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**The Governance Handbook**

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# Introduction

## Aims

The aim of this handbook is to provide all staff with an understanding of governance.

Governance is an essential component of any organisation to ensure that its day-to-day activities are both compliant and governed. A definition that is used by various sources is:

*“Governance is the establishment of policies, and continuous monitoring of their proper implementation, by the members of the governing body of an organisation. It includes the mechanisms required to balance the powers of the members (with the associated accountability), and their primary duty of enhancing the prosperity and viability of the organisation”.*

To meet our obligations, we are directed to have sound processes in place as stipulated by legislation, our NHS contract, our regulator and our commissioners. To achieve our obligations, it is a team effort, and all members are required to be compliant and always act in the best interests of both the organisation and the patient.

## How this Governance Handbook works

‘Governance’ is a word that is often used in any business. For the purposes of general practice, it was felt that this Governance Handbook should be split into four distinct ‘umbrella’ areas of governance which support the modern-day general practice.

These four areas of governance and their subsequent subheadings can be defined as:

Throughout this handbook, each of these headings has its own chapter and is supported by a referenced policy, external links or guidance documents.

For ease of use, the chapter contents are listed in alphabetical order.

All staff at this organisation have a responsibility to ensure that compliance is met and to understand the rules and regulations as detailed in the various policies. Whilst it is understood that some staff will have a greater understanding of a particular area, it is everyone’s responsibility to diligently ensure that the organisation meets its obligations.

To support staff learning and development, there are several areas within this handbook that have a HUB logo next to them. Where the logo is shown, there is a supporting eLearning course available in the [HUB](https://hub.practiceindex.co.uk/login?redirect=/help).

## Status

In accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents), we have considered how provisions within this policy might impact on different groups and individuals. This document and any procedures contained within it are non-contractual, which means they may be modified or withdrawn at any time. They apply to all employees and contractors working for the organisation.

# Clinical governance

## Definitions

In the NHS England (NHS E) guidance titled [Clinical governance](https://www.gov.uk/government/publications/newborn-hearing-screening-programme-nhsp-operational-guidance/4-clinical-governance), the definition for this subject is “*The system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”*.

Clinical governance is often thought of in terms of seven pillars. However, an eighth pillar called ‘Strategy’ should also be considered as this can be used to provide an additional level of oversight and safety to support practice service users and staff.

Further reading and definitions can be sought from the BMA in their document titled [What is clinical governance](https://www.bmj.com/content/330/7506/s254.3) and also from CQC [GP mythbuster 65: Effective clinical governance arrangements in GP practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-65-effective-clinical-governance-arrangements-gp-practices).

## Why is there a need for clinical governance?

Clinical governance (CG) is all-encompassing in terms of what we should be doing within our roles, and there are several tools that can be used as part of the practice arsenal to manage and support day-to-day requirements, all of which will be discussed in this chapter.

Imagine this scenario, as it encapsulates many of these tools:

*Following recent cold weather, a pothole has appeared in the practice-owned car park. A patient was walking through the car park and has tripped in it. She has sustained a nasty gash to her knee and is very upset.*

Apart from the clinical governance measures, the initial actions and/or responses would be:

* Provide any first aid measures and apologise to the patient
* Advise all of the potential risk and consider repairing the pothole soonest
* Advise the Partners of the incident
* Add to the Accident Book

But what tools should you have to support the management in this instance? How would you use them, and what tools should every practice have?

1. Issues Log

       As this event has *occurred,* this needs to be added to the Issues Log.

       The Issues Log is simply a to-do list and an incredibly useful tool to capture all that needs to be achieved. It can be used in meetings to detail new actions and to advise staff of completed actions and those that are nearing their deadline. Completed issues should be retained in the log.

       The action in this case is for an asphalt company to be contacted to fill in this pothole and any others in the car park.

Note the word *‘occurred’* as this is detailed later in the explanation of the difference between a risk and an issue. [Section 2.10](#_Risk_and_incident) provides further insight into the management of issues, as does the Health, Safety and Risk Management Handbook.

The Issues Log is part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/) which is accessible in the [HUB](https://hub.practiceindex.co.uk/).

1. Significant Event Log

In this instance, a significant event will certainly need to be raised. This can be used as a timeline of the event from initial incident through to actions, lessons learnt, training (if needed), any resulting audit(s) and outcome.

Whilst significant event analysis (SEA) would be raised in any incident like this, in this case a patient was harmed; therefore, there is even more reason to raise this, as there may be lessons that need to be identified and learnt from so that patient safety can be maximised. Furthermore, as this incident may also result in mitigation, having a robust SE Log that details all actions would be useful for any insurance or litigation claim.

All significant events are to be detailed in the SEA Log and this acts as evidence of learning and compliance. For this incident, as harm was caused, the NHS Learn From Patient Safety Events service (LFPSE) should be contacted as detailed in CQC [GP mythbuster 24: Recording patient safety events with the Learn from patient safety events (LFPSE) service](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-24-recording-patient-safety-events-learn-patient-safety-events).

In this scenario, an important point is to also share the event within your PCN and/or wider PM group and/or ICB as, due to the cold weather, other local practices’ car parks are likely to be frozen too and may have sustained the same frost damage, potentially resulting in the same outcome.

A SEA Log can be found in Significant Events Manager which is part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/), accessible in the [HUB](https://hub.practiceindex.co.uk/).

Note that should any event not be considered to be significant, but requires the staff to appreciate its importance, then this can be raised as a Learning Event. These can be logged in Learning Events Manager which is also part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/), accessible in the [HUB](https://hub.practiceindex.co.uk/).

For further reading, refer to [GP mythbuster 3: Significant Event Analysis (SEA)](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-3-significant-event-analysis-sea) and the organisation’s Significant Event and Incident Reporting Policy.

1. Risk Register

As more patients could trip, this incident also needs to be risk assessed and added to the Risk Register. In this register, you will need to consider any mitigating actions, such as placing signs in the car park and reception, and verbally advising staff to take care. In winter, the risk assessment might also suggest that better lighting is needed.

A Risk Register should also contain any risks that have been completely mitigated. [Section 2.11](#_Risk_and_incident) provides further insight into risk management, coupled with the Health, Safety and Risk Management Handbook which also details common risk assessments and their mitigation.

Risks can be logged in Risk Manager which is part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/) and accessible in the [HUB](https://hub.practiceindex.co.uk/).

1. Communication, meetings and minutes

In addition to initially advising Partners and staff, any SEA would need to be discussed at various meetings and incorporated in the respective minutes. These minutes are essential as they provide chronological evidence that there has been considered communication throughout the team, risk management considerations, and how best to promote safety within the practice.

All minutes should be saved in the appropriate area on the shared drive/intranet in accordance with the organisation’s Communication Policy.

1. Audit Log

Another action in this scenario would be to establish an audit. Initially there would have been a quick scan of the car park to perhaps take photographs and identify any other potholes.

This should be repeated frequently until the issue has been resolved and detailed as a non-clinical audit. All audits, both clinical and non-clinical, should be added to the Audit Log. A log is available in Audits Manager which is part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/) and accessible in the [HUB](https://hub.practiceindex.co.uk/).

Further reading can be found in the organisation’s Quality Improvement and Clinical Audit Policy and CQC [GP mythbuster 4: Quality improvement activity](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-4-quality-improvement-activity).

1. Complaints Log

The patient is very upset and has expressed her dissatisfaction. This is a verbal complaint and, as such, needs to be added to the Complaints Log.

It may become more formalised, and a letter of complaint may also be received as part of any preamble to any potential litigation. As for any complaint, the complaints procedure should be followed.

Having a complaints log ensures that the detail of dissatisfaction is logged and also includes the process, such as date of receipt, acknowledgement and completion. It will also mention whether any complaint was upheld or not and all evidence that is needed for the annual K014b complaints return.

All complaints, written or verbal, should be managed in accordance with the complaints procedure and added to the organisation’s Complaints Log. A log is available in Complaints Manager which is part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/), accessible in the [HUB](https://hub.practiceindex.co.uk/).

Further reading can be sought within CQC [GP mythbuster 103: Complaints management](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-103-complaints-management) and the organisation’s Complaints Procedure.

1. Training Matrix

All staff are to be aware of how to manage a complaint and this forms part of the mandatory training programme. All training is to be detailed in the Training Matrix.

The Training Handbook details the management of training requirements within any organisation and in particular:

* Training Matrix
* Staff development programme
* Organisational training programme
* Training application form
* Personal development plan template

Training can be logged in [Learning Manager](https://help.practiceindex.co.uk/articles/learning-manager-a-full-overview/) which is a free resource in the [Learning Package](https://practiceindex.co.uk/gp/solutions/learning/more-information) in the [HUB](https://hub.practiceindex.co.uk/). This log can be exported as a PDF/spreadsheet and shared with the relevant parties – for example, prior to any regulatory inspection.

Further guidance on training requirements can be found in CQC [GP mythbuster 70: Mandatory training considerations in general practice](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-70-mandatory-training-considerations-general-practice).

It is hoped that, in this section, this one example highlights how the spectrum of logs, registers and matrices can be used and how they interact with each other. By having these in place, the organisation can be satisfied that there is a full history and detailed sequence of events, should this be required for evidence purposes.

## How to highlight clinical governance activity

To support the understanding of clinical governance throughout the team, practices could consider having a noticeboard dedicated to CG matters.

The ‘Governance Noticeboard’ is not to replace the activity that is found in the various logs that are held in the IT system, it is simply a ‘quick win’ that is to be used in conjunction with other systems.

The benefits of having a Governance Noticeboard include:

* Being a focal point to highlight all areas of activity
* Becoming an easier way for all staff to locate any recent activity
* Focusing minds on not forgetting the importance of clinical governance
* Being a reminder to all staff that they have a key role to play in all aspects of clinical governance
* Continually considering how to quality improve
* Highlighting best practice to both team and regulator
* Detailing actions that are needed to be undertaken by the team
* Disseminating information
* Providing reminders of key events

Importantly, the Governance Noticeboard must be updated frequently so that staff appreciate the ongoing activity. It should hold information that is no more than 12 months old, but often this could be less than this. It should explain how CG affects the team, and as such, how all should be involved. No personal information should be added to this board, so even if there is a letter from a patient thanking them for the treatment they received, this is to be redacted.

Activity on the Governance Noticeboard can include the following topics:

|  |  |
| --- | --- |
| **Subject** | **Comment** |
| Complaints | Redacted information.  Detail any supporting CG actions that are needed, such as training, SEA or audit |
| Compliments | Redacted information |
| Audits undertaken | Detail actions and where they are in the audit cycle |
| Training matrix | An overview and this could also include those that are outstanding any mandatory training |
| Significant event analysis | SEAs should include both positive and negative events and should be redacted.  Detail the outcome and if it is linked to other aspects of CG, such as a complaint or compliment |
| Meeting activity | Minutes from various meetings such as Clinical, Admin or Nursing, even if simply a ‘Record of discussions’ as opposed to full minutes.  Some minutes would not be appropriate to detail due to their sensitive nature. However, some of the content could be listed, e.g., when an important decision is made that affects the whole team |
| Policy updates | A list of those updated in the month |
| CAS alerts | A list of relevant alerts from MHRA over the past 12 months |
| Important information | Detail information that is needed to be disseminated |
| Important risks | Detail any risks that all should know |
| Important issues | Detail any issues that staff need to appreciate |
| Statistics | Useful statistics, such as activity. This is often used in a positive light, as a thank you to the team |
| Upcoming events | This could be health promotion, planned training sessions, meetings or upcoming socials |

Due to the nature of the information, the noticeboard would ordinarily be placed in a heavily used staff-only area, such as a kitchen or meeting room.

Another consideration is to highlight the annual Patient Survey by extracting the information and placing key points and statistics on a ‘How we are driving’ type noticeboard. Ideally, this would be placed on one of the first/last-seen noticeboards in the practice such as in the foyer and entrance lobby for patients to appreciate the ongoing and dedicated efforts being made by the organisation.

## Clinical audit

A clinical audit is the quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change.

NICE guidance titled [Principles for Best Practice in Clinical Audit](https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf) provides the detail for a five-step process to manage audit, as follows:

|  |  |
| --- | --- |
| 1 | Preparing for audit |
| 2 | Selecting criteria |
| 3 | Measuring level of performance |
| 4 | Making improvements |
| 5 | Sustaining improvement |

The purpose of completing an audit is to enable staff to review their own practice and that of their colleagues with an overall aim of making improvements to benefit the service user.

Regular audits are to be undertaken and the overall aim is to ensure that the practice is meeting the standards required whilst reviewing processes to identify areas for improvement, as necessary.

A clinical audit will:

* Identify and highlight evidence-based practice
* Identify areas for improvement and enhance patient safety
* Provide data that can be used to review the effectiveness of service delivery
* Enhance multidisciplinary team communication
* Improve cross-functional working within the organisation

The features of a clinical audit are that it:

* Is a circular process system by which clinicians review their own clinical practice, but which can be used throughout the organisation to review effectiveness
* Has a quality improvement intent
* Is systematic
* Is undertaken with the active involvement of those directly involved in the care process
* Looks beyond the immediate care process and may encompass resources devoted to a particular care pathway
* Considers processes allied to the direct pathway of care, such as the initial selection of patients for the care pathway concerned
* Uses established and agreed standards which are in themselves means for ensuring good-quality care, leading to better outcomes
* Compares actual practice to these standards
* Confirms compliance with standards or that necessary remedial action is taken
* Remeasures to gauge improvement

This organisation’s handbooks and policies refer to audit:

* Quality Improvement and Clinical Audit
* Referral Choice Audit
* Caldicott and Confidentiality Guidance
* Cervical Screening Programme
* Medicines Management Policy
* Infection Prevention Control (IPC) Handbook
* Safeguarding Handbook

All staff participate in the audit process which also promotes reflective practice and individual learning. Once an audit is complete, the results are discussed during a practice meeting and then promulgated on the practice website, whilst also being discussed at Patient Participation Group (PPG) meetings.

Clinical audits enable the team to assess clinical performance and improve clinical practice, ultimately enhancing the care delivered to our patient population. Should an audit be instigated as part of a learning process, to understand ‘what went wrong’, the organisation will consider the following common quality improvement tools:

* [Five Whys](https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2015/08/learning-handbook-five-whys.pdf) to appreciate the root cause
* [Fishbone](https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2011/06/How-to-construct-a-fishbone-diagram.pdf) to understand cause and effect
* [Process mapping](https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.2-Process-Mapping-Analysis-and-Redesign.pdf) for general improvement

The NHS list of quality, service improvement and redesign (QSIR) tools can be found [here](https://www.england.nhs.uk/sustainableimprovement/qsir-programme/qsir-tools/). Further guidance from the NHS can be found on their webpage titled [Clinical audit](https://www.england.nhs.uk/clinaudit/).

## Clinical effectiveness

Clinical effectiveness means that any treatment modality you choose to perform on the patient must provide the best outcome for the patient. This means you must do the right thing to the right person at the right time in the right place.

Clinical effectiveness can be achieved by:

* Adopting only evidence-based approaches while treating patients
* Adhering to national standards and guidelines
* If current practice is inadequate, developing new protocols or guidelines based on your experience and evidence to upgrade your practice
* Conducting research to develop a body of evidence and enhance the level of care provided to patients in the future

The Quality and Outcomes Framework (QOF) rewards this organisation for the provision of quality care whilst also identifying areas for improvement. QOF is overseen by specific members; the responsibility of each element is shared across the clinical team. Furthermore, clinicians take an evidence-based approach to treatment, ensuring that the treatment delivered is appropriate and carried out at the right time and in the right place.

The clinical team meets weekly to discuss trends and to review practices, discussing new procedures that are compliant with NICE guidelines.

The National Institute for Health and Clinical Excellence (NICE) is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

For further detailed information, refer to the organisation’s policies:

* Clinical Supervision Policy
* Evidence-based Practice Policy
* Quality Improvement and Clinical Audit
* The use of NICE guidance

## Duty of candour

Organisations must fulfil their obligations to satisfy the ‘statutory duty of candour’ as part of [The NHS Patient Safety Strategy](https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/).

The intention is that there is a culture of openness and honesty to improve the safety of patients, staff and visitors, as well as raising the quality of healthcare systems. If patients or employees have suffered harm because of using our services, the organisation will investigate, assess and, if necessary, apologise for and explain what has happened.

We also aim to improve the levels of care, responsibility and communication between healthcare organisations and patients and/or their carers, staff and visitors, and make sure that openness, honesty and timeliness underpin our responses to such incidents.

It is important, depending on the degree of harm, to consider reporting the incident to the following:

* NHS E/Commissioner/Integrated Care Board (ICB) depending on the degree of harm as specified in their requirements
* Care Quality Commission (CQC)
* Learning From Patient Safety Events (LFPSE) service

For further detailed information, refer to:

* [Health and Social Care Act 2008 (Regulated Activities) 2014: Regulation 20](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20)
* Public Health England guidance titled [Duty of candour](https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour)
* CQC guidance titled [Regulation 20: Duty of candour](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour)
* This organisation’s Duty of Candour Policy



Duty of Candour eLearning training is available in the [HUB](https://hub.practiceindex.co.uk/login).

## Education, training and continuing professional development

It is vital that staff who are caring for patients have the knowledge and skills they need to do a good job. It is for this reason that they are given opportunities to update their skills to keep abreast of the latest developments as well as to learn new skills.

Furthermore, it is important to ensure that all staff have the skills they need to provide the best care for patients.

This organisation supports the ongoing development of both clinical and administrative staff. We have an established training programme in place. The premises periodically closes for training and development, and we ensure that all staff are permitted to participate in protected training sessions.

Annual appraisals form part of our education and training programme, with all staff given the opportunity to discuss their goals for the forthcoming year, identifying and agreeing training requirements that can be linked to individuals’ continuing professional development.

* **Coaching and mentoring**

Coaching is one of the key approaches through which leadership in organisations can be developed. It is a method of deploying techniques embedded in artful questioning and appreciative inquiry to help leaders unlock their full potential to achieve personal and professional success.

Whether as a one-to-one focused and bespoke relationship or within a group context, coaching is often perceived as the single most effective development intervention that a senior leader in the NHS can access.

Mentoring is quite different to coaching in terms of intent; support and guidance of a mentee is often led by more experienced and skilled professional mentors, to support and expand the professional leadership development of the former through the effective transference of knowledge, skill and experience. It can lead to enhanced innovation and performance within organisations, fuelled by reflective practice, shared learning and improved ownership for solution-focused thinking.

The emphasis is on developing the leadership expertise of the mentee in a work context, with the process of mentoring encouraging independence, autonomy and self-development. Mentoring arrangements can often deliver improvements in an individual’s performance that lead to enhanced leadership maturity.

The NHS Leadership Academy has identified the following four key drivers that underpin the purpose of Coaching and Mentoring in a wider leadership development and national context.

For further detailed information, see the [NHS Leadership Academy webpage](https://www.leadershipacademy.nhs.uk/resources/coaching-register/).

* **Continuing professional development (CPD)**

CPD needs to:

* Be a documented process
* Be self-directed, driven by the individual, not the employer
* Focus on learning from experience, reflective learning and review
* Help set development goals and objectives
* Include both formal and informal learning

CPD may be a requirement of membership of a professional body. It can help to reflect, review and document learning and to develop and update professional knowledge and skills.

It is also extremely useful to:

* Provide an overview of professional development to date
* Document achievements and progression
* Uncover gaps in skills and capabilities
* Open up further development needs
* Provide examples and scenarios for a CV or interview
* Demonstrate professional standing to employers
* Help with career development or a possible career change

Often each profession randomly selects registrants, asking for submission of their CPD profile to provide supporting evidence that shows the activities carried out have met the required standards and the dates they were undertaken.

