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AISMA Doctor Newsline

A helpful resource for the practice business

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White Paper Special

Brush up now for White Paper success

Sweeping changes in the offing for general practice will demand greater financial capabilities from GPs. The specialist medical accountant's input will pay dividends, says **Deborah Wood***

It's hurting out there!

Practices are already facing cuts to their current core PMS/APMS baseline, if not immediately, certainly with effect from April 2011. GMS practices are losing the benefit of MPIG through gradual erosion. And all practices face reduced income from enhanced services while many have less QOF funding.

Yet there is an expectation to continue providing essential and additional services to the patient population efficiently whilst maintaining a high quality service. In addition practices are being encouraged to innovate through PBC. Soon to follow will be revalidation and CQC registration and then into the mix comes the coalition Government's White Paper consultation.

GPs are to face compulsory involvement in GP-led commissioning consortia and a new nationally set contract. The time frame for change is short, commencing with consultation now, conclusions in October and a timetable for transition and implementation over the next two years.

These sweeping changes to the health service will place greater emphasis on GPs' financial management capabilities. Under the proposals, some £80bn of NHS funding will be given to GP-led consortia to buy care for patients in their area, which health ministers insist will cut management costs by almost half.

PCTs and strategic health authorities will be abolished by 2013 when GP consortia will take full responsibility for the procurement of primary care services and the financial management of the funding budgets for that commissioning.

GPs should start thinking about the implications of these changes sooner rather than later.

Currently, the Government's announcement is very broad brush and there is a great deal of detail to follow. But it is certain that all GPs will be affected to some extent or another by these wide-ranging changes. The Government is keen to have patient input into the running of these new organisations so the doctor-patient relationship will have a new dimension.

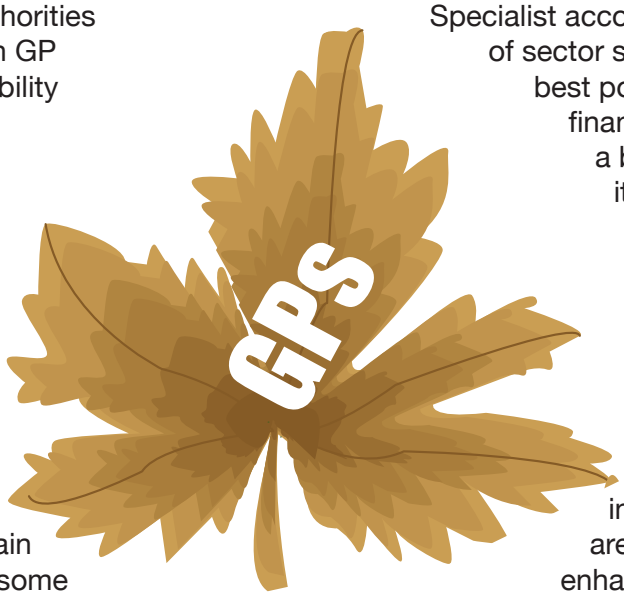
Organisations with multi-million pound budgets will be created, so financial recording and reporting requirements will be extensive. Individual practices will be held to account, which will mean their own financial management information must stand up to close scrutiny.

The Government is introducing the new system because it says GPs know what is best for their patients and can use this knowledge to buy healthcare services. However, because GP practices are small the Government will require them to join together into local consortia. The scale of each consortium is not yet known, but they are unlikely to have fewer than 100,000 patients each.

Possible structures for consortia include partnerships, limited liability partnerships (LLPs), community interest companies or companies limited by shares or guarantee. It is going to be crucial for GPs to decide at an early stage on the most effective structure because this will have far-reaching implications in terms of protection for members, remuneration, employment status, tax consequences and pension situations (*see AISMA Doctor Newsline, Summer 2010*).

More detailed information will emerge, but in the meantime some GPs will be naturally concerned that they are under enough pressure already, without the extra burden of these new management and leadership responsibilities.

The Government will have to deliver a management allowance that will provide a sufficient incentive for GPs to take on these additional burdens.



