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AISMA Doctor Newsline

At the heart of medical finance...

Make your merger magic – not manic

The last 12 months have seen practices working much closer together to respond to the pandemic and to deliver the network contract DES in PCNs. Many have seen the benefits of this and are now considering merging. But **Alison Oliver** warns there are some key issues to consider first

Why merge?

There are many reasons why practices merge. The administrative and financial burden on practices has increased significantly over recent years and smaller practices are more likely to struggle with this burden.

Bigger practices are likely to enjoy economies of scale as well as being able to offer more flexibility for staff and partners to develop special interests. It is widely recognised that practices will need to be more robust and resilient to have a strong position within integrated care systems, and merging is one way to achieve that.

Where practices have worked well together within PCNs, some are considering taking the plunge and merging to form a practice

covering a whole PCN patch.

But it is important to be clear about the benefits you hope to gain from merging.

Types of mergers

There are various types of mergers, including:

- Full merger – two or more practices merging to provide services under a single NHS contract
- Partial merger – two or more practices merge at an operational/organisational level but keep separate NHS contracts for different sites
- Federated model or super-partnership – multiple practice sites continue to operate semi-independently under the governance of an over-arching partnership and management board, and
- Incorporated model – practices merge and form a limited company to operate the merged practice.

Merging NHS contracts requires the approval of NHSE/I. It will consider matters such as whether the merger offers benefits for patients and value for money. NSHE/I consent is also required to novate NHS contracts into a limited company.

The NHS Primary Medical Care Policy and Guidance Manual includes further detail on the requirements for mergers and incorporation of NHS contracts:

https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

Look before you leap

You should get to know the other practice (or practices) before you commit to a merger. This involves carrying out due diligence to satisfy yourself they are well run and financially viable as well as identifying any potential liabilities which could become liabilities of the merged partnership later, such as employment claims, patient complaints or breaches of the NHS contract.

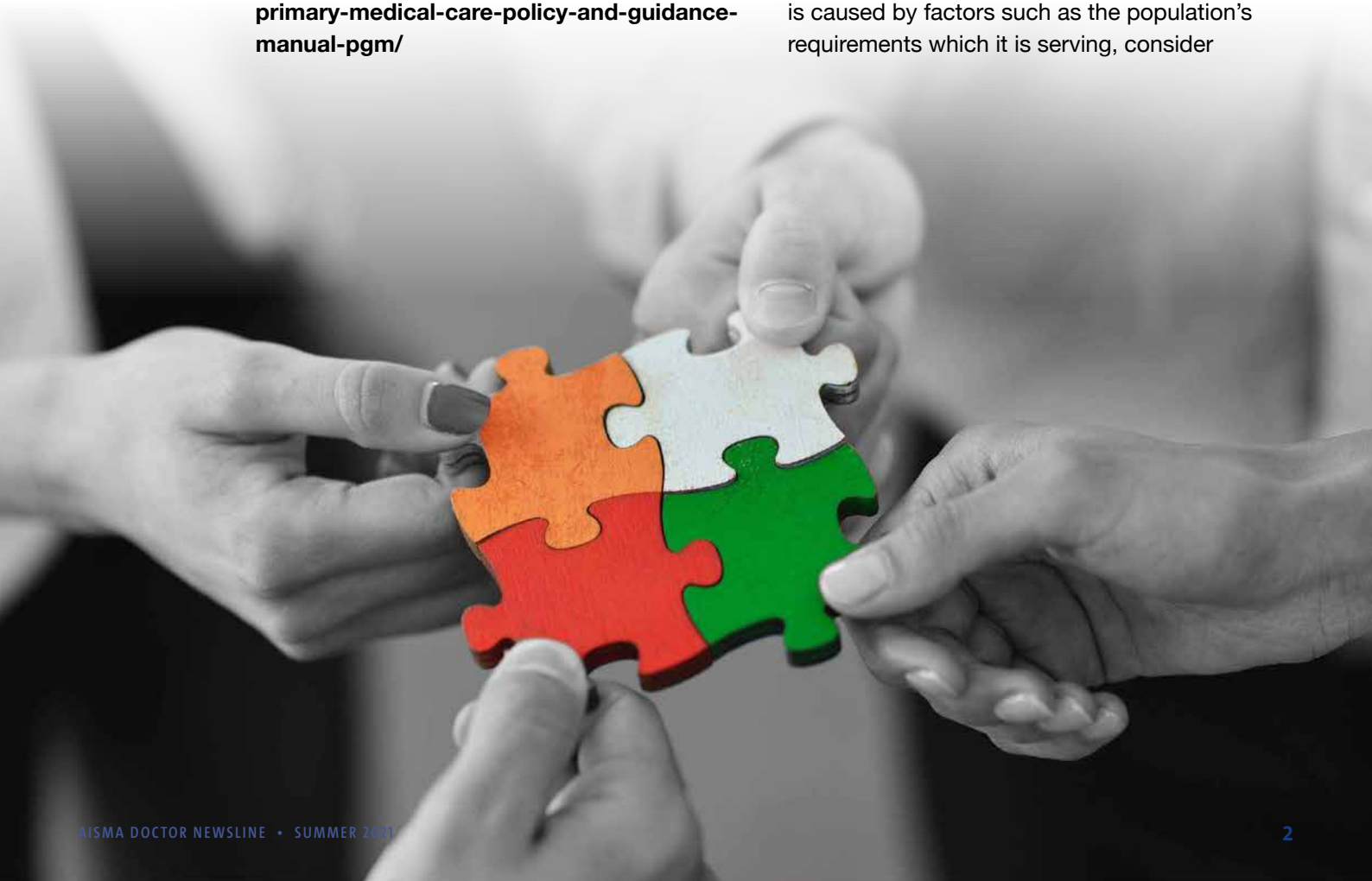
You should appoint specialist accountants and lawyers to assist with the financial and legal due diligence process. If issues are identified during due diligence, these should be addressed in the merger agreement to afford you some protection against historic issues affecting the other practice/s.

