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AISMA Doctor Newsline

A helpful resource for the practice business

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Avoid a federation disaster

So you are federating. **Andrew Lockhart-Mirams** provides an essential legal round-up of the pitfalls to beware of

It was reported recently that the RCGP and NHS leaders are warning GPs that they must start to develop federated models immediately or face new structures being imposed on them (Federate or face forced restructure, GPs told – Pulse, 19 May 2010).

The main reasons given for the urgency are that:

- only federations will be able to cope with the work which is expected to shift into the community in the near future
- individual practices will be disadvantaged under new commissioning plans, and
- primary care organisations will impose PCO-led polysystems anyway if GPs do not take the initiative themselves.

Despite pressure to move ahead with federating, there is little guidance for GPs on going about it. A toolkit promised by the RCGP is not expected to be ready until the autumn and, in any event, it is doubtful that a generic document can provide the tailored advice required in these situations.

Many GP practices have already formed federations or are in the process of doing so, some with greater success than others. Some PCTs are pro-active, perhaps providing funding to practices for set-up costs and allowing the practices access to the PCT's own legal advisors.

But while this kind of support may be welcomed by GPs, we emphasise caution: the impetus for federations is coming from the centre. It is essential for GPs to have control over how their own federation is structured and run, just as they must make the decisions about how their own practices are organised. It is almost certain that PCT advisors work with a PCT 'mind set' and federations need advice that is 'looking out of their own window'.

Unfortunately, many GPs have rushed the process without adequate advice, have chosen an inappropriate structure for the purpose, or have given insufficient thought to their constitutional requirements.

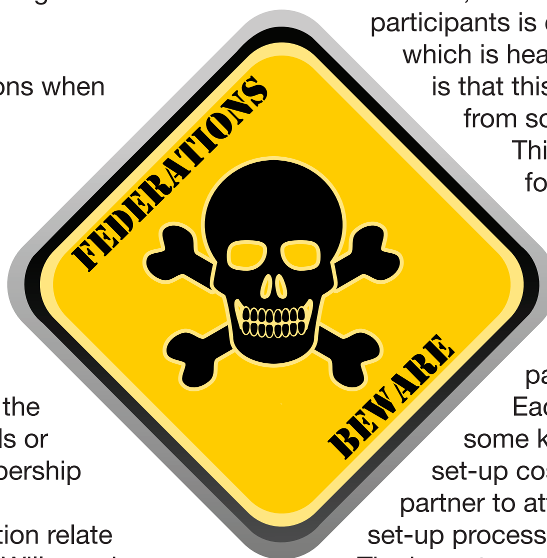
Legislation governing the NHS contains complex rules about which type of structure can do what. The choice of structure therefore depends on what the federation wants to do and it is essential that the correct one is chosen at the outset. If the wrong choice is made, this can be disastrous if the error is only discovered after a contract has been awarded.

If it is a contract for which the federation has competed

in a tendering process, it may not be possible to transfer the contract to a new structure, meaning that the federation may lose the contract altogether or have to re-tender.

An important consideration for GPs will be whether the federation is to employ staff and provide access for its employees to the NHS Pension Scheme. Again, the choice of structure is crucial. And the constitution must be drafted extremely carefully to ensure the federation does not contravene the strict eligibility rules for the Scheme, either at the outset or during the course of business.

There are many other considerations when forming a federation, including:



- How will the set-up process be managed and financed?
- What is the purpose of the federation? What exactly will it do?
- What are the criteria for membership? Is it limited to a particular geographical area? Will the membership be open to individuals or will it be practice-based? Is membership open to people other than GPs?
- How will the work of the federation relate to the work of existing practices? Will members be prohibited from competing with the federation for contracts? To what extent will the activities of the federation affect the core business and profits of the members' existing practices? What degree of control will the federation have over how practices operate and relate to each other?
- Are there circumstances in which a member practice could be forced to leave, say, as a result of poor performance?
- What happens if a member simply wants to leave? Is there to be an initial 'lock-in' period?
- How will shares in profits (or losses) and voting rights be divided? This could be equal or weighted, for example by patient list size of participating practices or according to the number of partners.
- Will the federation be profit-making, 'not-for-profit' or somewhere between the two, with distributions of profits to members being limited so as to retain a proportion of profits for reinvestment in services?
- Who will be responsible for managing the federation? Will directors, for example, be remunerated?
- If the federation is not self-funding within an agreed period, how will it be funded?
- How will decisions be made? How frequently will members and/or directors meet?

