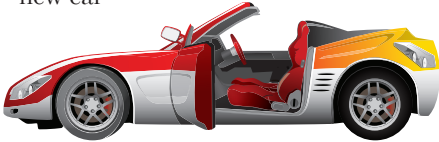


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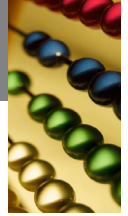
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Survive new legal threats

Rapid changes in general practice are bringing GPs face-to-face with new legal issues. Solicitor **Andrew Lockhart-Mirams** highlights current areas to watch for

Resource constraints are not new but GP practices are under increasing pressure to provide more services over longer periods and to deliver better value for money.

Small practices in particular feel under threat as they see the plans for 'GP-led health centres' and 'polyclinics' rolling out across the country.

The opening up of primary care services to commercial providers through APMS contracting means that the environment is becoming more commercial and competitive in nature.

As specialist legal advisors to the health professions, Lockharts has been witnessing a dramatic change in the types of issues that preoccupy our GP clients.

Advice on business structuring, tendering, mergers and acquisitions, and polyclinics now form a major part of our day-to-day work.

Business structuring

The majority of GP practices still function as partnerships. The GMS contracting arrangements envisage a partnership structure, although single-handed practices and corporate providers are accommodated.

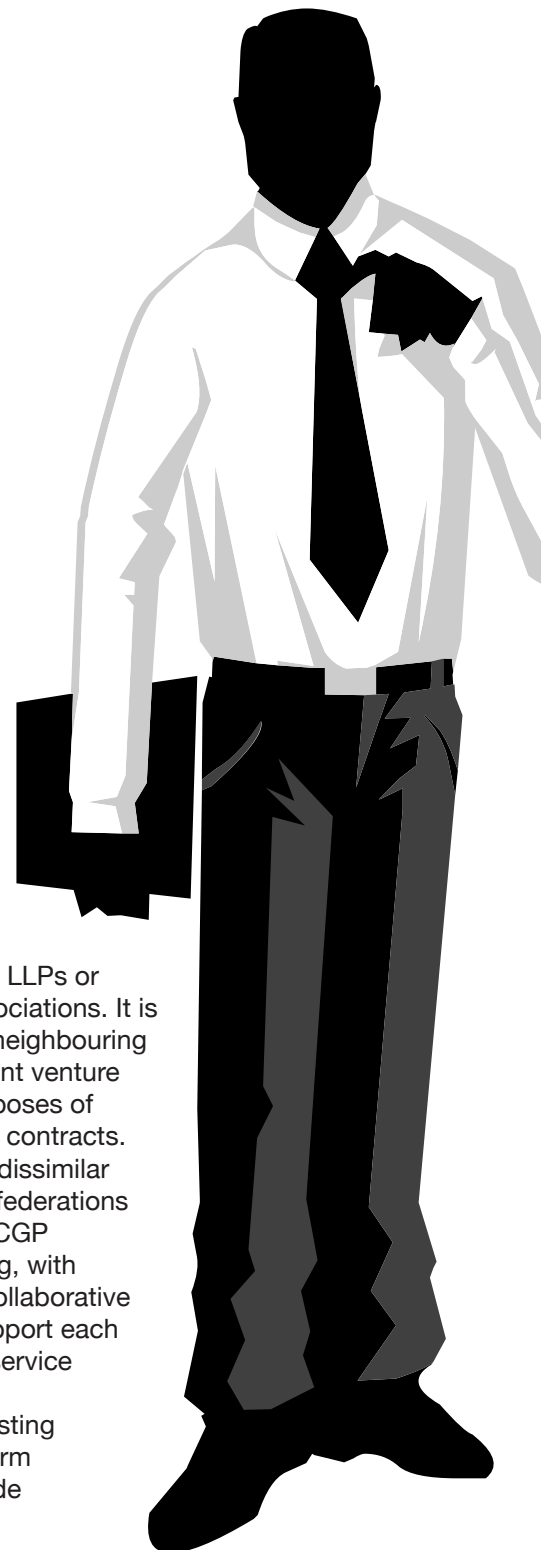
PMS contracting is less consistent with partnership arrangements, and the introduction of APMS contracting and other developments such as practice-based

