STARTING PRIVATE PRACTICE

IN DERMATOLOGY

SERVICE GUIDANCE

Clinical Services Unit
British Association of Dermatologist
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Key Considerations

- Independent practice should only be conducted by fully trained and suitably experienced doctors. The minimum requirements include a registerable medical degree, MRCP or equivalent, a certificate of completion of training or equivalent, and entry on the specialist register of the General Medical Council.

- Maintenance of the highest possible standards of ethics, medical care and clinical governance is mandatory in the performance of independent practice, as it is for NHS practice.

- Consultants with NHS contracts must take every possible step to ensure that their private practice does not adversely impact on their NHS duties.

- Consultants should only practise in hospitals in which they have been given practising privileges or admitting rights.

- Consultants conducting private practice should have appropriate medical indemnity.

- Consultants should keep clear and accurate records of their private practice activities.

- Groups or partnerships of consultants should be established under legally acceptable agreements.

Contents

1. Introduction

Many new consultants will wish to undertake a certain amount of private practice in parallel with their NHS work. As a private practitioner a consultant will be self-employed; in essence running a one man business. Like all businesses, however large or small, being successful and profitable depends on the application of sound business principles from the start.

Unfortunately, business management is taught at neither undergraduate nor postgraduate level. Many consultants start private practice in a rather ad hoc way learning as they go, and in particular, learning from the inevitable mistakes they make.

This information pack is designed as an introduction for those who may be thinking about working in or establishing a private practice. It outlines a number of areas that you should bear in mind before entering this field. It looks at different models of private practice, as well as some financial, equipment and marketing matters.

After reading this guide you are advised to:

- Talk to a range of private practitioners about their experiences;
- a recognised professional network that speaks on behalf of self-employed members and those employed in private practice such as the BMA or FIPO.
- Seek appropriate business, financial and legal advice.

As with any activity, there are pros and cons to independent practice. The advantages include additional income, more clinical freedom and an opportunity to develop closer relationships with colleagues and patients. The disadvantages include the additional time spent in practice, out-of-hours and antisocial working, and a need for flexibility. Consultants may also need to be on call for their private patients and will work more often on their own.

Anyone undertaking private practice will be required to pay a higher medical indemnity subscription, have more complicated accounts and must make sure that their private work does not conflict with their NHS contract.

The main purpose of private practice is the income that it generates. No consideration of private practice is complete without a clear description of the difference between benefits and fees. Benefits are what insurance companies pay out on behalf of patients according to the terms of their policy contract with them.

Fees are what consultants charge patients for their professional services.

These two terms should never be confused, and they should not be used interchangeably. Most private medical insurers (PMIs) make their benefit schedules available to consultants. Some, such as the Western Provident Association (WPA), make their schedule publicly available (http://www.wpa.org.uk). A small number of PMIs do not publish their benefit schedules.

No organisation can set consultants' private practice fees. If any membership organisation such as the BAD or the BMA were to attempt to set fees, it would attract unwelcome interest from the Office of Fair Trading (OFT). It is for the individual consultants to determine their own fees themselves.

Anyone considering conducting private practice should consider the matter fully before embarking on it. Although it provides financial and other rewards, it demands the very highest ethical, clinical and financial standards. Private practice income is difficult to estimate accurately over time, and the private practitioner must always put clinical governance and cooperation with colleagues ahead of financial gain.

2. Options for Working in Private Practice

A practice can be owned by a sole proprietor, by a partnership of two or more people, or by Directors of a Limited Company. Each of these scenarios will have different tax and legal implications, and these should be considered before choosing which is the most appropriate for your circumstances.

Whichever one you choose, you should appreciate that it is a business venture and that there may be financial risks, additional personal responsibilities and a large amount of administrative work.

While some practitioners choose to see clients in a home setting, others choose to share practice space with other health practitioners, renting by the hour, or having a room within a clinic or a private hospital. Each setting has advantages and disadvantages that need considering before making your decision.

2.1 Partnership

In a partnership, two or more people share the risks, costs and responsibilities of being in business. A partnership is a relatively simple and flexible way for two or more people to own and run a business together. However, partners may not enjoy any protection if the business fails. Each partner is self-employed and takes a share of the profits. Unlike a limited company, a partnership has no legal existence distinct from the partners themselves.

2.2 Sole Trader

This means you run your business as an individual. You are responsible for all aspects of the business and you pay personal tax on the profits of your business. You are personally liable for any debts that the business incurs, which can make this a risky option for businesses that need a lot of investment. Some of the advantages of being a sole trader include independence, and any profits made going to you. Some disadvantages include a lack of support, unlimited liability, and personal responsibility for any business debts.

2.3 Chambers and Group Practice

Consultants can work together through chambers or partnerships. Most chambers offer a system whereby the members contribute to these common expenses by paying a percentage of their gross income. However, there is no profit-sharing as in a partnership and individual members of the group keep the fees they earn beyond what they have to pay towards the chambers expenses. The advantages include sharing costs and expenses, practice accommodation and administrative support and strength in negotiating with private hospitals. This has to traded off against loss of professional autonomy and the tax advantages of paying a partner for secretarial work.

A partnership is a type of business entity in which partners share the profits or losses of the business undertaking in which they have all invested. The shares may be equal (equity partnership) or may be fractional, based upon the seniority or some other factor that varies only by the consent of all partners. A true partnership must have a legally drafted partnership agreement signed by all partners and there should be regular partnership meetings.

Generally, partners have an obligation of strict liability to third parties injured by the partnership. The liability of limited partners is limited to their investment in the partnership, hence the term *Limited Liability Partnership.*

Without a legally drafted partnership agreement, the group will not benefit from the legal advantages of a real partnership, such as the ability for all partners to charge the same fee without an accusation of price fixing.

Partnership administration can be largely left to the salaried partnership manager who acts under the immediate direction of the elected partnership chairperson.

More information can be gathered from the representative organisations FIPO and IDF.

2.4 Employment with a Private Provider

If you are considering a post with a private provider practice, you should be clear as to your proposed employment status. If you are being offered a post on a self-employed basis, you should ensure that you are given a written “contract for services”, which summarises the proposed relationship and arrangements. If you are being offered a post as an employee then you should receive a “contract of employment” (a written statement of the main terms and conditions of employment) in the same way as if you were applying for a post as an employee in an NHS Trust or independent hospital.