These are just some of the matters that must be decided early on. The constitutional provisions, whether in the articles of association, LLP agreement or other members' agreement, depending on the choice of structure, must be meticulously drafted to ensure that the requirements of the individual federation and the NHS regulations are properly accommodated. While it is relatively simple to set up a company, LLP or other structure, getting the constitution right is harder and is, unfortunately, often overlooked, resulting in problems later on.

Another of the major issues we have encountered in working with federating practices is the varying levels of commitment of the participants. It is perhaps inevitable that there will be some practices that are more committed to the process than others, or that are better equipped to drive the process forwards.

However, a basic level of commitment from all the participants is crucial. A problem with a process which is heavily directed and financed by a PCT is that this may disguise a lack of commitment from some or all of the GPs involved. This may only manifest itself later, in the form of a poorly functioning federation or one or more apathetic federation members placing a burden on the federation as a whole. Guarantees of commitment should be sought from the participants at an early stage.

Each participating practice should make some kind of financial contribution to the set-up costs and also pledge the time of a GP partner to attend meetings and assist with the set-up process.

The importance of expert advice during the early stages is not to be under-estimated: well-timed input from specialist accountants and solicitors can certainly help avoid many potential pitfalls.

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TIPS FOR GPs:

- Identify practices with whom you might federate.
- Hold an initial informal meeting of practices and form a steering group.
- Meet with the PCT regarding the set-up support that may be available and what kinds of opportunities may exist for the federation.
- Seek legal and tax advice on the most appropriate organisational structure as early as possible.
- Seek commitment – time and money – from participating practices.
- Agree the principal objects of the federation – what will the federation do and why?
- Consider the key features and operating principles of the federation (see list of considerations above).
- Set up the structure, with specialist and experienced legal and accountancy support.

Financial Diary

Topical jottings of a money-minded GP

Top Tips

- Consider staff pay rises carefully. Alternatives such as extra holidays can be offered.
- Never get in the position where work done is unclaimed.
- University work can be rewarding intellectually and financially.
- New for old can be more cost effective than running repairs for property maintenance.
- Essential medical equipment may be available on loan to GP researchers.

Extra day's holiday pays its way

All the GPs I lunched with at a university training day for GP tutors recently were concerned about falling practice profits. The big debate was whether practices could afford to give staff a pay rise this year.

One practice had already agreed to match any local health board pay rise and was committed to 2%. They felt their hands were tied. Another had advised staff there would be no pay rise this year. Their recently advertised receptionist post received 100 applicants.

They thought staff should recognise they had secure jobs that were reasonably well paid and should be grateful. They would have no trouble replacing any leavers. Another practice, instead of offering a pay rise, was offering two extra paid days of holiday for this year only.

My practice has given a 1% pay rise and one extra day's holiday. We have a very stable staff base in which we have invested significant training. We value what they do and wish to retain them. They know times are difficult and we cannot offer an inflationary pay award. But they are grateful for this small rise.

Catching a cold from unpaid fees

I find it amazing that practices do work and never claim for it. Practices around me were informed that some had not submitted a year end claim for seasonal and H1N1 flu payments. Now they face a claw back of interim payments.

Not claiming is a double whammy as most practices will have had significant extra expenses with paying staff overtime to administer vaccinations in extra slots outside normal opening times.

My own practice made a £9,500 net profit after expenses of £3,700 were deducted from the gross income. It seems to be common sense that all practices should ensure they have systems in place to claim all fees. Struggling practices should be contacting their local practice manager group for advice.

Now it pays me extra to learn

There are virtually no new sources of GP income right now. Health bosses have to make big efficiency savings and there are no new LESs. So to maintain my personal income I have had to look at other earning opportunities.

I am not interested in out-of-hours-work as I already do a full five days a week and do not want to do any extra consulting. As I am a part time tutor at the local medical school I asked if it had any new opportunities.

I was offered the chance to be an elective adviser and mark student electives. This is interesting work I can do in one or two hours in the evening. The income is reasonable and I reckon I should earn about £1,000 for marking about 20 electives this year.

