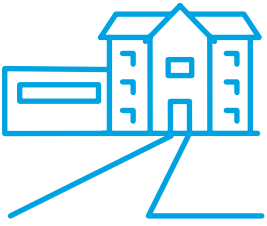


Principles of maintaining practice profitability





Principles of maintaining practice profitability

GPCW ['Save Our Surgeries'](#) campaign called for decision makers to commit to a rescue package to support GPs and patients. The aims of the campaign are to:

- **Commit** to funding General Practice properly, restoring the proportion of the NHS Wales budget spent in general practice to the historic level of 8.7% within three years, with an aspiration to increase to nearer 11% in the next five years.
- **Invest** in the workforce of General Practice to allow the implementation of a national standard for a maximum number of patients that GPs can reasonably deal with during a working day to maintain safe and high-quality service delivery.
- **Produce** a workforce strategy to ensure that Wales trains, recruits, and retains enough GPs to move toward the OECD average number of GPs per 1000 people. This must feature a renewed focus on retaining existing GPs and tackling the problems driving them out of the profession.
- **Address** staff wellbeing by producing a long-term strategy to improve the physical, mental, and emotional wellbeing of the workforce.

At a time of high inflation, increasing costs, increasing demands on practices and real-terms downward pressure on practice income via National Contracts, maintaining the viability of GMS practices via profitability is increasingly difficult.

General practice does not have sufficient funds for workforce, premises, or services to meet the growing needs of patients, undermining patient safety. This is in stark contrast to 2005/06, when the proportion of spend at a UK level was over 10% of the NHS budget, there were ambitious expansion plans for new services, excellent recruitment and retention, oversubscribed training, and high morale.

This document is designed to outline practical steps that you can take within your own practice to consider how you can stem rising costs.

The two main principles of maintaining profit are:

- maintaining revenue as a minimum/increasing revenue
- controlling expenditure/reducing cost



Maintaining revenue as a minimum/ increasing revenue

Patient list

This is your major asset. Consider increasing your list size wherever possible within the constraints of available clinical time and space. This will enable the practice to work in the most efficient way possible in terms of the ratio of GPs to patient numbers. If you plan to expand your list size, ensure that the additional workload for your weighted population is manageable. This is particularly important when considering sudden changes in population such as local practice closure, list dispersals and practice mergers.

Supplementary services

Consider the income levels from all supplementary services and how they can be offered in the most cost-effective way. Use of competent non-GP clinicians at the right level should always be carefully considered, but you should factor in the cost of any supervision required for delivery. Don't automatically sign up for a new supplementary service without ensuring that you can deliver it profitably. Ensure that all supplementary services are claimed for promptly and monitor the receipt of claims. Remember always look at the bottom line not the top line, consider the opportunity and extra staff costs of any offered supplementary service, not just the headline fee. We would advise practices to review any services that are not index linked on an annual basis to ensure maintenance of profit margins. See *Annex A*.

It is not wise to prioritise access above all else, as the capitation nature of the Unified Contract does not reward this. Time may well be better spent focusing on quality and other income-generating activities.

QIF

Engaging in this optional element of the GMS contract has historically been well rewarded and is of clinical value. This work requires liaison and planning with your GMS collaborative early in the QIF cycle which will enable you to work to the timelines required to deliver the outputs efficiently. Use the right skill mix within the practice and delegate effectively. Consider collaboration with your local practices to share best practice and to avoid duplication of efforts.

Drug profit levels-including FP34D non dispensing

Even for non-dispensing practices, having good internal controls and a solid buying policy for drugs are essential. Make sure everything used is claimed for and that all staff administering drugs understand the claims policy. Profit margins are being squeezed, so consider joining a buying group and don't overstock or you run the risk of drug date expiration.

Some FP34D drugs lose money so don't personally dispense those. Make sure your purchasing/ordering processes are reviewed regularly as reimbursements and costs and discounts can change monthly. In simple terms you make a loss on the reimbursement element on any drug where you secure less than 10% discount due to claw back. The margins on cheap drugs may be compensated by the dispensing fee, but expensive drugs, with inadequate discounts, will not be offset by personally dispensing and administering fees', so consider providing the patient with a WP10.

