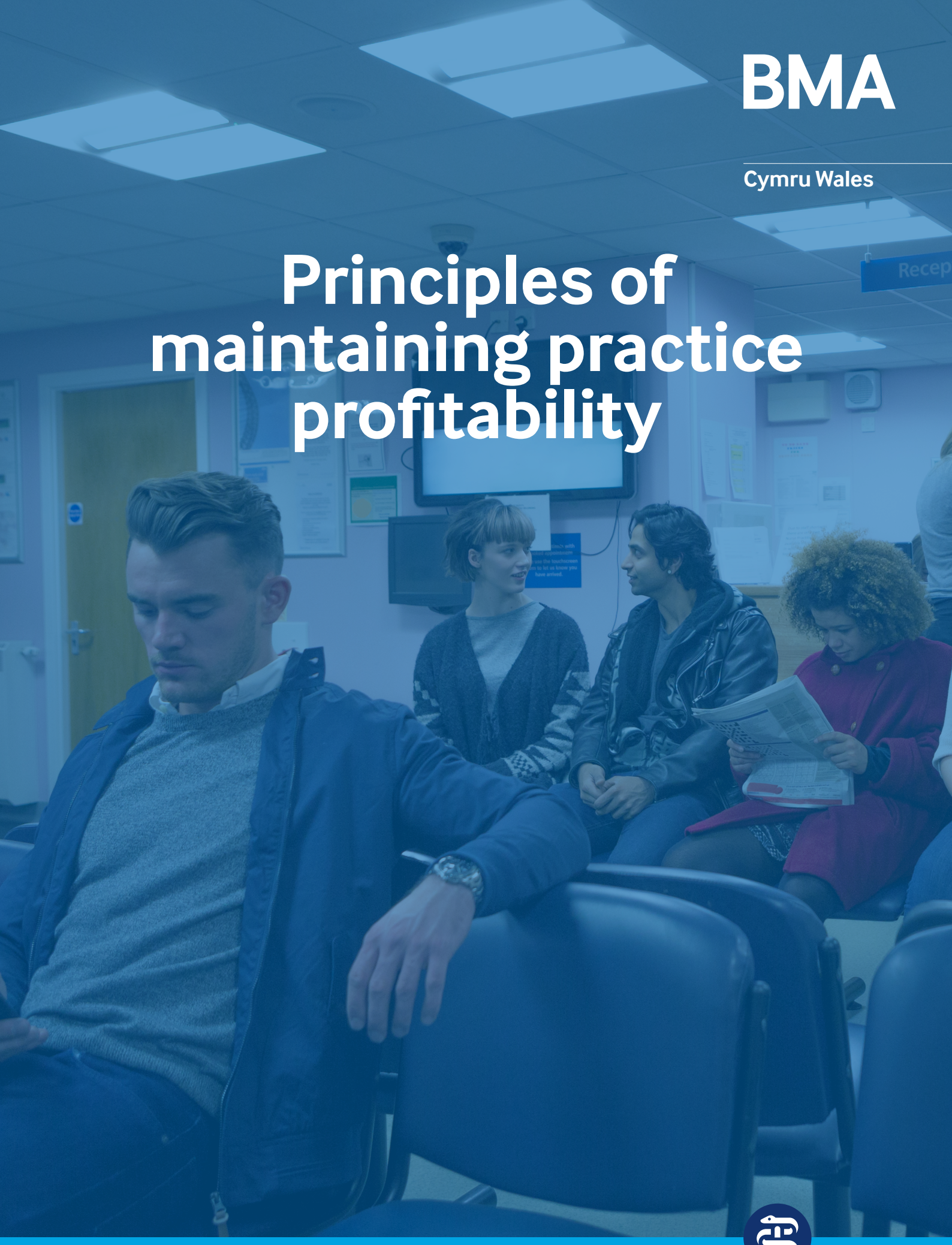
BMA

Cymru Wales

Principles of maintaining practice profitability



Principles of maintaining practice profitability

The GPC Wales '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.