Any activity from which people learn or develop professionally can be considered eligible for CPD, though it is important to ensure that these activities complement their practice and enhance the service provided.

CPD requirements for salaried GPs is stipulated in the [BMA Model Contract](https://www.bma.org.uk/media/3479/salaried_gp_model_contract_and_model_offer_letter_nov20.pdf) and [Salaried GPs Handbook](https://www.bma.org.uk/media/6582/salaried-gp-handbook-updateoct2022.pdf).

* **Medical devices**

Training in the use of medical devices is a primary factor in device safety. All staff should undergo training in the use of medical devices pertinent to their role and scope of practice.

Training for medical devices should cover, but not be limited to, staff knowing how to:

* Use the device and controls appropriately
* Fit adjuncts
* Interpret the displays/gauges
* Acknowledge and respond to alarms
* Report any defects with the device
* Decontaminate/clean the device in accordance with the manufacturer’s guidelines
* Access the user manual (be it online or held by the equipment manager)
* Report any adverse effects of devise usage appropriately

All medical device training should be recorded, and the records held should show the type of training delivered and that staff fully understand how to operate the device which the training covered.

For further detailed information, see the organisation’s Medical Device and Equipment Loan Management Policy.

* **Preceptorship**

Preceptorship will provide newly qualified nursing staff with the support necessary to enable them to develop their skills, confidence and autonomy.

A preceptorship framework will be used to support the existing induction process to enable the new incumbent to effectively familiarise themselves with the organisation, service users and the role of Practice Nurse. All newly qualified nurses will be required to follow the preceptorship programme for a period of 12 months. However, some programmes may also be for six or nine months depending on organisational requirements.

A preceptorship is a structured period of transition for any newly qualified nurse when they start employment in the NHS. During this time, the individual should be supported by a preceptor to develop their confidence as an independent professional and to refine their skills, values and behaviours.

For further information, refer to Chapter 9 of the organisation’s Training Handbook, NMC guidance titled [Principles for preceptorship](https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-principles-for-preceptorship-a5.pdf) and the NHS [Preceptorship Framework](https://www.hee.nhs.uk/sites/default/files/documents/CapitalNurse%20Preceptorship%20Framework.pdf).

* **Revalidation**

Revalidation is the process by which doctors and nurses are required to demonstrate on a regular basis that they are up to date and fit to practise.

* **GP revalidation**

Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. Licensed doctors must revalidate, usually every five years, by having regular appraisals and will also have to collect supporting information that demonstrates how they are meeting the standards in this guidance.

For further reading, refer to the RCGP guidance titled [Revalidation](https://www.rcgp.org.uk/your-career/revalidation).

* **Nurse revalidation**

Every three years, all nurses and midwives are required to apply for revalidation using NMC Online; this is a secure system that enables nurses and midwives to manage their registration online.

The NMC has stipulated seven requirements in their comprehensive [Revalidation](https://www.nmc.org.uk/revalidation/) guidance which nurses and midwives must meet to revalidate. Information for managers can be found in the NMC guidance titled [Employers’ guide to revalidation](https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/employers-guide-to-revalidation.pdf).

Further information can be sought from the organisation’s Nursing Staff Revalidation and Appraisal Policy.

* **Pharmacy staff revalidation**

Each year, pharmacists and pharmacy technicians must record what they have done to keep their knowledge and skills up to date and reflect on how they have put this into practice.

For guidance, refer to the General Pharmaceutical Council guidance titled [Revalidation and renewal](https://www.pharmacyregulation.org/pharmacists/revalidation-renewal).

* **Allied healthcare professionals**

Allied healthcare professionals (AHPs) are required to renew their registration every two years to ensure they remain on the Health and Care Professions Council (HCPC) register. Furthermore, they are also required to complete a professional declaration.

For further reading, refer to the HCPC guidance titled [How to renew your registration](https://www.hcpc-uk.org/globalassets/resources/guidance/how-to-renew-your-registration.pdf?v=637145224790000000).

* **Training and development**

Different staff members have different training requirements, and these should always be based on the role they are employed to do. There is, however, statutory and mandatory training that needs to be undertaken by all members of staff. A record should be kept of the date when each individual member of staff received their training. All staff training should be logged in a system, preferably one that highlights due dates for retraining.

[Learning Manager](https://help.practiceindex.co.uk/articles/learning-manager-a-full-overview/) is a free resource within the [Learning Package](https://practiceindex.co.uk/gp/solutions/learning/more-information) in the [HUB](https://hub.practiceindex.co.uk/). This tool can be used as a training matrix where successful training sessions can be recorded, and flags are sent as a reminder when the training renewal date approaches. Of note, this should be used for all personnel including Partners’ training to ensure they also do not miss their training needs. Also consider training needs for those who are returning to work following any extended absences such as maternity or sick leave.

For further detailed information, see the organisation’s Training Handbook and CQC [GP mythbuster 70: Mandatory training considerations in general practice](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-70-mandatory-training-considerations-general-practice).

## Freedom to speak up (whistleblowing)

All GP practices are required to adopt the national [Freedom to Speak Up policy for the NHS](https://www.england.nhs.uk/publication/the-national-speak-up-policy/) as a minimum standard to help normalise speaking up for the benefit of patients and workers. This is so staff know how to speak up and what will happen when they do.

Freedom to speak up is about encouraging a positive culture where people feel they can speak up, their voices will be heard, and their concerns and suggestions will be acted on without retribution. The content and guidance within this policy have been extracted from the [Freedom to Speak Up Policy for the NHS](https://www.england.nhs.uk/publication/the-national-speak-up-policy/).

Comprehensive reading can be found in:

* The National Guardian’s document titled [Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services](https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf)
* CQC [GP mythbuster No 87: Freedom to speak up](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-87-freedom-to-speak-up)
* The organisation’s Freedom to Speak Up Policy and Procedure

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Whistleblowing, and Whistleblowing: Listening Well – A Manager’s Guide eLearning are available in the [HUB](https://hub.practiceindex.co.uk/).

## Indemnity

Since 1st April 2019, NHS Resolution has been operating a new state indemnity scheme for general practice in England called the Clinical Negligence Scheme for General Practice (CNSGP). The scheme covers clinical negligence liabilities arising in general practice in relation to incidents that occurred on or after 1st April 2019. The CNSGP provides a fully comprehensive indemnity for all claims within its scope.

The [What’s covered by CNSGP?](https://resolution.nhs.uk/scheme-documents/scheme-scope/) document outlines the types of work carried out by general practice staff and whether or not it is covered by the CNSGP scheme.

All providers of NHS primary medical services are covered under CNSGP, including out-of-hours providers. The scheme extends to all GPs and others working for general practice who are carrying out activities in connection with the delivery of primary medical services including salaried GPs, locums, students and trainees, nurses, clinical pharmacists, physician associates, agency workers and other organisation staff such as ARRS employees.

In addition to NHS primary medical services, any other NHS services provided by general practice are also covered under CNSGP (namely, NHS activities carried out by or for a provider whose principal activity is to provide NHS primary medical services). These ‘other’ NHS services are referred to in the regulations that establish CNSGP as “ancillary health services”. This means general practices are covered for all their NHS services, including local authority-commissioned public health services.

The scheme applies to any liability (civil wrongdoings which include clinical negligence) that arises because of a breach of a duty of care owed by a GP contractor or GP sub-contractor to a third party in connection with the provision of primary medical services or ancillary health services where:

* An act, or omission, on the part of the GP contractor/sub-contractor (or any employee or other person engaged by them) results in personal injury or loss to the third party
* The act, or omission, is in connection with the diagnosis of an illness or the provision of care or treatment to the third party, and
* The act or omission occurs on or after 1st April 2019

Any treatment you provide privately (e.g., a patient who pays you for services not provided as part of the NHS) is not covered. It is possible, then, that some of the services you offer to an individual patient are covered by CNSGP and some are not (and, therefore, you require additional indemnity from another provider for services not covered under CNSGP).

For further detailed information, see the NHS Resolution Guidance titled [Clinical Negligence Scheme for General Practice](https://resolution.nhs.uk/services/claims-management/clinical-schemes/general-practice-indemnity/clinical-negligence-scheme-for-general-practice/).

It should be noted that CNSGP does not indemnify for advice given to a patient who is not in the UK. Guidance for overseas advice can be sought in the following:

* MPS document titled [Providing care to patients who are abroad](https://www.medicalprotection.org/uk/articles/providing-care-to-patients-who-are-abroad)
* GMC guidance titled [Prescribing for overseas patients](https://www.gmc-uk.org/professional-standards/learning-materials/prescribing-for-patients-overseas)
* MDU journal titled [Prescribing for a patient overseas](https://mdujournal.themdu.com/issue-archive/summer-2021/prescribing-for-a-patient-overseas)

Further reading can be found in the organisation’s NHS Services Whilst Abroad Protocol.

## Patient and carer experience and involvement

If the organisation is to offer the highest-quality care, it is important that it works in partnership with patients and carers. This includes gaining a better understanding of the priorities and concerns of those who use the services by involving them in the work, including policy and planning.

It is important to receive views via the PPG, comments, complaints and indeed compliments, such as:

* **Friends and family test**

The NHS Friends and Family Test is a contractual requirement, aimed at providing service users with an opportunity to give feedback which may not have previously been heard. Data is to be submitted to NHS E at the end of each month for that calendar month of data collection by using the Calculating Quality Reporting System (CQRS).

Access to CQRS is achieved by users logging in by using their unique username and password.

Refer to the NHS E guidance titled [Guidance on submitting Friends and Family data](https://www.england.nhs.uk/fft/fft-submission/) and [Using the Friends and Family Test to Improve Patient Experience](https://www.england.nhs.uk/wp-content/uploads/2019/09/using-the-fft-to-improve-patient-experience-guidance-v2.pdf) and also the organisation’s Friends and Family Test Policy.

* **Patient Participation Group (PPG)**

Since 1st April 2015, it has been a contractual requirement for all English organisations to form a Patient Participation Group (PPG) and to make reasonable efforts for this to be representative of the organisation’s population.

The PPG may wish to join the National Association for Patient Participation (NAPP) to widen its knowledge and usefulness. To support PPGs, NAPP has produced an NHS E-commissioned resource titled [A guide for Patient Participation Groups](https://storage.uk.cloud.ovh.net/v1/AUTH_f3100dad5acd4df793f8778d19bcea24/NAPP/2a37dc5e-a9b0-431e-a039-81eb267e9bfd.pdf?temp_url_sig=6ac2454b8a021c7d06e5a915068454974ecc05af&temp_url_expires=1932138907&filename=Start%20Grow%20and%20Sustain%20your%20PPG%20-%201.%20Introduction.pdf&inline=).

Other useful guidance on PPGs can be sought from [The Patients Association](https://www.patients-association.org.uk/mission-and-vision) or [Healthwatch](https://www.healthwatch.co.uk/) and within the organisation’s Patient Participation Group (PPG) Policy.

* **Patient surveys**

The [GP Patient Survey](https://gp-patient.co.uk/) is an independent survey run by MORI on behalf of NHS E. The survey is sent out to over a million people across the UK. The results show how people feel about their GP organisation. You also have the option to compare up to three organisations. Use of this survey to shape and manage your services better is a factor that CQC often uses in assessing responsiveness on the part of an organisation.

The organisation is no longer required to carry out a standard patient survey each year. Organisations may now carry out a survey designed by the organisation, with the help of the Patient Participation Group, and publish the results on the organisation’s website each year. The survey might cover access arrangements, telephones, extended hours services, the standard of the premises and the quality of the doctor-patient contact.

* **Shared decision-making**

Shared decision-making is a process by which individuals and clinicians work together to understand and decide what tests, treatments or support packages are most suitable bearing in mind a person’s own circumstances. It brings together the individual’s expertise about themselves and what is important to them, together with the clinician’s knowledge about the benefits and risks of the options.

Engaging in the shared decision-making process is a long-term commitment but one that will improve patient experience, the organisation and the wider NHS.

Empowering patients with knowledge and information about their healthcare and the decisions available to them will increase overall health literacy, reduce complaints, and ultimately lead to better healthcare and prospects for many patients. Affording patients the opportunity to express their opinions and be involved in their treatment plans will lead to improved outcomes.

For further detailed information, see the organisation’s Shared Decision-Making Policy.

## Risk and incident management

Risk management is simply minimising the risks to patients. It is an essential pillar of clinical governance.

How can one manage risks?

* By identifying what can and does go wrong during treatment
* By understanding the factors that may influence risks
* By learning from previous mistakes and adverse events
* By taking immediate action to prevent such mistakes and events
* By putting systems in place to reduce risks
* By having knowledge of the management of medical emergencies
* By having an emergency drug kit with medicines well within expiry date in an accessible place

Effective risk management will enable this organisation to identify issues that may prevent the delivery of safe and effective patient care. Risk is a standing agenda item at practice meetings and all risks are recorded on the practice Risk Register.

Risk assessments are undertaken to determine control, occurrence and the potential impact of identified risks. Examples of risk templates and general reading on risk management can be found in the Health, Safety and Risk Management Handbook.

Risk management is about minimising risks to patients by:

* Identifying what can and does go wrong during care
* Understanding the factors that influence this
* Learning lessons from any adverse events
* Ensuring action is taken to prevent recurrence
* Putting systems in place to reduce risks

All risk assessments should be logged in a Risk Register as detailed at [Section 2.2](#_Why_is_there).

[](https://hub.practiceindex.co.uk/)

Risks Manager is available as part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/) in the [HUB](https://hub.practiceindex.co.uk/).

* + **Business continuity plan**

The organisation is required to have a comprehensive Business Continuity Plan that is regularly updated. The organisation must be able to demonstrate that they have planned for, and can respond to, a variety of incidents which may affect patient care. The [Civil Contingencies Act (2004)](https://www.legislation.gov.uk/ukpga/2004/36/contents) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents whilst maintaining services

The updated plan should be circulated to all relevant staff when a change is made. A copy must always be held off-site to be available when there is no access to the building (e.g., during fire or flood) or there is no access to IT. In some organisations there is a box or bag available in the reception area, or kept close by but off-site, with paper copies of all the main forms needed to keep the practice running for an hour or two should they have needed to evacuate the building.

For further detailed information, see the organisation’s Business Continuity Policy.



In support of business resilience, Tabletop Exercises (TTX) – An introduction is available in the [HUB](https://hub.practiceindex.co.uk/).

* + **Significant event reporting**

CQC [GP mythbuster 3: Significant Event Analysis](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-3-significant-event-analysis-sea) should be considered when raising any significant event analysis (SEA), and reporting should be as detailed at [Section 2.2](#_Why_is_there). SEAs are a learning process for the whole practice. Individual SEAs can be shared between members of staff and focus on disseminating learning within the practice.

Each significant event covers both positive events and negative incidents and is discussed in detail and in an open manner which ensures that we review, obtain and provide feedback, and importantly, we learn from such occurrences.

SEAs are discussed in meetings, with any agreed actions documented.

The outcomes of SEAs are to be routinely forwarded to the [Learn from patient safety events or LFPSE](https://www.england.nhs.uk/patient-safety/patient-safety-incident-management-system/) service and as detailed within CQC [GP mythbuster 24: Recording patient safety events with the Learn from patient safety events (LFPSE) service](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-24-recording-patient-safety-events-learn-patient-safety-events).

For further detailed information, see the organisation’s Significant Event and Incident Policy.



Significant Events and Safety Incidents – An Overview eLearning is available in the [HUB](https://hub.practiceindex.co.uk/).

* + **Audit**

Following any incident, as part of the collective analysis into reducing the likelihood of an incident being repeated, or maybe to minimise the risk so that it is as low as reasonably practicable (ALARP), then processes need to be scrutinised to be fully understood.

All audits need to be logged, as detailed in [Section 2.2](#_Why_is_there), whereas [Section 2.4](#_Clinical_audit) provides detailed information on both clinical audit and the quality improvement tools that can be adopted.

* + **Training**

As a result of the above risk or incident, and following an SEA and audit, the outcome may be that additional or new training is needed to ensure that lessons have been both identified and learnt from.

All evidence of training is required to be logged, as detailed at [Section 2.2](#_Why_is_there), whereas [Section 2.7](#_Education,_training_and) details staff training needs and requirements.

## Staffing and staff management

The appropriate recruitment and management of staff is essential. Underperforming staff should be identified and addressed. Providing a good working environment is essential to boosting staff output. The encouragement and development of good staff is vital, and it can be done by motivating them. Doing this not only inspires them but also improves their efforts and outcome.

Every staff member should understand their responsibilities and work. There should be proper discipline and protocols in place for managing staff. Too much work pressure is not good for their performance. All such factors should be considered while managing your staff.

Staffing and staff management is crucial to our ability to provide high-quality care. At this organisation, we need to have highly skilled staff, working in an efficient team and in a well-supported environment. We will ensure that the working environment is fit for purpose and staff have the resources required to deliver safe, effective patient care, such as:

* HR policies and procedures
* Recruitment, induction, job descriptions and retention
* Appraisal
* Performance management
* Workforce development

For further detailed information, see the organisation’s Management by Objectives Policy and the relevant performance management and appraisal policies.

## Use of information

High-quality clinical care is underpinned by effective information management. Patient records are held in both electronic and paper format but are equally protected by robust confidentiality mechanisms.

From time to time, patient records will be searched to gather information for audit purposes; this helps us to analyse our services to be certain that patients are receiving an optimal level of care. Patients have the option for their records not to be used and if they have opted out, our clinical system reflects their wishes.

* **Appointment data collection**

NHS E has been [collecting data from general practice appointment systems](https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice) and publishing it, collated formally by area, since 2018. This published data provides a picture of general practice appointments. It includes details such as the number of appointments available, the healthcare professional carrying them out and, where possible, the mode of delivery, e.g., face to face or telephone.

* **ePACT2 data**

[ePACT2](https://www.nhsbsa.nhs.uk/epact2) gives authorised users access to prescription data. Access provides online analyses of prescribing data held by NHS Prescription Services.

Data is available six weeks after the dispensing month. ePACT2 provides analysis, reports and dashboards. To register, refer to the NHSBSA guidance titled [Registering for ePACT2](https://www.nhsbsa.nhs.uk/access-our-data-products/epact2/registering-epact2).

* **NHS Digital**

NHS Digital and HEE and NHS X are now part of NHS E, following a [merger](https://digital.nhs.uk/about-nhs-digital/nhs-digital-merger-with-nhs-england) in 2023. This single organisation is collectively known as NHS E and will remain as the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

This organisation continues to work with partners across health and social care to ensure that information flows efficiently and securely by managing services such as:

* Abdominal Aortic Aneurysm Screening
* Bowel Cancer Screening
* Breast Screening Services
* CQRS
* Data Security and Protection Toolkit
* Electronic Prescription Service (EPS)
* Falsified Medicines Directive Implementation Toolkits
* GPES
* GP2GP
* National Data Opt-Out
* NHS e-Referral Service
* NHS Mail
* SNOMED CT
* Spine System
* Summary Care Record
* **Risk stratification**

Risk stratification uses a mix of objective and subjective data to assign risk levels to patients. Information from health and social care records, using the NHS number provided via the [Secondary Uses Service (SUS)](https://digital.nhs.uk/services/secondary-uses-service-sus) at NHS E, is analysed to identify groups of patients who would benefit from additional help from their GP or care team.

Risk stratification is a tool for identifying and predicting which patients are at high risk, or are likely to be at high risk, and prioritising the management of their care in order to prevent worse outcomes.

To conduct risk stratification, Secondary User Services (SUS) data, identifiable at the level of NHS number, is linked with Primary Care data (from GPs) and an algorithm is applied to produce risk scores. Risk stratification provides a forecast of future demand by identifying high-risk patients. Commissioners can then prepare plans for patients who may require high levels of care. Risk stratification also enables GPs to better target intervention in primary care.