Training

Training can generate income for the surgery as well as varying degrees of staff resource/ clinical help to the surgery seeing patients, although trainees should be considered as supernumerary. Training can also help with recruitment and succession planning. You should explore available grant income via HEIW and other training bodies. Consider the specific training that would most benefit your practice and factor in the opportunity costs of training and supervision. Remember to include the ad hoc commitment that arises from supervision and queries that occur outside your rostered training sessions. When considering potential income ensure the different reimbursement levels that trainee supervision attracts, as some may not attract funding at all. In some quarters there are expectations that this training may be supervised as “a free gift” but you should make informed business decisions on whether to engage.

Consider diversifying your offering.

GP skills are highly transferable and allow practices to engage in outside work with attractive profit margins. You may need to undertake additional training in some areas, this is worth considering as this work can supplement income. Profit generation can indirectly support workforce expansion, GMS delivery and patient care. Practice agreements need to specify how income is shared and how time is created for partners to deliver outside activity.

Examples of additional outside work could be:

- Research practices
- School medical officers to local schools
- Prison work
- Private arrangements with other local medical facilities
- Occupational health work
- Cosmetic work
- Travel clinics
- LMC work/BMA work
- GPSI work
- Insurance medicals and forms
- Specialist private medicals-whiplash etc

Make sure your practice agreement is updated and covers the apportioning of profit and arrangements to release individuals to deliver this work.

Note:

Ensure that private income doesn't hit the level at which notional rent reimbursements are reduced.

Controlling expenditure/reducing costs

Staff costs

Staff costs are the major outgoing for any practice, approximating to 70% of your total expenses. Budget and plan for these carefully throughout the year as things change. Remember that the costs of a staff member include gross salary, employer's NIC, employer's superannuation and a notional average amount for sickness/maternity payments. You could consider reducing staff cost by arranging internal cover for an absent colleague where possible.

Ensure the right people are doing the right job. Doctors and practice nurses should be involved in clinical rather than administrative procedures. Healthcare assistants can reduce the number of simple clinical procedures being carried out by experienced GPs and practice nurses. Think carefully about the service you are providing and how it is being delivered. You may find that you can deliver identical care with a different skill mix for a smaller outlay. There is a Welsh Government additional capacity fund available to all practices which will continue until March 2025. This entitles practices to a 50% reimbursement of additional employed staff or increased hours for additional staff including on costs up to their capitation based allocated figure. This is non-recurrent money.

Consider the delivery of non-contractual and unfunded services

Spirometry, management of ear wax and some other services GPs traditionally deliver are unfunded and not a core GMS contractual responsibility to deliver. Delivering secondary care prescribing and other workload means you are impinging on your ability to deliver what is contractual. Think hard about whether you agree to this work. Also use the communication standards to reduce inappropriate workflow on GP surgeries allowing better use of staff operationally and financially.

Locum costs

Review the use of external locums and claim for locum reimbursements where possible via the SFE. There are contractual arrangements for sickness and parental leave as well as suspension absences. There are also differences in the provisions as to who can be engaged to provide cover and for which categories of health professional roles can be covered.

See appendix B.

Ensure that your top-up sickness insurance policies and practice agreements complement these contractual arrangements and suit your needs. Explore the opportunities of internal cover by reviewing staff rotas and contracts to cover absences where possible.

General running costs

Eliminate waste, reduce unnecessary telephone calls and take necessary steps to reduce your gas and electricity bills. Explore full utilisation of your building as an asset by allowing usage of spare space within premises and securing a fair service management charge. Periodically review all your current contracts and insurance costs (such as public liability) to ensure you are receiving the best deal possible. Take advice from your accountant, use price comparison websites and utilise local buying groups. Also remember that getting value and benefit for what you pay for is important. Skimping just to cut costs can be counterproductive. Ensure you claim for all the standard reimbursements, water and waste and that your notional rent reimbursement is up to date and correct. You have the right to challenge the district valuers estimate of the notional rent. This can be challenged by utilising a third-party contractor but in doing so beware the valuation could go down.

Stock control

Whilst control of stocks of drugs, dressings etc tends to be good within dispensing practices, it is sometimes less so for non-dispensers. In most practices the responsibility for ordering stock is often given to non-clinical staff, who won't always appreciate the financial implications of having money tied up in stock. Ensure you review your ordering processes of stock levels regularly and rotate stock. There is a trade-off between buying in bulk, ensuring discounts, and carrying too much stock that could go out of date.