If the issues identified are serious, you might conclude that a merger is not worth pursuing with that practice.

As well as legal and financial due diligence, the culture of practices you plan to merge with is also important. Do you all share a common vision and have enough common ground in the way you work to be able to gel properly as a merged practice?

Harmonisation and integration

The partners at each practice will have different profits. If there is a big discrepancy and this is caused by factors such as the population's requirements which it is serving, consider



"Some mergers become quite political, so do not ignore local councils and councillors"

carefully how they will be equalised, or if not, how they will be weighted. Your accountants will be able to assist with this.

Different practices are likely to have different terms and conditions for partners on various other matters such as leave entitlements, sharing workload, decision making, accounting practices and so on.

Discuss with your prospective merger partners how these different terms will be harmonised so that your merged partnership has consistent terms and conditions which are acceptable to all the parties.

You will also need to discuss how to integrate the practices' systems, procedures and records.

Staff

Most of the staff of the merging practices are likely to remain employed by the merged partnership. But it is possible that you will need some new roles. You may need to consider:

- appointing a single business manager for the merged partnership
- that some roles might no longer be required; for example, multiple practice managers might be unnecessary
- that some roles will change, such as staff working across multiple sites.

You should ensure you comply with employment legislation (such as the Transfer of Undertakings (Protection of Employment) Regulations - TUPE) covering transfers of staff and any redundancies or changes to terms and conditions.

Consultations

You will be required to consult with stakeholders, including patients, and the other practices in your PCN. It is wise to consider the impact the merger may have on others and ensure they are informed and will support you.

Some mergers become quite political, so do not ignore local councils and councillors.

Premises and other assets

Assets of the merging practices will generally transfer to the merged partnership. You should consider whether any consents are required for these.

For example, if you own your surgery premises you might transfer these to the merged partnership or you might retain them as an investment asset and grant a lease to the merged partnership.

And do not forget that if the premises are mortgaged, the consent of your lender is likely to be required.