Specialist accountants, with the benefit of sector specific experience, are best positioned to undertake financial reviews to ensure that a business fully understands its cost base in relation to the services that it has to, or chooses to, provide - whether this is the current GP practice business or the new GP-led consortia organisation.

In particular, access to relevant benchmarking information that can identify areas for performance enhancement will be vital in assisting with profitability reviews and cost streamlining exercises.

AISMA member firms have access to a great deal of such information regionally and nationally.

The commercial knowledge available from qualified advisors who also run their own businesses will also facilitate strategic planning and enable decisions to be taken in the light of appropriate tax and pension planning arrangements.

GPs will have to allocate their time in a number of different directions:

- Managing their own practices to deliver existing or new contract requirements.
- Seeing patients, providing clinical services.
- Developing more sophisticated data collection on which to base new ideas.
- Engaging more with patients, secondary care providers, social care providers, the voluntary sector, and local government.
- Contributing to consortia in the design of care pathways.
- Setting priorities for healthcare outcomes.
- Leading and managing the procurement process.

- Handling risk and public accountability for decisions taken.
- Maintaining their role as patient advocate.

Not all GPs will be involved at every level with each of these activities but there will inevitably be an impact on the work-life balance. New skills will have to be learnt, new networks developed.

To succeed at managing all the above roles and potential conflicts of interest arising within them, GP practices will have to improve productivity to create sustainable businesses and will have to work together with a variety of organisations across the primary care sector to find cost savings that are substantial.

Before starting to define their involvement in the new GP-led consortia, GPs need to spend time focussing on what is important financially and clinically within their existing practices.

To help you, check out the questions' checklist (below).

As the details emerge following the White Paper consultation process, proper planning and obtaining the right advice is essential to the future well-being and success of general practice.

Checklist of questions to ask

- What services can the practice currently provide that are profitable?

- Are they provided already and if not how can the practice get involved in providing them?

- How can the practice go about tendering to provide new or additional services?

- Can the current provision be organised more effectively? Is the skill mix right?

- Are existing resources being used to their full potential? Is the fee charged enough?

- To what extent is the practice currently involved in PBC and the redesign of care pathways?

- Do GPs really understand what their PCT's involvement in commissioning entails?

- Where does patient choice fit in? **Comment:** Patients need to be involved in the design of services and need to understand their role in reducing demand, on referrals and prescribing in particular.

- Can a long term strategy be set up within the framework suggested or is this approach just another short term changing of the goalposts? **Comment:** GPs need to be able to focus on practical improvements rather than concern about the overall process. Do they understand their referral patterns and patient profiles? Are they focussed on frontline delivery rather than back office bureaucracy?

- Which commissioning areas are going to be more problematical?
  - Continuing care.
  - Unplanned admissions.
  - Integrated care.
  - End of life care.

- Do GPs understand the risk management implications? Are they fully informed about service needs and availability? How will outcomes be measured?

- What is the process for feedback and review such that there is continuous improvement? What about public accountability for decisions made?

- Is £9 per head to run the new model of commissioning going to be sufficient? This is only about 1/3 of the current amount PCTs spend on their commissioning function. How will the cost base of the consortia be determined? **Comment:** A business plan and financial forecast will be essential. Budgets have to be set and worked within.

What might the steps to success within GP-led consortia look like?

- Identify the population covered.
- Identify their current and anticipated health needs.
- Identify aspirations for outcomes improvement.
- Set priorities for these.
- Ensure the team involved in leading the consortia has the right expertise.
- Ensure the right information is obtained before decisions are made.
- Procure services to meet the identified priorities.
- Build on existing best practice.
- Set clear standards as to what patients can expect from providers.
- Deliver the required outcomes, incentives may be needed.
- Measure/monitor success, learn from what works well.
- Give feedback to all participants.
- Review and improve service provision.

How to get ahead now

Smart practices can do a lot now to make the most of the White Paper. **Kathie Applebee** shows how

Proposed radical changes to the commissioning of healthcare are about to impact on every practice in England.

During this period of consultation documents and the planned winding down of PCTs by 2012-13, practice responses are ranging from ostrich ('can't happen, won't work') to eager beaver ('let's form a consortium and get started').