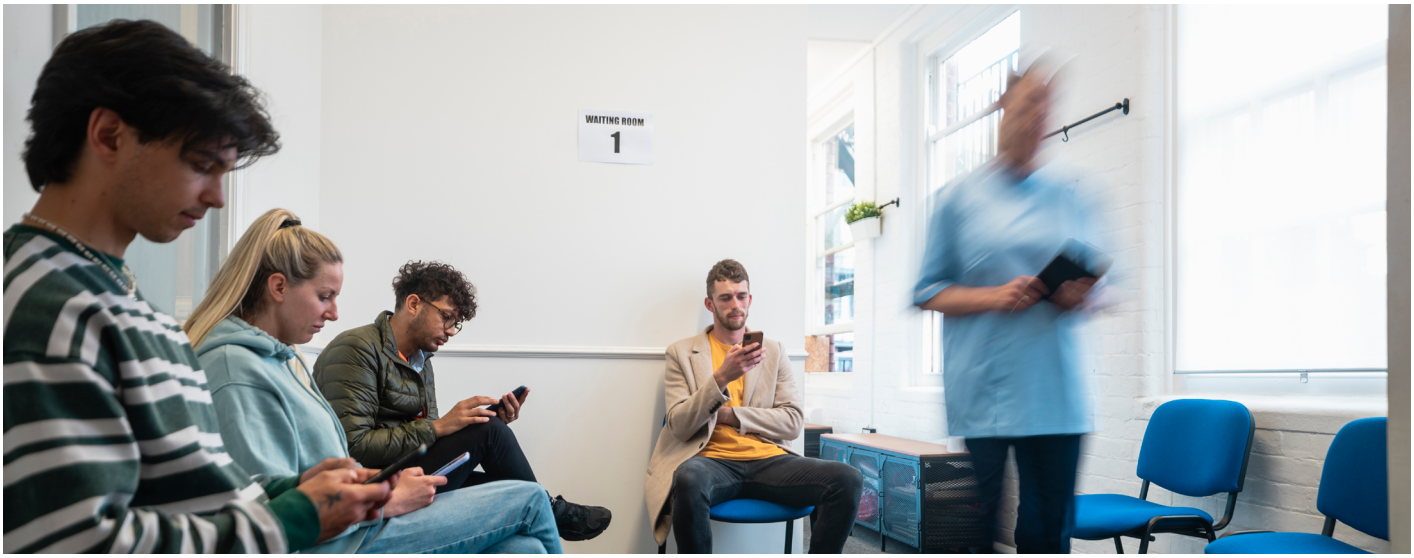
At a time of high inflation, increasing costs, increasing demands on practices and real-terms downward pressure on practice income via inadequate National Contracts, maintaining the viability of GMS practices via profitability is increasingly difficult.

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 and 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. We would recommend liaising with your local LMC to ensure that List Turnover adjustments are considered and if not applicable transitional payments are negotiated with your local Health Board.

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 safety, 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. Consider optimising workflow in the practice by introducing a daily template to illustrate the division of tasks among the staff and 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.

Key Monitoring Areas for Non-Dispensing GPs

– **Monitor the NHS Drug Tariff** for accurate pricing.
– **Track Discounts** received on drug purchases.
– **Ensure that** no more than 399 scripts per month are claimed under each individual Partners Names to avoid reducing the "dispensing" fee
– **Ensure accurate prescriptions** to avoid errors in claiming.
– **Reconcile claims** with NHS reimbursements to avoid clawbacks.
– **Monitor high-cost drugs** and ensure compliance with special schemes.
– **Report and document** all claims accurately.
– **Manage waste** and avoid unnecessary stock purchases.

By closely monitoring these aspects, non-dispensing GP practices can help ensure that they are **compensated correctly** for the drugs they prescribe, while staying compliant with NHS policies and maximising their financial viability.

Drug Purchasing Policies:

– Join buying groups to secure bulk discounts while avoiding overstocking.
– Regularly review contracts with suppliers to ensure you receive the most competitive terms.
– Avoid dispensing drugs with reimbursement rates that lead to financial losses; refer such prescriptions when necessary.

