Signposts to Success

A handbook for the establishing General Practitioner

Dr Peter Sloane

LET'S START

"To know the road ahead, ask those coming back."
[Chinese proverb]

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Dr Peter A Sloane

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Irish College of General Practitioners Network of Establishing General Practitioners

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"Success depends upon previous preparation, and without such preparation there is sure to be failure."

[Confucius]

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Foreword

It is a privilege to write the forward to the updated version of the ICGP NEGs publication 'Signposts to Success'. I wish to acknowledge the work which has gone into this new edition of the original, first published in 2008. While primarily aimed at establishing GPs, 'Signposts to Success' has also proven to be a reference and guide for those of us already in practice.

The title of the publication is especially apt at this time of uncertainty and upheaval in general practice. We have all had the experience of searching for signposts when in unfamiliar territory. Signposts not only depict the way forward but can also warn of dangers and opportunities on the route chosen.

General practice has undergone many changes since 2008, among them are the opening up of access to the GMS, the reduction of income to practices by FEMPI cuts, and the need to fulfil professional competence requirements. The introduction of Universal Health Insurance with 'free' GP care for all is a priority of the government and that will bring even greater change, challenges and we hope opportunities.

General practitioners provide continuing comprehensive community based care to patients. This is the core of what we do. However, to do this we need to run successful sustainable businesses which respond to the particular needs of the locality. As the business and administration of general practice evolve to meet the needs of a changing system and society this publication will be a valuable asset.

The electronic format of the document allows it to be dynamic and responsive. While most GP trainees now undertake a practice management module during their training, it is when faced with making decisions about their own business that this publication will be at its most useful.

The investment of time and resources in updating the 'Signposts to Success' publication is a mark of the commitment of the ICGP to ongoing continued investment in and the development of College members establishing in practice, and recognition of the College's commitment to improving quality and standards for patients and doctors.

Dr Mary Sheehan,
Chair ICGP,
August 2014

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THE SECOND EDITION

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Peter is the Director of the ICGP Network of Establishing GPs (ICGP NEGs). In this role he chairs the ICGP NEGs Steering Committee and the ICGP NEGs GP Trainee Liaison Group. He also represents establishing members of College on the ICGP Council, Membership Services Committee and Project Development Group. Within European general practice he is the Chairperson of the Vasco da Gama Movement, the WONCA Europe working group for new and future General Practitioners and Family Doctors. A graduate of the Western Training Programme in general practice, Peter is in the process of opening a new single handed practice in Galway city.

THE FIRST EDITION (2008)

Dr John Ball

John is a GP Principal and GP Trainer with the Dublin Mid-Leinster Specialist Training Programme in general practice. He is based in *Fairview and Raheny* in North Dublin. John served as co-Director of the ICGP Network of Establishing GPs between 2006 and 2008 and co-authored the first edition of Signposts to Success. He has also served as an ICGP Council Member and was Director of Communications between 2010 and 2013.

Mr Dermot Folan

Dermot is the Chief Operations Officer of the ICGP and has worked with the College for over 25 years. He developed the College's *Management in Practice Programme* which supports members and their practices through advice, information and training and has produced a number of publications and guidelines in this area. He was co-author and editor of the first edition of Signposts to Success. Dermot was instrumental in the setting up of the College's NEGs programme.

Dr Shane McKeogh

Shane is Managing Partner and GP Principal in *Solas Medical Centre* in Rathfarnham in South Dublin. He is also a co-founder and Director of *GPBuddy.ie*, a comprehensive online directory for Irish GPs and Healthcare Professionals which was launched in 2010. Alongside John Ball, Shane was co-Director of the ICGP Network of Establishing GPs between 2006 and 2008 and co-authored the first edition of Signposts to Success.

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The ICGP Network of Establishing General Practitioners (NEGs)

The *ICGP* Network of Establishing GPs Programme (*ICGP NEGs*) is a range of services and supports that the ICGP provides to establishing College members. The NEGs Programme is principally aimed at those who have been GPs for less than five years.

ICGP NEGs was set up in 2004 by the Membership Services Committee to enable the College to focus on and address in a practical way the unique needs of GPs who are establishing their career in general practice. The programme also aims to foster greater involvement of establishing GPs in College activities, thereby investing in the future of the ICGP, ensuring it remains robust, dynamic and effective.

The NEGs Programme is co-ordinated by a Director with support and input from a Steering Group of Regional Representatives from across Ireland. ICGP NEGs also has strong linkages with the Vasco da Gama Movement (VdGM), the establishing arm of WONCA Europe.

The NEGs Steering Group (August 2014)

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Disclaimer

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Introduction

It is my great pleasure to write the introduction to the second edition of Signposts to Success. At the outset I wish to acknowledge and pay tribute to the authors of the first edition, Dr John Ball, Mr Dermot Folan and Dr Shane McKeogh. Their determination and vision created a publication that is widely recognised as being an extremely valuable resource for establishing and established GPs in Ireland.

In writing this introduction, I am struck by the opening paragraph of the introduction to the first edition. The sentiments captured by John, Dermot and Shane hold as true today as they did when GPs first completed vocational training over 40 years ago. I therefore make no apology for restating in its entirety that opening paragraph.

"Newly qualified GPs sometimes finish their training with a sense of anti-climax. Time flies by and suddenly, ten or more years have passed and formal undergraduate and postgraduate medical training has been completed. The MICGP qualification and Certificate of Satisfactory Completion of Training have been attained, and one can call oneself a General Practitioner. The hospital years may have been prolonged and frustrating but they were also associated with a now much missed camaraderie. No longer is one a PAYE employee of the HSE but rather, self-employed, and without a permanent job, the future can seem rather daunting. Having just moved from a world of structure to a relatively unstructured environment, the sense of change may, at times, seem overwhelming. Whilst this time can be intimidating, and certainly represents a steep learning curve, the potential to use personal initiative to control the direction of one's life and manage the future can be exhilarating. You are trained to deal with anything and you look forward to a life in general practice. Now, it's time to make some real decisions."

Signposts to Success is intended to provide a comprehensive roadmap from the point of completion of GP training right through locum work, sessional work and assistantship all the way to being an employer and GP Partner. As the title aptly says, it is a handbook for establishing GPs; however, it also contains a wealth of information that is both relevant to and important for GPs at all stages in their career.

In publishing the second edition, there has been substantial revision, editing and re-ordering of exiting material. Up to date information on financial, tax and PCRS payments is included. In the context of the 2007 Medical Practitioners Act, 2009 Medical Council Guidelines, and the 2012 Open Access GMS, significant new material has been added. There are three new chapters in the areas of doctors' health, professional competence requirements and marketing and advertising in general practice as well as full details on the new open access GMS application process.

Another innovative change has been in the overall format of the publication with the second edition being entirely converted to electronic PDF format. Over time this will facilitate keeping the publication up to date as changes occur in the areas of taxation, PCRS etc., but more significantly, it will allow for the ongoing development and embedding of multimedia material.

These changes, revisions and additions have been made with the objective of providing readers with an up to date, invigorated publication which provides an interactive and dynamic experience.

At the conclusion of the introduction to the first edition, the authors of Signposts to Success wrote, *"We hope that this publication will serve as a useful guide to the business and organisational world of Irish general practice. It will hopefully provide the establishing General Practitioner with useful signposts, help to avoid pitfalls and make easier the steep learning curve of this aspect of general practice!"* It is my sincere hope that for readers of this second edition, Signposts to Success not only lives up to the high bar set by the first edition, but that it proves to be an equally valuable and informative resource.

Peter A Sloane
August 2014

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1: Sustaining a Career in General Practice: Managing your Health, Your Job and your Work-Life Balance

By Dr Andrée Rochfort

Introduction

Doctors' health is a crucially important subject that every GP should be mindful of. Good health starts with self-awareness, and increased self-awareness should be encouraged amongst all General Practitioners.

It is also extremely important to acknowledge and raise awareness of the complex views and attitudes that GPs hold about their own personal health. The job of being a GP may entail certain hazards and present challenges to one's own health, but this is often compounded by a complicated culture and the attitudes which many doctors have in respect of accessing personal healthcare.

Whilst most GPs finish training with an enthusiastic ideal of a long career in general practice, it is also difficult at the outset to appreciate the myriad of challenges that one may face along the way. Unfortunately, burnout is an all too common phenomenon amongst middle aged and older GPs. There is little point in opening a new practice or obtaining stable long term employment, only then to experience ill health, stress or burnout as a consequence of one's job.

It is hoped this chapter will provide a basic toolkit for establishing GPs to manage challenges and hazards associated with a career in general practice, thereby helping achieve long term job satisfaction whilst minimising the risk of burnout. The aspects of health which are considered in this chapter are:

1. Aspects of a Career in General Practice that can be challenging to one's Health
2. Aspects of Being a GP which can be Challenging to one's Health
3. Maintaining Good Mental and Physical Health
4. Where to Turn for Health Advice and Healthcare: the ICGP Health in Practice Programme

1.1 Aspects of a Career in General Practice that can be challenging to one's Health

The core principle of occupational medicine is the acknowledgement of a two way relationship between work and health. A worker's health may impact on the job they do, but it is also the case that the work or certain aspects of the work a person does, specifically their job tasks, may have an impact on the health of that worker. This is true whether one works as a builders' labourer, a computer software programmer, a teacher or a doctor.

A workplace hazard is something that has potential to cause harm. For example, the physical hazard posed by a wet floor. In this case, a "wet floor" sign is used to warn unsuspecting others about the hazard. Workplace hazards are best categorised as physical, biological, chemical and psychosocial. A workplace safety statement and risk assessment will address many of these hazards. The purpose of such a document is to identify hazards so they can be evaluated in order to minimise their potential for harm.

Hazards can be controlled in a number of ways. These include elimination (e.g. removing a trailing electrical cable from the floor), substitution (e.g. using disposable medical equipment instead of reusable medical instruments which need to be autoclaved), and modification (e.g. placing the incineration bin close to the place of phlebotomy instead of at the opposite side of the room). Every job will have hazards that cannot be fully eliminated, e.g. dealing with people who may become aggressive or violent. In these circumstances certain information and training in how to manage work processes (interactions) can help to minimise the risk.

The job of being a GP has its own unique range of potential hazards. Key aspects of the work of general practice include the hours of work, the clinical demands of the job, managerial and employer responsibilities, taking paperwork home, work life balance, personal healthcare and the time management of all of the above. The focus of this chapter is not the biological hazards, e.g. a sharps injury or transmission of communicable disease, but rather the psychosocial hazards of being a GP. We are hopeful that the reader will be prompted to appraise this aspect of their own potential work related hazards.

Some pressures of working in general practice are generic to the jobs of many healthcare professionals and include working

in an environment involving labour intensive, personal one to one interactions with other people including patients, patients' relatives, peers, other health professionals and administrators. Potential sources of pressure can also come from work processes and practices. For example, having to manage large volumes of paperwork where misplacing any individual piece of paperwork is more than just the loss of a piece of information; it also poses potential risk to patient health and safety. Other examples include the sheer volume of appointments, consultations, telephone consultations and patient related interruptions that occur within the time constraints of a twenty four hour day.

A GP can also be under pressure to ensure provision of continuous 24/7/365 cover as required by the GMS contract. Arranging medical cover for leave can create administrative and financial pressures. This doesn't just relate to holiday leave or out-of-hours cover but can also include study leave, time off for personal health needs or other family or personal requirements. Single handed GPs also need to ensure adequate time off to sleep, eat and spend with the family! Despite GPs nowadays encouraging patients to develop and maintain healthy lifestyles to minimise risks from cardiovascular disease, diabetes, anxiety and depression, it can still prove hugely challenging for GPs themselves to factor healthy lifestyle activities into their own heavy work schedules, and to arrange the necessary medical cover while doing so.

Over the last few years, there has also been added stress for Irish GPs in the form of increasing uncertainty about the future. As of 2014 there have been four rounds of cuts under Financial Emergency Measures in the Public Interest (FEMPI) legislation which have had a huge impact on the practice incomes of GPs who hold state contracts. In addition, the government has both proposed a new contract for GPs and also the introduction of universal health care via a model of universal health insurance. These proposed changes if implemented, will inevitably result in significant organisational change in general practice. In 2014, the associated uncertainty of future structures and processes of 21st century Irish general practice is therefore considerable and a significant source of stress for GPs.

1.2 Aspects of Being a GP which can be challenging to one's Health

Many studies have been published that seek to analyse doctors' personality traits and understand why doctors get stressed by the work they do. These studies have also tried to understand how some of the pressures of this work can be addressed through modifying personal attitudes or behaviours. Some well-recognised personality traits of doctors include perfectionism, conscientiousness, hard work, self-sacrifice, delayed gratification and dedication.

It is also true that some of these characteristics may contribute to the reasons why certain individuals self-select for medical school in the first place. Entry to medical school is only possible when the young student applies rigorous self-discipline to achieve the necessary high entry grades. This may necessitate giving up social activities and non-academic interests which are accepted by teenage peers as norms of growing up, e.g. musical interests, competitive team sports, fashion and social networking.

Perfectionistic traits also persist in the competitive hard working world of medicine. Hard work is openly promoted and doctors' conversations often focus on how busy they are at work and what on-call was like, e.g. how much they were up at night and how little sleep they had. It is also a fact that these traits are the very traits that contribute to high quality patient care; a strong sense of responsibility and an ability to cope with long working hours and multiple demands from different people every hour of every working day.

Managing the expectations of others for action or information requires skills of knowledge and experience. It also requires a variety of approaches to take account of a broad range of circumstances. For example, the response to a patient with terminal cancer will be quite different to managing a patient with smoking induced COPD, a teenager with depression, or an actor with facial psoriasis.

Another issue which can often cause stress is managing the sense of entitlement of others. This can manifest in many ways. For example, patient expectation to be seen on the spot or to have three items dealt with in one appointment despite ten minute appointments being necessary to cope with population demand. It may be an expectation of referral for scans, specialist opinions or for surgery. A further factor that increases stress and compounds the difficulty of managing patient expectations is the unfortunate reality of complaints to the Medical Council. It is a regrettable truth that in saying no to patients or attempting to save unnecessary work and expense a number of GPs have found themselves facing official complaints.

1.3 Maintaining Good Mental and Physical Health

The good news is that during a career in general practice there are many positive actions that can be taken to help maintain good physical and mental health. It is also important to recognise and affirm that being a GP can provide huge job satisfaction. Job satisfaction in any occupation nurtures a worker in their job, improves their attitude towards their personal performance, and breeds loyalty, innovation, resilience and coping skills. It is therefore important to consider and reconsider at intervals what it is about your work in general practice that gives you job satisfaction, and to develop and use this to sustain you over the decades of your career.

During undergraduate and postgraduate training, the clinical aspects of general practice are approached in a structured way, and post training, GPs are good at keeping up-to-date. Long before formal competence assurance requirements became mandatory, GPs had a track record of regular attendance at CME groups, clinical society meetings and other types of postgraduate medical education. However, beyond clinical general practice, there is also a need for GPs to address broader aspects of their work including all facets of running a practice and business as well as sensible self-care. With holistic consideration, there are two areas that one needs to consider:

1.3.1 Managing the Job

1.3.2 Managing Oneself

1.3.1 Managing the Job

Keeping a log diary for one session (an entire morning or afternoon) can be quite revealing for a GP, and when done from time to time is a very useful exercise. It allows assessment of the tasks performed and the stresses or pressures experienced. It can be a helpful way to analyse how time is actually spent and how changes might be made to increase efficiency or make use of help. It is quite possible for any GP to assess the demands on their time and how these demands are managed. Some examples are considered below.

1.3.1.1 Interruptions

The number of interruptions experienced during a defined period can be measured, e.g. during a one hour or three hour period. This should include interruptions both during and between consultations. Letting someone off at the desk or from the waiting room, or taking a non-emergency call interrupts the flow of a consultation and additional time is then required to recap what has already been said. Interruption may also influence the safety and quality of the diagnostic process.

1.3.1.2 Prescription Management

There should be a practice policy for managing prescriptions and all reception staff can be trained to consistently implement the policy. Requests for repeat prescriptions can be managed in a structured way, and there should be a clear consistent approach to on the spot requests for prescriptions. The practice policy may include limiting repeat prescriptions to a certain timeframe so that a GP must reissue an allotted allowance. This will prevent patients on certain medications from going too long without a medical or medication review. Patients taking medications which necessitate frequent laboratory tests can also be managed using an agreed system. Keeping patients informed of repeat prescription processes, reminding them of the normal interval between requesting and collecting a prescription, consistently applying practice policy, and ensuring that doctors sign prescriptions within an agreed timeframe will all contribute to lowering stress levels of practice staff, doctors and patients whilst also minimising interruptions and risks to patient safety.

1.3.1.3 Paperwork

Every day, an enormous number of letters, reports, results, and requests for signatures and reports arrive at a GP practice both in hard copy and electronic form. If this correspondence is not effectively managed the system can easily become disorganised and in turn this can lead to delays in response time, correspondence going missing, overflowing in-trays, multiple in-trays at multiple sites and chaotic unmanaged electronic information. The consequence will be increasing frustration amongst staff, doctors and patients.

Most GPs do paperwork at allotted times. This can include before clinic in the morning, during lunch hour, after surgery finishes in the evening and at home in the evenings and even at weekends. It is a frustrating reality that paperwork is a necessary part of running a business. It is also the case that inefficiently managed paperwork leads to the potential for staff and GPs to become stressed, frustrated and at risk of complaints. Therefore, in the same way that clinical consultations are given appointments, paperwork must also be scheduled into the working week and when possible should be carried out in allocated protected time.

Unfortunately, it may be necessary to re-schedule paperwork where home visits take up time or where a procedure needs to be performed. However, there must be some evenings or weekends that are kept paperwork free in order for the GP to address other commitments including CME, family events, physical exercise and one's own healthcare needs.

1.3.2 Managing Oneself

It is important that each of us looks after our own needs, i.e. manages oneself. We must do this in the context of being a person who happens to work as a GP. As part of this each of us needs to consider where the GP part sits in terms of one's overall existence, i.e. work-home or work-life balance. In relation to this work-life balance, it is important as a GP to be aware of whether one practices what one preaches. It is worth answering the list of questions below; however, it is also important to answer the questions honestly and not simply give aspirational answers reflecting actions intended to be taken at some point in the future!

Do you: -

5. Have good sleep hygiene?
6. Eat a balanced diet of adequate fresh fruit and vegetables with a minimum of convenience or '*on the go*' foods?
7. Drink too much caffeine?
8. Drink too much alcohol?
9. Smoke?
10. Do vigorous physical exercise four or five times a week or is your exercise wishful thinking armchair exercise i.e. watching a match on TV?
11. Drink enough water? Interestingly, many GPs state they regularly skip lunch or evening meals due to the pressures of work, and some GPs have also stated they are so busy that they postpone going to the toilet for lengthy periods of time to avoid interruptions. As it happens, given that many GPs do not drink enough water during the working day, they are also producing less amounts of urine!
12. Do other things outside work? What do you do outside your working hours? When do you "*switch off*"? If you do not have time outside your working hours then you need to address this as a matter of urgency!

In addition to being a GP, all of us also have to contribute to running homes. Examples of required chores include doing the shopping, cleaning the house, carrying out simple home repairs and maintaining the garden. Those of us with family will also have to manage the same activities as those of our patients who have family such as bringing and collecting children to and from social events, helping elderly parents and attending family gatherings. If these household and family activities are eroded by work, then work related tasks need to be rescheduled. If this is not done, work will permeate every waking hour of the life of a GP. Not only is this unhealthy, but it is also accepted by society that one person does not work on a continuous 24/7/365 basis.

1.4 Where to Turn for Health Advice and Healthcare: the ICGP Health in Practice Programme

In March 2000, the ICGP launched the Health in Practice Programme (HiPP) for members and GP trainees. The HiPP is a system of health related services and supports for GPs and future GPs. It provides support for management of personal health including physical health, occupational health and psychological/mental health. The programme has three main sections: -

1. Health care services and supports including web based resources and information
2. A telephone helpline and email address for contact
3. Medical education for promoting high quality self-care and healthcare for GPs

The ICGP HiPP encourages GPs to put their own health on a personal priority list. The programme is focused on the health and wellbeing of GPs from the beginning of specialist training right through to the post retirement period. This focus is delivered through a programme of integrated services including confidential GP healthcare and mental health services for GPs. Access is provided to a telephone helpline along with information, advice and medical education tailored to the wider health needs of GPs in the context of the particular occupational lifestyle and hazards of being a GP.

Self-medication and self-directed healthcare can lead to lack of objectivity, inappropriate management and knowledge gaps. Self-diagnosis and self-treatment also miss a golden opportunity for creating a trusting partnership between a patient and a doctor to manage acute and chronic health issues and conditions. Doctors experience exactly the same range of symptoms of acute illness, chronic conditions and mental health problems as the general population. And also like the general population, doctors benefit from being the recipients of healthcare when ill, including availing of the diagnostic process, medical investigations, rational prescribing and follow up of symptoms and signs. The HiPP has a number of *teams of health professionals* who are experienced in provision of healthcare to medically qualified patients.

In the first instance, the appropriate place to address one's primary healthcare needs is with one's own GP. However, like some of the very busy or more resilient members of the general population, GPs need to be encouraged to proactively address their general, physical and mental health in a structured way. This should include registering with a GP and availing of the high quality co-ordinated care that GPs deliver to the general population. It should not be forgotten that as patients GPs are also members of the general population! It is recommended that symptoms or signs should be addressed in a timely fashion by attending a HiPP GP, one's own GP, or a GP in the local area. This should be a priority in relation to one's own personal health.

Attending a doctor or other health professional may be a major challenge for a doctor. Some doctors may be uncomfortable because they are not familiar with the role of being a patient. Both patient and doctor face specific challenges when the patient is medically qualified and the dynamics of healthcare consultations are different when the patient is a health professional. The ICGP HiPP helps to address these issues. To access HiPP services, GPs and GP trainees can directly contact by telephone any of the listed GPs, occupational physicians or health counsellors for advice or a consultation. A panel of psychiatrists is also linked to the service and can be accessed through any of the listed GPs. All contacts take place within a private therapeutic arrangement separate to the ICGP. No personal details are ever communicated to the ICGP so that the identity of attending GPs is guaranteed to be protected. Services are provided by health professionals who have a special interest, training and experience in doctors'/healthcare workers' health.

1.4.1 Services Provided by the ICGP Health in Practice Programme

There are a number of different services available to GPs and their families including: -

1. **HiPP General Practitioners**: A GP service for GPs, co-ordinating healthcare for GPs;
2. **HiPP Occupational Physicians**: For occupational health advice, work absence, returning to work after sick leave, follow-up advice on sharps injuries, work-related illness, etc.
3. **HiPP Psychiatrists**: Psychiatric care on referral from one's GP
4. **HiPP Health Counsellors**: Helping one to develop solutions, life management skills and coping resources to resolve work-related issues and personal problems such as acute or chronic stress or anxiety, depression, bereavement, grief and loss, family disruption, psychosexual issues, relationship issues and other problems.

1.4.2 Accessing the ICGP HiPP

Full details of how to access the service are available on the *doctors' health page of the ICGP website*. To access confidential advice there are several options: -

1. To obtain advice or book an appointment, any of the professionals from the *health in practice teams* listed on the ICGP website can be contacted by telephone;
2. The HiPP helpline is available on 087 7519307;
3. The HiPP administrator, Ms Sally-Anne O'Neill can be contacted by telephone (01 6763705) or by email (*sallyanne.o'neill@icgp.ie*);
4. The Director of the HiPP, Dr Andrée Rochfort, can also be contacted by mobile (087 7519307), landline (01 6763705), email (*andree.rochfort@icgp.ie*), or in writing (addressed to Dr Andrée Rochfort, ICGP, 4/5 Lincoln Place, Dublin 2, being sure to mark your envelope '*private and confidential*').

1.4.3 The ICGP HiPP Education Service

The HiPP provides outreach and educational activity. To arrange a lecture, workshop or other presentation on matters of occupational health for healthcare professionals or on the topic of doctors' health and healthcare for undergraduates, postgraduates or CME purposes, one should contact the HiPP administrator, Sally-Anne O'Neill by email (*sallyanne.o'neill@icgp.ie*) or by telephone (01 6763705).

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Summary

The area of GP health is important and influenced by many factors. Not only does the job of being a GP bring its own unique challenges and hazards, but the personality and cultural traits of GPs themselves complicate attitudes towards and access of health services. Self-awareness of one's own health is of vital importance and it is highly recommended that all GPs have their own GP. In addition, accessing healthcare in a timely fashion is crucially important. GPs should also be proactive within their working lives to minimise aspects of being a GP and the associated work environment that contribute to stress, frustration and potential burnout. Ultimately, the safety net and support of the ICGP Health in Practice Programme exists for all GPs, GP trainees and their families.

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2: The Basic Requirements for Independent General Practice

Introduction

General practice is an academic and scientific discipline. It is a recognised clinical speciality with its own educational content, research and evidence base, and clinical activity orientated to primary care. WONCA Europe has a detailed definition of general practice/family medicine which was updated in 2011.

Since the publication of the first edition of Signposts to Success in 2008, there have been a number of significant changes to the Irish medical landscape. One of the most important of these occurred on 1st May 2011 with full enactment of the 2007 Medical Practitioners Act. This led to a number of changes in the requirements for practicing as an independent General Practitioner. These requirements are outlined in this chapter.

2.1 Registration

The 2007 Medical Practitioners Act introduced changes to the registration requirements for doctors working in Ireland. The registration requirements for General Practitioners are summarised below. Additional information on registration can be found on the Irish Medical Council website.

A doctor wishing to practise medicine in the Republic of Ireland must register with the Medical Council. It is an offence to practise within Ireland while unregistered, with only two exceptions. Firstly, when administering first aid or secondly, visiting EEA registered doctors attending in an emergency.

The Register of Medical Practitioners was established in March 2009 and replaced the General Register of Medical Practitioners and the Register of Medical Specialists. The Register comprises four Divisions. A Medical Practitioner can only be registered in one Division at a time, except when a specialist is training in another specialty, for example, a Medical Practitioner could be registered in the Specialist Division in the specialty of General (Internal) Medicine but is also registered in the Trainee Specialist Division while training in the specialty of Gastroenterology. Every doctor is responsible for ensuring that their registration is current and appropriate for their individual circumstances within one of the categories of the Register: -

- Trainee Specialist Division
  - Internship Division
  - Trainee Specialist Division
- Specialist Division
- General Division
- Visiting EEA Practitioners Division

In order to practice independently, in any health care setting, without supervision, a doctor must hold a certificate of full registration with the Medical Council. Following the presentation of required documents and payment of an annual registration fee, the Medical Council issue an annual Certificate of Registration. Full details of eligibility requirements and fees payable can be found on the Medical Council website.

2.1.1 Specialist Registration

Specialist registration is specifically for doctors who have completed specialist training which is recognised by the Irish Medical Council and who may practise independently as a specialist. This is the division in which all GPs who complete vocational general practice training in Ireland must be registered. A number of eligibility categories are available for registration within the Specialist Division of the Register.

2.1.1.1 Category A: Graduated from Higher Specialist Training Programme in Ireland

Category A specialist registration is for graduates of Higher Specialist Training Programmes supervised by postgraduate training bodies who have satisfactorily completed higher specialist training and have been awarded a Certificate of Satisfactory Completion of Specialist Training CSCST by that Training Body. In the case of general practice training in Ireland, the supervising postgraduate Training Body is the ICGP.

Once a GP trainee in Ireland has gained a CSCST from their GP training scheme and has passed the Membership of the Irish College of General Practitioner (MICGP) examinations, the process of transfer to the specialist division of the medical register will take almost automatically. The ICGP notifies the Medical Council of eligible candidates and transfer then takes place. Under Medical Council guidelines, doctors who have

completed vocational specialist training are expected to register in the Specialist Division.

2.1.1.2 Categories B, C and D: Trained and/or Recognised as a Specialist in an EU Member State

Categories B, C and D may apply to graduates of Higher Specialist Training programmes supervised by postgraduate training bodies in EU Member States who have been awarded a Certificate of Specialist Training (CSCT), a Certificate of Acquired Rights (CSTAR) or are established and recognised as a specialist by the competent authority of a Member State. These categories are as follows: -

Category B Graduated from Higher Specialist Training Programme in an EU member state

Category C Hold '*acquired rights*' from an EU member State

Category D Trained in a third country and established/ recognised as specialist in an EU member State

Nationals of Member states of the EU may be eligible to apply for entry into the Specialist Division of the Register under 'EU Directive 2005/36/EC of the European Parliament and of the Council on the Recognition of Professional', as amended. There are potentially a number of different eligible qualifications for each member state and applicants should consult the checklists available on the Medical Council website to determine which the appropriate qualification to submit is.

2.1.1.3 Category E: Medical Practitioners who have Completed Higher Specialist Training or Equivalent and who are not recognised in Categories A to D

This Category may apply to doctors who do not meet the requirements for recognition of their specialist qualifications and who must submit structured evidence of completion of their specialist training and experience. This will be referred to the relevant approved postgraduate training body in Ireland for assessment. In the circumstance where a trained specialised GP does not meet the eligibility criteria under Categories A to D, the Medical Council will refer their application to the Irish College of General Practitioners for assessment. The ICGP has clearly defined assessment criteria in this circumstance as outlined on the ICGP website.

2.1.2 General Registration

Doctors who have not completed recognised specialist medical training must register under General Registration. This is the only form of registration available to them. Doctors with general registration may practise independently without supervision but may not falsely represent themselves as holding specialist registration. Further information is available on the Medical Council website.

2.1.3 EU Certification: Certificates of Specific Training or Acquired Rights (CSTAR)

EU Certification is certification of doctors who are trained/ have their training recognised in Ireland. It is for the purpose of recognition in other EU Member states or for entry into the General Medical Services (GMS) Scheme in Ireland. In essence it provides for mutual recognition of professional qualifications in the EU.

From the perspective of the European Union, the general purpose of EU Certification at specialist level is, in accordance with certain EU regulations, to create an internal European market for doctors who have completed recognised higher specialist training. This is in order to allow those doctors automatic recognition of their qualifications in any EU member State. Furthermore, for General Practitioners, EU Certification may grant access to State Schemes in Ireland and other Member States. Additional information on European Union mutual recognition of medical qualifications can be found on the Europa.eu website.

As the designated Competent Authority, the Medical Council is responsible for issuing EU Certification. The EU Directive presently governing specialist training is 'EU Directive 2005/36/EC of the European Parliament and of the Council on the Recognition of Professional Qualifications'. Two basic types of qualifications are issued: -

Certificates of Specialist Doctor (CSD)
These cover and are issued for all recognised medical specialties with the exception of general practice

Certificates of Specific Training or Acquired Rights (CSTAR)
These cover general practice only

The purpose of the CSTAR is to grant the doctor recognition of their specialist training in general practice in any EU Member State, and thereby permit access to the social security network/ State Schemes of any EU member State. The CSTAR certifies that training meets with the requirements set down in Articles 28 or 30 and Annex V 5.1.4. of the Directive. It is important to note that if an applicant is trained in Ireland a CSTAR is required for entry into the GMS. If an applicant is trained in the EU the applicant must present qualifications that are equivalent to a CSTAR. Further details on the CSTAR and how to apply for a CSTAR are outlined on the Medical Council website.

2.2 Professional Competence

The full provisions of the 2007 Medical Practitioners Act came into effect on May 1st 2011. All doctors on the Irish Medical Council Register are now legally obliged to maintain their professional competence by enrolling in a professional competence scheme (PCS) and follow requirements set down by the Medical Council. While most doctors have always engaged in continuous professional development, this new system creates a formal process of lifelong learning which highlights doctors' dedication to developing their skills throughout their professional lives. Participation in a PCS helps registered doctors demonstrate that they are fulfilling their statutory duty under the Medical Council registration requirements. Schemes are in place for all registered doctors on the Specialist and General Division of the Medical Register. Doctors registered in the Supervised Division of the register must also enrol in a PCS related to their chosen specialty.

Professional competence schemes are operated on behalf of the Medical Council by postgraduate training bodies and have been developed to drive good professional practice which is centred on patient safety and the quality of patient care. The activities which doctors are required to engage in are straightforward and practice based. The ICGP operates the general practice PCS under arrangement with and on behalf of the Medical Council. The ICGP provides support to facilitate GPs in maintaining and recording their professional competence. The ICGP PCS is described in more detail in Chapter 3, 'On-Going Professional Development and the ICGP Professional Competence Scheme'.

2.3 Professional Indemnity

Under the 2007 Medical Practitioners Act, and as per the most recent 7th Edition of the Medical Council Guide to Professional Conduct and Ethics for Registered Medical Practitioners, published in 2009, all doctors must ensure they have adequate professional indemnity cover for the work they perform prior to engaging in the practice of medicine within Ireland. In the case of 'private' employers, e.g. individual GPs, GP practices, locum agencies, GP co-ops etc., employers will require registered doctors to hold professional indemnity insurance. In respect of state employment, i.e. the HSE, all healthcare Practitioners employed by the HSE are covered against clinical negligence claims by the Clinical Indemnity Scheme (CIS), under the State Claims Agency (SCA). However, despite the existence of the CIS, it is advisable that all State employed doctors obtain expert advice on having their own additional professional indemnity insurance in place.

For GPs, there are currently three medical indemnity insurance providers operating in Ireland. Subscriptions or premiums to a medical defence organization are a significant expense for most establishing GPs. The rate of subscription is based on the number of sessions worked per week and the amount of on-call work done. It is recommended to review all available indemnity options to choose one that best matches one's current mode of practice.

2.3.1 The Medical Protection Society

The Medical Protection Society (MPS) is a UK based company providing indemnity cover to Irish doctors. The MPS has a free phone membership helpline (1800 509 441). Payments can be made by monthly direct debit. Further information can be found on the MPS website.

2.3.2 The Medical Defence Union

The Medical Defence Union (MDU) is another UK based company providing indemnity cover to Irish doctors. The MDU has a free phone number (1800 509 132) for membership enquiries. Payments can be made by monthly direct debit. Further information can be obtained on the MDU website.

2.3.3 Medisec

Medisec is an Irish company. It was set up by Irish GPs to provide indemnity for Irish GPs through a policy with Allianz Ireland plc. Medisec can be contacted directly by free phone (1800 460 460) and further information can be found on the Medisec website.

2.3.4 "*Occurrence/Incident Based*" Cover Versus "*Claims Made*" Cover

It is crucially important to understand exactly what is covered under any indemnity policy. One key difference between the MPS and MDU when compared to Medisec is in relation to the basic coverage offered. Both the MPS and MDU offer *'occurrence'* or *'incident based'* indemnity. This gives protection for claims arising from incidents that occurred during the subscription period ***no matter when they are reported***, *even if it is many years after that subscription period has ceased.* This provides ongoing protection at retirement or death, the latter preventing one's estate being liable for claims. On the other hand, policies with Medisec are on a '*claims made*' basis. This means the insured doctor is only covered for claims arising from incidents which both occur and are reported ***whilst the policy is in force***. Usually, therefore, when the policy expires, so does the cover.

2.4 Membership of the Irish College of General Practitioners (MICGP)

In Ireland, the MICGP is a recognised registerable qualification in the speciality of general practice. It is the end point qualification for doctors undertaking specialist training in general practice.

There are a number of routes to membership of the College as outlined below.

2.4.1 Membership through Examination

To become eligible for election as a member of the ICGP, applicants for membership by examination must hold a Certificate of Satisfactory Completion of Training (CSCST) from an accredited general practice Training Scheme in Ireland and have achieved a pass in all required modules of the MICGP examination. This examination is a criterion-referenced competency based examination in which the pass standard is by recognised standardisation procedures, and all candidates who reach the standard for the module pass the examination.

2.4.2 Membership through Equivalent Qualifications

Doctors applying for membership through equivalent qualifications must hold a certificate of completion of training issued by an accredited training body within the EU which includes a form of summative/end point assessment. Applications for membership through equivalent qualifications will be considered from GPs who meet any of the following equivalent criteria outlined below. Full details are found on the ICGP website or can be obtained by contacting the ICGP directly. The various criteria are: -

1. **Qualifications in general practice obtained in the UK**
   - **a.** Doctors holding JCGPT certification without summative assessment
   - **b.** Doctors holding JCGPT/PMETB (UK) certificates with summative assessment (and/or MRCGP) and issued under Article 28 of Directive 2005/36/EC (formerly EU Directive 93/16)
   - **c.** Doctors holding JCGPT/PMETB (UK) certificates with summative assessment (and/or MRCGP) but not covered by Article 28 of Directive 2005/36/EC (formerly EU Directive 93/16)
2. **Doctors holding general practice Certificates from EU Countries other than the UK**
3. **Doctors holding Equivalent Qualifications in general practice Obtained Outside the EU**

2.4.3 Membership/Fellowship Reciprocity: MICGP/FRACGP

Doctors holding the fellowship of the RACGP (Royal Australian College of General Practitioners) who intend taking up a GP post in Ireland are eligible to apply for membership of the ICGP under reciprocity agreements between the ICGP and the RACGP. Equally, members of the college who wish to work in Australia may apply for the FRACGP qualification. The mutual

recognition agreement which exists between the ICGP and the RACGP is currently under review. It is important to note that direct reciprocity only applies in respect of GPs who hold the MICGP having completed general practice training in a training scheme accredited by the ICGP

2.4.4 Associate Trainee Membership

Associate trainee membership is open to doctors undertaking training in general practice in accredited GP training schemes and is appropriate for the duration of training. Applicants who are successful in obtaining a place on an Irish GP training programme are automatically made associate trainee members of the ICGP. This will last for the duration of training, i.e. four years.

2.4.5 Alternative Route to College Membership (MICGP-AR)

The MICGP-AR is a performance based assessment route to attain membership of the Irish College of General Practitioners (the MICGP qualification) for doctors who are currently working in Irish general practice who have not undergone accredited training in general practice ***and*** who meet the MICGP-AR eligibility requirements.

The MICGP-AR application process is by way of online application which is open at specified times during the year. Once candidates have submitted their online application and they are deemed eligible for the MICGP-AR, they will then be required to complete three modules of assessment: the SBA-AR (written paper), the practice portfolio and the oral examination. Once candidates have successfully completed all three modules, they will be offered membership of the ICGP (MICGP). Further details on opening dates for applications and on the assessments is available on the ICGP website.

2.4.5.1 MICGP-AR Candidates and Entry to the Specialist Division of the Register with the Irish Medical Council

Application for entry onto the SDR is a separate process to granting of MICGP. MICGP-AR candidates should understand that the granting of specialist registration is entirely at the discretion of the Irish Medical Council and that the ICGP cannot insist that any doctor be granted specialist registration, regardless of the route by which they have been awarded the MICGP qualification.

2.5 Other Essential Areas

There are many areas which although not mandatory are essential for a career in general practice. Perhaps paramount among these is commencing and maintaining basic financial management and record keeping. A list of examples of areas which should be considered essential and which are covered in other chapters includes:

1. Financial records
2. Banking
3. Taxation
4. Income protection
5. Pension planning
6. Professional advice

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3:

On-Going Professional Development and the ICGP Professional Competence Scheme

By Ms Jantze Cotter and Ms Mairéad Dempsey

Introduction

Continuing medical education (CME) or continuing professional development (CPD) has always been one of the core principles of general practice. As a professional group, GPs have a natural interest and enthusiasm for expanding their knowledge and skills, and in general strive within their role to be as competent as possible. While this inclination towards self-improvement and knowledge development has been voluntarily undertaken by the majority of doctors for as long as the profession has been in existence, following full enactment of the 2007 Medical Practitioners Act, it became compulsory for all doctors in Ireland to participate in a Professional Competence Scheme (PCS). During the process of annual renewal of medical registration with the Medical Council, doctors are asked to confirm that they are enrolled in a PCS.

The provisions of the 2007 Medical Practitioners Act came into effect on May 1st 2011. This stipulates that all Medical Practitioners on the Medical Council register must enrol on a PCS and meet the requirements of that scheme. Having a formal system in place for recording and monitoring professional competence helps promote confidence in the medical profession and is designed to ultimately ensure that patients receive a better quality and more consistent level of care. Similar CPD programmes have been in place in Australia (1987), US, Canada, UK and South Africa for many years. While there was some reluctance initially to the introduction of the PCS, GPs are becoming more familiar with the PCS requirements and the recording of same. Typically it is viewed as a positive development for the medical profession.

3.1 Overview

While CPD is nothing new for doctors, the introduction of a formalised scheme means that doctors now need to record their CPD activity. Doctors also need to engage in a variety of learning as there are minimum requirements in different categories which must be met. Doctors cannot therefore rely solely on didactic forms of learning. They are also required to undertake personal learning and to reflect on and evaluate their own practice through internal activities. The requirement to carry out an audit provides an opportunity to focus on a specific area of interest for further examination. While research and teaching is also encouraged, the schemes allow for flexibility. It is recognised that it may not be possible for all doctors to take part in research and teaching and therefore credits in this category are desirable rather than compulsory.

For doctors situated in more remote areas or for those who are unable to attend external courses or workshops for whatever reason, recognised online courses and eLearning resources are widely available and provide a valuable learning outlet. Internal credit activities encourage interaction and consultation with colleagues and other health professionals. Through doing these activities doctors are given a reason to reflect on and analyse their work to see if it could be improved upon. There are several different options for internal credit activities meaning that all GPs, including Locums and Single-handed Practitioners, should be able to fulfil the annual requirements.

3.2 The ICGP Scheme

The ICGP operates a PCS for GPs under arrangement with the Irish Medical Council (IMC). The IMC sets out the PCS requirements and monitors compliance, while the ICGP's role is to provide support to facilitate GPs in meeting these requirements.

An online e-portfolio is provided to all GPs enrolled on the ICGP PCS. This facilitates GPs in recording and monitoring their PCS activities. Along with being able to record, monitor and view activity, one can also: -

1. Upload documentation to the e-portfolio removing the need to keep hard copy certificates etc.
2. Access templates for practice meetings, primary care team meetings and significant event analyses
3. Use the '*Search Recognised Events*' option to find out about upcoming courses/activities and then add these to the e-portfolio in advance

3.3 The Professional Competence Scheme Requirements

All doctors on the Irish Medical Council (IMC) register are required to enrol on a PCS unless they are in a recognised training post. They must comply with the following professional competence obligations relevant to their scope of practice: -

1. Engage in CPD activity to meet the minimum requirements
2. Record CPD activity in a portfolio, ideally an e-portfolio, and keep evidence to support the activity recorded. All activity should be recorded by the 30th April each year in order for the activity to be reflected in the annual statement of participation
3. Maintain enrolment in a PCS by paying the €240 renewal fee and annually updating one's details online

In order to comply with the scheme requirements, doctors have a responsibility to achieve and record the following as a minimum each year: -

1. 50 CPD credits
2. One clinical/practice audit

The 50 CPD credits must include a minimum of: -

1. 20 external credits
2. 20 internal credits
3. 5 personal learning credits
4. 5 additional credits which can be obtained and recorded in any of the above categories or as research/teaching credits (which are desirable rather than compulsory)

All activity must be undertaken and recorded between the 1st May and 30th April each year. If an activity is completed after the 30th April, e.g. an audit, then it should be recorded in the year that most of the work was completed.

3.4 CPD Categories

3.4.1 External Activities

External credits relate to maintenance of knowledge and skills. They are typically obtained by attending courses, workshops, events and eLearning activities that have been recognised for CPD by a training body or another reputable organisation such as a university/academic institution within or external to Ireland. Examples of suitable activities include: -

- CME small group network meetings
- Faculty meetings
- Conferences
- Courses
- Workshops
- Examination
- Lectures
- Medical advanced degree
- Clinical meeting
- Online course
- Seminars

3.4.2 Internal Activities

These are activities that develop and improve the quality of practice. Therefore, only an individual GP will know if an activity is suitable to record in this category. Only the GP will know if they have had to evaluate an element of their own practice and/or put changes in place to bring about a practice development/improvement.

Internal credits are not '*awarded*' to a GP by a company or organisation, but rather a GP allocates them to him/herself and documents the activity that he/she considered to be internal. Examples of internal credit activities include: -

- CME small group network meetings
- Case presentation/conference
- Chart review
- Clinical club
- Clinical case discussion
- Clinical risk meeting
- Patient survey
- PCT/HSE meeting
- Peer review group
- Practice-based meeting
- Quality improvement project
- Significant event analysis

Examples of recorded entries for internal credits: -

Practice Meeting example:

"Friday meeting / one hour internal discussion: Sexually transmitted infections.

Learning Outcomes: More aware of recent evidence on how to reduce the transmission of sexually transmitted infections and how to reduce the rate. Able to apply this knowledge in your practice."

Clinical Club:

"Discussed an article in the January edition of the British Journal of general practice on Obesity; critical appraisal of the article and discussed current advice on management of obesity. "Evaluating the transferability of a hospital-based childhood obesity clinic to primary care: a randomised controlled trial."

Clinical Case Discussion:

"TRICKY CASES. pt presents with goitre and dysphagia and has normal tfts, retrosternal extension of multinodular goitre on ultrasound on a background of Achalsia from CREST. Incidental finding of small vessel ischaemia on a MRI brain of a 50 yr old. Discussed management plan. Also discussed other cases to get a second opinion."

Significant Event Analysis:

"I was called to a psychiatric emergency which resulted in an involuntary admission. During the course of the visit there was a significant risk to the safety of the patient, myself and the public. Dr. x (principle GP) and I discussed the event and completed a significant event analysis. We planned a clinical risk meeting regarding psychiatric emergencies for the following day"

Chart Review:
"Chart review on an 89 yr old pt with multiple co morbidities includes CRF, ccf, copd, AS. Needed to check interactions and safety of medication list."
Peer Review:
"Peer review/ clinical case discussion - abdominal pain peer review of recent cases (with Dr x) of patients presenting with abdominal pain. Discussed differential diagnoses, management and outcomes. Discussed diverticular disease, crohns and appendicitis.

Participation in committee meetings including Faculty meetings can also be recorded for internal credits. One internal CPD credit per meeting up to a maximum of 6 credits can be recorded per PCS annum.

3.4.3 Personal Learning Activities

For personal learning activity, one hour of personal learning is equal to one credit. Examples of activities for which personal learning credits can be recorded include: -

- Reading journals/articles
- E-learning
- Learning diary
- Online searches
- Personal reading

3.4.4 Research and Teaching Activities

Credits in this category can be recorded for any research or teaching work which enhances professional development. Up to 5 CPD credits can be used towards the overall 50 CPD credits required. Suggested evidence which could be supplied for research and teaching activity might be: -

1. A copy of notes for a presentation or of PowerPoint slides
2. References should be included for any published articles
3. A copy of the program used in the case of undergraduate teaching

3.4.5 Clinical / Practice Audit

"*Audit is a quality improvement process that follows a systematic review and evaluation of activities against research-based standards. An audit is a continuous process of aiming to improve patient care and practice excellence*".

Hence, the purpose of an audit is as a mechanism to reflect on one's practice and to document improvements arising from this reflective exercise. In an audit, one is asking '*Am I doing what I am supposed to be doing?*" An audit therefore assumes that standards, guidelines or evidence exists. This is in contrast and comparison to research which asks "*What should we be doing?*"

The minimum PCS requirement is to complete one audit per year. It does not need to be a '*clinical*' audit, rather the scope of one's audit should be based around whatever work one is involved in and should reflect current practice. For example, if a GP works primarily in teaching, then he/she could carry out an audit on some aspect of their teaching.