Further reading can be found in the NHS E document titled [Risk stratification: Learning and Impact Study](https://imperialcollegehealthpartners.com/wp-content/uploads/2018/07/ORE__Risk_stratification_learning_and_impact_study.pdf).

# Corporate governance

The Department of Health, in 2006, defined integrated governance as: “*Systems, processes and behaviours by which organisations lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations*”.

The structures, systems, processes and behaviours that NHS bodies have for ensuring good governance include:

|  |
| --- |
| How line managers operate, including codes of conduct and accountability |
| Business planning |
| Procedural guidance for staff |
| Risk register and assurance framework |
| Internal audit |
| Scrutiny by external assessors including CQC and other external audits |

## Annual declaration

NHS E guidance [General Practice Annual Electronic Self-Declaration (eDEC)](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/general-practice-annual-electronic-self-declaration-edec) details the mandatory collection that all GP organisations in England must complete annually. The guidance details what must be declared.

eDEC covers eight areas to be completed and each section will already be populated with the answers the organisation provided the previous year. The person completing the declaration needs to check these and update them if they have changed.

The eDEC is used for the following purposes:

* NHS E regional teams will use the information GP organisations provide to check that GP organisations are fulfilling their contractual requirements
* Integrated Care Boards (ICBs), which commission primary care services under formal delegation from NHS E, receive information from the annual electronic organisation self-declaration that they need to support their delegated functions
* The CQC uses it to check that GP practices meet the CQC registration requirements, including complying with the [Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/part/3) (as amended). The answers to the questions relating to the CQC’s regulatory requirements will form part of their pre-inspection documentation

A senior member of staff, such as the Practice Manager or Senior Partner, should complete the eDEC, although only one person in each organisation will be given the permissions to complete it. This is likely to be the same person who completes the K041b complaints collection.

The eDEC is submitted through the Strategic Data Collection Service (SDCS).

## Audit

GP organisations are still expected to monitor the quality of their work using both clinical and non-clinical audits of referrals, prescribing and clinical domains. The CQC will want to see evidence that the organisation is ‘safe’.

Where patients are being referred to an elective (i.e., non-emergency) consultant-led appointment, they have a legal right to be offered a choice of provider for that referral and, if they wish, to be able to choose a consultant-led team (or healthcare professional) for both physical and mental health referrals.

The [NHS e-Referral Service](https://digital.nhs.uk/services/e-referral-service/joint-guidance-on-the-use-of-the-nhs-e-referral-service) allows GPs to see a full range of available consultant-led outpatient services across England, allowing patients to make an informed choice to attend a local provider or to elect to go somewhere that, for example, may be closer to where they work or closer to a relative to support convalescence. Even for those patients who want to stay with their local provider or to follow a GP’s recommendation, e-RS often allows them a choice of date and time for their appointment and sometimes multiple locations.

The organisation should maintain a log of all audits, and this can often be combined with second-cycle audits/revisits of any critical events and complaints. Audits should be undertaken during the year, both clinical and administrative – e.g., DNA analysis, appointment analysis, patient surveys – but while many organisations use students or registrars to run audits, this alone will not satisfy the CQC inspectors and the direct involvement of doctors in their own audits as well as other staff, both clinical and non-clinical, is essential.

For further detailed information, see the organisation’s Quality Improvement and Clinical Audit Policy, Referral Choice Audit Policy and read these in conjunction with CQC [GP mythbuster 4: Quality improvement activity](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-4-quality-improvement-activity).

## Business planning

The organisation’s Business Development Plan (BDP) should detail strategic goals for the forthcoming three-year period and should be tailored to meet the requirements of the entitled population.

The BDP should include such information as:

* An overview of the organisation
* Premises information
* Management structure and staff
* Skills mix across the multidisciplinary team
* Training
* IT systems
* Communication strategies and processes within the organisation
* Patient service development
* Patient Participation Group focus
* Profitability

For further detailed information, see the organisation’s Business Development Plan.

## Conduct and accountability

The purpose of a Code of Personal Conduct is to provide a framework of principles that will guide this organisation and its staff in their daily work, and to outline the expectations that the practice has of its staff in terms of how they act.

The Code of Conduct applies to all Partners, employees and other personnel working in the practice, and its principles shall apply to any other persons who work on behalf of the practice.

The principles are intended to:

* Ensure legislative compliance
* Demonstrate integrity in the conduct of all staff on the practice’s behalf
* Encourage openness and transparency
* Create positive experiences for our patients
* Build ethical business relationships
* Support good community citizenship and social responsibility

For further detailed information, see the organisation’s Code of Personal Conduct Policy.

## Corporate manslaughter

The organisation should take every opportunity to incorporate the principles of the [Corporate Manslaughter and Corporate Homicide Act 2007](https://www.legislation.gov.uk/ukpga/2007/19/contents) within its health and safety and other related policies.

The organisation must aim to ensure that all systems of work, equipment and premises are safe, documented and fully compliant with the duty of care owed to employees, contractors, patients and visitors, especially those relating to health and safety.

The Corporate Manslaughter and Corporate Homicide Act 2007 aims to ensure that organisations are held to account when a death has been caused because of gross failings by its senior management. This means that companies and organisations can be found guilty of corporate manslaughter because of serious management failures resulting in a gross breach of their duty of care. As health service bodies, this includes GP organisations where such a gross breach leads to a fatality.

The Act allows for unlimited fines and may require an organisation to publicise details of the conviction and its fine, as well as taking steps to rectify a situation. This can impact hugely on GP organisations, not only financially but also in respect of reputational risk and the ability to continue providing health services.

While prosecutions under this Act will be corporate (rather than individual), other legislation, such as the [Health and Safety at Work Act 1974](https://www.legislation.gov.uk/ukpga/1974/37/contents), continues to provide for the prosecution of individuals in relation to their individual liability as a business owner or an employee, and common law process allows individuals to be prosecuted for gross negligence manslaughter where there is direct evidence of culpability. Therefore, employees should be aware that they may still be prosecuted (as an individual) for health and safety offences.

For further detailed information, see Annex E of the organisation’s Health, Safety and Risk Management Handbook.

## Closing the quarter

The Close Quarter Notification Transaction is sent from a linked TP(s) and is used to calculate how many regular patients the organisation has registered at each quarter. The quarter start and end dates are:

* 1st January – 31st March
* 1st April – 30th June
* 1st July – 30th September
* 1st October – 31st December

The nominated individual will receive the Close Quarter Notification Transaction in the first or second week after the quarter end date. It is appropriate to complete all tasks in the GP links inbox and outbox before the close quarter notification is received, to make it easier to process the notification when it arrives.

## Fit and proper person

The Fit and Proper Persons Regulations (FPPR) is a requirement under Schedule 5 of the

[Health and Social Care Act 2008 (Regulated Activities) Regulations 2014](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents) and applies to individuals employed in organisations or ‘corporate’ services that provide a regulated activity.

The organisation’s Fit and Proper Persons Policy details compliance that is needed to meet current regulations when employing a fit and proper person at director level. Note, only those organisations that do not form part of the traditional GP partnership model need to conform to this requirement.

The following models that operate a regulated service under the following entities will need to apply FPPR under Schedule 5:

* Public and private limited companies
* Charitable bodies
* Unincorporated associations
* Limited Liability Partnerships (LLPs)
* Community Interest Companies (CICs)

## Health and safety

The organisation is obliged under legislation to ensure continual improvement in the management of health and safety and other safety-related issues. The organisation must have a clear and accessible health and safety policy.

The areas where the organisation will need to evidence their procedures and assessments are listed in the Health, Safety and Risk Management Handbook. To ensure that the organisation is not prosecuted under health and safety legislation, it must:

* Ensure that risk management policies and procedures are up to date and applicable to the working environment. It is important to take the necessary steps to protect both the health and safety of employees and members of the public
* Check that risk assessments cover all the possible risks identified at the organisation and ensure that they are reviewed at least annually
* Regularly inspect the organisation to help to identify, and therefore prevent, common workplace hazards such as poor housekeeping and obstructed walkways and exits

Employers have a legal duty under the [Health and Safety Information for Employees Regulations 1989](https://www.legislation.gov.uk/uksi/1989/682/contents) to display the [approved poster](https://www.hse.gov.uk/pubns/books/lawposter.htm) in a prominent position in each workplace or to provide each worker with a copy of the approved leaflet.

As part of implementing health, safety and fire arrangements, it is important to remember that employee training plays a key part in this process and records are to be kept demonstrating legal compliance.

For further detailed information, see the Health and Safety Executive (HSE) website:

* [Health and Safety – A Short Guide](https://www.hse.gov.uk/pubns/hsc13.pdf)
* [Health and Safety Made Simple](https://www.hse.gov.uk/simple-health-safety/index.htm)



Health and safety eLearning is available in the [HUB](https://hub.practiceindex.co.uk/) and includes:

* Accident and Incident Reporting
* Anaphylaxis
* Dealing with Violent and Abusive Patients
* Display Screen Equipment (DSE)
* Fire Warden: Role and Responsibilities
* Health and Safety: Office, Electrical and Fire Safety
* Infection Prevention and Control (Tier 1 and 2)
* Legionella Awareness
* Lone Working
* Moving and Handling (Level 1 and 2)
* Preparing for a Pandemic
* Resuscitation – Basic Life Support (BLS) (Adults and Paediatrics)
* Risk Assessments including COSHH
* Working at Heights

## Insurance

Insurance in the organisation has a much wider remit and can range from key staff absence insurance through to cover for the fabric of the building and its contents, and then both employee and public liability.

Key staff cover is not often found and needs to be carefully considered as the cost of taking on a locum manager or advanced nurse practitioner can be costly. Can the organisation continue to run or cover patient demands without key staff (other than GPs who may well pay their own locum cover themselves or have something written into the organisation agreement)?

Whether an organisation insures the building it occupies or not will depend on whether it owns the property or is under a lease, where the arrangements for buildings cover and responsibilities for various aspects should be clearly spelled out. However, organisations should always take insurance to cover their own fixtures and stock such as vaccines in their refrigerated storage, practice equipment, e.g., desks, defibrillators or sphygmomanometers, as well as other consumables that they must buy in.

Consider the problems that could arise should there be some natural disaster, such as a flood or fire, and the manager must submit an insurance claim without the benefit of any past records to indicate what organisation-owned equipment forms part of the claim and its replacement value. An Information Asset Register or Asset Register (Non-Hardware) becomes invaluable.

For further detailed information, see the organisation’s Insurance Cover Checklist.

## Locum insurance

The organisation’s locum insurance can be provided by several commercial suppliers and may cover all GPs, managers and practice nurses although this is by no means always the case. The degree of cover for Partners may be governed by the partnership agreement.

## Practice area

A GP medical practice has a defined area, which is stated on the original application for inclusion in the Medical List of a local health organisation. The area can be defined by streets and geographical boundaries or local government or constituency boundaries.

An organisation would be best advised to keep a map on which the agreed boundaries are drawn, and keep the boundaries under review along with the practice list size. The organisation usually has a copy of this in each reception area for reference and it is contractually required to appear in the practice leaflet.

From time to time, the organisation may wish to review its list size and the extent or boundaries of its organisation area. The organisation would normally be expected to have an Open List and to accept patients without question. However, if an organisation decided to close a branch surgery to restrict its list size, it would need approval of NHS E before doing so. Organisations are now being afforded the option of providing limited services to patients who live outside their organisation area.

The practice area can be sought from [shapeatlas.net](https://shapeatlas.net/).

## Partnership agreement

Partnerships should always be governed by a partnership agreement setting out how they will work together and preferably written by someone with legal knowledge as the most common cause of problems in a partnership is when there is no agreement in place, or when one is badly written

Partnerships can be disbanded for many reasons, and this does cause the organisation significant problems regarding who may take it over, who will provide patient services, who might run the premises and even will NHS E agree. One of the reasons for changes in partnerships relates to extended ill health and many partnerships require a Partner who is absent for 12 months or more to resign. The agreement should also give details of what constitutes reasons for a Partner to be ‘dismissed’ and the usual reason is that they are no longer able to practise because they have had their GMC registration withdrawn for misconduct.

Partnerships in dispute cause a major problem for managers, and it is a matter of self-interest that the manager should ensure that the partnership agreement is fit for purpose. If no agreement is in existence, and in the event of a dispute, the partnership will have no alternative but to rely on the provisions of the [Partnership Act 1890](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj2wpzSpdn-AhVUEsAKHRnnBW4QFnoECA8QAQ&url=https%3A%2F%2Fwww.legislation.gov.uk%2Fukpga%2FVict%2F53-54%2F39%2Fcontents&usg=AOvVaw0Klc1LgTqGMXpFj6IbgYJX) which may be contrary to the Partners’ wishes.

An agreement should include:

* Profit-sharing ratios
* Definition of capital
* The requirements of premises ownership
* Provision for proper accounts to be kept
* Definition of income
* Definition of partnership expenses
* Each Partner should reside within or immediately adjacent to the organisational area
* Provisions for payments during sickness and/or maternity, paternity, adoption and study leave
* Provisions for the retirement of a Partner
* Arrangements for annual accounts, accountant and so on
* Responsibility for signing partnership tax returns

For a new Partner, the organisation would need to amend or redraft the partnership agreement. There may also be a change to who owns the organisation premises, which may require an amendment to the Trust Deed.

The [BMA provides guidance](https://www.bma.org.uk/advice-and-support/gp-practices/gp-partners/the-importance-of-an-up-to-date-gp-partnership-agreement) on what the agreement should cover but care needs to be taken when making changes to ensure that there are no legal loopholes created by poor and imprecise wording. It is normal for the incoming Partner to be asked to contribute capital into the partnership, based on an agreed scale or to a fixed capital account.

All valuations given to an incoming Partner for purchase of organisation assets must be fair and reasonable, in accordance with current market values and as agreed between both parties. It is also important to inform PCSE, CQC, Medical Defence Organisation, building and contents insurance brokers, HMRC and so on.

For further detailed information, refer to the Partners’ Joining and leaving Guidance.

## Partner resignation or retirement

Guidance can be found in the Partners’ Joining and leaving Guidance.

## Partnership shares

Partnership shares are based on the number of individual sessions worked by each Partner when compared with the total number of sessions worked in the organisation by the Partners. Sessions worked by GP registrars and salaried doctors are not included in the computation.

A session is normally regarded as a morning or afternoon consulting session. This excludes extended-hours sessions, and a session has been defined by the BMA as being four hours and ten minutes (based on the standard working week).

## Premises management

* **Asset register**

Ensuring the security of organisational assets is essential, and robust asset management will maintain financial efficiencies and contribute towards the delivery of safe and effective patient care.

In accordance with the [Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 – Premises and Equipment](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/15), the organisation must ensure that equipment is available in sufficient quantities and stored safely and securely to prevent theft, damage or misuse. The organisation must also make sure medical devices are available when required and are disposed of or recycled safely and securely.

The term ‘asset’ refers to, but is not exclusive to, medical and non-medical equipment, fixtures and fittings, consumable items and items supplied for use within the organisation.

The asset register should form part of the off-site business continuity plan and for insurance purposes needs to show where, when and at what cost any organisation-owned item was purchased. In any event, this information is equally valuable when any extended warranty claim is required or when assessing the durability and cost-effectiveness of a product in need of replacement.

For further detailed information, see the Asset Register (Non-Hardware).

* **Calibration**

Medical equipment testing and calibration is the act of ensuring that all medical equipment is in full working order and is calibrated to a known standard to ensure that the reading/result/functionality of the item is accurate at the point of delivery to a patient.

Tests should be carried out by adequately trained and appropriately qualified engineers.

Further detailed information is available in the following:

* + [Managing Medical Devices – Guidance for Healthcare and Social Services Organisations (MHRA)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/421028/Managing_medical_devices_-_Apr_2015.pdf)
  + [Devices in Practice: Checklists for using Medical Devices (MHRA)](https://www.gov.uk/government/publications/devices-in-practice-checklists-for-using-medical-devices)
  + [CQC GP mythbuster 52: Portable appliance testing and calibrating medical equipment](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-52-portable-appliance-testing-calibrating-medical-equipment)
  + Annex D to the Health, Safety and Risk Management Handbook
* **Couch servicing**

Calibration servicing companies repair and recover variable-height electric and hydraulic medical couches; furthermore, they can also load test. In line with [PUWER (Provision and Use of Work Equipment Regulations 1998)](https://www.hse.gov.uk/work-equipment-machinery/puwer.htm), calibration services can provide a full annual maintenance programme, including annual servicing so that the organisation is thoroughly compliant with all insurance, health and safety, and infection control requirements.

Intensive testing takes place and minor repairs, such as the replacement of feet and bungs, are included leaving every couch serviced with an extensive service sheet. The couch will be set up in perfect working condition, levelled, rams adjusted and tested for electrical safety.

Regarding [Lifting Operations and Lifting Equipment Regulations 1998](https://www.hse.gov.uk/work-equipment-machinery/loler.htm) (LOLER), the Health and Safety Executive (HSE) provides specific guidance for this in its document titled [How the Lifting Operations and Lifting Equipment Regulations apply to health and social care](https://www.hse.gov.uk/pubns/hsis4.htm).

Specifically, it states:  
  
*“Much equipment in health and social care premises has an element of lifting as part of its normal operation, for example a variable-height bed or dentist’s chair. However, the principal function of these items is as a bed or chair, and not as a device for lifting or lowering of loads. Height adjustability alone does not mean that LOLER applies to the equipment.”*

* **Emergency equipment and medicines**

All GP organisations must be equipped to deal with a medical emergency and all staff should be suitably trained as detailed within CQC [GP mythbuster 1: Resuscitation in GP surgeries](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-1-resuscitation-gp-surgeries).

Organisations must ensure that staff have access to resuscitation and emergency advice and training, and that emergency equipment is checked. In respect of emergency equipment, the practice should have a defibrillator, oxygen and pulse oximeter on-site. Practices should also have a small stock of common medicines for emergency use and as detailed within CQC [GP mythbuster 9: Emergency medicines for GP practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-9-emergency-medicines-gp-practices).

Further reading can be found in the organisation’s Medical Emergencies Guidance Document and DNACPR Policy for those patients who may not be considered for cardiopulmonary resuscitation.

* **Keyholders**

The arrangements will differ according to the ownership and operation of the premises, but in organisation-owned premises the main keyholders for the property are usually the Partners and Practice Manager. Permanent staff may also have keys to the buildings in which they work.

The nominated keyholder should be asked to sign a keyholder agreement to ensure that security is being maintained. Keyholders may also extend to a contractor, such as those that maintain the alarm system. In these instances, a Service Level Agreement would be needed coupled with a process for monitoring access when the practice is closed.

Full details and requirements are detailed in the organisation’s Key Security and Keyholder Agreement.

* **Maintenance**

In accordance with [The Workplace (Health, Safety and Welfare) Regulations 1992](https://www.legislation.gov.uk/uksi/1992/3004/contents/made#:~:text=The%20Workplace%20%28Health%2C%20Safety%20and%20Welfare%29%20Regulations%201992,10%20Room%20dimensions%20and%20space%20More%20items...%20), employers have a general duty under section 2 of the HASAWA 1974 to ensure, so far as is reasonably practicable, the health, safety and welfare of their employees at work. People in control of non-domestic premises have a duty (under section 4 of the Act) towards people who are not their employees but use their premises, also in accordance with the HSE guidance titled [Workplace health, safety and welfare](https://www.hse.gov.uk/pubns/indg244.pdf).

The appropriate manager or members of staff should be able to arrange and authorise minor repairs to the property, such as problems with the plumbing, central heating or electrical installations, without the need to refer to the Partners. A list of usual contractors should be kept for those occasions when the appropriate manager may be absent.