Whichever of the above situations is the case, members should be absolutely clear about what is contained in the contract as it should summarise the relationship between you and the private provider practice owner/employer and set out the expectations for both parties.

If you are working on a self-employed basis, then the situation is somewhat different as you are working to your own account, and are not covered by the same employment rights that apply to employees.

2.5 Admitting rights in Private Practice

All doctors who hold a substantive NHS hospital consultant appointment will usually gain automatic admitting rights to local private hospitals until the age of 70. Consultants are usually asked to confirm GMC registration, medical defence cover and hepatitis B inoculation status annually. Private hospitals have a medical advisory committee who advise on the suitability of those applying for admitting rights, about procedures and treatments and other matters relating to the medical aspects of the hospital.

Practising privileges are not awarded by right; some hospitals may refuse to award them even to consultants who meet the criteria. The private hospital will provide a consultant with the necessary application forms on request.

Consultants must adhere to the appropriate clinical governance requirements as determined by the private hospitals and agreed by the MAC of these hospitals.

2.6 Registration (recognition) with a Private Medical Insurer

Holders of the new certificate of completion of training (CCT) in dermatology may also gain 'recognition' by insurance companies but this depends on evidence of ongoing clinical experience though not necessarily as an NHS consultant.

Before a private medical insurer (PMI) will pay a consultant directly for treating their customers, consultants need to register with them. This may involve providing copies of documents that will satisfy the PMI that the consultant is suitably qualified to provide medical care to their customers.

Virtually all insurance companies use the GP or specialist as the gatekeeper for access to a dermatologist, although some specify patients choose from an approved list of specialists in their local area. The majority of insurance companies will limit the number of sessions reimbursed per course of treatment.

The larger PMIs include: Axa PPP Healthcare, BUPA, BCWA, Aviva and WPA.

3. Things to consider before setting up a business

3.1 Business planning

It is important to seek advice, develop a business plan and evaluate the risk. In addition to establishing viability, a business plan can also form the basis of future developments and should seek to address the following issues:

- What is the demand for the service?
- How strong is the competition?
- How much can you charge?
- Who will buy your service?
- How can you market the business?
- How do you evaluate the service and provide evidence of good practice?
- What are the costs involved (i.e. both initial and operating costs)?
- Who would provide the facilities and equipment?
- Will you have sufficient public and professional liability insurance?
- What would happen in the event of illness?

Further information on how to develop a business case is available on the BAD website:
http://www.bad.org.uk/healthcare-professionals/clinical-services/writing-a-business-case

Please see Appendix 1 for available advice, books and information on business planning provided by government organisations.

3.2 Indemnity in Private Practice

If you are a hospital doctor working in an NHS hospital undertaking contracted NHS work then you are covered by the Clinical Negligence Scheme for Trusts, or NHS indemnity[1]. This protects you from the financial consequences of clinical negligence. The NHS indemnity scheme does not extend to those undertaking private practice and appropriate additional cover is required before treating patients. Locum work in private hospitals is also not covered.

NHS indemnity does not cover the defence of staff involved in disciplinary proceedings conducted by statutory bodies like the GMC, police investigations arising from professional practice or Good Samaritan acts.

Any subscriptions for medical indemnity cover are allowable expenses against your private practice earnings. Policies with commercial companies are on a 'claims made' basis. This means that as the insured doctor you are only covered for claims arising from incidents which both occur and are reported while the policy is in force. When the policy expires, so

[1] NHSLA NHS Indemnity: Arrangements for Clinical Negligence Claims in the NHS
http://www.nhsla.com/claims/Documents/NHS%20Indemnity.pdf

does the cover unless a run-off payment is made. The mutual organisations offer 'occurrence or incident-based' schemes that give 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 had ceased. These provide ongoing protection at retirement or death – the latter preventing your estate being liable for claims.

For more information please see the links provided below:

Medical Protection Society (MPS)

http://www.medicalprotection.org/nhs-indemnity-why-it-is-not-enough.pdf

The MDU

http://www.themdu.com/

3.3 Medico Legal Work

Medico legal work can be divided into personal injury and negligence. The former entails examining clients who are making claims for injuries that they have sustained outside the medical arena, often occupational in nature.

The latter – clinical negligence – involves assessing the care of patients. The consultant has to derive a likely sequence of events from a bundle of documents, largely clinical records; explain those events in terms that an intelligent layman can understand and decide whether the standard of care would be regarded as acceptable by a reasonable body of peers. The consultant must produce a comprehensive medical report and may have to appear in the witness box.

The advantages are that much of the work can be done from home and it is reasonably rewarded. However, deadlines are tight and reports are often challenged and there are risks if you step outside your field of expertise. Professional liability insurance for clinical practice does not necessarily provide cover for medico legal work. Consultants can fall foul of doctors who might have been unfairly castigated in a report, of patients who feel that the consultant has not been sufficiently supportive of their claim, or of lawyers who are dissatisfied with the service the consultant provided. Cheap medico legal insurance is available from all the major defence organisations.

For more advice and training please visit:

Academy of Experts and the Expert Witness Institute http://www.academy-experts.org/

3.4 Care Quality Commission Registration

The Care Quality Commission (CQC) is the independent regulatory body for healthcare, adult social care and the operation of the Mental Health Act 1983 in England. The CQC holds responsibility for the regulation of private healthcare.

The current regulations (October 2013) set out certain exemptions that apply to independent private medical services, which mean that some of these providers do not have to register with CQC.

For the exemptions to apply, the service provider must be an individual medical practitioner who is (or a group of medical practitioners who **all** are):

1. A service provider, or employed by another service provider, that is registered with CQC for carrying on the regulated activity of 'treatment of disease, disorder or injury';

2. that the service provider is a designated body[2];

3. The provision of treatment is carried out in a surgery or consulting room by the service provider: and

4. The provision of treatment in the surgery or consulting room **must not include** treatment carried out under anaesthesia or intravenously administered sedation, **other than**:

    a. nail surgery and nail bed procedures on the foot and which are carried out using local anaesthesia.

    b. Surgical procedures involving curettage (scraping), cautery (burning) or cryocautery (freezing) of warts, verrucae or other skin lesions carried out using local anaesthesia.