The key elements of a full audit cycle are: -

Initial measurement	Measuring a specific element (or elements) of one's practice
Comparison	Comparing the results with the recognized standard/ guideline
Evaluation	Reflecting on the outcome of the above and where indicated, changing practice accordingly
Post-Change measurement	Re-measuring the same element(s) to establish the level of improvement

The ICGP Audit Toolkit provides more detailed guidance on how to carry out an audit. A range of useful audit examples are available on which have been developed by GPs.

3.5 PCS Requirements and Sessional, Locum and Out-of-Hours GPs

This group of doctors often report difficulty in achieving CPD requirements. It is usually internal credits and the audit which pose the biggest problem.

3.5.1 External Credits

If you are working as a Sessional, Locum or Out-of-hours GP, it may be difficult to attend some CPD activities or events. One may be covering for other doctors so that they can attend these events. If this proves to be a problem, external credits can be achieved via online learning. Online learning modules that have an assessment element such as those offered by the BMJ and GP Buddy can be recorded for external credits. Online learning modules are also available on the ICGP website. Successful completion of the *Forum* journal distance learning modules can also be recorded for 2 external credits per module.

3.5.2 Internal Credits

There is a perception that the only way to gather the required annual 20 internal credits is by getting into a CME Small Group. However, there are a range of activities which qualify for internal credits and which most doctors should be able to engage in. These include: -

1. **Case Discussions**: This is where you have a discussion with a colleague/consultant or another health professional, e.g. a nurse, dietician, physiotherapist etc. regarding clinical issues and approaches to a patient's treatment and care. These may not take place at set times but possibly at impromptu intervals during the week or month. In this case, the communication can be clustered together and added to the e-portfolio accordingly.
2. **Quality Improvement Project**: If any approach to care/ treatment is reviewed and outcomes implemented, this can be recorded under internal credits.
3. **Peer Review Group**: This is where patient cases/issues or practice issues are presented to peers who provide comment, advice and suggest alternative approaches to

care and treatment. If a GP is unable to join a CME Small Group, it is possible to set up a peer review group with colleagues and use the meeting template available on the e-portfolio to record discussion items and attendees.

4. **Chart Reviews: A chart review could mean a number of things, but one way of summarising "***chart review" would be that the patient is reviewed without being present. Examples of chart review might include: -*

   a. Reading through a patient's chart and summarising past history and medication so that someone new picking up the chart has an easier task of continuing with that individual's care. It might also remind the reviewer of a past event that had been forgotten or omitted from the existing patient summary.

   b. Reviewing the chart and ensuring that best practice/ guidelines have been adhered to. This is almost a mini audit. A practical example might entail reviewing the charts of five diabetic patients.

   c. As part of deciding why something went badly (or well) as an element of a significant event analysis, one might review the consultation notes over a number of consultations.

3.5.3 Audit

On the ICGP website there are several examples of audit which are designed to be suitable for GPs working as Locums, Sessional GPs or in the out-of-hours setting. It is not necessary to keep seeing the same set of patients in order to be able to conduct an audit, nor is it necessary to be based in one particular practice. The audit is about improving one's own practice. Therefore, it is not necessary to carry out re-audit on the same group of patients used to carry out the initial phase of the audit. One example on the ICGP website shows how an antibiotic prescribing audit can be adapted for GPs working as Locums, in the out-of-hours setting or those doing sessional work.

3.6 The Eight Domains of Good Professional Practice

As well as requiring diversity in the types of learning methods employed, doctors should also be conscious of trying to address the eight domains of good professional practice. These domains describe a framework of competencies applicable to all doctors across the continuum of professional development from formal medical education and training through to maintenance of professional competence. They describe the outcomes which doctors should strive to achieve. Doctors should refer to these domains throughout the process of maintaining competence. The eight domains are: -

1. Patient Safety and Quality of Patient Care
2. Relating to Patients
3. Communication and Interpersonal Skills
4. Collaboration and Teamwork
5. Management (including Self- Management)
6. Scholarship
7. Professionalism
8. Clinical Skills

More information on what is meant by each of these domains can be found on the Medical Council website.

3.7 ICGP PCS Support

For more comprehensive information on all aspects of the ICGP PCS, please consult the ICGP Professional Competence Guide available on the PCS section of the ICGP website. Online supports available on the ICGP website include: -

1. Video tutorials
2. Guidance on how to carry out an audit, as well as several sample audits
3. Frequently asked questions

The professional competence department of the ICGP can also be contacted by email (professionalcompetence@icgp.ie) or by telephone (01 6763705).

Summary

Continuing professional development has in the last few years become a formalised mandatory requirement of practicing medicine in Ireland. All GPs must be registered with the PCS operated by the ICGP on behalf of the Medical Council. The 50 credits required annually are reasonably straightforward to achieve, but it is also advisable to be fully aware of the precise details of what is required. Good record keeping is essential, as is uploading all PCS activity before the annual deadline of 30th April including the required audit. The annual cost of enrolling on the ICGP PCS is €240, a fee which is set by the Medical Council. For those who require additional advice and support, the ICGP has an excellent PCS section on its website and the professional competence department can also be contacted directly.

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4: Roles, Titles and Job Descriptions: Working with and for Others in General Practice

Introduction

Historically there has been a degree of ambiguity and overlap in the use of job descriptions in general practice. Titles such as Principal, Partner, Assistant (with or without a view), Sessional GP and Locum may be misleading in themselves as different people define these roles in different ways. Furthermore, there may be blurring of boundaries when it comes to the work practices involved in these roles and variation in expectations pertaining to these roles between different practices.

In any working relationship it is important that both parties have a clear understanding of communication between the parties, the work to be undertaken, the remuneration involved, and whether the business relationship will develop over time, e.g. in the case of a salaried Assistant progressing to Partner status. As well as understanding how the parties to the arrangement view one another, it is also important that others have a clear understanding of roles, e.g. colleagues and staff in the practice and Revenue. The law may also inform the definition of the relationship, e.g. whether one is an employee or self-employed.

There are a number of choices available when working with other GPs, each with its own advantages and disadvantages. Of course, the only real way of finding out if a particular employment arrangement is agreeable is to work within it for a period of time. This will allow one to assess if the practice has the potential to realise one's objectives and longer term career goals. In the long run, factors that define compatibility are fundamental to a successful outcome in working with other colleagues in general practice. Therefore, it is essential to establish whether a practice has the potential to meet one's needs and whether mutual compatibility is a likely outcome of continuing to work in that practice. Recognising this in the early stages of settling in may save many years of dissatisfaction.

In this chapter, we outline the differences between various roles and consider each in terms of the potential advantages and disadvantages.

4.1 Locum GP

Working as a Locum is very flexible with many potential advantages. It particularly suits GPs at either end of the career path. Directly after completion of training, many GPs will do locum work. Being a Locum provides an opportunity to gain a broad range of clinical and practice management experience, e.g. in the use of different software systems, and a chance to absorb the best features of many different practices. However, careful planning is required to make the most of locum work.

With an ageing population of Irish GPs and increasing female and part-time workforce, there is generally no shortage of locum work available at present. Positions can be found through networking and word of mouth (including the NEGs discussion board), advertisements in the ICGP classifieds, CME meetings, Locum agencies, and via direct advertising, e.g. the medical newspapers' classified sections. The ICGP classifieds is an online advertising service, hosted on the ICGP website, free to ICGP members, and on which practices can seek Locums and Locums can advertise their availability. It is open to the public and can also be used by non-members and commercial organisations for a fee. Irish Locum agencies are listed in Appendix 1. Locums and/or the practice can expect to pay commission to the agency, so it is important to clarify this at the outset. Out-of-hours services and GP co-ops also provide good opportunities for locum work.

With locum work, one can generally decide the time of the week that best suits one's personal schedule. However, working unsocial hours such as nights and/or weekends may prove more financially lucrative. From a negotiation perspective, one needs to decide the rates/fees and rationale for charging such fees. This will be informed by current rates, both nationally and regionally, the type of practice and work load, the costs incurred in providing the service, the expectations of the practice and the relevant experience and qualifications of the Locum.

Flexibility can bring a down side as there may not always be a supply of work to match one's availability, with a consequent deficit in income. Another negative side and inevitable trade-off for the freedom afforded by this type of work is the lack

of permanency and frequent changes of practice, location, patients and colleagues.

The day-to-day workload of the Locum is usually quite different to the Sessional or full-time GP. It often involves temporarily managing issues until the regular GP returns, rather than solving problems. Repetitive work is another feature, with repeat prescriptions and certification a component of the work that may not be professionally satisfying. Continuity of care, one of the cornerstones of general practice, is also absent. Different management regimes may not always be conducive to working efficiently. Additionally, a high standard of record keeping, both clinical and financial, is required.

In relation to financial management, even though Locums are almost always now paid as employees, it is still important to keep detailed records of income and expenses, and if necessary to ensure provision for tax liabilities, pension contributions, income protection, professional indemnity subscriptions, etc. One significant drawback to doing locum work can be delay in getting paid and receiving payslips, P45s and P60s. It is therefore vitally important both to keep good records to ensure all payments are received, and also to check in detail that all payments are correct. A consequence of delay in receipt of a P45 is that Locums can end up being taxed at emergency rates.

4.2 Sessional GP

A Sessional GP is a part time worker. Sessional work generally consists of a combination of regular sessions in one or more practices, e.g. two days per week or five mornings per week in one or more practices. Working on a sessional basis can provide job flexibility and an opportunity to develop special areas of clinical interest. Sessional work can also afford an opportunity to explore different styles of practice management, allowing the establishing GP to '*mix and match*' practice types and to explore what form of practice is best suited to them. It can be particularly worthwhile for newly establishing GPs to gain experience of working in practices where they may have an interest or prospect of a more full time commitment.

One obvious disadvantage is that a Sessional GP is unlikely to have a '*view*' to becoming a Partner/owner in the practice and therefore will not have a share in the practice. On the other hand, there can be advantages such as greater freedom regarding taking leave, be it annual, maternity or other leave. As with any contract of employment, it is important that all such issues are discussed and agreed with the Principal or practice at the outset of employment so that there is clarity regarding '*entitlements*' and to ensure misunderstandings are avoided.

As with all employees, it is a legal requirement of sessional (part time) employment to have a formal contract outlining terms and conditions of the working relationship. Within this it is essential that the definition of the duration of a '*session*' and the associated rate of pay is agreed. While most Sessional GPs are paid for working sessions of specific duration, they can find themselves working beyond the contracted time in order to see all attending patients without being reimbursed for the extra workload.

Generally speaking, Sessional GPs are not rostered for out-of-hours duties. Although less of a problem than with locum work, the difficulty in providing continuity of care and follow-up for patients is still an issue, and can be regarded as a significant disadvantage to sessional work. Follow-up of investigations and the processing of incoming and outgoing correspondence when the Sessional GP is not at work are very important and a specific member of the practice should be made responsible for this follow-up.

Many Sessional GPs are employed to fulfil a particular clinical need in the practice, e.g. women's health. While this may suit some, it can lead to the GP becoming '*pigeon-holed*' and deskilled in other areas of clinical practice.

Job satisfaction obviously plays a huge part in one's choice of work. It is likely that sessional work won't present an opportunity for full involvement in the management of the practice or in decisions that will affect all personnel working in the practice. Sessional GPs may not be involved in practice meetings or practice decisions and subsequently, a feeling of alienation can ensue. Whether this is an advantage or a serious hindrance or even relevant depends on the motivation and longer term objectives of the individual.

Patients' perceptions are also important; they may not be aware of the internal practice arrangements and their need for continuity can be frustrated if the Sessional GP does not have a long term commitment to the practice. Equally, patients may perceive that a Sessional GP is not as good as full-time GPs in the practice.

4.3 Assistant General Practitioner

4.3.1 Traditional GP Assistant

This is perhaps the title that causes most confusion among those entering and working in general practice. An Assistant is generally understood to be someone who has a commitment to a practice and takes on clinical responsibilities similar to the Principal(s). Although the Assistant is not a Partner in the practice, this role should be seen as one step in a progression towards Partnership. One long standing joke which highlights the importance of clarity at the outset of employment in relation to what is on offer is the anecdote that the only '*view*' available to Assistant GPs is that of the car-park. It is a lot less complicated and sensitive to discuss and agree the reality of future prospects at the outset rather than become frustrated and disillusioned when it has not been discussed and no view of Partnership subsequently emerges. It is also an extremely good idea to ensure that regular reviews of the situation take place, e.g. a six monthly appraisal of the '*view*' status. Some of the key questions to be considered in relation to knowing what is on offer in an Assistantship will be discussed in Chapter 6, 'Negotiation of Terms and Conditions of Employment and Partnership Agreements'.

For the newly qualified GP, the advantages of being a GP Assistant are that it may provide the most stable option from a financial point of view and also in terms of career perspective; it allows for a sense of inclusion in a practice, provides for continuity of care and allows one to integrate with patients and the wider community. It can also offer one a more detailed exposure to practice management, staff, finance, systems, and IT, all of which expand the establishing GP's skills and knowledge.

4.3.2 GP Assistant-with-a-View to Partnership in the GMS

In this situation a state contract is in question and there is a formal selection process. The post is governed by HSE regulations and externally regulated after appointment. A GMS Principal must be at least five years from the date of retirement in order to apply for a GMS Assistant. This is discussed in more detail in Chapter 11, 'State Contracts held by General Practitioners Including the General Medical Services Contract'. In the context of Assistantship-with-a-View to Partnership in the GMS, a written Partnership agreement is a pre requisite to obtaining a GMS number.

Assistantship-with-a-View to Partnership may not suit everyone. There are disadvantages, particularly immediately post-training, when a short term (six - 12 month) agreement may be more preferable. Attempting to obtain a clear picture of the practice and how it operates is essential in making a decision to join a practice, in whatever capacity.

4.4 GP Principal

A Principal is generally taken to be one of the main stakeholders in the practice. A Principal can be Single-handed, a Partner or an Associate.

4.4.1 Single-Handed Practitioner

In the model of single handed general practice, the GP is a sole trader and in almost all cases will hold a variety of state contracts including a GMS contract. Single-handed practice brings a unique set of challenges including the expense of and difficulty in sourcing locum cover for holidays, courses or emergency situations such as personal or family illness. Other difficulties may include working in an environment in which there is increased likelihood of professional isolation compared to Partnership or group practice, and an increased risk of burn-out and professional disillusionment. On the other hand, many Single-handed GPs experience a high degree of job satisfaction, being substantially autonomous and not having to negotiate or achieve compromise with professional colleagues.

4.4.2 GP Partner

The legal definition is that a Partnership exists if people are conducting business in common with a view to making profit. A Partner in a practice is a Principal who shares profits and responsibilities in an agreed proportion, with the other practice Partner(s). This should be expressed in an agreement and it is strongly advised to have a formal, legally robust written Partnership agreement. Partner/Partnership has a specific meaning in Irish law, and in the absence of a written agreement, the 1890 Partnership Act informs the rights and obligations of the Partners.

4.4.3 GP Associate

This is a term used to describe a relationship between GPs who share expenses and operating costs but keep their income (and possibly their patients) separate. Associateships are essentially group practices where incomes are separated between each Associate within the premises whilst overheads and administrative supports are shared. Various mechanisms can be used in the allocation of these overhead costs, e.g. proportioned on the percentage of patients seen by each doctor respectively. The Associates operate as independent businesses. The organisation and management of this type of practice formation works efficiently when supported with an effective IT system. Cross cover can be an advantage of this system, but agreement as to fees needs to be reached regarding patients seen by other Associates. Such arrangements require careful consideration and once again, are preferably expressed in a written agreement.

4.5 Corporate Models of General Practice

In the last few years corporate models of general practice have been introduced into Ireland. These involve a legal cooperation between a corporate entity and a number of GPs. Some of these corporate models merge existing practices and the company (corporate entity) itself becomes a Partner in the new business. Such models propose to facilitate the business organisation of general practice which may suit some GPs. As with other models, establishing GPs typically enter such arrangements as salaried employees, at least in the initial stages.

Other models rely on GPs as anchor tenants in their business relationship. The corporate entity in this case purchases a purpose built premises and sells part of the premises to a group of GPs, i.e. the GPs may have an option to purchase their section of the premises at a preferential rate. In turn the corporate entity benefits from other ancillary services which may be attracted to the building by virtue of its medical centre including for example physiotherapy, radiology, pharmacy, etc.

The details and specifics of each corporate arrangement is beyond the scope of this publication, but as in every model, including those described here, there are advantages and disadvantages and expert advice should be sought. As well as talking to GPs who are working or have worked in this format/model, it may also be worthwhile to evaluate the experiences from other countries where similar models have developed.

4.6 Primary Care Teams

In 2001 the Government launched the Primary Care Strategy. This proposed a new way of working in which GPs would be part of a team of professional colleagues tasked with delivering quality care for patients. At the time of publication in 2001 it was envisaged that Primary Care Teams (PCTs) would look after over 90% of all health and social needs and would be the central focus of the health system.

The core Primary Care Team consists of General Practitioners, Public Health Nurses, Practice Nurses, Occupational Therapists, and Physiotherapists. Other services such as home help, social work, community welfare, dietetics, podiatry, mental health services, and disability services may be shared between teams or considered as core team members depending on the needs of an area.

Primary Care Networks encompass several PCTs and are intended to provide access to services such as dentistry, psychology and speech and language therapy.

In the government's plan, a total of 530 Primary Care Teams and 134 Networks were identified for development by 2011.

A target set for 2008 was to progress the development of 97 PCTs to fully functioning stage. These 97 teams covered approximately 22% of the population. It was also planned to advance the development of a further 113 teams during 2008. In the intervening period, there have been many issues and problems with implementation of the Primary Care Team model. Not least are that many GPs find the timing of meetings extremely challenging, that the full complement of members of PCTs has frequently not been met, and that many urban GPs find themselves as members of multiple PCTs. For this and many other reasons, many Primary Care Teams do not function in the manner intended. It is estimated that of the PCTs currently in existence, one-third work effectively, a further third are partly functioning with the remaining one-third existing in name only. It is also the case that the planned projected numbers of PCTs been not met. From the most recently published figures, taken from the HSE Primary Care Division Operational Plan for 2014, the breakdown of PCTs is as follows: -

	End of 2013	Target for 2014
Dublin / Mid Leinster	120	140
Dublin North East	70	96
The South	127	134
The West	106	115
Total	423	485

As can be seen from this table, the targets set in 2001 have still to be met. With the many challenges that have arisen in implementation of PCTs, it is also difficult to see how the original target of over 500 functioning PCTs will ever be reached. That being said, it is important for establishing GPs to be aware of their existence. Further information on PCTs is available from the Local Health Office where an official (TDO or Transformation Development Officer) is available for help and advice on local Teams. Discussion with one of these officers would be advised especially if setting up a new practice.

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5: Employment Relationships in General Practice

Introduction

One of the first problems encountered by establishing GPs is to understand the terminology associated with employment and Partnership, including understanding what is meant by being an independent contractor and the term incorporation. This confusion prompts frequent requests from establishing GPs for advice and guidance. It is hoped this chapter will provide clarification for establishing GPs in this difficult area.

5.1 Working Relationships: Definitions

Accurate descriptions are important in defining one's status and working relationships with others. It is likely that such definitions will be new to establishing GPs and a certain ambiguity continues to surround their use among established GPs. Working relationships between GPs will, in theory at least, be described in the following three main categories: -

- **5.2** Employee (Contract of Service)
- **5.3** Independent Contractor (Contract for Services) / Incorporation
- **5.4** Partnership and Associate Agreements

Although almost all GPs are now treated as employees, an area that continues to create confusion is in the area of understanding the difference between a contract *of* service, i.e. an employment contract, and a contract *for* services, i.e. an independent contractor arrangement. To gain a full understanding of the differences between these two types of contract, one must appreciate something about taxation as well as Revenue's interpretation of employment status.

In December 2009 Revenue issued Tax Briefing #82 which "*set out Revenue's position as regards the status (employed or self-employed) of individuals described, correctly or otherwise, as 'Locums' in the fields of medicine, health care and pharmacy.*' It referred to the Revenue "Code of Practice for Determining Employment or Self-Employment Status of Individuals" which outlines criteria by which a person carrying out work is considered an employee or self-employed. Table 5a at the end of this chapter summarises these criteria. Both documents are short and understandable and worth reading. Under the Revenue guidelines, where a person providing work is subject to a high degree of control, via the '*control test*', it is likely that the relationship is one of employer and employee, i.e. a contract *of* service or employment contract.

Prior to 2009 many GPs worked in a self-employed capacity, i.e. they would get paid gross and settle their own tax affairs. Following Tax Briefing #82, Revenue retrospectively determined that a number of GPs who had worked as self-employed contractors had actually been employees. The GPs/practices for which they had done Locums had not deducted any tax at source, nor paid employer's or employee's PRSI. In many of these cases the employing GPs/practices were left to foot substantial retrospective tax bills.

What is clear from Revenue determinations and guidelines is that in most circumstances in Ireland, GP Assistants, Sessional GPs, Locum GPs and Out-of-Hours GPs should be employees. It is also true that as a consequence of Tax Briefing #82 almost all GP Assistants, Sessional GPs and Locums now do work as employees. Furthermore, it has also become increasingly common for GPs/practices to employ Locums and avoid using those who operate as self-employed contractors.

The Revenue position that GP Locums *are* employees has also been clearly illustrated a number of times. An example includes the upholding in 2009 by the Appeals Commissioners of a decision by Revenue that Mid-Doc, operating an Out-of-Hours GP in Longford and Westmeath, was required to deduct PAYE from doctors providing out-of-hours cover. In private correspondence with the IMO, Revenue has also indicated that the PAYE system should routinely be operated by GPs on payments to Locum doctors.

However, despite statements and determinations, Revenue has not made an explicit declaration that Locums *must* be employees, and the Revenue position therefore remains open to interpretation. Consequently, it is advisable to obtain independent financial and tax advice in relation to one's personal working circumstances.

In addition to understanding in detail the status of one's employment or provision of services, it is also equally important to understand how those outside general practice such as Revenue, creditors, banks, suppliers, planners, advisors, the courts, and regulatory bodies engage with General Practitioners as legal and business entities.

More detailed consideration of the tax regulations in relation to employment are also contained in Chapter 13, 'Taxation'.

5.2 Employment/Contract of Service

When a GP is '*employed*' under a contract *of* service, the status is one of employer and employee. With a contract of employment, the rights and obligations of both parties are defined by statutory regulations, the terms provided in the employment contract and by decision of the courts. As an employee of the practice, the GP is entitled to all the legal rights and entitlements provided to all employees including minimum statutory rights to annual leave, maternity leave, etc. Clearly, when formulating a contract of employment, a number of issues should be addressed, and these are outlined below. The law is very clear in relation to contracts of employment and a good place to find information is on the Citizens Information website.

In practice, in Ireland many GPs work as employees without written contracts. However, it is a fact that anyone who works for an employer for a regular wage or salary automatically has a contract of employment *regardless* of whether this is in writing or not. While the complete contract does not have to be in writing, it an employee's right and an employer's legal obligation to ensure that an employee is provided with a written statement of terms of employment within two months of starting work.

It is also the responsibility of an employer to calculate employee PAYE tax, USC and employee and employer PRSI.

5.2.1 The Employment Contract

As with other legal contracts, a legal relationship exists once one party makes a job offer, the other party accepts the offer and that consideration (remuneration) is involved. This relationship places legal obligations and provides legal rights to both parties. The relationship must be expressed in writing in the form of an employment contract. It is the duty of the practice/employer within 2 months of the commencement of employment to provide all employees (both clinical and administrative staff) with the terms and conditions of employment in writing.

An employment contract provides for the terms of employment as agreed between the parties while legislation and contract law provides the wider legal framework to the employment relationship. The main headings of an employment contract are given in Table 5b at the end of this chapter, but generally should include: -

1. The full names of employer and employee
2. The address of the employer
3. The place of work
4. The title of job or nature of work
5. The date of commencement of employment
6. The expected duration of the contract if temporary, and where a contract is for a fixed term, the date on which the contract expires
7. Details of rest periods and breaks as required by law
8. The rate of pay or method of calculation of pay*
9. The pay reference period for the purposes of the National Minimum Wage Act 2000
10. Pay intervals*
11. Hours of work including overtime*
12. That the employee has the right to ask the employer for a written statement of his / her average hourly rate of pay as provided for in the National Minimum Wage Act 2000*
13. Details of paid leave*
14. Sick pay and pension (if any)*
15. Period of notice to be given by employer and employee*
16. Details of any collective agreements that may affect the employee's terms of employment*

**In the case of these items, instead of giving each employee the details in writing, the employer may refer an employee to other documents, e.g. a pension scheme booklet or a collective agreement, provided that the employee has easy access to such documents.*

Any changes in the particulars given in the statement must be notified to the employee within one month of such change. The employer is also obliged to set out the practice procedures in relation to dismissal (under the Unfair Dismissals Acts 1977 to 2005).

5.2.2 Duration of a Contract

Employment contracts may take different forms, such as: -

1. A **fixed term contract**, which will cease at a specific stated date in the future.
2. A **contract of specific purpose**, e.g. in order to cover sick leave.
3. A **permanent contract**, i.e. one that ends upon retirement. In this context it is important to be aware of changes in the pension age which will take place over the next 15 years. These are outlined in chapter 12, "Providing for the Future: Insurance, Pensions and Wills".

'*Fixed term*' contracts and those for a '*specific purpose*' should be expressed in writing and signed by both employer and employee.

5.2.3 Renewal of Fixed Term Contracts

A fixed term contract which is continually renewed will be viewed as a contract of indefinite duration. In this case the provisions of the Unfair Dismissal legislation apply and cannot be excluded from such contracts.

As outlined in the '*Protection of Employees (Fixed Term Work) Act 2003*', where an employee has three years continuous service with an employer (prior to 2003); the employer may renew the employee's contract on only one more occasion. Any such renewal shall be for a fixed term of no more than one year, after which the employee is deemed to have a contract of indefinite duration, i.e. a permanent contract.

If an employee, who commenced employment on a fixed-term basis on or after the 14th of July 2003, has had two or more fixed term contracts, the combined duration of the contracts shall not exceed four years. Thereafter if the employer wishes the employee to continue, a contract of indefinite duration must be provided.

5.2.4 Contracts of Specific Purpose

A contract of specific purpose may arise where the work involves a task(s) or assigned objective, for which the end date is not immediately determinable. The duration / specific purpose of the contract must be clearly stated. A clause in the contract expressly stating that the contract will cease on completion of the work specified is recommended, e.g. when replacing a GP of the practice who is on sick leave, and for whom the return to work date is not currently definable.

It is also for employers to insert a clause such as the following in such contracts: - "*This contract is a fixed term / specific purpose contract. The provisions of the Unfair Dismissal Acts 1977 to 2005 shall not apply where dismissal consists solely due to the expiry of the contract / cessation of the purpose of the contract*".

5.2.5 Changing a Contract

An employment contract does not need to be a '*fixed*' agreement. It is likely that changes will occur over the duration of the contract, initiated either by the employer or the employee or both. Changes however are subject to negotiation and agreement between the employer and employee.

5.3 Independent Contractor/Contract for Services

In limited circumstances, it may be possible for a Locum GP to work as an independent contractor. This is the legal equivalent of the tax term '*self-employed*'. The relationship between a GP/practice and an independent contractor is described as a *contract for services.*

GPs that operate as independent contractors generally do so using the vehicle of an incorporated private limited company. In this case, the '*contractor*', i.e. the incorporated private limited company, provides services to a GP/practice and then invoices the GP/practice for the services which have been provided. The GP/practice then pays the incorporated private limited company the gross amount invoiced. The GP contractor, i.e. the GP providing service on behalf of the incorporated private limited company, will at various times draw income from the incorporated private limited company, i.e. get paid.

5.3.1 Incorporation of a Private Limited Company

The term incorporation is generally not well understood by GPs. It is hoped the information below will help remove some of the confusion and improve basic knowledge of incorporation.

At its most simple, incorporation is when an individual, in this case a GP, sets up or incorporates a private limited company. Services are then provided by that company to GPs/practices. The GP/practice to which the service is provided is then invoiced by the company and pays the company directly without deduction of tax. The GP providing the service on behalf of the company is not paid by the practice. Rather, at various times money is drawn down from the company by the shareholder, in this case the GP who incorporated the company.

One major benefit to working in this way is that expenses can be claimed. However, there is also a substantial amount of legal and taxation paperwork and law to comply with, and this will almost certainly require the retention of the services of an accountant. A private limited company must also make an annual tax return and settle tax liabilities including corporation tax. In addition to the company paying tax, the GP also has to make a personal tax return. It is therefore essential for a GP operating through a private limited company to set aside a percentage of each salary paid by the private limited company to go towards their annual tax bill. If considering incorporation it is worth bearing in mind that there will be extra work involved, and unless you have substantial business and tax experience one will need help in dealing with the administration. Unless locum earnings are substantial, considering the additional compliance costs and time involved in administering the company, the benefits may be marginal.

The practical steps of setting up a company include:

1. Registering or incorporating the company with the Companies Registration Office
2. Registering the Company with Revenue
3. Registering the Directors and Shareholders of the company
4. Setting up a bank account

On an on-going basis there will also be: -

1. Invoices that need to be prepared and submitted
2. Allowances and expenses that need to be managed
3. Various tax and revenue calculations to be done
4. A doctor's tax return to be taken care of

Specific examples of the requirements of having a company are: -

1. To prepare and submit P30 and P35 returns to the Revenue Commissioners
2. To prepare annual accounts and financial statements in accordance with applicable Irish law and generally accepted accounting practice in Ireland
3. To prepare and submit to the Revenue Commissioners a corporation tax return on behalf of the company
4. To have a Company Secretary who liaises with the Companies Registration Office and maintains a Statutory Minute Book and Register for the company
5. To prepare and submit to the Companies Registration Office abridged financial statements on behalf of the company
6. To prepare and submit 6 monthly and annual returns to CRO on behalf of the company

In practice, most GP Locums who operate through incorporated companies employ the services of an accountant who deals with the Revenue Commissioners on behalf of his or her company.

5.3.2 Expenses which can be claimed when Self-Employed

In contrast to an employee, a doctor '*contractor*' is responsible for meeting his/her own taxation obligations, pension contributions and the costs of equipment and '*tools of the trade*'. However, in contrast to employees who can only claim limited expenses from employers or Revenue, independent contractors also have the advantage of being able to claim a much more extensive range of business expenses for tax purposes against their profits. Rules governing expenses are clearly laid out on various pages on the Revenue website and all accountants will be familiar with the substantive details relating to expense claims.

Employees are entitled to claim deductions against their earnings for any expenditure which is incurred wholly, exclusively and necessarily for the purposes of their employment. In practice such expenses will be represented by the reimbursement of vouched out of pocket expenditure or accepted civil service motoring and subsistence rates, which can be made tax free. Doctors working in hospitals are also entitled to claim flat rate employee expenses; such deductions continue to be disallowed for GPs in employment. The payment of round sum expenses or amounts which confer benefits on employees (i.e. over and above actual costs incurred) will be subject in full to taxation under the PAYE system.

Expenses for self-employed doctors are more extensive than those allowed for employees, whereby deductions from trading receipts are allowed for any amounts incurred wholly and exclusively for the purposes of the profession. In order to ensure that all relevant annual deductions are allowed GPs should maintain good records and retain receipts where possible for all business expenditure incurred. The following would be typical examples of allowable business expenditure for GPs, but ultimately any expenditure incurred would need to be analysed in its own right to determine its legitimacy for tax purposes and in this regard an accountant will be able to confirm allowable and disallowable expenditure: -

1. Where one's personal vehicle is also used for the purposes of work, the actual costs of running the motor car for business purposes will be allowed, including proportionate fuel, servicing, insurance and annual depreciation costs (depending on the type of vehicle)
2. If used, public transport costs
3. Actual costs of meals and accommodation where travel is required
4. Approved annual professional subscriptions
5. Professional training courses
6. Home and mobile telephones where used for business purposes (itemised highlighted bills)
7. All '*reasonable*' work related equipment and costs, e.g. medical tools, stationary, IT equipment etc.

5.3.3 Drawing up a Contact *for* Services

In business, it is the norm that a service provider indicates in advance the terms and conditions under which the service will be provided and both parties negotiate and agree final arrangements. When one is working as an independent contractor, a written contract should be agreed between the contractor, i.e. the private limited company providing the services, and the practice. Theoretically, this should apply to any work done through the private limited company although in reality short term work is often agreed verbally.

Based on Revenue determinations all longer term commitments should be considered as contracts *of* service, i.e. contracts of employment. When formulating and reaching agreement on a contract *for* services, the issues listed below should be addressed. A more extensive list of issues to be addressed in contract negotiations is considered in Chapter 6, 'Negotiation of Terms and Conditions of Employment and Partnership Agreements'.

5.3.3.1 Hours of Work

The working hours/duration and number of sessions needs to be specified. Consideration should be given to administration time as well as direct patient contact time when agreeing duration of sessions. All contractor hours of work should be agreed and pre-approved by the practice. Commencement and finishing time should be specified. The times and dates on which services are to be provided should be specified in the contract. The interpretation of what constitutes a session varies but tends to be considered as approximately three to four hours' work.

5.3.3.2 Services/Duties

The contract should detail the services to be provided, e.g. house calls, paper work, minor surgery, out-of-hours commitment, phlebotomy, repeat prescriptions, etc.

5.3.3.3 Practice Policies

Practice policies, both administrative and clinical, that will impact on the contractor while working in the practice should be clearly identified to the contractor. It is recommended that practices provides a '*Locum*' pack to enable any new doctor to quickly and easily familiarise themselves with the practice. Practice policies should be included in the pack which should ideally be provided to contractors in advance of commencement. This is particularly important for contractors during any absence of the Principal(s), e.g. during holiday leave, sick leave, out-of-hours etc. Policies should include health and safety, patient and staff confidentiality, complaints procedures, billing and claims procedures, data protection, and use of IT/GP management systems including email and internet access. It should be a given policy that where a practice is computerised, all individuals log into the computer system and any practice software systems using an assigned password protected unique traceable identifier.

5.3.3.4 Clinical Protocols

Ideally, clinical protocols operating in the practice should be referred to in the contract e.g. practice formulary, referral procedures, nursing protocols, use of equipment, and clinical roles of different staff members.

5.3.3.5 Indemnity, Insurance, Accreditation and Work Permits and Visas

The GP working as an independent contractor on behalf of a private limited company should provide a practice with the following documentation: -

1. Confirmation of current medical indemnity status
2. A current certificate of full Medical Council registration

3. A work permit if required. Further information can be obtained on this from the Department of Jobs, Enterprise and Innovation

5.3.3.6 Contractor Fees
A clause detailing the specific fees/payments as agreed should be included in the contract. It is good business practice that a private limited company should invoice a practice for services provided by the GP. The method by which contractor fees are to be paid should also be specified.

5.3.3.7 Patient Fees
Should patients pay consultation fees directly to the contractor doctor, agreement should be reached in respect of this matter including financial recording procedures. Out-of-hours arrangements should also be addressed in this context.

5.3.3.8 Restrictive Clauses
Reference may be made to restrictions which apply to the contractor including confidentiality in relation to all clinical and business aspects of the practice. The practice may also require restraint of trade type clauses which attempt to restrict or influence future relationships, e.g. the contractor setting up in practice locally in the future. It is a matter for the contractor to assess the reasonableness and enforceability of such clauses.

The contract may also specify terms regarding the use and ownership of practice property e.g. all books, documents and data including patient files prepared in the course of providing services remain the ownership of the practice.

5.3.3.9 Revenue and Tax Liability
It is worth noting that a practice is legally obliged to complete and send a Return of Third Party Information (Form 46G) to Revenue annually in respect of all payments made to contractors over €6,000.

5.4 Partnerships and Associate Agreements

Where two or more people go into business with a view to making a profit from the business, then unless there is an agreement to the contrary, this is a Partnership under the 1890 Partnership Act. Further information can be found on the website of the Competition Authority by searching under the term 'General Practitioner'.

Frequently GPs operate within the one building, share some or all expenses and overheads but do not share profits; essentially they are operating as separate entities. This may be considered an *associate* agreement and this situation pertains in many practices.

If one is contemplating establishing a practice with another person or entering into any form of *profit sharing arrangement*, it is important to seek appropriate legal advice before committing to the arrangement. The main headings and clauses for a typical Partnership agreement are given in Table 5c at the end of this chapter.

Summary

Understanding one's work status is of vital importance. While confusion may exist over terminology, in their 2009 Tax Briefing #82, Revenue brought some clarity to the fact that a vast majority of establishing GPs are employees. If unsure, the most important thing is to obtain independent tax and financial advice. Also of major importance regardless of whether a GP is an employee, independent contractor or entering Partnership or Association is to have a written agreement.

Despite there being distinct disadvantages to doing locum work as an employee including difficulties with cash flow, being taxed on an emergency basis, having to chase payment, payslips, P45s etc., it is also true that all tax will be deducted at source thus avoiding a major tax bill at the end of the tax year, and there will never be any compliance issues with Revenue. In addition to the dubious tax compliance issues of self-employment via an incorporated private limited company, the big disadvantages to incorporation are the amount of mandatory legal paperwork, the necessity for rigorous record keeping, and that you will require to set money aside in order to pay tax to Revenue. Ultimately if you should opt to go down the route of incorporation, be sure to retain an accountant who is familiar with the law, the workings of Revenue, and who will be able to guide you easily through the entire process.

Table 5a
Determination of Employment Status (taken from Revenue document Code of Practice for Determining Employment or Self-Employment Status of Individuals)

While all of the following factors may not apply, an individual would normally be an employee if he/she: -

1. Is under the control of another person who directs as to how, when and where the work is to be carried out
2. Supplies labour only
3. Receives a fixed hourly/weekly/monthly wage
4. Cannot subcontract the work. If the work can be subcontracted and paid on by the person subcontracting the work, the employer/employee relationship may simply be transferred on
5. Does not supply materials for the job
6. Does not provide equipment other than the small tools of the trade. The provision of tools or equipment might not have a significant bearing on coming to a conclusion that employment status may be appropriate having regard to all the circumstances of a particular case
7. Is not exposed to personal financial risk in carrying out the work
8. Does not assume any responsibility for investment and management in the business
9. Does not have the opportunity to profit from sound management in the scheduling of engagements or in the performance of tasks arising from the engagements
10. Works set hours or a given number of hours per week or month
11. Works for one person or for one business
12. Receives expense payments to cover subsistence and / or travel expenses
13. Is entitled to extra pay or time off for overtime

Table 5b
Heads of Agreement of an Employment Contract

The terms below should be addressed in any employment contract and this list should be of assistance when drafting a contract of employment.

1. Full name of employer and employee
2. Address of employer in the State or where appropriate, address of the principal place of relevant business of the employer in the State
3. Position (Job Title)
4. Commencement Date and End Date, if applicable (i.e. temporary or fixed term contract)
5. Type of Contract
6. Place of Work
7. Probation
8. Duties
9. Remuneration to include rate and method of calculation, pay reference period and length of time between instalments e.g. weekly/monthly etc.
10. Terms and Conditions of Hours of Work
11. Retirement
12. Lateness/Absence from Work
13. Medical Examinations
14. Grievance Procedure
15. Discipline/Dismissal Procedure
16. Notice of Termination
17. Terms and Conditions of Annual Leave and Other Statutory Leave Entitlements
18. Absence/Leave Practice Policies including sick leave
19. Training
20. Capability and Competence
21. Employee Handbook
22. Health and Safety
23. Bullying and Harassment
24. Confidentiality
25. Competition
26. Lay-Off/Short-Time
27. Redundancy
28. Indemnification, Insurance and Accreditation
29. General
30. Data Protection
31. Implied Terms – Employee
32. Changes in the Contract
33. Signatures
34. Pension Entitlements (if applicable)/ or entitlement to access a Personal Retirement Savings Account (P.R.S.A.)
35. Any collective agreements in place (if applicable)

Note: All contracts of employment must be signed and dated and a copy must be held by the employer for the duration of the employee's contract and for 1 year thereafter.

Table 5c
Typical Headings and Clauses of a Partnership Agreement

1. Date of document
2. Name, title and address of the practice
3. Names of the parties
4. Date of commencement
5. Nature of practice business e.g. conventional v complimentary medicine
6. Duration of Assistantship
7. Partnership income (private fees, GMS, professional appointments etc.)
8. Profit sharing
9. Gifts
10. Hours of work
11. Leave (holidays, sick leave, maternity, parental/adoptive leave, study leave, sabbatical leave etc.)
12. Absence (rules applicable in all cases and specifically in relation to incapacity)
13. Retirement and Death (payments applicable and acquisition of outgoing Partner's share)
14. Further Provisions relating to outgoing partners
15. Goodwill (value placed if any and rules applicable)
16. Grounds for termination and notice of termination of contract
17. Dispute resolution procedures (specific mediation, arbitration mechanisms and avenues that will be followed etc.)
18. Practice expenses
19. Practice premises
20. Items to be provided by Partners (e.g. clinical instruments, car etc.)
21. Taxation issues
22. Management of the practice
23. Management of practice staff (including hiring and dismissal process and responsibilities)
24. Locum provision
25. Power to make decisions
26. Acts requiring consent of all Partners including limited non-compete and non soliciting of key employees and clients
27. Restrictive covenants
28. Professional medical indemnity
29. Banking arrangements (including signing of cheques etc.)
30. Drawings
31. Accounts

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32. Partnership capital

33. Review arrangements

34. Allocation of patients (GMS and private)

35. Confidentiality

36. Expulsion (and manner of winding up Partnership)

37. Insurance

38. Incoming Partners

39. Continuance of Partnership

40. Dissolution

41. Severance

42. Governing Law and Jurisdiction

43. Entire Agreement (i.e. whether this agreement supersedes or extinguishes all prior agreements between the parties

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6: Negotiation of Terms and Conditions of Employment and Partnership Agreements

Introduction

The process of negotiation between parties is similar regardless of the purpose of negotiation. Irrespective as to whether one is setting up in Partnership or joining an established practice, it is almost certain that negotiation will be required at some stage during a career in general practice!

It is also true that GPs often feel uncomfortable about negotiating. While it is unclear why this is the case, more than likely, cultural reasons are partially responsible. It is certainly true that in general practice, negotiating a deal that is favourable to all concerned can be a huge challenge.

Negotiation in general practice can take many forms. It may be negotiation of terms and conditions of an employment contract (e.g. between two GPs or between a GP employer and practice staff), of a contract for provision of services (e.g. for locum work), or for entry to Associateship or Partnership.

While at the establishing stage negotiation is likely to involve terms of an Assistantship or potential Partnership, later on it is likely to come into play as an employer, e.g. negotiating rates of pay with practice staff. This chapter outlines the process of negotiation and provides a model which should allow both parties to progress toward a successful outcome.

6.1 'Business' Negotiation in General Practice

As understood in a business context, many GPs are not effective negotiators. Despite GPs generally having high levels of communication skills, these same communication skills may not transfer well to the process of business negotiation, particularly when dealing with colleagues.

Whilst in a general practice consultation the goal is often to leave a patient feeling as positive as possible, business negotiation doesn't have this aim. This can result in a steep learning curve and significant challenges for a GP when addressing theoretically confrontational issues with a potential future employer, employee, or Partner.

Undoubtedly in many circumstances, arrangements are reached without difficulty. It is often the case that in general practice, mutual professional respect leads to agreeable working conditions. However, there are areas in which negotiation and agreement can prove difficult.

Between medical colleagues, practical issues such as hours of work, absence and remuneration are frequently approached in an ambiguous way. Negotiation on such matters is often misunderstood as being too '*delicate*', rather than as normal business practice.

Remuneration is a classic area in which GPs not only find negotiation difficult, but also find difficult even to raise. However, raising and negotiating on such an issue should not mean or infer lack of respect. In reality, if approached properly it should be possible to reach mutual agreement on all such issues, whilst at the same time maintaining professional values and relationships.

Good business practice and ethical conduct are not mutually exclusive. Mutually satisfying business arrangements foster better professional working relationships within a practice which benefit all involved, including the patient. There are implications for patients and patient care in these matters as well; consider the effect on patients, whom, having built up a relationship of trust, find it no longer available each time a doctor moves on.

To become more effective as a negotiator, it is important to explore some of these barriers to effective negotiation. In addition, should negotiations fail, and it proves impossible to broker an agreement, in order to learn from the experience it is important to understand what has occurred. It is often an incorrect interpretation of the other party's intentions which is the cause of progress being impeded or breaking down all together. It is therefore important not to make assumptions about the intentions of the other party and at all times to seek clarification of those intentions.

This chapter is designed primarily to assist and provide a platform to those who may initially not find it easy to

formulate an agreement, whether it is a GP Principal or an in-coming Partner or Assistant. The aim is to help both parties to find a successful formula, or at the very least, a structure for meaningful discussion to aid their negotiations, thus improving negotiation skills and increasing the opportunities for satisfactory outcomes. Finally, while this chapter considers in the main the perspective of the establishing GP, as outlined at the outset, the concepts discussed are equally applicable to GPs at all stages of their career.

6.2 Knowing What You Want

The first step before commencing negotiation is to know what you want and to have a realistic understanding of the '*market*'. This may seem self-evident, however, it is surprising the number of GPs who initiate discussions on terms but have failed to fully think things through. It is often a case of not having anticipated all the issues and therefore being in less than optimum position to achieve a good outcome. It is also equally important to be able to express in unambiguous terms, what one wants from a '*deal*'.

In preparing for negotiation, one must consider short, medium and long term needs. For example, a job that suits in the immediate post GP training period may not necessarily be a job in which one wishes to remain long term. On the other hand it may offer experience in an aspect of clinical practice that one may need or suits current lifestyle needs. Being clear on what you want also needs to take into account what a prospective practice can match. There is little point in having expectations which a practice cannot possibly fulfil.

6.3 Negotiation to Deadlines

6.3.1 Time Scale for Negotiation

It is imperative from the outset that there is agreement on the period of time that the process of negotiation will take, from commencement to conclusion. Finalising agreements can take longer than anticipated giving rise to frustration if there is not a consensus on the date for conclusion.

6.3.2 Time Scale for Conclusion of the Contract

GPs may frequently have a pre-negotiation period e.g. a new GP may work for six months as a salaried employee. However, if there is the prospect of further progression, this should be made clear as should the review period. In the past, arrangements have often not progressed due to conflicting expectations as to the timescale and conclusion of negotiations.

6.4 The Process of Negotiation

The model outlined below, adapted from the 2006 Royal Australian College of General Practitioners (RACGP) Employment Kit, applies equally to both parties involved in any negotiation. To fully prepare, one should complete a '*best outcome', 'must have', and 'trade off" priority grid for each contractual condition on which one is negotiating.* A simple example in relation to on call work is: -

Best outcome	No on call work
Must have	No more than 4 nights per month on call
Trade off	Remuneration for same

Working through a checklist of *contractual* conditions using a '*best outcome*', '*must have*' and '*trade off*' priority grid, will help individuals clarify what they need/want from a negotiation. It also clarifies and orders competing priorities and makes it easier to discern the following: -

1. The important conditions on which one is prepared to negotiate
2. Conditions on which one is not prepared to compromise
3. Conditions which on reflection are not important in the context/current situation

An advantage of this priority grid system is that negotiating parties will be well prepared and clear about their own respective agendas, and in this context are more likely to reach a successful outcome.