These are very informative and usually well written with lots of background information on the disease area studied. I can add this learning to my appraisal learning log. Being paid for learning is a real bonus.

Stopping a draft becoming an overdraft

Our practice's window sills need maintenance and in the past we have had a joiner replace them. This time we asked three window firms for estimates to replace the windows completely.

One recommended uPCV windows which are much harder wearing and offer better insulation which should reduce our heating bill. Its quote was the best price and actually cheaper than getting a joiner. We aim to replace the windows piecemeal over the next three years to ensure cash flow is not compromised.

Research deal is breath of fresh air

Last week our practice spirometer failed its annual service and unfortunately as it is an obsolete model it cannot be repaired, due to a lack of spare parts. I was resigned to a £1,000+ outlay and bemoaned this fact to a respiratory consultant who is a personal friend.

He said a colleague at the university was conducting a COPD project and looking for practices to recruit patients. The research team, comparing practice and hospital-based spirometry, were lending spirometers to practices.

The researcher was happy to use our surgery as a site. Now we have the loan of a spirometer for two years. We will eventually have to buy one but this delays the capital purchase for two years when hopefully cash flow will be better. And we will also get a fee for each patient we recruit - an added bonus.

Make the most of your salaried GP

Salaried GPs can be a positive addition to the practice. But employers need to do their homework properly for all to benefit, warns **Kathie Applebee**

Sessional or salaried GPs (SGPs) have become part of the fabric of general practice in a way which would have been hard to imagine a decade ago.

In the days when the basic practice allowance was linked to the numbers of GP principals, assistants were limited either to those practices with very large list sizes (the first GP needed 3,000 patients, and any other principals an average 2,500 before reimbursement could be obtained) or those accredited to accept GPs on the retainer scheme.

Now, SGP's have their own body, the National Association of Sessional GPs, the BMA has developed model contracts of employment and job plans, and the doctors' Review Body publishes annual salary scales. The recommended salary range for PCT-employed full-time salaried GPs for 2010-11 is £53,781-£81,158, a 1% increase on last year's scale.

Why employ an SGP?

While some practices will inevitably be looking to cut costs by replacing partners with SGPs, others simply do not want any more principals running the practice business. There are also those practices which find it difficult recruiting new partners, either because of their own lack of appeal or the calibre of applicants, and elect for SGPs instead.

In addition, not every GP outside a partnership is looking for such a role: the concept of being able to focus on the clinical work of general practice without having to worry about the practice infrastructure has its own appeal.

The potential downside for practices includes the need to cope with a new form of recruitment and management, and the BMA contractual terms for generous sickness leave and redundancy pay. The latter dates back not just to the commencement of the practice's employment date but to the SGP's date of joining the NHS.

Recruitment issues

Before advertising for an SGP, the practice needs to decide whether to follow the BMA contract and pay scales, or offer what might be termed an enhanced contract: a higher salary in return for longer working hours. The BMA contract is based on a 37.5 hours week, divided into nine 'nominal' sessions of four hours and ten minutes each.

Under the terms of the BMA contract, SGPs thus require time during, rather than after, these sessions to do patient administration – the work that is often done by principals after surgeries end – and this, along with visiting, may occupy at least half of every session. This contract also requires four hours per week of professional development time and 10 public holidays for full-timers instead of the usual eight.

Taking these constraints into account and comparing the expected work rates of each type of GP could result in an SGP being estimated to do 90% or less of the equivalent sessional workload of a principal, depending on the practice, the individuals concerned and the average working hours.

The rate per session for each can also be calculated and compared according to the amount of leave agreed and the actual numbers of sessions worked. The final calculation should include the SGP's on-costs: employers' national insurance contributions (NICS) and superannuation payments.

For example, the on-costs for an annual salary of £81,158 bring the total to £102,243. If an SGP on this salary is deemed to do 90% of a principal's clinical work, this would equate to the principal being paid an equivalent rate of £113,603, without taking non-clinical work into account.

Managing SGPs

A further cost which should not be overlooked is the management time required. While fellow professionals might be assumed to manage themselves, the practice should not lose sight of the fact that SGPs are legally practice employees and so are subject to the same employment law rights as other staff.