If you rent your premises, the lease will have to be assigned to the merged partnership or a sub-lease granted to the merged partnership

Get these ready

Documents needed in connection with a merger include:

- Confidentiality agreement – you might consider entering a confidentiality agreement before commencing negotiations to ensure that the merger discussions remain confidential in the early stages. This will help avoid unsettling your practice unnecessarily if the merger doesn't go ahead
- Heads of terms – it is a good idea to seek to agree key terms at an early stage to guide the negotiations
- Cost sharing agreement – you should agree how legal and financial costs in connection with the merger will be shared, particularly if the merger doesn't proceed to completion. A cost sharing agreement is advisable to avoid disagreements arising over these matters if negotiations don't go well
- Merger agreement – this is the main document setting out the terms of the merger and dealing with the transfer of assets, contracts and staff and apportionment of liabilities of the merging practices
- Partnership deed – this will set out the terms governing the partnership from the merger date and should be entered into on or before that date, otherwise the merged partnership will be a partnership "at will", which is an unstable structure.

All partnerships should have a valid and up-to-date partnership deed and this is particularly important for a merged partnership where the scope for disputes might be greater than with partners who have worked together for a long time

- Declaration of trust – where the merged partnership owns surgery premises, a declaration of trust is advisable to govern the rights and obligations of the partners who co-own the premises
- Lease – if existing premises will remain owned by some of the partners outside the merged partnership, a lease should be granted to the new partnership so the terms of occupation are clear.

and both will almost certainly require your landlord's consent.

Regulation and compliance

The merged partnership will require all the usual registrations, licences and permits and will need to comply with all the usual regulatory requirements.

You will have to apply to register the merged partnership with the CQC or make changes to the registration of one of the existing practices to bring the other sites within its scope.

Tax and financial matters

It is important to take early advice from a specialist accountant on the tax and financial considerations of merging and the proposed structure and accounting practices of your merged partnership.

There might be tax charges on the transfer of some of the assets into the merged partnership.

Various documents are required in connection with a merger (*see box above*).

Alison Oliver, a partner in the primary care team at leading health and social care law firm Hempsons, has handled numerous practice mergers. She advises GP practices, provider companies and PCNs on partnership and company law issues, NHS contracting, collaboration and governance arrangements

Key points

- Identify your reasons for merging and as negotiations progress, keep sight of your objectives – do not be afraid to walk away if negotiations fail to progress as you expect
- Consider entering a confidentiality and heads of terms agreement with your prospective new partners so that you have a roadmap for your negotiations and can share confidential information with greater confidence – also consider a cost sharing agreement dealing with how you will share costs of the merger process
- Get to know your new prospective partners and their practice
- Appoint specialist professional advisors early on to agree a structure for the merged partnership and to ensure that you deal with all the necessary legal requirements at the appropriate stage
- Appoint a working group comprising lead partners and staff from the merging practices to coordinate the process.

AISMA: proud to work for you and unlocking new ways to help

OPINION

Andrew Pow,
AISMA board member

Lockdowns, post lockdowns, vaccination campaigns, and weekly policy changes!

There's been much commotion, change, and new technicalities to get to grips with. And that's even before we mention the incredible efforts to deliver the Covid vaccination campaign.

But as we tentatively move towards a vaccinated economy and society, general practice is feeling the brunt of the wave of increasing patient demand. It is unprecedented.

Data for March showed practice appointments up 4.3m from March 2020. More telling, it was 2.8m up from the pre-Covid figures of March 2019. 3m more same or next day appointments were given compared with March 2019.

Although GP numbers have risen, when calculated on a full time basis they remain static having increased by only 111 over the past year. No surprise then that practices feel under pressure.

Practices also face similar issues to other businesses, including accountants. Staff not surprisingly have deferred their holidays to times when they can take them.

As someone who lives in a UK tourist destination, I can confirm staycations here are booming. But that means more staff absence at a time when demand is unprecedented.

Technology brings its benefits in inter connectivity. A 'Teams weary' population exists now but people have got used to going online to connect while still craving face-to-face contact.

