CHARTERED ACCOUNTANTS, TAX CONSULTANTS & FINANCIAL PLANNERS

ALBERT GOODMAN

PRACTICE NEWS FEBRUARY 2015

Welcome to the latest issue of the Albert Goodman e-Update specifically for medical practices.

If you have any feedback on the contents of this newsletter, or would like to discuss how this may affect your practice please click on the feedback link. Likewise, if you are not a client of ours and would like to see if we are the right team for you please forward Keith Miller, our medical practice specialist, your details who will be delighted to get in touch for an informal chat.

Thank you for taking the time to read this newsletter.

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GPC ISSUES 'NO PAY, NO WORK' ADVICE

Doctors are being warned by their national body not to do work they are not paid for.

The GPC says any care transferred from secondary or community care, and which is beyond a practice's contractual duty, should be resourced as an enhanced or similar service, if the practice is willing to take this service on.

And if a practice is providing a service that is an established enhanced service elsewhere then the practice should require the CCG or equivalent commissioner to pay for it.

Says the GPC: 'If the CCG or commissioner does not fund workload shift, or an enhanced service, then the practice should decline to provide it, since it would result in current practice staff being diverted away from providing core GP services.'

GPs have also been provided with a handy checklist to help them assess whether to take on or continue an enhanced service:

*If you are providing care above your contractual duty, is it resourced as an enhanced service or similar?

*Does the enhanced service provide sufficient resources to deliver care effectively?

In a new document: Quality First – Managing Workload To Deliver Safe Patient Care, the GPC warns that when practices are assessing the resource provided they need to factor in all expenses to include: employer pensions costs and national insurance contributions, provision for staff absence, equipment, consumables and premises running costs.

*Does the practice have the time, infrastructure and staffing capacity to carry out this work safely and effectively?

*What is the bidding or application process – some can be bureaucratic, time consuming and complex and detract from core duties.

*Will taking on the enhanced service detract from or undermine the practice's provision of core GP services?

GPs are advised that keeping a record of non-core work done and the time it takes can be a helpful way of focussing the practice's attention on the work being carried out when considering making changes. 'It could also serve as a useful method of alerting area teams and CCGs to the extent of the problem. This also ties in with NHS England's initiative to shape workload and reduce bureaucracy', says the GPC.

Quitting an enhanced service

*Practices should see that they serve the required notice period within their agreement.

*Remember that where enhanced services contracts are not nationally commissioned by NHS England, CCGs will be free to contract the services elsewhere and that there is no guarantee the practice will regain them in future.

*Give patients adequate notice of changes, including if appropriate, how to contact the CCG or commissioner regarding alternative access to ceased services.

*All relevant people working in the practice should be able to explain to patients, if asked, why the practice is making changes to its services and inform them who they should speak to if they have any concerns.

Doctors and managers are advised to talk to their LMC first if they plan to cease a service.

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INADEQUATE GP PRACTICES FACE RUIN IF THEY DON'T IMPROVE

A GP practice declared Inadequate by CQC inspectors will be placed in special measures and offered a package of help to improve 'at the earliest opportunity', under proposals announced today.

The CQC has been working with NHS England and the RCGP to develop a pilot programme of intensive support to practices placed in special measures.

Now the regulator of health and adult social care has set out its updated plans for how it will deal with GP practices providing inadequate care.

CQC is seeking feedback on these plans before finalising the approach for April 2015.

It proposes that when it rates a general practice as Inadequate overall then the practice will automatically be placed into special measures, opening the way to a 'package of support' from NHS England.

If its rating has not improved within a year then the CQC will cancel its registration.

In those circumstances NHS England will ensure that patients registered at the practice are able to continue to access GP services.

CQC first announced that it was introducing 'special measures' for GP practices in August 2014. Since then, the CQC has been working with its partners to develop what this could look like and testing it out in early inspections of GP practices.

The special measures regime will work alongside CQC's existing powers. If it has serious concerns about a GP practice then it will take immediate action.