6.4.1 Remuneration

While remuneration might be the most important thing about any job, and is often the first thing people will focus on, remuneration may not always be the most important factor in negotiation. There are many factors which will influence the achievement of a satisfactory outcome, and at that very least, if other issues are addressed first, it can provide a good starting point for proceeding to negotiate on salary. In determining salary there are two key questions to address: -

1. How much can a practice afford to pay?
2. What can the prospective incoming GP bring to the practice?

It is possible to estimate how much a practice can afford to pay/fund an incoming GP by looking at patients seen per hour/hours worked/average fee/GMS breakdown (including subsidies) and then factoring in bad debts and overheads generated. This figure will also be balanced against lifestyle benefits to the existing Principal(s), e.g. time off.

There is also an owner margin to be taken into account when calculating the remuneration figure as various Partners or Principals may be drawing different percentages of profit from the practice. There are in addition other considerations to be made such as flexibility to cover holidays, home visits or on call commitments. It is likely that the more flexibility one offers, the better a salary one can negotiate.

6.4.2 Negotiating What You Want

Having drawn up a list of contractual conditions and clarifying the *best outcome*, *must have*, and *trade-off* for each, one can then progress to putting the best case forward. It is important to prioritise the conditions of most value. This protects the factors/conditions which are most important and allows one to more easily negotiate conditions that are less crucial.

During negotiations one should make a table of the *must have* contractual conditions not met/fully satisfied followed by the contractual conditions where a better outcome is preferred (*best outcome*). A separate column should reflect the reasons for the other party not meeting these conditions.

A final column should detail what one may be prepared to do and negotiate in order to achieve ones best outcome. The following example illustrates the approach: -

Factor for Negotiation	Finishing time on Wednesdays
Best outcome	Wish to finish at 3pm on Wednesdays
Factor not met	Practice will not agree to this finish time
Reason other party does not agree	Patient demand is not met
Possible compromise solution (**on which to negotiate**)	Reduce salary so that the practice can pay extra administration and nursing staff in order to free up time for the doctor to see patients to be able to finish at 3pm

6.4.3 Checklist of Contractual Conditions

The list of contractual conditions below is by no means complete, but it should provide a good starting point by which one can draw up a comprehensive list of factors for consideration in respect of any post. The list provides a template to allow an individual to consider in detail their needs, and will hopefully be of assistance in preparing for negotiations. Ultimately, this will hopefully make any discussion more productive. The relevance of any or all of these conditions will obviously be dependent on the context and type of contract anticipated, e.g. statutory leave does not apply in case of a contract *for* services. Furthermore, in no way should this be a substitute for legal advice which will be crucial in the finalities of drawing up any contract

6.4.3.1 Job Tasks

1. Number of hours/sessions to be worked per week?
2. Number of hours per session?
3. Appointment length?
4. Patients to be booked by appointment?
5. Flexibility to book longer appointments?
6. Proportion of appointments pre-booked?
7. How are walk-in patients managed?
8. After hours and on call?
9. Home and residential aged care visit requirement?
10. The share and distribution of work load between GPs?
11. Education, teaching and supervision (e.g. with medical students)?
12. Cover for GPs on leave?
13. Completion of paperwork such as medico-legal reports, PMAs, social welfare certs?
14. Completion of prescriptions?

6.4.3.2 Leave

1. Sick leave, bereavement leave, force majeure leave, compassionate leave?
2. Annual leave?
3. Study leave?
4. Maternity/paternity leave?
5. Payment of public holidays if appropriate?
6. Long-service leave?
7. Agreed sabbaticals?

6.4.3.3 Work Related Expense Reimbursement

1. Telephone expenses?
2. IT expenses?
3. Mileage allowance for home visits?
4. Medical indemnity?
5. Education and training costs, e.g. skills courses?
6. Doctor's bag medications?

6.4.3.4 The Practice Environment

1. Suitability of town/city/geographical location?
2. Is this area going to generate the type of practice envisaged?
3. Premises and physical work environment, e.g. premises location, including branch surgery (if relevant)?
4. Reception area?
5. Shared consultation room?
6. Working in other practices i.e. multi-centre practice?
7. Decision making involvement in the practice?
8. Practice equipment and facilities?
9. Access to practice nurse and other allied health personnel?
10. Administrative support and practice management protocols and procedures?
11. Availability and access to other resources (e.g. pathology or radiology, other health professionals)?
12. Computer system and upgrades?

6.4.3.5 Professional Development and Continuing Education

1. Support/educational activities within the practice (e.g. attendance at courses, practice/staff meetings)?
2. Scope to develop special interests?
3. Ongoing study and professional development?
4. Role in practice accreditation?
5. Practice involvement in general practice projects, ICGP projects and other initiatives, e.g. Heartwatch, IPCRN?

6.4.3.6 Occupational Health and Safety

1. Is the practice compliant with health and safety requirements (e.g. the Health & Safety Authority) and how do you assess this e.g. a practice safety statement etc.?

2. Safety of working environment from physical, chemical and biological hazards, e.g. personal alarms, staff presence, list of patients posing threat to GPs, medicines storage and adequate car park lighting?
3. Presence of staff when the practice is open and closed?
4. Safety measures outside practice, e.g. home visits and after hours?

6.4.3.7 Other Conditions of a Contract

1. Who retains the patient list, the GP or the practice?
2. Patient notification on cessation at practice (notification pre- or post-departure)?
3. Responsibility for patient records?
4. Required qualifications and skills?
5. Scheduled contract review periods?
6. Probationary period?
7. Who pays for medical indemnity insurance, the practice or the individual?
8. Do all GPs in the practice have to use the same insurer?
9. Vicarious liability for practice clinical staff?
10. Steps in place to negotiate conflict including a written protocol?
11. Restraint of trade conditions? *(A restraint of trade is a condition to protect employers' business interests by restricting an employee's future work for a specified period of time within a defined geographical area. Legal advice is required to determine if such clauses are enforceable and / or legal, i.e. competition law. Additional information is available in the 2002 Competition Act and 2006 Competition Amendment Act and on the* Competition Authority website*)*

6.4.3.8 Remuneration

1. Contract duration and remuneration review periods (if any)?
2. Calculation of sessional payments, e.g. by time, percentage of earnings or hourly rates?
3. Different rate for after hours, home or residential aged care visits?
4. Payment cycle, e.g. weekly, fortnightly or monthly?
5. Pay slips (in the case of an employee), invoices, and other payment documentation?
6. Superannuation?
7. Associateship or Partnership at the end of the contract?
8. Consideration of a share and goodwill in the practice?

6.5 A Structured Process for Negotiation

6.5.1 The Opening Offer

It is important in the initial stages of negotiation not to sacrifice one's own position, certainly not beyond a '*no trade*' point. However, in order to identify areas for compromise, it is also important to understand the other party's perspective. It is crucial to recognise that in negotiation the point is not to '*out-do*' or gain an upper hand on those with whom you are negotiating, but rather to reach a deal that best fits the needs of both parties.

The opening offer in any negotiation is therefore a crucial step. There are 5 recommended points to an opening offer: -

1. **Know your walk away point:** For example, this could be a salary level or important life style condition, and once decided upon is obviously not for revelation!
2. **Avoid being the first to present an offer:** This allows one to get a better idea of what the other party expects. It is reasonable to ask what the opposition is offering.
3. **Unreasonable first offer:** If the initial offer is unreasonable then it should not be countered with a concrete one. This can back you into a corner. Simply request that they return with a more reasonable offer if negotiations are to continue.
4. **Caution is needed in immediately accepting the first offer:** It is always a sensible approach to fully consider the first offer and all related conditions and to do so without haste. One may need independent advice or seek clarification on specifics. It is not usually just the financial offer that needs examination but the whole '*package*' being offered.
5. **Don't use your walk away point as your first offer:** This obviously leaves both parties with no room to manoeuvre or bargain and will limit any opportunity for an acceptable outcome.

6.5.2 Moving Negotiations Forward

When the stage has been reached where both parties' proposals have been put forward, the next step is to attempt to close the gap between the parties. This might be achieved by the following approach: -

1. **Improve the offer:** Bring the other party closer by offering something they want. In exchange for a higher salary, one could offer to do procedural work or extra after hours work to cover the rota. When discussion is focused entirely on factors such as salary, people are more likely to dig in their heels and become entrenched. Equally, long term financial and other gains may be lost if relatively unimportant factors are insisted upon at the outset.
2. **Make concessions:** At some point one will need to make some concessions. Depending on what one prioritises, one can try to concede things that matter much more to the other party. As in any negotiation, one's own demands require reflection and need to be realistic.
3. **Decelerate concessions:** For example, if one reduces one's salary offer/request initially by €5,000 and then further by €10,000, it may set a precedent/tone that could continue in the same way. Instead, one should gradually reduce the level of reduction, e.g. initially €5,000, then €2,500, then €1,000. The aim is to get to a point half way between the negotiating parties.
4. **Uncover hidden agendas:** One should not always assume that one knows what the other party wants.

Attempting to explore their perspective and encouraging explanation of stance on issue(s) in question may uncover different concerns than initially expected, e.g. quality of life issues may be more important to some than the direct financial benefits.

5. **Fait accompli:** Most people will at a certain point accept a done deal rather than persisting with negotiations. If for example one has an agreement with a single clause that is unacceptable to a party, perhaps one could re-word it and sign the agreement with the change highlighted. If presented with a signed document, both parties are more likely to complete the deal.

6.5.3 Dispute Resolution

Within any contract/business relationship, it is important to schedule regular reviews. This allows terms and conditions to be updated to match changing circumstances. It is also important to have a process outlined for dealing with disputes. Outlining/agreeing on such a dispute resolution process in the initial agreement/contract is recommended. This may include the following: -

1. The other party must be notified about the issue and given adequate time to respond.
2. If a suitable response is not provided, a peer could provide an independent view to both parties and provide mediation between the parties.
3. Should this view not be acceptable to both parties, an independent mediation process, facilitated by a skilled independent person should be sought. The ICGP can assist in this regard.
4. If mediation is not successful, the process could move to arbitration, i.e. both parties willing to accept the independent decision of the arbitrator. The ICGP can assist in this regard.
5. If after all the above have been tried it may be necessary to seek recourse to legal advice.

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7: Sample Models of Partnership and Practice Succession

Introduction

Partnership is a common arrangement in Irish general practice and regardless of the prevailing economic circumstances there will always be establishing and retiring GPs for whom Partnership is of interest. In addition to Partnership there are also a variety of other models of practice succession. Some of these models have developed subsequent to the opening of access to the GMS and in particular in the context of the difficult economic circumstances in which Irish general practice has found itself.

A harsh reality for many GPs approaching the end of their career is that a GMS list is simply in itself no longer the asset which it used to be. Compounding this situation is that establishing GPs may not have ready access to finance to the extent that existed a decade ago. These two facts have resulted in an increasingly challenging situation for those GPs interested in retirement or succession in terms of finding interested younger GPs, and as a consequence, a search has developed for new and novel models of practice succession.

Questions frequently asked by both establishing GPs and Principals when negotiating the entry of a new GP to a practice or when discussing the financial aspects of succession are, "what is the '*norm*'" and "is there a '*formula*"? While various formulae may be quoted and vague descriptions given, no norm or formula will satisfy every situation. Quite simply, one size does not fit all!

The simple truth at the heart of all Partnership or succession negotiations is that the value of any arrangement will be specific to the particular situation, the individuals involved, and the worth placed by each party on various aspects of any possible arrangement. Ultimately it comes down to the negotiation of a deal acceptable to those involved and this may revolve around many non-financial factors such as the lifestyle choices and family considerations of the GPs involved. These considerations were discussed in detail in chapter 6, 'Negotiation of Terms and Conditions of Employment and Partnership Agreements'.

Some of the factors which can influence the type of arrangement reached include the ratio of GMS: private income, the number of existing Partners, ownership of premises, and the time commitment and flexibility of working arrangements. In the context of Partnership negotiations, decisions also have to be made as to what constitutes practice expenditure and what is to be regarded as personal expenditure of individual Partners, e.g. income protection, phone expenses, motor costs, medical indemnity, subscriptions etc. The following list provides an overview of factors which should at least be considered when appraising models of practice formation: -

1. Autonomy
2. Financial base
3. Legal entity
4. Complexity
5. Access to accurate information including financial information
6. Taxation issues
7. Professional compatibility
8. Personal compatibility
9. Continuity
10. Management supports
11. Status of the incoming Partner
12. Growth potential

Another key aspect of Partnership negotiation and succession arrangements is the need for full disclosure of practice information by the existing Principal/Partner(s). Any incoming GP should have full knowledge of all aspects of the existing practice. This would include all sources of income and in the case of Partnership, the practice policy with respect to allocation of new GMS and private patients. This particular point is very important as it may have significant financial and pension implications. An incoming GP may find it easier for his/her independent financial adviser to ask for this information.

Another extremely important aspect of the financial arrangements of any Partnership/succession negotiation is

to obtain independent external advice. Assessment of any possible deal is crucially important, ideally from an adviser familiar with the business of general practice. While this advice must be contextualised by the interests, desires and values held by each party, independent advice should also ensure that neither party ends up with a bad deal.

While it is almost always impossible to give detailed specific advice, it is worthwhile to illustrate how some practices have arrived at solutions which were right for them. It must be stressed that the case studies outlined are anecdotal and we are grateful to the practices who have contributed this information. It is also hoped these examples will give readers a starting point and variety of options when commencing negotiations on entry to or expanding a practice.

7.1 Buy-in Model 1

In this three Partner practice a buy-in figure was agreed with an incoming fourth Partner. The buy-in figure was calculated as follows: -

1. The previous three years gross earnings of the existing Partners were assessed, and
2. The growth in practice income with a new fourth Partner was estimated (it is unknown how this was estimated), and then
3. The gross practice income with an additional fourth Partner was projected, and then
4. The projected annual income of a Partner was estimated (in the context of a new fourth Partner)

A buy-in figure was calculated in terms of income lost to the existing three Partners by the addition of the new fourth Partner. To calculate the buy-in amount, an arbitrarily agreed multiplier of 2 was applied to the projected annual income of a Partner. This amount was paid as a *once-off payment* to the existing three practice Partners. For the incoming fourth Partner, this buy-in figure equated to two years projected minimum gross earnings.

While the objective logic of this formula may be questionable, it provided a way of arriving at a figure which was agreeable to all the parties. The rationale was that the buy-in amount would compensate the existing Partners for loss of earnings due to the additional division of profits.

The incoming fourth Partner used a tax efficient commercial loan to raise the buy-in amount. Clearly, instantaneous partnership has an impact on gross salary and personal financial planning. It may have implications for mortgage approval, repayments, pension contribution etc. All these need to be managed and worked out in detail. On the other hand, instantaneous partnership also brings long term stability.

7.2 Buy-in Model 2

In this example, a new Partner joined an existing two doctor Partnership. The progression to Partnership was agreed as follows: -

1. Year 1: The incoming Partner worked six sessions a week as a Sessional GP for a period of one year. The sessional rate was paid at 80% of the normal sessional rate in order to offset the final '*buy-in*' amount.
2. Year 2: The incoming GP became a partner in the practice with a '*buy-in*' figure being paid. The '*buy-in*' figure was arrived at as follows: -
   - **a.** A full figure '*whole egg*' amount was arrived at to calculate the '*buy-in*' amount.
   - **b.** This '*whole egg*' amount was calculated by averaging the previous two years gross practice profit and multiplying the resulting figure by 1.5.
   - **c.** This was then the '*whole egg*' amount used to calculate the '*buy-in*'.
   - **d.** To calculate the '*buy-in*', the number of sessions worked by each doctor also had to be taken into account. Including the new Partner, there were a total of 22 sessions worked per week in the practice. The incoming Partner wished to continue working six sessions per week. Therefore, the '*buy-in*' amount that had to be paid was 6/22 (27.27%) of the '*whole egg*' amount.
   - **e.** The amount foregone during the year worked as a Sessional GP also had to be taken into account. One full year (52 weeks) was worked at 80% of normal sessional rates. Therefore the buy in amount was 27.27% of the '*whole egg*' amount, less 52 x 20% of the sessional rate paid during the previous year.

It is important to point out that this was a recently established practice. Therefore, the traditional model of using three years profit averaged and multiplied by 1.25 for the '*whole egg*' figure could not be used as there had not been three years full trading at the time of the Partnership negotiation.

Again, while the objective logic of this formula may be questionable, it provided a way of arriving at a figure which was agreeable to all the parties.

7.3 Work-in Model 1

In this example, an existing two doctor practice decided to take on an Assistant-With-a-View to a relatively quick Partnership. For the initial six months, the new doctor, working as an Assistant, had an agreed salary. During this period there was also an opportunity to ensure that the parties were able to work together in a sustainable fashion.

After the first three month probationary period matters proved to be extremely satisfactory to all parties, and discussions commenced on a further one year's Assistantship which included salary plus bonus payments. Bonus payments were at the discretion of the existing Partners based on there being an increase in practice income with the additional doctor.

This was followed with an agreement to progress to full Partnership and profit sharing over a three year period as outlined below. In this example, each of the Partners worked an equal number of sessions per week with an equitable division of labour. As with the previous buy-in examples, the agreed percentages were arbitrarily arrived at by the negotiating parties. In this example, when calculating the gross

practice profit, the salary paid to the new Partner during the period of Assistantship was also taken into account as part of the overall gross practice profits.

	Existing GP 1	Existing GP 2	New GP
	Percentage of Gross Practice Profits		
Year 1	37.5%	37.5%	25%
Year 2	36%	36%	28%
Year 3	34.5%	34.5%	31%
Year 4	33.33%	33.33%	33.33%

7.4 Work-in Model 2

In this case which is similar to work-in model 1, a method of work-in whilst progressing to parity with the two existing Principals was used. The objective as with the previous example was to enable working-in with an incrementally increasing share of the profits.

In this example, even though the workload was again equitably divided, the joining Partner gave up a larger percentage of profits during the period of work-in than in work-in model 1. In effect, a worse deal. Clearly in this case there may have been other factors in the Partnership agreement relating to life style issues, location, working conditions etc. that compensated for this relatively worse financial deal. This again highlights that no two situations will ever be the same, and it is not simply the money or percentage profit share of a work-in that may be the most important factor in any deal.

	Existing GP 1	Existing GP 2	New GP
	Percentage of Practice Profits		
Year 1	39%	39%	22%
Year 2	37.2%	37.2%	25.6%
Year 3	35.3%	35.3%	29.4%
Year 4	33.33%	33.33%	33.33%

7.5 Work-in Model 3

This is a more complicated example of a work-in arrangement. In this case, an existing two doctor Partnership was joined by doctor C. It is more complicated than the previous two examples because the three doctors did not have an equitable division of work.

In this case it was agreed that full Partnership would be progressed over 3 years as follows: -

Year 1: Doctor C, was an '*Assistant-With-a-View to Partnership*' with an agreed salary.

Year 2: Doctor C became a Partner working 6 sessions per week. For the first 6 months there was an 80% profit share, increasing to 85% of profits in the second 6 months.

Year 3: Doctor C's profit share increased to 95% for the entire year.

Year 4: Doctor C achieved 100% full Partnership, i.e. 100% profit share.

However, the three GPs did not all work the same number of sessions. An adjustment was therefore made to take account of the relative number of sessions worked by each of the three Partners. This was calculated by the percentage of the total number of sessions worked by each individual doctor. The three doctors in the practice worked a total of 24 sessions per week. Doctors A and B each worked 9 sessions per week with the new Partner doctor C working 6 sessions. Therefore, at 100% profit sharing each Partner received the following: -

1. Doctor A received 9/24 (**37.5%**) of the profits
2. Doctor B received 9/24 (**37.5%**) of the profits
3. Doctor C received 6/24 (**25%**) of the profits

Calculation of the actual percentage of profits paid is further complicated by doctor C's increasing share of profits from 80% in year 2 to 100% in year 4. The table below outlines the division of profits between the three Partners during the work-in period. It is based on doctor C's 100% share of profits being 25% of the gross profits.

	Doctor A	Doctor B	Doctor C
	Percentage of Gross Profit		
Year 2 First 6 Months	37.5% plus 2.5% from doctor C = **40%**	37.5% plus 2.5% from doctor C = **40%**	80% of 25% of profits = **20%**
Year 2 Second 6 Months	37.5% plus 1.875% from doctor C = **39.375%**	37.5% plus 1.875% from doctor C = **39.375%**	85% of 25% of profits = **21.25%**
Year 3	37.5% plus 0.625% from doctor C = **38.125%**	37.5% plus 0.625% from doctor C = **38.125%**	95% of 25% of profits = **23.75%**
Year 4	**37.5%**	**37.5%**	**25%**

In this model of work-in, both doctors A and B earned an additional 5% of the practice profits in a 2 year period. As with previous examples, the agreed percentages were arbitrarily arrived at by the negotiating parties. This again highlights that no two situations will ever be the same, and it may not simply be money or percentage profit that is the most important factor in any deal.

7.6 Work-in Model 4

In this example, a single handed Principal working 10 sessions per week took on a new Partner. The existing GP planned to retire in four years and included in the Partnership agreement was a clause to this effect. In return for immediate full 50:50 Partnership, it was agreed for the four years of the Partnership that the incoming Partner would work more sessions than the existing Partner and do all the on-call work with the on-call commitment being once a week and one weekend in five as follows: -

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	Existing GP	New Partner
Existing	10 Sessions, All On Call 100% Profit	
Year 1	3 Sessions 50% Profit	7 Sessions, All On Call 50% Profit
Year 2	3 Sessions 50% Profit	7 Sessions, All On Call 50% Profit
Year 3	3 Sessions 50% Profit	7 Sessions, All On Call 50% Profit
Year 4	3 Sessions 50% Profit	7 Sessions, All On Call 50% Profit
End Point		10 Sessions, All On Call 100% Profit

In this model, while no money exchanged hands, the additional time worked could in reality be regarded as a buy-in, simply achieved using time (and the value of time) instead of money, i.e. time instead of cash. The new Partner therefore had no requirement to source finance and had the added advantage of becoming an immediate equal Partner in the practice. In four years' time the new Partner would take over full ownership of the Practice and take 100% of the profit, despite in the intervening period taking only 50% profits and doing approximately 80-85% of the work when on call commitments were included. While during this period the outgoing Partner could enjoy working substantially less while still drawing 50% of the profits of the practice, this represented a substantial reduction in income and no additional extraction of financial value from the practice at the exit point.

As with previous examples, the agreed arrangement was arbitrarily arrived at by the negotiating parties. This again highlights that no two situations will ever be the same, and it may not simply be money or percentage profit that is the most important factor in any deal. In this case for the two parties concerned, the model provided a template for successful succession.

7.7 Work-in Model 5 - for Free

In this novel and potentially challenging example, a retiring GP identified a potential successor in the form of a establishing GP. However, being close to 70 years of age he was unable to take on the new GP as an Assistant-With-a-View and neither GP was interested in Partnership. The arrangement reached was that the incoming GP worked for free in the practice for six months with the existing GP effectively retiring with immediate effect. After six months most GMS patients signed a change-of-doctor form to move to the new GP with a majority of the private patients also moving.

While the outgoing GP earned six months of practice profits without working, and the incoming GP worked for free, after six months the incoming GP then found himself with a viable patient list as a single handed Principal taking 100% of the profits. No additional financial exchange took place.

This model is not without significant risk for the incoming GP who is trusting that by investing six months of work into the practice and developing a relationship with the patients, they will chose to move their medical cards to him and that private patients will by enlarge also move.

As with previous examples, the agreed arrangement was arbitrarily arrived at by the negotiating parties. This again highlights that no two situations will ever be the same. In this case, for the two parties concerned, the model, although extremely novel, challenging, and fraught with risk, did provide a template for successful succession.

Summary

Negotiating the financial aspect of a Partnership or succession arrangement can be complicated. There is no one perfect or ideal formula that will suit all practices, and it is often the experience that neither a Principal nor incoming Assistant/GP knows where to start. It is therefore hoped this Chapter may provide some assistance in respect of Partnership/succession financial arrangements.

The models described in this chapter are examples of how GPs have ensured development and continuity of their practices. While the '*value*' of practices has and will continue to fluctuate over time, being influenced strongly by the prevailing '*market*' conditions, ultimately the value is determined by what the '*buyer*'/incoming Partner/successor is willing to pay.

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8: Setting up a new Practice

Introduction

Setting up or establishing a new practice applies to many different scenarios. In the old fashioned sense, it can be about putting up your plate and awaiting business, but the term also applies to situations such as acquiring a GMS list or modernising a long established practice.

Even before arriving at a decision to open a new practice, there are many questions which one must ask including is this right for me? Do I have the finances? Do I want to work with a Partner? Can I get a GMS list? Is this area viable long term? However, once these fundamental questions have been asked and a decision taken to open a practice, the discussion then moves on to the actual reality of doing just that, opening a new practice.

This chapter looks at the key issues which the establishing GP will encounter in setting up such a new practice and the basic requirements of this undertaking. However, many of the areas addressed are equally relevant to doctors joining an existing practice where change in the operation of the business is likely. This chapter makes reference to these issues, but they are also considered in greater detail in other chapters of this publication. The areas covered in this chapter are: -

- **8.1** Writing a Business Plan
- **8.2** The Physical Infrastructure
- **8.3** Financial Matters
- **8.4** Practice Structure
- **8.5** Marketing and Advertising the Practice

8.1 Writing a Business Plan

The very first item on the agenda for any new business should be to write a business plan. A business plan is simply a management tool to assist in the establishing, running, development and growth of a business. It should be regarded as an essential requirement of good business planning. Furthermore, it may also be used or adapted for making a submission to potential financial providers. There are many free templates online to help one write a business plan, but in drafting a business plan the headings and points outlined below (not necessarily in the order below) should be considered.

Other general points worth noting in relation to GP business plan are that GPs tend to undersell themselves whilst overcomplicating their plans! It is therefore advisable to focus first on the most important aspects of the business plan and to err on the side of overselling rather than underselling oneself!

8.1.1 The Executive Summary

At the beginning of every business plan should be a concise executive summary which outlines what the plan is trying to achieve and how the plan holds together. The overall layout of the plan is important including spaces, headings, subheadings, and graphs. The executive summary should focus on key messages.

8.1.2 Financial Figures

At every juncture possible, points made should be backed-up and illustrated using actual or projected figures. These should support any assumptions made.

8.1.3 An Overview of the Business

There should be an overview of how the '*business*' will work. This should include how the functional areas of the business will interact and support the overall practice, e.g. the GP, nursing staff, management and administration.

8.1.4 Products/Services

The services provided to patients by the practice should be clearly defined, highlighting any unique aspects and also outlining potential for new or additional services. Other aspects of the service that should be outlined are the actual or projected volume and level of usage/demand, where that demand will come from, the pricing structure and the modes of delivery, e.g. out-of-hours care. It is important to highlight what is unique about the services and service providers.

8.1.5 Market Information

This must be included to demonstrate growth potential. A market profile includes a population profile (age, gender,

socio economic grouping), distribution, access (transport), competition, access to other medical services (e.g. hospital, pharmacies, community services), planning and development in the area, and existing and potential sources of local employment. Such information can be obtained from a variety of sources including census figures published on the Central Statistics Office (CSO) website.

8.1.6 Sector Overview

This should describe the sector in which practice operates. It should allude to the structure of primary care, the relationship between general practice and primary care, the wider health care sector, and should use illustrative figures, e.g. the number of GPs graduating each year relative to demand. It should also outline developments in the sector and how the practice will be aligned to take advantage of any potential arising from such developments.

8.1.7 Money

A business plan should clearly describe how a practice intends to make money, and include estimates of profit/loss. In the early years of a new practice, the business may actually lose money; however, the business plan should show clearly when and how the practice is projected to become profitable. Clearly a practice must become profitable if it is to be viable.

In order to make financial projections and estimate profit/loss, one must be able to estimate income and expenditure. While this is an absolutely essential part of planning a new business, it is also an extremely useful exercise in of itself for any existing practice. Being able to comprehensively document and quantify all income and expenditure will very quickly identify and focus one's mind on areas of lost income and excess expense. Committing a list of all income and expenditure to paper along with known or estimated figures is a key part of good management of one's business. Carrying out this exercise will also allow one to appreciate that when financial circumstances are challenging, it is not only possible to consider cutting costs, but also to explore ways of increasing income.

As part of the business plan, there is also a need to consider the services provided in terms of quantity and the fee/price per item. For example, one should be able to estimate average consulting rates of private patients and the average fee per consultation (with the average fee per private consultation taking into account review charges, reduced fees and waived fees). There are many questions which one will need to answer. How much will the practice charge per private consultation? What and how will review charges work? How many appointment slots will there be per day and how long will an appointment be?

Detailed information including a schedule of all fees charged for all possible sources of income should be conveyed in the financial projections. It is customary to do financial projections for three years at the outset of a new business, with figures ideally broken down into quarterly or even monthly projections. This information should be presented in spread sheet format with yearly summaries and should include income, expenditure, and volume of delivery of services, margins and profitability.

Below, examples of income and expenditure are listed. These lists are far from comprehensive, but they will provide a good starting point for any practice to compile detailed lists of areas of income and expenses.

8.1.7.1 Income

Some examples of income streams for a practice are: -

1. State Schemes
2. The General Medical Services (GMS) Scheme
   - **a.** The Mother and Infant Scheme
   - **b.** Primary Childhood Immunisation Scheme
   - **c.** Treating Methadone patients
3. m certification for the Department of Social Protection
4. Private patient fees
   - **a.** Paid for directly by patients, i.e. cash
   - **b.** Paid for by private insurers, e.g. VHI, Aviva etc.
5. Occupational health work
6. Insurance medicals
7. Medico legal reports
8. Department of Justice work, e.g. drug and alcohol testing
9. On call work and weekend locum work
10. Special interests, e.g. minor surgery, travel vaccinations, women's health
11. Teaching, e.g. medical students
12. Giving talks and presentations
13. Writing, e.g. a medical column
14. Pharmaceutical trials

Many of the items on this list require GPs to apply for a contract or to register as a provider. GPs should register with all health insurance companies to ensure they can get paid for claims made by patients through their insurer for services provided, e.g. cryotherapy, venesection for haemochromatosis and minor surgery.

All health providers have websites and either a simple email or phone call is all that is required to obtain the necessary forms to register as a provider. Likewise, one can contact insurance providers (e.g. Irish Life, BoI Life) in relation to carrying out insurance medicals on behalf of these providers. Details on applying for contracts from the State including a GMS contract are discussed in more detail in chapter 11, 'State Contracts held by GPs'.

8.1.7.2 Expenditure

When setting up a new practice, expenses will fall into a number of categories. These may include: -

1. **Professional fees in relation to set-up**: These will include fees in setting up the business and establishing a premises and might include fees for: -
2. **Accountancy**
   - **a.** Banking
   - **b.** Business advice
   - **c.** Architectural expertise
   - **d.** Engineering input

e. Builders costs
f. Local authority fees

3. **Once off capital set up costs**: These might include: -
   a. Purchase of a premises
   b. Basic office and building furnishings (e.g. sinks, desks, chairs, bookcases etc.)
   c. Furnishings specific to a medical premises (e.g. examination couch, curtain for privacy, lighting)
   d. Essential medical equipment (e.g. a defibrillator, thermometer, stethoscope, sphygmomanometer, adult and baby scales, height measure, 24 hour blood pressure monitor, ear syringe, autoclave etc.)
   e. Essential medical IT equipment (e.g. computers, software, printers)
   f. Administrative / management equipment (e.g. computers, software, telephones, money box, cash register, till, safe, filing cabinets etc.)
4. **Ongoing costs**: These will occur in many areas and will include: -
5. **General sundries** (e.g. toilet paper, bin bags, hand towels, cleaning materials, etc.)
   a. Medical sundries and equipment (e.g. gloves, tongue depressors, alcohol swabs, dressings, gauzes, peak flow mouthpieces, sterile water, needles, syringes, disposable instruments etc.)
   b. Administrative costs (e.g. stationary, insurance, data storage, annual software licence fees, retainers, refuse collection, courier collection of bloods etc.)
   c. Building running costs (e.g. electricity, rent, commercial rates, building managements fee, security cost etc.)
   d. Business associated costs (e.g. tax, banking fees, accountancy fees, payroll costs, staff salaries, employer's PRSI etc.)
   e. Professional medical fees (e.g. annual medical registration, professional competence fees, memberships (ICGP, IMO, NAGP), education and training costs (courses, conferences) etc.)

There are also a few hidden aspects to practice expenditure which are important to be aware of, including local authority fees and VAT.

Local authority fees can be very significant. They may include costs associated with planning permissions for change of use, planning permission for signage, costs related to certificates for disability access and fire and the associated costs of having professionals such as an architect prepare and process applications and paperwork in relation to each of these items. Additionally, there may be extra cost if building plans have to be redesigned to achieve compliance in respect of any of the above, particularly disability access and fire regulations compliance.

It is also important to remember that when getting quotations for goods and services one should always ask for VAT to be included. Many businesses in construction and planning will issue quotations excluding VAT. This is on the assumption that VAT will be claimed back. However, in a vast majority of instances, GPs/practices are unable to reclaim VAT, and the addition of an extra 23% on top of the anticipated cost of a good or service can be an unexpected and unwelcome experience.

It is also possible to think outside the box when it comes to the purchase of furniture and equipment. Medical and office supply companies generally tend to be expensive and one can use cheaper alternatives such as from flat-pack furniture suppliers, kitchen makers or source second hand items.

8.1.8 People and Track Record

A business plan should document the history to date of the practice and/or GP. This should include the qualifications, skills, and competencies of all staff working in the practice. From the perspective of the GP this should include general practice experience, other medical experience and experience in other fields that may be relevant, e.g. administration, management, business, accountancy, bookkeeping etc.

8.2 The Physical Infrastructure

8.2.1 Choosing a Premises

The old adage of location, location, location holds true for any business and general practice is no exception. A poor location may negate all other considerations. This is obviously a big decision but may not have to be made immediately if joining an established practice. Irrespective, it is likely that moving or developing a new practice building will happen at least once during one's working life in general practice.

When setting up, a general practice premises must be affordable for one's initial needs, yet also match short to medium term plans. It is advisable to plan for at least one spare consulting room from the outset. Due consideration should be given to a wide range of issues when deciding on the location and design of practice premises. Further information and guides on these matters can be found on the ICGP website and from a variety of other sources as listed in the "references and further reading" section at the end of the book. It is also highly recommended to employing the services of an architect with experience in the area of general practice premises design.

It is also important to be aware of potential future developments in relation to healthcare premises. For example, it is likely in the future that the Health Information and Quality Authority (HIQA) will licence general practice premises based on specific criteria and standards with interval practice inspections.

8.2.1.1 Budget

Calculating the difference between the estimated cost of new premises (rental, lease or purchase of a new site or premises) and the amount of finance at one's disposal will determine the additional funding required. Consideration also needs to be given to any fixtures, fittings and equipment that will be needed.

The usual financial considerations should also be made: cost of finance, interest rates, repayment period, and the variety of financial packages available. A choice of financial providers exists in the market place, including those allied to professional organisations. Thorough research should be undertaken and all facts and figures need to be committed to paper for effective comparison.

Whether renting or purchasing premises one needs to educate oneself about commercial realities. Consulting a number of commercial estate agents will provide an idea of current property values (i.e. the price per ft^2/m^2). Ground floor premises will typically cost more compared to other levels, however, the impact that working from non-ground floor premises may have on business must be taken into account. In the 2014 market place, in order to estimate the purchase value of a property, it may be appropriate to multiply the annual rental cost by a factor of 10. Interestingly, when the first edition of this book was published in 2008, the advice was to multiply the annual rental cost by a factor of 20-22. This provides a stark illustration of the financial contraction that the Irish economy has suffered since 2008. Values will obviously be location specific and will change depending on market climate.

8.2.1.2 Space Requirements

One needs to estimate how much space is required and the relative breakdown of different work spaces within the premises. Consultation, treatment, waiting, administrative, and storage areas within an overall premises size (ft^2/m^2) need to be considered and requirements need to be fully researched including hygiene needs, building and other regulations and quality guidelines. Typically, GPs underestimate the amount of administrative space needed.

Consideration needs to be given to immediate needs and any future potential including such factors as the number of patients/consultations, access systems (appointment, open access or mixed), and the number of doctors, nurses, ancillary clinical services and administrative staff. Health and safety regulations also mandate minimum work space requirements.

While it is obviously difficult to make definitive recommendations on size, typically 600-700ft^2/55-65m^2 should provide initial sufficient space for a good size reception, waiting room, 2 consulting rooms, administration office, kitchen facility and toilet(s). However, if it is intended that a practice will expand in the foreseeable future and should finances allow, it may make sense to aim for nearer to 1,000ft^2/93m^2. This should provide for 3 clinical rooms and space for at least 10 years. If an initial practice space is too small, there will be unnecessary trauma and inconvenience caused in having to move. This will not least involve patient inconvenience and require multiple institutions to be informed of a change in address.

There are a number of documents available that give good advice in relation to design of premises. As already mentioned, these are listed in the "references and further reading" section at the end of the book.

8.2.1.3 Location, Location, Location!

This is a key consideration. The practice needs to be as visible and accessible as possible to patients and any potential patients it seeks to serve. In deciding on a location, one needs to gather key information on building developments in the area, population growth trends/projections, age/gender distribution, access to transport and other services (IT, waste disposal etc.), proximity of other general practices and primary care centres, and location of '*complimentary*' businesses, e.g. pharmacies and supermarkets. Patterns and volumes of pedestrian and motor traffic, parking locations, public transport access, and crime levels are all factors to consider. It is important to determine the secondary/tertiary care area in which the practice/potential practice will be located.

In most urban environments travel time and transport to work from home will be a factor for the newly Establishing GP and other practice personnel in terms of location decisions.

An obvious but sometime overlooked issue in planning premises and location is that of locating treatment and consultation areas on the ground floor. For example, locating in a retail development there may be considerable pressure to set up on the first floor. Even with lifts, this may act as a disincentive to potential patients, particularly the elderly and mothers with children. The same principle applies in other types of practice premises. Even if there is additional cost, ground floor locations add greatly to the value of the practice.

Taking on a new GMS list/contract will to some extent limit choice on location in that the participating doctor is required to locate the practice within a specific geographical radius. If one is taking over an existing GMS patient list but providing services from a new location there is a requirement to comply with these distance restrictions. For example, there is a significant difference between moving three miles to a new practice location in an urban area that has poor public transport connections compared to a similar move in a rural area where access is much less affected.

The visual impact of any practice premises is important. A new practice must have visibility within its immediate environment in order to attract new patients. As with any other business premises the opportunity for optimum signage '*exposure*' is desirable. Parking and access are other very important considerations which can strongly influence choice and decisions on location. Allowances for disabled parking must also be considered. It is also important to take lighting into account, both internal (natural light in work and examination areas) and external (for visibility and safety).

Health and safety legal requirements are considerations in setting up and operating in practice; therefore health and safety factors such as fire regulations must be factored into any decisions regarding new or renovated premises. In the first instances it is advisable to seek professional advices, e.g. from an architect, as well as looking up relevant sources such as websites of local planning authorities

8.2.1.4 Lease Agreements

If one is renting premises, then the duration of the lease and other terms and conditions will have to be negotiated in order to best meet practice needs, both current and future. Some features of leases that one should be aware of and on which one may wish to negotiate are: -

1. Consider an internal repair only form of lease, not an '*FRI*' type of lease, i.e. a full repairing and insuring category of lease. '*FRI*' leases are more common in long term leases, while internal repair leases are more common for short term leases.
2. Negotiate an extended rent free period. Three months is standard.
3. Negotiate a break clause. Having this is an extremely important factor and should be regarded as key. If the

practice is thriving, one may want larger premises or to consider purchasing a building. If the practice location transpires to be poor one may wish to relocate. Having a break clause in a lease will provide the option to move for reasons which are either positive or negative.

4. A formal rental/lease agreement should be requested and one should consider what leasing/rental period or duration will meet future plans. Is a short term or long term lease better for your requirements? For example, if one is awaiting a GMS panel/contract, such a panel may arise outside of the current practice area. Therefore, being committed to a long term lease may limit choice and opportunities. Many leases have a '*buy out*' clause. It is important to be aware that a lease of over 5 years' duration provides tenants with rights and protections.
5. In the past, long term leases, e.g. 25 or 30 years, were often '*for sale leases*'. '*Key money*' was often sought with considerable sums being requested for the privilege of a long term lease. With so many vacant properties currently available, paying '*key money*' for, or even entering into a long term lease in the first place, may not be advisable, unless in exceptional circumstances. In the current climate, GPs should be in a good position to negotiate good value rents and avoid the necessity to pay '*key money*'. In the event that a landlord is insistent on a long term lease, it is advisable to seek the advice of a solicitor who may be able to suggest mechanisms to reduce personal exposure to risk due to the long term nature of a lease. An example would include using the vehicle of a limited company to act as the tenant.

8.2.1.5 Planning Permission and Other Regulations

When considering the purchase or lease of premises or a site, it is vital to assess the planning status of the property in advance. If applicable, one may need to consider a planning application and seek information from the local council/ corporation planning officer on any relevant restrictions related to premises. For example, if taking over a retail premises one will require permission for a '*change of use*', and extending premises may require planning permission. It is also advisable to enlist the professional advice of an architect/engineer with regard to planning status. Employing professional advisors may be expensive, but there is no point in initially saving money with the end result of having to make more costly changes.

One also needs to factor in the time required to achieve permission. This is likely to take a number of months. One should also bear in mind that BER guidelines, fire, and health and safety requirements can be onerous when developing premises. It is also vital to be aware of the risk that a planning application may not be granted permission, even after acquisition of a property.

In the context of local and regional developments in Primary Care and Primary Care infrastructure, it is also worthwhile contacting the HSE. Information on government and public sector procurement across Ireland is available on the government etenders website.

8.2.2 The Practice Name

From a '*branding*'/marketing point of view, the business name of the practice is crucially important. This needs to be decided at an early stage to allow the ordering of stationery, placement of notices, registration in the telephone and other trade/ professional directories, and advertisetment on websites and in other media.

As a '*brand*', the practice name will seek to become established and the name chosen should allow for future changes in the context of taking on possible Partners or a change in location. For example, one may not want the practice/business to be named after a particular doctor or to have a name associated with a very specific address.

If opening a practice and using a 'business' name which differs in any way from one's surname, there is a requirement to register the business name with Companies Registration Office. The registration certificate is required to enable one to open a business bank account in the '*new*' name and the process of obtaining the certificate can take a number of weeks. The certificate must be displayed at the business address.

8.3 Financial Matters

8.3.1 Selecting an Accountant/Financial Advisor

When choosing an accountant, one should be aware of both the normal professional services provided by accountants, as well as the additional wider professional advice they can and do provide. The range of services available from accountants is broad, and in addition to basic tax and financial management many accountants/accountancy firms also provide business consultancy, prepare business plans, give investment advice, etc.

Ideally a GP should engage a multi-faceted firm of professional advisors who will have the skills to advice on all financial matters including set up and monitoring of financial control systems, preparation of business plans, consideration of incorporation of aspects of the business, accounts and tax returns, provision of tax consultancy and financial planning advice, etc.

One key factor when selecting an accountant is to ensure that the accountant chosen has very good knowledge of the day-to-day workings of a professional medical practice, and has a practical understanding of the characteristics unique to general practice. An accountant (or accountancy firm) with a track record of working successfully for GP clients is recommended.

It is also generally recommended to discuss specific requirements with a number of potential providers and to compare the services provided, the professional fees structure, as well as any '*added value*' services. When doing this, it is prudent to consider future as well as current requirements.

Fees are determined by the time taken, the seniority of the person doing the work, and whether general or specialist work is undertaken. Examples of factors that may impact on fees include if the service provided is general accounting or specialist tax advice, the complexity of the practice/business, and the standard of financial records maintained by the practice. Although fees are important they should not be the only determining factor in choosing an accountant. However, it is important that the GP is advised of the cost of the services in advance of engaging the professional advisors and at the outset an advisor should be able to explain the rationale for

professional fees relative to the services offered/provided. It is worth noting that professional accounting fees are allowable for tax purposes.

In selecting an accountant/firm of advisors the GP should: -

1. **Get advice**: Speak with colleagues and get information about the professional advisors that they use. Ask whether they would recommend that practice. A detailed list of suggested criteria for choosing an accountant can also be found on in the Management in Practice section of the ICGP website.
2. **Ensure membership of a regulatory body**: Although it is not a prerequisite that the firm of advisors be a member of a regulatory body it is preferable. As with all professions where there is regulation one can expect a high level of professionalism and thoroughness. The relevant recognised accountancy bodies are the Institute of Chartered Accountants in Ireland (ACA or FCA), the Association of Chartered Certified Accountants (ACCA or FCCA) and the Institute of Certified Public Accountants in Ireland (CPA or FCPA).
3. **Shortlist**: Generate a short list of professional advisors and request a meeting with each firm to discuss the requirements. A GP should where possible arrange to meet the various advisors within each firm that specialise in different aspects of advice such as accounting, tax and financial planning.

As with other relationships, it is ultimately a matter of personal choice and a question of compatibility. One should be able to easily communicate with one's business advisor and have a comfortable relationship as it is likely to be a long lasting one.

8.3.2 The Role of the Accountant/Financial Advisor

Once a firm of professional advisors has been identified, it is necessary to agree the terms of the engagement. It is normal practice for a firm of professional advisors to issue an engagement letter detailing their understanding of the services required, the cost of the services and the manner in which the agreement can be terminated etc. The GP will be required to sign the letter of engagement as acceptance of the terms.

In order to understand what services will be required from one's accountant/business advisors, a comprehensive list of functions should be prepared detailing all the practice financial and financial management work that needs to be performed on a daily, weekly, monthly and annual basis. This list should then be separated into the services to be provided by professional advisors (i.e. paid work) and those tasks that can be performed by the GP and / or practice staff. There is no value in paying an accountant or tax advisor to do work that can be carried out relatively easily by a member of the practice staff. Clearly, what can be done by members of the practice staff will depend on their knowledge, skills and experience, and it may be cost saving to get members of staff trained to be able to undertake some of the tasks.

A comprehensive list should cover the following: -

1. Maintenance of daily accounting records
2. Preparation of regular reconciliations
3. Preparation of PAYE/PRSI returns
4. Preparation of budgets and cash flow forecasts
5. Preparation of annual (or other periodic) financial statements
6. Preparation of annual tax return

Outside of ad hoc consultancy assignments the accountant should provide the following services on an annual basis: -

1. Financial statements for the practice detailing the income and expenditure, the resultant net profit, and a balance sheet detailing assets owned, monies in hand, monies receivable and monies payable
2. Computation of the GP's tax liability for the year
3. Preparation of the GP's annual return of income
4. Summary review of the financial performance of the practice comparing actual and budgeted financial performance and the practice business plan
5. The accountant should also prepare a note on any recommendations regarding the maintenance of the accounting records that would assist in the preparation of future financial statements

8.3.3 Banking

A practice bank account should be set up in the form of a business bank account, including credit and debit card services. This should be separate from any personal account(s). It is crucial that the GP should operate distinct business and personal bank accounts.

