanced services, but none of it is the proverbial rocket science. What cannot be learned on the job, unaided, is the art of management. Get training!

Failing 2: Being insular

Practices can be isolated, and the practice management role is further affected by being the only one of its kind in most practices.

Lack of familiarity with the bigger picture, both locally and nationally, may result in small problems being exaggerated out of proportion and large ones being recognised dangerously late. Go to local meetings and keep up with the regional and national news.

Failing 3: Trying to please everyone

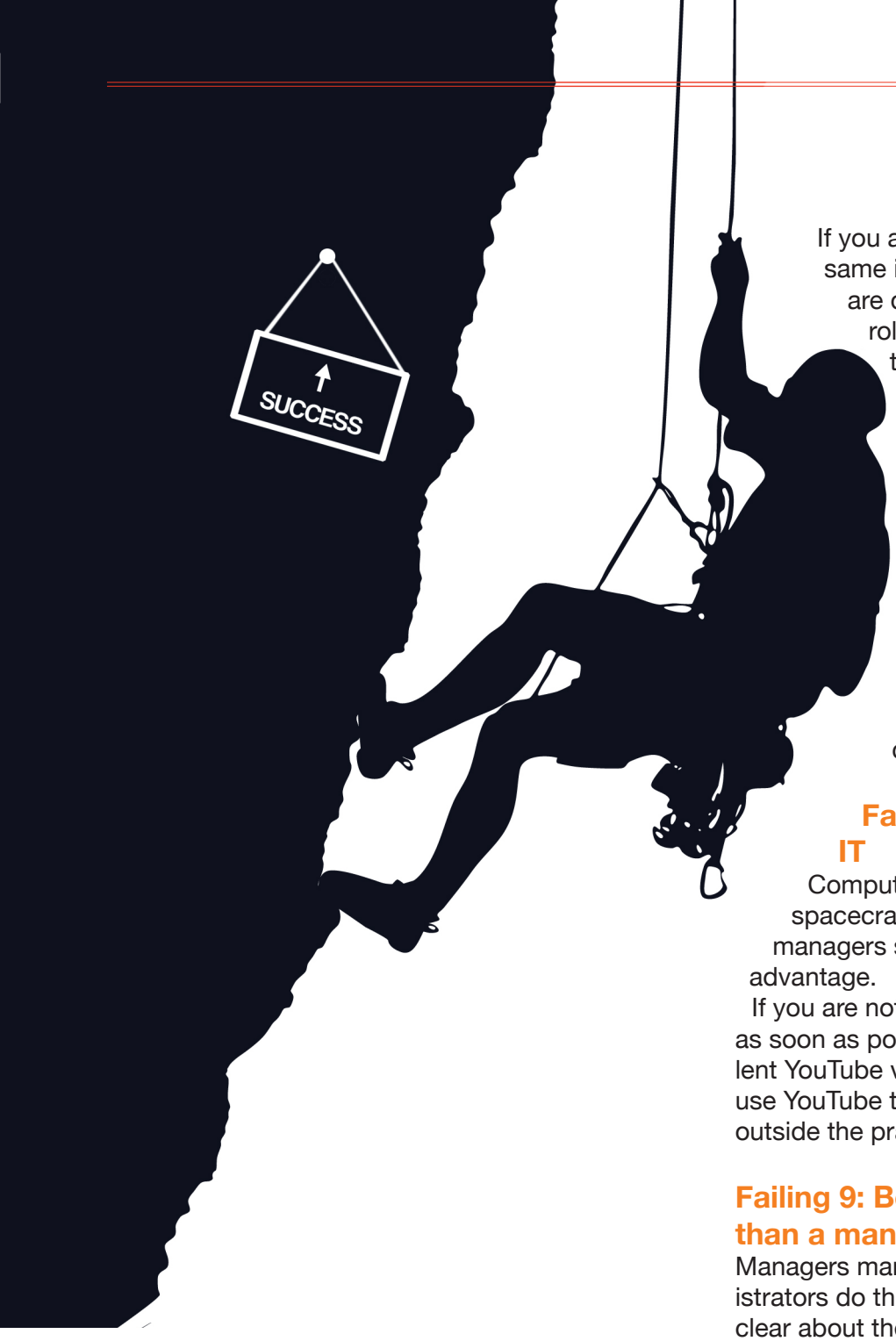
This is not a vote for bullying and unpleasantness. There is, however, a happy medium between the extremes of tyranny and timidity. It is an unfortunate fact of life that you cannot please everyone all of the time - and, on some days, it can be a struggle to please anyone.

Managers need to be effective and this requires recognising painful problems, planning how to address them and then dealing with any associated fallout. Manage change but do not expect it all to go perfectly.

Failing 4: Micromanaging

When the future seems too complicated or unattainable to address, it is easier to focus on today's trivia.

Some of this is inescapable but warning bells should sound if they always take precedence. As Alvin Toffler, the author of *Future Shock*, advised, you have got to think about the big things while doing the small things to ensure that the latter go in the right direction. Keep track of your activities and work to your pay grade.



If you always give opportunities to the same individuals, for example, then you are displaying favouritism. When new roles and tasks arise, open them up to all and award strictly on merit.

