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Welsh Practice Management Conference

Oliver Pool - Partner

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- Oliver Pool – partnerships specialist
- VWV – a full service law firm
- Specialists in property, employment, litigation etc
- Offices in Bristol, London, Birmingham and Watford
- Merger with Lockharts 2017
- Acted for around 2000 GP practices

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Agenda

- Trust Registration Scheme
- Long covid
- Locum costs
- Reasons to be cheerful?
- EOTsTrust Registration Scheme
- Long covid
- Locum costs
- Reasons to be cheerful?
- EOTs

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Trust Registration

- Background – ML Regs – increasingly complexity
- Trust relationships:
  - Nominee shareholders
  - Lead practice holding £ for others
  - Premises with only 1,2 or 3 named on title
- But hurrah for FOIA! Public authorities not caught
- Watch out if you have APMS, or retired partners as owners, or premises is “off the books”.

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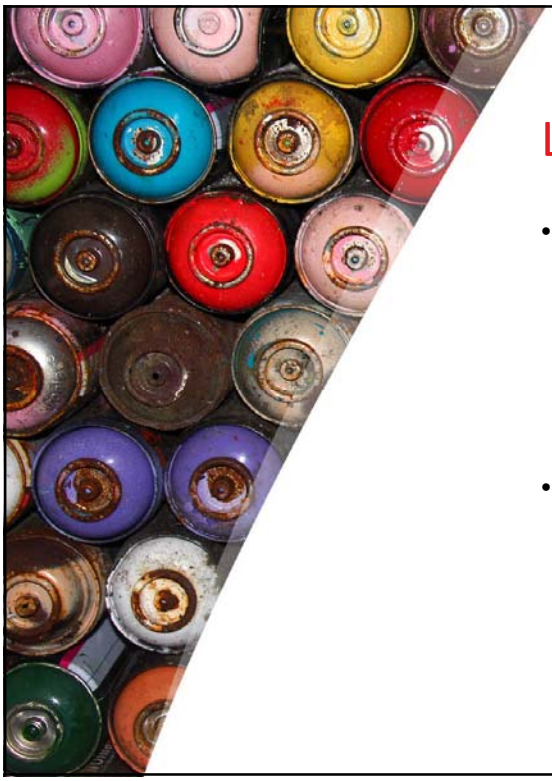

Long Covid

- Can be recognised as a disability IF
  - physical or mental impairment
  - adverse effect on their ability to carry out normal day-to-day activities
  - effect is substantial and long term
  - i.e. lasted or likely to last for 12 months

- Burke v Turning Point – Scottish Tribunal

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Case	*Burke v Turning Point Scotland ETS/4112457/2021*
Facts	Mr Burke was employed by Turning Point as a caretaker. In November 2020, he tested positive for Covid-19. Initially, his symptoms were very mild. However, after the initial isolation period, he developed severe headaches and fatigue. After waking, showering and dressing, he had to lie down to recover and struggled standing for long periods. In addition, he: • could not undertake household activities such as cooking, ironing and shopping; • experienced joint pain; • suffered from a loss of appetite; • had difficulties concentrating and sleeping; and • felt unable to socialise and attend important events. His symptoms were unpredictable; he would experience improvement only to suffer from fatigue and exhaustion again. From January 2022, his health began to improve. However, sleep disruption and fatigue continued to affect his day-to-day activities. He remained off work from November 2020. Later fit notes referred to the effects of long Covid and post-viral fatigue syndrome. By contrast, two Occupational Health reports stated he was fit to return to work and that the disability provisions of the EqA 2010 were unlikely to apply. However, relapses of his symptoms (in particular, fatigue) meant that he did not return to work. He was eventually dismissed in August 2021 because of ill health and brought disability discrimination claims, among other claims.
Decision	As a preliminary issue, an employment tribunal had to determine whether Mr Burke was disabled within the meaning of *section 6* of the EqA 2010 during the relevant period. It concluded that he was. • He was not exaggerating his symptoms and had a **physical impairment** (post-viral fatigue syndrome caused by Covid-19). The tribunal noted that there was no incentive for him to remain off work when he had exhausted sick pay. The lack of particularisation within initial fit notes could be explained by the restrictions on in-person GP consultations at the time, and his fluctuating symptoms were consistent with a *TUC report* published in June 2021. • His physical impairment had an **adverse effect on his ability to carry out normal day-to-day activities**. • The effect was **more than minor or trivial** (in other words, it was substantial). Concentrating on matters that he could **not** do, the tribunal noted that he could not cook, iron, shop, sleep through the night, or concentrate for any length of time. Even when his health began to improve, he still suffered from fatigue which affected his ability to carry out normal day-to-day activities. • The effect was **long-term** because it "could well" be that it would last for a period of 12 months when viewed from the date of his dismissal (the last alleged discriminatory act). The tribunal noted that the employer's own view was that there was no date when a return to work seemed likely.