Online patient consultation software came to the fore in 2020. It was not new technology, but adoption increased dramatically as practices had to move online to deal with the limitations Covid put on face-to-face contact.

Social distancing is difficult in busy surgeries which were never built for a pandemic. Increased time needed to see patients face-to-face impacts on how many patients you can see safely.

But that brings downsides if you cannot control the flow. Patients have got the habit of dropping a quick message to their practice. They previously might have looked things up, taken time to see if they got better, or consulted someone else first like a pharmacist.

So while face-to-face needs may have dropped, online needs have risen and they all need dealing with.

Telephone triage was also entirely the right thing to do, the downside being the possible doubling up of a telephone consultation and a face-to-face one. And I won't even mention the backlog in secondary care.

There is a perfect storm of increased demand, less time to deal with each person and a workforce not growing.

The newly formed Institute of General Practice Management's video 'If I die it will be your fault' recorded the levels of abuse that practice teams are now facing. It is never justified but when you are trying to do your best it's even tougher to deal with.

AISMA accountants are always incredibly proud to work with general practice. No more so now having seen our clients lead the vaccination campaign which will hopefully see some end to this problem. We say 'thank you' to every member of the GP team who are all delivering in their different ways.

We are here to help – technology improvements allow accountants to be more connected with practices through Cloud accounting.

PCSE has moved online in England – it's early days but we remain hopeful that over time this should reduce one of the biggest frustrations both we and practice managers have in getting things updated.

Our efforts continue to support general practice behind the scenes and have had some success in ensuring that Final Pay Controls legislation will hopefully be a thing of the past for most practices with changes now agreed to exempt a lot of situations where charges previously were made.

We will continue to work with NHS commissioners, the BMA, pension agencies and PCSE to try and ensure general practice gets the support it deserves.

Working with Murphy's law

Operational failures in general practice steal your time and add to stress. Fiona Dalziel sets out some treatment options to minimise the risks

Murphy's law states that 'Anything that can go wrong, will'. I find this is especially true when doing something under pressure.

And that is why I like to set up to deliver a training session to an empty room, not one full of an interested audience of delegates trying to be helpful.

I am struck by how similar this is to a day in the life of a practice; Murphy's law applies. A simple example would be the machine for when a consultation required a translator.

Longer appointment: booked. Translator: booked. Patient: in the consulting room. Machine: in the room - but missing the all-important cable. A frantic search ensues while the GP tries to rig up a quick alternative arrangement.

An interesting article in the *British Journal of General Practice (November 2020, see reference on the next page)* looks in more detail at this issue in general practice.

Entitled 'Operational failures and how they influence the work of GPs', the feature explores through qualitative research the impact on GPs of having to sort what has gone wrong.

The authors define 'operational failures' as 'inadequacies or errors in the information, supplies or equipment needed for patient care'. The work the GP does to solve the issue is described as 'compensatory labour'.

The article examines the fact that, when something does go operationally wrong, GPs tend to find a quick fix right away. This action may well find an immediate solution to the problem and the GP breathes a sigh of relief, notes how late they are running now, and moves on to the next patient or task.

But have these efforts stopped things from being able to go wrong?

The immediate fix may well function as a temporary sticking plaster, hiding a more deep-rooted problem which is still unresolved and which will recur again and again, taking up yet more time.

Ironically, the problem is perpetuated because risk of harm to a patient still exists – the risk has not been removed from the system.

This will sound extremely familiar to GPs and managers alike. A litany of familiar 'operational failures' spring to mind, including (but not limited to):

1 Discharge letter had far too much information/ not enough information
2 Discharge letter had not been sent
3 Prescription missing in the pharmacy – a duplicate needs to be printed and signed
4 Computer needs to be rebooted
5 Consulting room not properly restocked.