Prof Steve Field, CQC chief inspector of general practice, said: 'Our inspections are showing the majority of general practices are providing good care, which should be commended. Looking at the inspections we have published so far – the overwhelming majority have been rated Good or Outstanding. This is fantastic news and I hope the minority of practices that are not providing this level of care can learn from what these are doing.

'However, when we find that general practices are providing Inadequate services, the public expects us to take action and our special measures regime will give practices clear deadlines to make the necessary improvements.'

He added: 'We will only cancel the registration of a GP practice if we think it is absolutely necessary – and in any case our priority will be to help the practice improve, if that is appropriate.'

Dr Mike Bewick, deputy medical director at NHS England, said: 'Closing a GP practice in response to quality concerns would be very rare, and the first response will be work with GPs, LMCs and CCGs to help turn affected practices around. In all circumstances, patients can be reassured that their safety is the NHS' overriding concern.'

Dr Katherine Rake, chief executive of consumer champion Healthwatch England, said: 'Whilst we sincerely hope that no surgeries will be forced to close, where such action is necessary to protect patients, it is absolutely vital alternative access to GP care is provided.'

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GPS INVITED TO BID FOR PREMISES CASH

GPs in England are being invited to submit bids to improve their premises using money from the £1bn building fund announced last year.

The money can be used for either making improvements to existing premises or building new ones.

£250m is being promised for GP premises every year for the next four years.

The NHS England funding aims to deliver on the promise of a new deal for primary care, as highlighted in the NHS Five Year Forward View.

In the first year it is anticipated that the money will predominantly accelerate schemes which are in the pipeline.

Bidding GPs should show how the money will give them:

- capacity to do more
- provide value for money, and
- improve access and services for the frail and elderly.

As many as 40 per cent of practices feel their premises are inadequate, according to the BMA.

GPC chair Dr Chaand Nagpaul welcomed the investment. He said: 'It is encouraging that there is finally central recognition of the huge historic underinvestment in GP premises following prolonged pressure from the BMA's GPs committee and a commitment we secured in the 2015-16 contract negotiations.'

He said the GPC was committed to working with NHS England to ensure the funding reached 'everyday practices on the ground' so that GPs and their staff could work in fit for purpose facilities.

RCGP chair Dr Maureen Baker said: 'We hope that this pledge of new money is the beginning of a 'new deal for general practice' and will allow us to treat more patients in the community, keeping them out of hospitals unless absolutely necessary.

'Our patients deserve to see their GP in modern surroundings with state of the art equipment, but this must go hand in hand with funding for frontline patient care – and proactive initiatives to boost GP numbers.'

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LEGAL TIPS FOR GP FEDERATORS

Solicitors have produced a checklist of tips for GPs who wish to federate.

Lockharts warned that if local groups did not federate then there were other large groups, waiting in the wings, to jump in.

Tips:

1. There needs to be a competent steering group who are properly supported by the members. This should involve putative members agreeing to underwrite the costs, which the steering group will incur obtaining early legal and accountancy advice.
2. Putative members have to understand the benefits of operating through a share company and the protection it offers shareholders in terms of limited liability.
3. Groups intending to federate have to keep the pressure up, linking back directly to the 2 key questions above.
4. An early meeting between all interested parties and key advisers is essential. At the outset, this is almost certainly going to involve experienced lawyers and accountants.
5. Applications for tax relief under the Enterprise Investment Scheme need careful lawyer/accountant co-ordination at an early stage.
6. Obtaining proper project advice is also very valuable but this must be from a consultant specialised in GP practice and not merely a 'business consultant'.
7. Decisions have to be made at an early stage about funding. CCGs may be able to assist with providing money for educational advice, but cannot fund individual projects.
8. In most cases, funding will be by subscription for shares coupled with loans to the company. There is no set rule but 50p per patient seems to be the figure that many groups have settled on.

9. Even if staff are not to be employed at the outset, the provider structure must ensure that it can hold employing authority status so as to be compliant with the NHS Pension Scheme for all staff.

