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association of independent specialist medical accountants

AISMA Doctor Newsline

A helpful resource for the practice business

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10 top money issues for GPs

The credit crunch is hitting everyone but there is much that GPs and their practices can do to make the most of their finances

1 Payment checking procedures

PCTs are often making errors in their payments to practices so GPs should ensure they have strong claiming and checking systems in-house to be confident nothing is missed.

Although much of a practice's income is calculated automatically this does not mean there are no faults. Practices do not always receive everything they are entitled to.

Documentation provided to practices varies between PCTs so it is crucial to check in detail the monthly PCT schedules you receive. Check QOF payments tally with the points achieved, the list size for the calculation of the global lump sum, payment for agreed enhanced services and the application of nationally agreed uplifts. It is essential for PMS practices to regularly check their contract sums.

All too often PCTs also 'forget' to make payments that practices are entitled to and have claimed for. Or they make payments very late.

2 Pursuing profitability

There are some key issues to consider in the quest for profitability:

- 1. QOF points.
- 2. GMS/PMS income per patient. The average is close to £120.
- 3. Outside income levels – AISMA clients average 7.7 per cent of total income from sources outside GMS or PMS. This is an average of £22,362 for a full-time equivalent GP.
- 4. Dispensing – this might be an opportunity for practices to do alone or in a joint venture.
- 5. Enhanced service – are you doing enough? Do you need to specialise?
- 6. Watch your list size: money follows the patient.

3 Identify quick-wins

Recognise potential quick-win situations. Bidding for PCT-run practices is one. Remember you need to negotiate £100-£120 per patient for PMS or GMS contract income.

Taking over solo GP practices may be another opportunity. Again, look at £100-£120 per patient.

Getting involved in providing new services may be another quick-win for your practice. But it may involve some form of specialisation, such as cardiology, diabetes, elderly, palliative medicine, mental health, dermatology, musculoskeletal, women and children, ENT, homeless/asylum seekers, or procedures, such as vasectomy or endoscopy.

4 Contain costs

Join buying consortiums, perhaps to purchase drugs. Shop around for better deals and use internal rather than external locums if you can.

GPs should delegate to their practice managers – but always make sure not to abdicate responsibilities. There have been too many horror stories.

5 Check endowment policies

Following recent stock market falls it is wise to check if there is likely to be a shortfall on any endowment policies you have to secure your practice or home loans. You have six options.

- 1. Do nothing and hope growth rates pick up.
- 2. Pay more money into the plan.
- 3. Save elsewhere to pay off the shortfall.
- 4. Pay more into the mortgage loan by converting part of it into a repayment mortgage. If it is a flexible loan you could increase the payment to the lender and cut the capital balance.
- 5. Surrender the policy, pay off part of the loan with the proceeds, and convert the rest to a repayment (capital and interest) mortgage.
- 6. Leave the plan running as a savings vehicle and convert the whole loan to a capital and interest basis.

6 Beware private work pitfalls

All that glistens is not gold and there are pitfalls to watch out for if you take on outside work. A couple of sessions away from the practice might appeal but will it cover the additional costs of taking it on? There will still be paperwork to do when you come back.

Also watch out for partners' resentment, which is bound to be created if the practice loses money. It is best to take on work that earns all of the partners a visible profit.

And guard against compressing existing surgery work into a shorter time. Always delegate something else in return and decide how busy you should be. Letting work mount up is not the way to maximise profit.

It is now more important than ever for partners to agree precisely what constitutes partnership income and what constitutes either private income or a prior share of partnership profit.

7 Don't keep secrets

It is never good for partners to keep secrets from one another. And it is not healthy for your practice if individual partners harbour jealous feelings.

Be upfront with one another and fully accept what is agreed between you. Then it will be easier for private income to be channelled through the practice accounts, making tax and superannuation calculations easier.

8 Plan for the future

An away day, possibly facilitated by a consultant or a specialist practice accountant, is a great opportunity to formulate future practice strategy.

You should consider six key questions. What do we want to do? What have we done in the past? What must we do well to succeed? What could we do? What might we do? What should we do?

Involve your practice manager either as a facilitator or an integral part of the team and record all major points. All partners must contribute equally and be totally honest without being hurtful or unnecessarily aggressive.

Ban anecdotes, such as 'we always used to'. Niggling at each other helps nobody.

9 Learn to collaborate

GP practices are beginning to discover the advantages of working collaboratively to share clinical and management expertise, and the burden of financial risk. In fact, LMCs are advising practices to meet the challenges of competition and commissioning by collaborating, forming larger groups or partnerships, establishing GP cooperatives, creating practice-based commissioning consortia and working in partnership with the PCT.

In this way, GP practices can provide a host of services rather than leave them to others, such as private companies. A creditable consortium of GPs must surely be the best option because of their trustworthiness and concern for patient care.

Commercial organisations are more accountable to their owners. The alternative is unthinkable – there is a real threat that GPs could lose their independence and have

no choice but to become employees of a commercial APMS organisation.

10 Gear up for retirement

Before you go, obtain an estimate of your own pension and lump sum. Make sure you give the notice required under your partnership agreement and give your primary care organisation three months notice.

