

Chapter 1 **The business as an organism**

The Green practice used to be a successful five-partner practice led for many years by the two senior partners, whose main aim was to provide excellent clinical service. As a result the practice expanded rapidly, although the partners showed little interest in the accounts, referring to them as ‘Monopoly money’. At their annual meeting the accountant expressed concern that profits were falling faster than expected. Instead of trying to get to the root of this downward pressure on profits, the partners remained disinterested and continued with their usual drawings. At the following annual meeting, one of the senior partners revealed that the practice funds were exhausted and the bank had recalled the existing overdraft, with no prospect of extending a new one, due to the current economic climate. As a result the partners had to repay six months’ drawings and accept reduced continuing drawings. Two partners subsequently resigned. Not surprisingly, the Green practice is now a shadow of its former self.

Dr Stevens was one of a four-partner GP practice in Northampton. Instead of saving money each month to pay his tax, he borrowed the funds whenever this payment was due. In January 2009 he requested the usual finance from his bank manager, but this year, as a result of the economic downturn, the bank refused. Dr Stevens ignored the demands and letters from HMRC and was ultimately bankrupted by them. As a result, he was expelled from his partnership because, by law, he could not be a principal and a bankrupt. Dr Stevens was employed as a salaried GP before finally being made redundant.

The two examples above may seem extreme, but they are both real-life cases, and demonstrate issues which can, to a greater or lesser degree, affect many GPs. In this book the authors will use a range of anecdotes like these to illustrate what it takes to run a successful practice as well as highlighting the pitfalls along the way. The examples given may push the boundaries of

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credibility, but they are all genuine cases. The names and locations have been changed to preserve anonymity. By drawing on examples in other business disciplines, we aim to arm GPs with additional tools to make the most of their practices. This book explains best practice with regard to accounts, partnerships, staff and competition, whichever government is in power and whatever changes are taking place in the NHS, from the dissolution of primary care trusts (PCTs) to the creation of consortia. The business skills detailed here are eminently transferable across disciplines and economic conditions. GPs can operate as sole traders, partners in a partnership or directors of a limited company, and although the text refers to partners the issues will apply to all roles. Most importantly this book is definitely not a 'GPs *should* do this' or 'GPs *must* do that' title: we feel there is quite enough lecturing in other publications. Instead we hope that, as a specialist GP accountant who has advised thousands of GP practices for many years, and a former GP with decades of experience running commercial businesses at main board level, we have valuable expertise to share with colleagues. Most of all, we hope GPs will enjoy reading this book, benefit from those chapters which are most relevant to them and feel far better informed and equipped at the end of it than they did at the beginning.

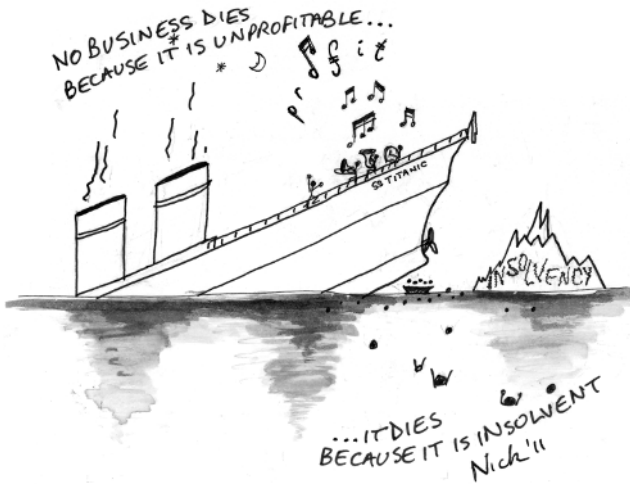
Dirty money or life blood?

To many GPs, 'money' is a dirty word in the context of professional practice. This is perfectly understandable: after all, the vast majority have grown up in the NHS where best clinical practice, not revenue and profit, governs their professionalism. Even those who eventually work in private practice always put their patients before the profit, and the authors would not have it any other way. However, a healthy practice is not simply one which treats its patients successfully. Indeed a healthy practice, like any commercial business, will be more successful if it manages all aspects of its being, including its staff, buildings, contracts, relationships and, yes, finances at optimum levels. Only by doing this effectively can a practice truly develop, grow and serve its patients to its full potential.