Improvements to the property will invariably need to be agreed in the first instance with the Partners or may be covered by the lease with the owners where the property is not organisation owned. Sources of funding may need to be investigated as there are funds for organisation development being flagged by the NHS and private contractors all the time.

For further detailed information, refer to the external and internal premises checklists in the Health, Safety and Risk Management Handbook, and the organisation’s Risk Assessment – Locking and Unlocking Premises.

* **Music licence**

Under the [Copyright, Designs and Patents Act 1988](https://www.legislation.gov.uk/ukpga/1988/48/contents), permission is needed from the copyright holders – generally those who create, record and publish music – to play or perform music in public (broadly, this means in any other context than a domestic one). Through their many thousands of members, PPL and PRS for Music manage these rights for the vast majority of commercially released music available and license that music for use by businesses and organisations in the UK via TheMusicLicence.

This means, should you play or perform music in an organisation in the UK, you will usually need TheMusicLicence. Instead of potentially having to contact many thousands of music rights holders individually for permission to play or perform their music, TheMusicLicence gives you those permissions in a single, simple transaction.

You can apply and reapply for [TheMusicLicence](https://pplprs.co.uk/get-themusiclicence/) online.

* **PAT testing**

[The Electricity at Work Regulations 1989](https://www.legislation.gov.uk/uksi/1989/635/contents/made) do not specify the frequency of inspection but require that “regular”, planned, formal inspection and testing of portable appliance equipment is carried out by a competent person. Therefore, the organisation should adopt an annual inspection and testing programme that will enable compliance with the requirements of testing at “regular” intervals.

The CQC provides guidance in [GP mythbuster 52: Portable appliance testing and calibrating medical equipment](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-52-portable-appliance-testing-calibrating-medical-equipment). Furthermore, the organisation’s Health, Safety and Risk Management Handbook details calibration requirements and portable appliance testing.

* **Refrigerators**

The vaccine fridge should have the sole purpose of storing vaccines. It should not be used for the storage of any other products. Temperature recordings should be in accordance with The Green Book guidance titled [Storage, distribution and disposal of vaccines](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/223753/Green_Book_Chapter_3_v3_0W.pdf).



The logging of temperatures can be done via the Checks Manager which is in the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/) that sits within the [HUB](https://hub.practiceindex.co.uk/login?redirect=/help).

Further detail on the management of the cold chain can be found in [CQC GP mythbuster 17: Vaccine storage and fridges in GP practices](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-17-vaccine-storage-fridges-gp-practices) and the organisation’s Medicines Management Policy.

* **Shredding**

The Secretary of State for Health and all NHS organisations have a duty under the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) to make arrangements for the safe keeping and eventual disposal of all types of records. For health and social care, the primary reason for managing information and records is for the provision of high-quality care.

The shredding of confidential material may either be done by the organisation itself or by a contractor who takes the confidential papers off-site to a shredding facility or destroys them on-site, usually in a specially equipped lorry. It is important when using a contractor to ensure that an appropriate destruction certificate is received each time a load is shredded to prove secure disposal.

The data controller (the organisation) is responsible for ensuring that the provider chosen to carry out off-site destruction is fully compliant and accredited as detailed in the organisation’s Confidential Waste Policy.

* **Waste management**

Organisations have a requirement to maintain safe, effective, waste management processes in line with extant legislation, thereby reducing the risk of infection.

Full guidance to support the requirement can be found in the organisation’s Waste Management Policy and Infection Prevention Control (IPC) Handbook.

## Procedural guidance for staff

The organisation should have a readily available directory of policies and protocols that all staff can access when needed.

The CQC will look for ‘document control’ when reviewing policies, so each must be clearly annotated with the date it was written and version number as well as the planned date when it should be reviewed. There is no requirement for policies to be slavishly reviewed each year, but good monitoring of the working environment should help a manager spot when operating issues change.

A digital filing system/software should prompt when review dates are due.



Policy Manager can support document control and is a FREE resource in the [HUB](https://hub.practiceindex.co.uk/).

Further support, including a list of commonly required policies that are expected in any GP practice, can be found in The CQC Handbook at Annex B. Refer to Annex D for recommended policies and protocols that practices should consider.

## Risk and assurance

The risk-based approach looks at providing assurance about the key controls that are in place to mitigate the strategic or main risks that threaten (or provide opportunity for) the achievement of your objectives and should build on the foundation created by your existing risk management process.

* **Quality assurance**

In order for organisations to meet the requirements of the [Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17](http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance#guidance), there must be demonstrable evidence of quality assurance. This includes effective governance, assurance and auditing processes which are aimed at improving the quality of service delivery.

It is the responsibility of all staff to ensure that service delivery and patient care are of the highest standards. This will be achieved through an organised approach to quality assurance that involves all staff. Excellent communication combined with a clear understanding of individual roles, and embracing a culture of quality improvement and learning, will ensure that an excellent service is always offered to all patients.

For further detailed information, see the Quality Assurance and Clinical Audit Policy and CQC [GP mythbuster 4: Quality improvement activity](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-4-quality-improvement-activity).

* **Risk assessment**

Risk assessments are often perceived as being complicated and very time-consuming. The organisation’s Health, Safety and Risk Management Handbook helps assessors to complete a suitable and sufficient assessment of risk and manage it in context with others. It must be understood that whilst this guide contains information and explanations of some of the broader principles of risk, it is not intended to cover every aspect or circumstance.

There is an expectation from the CQC that all risk assessments will be robust and considered with appropriate mitigation. All should be logged and available during an inspection.

The core function of a risk assessment is to establish its relative priority. Therefore, when several risk assessments have been completed, numerically, they illustrate which has the greater risk rating, giving the relative priority. However, the core function of risk management is to allocate resources against the relative priorities. To achieve this, a common methodology that is data driven is to be applied, appropriate to the levels of risk with quality assurance and without bias.

Managers must understand the extent of the resources available to them to enable sensible risk controls to be implemented against the relative priorities identified. The objective is to reduce risk to as low as is reasonably practicable ([ALARP](https://www.hse.gov.uk/managing/theory/alarpglance.htm)) using available resources.

Further detailed information, including a recommended list of risk assessments, can be found in Chapter 11 of the Health, Safety and Risk Management Handbook.

* **Risk register**

It will be of huge benefit to adopt a systematic approach to the identification, assessment and management of risks and issues. This will enable a much better understanding of what needs to be managed and to what extent.

The use of both a risk register and an issues log will enable the senior management team to prioritise, manage and mitigate risks and issues to meet their duties and responsibilities detailed in the [Health and Safety at Work etc. Act 1974](https://www.hse.gov.uk/legislation/hswa.htm).

Risk registers and issues logs are only as good as the data contained within them. Therefore, it is essential to have a quality-based system for monitoring and reviewing risks and issues on a continual basis. If the data is inaccurate, the descriptions poorly articulated or it is infrequently monitored and reviewed, then it is likely that poor decision-making and/or an increased risk profile will be the resulting outcome.

Risks can be identified reactively or proactively, and the risk register is a comprehensive tool aimed at reducing the possibility of adverse outcomes.



Risk Manager is part of the [Compliance Package](https://practiceindex.co.uk/gp/solutions/hub/compliance-package/) in the [HUB](https://hub.practiceindex.co.uk/).

## Security

The organisation faces several risks that must be appropriately assessed and actions taken to mitigate the risks if service users are to continue to receive safe and effective patient care.

* **General access**

Controlling access is particularly difficult given the number of people who visit the organisation daily. It is therefore essential that only authorised personnel can access staff-only areas within the building. Staff must ensure that those areas protected with locks always remain secure; doors must not be wedged open under any circumstances, nor are codes to be given to patients or visitors.

* **Staff identification**

All staff must always wear their NHS identification badge when on the premises.

* **Staff access**

All staff are permitted to access all areas of the building to enable them to carry out their daily duties effectively. All areas that need to be secured are fitted with a lock, the codes for which have been issued to all staff.

Door codes will be changed:

* Every six months
* When a member of staff leaves their role at the organisation
* In the event of a security breach
* At any other time it is deemed appropriate to do so by the organisation’s management team

To maintain effective security, when entering or leaving staff-only areas, all staff must be aware of ‘tailgaters’ and challenge anyone who is trying to access staff-only areas if they do not have the appropriate ID.

* **Patient access**

Within the organisation, patient movement should be restricted to the following areas:

* Reception
* Waiting area
* Clinical rooms (for appointments)
* Patient toilets
* Dispensary waiting area

Patients who attempt to enter staff-only areas or those acting in a suspicious manner must be challenged. There may be on occasion a requirement for patients to visit staff-only areas for them to meet a member of the management team, for example. In such instances, they are to be issued with a visitor badge and escorted from and back to the reception area.

* **Visitor and contractor access**

All visitors and contractors are to sign in and out of the organisation in the visitor log which is kept at reception. Any visitor or contractor who requires access to staff-only areas should be issued with a visitor badge and escorted by their host when inside staff-only areas. Reception staff must ensure that when a visitor or contractor leaves, the staff member must sign the log to confirm the individual has left the premises.

Organisations need to recognise that some standard signing-in books do not comply with UK GDPR requirements. When a visitor signs in, there is nothing preventing the visitor from scanning the visitor book to see who has visited before them. Organisations need to be mindful of this issue and recognise the solutions on offer including specialist signing-in books that protect all personally identifiable information or the use of a digital visitor book which can be utilised on an iPad.

The organisation’s Third Party Confidentiality Agreement incorporating fire safety and risk awareness for visitors form can be used for this purpose.

* **Opening the organisation at the start of the working day**

The individual responsible for opening the organisation (as per the rota) is to enter the organisation ensuring access is secured behind them. They must then:

* Deactivate the alarm
* Conduct a walk around the organisation, turning on corridor lighting
* Open the reception area, turning on computers and other electrical equipment
* Turn on TVs in the waiting area (if applicable)
* Ensure there are sufficient cups for the water dispenser and so on

Staff must not open the organisation to patients until there are at least two members of staff present in the building.

* **Securing the organisation at the end of the working day**

All staff have a shared responsibility for the security of the organisation. Prior to leaving the organisation at the end of the working day, staff must ensure that:

* Where appropriate, all electrical equipment is turned off
* All computers are shut down
* Medical records cabinets are locked (if applicable)
* All windows are shut and locked (if locks are fitted)
* Blinds are closed (if fitted)
* All internal doors are closed and locked (if applicable, e.g., the medical records area)

The individual responsible for securing the organisation (as per the rota) must ensure that they conduct a walk around the building to confirm that all the above actions have been completed. Once they are satisfied, they are to activate the organisation alarm, leave the building and secure the door behind them.

For further detailed information, see the organisation’s Practice Security and Risk Assessment Policy and Risk Assessment – Locking and unlocking premises. Furthermore, guidance can be sought from the Health, Safety and Risk Management Handbook.

* **CCTV**

See the [CCTV](#_Closed_Circuit_Television) guidance in the Premises and Information Governance sections of this handbook.

For further detailed information, see the organisation’s Practice Security and Risk Assessment Policy.

## Vision and values

A vision statement helps all stakeholders to understand what the organisation’s strategic direction is, the purpose of the organisation and its future aspirations. A precise and well-written vision statement is motivational and helps to create a common goal that can help to influence performance. The leaders within this organisation are the key determinants of whether the vision and values are achieved, so it is crucial that this organisation has a clear strategy that is shared by all staff.

The CQC expects service providers to have in place a clear vision and strategy to deliver high-quality care and promote good outcomes for people. The vision and values of a service provider highlight their strategic objectives and on what the organisation places value, as stated in CQC [GP mythbuster 48: Well-led – vision and strategy](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-48-well-led-–-vision-strategy).

Under the ‘well-led’ key question, the CQC will seek assurance that this organisation has a shared vision, strategy and culture. The [shared direction and culture quality statement](https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/well-led/shared-direction-culture) outlines what the regulator will look for and offers links to best practice guidance.

For further reading, refer to the [Vision and Values Guidance Document](https://practiceindex.co.uk/gp/forum/resources/vision-and-values-guidance-document.1003/).

# Financial governance

The core of financial governance regulations, such as Standing Financial Instructions (SFIs), is the requirement that all financial processes should be managed according to a stringent set of rules and regulations, backed up by accurate reporting capabilities.

## Accountant

The organisation might consider appointing an accountant who can provide specialist support for GP practices as there are financial nuances, especially with a dispensing practice.

The appointed accountant will prepare the formal annual accounts and deal with the Partners’ tax returns for submission to HMRC. The documentation is usually submitted to the accountant following the year end. The organisation year end does not have to run concurrently with the tax year, although this will often be the case. The annual accounts are presented to the Partners at a business meeting which may take place two or three months after the year end. Other business meetings can occur throughout the financial year.

For further detailed information, see [Choosing an Accountant](https://www.ccab.org.uk/choosing-an-accountant/).

## Accounts

Accounts are to be maintained electronically and with using software packages such as Iris GP Accounts, Sage, Quicken, Xero or Microsoft. Making Tax Digital (MTD) ensures that products are now cloud based so there is no need to be concerned about lost data.

It is important for dispensing organisations to utilise an accounts package that understands the complexity of dispensing finance and the de minimis and partial exemption for VAT recovery when undertaking the VAT return.

With any accounting software package, it is important to set it up with all bank accounts individually and not blend them into one. It is also vital that sufficient categories are set up to reflect the income and expenditure of the organisation adequately and to monitor increases and decreases along the way. The categories should at least reflect those shown in the organisation’s annual accounts.

Different payments should be coded by category to keep track of expenditure. It is also useful to separate income, such as NHS payments, petty cash and private income.

The process of entering ALL payments should take account of both the Category and Class of payment. It should also record the cheque number where a cheque has been used. Sufficient information about the type of payment should be recorded to enable the accountant to easily prepare the annual accounts without reference back to the organisation. Any NHS reimbursements, refunds or grants received should be properly associated (or reversed) with the organisation expenditure it relates to.

It may also be necessary to re-credit any bounced cheques. You will need to be aware of any failed transmissions of bank payments, although this is more likely to occur with transmissions to Inland Revenue or the NHS Pension Agency.

The details of Inland Revenue payments, including student loans, statutory sick pay and statutory maternity pay, will need to be shown in the organisation accounts system. Payments made in respect of GP registrars and salaried GPs should be shown separately from organisation staff costs.

It is extremely important to ensure that the accounts are reconciled monthly and as detailed within [Section 4.3](#_Bank_statement_reconciliation).

The formal year end for the preparation of the organisation’s annual accounts is the date when business accounts close. The accountant will provide a list of everything that is required to be sent after year end, when all invoices relevant to the year end will have been paid.

At the year end, the first task is to make sure that all transactions have been accounted for and entered into the accounts package. A reconciliation of all bank statements against the entries in the bank’s current account should then take place. It may be helpful, if online banking is used, to print a complete set of the year’s accounts. The Bank Charge Projection tool can be used to forecast the organisation’s banking charges for each financial year.

For further detailed information, see the organisation’s Financial Management and Procurement Policy.

## Bank statement reconciliation

The bank reconciliation process requires that the entering of all income and payments is brought up to date.

Reconciliation of all accounts needs to be undertaken before any VAT return can be calculated and submitted to HMRC. To undertake reconciliation, you will need to utilise the reconciliation report on your chosen accounts package for all accounts each month, or more frequently if possible.

For further detailed information, see the organisation’s Financial Management and Procurement Policy.

## Banking

An organisation’s main business current and other accounts should be more manageable using the web-based online banking service. This should only be accessible by approved users who are allocated a username and a series of passwords. Banks and building societies have rules about opening accounts in the names of large partnerships. It may be easier to open accounts in the name of one or up to four ‘trusted’ Partners.

Most banks have business relationship managers who should be able to help with setting up all banking processes and advise on the fees they charge, as well as explain what account benefits there may be with your account. Remember that banks make interest out of credit balances, and this should be offset against the charges they make for processing cheques, payroll and so on. Changing banks, while not always a seamless process, is improving and may result in significant savings in charges and better benefits.

It is good practice for a file containing all bank statements and building society statements received to be compiled and retained in folders with invoices. It may be necessary to request annual statements for any building society accounts held, to show interest earned and tax paid during the financial year.

The organisation often has an overdraft facility on the current account, but the objective is to use it sparingly on the grounds of cost. Overdraft facilities usually carry an arrangement fee which needs to be factored in, and taking the advice of the organisation accountant is always recommended. In addition, should there be any significant expenditure needed in the organisation, which cannot be covered by reserves, then as part of the borrowing research, the use of an overdraft should be considered as it may work out to be more cost-effective than a loan.

The exact details of who can authorise expenditure, especially if there is internet banking available to the organisation, needs to be clearly set down and understood. Consideration needs to be given to the limits of authorisation, not forgetting that monthly payroll needs to be processed when the required number of signatories may not be present. Note that holiday periods can prove particularly testing when it comes to the availability of someone to authorise expenditure.

An annual statement of any mortgage account and loan should also be available for the annual accounts.

## Card payments

Most organisations now accept card payments which should be in line with the Payment Card Industry Data Security Standard (PCI DSS), which is a set of security standards designed to ensure that all companies that accept, process, store or transmit credit card information maintain a secure environment.

The Payment Standard has grouped the 12 high-level standards into six categories along with guidance as to how organisations can achieve compliance. Not all organisations have to comply with all the requirements. Compliance is dependent on the volume and type of transactions undertaken in a 12-month period.

Failure to comply with the PCI DSS requirements can result in a fine for the acquiring bank; however, this fine can be passed to the merchant (organisation). Penalties are not detailed in the PCI guidance and are determined by the acquiring bank. Full details relating to the penalties applicable are usually detailed in the account agreement with the service provider.

For further detailed information, see the organisation’s Payment Card Industry Policy.

## Claim process for NHS activity undertaken

The organisation receives income from a variety of NHS sources. Claims are monthly, quarterly or annually. Some of these claims are auto-extracted by CQRS and others require a manual claim to be made via the CQRS claim web page or via an appropriate form.

Typically, GP information is collected using the following process:

* GPs record activity for the services they provide in their clinical system
* NHS E, or another, requests information about a particular GP service
* NHS E area teams offer GPs the option to participate in collections for that service
* GPs agree to participate in collections for that service on CQRS
* CQRS collects information from GP clinical systems using GPES over a specified period; this is called an extraction
* If required, GP staff enter information manually into CQRS
* CQRS displays the information collected in CQRS
* GPs check the information collected is the same as that contained in their own clinical system
* If it is payment related, GPs then must ‘declare’ information from that collection to area teams to approve using CQRS
* CQRS then provides the information to the organisation that requested it for authorising payment or analysis

All auto-extracted data is generally available for review within 14 days.

In addition, a spreadsheet of all income is recommended to keep abreast of all claims submitted, payments expected and when these payments are received as there is a tendency for PCSE not to get this right. Unfortunately, many practices experience difficulties

with payments made through the NHS; as such, it is recommended that those processing NHS payments keep on top of what is owed and what is received.

To log in to [CQRS](https://login.cqrs.nhs.uk/cas/login), practices need to establish a user ID and password. Support can be found within the [CQRS User Guides](https://digital.nhs.uk/services/calculating-quality-reporting-service/user-guides) and their [Make claims for providing primary care services webpage](https://welcome.cqrs.nhs.uk/).



The [Finance Package](https://practiceindex.co.uk/gp/solutions/hub/finance-package/) is available in the [HUB](https://hub.practiceindex.co.uk/login?redirect=/help) to support various aspects of the practice’s financial management.

## Contracts

There are three different types of GP contract arrangements used by NHS Commissioners in England:

* General Medical Services (GMS)
* Personal Medical Services (PMS)
* Alternative Provider Medical Services (APMS)

Contracts are explained in full in the following King’s Fund document titled [GP funding and contracts explained](https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained#:~:text=There%20are%20three%201%20different,the%20national%20standard%20GP%20contract.).