10. Clear decisions need to be taken about whether the provider entity aims to secure contracts for 'essential services' type work from CCGs or local authorities or whether a company is to be established for work on a much grander scale, such as, operating an urgent care centre or an extended access provision. It may be difficult to put both types of operation together but identifying the aim is important, as it will have a substantial bearing on the share structure of the company.

11. The majority of entities have been formed to reclaim the old 'essential services' type work, which could be commissioned from a whole range of providers. In most cases, this is work which can be done by the local practices who can be subcontracted to provide services. A company working in this way is unlikely to make a profit as such, as a large part of the contract price will be paid through to the providing practices. Only with larger scale work will the company be likely to make money. Advice needs to be obtained about the ways in which dividends can be distributed to members.

12. When a provider entity has been set up, provisions needs to be made for 'late joiners'. It is suggested that all participating practices should stay in the company for a period of three years to allow it to become established.

13. In almost every case, shares in the company are held for the benefit of the members of participating practices and a simple Declaration of Trust can be used. This does not involve the revision of partnership arrangements.

14. Often concerns arise about potential conflicts of interest between the provider company and individual practices or between the provider company and other organisations in the area providing comparable services. These issues have to be addressed but participants should not be overawed with worry. A simple test is whether an ordinary person sitting on top of a bus would perceive there to be a conflict, or a possible conflict.

15. Apart from preparing the documentation, advisers should be able to guide GPs through the establishment of the company, the first meetings of directors and the resolutions that need to be passed to comply with company law.

16. Finally, the greatest risk is to start with a lot of enthusiasm but then find inertia creeping in.

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GPS URGED TO ADOPT A BIG FREEZE PAY POLICY

GP practices should have a bad weather pay policy to ensure they are fully prepared for any staff disruptions caused by the harsh winter weather, according to a defence body.

MDDUS employment law adviser Dr Liz Symon believes practices need to be flexible so disruptions are kept to a minimum during adverse weather conditions.

She said: 'There is no legal obligation to pay staff if they cannot attend work due to the weather conditions. However, the practice may have contractual obligations or have custom and practice arrangements in place from previous years.

'That said, few contracts will include a clause allowing the practice to deduct a day's pay if an employee cannot make it in and employees also have a statutory right protecting them against unlawful wage deductions.

'So, if the practice does not have the contractual right to deduct pay and the employee does not consent to the deduction, a complaint could be raised.

'Therefore, it is important for the practice to be flexible. How such matters are handled can often affect morale and productivity so it is advisable to introduce a bad weather policy that should be clearly communicated to all employees and applied consistently.'

Possible options within the policy include the employee:

- Receiving a set payment – for example, one day's full pay only
- Being asked to make the time up at a later date
- Being given the option to use holidays
- Taking the time unpaid
- Working from home, if possible

She said any policy should be clearly communicated to all employees and consistently applied.

Dr Symon said it was reasonable to ask employees to consider alternative modes of transport if their usual option for getting into work was unavailable.

If that is not possible, then one option was to ask staff to take holidays for these periods of absence and explain that if further days off were needed then these too would be deducted from their annual leave entitlement.

She added: 'Where employees are absent due to school closures, employees have the statutory right to unpaid time off to deal with emergencies. The key word here is emergencies and not simply because the employee has general childcare issues.

'This time off is for the employee to arrange alternative childcare cover and not to take two or three days off to look after the child themselves. A school closing on a morning, without prior warning, could be classed as an emergency.'

Dr Symon warned practices should consider health and safety obligations because each practice had a duty of care to its employees. 'If there is a Met Office warning advising only essential travel, it is probably not reasonable to be encouraging employees to try and come to work.'

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'BIG INCOME OPPORTUNITIES' FOR ENTREPRENEURS IN NHS

Big opportunities are emerging for innovative and cost effective healthcare providers to offer a range of new specialist services away from traditional hospital settings, according to a healthcare analyst's report out today.