Consultant Dermatologists will not currently comply with the surgical exemption criteria (Regulation 3) where they carry out surgical procedures involving punch biopsies and/or surgical treatments of skin lesions using local anaesthesia.

Providing medical advice remotely also requires registration with the CQC when:

- It constitutes triage and is provided over the telephone or by electronic mail, and
- It is provided by a body established for that purpose (as opposed to, for example, the occasional provision of advice by a body such as a hospital or university on an informal basis).

[2] In point2, a 'designated body' means a body prescribed by Regulation 4 of the Medical Profession (Responsible Officers) Regulations 2010 www.legislation.gov.uk/uksi/2010/2841/made.

Please see the CQC website page on registration:

http://www.cqc.org.uk/content/what-registration#accordion-1

3.5 Disclosure and Barring Service (DBS)

The Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) have merged to become the Disclosure and Barring Service (DBS). CRB checks are now called DBS checks. There are different rules for getting a criminal record check in Scotland and Northern Ireland.

In accordance with the regulations laid down by the National Care Standards Act 2000, doctors who have or are applying for practicing privileges at private hospitals are required to provide a 'disclosure' report and pay the relevant fee for this enquiry.

A DBS check has no official expiry date. Any information included will be accurate at the time the check was carried out. It is up to an employer to decide if and when a new check is needed. DBS no longer automatically sends a copy of the certificate to a registered organisation. Employers need to ask the applicant to see the certificate.

If the consultant is the applicant and has subscribed to the DBS update service, the employer can check their certificate online. If applicants need to run a check on themselves, they can get a 'basic disclosure' with details of any unspent convictions from Disclosure Scotland (they can do this anywhere in the UK).

There are now two different types of enhanced disclosure; 'Enhanced' and 'Enhanced with List Checks'. Enhanced with List Checks disclosure is required by any doctor who will come into contact with children or 'vulnerable adults'.

3.6 Compliance with the Data Protection Act

Compliance with the Data Protection Act 1984, the Data Protection Act 1988, the Data Protection Act 1998, and the Data Protection Act 2003 is essential. Doctors who are in private practice will need to register with the Information Commissioner as a data controller, as will certain doctors who manage an NHS services under contract. Some referrers will ask you for your registration number. Also, registering helps to instil trust in potential clients - they'll know that you take protecting their data seriously.

The first step is to register with the Information Commissioner's Office (ICO). You'll be charged an annual fee of £35. Once registered, you'll be added to a list of data controllers and will receive a registration number.

Visit http://www.ico.gov.uk/notify/4b.html to get started.

It is essential that doctors and healthcare organisations have in place an up to date and regularly reviewed data protection policy. One which details the type of data that is held, the nature of any data examination, the people who will have permitted access, how the data will be kept secure.

The GMC has also created a useful set of guidelines, which focus on healthcare and the protection and storage of data. The guidelines also make reference to Department of Health guidelines for the safe handling of medical records. Download from the GMC in PDF format the latest guidelines: Confidentiality. See also the GMC's supplementary advice on when to disclose confidential information

3.7 Appraisal and Revalidation for Private Practice

Doctors working in both the NHS and independent sector need to ensure that their appraisal for revalidation covers all areas of practice. The Independent Healthcare Advisory Services has produced guidance on whole practice appraisal for doctors working in the independent sector.

The GMC states that if you are an employee of both organisations your connection will be with the organisation where you spend the majority of your practice. The consultant is responsible for presenting supporting information in relation to their minority areas of practice at appraisal with their majority employer.

However where a consultant is employed in the NHS and also has practising privileges with a private hospital, the designated body is the NHS organisation. The contract of employment takes priority over practising privileges for the purposes of their connection for revalidation. See GMC website.

Doctors working solely in the independent sector and private practice are required to revalidate in the same way as doctors working within the NHS. Consultants will need to have a prescribed connection to a designated body and responsible officer, participate in annual appraisal with a suitably trained appraiser, and collate a portfolio of supporting information to bring to your appraisals.

Some independent organisations might not conduct appraisals and alternative routes to an annual appraisal must be organised (this may incur a fee). The Independent Doctors Federation has appointed a Responsible Officer for doctors without a prescribed connection to an NHS RO:

Visit the Independent Doctors Federation

The Federation of Independent Practitioner Organisations also offers an appraisal service:

Access The Federation of Independent Practitioner Organisations (FIPO) website

Annual appraisal for locum doctors will be carried out by the organisation assigned as your designated body, with which you have a prescribed connection (e.g. locum agency, NHS organisation or other healthcare provider) and will cover your 'whole practice'. A full list of current designated bodies is available on the GMC website.

Responsible officer (ROs) regulations specify that a locum doctor registered at more than one agency (but without an NHS employer) has a prescribed connection to the agency with which they have done the most work in the previous calendar year. If you are employed by

the NHS and also as a locum you should confirm that your designated body is with the NHS organisation, depending on your contract of employment.

The Royal College of Physicians Revalidation Support Team has produced a short *Briefing for Locum Doctors*, to advise locum doctors on:

- how to find a responsible officer
- how their appraisals should be conducted
- how to collect appropriate supporting information
- arrangements for locum doctors working or living abroad.

Consultants working within a number of organisations are responsible for collecting and providing supporting information at their revalidation appraisal. This must covers all areas of practice, including comprehensive details of each role. Consultants are responsible for ensuring that information is transferred between organisations appropriately. ROs should work with the agencies and independent doctors to agree local arrangements for information sharing. See the NHS Employers Revalidation FAQs for further information on working across organisations.

In Scotland there is ongoing discussion with ROs to identify a robust process whereby locum doctors can provide supporting evidence from their locum appointments.

4. Starting Private Practice

4.1 Consultations from Home

Providing consultation to patient from your own home is perhaps the most difficult way of starting private practice. Many doctors practice mainly elsewhere and use the home to see occasional patients.