Failing 7: Apologising when you have not done anything wrong

Conversely, do not apologise unless you know that you have made a mistake. You can express concern or regret about a situation, and commit to investigating it, but automatic apologies will make you seem either inefficient or lacking in confidence.

Failing 8: Not keeping up with IT

Computers and smart phones are not alien spacecraft. They are everyday tools that managers should be able to use to their own advantage.

If you are not fluent in Excel, get some training as soon as possible. There are dozens of excellent YouTube videos on the subject. If you do not use YouTube to support your work, get someone outside the practice to show you how it is done.

Failing 9: Being an administrator rather than a manager

Managers manage people and systems. Administrators do the associated admin tasks. Be very clear about the difference and make sure that a significant proportion of your management time is spent on the key requirements of the role.

Failing 10: Not making lists

The role should be too complicated to carry in your head. Simply doing the first thing that you think of each day is not a good start.

Although much of your time will inevitably be taken up with trouble shooting, take this into account and make best use of the remainder. Time is a manager's most precious resource so make every 15 minute segment count.

Failing 5: Doing repetitive tasks

As with micromanaging, repetitive tasks are good ways of evading the tough issues. If a task is repetitive, it could be delegated as it does not require new skills to repeat it once it has been learned.

You may not have a PA but you might be able to free up some staff time to take on certain tasks if you review their working patterns periodically. Be ruthless with time-wasting tasks.

Failing 6: Taking sides

It is a natural inclination to side with friends or those whom you favour but managers need to be seen to be fair and impartial.

It's all change!

So now work out the most profitable route to take

Another financial year is upon us and with it – as ever – more big changes for GPs. **Deborah Wood **** gives an expert round-up and commentary

Significant GMS contract changes from last April together with yet more from April 2015, plus expected increases in general costs, mean it is now even more difficult to maintain practice earnings while balancing workload demand.

Personal Medical Services (PMS)

PMS reviews are now fully underway with some practices seeing significant proposals for reducing their contract income over the next five-six years. The GPC has been successful in securing a commitment from NHS England that all the clawbacks from current PMS payments will be reinvested in primary medical services, subsequent to PMS practice reviews.

LMCs in some areas have been able to negotiate favourable transitional deals for practices to revert back to GMS.

Publication of GP net earnings

It will be a contractual requirement for practices to publish average net earnings for 2014-15, including all contractor and salaried GPs, on their practice websites by 31 March 2016.

The number of full and part-time GPs associated with the published figures will also have to be stated. But there will be no requirement to publish individual named incomes.

Detailed guidelines regarding how the figures will be calculated have yet to be published however the intention is to include only the mean net earnings that relate to the GMS contract.

This will include earnings from NHS England, CCGs and local authorities for the provision of GP services that relate to the contract, or which have been nationally determined or which are for the provision of public health services.

These are the services that would have previously been commissioned by PCTs following direction by NHS England or the Department of Health.

Quality and Outcomes Framework (QOF)

There are no plans to change the QOF points arrangements in 2015-16 or to change QOF thresholds.

The value of a QOF point will be adjusted to take into account population growth and relative changes in practice list size using data at 1 January 2015.

Enhanced Services

The Patient Participation enhanced service will be removed completely for 2015-16. The associated funding will be recycled back into the global sum.

From 1 April 2015 it will be a contractual requirement for all practices to have a patient participation group which is representative of the practice population.

The Avoiding Unplanned Admissions enhanced service has been extended into 2015-16 with a few changes intended to focus on the patient. This includes patients not requiring a new care plan who had been registered in the previous year.

£500K funding has been set aside for a national survey. There will be changes to the reporting and payment processes

The Alcohol enhanced service will also be removed and funding recycled into the global sum. From 1 April practices will be under a contractual requirement to identify newly registered patients over 16 who are at risk regarding higher drinking levels.

This year the GPC will be working with NHS Employers and NHS England to establish a consistent set of standards which commissioners will apply for the provision of enhanced minor surgery services.

The aim is to ensure that area teams or CCGs cannot introduce their own additional requirements for the enhanced service - as has been happening recently in some areas of England.

The Extended Hours Access scheme is to continue in 2015-16 for another year with a number of flexibilities included to allow practices to work together to provide the most appropriate service for their patients.

The Learning Disabilities enhanced service will also continue unchanged for another year.

Seniority

As part of the 2014-15 GMS contract agreement, NHS Employers and the GPC agreed that seniority payments will cease on 31 March 2020 and that there would be a 15% reduction in seniority payments year-on-year.

Those GPs in receipt of seniority payments on 31 March 2014 will continue to receive payments and will progress as currently set out in the Statement of Financial Entitlements (SFE) during the phasing out process.

A retrospective mechanism for achieving the 15% reduction has now been agreed. Where the rate of retirement in one year does not amount to 15% of the total remaining seniority funding, the pot - and therefore seniority payments for those still in receipt - will be reduced by the remaining amount.

Retrospective adjustments will be made to ensure that when this money is transferred into the global sum, no money that would have been received by the profession is lost.

All of the money that would have been paid in seniority will be received by the profession via core funding.