According to Primary Care & Out-of-Hospital Services, from LaingBuisson, the latent market for reconfigured services could be £10-£20bn a year, involving the expansion of home healthcare, telehealth and telecare, disease management and 'whole pathway' commissioning.

The report argues that the UK healthcare system has to step up the pace of change if it is to build on the success claimed in meeting the first Nicholson Challenge to release efficiency savings of £15-20bn between 2011 and 2014.

It says the NHS has now to tackle the spectre of a £30bn funding gap set to hit by 2020-21 as a result of the growing gulf between flat funding and rising demand driven in the most part by an ageing population.

While there may be limited further scope for efficiency savings in terms of containing NHS pay rates and reducing administrative costs, both 'easy wins' to date, LaingBuisson reports that the prospect of further driving down tariff rates in the face of a number of NHS Trusts running into financial difficulties is much less likely.

It says NHS productivity initiatives will in the future therefore have to be more focused on reconfiguration of services away from hospital based care towards new kinds of services in primary and secondary care settings and people's own homes.

The report identifies outcome-based, whole pathway contracts as potentially the most important driver of the sort of NHS reconfiguration which could deal with the root of these chronic problems in the medium to long term.

Increasingly adopted by CCGs, early examples include the ground-breaking Cambridgeshire and Peterborough contract for a range of older people's services (£800m over five years), and similar tenders run by innovative CCGs in Oxfordshire for older people's services.

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CQC REVEALS MORE 'OUTSTANDING' AND 'INADEQUATE' GP PRACTICES

The latest batch of CQC inspections of GP practices have found three Outstanding, 57 Good, 10 rated Requires Improvement and five labelled as Inadequate.

Under CQC's new programme of inspections, all of England's GP practices are being given a rating according to whether they are safe, effective, caring, responsive and well led.

Full reports on all 75 inspections are available at: http://www.cqc.org.uk

The three practices rated as Outstanding are:

- Radbrook Green Surgery, Shrewsbury
- Dr P J P Holden & Partners, Matlock, Derbyshire
- St Thomas Health Centre, Exeter

Three of the five practices which have been rated Inadequate have been placed into special measures and have been offered a package of support by NHS England to help them improve.

The other two practices have been told they will be put into special measures if they fail to improve.

Prof Steve Field, chief inspector of general practice, said: 'So far we have published ratings on 143 practices – of which the vast majority have been Good or Outstanding. It is disappointing that we have found any to be Inadequate, but it is important that those practices are offered help at the earliest opportunity to improve.

'In each case, we have found significant areas of concern. Patients should be able to expect high quality and consistent care from their GP which is why I have put the three practices into special measures. Two practices have already begun to show signs of improvement but we will monitor their progress closely, returning to inspect in the near future.

He said the CQC would only cancel the registration of a GP practice if it thought this was 'absolutely necessary'.

The three practices which have been placed into special measures are:

- Dr Srinivas Dharmana, Queens Drive, Liverpool. The service was rated Inadequate for being Safe, Effective, Caring, Responsive and Well-led.
- Dr Michael Florin, Norris Road, Sale, Trafford. The service was rated Inadequate for being safe and well-led, Good at caring for patients but required improvement to be responsive and effective.
- Priory Avenue Surgery, Priory Avenue, Caversham, Reading. The service was rated Inadequate for being safe, effective and well-led, and required improvement to be caring and responsive.

The two practices which have been told they will be put into special measures if they fail to improve are:

- Dr Sunil Srivastava, Richmond Medical Centre, Upper Accommodation Road, Leeds. The service was rated Inadequate for being safe, effective, responsive and well-led, and required improvement to be caring.
- Widdrington Medical Practitioners, Grange Road, Widdrington, Northumberland. The service was rated Inadequate for being safe and well-led, and Good for being caring, responsive and effective.

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GPS' LEADER SAYS CQC INSPECTIONS 'FLAWED'

GPC chair Dr Chaand Nagpaul has criticised the CQC for continuing to 'name and shame' GP practices deemed to be having problems.