So what should practices do during this period of apparent limbo?

The first and most obvious answer is to keep abreast of national strategy decisions. Your LMC will doubtless be publishing local responses to these.

Although interest within the practice may be slight, try to keep practice members informed of developments, perhaps through a special section of an Intranet or notice board.

PBC in the practice

Next, review the internal situation regarding practice-based commissioning (PBC). If the practice is part of a PBC group, is this active engagement in a dynamic group or simply a token exercise?

Practices already working well within such a group are well-placed for the next step – consortium development – but those who lack internal or external support may wish to start trying to inspire practice and/or locality colleagues with the potential benefits of commissioning.

Although commissioning may seem irrelevant to some in general practice, it is one of the key factors which determine how well an individual practice can function.

For example, if patients are being discharged prematurely, or with chronic conditions unmanaged during admissions for acute or elective care, there is a damaging impact on primary and community services.

If the latter are also poor, the practice and its patients are in even worse straits. Being able to make positive changes in areas such as these will directly benefit practices along with patient care.

Although the media has made much of GPs doing the work of commissioning, the day-to-day work will be done by employed managers and staff, as currently happens within PCTs. The key differences include a planned

reduction in the current levels of bureaucracy and the ability of practices to inform and control the commissioning process to a much greater degree.

Locality and size issues

Practices should assess their current PBC status and, where interest has been lukewarm to date, decide on a lead who will need to be given protected time to gain greater involvement and protect the practice's interests at a local level.

This is especially important in practices which may have some form of border status. Those that neighbour Scotland and Wales will have a specific set of cross-border issues to deal with.

But these may be more straightforward than for those that are on the edge of another county, use multiple providers with no clear major provider, or inhabit an urban/rural divide with very different patient populations.

A balancing act will be needed to represent patients' interests and local health needs with the requirement to be part of a suitably-sized consortium.

The recommended size-range for a consortium population is currently 100,000 to 750,000 people, although those below 500,000 are likely to need to join together with other smaller units to share financial risk and management costs.

There are also concerns that smaller consortia may be unable to influence larger acute care trusts and local authorities – one suggestion is that the consortium population should seek to match the population sizes of their local trusts or authorities.

Practice preparation

Within the practice, a key need is the recording and analysis of patient data, and a related knowledge of referral patterns and the impact that these have on current PBC budgets.

Practices may need to undertake self-directed audits to ensure that they have a clear understanding of their strengths and weaknesses regarding their current budgets. Although high-spending practices may not be excluded from consortia, they will find themselves under increasing pressure to conform with peer expectations, especially as continued overspends will threaten the stability and viability of the consortium.

They will also lose out on any so-called quality premium payments that are being suggested as a reward for high-achieving practices.

Any practices without Patient Participation Groups may wish to start setting them up now. It is important that patients understand that practices will not be benefitting personally from commissioning decisions that may result in changes to the ways in which services are delivered.

While many services may improve, others may have to be adapted to meet commissioning needs and an informed practice team and patient population will help cope with any such changes.

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

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Opinion

Seize the opportunities - but be aware of the threats

Bob Senior, Chairman, AISMA

The NHS White Paper and the subsequent publication *Liberating the NHS: Commissioning for patients* leads the introduction of fundamental changes in the way the NHS is managed.

As is always the case, these initial documents lack much of the important fine print needed to actually start to plan for the changes in detail.

But there is no doubt that the handing of commissioning responsibilities to bodies run by GPs offers both opportunities and threats.

The opportunities are for GPs to finally take an active part in commissioning services and ensure that money is spent in the most appropriate manner. Commissioning will not equal Fundholding Mark II, however, and the opportunities will not extend to GPs being able to directly benefit from 'savings'.

The threats are varied. The most obvious is that although GPs will not be able to benefit from any under-spends, they will be hit in the pocket if the commissioning group overspends – a real example of heads they win, tails you lose!

Obviously being put in a position where a GP's role of gatekeeper can directly affect their own income will leave ample opportunity for patients to challenge the reason for GPs' clinical decisions. That is bound to leave many GPs feeling very uncomfortable.