There are certain requirements which will need to be met by using your home as a place of business and treating patients. Your home should be big enough for anticipated present and future family needs as well as a private practice. The house should be accessible (e.g. not 0.5 km down a muddy lane impassable in winter!) and have adequate parking. Providing a cloakroom/toilet is essential particularly as patients may have travelled some distance for their consultation. A receptionist must be available to greet patients and direct them to the waiting room area.

The standard home insurance policy will not cover furniture and equipment etc used in a professional capacity at home. Separate insurance must be taken out and this may also cover equipment in other sites including that carried in the car, e.g. cryotherapy equipment or camera.

4.2 NHS Premises

Those wishing to consult in their NHS premises need to discuss requirements with management and senior nursing staff. Private patients seen on NHS premises are charged separately for the use of facilities. This is usually a fixed charge which may include use of room, minor procedure equipment, liquid nitrogen and stationery. It should be established at the outset what is included. Use of NHS equipment etc and/or failure to inform the hospital that a patient has been treated privately may be considered serious misconduct.

The advantage of using NHS facilities is familiarity; with site, staff, equipment, etc and low overheads. The disadvantages are that the surroundings may not be to the standard expected by private patients and parking may be difficult.

4.3 Private Premises

Those wishing to practice solely in private premises or hospital will need to discuss the requirements with the appropriate manager. One disadvantage of consulting in private premises or hospital (unless attached to the NHS hospital) is that need to travel. Enough travel time should be allowed so that NHS commitments are not compromised.

Furthermore, consultants practising in premises owned by themselves will have responsibility for the day to day running of the property. This will also involve scheduling for staff holidays and sick leave.

4.4 Private Hospital

The advantages of working in a private hospital outweigh any disadvantages. Secretary and receptionist are usually provided and holidays and sickness leave are covered. Rental may include a secretary, stationery and sometimes postage. Establish at the outset what is included in the rental. It may be possible to negotiate for things to be included such as consumables, (e.g. gauze, sterile gloves) which managers may be pleased to include to attract a practitioner to consult in their hospital. Do not be afraid to ask for as much as you can. Most hospitals will offer consultant's accommodation either at a substantially reduced rental or rent free until their practice is established.

Private hospitals, unlike private premises (eg consulting rooms in Harley Street) have most of the facilities dermatologist require including radiography, phlebotomy, pathology, operating theatres and so on, which are convenient for patients and doctors. With the changing pattern of private medical insurance it is becoming more important than practitioners have a link with private hospitals approved by the major insurance companies. In the future preferred provider status may be given only to those consulting in specific hospitals

4.5 Renting a Consultation Room

Renting a consulting room on an hourly basis means that there is no disincentive to take annual and study leave. Monthly or quarterly rental means that rent has to be paid whether or not the practitioner is consulting. If rental charges are low this is probably unimportant.

If charges are high the tendency is to consult during periods of leave which can have major implications for a doctor's family and social life.

4.6 Secretary

A private secretary is the single most important part of a private practitioner's business. A private secretary provides many of the functions carried out by different people in the NHS. Although a doctor may consult privately for only one session per week, the secretary will need to make appointments, answer queries and possibly do accounts throughout the week. A secretary who is efficient, pleasant, discrete and who can handle difficult patients well is a great asset. Whoever is chosen as secretary should be paid well. Rates of pay will vary considerably. Secretaries in central London may be paid more than elsewhere in the Country. The best way to ascertain local rates of pay is to ask local consultant colleagues. Which secretary is chosen will depend to some extent on where the consulting rooms are situated.

If NHS premises are used the departmental dermatology secretary may agree to take on this position. If the amount of private practice is not excessive the secretary's NHS commitments will not be unduly compromised by private patients' appointments, queries and letters etc. If the private work becomes excessive, moving to alternative premises and using a dedicated private secretary may be necessary.

Some practitioners, particularly if consulting privately from home, may employ their spouse as secretary/business manager/receptionist.

In private hospitals secretaries are usually provided and paid for by the hospital. Room rental includes secretarial services.

4.7 Notification of Colleagues

The GMC is now in favour of doctors providing accurate information about services to patients as long as both their own guidance, and that of the Advertising Standards Authority (ASA), is heeded.

The ASA Codes require that all advertisements ARE legal, decent, honest and truthful and prepared with a sense of responsibility to customers and society. All advertisements respect the principles of fair competition, and should not bring advertising into disrepute.

There are a number of legitimate ways of letting colleagues know that a private dermatology service is available. A card or letter with the appropriate information can be sent to consultant colleagues and general practitioners served by the local NHS hospital. Name and professional address should be in the local telephone directory and other information may be placed in directories such as Yellow Pages.

Private hospitals usually circulate the general practitioners with the names and special interests of consultants who have admitting rights. However, there is no doubt that the best advertisement is the service offered to the NHS patients of local general practitioners.

4.8 The Patient Consultation Process

Once the private practitioner has a designated consulting room and secretary the consulting process can begin. In general, a letter from a General Practitioner (GP) will be received requesting a private appointment. Sometimes a patient will be told by their GP to phone for an appointment and a letter will be brought by the patient to the consultation. It is preferable for the secretary to send an appointment card if there is time. Appointments made over the phone can lead to problems if the patient takes down the time/date wrongly. The secretary should (if possible) ascertain whether the patient is insured and with which company and also to obtain authorisation.

First consultations should be 20-30 minutes long and follow up consultations 15-20 minutes. If consulting from home it may be preferable to have longer consultations so that the waiting area does not become crowded. It is sometimes difficult to keep strictly to these times if demand is heavy. Accepting patients without GP referral letter, problems relating to patients who are seen privately but for one reason or another would be more appropriately seen as an NHS patient and patients requiring expensive investigations or drugs are considered elsewhere (see further reading).

4.9 Prescribing

All prescriptions are made on a private basis, i.e. the patient will pay the cost of the drug(s), plus a fairly large prescription charge. Many patients will ask whether their GP can issue an NHS prescription. Views differ as to how this request can be managed. Some GPs hold strong views regarding private practice and it is generally unwise to ask GPs to prescribe for private patients. At the first consultation and the issue of a private prescription, it is reasonable to tell the patient that a letter will be sent to their GP stating what drugs have been prescribed and that it is a matter between the patient and their GP whether an NHS prescription is issued. Invariably, long term therapy and repeat prescriptions are issued without problem by most GPs. In the UK cost of outpatient drugs cannot be recovered from health insurance. Drugs prescribed to inpatients are usually covered.

