NEWSLETTER
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1. LMCs bulk buy to help GPs beat credit crunch

Many LMCs are attempting to help practices survive the present difficult financial climate, by setting up buying groups in order to secure large discounts on medical supplies.

Several LMCs, including Kent, Essex, Surrey and Sussex, and Somerset have all set up schemes in the past month that will allow GPs to make savings on a wide range of services, including flu and travel vaccines, medical equipment, energy and telephone bills and locum insurance.

To increase the collective buying power further, there are also plans for a national LMC Buying Groups' Federation, which will initially comprise of 11 LMCs but the number could increase with added interest and success.

The services covered by these buying groups are available to all practices in the areas covered by the LMCs, with GPs free to take advantage of any deals negotiated.

In these tougher economic times, practices may be able to make significant savings and in one example, a practice in Mansfield secured a 25% saving in one year on its bill for medical consumables and stationary, amounting to a reduction of £2,500.

Kent LMC revealed it had recently struck up a series of deals with companies to supply GPs with medical consumables, energy supplies and locum insurance.

The groups are also offering discounts on medical equipment, calibration and testing, office stationary and furniture, car purchase and leasing and even practice website design.

The LMC said that the more practices who took advantage of the scheme, the bigger the savings and that 'no practice can afford to overlook opportunities to save money.'

They further advised that practices should 'look at the prices that have been negotiated and compare them with what you are currently paying.'

Chris Locke, secretary of Nottinghamshire LMC, which first developed the plans for use in the East Midlands, said the schemes could be hugely beneficial to GPs in these financially uncertain times.

He said: 'GPs have had no contract uplift for three years, and the prospects are looking quite gloomy for the DDRB this year. Against the backdrop of the credit crunch, it behoves practices to look at how it operates, how you can save money and reduce expenditure.'

2. Patient choice to become a contractual requirement

Ministers are planning to force GPs to offer patients a choice of hospital at every referral by making it a core contractual requirement.

This move, like several other measures being considered by the Department of Health (DoH), comes amid an increasing frustration at its struggling choice policy.

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Figures have shown that, as of September 2008, just 46% of patients recalled are being offered a choice of hospital for their first outpatient appointment; a figure that the DoH admitted has 'flatlined' having remained unchanged since early 2007.

In any case, for GPs, choice offering is no longer simply optional, as the NHS Constitution guarantees all patients a legal right to choose both their hospital and GP practice.

However, as David Stout, director of the NHS Confederation's PCT Network, points out: 'The truth is that nowhere in the GP contract is it stated they have to offer choice, so that's where there's a disconnect between the legal rights of the patient and no obligation on the practice.'

GPs would not be paid for offering choice, but would have to demonstrate that they are complying with the requirement, or risk facing deductions in pay or other regulatory action.

PCTs also have a 'duty' to promote choice. Bob Ricketts, director of system management and new enterprise at the DH comments: 'It is about saying to PCTs you've got to take choice seriously. You've got to make sure the public are aware of their rights and if for some reason somebody isn't offered a choice then you need to facilitate that.'

GP leaders have responded angrily to the plans and have suggested that the Government should focus on improving the mechanisms for delivering choice. Many have claimed that patients simply want to go to their nearest hospital or that patients do not understand the processes due to the meddling by PCTs with Choose and Book system.

Patients groups have also argued that patients are only able to exercise real choice when relevant information is made easily accessible.

Katherine Murphy of the Patients' Association says that: 'Until patients have information on hospitals, the clinician, doctor, infection rates, how good the person looking after them is, the individual doesn't have the right information to make that choice,' she says.

Other measures that have been proposed to increase patient choice include:

- Expansion of the Partnership for Patients Pilot Programme, where librarians help patients select and book their appointments, and a national advertising campaign.

- A marketing campaign that will target patients at 26 Primary Care Trusts alongside stands and trailers outside supermarkets; 'Life Channel' broadcasts (which are now in place in over 4,400 surgeries).

- PCTs to ensure choice offered at a local level, by monitoring complaints from patients.