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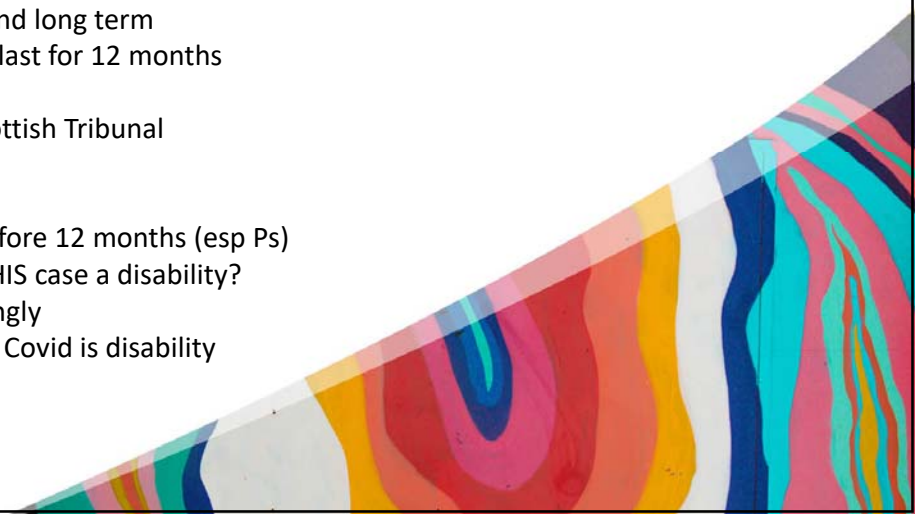
- Burke v Turning Point – Scottish Tribunal
- Practical tips:
  - Beware dismissals before 12 months (esp Ps)
  - Use occ health – is THIS case a disability?
  - If so manage accordingly
  - Can't assume all long Covid is disability
  - Careful management



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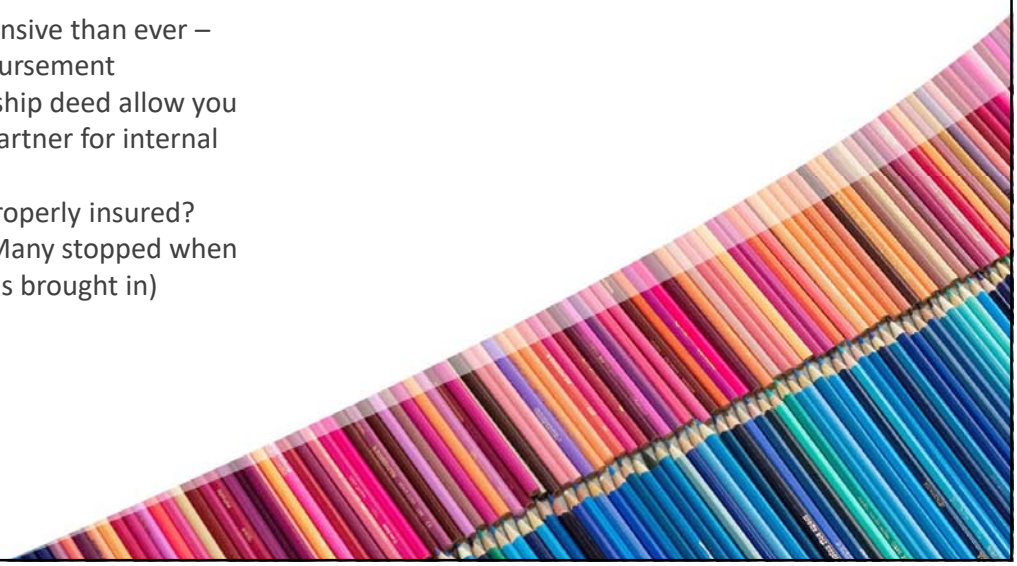
Locum Costs

- Locums more expensive than ever – outstripping reimbursement
- Does your partnership deed allow you to charge absent partner for internal locums? It should.
- Are the partners properly insured? They should be. (Many stopped when reimbursement was brought in)



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Financial trap could force GP partners to work through burnout

By Emma Bower and Nick Bostock on the 1 November 2022

GP partners off work with burnout are being forced to consider returning to their job before they feel ready because of a yawning gap between reimbursement for sickness absence and the actual cost of locum cover, GPonline has learned.