All types of contracts are managed by the NHS Commissioner (either NHS E or ICBs). Where contracts are negotiated locally, [Local Medical Committees](https://www.bma.org.uk/what-we-do/local-medical-committees) representing GPs may advise or participate in discussions alongside regional BMA representation.

These are the core parts of a general practice contract:

* Agree the geographical or population area the organisation will cover
* Require the organisation to maintain a list of patients for the area, setting out who this list covers and under what circumstances a patient might be removed from it
* Establish the essential medical services a general practice must provide to its patients
* Set standards for premises and workforce, and requirements for inspection and oversight
* Set out expectations for public and patient involvement
* Outline key policies including indemnity, complaints, liability, insurance, clinical governance, and termination of the contract

In addition to these core arrangements, a primary care contract also contains several optional agreements for services that an organisation might enter, usually in return for additional payment. These include the nationally negotiated [Directed Enhanced Services](#_Direct_Enhanced_Services) (DES) that all commissioners of general practice must offer to their organisations in their contract and the locally negotiated and set [Local Enhanced Services (LES)](#_Local_Enhanced_Services) that vary by area.

General practices are contracted to perform broadly five types of service for the NHS, although some are optional:

* Essential services are mandatory for an organisation to deliver to registered patients and temporary residents in its organisation area. They include the identification and management of illnesses, providing health advice and referral to other services. GPs are required to provide their essential services during core hours, which are 8.00am–6.30pm, Monday to Friday, excluding bank holidays.
* Out-of-hours services are those provided outside core working hours. An organisation is assumed to be providing these by default but can opt out. Where an organisation opts out, as most organisations do, commissioners have the responsibility for contracting a replacement service to cover the general practice area population.
* Additional services include specific other clinical services that an organisation is assumed to provide but can opt out of – for example, cervical screening services and minor surgery.
* Enhanced services are nationally agreed services that holders of almost all GP contracts (GMS/PMS/APMS) can also provide if they choose to opt in. Services specified include some vaccination programmes and health check schemes for at-risk groups and PCNs.
* Locally commissioned services are locally set services that organisations can also opt in to. Unlike other GP services, these might also be commissioned by non-NHS organisations such as local authority public health departments. Examples include services for people who are sleeping rough or mental health support programmes.

## Directed Enhanced Services (DES)

Enhanced services are nationally negotiated over and above those provided under usual contracts, which the area team/ICB is obliged to commission.

For advice and guidance on DES specifications, refer to the Practice Manager’s Handbook.

## Expenses

Each business should have an Expenses Policy and an expenses claim form giving guidance on the payment of expenses.

For general practice, this policy should detail when staff members travel between main and branch surgeries, and the payment of travel and subsistence allowances that will apply whilst staff members are away from home for the purposes of business (including training courses and conferences). In addition, the policy will include expenses that will not be reimbursed, and the action taken regarding false claims.

This guidance should be read with reference to any Training Costs Agreement.

## Fraud

[The NHS Counter Fraud Authority (NHSCFA)](https://cfa.nhs.uk/) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. NHS fraud is deception carried out for personal gain, usually for money. Fraud can also involve the abuse of a position of trust.

Within the NHS, fraud can follow various guises, as detailed in the [NHSCFA guidance](https://cfa.nhs.uk/fraud-prevention/reference-guide/types-of-fraud-within-the-NHS/NHS-employees/gp-practice-general-practitioner).

As providers of NHS services, all organisations must put in place and maintain appropriate counter fraud arrangements, as outlined in the [CFA Standards for NHS Providers guidance document](https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2020_v1.3.pdf). Staff can access the joint [DHSC / NHSCFA online reporting tool](https://reportfraud.cfa.nhs.uk/).

For further information, see the organisation’s Anti-bribery and Counter Fraud Policy.

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Fraud Awareness eLearning is available in the [HUB](https://hub.practiceindex.co.uk/).

## Global sum

Practices receive an amount of money per patient called the global sum; this is so that practices can deliver the core parts of their contract. This includes payment for out-of-hours and additional services. If an organisation opts out of these, percentage deductions are applied to the global sum payment to account for this.

Global sum payments are based on an estimate of an organisation’s patient workload and certain unavoidable costs (e.g., the additional costs of serving a rural or remote area or the effect of geography on staff markets and pay), not on the actual recorded delivery of services. The global sum payment for each organisation is based on a weighted sum for every patient on the organisation list. The Carr-Hill formula is used to apply these weightings, which account for factors such as age and gender. The global sum amount is reviewed quarterly to account for changes to the organisation’s patient population.

The global sum is a per capita payment of £121.79 per weighted patient for the 2025/26 financial year, although it should be noted that there are some variations between the four countries of the UK. London Weighting Allowance is calculated for patients who have home addresses in the Greater London Authority area. This adjustment is the count of registered patients in that area multiplied by 2.18.

Organisations with varying types of populations receive global sums that differ not only because of the numbers of patients but also because of the composition of their patient lists and the effect of the allocation formula on these lists.

Further reading can be found in the BMA’s document titled [Global sum allocation formula](https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/global-sum-allocation-formula).

## GMS contract

NHS E may have entered into a GMS contract with the organisation, which sets out in general terms what the organisation is obliged to do while working for the NHS, and updates to this are received regularly and should be filed for reference. It is important to understand the basic requirements of the contract as NHS E (or the ICB, if working to delegated powers) can impose significant penalties for breach of the contract.

The organisation can, however, designate themselves to be an ‘NHS body’ under the contract and this limits them to the use of the NHS mediation services in the event of a contract dispute. Many organisations remain outside this designation, which allows them to take legal action for any breach of the contract on the part of NHS E, and this does seem to bring with it some obvious benefits.

The formula for GMS contract payments is complicated but is attributed by identifying spending and applying ratios on:

* Global sum
* Global sum plus correction factor
* QOF
* Enhanced services
* Locum payments

This means that an overall annual percentage pay award will mean different increases to each of the above areas.

For further understanding of the GMS contract changes, see the NHS E guidance titled [Standard General Medical Services Contract Variation Notice](https://www.england.nhs.uk/wp-content/uploads/2024/08/PRN01358iv-standard-general-medical-services-contract-variation-notice-august-2024.pdf).

## HMRC

* **Annual returns**

The P32 return must be submitted to the Inland Revenue by 19th May each year, which is now mandatory, and the submission arrangements have been significantly simplified as they are submitted electronically. The P32 return is produced by the chosen payroll software or agency and details the Employer Payment Record as a summary that the employer has paid to HMRC each month.

A reconciliation of monthly payments made to the Inland Revenue should be prepared and checked against the annual return to show that no further balancing payments are due. A balancing payment might need to be made if any errors are revealed or late payments are due.

Further information on the P32 can be found at the Sage webpage titled [Employer payment summary (EPS) submissions and P32 payments](https://gb-kb.sage.com/portal/app/portlets/results/viewsolution.jsp?solutionid=222001000101770&hypermediatext=null).

In addition to the P32, the organisation must prepare the following forms:

* Form P11 – this is a large deduction working sheet used as a PAYE and NIC summary sheet for each employee. The form is usually generated by your software or agency.
* Form P60 – this is the certificate of total pay and tax issued by the organisation as the employer to each employee for the tax year.
* Form P14 – this is a copy of the P60 which is submitted to the Inland Revenue, one form for each member of staff.

The PAYE and NIC payments must be made no later than 22nd of each month (19th if paying by cheque).

* **Payments**

The payments for Partners’ taxation to HMRC are made during late January and late July each year. The organisation accountant will estimate the taxation due and submit returns to the Inland Revenue with each Partner signing an annual tax return. The Partners receive a notification of tax due each half-year, which is normally sent to their home address. Any notifications received at the organisation should be passed to the named Partner for payment unless the organisation operates a system whereby the organisation covers the tax liability payments which are adjusted in the annual drawings calculations.

The individual Partners’ payments will be made by themselves direct to Inland Revenue in most cases.

A capital account shows the income and drawings that can be attributed to each Partner. In effect, it shows the Partner’s share of the organisation finances. This is usually monitored by the accountant.

The payroll system must keep a record of National Insurance and PAYE contributions for each member of staff employed in the organisation, including any salaried doctors employed by the organisation. Members of the NHS Pension Scheme now pay Class A NIC contributions. The payroll system should maintain a P11 record of deductions form. Monthly returns are now made online via a Government Gateway in relation to all PAYE and NIC payments made for each staff member.

It is vital to make submissions before the end of the working month.

## Income (including remittances)

NHS income is mainly received from three different sources: NHS E (via PCSE), ICB and the local government authority. In addition, income is received from private sources. Income is received by cheque, direct credit and cash. Some income is received from the local deanery and may be attributable directly to the GP trainers. Work carried out by the doctors for the ICB during organisation time can also be attributable to the organisation, depending on the partnership agreement terms.

All remittances, copy invoices or BACS payment notifications should be entered into the account’s software package including a reference that enables the organisation accountant to correctly attribute income at the year end.

## Invoices

Proper, consistent invoicing processes are an important part of running a business. Good invoice management encourages regular cash flow and helps ease accounting stress.

* **Invoices received**

Invoices may be filed in alphabetical or date order which makes it easier to locate previous invoices when reconciling account statements. As previously indicated, invoices are paid probably twice a month, although urgent payments can be made as required, and many organisations are using internet banking systems in preference to the BACS system.

When paid, it is good to note the date of payment, amount and any online banking payment reference number. A copy of the payment advice could also be printed off from the banking online system and filed. For payments made by cheque, it is important to record the cheque number, value and date of payment on the original invoice. Keep cheque stubs along with cancelled cheques for submission to the accountant at the end of the financial year.

The accounting software in use will also have a facility to note invoices and payments.

* **Invoices raised**

The organisation may decide to issue all claims and invoices under the regulations relating to the payment of debts to small businesses, which entitles you to add interest of 8% over the Bank of England base rate at the time should the invoices not be paid within a specified timescale (often 30 days).

* **Invoices for collaborative fees**

These collaborative fees, which are paid by the local authorities via NHS E, should also be checked for the amount owed. A separate file of invoices owed is usually kept. A list and value of invoices received prior to the year end but paid afterwards should also be prepared for the accountant.

The organisation accountant will also wish to know what income is owed for the last quarter of the financial year. Some NHS payments may remain unpaid for much longer periods.

## IR35

Intermediaries’ legislation, or IR35 as it is commonly known, is a form of UK tax legislation that looks to differentiate between genuine businesses and workers who are, to all intents and purposes, temporary employees. The responsibility of determining whether IR35 applies rests with the [public authority](https://uk.practicallaw.thomsonreuters.com/w-014-8196?transitionType=Default&contextData=%28sc.Default%29) or medium and large-sized organisation outside the public sector whereas previously it rested with the [intermediary](https://www.gov.uk/guidance/employment-status-employment-intermediaries).

As an NHS provider, a primary care organisation is classed as a public authority and has a responsibility to determine if [locum](https://www.id-medical.com/what-is-a-locum-doctor/) and [agency workers](https://www.cipd.co.uk/knowledge/fundamentals/emp-law/employees/agency-workers-guide#gref) fall within IR35. To determine the employment status for taxing the individual providing the services, it is advised that [the Check Employment Status for Tax Tool](https://www.gov.uk/guidance/check-employment-status-for-tax) is used to understand a worker’s employment status. For further detailed information, see the current [governmental information](https://www.gov.uk/guidance/april-2020-changes-to-off-payroll-working-for-clients) and the organisation’s IR35 Policy.

## Local Enhanced Services (LES)

Local enhanced services are schemes agreed locally between ICBs and their primary care contractors to meet identified needs and priorities. These could either adopt national specifications or be locally agreed, although there is an expectation that ICBs should review their existing LES portfolio and develop commissioning intentions for relevant community-based services to be commissioned using the standard NHS contract.

## National Living Wage (NLW) and National Minimum Wage (NMW)

Both the NLW and NMW are set annually each April with information being detailed in the Government webpage titled [National Minimum Wage and National Living Wage](https://www.gov.uk/national-minimum-wage-rates).

Within businesses, the following common errors are made when it comes to calculating minimum wages.

* **Working overtime?**

If an employee receives a higher hourly rate for overtime or working antisocial hours and is paid below the NMW / NLW for their regular shifts, then you could be underpaying what they are legally owed.

* **Holiday pay overtime**

Following a tribunal ruling, employers must now consider whether the employee is regularly working voluntary overtime when calculating holiday pay. If they are, their holiday pay must account for that.

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To support planning, [Holiday Manager](https://practiceindex.co.uk/gp/solutions/hub/holiday-manager/) is a FREE resource in the [HUB](https://hub.practiceindex.co.uk/).

* **Is the cost of workwear or equipment deducted from an employee’s wages?**

If you have deducted anything from staff wages to cover the cost of items connected with their job, such as uniform, safety clothing, specified workwear or equipment, then they may have been underpaid. Deductions for items connected with the job must not take staff below the National Minimum or Living Wage for any given pay period.

* **Do any staff get paid for travel while working?**

If their work involves travel between different assignments, and the organisation does not pay them for that time, they might not be getting all that they are owed. Additionally, if their work does not cover the cost of travelling between different assignments, then you could be underpaying them.

* **Do staff often start early or leave late, and are not paid for this time?**

If staff are working a little unpaid extra time on a regular basis, such as helping to open up the practice or having to wait in the workplace before they can go home after their shift (e.g., if there are patients still on-site because a GP is running late), then your staff could be underpaid.

Additionally, if they have not been paid for time spent training or whilst on a trial period, they may also have been underpaid. If they do this regularly, this unpaid time can quickly add up and you might find that staff are missing out on the National Living Wage.

## NHS statements (PCSE Online)

PCSE provide monthly statements that can be accessed via their webpage titled [Access your practice](https://pcse.england.nhs.uk/gp-practices/managing-payments/access-your-practice-statements).

PCSE is responsible for administering the following payments to GP practices:

* Global sum payments
* PMS contract baseline payments
* Drugs payments (prescribing and dispensing)
* Childhood immunisation payments
* Ad hoc payment instructions (locum/premises/rates)
* GP trainee payments and expenses (for non-lead employer areas)
* GP training grant payments
* Enhanced Service payments via CQRS
* Quality and Outcomes Framework payments (aspiration)
* Quality and Outcomes Framework payment (achieved)
* Public Health Immunisation Schedules payments
* GP retainers
* Local Medical Committee levies (depends on contract type)

## Partners’ drawings

The Partners’ drawings are reviewed by all the Partners at the review with the organisation accountant, usually at the presentation of the year’s accounts.

Accountants make recommendations on drawings levels, usually attributable to their capital accounts. Whilst the organisation accountants will often give advice on the level of drawings, it is advisable to set aside funds each month for Inland Revenue taxation payments, sometimes in an interest-bearing savings account.

The manager should advise the Lead Finance Partner accordingly when credit balances are high to transfer excess funds to savings accounts. If additional drawings are made, these need to be added into the organisation accounts and clearly annotated as being a drawing.

Control of drawings will be a matter for each organisation, but some system will still need to be in place to make the agreed drawing payments to each Partner at the end of each month using the BACS process or standing orders.

## Partners’ earnings declaration

As of 1st April 2023, all staff, including Partners (both clinical and non-clinical), are to publicly declare their NHS earnings above that year’s established threshold. Self-declarations are to be made by 30th April in the financial year beginning immediately after the end of the financial year.

The [General practice pay transparency guidance](https://www.england.nhs.uk/long-read/general-practice-pay-transparency-guidance/) from NHS E explains the requirement further, including the established thresholds for earnings as detailed in the below table.

|  |  |
| --- | --- |
| **Financial year**  **(1st Apr to 31st Mar)** | **NHS earnings threshold above which a self-declaration must be made** |
| 2021-22 | £156,000 |
| 2022-23 | £159,000 |
| 2023-24 | £163,000 |

No subsequent threshold limits for 2024/25 have been published by NHS E. At the time of publishing this handbook, the latest information from the BMA is available in their document titled [Declaring GP earnings over £150,000](https://www.bma.org.uk/pay-and-contracts/pay/gp-pay/declaring-gp-earnings-over-150-000) dated 28th June 2024.

In addition to this, and as it is deemed that only a minority will meet the above thresholds, practices will also continue to be required to publish their GPs’ net earnings on their website along with the number of GPs. Organisations or their accountants must generate the earnings report. NHS E has acknowledged that it is difficult to simply separate income and outgoings. It recommends that organisations should work within the reporting guidelines as much as possible.

To calculate the figures, guidance can be sought from the BMA document titled [Publishing GP net earnings](https://www.bma.org.uk/advice-and-support/gp-practices/communication-with-patients/publishing-gp-net-earnings).

## Partners’ personal expenses

Some or all of the personal expenses of the GP Partners may be paid by the organisation and attributed to the Partners’ drawings account, including the GMC annual registration fee, membership fees of the RCGP and personal home or mobile telephone bills. Some doctors charge their car expenses to the organisation. The GPs should be encouraged to introduce direct debit arrangements for such payments.

The organisation may pay some of the professional fees due for any salaried doctors working in the organisation. Therefore, it is wise to check the correctness of records held by the GMC as it is not unknown for a doctor to change address and find that the annual retention fee has not been paid.

It is recommended that a file is kept for each doctor with copies of annual certificates for the GMC.

## Partnership superannuation

This is paid via the GMS statements every month and then a reconciliation is done once a year following submission of the superannuation form, which is completed by the organisation accountant and then passed on to the Partner’s own accountant for any additional information.

Before 28th February, all practitioners need to have returned their forms to PCSE via the portal. Further reading can be found on the PCSE webpage titled [GP and Non-GP Partners – Type 1 Annual Certificate](https://pcse.england.nhs.uk/services/gp-pensions/end-year-processes/gp-non-gp-partners-type-1-annual-certificate).

|  |  |
| --- | --- |
| **Type** | **Actions** |
| GP Partners and non-GPs (Type 1) limited company/partnership/single hander | Complete the Annual Certificate of Pensionable Profit |
| Salaried/Assistant GPs (Type 2) | Complete the Type 2 Medical Practitioner Self-Assessment of Tiered Contributions form |
| GP organisation | Complete the Estimate of GP (and non-GP) Providers NHS Pensionable Profits/Pay form |

If a salaried doctor has other earnings outside the organisation, they need to ensure themselves that pensionable earnings for that work are similarly advised to NHS E.

## Partnership superannuation returns

* **GP superannuation payments**

NHS E deducts from the monthly income of the organisation both employees’ (varying rates) and employers’ NHS Pension Scheme contributions. The deductions are based on a provisional calculation that is made following submission of the Annual Certificate of Pensionable Profits in February.

GP employees’ contributions are based on a percentage of the estimated income of each GP. A pension guide for GPs is available from the NHSBSA document titled [GP Member Pension Guide](https://www.nhsbsa.nhs.uk/sites/default/files/2023-11/GP%20Member%20Pension%20Guide-updated%2022.11.2023%20-%20v4.doc).

An organisation is not to create a pension record under its own unique Employing Authority (EA) code for any new GP starters. However, the organisation should inform PCSE of the GP’s estimated pensionable income at the commencement of their post (if appropriate) so that NHS Pension Scheme contributions are paid throughout the year on account.

* **Annual superannuation certificates**

In many cases, the accountant will prepare the Type 1 certificate, which NHS E requires, showing the superannuable income for organisation Partners. This certificate allows NHS E to adjust the deductions for Partners’ superannuation, which is done currently through PCSE Online payments, and it is the responsibility of the organisation to see that it is sent by the due date – usually in February, one year in arrears.

Salaried GPs must provide a Type 2 certificate through the organisation, who should fill it in with all payments made, but it is the responsibility of the salaried GP to ensure that income from outside the organisation (e.g., out-of-hours or locum fees) is included – and they will often employ their own accountant to collate the amounts.

