A group task for general-practitioner trainees: planning a group practice

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Doncaster has a new general-practitioner training scheme with four training posts at present. The four trainees spent the first six months of this three-year scheme in general practice. An educational programme had been organised with a half-day release course consisting of talks and seminars, which introduced the trainees to the wider aspects of community health care.

These methods were satisfactory when covering topics which the trainees had met before, but some topics such as practice management required an alternative approach as the trainees had no previous experience. It was felt that the trainees would learn more about these subjects by doing rather than listening.

Therefore the group was given a project, which it undertook partly in its spare time and partly in the half-day release course. The project created problems the trainees would not otherwise have met until entering general practice.

METHOD

As a starting point each trainee was given an information sheet (appendix 1) stating the problem, which was to create a new group practice. The project was regarded by the trainees as an actual rather than imaginary problem and the help obtained from expert sources was given in the same spirit. Below is a description of the three meetings the trainees held.

The first meeting: problem definition

The brief was re-examined. The combined list of the vacant practices contained 9,100 patients. The husband and wife team wanted to remain in the house from which they had practised. The single-handed doctor had practised from his centrally situated house and a branch surgery, which served 600 patients, in a nearby village. None of these premises would be available for future practice use, so suitable premises had to be found.

The following points were raised about future premises: locality, size, whether to buy or rent; if they were to be permanent or temporary.

It was thought that the chances of finding suitable premises immediately ready for use as a permanent practice were remote, and that temporary premises must be sought.

Faced with the problem of beginning practice in one month's time, great care was needed in selecting temporary premises which would be used for at least three years, the minimum time required for conceiving and building any purpose-built premises.

The practice site had to be close to the centre of the practice area and easily accessible by public transport. Such a site would have been disadvantageous to the 600 branch surgery patients, who would be given the chance of changing their general practitioner. To help communications between the hospital services and the practice it was felt that the site should be as near the district general hospital as possible.

As far as temporary premises were concerned, the following minimum requirements were chosen: two consulting rooms, one waiting room, one reception/filing room, and one spare room, later to be used as a third consulting room or staff rest room, but at present to help alterations and redecoration. Assuming the temporary premises have two storeys, the reception, waiting, and one consulting room would be on the ground floor. At least one consulting room

would be necessary on the ground floor for patients unable to manage stairs. This would also be the drawback to having a treatment room upstairs. There would have to be lavatories on both levels. We thought it desirable that adjacent ground could be used as a car park.

It was now realised that expert knowledge was needed about the legal requirements before premises were used for medical practice, and we approached the local executive council.

At this stage the question of whether the premises should be rented or bought was left open, although we thought that funds would be required very soon whatever was decided. A practice bank account was opened with the possibility of an overdraft. At the same time a source of capital was sought, which had to be discussed with an accountant.

Also important were the present and predicted financial states of the group. This led to a discussion of the cost of running a group practice.

When laying down the minimum requirements for the size of the practice premises it had already been decided that ancillary staff would be employed. A list of essential staff included: one full-time shorthand typist also to be in charge of staff, one full-time receptionist, two nurses, preferably state registered and one part-time cleaner. Any gaps, we hoped, would be filled by enthusiastic doctors' wives.

A summary of problems arising from the first meeting

1. Premises had to be found.
2. The local executive council had to be consulted about statutory requirements for the premises.
3. A bank account was to be opened.
4. The practice income had to be estimated and an accountant consulted about budgeting for future expenses.
5. Recruiting staff.
6. A solicitor had to be consulted about drawing up a practice agreement.
7. An architect was needed for building permanent premises and the alteration of temporary premises.

Each of the trainees was allocated a specific area of research and arrangements were made for the next meeting.

The second meeting

Practice agreement

At this stage the four trainees had had only a few weeks' experience of general practice and as rainees had had little or no experience of practice agreements. However, as part of the half-day release course, they had received a talk from a solicitor on this subject and so had an idea of the content of such agreements.

Dr John Kelly, a teacher, with one of the trainees kindly produced a draft agreement (appendix 2). In practice such an agreement is submitted to the executive council and the local medical committee. After detailed discussion the draft agreement was thought to be satisfactory and was frequently referred to in subsequent planning.

Temporary premises

Evidence showed that only minor alterations would be required to convert any suitably sized building to meet the requirements of the local executive council. Three types of buildings were discussed.

Portable buildings were dismissed as unsuitable since in the opinion of an architect much work was required in preparing foundations and providing services.

Council houses have been used as surgeries by converting two semi-detached houses into one functional unit. However, it was thought that the local authority would not be willing to agree to this for the provision of temporary premises.