Make your final pension contributions and review carefully. You should explore open-market options and transfer all non-NHS pension funds if appropriate. Invest your capital for a combination of growth and income, and address inheritance tax issues.

• *Adapted from AISMA's essential guide Managing Money For General Practitioners second edition, edited by Mike Gilbert, Radcliffe Publishing, £24.99.*

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GPs face tough new tax penalties

Ouch! The taxman's new penalty regime is going to hurt. **Stephen Adams*** advises GPs to take cover

This month marks the start of a new fine collection regime for any misdemeanour you make on almost any type of tax related document filed with HM Revenue and Customs (including VAT and PAYE).

Taxpayers and their accountants now have to try to forget the previous separate systems for settling disputes with the former Inland Revenue, and Customs & Excise, and get used to dealing with a new aligned system.

In future, if you make a 'careless' undisclosed error you could be fined 15-30 per cent of the amount of error. If you tell the taxman first then this may be waived.

But things hot up for an 'unconcealed/deliberate' mistake. That will cost you between 35-70 per cent of the figure – or 20 per cent minimum if you disclose it without being prompted.

If you are deemed guilty of a 'concealed/deliberate' error then the charge will rise to 50-100 per cent, and 30% minimum for unprompted disclosure.

Fortunately there is no fine for making an innocent mistake. And some fines for 'careless' errors can be suspended to encourage better behaviour. But much greater care will be needed to manage the risk (and especially the resolution) of disputes with HMRC from now on.

GPs without fee protection insurance to cover the cost of routine checks by HMRC should now seriously consider buying it. Costs can otherwise hit the £5,000 mark, or

more.

It will be crucial to avoid too many innocent mistakes as these will soon be regarded as 'careless' errors. And it will be wise to record evidence to show that reasonable care was taken to avoid 'careless' mistakes.

Several new errors will also need to be disclosed to HMRC to avoid fines, including:

- 'Careless' VAT errors, which must be disclosed separately to HMRC irrespective of their size.
- Failing to advise HMRC if it has understated your tax bill (to avoid a new 30% fine).
- Overstated (but unrelieved) trading losses carried forward (to avoid a new 10% fine).
- Timing differences – such as incorrect year end debtors figures (to avoid a new 5% per annum fine).

HMRC now also has further considerable powers to inspect records and intervene in current business accounts and/or tax returns to carry out checks in 'real time' instead of waiting for tax returns to be filed up to 12 months after the year end.

Experience in managing the risk, and especially the resolution, of disputes with the former parts of HMRC will be critical in the months and years ahead.

If you are not 100 per cent sure that your systems provide 100 per cent correct figures for HMRC please get in touch with your AISMA accountant soon because their considerable experience will quickly highlight required remedies at minimal cost.

Think smart before making cost cuts

With money so tight, practices should avoid 'knee-jerk' responses to the need to make economies. **Kathie Applebee** explains

Maximising profitability may once have been regarded as more suited to the commercial than the public sector - but the current financial climate is sweeping away such distinctions.

With rising levels of national debt, the NHS will inevitably come under increasing scrutiny and general practice, already labelled the fat-cat sector of the NHS, will not escape these unwelcome attentions.

When life gets difficult in general practice, two common themes emerge: people retreat into the 'real' business of the practice and focus solely on patient care, to the exclusion of all other demands, or else they have a knee-jerk response which seems to necessitate making radical changes in order to improve efficiency. At times

of financial pressure, staffing costs are an obvious target for such economy drives. Staffing levels do need to be reviewed at regular intervals, and it is not unreasonable to have a financial motive for this, but the task needs to be approached with care and sensitivity.

Announcing loudly at a practice meeting that the practice has too many staff creates a problem rather than solving one, especially when most practices leak gossip faster than Downing Street.

A more systematic approach combines theory and practice. The theoretical approach involves reviewing the jobs that are done independently of their post holders.

This means working out how many receptionists are needed on duty at a time. It may be one for the front desk, two on appointments until 11.00am and then reducing to one, one on visits and inquiries, and one doing repeat prescriptions. This is regardless of who does what and when – for example 'we have to have two on the desk when Angie is working as she can't manage on her own'.

The purpose of this approach is to try to separate the people from the jobs and thereby ascertain whether the practice's real needs are being met.

It may be that the practice needs two receptionists on duty at the front desk at certain times of the day but can only provide one. In this case, the job needs to be redesigned to handle the excess workload and the practice might introduce automatic check-ins and rope-and-post systems to keep queues orderly with polite signs requesting patience.

The Angie problem

If it has two receptionists on duty at times when the workload only indicates that one is necessary, a change can be made but only after the full circumstances have been carefully studied. In the example of Angie above, leaving her on her own is likely to have widespread adverse effects and thus the 'Angie problem' will need to be tackled before any associated staffing changes are made.

The complementary practical approach requires that the workload be audited. How many repeat prescriptions does the practice issue each day and what are the patterns of demand? How long does it take to issue the prescriptions and what problems arise while this task is being done?