3. Pilot Trusts: Use in relation to pension's lump sum death in service benefit

Where a lump sum death in service payment is made, that payment can be made to the free estate of one of the member's dependants. By definition that will mean the value is part of the IHT estate of the recipient. A nomination to a spouse will not instigate any adverse IHT consequence; but on the spouse's demise the benefit received will form part of his/her chargeable estate.

Alternatively, if the member had created a lifetime discretionary trust with, say £10.00, he can request the trustees of the pension scheme to make payment of the lump sum be diverted to the trustees of the new Pilot trust. (The trustees of the new Pilot trust then give a formal discharge to the pension scheme trustees).

By this means, the payment will not form part of anyone's IHT estate- but the trustees of the pilot trust can use the funds for the benefit of any one or more of the beneficiaries of the pilot trust- often the surviving spouse.

With the appropriate powers in the pilot trust; the monies can be loaned interest free, to the surviving spouse –thus giving her the free use of the capital funds but which will comprise a debt of her estate (on her demise) and reduce the IHT payable on her death. This arrangement therefore is flexible and tax efficient.

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If the pension death benefit monies remain in the discretionary trust for ten years there could be a ten yearly anniversary IHT charge but at a rate of only 6% (if, at the 10 year anniversary date the value of the funds within the discretionary trust exceed the IHT nil rate band applicable at that time). This compares favourably with a rate of 40% if the spouse had simply received the Pension trustee's absolute nomination direct; the capital then being comprised in the spouse's estate upon his/her death.

The Pension Scheme Trustees must have power within their Rules, to be able to make lump sum death benefit payments to a discretionary trust for the benefit of a spouse and issue.

For further information please contact Andrew Murdoch at am@lockharts.co.uk

4. Redundancy – Issues for Practices

Employers must be aware of the legal framework that surrounds the area of redundancy to avoid any possible liability that they may face as a result of making an employee redundant. This framework is set out in the Employment Rights Act 1996.

Redundancy could occur in practices where there is a reduction in the requirement for employees to do work of a particular kind. This could be because the amount of work has reduced, or because less people are needed to do the work. A redundancy situation could also arise if a branch surgery closes or if practices merge. The employee's job must disappear for there to be a genuine redundancy.

Employers should try to avoid compulsory redundancies and attempt to use alternatives if they can; this could in turn avoid litigation and save costs. Employers could initially try finding employees who want to volunteer for redundancy or early retirement, or even see if any employees are willing to work more flexibly by reducing their hours or days of work.

Voluntary redundancies have the advantage of being less disruptive to the workplace, being less demoralising for the workforce and reducing the amount of work needed to check that the redundancy selection criteria was fair.

If there is no option but to make compulsory redundancies then employers must follow a fair process and act reasonably in order to avoid any claims of unfair dismissal.

The employer should make sure that all employees that may be affected are warned and consulted about the possibility of redundancy. This consultation should be within a reasonable time before the redundancies take place and there should be an individual consultation with each employee that could be made redundant. Each employee should be given written details about certain matters, including the reasons for the redundancies, the numbers and categories of employees involved, what selection criterion will be used and how redundancy payments will be calculated.

A fair basis of selection for redundancy must be used with objective, non-discriminatory criteria applied fairly to all employees. The criteria can include capability or qualifications to do the job, standard and performance of work, the disciplinary records and length of service (i.e. last in first out). The employer should bear in mind that more than one criterion should be used to avoid the argument that the process was not fair.

If an employer offers alternative employment this must be suitable. The offer must be made before the employment contract ends and it must take effect within four weeks of the end of the original contract.

The main right that a redundant employee has is the right to receive a statutory redundancy payment. In order to qualify for this an individual must be an employee with at least two years' continuous service as at the date of termination of their employment contract and they must have been dismissed for redundancy reasons. Dismissal can include actual dismissal (which is termination by the employer of the employee's contract), ending of a fixed term contract without renewal, or termination of a contract on completion of a specific task.

The statutory redundancy payment is worked out by taking into account the employee's age, the number of years of employment up to a maximum of twenty years and the employee's

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weekly pay up to a maximum of £330. The current maximum payment is £9,900.