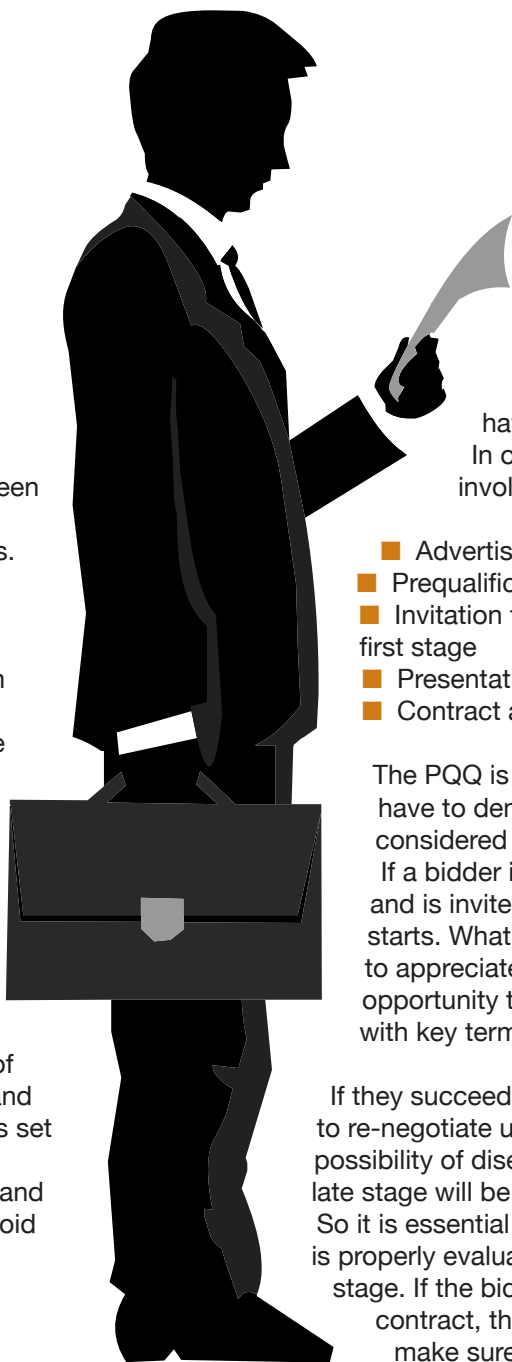
commissioning, mean that alternative business models are becoming much more common in general practice.

GP providers are increasingly forming companies, LLPs or unincorporated associations. It is not uncommon for neighbouring practices to form joint venture vehicles for the purposes of bidding together for contracts.

Arrangements not dissimilar to the primary care federations envisaged by the RCGP are already emerging, with practices forming collaborative organisations to support each other and improve service provision.

In some cases, existing practices want to form companies to provide





specialist services alongside their main contract with the PCT.

But while there are many parallels between general practice and any commercial business, there are also many differences. The NHS regulations restrict the type of business structure that can be used in different circumstances.

We have seen practices advised to form LLPs for tax reasons, for example, who then find that this vehicle is inappropriate for the particular type of contract they are bidding for, or that they cannot offer the NHS pension scheme to LLP employees.

Provider companies can easily find themselves in a position where their provider contract or their status as an NHS pension employing authority is in danger because shares in the company have fallen into the hands of people who do not satisfy the rigorous, and often somewhat impenetrable, conditions set out in the relevant NHS regulations.

Carefully drafted articles of association and shareholders' agreements can help to avoid this situation.

Tendering and procurement

High value NHS contracts are covered by parts of the regulations on public procurement. When an existing practice contract terminates, when a new practice opens, or when there is a need for a particular new service to be provided, the contract is likely to be put out to tender by the PCT.

GP providers who already practise in an area are clearly in a strong position to compete for contracts. They have important local knowledge and will already have experience of the clinical governance and local social security systems that the PCT is looking for in potential providers.

However, they will also be expected to demonstrate a businesslike approach to the process. There are strict deadlines and limited opportunities to raise questions.

Bidders only get one chance to put their case at the various stages of the process and the scope for getting things wrong is enormous, particularly for bidders who

have never tendered before. In outline, the tendering process involves:

- Advertisement
- Prequalification questionnaire (PQQ)
- Invitation to tender to those who pass the first stage
- Presentation and interview, and
- Contract award to the preferred bidder.

The PQQ is the first opportunity that bidders have to demonstrate their suitability to be considered as potential providers.