One GP partner told *GPonline* she was facing the choice between racking up huge financial debt or returning to work while still unwell.

The GP, who asked to remain anonymous, has found herself owing nearly £10,000 to her practice – and facing a possible bill of £24,000 if she remains off work until the new year, as recommended by her doctor – because her partnership agreement requires that she makes up the shortfall between the NHS reimbursement and the actual cost of covering her seven clinical sessions a week.

Currently NHS GP locum reimbursement for sickness leave in England is £1,751.52 a week after the second week of absence until 26 weeks, followed by half that amount for the following 26 weeks. However, this amount applies regardless of how many sessions the GP who needs to be covered works.

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Locum Costs

- Locums more expensive than ever – outstripping reimbursement
- Does your partnership deed allow you to charge absent partner for internal locums? It should.
- Are the partners properly insured? They should be.
- Without a practice locum insurance policy, an individual's decision can become everyone's problem
- Costs can be split out so it doesn't have to be pooled

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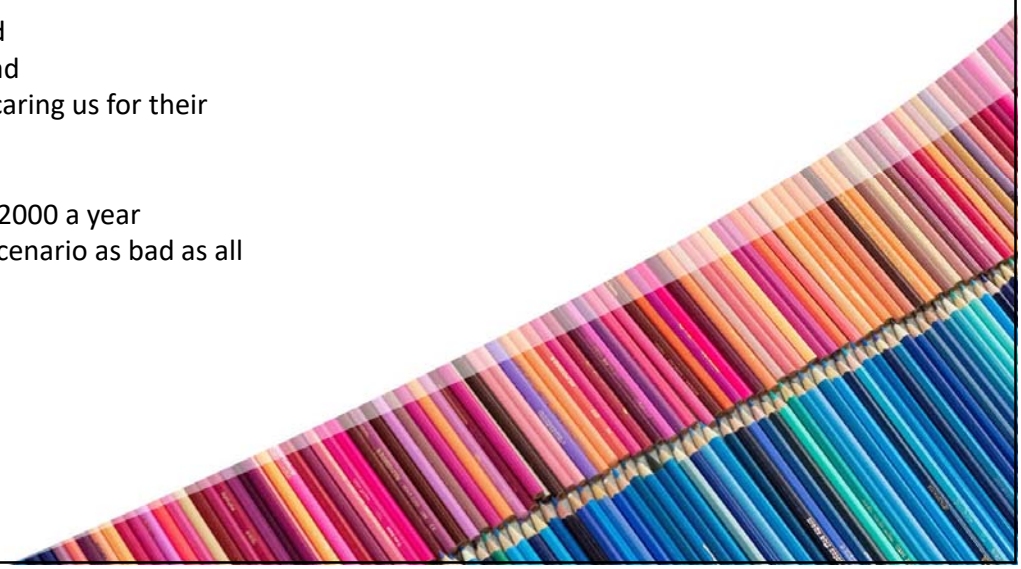
Reasons to be cheerful

- Why we are scared
  - Things are bad
  - People are scaring us for their own reasons
- BUT
- Lots of new GPs – 2000 a year
- Is the worst case scenario as bad as all that?



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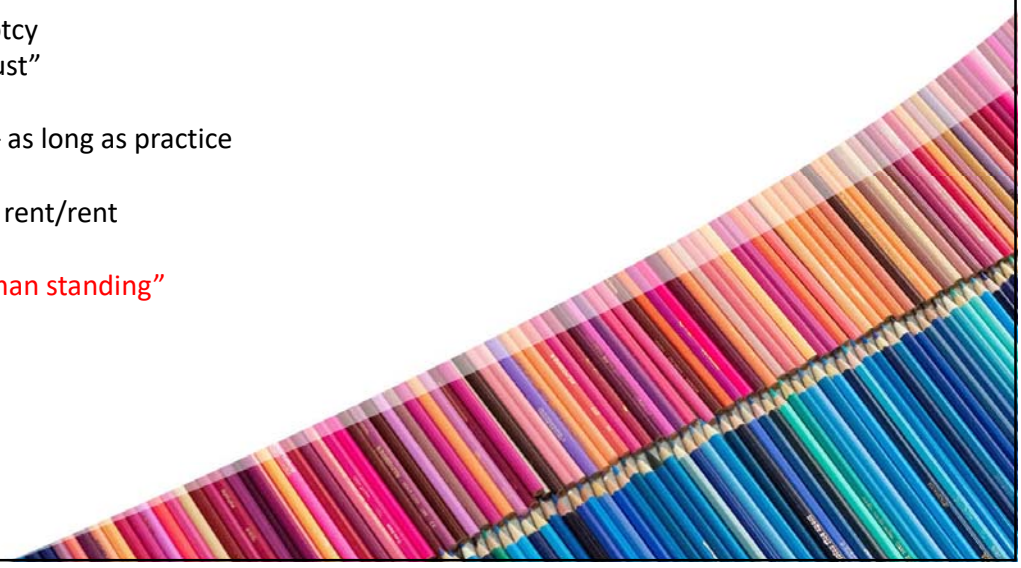
Things NOT to worry about