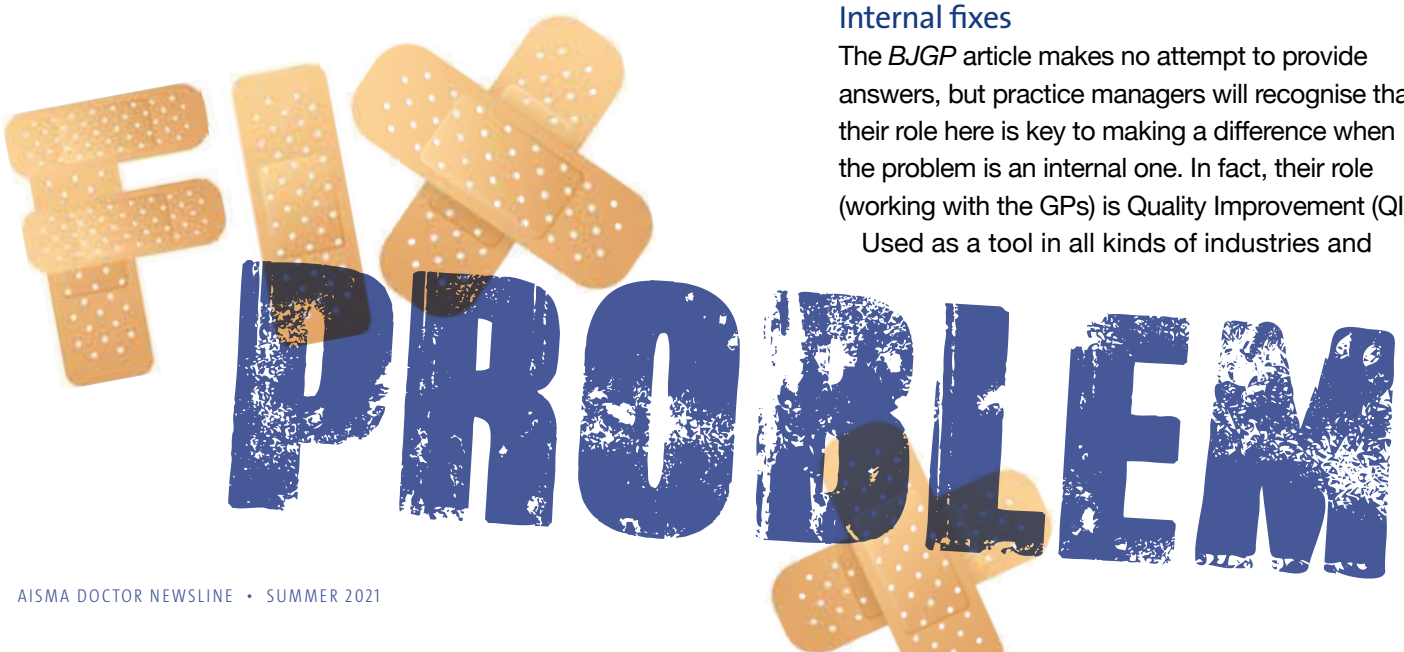
Minimising the impact of Murphy

There are no quick answers here. Even well-designed systems can fail because of the human factor and, besides, it is easier to manage internal systems than externally generated ones involving third or even fourth parties.

Internal fixes

The *BJGP* article makes no attempt to provide answers, but practice managers will recognise that their role here is key to making a difference when the problem is an internal one. In fact, their role (working with the GPs) is Quality Improvement (QI).

Used as a tool in all kinds of industries and



workplaces, QI provides a framework within which to:

- Define the problem and what success will look like
- Review the present situation, gather data
- Identify solutions
- Implement the change
- Gather data to determine whether the solution is working

Examples of QI techniques to identify the root cause of problems include fishbone diagrams and process mapping *(see link below)*.

No specialist knowledge is required, but both these techniques help practice teams identify what might be going wrong and help towards defining solutions to internal problems. Both techniques provide a clear visualisation of what is going on. Just on a flip chart is fine.

Beginners may find process mapping a good starting point. Depending on the complexity of the system under review, stick a few flipchart sheets on the wall end-to-end in landscape.