Training

Training can generate income for the surgery as well as varying degrees of staff resource and 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, where day-to-day pressures allow, 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 and reducing costs

Staff costs

Staff costs are the major outgoing for any practice, approximating to 66% 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 that GPs have traditionally delivered are unfunded and not a core GMS contractual responsibility to deliver.

Insertion and changing of Vaginal Pessaries(not Shelf) are not contractual services and like other areas could/should be funded by LSS negotiated by the LHB with the LMCs, if they are not funded then consider handing the work back.

Remember non-contractual work must be resourced. If not, give three months notice to the Health Board and hand it back, you are "subsidising the Health Board "in terms of staffing, infrastructure and very importantly financing of this work. **"New work/non contractual work needs new money."**

If you hand the work back, be assured, you will not be the only Practice who doesn't do this non contractual work when challenged by the LHB.

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.

All Wales Communication Standards

Use the communication standards to reduce inappropriate workflow on GP surgeries allowing better use of staff operationally and financially. We are currently looking to review and update the CCP where necessary and consider mechanisms to improve compliance across Health Boards in Wales

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.

Explore joint hiring of locum staff or administrative support to reduce individual practice costs.

General running costs

- Eliminate waste, reduce unnecessary telephone calls, and take necessary steps to reduce your gas and electricity bills. Suggest specific energy-saving practices, such as switching to LED lighting, installing smart meters, or leveraging government schemes for green energy grants.
- Conduct annual reviews of all service contracts (e.g., utilities, cleaning) to identify savings opportunities.
- Utilize price comparison tools and seek recommendations from peer practices for affordable, dependable vendors.
- 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 use local buying groups. Also remember that getting value and benefit for what you pay for is important. Ensure you claim for all the standard reimbursements, water, 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 using 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 will not always appreciate the financial implications of having money tied up in stock. Establish clear protocols for tracking medical and administrative stock levels and train non-clinical staff on the financial impact of stock mismanagement. Ensure you review your ordering processes of stock levels and rotate stock regularly to minimise wastage and reduce costs from expired items. 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.

Managing Redundancies in General Practice

At times, GP surgeries may need to consider redundancies as part of cost-saving measures. This decision should only be taken after all other avenues to reduce costs have been explored. Below is a guide to understanding redundancies, how to approach the process, and the associated pros and cons. *See annex C.*

What is Redundancy?

Redundancy occurs when an employer decides to reduce its workforce because a role is no longer required. This might happen due to:

- Financial pressures.
- Changes in the practice's operational needs (e.g., adoption of recent technology).
- Mergers or restructuring of services.

Redundancy is not a reflection of employee performance, but a business decision related to the role.

General considerations

Profit not income

When considering "new" income streams do not 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. **"Invest your time doing this to save your Money"**

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 and Collaboration

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? Do not be afraid to use and adapt ideas from your neighbours. To maintain profitability, practices should actively engage in benchmarking and collaborative efforts.

Benchmarking Strategies:

Use Financial Metrics:
- Regularly compare your practice's financial performance (e.g., revenue per patient, staff costs as a percentage of income) against regional or national averages.
- Collaborate with a medical accountant, ideally one affiliated with AISMA, to identify discrepancies and areas for improvement.

Leverage Regional Data:
- Collaborate with local surgeries to gather data on shared challenges (e.g., staffing, service costs).
- Benchmark participation in supplementary services to assess cost-effectiveness compared to peers.

Collaboration Opportunities:

Shared Resources:
- Explore joint hiring of locum staff or administrative support to reduce individual practice costs.
- Collaborate on bulk purchasing agreements for medical supplies or technology investments.

Knowledge Sharing:
- Form local forums or online groups(WhatsApp) for sharing strategies on workforce management, reducing inefficiencies, and income diversification.

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.

Emergency Reserves

- Set aside 3-6 months' worth of essential expenses as a financial buffer.
- Ensure a balance between GMS contract income and supplementary services.
- Identify potential risks, such as sudden changes in patient list size, locum shortages, or new regulatory requirements.
- Develop action plans to mitigate these risks (e.g., quickly hiring temporary staff, redistributing workloads.
- Invest in monetary management software to provide real-time monitoring of cash flow and expense tracking.
- Utilise telemedicine solutions during crises to maintain service delivery (BOMGAR).