Control of administrative stock

In addition to medical stock, another area where tighter control is needed in all practices is with administrative stock, such as stationery and other consumable items. Buying groups can help reduce the cost of purchases. This saves money and reduces administration time. Ensure you review your stock levels and ordering processes regularly.



General considerations

Profit not income

When considering “new” income streams don’t look at the potential income in isolation. You need to weigh up whether the costs (hard costs and the time of both partners and staff) make the income worthwhile.

Consider having a Managing Partner or Business Partner

A partner with an overall understanding of the systems in place can support the Practice Manager with business queries. Remember it is your business.

Benchmarking

Do you know what local surgeries are doing and claiming for? A Medical Accountant can identify gaps and areas where improvements and savings can be made? Is your Accountant linked with AISMA? Don’t be afraid to utilise and adapt ideas from your neighbours.

Budgeting

Prepare a budget and cashflow forecast at the beginning of each financial year. Keep monitoring your progress throughout the year making updates when they are needed. Times are uncertain and keeping a close eye on financial progress throughout the year will be essential to keep the practice on track in the months ahead.

We appreciate that this guidance reflects what the vast majority of your practice managers will already be doing, to great effect. However, we hope that it will work as a reflective tool and maybe be beneficial for some.

GPCW would welcome any constructive feedback and including suggestions for future iterations. We hope to keep this document dynamic with your support. Please contact info info.gpcw@bma.org.uk.

Annex A

Are you considering from withdrawing from supplementary services? If so ensure that you:

Work out the cost of the service.

- Look at current level of remuneration and cost to deliver service.
- Have a chat amongst clinical team and with practice manager to decide next steps.
- If you wish to continue, then read no further.

Payment not covering costs and / or impacting on GMS care?

- You can withdraw from the service.

How to withdraw:

- Give 3/12 notice in writing to the health board of your intention and reasons.
- Ask for them to inform you of where to redirect patients once notice period has ended. Put a time date on response to this and put a diary marker in your diary to check this has been responded to.
- Copy in the other services affected by the decision.

Top tip – make sure you get confirmation of receipt – email route perfect for this.

Continue to provide the service for 3/12

- Start updating your staff that service is no longer going to be provided and ensure they know where to refer patients once service has ended. Consider giving them a “script” to use when faced with such requests.
- Start to inform your patients via posters / screen messages / during consultations of when this service will no longer be available and why (if appropriate).
- Your LMC may develop patient information materials for you to use in some cases.
- Consider how you can best utilise the freed-up resource/ time to provide additional capacity within your clinical team.
- Keep track.
- Make a note on your systems when service is due to end.
- Remind all staff after that date that you no longer provide these services and where they should send patients.

Note: Should your health board not advise what to do with patients after the notice period please contact your LMC for advice.

Annex B

	Who can cover be claimed for?	Who can provide cover?	Maximum amounts payable
Parental leave <i>SFE section 11</i>	<ul style="list-style-type: none"> – GP partners – Salaried GPs 	<ul style="list-style-type: none"> – Locum GPs – Salaried GP on fixed term contracts – Additional hours for GP performers already party to contract or engaged by contractor – Independent prescriber locums 	<ul style="list-style-type: none"> – £1,131.74 / week for first two weeks – £1,734.18 / week thereafter
Sickness leave <i>SFE section 12</i>	<ul style="list-style-type: none"> – GP partners – Salaried GPs – Employed independent prescribers 	<ul style="list-style-type: none"> – Locum GPs – Salaried GP on fixed term contracts – Additional hours for GP performers already party to contract or engaged by contractor – Independent prescriber locums 	<ul style="list-style-type: none"> – £1,734.18 / week – Not claimable for first two weeks of absence – Full amount for up to 26 weeks – Half amount for further 26 weeks
Payments to cover suspended doctors <i>SFE section 13</i>	<ul style="list-style-type: none"> – GP partners or Salaried GPs suspended from Medical Performers List 	<ul style="list-style-type: none"> – Locum GPs 	<ul style="list-style-type: none"> – £1,131.74 / week

BMA

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