This means introducing arrangements for leave taking, for example, and agreeing what elements of professional development protected time will, for instance, be used for practice-based audits.

SGPs can be a very positive addition to the practice if recruited in a professional manner and for the right reasons.

But poor recruitment practices and lack of attention to their roles and job satisfaction is likely to be detrimental to all involved, and could prove to be a costly mistake if the relationship ends in acrimony.

National Association of Sessional GPs http://www.nasgp.org.uk/

BMA employment contracts http://www.bma.org.uk/employmentandcontracts/index.jsp

©Kathie Applebee

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

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Opinion

Our 15 years' experience will keep you a step ahead

Bob Senior, Chairman, AISMA

We have been celebrating the 15th anniversary of AISMA by holding a host of fund-raising events for Médecins Sans Frontières. Some of your accountants have been working up a sweat running, rowing, and biking while others have run quizzes or baked cakes to raise over £14k so far.

One cannot help but be impressed by how the association has developed in the last decade and a half. Growing from a handful of founder members to a position where our 78 member firms act for approximately 25% of UK practices is a tremendous achievement.

The last 15 years have seen the NHS move through many changes but some old issues are now resurfacing. Perhaps the biggest change was 2004's new GMS contract, which overcame the GP recruitment and retention problems. But now the Government's apparent desire to reduce GP incomes and pensions, and hand back responsibility for commissioning out-of-hours care, is at risk of undoing much of what the new contract achieved.

An AISMA member's role has always been that of adviser to GPs. Increasingly we must focus our efforts on helping practices achieve the best results they can in a time of continually moving targets. In the short term that includes riding the storm of political pressure around the federated model for GP practice (see front page), whilst facing up to the fact that better economies of scale can be achieved in the long term by operating in larger units.

Simply getting the accounts, tax returns and superannuation certificates right is no longer enough for a specialist medical accountant. We want to ensure we give our GP practices the benefit of our experience and advice so that they can do what they do best – work out how to stay one step ahead!

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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Build for a new business structure

Government cost-cutting means GP practices must reinvent themselves as commercial businesses, warns **Deborah Wood***

Whereas the Department of Health under Labour announced in the March budget that it will deliver £4.35bn of savings, the Coalition Government has said that it will guarantee health spending increases in real terms each year over the five year life of the Parliament.

The Coalition has also said that savings made will be redirected to the front line. So it is possible that some of Labour's savings ideas may actually be implemented, for example:

- By driving down the costs of procurement through securing best prices for goods and services.
- By reducing staff sickness absence, improving staff productivity and reducing dependency on agency staff.
- Savings in management and back office costs and more efficient use of the hospital estate.
- Through more effective commissioning, by reducing unnecessary referrals and prescribing.
- By transforming the lives of those with long-term conditions, through best practice in care planning and case management, empowering patients to self-care, reducing emergency admissions levels to be on a par with the best levels internationally and through providing more efficient, integrated community services.

What might this mean for general practice?

GPs have to manage their finances with only a 0.8% pay award for GMS 2010-11 and many who have a PMS contract are seeing downward reviews of their baseline contract values.

Latterly the APMS contracts tender process is being conducted with a capped financial envelope based on GMS global sum prices which are much less than had previously been available.

All businesses are facing inflationary pressures and increasing staff and overhead costs.

The PCTs are expecting greater innovation and quality improvement for the same price.

This all means GP practices have to reinvent themselves as commercial businesses, looking at new income streams and managing cash flow and profit.

New ways of working may have to be considered

Rather than the traditional GP partnerships that hold GMS, PMS or APMS contracts and are employing authorities for the purposes of the NHS pension scheme, other business structures may need to be considered.

A partnership is not a separate legal entity and therefore the partners have unlimited liability. A Limited Liability Partnership can be used to create limited liability but it may not hold a GMS or PMS contract and cannot be an employing authority for superannuation purposes.
Some practices have considered operating as a company limited by shares:

Advantages

- Limited liability for members.
- Raise capital by issuing shares.
- Employees can have a stake in the business.
- Separate legal entity that can continue after a death.
- Useful to mitigate tax liabilities in some circumstances.
- Can be used to separate procurement and provision.
- Goodwill may be generated.
- Profits can be distributed.
- In some cases can be an NHS employing authority.
- In some cases can hold a GMS, PMS or APMS contract.