He said: 'While any issues with patient care must be immediately resolved, it is not helpful that the CQC continues

to pursue an inspection regime that is flawed in many aspects.

'For example, it is absurd that judgments are being made before physical inspections take place on a number of questionable indicators such as how many internal meetings a practice holds.'

Latest CQC findings on GP practices were published earlier today on this website and have been widely reported to the public on television, websites and social media.

Dr Nagpaul said: 'We really must strive for a more robust and fair approach that maintains patient care while at the same time supporting and helping those practices that are struggling.'

But he said it was encouraging that the vast majority of inspection reports returned good or outstanding ratings for GP practices.

'This does demonstrate that GP practices across the country are delivering high quality, responsive care to their patients despite the incredible workload and funding pressures that GP services are facing.'

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DOCTORS' COMMERCIAL INTERESTS COULD BE ON MEDICAL REGISTER

The General Medical Council (GMC) is exploring the possibility of recording doctors' commercial interests on its Medical Register as part of a review to make it more useful to interested parties.

But it said today this would require a change in primary legislation and was in the hands of Parliament.

Its guidance in Good Medical Practice says doctors must be honest in financial and commercial dealings and 'must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.'

Explanatory GMC guidance on Financial and commercial arrangements and conflicts of interest expands on this.

Chief executive Niall Dickson said: 'We set out that doctors 'must be open and honest with your patients about any such interests that could be seen to affect the way you prescribe for, advise, treat, refer or commission services for them.'

The GMC aims to write to all independent healthcare providers and their Responsible Officers (ROs – who deal with revalidation of doctors) seeking assurances from them that they are not putting their doctors in a position where they could be acting outside our guidance.

This includes the offer of any incentives that could affect the way they prescribe, treat, refer or commission services for patients.

The GMC is on a working group with the BMJ and the Royal College of Physicians (RCP) looking at a project on conflicts of interests for doctors.

Mr Dickson said: 'Our liaison teams work with doctors, employers, educators and patients – we are determined that this guidance should be understood, followed and, where any concern exists, there are clearly understood ways of seeing that it is escalated.'

The GMC is also reviewing the Competition and Markets Authority (CMA) report into private healthcare which has raised the issue of the potential for conflicts of interest to arise when doctors refer patients for medical treatment.

Added Mr Dickson: 'It is a complex document and we have also asked Counsel (independent senior lawyer) to review the wider implications of the report relating to Fitness to Practice (FtP).'

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NOW GPS FACE NEW DATA PROTECTION INSPECTIONS

Inspection focus on GPs is set to intensify following a change in the law this week which will give Information Commissioner inspectors the right to force NHS authorities to be audited for compliance with the Data Protection Act.

As GP concern about CQC inspections mount they have been told that the Information Commissioner's Office (ICO) will be able to subject their surgeries, along with other public healthcare organisations, to a compulsory audit.

These compulsory audits have previously only applied to central government departments.

The audits review how the NHS handles patients' personal information, and can review areas including security of data, records management, staff training and data sharing.

The ICO will be able to assess data protection by England's NHS foundation trusts, GP surgeries, NHS Trusts and Community Healthcare Councils, and their equivalent bodies in Scotland, Wales and Northern Ireland under section 41A of the Data Protection Act.

But the new legislation will not apply to any private companies providing services within public healthcare.

Christopher Graham, the Information Commissioner, said: 'The Health Service holds some of the most sensitive personal information available, but instead of leading the way in how it looks after that information, the NHS is one of the worst performers. This is a major cause for concern.

'Time and time again we see data breaches caused by poor procedures and insufficient training. It simply isn't good enough.

'We fine these organisations when they get it wrong, but this new power to force our way into the worst performing parts of the health sector will give us a chance to act before a breach happens. It's a reassuring step for patients.'

The ICO has issued fines totalling £1.3m to NHS organisations.