In some cases employers will have to consider whether employees are entitled to a contractual redundancy payment. For example, some employees may be employed under Agenda for Change or salaried GPs may be entitled under the Whitley Council Handbook. If you are in any doubt you should obtain legal advice.

If you want to try to avoid an employee complaining that they have been unfairly dismissed because of the way the redundancy was implemented you can invite an employee to sign a compromise agreement. Although more expensive for the employer the cost would be minor in comparison to defending a Tribunal Claim.

Finally, do not forget that as a redundancy involves a dismissal of the employee, the statutory dismissal and disciplinary procedures must be followed as a minimum. If this procedure is not followed the redundancy will be considered to be automatically unfair. The basic procedure has three steps to it and further information can be found on the ACAS website at www.acas.org.uk. If the practice has an enhanced procedure this must be followed.

5. Watchdog says doctors should be given more control over NHS spending

Independent watchdog the Audit Commission, released a statement that wants doctors to take more control over how billions of pounds of NHS money are spent, in order to help improve the quality of patient care.

The statement, *Clinicians and finance: Improving Patient Care*, made jointly with other organisations, including the Department of Health and Academy of Royal Medical Colleges, was released in early February and says that improvements for patients can only be made with involvement from local healthcare staff.

The statement sets out practical steps that can help doctors get to grips with NHS finance. Clinicians should understand the basics of NHS finance and have a right to expect reliable information presented in a way they understand and well supported by IT. It adds that this amounts to more than simply being given budgets to manage.

Health minister Lord Darzi welcomed the statement: 'As well as harnessing the skills of health professionals in making tough clinical decisions, the NHS needs to bring their expert judgement to bear on difficult financial and management decisions that impact on patient care.'

6. Tenon Group PLC acquires HWSEG to strengthen its medical division

Business adviser Tenon Group PLC announced on Tuesday 10th February, that it had acquired HWSEG Ltd (formerly Sandison Easson & Gordon), the specialist medical accountants and tax advisers.

Tenon Medical Services is one of the medical accountancy specialists in the UK and is a division of Tenon Group PLC. The deal takes Tenon's network of specialist medical support professionals across the UK to 60 staff. The combined national business will act for 420 practices comprising over 2,100 doctors.

Andy Raynor, Tenon's chief executive, said: 'Operating in the growing health care market, Tenon Medical Services is already one of the most prominent medical accountancy specialists in the UK. This acquisition will further enhance our leading market position.'

Tenon's head of Medical Services, Bob Senior, added, 'The acquisition of HWSEG will provide a stronger presence across the North of the Country.'

7. Locum Insurance Provider

We have been informed of a recent NHS circular that contained communication by the Financial Services Authority (FSA) on the withdrawal of permission to trade for *Synergys Ethical Limited*, who used to provide insurance contracts and specifically locum insurance policies to GP surgeries.

We have also been made aware of another company called *Aquote* (which the FSA believes to be run by a former director of

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Synergys Ethical Limited) that trades purely on the internet at www.aquote.biz and www.myaquote.co.uk. This company appears to offer locum insurance, but the FSA state they are concerned that this company is:

(a) Offering to renew old Synergys' clients policies; and
(b) Not forwarding on premiums to the relevant insurance providers.

You should contact the particular insurance company with whom you believe the policy is held to check cover, and if you discover you are no longer covered then you should take immediate steps to arrange new cover.

For more information on the FSA's warnings please visit the following links:

http://www.moneymadeclear.fsa.gov.uk/news/firm/warning_synergys.html

http://www.moneymadeclear.fsa.gov.uk/news/firm/2009/warning_aquote.html

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Contacting Lockharts

Lockharts Solicitors
Tavistock House South
Tavistock Square
London
WC1H 9LS

Tel: **+44 (0)20 7383 7111**
Fax: **+44(0)20 7383 7117**
Email: csd@lockharts.co.uk
Web: www.lockharts.co.uk

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"Under Andrew Lockhart-Mirams, Lockharts is an 'established leader in medical law' that acts for over 1,500 GP practices on a variety of corporate and commercial issues, including private APMS contracts with PCTs"

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