- Individual bankruptcy
- Practices “going bust”
- Clinical liability
- Premises liability – as long as practice continues
- Ending of notional rent/rent reimbursement
- Becoming a “last man standing”



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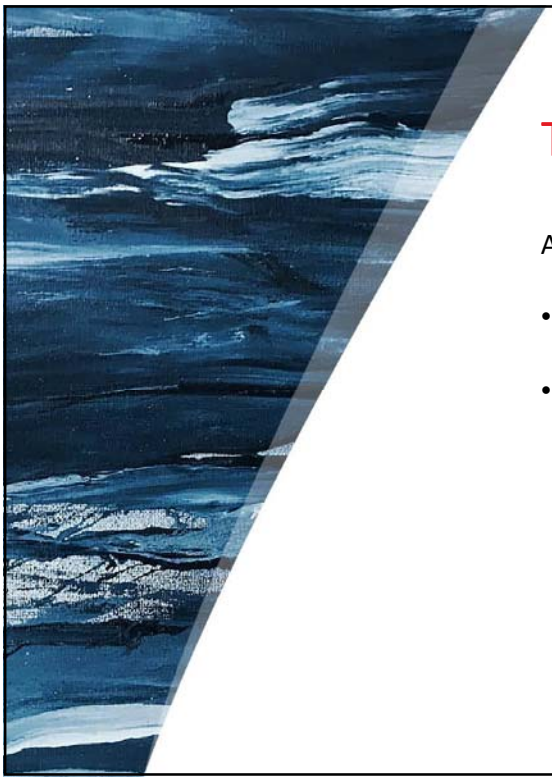

The two big costs

Arise when practices come to an end:

- Staff costs (redundancies)
- Premises costs
  - Lease – pay off rent for remainder of term (with no rental reimbursement)
  - Freehold – reduction in value of building

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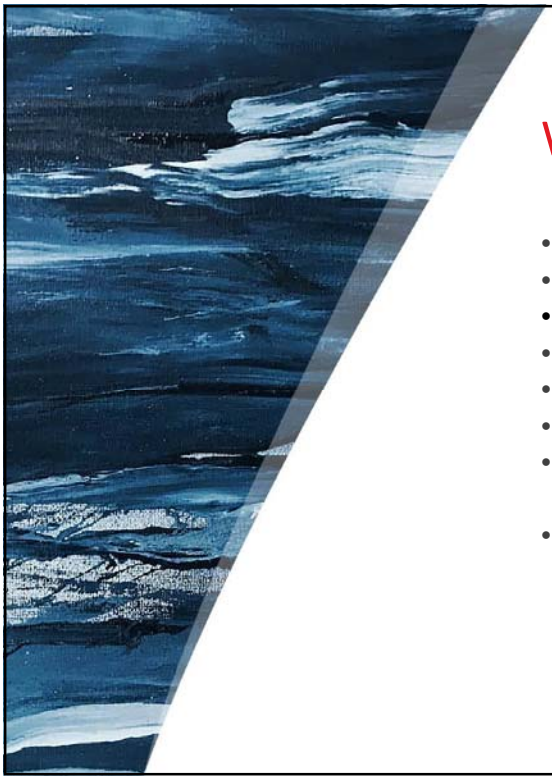

Worst case scenario

- Total failure of recruitment AND
- Individual becomes last man standing AND
- Can't continue, hands back contract AND
- Building isn't needed, no one else takes over AND
- List dispersed AND
- EITHER Freehold – no alternative use value
- OR leasehold – no break clause and long term left

- THEN redundancy and premises costs

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More likely scenario

- If recruitment fails AND
- If you can't manage to continue THEN
- Hand back the contract (3 or 6 months of difficulty)
- ICB gets caretaker provider who will have to:
  - Take staff via TUPE (no redundancy costs)
  - Occupy your building (pay rent)