The agreed mechanism will mean that changes to seniority payment will commence part-way through 2015-16.

Premises

The GPC has secured agreement with NHS England to establish a working group to explore a strategy for the development of GP premises and primary care estate.

NHS England recently announced that £250m will be invested in GP premises every year for the next four years.

Of the initial £250m available in 2015-16, £75m will be allocated for capital investment with the remaining £175m put by for revenue (recurrent) costs. The capital/revenue split for 2016-17 onwards is currently unclear.

Practices are encouraged to apply for this funding from the Primary Care Infrastructure Fund. Improvement grants will fund the majority of schemes in 2015-16.

More information about what types of project can and cannot be funded through improvement grants is outlined in Paragraphs 8 and 9 of the 2013 Premises Cost Directions.

From 2016, funding for larger, more strategic activity - moving practices, constructing new buildings - is likely to be considered.

Challenge fund

A wide variety of innovative ideas are being tested in the first wave of Prime Minister David Cameron's £100m challenge fund, including extended opening hours, more ways for patients to access services, and new services to better support patients with complex needs.

Last September he announced a new second wave of access pilots, with further funding of £50m for 2015-16. The Government has asked NHS England to lead the process of inviting practices to submit innovative bids and oversee the new pilots.

NHS England has published details on how to apply to become a wave two pilot site, the application criteria and timescales, together with some questions and answers.

GP recruitment

NHS England has agreed to work with the GPC to explore timely solutions to workforce issues in respect of GP recruitment

Three months ago health leaders announced a £10m investment to kick start a new plan to expand the general practice workforce. The money will be used to recruit new GPs, retain those who are thinking of leaving the profession, and encourage doctors to return to general practice.

This work will be underpinned by a national marketing campaign aimed at graduate doctors.

To retain GPs the plan includes establishing a new scheme to encourage those who may be considering a career break or retirement to remain working on a part-time basis.

NHS England will publish a new induction and returner scheme to encourage GPs to return to practice.

GP superannuation

The new 2015 NHS Pension Scheme comes into force on 1 April 2015.

Tiered rate contribution levels have been set for the four years to 31 March 2019 as in the box below.

Tier	Pensionable pay in 2015/16	Contribution rate in 2015/16
1	Up to £15,431	5.0%
2	£15,432 to £21,477	5.6%
3	£21,478 to £26,823	7.1%
4	£26,824 to £47,845	9.3%
5	£47,845 to £70,630	12.5%
6	£70,631 to £111,376	13.5%
7	£111,377 and over	14.5%

The employer contribution rate increases to 14.3%

CCG co-commissioning

Co-commissioning refers to the process whereby CCGs are being given the opportunity to assume greater powers to directly commission primary medical services and performance manage practices but not individuals (see page 4).

Under plans released in early November 2014 in the report *Next Steps Towards Primary Care Co-commissioning*, NHS England is offering each CCG in England the opportunity to adopt one of three commissioning models if they wish to take on greater powers.

The report makes it clear that CCGs are not obliged to apply for any of the co-commissioning models and may continue to operate under their existing arrangements.

Co-commissioning is considered by NHS England to be a key enabler of the *NHS Five Year Forward View*: both to implement the new deal for primary care, and to support the development of new models of care.

Some other changes for 2015-16 include:

- There will be a named accountable GP for all patients including children. The GP must take overall responsibility to co-ordinate all appropriate services for that patient within the terms of the contract.
- Patient online access to their medical records will be widened but some flexibility for practices in how this is implemented has been negotiated. An improvement in the availability of making online appointments is also included. There will be additional promotion of IT, to include electronic submission of prescriptions, electronic referrals and offer to patients of secure electronic communication.
- Armed forces personnel will be able to register with a GP practice.
- MPIG will continue to be reduced by a further 1/7th and is recycled back into global sum.
- The GMS income per weighted patient is expected to reach £78.66 by 1 April 2021, excluding any inflationary rises as a result of the withdrawal of MPIG.
- From 1 April 2015, practices who have not opted out of providing out of hours care are to provide information to the CCG to allow it to ensure the service provider is delivering this care in line with the National Quality Requirements.
- NHS England has also said it is committed to examining the Carr-Hill formula from 2015 to better reflect deprivation.
- The Government has accepted the DDRB recommendation for a 1% increase to GP contractors' pay. Once expenses of running their businesses are taken into account, the Government has said this equals a 1.16% increase to the GP contract for 2015-16.

Statistics published for 2012-13 in September 2014 on the HSCIC website show that average expenses are increasing faster than gross income and so average net income is continuing to decrease. This is also likely to have been the case in 2013/14 and 2014/15. This pay award is therefore unlikely to be sufficient to deliver the intended 1% net increase for GPs, the core payment to adequately reflect this from April 2015 needed to be in the order of at least 2% just to stand still.

- There are to be improved arrangements to cover maternity/paternity leave including external locum and internal locum provision

So adding it all up…

As ever practices have to be fully aware of these many changes and the impact they might have on their funding and workload.

It follows that practices need to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources.

A practice away day facilitated by your local specialist medical accountant might be just what the doctor ordered!

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.
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