If a bidder is successful at the PQQ stage and is invited to tender, the real work starts. What GP bidders sometimes fail to appreciate is that this stage is the main opportunity to iron out potential problems with key terms of the tender.

If they succeed in the tender it may be too late to re-negotiate unacceptable terms and the possibility of disengaging from the contract at this late stage will be very limited.

So it is essential that the tender documentation is properly evaluated at the invitation to tender stage. If the bidder succeeds in winning the contract, the last part of the process is to make sure that the contract documentation complies with the information given in the tendering process and with the NHS regulations.

Deadlines in public procurement are tight and it is often difficult for GP bidders without tendering experience to know how to put their case effectively in the short timeframe, and to know what questions to put when.

Specialist advice is crucial if bidders are to maximise their chances of success and address potentially 'deal-breaking' concerns early on.

Mergers and contract transfers

Mergers and contract transfers between family doctors are an increasingly popular way of ensuring a provider contract continues in the hands of GP contractors.

A retiring doctor may want to transfer his contract to another GP before retiring, or two or more practices

may wish to come together to achieve greater long-term stability and economies of scale.

It is important to seek advice early on and to properly coordinate the process to ensure that any related property dealings are synchronised and the contract rolls over without falling foul of the NHS regulatory requirements.

PCT consent is required to vary a PMS agreement so as to admit incoming contractors and release outgoing contractors from their obligations. But in GMS the practice based contract can continue, despite changes in internal partnership arrangements, as long as the provider conditions and the relevant PCT notice requirements set out in the legislation are satisfied.

The parties will need to conduct due diligence before entering a binding contractual arrangement - as with any commercial merger or acquisition.

But inquiries will need to be tailored to the particular features of the sector. They should address, among other things, issues such as the fitness to practise of potential

partners and clinical governance of the practices.

Polyclinics

Despite being unpopular with many GPs, plans to open polyclinics or GP-led health centres are going full-steam ahead. Some of our clients have already successfully won contracts to provide the GP services at such centres.

Others are anxiously anticipating the impact that these centres will have on their practices, or are in the process of putting together their tender applications.

As with any contract, it is crucial that bidders seek advice on the tendering process and the contract terms in order to identify potential problems at the earliest stage possible.

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Drive a smart bargain

Doing your homework before you splash out on that new car will save you £££s. **Robin Stride** reports



The credit crunch has left thousands of would-be car buyers just dreaming. But work demands mean many GPs will be looking for a new vehicle before their accounting year ends.

If you have not succumbed to one of this month's '58' registrations so far then there are some excellent deals out there.

But you will do best if you ensure you have the upper hand when heading for the showroom to buy.

Mark Boyle, personal loans manager at Alliance &

Leicester, says: 'When buying a car, it is a battle of wills with the salesman. They understandably want to sell at the highest possible price and motorists need all the tools available to side-step the patter and make sure they do not pay over the odds.'

'Having the money to hand means motorists can concentrate on buying at the best price, without being enticed into taking out pricey car dealer finance that can see them lumbered with double-digit interest rates'.

If you are not paying outright then sorting the finance first

might also swing things in your favour when thrashing out a deal for part-exchanging your existing car.

The bank advises you do your research before you go to a showroom. Know what type of car you want that suits your needs. And do not get charmed into looking at something bigger and more expensive.

Be realistic about how much you will get for your current car in part exchange. Make sure the car is clean inside and out, and see that all the paperwork, such as log book, service history and MoT are up to date.

Watch out for hidden costs, like delivery charges, number plates, administration charges, or the cost of a warranty.

And haggle as much as you can to get the best deal. This can save you hundreds. Mr Boyle suggests if a salesman says he is going to speak to his manager about a deal then ask to speak to the decision-maker yourself so you can negotiate directly.

Know the rate

Steve Fowler, What Car? group editor says: 'With so many new cars being bought with finance, it's vital that buyers arm themselves with information before they go into the dealership. It's important to know what sort of finance packages and rates are available from other lenders so you can compare what's on offer from the dealer.'

Financing your car could be 14% more expensive just by choosing the wrong loan, according to Michelle Slade, analyst at Moneyfacts.co.uk, the personal finance information website.

Motorists may search hard for the best price but then put less time and effort into finding the best finance deal. Getting the finance choice wrong can prove a costly mistake.