All monies generated in the practice should be lodged to the business bank account and all practice related expenses should be paid from the business bank account. A monthly standing order should be set up to transfer funds, referred to as drawings, from the business bank account to a personal bank account.

All personal expenditure should be paid from the GP's personal account. Where pension payments are being funded monthly then these can be withdrawn from the practice bank account. By keeping total separation of business and personal banking, the practice account can becomes the basis for the practice accounting system allowing for accurate tracking and monitoring of all transactions in and out of the business.

Online banking facilities allow much greater efficiency in the regular (weekly, monthly) management of practice finances and transactions to be made from the practice. It must however be remembered that the bank balance on the screen may not be the real bank balance as it may not take account of cheques or lodgements not yet cleared. It is more accurate to review the bank reconciliation prepared by the bookkeeper.

There are significant advantages to setting up debit and credit card facilities and the minor inconvenience of set-up is more than offset by the cost savings, particularly the significant reduction in bad debt levels. The reasons that having a debit/credit card facility are advantageous are: -

1. It is convenient for private patients who don't have to draw cash to pay for GP services, particularly in the context of the diminishing use and imminent demise of cheques.

2. Debit/credit card facilities reduce practice bad debts. Not having these facilities therefore results in higher levels of bad debt than is necessary.

Before a debit/credit card machine is installed, it is important to ensure that all associated bank charges are highlighted and that the telephone facilities in the premises can dedicate a line to the machine.

General practice is a '*cash business*', and consideration therefore needs to be given to regular cash lodgements and safety and convenience in this regard. The proper and accurate recording of lodgements and related transactions should become a norm. Given the significant level of cash transacted within a general practice it is necessary to safeguard against loss and/or theft. Making regular lodgements will act as a safeguard. The installation of a fireproof safe will allow for the safekeeping of monies received after banking hours. Care should be taken with regard to personal safety of the GP and practice staff when making lodgements.

8.3.4 Financing

When opening a new practice, a business loan, mortgage and/or an overdraft facility may be required. An example would be an overdraft facility to cover short term cash flow deficits in the initial period after opening. It may also be appropriate to consider other sources of finance such as a loan from a friend, relative or business colleague with available finance who may wish to invest in a new business.

As discussed in the early part of this chapter, writing a business plan is of vital importance. It gives structure and objectivity to the planning and development of the practice. In general, having a written business plan will also greatly assist in negotiating optimal terms with a finance provider. Feedback from GPs who have set-up practices suggests that having a well prepared business plan with one to five years financial projections puts one in a much stronger negotiating position compared to someone with either no plan or a poorly prepared plan. Professional advice from an appropriate advisor in business planning is recommended and will also be advantageous in negotiating with financial institutions.

Despite the current unclear economic climate and uncertainty within general practice and the Irish healthcare system generally, doctors and general practices continue to be viewed as attractive customers from the perspective of finance providers. It is no longer a '*buyers*' market and one must conduct thorough research of the increasingly competitive financial services market. All potential providers should be considered including those allied to professional medical organisations. Factors that are of value may include convenience and the benefits of being able to build up a good business relationship with the company's representative over the life time of the practice.

8.3.4.1 Raising Finance

There will undoubtedly be a stage in the development of a practice where a GP will need to approach a financial institution for some form of finance, be it short or long term. The GP should discuss the finance requirement with the practice's professional advisor who will be able to advise on what type of finance best suits the GP's needs. The objective of all financial institutions is to '*sell*' financial products, but the establishing GP needs to be sure that whatever form borrowings take suit his/her requirements. Banks will typically require the following information before providing funds: -

1. Up to date financial statements for the practice
2. A detailed business plan
3. Financial projections for a period of up to three years, including projected income and expenditure statements and a cash flow statement
4. A statement of the GP's net worth

While the main source of finance will typically be a bank, it is appropriate before making any final decisions to evaluate what other providers can offer, including building societies, credit unions, relatives and business acquaintances. As with the practice accountant, building a relationship with a bank, building society or credit union manager is important. If a relationship already exists with a bank then it is good practice to allow the bank quote for finance, however bear in mind that the bank still needs to be offering competitive products. Together with the accountant, the GP should compare and assess the offers received.

8.3.4.2 Types of Finance

8.3.4.2.1 Overdraft

An overdraft is a flexible source of short-term working capital finance. It is used where there are shortages in cash flow. These typically arise when there are significant non regular cash outflows. Interest is only charged on the overdraft amount daily, and therefore, if an overdraft is operated effectively, depending on circumstances, it can be one of the cheapest forms of borrowing. However, if an overdraft is used to build up debt, then this becomes an expensive form of finance both in terms of interest and charges. When an overdraft is exceeded, a bank will charge a '*referral*' fee for every amount presented on a bank account.

To enable a practice to determine when cash shortages are likely to occur and arrange for the provision of an overdraft facility for these occasions, cash flow forecasts will have to be prepared on a monthly basis. These are usually prepared with the assistance of the practice accountant. A cash flow forecast details the projected income and outgoings for the practice, highlighting the periods where the outgoings are increased. When the practice is making use of the overdraft facility it will be necessary to monitor the bank account on a weekly basis using bank reconciliations. This will allow the GP to monitor the expenditure within the practice so that there is less likelihood of the overdraft being exceeded.

8.3.4.2.2 Short Term Loan

A short term loan is a loan for a short period, usually between one and seven years. A short term facility should be used to finance asset purchases which will benefit the practice over a similar period as the loan. For example, short term finance might be used to purchase the capital equipment needed to set up a new practice, e.g. furnishings, computers, medical equipment etc.

Interest is charged at a fixed or variable rate on a short term loan. A fixed rate of interest gives the security of knowing how much the finance will cost during the life time of the loan as

well as knowing the exact amount of repayments. However, fixed rate loans can be inflexible if a GP has the means to repay the loan earlier than its term. There is usually a penalty for settling a fixed interest loan early.

A variable interest rate loan is more flexible but does not provide the GP with the security of knowing how much the loan will cost from the outset. If interest rates rise the cost of the loan rises accordingly. However, if the rates decrease the Practitioner gets the benefit in a reduced cost of the loan.

Loan repayments should be factored into the cash outgoings of the practice, and form part of the cash flow forecast that is used to identify cash shortages to be funded by an overdraft facility.

8.3.4.2.3 Leasing

Leasing is similar to short term loan finance. It is designed to fund purchases, typically over a three to five year term. It is usually capital equipment or vehicle purchases that are financed by leasing as the asset is usually held as security for the lease. In many instances the ownership of the asset does not transfer until such time as all the lease payments are made. It is normal with lease finance that the capital injection required by the Practitioner is minimal with the advantage that the asset is 100% financed.

8.3.4.2.4 Long Term Loan

Long term loans are used to finance the purchase of assets that will benefit the practice over a period of longer than ten years. Repayment is usually over a period of between ten and 20 years, but this is somewhat determined by the age of the Practitioner. Interest rates can be fixed or variable with the same issues attaching to long term borrowings as to short term borrowings.

When borrowing over a longer period the financial institutions will only finance approximately 85% of the asset value. As the asset purchase being financed is of a higher value the Practitioner must provide alternative funds to meet the 15% shortfall.

When borrowing over a longer term there is also the option to postpone the capital repayments for a period of the loan. This interest-only period can be negotiated with the financial institution. This could assist the establishing GP with cash flow at the commencement of the practice.

8.3.4.2.5 Loans from Other Sources

In the event that a loan can be negotiated with a friend, relative or business acquaintance, the nature of repayments will be individually negotiated and set up on a one-off basis. It may be possible to achieve lower rates of interest with loans obtained in this way. Repayments can be set up on an individual basis and obviously interest may be lower and therefore cost-saving. Clearly, before entering any such arrangement, this should be discussed in detail with the practice's professional financial advisor.

8.3.4.2.6 Restructuring Loans

Quite often it pays to consolidate a number of smaller loans into one larger loan. There is usually a cost saving in doing this. The cost saving can be achieved by negotiating a more competitive interest rate or extending the term of the new loan.

8.3.5 Taxation

Taxation is such a substantive topic that it is considered in detail in chapter 13, 'Taxation'.

8.4 Practice Structure

8.4.1 General Considerations

At the initial stages in starting up in practice one may have a number of aspirations with regard to practice structures, some or all of which may be contradictory. This might include a desire to have small numbers of staff that one knows and trusts, as opposed to having a large practice which is likely to provide flexibility in terms of back-up and holidays. In addition, as the practice and business grows and develops, needs may change.

In retrospect, most GPs (and others) who set up a new business appreciate the importance of having a full-time or almost full-time receptionist from day one. Having a receptionist gives a professional impression and more importantly, allows you as a GP to focus on the patient rather than having to answer the phone during a consultation. Using an answering machine will result in the loss of new clients and corresponding income, and therefore, regardless of the perceived affordability, having a receptionist should be regarded as a necessary expense. When shortlisting candidates for a receptionist position, anecdotal evidence suggests that previous medical experience is unnecessary in a new start-up practice, and if anything, starting out with an untrained receptionist in the context of having the time to train them in the way your want your practice run, can be hugely advantageous.

If one works with other GPs, a mutually agreeable business relationship will need to be arrived at, whether this is in a Partnership or Associateship arrangement, or with independent practices sharing premises. During the planning, establishment and development phases of a practice decisions need to be made on practice systems, organisational structure, access, size, and staffing. Some of these are outlined below and others are discussed in Chapter 10, 'Practice Management'.

8.4.2 Personal Drawings/Remuneration

In common with other '*entrepreneurs*', GPs establishing in practice may not be realistic with regard to drawing down personal remuneration from the business. Similarly, many do not plan for adequate time off. Established GPs often reiterate this point with regard to pay and holidays.

While a new practice may not have the finances to be able to pay for Locum GP cover, networking and maintaining good relationships with local colleagues may give opportunities for cover for half-days/days off in lieu of returning the favour, thus facilitating time off without needing to fund the cost of a Locum GP. It may be easier to come to these arrangements with other GPs who have recently set up in practice.

8.4.3 Financial Records and Procedures

Right from the outset, and even during the planning phase before a practice opens, financial systems and procedures will have to be determined. This involves keeping detailed daily/weekly/monthly financial records, including a day-book/summary transaction sheet, whilst at the same time working to a set budget. Good financial management is crucial to the

administration of the practice and good financial records will form part of preparing financial statements, understanding the underlying financial strengths and weaknesses of the practice, thus maximising profitability and minimising the risk of loss.

8.4.4 The Working Day, Appointment System and Patient Access

The issue of patient access to the practice is a long standing challenge and when considering this issue, various factors need to be considered including opening hours, days of business, appointment system, length of consultations, and on call and holiday arrangements. Ideally one will want to encourage patients to attend at planned times that suit both parties. However, during the start up phase of the business, accessibility will certainly be a very important factor in encouraging new patients to re-attend. One's preferred consultation length and that of other clinicians will also influence any appointment system.

In relation to holiday arrangements, it is likely that one's view may change considerably when as a Principal one must find the money to meet Locum GP fees.

When setting-up it is prudent to space patient appointments in order to allow for walk-in patients and provide for good quality first-time consultations. It is important that all staff and patients are clear as to the system in operation and that clinical staff apply the system consistently so that staff are supported in their operation of the appointment system. This latter point is important as reception staff must be trained and assisted to operate the appointment system effectively and be able to deal with inherent pressures that can arise.

8.4.5 Telephone Systems and the Internet

Installation of a telephone system and connection to the internet should be considered a priority. While in the past many GPs have found that this can take a lot more time than expected, therefore becoming a rate-limiting step, in the last few years, this has become less of an issue, with connections being set-up more quickly. One must first establish if an existing telephone line is present and whether this is already connected to or has the capacity to be connected to the internet, ideally via broadband. If a line needs to be installed, one's service provider of choice will request Eircom to install a line. If a line already exists, it may simply require to be reactivated. Even though the telephone network is managed by Eircom, all service providers can manage all aspects of telephone line set-up and internet connection. It is also possible to get a line installed or reactivated by Eircom without yet having a service provider.

When setting up the line, one should ask about types of lines e.g. analogue or ISDN, as this will determine fax/broadband capability, the number of calls that can be taken/made, what messaging service can be operated etc. These factors are extremely important as one may underestimate the number of lines required when setting up. Call answering and call forwarding facilities should also be investigated. In addition one should consider broadband a '*must have*' (despite coverage issues nationally) and ensure an integrated system. One also needs to plan for the space required and best location for the operating system.

Since the telephone line is initially obtained from Eircom, Eircom is also a reasonable starting point to research quotations and cross compare rates and services from a range of providers. There are quite a few providers in the Irish market and it is important to understand exactly what service each provides. It may prove useful to contact practices of similar size to investigate matters from a user's perspective and form a view on suitability, effectiveness, potential problems and costs. Even though the Golden Pages may be a useful place to start identifying providers, it is more likely that a web search will yield a more comprehensive result. Providers should be requested to email information in a standardised format to allow one to cross compare services and costs. One can then request a follow up from a sales person in the company.

In relation to the practice telephone number, one can request an easily remembered phone number from the telephone company. This is useful for patients and staff alike. One can also ensure that the practice is listed with directory enquires and other directories under both one's own name and also the practice name (if different).

In addition to a landline and internet connection, many practices now also operate an "emergency" mobile number for use at lunchtimes and before out-of-hours cover starts. This is usually a pay-as-you-go mobile phone kept dedicated for this purpose.

8.4.6 Practice Computerisation

It is a given that the modern practice will be computerised as it simply isn't sustainable to operate otherwise. The choice of hardware and software for the practice will be a product of one's own personal experience and preferences, current budget and what can be offered by the various suppliers.

Software should comply with the accreditation criteria applied by the National GPIT Group (HSE/ICGP) and a list of the currently GPIT accredited software is given in Appendix 2. These criteria are available on the 'Software Companies' page of the Information Technology section of the ICGP website. Also within the IT section of the ICGP website are access to a number of guidelines, advisory documents and FAQs on computer use, broadband, data transfer, data back up and security issues (e.g. the brochure 'No Data No Business'), software and hardware issues, computerised prescribing systems, practice websites and social media usages.

The initial outlay can be high when software, hardware and maintenance costs are considered. One should budget for somewhere in the region of approximately €10,000 for a two work station practice. Decisions on the choice of package will be influenced by such factors as user experience of packages, ease of use to new users, back-up and quality of support, training and costs. Many companies will offer an 'online' support system and can carry out updates and depending on the complexity of the problem often address technical problems remotely via broadband.

Providers can organise demonstrations of their products and it is important to ask the provider to demonstrate how the software deals with the typical daily routines and requirements of one's practice during the demonstration, rather than only covering the positive 'selling' points of the system. It is also very important to ask about the flexibility of the system

and ease of transfer of current/future patient database to a new system. It is also recommended to contact other users/ user groups before making a final decision. The ICGP GPIT tutors/tutor network can be of assistance in this matter. One advantage of modern GP software packages is that all electronic links will work through Healthlink, the National Messaging Broker. All accredited GPIT systems are compatible with Healthlink, thereby negating the need to confirm this with the software companies.

Under the Data Protection Act, registration with the Data Protection Commissioner is a legal requirement. Full details on how to register and the fees payable are available on the website of the Data Protection Commissioner useful information is also available on the ICGP website. Registration fees relate to business/practice size and the current minimum registration fee (as of 2014) is €35.

8.4.7 Stationery

While ordering practice stationary shouldn't present too much of a challenge, before ordering stationery, it is worth spending time deciding on the name of and any branding/logo for the business/practice.

By ordering prescription pads, headed letter paper and certificates together, efficiency can be increased. An alternative option, available with some of the accredited software packages, is to embed the practice '*header*' into the settings, thereby allowing the practice header to be printed directly onto blank letters, prescrptions, certificates etc.

If one wishes to order stationary, prices and services from different printing companies should be compared and a full assessment of what is on offer made. Factors such as the facility to reprint at short notice should be considered. In general larger orders are less costly but in this case it is important to ensure that the text does not require frequent changes.

8.4.8 Out-of-Hours Cover

There is no legal obligation to provide out of hours cover for private patients. It is essential however, to consider one's policy with respect to out of hours care. There are specific contractual obligations with regard to out-of-hours services provided to GMS patients. These are outlined in chapter 11, 'State Contracts Held by General Practitioners Including the General Medical Services Contract'.

Historically, one of the most common sources of complaint by patients to the Medical Council relates to the patients perception of not being able to contact their GP out of hours. It is therefore extremely important to convey the correct information to patients regarding out of hours arrangements and to do so consistently. Posters in the waiting room, telephone answer messages and information on practice leaflets and/or the practice website will reinforce and ensure all patients should be aware of the on-call arrangements. It is important to regularly check the telephone answering message to ensure it is clear and easy to understand. A daily check will ensure that phones are switched over correctly.

Nowadays, many GPs in urban and semi-urban areas belong to GP co-ops. There are also a proportion who remain in on-call rotas. Not only do co-ops and GP rotas allow for a better work/life balance whilst fulfilling clinical obligations, but they may also provide an opportunity for additional income when starting off in practice. Establishing GPs should become familiar with the options for on-call cover, bearing in mind that under the new open access GMS contract, the arrangements for provision of out-of-hours emergency cover must be indicated as part of the application.

8.5 Marketing and Advertising the Practice

Marketing and advertising are a key consideration of any business. Given the size of this topic, it is considered in detail in Chapter 9, 'Advertising and Marketing in General Practice'.

Conclusion

At the best of times opening a new practice can be a daunting and challenging experience. However, it is also a very worthwhile and potentially rewarding and satisfying enterprise. Having a clearly thought out and structured plan in advance of commencing business is crucially important and it is hoped that this chapter will provide a road map that is of assistance in addressing the key issues and formulating that plan.

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9: Advertising and Marketing in General Practice

By Dr Nicola Black

Introduction

Since the publication of the first edition of Signposts to Success, there has been a complete sea change in the regulations pertaining to how doctors may advertise. Prior to 2009, advertising in Irish medicine was extremely restrictive. However, as part of the 2007 Medical Council review of the 'Guide to Ethical Conduct and Behaviour', a Competition Authority submission highlighted that advertising restrictions went beyond what was required to protect the public from misleading advertising. The Competition Authority further pointed out that restrictions had a number of negative effects including discouraging price competition and limiting consumer knowledge about GP services in their area. They also recommended that restrictions on the content, location and size of practice signs and advertisements be removed, along with the restrictions on distributing price information.

The Medical Council subsequently removed these restrictions and following the publication in 2009 of the 7th edition of the Medical Council 'Guide To Professional Conduct And Ethics For Registered Medical Practitioners', doctors may now undertake marketing and advertising subject to certain limitations as laid out in paragraph 54 of section E, '*provision of information to the public*'. Here, the Medical Council guide states: -

1. The provision of information about the availability of medical services through the media, internet or other means is generally in the public interest - provided that the information is **factually accurate, evidence based and not misleading.**
2. You may advertise your practice by publicising the **name and address** of the practice, the practice **hours** and **contact details**. You may include your **area of speciality** if it is one that is recognised by the Medical Council and you are entered for that speciality in the Specialist Division of the Register.
3. The **fees** you charge should be appropriate to the service provided. Patients should be informed of the likely costs before the consultation and treatment.
4. If you consider publicising information further than that specified in paragraph 54.2 in relation to services you provide, either directly or indirectly, you must make sure that the information published in the advertisement is **true**, verifiable, does not make false claims or have the potential to raise unrealistic expectations. This should include information about any inherent risks associated with the services provided.
5. You should avoid using photographic or other illustrations of the human body to promote cosmetic or plastic surgery procedures, as they may raise unrealistic expectations amongst potential patients.
6. To ensure that members of the public can identify doctors registered in Ireland, you must include your **Medical Council registration number** in any information you publish about your practice.
7. If you have a **website**, you must make it clear on the website that doctors may only practice in countries in which they are registered.
8. If you have a website that invites users to enter **personal information**, a privacy statement and adequate security measures should be in place to safeguard the information's confidentiality.

What this means in practice is that Irish GPs may now advertise their services. In fact, the Medical Council explicitly welcomes this as being in the public interest. This new reality can be seen by the fact that many practices now have websites, some have a presence on social media platforms such as Facebook and Twitter, many have erected signs outside their premises, and some have carried out traditional advertising in the form of direct flyer drops and newspaper advertisements. Marketing and advertising has become an integral part of general practice and in the context of the business of general practice, should not and cannot afford to be ignored.

This Chapter outlines some basic principles of advertising and marketing and provides a structure by which GPs might put a marketing strategy into operation for their businesses.

9.1 What is Marketing?

The Chartered Institute of Marketing in the United Kingdom defines marketing as '*the management process responsible for identifying, anticipating and satisfying customer requirements profitably*'. In other words, marketing in general practice is about letting *your* patients know what services *your practice* provides, influencing patients to choose *your practice* over your competitors, and facilitating easy access to *your* service. It is about meeting patients' needs and expectations, ensuring patient satisfaction, while at the same time maintaining profitability. At its simplest, the objective is to make a profit while keeping the patient happy.

Until recently, GPs were given no training in the '*business*' of general practice and due to the advertising restrictions of the Medical Council, there was no role for or requirement to know about marketing. However, this has all changed and it is now well recognised that general practice is a business. Illustrating this fact is that almost all GP training schemes in Ireland provide some training, however rudimentary, in business. Traditionally GPs relied on their reputation to '*sell*' their business. Whilst there is a cohort of older GPs who feel that the new paradigm is distasteful and that advertising and marketing are dirty words, preferring time-honoured '*covert*' methods such as being seen at GAA matches, Sunday mass and other community events, the world of marketing and advertising in general practice is now a reality and cannot therefore be ignored.

It is also important to understand that marketing is not just advertising. Marketing is a key management discipline that enables the producers of goods and services to interpret what the customer wants, needs and desires, and to match, or exceed these wants, needs and desires in delivery to their target consumers. Remember that even if you're an excellent doctor, patients aren't going to beat a path to your door if they don't know that your practice exists.

9.2 The Seven Ps of Marketing: the 'Marketing Matrix'

Successful marketing depends upon addressing a number of key issues, known as the '*marketing mix*'. These are: -

Product

Price

Place

Promotion

People

Process

Physical evidence

9.2.1 Product

A successful business will find out what customers need or want and develop their service to meet these needs and wants. There are a number of key questions which any practice should ask of the services it provides: -

1. Are patients aware that you provide these services?
2. How do you promote them?
3. Are patients aware of the costs?
4. Is the environment in which the service is provided adequate/of a high enough standard?

It is not only a good idea, but an important idea to take an objective look at one's own practice. The key question one is trying to answer is '*if as a patient one walked into the practice, would one know what services were provided and at what cost?*'

9.2.2 Price

While as a GP you might offer the most fantastic services, the value or worth of those services is only what a patient is prepared to pay for them. It is important to remember that patients are rarely influenced by price alone when choosing a particular practice. As with most services provided in society, patients want '*value for money*'. Some of the factors which impact on the patient view of value for money are: -

1. Being seen on time
2. Being given enough time
3. Perceiving that they have been listened to and dealt with appropriately

It is crucial to remember that patients don't want surprises when it comes to paying. In line with Medical Council guidelines, it is important that patients are forewarned about fees. Effectively this means a price list should be on display in a practice, ideally in a high visibility location. In 2010 the National Consumer Agency (NCA) carried out a survey of GP practices and found that only 50% had fees displayed. They made a recommendation to the Irish Medical Organisation (IMO) in this regard and in November 2011 the IMO advised its GP members to display their prices for routine medical treatments. It goes without saying that a price list should be clear-cut and easily legible. The minimum information considered acceptable on a practice price list is: -

GP consultation during normal hours	€ fee
GP consultation out-of-hours	€ fee
GP home visit during normal hours	€ fee
GP home visit out-of-hours	€ fee
Nurse consultation	€ fee

A practice should also display charges for other services including specialist consultations, procedures, driving licence medicals, review consultations, certificates, forms, reports etc. In addition, the NCA advises that if in the course of a treatment the estimate of cost has to be revised, this should be done at the first opportunity and explained to the patient.

9.2.3 Place

The location of a practice is of prime importance to patients and where possible should be appropriate and convenient to: -

1. Public transport
2. Parking
3. Proximity to a pharmacy, schools and shops

Particularly when setting up a new practice, the proximity to a pharmacy or school cannot be underestimated. Footfall is crucial as ultimately footfall equates to patients which equate to business. When deciding on practice location, it is possible to carry out or employ someone to carry out a footfall survey. Another aspect of the movement of people which should

be considered is parking. This can be in terms of how many and for how long people stay parked. Again, it is possible to undertake a parking survey. Parking factors may be important in persuading a local authority as to the adequacy of parking for a new off-street practice premises. Other considerations in relation to the physical aspects of the practice are: -

1. The availability of a lift if a practice is upstairs
2. The provision of baby changing facilities
3. The practice waiting room itself

9.2.4 Promotion

Promotion is the way the practice communicates what it does and what it can offer to its patients. It is very important to keep this information up to date. Promotion should be eye catching, appealing, easily understood and should give the patient a reason to choose your practice over that of your competitors. Examples of promotional methods include: -

1. Branding, e.g. a business name, a business logo, business cards, children's stickers
2. Advertising, e.g. local papers, local school journals, leaflet drops
3. Signage
4. The practice waiting room
5. Practice information leaflets
6. A practice website
7. Practice text and emails (for which consent is required)
8. On social media, e.g. Facebook, Twitter, LinkedIn, Pinterest etc.

9.2.4.1 Branding

Branding is an important aspect of professionalism. It can be as simple as the headed paper which is used for practice letters or can extend as a professionally designed practice logo. Branding doesn't have to be expensive but is certainly worth investing time if not money into developing a brand. Once a practice has a brand, it is also important to push the brand. This can be in the form of dropping business cards to Emergency Department liaison nurses, local pharmacies, and ancillary clinical services such as counsellors, psychologists, physiotherapists etc. The practice brand must also be used consistently across all platforms, from all correspondence and communication from the practice, through to any advertising, signage, in the practice waiting room and on any website or social media platforms. Remember too that branding goes beyond design; both the GP and the practice support staff are part of the brand.

9.2.4.2 Advertising

There are a number of different media in which one can advertise including the journals and magazines of local sports clubs, schools and groups, local newspapers and magazines, and local radio. Listing the practice telephone number in the Golden Pages and any other relevant telephone directories is potentially very beneficial. Other avenues which are open but are likely to be prohibitively expensive are billboards, at the local cinema, sports ground hoardings etc. It is unlikely that a practice would use national press or television. More local methods of advertising include a straightforward leaflet drop in a local area using good quality and visually appealing materials

When it comes to local newspapers, there are some useful tips and tricks. Firstly, consider which newspapers are more likely to be read by the target patient population. It is a good idea to take adverts in different papers and then assess which people have read. Subsequent adverts can be taken out only in the most popular paper or in the paper which generated the best return. The timing of advertising is also important and it may be pertinent to get some advice about when is the best time to run an advertisement.

9.2.4.3 Signage

In terms of outside advertising e.g. plaques and signs, there are no longer Medical Council restrictions. However, it is important to check with the relevant local authority to ensure that any sign is compliant with regulations and planning law. If erecting a sign, it should be clear and of an adequate size; if people can't find you easily they may not turn up! One should also consider if signage is visible in the dark and if not, consider investing in some simple lighting. An inexpensive means of advertising a surgery to passers-by is to display the business name and logo on window decals in some or all of the surgery windows.

9.2.4.4 The Practice Waiting Room

The practice waiting room is an interesting space which is vastly underutilised by most practices as a marketing tool. It is a space which is rarely used to even a fraction of its potential. A waiting room which is a pleasant environment is likely to give patients a welcoming sense of the practice, and the space can be used to advertise and promote services offered by the practices. Some simple examples of effective utilisation of a waiting room to both promote the practice and enhance the patient experience are: -

1. Simple changes can be very effective, e.g. reducing clutter and putting up a notice board.
2. Less can often mean more!
3. Brighten up the waiting room environment by giving it a fresh coat of paint and putting up some pictures.
4. Ensure there is promotional information about the services offered by the practice.
5. Provide a mechanism in the waiting room for patients to give feedback.
6. Use music in the waiting room to maintain a calm and if possible relaxing environment. Following a European Court of Justice (ECJ) ruling which has been upheld in the Irish courts, it is not necessary to pay a licence fee to the Irish Music Rights Organisation (IMRO) or Phonographic Performance Ireland (PPI) for use of music in public places.
7. Consider using a television screen in your waiting room to advertise staff, services, and prices. This is simple to do and involves developing a simple slideshow (with images saved as JPEGS) uploaded onto a flash disk and inserted into the back of your waiting room television. The slideshow can then be played on a loop. This negates the need for posters that tend to clutter up waiting room walls, looks very professional and can be updated or changed easily. Do remember however, that a television used in this way requires a television licence.

9.2.4.5 Practice Information Leaflets

A practice leaflet is a good way to inform patients of the entire range of services provided by a practice as well as basic information such as the opening hours, on call arrangements, practice staff and any new services offered. An attractive information leaflet may encourage patients to take it home and keep it for future reference or entice others to pick up a leaflet to find out about the practice.

9.2.4.6 A Practice Website

The online world is now hard to escape and it is certainly true that in Ireland a vast majority of younger people are very active online. Many young people will turn to online search engines such as Google to find services including medical and GP services. Particularly for a new practice, it is important to at least consider the value of having an online presence in the form of a website. Aside from allowing one's practice to be found in an online search, other advantages of having a website are: -

1. It may generate increased business by making the public aware of additional services, e.g. occupational health, travel medicine, areas of special interest etc.
2. It promotes the practice.
3. It projects the practice as a modern, forward looking practice.
4. A website can replace a practice information leaflet and contain much more information on policies, procedures, times, fees, staff as well as host links to forms and other information etc.
5. It can provide much information that would otherwise occupy your receptionist, e.g. taking calls to give directions, thus freeing him/her up for other duties.
6. It can provide useful information to patients on topical matters, e.g. at the time of an influenza outbreak etc.
7. It is possible to have a website with a high degree of functionality that will allow patients to book online appointments, order repeat prescriptions etc.

There are of course some realities about websites which might be considered downsides including: -

1. The costs of setting up, running and maintaining a website
2. The need to update the website and keep it relevant
3. A website may lead to unwanted spam or calls from marketing companies
4. Possible legal considerations including ensuring that information posted is true and accurate, that patient confidentiality is maintained, and that the website doesn't contravene the Medical Council ethical guide

In the event that a practice decides to create a website, what is involved? The process can be broken down into a number of steps.

9.2.4.6.1 A Domain Name

Firstly, you will need a domain name. This is simply a unique address on the internet. For local businesses in Ireland, the most appropriate domain code to use is .ie. All internet addresses/domains using the .ie country code are managed by the IE Domain Registry Limited (IEDR). One can also with the IEDR to see if one's preferred domain name is already registered or in use.

9.2.4.6.2 Registering a Domain Name

The next step is to register your domain name through an accredited registrar. Accredited registrars are companies, organisations or individuals who have proven knowledge and expertise in managing .ie domains on behalf of registrants. There are many companies in Ireland providing this service and a full list is available on the IEDR website.

The cost of registering a domain will vary depending on which provider used, but in May 2014, a simple online search with two of the larger providers gave prices ranging from €29.99 per annum to €204.50 for ten years' registration. On an ongoing basis there will be an annual domain name registration fee, and the IEDR has certain requirements when a .ie domain is first registered. In particular this will include the necessity to provide proof of either company status or registration as a business entity with the Companies Registration Office (CRO).

It is of course an option to register using a code other than .ie, such as .com. However, in the context of local business services and search engine optimisation (SEO), using a .ie domain code is likely to generate more traffic to one's website. It may also be appropriate to consider purchasing the .com domain code so that anyone accidently entering the practice domain name with .com instead of .ie would be re-routed to the practice website. Typically registration of .com domain codes is more straightforward and cheaper than registering a .ie domain name.

9.2.4.6.3 Webhosting

Having registered a domain, one will now need to employ the services of a company to host one's website. Hosting simply refers to the fact that the files, data and information needed to create a website require to be stored on servers. Most webhosting companies also provide other services such as online backup, email accounts, virus and spam filters, visitor stats etc. Many of the companies providing accredited registration for domains also provide webhosting services. Costs will vary from provider to provider depending on one's exact requirements, but it should be possible to source webhosting from a reputable company for somewhere in the order of €40 to €60 per annum.

9.2.4.6.4 Web Design

Owning a domain name and having this hosted somewhere doesn't mean that one has a website. A website has to be created. There are many ways in which this can be done. There are free packages available that allow one to create a DIY website from a selection of templates. Whilst this is clearly free, the functionality of such packages is limited compared to having a web designer create a specific website tailored to one's particular needs. In addition, free packages will not accommodate the incorporation of unique branding in the same way as a paid for package.

When it comes to designing a website, the best thing to do is to get recommendations from GPs who have created websites of their own to get a feel for what process they used, if and which web designer they used, and how they feel about the end product, i.e. their website. The cost of having a website

designed is mostly a one off cost. The more customised and functional a website, the more time it will take to create, and the more the design will cost. Therefore, one's budget is also relevant.

In terms of creating a website, there are a number of factors to consider. These include: -

1. **What makes a good website?** There are a number of characteristic features of a good website. A brand co-ordinated website acts as a virtual employee. Considering you want your best employee greeting web visitors it is worth spending some time planning your site. Advice can be sought from both web designers as well as GPs who have created websites. While it is possible for a website to have lots of added functionality, e.g. appointment bookings, this is not absolutely necessary. Basic principles of what makes a good website include that it should: -
   - **a.** Be relevant to the viewer
   - **b.** Be easy on the eye
   - **c.** Be easy to navigate
   - **d.** Serve the purpose for which it was designed
   - **e.** Be up to date
2. **What should one put on a website?** There are many variations on both style and content of a website, but the following are considered vital pieces of information for any website: -
   - **a.** Home/welcome
   - **b.** Who we are/staff profiles. '*Meet the team*' pages are a valuable addition to any GP website, as human contact is the essence of our business. They add a personal touch to the website and can lend trust to visitors
   - **c.** What we do/services offered to include fees/prices
   - **d.** What makes us different/unique selling point (USP)?
   - **e.** Practice policies e.g. appointments, repeat prescriptions, emails etc.
   - **f.** How can the practice be contacted/location, e.g. via Google Maps, directions from various transport links etc.?
   - **g.** How we can help including useful information/forms/ links
3. **What different types of website are available?** To understand the types of websites and the potential functionality available, get the advice of someone with expertise. At a basic level there are static websites and dynamic websites: -
   - **a. Static websites**: These contain information on a number of pages that do not change and are only updated infrequently. Clearly this requires much less time and cost to maintain than a dynamic website, however, content can date easily, is harder to change, and the website typically ends up with lower ranking on an internet search. There are many template options available online that will allow an end user to create their own free or low cost, low maintenance static website. However, a web designer will be able to create a more professional looking static website.
   - **b. Dynamic websites**: As the name suggests, dynamic websites are generally more professional and dynamic in appearance and can have interactive functionality. They are designed to be kept up to date although this does require time and effort. Search engine optimisation (SEO), the process by which website are ranked in an internet search, also becomes relevant with dynamic websites. This can either be paid for, or as new content is added to a website, search engines such as Google, Bing and Yahoo detect changes and push the website further up the results page. SEO is very relevant when one considers that most people searching for a product or service will tend to click on pages and sites from the first page of internet search results. It may therefore be worthwhile to ensure maximised SEO to increase the likelihood that one's website is ranked on the first page of search results. As opposed to a static website, unless a GP or practice manager has expertise in web design it is likely that most will employ the services of a web designer to create a dynamic website, train staff in how to update and use any interactive functions, and also put in place SEO for the website. To source a good web designer it is advisable to get recommendations from GPs who have created websites of their own. Prices of course will vary and are likely to start from around €1,000 for an entry level dynamic site with SEO.
4. **How does one get a website seen?**: Once created, it is not enough simply to have a website, but one most also try to ensure the website is seen, i.e. receives traffic. Having a professional dynamic website that is never seen is akin to printing a beautiful practice brochure which is never taken out of the box. While the SEO is key to any website getting hits and visitor traffic, there are also various online directories on which one's website can be listed. If these are paid directories, no different than with a physical directory, it is of course essential to be fully aware of the terms and conditions. Such directories include amongst others: -
   - **a.** Online medical directories and listings, e.g. on the *ICGP 'find a GP' page* and *GP Buddy*
   - **b.** Directories that can be searched online, e.g. the *Irish Medical Directory*
   - **c.** Free listings in online portals, e.g. local business directories, Chambers' of Commerce, city and town Councils and business associations

9.2.4.7 Practice Texts and Emails

It is possible to send reminder text messages and emails to patients, provided that patient consent has been obtained to do so. Such consent, and indeed their updated contact details, must be clearly recorded in the patient notes and should be reviewed and renewed regularly. Similarly all texts sent and e-mails (sent and received) must be recorded in the notes. Examples of what can be sent in this cost efficient and time saving manner are reminders of smears, that the practice is giving influenza vaccinations etc. The Medical Protection Society (MPS) has published factsheet guidance

on 'communicating with patients by text message', and 'communicating with patients by fax and e-mail'. It is worth referring to these if you are considering using these methods of communication.

9.2.4.8 Social Media Platforms

Since the first edition of Signposts to Success, there has been a global revolution in terms of Social Media. Social Media has been defined by Kaplan et al as '*a group of Internet-based applications that build on the ideological and technological foundations of Web 2.0, and that allow the creation and exchange of user-generated content*'. Perhaps the best known Social Media site is Facebook, but there are many others including Twitter, Google+, LinkedIn, YouTube, Pinterest and Instagram to name a few.

The rapidity of development of Social Media can be hard to fathom. From set up in 2004, in September 2006 Facebook openly launched to anyone with an email account over the age of 13 years, by late 2007 had 100,000 business pages, and as of the end of January 2014 had 1.23 billion active users. From these figures, it is hard to dispute that huge numbers of Irish people use Facebook and by extrapolation, Social Media generally. It is also a fact that a vast majority of those under the age of 30 are active users of Social Media. For any new business to therefore ignore Social Media is inadvisable.

While many GPs may feel that using Social Media as a marketing tool is unnecessary or undesirable, the modern paradigm of how potential patients, particularly younger patients identify services, including medical services and GPs, is that they most often identify these services through Social Media.

One big advantage of using Social Media when compared to a website is that Social Media is free and relatively easy to use. For anyone thinking of marketing in this way, whilst it may be easy to use, it is also advisable to get some expert input. Just as with a website and traditional media, the importance of strong branding and a professional presence on Social Media cannot be overemphasised. There are already many Irish general practices which have a Social Media presence, and it is probably a good idea to look at some of their pages and get recommendations and advice from the GPs who already promote and market their business in this way.

Existing examples and pages will also give examples of the type of information suitable for Social Media including promotion of events such as asthma week, world AIDS day, the daily pollen index etc. With this kind of information, Social Media can do much more than simply make users aware of one's presence. It can also target relevance to specific groups, especially young people, whilst at the same time making a practice seem modern and savvy.

For a good starting point in relation to Social Media usage, in 2012 the British Medical Association (BMA) published "Using social media: practical and ethical guidance for doctors and medical students" and in 2013, the Royal College of General Practitioners (RCGP) published the "Social Media Highway Code".

9.2.5 People

Any member of your team who comes into contact with patients will make an impression. Whatever impression they make, be it good or bad, can have a profound effect on patient satisfaction and may influence whether they remain with or return to your practice. Staff must therefore be properly selected, properly trained and must have a shared view of the ethos and image the practice wishes to project. The importance of good staff can quite simply not be overstated.

9.2.6 Process

The process of providing care and the behaviour of those delivering it is crucial to patient satisfaction. Consider the processes from the patient point of view rather than from that of the practice. Examples might include: -

1. Difficulty in getting through on the telephone
2. Delays in the waiting room
3. The procedure for reordering a prescription
4. The procedure for making a complaint

It may be well worth while carrying out patient satisfaction surveys from time to time or encouraging patient feedback in the waiting room through the use of a comments box. However, it is also possible to do simpler yet highly effective investigation such as getting someone to ring up and see how long it takes to get through on the phone. These types of simple checks can be very revealing from the patient perspective.

9.2.7 Physical Evidence

As GPs, we spend many hours a week in our practices, often so busy that we barely have time for lunch. It is often the case that as GPs we become habituated to our your surroundings and fail to see little things that our patients are sure to notice, e.g. ripped upholstery on a waiting room chair. What patients see when they walk in creates an impression of our practice, and we want it to be a good one. It is therefore worth taking a step back from time to time, to try and see our practices as our patients do and to address any issues that may have a negative impact on their impression of our practices. In June 2008, Stewart et al in the journal of the American Academy of Family Physicians (AAFP) published an excellent article on this topic titled "How to see your practice through your patients' eyes".

It is also important to take measures that will help both alleviate any patient uncertainty and instil a sense of confidence in one's practice. Examples of how this can be achieved include: -

1. Ensuring premises are clean and tidy
2. Providing evidence that the practice values patient feedback, e.g. a comment/suggestion box in the waiting room or at reception

Summary

General practice is a business and whether GPs like it or not, marketing is a fundamental principle of any business. It is the management process responsible for identifying, anticipating and satisfying customer requirements profitably. Successful marketing depends on addressing the seven Ps of the '*marketing mix*'.

While it remains true that some established GPs see no role for marketing, the reality is that in the service they provide,

from the welcoming helpful staff, to the nature of the waiting room and premises, to the information in the waiting room, to the headed paper used for practice letters, some form of marketing is being undertaken by them all. It is also true that such practices are significantly dependent on patient loyalty which should in reality never be taken for granted.

Some GPs are resistant to the concept of marketing for fear of being accused of '*patient poaching*' and of the reaction of other local GPs. However, good marketing is not about '*patient poaching*', rather it about using various internal and external tools to effectively communicate with patients and potential patients. GPs should be reassured that if patients are satisfied with the service they are already receiving in a practice, they generally won't move to a new practice, regardless of any marketing undertaken by other practices. However, it may the case that patients are not actually happy or satisfied by their existing practice. In this case, it may be that they opt to move due to effective marketing of services by another practice in the locality.

Therefore, as part of marketing, a practice should from time to time take a good look at itself. Are patients satisfied with the practice from the perspectives of the surgery, staff, resources, care, time and value for money? As the GP, are you satisfied with your office staff and their interactions with patients? Unhappy staff simply won't provide a good environment for patients or contribute to a great practice, so are the practice staff happy? Is the practice using all the tools available both externally and internally to communicate effectively with its patients? By applying the principles of marketing outlined in this Chapter, should any of these issues be problematic, a plan can be drawn up to ensure they are addressed, thereby ensuring a profitable, viable business.

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10: Practice Management

Introduction

This chapter outlines basic management principles and describes the management of the key assets of the practice/ business. The establishing GP needs to acquire and develop the skills necessary for effective management. These include: -

1. Financial management
2. The management of people
3. Management of time (one's own and others')
4. Creation and organisation of practice systems
5. Use and management of IT systems
6. Generation and use of information

The skills, knowledge and competencies needed to effectively manage or participate in the administration and management of a practice are perhaps acquired progressively. This process should ideally commence during GP training, and many of the Irish training programmes do incorporate some element of practice management training.

Equally, the opportunity should also be taken to observe and gain management experience in a variety of practices in the period immediately following training. Astute observation (and participation) on the part of the Locum, Assistant, or Sessional GP, provides valuable knowledge on how to manage, or indeed mismanage, a practice. It is also very worthwhile if the opportunity presents itself to gain an insight into how other businesses are operating using '*normal*' business/management conventions.

A typical general practice is analogous to a small/medium size enterprise. Given that a business is any activity supplying goods or services for profit, it is clear that general practice is certainly a business enterprise. As such there are fundamental management principles that apply in the same way as for other businesses.

This chapter provides an overview of requirements for the successful management of a practice and is supported by the specifically dedicated ICGP Management in Practice Programme webpage. There are also specific sections dedicated to Practice Management and GPIT issues in *Forum* journal and on the NEGs pages of the ICGP website. *Forum*, the ICGP's monthly journal, is free to ICGP members. For information on subscription, non-members should contact the publishers, Med Media.

10.1 What is Practice Management?

The practice management function is both general and specific, and GPs frequently set up de novo or join an existing practice without giving serious consideration as to how the practice operates, or should be managed.

Management is about knowing how to make the right choice between competing demands and utilizing the limited resources of the practice in an optimal way. It is about knowing how to delegate, how to communicate, how to set objectives and monitor achievements, as well as leading, supporting and motivating those who are employed in the practice. It requires that the GP and/or practice manager, frequently one and the same person, know how to take decisions and how to exercise authority.

The primary function of management is to ensure that the practice is and remains a viable and profitable business. Another key function of good management is about enabling the GP and other clinical care providers to maximise their time in performing their primary role, i.e. treating the patient.

Some of the required skills will be new and must be acquired, and some the GP will already possess. However, one will need to be flexible enough to adapt to a new role, and be capable of moving between the role of doctor/care provider and business manager/entrepreneur.

Sometimes GPs experience role conflicts. Some examples of such situations include being both doctor and employer to practice staff, addressing the question of outstanding fees with patients, closure of lists, etc.

10.1.1 Defining Management

A well-managed practice is a content place to be for patients, for staff and for the GP. Patients are likely to receive a better

quality of care, while the GP and staff enjoy a better quality of working life. Well managed organizations/businesses are more profitable, productive, competitive and responsive to change.

GPs should be no strangers to management. In the clinical care of patients, the GP attempts to assess the problem, develop a treatment plan and review the outcome. Clinical management is more effective if the patient is actively involved in the process. Managing the business side of the practice involves many of these same processes. It similarly involves a diagnosis of issues/problems, decision making, planning, implementation and review, and active involvement of the other person in the decision making process. The well managed practice does not necessarily have to grow bigger but a practice which is effectively managed will grow *better*.

If the GP is to improve their performance in providing a health care service to patients, including the promotion, preservation and restoration of health, he/she must enhance the organisational performance of the practice. To optimize income, it is necessary to have systems of allocating, coordinating, recording and billing of services provided. This is an administrative function as distinct from a management one.

Effective administration promotes organisational efficiency through systems which achieve a better quality output for a given input. Administration is the means of achieving a certain purpose. Management provides the vision. It is therefore the role of management to decide and define the purpose(s), and where others are involved, to evoke their commitment to that purpose.

10.1.2 Defining the Purpose

In undertaking the management function the establishing GP must define the following: -

1. What 'business' are we in?
2. What is the distinctive competence of the practice?
3. What is the potential of the practice?
4. What do we want the practice to become?

These are fundamental questions, the answers to which give meaning, purpose and focus to the work of the GP and the services provided by the practice. Answers to these fundamental questions must be fully explored by the individual and the Partners/potential Partners before one can get to grips with the management function.

10.1.3 Strategic Questions

In order to manage the practice a GP must decide and define both the objectives of the practice and their own personal objectives and then set the practice direction. Without direction, no real management can take place. In order to determine practice objectives it is necessary to ask a number of strategic questions, which include but are not limited to: -

1. Where do we want the practice to be in 2, 5, or 10 years' time?
2. What do we need to do in order to get there?
3. How will we know when we have arrived?
4. If we don't succeed, will we know why and what alternative strategies are available?
5. What is the optimum GMS list size?
6. What is a viable practice size in terms of number of Partners, staff, etc.?
7. What is the actual and projected income level of the practice?
8. What level of services do we wish to provide?
9. Where does the practice position itself in terms of its external environment, e.g. competitors, allies, regulators, etc.?