Until further details are published, particularly relating to exactly how much the 'maximum management allowance' will be, it won't be possible for GPs to decide exactly how commissioning groups should function and what, if any, involvement there is likely to be from the private sector.

A white what?

For anyone in your practice who has yet to catch up with this summer's White Paper *Equity and excellence: Liberating the NHS*, lawyer **Jonathan Lisle** gives a round-up and perceptive commentary

GPs to have the power of commissioning

The main feature of the proposed NHS re-organisation is that consortia of GPs will have the power of commissioning medical services.

Certain services will be excluded including dentistry, maternity, ophthalmic procedures, pharmacy services and other highly specialised services such as heart transplants, treatment of spinal injuries, burns and renal dialysis. These will be commissioned by the new NHS National Commissioning Board (NCB).

PCTs, who currently commission medical services, and Strategic Health Authorities (SHAs), will be abolished by 2013.

Each consortium must be authorised by the NCB. The vehicle to be used (company, partnership etc.) is to be determined by each one.

All GPs will be required to be a member of a consortium and it is proposed that there will be around 500 consortia. Approximately £80bn will be allocated to these consortia by the NCB. The average size for a consortium will be around 80 GPs.

Some commentators have criticised the proposals on the grounds that GPs have limited time and resources and do not have the skills required for the complex process of commissioning, including due diligence, specifications, assessment of capacity/capability/price and measuring outcomes/risks.

But the proposed model does not envisage that all GPs, practice nurses and other practice staff will be actively involved in commissioning. It is likely that a small group of primary care practitioners will lead each consortium and play an active role in the clinical design of local services.

And I expect each consortium will employ staff or buy in support from external organisations, including local authorities, voluntary organisations and independent sector providers, to analyse population health needs, manage contracts with providers and monitor expenditure and outcomes.

The size of each consortium's budget will require care-

ful thought. It is proposed that the consortia will have the freedom to decide which aspects of commissioning activity they will undertake themselves and which aspects require collaboration with other consortia, for example, a lead commissioner may manage the contract with a large hospital.

GPs clearly have the central role in implementing these proposals. They will hold the public purse strings and their operations will therefore be under greater scrutiny. Transparency of funding and accountability of GPs is a critical issue and it is hoped that Monitor's new, increased powers (see opposite) will ensure that each budget is allocated in a proper way for the benefit of the patients.

Some GPs are concerned that they may become scapegoats for implementing cuts and it is critical that their support can be secured.

The competition and procurement laws which GPs must comply with are complex. For example they will have to commission services 'from providers who are best placed to deliver the needs of their patients' and the process must be 'transparent and non-discriminatory'.

How GPs will be remunerated is a key issue. The White Paper envisages a management charge being payable to GPs. Some recent reports suggest that GPs could earn £9-10 per patient. The BMA's GPC has outlined a number of principles for commissioning including that GPs must not personally profit from commissioning budgets. Freed up resources must be reinvested in patient care, it says.

A key question being asked is what if a consortium fails? At the moment the covenant of PCTs is backed by the Government. It is not clear whether a failing GP consortium will be allowed to go insolvent.

A further concern which has been expressed is the extent to which consortia will compete with each other. Two or more consortia may share services of the same hospitals. In the absence of SHAs and PCTs, it is hoped that the NCB and Monitor will oversee such matters and ensure fairness.

In December 2008, the King's Fund published a study of Practice Based Commissioning in four PCT areas and found that in some instances, GPs focussed on commissioning services they knew they could provide and would select themselves in preference to other providers.

One view on the White Paper is that GPs will seek to do more of the work themselves. It is expected that Monitor will be empowered to regulate the obvious potential conflicts of interests and potential anti-competitive behaviour.

The new principles of the GPC state that 'a contract held by a GP should never be allowed to conflict with their professional responsibilities in providing care for patients'.

Monitor

Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services. It will regulate all NHS organisations, not just Foundation Trusts.

Tariffs may be amended by Monitor such that more is paid for better quality care (rather than being based on average costs of care). Monitor will also licence providers (jointly with the CQC) and be responsible for creating competition.