Thirdly, a detached house with at least six rooms and with adjacent land was considered. The cost of conversion would be borne by the doctors whether the building was bought or rented. It was decided that in view of the possible financial appreciation over three years the premises should be bought. The cost was estimated at £6,000 to £8,000 at Doncaster prices in autumn 1971. The conversion would cost £1,500 to £3,000 and £500 to reconvert before selling. Thus between £8,000 and £11,500 would be required.

The conversion of a house to a surgery is a ' change of purpose ' and requires planning permission. This takes two forms, outline and detailed, and together these may take up to six months to be granted. For a project of this type an architect's help is essential. For example, the architect thought we would need adequate car parking space before permission would be granted. In this case it was thought a delay would be unlikely as the area was urgently in need of doctors. However, should delays occur the premises could be rented from the vendor and conversion started before permission had been officially granted. This might prove to be risky and expensive.

Finances

The annual income of the practice was estimated to be £18,000, staff salaries estimated at £4,600 of which £3,220 (70 per cent), would be reimbursed. National insurance contributions would be about £650.

Permanent premises

There were three possibilities:

(1) A Section 21 health centre.
(2) Purpose-built premises owned by the practice.
(3) Converted premises owned by the practice.

These were discussed in detail, but the only conclusion reached was that we were unlikely to find premises suited to conversion which would match the high expectations we had of the building from which we would be prepared to practise.

Thus the following subjects were due for detailed examination during the next few days: Section 21 health centres, purpose-built practice premises, and rent rebates.

Third meeting—final decision

Temporary premises

The earlier decision to buy temporary premises was reversed. An accountant advised that they should be rented first, as rent is 100 per cent allowable for tax relief; secondly, he thought three years too short a time in which to expect a worthwhile capital gain.

For the conversion of temporary premises a grant is available from the executive council, which will give one third of the cost of conversion to a maximum of £1,000 per doctor, provided:

(1) It is possible to practise medicine from the premises prior to conversion,
(2) That planning permission has been given,
(3) That it requires security of tenure with a guaranteed period of use of about three years.

Permanent premises

If in the long term the idea of a Section 21 health centre was rejected, a large sum of money would be needed for purpose-built practice premises. Working from ECN 858 for a building area of 3,300 sq. ft. the cost would be £23,570, externals £3,967, and professional fees £2,771, the total being £30,500; each partner's share being £7,622. However, premises based on 2,500 sq. ft. would make each partner's share £5,534.

Sources of money

Sources of capital were thought to be banks, building societies, merchant banks, finance corporations, and the General Practice Finance Corporation.

Banks will lend money at 3·5 per cent over base rate. They require adequate collateral and the normal term of a loan is four years. In exceptional cases they give a ten-year loan. Even this was thought too short a time to repay a minimum of £5,000 with interest in view of the financial commitments a young general practitioner would already have.

The services provided by building societies were also inadequate for our purpose. Some would lend up to two thirds of the capital involved for the building of business premises, and some would not lend any at all.

Linking repayments with an endowment assurance policy without profit looked promising. However, problems arose when it was considered what might happen if one or two of the doctors wanted to leave the parnership during this scheme. It would be difficult to work out

how much the departing partner was due and how much the incoming doctor would have to pay, and if two left simultaneously, the scheme would probably collapse.

A long-term loan from the General Practice Finance Corporation seemed the best method giving a 100 per cent loan repayable over 30 years (appendix 3). This was felt to be the best source of capital. At this point the rent rebate scheme was discussed as it has a direct bearing on the economies of paying for the cost and upkeep of premises (appendix 4). The scheme would need close contact between the doctors and the executive council throughout the planning and building of the premises secondly, should larger premises be wanted the maximum payable would still only be £726 per annum; thirdly, this scheme is under constant review.

Section 21 health centre

With reference to our project the local authority were willing to build to provide a Section 21 health centre and the partners would be involved in its planning. It is common experience that local authority architects are sympathetic to the suggestions of the doctors, and will accommodate their wishes within the limits laid down by the Government.

If they require it, the doctors may select and organise their ancillary staff; alternatively, the organisation of the staff and the running of the whole centre may be left in the hands of a management committee, or a practice manager. In this way the doctors may opt out of a great deal of time-consuming administration. Each doctor in the practice pays the local authority a set sum for each session per week per year he uses his consulting suite and this is a comprehensive charge for rooms and services. This certainly helps to estimate expenses.

Health centres are used by a variety of providers of care, including dentists, regional medical officers, health visitors, chiropodists, and consultants for outpatient sessions. It is to be hoped that this will reduce the amount of travelling done by patients and lead to better working relationships between all staff.

To build practice premises to the same standard as a Section 21 health centre would cost £23,000. The source of this money has been discussed. To build premises with larger consulting suites and to cater for personal tastes in decorating and equipment would add £1,000 per doctor to the cost. However, this cost does include building the premises with a view to later expansion, in particular, buying more ground than is currently necessary to allow for the building of two more consulting suites and expansion of car and pram parks.