Strategic management involves setting objectives, optimally allocating limited resources, and acting in a predefined time frame, as well as reviewing the ensuing results. Plans are made based on best available information. Strategic management involves both risk and reward, and taking opportunity may have attached cost. Making a choice means that other opportunities must be foregone.

10.1.4 Management is about Getting Things Done

Management is essentially about getting things done and achieving results. In 1984 Pritchard et al defined practice management as '*the systematic applications of common sense and specialist knowledge in order to achieve aims now and in the future*'. Practice management involves: -

1. Planning
2. Organising
3. Controlling
4. Directing

10.1.4.1 Planning

The most important function of management is planning. The main purpose of planning is to define goals and to answer the questions posed above, i.e. where is the practice going? Planning sets the boundaries for all subsequent decisions and the context for all activities. This statement on the objectives of the business must be clearly defined and agreed by all stake holders concerned, not just the GP. This will include Partners, staff and even spouses!

A statement of objectives becomes the compass by which the progress of the practice will be directed. For any organisation or business, a common purpose is essential, with all resources and actions geared to the achievement of common objectives. The setting of objectives helps to highlight the issues facing the practice and can suggest various solutions to problems when they occur.

There will always be constraints limiting the achievement of objectives such as limited finance, reluctance to change, time limitations, attitudes, external forces, etc. In the role of planner, all these must be taken into account by the GP. The planning process, once the objectives have been agreed, is to formulate clearly the rationale decisions, i.e. the stating of the problem, analysing the problem and putting forward alternative solutions. One must consider all known factors and their implications, and then map out how the objectives are to be achieved. An example of a business plan has already been given in Chapter 8, 'Setting up a New Practice'.

10.1.4.2 Organising

Organising is concerned with the sequencing, systemisation and coordination of work tasks in the practice. The establishing

GP needs to be fully au fait with standard practice systems and how they are organised/can be organised, e.g. systems for repeat prescribing, for processing results, controlling access, data security, call/recall systems, and so on.

Organising is also concerned with structure, i.e. the reporting relationships, decision making, and implementation. In a typical general practice it may not be immediately obvious to a new joining GP what the structure is. Equally, when setting up a practice, the establishing GP needs to define the structure as the practice expands, particularly in relation to decision making and delegation.

10.1.4.3 Controlling

Control is about setting down standards, markers, benchmarks, procedures and systems that allow control to be maintained and to indicate that objectives are being achieved. It also functions to flag the need for corrective action, ideally in good time. Examples of procedures and systems which provide for control include: -

1. Comparing projected income with actual income
2. Comparing pre-determined expenditure and against actual costs
3. Determining acceptable level of bad debts and comparing actual level of bad debt
4. Analysing the time set for completion of work tasks, e.g. if the consulting time is continuously conflicting with the given appointment length then action is needed
5. Setting estimates for performance indicators. These can be established from past performance for an equivalent period and conditions and/or by comparison with other practices/similar businesses

10.1.4.4 Directing

This is achieving results through managing and directing others and involves delegation, instruction, training and review and appraisal of the work performance of others.

10.2 Managing the Key Resources of the Practice

The key resources of a practice are: -

1. Time
2. People
3. Information
4. Money

10.2.1 Time

Time is probably the key resource in a practice and time management in a busy general practice is to say the least challenging. Each clinical member of staff can provide services to only one patient at a time. Time therefore needs to be managed appropriately. Time also needs to be managed to ensure that work/life balance is optimised. Some of the factors that time needs to be allowed for are: -

1. **Consulting time**: Time for professional development.
2. **Management time**: Planning time, including strategic planning.
3. **Administration time**: Time for review.

Fundamental to the success of any practice is the appropriate management of patient access to services and service providers, i.e. GPs and practices nurses. Effective systems, operated consistently, will allow for appropriate consultation time. These systems also need to be flexible enough to deal with unplanned/urgent work and necessary interruptions, e.g. walk-in emergency patients.

Time management for the individual GP is also important. Everyone recognises in retrospect that in a start-up situation the amount of time given to new patients is usually not sustainable. As the practice grows, access therefore has to be controlled. The old adage of commencing as you plan to continue may in reality be more challenging to follow than expected.

As the practice grows or in the case where the establishing GP joins an existing practice, his/her personal time management will have a key influence on the '*business*' performance of the practice. Being in independent professional practice gives one a lot of flexibility, but as in other workplace situations, this needs to be balanced with due regard to punctuality and efficiency.

Good time management is that which maximises patient/doctor contact time while ideally all the other functions of the practice are delegated to competent and effective staff. Moreover, effective time management also achieves the objective of healthy balance between work and protected personal time.

Well managed control of access to services all support optimal times management. Some management strategies that may help achieve well managed access to services include clear communication with patients, high level reception skills, use of the IT supports (e.g. appointment waiting prompts, electronic patient records), consistency in application of policies, use of appointment systems, making allowance for unplanned demand, and ensuring that average consultation times are congruent with the clinician's consultation style.

10.2.2 People

Whether in a start-up situation or joining an existing practice, the establishing GP needs to have knowledge of best practice people management and the '*normal*' constructs that pertain in the workplace environment. Such constructs are informed by the law, statute and common law, custom and practice, societal expectations, and accepted management practices. To some extent medical training and education has in the past not exposed GP trainees to such norms with a resultant significant deficit in this area.

At some point, usually sooner than expected, the establishing GP will become an employer and/or have direct responsibility for the supervision/management of staff including practice receptionists, secretaries, administrators, practice nurses, practice managers, GP Locums, Sessional GPs, other clinical staff, and full time GP employees. To some degree the management of Partners may also be included in this context.

This management of people may be broadly divided into the following areas: -

1. **People management skills**: To be successful, the recruitment, selection, training, induction, supervision, motivation and appraisal of individual employees all require specific knowledge, skills and competencies.
2. **Knowledge**: This encompasses understanding the psychology of work, what promotes or detracts from a healthy and productive work environment, and how these factors inform the management role.
3. **Skills**: This includes interpersonal communications skills, the ability to persuade, and skills of leadership.
4. **Competencies**: This entails conducting performance appraisal of another's work and effective training.

All of the above relate to the management of the individual employee, but people management should also address how people work together as part of a team, with each functional role contributing to the overall performance of the practice as a unit.

10.2.2.1 The Employment Contract: Legal and Human Resource Compliance

There is a legal framework which defines the employee/employer relationship. At its core is the employment contract. Where a job offer is made, the offer accepted, and where consideration is present (payment), a legal relationship exists, regardless as to whether this is expressed in writing or not. This is the fundamental core of the employment relationship providing, as it does, both rights and entitlements to both parties.

From this fundamental legal concept a continuingly expanding regulatory frame work is built by both the courts and legislators. The rights and obligations of both employees and employers are continuously being redefined and therefore employers must maintain their knowledge in this area e.g. legislation governing minimum wage rates, minimum statutory leave entitlements, unfair dismissals protections, notice periods, access to pension fund, etc.

10.2.2.2 Employer Rights and Entitlements

A GP employer has a right to expect the following from practice personnel: -

1. Compliance
2. Competence
3. Adherence to practice policies, protocols and procedures
4. Confidentiality
5. Safe conduct
6. A professional standard of work

10.2.2.3 Employee Rights and Entitlements

Employees of a GP or practice have a right to expect the following: -

1. Written terms and conditions of employment
2. Fair procedures
3. Minimum leave under statutory provisions for employment leave
4. A healthy and safe work environment
5. Freedom from harassment and bullying
6. Access to a Personal Retirement Savings Account (PRSA)
7. Maintenance of employee records

10.2.2.4 Legislation

The legislation under which all employers must operate includes: -

1. Adoptive Leave Act
2. Data Protection Act
3. Electronic Commerce Act
4. Employment Equality Act
5. Equal Status Act
6. Industrial Relations Act
7. Maternity Protection Act
8. Minimum Notice & Terms of Employment Act
9. National Minimum Wage Act
10. Organisation of Working Time Act
11. Parental Leave Act
12. Payment of Wages Act
13. Protection of Employment Act
14. Redundancy Payment Act
15. Safety Health and Welfare at Work Act
16. Terms of Employment (Information) Act
17. Transfer of Undertakings Regulations
18. Unfair Dismissals Acts

As an employer, a GP must be fully aware of practical implications for both employer and employee. For comprehensive information on human resource compliance in the practice refer to the 'GP as Employer' page of the Practice Management section of the ICGP website.

10.2.2.5 Remuneration and Related Costs

Salaries and other expenditure related to staff employment typically represent a high percentage of overall practice expenditure. The negotiated level of salary will be dependent on qualifications and competencies, the '*going rate*', supply/demand in the market, the type of post offered, and existing precedents in the practice.

Prospective GP employers frequently do not consider the full cost of employing staff. In addition to salary, additional costs may include: -

1. Employers PRSI
2. Pension contribution (if paid)
3. Training and development
4. Continuity of payment during absence if this is a condition of the contract
5. Locum costs if staff members are temporarily replaced during periods of absence
6. Employer's liability insurance

7. Professional indemnity if paid/sub-vented
8. Equipment, furniture, tools and other facilities required to enable the individual to undertake their work

10.2.2.6 Personnel Administration

Apart from the fact that the maintenance of good personnel records is in keeping with best practice, there are also legal requirements with regard to maintenance of such records. This includes the terms and conditions under which staff are employed, general rules of conduct e.g. telephone usage, email and internet access/use, formal communications with individuals e.g. performance appraisal reports, grievance and disciplinary procedures, salary calculations, deductions from salary, and deductions and payments of taxation.

Further information on human resource management is also available on the 'GP as Employer' page of the Practice Management section of the ICGP website.

10.2.2.7 Taxation

Where staff members are employed, the employer is obliged to apply PAYE (pay as you earn) and PRSI (pay related social insurance) deductions to an employee's salary. The administration of the payroll is best done using computer based systems. Confidentiality is an issue to consider regarding delegation of this work. The payroll function can also be outsourced to the practice accountant and/or book-keeper. Recommended reading for all first time employers is the Revenue 'Employer's Guide to PAYE Version 2.1'

10.2.3 Information Management and Information Technology

The technology is now available to allow for almost completely paperless practice.
To achieve this, or at least to the extent desired, the Establishing GP must have a good understanding of the hardware and software applications available and appropriate to the GP setting. The Establishing GP needs to be aware of main issues concerning: -

1. Set up, maintenance and development costs (both time and money)
2. Training and utilisation protocols
3. Security of the database including back up, password protections and encryption
4. Legal issues regarding record management and access to personal data
5. Internet usage and security and transfer of data e.g. tests results
6. Health and safety of the computer user

IT communications applications are also developing at an exponential rate providing both challenges and opportunities to practices. Information, advice and training are provided to GPs by a country wide network of GP GPIT facilitators. The General Practice Information Technology Group (GPIT) is a joint ICGP HSE initiative. As outlined in chapter 8, the GPIT group publishes information, practical guidelines and also a list of accredited GP software. Further information can be found on the GPIT page of the ICGP website. The list of GPIT accredited GP software is contained in Appendix 2.

10.2.3.1 Managing Information Technology in the Practice

The key issues with regard to IT from a management perspective are: -

1. The selection of efficient hard ware and software systems
2. The effective use and consistency with regard to authorised access
3. Daily usage
4. Input and changing of data
5. Data security
6. Training of all users
7. Ensuring the practice obtains value for money in relation to IT support

The management of IT in the practice is likely to be an ongoing process given the rate of change and development in IT applications. As well as the management of data, technology allows for that data to be translated into information which should inform both clinical planning and organisational management.

Also relevant to IT within the practice is the capacity of software to generate valuable information on clinical parameters e.g. chronic disease management, patient demographics, work load, financial analysis, equipment usage, phone call patterns etc. Practice software systems can now process and analyse huge volumes of practice data and it is possible through the Irish Primary Care Research Network (IPCRN) to contribute anonymised clinical data to multicentre comparative analysis. This provides feedback on practice performance and can contribute towards improved quality of care. The IPCRN is a collaborative between the ICGP, the National University of Ireland, Galway (NUIG), and the Health Research Board (HRB) Centre for Primary Care Research.

10.2.4 Money

This asset has been discussed in detail from many perspectives in other chapters but it is worthwhile reiterating a number of the key principles with regard to financial management. These include: -

1. Separating, both conceptually and practically, private income/earnings from business/practice income
2. Setting practice fee levels at a level that covers costs and creates a profit margin
3. Collecting all fees charged whether from individual patients or from the State
4. Recording all income '*collected*' both for management purposes and as required by tax law
5. Managing cash flow so that income matches monthly, quarterly, and annual expenditure
6. Ensuring practice income is sufficient to cover: -
   a. Practice expenses
   b. Drawings of the Practitioner
   c. Tax liability
   d. Income protection
   e. Pension
   f. Re-investment in practice development

10.2.4.1 Financial Administration

The following is a list of the '*books*' and records that should be maintained for monitoring and management of all practice income and expenditure. '*Books*' are simply records of financial transactions.

1. Daily list of patient visits, amounts paid and method of payment
2. Details of all lodgements made to the business bank account, to include manual lodgements, GMS lodgements and laser/credit card lodgements
3. An analysis book containing details of all payments made from the practice bank account. This should include all cheques written together with all direct debits, standing orders and charges on the bank account
4. A list of all purchase invoices received in the practice. As the invoice is paid, the cheque number and date should be recorded on the invoice to avoid payment duplication
5. A list of all withholding tax certificates received with the notification of the GMS Payment. This list should detail the number of the certificate, the date, the gross amount, tax amount and net amount received

The analysis books should be totalled weekly. In addition, weekly bank reconciliations should be prepared to ensure that the GP is aware of the accurate bank balance at the end of each week. Regular checks should be performed on statements such as the merchant services card statement to ensure that all credit and debit card transactions have been honoured. The GMS statements should also be checked to ensure that all payments due have been received.

Where practical, it makes sense to outsource the practice bookkeeping to a book-keeper who has experience of working with GPs. The bookkeeper may attend the practice one half day a week to process the accounting records. Not only does this mean that there is a person with experience maintaining the records but it also frees up the Practitioner's time to develop the practice. As the practice grows practice administration staff may become equally adept at financial administration if trained or qualified.

To ensure that the record keeping is accurate it is recommended that the GP should arrange for the accountant to periodically review the records being maintained. This process can cease once the accountant is satisfied that the bookkeeper is competent. This will protect against any significant additional time being required at year end to unravel errors created throughout the year.

10.2.4.2 Accounting Software

It is recommended that the practice should purchase an affordable accounting software package. The most appropriate will depend on the needs and financial applications of the clinical software used in the practice. The practice accountant should assist in selecting an appropriate package. A relatively simple spreadsheet system can also be designed in Microsoft Excel, with a template being available from the ICGP. Accounting and book-keeping software is also available in the form of off-the-shelf programmes that vary in complexity, e.g. TAS Books, Big Red Books and SAGE. Aside from using a Microsoft Excel spreadsheet or purchasing off-the-shelf accounting software, most of the GPIT accredited GP software systems incorporate some accounting applications e.g. fees' management. It is important to discuss your requirements both with your accountant and also with the GP software supplier in relation to the integration of GP software systems and any accounting software.

10.2.4.3 Financial Records

It is very important that financial records are maintained for the required period of time. The Health Service Executive recommends that financial records should be kept for a period of 7 years while Revenue requires records to be kept for 6 years. Among the financial records that need to be retained are: -

1. Bank statements
2. Cheque books
3. Lodgement books
4. Supplier invoices
5. GMS payment statements
6. Payroll records

10.2.4.4 The Role of the Practice Accountant

The accountant/accountancy firm/firm of advisors should provide certain agreed information and services to the practice. They will prepare the year-end financial statements from records maintained by the Practitioner. It is therefore in the best interest of the Practitioner that the records be maintained in the most professional manner possible. The accountant will require details of all financial transactions carried out by the Practitioner in running the practice during the financial period. If this can be provided in the form of reports from an accounting software package then this should result in a reduced time input by the accountant and a reduction in the level of queries to the accountant.

Further details on how to select an accountant and agree on what services should be provided by an accountant are contained in chapter 8, 'Setting up a New Practice'.

10.2.4.5 Management of Income

It is extremely important to set up systems to administer and manage all income. This includes income from both private practice and in respect of services provided to patients under State Schemes. The objectives are to claim for all services provided, ensure that full and timely payment is received for all claims made, and also, to ensure that all additional benefits and entitlements under the terms of these schemes are received.

10.2.4.5.1 Income from State Contracts

GPs are remunerated under the GMS contract in a number of different ways: -

1. **Capitation**: Capitation payments are received monthly and are calculated based on the panel size and age and gender of the patient.
2. **Practice allowances and subsidies**: Practices will also be in receipt of allowances and subsidies for the costs of employment of practice staff, Locum allowances in respect of annual leave, sick leave, study leave etc. These payments are made quarterly.

10.2.4.5.2 The Cycle of Claims and Payments

From a practice management perspective, the key objectives

are that the practice claims for payment within the appropriate date cycle for all services. Secondly, the practice must ensure it receives accurate and timely payments from the State through the HSE Shared Services Primary Care Reimbursement Service (PCRS). Payments are issued and received by the practice and the GMS patient panel is the key determinant for the calculation of payments.

Table 10.1 - The cycle of claims and payments

Frequency	Payment	Notes
As submitted	Hepatitis B vaccine	After 3rd shot given
	Locum expenses for leave	
Monthly	GMS capitation	Current month
	Asylum seekers	Current month, once off payment
	Non-EU registration fee	
	Dispensing fees	Monthly in arrears
	Practice support subsidy	
	Health amendment Act	1 month in arrears when submitted online and 2 months in arrears when submitted manually
	Special services	
	Special type services (STCs)	
	Vaccination claims, e.g. influenza, pneumonia	
	Palliative care fee	As submitted
	Primary childhood immunisation scheme	
	Cervical smear programme	
	Maternity allowance	
Quarterly	Medical certification	Department of Social Protection
	Medical reports (social welfare)	
	Mother and infant scheme fees	
	Rural practice allowance	
Annually	Medical indemnity refund	Must be applied for

10.3 Marketing Practice Services

Marketing is a key management tool and is dealt with in detail in chapter 9, 'Advertising and Marketing in General Practice'.

10.4 Management Training

The ICGP Management in Practice Programme (MIP) provides specific web supported management training and development for GPs and Practice Managers. The following areas are covered on the MIP Diploma course: -

1. Management principles / the role of the Manager
2. Practice and health care services in Ireland
3. Financial control
4. Strategic business planning
5. State contracts
6. Human resources legal compliance
7. Taxation
8. Systems / processes
9. IT / communication
10. Marketing practice services
11. People management
12. Health and safety
13. Stress management
14. Personal effectiveness / time management

Postgraduate masters programmes (MBA or MSc) are another means by which one can avail of management training. Shorter, subject specific training may also be available locally and should be considered. The following organisations may also be of interest to establishing GPs as their careers progress: -

1. *The Irish Small/Medium Size Firms Association (ISME)*
2. *The Irish Business and Employers Confederation (IBEC)*

10.4.1 ICGP Information, Reference, Advice and Consultancy

The 'In the Practice' section of the ICGP website provides members with access to detailed up-to-date information and advice on the full spectrum of practice management issues. Further information on publications, guidelines, protocols, support, training, and related aspects of practice management is available from the ICGP Management in Practice Programme.

10.5 Physical and Psychological Health

This is a hugely important area, particularly in relation to the health of health care professionals. Given its importance, an entire chapter in this book, chapter 1, 'Sustaining A Career in General Practice: Managing Your Health, Job and Work-Life Balance' has been devoted to this area. Here we briefly review the topic.

The physical and psychological health of the GP and practice staff is very important. In a corporate setting the HR department typically has the specific responsibility for the occupational health of all who work in the organisation. However, irrespective of the size of the organisation, worker health, psychological and physical must be appropriately managed. In general practice this should include the health and psychological well-being of the GP him/herself, and a very important area for the establishing GP to be aware of is '*self-care*'.

Many of the risks to health in general practice are common to most work place environments. However, there are some risks which are unique to general practice settings. Regular practice health and safety audits are a management responsibility and legal requirement, and should culminate in '*active*' health and safety policies.

From an individual perspective a GP needs to be '*self-aware*' and be in a position to manage the stressors that are likely to occur in the clinical care of patients and management of a business enterprise. Moreover, the GP as manager/employer needs to be able to effectively manage the potential negative effects of stress on practice staff. When considering the

relationship an individual has with their job in the context of '*stress management*', the following headings are useful: -

1. **Workload**: Workload may be excessive with an overload, especially of emotional work.
2. **Control**: One may have insufficient control over resources, leading to a feeling of being overwhelmed by responsibilities.
3. **Reward**: There may be lack of appropriate reward, whether it be in the form of financial or social recognition.
4. **Community**: One may be or have a feeling of being isolated from work colleagues or there may be conflict within the workplace.
5. **Fairness**: There may be or one may perceive there to be a lack of respect or inequity of work or pay, and that one has no voice within the workplace.
6. **Values**: One may have a conflict of personal principles with other staff.

Burnout arises from chronic '*mismatches*' between the individual and their work setting in some or all of these six areas. Management training can provide the knowledge and skills to cope with work related stress and health and safety issues in the practice. In addition it is important to know how to access individual support when this is needed. One example of the external supports available to GPs and their families is the ICGP Health in Practice Programme.

10.5.1 Services Provided by the ICGP Health in Practice Programme

There are a number of different services available to GPs and their families including: -

1. **HiPP General Practitioners**: A GP service for GPs, co-ordinating your healthcare for you.
2. **HiPP Occupational Physicians**: For occupational health advice, work absence, returning to work after sick leave, follow-up advice on sharps injuries, work-related illness, etc.;
3. **HiPP Psychiatrists**: Psychiatric care on referral from your GP.
4. **HiPP Psychological Therapists**: Helping you to develop solutions, life management skills and coping resources to resolve your work-related issues and personal problems such as acute or chronic stress or anxiety, depression, bereavement, grief and loss, family disruption, psychosexual issues, relationship issues and other problems.

10.5.2 Accessing the ICGP HiPP

Full details of how to access the service are available on the ICGP website. To access confidential advice there are several options: -

1. To obtain advice or book an appointment, any of the professionals from the health in practice teams listed on the ICGP website can be contacted by telephone.
2. The HiPP helpline is available on 087 751 9307.
3. The HiPP administrator, Ms Sally-Anne O'Neill can be contacted by telephone (01 6763705) or by email (sallyanne.o'neill@icgp.ie).
4. The Director of the HiPP, Dr Andrée Rochfort, can also be contacted by mobile (087 751 9307), landline (01 676 3705), email (andree.rochfort@icgp.ie), or in writing (addressed to Dr Andrée Rochfort, ICGP, 4/5 Lincoln Place, Dublin 2, being sure to mark your envelope '*private and confidential*').

Summary

Being able to successfully manage a general practice business will depend on developing a good understanding of management. Having the associated key management skills at one's disposal will not only play an important role in ensuring one's business is sustainable and profitable, but it will ultimately lead to a better run and administered business, happier more fulfilled staff, and hopefully a GP who continues to enjoy the work of general practice without experiencing the phenomenon of burnout.

v.2.0 / August 2014

11: State Contracts held by GPs Including the General Medical Services Contract

Introduction

This chapter describes state contracts held by GPs for the provision of services to eligible patients and outlines the contractual terms and conditions of those contracts. Given the incremental manner in which these schemes have developed, this is a complex area.

The chapter is presented in two sections. The first section deals with the General Medical Services (GMS) contract. The second section deals with other state schemes including the Mother and Infant Care Scheme, the Primary Childhood Immunisation Scheme, and Medical Certification with the Department of Social Protection.

It is useful to have an overview of the size of the GMS and other such schemes operated by the State. It is also useful when doing so to refer to the publication by Tom O'Dowd et al, "Structure of General Practice in Ireland: 1982 – 2005" which provides some manpower context to where we have come from. Figures in table 11a below come from Department of Health figures released on 14th May 2014 in response to written parliamentary question 190 and from Primary Care Reimbursement Service (PCRS) data contained in the 'PCRS Statistical Analysis Of Claims And Payments 2012' report. Figures show the number of GPs holding GMS contracts, and those holding contracts for other state schemes including the Primary Care Immunisation Scheme, the 1996 Health (Amendment) Act, Heartwatch, the Methadone Treatment Scheme and the National Cancer Screening Service.

Table 11a - Number of State Contract Holders

Date	GMS Contracts	Other Contracts
31/12/2004	1,984	
31/12/2005	2,018	
31/12/2006	2,095	
31/12/2007	2,129	
31/12/2008	2,098	
31/12/2009	2,136	
31/12/2010	2,258	
31/12/2011	2,277	
31/12/2012	2,353	468
31/12/2013	2,413	
30/04/2014	2,416	475

From the published PCRS figures, we also know that in 2012, the fees and allowances paid to GPs totalled €483.14m. This included €8.24m in respect of the Primary Childhood Immunisation Scheme, €0.21m in respect of the Health (Amendment) Act 1996 and €6.67m in respect of the Methadone Treatment Scheme.

As of May 2014, almost 42% of the population has a Medical Card. Figures in table 11b come from Department of Health figures released on 27th May 2014 in response to written parliamentary question 838 and from Primary Care Reimbursement Service (PCRS) data contained in the 'PCRS Statistical Analysis Of Claims And Payments 2012' report. Figures show the number Medical Card holders.

Table 11b - Number of Medical Card Holders

Card Type	31/12/2011	31/12/2012	01/05/2014
GMS	1,694,036	1,853,877	1,800,182
GP Visit Card	125,657	131,102	125,166
Total	1,819,693	1,984,979	1,925,348
% of Population	39.66%	43.26%	41.96%

Also of significance is the current uncertainty that exists in relation to state contracts for GPs. In January 2014 the government published a draft contract for provision of free at the point of access care to under six year olds. Government policy is also to move to a single tier health system through a Universal Health Insurance model. While it is hard to predict the future, it is almost certain that some form of new GMS contract or contracts for provision of GP services will emerge and this is likely to include changes to the model by which GPs are paid to provide those services.

11.1 The General Medical Services (GMS) Scheme Contract

The most significant State contract held by GPs is the GMS contract. Persons who are unable without undue hardship to arrange General Practitioner services for themselves and their dependants receive a free General Medical Service.

When the GMS scheme was introduced in 1972 it was a fee per item based scheme. Following a review of operation of the scheme in 1989, the basic payment structure changed to a capitation system. The terms and conditions of GPs under this 1989 capitation based contract have been amended from time to time following negotiations between the IMO and the Department of Health and Children and Health Service Executive. The revised terms are given effect by means of Circular letters to contract holders from the Department of Health and Children.

A separate GP visit card (GPVC) contract was introduced on the 1st July 2005 to allow for the introduction of up to 200,000 GP visit cards. At the time of introduction, this contract was available to all GPs who were eligible for GMS entry and who had been in practice for a period of one whole year prior to 1st July 2005 (or had, on or before that date, entered into a Partnership with, or a legally binding contract to acquire a practice from an existing Practitioner or Practitioners). These entry requirements were superseded by the introduction on 12th March 2012 of the 'Health (Provision of General Practitioner Services) Act' 2012 which eliminated restrictions on GPs wishing to obtain contracts to treat public patients under the GMS scheme.

A key feature of the GMS contract is that it provides for a choice of doctor for the patient. Under the contract, the GP is expected to be routinely available for consultation with eligible patients for a total of 40 hours per week and the contract commits the GP (personally or in conjunction with his or her deputy) to providing 24 hour cover. An out-of-hours fee is paid in respect of non-routine consultations necessarily carried out outside the hours 9am to 5pm Monday to Friday, and all hours on Saturday, Sunday and Bank Holidays. Excluded from these payments are consultations made outside the above hours but which occur during normal contracted surgery hours and consultations made as part of an overflow occurring during normal surgery hours. Other important provisions of the contract allow for the assignment of a patient to a GP's panel by the HSE and for the removal of a patient from the doctor's panel at the request of the doctor.

11.2 Routes of Entry to a GMS Contract

Since the publication in 2008 of the first edition of Signposts to Success, there has been a major change in the requirements for entry into the GMS Scheme. On foot of the 2010 Competition Authority 'General Medical Services Report' into General Practice, in March 2012, the Government passed the 'Health (Provision of General Practitioner Services) Act'. This removed restrictions on GPs who wished to treat public patients.

Prior to this Act, entry to a GMS contract had been restrictive. Despite various one off entry arrangements (1999, 2001, 2005 and 2009), it was only with the publication of the 2012 Act that any suitably qualified trained GP could apply for and enter into a GMS contract. To contextualise and understand the background to this Act, Appendix 3 gives an overview of historical once off entry arrangements to the GMS.

As of March 2012, there are three ways to enter the GMS Scheme: -

1. **A GMS vacancy**: By means of filling of a GMS vacancy, for example, where a single handed GP dies, retires or resigns and his/her panel is advertised by the HSE as a single handed vacancy
2. **Assistantship-with-a-View**: By means of appointment as an Assistant with a view to GMS Partnership with an existing GMS Principal
3. **Open access**: By applying for a GMS contract under the new open entry arrangements

11.2.1 GMS Vacancies

If a GP GMS Contract holder resigns or dies while in post, or retires without having any arrangement in place with an Assistant or Partner in respect of the GMS Contract, the HSE can either allow a dissolution of the '*list*' of patients, or alternatively, advertise the post. Unless the GMS contract in question relates to a very small number of patients, it is almost certain that the post would be advertised.

These posts are advertised on the HSE website and anyone either on or eligible to be on the Medical Council Specialist Register as a GP may apply. An application form must be submitted and an interview will be held. The interview process is described below.

11.2.2 Appointment as a Partner or Assistant in the GMS

11.2.2.1 Eligibility of a Principal to Appoint a Partner/ Assistant in the GMS

In order for a GMS Principal to be eligible to appoint a Partner, or more commonly, an Assistant with a view to Partnership in the GMS Scheme, he/she should meet the following criteria: -

1. Ordinarily be five years or more from retirement age (70 years of age), ***and***
2. Have 500 or more GMS patients

Where a GP fulfils both of these criteria, he/she is automatically eligible to appoint an Assistant/Partner in the GMS. Where a Principal does not fulfil these criteria, it is at the discretion of the CEO of the HSE as to whether he/she will be allowed to appoint an Assistant/Partner in the GMS. There will be an interview for any shortlisted candidates, and this interview process is described below.

11.2.2.2 Process for Appointment of an Assistant/Partner in the GMS

This is a well-defined process. It takes place as follows: -

1. The GMS Principal applies to the local HSE Primary Care Manager.
2. The HSE consults with the IMO for its view on the application. The IMO has a formal consultative role in relation to the filling or dissolution of all GMS vacancies, the creation of new GMS posts, and the appointment of Assistants/Partners in the GMS.
3. The HSE approves the application and advertises the post nationally on its website.
4. The process of short listing and interview of candidates is put in place by HSE.
5. The GP principal has the right to sit on the interview board.
6. Following the interview, a panel of successful candidates is created.
7. Once a successful candidate is appointed, this is followed by a 6 month trial/probationary period.
8. At the point when the Principal and Assistant are happy to proceed with the Partnership, the Assistant will be issued with his/her own GMS number/contract.
9. The point at which the Assistant becomes a full Partner is a matter for negotiation between the Principal and GMS Assistant.

11.2.2.3 Rules Governing the Rights of Assistants/Partners in the GMS

The rules governing the rights of Assistants/Partners in the GMS are set out in Department of Health and Children Circulars. The principal Circulars are numbers *9/1980, 9/1981, 3/1996, and 3/2001*. These Circulars are complex and because no single consolidated Circular exists, each has to be read in conjunction with the others. Access to all Department of Health and Children GMS Circulars from 1972 can be obtained on the ICGP website.

GMS Assistants and Partners have various rights to panels when Partnerships dissolve. These rules do still have significant relevance, but the time limits previously applied in relation to these rights were abolished by the 2012 'Health (Provision of General Practitioner Services) Act'. These rules and rights are outlined in appendix 4.

11.2.3 Open Access GMS Contracts

In March 2012 the Minister for Health signed into law the 'Health (Provision of General Practitioner Services) Act' which removed restrictions on GPs who wished to treat public patients. The Act provides that: -

1. Access to GMS contracts is now open to all fully qualified and trained GPs.
2. GPs are free to establish a practice and treat public patients in the location of their choice.
3. The viability of existing GP practices in an area is no longer a factor in awarding GMS contracts.
4. GPs who received a GMS contract under the 2009 interim entry provisions are free to accept any patient who chooses to attend them, including existing medical card holders who wish to transfer from another practice.
5. Time limits which previously existed in relation to the dissolution of GP Partnerships have been abolished.

11.2.3.1 Applying for an Open Access GMS Contract

Despite there being a substantial amount of paperwork involved, the process of applying for an open access GMS contract is very straightforward. The process is as follows: -

1. **Request an application pack**: An application pack is requested from the HSE by emailing the HSE National Contracts Office at natcontractsoffice@hse.ie. They will want to know in which HSE area you are planning to open so that the application pack can be sent out by the relevant local Primary and Continuing Care Manager.
2. **Complete the application form**: The information requested is outlined below.
3. **Provide any clarifications**: Further information may be requested following submission of an application.
4. **Sign the contract**

11.2.3.2 The Application Pack

The application pack consists of: -

1. A cover letter outlining the information required
2. An application form
3. A Garda Vetting form and instructions on how it should be completed
4. A Statutory Declaration to be completed
5. A letter relating to Occupational Health
6. An Occupation Health Pre-Placement Declaration Form
7. An Occupational Health Exposure Prone Procedure/Job Function Analysis
8. A copy of a HSE HR Circular 19/2008

11.2.3.2 Information Requested in the Application

Candidates are requested to submit the following to the office of the local HSE Primary Care Department Manager: -

1. The completed application form
2. A current copy of Medical Council Registration Certificate
3. A current copy of Medical Council Specialist Division of the Register for General Practice (General Practice (SDR) Register Certificate
4. Completed Garda Vetting form (ensuring the form is filled out completely and is legible or it will be returned)
5. Police clearance for time spent outside of the Republic of Ireland for any period in excess of six months or over
6. A Statutory Declaration From (which must be signed by either a practising Solicitor, Commissioner for Oaths, Notary Public or Peace Commissioner
7. Current copy of Medical Indemnity Certificate (to cover full time practice)
8. Birth Certificate (original version)
9. Two passport size photographs
10. Completed Health Questionnaire and Exposure Prone Procedure / Job Function Analysis Questionnaire (which should be returned directly to the Occupational Health Department)

The application form consists of 16 questions, many of which are straightforward. The information requested includes: -

1. **Basic information:** This includes name, address, telephone number, date of birth, if one holds a current driving licence and details of one's Medical Council registration.
2. **Business address:** Question 4 asks for one's business address. It is possible to make an application without having an actual premises or before final arrangements have been made such as the formal signing of a lease, however, the nature of one's premises is a key part of the contract and therefore it is almost certain that no contract would be issued unless and until the HSE were satisfied as to the exact nature and standard of one's business premises.
3. **Training and education:** Question 9 asks for detailed information on one's professional and vocational training, any full-time or part-time courses completed, and one's general practice experience.
4. **Medical indemnity:** Question 13.1 asks for provision of details and documentary evidence of current medical indemnity insurance to cover full-time practice. It is recommended to discuss with one's insurer what they consider to be full-time cover and to obtain and enclose a letter from one's insurer stating that one's level of cover is considered full time. For example, the MPS considers that cover for nine sessions per week is full-time cover.
5. **Referees:** Part 13.2 seeks the names of two referees. It is of course common courtesy to ask permission from one's referees or to make them aware that your have submitted their names as referees.
6. **Premises:** Question 14 asks for details of one's premises. Within this question the following statement is made, clearly identifying the preference of the HSE that contractors would practice from a single site: - "*Please note that doctors admitted to the scheme under these arrangements will ordinarily be required to work from a single designated centre of practice*". A statement is also made in relation to examination of the premises, indicated that the HSE may undertakes such examination of a premises as it deems necessary.
7. **Hours of service:** Questions 15 and 16 asks for scheduled surgery hours and out-of-hours/rota arrangements. If one's proposed premises are in the locality of an out-of-hours co-op or rota arrangement, it may be worth approaching the members of the co-op or rota to discuss the possibility of joining the co-op or rota.

The Occupational Health part of the pack consists of: -

1. A cover letter
2. A Pre-Placement Health Declaration Form which seeks details of personal information, one's most recent three jobs, sick leave from work or education in the last two years, details on one's medical history and a history with supporting documentation of immunisations and immunity status
3. An Exposure Prone Procedure/Job Function Analysis form which seeks information on the both the nature of the job and whether there are any elements of the job which are considered to involve Exposure Prone Procedures
4. HSE HR Circular 19/2008 which outlines "*Implementation of Recommendations of Report on The Prevention of Transmission of Blood Borne Diseases in the Health Care Setting*" which includes details on what procedures constitute Exposure Prone Procedures

Once all the above has been completed and submitted, your application will be acknowledged in writing and processed by the local HSE Primary Care Office.

11.2.3.3 Clarifications

It may be the case that additional information is requested in relation to some of the application. This could relate for example to one's proposed premises. Should additional information be required, this will be requested in writing and outlined in detail. It will then be up to an applicant to furnish such requested detail to the local HSE Primary Care Office before an application can proceed.

11.2.3.4 Issue of a Contract

Provided all the requirements of an application have been met, in particular the nature of one's proposed or actual premises and the details of one's out-of-hours arrangements, a GMS contract will be issued.

11.2.4 The Application Process and Interview for GMS Vacancies and GMS Assistantships

In the case of both advertised GMS vacancies and appointments of GMS Assistants, there is an application form and interview process. This contrasts with the new open access GMS application, where the application form is different and there is no interview.

11.2.4.1 The Application Process

GMS posts are currently advertised by the HSE on the jobs section of the HSE website. A standard application form requests a variety of information including qualifications, reasons for applying for the post etc. as well as a number of pieces of documentary evidence including for example, evidence of current Medical Council registration. Applications should be typed and proof read to ensure no errors in spelling or grammar. All requested material should be provided. It is reasonable to attach a copy of ones Curriculum Vitae to the application (and bring copies of this to an interview) if you consider you have '*more to say*' than will fit on the application form.

It is of course a matter of courtesy that referees should be contacted in advance of being contacted by the HSE. One should also ensure the application form is completed thoroughly, in detail and exactly as requested. It is useful to have at least one independent person give honest feedback on the application so that it can be amended if necessary. The application must be regarded as one's '*shop window*', and the function of the application is to sell oneself.

Under this application process, the rights of candidates are clearly set down. From time to time additional information may be requested. All applications received will be considered and it is usual for a panel of short listed candidates to then be called for interview.

11.2.4.2 The GMS Interview

If called for interview for a GMS post, be it a vacancy or for an Assistant with a view post, it is important to be well prepared and to understand the process and procedure for GMS interviews.

The composition of Interview Boards is set out in Circular *3/1996*. Normally, a Board will comprise at least three individuals. Usually, but not always, the chair is a HSE official, most often an administrator from the primary care sector. The second interviewer will be a Director of Public Health or a deputy on his/her behalf. The third interviewer will be a GP selected by either the IMO or the ICGP from a nominated panel. In the case of interviews for GMS Partners or Assistant-with-a-View posts, the GP Principal will also be included on the Interview Board.

The structure of the interview is also relatively standard. Normally the HSE official will run through the procedure before the interview begins. The technical and vocational questions tend to come from the two doctors and the interview will generally last for about half an hour. It is recommended during the interview that one speaks honestly, says what one thinks and not what one thinks the interviewers wish to hear, and that one also avails of the opportunity that will be provided to ask any questions of the Interview Board about the job.
The marking schedule for GMS interviews is also very clearly defined and is set out in Department of Health and Children Circular *3/1996* which can be accessed on the ICGP website. Candidates should familiarise themselves with this Circular and the marking schedule prior to interview. At interview, candidates are marked in four categories with 100 marks being available in each category. The marks available within each category are also clearly defined, e.g. there is a clear stipulation as to how many marks a certificate or diploma is worth. The categories and available marks are: -

1.	Professional qualifications and research	100 marks
2.	GP training and hospital experience	100 marks
3.	General practice experience	100 marks
4.	General suitability	100 marks
	Total	**400 marks**

An important point to emphasize is that in relation to general practice experience, what counts is time spent working in a GMS practice. Five years as a GMS Principal equates to 100 marks, whereas a newly qualified GP will have either zero or single figure marks for GMS experience. It can be seen clearly from this that the marking schedule for advertised GMS posts significantly disadvantages recently qualified GPs. This inequity was one of the main reasons the Competition Authority recommended open access to the GMS Scheme.

11.2.4.3 Preparing for a GMS Interview

Clearly, when being interviewed for any position, it is very important to be well prepared. Feedback from GMS Interview Boards does give some insight into how to prepare. It is unfortunately the case that feedback often identifies that candidates sell themselves short during interview. Some basics to get right are: -

1. The Interview Board should not have to extract information that should be provided in the application, i.e. it is important to ensure one's application is completed thoroughly, in detail and as instructed.
2. Candidates should know the job, the practice, and the area.

Important aspects of interview preparation and a suggested preparation strategy are: -

1. If possible, find out who will be on the Interview Board, and research the background of each Board member.
2. Review your application form, ensure you know it inside out, and be familiar with any material referred to in the application. Consider any possible questions that are likely to arise based on the information you have supplied. For example, if you have a special interest or specific expertise, it is possible you might be asked as to how this would be incorporated into the services offered to patients.
3. Review the job specification including the required skills, competencies, qualifications and knowledge. Try to have an appreciation for the criteria which were likely used to shortlist candidates.
4. Review the marking schedule for GMS interviews.
5. Talk to people who have recently done interviews and anyone else who may be able to provide advice. This might include seeking opinions, views and advice via the online NEGs discussion forum. Talking to those who have done GMS interviews will give an idea of issues that are topical, recurring themes that have been raised, a general feel for the overall tone and thrust of interview, and a list of specific questions which have been asked.
6. Prepare a business plan and bring it with you to the interview. This is a very important document to prepare, and will demonstrate knowledge, management skills and consideration of planning. Preparation of a business plan serves to focus the mind. The process of writing a business plan and what should be included is addressed in chapter 8, 'Setting up a New Practice'. Preparing a business plan will mean studying the proposed practice, practice location/proposed location, and the local geographical area in detail. One must try to know as much about the practice and its patients as possible. This not only includes the physical aspects of the practice, but also information such as immunisation uptake rates, the ratio of GMS:private patients etc. Demographics are available from the CSO website, and there will be lots of sources of information about the local area. One must be fully aware of the density of GPs and other practices in the area and how much competition is likely to result.
7. Candidates should be aware of any issues that are topical in general practice, Primary Care and Public Health. In 2014 this would include the draft U6 contract, proposals on Universal Health Insurance, vaccination uptake rates, measles outbreaks, and the international spread of Polio or Ebola.
8. Candidates should also be fully appraised of and familiar with any relevant government or HSE publications, e.g. the 2001 Primary Care Strategy, the Annual HSE Primary Care Service Plan, HSE structures and policies etc. It may be that candidates are asked their personal view of such documents, and it is therefore important to have read these documents, to have formulated a view, and to be able to articulate this view if required.

9. One must be fully prepared to answer questions around maintenance of professional competence, research interests, keeping up to date, teaching activity etc. Candidates are frequently asked about recent journal papers they have read. It is reasonable to take this fact into consideration when preparing for interview.
10. Finally, it is highly recommended to consider and prepare answers to likely and possible questions, e.g. it is highly likely that one may be asked about vaccination rates, the Primary Care Strategy and specific information about both the practice and locality. Therefore one should be well prepared in these (and other) anticipated areas.

11.2.4.4 Examples of Questions that have been asked at GMS Interview

Clearly it would be impossible to give a comprehensive list of all questions that have been ever been asked. However, the following are examples of actual questions that have been asked during GMS interviews. They have been compiled from a variety of sources including the ICGP NEGs discussion forum. From the list it can be seen that questions fall under a broad range of headings, are sometimes quite specific, more often general, and may also include questions for which it is simply not possible to prepare. Questions can be considered under various headings: -

1. **Questions based around information on one's application form**
   Tell us about your research publications.

   How will you balance research demands against the need to provide a service in practice?

   To a candidate involved with the University - Will you keep a link to the University?

2. **Chronic disease management / screening**
   How will you identify patients with chronic disease within the practice?

3. **Primary care teams**
   What people do you expect to liaise with in the care of patients?

   What is your knowledge of PCT proposals in the area?

4. **Business**
   How do you propose to get the practice off the ground?

   Can you tell us about your business plan: -

   a. Have you identified premises?
   b. What are your proposed out-of-hours cover arrangements?
   c. Have you approached the banks for finance?

5. **Practice management**
   What management experience do you have?

   How will you balance being a manager with other time constraints within the practice (Partners?)

   What are you proposed opening hours?

6. **Local knowledge**
   What changes have occurred in the area in the past two years?

   What do you know about the local population?

7. **CPD**
   How do you keep up to date?

   When I said I read the BMJ, I was immediately asked about a recent BMJ paper on HTN. Read what you say you read!

   What is your opinion of EBM?

   Is EBM all it's cracked up to be?

   How does EBM translate into practice?

8. **Leftfield unanticipated questions!!!**
   Do you know of any law on radiological doses allowable to patients?

11.2.4.5 Feedback and Debriefing

It is generally advisable and important to get feedback on applications and interviews. This allows one to learn from mistakes and shortcomings so that these can be addressed in subsequent applications and interview, whether it be for a GMS post or indeed in any other application/interview. Feedback can be obtained from the members of the Interview Board and from the HSE.

11.2.5 Contractual Matters

Should one be the successful candidate in a GMS interview, this will not only lead to a GMS contract, either immediately in the case of a GMS Partner, or all being well after a probationary period in the case of an Assistant, but it will also trigger a process of negotiation of a Partnership agreement, either within a very short period of time in the case of a GMS Partnership or at some future date in the case of a GMS Assistantship. Chapters 5 and 6, 'Employment Relationships in General Practice' and 'Negotiation of Terms and Conditions of Employment and Partnership Agreements' deal comprehensively with employment relationships and contracts including Partnership agreements.

11.3 Payment and the Administration of Payments to Practices under the GMS Scheme

GMS payments to GPs are made under a capitation system. Contract holders are also paid practice allowances and subsidies. These payments contribute to the cost of Locum GP cover, practice staff salaries (nurse, secretary and practice manager), and medical indemnity insurance. There is also a rural practice allowance. Payments are processed and administered by the HSE Shared Services Primary Care Reimbursement Service (PCRS). Online processing and interaction is available via the SSPCRS portal once you have registered and obtained a certificate. Access to various services is via https://hse.sspcrs.ie/doctor. This requires a client authorisation certificate. Once logged in the following can be accessed: -

1. **Claiming**: This includes STC/SS claim entry and vaccination claim entry.
2. **Panel Management**: This includes doctor panel updates, all listings, capitation drilldown, a client checker and panel corrections.
3. **Account Details**: This includes prescription pad orders and contact details.
4. **Reports**: This includes reports of birth/death adjustment and fees listing.