Your practice is a living, breathing organism: it has objectives and purpose, but it also needs a life force to support it. Money represents the blood circulating through the practice: cut off the supply and the practice will die. Ensure nothing is blocking or reducing the circulation and the practice will thrive.

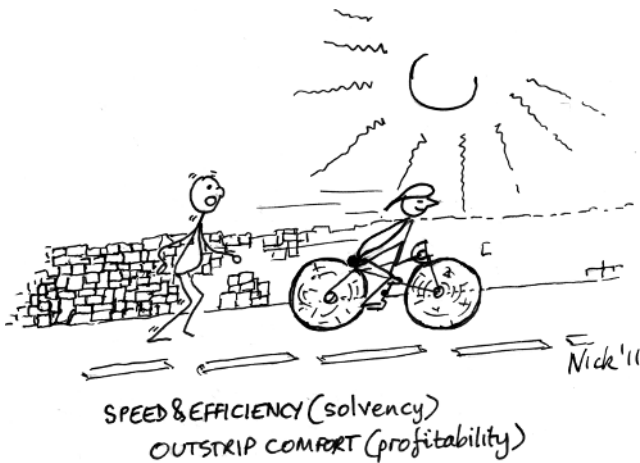
What do we mean by money? When someone says they are making lots of money we assume they are making profits. Conversely, when they say they are not making money we assume they are unable to pay their debts, which

means, they are insolvent. In this context, money has two meanings, profitability and solvency, and it is vital to understand the difference to maintain a healthy practice. A healthy practice will be profitable and solvent.



An unhealthy practice will be profitable and insolvent, or unprofitable and solvent, or, worst of all, unprofitable and insolvent.

No business dies because it is unprofitable; it dies because it is insolvent. If, for example, it is unprofitable but is still solvent, that is, it can still raise funds,



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it is sick, but it is not dead. However, if that business has a number of creditors and the bank calls in its overdraft facility, then it will switch from being unprofitable and solvent to unprofitable and insolvent, at which point it *will* die. This is what happened to the Green practice. If a company cannot pay its bills, a creditor can petition for it to be put into liquidation. For professional partnerships, unless they operate as a limited company, the equivalent of liquidation is the bankruptcy of a partner. Both liquidation and bankruptcy have catastrophic results. In the case of the Green practice, the problem only became critical when the bank withdrew the overdraft, effectively cutting off the practice's blood supply and rendering it insolvent. In Dr Stevens' case, it ended a successful medical career and added considerable tensions to his private life.

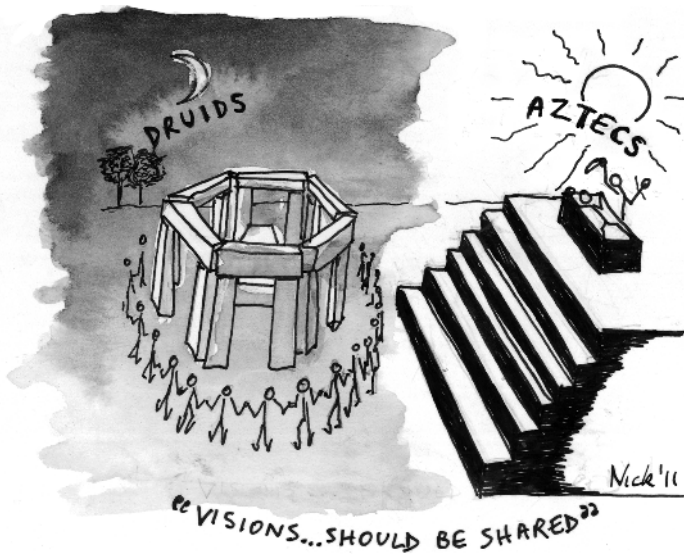
The keys to success

In a successful practice, the following key components work together in harmony:

- Vision
- Direction
- Decision making
- Partnership
- Staff
- Premises
- Service
- Patients

Your vision or mine?

Every component of a successful practice stems from its vision. By vision we mean the aims and targets for that practice and its partners. These may be long term, for example doubling the practice size over the next five years through a combination of acquisition and organic growth. Or they may be short term, for example introducing a specialist facility or extending an existing building within six months. Of course many practices will have a combination of long and short term visions, and, as with any business, these will require review and revision from time to time, depending on progress and changing circumstances. There are no hard and fast rules governing visions, except perhaps that they should be shared and documented. The worst thing would be for three partners in a practice to be dreaming of three quite different aims in isolation in their individual consulting rooms. This makes the likelihood of success rather slim.