4.10 Charges

The question that most new private practitioners wish to ask is what to charge for consultation and other procedures. It is not possible to give a specific answer since both geography and time will affect this answer. However, consultation charges made by different specialists in an area should be fairly similar and on a time basis, i.e. a 40 minute cardiology appointment will be about twice the cost of a 20 minute dermatology consultation. It is therefore important to ask local consultant colleagues about charges and especially fellow dermatologists. There has been a tendency for charges to be shrouded in secrecy. However, it is important that information about charges be freely available and the private practitioner and secretary must be in a position to quote a charge for consultation or any particular procedure e.g. patch testing and surgery so that patients can assess the adequacy of their insurance cover.

Practitioners may be asked to make private domiciliary visits from time to time. As with NHS visits this can be time consuming. It is quite reasonable to add 50% or more to the normal consultation charge in recognition of the extra time spent travelling.

Private hospitals charge patients separately for use of inpatient facilities. This includes all day cases. If a patient is uninsured a fixed rate for a particular procedure may be quoted which is usually considerably cheaper than the quote given to insured patients. Whether a charge is made for minor procedures carried out in the consulting room seems variable. Most private hospitals probably do not charge. Physicians' charges should be increased regularly, usually on an annual basis. It is clearly inappropriate to suggest a figure! However, to maintain the level of remuneration changes should be increased at least by the prevailing inflation rate or by a percentage equivalent to the annual NHS pay award.

4.11 Procedure Codes

All procedures and consultations have a designated code. Many insurance companies use the same code for a particular procedure: for example, S0632/S0633 for excision of a benign lesion and S0602/S0633 for excision of a malignant lesion. However, the amount of cover allowed by one company may be different to that allowed by another. Once a consultant becomes a recognised provider, a schedule of procedure codes and scales of cover will be sent automatically by some insurance companies or can be requested. Whilst there is no reason why a practitioner should adhere to the scale of fees laid down by any particular company, by so doing, it should avoid the problem of patients finding they are not covered following an operation, a frequent cause of dispute between patient and doctor. There are times when a procedure may reasonably be expected to cost more than allowed for by the procedure code. For instance, when a large but benign lesion, perhaps on the face, requires considerable time for excision and repair. If the patient finds they are not fully covered a letter of explanation to the insurance company (and a copy to the patient) frequently results in full compensation.

4.12 Signing Insurance Claim Forms

The contract between doctor and patient does not involve insurance companies. That is regardless of the level of insurance cover, the patient is duty bound to pay the agreed charge for the service provided. If there is a shortfall in insurance cover it is the patients' responsibility and this fact should always be made clear in any information given to the patient.

Private health insurance is not a substitute for the NHS. The insurance cover almost always excludes pre-existing diseases, before and within a period after insurance is taken out. Many chronic diseases and all cosmetic procedures are excluded and many policies have restrictions relating to availability of NHS services within a certain allotted time, or carry an "excess" making the patient pay, for instance, the first £50-£100 of any claim.

Some insurance claim forms need to be filled in by the GP and a charge is usually made for this service. Consultants should not charge if asked to fill in a form. Forms must be completed properly to ensure minimal delay in payment. Most insurance companies now

pay the consultant directly. Unfortunately, this means that any shortfall will have to be pursued directly with the patient. It is not enough to state on the claim form for example:

Diagnosis: Mole

Procedure: Shave/curettage/excision

Since this may be considered a cosmetic procedure and the claim rejected. If appropriate, the form should be completed more comprehensively, for example:

Diagnosis: Atypical mole (which has bled) referred for exclusion of malignancy.

Procedure: Removal by excision/curettage or shave/cautery under local anaesthetic for histology.

Codes:	e.g. BUPA codes	S0632/S0633	(excision)
		S1110	(curettage/cautery)
		S1420	(shave/cautery)
		AC100	(local anaesthetic)

Although verbose, this claim is more likely to be accepted by the insurance company. Occasionally, patients find their claim has been rejected because of information supplied by the patient themselves to the consultant. A patient may request that this information be altered in order to justify the claim. It is imperative that such pressures be resisted. However, problems arise out of genuine claims and consultants should be prepared to write to insurance companies on behalf of the patient when there has been a misunderstanding. Usually, additional claim forms do not have to be filled in if follow-up visits which relate to the presenting condition and treatment are made within 3 – 6 months.

4.13 Avoiding Disputes

Disputes between patients and doctors are common in private practice. Some relate to charges, others to outcome, or lack of outcome, of treatment and in particularly surgery. To avoid disputes practitioners should always have a current list of charges for all consultations and procedures. If undertaking procedures in hospital it is important that the patient knows in advance that the hospital charges are separate from the medical charges and may receive other accounts for investigations such as histopathology. It is quite legitimate to ask patients to sign a form agreeing to pay medical charges and this is legally binding.

It is important always to discuss in full potential problems, side effects and possible results of surgery. Information “hand outs” are a useful additional adjunct to such discussions. Most dermatologists will already be using these in their NHS practice.

Disputes relating to rejected or incompletely refunded insurance claims are very common. The fault always lies with the insured patient who should know the extent of their cover (as they should for home or car insurance) and should also request a quote for potential medical expenses. Unfortunately, a large proportion of patients have corporate insurance cover and are usually not informed as to the exact limitations of cover by their employing company. Equally, companies may change their corporate health insurance from one year to the next, seeking ever more economical cover. This is a problem of communication and needs to be addressed by both health insurers and companies.

4.14 Medical Record Keeping

In the UK record keeping in private practice is generally not always as good as in the NHS. Litigation in the private sector is quite common and good records are essential not only as an accurate record of the patients' treatment but as a defence in any form of medico-legal dispute.