Detailed information on the administration, claiming procedures and operation of GP state contracts is provided in the Primary

Care Reimbursement Service's '*Information and Administration arrangements for General Practitioners Handbook*' which can be downloaded from the relevant page on the PCRS website. Further information on the management of claims' systems is also contained in chapter 10, 'Practice Management'.

11.3.1 Schedule of Fees and Allowances under the GMS Contract

A list of current capitation payments, subsidies and allowances under the GMS contract, as of 24th July 2013, is given in Appendix 5. Appendix 5 also includes guidelines on payments for temporary, emergency and out-of-hours claims. These guidelines are taken from two joint HSE/IMO documents, the '*Temporary Resident/Emergency Treatment Clarification*' document' published on 19th October 2012, and the '*Out of Hours Clarification*' document published on 26th July 2013.

While a GMS Medical Card entitles a patient to a wide range of services, there are also a large number of services for which the GP is not paid by the State. Patients are required to pay directly for these services which are listed in Appendix 6.

11.3.2 Other State Contracts

A number of other non GMS State contracts with the HSE and other State bodies are available to GPs. There are also payments made by the Department of Justice for services provided by GPs. These contracts and payments include: -

The Mother and Infant Care Scheme (contract held with the HSE)

The Primary Childhood Immunisation Scheme (contract held with the HSE)

Social Welfare Medical Certification (contract held with the Department of Social Protection)

Various Other Contracts, State Contracts and Payments

11.3.2.1 The Mother and Infant Care Scheme Contract

The Mother and Infant Care Scheme provides for the delivery of services under Section 62 and 63 of the Health Act 1970. Every woman who is pregnant and ordinarily resident in Ireland (i.e. is living here or intends to remain living here for at least one year), is eligible for services under this Scheme. You are entitled to this service even if you do not have a medical card.

If a woman chooses to avail of services under this Scheme, she will be under a programme of joint care provided by a GP of her choice who has a contract with the HSE to provide services under the Scheme, in conjunction with and alongside a hospital Obstetrician. The GP provides an initial assessment and a further 5 examinations (if it is your first pregnancy) or 6 examinations (if it is a 2nd or subsequent pregnancy). These examinations alternate with visits to an obstetrician or maternity unit.

After the birth of an infant the Scheme also allows for the following: -

1. The baby to be examined at 2 weeks
2. The mother and baby to be examined at 6 weeks

A GP who wishes to provide services under the Maternity and Infant Care Scheme must apply to the HSE to do so. A standard agreement will be issued to be completed and returned to the HSE. It is the responsibility of the HSE to ensure that the GP is appropriately registered and insured. There is no reason why a GP should not be given a contract for the provision of maternity services. A copy of the signed agreement should be sent to the GP by the HSE.

In June 1998 the current structure of terms and conditions for GPs under the Mother and Infant Care Scheme was agreed. The current Schedule of visits is as follows: -

Week of Pregnancy	GP Visit	Hospital Visit
Before 12 weeks (**preferably** ASAP after conception)	*	
Before 20 weeks		*
24 weeks	*	
28 weeks	* (2nd/subsequent pregnancies)	* (1st pregnancy)
30 week	*	
32 weeks		*
34 weeks	*	
36 weeks		*
37 weeks	*	
38 weeks		*
39 weeks	*	
40 weeks		*
Birth of Baby		
2 weeks after birth (for baby)	*	
6 weeks after birth (for mother and baby)	*	

Where additional visits are required by women suffering a significant pregnancy related illness e.g. diabetes or hypertension, the doctor may request up to a maximum of 5 additional examinations. From the list of fee rates that are current as of 24/07/2013, the doctor will be paid €27.67 per additional visit.

It is important to note that care for all other illnesses which are co-incidental but not related to the pregnancy do NOT form part of the Scheme and a GP will not be paid for these visits under the Mother and Infant Care Scheme.

In addition, except for the planned 2 and 6 week post natal visits, the Scheme does NOT cover any other visits to the GP by mother or baby during the 6 week post natal period.

The fees paid to General Practitioners under the Mother and Infant Care Scheme with effect from 24/07/2013 are listed in Appendix 7.

11.3.2.2 The Primary Care Childhood Immunisation Scheme
A GP who wishes to provide services under the Primary Childhood Immunisation Scheme must apply to the HSE to do so. A standard agreement will be issued to be completed and returned to the HSE. It is the responsibility of the HSE to ensure that the GP is appropriately registered and insured, and there is no reason why a GP should not be given a contract for the provision of immunisation services. A copy of the signed agreement should be sent to the General Practitioner by the HSE.

The GP contractor will deliver the Primary Childhood Immunisation Programme agreed under the scheme. Vaccines are provided free of charge to all children. Parental or Legal Guardian consent is required for the administration of vaccinations to children and young people up to the age of 16 years. Vaccination is not mandatory in Ireland, however, with the Childhood Immunisations currently available it is possible to eradicate the diseases in question if an uptake level of not less than 95% of the child population is achieved and maintained. The objective of this Scheme is therefore to achieve and maintain an immunisation rate of not less than 95% of the total child population. It is when this uptake target figure of 95% is met that a bonus payment is made to a practice.

To help achieve the objective of this Scheme it is recommended that a practice notifies the local HSE child health office of immunisation defaulters and refusals. There are specific prescribed forms for making these notifications. Defaulters are those children who have not been vaccinated despite their parent(s) having been contacted by the GP. Refusals are where parents have indicated that they do not wish to have their child vaccinated.

The current payment structure and fees paid to General Practitioners under the Primary Childhood Immunisation Scheme with effect from 24/07/2013 are listed in Appendix 8.

11.3.2.3 Social Welfare Medical Certification
GPs who wish to become Medical Certifiers should contact the Department of Social Protection in order register and obtain a contract. The department can be emailed at help.mras@welfare.ie. GPs will be issued with a unique DSP Panel number. The DSP Panel number is different to the GMS number. The DSP Panel number must be on all claims forms submitted for payment.

Under Social Welfare Legislation, the duties of a Medical Certifier are to: -

1. Examine patients who are making claims to illness or disability schemes
2. Complete and issue, free of charge to the patient, a medical certificate on the official form, where the Certifier is satisfied that the patient is incapable of work due to some specific disease or bodily or mental disablement
3. Complete and issue medical certificates of confinement, free of charge to the patient, on the official form in relation to Maternity Benefit Claims
4. Complete and return Medical Report forms, free of charge to the patient, when requested to do so by the Department

From August 2011 the Department of Social Protection introduced a new system for the payment of MC2 certificates (i.e. intermediate/final certificates). Medical Certifiers are now paid on the basis of scanned MC2 certificates and are no longer required to submit MC2 counterfoil in order to receive payment. However, it is important to ensure that the DSP Panel number is on each certificate otherwise payment may not be processed. There is no change to the system for claiming for MC1 (i.e. first / first and final) certificates, and the counterfoils must be submitted directly to the Department of Social Protection to receive payment.

The fees payable to Medical Certifiers under an agreement between the IMO and the Department of Social Protection are paid on a quarterly basis. As of 2008 payments are as follows: -

1. Medical Certificates €8.25 per certificate
2. Medical Reports €44.44 per report

For further information on medical certification, the booklet 'The Medical Certifier's Guide to Medical Certification under Social Welfare Certification' is available from the website of the Department of Social Protection. The booklet was most recently revised in February 2014.

11.3.2.4 Department of Justice Fees
GPs may be requested by the state to undertake examinations, be professional witnesses, and provide testing and reports. While this is not specifically a '*contract*', there is a defined fee payment schedule. This schedule is detailed in full in Appendix 9.

11.3.2.5 Various Other Contracts, State Contracts and Payments
Other State Contracts and payments which GPs can apply for include: -

1. Payments under National Immunisation Programmes other than the Primary Childhood Immunisation Programme (see appendix 8)
2. Level 1 and 2 Contracts under the Methadone Treatment Protocol
3. District/Community Hospital and Long Stay Unit for the Elderly Medical Officer Contracts
4. GP Unit Doctor Contracts
5. GP Trainer Contracts
6. Director and Assistant Director of GP Specialist Training Scheme Contracts
7. C.I.E, Port and Docks, An Post and An Garda Síochána Medical Officer Contracts

Further information on these can be obtained from the Irish Medical Organisation.

11.3.2.5.1 Palliative Care
While there is no specific contract for the provision of Palliative Care services, there is an agreed fee which as of 24th July 2013 stands at €217.80.

v.2.0 / August 2014

12: Providing for the Future: Insurance, Pensions and Wills

Introduction

Due to the length of time spent in university and training, GPs generally tend to be much older than the average professional when they begin to earn significant income. Making adequate provision for the future should therefore be of paramount concern to any newly qualified Practitioner as he or she has a significant amount of catching up to do.

Provision for the future will be made from the profits which the practice achieves or from employment income and it is easy in the busy day to day routine of practice to ignore or postpone planning for the future. It is therefore important to have an overall financial plan which contains within it provision for the future. Such a financial plan should take into account ones expected income and likely outgoings over the next few years.

It is often the case that GPs assume that once established their practice will continue with a consistent level of activity and that they themselves will carry on working up to the point of retirement. At that stage, their hope may be to have a retirement which is funded on the proceeds of capital that has been accumulated in the intervening years. Unfortunately, such assumptions are rarely valid. Without provision for ill health, retirement and/or death, a Practitioner may carry an inordinate level of personal risk.

This chapter deals with: -

1. **Insurance**
   - **a.** Income Protection
   - **b.** Specified Illness Cover/Critical Illness Cover
   - **c.** Life Cover/Life Insurance
   - **d.** Insuring The Assets Of The Practice
   - **e.** Cash Insurance
   - **f.** Insuring Against Legal Action
   - **g.** Insuring Practice Partners/Key Person Insurance
   - **h.** Spousal Cover
   - **i.** Insuring Against Future Tax Liability
   - **j.** Investment Policies
2. **Pensions**
3. **Wills**

12.1 Insurance

In the context of general practice, there are various types of insurance cover that need to be considered. These include various types of insurance that apply to the GP's personal financial circumstances and risk profile and others which apply to the circumstances of the business.

12.1.1 Income Protection

Income Protection, also known as Permanent Health Insurance (PHI) or Salary Protection, is an insurance Policy that after a certain period of time, known as the deferred period, provides replacement income if one cannot work or earn income as a result of an illness or injury. You can take out Income Protection if you are in full-time work or earn self-employed income. It protects only in circumstances of illness or injury, i.e. it will not be paid if you become unemployed. Further general information on Income Protection is available from the National Consumer Agency's website.

You may ask why might you might need Income Protection, but just imagine what your standard of living would be if you were unable to work. Your income is probably your most important asset. It funds your whole lifestyle from what's in your fridge to where you go on holidays. Any dependents will be reliant upon it. Children for example depend on it from birth right through to college and often beyond. GPs with dependants and significant monthly outgoings should ensure PHI is a central part of their protection planning.

12.1.1.1 The Deferred Period

The deferred period is the length of time that passes before an Income Protection policy starts to pay out. This is one of the most important aspects of Income Protection.

Whilst standard Income Protection policies generally pay out after the policyholder has been off work for three months (simply because many employment contracts will provide sick pay during this period), it is possible to take out a policy which has no deferred period, i.e. day one cover, or with a deferred period of four, eight, 13, 26 or 52 weeks. It is therefore important to understand the type of employment you are in, and what if any sick leave entitlements you may already have.

For doctors who work as Locums and have no contract of employment it may be very appropriate to have day 1 cover. In the event of being sick for even a single day Income Protection will be paid. Considering that there would be no other payment whilst unable to work, this would compensate the loss of earnings even for a single day. This type of Protection might also be very appropriate for other self-employed individuals.

If you are self-employed, your income would stop immediately if you become unable to work, as you will neither be entitled to social welfare disability benefits nor sick pay from an employer. As opposed to employees who are entitled to €188/week, the self-employed are entitled to nothing. In these circumstances, this type of policy could provide an invaluable financial safety net.

If on the other hand you have a sufficient nest egg of savings available which you are willing to dip into, you may wish to consider a deferred period. The significant and not insubstantial disadvantage of day one cover is of course that the premiums will be higher.

If you are employed as a Sessional GP or Assistant without a GMS number, it is important to know what sick payment arrangements are in place within your contract of employment. How long will your employer pay you for if you are on extended sick leave? Depending upon your contract of employment, you may get sick pay for a short period, a long period, or not at all. In these circumstances you may wish to tailor the deferred period to match the sick leave payments you receive through your contract.

PHI cover is particularly important for the self-employed as it provides a replacement income should the policyholder be unable to work for an extended period of time. Given the fact that the benefit is '*permanent*' this benefit could continue to be paid until retirement age in the event of a disability or other severe accident which prevented the Practitioner from ever returning to work. The underwriting requirements are much stricter than for other protection policies and the policy structures can vary dramatically from provider to provider, some offer '*guaranteed*' cover while others will only offer '*reviewable*' cover. Expert advice should always be sought before a PHI policy is taken out.

12.1.1.2 How much does Income Protection Pay-Out?

If you are unable to work due to illness or injury, after the deferred period, Income Protection will pay you an agreed monthly benefit of up to 75% of your salary until you are able to return to work or reach retirement age. Anyone taking out an Income Protection policy is in effect insuring a proportion of their income. Typically the maximum proportion of income that can be insured is 50% of current salary. However, because Income Protection is paid tax-free, in net terms, the amount of benefit paid is approximately 75% of take home pay.

When you take out an Income Protection policy, you decide on the amount of benefit you would like to be paid in the event of a claim. The maximum level that you can claim is 75% of your income to a maximum of €250,000. Benefits paid are less any State benefits or other Income Protection plans to which you may be entitled.

In some policies there is partial benefit, i.e. if you return to work but suffer a drop in earnings you may be entitled to a partial benefit payment.

12.1.1.3 Cost of Protection

The cost or premium of an Income Protection policy will be dependent on many factors including age, income, health, the benefit you choose, and very importantly, the deferred period. It is possible to reduce the cost of premiums by extending the deferred period, however this is a balance that will require careful consideration.

12.1.1.4 Other Important Things to Note about Income Protection Policies

Income Protection policies are designed to support individuals when they cannot work, but may also help get individuals back to work. It is clearly in the financial interest of insurance companies to get you back to work and therefore, a policy may provide access to rehabilitation services and in some cases to leading edge medical advice and treatment.

It is extremely important to understand exactly what is, and isn›t, covered under the policy. Some Income Protection policies cover you only if you become severely disabled and are not able to carry out any job. Such a policy provides very little protection and you would need to become severely and permanently disabled before you could claim any benefit. It is therefore important to have '*own occupation*' cover. This ensures that a policy pays out if you are unable to do your own job. Some cheaper policies may offer '*any occupation*' cover which means they will only pay out if you are too ill to undertake any type of paid work.

Policyholders can also claim more than once on an Income Protection policy. For example, if you are off for months with a back complaint, the policy will pay out. Provided you keep paying the premiums when you go back to work, you will still be covered and you can claim for the same condition again.

If employed, your cover may continue in the event of you changing employment. If you are made redundant you can keep your policy in place, but you cannot claim under the policy if you are unemployed. You are under full cover if you are working in the EU.

PHI premiums are allowed as deductions for income tax purposes. The rate of tax relief will depend on your current tax bracket. The deductible premium cannot exceed 10% of your total income for the tax year in question. Any pay-out that you receive from a PHI policy is charged to tax under PAYE.

The continued payment of pension premiums should also be considered when examining PHI coverage. Waiver of premium benefit can be arranged which will mean that after a period of 26 weeks of illness the insurance company will continue to pay the premium to your pension plan until retirement age. This provides the benefit of a pension income after PHI benefit ceases. PHI usually ceases at retirement age, normally 65, although it is likely that as retirement age increases in the coming decades, the age at which PHI ceases will also increase.

If and when taking out Income Protection, it is important to select an appropriate level of income required, and review this

every few years. Otherwise you could end up in a situation in which you are under or over insured. For example, if an individual is earning €75,000 when they become sick, their replacement salary will be based on this amount, even if they have insured themselves for €100,000. Clearly in this case the individual would be over-insured and paying higher premiums than necessary.

12.1.1.5 Income Protection and the GMS Contract

12.1.1.5.1 The GMS Sick Leave Scheme

The General Medical Services Scheme provides for payments to be made to GPs via the PCRS in respect of Sick Leave. Circular 014/14 dated 28/03/2014 advises contract holders of amendments to the Scheme as part of the new public service Sick Leave Scheme which came into effect on 31st March 2014. These amendments substantially reduced the Sick Leave entitlement under the GMS Scheme. The GMS Sick Leave Scheme is based on a rolling four year period, and provides for sick pay as follows: -

1. A maximum of 92 calendar days on full pay in a year ***followed by***
2. A maximum of 91 days on half pay ***subject to***
3. A maximum of 183 calendar days paid Sick Leave in a rolling four year period

In practice this means that in any four year period a cumulative total of 183 days Sick Leave can be accrued but that if a GP has taken a cumulative total of 183 days Sick Leave, i.e. six months, they will have to wait for four years to be entitled to more Sick Leave. Full capitation will be received for the first 92 days, and half capitation for the following period of 91 days.

In recognition that sometime a longer period of Sick Leave can be required to address a very serious/critical illness or serious physical injury there is provision for additional payments in these cases to apply in line with those which apply to officers of the Health Service Executive. The award of extended Sick Leave for critical illness or serious physical injury is at the discretion of the HSE, after medical advice has been received from an Occupational Health Physician nominated by the HSE.

Locum payments are also made under the Sick Leave Scheme. Under the new arrangements, if unable to work due to ill health, GP contractors with 100 or more GMS patients receive the appropriate contribution towards Locum expenses at a full rate up to a maximum of six months and at half the appropriate rate for a further six months to an overall maximum of 365 contribution days in a rolling four year period. Locum payments are also dependent upon the panel size, with the entitlement being divided into two bands, 100 to 700 patients and 700 or more patients.

In respect of the system having changed on 31st March 2014, GPs who were on Sick Leave prior to 31st March 2014 and who remained absent when the new arrangements came into operation retained their existing contribution to Locum expense entitlement until such time as they returned to practice after which the new arrangements will apply.

12.1.1.5.2 Retirement from the GMS on Grounds of Ill Health

Under the GMS Superannuation Scheme a GP who is aged under 55 and who suffers permanent and serious ill health and is retiring for this reason will be provided with a sum of twice the average annual GMS capitation fees, plus a refund of his/her own adjusted 5% GMS Superannuation contributions with interest. A choice then exists. The sum may be used to provide either: -

1. An immediate lump sum plus a pension and dependants pensions or
2. A deferred lump sum pension and dependants pension

During the period of deferment, the fund will continue to accumulate. This option may therefore be preferred if the GP has Income Protection/PHI cover that provides adequate continued income.

In reviewing Income Protection/PHI a GP holding a GMS contract should pay particular attention to the following: -

1. The proportions of GMS and private practice earnings
2. The fact that on becoming ill, private income will reduce within a short period of time while GMS capitation fees continue for a year
3. The need to provide for an income in retirement after Income Protection ceases

Where practice income is derived from both private fees and GMS payments, it may be necessary to arrange separate Income Protection/PHI Policies. Clearly, because there is sick pay under the GMS contract, any Income Protection/PHI Policy would have a deferral period of at least 13 weeks, if not 26 weeks and be payable to age 65. Even though capitation income will be paid for a full twelve months, under the new GMS Scheme Sick Leave arrangements, sick pay will only be for a maximum of 183 days, i.e. six months. At a minimum an Income Protection policy must kick in at 12 months so that when capitation income ceases after one year, the Income Protection payment will commence. It may be preferable with the change in Sick Leave arrangements for Income Protection payments to start at six months. It may also be advisable to arrange a separate policy in respect of private earnings with a short deferred period and payable to age 65.

Many insurers impose HIV/AIDS exclusions on new policies. As with any other Insurance Policies, GPs should be wary of discontinuing existing Income Protection/PHI Policies before being sure that replacement policies offer at least equivalent cover.

In relation to Sick Leave, it is important to note that fluctuations in practice income may be queried by Revenue and must be accounted for. Therefore, it is crucial to record all days not worked due to illness and to keep supporting documentation.

12.1.2 Specified Illness/Critical Illness Cover

Critical illness cover is also known as Serious Illness Cover or Specified Illness Cover.
This is a policy which will pay out a once off tax free lump sum if you are diagnosed with one of the illnesses specified in the policy. The medical conditions covered can include forms of cancer, heart attack, stroke and so on and will vary from policy to policy. They should therefore be studied in detail before a policy is taken out. The policy could also cover permanent total disability as a result of an accident. In theory, this should

pay off any outstanding mortgage if the breadwinner is forced to give up work because of cancer or a heart attack. However, remember that the most common reasons for people to be signed off sick are stress, depression and back pain. None of these would trigger a pay-out from a critical illness policy but would on the other hand be covered by an income protection plan. Most serious illness policies will not cover you for many of the most common illnesses that prevent people from working.

Serious illness cover can be a godsend if you fall ill and have no other cover in place, but only if your interpretation of what constitutes a '*serious*' illness matches the exact definition in your policy. It is all too often the case that people discover that the particular condition they›ve been diagnosed with is not actually included. Historically there have been problems with certain conditions being tightly defined and customers thinking they›re getting broader coverage than they are. For example, most of us would assume that being diagnosed with cancer is about as serious as it gets, but if the disease is caught early, before it has invaded the surrounding tissue, in many cases you won›t be able to make a claim under a serious illness policy. Even if you develop an illness that is serious enough to prevent you from working and earning an income, your policy might not pay out any benefit. It›s essential to check not only which illnesses are covered by your policy before signing on the dotted line, but also how these illnesses are defined. And ***do not*** confuse Critical Illness Cover with Income Protection! They are very different.

When taking out Critical Illness Cover, avoid being swayed by the price alone. The level of cover and service provided should also be factored in. It is also important to review your situation on an on-going basis to make sure that the product still matches your circumstances. For example, as people approach retirement, they may well decide that the need for Serious Illness Protection is no longer as pressing, perhaps because their children have flown the nest and they no longer have dependants. It could make more sense at that stage of life to divert the money away from insurance policies and towards a better retirement. Critical Illness Cover can also be an additional benefit to a Life Insurance policy instead of a stand-alone policy.

In relation to Serious Illness Cover, general industry recommendations are that all mortgage debt and short term debt is covered first. In addition, it is recommended to have a lever of cover that provides for two years net income.

12.1.3 Income Protection versus Critical Illness Cover

It is very important to have a clear understanding of the difference between Income Protection/PHI and Critical or Specified Illness Cover. They are entirely different types of insurance policies and differ dramatically in their structure and tax treatment. Both options should be thoroughly explored before a decision is made on what type of cover is appropriate for a given situation.

Income Protection or PHI (Permanent Health Insurance) provides cover from any medical condition which prevents the policyholder from working. It does not specify any particular medical conditions which must be diagnosed before the benefit becomes payable. It will continue to pay until retirement age or until the policy holder is able to return to work.

On the other hand, Specified or Critical Illness Cover only pays out only if certain medical conditions develop in which case a lump sum is paid out. Critical/Specified Illness policies are often very restrictive, e.g. many common illnesses such as prostate cancer (at the early stage of diagnosis) or skin cancers are excluded from Critical/Specified Illness policies by various life offices. Given the fact that Income Protection covers any medical condition, the underwriting requirements tend to be much stricter than Critical/Specified illness policies.

Income Protection/PHI is more appropriate in providing long term cover against loss of earnings as a result of medical illness or accident while Critical Illness/Specified Illness Cover might be appropriate where a lump sum benefit would be more appropriate e.g. in connection with mortgage protection.

12.1.4 Life Cover/Life Insurance

Life Cover or Life Insurance is an insurance we take out on our own lives or the lives of our partners which pays out a predetermined once off tax free lump sum of money to loved ones if the insured person dies within a specified time period. The payment can be used to protect your loved ones financially if you die, or ensure the financial survival of any business.

There are many different types of Life Insurance policies but they can all be divided into two basic types: death policies (also known as term insurance) and investment policies. The main categories are: -

1. ***Term insurance:*** This gives the policyholder the assurance of a specific sum should he/she die within a specific period, e.g. a sum of €1,000,000 in the event of death at any time within a period of 20 years (or whatever length of time the policyholder wishes to be covered for). If the insured person dies during the term of the policy, the sum insured becomes payable; if he/she survives the policy will have no encashment value. Term insurance is the cheapest way of providing protection and at a minimum every individual with dependents should have this type of cover. ***An endowment plan*** is a long-term regular savings plan with included life cover. At the end of the plan the policyholder receives a lump sum equivalent to the sum assured plus any bonuses which have been added over the years. Unlike simple term insurance the policy also carries an encashment value. It is likely that this encashment value will be less than the total premiums paid during the early years of the policy.
2. ***Convertible term:*** This type of policy is similar to term assurance but by paying an additional premium the policyholder receives the right to convert the policy to either a whole-of-life contract or an endowment plan, irrespective of his state of health. One limiting factor is that the sum assured on the new policy cannot exceed the sum assured under the original policy.
3. ***Whole-of-life:*** This category provides an individual with life assurance for life provided that he/she continues to pay the premiums required by the policy. A whole-of-life policy normally includes an investment component with the result that the policy acquires an encashment value. However because the rates of return on the investment portion of this policy tend to be much lower than those available from other life-office investment products this kind of policy rarely makes economic sense. However, a policy of

this type may provide tax efficient inheritance planning cover for your family so as not to impact their inheritance. It is advisable to take independent financial advice on this. Life-long cover does offer guaranteed cover against the following incidents which could affect your family's future income – death, terminal illness (within a defined time frame from diagnosis of condition), accidental death and death of children up to a specified age.

It is also possible for Life Insurance policies to cover different individuals or combinations of individuals. This includes single, dual and joint Life Cover: -

1. **Single Life cover**: This is taken out by one person and is payable on their death during the term of the Policy.
2. **Dual Life cover**: This is taken out on behalf of two people and is payable on each death during the term of the Policy.
3. **Joint life cover**: This is also taken out on behalf of two people. It can be taken out on a First Death or Second Death basis, i.e. paid on the death of either the First Life or the Second Life during the term of the Policy.

The primary role of Life Insurance is the provision of financial protection for family and other dependents. In taking out life cover your aim will be to make enough money available to provide adequately for your dependents in the event of your death. Clearly, the requirements for Life Cover will vary according to each life stage and will be influenced by the number of children and their ages. The ideal way to assess how much cover is required is for your partner to decide how much they would need in the event of your death.

In selecting a suitable Life Insurance policy it is important to keep in mind the distinction between '*protection*' and '*saving/investment*'. The reason for this is that in addition to simply providing low cost insurance products most life insurance offices also offer more expensive policies that combine insurance with a savings plan. Before one decides on the type of insurance product required it is important to examine the differences between the various types of policies offered. The choice of policy will depend on the type of cover you require *and* the finance available to you. Availability of finance may be the deciding factor for the establishing GP. Term insurance is likely to be chosen by the establishing GP as it is the most cost-effective option. As there can be quite considerable differences in quotations for life assurance products it may be advisable to use the services of an independent broker. Usually the cost of arranging cover will be the same whether dealing directly with the insurance company or using a broker.

Life Cover arranged with loans tends to be extremely expensive. Normally this type of Life Cover should be avoided and all such debts should be covered by a separate Life Insurance policy. Normally only a mortgage on the principal primary residence will require Life Cover. Other loans should be covered by a separate Life Insurance policy.

12.1.4.1 How Much Life Cover?

The level of cover required should be determined by the minimum income needs of your survivors. A rough guide based on a 2014 rate of return, using a net interest rate of 0.885% (1.5% less 41% tax), on a capital and interest basis, is that a fund of €500,000 worth of Life Cover will provide a dependent with a tax-free income of around €29,800 per annum. This also assumes that deposit rates are static, but if we further account for inflation, the relative value of the dependent's income will gradually reduce from €29,800 per annum.

Previously, general industry guidelines would have suggested that a person with dependents should have Life Cover of between 10 and 15 times their gross income. However, a more accurate industry standard recommendation in relation to Life Cover is based on a net monthly replacement income requirement, up until the youngest child is 25 years of age, i.e. the amount of income required after all loans are paid. It is also recommended that all mortgage debt and short term debt is covered for Life Cover first. If in addition a client required €5,000 per month and the youngest child was aged 5, the recommendation would be to have €1.2 million in cover over 20 years.

It should also be remembered that any outstanding debts, loans and other liabilities will need to be paid on death and this amount should be added to the multiple of income you compute. Naturally, higher levels of cover have stricter underwriting requirements. These requirements vary with age.

12.1.4 Insuring the Assets of the Practice

A GP should check that all the fixed assets of the practice, e.g. fixtures, fittings, equipment and premises are insured adequately against loss, damage and theft. The cover should be reviewed regularly, especially when significant changes are made to the practice, e.g. after the purchase of new medical equipment or any structural alterations made to the premises such as an extension, etc. Individual items may be insured separately but it is perhaps more convenient to take out a comprehensive policy. If the practice has any expensive medical equipment then the Practitioner should ensure that these items are covered by the comprehensive policy and they made need to be specifically listed. Some insurers provide specific medical surgery cover.

Eventualities such as fire and theft must obviously be covered and most policies will include standard cover of this nature. It is advisable however to check that there is specific cover in the policy and that it is up to date. The primary consideration when assessing the level of insurance coverage required should be the cost of replacing any damaged or stolen equipment or fixtures.

Points to consider when insuring premises include: -

1. Any property is not fully covered for loss or damage unless it is insured for the full value. Cover should be reassessed at each renewal and increased appropriately, if there is no automatic adjustment. It is the responsibility of the policy holder to check this matter.
2. The cost of insurance varies and it is worthwhile shopping around as the policies provided by a finance house will usually not be the most competitive. It is advisable to seek the advice of a broker.
3. In most policies an '*Average Clause*' exists. This means the insurance company will only pay out on a claim an amount in proportion to which the sum insured relates to the value at risk. The easiest way to illustrate this is with

an example. A practice suffers damage amounting to €50,000. The premises are insured for €200,000 and the value at risk is €300,000.

Sum insured	=	€200,000
Value at risk	=	€300,000
Total loss	=	€50,000

Because the sum insured is 2/3rds of the value at risk, one is insured for two thirds of the actual loss, i.e. two thirds of €50,000. In this case the actual compensation will be €33,333.

4. All the details of a policy should be noted, in particular the exclusion clauses.

Points to consider when renewing insurance cover include: -

1. Insure premises, equipment, fixtures and fittings
2. Have adequate cover
3. Undertake regular review
4. It is important to review cover after major practice changes or investment
5. 'Shop' around
6. Seek independent advice
7. Some insurers provide specific medical/surgery cover

12.1.5 Cash Insurance

Cash insurance covers loss of money by robbery, theft or other causes while at the business premises, in transit or while in the GP's home. Cash insurance will normally be covered in a comprehensive combined policy, but one should be aware of the limitations of a policy in relation to cash.

12.1.6 Insuring Against Legal Action

12.1.6.1 Public Liability Insurance

It is essential that a public liability policy should be taken out at the commencement of practice and that is maintained. It is compulsory if using one is using an HSE premises. A public liability policy covers legal ability of the insured in respect of injury to persons, or damage to their property arising through negligence of the GP or that of his employees or through any defect in the property of the insured.

Current recommendations are that public liability policies should provide cover of up to €6.5 million against claims arising from accidents to third parties in the premises. Care should be taken in the structure and design of the surgery premises and fittings in order to decrease the risk.

12.1.6.2 Employers' Liability Insurance

The purpose of this type of cover is to protect the GP against claims for damages brought by an employee. Such action may arise through the negligence of the GP or through failure to provide a safe place of work, a safe system of work, or failure to engage suitable and competent employees. Such policies can also provide cover against an unfair dismissal case as well as any legal or other associated costs. The practice Health and Safety Statement will be of assistance in lessening the risk with regard to the above.

12.1.6.3 Medical Indemnity

It is compulsory to have medical indemnity cover under the GMS and under the current Medical Council Ethical Guidelines, all doctors must carry adequate indemnity for the work they perform. This is covered in more detail in chapter 2, 'Basic Requirements for Independent General Practice'.

12.1.7 Insuring Practice Partners/Key Person Insurance

The consequences of the death (or disability) of a practice Partner should be considered in any review of the insurance cover of the practice. The point being that in the event of a Partner being unable to contribute to the practice, funds will be required to ensure the continued smooth operation of the practice and to compensate for the loss of the Partner's contribution towards costs. Various forms of Life Policies can be utilized, ranging from pure term assurance and whole-of-life cover, to Critical Illness cover.

The most flexible approach to this form of protection is an '*own life in trust*' policy, i.e. the GP takes out a policy on his own life in trust for his/her Partner(s). If the GP survives until retirement age, or the Partnership is dissolved, the trust can be revoked and the policy will then revert back to the GP who may then put it in trust for a new Partner or spouse. It is also important to include specified or critical illness cover and total permanent disability when arranging cover, e.g. if a Partner suffers a stroke and cannot work again, the other Partner(s) may wish to buy his/her share of the practice.

A further point to be remembered in dealing with Partnership insurance is that problems can arise for a younger Partner when an older Partner survives to retirement. For example, the older Partner's share may have to be purchased yet no insurance policy has paid out to the younger Partner to fund the purchase of this share. In this case it may well be that the younger Partner will have to borrow money to purchase the older Partner's share unless he/she has made prior arrangements. If this problem is anticipated the younger Partner should be able to invest in a savings plan so that a lump sum will be built over the years.

A couple of things to note are: -

1. Where a GP already has an existing life insurance policy for Partnership purposes he should arrange critical illness cover separately.
2. Professional advice should be sought in order to ensure that the sum assured is adequate and the buy-out of the retiring Partner's share is structured tax efficiently.

12.1.8 Spousal Cover

Quite often the contribution of a spouse to the running of a practice goes unnoticed and it is often the case that a spouse's contribution to the financial performance of a practice is not appreciated until absent. If the spouse were to die, the impact on the smooth running of the practice could be very significant indeed. In this context, taking out a policy on the life of a spouse is worth considering even if the spouse has an independent income. By arranging adequate cover the surviving spouse would be in a position to pay for services such as administration and secretarial work that the deceased spouse had been contributing. The tax treatment of payments of these premiums requires expert advice.

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12.1.9 Insuring Against Future Tax Liability

Capital Acquisitions Tax (CAT) on inheritances and gifts is '*beneficiary-based*', i.e. the recipient (as opposed to the deceased or the donor) is liable to pay any tax that falls due. No tax arises where a spouse inherits or is gifted property by his or her spouse.

It is prudent to make advance provision if your successors are likely to incur a tax liability on any inheritance from you. Tax is normally payable within four months of receiving an inheritance and if no provision is made the beneficiary may be forced to borrow to meet the liability. Note however that CAT is not charged on gifts or inheritances from a spouse.

CAT legislation enables advance provision to be made for the payment of CAT. It does this by providing that the benefit of certain life assurance policies is not taxable where the proceeds from the maturation of the policies are used to pay a successor's CAT liability. In order to comply with this legislation and receive the benefit free from tax the policy must be designated in advance that the proceeds will be used to pay a projected CAT liability. The projected CAT liability is known before the policy is taken out and the policy document is stamped to indicate that the benefit will be used to pay CAT. If the CAT liability turns out to be less than the benefit received upon maturation of the policy, the excess becomes taxable and subject to CAT in the normal manner. Also, if the benefit received is not used for the payment of a CAT liability the benefit becomes subject to CAT in the normal manner. If proper estate planning is undertaken with a competent tax adviser it should be possible to minimize the inheritance tax liability.

12.1.10 Insuring Against Costs of Audit/Agency Review

Each year Revenue and other agencies such as the National Employment Rights Authority (NERA) audit a number of GPs. Clearly, in the case of such an audit, preparation will be required resulting in the incurring of costs. It is possible to obtain insurance against such costs arising from Revenue or other agency audit. The cost of such insurance is non-deductible for tax purposes. A number of firms provide such insurance and it is advisable to speak to a broker.

12.1.11 Investment Policies

In addition to Pensions and Term Insurance, banks and life offices offer a range of investment policies. These policies are designed to provide the policyholder with a future lump sum. Usually, but not always, an element of Life Cover is built into these policies.

Generally it is more efficient to make separate arrangements for Life Cover and Savings Cover rather than opt for a policy which contains both. Quite often the cost of providing protective cover (such as Life Insurance) will dramatically diminish any potential investment return from a Savings policy. It is for this reason that it is better to keep savings needs and protection needs in separate policies.

In deciding on an investment policy you need to examine what the policy is invested in. Investment policies can invest in a variety of assets from stocks to government bonds to property. How a policy is invested is known as its asset allocation policy. Investment assets can vary from high risk e.g. emerging market equities or volatile commodity assets such as oil, silver or gold, to low-risk e.g. government guaranteed bonds. Life offices will offer policies according to the risk profile of the investor. A policy which is 100% invested in emerging market equities will be much higher risk than a policy which is 100% invested in Euro denominated government bonds.

The range of charges can also vary dramatically from one type of policy to the other. For example, a unit-linked guaranteed policy with a protection mechanism that invests in a managed fund will be more expensive than an index tracking policy which simply follows the performance of a stock market index e.g. FTSE-100. The increased charges are used to pay for any additional features; in the case of the first example given, the guarantee and protection mechanism.

In choosing a policy one of the most important factors to consider is the policy's net-of-cost investment performance. The performance figures published by the life offices generally do not include any annual management charges or policy fees. These performance figures illustrate how the funds have performed over the past number of years. While past performance is not a predictor of future performance, a life office which has consistently performed well inspires more confidence than one with a very erratic investment performance.

Before purchasing an investment policy from a vendor such as a life office or bank it is highly advisable to seek independent financial advice. The range of investment policies currently available is quite extensive and can vary from with-profits to unit-linked with guarantees with or without protection. These can be quite bewildering to the novice investor. A competent independent adviser will be able to examine your attitude to risk and your expectation of future returns. He/she will also discuss whether these investment funds are likely to meet your needs. Unlike pension premiums, premiums on life insurance policies are not tax-deductible.

While most investment policies provide for early encashment, early encashment usually gives rise to a penalty which can be quite severe. In the case of some policies, encashment during the first year would lead to a loss of around 5% of the capital. Protection policies such as Term Life policies, Mortgage Protection and convertible term do not have a surrender value as the policies have no investment content.

12.2 Pensions

Pensions can be quite confusing and many people find them difficult to understand. It is important to remember that there are two separate elements to a pension. The first is the pot of money into which you invest throughout your working life. This is known as your pension fund. The second is the income you take at retirement. When you retire, you can usually take a percentage of your pension fund as a tax-free cash lump sum. You don't have to take a tax-free cash lump sum; you could choose to use your entire fund to provide you with an income during your retirement. The remainder of the money in your pension fund, i.e. the money not taken as a tax-free lump sum, is used to buy a product that will provide you with an income during your retirement.

In essence, a pension is a special type of savings plan in which you build up money in order to provide yourself with an income

in retirement. The basic concept of pension planning is to defer part of your current income in order to provide an income after retirement. It is a long-term arrangement and you can't dip into it before you retire, except in exceptional circumstance. This form of investment enjoys an important tax advantage in that, within limits, your pension contributions will attract tax relief. If you fail to take advantage of this tax relief you are in effect giving money to Revenue instead of saving for your own retirement. There are lots of advantages to pensions including: -

1. It will provide replacement income in retirement
2. It will allow one to achieve greater financial security during retirement
3. There are generous tax reliefs on pension contributions
4. Pensions growth is tax free, although at present a temporary Government levy applies
5. There is an opportunity to take a generous once off tax free lump sum
6. A pension can either be professionally or self–managed

It is important to have a pension as a form of provision for retirement income, because it is simply a fact of life that we have to pay to keep on living during retirement. It is also a fact that many of us are living longer meaning that many of us will also have long retirements. If for example you retire in your sixties, it is likely that you will live for another 20 to 30 years.

While the basic state pension is a start, and may be supplemented by other benefits to which you are entitled, it›s unlikely to be enough to give you the standard of living you want. Therefore, it is worthwhile to consider having your own pension. It may even be the case that despite having your own pension, that your pensions alone will be insufficient to provide a comfortable living in retirement. This may require consideration of other investments such as equity (stock-market) investments, bonds, and gold, art and/or property investments to supplement projected pension income. As with any type of investment, pensions included, it is important to remember that the value can go up as well as down. It is also prudent with all financial investments to obtain good quality independent financial advice.

What is not in doubt is the importance of trying to ensure you have put enough into your pension to provide you with sufficient retirement income. The more you can save during your working years, the better standard of living you will likely be able to afford on retirement. Practically, this means the earlier you start paying into your pension, the better. By saving more money over a longer period of time your pension fund will have longer to grow. Whether that›s through your employer, a personal pension or both, is up to you. If you work or have worked for the HSE you will be entitled to an HSE pension, and if you have a GMS contract there is a GMS pension scheme which is overseen by a Board of Trustees of GPs.

After retirement a GP and spouse will usually have three main sources of income with possibly a small HSE pension from time worked in either the HSE or Health Boards: -

1. General Medical Services pension
2. State pension
3. Private pension policies
4. HSE pension

12.2.1 The GMS Pension Scheme

GPs who hold a GMS contract participate in the GMS Superannuation Plan in respect of the capitation payments made to them. This plan is overseen by a board of trustees which includes ten GPs. The plan is administered by Mercer (Ireland) Limited. Membership of the plan is not optional; rather it is a mandatory aspect of having a GMS contract. GPs contribute at the rate of 5% of their GMS income, with the GMS Payments Board contributing at the rate of 10%. The GP's contribution is tax deductible. Furthermore, the contribution by the GMS Payments Board is not treated as part of the GP's taxable income. GPs are not entitled to make any further pension contributions in respect of GMS payments, and as a result, for most Practitioners, the GMS pension will not provide sufficient retirement income. Consequently, they will need to contribute to a private pension. Almost all insurance companies market private personal pension plans, with private group plans available for GPs.

One important point to note in relation to the GMS Pension Plan is that when negotiating Partnership in a GMS practice, in addition to issues such as profit sharing, the parties will have to address the treatment of the Partners' GMS pensions and related issues including years of service and private pension arrangements.

12.2.2 The State Pension

The contributory State pension, which is not means-tested, is funded from the PRSI contributions paid by a GP. As with all citizens, a GP will be entitled to a contributory State old age pension if 10 years PRSI contributions have been made. This means for a GP who works until 70 years of age, contributions must have at least been made before the age of 60. Where a Practitioner is entitled to this State pension, its contribution to overall retirement provision is quite small, currently €230.30 per week or €11,975.60 per annum.

Changes in pension rules must also be factored in, particularly for GPs who wish to retire before 70 years of age. From 1st January 2021 the State Pension age is increasing to 67, and to 68 from 1st January 2028. In relation to date of birth, for those born between 1st January 1949 and 31st December 1954 inclusive, the minimum qualifying State Pension age will be 66, if between 1st January 1955 and 31st December 1960 inclusive, the minimum qualifying State Pension age will be 67, and for those born on or after 1st January 1961 the minimum qualifying State Pension age will be 68.

In the event of death, a surviving spouse or civil partner will remain in receipt of an income from this source. It is necessary that a minimum of three years contributions are paid.

12.2.3 Private Pension Plans

Despite not being able to make additional contributions from GMS income to the GMS Pension Plan, GPs in receipt of GMS income can make pension contributions in respect of their non GMS private practice income. A professional advisor will be able to calculate the amount of a GP's income in respect of which pension contributions can be made to a private pension. GPs are entitled to make private pension contributions of between 15% and 40% of the private practice fees net of the expenses

allocated against those fees. The maximum percentage that can be contributed depends on the GP's age in the tax year for which the payment is made, and the maximum gross income figure for relief purposes is €115,000.00.

Table 12.1
The amount of money which GPs can invest in a private pension and receive full tax relief on their relevant earnings (i.e. non GMS practice fees net of allocated expenses), subject to an earnings cap of €115,000

Highest Age At Any Time During Tax Year	% Of Relevant Earnings
Under 30	15
30-39	20
40-49	25
50-54	30
55-59	35
60 and over	40

The pension contribution is deducted from total income with the result that tax relief is given at the contributor's marginal rate of tax (up to 41%). It is this generous tax relief which makes pensions an essential part of retirement planning.

The earlier a private pension plan is started the better off the contributor will be. This is primarily due to the effect of compounding. A stark illustration of this is the difference in the size of the final pension fund of an individual who started a pension at age 25 contributing €1,000 a month compared to an individual who started a pension at 35 also contributing €1,000 a month. Assuming that both retire at age 60, the individual who started the pension at age 25 would have a final pension fund of €1.3 million (assuming fund growth of 5.4% p.a.) compared to his colleague's fund of €677,000! By starting 10 years earlier one retiree would have a fund almost twice as large as the other who started his/her pension at 35.

It is also crucial to review the performance level of contributions to a private pension on an annual basis in order to avoid any nasty surprises as one nears retirement.

12.2.3.1 Death Benefit
If a GP dies while contributing to a private pension, the accumulated private pension fund forms part of the Practitioner's estate. This is different from an occupational pension scheme where Revenue limits the death benefit payable to 4x annual earnings.

12.2.4 The HSE Pension (Superannuation Scheme)
One issue which is of immediate relevance to the GP Registrar on completion of training is the decision on culmination of previously accrued public service superannuation (the HSE NCHD pension). As former NCHDs, contributions will have been made to an employee superannuation scheme. Contributions will have been deducted at source by the employer (hospital/HSE) and deductions recorded in paycheques each month. All employees pay into this scheme which is a defined benefit 'pay as you go' scheme with pension based on final salary and payable at reaching minimum retirement age (65 for new entrants or 60 for non-new entrants).

When GPs leave the public service domain on graduation, the question arises as to what to do with the money already paid into this superannuation fund? There are two options: -

1. Do nothing. Benefits become payable on reaching minimum retirement age (as above) and if you do re-enter public sector employment at any stage prior to reaching minimum retirement age you can accrue additional reckonable service.
2. If superannuation payments have been made for less than 2 years, the facility exists to reclaim the contributions paid through your last employer. It is worthwhile noting this refund will be taxable.

12.2.5 Pension Review
There is one major caveat to pension saving – success will only come to an investor who is vigilant. Most individuals make contributions to a pension policy which is sold to them by a broker or a bank and rarely examine the investment performance of the pension itself. The generosity of the tax relief sometimes overshadows what might be an extremely poorly performing investment. Research has shown that over a 25 year period, for an annual contribution of €10,000, the difference between the best performing and worst performing pension fund can be as much as €526,000! Clearly, before starting any pension policy, professional advice from a competent financial adviser should be sought. Such advice will involve a pension funding analysis. This will help quantify the contributions required to provide an adequate income in retirement.

In general it is not advisable to contribute any money to a pension plan that does not attract relief. There are more efficient forms of saving than non-deductible pension investments. These investments are important since they will generate returns that will be subject to capital gains tax (CGT), currently taxed at 33%. In contrast, pension income is taxed at normal income tax rates.

At retirement age the individual has the option of taking a tax free lump sum of 25% of his/her accumulated pension fund (subject to a lifetime threshold of €200,000). The balance is either used to provide a pension for life through the purchase of an annuity, or is transferred into an Approved Retirement Fund (ARF). It is likely that most Practitioners will transfer the majority of their pension fund into an ARF as this fund can continue to grow free of capital gains tax and may be passed on to beneficiaries as part of the Practitioner's estate.