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 months 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 too.
– 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 months

– 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

How to Approach Redundancy

To ensure a fair and compliant redundancy process, follow these steps:

Assess the Need for Redundancy:
- Review the practice's financial situation and operational requirements.
- Explore alternatives, such as retraining, redeployment, or reducing hours across the workforce.
- Seek advice and guidance at the earliest opportunity from the BMA's HR Advisory service and/or ACAS.

Identify Roles at Risk:
- Determine which roles are no longer necessary.
- Use objective criteria to avoid discrimination (e.g., role function, not individual performance).

Consultation Process:
- Engage in meaningful consultations with affected employees.
- For practices seeking to make more than 20 staff redundant, consult with employee representatives or trade unions.
- Provide clear reasons for the redundancy and explore alternatives during the consultation.

Selection Process:
- If reducing multiple roles, apply a fair selection process based on agreed-upon criteria such as skills, qualifications, and experience.
- Avoid discriminatory criteria (e.g., age, gender, disability).

Notice Period:
- Provide appropriate notice based on the employee's contract and length of service.
- The statutory minimum is:
  - **One week for each year of service (up to 12 years).**
  - **One week's notice if employed less than two years.**

Redundancy Payments:
Offer statutory redundancy pay to eligible employees:
  - Half a week's pay for each full year under age 22.
  - One week's pay for each full year aged 22-40.
  - 1.5 weeks' pay for each full year over age 41.
  - Enhance statutory pay if specified in employee contracts.

Support and Documentation:
- Provide references and support for employees seeking new roles.
- Document every step of the process for legal compliance.

Legal Considerations

Compliance with Employment Law:
- Follow the Employment Rights Act 1996 (UK) to ensure fair treatment.
- Maintain transparency throughout the process.

Avoiding Unfair Dismissal Claims:
- Ensure that the redundancy process is objective, non-discriminatory, and documented.
- Employees with over two years of continuous service have the right to claim unfair dismissal if procedures are not followed.

Consultation Periods for Larger Redundancies:
- If 20+ employees are at risk, begin consultation at least 30 days before the first redundancy.
- For 100+ redundancies, the period is 45 days.

Pros and Cons of Redundancy

Pros	Cons
Immediate cost savings by reducing payroll expenses.	Potential damage to morale among remaining staff.
Opportunity to restructure and improve efficiency.	Loss of skilled and experienced staff.
Ensures practice remains financially sustainable.	Possible reputational damage.
Frees up funds for other critical investments.	Risk of unfair dismissal claims if mishandled.
Can be a precursor to modernizing workflows.	Redundancy payments can strain short-term budgets.

Alternatives to Redundancy

Before finalising redundancies, consider:

Voluntary Redundancy:
- Offer enhanced packages to encourage employees to leave voluntarily.
- Flexible Working.
- Reduce working hours or introduce job-sharing.

Redeployment:
- Move employees to different roles or locations.

Career Breaks or Sabbaticals:
- Offer unpaid leave for a set period.

Natural Attrition:
- Do not replace roles that become vacant.

By approaching redundancies with transparency, fairness, and adherence to legal frameworks, practices can minimise risks while ensuring the financial sustainability of their operations.

Please read BMA Guidance Notes for GP partners and Practice Managers

Annex C

	Who can cover be claimed for?	Who can provide cover?	Maximum amounts payable
Parental leave *SFE section 11*	– GP partners – Salaried GPs	– Locum GPs – Salaried GP on fixed term contracts – Additional hours for GP performers already party to contract or engaged by contractor – Independent prescriber locums	– £1,131.74 / week *for first two weeks* – £1,734.18 /. week *thereafter*
Sickness leave *SFE section 12*	– GP partners – Salaried GPs – Employed independent prescribers	– Locum GPs – Salaried GP on fixed term contracts – Additional hours for GP performers already party to contract or engaged by contractor – Independent prescriber locums	– £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 *SFE section 13*	– GP partners or Salaried GPs suspended from Medical Performers List	– Locum GPs	– £1,131.74 / week

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