Horizontally, mark up all the stages of how a process is meant to function (key words will do), leaving space in between each stage. As a team, work through the stages, and enter into the gaps the things that go wrong at each stage.

The RCGP provides a free online tool called QI ready, and also a QI programme which is free to members (*see link below*).

External fixes

Of course, finding system solutions working with external organisations such as a pharmacy or the local hospital is a challenge.

However, there may be local structures which would provide a useful starting point in establishing opportunities for system improvement. Consider local PCN, practice manager groups and GP/consultant initiatives.

Identify an individual in your practice who is keen to gain wider leadership experience in the sector and take it from there.

Minimising Murphy's impact

QI and risk management are inextricably linked. If we want to reduce the number of things that could go wrong, we need to minimise the patient's risk of coming to harm and improve our operational systems.

Although we will never eliminate operational failures, we can work to limit them.

Fiona Dalziel runs DL Practice Management Consultancy

Reference material

1 Operational failures and how they influence the work of GPs: a qualitative study in primary care
Carol Sinnott, Alexandros Georgiadis and Mary Dixon-Woods
British Journal of General Practice 2020; 70 (700): e825-e832. ***DOI:***

https://doi.org/10.3399/bjgp20X713009

2 Fishbone diagrams, process mapping:

https://www.businessballs.com/dtiresources/TQM_process_improvement_tools.pdf

3 RCGP QI Ready:

https://qiready.rcgp.org.uk/?_ga=2.190632107.1636399092.1621859532-220487164.1621859532#.YKuc96hKiUk

***4** For more on organisational risk management, try reading **Managing the Risks of Organizational Accidents**: James Reason, Ashgate Publishing Ltd 1997*

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*Abi Newbury is a partner at Honey Barrett Ltd

ASK AISMA!

Getting a new partner does not always go to plan. Some topical questions from GPs are answered here by Abi Newbury*

You can ask a question by contacting your local AISMA accountant or messaging us through Twitter @AISMANewsline

NEW PARTNERS WON'T BUY IN

Q **My recent new partners don't want to buy into the property, and I don't want to end up being the last man standing – what can I do?**

A It is becoming an increasingly common occurrence that new partners don't want to buy into the practice premises, and it's understandable you want to protect your own position.

The first consideration here is – are the premises suitable for long term use as a medical practice?

If the answer to this question is yes, then you may want to consider retaining the premises as an investment – with the rent paid at the higher of market value or notional rent received. With current interest rates being so low, that might be a good investment.

If the answer is no, then what can be done?

- Developers will often buy the practice premises at a premium price provided they get to build the new premises.

Ideally you would want to sell your share to the developers at the same time as you retire, so that you can claim Business Asset Disposal Relief (BADR) – previously known as entrepreneur's relief. Selling the property without changing your share in the profits would mean paying the full capital gains rate.

- If selling to a surgery developer isn't possible, would the premises be of interest to a developer to convert to residential use? Or might you want to convert them yourself when no longer needed? That might also depend on expected timescales.

Be careful when considering taking the property out of the practice business – that can give rise to unexpected stamp duty land tax.

In a different market, you could insist that the terms of joining the practice include a mandatory buy-in – but that carries the risk of not being able to fill the position at all.

You need to make sure the partners who won't buy in understand that they will have to sign up to a lease to use the premises which could be more onerous than owning a share in the building.

Explain that while the practice premises are a potentially saleable income-generating asset, getting out of a lease could be very expensive.

NEW PARTNER IS NOT PLAYING FAIR

Q **We've taken on a new partner at parity, but she's not pulling her weight and I don't think she should share in QOF income. She thinks I'm unreasonable.**

A As in many cases, where there are differences between partners' expectations, your first port of call should be the partnership agreement.

If your new partner is entitled to x% of the profits, then you have no grounds for depriving her of a share of the QOF income.

Historically new partners were taken on at less than parity to allow them time to get up to speed and work as a full partner rather than a 'partner in training'.