In planning a health centre the needs for future expansion are allowed for, but, of course, in premises owned by the doctors they have a greater amount of control in management.

It was felt that this degree of independence might prove useful in the future in maintaining the general practitioner's contractual status.

The financial advantages of owning one's premises are straightforward; the premises are an investment, particularly if easily converted to another role, e.g. offices.

The disadvantage financially is that future partners will of necessity have to buy their way in, and out-going partners be paid their share. In a health centre comings and goings should have no financial attachments.

Group decision

We felt that a decision had to be made whether to build premises or move into a health centre. Three trainees were adamant that they wanted their own premises; the fourth was equally adamant that at this stage in his career he was not prepared to involve himself in such a complex project, feeling that a general practitioner could give just as good a service from a Section 21 health centre.

An outline of a purpose-built group practice centre is given in appendix 5.

Discussion

For about a month the trainees worked closely together on this project. They met in each others' homes and each meeting contained the following elements in varying amounts: discussion planning, reporting back, and recording.

The time between meetings was spent seeking material and editing it for the next meeting. Some of the research involved reading, much of which is to be found in the Royal College of General Practitioners' reading list.

For the rest, our research was involved with people. Our general-practitioner teachers, from whom we got much help and criticism and in turn introductions to others, an accountant, a bank manager, an architect, and the clerk to the executive council.

But the trainees have learnt much more than how to set up a general practice. They have got to know people; the teachers, the non-medical professionals, and each other. They have learnt facts: some of the legal, financial, and administrative aspects of general practice, and the sources and nature of relevant knowledge. Perhaps most important of all, they have developed attitudes and opinions regarding general practice directly as a result of this project. They now feel more confident, particularly as the subject matter was outside their previous sphere of knowledge.

Although it is hoped that this subject matter will be of help to others, the more important aspect has been the setting up of a valuable learning situation, which, with a co-operative and enthusiastic approach is enjoyable and educational. Moreover, for certain topics it is better than the more traditional lectures and seminars.

Conclusion

We found the group task a satisfactory way of gaining practical experience of a problem we had not previously met, and would not otherwise meet for at least three years.

Other subjects could be covered in this way, provided that they are carefully chosen. We found: (1) a good educational content, (2) an attractive learning process as learning was by doing and there was contact with people; each other, their trainers, and the various non-medical professionals.

In general it is felt that the group task, or project, is a useful adjunct to the more traditional methods of trainee education.

Appendix 1—Group task; Planning a group practice

An advertisement has appeared in the *British Medical Journal* inviting applications to fill vacancies in a South Yorkshire town caused by the death of one doctor in single-handed practice who has 2,800 patients, and by the simultaneous resignation of a two-doctor, husband and wife partnership, in the same district who have decided to emigrate. The latter practice has 6,300 patients. None of the practice premises are available for incoming doctors and there are no Section 21 health centres available. The single-handed practitioner had practised from his house and also held a branch surgery in a village adjoining the town; this served 600 patients. A large group practice is already established in this village which is about two miles from the deceased doctor's residence. There is a district general hospital in the town about three miles from the main practice area but with heavy traffic and a river with one bridge between.

The vacancies have been advertised together because the executive council is anxious to encourage a group of three or four doctors to start up in either group practice or health-centre practice. The advertisement mentions that the local authority might be willing to consider providing Section 21 health centre accommodation and would be interested in encouraging the attachment of local authority nursing staff. The area is designated.

You are to imagine that you have completed your vocational training and have got on so well together as a group that you decide to apply for the vacancies, do so, and are finally accepted by the executive council. You are now faced with the task of setting up in general medical practice looking after patients on the original practice lists.

You will require advice and information on a number of matters from different sources, among them your individual trainers, tutor, executive councils, British Medical Association, Royal College of General Practitioners, local planning officers, medical publications such as *Pulse*, and the hospital library. You will, in the course of the coming weeks, get some experience in different types of medical practice and should take the opportunity to gather information which will be of value to you in planning your own practice organisation.

The following are a few points to consider:

1. How you will organise yourselves as a group to deal with the task.
2. Early decisions about arranging temporary accommodation to carry on practice until you have made permanent arrangements.
3. The type of practice you will engage in, e.g. partnership, single-handed or a combination.
4. Legal arrangements, particularly about partnership agreements.
5. You will need knowledge about income and different types of finances available under different conditions of practice.

6. Permanent surgery accommodation, whether it should be self-owned, rented, converted, purpose-built or local authority Section 21 health centre.
7. Staffing and management, local authority attached staff. You will have to make some decisions about the numbers of staff you would employ and how you allocate their duties. What sort of contractual arrangements will you have with them?
8. Miscellaneous considerations including the type of telephone system, e.g. the number of lines you might need. The organisation and planning of appointment systems.