As with any medical record, notes should be dated, signed and legible with no additional personal comments that might be misconstrued by a third party. Abbreviations should be limited to those generally recognised by the medical profession. Any alterations, if unavoidable, should be dated and signed and no attempt be made to falsify original notes. A contemporary typed letter to the GP also acts as a good record and gets round the problem of "illegible" handwriting. All investigation results should be seen by the doctor before filing. Signing and dating the results shows that this has been done.

Notes should be kept securely and theoretically, indefinitely, since medical litigation is subject to a limitation period of three years from the date the patient became aware of the problem and not from the date of the original treatment/incident. However, it is impractical to keep all records indefinitely and the defence organisations recommend adhering to the Department of Health guidelines:

- Most records be kept for 8 years after conclusion of treatment
- Children's records kept until the 25th birthday
- Psychiatric patients' records kept until 20 years after no further treatment needed
- Obstetric records kept for 25 years or 8 years after the death of the child

Clearly, in dermatology, there is a difference between a child who comes to have a viral wart treated on one occasion and one who, for instance, has a portwine stain necessitating laser treatment or a child requiring extensive surgery.

When notes are destroyed they should be shredded or incinerated and not simply dumped at the local Council's waste disposal site.

Consent forms are recommended for minor procedures carried out under local anaesthetic. It is wise to note: indications for procedure (cosmetic, requested by patient) risks e.g. scarring lumpy scar, wide scar, recurrence and cosmetic end result) List information provided: e.g. BAD information on BCC

If a practitioner is the subject of litigation, or a patient requires a copy of their medical records (which they are legally entitled to do) he/she should immediately contact their

defence organisation and should under no circumstances communicate with the litigant or their solicitor. A copy of the notes should be supplied. A charge for administrative costs is payable.

In general, if records are kept well and patients treated in a way that seems acceptable and reasonable to the majority of colleagues, most practitioners will avoid medico-legal problems.

5. Financial Management and Investment

5.1 Processing Payments

Since the majority of patients are insured it is usual for the account to be settled by electronic transfer directly to the doctor from the Insurance Company. Non-insured patients generally settle their accounts by direct debit or cheque payment. A few patients, often the uninsured, pay cash at the end of the consultation. This is more common in London where there are a greater proportion of overseas patients. Credit card payment, especially in private hospitals, is quite a normal form of transaction. It is a safer way of receiving payments from an overseas visitor than a personal cheque. Relatively few individual practitioners accept this method of payment because of the charge made by credit card companies.

5.2 Sending Accounts

When accounts are sent following consultation or any procedure/investigation is to some extent a personal decision. If a patient has no general practitioner, is uninsured, comes from abroad or is about to leave the country it is quite reasonable to ask that all charges be settled at the end of the consultation. Otherwise, for non-insured patients an account can be sent to their home address, or as otherwise indicated. However, the majority of private patients have health insurance cover and it is customary to send the account direct to the insurance group at the end of a treatment episode, which may mean after one or two follow-up appointments. If patients require regular follow-up, e.g. if on cytotoxic/immunosuppressive therapy or post-melanoma excision, their account can reasonably be sent after each visit. In the private sector it is important to write to the patient, as well as the GP with the results of any investigations. It is often convenient to send the account at the same time. Sending the account prior to writing with results may antagonise the patient.

There is usually a time limit of 6 months between consultation/treatment and making a successful insurance claim so it is important that accounts be sent reasonably promptly.

5.3 Unpaid Accounts

Once an account has been sent out it is reasonable to wait one month before a reminder is sent. This will allow time for an insurance claim to be processed. If after a further month the account has not been settled a second reminder in the form of a letter can be sent asking for the account to be settled within a 30 day period. In addition, the letter should ask whether there is a problem with the insurance claim process or some other reason why the

account has not been settled. If the account is then not settled a firm letter stating that the debt will be passed to a debt collecting agency should be sent.

Debt collecting agencies usually act on a "no win, no fee" basis and will take a substantial portion of the recovered money as a fee. However, it should be recognised that recovery of a proportion of the original fee is better than losing the fee altogether and, the agency fee (without VAT) can be claimed against tax. Pursuit of debt is an important part of managing a business.

5.4 Managing your Accounts

The traditional way of keeping a financial record is to use a simple card system. The demographic details of the patient (including name, address, date of birth, work and home telephone numbers, GP and insurance company) are typed on to a card and the doctor fill in the date and charge of any consultation/treatment. The secretary marks the card with the date the account is sent out (and date of any reminders) and the date and the amount paid when the account is settled, usually by cheque. Cards are conveniently kept alphabetically in three storage boxes; one for patients currently being seen and/or treated but not yet paid; and eventually the largest – cards of those patients who have paid.

From the doctors' point of view this system has great merit because of its simplicity. The card is fixed to the front of the notes and it can be seen at a glance what has or has not been paid and when; and moreover, the appropriate charge can be marked immediately. This avoids the secretary having the responsibility of noting the appropriate charge at a later time.

Desk top computers and accountancy software packages are a preferred method of recording information. Unlike a card system, accounts can be printed automatically at any time as well as having reminder accounts printed at specific times. Moreover, the database will allow total income to be monitored and income reports for the year can be printed out for the accountant. .

If a doctor wishes to do all the accounts personally (or use a personal secretary) it is recommended that professional advice be sought before buying any equipment/software.

5.5 Keeping a record of accounts

Tax law has changed, making it obligatory that individuals be responsible for their own tax affairs and must be able to justify their own accounts with appropriate documentation, receipts etc. The self-employed have always had to do this. Although computer software packages allow accounts to be computerised, the principle of keeping good accounts remains the same.

Most importantly, a separate private practice bank account is required and as far as possible all financial transactions should be paid by cheque, private practice credit card. This makes record keeping much easier as the (monthly) bank statement allows a check on expenditure, as does examination of cheque book stubs. If possible try to persuade the bank not to make this a business account which attracts higher bank charges than a personal account.

All expenditure must be recorded in an appropriate accounting book – or software database, which may also contain a record of income. Documents relating to expenditure such as receipts, railway and parking tickets, and old cheque book stubs etc, must be kept for 6 years.