The practice vision may come from all the partners or just one person. But, if there is nobody with vision, the business will be devoid of direction, and without a direction the partners and staff will work in a vacuum, unable to prioritise and coordinate with each other to achieve the same goals. Therefore every practice will benefit from identifying those individuals who are visionary, without automatically assuming that this person is the senior partner:

Dr Collins, aged 43, and Dr Graham, aged 29, were part of a well respected, successful surgery that was run by Dr Smythe, an autocratic but extremely talented senior partner. When Dr Smythe died suddenly aged 55, Dr Collins automatically took over the 'senior' role including the financial and directional responsibilities. He was preoccupied with detail, spending extraordinary amounts of time preparing schedules of the practice expenses, and analysing invoices from each and every supplier. He was troubled by making claims to the PCT unless he was satisfied the content was complete and correct, and referenced back to the original work done in the practice. But Dr Collins never stepped back to take a strategic, long term view of his practice. At the same time Dr Graham generated 80% of the practice work. Within a year of Dr Smythe's death, the practice was in debt and unable to service its bank overdraft. Dr Graham, who was unaware of the severity of the situation, was horrified when the bank asked both partners to take out second mortgages on their homes. He held an emergency

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meeting with the bank manager in which he explained how the practice had been working. As a result, he dissolved the partnership and set up on his own without a second mortgage. Dr Graham now runs a successful practice with two new partners, while Dr Collins barely manages to stay afloat.

Vision alone is not enough for success. Indeed, those without vision will still have very important qualities which are vital for a practice. Success requires a balance of partners, each playing to their individual strengths. A business full of visionaries will fail if it is unable to manage those visions when they become reality:

The Black practice had four visionary partners and an equally visionary manager. As a team, they had no difficulty agreeing and executing their aims, meaning the practice expanded rapidly by taking over a number of local surgeries. Their size doubled, but their profits fell. When this was investigated, it turned out that none of the partners, or the practice manager, took an active interest in running the new surgeries post acquisition. They had not even visited any of the new sites, which were left to manage themselves. No effort was made to boost morale or control costs. In the end, the acquired practices were disbanded and the patients dispersed to neighbouring surgeries.

When commercial companies make acquisitions, they go through a vigorous process involving business plans, due diligence and, as importantly, a post-acquisition consolidation plan. In these plans the methods by which the new business will be incorporated into the existing one are set out in detail. Cost savings are identified together with the timescale for executing them, as well as opportunities for further growth. Above all, the individuals who will carry out the consolidation process are clearly identified and charged with this responsibility. This is because what can be achieved on paper is often different when it comes to the reality of encouraging new and old staff with differing working practices to work together to deliver the plans. GPs may be a unique group, but the principles governing the consolidation of two companies are the same for any business.

You go in that direction and I'll go . . . !

All practices both have and need a direction. A practice may go round in circles, but it still has a direction, albeit one which drains its energy without taking it forward.

Everyone involved in the practice needs to know where it is going and why it is going there, together with some idea of the method and timescale.

Mission statements are somewhat clichéd, but nevertheless without direction a practice will never achieve its goals:

Partners at the Blue practice had two issues: they owed their ex-partner Dr Hill £100,000 to buy her out of the premises, and they also wanted to expand their activities. As a result they swung from negotiating with Dr Hill to searching for new premises, but never in a co-ordinated fashion. The partners remained stuck in this hopeless position for more than five years without resolution: Dr Hill continued to demand her money, while the premises were increasingly unsuitable and limiting. If the partners had written a plan, together with a realistic timetable to achieve both aims, they would have avoided this impasse.

Can we decide who's making the decisions?