There are advantages and disadvantages in choosing to transfer to an Approved Retirement Fund or to purchase an annuity. Annuity rates are primarily determined by medium to long-term interest rates and these rates are currently very low compared to historical norms. For example, €100,000 used to purchase a level 50% dual-life 5-year indexed guaranteed annuity for a 65 year old would provide an income of €4,252 per year at current annuity rates, i.e. 4.25%. In contrast, with an ARF you can invest in a wide range of funds. For example, an investment in a deposit account may currently yield a return of approximately 2% per annum and you still retain ownership of the investment capital. While you still own the investment capital with an ARF, when you purchase an annuity, you give up the investment capital.

Another attractive feature of an ARF is that it is inheritable whereas with an annuity your pension will stop when you die unless you have built in a spouse's pension or a minimum payment period. In order to illustrate this we will assume the trustees of your pension fund purchase a single life annuity for €1,000,000 which produces an annual income of €48,000 and you die after 6 years. In return for your €1,000,000 you will have received a grand total of €288,000 in income. On the other hand, had the same pension holder lived for 30 years the total income received would have been €1,440,000! Essentially therefore by purchasing an annuity you are betting on your life expectancy. If this is longer than average you receive more, if it is shorter you will receive less.

This should not blind you to the fact that annuities can be useful. One of the most attractive features of an annuity is that the income is guaranteed until the retiree dies. With an ARF there is always the possibility that you could exhaust the fund before death. This might be due to poor investment performance and/or taking excessive levels of withdrawal. An annuity provides insurance against the risk of living longer. In the case of both an annuity and an ARF withdrawals are taxed as ordinary income at income tax rates.

12.2.6 Other Pension Information

12.2.6.1 Pension Schemes

If you are self-employed or working for an employer who does not provide a pension, then you can start contributing to a Personal Pension Plan or PRSA (Personal Retirement Savings Account). You will pay contributions to this plan and will be entitled to claim tax relief on the contributions as shown in table 12.1. Additionally, your employer can make contributions to your PRSA. These plans are provided by financial institutions with professional fund managers who will invest money on your behalf so that it has the potential to grow in value. When you retire you can normally take up to 25% of your fund as a tax-free lump sum and use the rest to provide a regular income.

A company/occupational pension is a scheme in which you join your employer›s trust-based defined contribution scheme. You make regular payments during your working life. Your payments are then invested in your choice of one or more of a range of professionally managed funds and remain invested until you retire. The investment performance of the fund(s) will determine how much money you may have available when you are ready to retire. Charges and investment performance will affect the fund value. However, as with all investments, the value of your investments can go down as well as up and you are not even guaranteed to get back the amount you invested.

The money built up in a pension fund is used to buy an annuity or another product which provides you with an income for the rest of your life. Your pension income will be taxed as earned income. You can usually take up to 25% of your pension fund as a tax-free lump sum or an amount equivalent to 1.5x your salary at retirement (provided you have 20 years' service with your employer), which means you will receive a smaller pension. Usually, your employer also pays into the scheme. If you can join your employer›s scheme it›s usually a good idea to do so, particularly if the employer pays towards your pension fund.

Some schemes are very generous. Unfortunately, no one can know how much your fund will be worth when you retire or how much income you will receive each month. A pension scheme lets you invest in a range of funds, giving your money the best chance of growing to give you a decent fund for your retirement. You need to understand more about the funds to make the best choices about where to invest your pension payments and it is very advisable to both talk to an independent financial adviser and also review the performance of your funds from time to time.

12.2.6.2 What is a Pension Fund?

Pension funds are a way for you to pool your money with other investors so you can take advantage of buying in bulk, spread your money across lots of different investments and get the services of an expert who you wouldn›t normally have access to.

You can usually choose which funds to put your money in. There are lots of different types of fund and there are many options to choose from; if you›re not sure which one(s) to pick a financial adviser will be able to make recommendations for you. The differences between funds are usually in the way in which they are invested, the way they are managed, the assets they are invested in, and the level of risk they take in relation to the amount of reward they›re aiming for.

Most funds are managed on a risk basis, from cautious to aggressive. A cautious fund aims for steady growth over a long period of time with little risk of you losing money. An aggressive fund aims for higher growth but this increases the risk of you losing money. The assets that a fund invests in are also an important factor in the returns you›re likely to get. An aggressive fund may invest in companies that have just issued shares and so have the potential to do very well and make a lot of money, but they also have a risk of failure. A cautious fund may invest in Government bonds which provide a guaranteed growth rate. This growth rate may be smaller than you could make on the stock market, but there is less risk to your money.

12.2.6.3 What Happens if I Move Job?

Pensions are designed to be flexible so that if you change jobs you can bring your pension fund with you. If you had a company pension scheme then moving jobs means that you won›t be able to carry on paying into it; your old employer will also stop making payments. If you have been paying into the HSE superannuation scheme this will stop when you cease to be an HSE employee. Instead you can choose to leave the money where it is in your old company's pension fund or you can transfer the money in your old company's pension scheme into a scheme with your new employer.

Another option is to transfer money in your old company's pension scheme into a buy-out bond. This is a lump sum pension product into which you can pay the proceeds of your old company's pension scheme and access the benefits at the retirement age applicable to your old company's pension scheme. Alternatively you could transfer the money in your old company's pension scheme to a PRSA. Other options may be available depending on your old employer›s scheme.

If you decide to leave the money in your old company's pension you can still join your new employer›s scheme. That way, when you come to retire, you can use the money from both schemes to provide your income. Should your new employer not have

a company pension scheme, you could see if they would pay into a PRSA on your behalf instead. Ultimately, you should get financial advice before you decide to transfer your old pension to make sure it›s the right thing to do.

12.3 Wills

If a will has not been made already, the necessity of doing so cannot be overemphasised. The consequences of dying intestate are particularly stark if a GP is married or in a civil partnership with young children or is unmarried/not in a civil partnership with a long-term partner. If a GP dies without a will his/her estate will be dealt with by a prescribed set of rules as laid out in the Succession Act 1965.

Some rules of the Succession Act could provide difficulties for those who are unmarried/not in civil partnership but are in long-term relationships. If a GP were to die, his/her partner would receive nothing and his/her parents and family members would benefit from the deceased's estate.

If a GP is married or in a civil partnership and has children, the estate will be divided between his/her spouse/civil partner and his/her children. If the children are under 18 this may cause difficulties for the spouse/civil partner as one-third of each of the estate's assets will be held in trust for the children until they are 18. This can create difficulties for the spouse/civil partner in dealing freely with the estate.

If a GP and his/her spouse/civil partner were to die at the same time, in the absence of a will the courts will decide who looks after his/her children. A will can be used to appoint guardians for one's children.

These are just some of the examples of difficulties that can arise if a will has not been made. It is therefore extremely important for everyone, including GPs, to draft a will.

12.4 Summary

At the stage of establishing a career in general practice, probably with many life commitments and almost certainly quite a lot of professional uncertainty, the most appropriate priority is Income Protection. After that, it's never too early to start planning for your retirement.

It is easy to take small practical steps to work out what position you're in now and what you need to do next. It is possible that every month of every year that goes by without you sorting out your pension arrangements may make a big difference to your financial security during your retirement.

With a pension it is important to ensure as high a percentage as possible of the fund is invested, that charges are minimised, and that you have actively considered what investment strategy is best for your fund. In relation to a pension there are a number of other things which are worth considering including: -

1. How much your pension is currently worth? (contact your pension provider)
2. Will your employer match contributions (not an issue with the HSE or GMS)
3. Does your partner have a pension?
4. When do you think you might like to retire?

The age at which you take your benefits will greatly affect how much money you should be saving. The earlier you intend to retire, the more money you will have to invest now. Don't forget that you will also receive tax relief on your payments into your pension.

Finally, it is worth ensuring that your dependents will be financially secure in the event of your incapacity or death and part of doing this involves having a will.

Table 12b
The costs of providing various types of cover for a 40 year old male GP who is married and a non-smoker. It assumes a net practice income of €300,000 per annum with a 2:1 ratio of GMS: private income. The example of a 40 year old male GP was chosen randomly.

		Monthly (Gross)	Monthly (Net)*
Life Cover (Includes Indexation @ 5% Premia Increase)			
€1,000,000	Pension death to age 65	€149.92	€88.45
€1,000,000	Convertible term 15 years	€119.15	€119.15
€500,000	Convertible term 20 years with accelerated Serious Illness Cover**	€323.91	
Income Protection* **			
€75,000	Private cover, deferred 13 weeks (Class I) 20 Year Cover	€194.07	€114.50
AVC / PRSA AVC** ** (Revenue Direct that GPs Must Prioritise AVCs / PRSA AVCs on GMS Income Whereas in the past GPs typically would had a Personal Pension on Private Income)			
€18,750	25% of €115,000 pension earnings cap, less 5% of €200,000 GMS capitation fees*****	€1,562.50	€921.88

* *The monthly net figure assumes tax relief at 41%*

** *The GP will also be entitled to GMS Sick Leave payments based on capitation income*

*** *It makes sense to have Life Cover attached to the Serious Illness Cover as there is normally a 14 day survival clause for Serious Illness Cover*

**** *The GP will also have a GMS pension based on capitation payments*

***** *25% is the maximum tax relief available on pension contributions at age 40*

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13: Taxation

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Introduction

Newly established GPs' knowledge of taxation is likely to be limited. GP trainees are PAYE workers and most have little exposure to the way the tax system works. The change to self-employed status post training (or a combination of self-employed and employee status) requires an understanding of taxation. This includes an understanding of the GP's specific legal obligations for making returns and payments to Revenue.

Most financial decisions taken by a GP have tax implications, though tax considerations alone should never be the only basis for making financial decisions. It is also a fact that tax is a complex area that requires the assistance of a competent professional advisor. Competence on the part of the GP/ Practice Manager in dealing with financial and taxation advisors is also a requirement for successful financial management of a practice. The taxation implications and regulations imposed on GPs as employers also need to be understood.

This chapter is intended to provide an outline of how the tax system in Ireland operates. It is divided into three sections: -

1.1. Taxation Generally
1.2. Taxation for the Self-Employed
1.3. Taxation for Employees

The topics covered in each area of this chapter are as follows: -

1.1. Taxation Generally

- Key dates and actions required in the tax year cycle
- Explanation of withholding tax and implications for GP State contract work
- Explanation of how Partnerships are treated for income tax purposes
- Summary of the tax status of Locums, Sessional GPs and GP Assistants
- Summary of the Revenue Audit process
- Description of the tax relief associated with pension contributions
- Summary of the taxation of investment assets

1.2. Taxation for The Self-Employed

- Description of taxable profits
- Summary of the tax rules for assessing profits
- Explanation of how capital items are treated for tax purposes
- Explanation of how leasing is treated for tax purposes
- An example of how a tax liability is computed
- An example of the tax credits/reliefs that may be claimed
- A summary of how the VAT exemption for medical care services operates

1.3. Taxation for Employees

- The operation of the PAYE system
- Tax credits and the standard rate cut-off point
- Expenses of employment

13.1 Taxation Generally

13.1.1 The Irish Tax System

The tax year runs from 1 January to 31 December. The self-assessment system applies to any person who has income that is not taxed under the PAYE system. Under the self-assessment system the taxpayer is obliged to: -

1. Register for income tax, ***and***
2. Pay preliminary tax on account of the tax year by 31 October in that year, ***and***
3. Complete and file a tax return for each tax year by 31 October in the following year, ***and***
4. Pay the balance of any tax due for the year (i.e. net of preliminary tax paid for that year) by 31 October following the tax year

Each of these stages in the self-assessment system is examined further below.

13.1.2 Registering for Income Tax

To register for income tax a GP with the help of his/her advisor will complete a Revenue Form TR1 and submit this form to the registration section of his/her local tax office. A GP should register well in advance of the due date for filing the return.

13.1.3 Preliminary Tax

Preliminary Tax is an estimate of the income tax payable for the year. The payment of preliminary tax is due on 31 October. For example, preliminary tax for 2014 is payable by 31 October 2014. The taxpayer must ensure that the preliminary tax payment for any year is **not** less than the **lower of**: -

1. 90% of the final income tax liability for the current year, ***or***
2. 100% of the prior year's income tax liability, ***or***
3. 105% of the final liability for the pre-preceding year where the preliminary tax is paid by direct debit

If preliminary tax is not paid by the due date or if the amount of preliminary tax paid is too low then Revenue can charge interest. Interest is charged at 0.0219% per day.

Example of Calculation of Preliminary Tax
Dr Good's tax liabilities for 2012 and 2013 and his estimated liability for 2014 are as follows:

Year	Liability €
2012	20,000
2013	30,000
2014	40,000 (**estimated liability**)

By 31 October 2014 Dr Good is required to pay preliminary tax for 2014. He can pay the lower of: -

1. 90% of €40,000 = €36,000, ***or***
2. 100% of €30,000 = €30,000, ***or***
3. 105% of €20,000 = €21,000, if the tax is paid by 8 equal monthly direct debits in the months of May to December 2014

Taxpayers generally pay the lowest amount of preliminary tax that will satisfy their payment obligations for the year.

13.1.4 Filing a Tax Return

The taxpayer is required to complete and file a tax return for each year not later than 31 October in the following tax year. For example, the tax return for the tax year ending 31 December 2013 must be submitted to the Collector General by 31 October 2014. Failure to submit a tax return by the due date will result in a surcharge of 10% of the tax liability (or a reduced charge of 5% if the return is submitted within 2 months following the due date).

Revenue operates a secure online service (ROS) that enables taxpayers and tax practitioners to file tax returns and pay tax liabilities online.

13.1.5 Paying the Balance of Tax Due

The taxpayer is required to pay the balance of tax due for the year by 31 October in the following year. For example, the balance of any tax for 2013 in excess of preliminary tax already paid on account of 2013 must be paid by 31 October 2014.

In addition to the obligations under the self-assessment system the GP is required to: -

1. Advise the local Revenue office of the date of commencement of the practice and notify Revenue of any change in the nature of the practice e.g. a change from a sole tradership to a Partnership.
2. Keep accurate records of all the business/financial transactions of the practice so that the full amount of profits or gains assessable for tax purposes may be calculated. A professional advisor should be contacted to assist with the installation and operation of an effective accounting system.
3. If the GP is an employer he/she is obliged to register as an employer with the local Revenue office and operate PAYE/PRSI on payments made to employees of the practice. The PAYE system applies to all employees who earn more than €36 per month or €9 per month if the employee has more than one employment and includes family members who work in the practice. A professional advisor should be contacted to assist with the operation of an effective payroll system. There are a number of payroll software packages available for this purpose.

13.1.6 Tax Clearance Certificates

A tax clearance certificate is a written confirmation from Revenue that a person's tax affairs are in order at the date of issue of the certificate. A tax clearance certificate may be applied for online at www.revenue.ie. The requirement to produce a tax clearance certificate usually arises in the context of a GP seeking payment under the PCRS.

13.1.7 Professional Services Withholding Tax (PSWT)

When making payments for professional services, the PCRS and other government and semi-state bodies deduct withholding tax at source at the standard rate of tax (20%). On making a payment the payer issues Form F45. This outlines the gross amount due and the amount of PSWT deducted. Form F45 is a valuable document and should be retained carefully to be given to the professional advisor when the accounts and the tax return are being prepared. In computing the tax payable for a tax year, credit is given for PSWT that was deducted from payments for services provided in the relevant accounting period. Provision is made for interim refunds of PSWT under three categories: -

1. Business ongoing
2. Commencing business
3. Cases of particular hardship

13.1.7.1 Business Ongoing

In order for a refund to be made in the case of an ongoing business: -

1. The profits of the basis period immediately preceding the basis period for the tax year in question must have been agreed with Revenue, ***and***
2. The tax liability for the previous tax year must have been agreed and paid, ***and***

3. The GP must supply Revenue with the relevant Forms F45

An interim refund may be made comprising an amount equal to the excess of the amount of tax withheld over the tax liability for the previous year less any outstanding amounts of VAT, PAYE and PRSI.

As one of the requirements of claiming an interim refund is that the tax of the previous year is agreed and paid it is advisable for GPs to get their tax affairs up to date as soon as possible after the end of a tax year.

Example of Calculation of an Interim Refund of Withholding Tax
In the year 31 December 2013 a GP has withholding tax deducted of €20,000. Her accounts to 31 December 2012 have been submitted to Revenue and the liability agreed for 2012 is €12,000. This tax has been paid. The GP owes PAYE / PRSI of €2,000. In order for the GP to qualify for an interim refund her 2012 return must be submitted to Revenue. Her tax liability must also be agreed and paid for that year. The calculation of interim refund is as follows: -

Withholding Tax Deducted	€20,000
Tax Liability For 2012	€12,000
Excess	**€8,000**
Less PAYE / PRSI Due	€2,000
Interim Refund	**€6,000**

13.1.7.2 Commencing Business
A formula is used by Revenue to calculate the interim refund of PSWT where a GP has recently commenced business.

13.1.7.3 Cases of Particular Hardship
In a case of particular hardship and where any of the conditions in either an ongoing business or in a commencement situation cannot be fulfilled, Revenue may waive one or more of the conditions. In these circumstances the amount of the refund is at the discretion of Revenue.

13.1.8 Partnerships and Income Tax
While there is no legal requirement for a Partnership agreement to be in writing it is recommended that where the intention is to form and work in Partnership, a formal written Partnership agreement should be drawn up. Failure to do this often gives rise to difficulties. Chapter 5, 'Employment Relationships in General Practice' gives an example of heads of agreement that should be considered in a Partnership agreement.

The Partnership accounts will be prepared and adjusted to arrive at the taxable profits of the practice. The Partnership is required to file an annual tax return. The Partnership does not have a tax liability in its own right. Instead the Partnership's income and gains are allocated to the individual Partners and these amounts are included in the individual Partners' returns of income.

13.1.9 The Tax Status of Locums, Sessional GPs and GP Assistants
The question of whether a Locum etc. is employed or self-employed is important for tax reasons. This has already been considered from an employment relationship perspective in Chapter 5, 'Employment Relationships in General Practice'. Here we consider this question from a taxation perspective.

A Locum who is an employee will have PAYE and PRSI deducted from his/her remuneration. In contrast, a Locum who is self-employed will be paid gross of tax but will have an obligation to pay to Revenue the tax on the income received. Tax difficulties arise if a Locum who is an employee is wrongly treated as self-employed. In these circumstances Revenue will look for the tax and PRSI that should have been deducted by the payer to be paid to them together with interest and penalties. To avoid such painful consequences it is necessary to be clear on the distinction between an employee and a self-employed person. This distinction is not unique to the medical profession. It is relevant in any case in which an individual is engaged by a business and as a result is important for all categories of business.

The basic distinction between an employee and a self-employed person is that an employee provides services under a contract ***of*** service whereas a self-employed person provides services under a contract ***for*** services. For this reason it is necessary to look to the terms of the contract under which the GP provides services to the engagor. These can be written or oral or a mixture of both. For example, a court will not necessarily accept that it should be bound by written terms agreed by both parties if these are not in keeping with the reality of the business relationship.

Because the terms of the contract will differ from case to case, each case must be considered on its own facts in the light of the principles laid down by employment law. These principles are relatively broad. The main ones (as applied to the medical profession) include: -

1. **The "Business On Own Account" Principle**: A Locum who provides services to a GP in the context of carrying on a business of his own is more likely to do this under a contract ***for*** services (and thus be acting as a self-employed GP) than under a contract ***of*** service. A Locum who carries on a business of his own will have control over the amount of income he generates, the costs that he incurs (and hence will be able to influence the profits that he earns), will be able to employ his own staff, will have his own equipment and will assume business risk, etc.
2. **The "Control" Principle**: Although the control principle is less relevant in cases where professional services are being supplied, it is nevertheless a consideration. If the engaging GP is able to control what is to be done, how it is to be done, and when it is to be done, these factors will point to the existence of a contract ***of*** service.

13.1.10 Revenue Audit
A Revenue Audit is essentially a partial or total review by Revenue officials of a taxpayer's return of income, books and records over one or more years. It is normally concerned with the review of the taxpayer's return of income for a single year but Revenue may extend the audit to other years where significant doubtful or unexplained issues arise in the course of an audit.

The taxpayer will normally receive at least 21 days' notice of an impending audit. From a GP's perspective, an audit may

involve the attendance of a Revenue inspector at the practice. Revenue inspectors are entitled under law to enter the practice premises, require the production of accounts and records and remove records for further examination. They are also entitled to interview and question practice staff either with or without the presence of the GP. Revenue inspectors are not entitled to access to patient medical records and they may not enter (other than by invitation) any premises that is occupied wholly and exclusively as a private residence except when a warrant is issued by a District Court judge.

Upon notification of an impending audit a GP should seek an immediate meeting with his / her professional advisor to plan for the audit. Points to be covered at this meeting should include: -

1. Identification of any problem areas. If any issues come to light which have given rise to an underpayment of tax then the GP should make a prompted qualifying disclosure. Depending on the nature of the error or omission it may also be necessary to take legal advice.
2. Identification of likely questions and preparation of answers.
3. Identifying members of staff who will answer questions.
4. Identifying suitable accommodation for the Revenue inspector which will cause minimum disruption to the practice.

The benefits of making a prompted qualifying disclosure include reduced penalties and non-publication of the GP's name in Revenue's list of tax defaulters.

The main methods that Revenue uses in selecting businesses for audit are as follows: -

1. **Screening of Tax Returns**: This involves examining the returns made by a sample of taxpayers and reviewing their tax compliance history. The figures are analysed in the light of trends in a particular profession or industry to identify any potential irregularities. Any of the following points could be responsible for a GP being audited: -
   - **a.** Late submission of tax returns or late payment of tax
   - **b.** Inadequate levels of private drawings reflected in the practice accounts
   - **c.** Fluctuating or unusual income or profit margins in the practice accounts
   - **d.** Failure to adjust for non-allowable expenditure
   - **e.** Unexplained variances in expenses on previous years
   - **f.** Unexplained capital introduced into the practice accounts
   - **g.** Unexplained items in the practice accounts
2. **Risk Evaluation Analysis and Profiling (REAP)**: Taxpayers are also selected for audit by Revenue using REAP, an internal software package that scans information from tax returns and registrations. The data is then compared against a set of rules and the system assigns scores which determines whether the taxpayer should be selected for audit.
3. **Random Selection**: Each year Revenue also conducts a purely random selection of taxpayers for audit. This ensures that every taxpayer runs the risk of being selected for audit.

13.1.11 Tax Relieved Pension Contributions

13.1.11.1 Pension Contributions for GPs with GMS Income

GPs with GMS income participate in the GMS Superannuation Plan in respect of the capitation payments made to them. The GMS Payments Board contributes at the rate of 10% of such amounts to the scheme and GPs contribute at the rate of 5%.

GPs in receipt of GMS income may make tax-deductible pension contributions in respect of their private practice income. Professional advisors will be aware of the method of computing the income from which pension contributions can be deducted. Briefly, in the first instance this is computed by setting practice expenses against non-capitation GMS income and allocating the balance of the expenses on a pro-rata basis over GMS capitation income and private practice fees.

GPs will be entitled to make pension contributions (at rates that vary between 15% and 40% depending on the GP's age in the tax year for which the payment is made) based on private practice fees net of expenses allocated against those fees. An important issue to note is that in allocating GMS pension contribution relief, GMS income takes priority. As a result, if GMS income exceeds the pension contribution limit of €115,000 (see the next section) relief will only be available against GMS income.

13.1.11.2 Tax Deductibility of Contributions

The pension contributions that can be made in respect of relevant earnings (non- GMS practice fees net of allocated expenses) are as follows: -

Age	% of Net Relevant Earnings
Under 30	15%
30 - 39	20%
40 - 49	25%
50- 54	30%
55 -60	35%
Over 60	40%

There is an upper limit on the amount of relevant earnings that may be taken into account for the purposes of tax relief. The limit is €115,000. The pension contribution is given as a deduction against total income with the result that tax relief is given at the marginal rate of tax (up to 41%).

13.1.11.3 Tax Benefits

There are several tax advantages of investing in a pension fund. Firstly, as outlined above tax relief can be claimed on the contribution. While the pension that is eventually paid in retirement is taxable, an opportunity will exist to extract a tax-free lump sum from the fund of up to the lower of €200,000 or 25% of the value of the fund. Secondly, the income and gains generated by the fund grow free-of-tax. This enables the fund to grow at a faster rate than one that is taxed on its income and gains.

13.1.12 Taxation of Investment Assets
This section deals briefly with the taxation of investment income such as interest income, dividend income, rental income and investment gains.

Interest income earned from funds held on deposit with Irish Banks is subject to tax at source. This source tax is known as Deposit Interest Retention Tax or DIRT. At present DIRT is taxed at 41%. Taxpayers are required to include the deposit interest income in their return. PRSI may be charged on the interest income. The Universal Social Charge is not charged on the interest income.

Dividend income from shares is liable to income tax at a GP's marginal rate of tax (up to 55% including PRSI and the Universal Social Charge). On the disposal of the shares any gain would be subject to capital gains tax (CGT) which is currently charged at 33%.
In computing taxable rental income certain expenses can be deducted. These include either all or a proportion of the interest on borrowings used to purchase, improve or repair the property (on the basis that, in the case of a residential tenancy, it is registered with the PRTB). In our experience taxpayer's often arrange their borrowings in a non-tax efficient manner. For this reason we advise GPs to take professional advice to ensure that the acquisition of property assets is structured in a tax efficient manner.

On the disposal of an investment property the GP will be liable to CGT on any chargeable gain generated. Acquisition and disposal costs together with enhancement expenditure can be deducted from the selling price to reduce the chargeable gain.

13.2 Taxation for the Self-Employed

13.2.1 Taxable Profits

Income tax is charged for each tax year on the profits of the profession carried on by the GP in that year. The starting point for calculating the amount charged is to compute the taxable profits. This is done by reviewing the accounts for the relevant period.

13.2.1.1 Accounting Profit
The GP's professional advisor will prepare the practice accounts in accordance with general accounting principles. The profit or loss as shown by these accounts is then adjusted in accordance with tax legislation.

13.2.1.2 Allowable Expenditure
In general for expenditure to be allowable it must be: -

1. Revenue expenditure (e.g. wages, consumable medical supplies) as opposed to capital expenditure (e.g. construction cost of a new surgery), ***and***
2. Incurred wholly and exclusively for the purposes of the practice, ***and***
3. Not be specifically disallowed by tax legislation

The following are examples of expenditure that should be allowable for a GP's practice: -

Motor expenses incurred for the purpose of the profession are allowable. The GP should keep records of all expenditure incurred on running the vehicle (e.g. insurance, repairs, servicing, fuel costs etc.). Records should also be kept of the usage of the car for business and private purposes. The allowable expenses would comprise the portion of the overall expenses that relate to business use, e.g. travel to and from work is not allowable, while travel involved in making house calls is allowable.

Interest on borrowings is allowable if the borrowed money is used for the purpose of the practice, e.g. interest on borrowings used to build / purchase a surgery.

Staff costs are allowable. These include salaries, bonuses, training, staff entertainment and mileage payments within civil service guidelines. If a GP employs his/her spouse the cost is deductible provided the spouse is a bona-fide employee. Where payments are made to employees, both full and part time, including spouses, it is essential that the GP registers as an employer and deducts PAYE and PRSI. The GP should contact his/her professional advisor regarding the correct implementation of the PAYE system.

Payments to Locums (contractors) are allowable. A GP should in conjunction with his professional advisor take care when drafting a contract to ensure that the Locum is providing services in a self-employed capacity and not as an employee as the GP would be liable for uncollected PRSI if it was held that a Locum was providing services as an employee.

Education / training costs are allowable. This includes the cost of CME activities, courses, conferences, seminars, exam fees, books and professional journals incurred wholly and exclusively for the purpose of the profession. Education and training costs for practice staff are also a business expense and are allowable.

Subscriptions are allowable if they can be shown to be incurred wholly and exclusively for the purpose of the practice e.g. Medical Council registration, MICGP, MRCPI and IMO subscriptions.

Medical indemnity subscriptions (net of any subsidy).

Telephone expenses, including mobile phones, are allowable. If such expenses include a personal element usage, these must be proportioned between personal and business use, with the personal element not allowable.

Dual expenses are allowable on a proportional basis. For example the part use of a residence is allowable if part of a house is used as a surgery. The amount allowed would be based on a proportional share of the running costs (e.g. rent, rates, light and heat) of the house. To justify such a claim it is recommended that there is evidence that the house is used for business purposes on a regular basis.

Accountancy fees are allowable.

13.2.1.3 Disallowed Expenditure
Expenses which are not allowable include: -

Personal drawings together with the private element of expenses which may be included in the practice accounts, e.g. the private element of heat, light, telephone and repairs (including personal expenses charged to credit cards).

Capital expenditure occurs when a business spends money either to buy fixed assets or to add to the value

of an existing fixed asset with a useful life that extends beyond the taxable year. Expenditure is generally capital in nature if the effect of the expenditure is to provide a long term benefit to the practice, e.g. new air-conditioning unit installed in a surgery, a new examination couch, an extension to a building, a cryotherapy unit, etc. This type of expenditure is not allowable in arriving at taxable profits. However it may qualify for capital allowances (see section **13.2.3** below).

Depreciation is an accounting concept and represents the decrease in the value of capital assets through wear and tear and the passage of time. It describes any method of attributing the purchase cost of an asset across its useful life, roughly corresponding to normal wear and tear.

Entertainment expenses (other than the entertainment of staff) are specifically disallowed.

Interest paid on overdue tax liabilities is also specifically disallowed.

13.2.2 Basis of Assessment

Once the taxable profits for the accounting period are computed they are allocated to a year of assessment. There are special rules for assessing profits in the first three years of trading. In year 4, profits are assessed under the normal basis of assessment.

13.2.2.1 Commencement

The profits assessable in the first year of carrying on the profession are those profits arising from the date of commencement of the practice to the following 31 December.

Example

Dr Good transfers from salaried employment with the HSE to self-employed status on 01.04.2013. Dr Good will need to register for Income Tax and file a tax return for the period from 01.01.2013 to 31.12.2013 by the 31.10.2014. The tax payment that Dr Good will make for 2013 plus the preliminary tax payment for 2014, which are both due by 31.10.2014, will depend on the amount of profits generated by the practice in the period from commencement (01.04.2013) to the following 31 December (31.12.2013).

13.2.2.2 Normal Basis of Assessment

The normal basis of assessment for a continuing practice is the accounting period for 12 months ending in the tax year. For example the taxable profits for the year ended 31.03.14 will be assessable in the tax year 2014.

13.2.2.3 Cessation

On cessation of a practice, the GP is liable to tax on the profits from the first day of the tax year (1 January in the year of cessation) to the date of cessation. If the profits assessed in the prior year were lower than the profits earned in that calendar year then an additional assessment will be made in respect of that year.

13.2.3 Capital Allowances

Expenditure on capital items is not deductible for income tax purposes. Tax legislation provides for a specific deduction for certain types of capital expenditure. This type of deduction is known as capital allowances. Presently an annual wear and tear allowance of 12.5% (per annum) for years 1 to 6 and 10% for year 7 is allowed on most items of equipment or plant (e.g. cryotherapy equipment, an examination couch, computer hardware, an air conditioning unit etc.). In order to qualify for a wear and tear allowance the equipment or plant must be used for the purposes of the profession.

Many GPs fail to claim wear and tear allowances on plant and equipment in use for the purpose of their profession. This is especially true in cases where a GP has a purpose built surgery and the amount of the total expenditure on the surgery that can qualify for allowances can be quite significant. The capital allowances for a tax year are allowed as a deduction from the taxable profits allocated to that year. Your tax advisor will be in a position to advise on the capital items that will qualify for a deduction.

13.2.4 Leasing

There are various ways in which a GP can obtain plant for use in his/her practice. He/she may lease an asset, acquire an asset under hire purchase or buy an asset outright. Because leasing rates and bank interest rates are constantly changing it is necessary to make a lease/purchase evaluation each time a GP plans to acquire an asset. When plant is leased by a GP and the burden of wear and tear falls on that GP, it is the GP who is deemed to have incurred the expenditure and he/she is entitled to claim the wear and tear allowance. When assets are leased the full lease rental or hire charge is generally deductible in calculating taxable profits.

13.2.5 Calculation of Tax Liability

Once the taxable profits are computed and allocated to the relevant year of assessment, the professional income can be aggregated with the GP's other income (if any) and his/her tax liability can then be computed.

Example of a GP's Income Statement as Shown in the Accounts of his/her Practice

In the tables below, figures in red signify losses or money owed.

Statement Of Practice Profit / Loss		
	Expense	Income
Fees		€230,000
Locum	€21,000	
Wages And Salaries	€21,000	
Telephone	€3,000	
Insurance	€1,500	
Motor Expenses	€5,000	
Light And Heat	€1,500	
Accountancy And Consultancy	€4,500	
Repairs And Maintenance	€2,000	
Interest	€2,000	
Rates	€1,000	
Depreciation	€7,500	
Total Expenses		€70,000
Profit		**€160,000**

In addition to his/her practice income the GP has other income from investments (bank interest and rental income) and other employment. These are shown in the table below: -

Income Tax Computation For The Year Ended 31/12/2013		
Income		
Profits From Practice	€160,000	
Add Back Depreciation	€7,500	
Total Tax Adjusted Profit		**€167,500**
Additional Income		
Bank Interest Income (Investment)	€1,500	
Rental Income (Investment)	€10,000	
Employment Income (Other Employment)	€2,500	
Total Additional Income		**€14,000**
Losses / Capital Allowances		
Rental Losses	€8,500	
Capital Allowances	€1,000	
Total Capital Allowances		**€9,500**
Allowances And Reliefs		
Permanent Health Insurance	€1,000	
Retirement Annuity (Pension Contribution)	€17,250	
Total Allowances And Reliefs		**€18,250**
Total Taxable Income		**€153,750**
€153,750 Charged To Tax As Follows		
€32,800 @ 20% Tax	€6,560	
€1,500 @ 33% Tax	€495	
€119,450 (The Remainder) @ 41%	€48,975	
Total Income Tax		**€56,030**
Credits And Reliefs		
Personal Tax Credit	€1,650	
DIRT Credit	€495	
PAYE Credit	€500	
Health Expenses Credit	€300	
Total Credits And Reliefs		**€2,945**
PRSI / Universal Social Charge		
PRSI Self: €178,000 @ 4%	€7,120	
Universal Social Charge: €10,036 @ 4%	€201	
Universal Social Charge: €5,980 @ 2%	€239	
Universal Social Charge: €162,984 @ 7%	€11,409	
Universal Social Charge: €76,500 @ 3%	€2,295	
Universal Social Charge: €8,500 @ 5%	€425	
Total PRSI / Universal Social Charge		**€21,689**
Other Credits / Reliefs		
Paid PAYE	€500	
USC Deducted Under PAYE	€50	
Withholding Tax Already Paid On Fees	€30,000	
Total Allowances And Reliefs		**€30,550**
Total Liability		**€44,224**
Preliminary Tax Already Paid For 2013		**€20,000**
Balance Of Tax Due		**€24,224**

The tax liability has been calculated on the normal basis of assessment for a continuing practice.

13.2.6 Tax Credits and Reliefs

In order to minimise an income tax liability the tax payer should ensure that all available tax credits and reliefs are claimed. Depending on a GP's particular circumstances the following are examples of the tax credits / reliefs which may be claimed in the tax year 2014: -

- Personal tax credit of €1,650 for a single person and €3,300 for a married couple who are jointly assessed
- PAYE tax credit of €1,650
- Single Person Child Carer tax credit of €1,650
- Incapacitated Child tax credit of €3,300
- Home Carer tax credit of €810
- Health expenses. Relief is available at the standard rate of 20% for health expenses incurred (e.g. medical, non-routine dental and prescriptions)
- Permanent health benefit schemes. Relief is available for premiums paid under a permanent health benefit scheme approved by Revenue. The amount of the premium allowable is limited to 10% of a GP's total income
- Employed person taking care of an incapacitated individual. Relief is available to an individual whose family members or relatives are totally incapacitated and a carer is employed. The amount of the allowance is the lower of the expense actually borne or €50,000
- Relief for fees paid for third-level education. Relief is available at the standard rate of 20% in respect of qualifying fees paid by a GP on his/her own behalf or on behalf of his/her dependents. The maximum amount available for relief is €7,000 with the first €2,750 disregarded
- Pension contributions made to Revenue approved schemes are an allowable deduction for tax purposes. Refer to Chapter 12, "Providing for the Future: Insurance, Pensions and Wills" for further information

13.2.7 Value Added Tax (VAT)

While VAT is chargeable on the supply of goods and services in the course of business, professional medical care services supplied by a GP are VAT exempt. In general the exemption applies to the full range of medical services carried out for the purposes of: -

- Protecting, maintaining or restoring a patient's health, ***or***
- Diagnosing, treating and curing health disorders and diseases

Services such as these when supplied by a GP include: -

- Post-offer of employment medical examinations including assessments for fitness to operate machinery and undertake manual work
- Sight and hearing tests and similar health surveillance services
- Health screening, smoking-elimination and stress management programmes
- Cosmetic surgery procedures required to maintain or restore a patient's health or to treat a disease or illness
- Vaccination programmes to protect employees in cases where there is a high risk of the transmission of infectious disease

However, not every service supplied by a GP will qualify for exemption from VAT. The European Court of Justice has held that the following services do not qualify for the exemption: -

- Genetic tests carried out to establish paternity
- General care and domestic help provided as part of an outpatient service
- The provision of a report on a patient's state of health for the purpose of a claim for a war or disability pension claim or for the purposes of personal injury litigation when the purpose of the service is to enable a third party to make a decision (and not for the purpose of the protection of that patient's health)

Even where a service does not qualify for exemption from VAT, it does not necessarily follow that a GP should charge VAT. This is because VAT law only requires a service-supplier to register for VAT and charge VAT if that supplier's turnover from the supply of VAT able services exceeds an annual threshold of €37,500. In practice it's likely that relatively few GPs will generate VAT able services in any year that exceed the threshold.

Because GPs will be either largely or totally exempt from VAT it follows that they are either largely or totally unable to recover VAT charged to them on the purchase of goods such as furniture, equipment, etc. or on the provision of services such as the leasing of equipment or premises or on the supply of legal and accounting services etc. As the standard rate of VAT is 23%, the inability to recover VAT can add considerably to certain costs.

13.3 Taxation for Employees

13.3.1 Operation of the Pay As You Earn (PAYE) System

The PAYE system is a method of tax deduction for employees where income tax/PRSI and USC is deducted from salaries and wages by the employer and paid over to Revenue on the employee's behalf. Where tax is charged under the PAYE system the taxpayer effectively pays tax each week/month as he/she receives his/her wages or salary. The system is designed to ensure that an employee's liability to tax/PRSI and USC is spread out evenly over the year.

13.3.2 Tax Credits and the Standard Rate Cut-Off Point (SCROP)

Every employee is allocated tax credits (refer to **13.2.6** Tax Credits and Reliefs) and SRCOP at the beginning of each year. A married couple may split tax credits as they wish provided that each individual claims at least their own PAYE tax credit if applicable. A SRCOP is the portion of an employee's wage/salary which is taxed at the standard rate of tax of 20%. The SRCOP for a single person is €32,800. For a married couple the maximum SRCOP is €65,600 provided that a minimum of €23,800 and a maximum of €41,800 is allocated to either spouse. This means that for optimum tax efficiency each spouse should have a minimum annual income of €23,800. A couple may choose to be assessed under joint, separate or single assessment. The splitting of tax credits and the SRCOP does not apply to couples assessed under the single basis of assessment. A breakdown of an employee's tax credits and SRCOP for the year is given on the tax credit certificate issued to the employer by Revenue. Under the PAYE system, the weekly/monthly deduction of tax for an employee is based on the information supplied in the tax credit certificate.

13.3.3 Expenses of Employment

An employee may receive re-imbursement of expenses of his/her employment free of tax that are incurred wholly, exclusively and necessarily in the performance of his/her duties. Typical expenses would include subscriptions, motoring and accommodation. For example, a GP may use his private car for a house visit to the patient of the practice that he/she works for. In this case the GP would be entitled to charge his/her employer mileage up to the prevailing civil service mileage rates. In addition, there is a standard flat rate expense allowance agreed with Revenue for various classes of employees. For doctors in a hospital an annual flat rate expense of €695 may be claimed as a deduction from their wage/salary.

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Acts

Most are available online via the **Irish Statute Book**:
http://www.irishstatutebook.ie/

Adoptive Leave Act
Competition Act
Data Protection Act
Electronic Commerce Act
Employment Equality Act
Equal Status Act
Industrial Relations Act
Maternity Protection Act
Minimum Notice & Terms of Employment Act
National Minimum Wage Act
Organisation of Working Time Act
Parental Leave Act
Partnership Act 1890
Payment of Wages Act
Protection of Employment Act
Redundancy Payment Act
Safety Health and Welfare at Work Act
Succession Act
Terms of Employment (Information) Act
Transfer of Undertakings Regulations
Unfair Dismissals Acts

Appendices

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Appendix 1 – Locum Agencies

Call a Locum Limited

Website *www.callalocum.com*
Email *admin@callalocum.com*
Telephone 01 6874515
Fax 01 4430646
Address The Black Church, St. Mary's Place, Dublin 7

Doctor on Duty

Website *mediserve.ie/doctor-on-duty-1/*
Email *info@doctoronduty.ie*
Telephone 01 4539333
Fax 01 4537975
Address 344 South Circular Road, Dublin 8

Jobs 4 Doctors

Website *www.jobs4doctors.ie*
Email *info@jobs4doctors.ie*
Telephone 065 6869300
Fax 065 6869303
Address TTM Ennis, Ballymaley Business Park, Gort Road, Ennis, County Clare

Locum Express

Website *www.locumexpress.ie*
Email *info@locumexpress.ie*
Telephone 021 4297901
Fax 021 4297943
Address IDA Industrial Estate, Little Island, County Cork

Locumlink

Website *www.locumlink.ie*
Email *info@locumlink.ie*
Telephone 01 4956666
Fax 01 4936102
Address 32 Ranelagh Road, Ranelagh, Dublin 6

Locumotion

Website *www.locumotion.com*
Email *info@locumotion.com*
Telephone 01 2993550
Fax 01 2993551
Address 1st Floor, North Block, Rockfield Medical Campus, Balally, Dundrum, Dublin 16

MedSource Medical Services Limited

Website *medsource.vpweb.ie*
Email *info@medsource.ie*
Telephone 046 9241533
Fax 046 9241576
Address Farrell Street, Kells, County Meath

Stanwood Medical Services Limited

Website *www.stanwoodmedicalservices.com*
Email *info@stanwoodmedicalservices.com*
Telephone 074 9732924
Fax 074 9741133
Address Harbour View Court, Killybegs, County Donegal

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Appendix 2 – ICGP Accredited GP Software Packages

As of 19/03/2014 five GP practice software products have achieved certification by the National General Practice Information Technology (GPIT) Group. The products are: -

- CompleteGP, version 2.1
- Health One, version 6
- Helix Practice Manager, version 1
- Socrates, version 1.5
- Medtech32, version 4.0

Certification covers areas such as service level agreements between GPs and vendors, help desk and support, training and escrow agreements as well as the specific functional requirements needed for GP systems, such as consulting, prescribing and vaccinating.

The GPIT Group has issued a certification logo to products that have achieved certification. This can be displayed by the vendors on their promotional literature and web sites. The certification process and logo relate to a specific software product rather than a vendor.

Information on costs, support and training should be sought from the provider.

Software	Company	Web	Contact Details
CompleteGP	CompleteGP	*www.completegp.ie*	**Email:** info@completegp.ie **Tel:** 022 47819 **Person:** Carl Bearne
Health One	Helix Health	*www.helixhealth.com*	**Email:** sales@helixhealth.com **Tel:** 01 463300 **Person:** Creavan O'Malley
Helix Practice Manager	Helix Health	*www.helixhealth.com*	**Email:** sales@helixhealth.com **Tel:** 01 4633000 **Contact:** Creavan O'Malley
Medtech32	Medtech Global	*www.medtechglobal.com*	**Email:** irsupport@medtechglobal.com **Tel:** +9144 43438600, Ext 632 **Contact:** AD Sathyanarayanan
Socrates GP	Socrates Healthcare Informatics	*www.socrates.ie*	**Email:** sales@socrates.ie **Tel:** 071 9193600 **Contact:** Emmet Gilhooley

Appendix 3 – Once-Off Entry Agreements to the GMS

Between the creation of the GMS in 1972 and the signing into law in 2012 of legislation creating open entry access to the GMS, obtaining a GMS contract was a restrictive process. The original blueprint for the development of general practice envisaged entry to GMS practice by way of either vacancy or Assistantship/Partnership as a means of encouraging group practice. The blueprint did not prevent GPs from setting up de novo in private practice. In 1989, the 5 year rule on GMS entry (whereby if a suitably qualified GP was in private practice for 5 years he/she was entitled to obtain a GMS contract) was abolished. The last doctors to enter under this mechanism were to do so by the 31st December 1993. At various points subsequent to this, in addition to the traditional routes of vacancy or Partnership, once off entry arrangement provided opportunities for GPs to gain access to the GMS.

1999 Once-Off GMS Entry Agreement

In 1999 the IMO secured a once off agreement with the Department of Health and Children on GMS entry for GPs established in private practice. This was in the context of the Government's decision to extend the GMS Scheme to patients over the age of 70s by means of trebling the income eligibility guidelines for this age group. The agreement provided as follows:-

- A General Practitioner, having such qualifications as would make him or her currently eligible for entry to a GMS Scheme position and who, on March 1, 1999, is engaged in full-time general practice in one location in the State for a period of 5 consecutive years or who from a time commencing before that date subsequently accumulates the five consecutive years, shall be entitled to take on *any of their patients who become eligible for a medical card for the first time on or after that date* (or the date of the relevant accumulation of the five years referred to, as appropriate)
- Three years subsequent to the first limited entitlement referred to above, the General Practitioner shall be entitled to take as medical card patients *any person holding such a card*; this three year requirement *will not* apply in the case of bona fide Partnerships which have existed for five years and the onus for demonstrating the existence of the Partnership and its duration will be the responsibility of the General Practitioners involved.

2001 Once-Off GMS Entry Agreement

A further once off GMS entry agreement was reached in July 2001 in the context of the granting of automatic medical card eligibility to all persons aged 70 and over.
The agreement provides as follows: -

- A one off entry arrangement for doctors to the GMS Scheme which gives the right of entry to any fully qualified and approved vocationally trained General Practitioner (meeting the general conditions relating to eligibility for appointment to the GMS scheme) who is in practice on 1st July 2001, such a person having been in practice for a period of one year immediately prior to that date (or has, on or before that date, entered into a Partnership with, or a legally binding contract to acquire a practice from an existing Practitioner or Practitioners.
- This right of entry to be *limited for a period of five years to the acceptance of such medical card patients as acquire their medical cards under the new eligibility provision*. However, in the case of a person in a Partnership on the date s/he acquires limited entry that five years period will be reduced to two years if s/he continues in that Partnership for the period of two years. After the period on limited entry has passed, the doctor concerned will be free to accept any medical card patient nominating him or her as their doctor of choice. This provision is subject to the normal rules of good character and suitable premises and does not restrict or affect other existing rules on entry. Further, persons having limited entry contracts under this provision will enjoy appropriate benefits determined on a pro-rata basis.