The shortage of new partners means that most are taken on at parity now, except in extremely high earning practices, and existing partners have to just accept that that is a cost of obtaining a new partner who hopefully will be around for a long time.

Rather than getting into a confrontational situation or leaving her feeling resentful, why not try to find out why she is not performing as you were expecting and whether any additional training or assistance will enable her to get up to speed.

Remember it is a big jump from being a new GP, to taking part in running a business.

At the end of the day, it may be that this new partner is better cut out to be a salaried doctor than to be a partner, and there may be a better partner out there – so take action to help her grow, give her a reasonable time to improve, but don't let it drag on indefinitely with resentment building on both sides.

If she really isn't pulling her weight and things aren't likely to improve, what options does the partnership agreement give you?

Hopefully your partnership agreement has clauses to permit terminating a partner at the end of their probation period (or extending it and then terminating if not working), or failing that, has a suitable clause to enable the partners to remove a partner who is not delivering.

If there are no such clauses, then you may have a problem and you should seek legal advice. You will certainly need a specialist solicitor to draft you a suitable agreement for the future.

OUR NEW PARTNER COMPLAINS WE ARE UNDERPAID

Q **The new partner is very money orientated and thinks we're not getting paid enough for what we do. Where do we start looking to improve?**

A Get them to tell you where they think you are not earning enough. Often there is scope to increase profits, and it's something you should review on a regular basis in any case.

Common problem areas include:

- Not coding things correctly. Do you have water-tight systems – does everyone know what they should do? How does your disease prevalence compare to other local practices with a similar patient population? Quite substantial additional income can be obtained for work you are already doing, just by ensuring everything is correctly coded.
- Do you have systems to ensure that you are getting paid for claims made? It is quite common for claims to get missed or be paid totally incorrectly.
- What about personally administered drugs? Are all claims being made correctly? Does everyone understand what is reimbursable and what is not? Do you know what reimbursement levels you can obtain for high price items – and is that more than you are paying for them?
- Charging for reports and certificates. Are you charging market rates and being consistent in charging everyone alike? Are you billing promptly and getting paid either in advance or on delivering the report? Do you have a system for following up unpaid invoices?

Tackle one area at a time and see what additional income you can bring in. You might be surprised.

Your AISMA accountant can help you with this – and there are specialist consultancies that can review specific areas.

Modern practice management passes ultimate test during pandemic

Covid-19 has brought out the best in primary care teams as they learned to work collaboratively, bravely and quickly adapting to difficult and constantly changing circumstances. Practice management partner Diane Eaton traces an unrivalled few months and reflects on a monumental achievement

As we entered the 11th month of the world pandemic, Pfizer and BioNTech announced the initial results of clinical trials on a vaccine to protect against Covid-19. On 2 December 2020 they became manufacturers of the first vaccine to be given approval by the UK medicines regulator, MHRA.

Alongside and in anticipation, NHSE/I were working with the Department of Health to agree a mechanism for delivering the vaccine to the most vulnerable patients. The initial enhanced service (ES) specification was released to primary care on 10 November, with tight deadlines for site nominations and sign up.

There was an expectation that PCNs would work collaboratively to deliver the vaccination programme from a local designated site. This process had to be completed by 17 November 2020 and was closely followed by a 23 November deadline by which time, practices would need to sign up to the enhanced service, should they wish to take part.

In doing so, practices could sign up to deliver as a PCN, federation or as an individual practice, delivering the programme as a local vaccination site for their entire PCN population.

A collaboration agreement supplemented the enhanced service specification and detailed the local arrangements between the signing practices, for example payment arrangements and vaccine responsibilities.

The initial ES provided a payment of £12.58 per dose, paid on completion of the second dose. The service had to commit to deliver the programme seven days a week between 8am and 8pm and be available to accept the vaccine delivery within these time frames.

Additional support for IT, vaccination equipment and consumables were provided along with access to training and support materials to promote the programme.

The first vaccine was given in primary care by wave 1 sites in the week beginning 14 December 2020. Given the fragile nature of the Pfizer/BioNTech vaccine, there was a short timeframe for the 975-dose batch, which had to be used within five days from delivery.