Even when it appears to be going nowhere, a business does not stand still. Therefore effective decision making and subsequent active management are key to ensuring a practice runs smoothly. All partners in a partnership will benefit from an agreed decision making process with a corresponding written protocol which has been incorporated into the partnership agreement. For limited companies, the directors' powers are set out in the Articles of Association while the shareholders work within the protocols set out in the Shareholders Agreement. At first sight this might appear to be overkill, but doing this in advance, when there is not a pressing issue to deal with, really can help the partners and directors when difficult decisions do need to be made. The protocol can cover a range of situations from decisions which can readily be delegated to one individual to those requiring consideration by all the individuals involved with the business. Similarly non-contentious issues like setting staff pay rises may be decided by a majority vote, while more significant ones such as taking on a new partner, appointing a new practice manager or dismissing a member of staff may require unanimous agreement.

It is important to get the right balance into the agreement so that the protocol is neither too loose nor too restrictive, and works for the practice overall. If all decisions require unanimous consensus by all partners, an unnecessary amount of energy will be spent discussing each one and simple problems will become complicated. Far better for critical decisions to be made by all partners and operational ones reached by a simple majority. Partnership dynamics, like boardroom dynamics, are complicated and at times uncomfortable. Furthermore GPs do not like to be seen to disagree with colleagues, but if the protocols are clear and every partner has signed up to them in advance, it is far easier for an individual who finds themselves outvoted on a particular issue to not take it personally.

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Box 1.1 Partnership decision grid

	Unanimous	Majority	Delegated
Appointing a new partner	x		
Appointing or dismissing staff	x		
Engaging in another business activity	x		
Forgiving a debt >£1,000	x	x	
Deciding to charge, sublet, assign, sell, transfer, lease or mortgage any practice asset	x		
Approving an expenditure <£500			x
expenditure >£5,000		x	
Approving an expenditure >£50,000	x		

Senior staff as well as partners make decisions in the practice. This means the parameters within which they are expected to function must be made clear at the outset as failing to do so can have disastrous results:

The six-partner Lavender practice in East London asked their accountant to investigate why the partnership was increasingly overdrawn. He duly prepared and analysed the year to date accounts and was surprised to find the staff costs were more than 90% of the total practice income. This was before the partners' drawings and contrasted sharply with most GP partnerships, where staff costs account for around 30% of the total practice income.

Further investigation revealed that the practice manager had been paying herself overtime as well as employing her husband and sister at generous hourly rates. On discovering this, the partners dismissed her immediately. Her response was to sue them for unfair dismissal, claiming that her instructions on employment were to deal with problems and ensure the practice ran smoothly, without bothering the busy partners. She reasoned that employing her family was necessary to achieve this and that she had acted within the authority given to her by the partners. The tribunal found in her favour, and awarded her £20,000 in compensation.

The above example clearly illustrates why the decision making process needs to be established early in the life of the practice, preferably before the partners start working together. A prospective or new partner would benefit from asking to see the protocol in the agreement before signing it. If none exists, this is a good time to suggest compiling one. Some partners debate the partnership agreement for literally years before finalising it, which is in itself diagnostic of trouble ahead. For busy partners, hammering

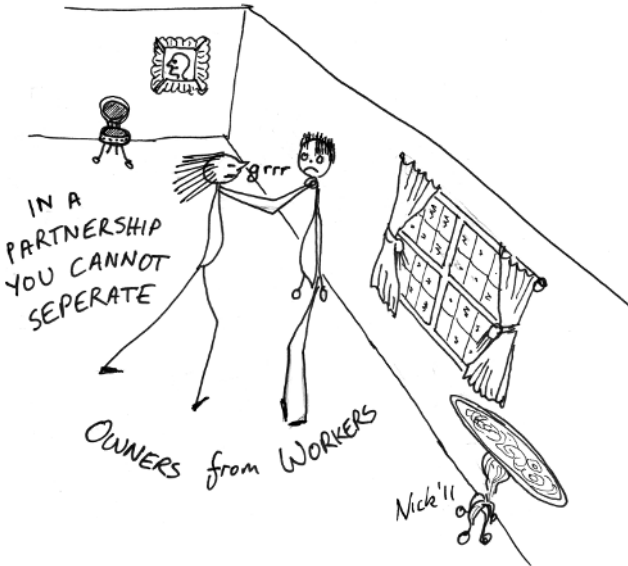
out a practice agreement or shareholders arguing over their respective rights may seem low priority compared to other pressing issues, but an unsigned agreement will leave individual partners and the practice overall at serious risk.

Which operational model works for me?

The partnership model of practice referred to above is not the only one, and the use of limited companies has a place. The box below highlights the salient points of the two models.