2005 Once-Off GMS Entry Agreement

In 2005, a further once off agreement on GMS entry was agreed in the context of agreement on the introduction of up to 200,000 GP Visit Card patients. The Labour Relations Commission brokered agreement on entry to the GP Visit Card Scheme provided as follows:-

- A one-entry arrangement for doctors to the GMS Scheme (and to the GP Visit Card Contract) which gives the right to entry to any fully qualified and approved vocationally trained General Practitioner (meeting the general conditions relating to eligibility for appointment to the GMS Scheme) who is in practice on the 1st July 2005, such a person having been in practice for a period of one whole year prior to that date (or has, on or before that date, entered into a Partnership with, or legally binding contract to acquire a practice from an existing Practitioner or Practitioners).
- This right of entry to be *limited for a period of five years to the acceptance of such GP Visit Cards patients as acquire their GP Visit Cards under the new eligibility provision*. However, in the case of a person in a Partnership on the date s/he acquires limited entry that five years period will be reduced to two years if s/he continues in that Partnership for the period of two years.
- After the period on limited entry has passed, the doctor concerned will be free to accept *any* medical card patient nominating him or her as their doctor of choice. This provision is subject to the normal rules of good character and suitable premises and does not restrict or affect other existing rules on entry. Further, persons having limited entry contracts under this

provision will enjoy appropriate benefits determined on a pro-rata basis, in accordance with existing arrangements. Any interpretation which arises under this provision should be subject to joint examination by the parties to this agreement.

- Doctors who currently hold limited GMS contracts or are entitled to limited contracts under existing entry agreements will also be eligible to hold the GP Visit Card contract.

2009 Once-Off GMS Entry Agreement

On 30th September 2009, Mr Tommy Wilson, Assistant Principal of the Primary Care Division of the Department of Health was instructed by the Minister, Mary Harney, to send a letter to Professor Brendan Drumm, CEO of the HSE. This letter related to changes to the entry provisions for GPs to the GMS Scheme. The letter read as follows: -

"As you are aware, the Minister has for some time expressed her desire to see open access to GMS Contracts for all suitably qualified and approved vocationally trained GPs. Following consultation between the Department of Health & Children, the Health Service Executive (HSE) and the Irish Medical Organisation (IMO), the Minister has agreed as an interim measure to extend the entry provisions to the GMS Scheme as follows:

Any fully qualified and approved vocationally trained General Practitioner (meeting the general conditions relating to eligibility for appointment to the GMS Scheme) who was in general practice on the 1st September 2009 and was in full time general practice for a period of one whole year prior to that date (or having, on or before that date, entered into a Partnership, or signed a legally binding contract to enter into a Partnership, with a General Practitioner who holds a GMS contract) shall be entitled to apply for a GMS contract under the terms of this letter.

For the purpose of these provisions, "full time practice" means the provision of GP services to patients continuously at one location in the Republic of Ireland during the period 1st September 2008 to 31st August 2009. GPs who obtain contracts under these provisions will be entitled to accept: -

1. Patients who, on or after the 1st October 2009, become eligible for a medical card under the provisions of the Health Act, 2008;
2. Patients who, on or after the 1st October 2009, become eligible for a GP Visit Card under the provisions of the Health (Amendment) Act, 2005;
3. Any of their patients who become eligible for a Medical Card/GP Visit Card/Health (Amendment) Act card under the relevant provisions of the Health Acts on or after the 1st October 2009.

These arrangements shall apply for a transition period ending on 31st August 2013. After that date, the doctor concerned will be free to accept any Medical Card / GP Visit Card / Health (Amendment) Act patient nominating him or her as their doctor of choice, in accordance with the existing rules relating to GMS panel size, etc. In the case of a GP who qualifies for a GMS contract under the terms of this letter relating to Partnership and who continues in such Partnership, the transition period will end on 31st August 2010, after which he/she will be free to accept any Medical Card / GP Visit Card / Health (Amendment) Act patient nominating him or her as their doctor of choice, in accordance with the existing rules relating to GMS panel size etc.

During the transition period(s), relevant GPs may only register patients in the immediate area in which he/she was in general practice during the period 1st September 2008 to 31st August 2009. Any exemptions to this requirement will require the prior approval of the HSE, following consultation with the IMO. These entry provisions are subject to the normal rules of good character and suitable premises and do not restrict or affect other existing rules on entry. Furthermore, persons obtaining contracts under these provisions will enjoy appropriate benefits determined on a pro rata basis, in accordance with existing arrangements.

A doctor gaining access to the GMS under these entry provisions shall for the transition period hold no more than one medical card contract and one GP visit card contract simultaneously. The normal GMS rules on centres of practice apply in accordance with the GMS Contract. GPs wishing to avail of these provisions must submit their application to the HSE not later than 31st January 2010.

Any question of interpretation which arises under these provisions shall be determined by the Minister, following consultation with the HSE and the IMO. The implementation of the provisions outlined in *this* letter will be formally reviewed no later than 28th February 2010 and thereafter as required.

The contents of this letter shall be considered as forming part of the agreement with registered medical Practitioners for the provision of services under the General Medical Services Scheme."

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Appendix 4 – Rights and Rules on Dissolution of Partnerships

GMS Assistants and Partners have various rights to panels when Partnerships dissolve. These rules do still have significant relevance, but there were time limits applied in relation to these rights which were abolished by the 2012 'Health (Provision of General Practitioner Services) Act'.

All the rules governing the rights of Assistants / Partners in the GMS are set out in Department of Health & Children Circulars. The principal Circulars are numbers *9/1980, 9/1981, 3/1996, and 3/2001*. These Circulars are complex and each has to be read in conjunction with the others as in this area no single consolidated Circular exists. Access to all Department of Health and Children Circulars relating to the GMS Scheme from 1972 can be obtained on the ICGP website.

Rights of Assistants to GMS Panels on Dissolution of a Two Handed Partnership

As per Circular 3/1996 in general terms, the following arrangements apply: -

1. On the death of the senior Partner, the Assistant retains his/her contract and panel of patients provided their junior Partner's entry to the Scheme as a Partner had been approved by the health board.
2. On the retirement/resignation of the senior Partner, the junior Partner retains his/her contract and panel provided he/she has served for a period in excess of three years.
3. On retirement, resignation of the senior Partner, where this arises as a result of the senior Partner: -
   - **a.** resigning to take up another GMS post
   - **b.** retiring to take up a post in another section of the health services
   - **c.** forfeiting his/her GMS contract as a result of disciplinary proceedings, or resigning on the grounds of ill health

   The junior Partner continues in the Scheme provided he/she has at least two years' service as a Partner.
4. Where the Partnership is dissolved for any other reason, the junior Partner retains his/her contract and panel of patients provided the Partnership has existed for a period of five years.

Circular *3/1996* was updated by Circular *3/2001* following agreement between the IMO and the Department of Health and Children and updated the rules on the rights of Assistants/Partners on dissolution of two handed Partnerships. Circular 3/2001 states that in the case of dissolution of such a Partnership: -

1. Where one Partner dies, retires through illness or resigns to take up another contract or forfeits his or her contract as a result of statutory or contractual proceedings the remaining Partner shall, subject to the approval of the Health Board (and provided his entry as Partner in the Scheme had been approved by the appropriate Health Board prior to that date) retain his GMS Scheme contract and succeed to the panel of the outgoing Partner.
2. Where the Partnership is dissolved by mutual agreement of the Partners, the remaining Partner shall, subject to the approval of the Health Board (and provided his entry as a Partner in the Scheme had been approved by the appropriate Health Board prior to that date) retain his GMS Scheme contract but not succeed automatically to the contract of the other Partner.

In both of the above cases, the approval of the HSE to retention or succession should be given unless there are reasons consistent with the proper operation and integrity of the GMS Scheme that indicate clearly that such approval should not be so given, e.g. where the combined panel numbers exceed 2000 patients.

Dissolution of Multiple Partner Partnerships

Circular *3/96* provides as follows:-

> Where a multiple Partnership is dissolved on the death, retirement or resignation of a doctor the health board is required to freeze the panel of that doctor and decide whether to continue with the Partnership, fill the vacancy as a Single-handed vacancy or disperse the panel among remaining doctors in the Partnership. The Board's decision is made having regard to the requirements for consultation with the IMO.

Appendix 5 – Payment and the Administration of Payments to Practices under the GMS System

Payments to GMS contract holders are made under a capitation system and are processed and administered by the HSE Shared Services Primary Care Reimbursement Service (PCRS). Contract holders may also be paid additional practice allowances and subsidies. These extra payments contribute to the costs of running the practice such as the cost of Locum cover and practice staff costs, e.g. salaries for a practice secretary, practice nurse or practice manager.

Further detailed information on PCRS payments can be found in the HSE's National Shared Services Primary Care Reimbursement Service handbook, "Information and Administration Arrangements for General Practitioners".

Fees and Allowances Payable under Capitation Agreement (Effective 24th July 2013)

Capitation Fees per Annum

Patient Age (Years)	Male	Female
0 – 4	€74.59	€72.76
5 – 15	€43.29	€43.79
16 – 44	€55.26	€90.37
45 – 64	€110.38	€121.29
65 – 69	€116.28	€129.72
70 and over	€271.62	€271.62

Special Circumstances

Private Nursing Home Patients over 70 Years

A capitation rate of €434.15 per annum will apply to anyone aged 70 years or over who has resided for more than five continuous weeks in an HSE approved private nursing home. There is no payment during the first five weeks.

Supplementary Out-of-Hours Fee

To take account of out-of-hours, €3.64 has been incorporated into the annual capitation fee.

Rural Practice Allowance

The Rural Practice Allowance fee per annum is €16,216.07.

Out-of-Hours Fees

A Medical Practitioner is remunerated by way of a fee for each out-of-hours consultation (other than day consultations or consultations occurring as part of an overflow in respect of normal surgery hours). All fees are inclusive and are as follows:

Consultation	Fee
Surgery consultation Monday to Friday, excluding public holidays, between 5pm and 6pm on the same day and 8am and 9am on the same day	€13.88
Surgery consultation Monday to Friday, between 6pm and 8am the following day and ALL DAY Saturday, Sunday and Public Holidays	€41.63
Domiciliary visit out-of-hours	€41.63
Surgery or domiciliary visit out-of-hours where a GP sees an additional patient during the same consultation	€13.88

Temporary Residents/EHIC Holders/Emergency Consultations

A Medical Practitioner is remunerated by way of a fee in respect of temporary residents, EEA visitors and emergency consultations where a GP sees another GP's patient in an emergency. The fee rates are: -

Surgery consultation fee	€40.94
Domiciliary visit fee	€40.94

Reimbursement of Health Costs for EHIC Holders/UK Residents

In relation to holders of European Health Insurance Cards (EHICs), clarification in relation to reimbursement was issued on 28/03/2014 by the PCRS in Circular 013/14 as follows: -

A resident of a State in the European Union (EU) or European Economic Area (EEA), on a temporary visit to Ireland and who has a valid European Health Insurance Card (EHIC) from that State is entitled to receive necessary general medical services from both GP and Pharmacy.

In addition, Ireland has a reciprocal arrangement with the UK which entitles UK residents on a temporary visit to Ireland to receive necessary services on production of the specified documentation. Necessary service covers the treatment required to allow the visitor continue his/her temporary stay in Ireland and return home as previously planned.

The Health Services Executive, as the competent institution in Ireland for the provision of health services under EU Regulations 883/04 and 987/09, is required to recoup the costs of provision of health services in Ireland for EHIC holders from other EU/EEA States. In the past there have been arrangements between many States to waive the costs associated with these services. Recent interpretation of the Regulations now requires Member States to fully reimburse each other in respect of the costs incurred. As a result the HSE will in future be required to submit a detailed account in respect of the costs incurred for each patient to the Member State responsible for the provision of health care.

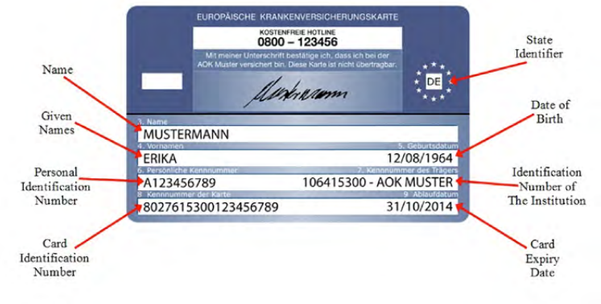
As this is a statutory requirement of the Department of Health and the HSE, the collection of the required information will be incorporated into the Special Type Consultation Claim process from 1st May 2014. It will be necessary to collect the required information at the point of provision of service to eligible persons. The required information for a claim to be deemed valid and therefore reimbursable to the claiming GP must contain the following: -

- The prescription serial number if applicable ***OR*** that no prescription was issued
- State identifier
- Patient's name

- Patient's date of birth
- Patient's personal identification number
- Identification number of the competent institution
- Identification number of the EHIC
- EHIC expiry date

It is important to note that at the time of going to print, no facility exists to record the patient's date of birth on an STC form. However, this is required when payment claims are being submitted online, and it is therefore advised to write the patient's date of birth on the STC at the time of completing the paper form.

The location of the various pieces of information is outlined in the sample diagram of a card below. This example is a German EHIC.



In the case of a UK resident there is a separate arrangement for the calculation of costs. It is necessary to confirm the identity of persons from the UK receiving a service. If the person from the UK presents with an EHIC, the card number should be recorded as per EHIC holders above. If the person does NOT have an EHIC, there are a number of different options for how this can be achieved. The following information should be recorded: -

- Client's name, ***and***
- Client's date of birth, ***plus***
- NHS number, i.e. numeric in the form of 123 456 7899, ***or***
- Passport number, i.e. numeric in the form of 123456789, ***or***
- Driving licence number, i.e. alpha numeric in the form MURPHMA123456789, or 123456789, ***or***
- A National Insurance Number (the same as an Irish PPS), i.e. alpha numeric in the form of AB123456C

It is also important to retain a copy of the documentation confirming the person's identity.

Persons who are deemed to be ordinarily resident in Ireland are NOT covered by the scheme. Such persons may be eligible for a medical card or alternatively may have to pay fees as a private patient. If a GP has reason to believe that a person, while in possession of appropriate documentation, is in fact ordinarily resident in Ireland, that person should be asked to either have his/her eligibility under the medical card scheme confirmed by the HSE or should pay fees as a private patient.

All queries on the gathering or use if EHIC information, should be directed to the HSE EU Regulations Office at euregulations@hse.ie.

Guidelines for Temporary, Emergency and Out of Hours Claims

Two joint HSE/IMO documents have been published which clarify payments for out-of-hours, temporary resident and emergency consultations. These documents are: -

- "Temporary Resident/ Emergency Treatment Clarification", 19th October 2012
- "Out-Of-Hours Clarification", 26th July 2013

Temporary Residents

Payment of fees for temporary residents is to ensure that when patients have moved temporarily and are staying in a different geographic area from their normal place of residence, for the duration of their stay (which should not exceed three months) they will have access to GMS services. The change of living arrangements should not be permanent and includes holidays and clients staying with relatives / friends for whatever reason on a short term basis.

An STC form should be completed and CODE "T" used for both daytime and out of hours times. CODE T cannot be used for clients who are registered with a doctor in one's locality.

Circumstances in which Temporary Resident Claims will not be Paid

1. The claiming GP is the registered GP /doctor of choice
2. The claiming GP is operating in the same practice or locality as the registered GP
3. The claiming GP is operating in a rota arrangement with the registered GP
4. The client is not temporarily resident outside his/her own area and is living at his/her permanent address
5. The client opts to attend a GP who is not his/her doctor of choice
6. The client is resident in the location of the claiming doctor for a period in excess of three months
7. Pending completion of the clients' change of doctor process

Emergency Treatment

If a patient has an accident or requires an emergency consultation for urgent treatment and is unable to receive that treatment from his/her registered GP/Practice because it would be unsafe to wait to attend his own GP and/or impractical due to travel distance, the patient may attend another GP in the locality where the patient finds themselves in need of services.

An STC form should be completed and CODE "E" used.

Circumstances in which Emergency Treatment Claims will not be Paid

1. The claiming GP is the registered GP/Doctor of choice
2. The claiming GP is operating in the same practice as the registered GP
3. The claiming GP is operating in a Rota with the Registered GP and the consultation occurred during the hours of the Rota arrangements
4. The consultation is not in emergency circumstances
5. The patient's condition does not necessitate an immediate consultation to be carried out and does not necessitate emergency treatment
6. The consultation is routine in nature.
7. Pending completion of the clients' change of doctor process

Out-of-Hours

Out of hours claims are not appropriate where a consultation takes place during normal contracted surgery hours or during normal routine surgery hours. Out-of-hours claims may only be made in respect of appropriate out of hours treatment given by the GP outside the hours of 9am to 5pm Monday to Friday and during all hours on Saturday, Sundays and Bank Holidays.

Circumstances in which Out-of-Hours Claims will not be Paid

1. The consultation is not urgent and/or is not unforeseen
2. The consultation takes place during an overflow clinic
3. The consultation takes place during normal contracted surgery hours
4. The consultation takes place during normal/routine surgery hours
5. The patient did not require urgent treatment directly by the GP concerned
6. No face to face Out of Hours consultation actually took place
7. The consultation is otherwise routine
8. The time of the consultation was not during the specified out of hours period

Claims for Special Items of Service in Addition to Out-of-Hours Claims

If in the course of an appropriate out-of-hours consultation it is identified that a patient urgently requires a special item of service that cannot be deferred until the next scheduled surgery, then the GP may claim a fee for that special item of service in addition to the out of hours fee provided that the service is on the agreed list of services which may be reimbursed in respect of out-of-hours. This agreed list includes:

1. Excisions
2. Suturing of cuts and lacerations
3. Treatment and plugging of dental and nasal haemorrhages
4. ECG tests and their interpretation
5. Removal of adherent foreign bodies from the conjunctival surface of the eye
6. Removal of lodged or impacted foreign bodies form the ear, nose and throat (not including syringing of the ear of wax)
7. Nebuliser treatment in the case of acute asthmatic attack
8. Bladder catheterisation
9. Attendance by GP at HSE convened case conference
10. Vaccination – Hepatitis B

If the following services are provided Out of Hours an STC claim ONLY can be made: -

1. Cryotherapy/diathermy of skin lesions
2. Draining of hydroceles
3. Recognised vein treatment
4. Instruction in fitting of a diaphragm
5. Advice and fitting of a diaphragm
6. Counselling and routine fitting of an intra-uterine contraceptive device (IUCD)
7. Vaccination – Influenza, Pneumococcal

Change of Doctor

Temporary Patient and Emergency Treatment fees cannot be claimed pending the completion of the change of doctor process. '*Change of Doctor*' is activated following the processing of an application by PCRS of a request for a '*Change of Doctor*'. Payment for the patient commences from the date the transfer is processed. Therefore, the patient needs to continue seeing their previous choice of doctor until their card details are issued to a practice.

Asylum Seekers

A one off super-annuable registration fee of €173.69 per relevant patient will be paid to doctors in respect of each such patient on their GMS panel.

Special Type Consultations (STCs)

As well as remuneration under Capitation, GMS contract holders are paid on a '*fee per item*' basis for specific special type services provided to patients as shown in the table below. These payments are detailed in Statutory Instrument S.I. No 277 of 2013, Health Professionals (Reduction of Payment to General Practitioners) Regulations 2013.

Special Service	Fee Per Item
Excisions / cryotherapy / diathermy of skin lesion	€24.80
Suturing of cuts & lacerations	€24.80
Draining of hydroceles	€24.80
Treatment and plugging of dental and nasal haemorrhages	€24.80
Recognised vein treatment	€24.80
Electrocardiography (ECG) tests and their interpretation	€24.80
Instruction in the fitting of a diaphragm	€24.80
Removal of adherent foreign bodies from the conjunctival surface of eye	€24.80
Removal of lodged or impacted foreign bodies from ear, nose and throat	€24.80
Nebuliser treatment in the case of acute asthmatic attack	€37.21
Bladder catheterization	€37.21
Advice and fitting of a diaphragm	€41.74
Counselling and fitting of an intra-uterine contraceptive device (IUCD)	€66.79
Attendance by General Practitioner at HSE-convened case conference	€62.02

Contribution to Locum Expenses as at 24/07/2013

The PCRS will make a contribution towards the expense of providing Locum cover in cases of leave including Annual Leave, Study Leave, Sick Leave, Maternity Leave, Paternity Leave, Adoptive Leave and Leave required for attendance at various statutory and GP committee meetings.

Entitlements and contributions are based on the panel size of a contract holder, with a minimum requirement of a panel size of 100. Those contract holders with panels of less than 100 will receive no contributions in respect of any type of Leave.

Annual Leave

The Annual Leave contribution is calculated on a pro-rata basis. Contract holders with panels of less than 100 receive no Annual Leave contribution. A 100% contribution is based on a panel size of 1,500 patients. Rates are as follows: -

Per day €197.24

Per week €1,380.65

Panel Size	Number of Days	Contribution Rate
100	14	€2,761.30
200	16	€3,155.78
300	18	€3,550.26
400	20	€3,944.74
500	21	€4,141.95
600	22	€4,339.19
700	23	€4,536.43
800	24	€4,733.67
900	25	€4,930.91
1,000	28	€5,522.60
1,100	29	€5,719.84
1,200	30	€5,917.08
1,300	31	€6,114.32
1,400	32	€6,311.56
1,500	35	€6.903.25

Study Leave

Once a doctor's panel size exceeds 100 patients, that doctor can apply for a contribution towards Locum expenses for up to 10 days Study Leave. Irrespective of how large the panel, once it is greater than 100, all contract holders are entitled to apply for up to 10 days study leave. The rates are as follows: -

Per day €197.24

Per week €1,380.65

Sick Leave

On 28/03/2014 GP Contractors were notified of changes to the Sick Leave scheme. Circular 014/14 outlined these new arrangements and the new Sick Leave scheme came into operation on 31st March 2014. As a result, there was a reduction in the number of Sick Leave days for which payment is made. Payments in respect of Sick Leave are now made as follows: -

A maximum of 92 days on full pay in a year ***followed by***

A maximum of 91 days on half pay s***ubject to***

A maximum of 183 days in a rolling four year period

In respect of panel sizes, Sick Leave payments are shown in the table below. Of note, those in receipt of the Rural Practice allowance are entitled to a full contribution irrespective of their panel size.

Panel Size	Sick Leave Payments	
<100	No Sick Leave Payment Entitlement	
100 – 700	First 92 Days	Full capitation earnings
	Subsequent 91 Days	Half capitation earnings
>700	First 92 Days	€197.24 per day / €1380.65 per week
	Subsequent 91 Days	€98.62 per day / €690.33 per week
Rural Practice Allowance Recipients	First 92 Days	€197.24 per day / €1380.65 per week
	Subsequent 91 Days	€98.62 per day / €690.33 per week

In recognition that sometime a longer period of Sick Leave can be required to address a very serious/critical illness or serious physical injury there is provision under the new arrangements for additional payments in these cases to apply in line with those which apply to officers of the HSE. The award of extended Sick Leave for critical illness or serious physical injury is at the discretion of the HSE, after medical advice has been received from an Occupational Health Physician nominated by the HSE.

GPs who were on Sick Leave on 31st March 2014 retained entitlement to existing payments until return to practice, at which time, they become subject to the new arrangements.

Sick Leave Arrangements Prior to 31st March 2014

These arrangements are only of relevance to GPs who were on sick leave on 31st March 2014 and who have not yet returned to work. Up to 31st March 2014, payments in respect of Sick Leave were made as follows: -

A maximum of 6 months on full pay in a year ***followed by***

A maximum of 6 months on half pay s***ubject to***

A maximum of 365 days in a rolling four year period

In respect of panel sizes, the associated Sick Leave payments are shown in the table below. As with the current arrangements, those in receipt of the Rural Practice allowance were entitled to a full contribution irrespective of their panel size.

Panel Size	Sick Leave Payments	
<100	No Sick Leave Payment Entitlement	
100 – 700	Week 1	Full capitation earnings
	Weeks 2-26 Inclusive	Full capitation earnings
	Weeks 27-52 Inclusive	Half capitation earnings
>700	Week 1	€197.24 per day / €986.14 per week
	Weeks 2-26 Inclusive	€197.24 per day / €1380.65 per week
	Weeks 27-52 Inclusive	€98.62 per day / €690.33 per week
Rural Practice Allowance Recipients	Week 1	€197.24 per day / €986.14 per week
	Weeks 2-26 Inclusive	€197.24 per day / €1380.65 per week
	Weeks 27-52 Inclusive	€98.62 per day / €690.33 per week

Maternity Leave

In relation to contributions towards Locum expense during Maternity Leave, panel size is very important. For contract holders with less than 100 patients, there is NO contribution towards Locum expenses. GP with more than 100 patients are entitled to Maternity Leave payments for 26 weeks Maternity Leave outlined in the table below.

Panel Size	Maternity Leave Payments (For 26 Weeks)
<100	No Maternity Leave Payment Entitlement
100 – 500	Full capitation earnings*
>500	€197.24 per day / €1380.65 per week

*In relation to those with panel sizes between 100 and 500 patients, the level of payment shall be equivalent to their capitation earnings during the first and subsequent weeks of maternity leave but not exceeding the current weekly Locum payment published by the HSE PCRS and as specified in the fee schedule Statutory Instrument S.I. No 277 of 2013, Health Professionals (Reduction of Payment to General Practitioners) Regulations 2013.

A Medical Practitioner with a panel of 100 patients upwards can also avail of an additional 16 weeks leave at their own expense on grounds under the Maternity Protection Acts, 1994-2004.

Paternity Leave

Fathers may take 3 days special leave with pay in respect of children born on or after 1st January 2001. This leave may be taken at the time of the birth or up to 4 weeks after the birth. In cases where 2 or more children are born, the entitlement to paternity leave will be 3 days for each child, e.g. where twins are born, the father would be entitled to 6 days paid leave. The rate of contribution is: -

Per day €197.24

Adoptive Leave

In the cases of adoption, leave may be taken on or up to 4 weeks after the date of the placement of the child.

In the case of a mother applying for Adoptive Leave, payments will be made for a period of 24 weeks at the same rates which apply for Maternity Leave.

In the case of a father applying for Adoptive Leave, entitlements and payments are exactly the same as for Paternity Leave.

Leave for Attendance at Meetings of Statutory Bodies or GP Committees

The rate of contribution toward Locum expense in respect of attendance at such meetings is: -

Per day €197.24

Practice Support Subsidies

Medical Practitioners with a panel size of 100 or greater can claim Practice Support Subsidies. These contribute towards the cost of employing a practice nurse, practice secretary and/or practice manager.

The calculation of Practice Support Subsidy is by a complex algorithm based on the following factors: -

1. The "relevant experience" of the nurse or secretary
2. The panel size, which is weighted
3. The PRSI category of the staff employer
4. The number of hours worked
5. The P60, P35 and P35L

"Relevant experience" is defined as the number of years for which a Practice Support Subsidy has been claimed for the employee in question. This will be 1, 2, 3 or 4 plus years of experience. It can include time spent employed in other practices. The determining factor in "relevant experience" is whether an employee has been registered under the scheme and Practice Support Subsidy previously claimed for that employee, regardless of the employer. In the case of a practice manager, the first tier of nursing payment is made regardless of experience.

Panel weighting refers to the process by which medical card patients over the age of 70 are considered at a 2:1 ratio, i.e. counted twice when the panel size is being calculated. Practice Support Subsidy is the only circumstance in which panel size is

weighted. The maximum Practice Support Subsidy is paid for a weighted panel of 1,200. The current year's Practice Support Subsidy is derived from the weighted panel size pertaining to the previous 12 months. GPs in a Partnership/Group practice may apply in writing to have their GMS lists amalgamated for the purposes of maximising Practice Support Subsidy payments. The panel numbers of all Partners/applicants must be included for benefits to be amalgamated.

Based on "relevant experience", payments for practice secretaries and nurses are tiered. Assuming a weighted panel of 1,200, i.e. the maximum level of Practice Support Subsidy, the tiered payments for secretaries and nurses based on "relevant experience" are as follows: -

Practice Support Subsidy Based On Weighted Panel Of 1,200			
Practice Secretary		**Practice Nurse**	
"Relevant Experience"	**Tiered Payment**	**"Relevant Experience"**	**Tiered Payment**
1 Year	€20,630.57	1 Year	€30,945.86
2 Years	€22,349.80	2 Years	€32,665.07
3 Years or more	€24,068.99	3 Years	€34,384.29
		5 Years or more	€37,822.72

Given the complex algorithm used to calculate Practice Support Subsidies, it is not possible to give accurate examples. However, should a GP or practice wish to receive a detailed and complete breakdown of Practice Support Subsidy payments illustrating the precise calculation used, one can apply in writing to the GP Unit of the PCRS for the breakdown and this information with be provided.

Appendix 6 – Services not covered under the GMS Contract

A medical card entitles the patient to a wide range of services. However, a number of additional services are not covered under the GMS contract and patients are required to pay directly for these services. The following items are not covered by the GMS Scheme: -

- Medical examinations or reports for legal purposes
- Examinations relating to insurance policies
- Examinations relating to fitness to drive including eye test
- Pre-employment examinations
- School entry examinations
- Examinations for fitness to take part in sports
- Some vaccinations
- Some family planning services
- Preventative services e.g. screening services or health checks including cholesterol testing
- Cervical smears (if falling outside the guidelines of the national cervical screening programme)
- Dressings
- 24 hour blood pressure monitoring

Appendix 7 – The Mother and Infant Care Scheme Fee Schedule

As of 24/07/2013 the fee schedule is as outlined in the table below. There are also additional payments available as follows:

1. Fee per additional visit (to a maximum of five visits) €27.67
2. Fee per emergency delivery €230.53

Visit	Payment
1st Visit – Antenatal	€38.42
2nd Visit – Antenatal	€27.67
3rd Visit – Antenatal	€27.67
4th Visit – Antenatal	€27.67
5th Visit – Antenatal	€27.67
6th Visit – Antenatal	€27.67
7th Visit – Antenatal	€27.67
8th Visit – Postnatal (Baby)	€27.67
9th Visit – Postnatal (Mother and Baby)	€38.42
Total Fee Per Birth (1st Pregnancy)	**€242.85**
Total Fee (All Other Pregnancies)	**€270.52**

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Appendix 8 – Payments Made to GPs for Immunisations Including the Primary Childhood Immunisation Programme

Payments made to GPs for immunisation are detailed in Statutory Instrument S.I. No. 278 of the Health Professional (Reduction of Payments to General Practitioners) (National Immunisation Programmes) Regulations 2013.

Under this legislation, payments are detailed in 2 schedules. Schedule 1 refers to payments made under the Primary Childhood Immunisation Programme. Schedule 2 refers to payments made for services rendered under other national immunisation programmes.

The full list of all immunisations for which payments are made under both Schedules 1 and 2 is as follows: -

- 6 in 1 vaccine (Diphtheria, Tetanus, Pertussis, Haemophilus influenzae type b, Poliomyelitis and Hepatitis B)
- 4 in 1 vaccine (booster vaccine against Diphtheria, Tetanus, Pertussis and Poliomyelitis)
- Influenza vaccine (seasonal influenza)
- Hib booster (additional dose of the vaccine against Haemophilus influenzae type b)
- Men C vaccine (Meningococcal group C bacteria)
- MMR vaccine (Measles, Mumps and Rubella)
- PCV (Pneumococcal Conjugate Vaccine)
- PPV (Pneumococcal Polysaccharide Vaccine)

Schedule 1: Payments for Services Rendered Under the Primary Childhood Immunisation Programme (PCI)

Vaccinations under the Primary Childhood Immunisation Programme (PCI) are provided free of charge to all children. Parental consent is required for the administration of vaccinations to children and young people up to the age of 16. Vaccination is not mandatory in Ireland, but strongly advised by the health authorities. Fees are payable for the registration of infants and for each primary immunisation. The current immunisations given are: -

1. 6:1 (Diphtheria, Tetanus, Pertussis, Hib (Haemophilus Influenza B), Polio, and Hep B (Hepatitis B))
2. PCV (Pneumococcal Conjugate Vaccine)
3. MMR (Mumps, Measles and Rubella)
4. Meningitis C (Meningococcal C)

A bonus is paid if target levels are met for the infant population registered to each practice. All GPs (including non-GMS contract holders) are entitled to apply for a contract with the local HSE office to provide this service.

Payments are divided into six parts, A to F as follows: -

Part A Amounts payable to a GP in respect of the administration of vaccines to a **registered child** under the PCI

Part B Amounts payable to a GP in respect of the administration of vaccines to a **registered child** under the PCI where the GP **does not administer all of the vaccines** under the PCI to that child

Part C Amounts payable to a GP in respect of the administration of vaccines to a child who is **not a registered child** in respect of the GP under the PCI where that GP **does not administer all of the vaccines** under the PCI to that child

Part D Amounts payable to a GP in respect of the administration of vaccines to a **registered child** under the PCI where **no other vaccines are administered** to that child under the PCI by any other GP

Part E Amounts payable to a GP in respect of opportunistic screening and administration of one set of vaccines to a child under the PCI

Part F Amounts payable to a GP in respect of the administration of a 4 in 1 vaccine or an MMR vaccine or both scheduled to be administered under the PCI to a child who is more than 4 years of age where the GP has been informed that it is not possible for the vaccine or vaccines concerned to be administered by the HSE in a school setting

Payments under each of these parts are now detailed in the following tables: -

Part A

Amounts payable to a GP in respect of the administration of vaccines to a registered child under the PCI	
Once-off amount payable to a GP in respect of a registered child.	€37.78
Amount payable to a GP for administering to a registered child all of the following vaccines: - **a.** 6 in 1 vaccine scheduled to be administered at 2, 4 and 6 months of age; **b.** Men C vaccine scheduled to be administered at 4 and 6 months of age; **c.** MMR vaccine scheduled to be administered at 12 months of age; **d.** Men C vaccine scheduled to be administered at 13 months of age.	€125.87
Once-off bonus amount payable to a GP in respect of a registered child who has reached his or her second birthday in a particular year where the GP concerned has administered all of the following vaccines under the PCI to that registered child and to at least 95 per cent of the registered children of that GP who have reached their second birthday in that year: - **a.** 6 in 1 vaccine scheduled to be administered at 2, 4 and 6 months of age; **b.** MMR vaccine scheduled to be administered at 12 months of age.	€60.63
Amount payable to a GP for administering to a registered child under the PCI, after the child has reached 12 months of age, a Hib booster scheduled to be administered at 13 months of age, provided that one or more of the 6 in 1 vaccines that were scheduled to be administered to the registered child at 2, 4 and 6 months of age was not administered to that registered child after he or she reached 12 months of age.	€18.82
Amount payable to a GP per PCV up to a maximum of 3 PCVs administered to a registered child under the PCI provided that the amount payable for administering the third PCV is payable only where the PCV concerned is administered to the registered child on or after the day on which he or she reaches 12 months of age and before the day on which he or she reaches 24 months of age.	€18.82

In practical terms, most children are registered with a single GP or GP practice, and payments will therefore be made as per Part A above. As of 24/07/2013, the payment structure to GPs for administered infant vaccines is outlined below. This assumes the full course is administered by the same GP. In addition, where 95% uptake has been achieved, there is a bonus payment of €60.63 per child.

Date	(Scheduled) Vaccines Given	Payment Due
Registration	Usually automatic at 2 month attendance	€37.78
2 months	1st 6:1 and 1st PCV	€18.82
4 months	2nd 6:1 and 1st Men C	€0.00
6 months	3rd 6:1 and 2nd Men C	€125.87
	2nd PCV	€18.82
12 months	MMR and 3rd PCV	€18.82
13 months	Hib Booster and 3rd Men C	€18.82
Total Payment		**€238.93**
If 95% Uptake, Bonus Payment		€60.63
Total Payment Including Bonus		**€299.56**

Part B

Amounts payable to a GP in respect of the administration of vaccines to a registered child under the PCI where the GP does not administer all of the vaccines under that Programme to that child	
Amount payable to a GP for administering to a registered child a 6 in 1 vaccine scheduled to be administered at 2 months of age where another GP administers to the child concerned other vaccines scheduled to be administered to that child under the PCI after 2 months of age.	€18.27
Amount payable to a GP for administering to a registered child all of the following vaccines where another GP administers to the child concerned other vaccines scheduled to be administered to that child under the PCI after 4 months of age: - **a.** 6 in 1 vaccine scheduled to be administered at 2 and 4 months of age; **b.** Men C vaccine scheduled to be administered at 4 months of age.	€74.37
Amount payable to a GP for administering to a registered child all of the following vaccines where another GP administers to the child concerned other vaccines scheduled to be administered to that child under the PCI after 6 months of age: - **a.** 6 in 1 vaccine scheduled to be administered at 2, 4 and 6 months of age; **b.** Men C vaccine scheduled to be administered at 4 and 6 months of age.	€125.86
Amount payable to a GP for administering to a registered child all of the following vaccines where another GP administers to the child concerned other vaccines scheduled to be administered to that child under the PCI after 12 months of age: - **a.** 6 in 1 vaccine scheduled to be administered at 2, 4 and 6 months of age; **b.** Men C vaccine scheduled to be administered at 4 and 6 months of age; **c.** MMR vaccine scheduled to be administered at 12 months of age.	€46.62

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Part C

Amounts payable to a GP in respect of the administration of vaccines to a child who is not a registered child in respect of the GP under the PCI where that GP does not administer all of the vaccines under that Programme to that child	
Amount payable to a GP for administering to a child any of the following sets of vaccines where the child concerned, although a registered child in respect of another GP, has not received any vaccines under the PCI from the GP in respect of whom the child is a registered child, provided that the GP administers the vaccine scheduled to be administered to that child under the PCI: **a.** 6 in 1 vaccine scheduled to be administered at 2 months of age; **b.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 4 months of age; **c.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 6 months of age; **d.** MMR vaccine scheduled to be administered at 12 months of age and Men C vaccine scheduled to be administered at 13 months of age.	€46.62
Amount payable to a GP for administering to a child any of the following sets of vaccines where the child concerned is a registered child in respect of another GP, and has received all vaccines under the PCI from another GP (whether or not the GP in respect of whom the child is a registered child), provided that the GP administers the set of vaccines scheduled to be administered to that child under the PCI: - **a.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 4 months of age; **b.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 6 months of age; **c.** MMR vaccine scheduled to be administered at 12 months of age and Men C vaccine scheduled to be administered at 13 months of age.	€56.07
Amount payable to a GP for administering to a child either of the following sets of vaccines where the child concerned is a registered child in respect of another GP and has received vaccines scheduled to be administered at 2 and 4 months of age under the PCI from another GP (whether or not the GP in respect of whom the child is a registered child), provided that the GP administers the set of vaccines scheduled to be administered to that child under the PCI: - **a.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 6 months of age; **b.** MMR vaccine scheduled to be administered at 12 months of age and Men C vaccine scheduled to be administered at 13 months of age.	€56.07
Amount payable to a GP for administering to a child both an MMR vaccine scheduled to be administered at 12 months of age, and a Men C vaccine scheduled to be administered at 13 months of age, under the PCI where the child concerned is a registered child in respect of another GP and has received vaccines scheduled to be administered at 2, 4 and 6 months of age under the PCI from another GP (whether or not the GP in respect of whom the child is a registered child).	€60.63
Amount payable to a GP for administering to a child a Hib booster scheduled to be administered at 13 months of age under the PCI where the child concerned is not a registered child in respect of the GP but is a registered child in respect of another GP and provided that one or more of the 6 in 1 vaccines that were scheduled to be administered to the registered child at 2, 4 and 6 months of age was not administered to that registered child after he or she reached 12 months of age.	€18.82
Amount payable to a GP per PCV up to a maximum of 3 PCVs administered to a child under the PCI where the child concerned is not a registered child in respect of the GP and provided that the amount payable for administering the third PCV is payable only where the PCV concerned is administered to the child on or after the day on which he or she reaches 12 months of age and before the day on which he or she reaches 24 months of age.	€18.82

Part D

Amounts payable to a GP in respect of the administration of vaccines to a registered child under the PCI where no other vaccines are administered to that child under that Programme by any other GP	
Amount payable to a GP for administering to a registered child a 6 in 1 vaccine scheduled to be administered at 2 months of age under the PCI, where no vaccines scheduled to be administered after 2 months of age under that Programme are administered, by the GP concerned or any other GP, to the registered child concerned.	€3.15
Amount payable to a GP for administering to a registered child both of the following vaccines, where no vaccines scheduled to be administered after 4 months of age under the PCI are administered to the registered child concerned by the GP concerned or any other GP under the PCI: - **a.** 6 in 1 vaccine scheduled to be administered at 4 months of age; **b.** Men C vaccine scheduled to be administered at 4 months of age.	€44.07
Amount payable to a GP for administering to a registered child all of the following vaccines, where no vaccines scheduled to be administered after 4 months of age under the PCI are administered, by the GP concerned or any other GP, to the registered child concerned: - **a.** 6 in 1 vaccine scheduled to be administered at 2 and 4 months of age; **b.** Men C vaccine scheduled to be administered at 4 months of age.	€47.22

Part E

Amounts payable to a GP in respect of opportunistic screening and administration of one set of vaccines to a child under the PCI	
Amount payable to a GP for administering to an individual any one of the following sets of vaccines where the individual is not a registered child in relation to any GP provided that the set of vaccines concerned is administered to the individual on the same day by the GP (or by the GP concerned and another GP in the same practice) and that the GP or GPs concerned do not administer any of the other sets of vaccines to the individual concerned: - **a.** 6 in 1 vaccine scheduled to be administered at 2 months of age; **b.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 4 months of age; **c.** 6 in 1 vaccine and Men C vaccine scheduled to be administered at 6 months of age; **d.** MMR vaccine scheduled to be administered at 12 months of age; **e.** Men C vaccine scheduled to be administered at 13 months of age; **f.** MMR vaccine scheduled to be administered at 12 months of age and Men C vaccine scheduled to be administered at 13 months of age.	€40.90

Part F

Amounts payable to a GP in respect of the administration of a 4 in 1 vaccine or an MMR vaccine or both scheduled to be administered under the PCI to a child who is more than 4 years of age where the GP has been informed that it is not possible for the vaccine or vaccines concerned to be administered by the HSE in a school setting	
Amount payable to a GP for administering to a child either: - **a.** a 4 in 1 vaccine, or **b.** an MMR vaccine, where the child is more than 4 years of age provided that the vaccine which is administered is not administered by the GP (or by another GP in the same practice) on the same day as the other vaccine.	€36.03
Amount payable to a GP for administering to a child: - **a.** a 4 in 1 vaccine, and **b.** an MMR vaccine, where the child is more than 4 years of age and both vaccines are administered on the same day by the GP or by the GP concerned and another GP in the same practice.	€54.04

Schedule 2:

Payments for Services Rendered under Other National Immunisation Programmes	
Amount payable to a GP for administering to an individual a vaccine in situations of disease outbreak in a specific area in the State.	€28.50
Amount payable to a GP for administering to an individual a vaccine during a pandemic.	€10.00
Amount payable to a GP under the GMS Scheme for administering a full course of vaccines against Hepatitis B, including post-vaccination testing where necessary, to an individual in an at-risk category.	€142.57
Amount payable to a GP for administering to an individual in an at-risk category a PPV under the GMS Scheme provided that the PPV is not administered by the GP (or by another GP in the same practice) on the same day as an influenza vaccine.	€28.50
Amount payable to a GP for administering to an individual in an at-risk category an influenza vaccine under the GMS Scheme provided that the influenza vaccine is not administered by the GP (or by another GP in the same practice) on the same day as a PPV.	€15.00
Amount payable to a GP for administering to an individual in an at-risk category: - **a.** a PPV, and **b.** an influenza vaccine, under the GMS Scheme where both vaccines are administered on the same day by the GP or by the GP concerned and another GP in the same practice.	€42.75

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Appendix 9 – Department of Justice Medical Fees

These fees have been in place since 1st March 2009 and are current as of 24th July 2013. They can be considered under 4 headings or schedules: -

Schedule 1 Special examinations and reports in cases of criminological character – service requested by the Garda

Schedule 2 Medical witnesses giving professional evidence on behalf of the state in criminal prosecutions

Schedule 3 Psychiatric reports on accused person requested by the Courts and subsequent attendance in Court by psychiatrists, if required

Schedule 4 Service provided by a consultant psychiatrist for prisons and courts

Schedule 1: Special examinations and reports in cases of criminological character – service requested by the Garda	
1. Medical examination in cases of attempted murder, grievous bodily harm, accident etc.	
2. Medical examination in case of sexual offences	
3. Medical examination in cases under drug acts	
4. Medical Examination in drunk-driving cases under the Road Traffic Act 1961	
5. Medical examination and taking of blood and urine samples under part V of the Road Traffic Act, 1968 and part III of the Road Traffic Act, 1978	
Fees (for 1 to 5 above)	
9am – 5pm	€87.02
5pm – 9am	€139.19
Where more than one examination is carried out at the same time, an additional fee for each case inclusive of report if required	
9am – 5pm	€52.19
5pm – 9am	€95.72
On the principle of a 5 day week	
Medical examinations carried out on Saturdays, Sundays and bank holidays	€139.19
Additional fee where more than one medical examination is carried out on Saturdays, Sundays and bank holidays	€95.72

The above (1-5) are special fees arising from the criminological nature of the work	
6. In the case of medical examination at scenes of road traffic accidents where a doctor has been called by the Gardaí, the patient whom they treat (or his/her dependants) to be primarily responsible for the payment of fees but if the fees are not forthcoming within a reasonable period (e.g. 2 months) the fees at 1 above to be payable from state funds	
7. Treatment of persons taken ill or injured, including prisoners; primarily the patient is responsible for fee, but in cases of default, fees to be the same as normal treatment fees	
8. Furnishing of report only in case of medical examination or treatment where fee does not expressly include report	€243.60

Schedule 2: Medical witnesses giving professional evidence on behalf of the State in criminal prosecutions	
Daily **attendance** *fees*	
Where absence from home is half day	€348.01
Where absence from home is full day	€695.99
In addition, vouched Locum expenses	
Half day	€130.52
Full day	€260.99
Where a summoned doctor's attendance is NOT required a fee will be allowed	
The Court is within 5 miles of the doctor's home and less than 24 hours' notice is given	
The court is more than 5 miles from the doctor's home and less than 4 days' notice is given	
Travel and subsistence	
Where a doctor attends court outside their home town subsistence at CS class A rates	
Travel by first class rail, where suitable, or otherwise mileage at appropriate CS rate	

Schedule 3: Psychiatric reports on accused person requested by the Courts and subsequent attendance in Court by psychiatrists, if required	
Examination and report	€207.91
Subsequent report	€176.70
Consultation with Counsel (on day other than the court sits)	€66.83
Attendance in Court	
High Court per day or part thereof	€159.29
Circuit Court per day or part thereof	€144.83
District Court per day or part thereof	€96.48

Schedule 4: Service provided by a consultant psychiatrist for prisons and Courts	
Fee per session of 3 hours and pro rata (travelling expenses are not paid)	€252.81
Examination and report (travelling expenses are paid from doctor's base to prison)	€207.91
Subsequent report	€176.70