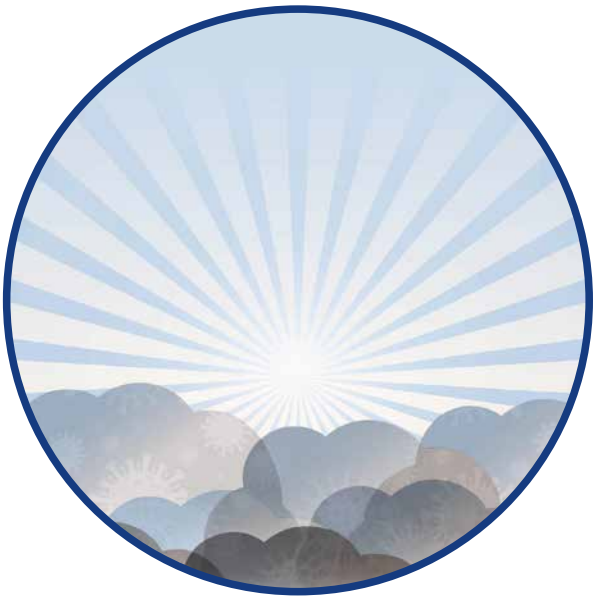
Wave 1 sites were challenged to stand up

"We have learned to work collaboratively with other organisations and teams and benefited from the support of colleagues in the wider NHS family"

a service, invite patients and deliver the first batch of vaccine to Cohort 2 of the JCVI defined priority groups - those aged over 80 - with just 10 days' notice. This was complicated by a 15-minute post vaccination wait time, introduced for patient safety less than a week before the delivery was due.

Towards the end of December more sites became live and vaccine supply slowed down, leading to the decision to extend the time between first and second doses, from three-four weeks to 12 weeks.

This allowed sites to prioritise first doses to protect the greatest number of people and led to a change in the payment mechanism, with each dose claimed separately.



On the 30 December 2020 the MHRA announced the approval of the Oxford/Astra Zeneca (AZ) vaccine. By early January delivery of the vaccine to Cohort 1, residents in care homes and their carers was well underway and supported by the new AZ vaccine, which had a longer shelf life and was easier to handle.

To incentivise completion of this cohort by mid-January 2021, an additional payment of £30 per vaccine was introduced. Further incentives on a sliding scale applied to vaccines completed by the end of the month.

Vaccines delivered in a patient's home also qualified for an additional payment of £10 per dose, to acknowledge the additional time and workload associated with home visits.

Local vaccination sites continued to work down the cohorts one to nine as directed and supported by the JCVI and NHSE/I, with early adopters reaching second dose requirements in March 2021.

As I write, phase 2 of the programme is well underway with those under the age of 50 now being offered the vaccine. Not all phase one sites have continued to offer this group and will complete their ES obligations once all phase one second doses have been completed.

The current ES is in place until 31 August 2021 and at this stage it is unknown whether this will be extended or re-offered to include a booster programme in autumn.

There is no doubt that the Covid Vaccination Programme has been a huge success and contributed to the reduction in Covid cases and adverse effects for patients.

There have been challenges along the way, with an ever changing and evolving programme. For our PCN just one practice signed up to the enhanced service and has offered the vaccine to the whole PCN eligible population.

Uptake was much greater than anticipated with over 95% of patients in cohort one to nine accepting the vaccine. So far, we have delivered over 41,000 vaccines.

We were fortunate to benefit from the commitment of retired clinicians and support from clinical and non-clinical staff from local practices, along with a band of willing volunteers from the local community, without whom none of this would have been possible.

We have learned to work collaboratively with other organisations and teams and benefited from the support of colleagues in the wider NHS family.

Bravery, determination and the ability to quickly adapt in difficult circumstances is testament to the dedication and resourcefulness of the modern Primary Care Team and we are proud to have been part of this momentous achievement.

Diane Eaton is management partner at Fernbank Surgery, Lytham St Annes