The payment made will need to be broken down carefully and shown in the GPs capital accounts. It is best not to overestimate NHS income as this may result in awkward overpayments. Normally, the organisation will need to make a balancing payment to PCSE where income has been underestimated.

The organisation is also required to submit a revised statement of superannuable NHS income and partnership shares estimate in February each year, which is effective from 6th April, and make any balancing payments for the previous year of employer and employee contributions and added years.

For further detailed information, see the [GP Pensions section](https://pcse.england.nhs.uk/services/gp-pensions/) of the PCSE website.

## Pay As You Earn (PAYE) payments

The Inland Revenue staff payment must be made by the 22nd working day of the next month, otherwise a fine may be levied. Most, if not all, accounts or payroll packages now have the facility for online submission of payroll data. Organisations are to confirm with HRMC if there will be different references required to match these PAYE payments. HMRC do not have a direct debit arrangement for income tax and National Insurance, and as the amount varies from month to month, a standing order is not appropriate. As such, individual monthly payments need to be made.

Further detailed information is available on the gov.uk website, [PAYE and Payroll for Employers](https://www.gov.uk/paye-for-employers) guidance and [Pay Employers’ PAYE](https://www.gov.uk/pay-paye-tax) guidance.

## Payroll

Company payroll software such as Iris GP Payroll will have several updates annually to take account of any tax changes and year-end processes. Using such payroll systems, the organisation will be able to regularly update the system online. If the organisation is not using a cloud-based system, at year end it is important to take a backup copy of the year’s accounts before undertaking the close-down for the year.

Pay increases will usually be agreed with the organisation Partners or senior management and should be added to the payroll system according to practice policy. Many organisations outsource their payroll to an agency or their accountants, so the preferred system that might vary widely. Annual increments need to be amended in the personal pay details of each employee.

Where payroll is outsourced, a monthly list of overtime, new starters, etc. is usually required to build the payroll, PAYE, payslips and other documentation that might be needed. You will need to have some system to get the payroll actioned at the bank and it is worth noting that organisations sometimes pay Partners through the payroll system while others set up monthly standing orders to pay drawings directly.

In all cases involving partnerships, however, the involvement of the practice accountants will be necessary in making pension and HMRC annual returns.

* **Salaries**

The pay rates that the organisation uses may be their own local rates or those adopted and tied to Agenda for Change. Annual pay rises will need to be advised to the payroll agency once agreed.

* **Additional hours and overtime**

Staff should be aware of the cut-off dates for submission of any approved additional hours or overtime. Additional hours and overtime will be paid at the agreed hourly rate. The usual full-time working week in the NHS is either 37.0 hours or 37.5 hours per week depending on the contract of employment. Organisations may use a different standard for the working week, but for pension purposes anything over 30 hours per week is considered full-time.

For further detailed information, see the organisation’s Time Off in Lieu and Overtime Policy.

* **Running the payroll**

The payroll should be run monthly. Prior to making payments to staff, it is important to remember whether any or all the following need to be considered:

* + Have any employees been off sick for more than three days?
  + Are any employees wishing to claim overtime or additional hours?
  + Have any employees started or are on maternity leave or paternity leave?
  + Are employees due for an annual increment?
  + Are all employees due for a cost-of-living increase?
  + Have any new staff been employed by the organisation?
  + Have any existing staff left or will be leaving during the month?
  + Have staff claimed expenses, e.g., travelling?
* **New employees**

For new employees, the organisation will need to have decided at the time of the job offer the number of hours to be worked per week, and the hourly rate of pay.

New staff should be asked whether they wish to join the NHS Pension Scheme and complete the appropriate joiner form or sign a SD502 form indicating that they do not wish to join the scheme.

The organisation should receive a P45 form from the previous employer with total pay and tax paid to date. The P45 contains the tax code to be used. Failing that, the new employee should complete and sign the [HMRC new starter checklist](https://www.gov.uk/government/publications/paye-starter-checklist) which should be used to notify a new starter to HMRC either via the payroll software or agency.An emergency tax code basic rate (BR1) should be used for the time being. In return, the organisation or agent will receive a form P6 electronically from HMRC which will set out the tax code to be used and will need to be actioned to affect the record.

Employees include the salaried GPs employed by the organisation.

Further detailed information is available from the HMRC webpage titled [Tell HMRC about a new employee](https://www.gov.uk/new-employee) and the [HMRC PAYE Manual](https://www.gov.uk/hmrc-internal-manuals/paye-manual).

* **Monthly staff payments**

Wages should always be paid on the date due and in the event of that date falling on a weekend or bank holiday date, on the first working day prior to the due date. The guidance from ACAS titled [Payslips](https://www.acas.org.uk/payslips) details what information is required to be included in a payslip.

Payslips will either be forwarded by the agency or otherwise produced by the payroll software for distribution prior to the pay date as will the P60s at year end.

* **P60s**

The P60 is a unique document that shows the tax the employee has paid on their salary between 6th April to 5th April. Employers must provide the P60 to every employee employed in the organisation by 31st May.

* **Statutory sick, maternity and paternity pay**

The payroll software should provide a process to ensure that payments of statutory sick and maternity pay are calculated, and to ensure that any periods of full pay and half pay are recorded correctly. It is also important that the periods of full pay and half pay tie in with the employee’s contract of employment.

Further detailed guidance is available from the following Government webpages:

* + [Statutory Sick Pay (SSP) employer guide](https://www.gov.uk/employers-sick-pay)
  + [Maternity pay and leave](https://www.gov.uk/maternity-pay-leave/pay)
  + [Paternity pay and leave](https://www.gov.uk/paternity-pay-leave)
* **Employer’s/organisational sick pay**

A member of staff may be entitled to a period of employer’s/organisational sick pay which is over and above any statutory sick pay. Payment of organisational sick pay is discretionary and subject to eligibility within the contract of employment and also any specified qualifying period.

Staff may also need to return to work for a specified period between episodes of sickness to claim contractual sick pay.

Employees who need to be absent from work due to sickness or injury must comply with the rules and notification requirements set out in the contract of employment and the organisation’s Sickness Absence Management Policy and Sickness Absence (Reporting Procedures) Policy.

Employees should understand that the organisation reserves the right to withhold statutory sick pay and/or organisation sick pay and/or take disciplinary action if:

* + They fail to comply with the organisation’s sickness policy and procedures
  + Their absence from work is unauthorised, or
  + The organisation has any reason to doubt the validity of the sickness or injury, or the reason given for their absence

Employees who have been absent due to sickness or injury and found not to have been genuinely ill will be subject to disciplinary action, which could result in dismissal. For further detailed information, see the organisation’s Sick Pay Policy.

* **Annual pay increments**

Annual increments are not compulsory unless contractually agreed. An annual pay increase may be given at the discretion of the Partners following consultation with the accountant at the year end. If a pay rise is agreed, then this uplift and back pay (if appropriate) will need to be reflected in the next payroll run, remembering to ensure that the uplift is applied to all relevant overtime and holiday payments.

Organisations who have adopted Agenda for Change in its entirety may find that they are obliged to uprate pay in accordance with national pay awards in the NHS.

* **Agreed expenses**
  + **Travelling expenses**

These are incurred by staff for attending meetings or training courses and are often reimbursed at the rate of 45p per mile. Staff should keep a record of journeys, miles travelled and addresses travelled to and from, and provide an expense claim form should the organisation have agreed to cover these costs.

For further detailed information on how to claim expenses, travel between main and branch surgeries, use of one’s own vehicle, meals/accommodation, expenses that will not be reimbursed and false claims, see the organisation’s Expenses Policy and Expenses Claim Form.

* **Deductions**
  + **Student loan deductions**

These deductions are made from staff salaries monthly when an instruction is received from the Inland Revenue to start deductions. Payroll software will calculate the deduction once the earnings level has been reached. These are statutory deductions. Similarly, the deductions should be stopped when an Inland Revenue instruction is received.

Further detailed information can be found on the HMRC webpage titled [Student and Postgraduate Loan Deduction Tables](https://www.gov.uk/government/publications/sl3-student-loan-deduction-tables/2020-to-2021-student-and-postgraduate-loan-deduction-tables).

* + **Attachment of earnings**

On rare occasions, the organisation may be asked by a court to recover a sum of money from employee earnings, known as Attachment of Earnings. This may be because of a court judgement where the employee is required to repay a debt or unpaid Council Tax by the court direct from their salary.

Such a request does not require the employee’s agreement. Otherwise, all other deductions, apart from PAYE, NIC and pensions contributions, require the written consent of the employee. Do not forget to pay the amount collected to the body requesting it or to the court.

Further detailed information can be found in the gov.uk [Make Debt Deductions from an Employee’s Pay](https://www.gov.uk/debt-deductions-from-employee-pay/getting-an-order) guidance.

* + **Staff leaving**

Full detailed information can be found on the gov.uk [What to do when an employee leaves](https://www.gov.uk/employee-leaving) webpage.

* **Payroll enquiries**

Occasionally the organisation, as an employer, is asked to respond to enquiries on behalf of staff from the Department of Work and Pensions and from mortgage companies. Information should be provided only with the agreement of the member of staff concerned.

* **Previous years’ payrolls**

It is particularly important to make a backup of the payroll. Saving to a cloud-based storage system is preferable, or if not viable, save to a shared or external drive. Doing so ensures that the payroll is saved elsewhere and can be used to reinstate the payroll as required.

## Pension management

Extensive guidance for [employers](https://www.nhsbsa.nhs.uk/employer-hub) and [employees](https://www.nhsbsa.nhs.uk/member-hub) is available on the NHS Pensions website and it is recommended that both organisations and employees refer to this.

NHSBSA can be contacted to discuss NHS pension schemes via the following:

* For employers, the NHS Pension Scheme website [Pensions Online](https://www.nhsbsa.nhs.uk/employer-hub/pensions-online) is now the main method of communication with NHSBSA
* For employees, the [NHSBSA webpage](https://www.nhsbsa.nhs.uk/member-hub/contact-nhs-pensions-members) details the following information

Should a staff member have retired and taken 1995 Section benefits and subsequently returned to work in the NHS prior to 1st April 2023, they are now eligible to join the 2015 Scheme.

Staff who are now eligible to join the 2015 Scheme must be advised that this organisation will not automatically enrol them into the scheme. The organisation will, however, notify staff that they are eligible to join the 2015 Scheme should they so wish.

It is the responsibility of the organisation to set up membership for any member of staff who wishes to join the 2015 Scheme.

If a staff member has an alternative pension arrangement and they have decided to end that pension (i.e., NEST) and join the 2015 Scheme, they may be eligible to transfer their accrued benefits from that pension into the 2015 Scheme. Staff are to be advised that there is a time frame of 12 months after becoming eligible to join the scheme to do so, and this must be completed before normal pension age.

Further information is available on the [transferring into the scheme webpage](https://www.nhsbsa.nhs.uk/member-hub/transferring-scheme) and the organisation’s Retire and Rejoin and Partial Retirement Guidance Document.

For all pension information, and detailed information to support pension questions for both employers and employees, refer to [The Pension Regulator](https://www.thepensionsregulator.gov.uk/) and [Money and Pensions Service](https://maps.org.uk/en).

## Petty cash

An [Imprest system](https://www.accountingtools.com/articles/what-is-the-imprest-system.html) is usually utilised to manage any petty cash used in the organisation. Cash income can be received for private work and cremation fees amongst others, such as Goods Vehicle Driver and Taxi Driver medicals. A careful record should be kept of all incoming cash. Organisations may have different ways of sharing private income among Partners. The cash income can be utilised to fund the petty cash used in the organisation, thereby avoiding bank charges when cashing cheques.

All petty cash that is topped up using the cash income needs to be added to the accounts as such.

It is vital that a dated receipt is obtained for all cash purposes and that a clear record is kept of the type of purchase made. Some purchases may simply be consumables and attributed to stationery or cleaning supplies, but other purchases might be assets such as a television or fridge. The receipt may also need to show the VAT element if the organisation is VAT registered. Otherwise, a voucher must be created giving details of the value of the payment made, the date of payment, and the type and nature of the purchase.

The voucher should be signed by the purchaser and a manager.

Cash can be insured via your contents insurance; however, the organisation should ensure that they comply with any terms imposed by their insurer, including the amount of cash that can be kept on-site and the methods and personnel used to transport the cash to the bank.

A safe should be provided in the organisation to secure cash and cheques prior to banking. Access to the safe should be restricted to senior staff and the Lead Partner. It should be noted that there has been a history in the UK of theft and fraud in general practice by organisation staff, as there has been in all environments where cash is handled routinely.

For further detailed guidance, see the organisation’s Financial Management and Procurement Policy.

## Private income

Private practice is significantly restricted in terms of NHS-registered patients for GMS (General Medical Services) and PMS (Personal Medical Services) contractors.

Part 5, Regulation 24 of the National Health Service (General Medical Services Contracts) Regulations 2015 (which are replicated in any PMS contract), sets out the basic exclusion in charging NHS patients for care.

It states:

* *The contract must contain terms relating to fees and charges, which have the same effect as those set out in paragraphs (2) to (4)*
* *The contractor must not, either itself or through any other person, demand or accept from any of its patients a fee or other remuneration for its own benefit or for the benefit of another person in respect of the provision of any treatment whether under the contract or otherwise, or a prescription or repeatable prescription for any drug, medicine, or appliance*

There are some very limited circumstances where a fee may be charged for services to an NHS-registered patient, which are set out in Regulation 25. Neither GMS or PMS contracts stop contractors accepting private patients for care, but they cannot simultaneously be NHS-registered patients with the practice holding the GMS or PMS contract under which they are cared for.

Updated contractual regulations, introduced in October 2019, restrict GP practices from offering or advertising, during NHS working time and on NHS-funded property, private services to anyone (whether a registered patient or not) if those services fall within the scope of primary medical services. This means that if a practice provides an NHS-commissioned service, they cannot then charge for (or host) that same service during hours when they provide those NHS services and on their practice premises.

This does not affect a practice’s ability to charge non-registered patients for services that are not part of primary medical services (i.e., not NHS-commissioned services) or to charge their own patients in the limited circumstances outlined above.

In addition to NHS income received for entering into a General/Personal Medical Services agreement with NHS E, an organisation can undertake a limited amount of private work which supplements the NHS income stream. It is worth noting that under NHS contracts, an organisation cannot provide private treatment to any registered patient apart from travel vaccinations, but this restriction does not extend to making private referrals which are permissible.

It is also important to be aware that travel advice is an NHS service so cannot be charged for (as are some vaccines used to protect travellers).

Specialist training for nurses and reference to [The Green Book](https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#part-2:-the-diseases,-vaccinations-and-vaccines) on vaccines will provide the latest advice in this area.

Private work includes:

* Heavy goods and public service vehicles medicals
* Life insurance reports and medicals
* DVLA reports
* Criminal Injuries Compensation Authority
* Applications for disabled parking badges, disabled bus passes, adoption, fostering, childminding, Disability Living Allowance
* Forms from patients claiming against insurance policies for sickness absences, accident claims, occupational health, pension applications, holiday cancellations

The organisation will receive multiple requests for reports. These include requests for expert witness reports for the courts and medical reports to support accident claims. The doctors also receive requests to report on patients where a power of attorney application is being lodged in court. Reports are also requested in children at risk cases.

The level set for private fees is normally reviewed in April each year, and organisations should take care that if they canvass what other organisations charge for private work it may give the appearance of price-fixing and result in an embarrassing prosecution.

For further detailed guidance, see the organisation’s Financial Management and Procurement Policy.

## Procurement

The organisation should always ensure that procurement activities are ethical and that they are:

* Processed in a transparent manner
* Conducted with integrity
* Sustainable
* Sufficiently protected to avoid fraud and substandard goods
* Void of any conflict of interest

The organisation’s management team should agree on financial thresholds; an example could be:

* Expenditure up to the value of £5,000; a minimum of two quotes are required
* Expenditure between £5,000 and £10,000; a minimum of three quotes are required
* Expenditure exceeding £10,000; a minimum of four quotes are required

All quotes must be provided in writing (email preferably) and retained for audit purposes.

For further detailed information, refer to the organisation’s Financial Management and Procurement Policy.

## Purchasing

The organisation may be part of a buying group or other collaborative where the purchasing of much essential equipment is carried out collectively. Alternatively, there may be local or national suppliers who are able to offer better terms, and this will be an organisation decision based invariably on a cost/quality assessment.

Organisations also have a need to purchase what are known as ‘ethicals’. These are items that are medical products such as drugs, vaccines, equipment and dressings. They may sometimes be directly purchased from the manufacturer or through specialist pharmaceutical wholesalers.

A picture containing text, clipart

Description automatically generatedThe Understanding Personally Administered Items (PPA Claims) eLearning course is available in the [HUB](https://hub.practiceindex.co.uk/). Furthermore, PPA Manager is part of the [Finance Package](https://practiceindex.co.uk/gp/solutions/hub/finance-package) which is also available in the [HUB](https://hub.practiceindex.co.uk/).

## Reimbursements

Reimbursement, depending on how the arrangements were set out with the NHS originally, can also cover business rates and water rates/charges. It is worth noting that reimbursement of rent payable to a private landlord could also cover cleaning and electricity and gas costs if it proved impossible to separate them out of the sum payable (shared premises with a single metering, for example).

Copies of the appropriate invoices should be sent to the NHS E Area Finance Team quarterly and, once authorised, they will be reimbursed back to the organisation in the GMS payment in the relevant month. CQC fees can also be claimed for reimbursement once paid.

When a salaried GP or GP Partner is absent due to parental leave (maternity, paternity or adoption), sickness leave or suspension, the organisation is eligible to receive funding towards the cost of cover for that doctor.

This is an outline of the reimbursement schemes, as set out in the [SFE (Statement of Financial Entitlements)](https://assets.publishing.service.gov.uk/media/66f6bde1e84ae1fd8592eabd/general-medical-services-statement-of-financial-entitlements-directions-2024.pdf):

* **Locum reimbursement for parental leave**

The GP must be on leave for longer than one week and must be entitled to parental (maternity, paternity and adoption) leave under statute, their contract of employment (in the case of salaried GPs), the partnership agreement or other agreement between the partnership (for GP Partners).

Cover for the absent GP can be provided either by an external locum or another GP already employed in the organisation. Under the SFE, organisations are eligible to reclaim a fee. The details are as given in Part 4, Page 26.

* **Locum reimbursement for sickness leave**

The GP must be absent for more than two weeks before reimbursement costs will be paid. The only requirement is that the absent GP provides a fit note. The full details can be found in the SFE, Part 4, Page 28.

* **Payments for locums covering suspended doctors**

Organisations are entitled to be reimbursed for locum cover that applied to a suspended doctor. The rules and requirements to support this are detailed in the SFE, Part 4, page 31.

* **Other considerations**
* **Claiming for a part-time GP**: Payments in respect of locum cover for sickness or parental leave will not be pro-rated. The organisation will be paid at the invoiced cost, and up to a maximum of £1,751.52 (£1,143.06 for the first two weeks of parental leave).
* **Locum insurance:** Organisations should be aware that the current maximum weekly payment may not fully cover the cost of a locum and the amount of time they are needed, particularly if they are replacing a full-time GP. The BMA recommends that practices review their current cover and consider maintaining a level that will allow them to top up the national payments based on their individual circumstances.

## Rent abatements

From time to time, an organisation may receive additional grant funding to refurbish and/or extend its premises, normally (but not exclusively) where it owns its building. Where this is the case, it would be unfair for the organisation to receive immediate additional notional rent in respect of the additional space, so an ‘abatement’ (delay) is applied.