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THREE WEEK DEADLINE FOR GPS' RESPONSES TO CQC RATING PLAN

The Care Quality Commission (CQC) has issued draft guidance for consultation on how providers across England can make sure they are meeting the Government's new requirement for them to prominently display their performance ratings from April.

This follows an amended regulation laid before Parliament by the Department of Health that will require providers to display their CQC ratings at their registered locations and on their websites.

CQC rates services as Outstanding, Good, Requires Improvement or Inadequate and has been doing this for GP practices since last November.

GPs have until Wednesday 25 February to comment.

CQC chief executive David Behan said: 'Following an inspection we publish our report and rating on our website. In the future there is a new requirement for all providers to display their rating. This will provide even greater transparency in helping people to make more informed choices about their care, either for themselves or their loved ones.'

More information – and to provide feedback – on the display of ratings and other amended regulations is available at **http://www.cqc.org.uk/guidanceconsultation**

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NHS 111 CALLS TO GPS 'UP 186%'!

GPs' leaders have warned that more pressure is being put on overstretched NHS services by NHS 111 after a new analysis by the BMA suggested that the number of calls referred through to GP services had gone up by 186 per cent, and to A&E by 192 per cent.

Separate figures also suggest a sharp drop in the percentage of calls where patients had been given safe 'self-care' advice over the phone rather than being referred to NHS services.

The analysis by the BMA of NHS England's latest statistics on NHS 111 found:

- The number of calls referred to GP services from NHS 111 rose by 186 per cent when comparing January-October 2013 to January-October 2014, from 2,844,452 to 8,138,863 – an increase of 5,294,411.
- The number of calls referred to A&E services from NHS 111 rose by 192 per cent when comparing January-October 2013 to January-October 2014, from 374,506 to 1,092,967 – an increase of 718,461.
- Figures from the Primary Care Foundation estimate that the number of calls designated as 'self-care' – where patients can safely treat their condition after advice from a call hander – may have also declined from 48 per cent in 2012 down to an average of just 15 per cent in 2013 and 2014.

Dr Charlotte Jones, BMA's GP lead on NHS 111, said: 'The BMA has consistently highlighted serious concerns about NHS 111 and how it is not delivering appropriate advice and outcomes for patients who call the service.

'Before it was launched in March 2013, the BMA's GP committee warned that it would struggle to cope with demand, a prediction that proved to be correct when large parts of the system collapsed immediately after they opened1.

'Although there have been some improvements in capacity since its disastrous early introduction, this analysis of referrals over the past two years demonstrate that there has been a huge increase in the number of people put through to key parts of the NHS such as A&E and general practice. There is no doubt that if a patient needs any form of medical care they should be referred through to an appropriate doctor or nurse, but there are serious doubts as to whether this huge increase in workload is clinically necessary.'

She continued: 'Anecdotally, GPs have reported to the BMA that patients have been referred to them with colds, sore thumbs or other conditions that could have been treated safely by sensible advice over the phone, advising a patient on how to self-care, such as picking up medication from a local pharmacist. The number of calls logged as 'self-care' seems to have dramatically fallen since the introduction of NHS 111.

'There is little doubt that the NHS cannot afford to have unnecessary workload being created given the unprecedented pressure on our health service. GP practices are already struggling to deliver enough appointments to their patients as demand rises, resources fall and staff shortages continue to undermine GP services2.'

Dr Mark Porter, BMA chair of Council said: 'A fundamental problem with NHS 111 is that it employs non-clinically trained staff who follow a formulaic script rather than using clinical judgement to assess how calls are dealt with.

'Understandably this is likely to lead the call handlers, with limited experience of medicine, to be cautious and refer patients to the NHS when a trained professional could have encouraged them to effectively self-care.

'Key NHS services cannot afford to be taking on unnecessary work when they are struggling to treat the number of patients who do need genuine care. It is also an enormous waste of patient's time if they are sent to a GP or A&E when they could have had their issue dealt with during a few minutes on the phone.'