In order not to miss items of expenditure which can be offset against tax, bank statements, cheque book stubs and receipts should be cross checked with the accounts book on a weekly or monthly basis. This will allow a running total of expenditure to be maintained and will also make preparation of the end of year accounts much easier.

If a computer is used, the same information will need to be loaded into the database and the potential for missing items of expenditure will be the same as for a manual record.

5.6 The Accountant and End of year accounts

Profit in any business is essentially income less allowable expenses. Only those paying schedule D tax, i.e. the self-employed, are allowed to claim against tax expenses that are wholly necessary for running a business. Inspectors do not have a specific list of allowable expenses relating to medical practice and so one doctor's expenses may differ slightly from another.

If the home or personally owned/part owned consulting room is used for medical practice a proportion of the total cost of running the home can be claimed against tax. The proportion allowed depends on the number of rooms in the house and the number that are used exclusively for private practice. For instance, if one room is used for private practice in a 10 roomed house, 10% of the household expenditure can be claimed against tax.

When only a relatively small claim is made there are no implications regarding capital gains tax when the home is eventually sold.

When a spouse is employed by a private practitioner it may be necessary to demonstrate that some genuine contribution is made to running the practice such as, keeping accounts, secretarial/receptionist duties and so on. It is customary to pay up to the prevailing single person allowance to avoid paying national insurance contributions. The salary paid must come out of the practice account into the spouse's account. In addition, a pension plan can be taken out on behalf of the spouse. The contributions are paid by the employer only (the practitioner) and are tax deductible.

Costs associated with attending meetings, courses etc both home and abroad, are tax allowable. All forms of continuing medical education, even if they appear to be exclusively related to the NHS are relevant to a doctor's practice. This is increasingly important as the funds allocated for CME by NHS Trusts become less generous.

Allowable motoring expenses can be another difficult area for doctors to understand. Table 7 lists those items of expenditure that should be included in the accounts. A proportion of the expenses relating to a second car may be allowable (usually 20/25%) since it is recognised that the primary car may not be available from time to time. If a second car is not available a hire car would be an allowable expense. It is important to keep a record of

mileage at the beginning and the end of the year to establish total mileage, and a log book would be helpful to establish an acceptable split between private and business mileage.

When starting private practice a certain amount of equipment etc may have to be purchased. Items such as desk, chairs, filing cabinets and even cars fall into the category of capital expenditure. Particular rules relate to capital allowances which can change from time to time and the accountant will advise on what and how much can be claimed.

At the end of the financial year all the information relating to total income and expenditure should be gathered together and submitted to the accountant who will prepare the formal accounts, which are then signed as correct by the doctor and submitted to the Inspector of taxes.

If the allowable expenses claimed seem reasonable in relation to the total income it is unlikely the inspector will query the accounts. Minor points can usually be settled by the accountant. More major queries may require submission of documents, hence the importance of retaining everything pertaining to the business and the accounts.

The best accountants are those who have the accounts of doctors and know well the particular circumstances of employment (doctors are almost unique in being both self-employed and employed at the same). Asking colleagues will usually reveal a name of a firm or individual accountant who has appropriate expertise and confidence of local doctors.

Charges made by an accountant are tax deductible and will vary according with amount of work and advice required in any one year. Some doctors hand over all invoices/receipts to their accountant and have very little to do with preparation of annual accounts. This is expensive and most doctors keep a record of their income and expenditure which not only allows them to monitor their own business but keeps down accountancy costs.

5.7 National Insurance Contributions (NIC)

Anyone employed or self-employed is required to pay National Insurance Contributions (NIC) towards the provision the state pension and other benefits. Employed individuals pay class 1 NIC and self-employed people (including those undertaking private practice) class 2 and 4 NIC (based on a flat rate and percentage of profit respectively). If you expect to be both employed and self-employed you may be able to defer some of your Class 2 and/or Class 4 National Insurance contributions so that you pay what is due after the end of the tax year when the actual amount has been worked out. Doing this ensures that that you will not pay too much National Insurance on your self-employment income. This needs to be done before 6th April at the start of the tax year by sending a 'deferment of class 2 and 4 NIC' form to HMRC, with which an accountant will be able to assist.

5.8 Pensions

One of the major advantages of private practice is that the NHS consultant salary may be enhanced considerably. The NHS Pension Scheme was changed in 2008 and again in 2012, so that consultants will probably have make much higher salary contributions and have to retire later (currently proposed age is 68). New NHS staff will probably have pension calculated on career-average earnings rather than their final salary. At the time of writing it

is not proposed to change current staff to career -average schemes. Despite these changes, the NHS Pension Scheme is still generally regarded as good value. It is increasingly prudent to use private practice income to enhance ones final pension by taking out an additional private pension. Although young consultants may have other more immediate calls upon their financial resources such as a mortgage and school fees, investing in a pension plan may be a worthwhile and an extremely tax efficient way of saving, with tax relief on pension savings currently applying up to certain annual saving limits.

5.9 Investments

Private practice may well produce surplus income, even if it does not in the first years when outgoings related to home and family are fairly high. Surplus income should be invested. Professional advice from an accountant or other independent financial adviser should be sought. In general, after paying the maximum allowable pension contributions, all tax-free investment opportunities (such as ISAs) should be taken before investing in those that are taxed, because doctors will usually be paying the maximum rate of tax on investment income.

Since there is an upper limit on pensions that are paid out of funds that have enjoyed tax relief, other investments can add considerably to retirement income. The earlier investments are made the better off a person will be in retirement and early retirement becomes a realistic possibility.

5.10 Insurance

Apart from buildings, contents and third party insurance for private equipment and premises, other forms of insurance should be considered to protect the practitioner and his/her family against the unfortunate possibility of untimely ill health, disability or death. Life assurance provides a lump sum on death. Income protection insurance pays a regular income if the practitioner has a prolonged illness or disability preventing him/her working. Critical illness insurance provides a lump sum if a practitioner is diagnosed with a serious (although not necessarily terminal) disease such as cancer of myocardial infarction.

The earlier that insurance is taken out the cheaper the cover. An independent financial advisor should be consulted.