The abatement periods contained within the current directions are:

|  |  |
| --- | --- |
| **Value of works (ex VAT)** | **Abatement period** |
| Up to £100,000 | 5 years |
| £100,000 to £250,000 | 10 years |
| Over £250,000 | 15 years |

It should be noted that the abatement period is driven by the overall value of the works (ex VAT) and not the value of the grant. For this reason, in some cases, it may be more beneficial (for the organisation) to fund all the works and to decline a grant.

This is a matter upon which the organisation may wish to seek, at its own expense, professional advice in advance of entering into a grant agreement. Once an abatement period ends, the commissioner is responsible for the payment of the full CMR value of any additional space created by the capital works.

Further reading on rent abatements in GP practices can be found in this GP Surveyors blog titled [GP practice rent abatements explained](https://www.gpsurveyors.co.uk/gp-practice-rent-abatements-all-you-need-to-know/).

## Rent reimbursement and review

Organisations are eligible for rent reimbursements with different terms depending on whether they own the premises or not, as detailed in the BMA guidance titled [Rent reimbursement for GP practices](https://www.bma.org.uk/advice-and-support/gp-practices/gp-premises/rent-reimbursement-for-gp-practices).

[NHS (General Medical Services – Premises Costs) Directions](https://www.gov.uk/government/publications/nhs-general-medical-services-premises-costs-directions) further explain the areas that should be considered for any organisation’s rent and how this should be calculated:

* Premises owned outright by the Partners is known as notional rent

For notional rent, refer to NHS (General Medical Services – Premises Costs) Directions, Part 5, Recurring Premises Costs, Directive 42 (page 24)

* If there is a mortgage, this is cost rent or borrowing cost reimbursements

For cost rent, refer to NHS (General Medical Services – Premises Costs) Directions, Part 5, Payments in respect of running costs, Directive 47 (page 27)

* If the Partners are tenants in the property, they receive leasehold cost reimbursements

For leasehold rent reimbursement, refer to NHS (General Medical Services – Premises Costs) Directions, Part 5, Abatements in respect of contribution towards recurring premises costs from third parties, Directive 49 (page 28)

Further information is available from the [BMA Guidance – Rent Reimbursement for GP Practices](https://www.bma.org.uk/advice-and-support/gp-practices/gp-premises/rent-reimbursement-for-gp-practices).

## Seniority

Seniority payments have been phased out and the scheme ended completely on 31st March 2020. Only GP Partners who previously qualified remained in receipt of these payments, which are subject to an annual reduction. However, due to the delays at PCSE in undertaking these calculations, some practices are still seeing payments being reflected in their income statements.

These payments were calculated on a doctor’s NHS Reckonable Service and were included in the organisation’s quarter-end payment in June, September, December and March. The doctor’s annual estimated income was used to calculate whether they qualified for payments in full, whether they got these payments abated by 60% or if they did not qualify for payments at all.

Further reading can be found in the NHS E / PCSE document titled [Seniority Payments](https://pcse.england.nhs.uk/help/gp-payments/seniority-payments#:~:text=What%20is%20the%20current%20situation,subject%20to%20an%20annual%20reduction.) and the BMA’s guidance titled [PCSE Seniority Payments Reconciliation Exercise 2023](https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/pcse-primary-care-support-england-seniority-payments-reconciliation-exercise-2023).

## Service charges/subletting organisation space

Generally, if the organisation is receiving rent from subletting, then it would be reasonable for the notional rent to be abated. However, if any room is being used to provide services that are supporting the delivery of primary care, this would not be the case, though it is a bit of a grey area!

The NHS funds GP premises costs under the terms of their GMS contract. Locally, these terms are equally applied to PMS contracts and some APMS contracts where GMS services are commissioned. The contract provides for recurrent premises costs to be reimbursed to contractors, all of which are detailed in the [NHS (General Medical Services – Premises Costs) Directions](https://www.gov.uk/government/publications/nhs-general-medical-services-premises-costs-directions).

The commissioning of services by ICBs means that additional services can often be hosted in GP surgeries. This leads to questions regarding the premises payments linked to these arrangements.

In brief:

* There is an expectation that the floor area approved for reimbursement under the Directions is used for the delivery of GMS services
* Where there is the hosting of ad hoc sessions of other primary/secondary/community care services, this can generally be accepted without the need for adjustment to the premises costs. However, where the hosting arrangements see the hosted service(s) occupy space within a surgery effectively full-time (8-10 sessions per week), then the NHS reserves the right to abate the premises payments made to contractors.

Questions are often raised in terms of what premises costs can be passed to these tenants:

* There is an expectation that a formal agreement will be in place between the organisation and any other service provider/tenant. This agreement will lay down the terms of occupancy, to include the space occupied, length of agreement, notice period and any costs that may be related to that space. Both parties will agree and sign the document, each holding a copy. A further copy will be passed to the commissioner.
* Where the NHS funds organisation premises costs in full (100%), to include current market rent (notional, actual or cost rent), business rates, water charges and clinical waste, the contractor may not seek to cover those costs a second time through direct invoicing to that tenant.
* A GP contractor is entitled to a triennial current market rent review under the Directions. The CMR assessment considers the tenant’s liabilities. This will typically include internal maintenance and decoration (and, in many cases, external maintenance and decoration), insurance and other general maintenance items. Where covered by the commissioner, these cannot be recharged.

This CMR assessment is subject to triennial reviews under the terms of the NHS (General Medical Services – Premises Costs) Directions, Part 5, Directive 34 (page 21).

* Where the NHS funds organisation premises costs only in part, agreement needs to be sought from the commissioner to ensure that the area supported by the NHS can de delineated on a floor plan, with the area excluded from support clearly defined. Agreement for direct charges to be levied against that area can then be offered by NHS E.
* There is an expectation that any charges made are reasonable. This will mean that rental charges (where properly incurred) are in line with the CMR assessment for the property and that utility and service costs are valid and can be supported with evidence. Such charges may include cleaning, consumables, telephony and, in some instances, reception and admin support where this is directly offered by the organisation.
* Often the simplest way to determine charges is to take the full-year liability/cost for each element (where it can be charged) and pro-rate that cost according to the space/time occupied. Given the vast variation in the type of buildings, age and current market rent assessments, it is not possible to determine an average rent or an average utility cost either.

The NHS will look to support such hosting arrangements; however, it must be clear that this must not be to the detriment of the delivery of GMS contracted services. GPs are commissioned to deliver their core contracted and enhanced services, and the premises costs awarded are to deliver those services.

Where it is possible to host additional primary/secondary/community-based clinics, this must be reasonable and not require the need for additional investment/extensions to organisation premises, or force organisations to relocate to support hosting arrangements.

* **Calculation of service charge**

The service charge may be calculated by apportioning the internal floor area occupied by the third-party users of the surgery set against the running expenses of the surgery. This charge needs to be reviewed annually. The calculation should include depreciation, cleaning and security costs, light and heating, and use of equipment including telephones and photocopiers.

It also needs to reflect surgery insurances and an element of staff costs to administer the arrangements and provide reception facilities.

* **Other third-party users**

Any other users would be charged per session depending on the length of time a room is used. Other users might include, for instance, dementia workers and mental health workers.

The organisation may also offer accommodation free of charge to a variety of others including the midwife, health visitor and others, should the Partners feel that it affords a patient benefit and are prepared to accept the cost.

* **Review of service charges**

From time to time, the organisation will need to review to whom a service charge is levied. VAT should be added to any invoice for service charges if the organisation is VAT registered.

Further information is available from the [NHS General Practice Premises Policy Review](https://www.england.nhs.uk/wp-content/uploads/2019/06/general-practice-premises-policy-review.pdf) document and BMA guidance titled [Rent reimbursement for GP practices](https://www.bma.org.uk/advice-and-support/gp-practices/gp-premises/rent-reimbursement-for-gp-practices).

## VAT

A standard, non-dispensing GP organisation is generally not registered for VAT because the taxable turnover tends to be under the VAT registration threshold of £85,000 per annum. This is because core contract and enhanced services income from NHS E is covered under the medical exemption for VAT.

* **VAT allowance**

NHS GPs are paid the cost of supplying the drugs and appliances that they both personally administer and dispense on behalf of the NHS. Until April 2006, this included an amount to cover the VAT incurred (the VAT allowance) unless the GP was registered for VAT. The VAT allowance was paid regardless of whether the drugs and appliances were used in making taxable or exempt supplies.

From 1st April 2006, the rules for paying the VAT allowance to doctors in England changed. Since that date, the NHS only pays a VAT allowance for drugs that are classified as being for personal administration. This change in the Department of Health’s rules on remuneration has prompted many dispensing GPs to register for VAT as they now have no other means of recovering the VAT incurred on drugs purchased for dispensing.

* **VAT registration**

A medical partnership or other NHS provider organisation may form a registered company and register for VAT purposes in relation to a building project or may need to register based on their income (as defined) being in excess of the VAT threshold – mainly relating to dispensing organisations or organisations with large private income streams. This may require complex negotiations with HM Customs.

* **Input and output tax**

Because doctors usually provide services which attract varying VAT treatment, an organisation will be required to attribute VAT incurred on expenditure (input tax) to each of these categories. Only VAT incurred in respect of zero-rated and standard-rated services may be recovered.

In addition, there will always be input tax which is not attributable to any specific service and is “overhead”, e.g., property costs, professional fees and telephones. There is a set way in which the recoverable portion of this VAT is calculated. VAT-registered entities which make both taxable and exempt supplies are deemed “partly exempt” and must carry out calculations on every VAT return.

Once the calculations described above have been carried out, the resultant amount of input tax which relates to exempt supplies is compared to the de-minimis limits (broadly £625.00 per month VAT and not more than 50% of all input tax). If the figure is below these limits, all VAT incurred is recoverable regardless of what activities the organisation is involved in.

The organisation can claim a refund of VAT paid on purchases and supplies relating to any premises development project. In effect, this includes all the building costs and the cost of professional fees to the architect, structural engineers, quantity surveyors and other advisers. The organisation must also declare any VAT added to rent and service charges levied on third-party users of accommodation in the new surgery development. The invoices must be clearly addressed to the ‘development project’.

Further detailed guidance on how to account for VAT on goods and services provided by registered health professionals is available from the HMRC guidance titled [Health professionals and pharmaceutical products (VAT Notice 701/57)](https://www.gov.uk/guidance/health-professionals-pharmaceutical-products-and-vat-notice-70157).

* **Refund of VAT**

Organisations will be able to reclaim VAT charged on purchases and other expenditure subject to partial exemption rules.

Further detailed guidance about partial exemptions and the methods and calculations that can be used to see how much input tax can be recovered is available on the HMRC webpage titled [Partial Exemption (VAT Notice 706)](https://www.gov.uk/guidance/partial-exemption-vat-notice-706).

* **VAT returns**

The organisation is required to make a monthly or quarterly return to HM Customs setting out the total value of purchases and the refund amount requested. Failure to do so may lead to a fine being imposed.

The VAT return schedule is:

|  |  |  |
| --- | --- | --- |
| **Month to go to HMRC** | **Month PA drugs** | **When to send** |
| April | April | End May |
| May | May | End June |
| June | June | End July |
| July | July | End August |
| August | August | End September |
| September | September | End October |
| October | October | End November |
| November | November | End December |
| December | December | End January |
| January | January | End February |
| February | February | End March |
| March | March | End April |

For further detailed information, refer to the HMRC guidance titled [Sending a VAT Return](https://www.gov.uk/submit-vat-return).

# Information governance

Information governance (IG) supports the provision of high-quality care through the

effective and appropriate use of information. It provides a set of rules with which the organisation must comply to maintain comprehensive and accurate records and includes keeping those records confidential and secure.

Information governance starts with looking at how information is collected, how it is recorded (on paper and computers), how it is then stored, how it is used (whether for audit, research or performance management) and then on what basis it is shared with others, both inside and outside the organisation.

The principles of information governance incorporate several important policies or frameworks for using information, as required by the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) which incorporates the [UK General Data Protection Regulation (UK GDPR)](https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/) at Part 2, the [NHS England Data Protection and Security Toolkit](https://www.dsptoolkit.nhs.uk/) and elements of the International Standard for Information Security Management Systems – ISO27001.

IG provides a unified approach for handling information, which complies with the law and outlines best practice.

Information governance eLearning is available in the [HUB](https://hub.practiceindex.co.uk/) incorporating:

* Accessible Information Standards
* Caldicott and Confidentiality
* Information Governance and Data Security
* General Data Protection Regulation (UK GDPR)

## Access to medical records

In accordance with the UK GDPR, individuals have the right to access their data and any supplementary information held by an organisation. This is commonly known as a data subject access request (DSAR). Data subjects have a right to receive:

* Confirmation that their data is being processed
* Access to their personal data
* Access to any other supplementary information held about them

The Access to Medical Records Policy outlines the procedure to access health records at the organisation as follows:

* For an individual, for information about themselves
* For access to the health records of a deceased individual (refer to [Section 5.16](#_Deceased_patients’_records))
* For access to the health records of an individual by an authorised person (by a court) when the individual does not have the capacity to make such a decision
* For organisations requesting information about an individual for employment or insurance purposes as governed by the [Access to Medical Reports Act 1988](http://www.legislation.gov.uk/ukpga/1988/28/contents)

There are occasions when a GP may firmly believe that it is not appropriate to share all the information contained in the individual’s record, particularly if there is potential for such information to cause harm or distress to individuals or when the record contains information relating to a third party.

Patients may request paper copies of health records and, regardless of the preferred method of access, patients and authorised third parties must initially complete a DSAR form. Requests may be received from the following, with detailed information being found in the Access to Medical Records Policy:

* Competent patients
* Children and young people
* Parents
* Individuals with a responsibility for adults who lack capacity
* Next of kin
* Police
* Court representatives
* Patient representatives and solicitors
* Insurance requests

The ICO refers to the use of DSARs to obtain medical information for insurance purposes as an abuse of access rights, and the processing of full medical records by insurance companies risks being in breach of the UK GDPR. Therefore, the patient should be contacted to explain the extent of disclosure sought by the third party. The organisation can then provide the patient with the medical record as opposed to the insurer. The patient is then given the opportunity to review their record and decide whether they are content to share the information with the insurance company.

Insurers should be advised to use the [Access to Medical Reports Act 1988](https://www.legislation.gov.uk/ukpga/1988/28/contents) when requesting a GP report and an appropriate fee should be charged.

In the case of anythird-party requests, the organisation must ensure that the patient has consented to the disclosure of this information by means of a valid signature of the patient.

In accordance with the UK GDPR, patients are entitled to receive a response within the maximum given time frame of one calendar month from the date of submission of the DSAR. To ensure full compliance regarding DSARs, this organisation will adhere to the guidance provided in the UK GDPR. In the case of complex or multiple requests, the data controller may extend the response time by a period of two months. In such instances, the applicant must be informed in the first month and the reasons for the extension given.

Should the request involve a large amount of information, the data controller will ask the data subject to specify what data they require before responding to the request. The organisation can only refuse a DSAR if an exemption or restriction applies, or if the request is manifestly unfounded or excessive. Should a DSAR be refused, then a letter detailing the reasons is to be provided.

A template can be found in Annex I of the Access to Medical Records Policy.

Further reading can be found in the BMA document titled [Access to health records](https://www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/access-to-health-records) and the ICO guidance titled [How to deal with a request for information: a step-by-step guide](https://ico.org.uk/for-organisations/advice-for-small-organisations/how-to-deal-with-a-request-for-information-a-step-by-step-guide/) and their [Guide to subject access](https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/subject-access-requests/a-guide-to-subject-access).

## Access to online services

Patient Online was designed to support GP organisations offering and promoting an online service to their patient population. The service is referred to as [GP online services](https://www.england.nhs.uk/gp-online-services/about-the-prog/) and is offered to patients in addition to telephone and face-to-face interactions at GP organisations.

As of 31st October 2023, all patients should have been granted online access to their full record, including the ability to add their own information, with new registrants of an organisation having full online access to the digital record for their prospective information starting from the date of their registration for online services. The NHS E document titled [Online access to GP health records](https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/guidance-on-nhs-app-features/online-access-to-gp-health-records) details how patients with online accounts such as the NHS App will be able to read new entries, including free text, in their health record.

This change only applies to future (prospective) record entries and not historical data.

The organisation’s Access to Medical Records Policy provides detailed procedures on this subject; furthermore, the Consent Guidance should be consulted for support if the request requires consent.

## Breach and incident reporting

Any breach that is likely to have an adverse effect on an individual’s rights or freedoms must be reported. In order to determine the need to inform the ICO, to notify them of a breach, the data controller is to read the guidance titled [Incident reporting](https://ico.org.uk/for-organisations/the-guide-to-nis/incident-reporting/).

The organisation will investigate and manage information incidents and provide staff with guidelines to identify and report information incidents, including near misses, and should be read in conjunction with the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) and UK GDPR as Chapter 4 details the requirements for breach reporting.

When a breach is identified and it is necessary to report it, the breach must be reported without undue delay or within 72 hours of the breach being identified. For full guidance, refer to the organisation’s Information Governance Breach Reporting Policy.

For additional information, refer to the organisation’s UK GDPR Policy and Data Security and Protection Toolkit Handbook.

## Caldicott Guardian

All staff are to understand the need for effective controls of personal confidential data (formerly known as patient identifiable information). Compliance will be monitored through the DSPT return that is derived by audits. Furthermore, annual eLearning is a requirement to be undertaken by all staff.

Reading on the Caldicott can be found in the following:

* [Information Governance Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf)
* [A Manual for Caldicott Guardians](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/581213/cgmanual.pdf)

The organisation’s Confidentiality and Data Protection Handbook, Data Security and Protection Toolkit Handbook, Caldicott and Confidentiality Policy, and Employee Handbook all provide guidance on this subject.

## Clear desk, clear screen routines and confidential waste

All staff working in the NHS are bound by a legal duty of confidence to protect personal information they may encounter during the course of their work. As such, all staff are personally accountable for the security of data that is accessed, or that within their possession. This is not purely a requirement of their contractual responsibilities; it is also a requirement within the common law duty of confidence and the NHS Care Record Guarantee.

The latter is produced to assure patients about the use of their information.

Should the personal data you access or have in your possession become lost, stolen or compromised, it will constitute a breach of the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents). To maintain confidentiality, staff cannot leave any confidential information that could result in a breach on their desk overnight. This includes logging out of PCs, strict password control, contents within an in-tray, handwritten notebook pages, the contents of the disposal waste bin and any Post-It notes, all of which often contain confidential data.

Regular audits are conducted by the management team, and anything considered a breach may result in disciplinary action.

All staff are to adhere to the principles of confidentiality as outlined in the DHSC [Confidentiality: NHS Code of Practice](https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice) and [NHS E Confidentiality Policy](https://www.england.nhs.uk/wp-content/uploads/2019/10/confidentiality-policy-v5.1.pdf).

For further detailed information, see the organisation’s

* Clear Desk and Clear Screen Policy
* Confidential Waste Policy
* Employee Handbook

## Clinical photography

Audio-visual recording is a common and useful tool in primary care. While it can be used for training purposes, it has become more commonplace for clinicians to use this as an alternative to face-to-face consultations. It is essential that staff adhere to guidance to ensure that the procedure is effective and compliant with extant legislation.

Clinicians must be confident of their ability to capture images safely, and to store and transfer images securely. They must also be able to delete images or recordings when transfer has taken place or when the images/recordings are no longer to be used.

Further reading can be found in the organisation’s Audio, Visual and Photography Policy to support:

* The need for traditional uses of clinical imagery within primary care, such as training
* The guidance on the increased reliance on audio-visual technological software that is used to support or provide consultations, be it within the organisation or at home

Further reading can be sought in CQC [GP mythbuster 100: Online and video consultations and receiving, storing and handling intimate images](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-100-online-video-consultations-receiving-storing-handling).