Box 1.2 Partnership or limited company		
	Partnerships	Limited companies
Advantages	<ul style="list-style-type: none"> • Simplicity • Minor legal obligations • Unless an LLP no obligation to publish accounts • Usually more tax efficient than companies 	<ul style="list-style-type: none"> • Limited liability • Company law requirements comprehensively govern conduct of companies and their officers • Ability to separate owners from workers
Disadvantages	<ul style="list-style-type: none"> • No limited liability • Cannot separate owners from workers • All partners bound by the agreements made by other partners 	<ul style="list-style-type: none"> • Company law requirements comprehensively govern the conduct of companies and their officers • Financial results of the company have to be published at Companies House for any member of the public to access

Whether a practice opts for a partnership or limited company is a matter of choice. Legally, a partnership does not exist as a separate legal entity, meaning that when the partners leave, the partnership ceases to exist. Limited companies are different. A limited company has its own legal identity with a name and a company number. Closing it requires formal termination through either a formal liquidation process or a request to the Registrar of Companies to strike it off the register. Accordingly, many fledgling businesses start off as partnerships and transfer into limited companies as they evolve. This may be because the business expands and the key individuals involved want the protection of limited liability or because the business has expanded to such a point that it requires funding from external shareholders, for example, the business may become a public company. Company law and tax law

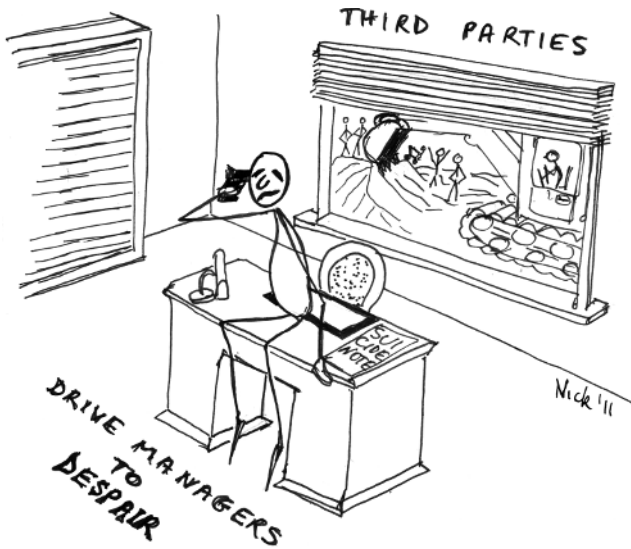


facilitate this healthy development by, for example, allowing business assets to be transferred from a partnership to a company, but the same does not apply in reverse. Starting with a company and moving into a partnership can be done, but the legal and tax framework in the United Kingdom does not make this as easy.

What constitutes practice staff?

In general practice, 'staff' encompasses the entire multidisciplinary team required to deliver a service to patients. The position of staff immediately associated with the practice, such as the receptionists, nurses and partners, is relatively straightforward. Third party associations including consultants and other outsourced clinical and administrative services may be less directly within the GP's control, but will still be viewed by patients as an extension of the practice and integral to the care from their GP. For many businesses, controlling third parties drives managers to despair, as they see their clients, in a GP's case their patients, let down by someone or something beyond their control.

Pre-empting and dealing with this is not straightforward for any business, which explains why so many GPs send their patients to preferred third parties. In business, relationships and trust are recognised as extremely important for success. While GPs may be less conscious of their benefits, the



same applies in general practice. Broadening 'staff' to include those beyond the confines of the practice walls or immediate payroll makes routine business activity such as networking, attending meetings and conferences and obtaining feedback from patients less of an anomaly and more a necessity for a healthy practice.

Staff costs are a significant fixed outgoing for any practice, meaning it is worth reviewing the balance and number of staff at regular, ideally annual, intervals to ensure they are still appropriate.

Staff retention and recruitment are also key issues for every business. Staff turnover varies depending on a number of factors, including the nature, location and philosophy of the business. In competitive environments, businesses benchmark their staff turnover figures against those of their competitors. If turnover is higher than the industry norm, they may introduce changes to bring it down. Although it could be argued that general practice is different, the principles still apply. If a practice experiences a high level of staff turnover, it may be worth reviewing its staff policies.

What is great service?