Taking out private medical insurance should also be considered. Members of the medical profession have a mutual understanding that we provide care for each other in times of need. However for private consultations it will be easier to ask colleagues to see oneself or members of ones family if the colleague knows that you are insured. For medical colleagues who are not insured the general discretionary rule is that a charge should not be made for dependants such as a spouse, school/university aged children, or elderly relatives permanently living with the practitioner.

Appendix 1: Business planning information

Advice, books and information on business planning can be obtained from the following organisations/sites:

Organisation name and website	Information provided
Business Link www.businesslink.gov.uk	A government online resource for businesses, managed by the Department for Business, Innovation and Skills, providing business support, advice and information.
Department for Business, Innovation & Skills www.bis.gov.uk/	Responsible for UK government policy in areas that include: business regulation and support, consumer protection, intellectual property and competition. (Some policies apply to England alone due to devolution)
Skills Funding Agency www.skillsfundingagency.bis.gov.uk/	An agency of the Department for Business, Innovation and Skills who fund and regulate adult further education and skills training in England.
Federation of Small Businesses www.fsb.org.uk/	A campaigning group promoting and protecting the interests of the self-employed and owners of small firms. Various services are offered for members.
British Association of Women Entrepreneurs (BAWE) www.bawe-uk.org	Seeks to provide an environment for women in Britain to develop their businesses.
bCentral www.bcentral.co.uk	Microsofts online business centre that offers information, free advice and downloadable documents to help small businesses.

Appendix 2: Other useful resources

Organisation name and website	Information provided
British Chambers of Commerce www.chamberonline.co.uk	Local chambers seek to represent the interests and support the competitiveness and growth of all businesses in their community.
Business in the Community www.bitc.org.uk	Aims to challenge engage and support business in continually improving its positive impact on society.
Business Gateway - Scottish Enterprise www.bgateway.com	Scottish Executive and Local Authorities partner to support economic development in Scotland bringing together a range of services for businesses
Business Rates www.mybusinessrates.gov.uk	A government funded site designed to provide businesses with a single source information on business rates
Chartered Management Institute www.managers.org.uk	Professional management information
Department of Business, Innovation and Skills www.bis.gov.uk/	Information source and advice for businesses of all sizes.
Department for Work and Pensions www.dwp.gov.uk	Information on services and benefits for people of working age, including those starting a business
Direct Selling Association www.dsa.org.uk	Information and advice on Direct Selling in the UK

Disclosure and Barring Service (DBS) checks (previously CRB checks) **Disclosure helpline customer services** customerservices@dbs.gsi.gov.uk Telephone: 0870 909 0811 Minicom: 0870 909 0344	Contact the disclosure customer services department with any questions. On emails, include the full name, address, telephone number and any DBS reference numbers.
Federation of Small Businesses (FSB) www.fsb.org.uk	A campaigning pressure group promoting and protecting the interests of the self-employed and owners of small firms
HM Revenue & Customs National Advice Service (VAT) www.hmrc.gov.uk	HMRC is responsible for collecting the bulk of tax revenue as well as paying tax credits
My business www.mybusiness.co.uk	Online resource for start-ups and established businesses offering guidance on a wide range of business topics
Office of Fair Trading (OFT) www.oft.gov.uk	Business information and explanations of some of the laws that may affect you
Welsh Development Agency – Wales www.wda.co.uk	The economic Development Agency for Wales, helping businesses to start and develop
Health and Safety Executive (HSE) www.hse.gov.uk/	Englands national independent watchdog for work-related health, safety and illness
Health and Safety Executive (HSE) – Scotland www.hse.gov.uk/scotland/	Scotlands national independent watchdog for work-related health, safety and illness

Appendix 3: HM Revenue & Customs documents and leaflets

Find information here on:

- Working for yourself
- Business and tax
- Personal tax
- Forms and publications for employers
- Pension scheme guidance
- National insurance contributions

URL: http://www.hmrc.gov.uk/leaflets/

Appendix 4: Additional references and reading material

Good Small Business Guide 2012: How to Start and Grow Your Own Business. 6th ed. London: A & C Black Publishers Ltd; 2011.

Blackwell E. How to Prepare a Business Plan. London: Kogan Page Ltd; 2011.

Citizens' Advice Bureau. Self-employment: checklist http://www.adviceguide.org.uk/england/your_money/employment/self-employment_checklist.htm

Deekes S. Teach Yourself Understand Tax for Small Businesses. London: Hodder Education Teach Yourself Books; 2010.

Duncan K. Make Your Small Business Thrive. London: Hodder Education; 2011.

Gibson S. Going Self-employed: How to Start Out in Business on Your Own. London: Constable and Robinson; 2008.

HM Revenue & Customs. Starting in Business. www.hmrc.gov.uk/startingup/

HM Revenue & Customs. First Steps to Register as Self-employed. www.hmrc.gov.uk/selfemployed/register-selfemp.htm

Hoxie M. 90 Days to Success Marketing and Advertising Your Small Business. Andover: Cengage Learning; 2010.

Resources and useful contacts

Medical Defence Union www.the-mdu.com
Medical and Dental Defence Union of Scotland www.mddus.org.uk
Medical Protection Society www.mps.org.uk
Action Against Medical Accidents www.avma.org.uk
Criminal Records Bureau www.crb.gov.uk
Department of Constitutional Affairs www.dca.gov.uk
Expert Witness Institute www.ewi.org.uk
General Medical Council www.gmc-uk.org
Healthcare Commission www.healthcarecommission.org.uk
Intensive Care Society www.ics.ac.uk
Legal Services Commission http://www.legalservices.gov.uk
National Institute for Health and Clinical Excellence www.nice.org.uk
National Patient Safety Agency www.npsa.nhs.uk
NHS Litigation Authority www.nhsla.com
Office of Fair Trading www.oft.gov.uk
Royal College of Anaesthetists www.rcoa.ac.uk
Small Claims Court www.hmcourts-service.gov.uk
UK Department of Health www.dh.gov.uk
AXA PPP www.axappphealthcare.co.uk
BCWA www.bcwa.co.uk
BUPA www.bupa.co.uk
CIGNA www.cigna.co.uk
Norwich Union www.norwichunion.com/health
Standard Life www.standardlifehealthcare.co.uk
WPA www.wpa.org.uk