It is suggested that you work through this task together and be prepared to report back at the end of term. You might find it helpful to organise a number of your own meetings to deal with it.

Appendix 2

The agreement is a mutual covenant and contains the following:

Date of commencing the agreement, names of partners in alphabetical order, term determinable; making provisions for terminating partnerships, name and business address of firm, provision of capital. Equipment: specify what personal property is to be supplied and specify what is to be considered property of partnership, record the division of profits or losses, salaries and remuneration: all income from the practice of medicine shall be the property of the partnership. Exclusions: seniority pay, trainees allowance, superannuation (i) from general medical services equivalent to share, (ii) from other appointments it is property of individual, provision for charging of private fees—by mutual agreement. Shares of partners: specify dates. Provision for bank account and drawing of cheques, books of accounts: name where to keep and that each partner must have free access to books, annual audit of account—on anniversary of agreement; copies sent to each partner; each must agree on name of accountant. Division of profits and drawings: agree on interva!s at which salaries can be drawn in advance of annual accounting, capital payable but not brought in—no partner to give credit if forbidden by others. No partner to pledge practice assets as security for personal debt, employment of ancillary staff by mutual agreement, membership of a Medical Defence Union and must remain a member for six years after end of partnerships, individual expenses, holidays, study leave for recognised courses. Service with Her Majesty's Forces; agree on amount to be paid, usually equals share minus locum's pay. Incapacity: any partner away for more than one month is responsible for the payment of a deputy, executive council pays £45 per week for a locum, therefore partner must make provision for his own sickness insurance on top of this, prolonged incapacity; over six months, retirement required at discretion of other partners, retirement: amount of notice to be given, out-going partner cannot practise within specified distance from present practice, power to expel a partner in extreme circumstances, effect of death or bankruptcy of a partner, valuation of practice assets. Provision for arbitration when disagreements arise.

Appendix 3—Loans

Repayment of 100 per cent loan by General Practice Finance Corporation.

30-year loan on £7,622.

£830 per annum (per doctor)—tax relief £240 per annum.

Total in 30 years=£24,900.

30-year loan on £5,534.

£586 per annum (per doctor)—tax relief £177 per annum.

Total repayment=£17,598.

15-year loan on £7,622.

£99 per annum—tax relief £240 per annum.

Total repayment=£14,990.

15-year loan on £5,534.

£727 per annum—tax relief £177.

Total repayment=£10,917.

None of the total figures includes deduction for tax relief, this is difficult to calculate as it relates to interest paid.

The rent rebate scheme allows the general practitioner an annual payment towards the cost and upkeep of his premises.

It is controlled by the local executive council, and information can be obtained from ECNs 569 and 858, and to a lesser extent from ECNs 582, 634, 678, 681, 733. It is complicated and covers most types of practice premises.

Taking this scheme as it would affect our planning of a purpose-built premises: the following points were noted.

It defines ' cost rent ' as ten per cent p.a. of (a) actual cost of site or current material value assessed by the District Valuer who takes whichever is less.

(b) Fees and legal cost arising out of (a).
(c) Lowest acceptable tender, usually of three, or notional cost, see appendix (B) E.C.N. 858, whichever is less.
(d) Professional fees from (c).
(e) Interest charges on loans incurred in buying land.

It defines notional rent as the current market rate as assessed by the District Valuer.

The practitioners are thus able to choose which they will receive; as a rule the cost rent is initially higher but it is stationary and the notional rent will be expected to rise in time. The position is assessed at five-yearly intervals and when the notional rent reaches the cost rent value it is possible to pay the notional rent. However, this decision is not reversible. Based on the figures in appendix (B4) E.C.N. 858 the maximum cost rent would be £762 p.a. a partner.

Appendix 5—Proposed areas

Outline of purpose-built group practice centre.

Based on minimum criteria laid down for planning a Section 21 health centre.

	Sq. ft.
Entrance lobby	30
Reception/office	200
Waiting area	280
W.C. patients	48
Consulting room (4 × 120)	480
Examination room (4 × 80)	320
Treatment room and drug store	280
Health visitor and general purpose room	120
Staff rooms	200
Cleaner's room	8
General store	12
Meter cupboard: G.P.O. equipment	8
Circulation, 15 per cent of total	300
Total	2,286 sq. ft.

At £7 per sq. ft. (1966 prices)—£16,000
(1971 prices)—£23,000

(External: pram shelter 200 sq. ft., car park for 32—6,500 sq. ft.). Space for two more consulting suites—400 sq. ft.

Increase in car park for two more doctors and patients would require an extra 35,000 sq. ft. of land at a cost of £2,000 to £4,000.