Most successful business sell something, be it cars, corn or advice. The medical profession is no different in this respect which is why everyone

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inside and outside the practice needs to clearly understand the services it offers. This service must be robust, stand up to scrutiny and criticism and be protected by the partners with the same parental ferocity they would show their children.

To many practices, like many businesses, the range and level of service comprise its unique selling point, or USP. Whether from the partners, other medical staff or the receptionist, this service is key to attracting and keeping patients.

Businesses and practices evolve, and in its early life a new practice may target patients on another GP's list. Dissatisfied patients or those who perceive that the new surgery offers something 'better' may be tempted to move. When this happens in sufficient numbers, the existing practice will experience a 'double whammy' in business terms, in that it will become weaker while at the same time the 'opposition' will become more established.

Business is also dynamic, and the process may be repeated years later when a new group of GPs targets the now established practice. How successful the partners are at defending themselves against the young upstarts will depend on how good they have been at maintaining a sufficiently high level of service for their patients.

Premises: to rent or buy?

A practice takes many forms, from a room in a GP's home to a multilayered purpose built premises. GPs often say they would rather rent than own their premises because of the risks of taking a loan to purchase and develop the site. However, it is fundamentally flawed to assume that renting is less risky than owning.

Taking out a loan carries obvious risks, for example if the partners or business defaults the mortgage company can sue for repayment and ultimately bankrupt the individuals or liquidate the company. Only exceptionally wealthy partners or businesses can purchase premises outright without a loan.

The risks associated with renting may be less obvious but are just as significant. Renting in almost all circumstances requires a lease which sets out the terms between the tenant and the landlord. Two of the most important elements of the lease are the term of the lease with possible break clauses, and the obligation to return the property at the end of the lease to the landlord in the same condition as at the beginning. A developer, who may well become the landlord, will want a secure return on investment. Twenty-five year leases are common in the public-private interface and mean the tenant is obliged to pay rent to the landlord for 25 years. Some leases have break clauses at specific intervals, commonly every five years, when either party can terminate the

arrangement. However, many leases recently issued under the Private Finance Initiative (PFI) have no such break clauses.

The fact that the practice is a limited company will not guarantee protection with limited liability status as the landlord will almost certainly require personal guarantees from the GPs who make up the partnership.

A lease is an obligation to pay rent. Failure or refusal to do so will result in the landlord suing the tenant for the rent for the rest of the lease. This could happen if for example a practice lost its NHS contract. If the tenant is unable to use the premises or to generate sufficient income to pay the rent, they are left with three main options:

- 1 Hand the lease back, but only if the landlord is willing to take it back.
- 2 Sublet the premises, but only if the lease permits this and a new tenant can be found.
- 3 Refuse to pay with the risk that the landlord will sue and potentially bankrupt the tenant.

Box 1.3 Pros and cons of renting or buying		
	Pros	Cons
Rental	<ul style="list-style-type: none"> • No capital outlay. • Income and expenses should be neutral. • New partners do not need to find capital. 	<ul style="list-style-type: none"> • Obligation to pay rent in future. • Possible dilapidations at end of lease. • Landlord will be entitled to payment even if practice ceases to exist.
Buying	<ul style="list-style-type: none"> • Possible capital profit. • Ownership gives control. • No need to deal with landlord (e.g. for dilapidations or service charges). 	<ul style="list-style-type: none"> • Requires large loan at outset. • Vulnerable to increases in interest rates. • Problem of raising capital to buy out owners or to buy in.

Failing to appreciate the significance of a lease can catch out the partnership or an individual GP:

Dr John left the Red practice to join a new surgery. Four years later he received a letter from the landlord advising him that, since no rent had been paid on the Red practice for the last six months, he was pursuing Dr John and all his ex-partners for the arrears. Despite Dr John's departure years earlier, he had not been removed from the lease and was still responsible for the rent until it came to an end. Dr John ended up paying £60,000 to the landlord to extract himself from this predicament.

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Rent is not the only expense of a lease. Most leases require that the building is returned in the same condition as when the agreement was signed. If the building was new or had been refurbished, considerable funds will be required to maintain it to this standard.

During the term of their 25 year lease, the Purple practice changed the configuration of their rooms and reception to make them more patient friendly. At the end of the lease they were given a £250,000 dilapidations charge by the landlord to move the rooms back into their original positions.