She says: 'There are over 40 providers offering a range of unsecured loans and many offer different rates depending

on if you apply online or over the telephone.

'Latest Moneyfacts.co.uk research has shown that, on a £5K loan, the difference between choosing the best and worst loan deal could cost you an extra £769, while the wrong choice on a £10K loan could see you out of pocket by more than £2.4K - or to put it another way, increases the cost of financing your car by a massive 14%'.

If you are going for a loan then her company suggests you compare deals by considering the total repayment figure. Beware of specialist car loan deals. Often the freebies, discounts or perks do not make economical sense if you have to pay a higher interest rate.

And know the cost of tempting repayment holidays. If you took a £10K loan over five years at 8.0% APR and a three month repayment holiday at the start then you would pay an additional £156 in interest charges.

Do not forget your insurance when buying. Never be fooled into thinking an existing insurer will offer you the best premium rate out of loyalty - you may get a cheaper quote elsewhere by shopping around.

But watch out for garages offering tempting 'then and there' insurance so you can drive your new car straight off the forecourt. New research from uSwitch.com found that the cost of manufacturer insurance carries an average 10% mark up.

A GP buying a Mercedes C200 sport coupe and insuring it with the manufacturer through Norwich Union at £462 would be paying £170 more than the nearest best buy equivalent of £291, offered by Swiftcover.

But if a manufacturer offers free insurance then consider it seriously. Just check you fully understand the policy before signing on the dotted line, especially that the voluntary excess is not unreasonable. And note the renewal date so you are not stuck with the same insurer after the free cover expires.

Flogging a dead horse?

If your staff are failing to deliver then you have to act. **Kathie Applebee** spells out the options

There is a saying in equine circles that it costs as much to keep a bad horse as a good one.

This is not strictly true as horse riders tend to invest in training and equipment for good horses whereas they will spend the bare minimum on a bad one.

In general practice, staff costs are usually the prime area of expense and the concept of investing more in this financial black hole appears contradictory.

However, as with good horses, good staff will generally repay any investment in their development, assuming they are looked after by the practice and are able to stay

with it.

But what about the 'bad' or inadequate staff? Do they warrant further investment or should they, like bad horses, be given the bare minimum of attention?

In order for a practice to answer this question, it first has to establish why it is asking it in the first place. In other words, why does it have inadequate staff? The possible answers include:

- Poor recruitment
- Inadequate management and/or supervision

- Bad job design
- Low pay rates
- Unsatisfactory working conditions
- Lack of a suitable labour pool
- Competition from other employers.

Before deciding on a possible solution, the causes need to be established so as to prevent reoccurrences. In my experience, general practice employers are often hesitant about taking action against failing staff.

While this may be appropriate when the causes are self-inflicted, such as in the cases of weak management, it is inappropriate when the employee is either incapable of doing the job to the necessary standards or does not meet the practice requirements for conduct or turnout.

However, capability requires that the practice demonstrates that it has done its best to address employee shortcomings. So, in answer to the question posed earlier, practices have no choice but to invest in poor staff, but their investment will only be sound if the staff member either improves as a result of this or is dismissed.

Leaving them working in a sub-standard, and hence costly, manner should not be regarded as an option.

Staff dismissals

The costs of dismissing staff members can be high if it is not done correctly. The ACAS website (www.acas.org.uk) provides a wide range of useful information but there is no

substitute for specific legal advice.

Practices may opt for centralised help lines, possibly as part of subscriptions to professional bodies or journals, but there are potential advantages to using local law firms that specialise in employment law. The latter organisations are not only able to provide a personalised service but should also have a useful knowledge of the local employment tribunals.

Practices can take out so-called tribunal insurance to protect against the costs of legal action by staff. These policies usually specify working with a named legal advisor and following all their directions.

Although such insurance is yet another cost for a practice to pay, like all insurance policies it uses known costs to protect employers against unknown ones of potentially much greater magnitude.

If practices cannot get it right from the outset, in terms of staff recruitment, management and development, they will effectively have to pay in arrears.

Such 'payments' include improving staff policies and training, and working to achieve the best possible return from the practice's employees.

Skimping on staff development is the ultimate false economy.