If more are done on Mondays, what happens to the 'spare' time on other days? Usually, the work expands to fit the available space with the staff working at an easier pace on the quieter days. However, as with the Angie example, identifying potential economies is only the beginning of a process that must be carefully managed to ensure that these can eventually be achieved.

Economies may be there for the taking but they are seldom offered in ready-packaged slices. Rather, the practice's management may need to sweep together several different piles of crumbs and then produce a new dish that, although more cost effective, is still palatable to all concerned.

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

What to do

- Knee-jerk economies have a habit of proving expensive in the long run: think through ideas carefully and make proper plans before proceeding.
- Avoid petty economies: you may save £100 a year by making staff members provide their own tea and coffee but the lost goodwill will inevitably cost you more than that in terms of reduced efficiency.
- If money is tight, warn employees and ask for ideas for economies. If nothing else, they may turn off lights and computers in unused rooms.

Opinion

Profit from our advice as pay clouds loom

David Clough, Chairman, AISMA

It is now five years since the new GMS contract came into being. Over this period we have had an unprecedented number of changes with which GPs have had to cope.

It is disappointing that stability has not yet been reached. The sad part of all this is the huge uncertainty that still hangs over doctors and their staff.

The realignment of the global sum and QOF income through adjustments to correction factors and the prevalence funding formula is causing great concern to our clients who are completely at a loss as to how these alterations will affect their income.

Calculations by some AISMA members have thrown up odd and unexpected results producing reductions in income where increases were anticipated.

Maybe there is a need to adjust irregularities to create a fairer distribution of income. But the fact that this is happening five years too late seems to escape the Government.

There is a large lack of confidence in the country at present, and doctors are finding that their situation is being aggravated by the uncertainty of future NHS income.

Scaremongering in the GP press that hundreds of practices could close following the changes to pay does not help, especially as many PCTs are being slow to show support for those practices that will be hardest hit.

As accountants we do not have control over the NHS but we can help by offering specialist advice to prevent profits from falling too far.

Financial Diary

Topical jottings of a money-minded GP

£400 speaker fee helps GP breathe more easily

A friend who is a GPSI in asthma agreed to talk to a large meeting for nurses but made no fee arrangement at the time. He mentioned that rather than give a one hour talk he had been asked to give three 45 minute workshops. With travel time taking two hours this meeting will use a whole day. But a letter said his speaker fee would be £150.

I said no matter how enthusiastic he was about asthma management he was a mug to give up a Saturday for anything under £400 plus travel expenses. He is just as much an expert as any consultant and I am sure they would not get out of bed for £150.

He contacted the organisers and said that he had only agreed to a lecture and that his standard fee for a Saturday was £600 but he would offer them a discount price of £400 plus expenses. They granted him everything he requested. The lesson is never under value your time.

Private bank deal rates attractive

Our senior partner is retiring and this will involve buying him out of his surgery premises share. When we bought our surgery years ago each partner took out a personal loan with interest rates pegged at base plus one per cent.

With interest rates at a record low the bank can only offer business loans at base plus three per cent. But we have been offered personal loans of base plus two per cent if we each sign up to a private bank account.

This will cost £300 a year but will save about £2,000 a year in interest. Personal banking will offer other bonuses like annual travel insurance so the real cost is less than the quoted £300. If in the future business rates beat personal rates we will be able to swop at no extra cost. I never thought we could get a personal loan on a commercial property but it was the bank who suggested it.

Fighting unfair PCO treatment

A local colleague ran a diabetic clinic long before QOF and manages all his type 1 and 2 diabetics except type 1 diabetics aged under 14 and women who are pregnant. I asked how he found time to see them and was told that five years ago the PCO agreed to fund all his nurse time and pay for patient transport.

Top Tips

- Always charge the proper rate for time even for something you enjoy.
- Private banking may offer better loan rates for premises than business loans.
- Talk to neighbouring practices about income they get that your practice is eligible for.
- Waiving private fees to patients should be the exception rather than the rule.
- Accurate mileage logs are required to prevent tax investigations.

A local DES now pays practices on a scale for the percentage of diabetics managed in primary care. One must use the money to fund nurses. I approached the PCO and it agreed in principle to fund patient transport for patients who currently need it to attend secondary care clinics. But it suggested the extra nurse funding was historic and could not be applied to other practices. I will raise this with the LMC.

Why we got tough on fees

We have tightened up on fees charged to patients for private certificates and forms. In the past each doctor did their own thing and had discretion to waive fees if they felt the patient could not afford them.

But doctors' inconsistency confused staff and meant a loss of income as some GPs were less business minded, especially our employed staff. Things came to a head when two families travelling together on a holiday had to cancel and one lot was charged for a cancellation letter and the other was not.

We decided all patients would be charged and if the GP wanted an exception then this would be run past the practice manager. We now also collect all fees in advance after one family had their passport forms completed then failed to pay up.

Log your mileage

I keep an accurate mileage log over six months to prevent doubt about my claimed business mileage. But two colleagues did not and had large percentage claims investigated. The taxman went into their whole returns. Anything they could not prove was taxed and despite having insurance they reckon that for the stress and money it cost them it would have been better to have claimed no business use at all. I still think it is worthwhile but accurate records and receipts are needed.

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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