In order to avoid this charge, the partners had to renegotiate taking on a new lease for a further 25 years. Clearly these negotiations were conducted from a position of weakness as the partners not only had the charge hanging over them but also were unable to argue that they would find alternative, less expensive premises.

To rent or buy . . . that is the question

In many cases, tenants fail to spend sufficient amounts on the property during the term of the lease which results in a large dilapidations charge from the landlord at the end. The partners need to find sufficient money to spend on the property and ensure that all the tenants who have had the benefit of the lease pay their share of the dilapidations if they leave the practice before the end. If the tenants do not make sufficient provision during the term of the lease, then those who are using the property at the end will pay all the refurbishment costs. Recovering a share of costs from former partners who have since retired or died is often impossible. As with saving for tax, the partnership accountant should set aside a dilapidation fund during the term of the lease. This can involve considerable guesswork, and it is better to be prudent than bullish. Businesses faced with a dilapidations bill will obtain estimates from a number of independent contractors, just as one would for building work at home, and negotiate with the landlord before agreeing on a final settlement. Even if sufficient funds have been set aside, this is still good practice.

Renting is not automatically safer than buying, and in the end the partnership will make the decision based on merit. If the partners purchase their premises, then the GPs may need a mortgage, but if they run into trouble they can sell the property, sub-let it to pay the mortgage or find an alternative use for it. If the same GP partnership rents their property and runs into problems, the landlord will force them to continue to pay the rent.

The tax position on either renting or buying is broadly similar. Notional rent income is taxable income. Rent payments for landlords and interest payments for owner-occupiers are both tax deductible expenses. If an owner makes a profit on the sale of their share of the building, that gain is subject to

capital gains tax (CGT). Traditionally, there has been a preferential rate of CGT for business assets, including surgery premises. This was called retirement relief, then business taper relief, and it is now labelled as entrepreneur relief. This preferential rate can be lost by accounting for the rent and interest in a way which allows HMRC to argue the premises were not a business asset but an investment. This means it is worth taking professional advice to make sure partners keep the preferential rate.

A surgery building will normally carry two values. The first value is that for the bricks and mortar of the building, and the second is based on the generated rental. The following case shows why it is so important to plan for negative equity:

The Orange practice was given the opportunity to purchase its health centre. The building was not ideal, but the GPs there had been increasingly fed up with poor maintenance and inexplicable but expensive charges. After seeking professional advice, the PCT set the notional rent at £48,000. Using this figure together with an assumed current market investment return of 6%, the capital value was set at £800,000, that is, $£800,000 \times 6\% = £48,000$. In fact, the building was valued at £500,000. The PCT value stood up in the light of the proposed rental, but the GPs were all in their early 50s and needed to consider what would happen on their retirement. If the practice were disbanded or if the PCT decided to move it out of the building, they would be left with negative equity. Younger GPs might have taken the risk, but in this case the partners decided not to proceed.

Appealing to your patients

In business, patients correspond to clients, target audiences or purchasers. Whatever the term used, they are essentially the end users of the product on offer and they usually pay to receive it. Alternatively, sufficient numbers use the product to attract third parties such as advertisers, in which case the end user attracts money indirectly. Businesses compete with each other to attract and keep end users, and they view marketing as an essential part of their activity. Most successful businesses have a separate marketing budget, which is so important that it is ring-fenced, this means whatever the general trading conditions, the marketing spend remains protected. GPs as a rule take a conservative attitude to marketing and active competition. Having said that, if a practice exists, whether it likes it or not, it is necessarily in competition at some level. Professional etiquette and distaste at poaching patients from fellow GPs are of course a consideration, but money has always followed patients in UK general practice. This means a practice offering a superior service which patients want to take advantage of will generate financial reward.



Key points

- Every practice needs a healthy cash flow to survive.
- Profitability is the measure of the practice's ability to earn money.
- Solvency is the state of a practice's financial wealth at any one time.
- A partnership is not the only model in general practice.
- A practice needs concerted direction to achieve its goals.
- 'Staff' extend beyond the practice walls and the payroll.
- Agree which decisions should be made on an individual, majority or unanimous basis.
- Do not assume that leasing premises is a lower risk than buying.
- Plan carefully to ensure that the maximum CGT relief is obtained on sale of business assets.
- A practice offering superior services will generate higher financial rewards.