Kathie Applebee is an organisational psychologist for primary care, and strategic management partner at the Callington & Gunnislake Group Practice www.practiceservices.co.uk

Opinion

Don't let the clouds hamper your vision

Mike Gilbert, past chair, AISMA

I cannot recall a time when so many financial issues caused such fear, uncertainty, and mistrust among GPs.

Earnings on average seem to be falling by as much as 3% - 5% for 2006-07 and 2007-08. There is no certainty at all as to future pay awards.

Meanwhile, space restriction prevents many GPs from providing additional services and yet money seems to be available for polyclinics. But not for improving existing surgeries.

Bidding for services and practices is stressful. GPs have never been trained for it and the procedure is time consuming and riddled in politics.

Then there are confusing pension changes. It may be good news for those retiring in the very short term with a pension of £50,000 a year and

a tidy lump sum for those who have 35 years service or thereabouts. But how are the pensions of young GPs to be afforded? Is the 2.5% hike in contributions a measure of things to come?

We see the structure of medical practice changing and more clinical employees than ever before. GPs without business training struggle to identify the opportunities this may create. At the same time many are finding it stressful to know how to use their time most effectively.

All this is only the tip of the iceberg for some practices. Yet it is vital for GPs not to get so bogged down that they fail to see the business opportunities around them.

In the current climate it is all too easy to take one's eyes off the ball and miss out on the chance to do better and improve services.

Financial Diary

Topical jottings of a money-minded GP

New LESs spelt losses

GPs' finances are being squeezed between a zero uplift in the contract and ever rising costs. Just to stand still practices must be leaner and meaner. All opportunities to earn money need considering but they must make sound financial sense.

We had the opportunity to sign up to two LESs, one on heart failure and one on diabetes. Both involved the practice taking back the care of patients from the hospital. On a casual glance they both seemed okay.

But closer scrutiny revealed the workload involved was so open ended that both contracts could tie up GP, nursing and admin staff for vast chunks of time for minimal reward. It would have probably required the use of locums which would have resulted in a net loss for the practice. We said no.

Computer audit pays off

Maximising QOF income remains our top priority. The first important step is having accurate disease registers. We were confident we had these with the exception of chronic kidney disease. National prevalences would suggest at least 5% of the practice population should be coded for this yet our practice figure was 2.2%.

A computer audit was run searching for all patients with eGFR <60. It identified almost 200 patients who had either not been coded or the wrong code had been added for CKD. The main problem seemed to be that our clinical system, Vision, required two mouse clicks to record the diagnosis in a format recognised by QMAS.

When the CKD diagnosis icon was clicked, the default setting for episode type had to be changed to new. As ever GPs are the weakest link and often forgot to do this. Over the last few weeks I have gone through the patients' list and coded them properly.

An extra 200 patients will double the number of CKD patients and should significantly increase our payment for this QOF work.

Mini bus delivers QOF points

One difficulty we have with QOF is encouraging some elderly patients to attend chronic disease management

Top Tips

- Carefully consider any extra work such as local LESs to make sure financial rewards match workload
- Disease registers are the fundamental building blocks of QOF. Any variance from national prevalences should prompt an audit.
- A practice based transport system for patients may help get elderly patients to chronic disease management clinics.
- Taking a chance and empowering staff to make changes to their roles and responsibilities

clinics. GPs often do house calls to maximise points and ensure care is not compromised.

An old medical school friend has got round this problem by running a practice minibuss, set up as a separate charity to the practice. It is a people carrier on a long term loan from a local garage and the drivers are volunteers from the practice population.

Patients are asked for a donation that they can afford towards the costs but this is not obligatory. The take up from patients has been fantastic. Their clinics are well attended and the practice gains maximum QOF points with few being exception reported for refusing an invite.

Staff solve manpower problems

Recently we had problems recruiting and retaining afternoon reception staff especially for late afternoons. We spent a small fortune on adverts and even used a recruitment agency.

Our permanent staff were getting unsettled by all the change and the extra hours they had to work to cover shifts. Things came to a head when our practice manager had to take time off and nothing seemed to be happening to fill the vacancy again.

The staff asked if they could sort it themselves and did so. Firstly they reorganised their duties to accommodate new hours and new roles with the practice in the transition to paper light. Secondly they found a retired medical receptionist who is looking for part time work but can be flexible with her hours.

Everyone is delighted with the arrangements. It proves staff can be empowered to make changes.

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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