- No guarantees, but…

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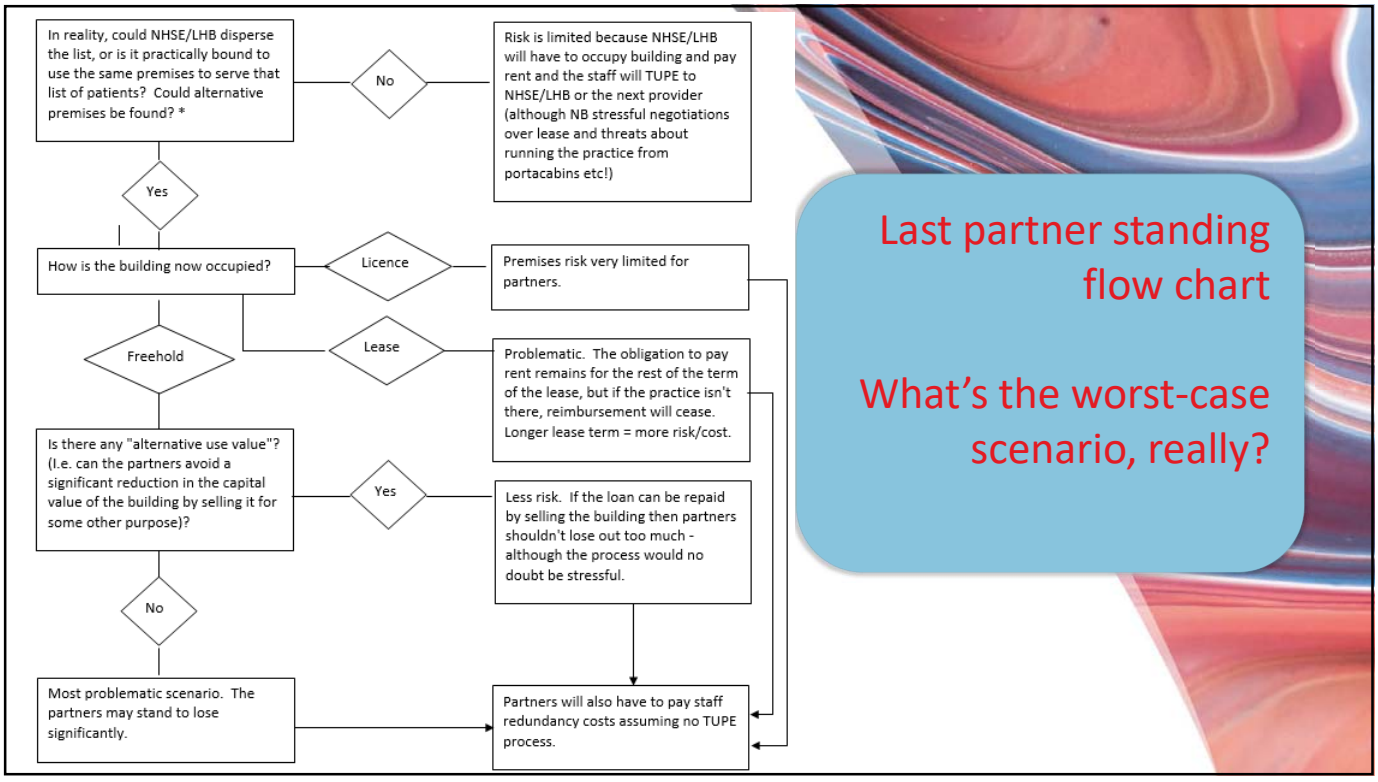

Last partner standing flow chart

What's the worst-case scenario, really?

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Conclusion

- Not *everyone* is in crisis
- Being last man standing isn't itself the end of the world
- If you're a low-risk practice – emphasise it to potential new joiners
- None of these risks are new - we're just thinking harder about them
- Don't look down!

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False solutions

Questions to which the answer is no:

- Move to an LLP?
- Move to a company (?)
- Insurance?
- Abandon the partnership model?

Should we set up an EOT?

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EOT – the "Minehead" model

- Move GMS contract into company
- Over half of business must be held by staff
- Tax efficient way of giving staff bonuses
- Does it change recruitment issues?
- Specific circumstances. Need:
  - ICB behind the idea (procurement?)
  - Group of GPs willing to hand over control and profit
  - Staff willing to take it on
  - Recruitment situation where that will solve it all

Are there pension issues…?

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Get in touch

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