Dr Porter called on the Government to do a serious and urgent analysis of the effect of NHS 111 on the wider urgent and unscheduled care system to determine where it may be working inefficiently and to ensure that it is cost effective.

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KINGS'S FUND CALLS NHS REFORMS 'DAMAGING'

A major assessment of the coalition government's record on NHS reform by The King's Fund concludes that the upheaval caused by the Health and Social Care Act has been damaging and distracting.

The new report highlights some positive developments as a result of the Act including closer involvement of GPs in commissioning services, giving local authorities responsibility for public health and the establishment of health and wellbeing boards.

However, it criticises the decision to implement complex organisational changes at a time when the NHS should have been focused on tackling growing pressures on services and an unprecedented funding squeeze.

Other key findings from the assessment of the Act are that:

- an unwieldy structure has emerged with leadership fractured between several national bodies, a bewilderingly complex regulatory system and a strategic vacuum in place of the system leadership that was previously provided by strategic health authorities
- while claims of widespread privatisation are exaggerated with less than 10 per cent of the NHS budget spent on non-NHS providers, the emphasis on competition has resulted in greater complexity and uncertainty about when contracts should be put out to tender
- despite the intention to devolve decision-making and reduce political interference, the period since the Act was implemented has been characterised by regular ministerial intervention and a continued focus on targets
- responsibility for commissioning has been fragmented between different bodies and NHS England has been slow to establish itself, weighed down by its wide-ranging responsibilities
- although not an explicit aim of the original reforms, progress has been made in developing integrated care and the Care Act 2014 is an important step towards a fairer system for funding social care

The report highlights a significant change in the coalition's approach to the NHS, with the second half of the parliament characterised by a welcome shift away from the technocratic changes contained in the Health and Social Care Act to concentrate on safety and quality of care.

Ministers have turned their attention away from competition and choice to focus on regulation and transparent reporting of performance data to improve care standards. The report argues that the next government should build on this with less emphasis on inspection and more support for hard-pressed staff to improve patient care, and accelerate moves to achieve closer integration of services.

Chris Ham, Chief Executive of The King's Fund, said: 'Historians will not be kind in their assessment of the coalition government's record on NHS reform. The first three years were wasted on major organisational changes when the NHS should have been concentrating on growing financial and service pressures – this was a strategic error. Only latterly has the government adopted a more positive focus on improving patient care and achieving closer integration of services. Politicians should be wary of ever again embarking on such a sweeping and complicated reorganisation of the NHS.'

Doctor's Reaction

Dr Mark Porter, BMA council chair said: 'The Health and Social Care Act was opposed by patients, the public and NHS staff, but politicians pushed through the changes regardless.

'This report highlights the damage that has been done to the health service and the major shortcomings of the Act, which distracted attention from rising pressure on services and cost billions to introduce.

'The test for any health policy should be whether it benefits patients, but a BMA survey of doctors found that 95 per cent did not believe the Act had improved the quality of services for patients, with three quarters believing it has made the delivery of joined-up care more difficult1. This is because it prioritises competition over integration, a concern which is highlighted front and centre in this report.'

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aisma
association of independent specialist
medical accountants

Keith Miller

Keith joined Albert Goodman in 2006 from a local Somerset firm of Accountants where, having qualified as a Chartered Accountant in 1988, he had been a Partner since 1990. He recently went on to achieve further success becoming a Certified Financial Planner in 2006.

Although best described as a General Practitioner, providing financial and taxation advice to an expanding portfolio of high net worth individuals, limited companies, sole traders and partnerships, Keith specialises in assisting medical practices and solicitors on all aspects of financial and taxation advice. He leads our GP medical team and is a member of AISMA, the Association of Independent Specialist Medical Accountants.

As a qualified Certified Financial Planner, he is ideally suited to obtaining a detailed understanding of the issues facing proprietors and their personal objectives in order to make a key contribution on strategic and tax issues, as well as dealing with the very complex areas of Capital Gains Tax and Inheritance Tax planning

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