Patient Choice

A key principle of the new regime is 'no decision about me without me'. Patient choice is at the heart of the new proposals. GPs must ensure that commissioning decisions reflect the views of their patients' needs and their own referral intentions. Patients will have the choice of any provider - a named consultant-led team, any GP practice and any specific treatments. They will have access to more information about consultants and the options for care and increased control over their records.

The Government is looking at ways of ensuring that Choose and Book usage is maximised and intends to amend the standard acute contract to ensure that providers list named consultants on Choose and Book.

Usage of tools such as Patient Reported Outcome Measures, patient experience surveys and real time feedback will be increased across the NHS. Information on the outcomes achieved by individual consultants will become more widely available.

Another key theme to note is that 'money follows the patient', through transparent, comprehensive and stable payment systems which promote high quality but efficient care. It is envisaged that quality standards, developed by NICE, will inform commissioning and providers will be paid according to their performance. Payments will reflect outcomes not simply activity.

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Financial Diary

Topical jottings of a money-minded GP

We clean up on costs

In these difficult economic times the only way to keep profits up when income is falling is to be ruthless with expenses.

I have written before on this but will update you now on the latest ideas our practice manager has had. Up until four months ago we had our windows cleaned by a local window cleaner. He was very good but we wondered if we could get them cleaned for less.

So we approached the company that cleans the surgery and it agreed to take on the windows in a deal that saved us about £325 a year.

But a month ago the cleaning firm unfortunately went into administration. However another company bought it and asked to retain the business. We agreed on the basis of a reduction in costs as part of a trial six month period. This has saved another £275. If you don't ask you don't get.

Everyone profits from evening deal

I have some outside interests that I personally earn from that don't go through the practice. Recently I had a number of meetings during the school holidays and locums were hard to find.

So I agreed with my partners that I could do some evening surgeries to cover my routine workload. I pay the receptionist's time myself and as this is less expensive than a locum my outside work is more profitable as the expenses are less.

My partners and patients are happy with this arrangement as my patients still get to see me rather than a locum and my partners don't have extra admin work as I can pick this up in the evening.

The other bonus for me is that I don't have to take a day's holiday to enjoy my profitable outside interest.

Now my spouse gets the money in

One problem with having outside interests is invoicing for my time and chasing up payments. It is important to log everything I do and have a system to monitor payments.

My wife recently stopped working so I now employ her to do this. I pay a fair hourly rate that works out over the year to be less than the annual National Insurance and tax thresholds. My accountant is able to use this as a legitimate business expense and this saves a few hundred pounds a year in tax. My wife is also much better at this than me and she makes sure we are always paid for my time.

Top Tips

- Review all contracts such as cleaning contracts to see if suppliers will offer a discount.
- Flexible hours to cover outside commitments can save locum costs and provide continuity of care.
- Log all personal private earnings and consider paying a spouse to manage the accounts if appropriate from a tax perspective.
- University research studies can be well paid for the time and effort involved.
- Check with PCTs and Health Boards whether they have staff discount schemes with local and national businesses.

£5k list bonus is no trial

Our local university medical school is part of a research network and conducts clinical trials that require recruitment from the general population. We have agreed to act as a feeder practice and regularly get invited to provide lists of patients with certain diseases or lists of patients to act as control groups.

The university usually sends a researcher to the practice who works with our secretaries to produce lists of patients appropriate for the particular study. My job is to simply review any list and make sure that no patient on the list would be unsuitable to send an invitation to, for example a patient being treated for cancer.

I reckon 70% of the work is done by the researcher, 20% by my secretary and 10% by me. The payments depend on the study but vary from £250 to about £900. In the last year we have helped with 10 studies and earned £5,375. This is a good earner.

NHS buying power pays off

Our local area health bosses have negotiated discounts with a large number of local retailers on behalf of staff. This scheme has been extended to primary care staff.

The range of retailers is large - from local shops, hairdressers, restaurants and pubs through to some national retailers such as insurance and travel companies.

My staff use the scheme frequently and in fact have used it to book the Christmas night out, saving £10 per head. I used the scheme recently at a local bike shop and saved £30 on a new bike for my daughter.

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