Disadvantages

- Costs of statutory compliance and regulatory burden.
- Possibility of need to give personal guarantees.
- Information held on public record.
- Filing deadlines.
- Need for a shareholders agreement.
- Less pensionable earnings for principals.

But be aware that if a company is limited by guarantee then it cannot hold a GMS or PMS contract.

Practices may work together via consortia or with other local bodies as a Community Interest Company (CIC)

If this is the case it is important to establish an executive board, rules re tenure and voting rights, together with establishing procedures if a practice is required or wants to leave, how and when savings are to be allocated, day to day operational rules and future winding up mechanisms.

A federation (see front page) or unincorporated association (consortium) is not a separate legal entity and therefore there is unlimited liability. They are also not eligible to be an employing authority for the purposes of the NHS superannuation scheme unless they reorganise into a more formal entity, such as a company.

Advantages of a CIC

- Suitable for social enterprises and not for profit organisations.
- Limited liability for members.
- Can borrow for finance and can sell shares.
- May be able to access grants and government funding.
- Continuity of purpose.
- May be eligible to hold a GMS, PMS or APMS contract.

Disadvantages of a CIC

- Annual report and accounts on public record.
- An asset lock is required.
- Taxed as a company, no tax breaks that a charity gets.
- Transparency of directors' remuneration.
- No windfall profits for members.
- Have to pass the community interest test.

Integrated Care Organisations (ICOs) could well be what we see in the future

These enable health and social care to work together with other community services. There are currently 16 pilot projects underway.

The Coalition's intention to strengthen GPs' power to commission care on behalf of patients could well be realised through ICOs. A GP will become a patient's expert guide through the health system.

Patients will have the right to choose which GP they register with and to choose any healthcare provider that meets NHS standards, within NHS prices including the independent, voluntary and community sector providers.

Are your staff a data risk?

GP practices are being advised to ensure their staff are complying with Data Protection Act requirements following the case of a lost unencrypted memory stick containing 8,000 patients' personal details.

The privacy watchdog, the Information Commissioner's Office, reported that one surgery staff member downloaded a database containing patient details in contravention of practice policy.

This information then went on to an unencrypted and non password protected computer memory stick. It was then posted by recorded delivery to a health authority department. But the stick failed to arrive at its intended destination and is now accepted as lost.

Remedial action by the practice included ensuring all mobile devices including laptops and memory sticks were encrypted, ensuring physical security measures were sufficient and making staff fully aware of the organisation's data security policy.

Sally-Anne Poole, IFO enforcement group manager, said: 'It is unnecessarily risky to download 8,000 personal details on to a memory stick. It is imperative that staff are made fully aware of an organisation's policy for securing personal data and any portable device containing personal information should always be encrypted to prevent it being accessed in the event of loss or theft'.

As many as a quarter of the breaches involving people's personal information reported to the ICO occur in the NHS. The NHS has accounted for 250 breaches – 'far too many' according to the watchdog.

The ICO said staff need simple procedures on how to handle personal information with appropriate training to ensure the importance of personal information is fully understood.

Many data security breaches are a result of human or technical error. Mistakes include staff disclosing personal details to the wrong people and automated machines which send letters out to the wrong addresses.

Protect data from wrongful disclosure – a checklist

- Are you sure that you know who you are disclosing personal information to? Have you checked that they are genuine and entitled to the personal details that they are asking for?
- Beware of email dangers. Be very careful when selecting recipients of personal information from drop down lists to get the right ones. Do not click on 'reply to all' and automatically include all the copy recipients in your disclosure of personal information. For more sensitive information simple email disclosure may not be sufficiently secure.
- Check that automated systems, such as for stuffing envelopes, are working properly and do some dip sampling to verify this.
- Beware of window envelopes. Ensure that only the name and address can be seen through the window.
- Check the positioning of screens particularly in open areas or by windows where they might be seen by members of the public.
- Train your staff in the risks of wrong disclosure and make sure that they do not get careless about who they are passing information on to.

The ICO has produced a plain English Guide to Data Protection to provide practical advice about the Data Protection Act.

Source: ICO