## Closed-Circuit Television (CCTV) monitoring

CCTV systems are valuable tools that enhance the safety, security and wellbeing of services, staff and patients and are an increasingly common sight in GP practices. This organisations CCTV system has been installed and is used in accordance with extant legislation:

* [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted)
* [Surveillance Camera Code of Practice 2013](https://www.gov.uk/government/publications/update-to-surveillance-camera-code/amended-surveillance-camera-code-of-practice-accessible-version) (Amended 2021)

The Surveillance Camera Code of Practice details the guiding principles that strike a balance between protecting the public and upholding civil liberties. A proportionate approach is used to inform retention periods. However, images and information acquired from the surveillance system should not be kept for longer than is necessary. There may, however, be occasions when it is necessary to retain images for a longer period, e.g., when a crime is being investigated.

For further detailed information, see the organisation’s CCTV Monitoring Policy.

## Communication

Communication may be between clinicians, clinician and patient, clinician and non-clinical staff, non-clinical staff and patient. All staff must be effective communicators as they play a key role in providing information to patients, carers, colleagues and external stakeholders. It is therefore pivotal that information is relayed in the most appropriate and timely manner to ensure the safe and effective care of patients and to enable the organisation to function efficiently and effectively.

For correspondence, all staff who are expected to undertake this role, and/or conduct clinical coding, must be trained appropriately. Training should ensure that individuals understand their additional responsibilities and the requirement to adhere to information governance guidance and protocols.

Patients may actively and consistently use email or SMS text messaging as their preferred method of communication. Therefore, is imperative that the patient confirms both email address and mobile telephone number to enable this organisation to verify the accuracy of the information held. While it is the responsibility of the patient to ensure that they provide up-to-date contact details, we will often confirm these details either when the patient is in attendance or when they are contacting the practice.

As consent is not used as a legal basis for data processing, messages are therefore sent on an ‘opt-out’ basis. If a patient informs this organisation that they do not wish to receive text messages, a member of staff must update their ‘notification preferences’ in the clinical system.

Patients will be reminded that the organisation is not responsible for the protection of the information once it has been received by the patient. It is also to be recommended to the patient that they do not use a shared email address for the purpose of communicating so that confidential information will not be seen by family members. Furthermore, and specific to emails, patients are to be advised that internet email accounts are not secure and that there is a risk of their email being hacked.

Patient circumstances can change over time and these preferences should be actively maintained. The fourth Data Protection Principle adopted into UK law states that all personal data processed shall be accurate and, where necessary, kept up to date. This is commonly referred to as the accuracy principle.

Only appropriate matters will be dealt with using email and the following is suggested as being acceptable:

* Appointments
* Repeat prescription queries
* Requesting test results
* Requesting copies of medical records
* Emails containing images of a clinical condition

Requests for complex information about medical conditions or symptoms are not appropriate for email communication. Instead, the organisation will telephone the patient to ask them to make an appointment to discuss the matter with an appropriate member of the clinical team.

Additional information can be found in NHS Digital [Guidance for sending secure email (including to patients)](https://digital.nhs.uk/services/nhsmail/guidance-for-sending-secure-email).

Further detailed information about all forms of media that may be used in communicating with, or receiving from, a patient can be found in the Communication Policy. Detail to support social media can be found in [Section 5.26](#_Intranet_and_social) for staff and [Section 5.29](#_Patient_social_media) for patients.

For additional information to support this subject, refer to the organisation’s:

* Correspondence Management Policy
* Managing Incoming Pathology Results

## Confidentiality

Confidentiality is the basis of trust between the patient and the organisation. All staff working in the NHS are bound by a legal duty of confidence to protect any personal information they may encounter during the course of their work.

This is not purely a requirement of staff’s contractual responsibilities; it is also a requirement within the common law duty of confidence and the NHS Care Record Guarantee. The latter is produced to assure patients about the use of their information.

All staff are to adhere to the principles of confidentiality as outlined in the DHSC’s [Confidentiality: NHS Code of Practice](https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice) and the [NHS E Confidentiality Policy](https://www.england.nhs.uk/wp-content/uploads/2019/10/confidentiality-policy-v5.1.pdf).

For further detailed information, refer to the organisation’s:

* Confidentiality and Data Protection Handbook
* Data Security and Protection Toolkit Handbook
* Employee Handbook
* Caldicott and Confidentiality Policy

## Cookies

Cookies are generally small text files, given ID tags, which are stored on a computer’s browser directory or programme data subfolders. Cookies are created when a user visits a website that uses cookies to:

* Keep track of their movements within the site
* Help users to resume where they left off
* Remember their registered login
* Theme selection
* Preferences
* Other customisation functions

There are many types of cookies and the following information has been obtained from both [About cookies](https://aboutcookies.org.uk/cookie-types) and [Age UK](https://www.ageuk.org.uk/help/cookies/).

The overarching legislation is the Privacy and Electronic Communications Regulations (PECR). This covers the use of cookies for accessing and storing information on a user’s equipment or mobile device. [Regulation 6](https://www.legislation.gov.uk/uksi/2003/2426/regulation/6/made) of the PECR, which details the confidentiality of communications, decrees that users must provide clear and comprehensive information about the purposes of the storage of or access to that information and are given the opportunity to refuse the storage of or access to that information.

The PECR can refuse the storage of or access to any information.

To comply with the information requirements of the PECR, organisations need to make sure users will see clear information about cookies. In any case, doing so will increase levels of user awareness and control, and also assist in gaining valid consent.

To ensure that users are aware that the organisational website uses cookies and their subsequent information, the ICO advises on the importance of the location of this within the website. Valid consent needs to be specific, informed and freely given, allowing the reader to fully understand that they are giving consent, and this should be confirmed by requesting a positive action, such as by ticking a box or selecting a link.

Consent must be separate from other matters and cannot be bundled into terms and conditions or privacy notices.

In cases where organisations refuse or fail to comply voluntarily, the ICO has a range of options available for taking formal action when this is necessary.

Whilst the UK GDPR gives the ICO enhanced powers, the enforcement regime for PECR remains that which was in effect under the previous Data Protection Act – that is, except where personal data is processed. Where formal action is considered, such as an organisation refusing to take steps to comply, or it has been involved in a particularly privacy-intrusive use of cookies without advising the user or obtaining any consent, the use of formal regulatory powers would be considered in accordance with the [ICO Regulatory Action Policy](https://ico.org.uk/media/about-the-ico/documents/2259467/regulatory-action-policy.pdf).

For further detailed information, see the organisation’s Cookie Policy.

## Cyber resilience

It is inevitable that the organisation will at some point be affected by an incident that is out of its control. Such incidents will require effective, timely management if the expected level of service is to be provided to the entitled patient population. Ensuring that staff understand the potential impact and exercising the scenarios with staff will enable the team to manage situations effectively and minimise the disruption until normal services are resumed.

For further information, refer to the organisation’s Cyber Resilience Policy, Data Security and Protection Toolkit Handbook, and Business Continuity Policy.

## Data mapping

Data mapping is a means of determining the information flow throughout an organisation. Understanding the why, who, what, when and where of the information pathway will enable the organisation to undertake a thorough assessment of the risks associated with current data processes.

Effective data mapping will identify what data is being processed, the format of the data, how it is being transferred, if the data is being shared and where it is stored (including off-site storage, if applicable).

Data mapping is linked to the Data Protection Impact Assessment (DPIA) and when the risk analysis element of the DPIA process is undertaken, the information ascertained during the mapping process can be used. Data mapping is not a one-person task. All staff will be involved in the mapping process thus enabling the wider gathering of accurate information.

For further detailed information, refer to the organisation’s UK GDPR Policy.

## Data Protection Impact Assessments (DPIAs)

The DPIA is the most efficient way for the organisation to meet its data protection obligations and the expectations of its data subjects. DPIAs are also commonly referred to as Privacy Impact Assessments or PIAs.

In accordance with [Article 35](https://gdpr-info.eu/art-35-gdpr/) of the UK GDPR, a DPIA should be undertaken where:

* A type of processing, using new technologies, and considering the nature, scope, context and purposes of the processing, is likely to result in a high risk to the rights and freedoms of natural persons. The controller shall then, prior to the processing, carry out an assessment of the impact of the envisaged processing operations on the protection of personal data. A single assessment may address a set of similar processing operations that present similar high risks
* Extensive processing activities are undertaken, including large-scale processing of personal and/or special data

The DPIA process is formed of the following key stages:

* Determining the need
* Assessing the risks associated with the process
* Identifying potential risks and feasible options to reduce the risk(s)
* Recording the DPIA
* Maintaining compliance and undertaking regular reviews

For further detailed information, see the organisation’s UK GDPR Policy.

## Data Security and Protection Toolkit (DSPT)

The preservation of data and information security are crucial to maintaining the trust of the entitled patient population. All staff have a duty to ensure they handle information correctly and safely, in accordance with extant guidance and in line with the data security standards.

The [Data Security and Protection Toolkit](https://www.dsptoolkit.nhs.uk/) is a mandatory online self-assessment tool that allows organisations to measure their performance against the National Data Guardian’s data security standards.

The organisation is required to complete an annual assessment to provide assurance that data security is of a good standard and patient data and information are handled in line with the standards. Assessments are ordinarily submitted by 30th June annually.

For further detailed information, including the annual assertions, refer to the Data Security and Protection Toolkit Handbook.

## Data quality

It is the responsibility of all staff at the organisation to ensure that service delivery and patient care are of the highest standards. This will be achieved through an organised approach to quality assurance which involves all staff. Producing robust data is an integral part of operational performance management and governance arrangements.

The organisation recognises that there are several key characteristics of good quality data. Data should be:

The organisation’s corporate objectives for data quality define a framework of management arrangements that will assure Partners and other stakeholders that the quality of data is reliable and sustainable.

The organisation is committed to collecting and processing data according to national or, where these are not available, locally defined standards.

A formal set of quality requirements will be applied to all data that is used, shared externally or provided by a third-party organisation. Achieving these standards will satisfy the organisation and its stakeholders that the data is sound and that it can be used with confidence.

For further detailed information, refer to the following organisational policies:

* Quality Improvement and Clinical Audit Policy
* UK GDPR Policy
* Caldicott and Confidentiality Policy
* Cyber Resilience Policy
* Employee Handbook

## Deceased patients’ records access

Deceased patients retain the right of confidentiality. There are several considerations to be taken into account prior to disclosing the health record of a deceased patient. Such considerations are detailed in the [Access to Health Records Act 1990](https://www.legislation.gov.uk/ukpga/1990/23/contents).

Under the terms of this Act, the organisation will only grant access to either:

* A personal representative (executor of the deceased person’s estate), or
* Someone who has a claim resulting from the death

Access to a deceased person’s health records may not be granted if a patient requested confidentiality whilst they were alive. No information can be revealed if the patient requested non-disclosure in accordance with the [Access to Health Records Act 1990, Chapter 23, 4(3)](https://www.legislation.gov.uk/ukpga/1990/23/pdfs/ukpga_19900023_en.pdf). Disclosure may also not take place if there is a risk of serious harm to an individual, or if records contain information relating to another person as per [Chapter 23, 5(1)(a)](https://www.legislation.gov.uk/ukpga/1990/23/pdfs/ukpga_19900023_en.pdf).

Since the 2022/23 GP contract, practices are no longer required to print and send copies of the electronic record of deceased patients to PCSE. Consequently, requests for patients’ medical records via the Access to Health Records Act (AHRA) now lie with the organisation.

GP records of deceased patients are retained for ten years, after which time they will be destroyed as detailed in the organisation’s Records Retention Schedule.

Further detailed information is available in:

* Medical Protection Society article titled [Medical records – An essential guide](https://www.medicalprotection.org/uk/guides/medical-records)
* PCSE guidance titled [Deductions, amendments and rejections](https://pcse.england.nhs.uk/help/patient-registrations/deductions-amendments-and-rejections#faq824)
* The organisation’s Access to Deceased Patients’ Records Policy

## Disclosure and sharing of information

When there is a requirement to share information for the purpose of providing direct care, it is crucial that the data subject is fully aware of how their information may be shared and who it will be accessed by. Where applicable, information sharing agreements must be in place and adhered to so as to prevent data breaches. For further reading on both disclosure and non-disclosure, refer to the Access to Medical Records Policy.

When there is a requirement to share information, it is essential that the information being shared is protected and only disclosed to the intended recipient(s). Failure to adhere to the terms of the agreement could result in a data breach, the consequences of which could be of detriment to both the organisation and the data subject(s). For further information, refer to the organisation’s Information Sharing Agreement.

## Electronic transfer of and access to the healthcare record

It is vital that organisations offer an array of services to patients to keep up with the demand for greater efficiency and, of course, for improved healthcare.

To support this, systems such as GP online services, GP2GP and Summary Care Records (SCRs) are detailed in the organisation’s policy on Electronic Transfer of and Access to the Healthcare Record.

## Email and internet usage

All staff will be given an NHS email address upon joining, which is for the use of practice business only. NHS emails should not be used for personal use, nor should the content of any email bring this organisation into disrepute.

Furthermore, all staff will have access to the internet, shared network drives and the intranet to enable them to perform their duties. The use of the internet facility by staff is permitted; however, it is only authorised during official breaks or when it is necessary to complete a specific task or when approved by line managers.

Staff are reminded that they are not permitted to use the internet for any of the following purposes:

* Pornography
* Gambling
* Promotion of terrorism and/or terrorism skills
* Cult-promoting websites
* Any other website that may reasonably bring the organisation into disrepute, such as those that are likely to cause offence

To support this, remote access from CSU, the Information Governance Lead or Practice Manager all have the right to scrutinise the internet browsing history of staff members and, if it is found that staff are using the organisation’s IT facilities for such activities, disciplinary action will be taken. This may include involving the local police depending on the nature and source of the information.

For further detailed information, see the organisation’s Communication Policy.

## Freedom of Information (FOI) Act

The organisation has an obligation to make sure it adheres to the principles of the Act, ensuring right of access to information held at the organisation. In doing so, the organisation is demonstrating that it is operating in an open and transparent manner and complying with the provisions of the [Freedom of Information Act 2000](https://www.legislation.gov.uk/ukpga/2000/36/contents).

For further detailed information, see the ICO’s [What is the Freedom of Information Act?](https://ico.org.uk/for-organisations/guide-to-freedom-of-information/what-is-the-foi-act/) and the organisation’s Freedom of Information Policy.

The purpose of the policy is to ensure that staff and patients are aware of the ways in which the organisation adheres to the Freedom of Information (FOI) Act 2000. The Act enables the public to access information held by public authorities in two ways:

* Public authorities are obliged to publish certain information about their activities
* Members of the public are entitled to request information from public authorities who, in turn, are required to provide the requested information within 20 working days, unless it is exempted

It is important to note that the Act does not give individuals access to their own personal data, i.e., healthcare records. This is processed by means of a DSAR and as detailed at [Section 5.1](#_Access_to_medical).

## Good practice guidelines for electronic patient records

There is an expectation for healthcare providers to maintain good quality medical records. All staff are aware that with medical record-keeping, accuracy, clarity and timeliness are essential factors for effective communication between healthcare professionals and patients. The information contained in the record should be comprehensive enough to enable a colleague to carry on where you left off.

NHS E guidance titled [Digital Primary Care: The Good Practice Guidelines for GP electronic patient records (GPGv5)](https://www.england.nhs.uk/digital-gp-good-practice-guidance/) should act as a source of information for all those involved in developing, deploying and using general practice IT systems.

## GP2GP

As part of the General Medical Services contract, organisations are required to transfer patient records using [GP2GP](https://digital.nhs.uk/services/gp2gp); this supports the objective set out by the DHSC, which was to ensure that the patient’s digital record can follow them around the health and social care organisation.

NHS E advises that the integration process is to be carried out promptly, while any updates, or authorisations can be completed later by summarisers or clinicians. Integration should be carried out within eight days to avoid the sending organisation printing a copy of the healthcare record, thereby reducing cost and workload for the sending organisation.

For further detailed information, see the organisation’s [Electronic Transfer of and Access to the Healthcare Record](https://practiceindex.co.uk/gp/forum/resources/electronic-transfer-of-and-access-to-the-healthcare-record.1397/) guidance.

## Home and mobile working

While working at home, the employee must develop a strategy to cope with the potentially conflicting demands of work and home and/or family, and endeavour to work in an organised and disciplined way.

They will be expected to manage their domestic arrangements in order that there is minimal disruption to other family members, where applicable, and no disruption to themselves during their shift/working time. They should be able to undertake the work expected of them in a secure environment in accordance with the organisation’s policies and procedures. Operationally, homeworkers will replicate their normal roles, only the location will be different.

Managers will involve homeworkers, as appropriate, in one-to-one meetings, ensure continued compliance with health and safety requirements, and arrange supervision sessions and regular team meetings. Meetings may be face to face, via telephone or video conference facilities.

Whilst the organisation will endeavour to be supportive in its approach to the requirements of our employees and the benefits that homeworking can bring, the needs of the organisation will always be the foremost consideration.

For further detailed information, see the organisation’s Homeworking Policy and Procedures.

## Information asset register

The organisation must ensure that appropriate procedures are in place for effective information risk management and provide the structural means to identify, prioritise and manage the risks involved in all information activities. Measures should be taken to ensure that each system is secured to an appropriate level and data protection principles are maintained.

Maintaining an accurate asset register supports the process of effectively identifying and managing assets within the appropriate designation of Information Asset Owners (IAOs) and Information Asset Administrators (IAAs).

The asset register should be reviewed at least annually before the DSPT declaration to ensure it is up to date.

For further information, see both the organisation’s Information Asset Register and Information Asset Owner (IAO) and Information Asser Administrator (IAA) Guidance.

## Information security

Article 24 of the UK GDPR outlines an organisation’s responsibility to implement “appropriate technical and organisational measures” to ensure and demonstrate the proper processing of personal data.

Article 32 goes a step further, explaining that“in assessing the appropriate level of security, account shall be taken of the risks that are presented by processing, in particular, from accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed”.

An important aspect of this regulation is the emphasis on preventing unauthorised access. This is where physical security is essential. Specifically, it can help to safeguard data against internal and external human threats that aim to exploit gaps within your organisation’s firewalls and through your workforce. This includes limiting what data can be observed, stolen or accessed.

While the aim of premises security traditionally has been to safeguard medicines and staff, the NHS Information Governance requirements require procedures to be in place to safeguard the security of hardware, software and information. Therefore, there must be measures in place to delay and prevent unauthorised access, to detect attempted or actual unauthorised access, and to ensure that there are procedures for staff to follow if unauthorised access does occur.

Points to bear in mind are these:

* Particular attention should be paid to the consultation and surgery areas. These are likely to contain patient or service user information on computers or in hard-copy form. Paper copies of sensitive information should not be left unattended in the consultation/surgery area. Computer workstations in the consultation/surgery area, if left unattended, should be physically secured and password protected when not in use.
* The dispensary area (if applicable) should never be left completely unattended during the hours of business. Pharmacies should consider the minimum number of staff required to be in attendance in the dispensary given the floor space of the premises, the time of day and any other risks. Consideration should be given to the physical security of paper records and computer workstations, relative to risk. If necessary, specialist guidance on security may be available from loss adjustment/commercial risk advisers or local crime prevention agencies.
* A risk assessment should be undertaken on the security of offices and storerooms. Key considerations are the type of information stored in these areas, whether there is an adequate minimum staff level in these areas, and whether the rooms are in routine use. There may be a need to consider physical security measures such as keeping doors locked during working hours when the rooms are not in use.
* Windows in ground-floor rooms are favourite access points for burglars and, particularly during hot weather, staff should ensure that they are closed when the rooms are not occupied. A risk assessment should be undertaken to review physical security measures including window locks or if the area contains information or products that need to be particularly protected.
* There should be an alarm system of adequate specification to protect the premises. Security specialists should be engaged when installing a new alarm system or taking over new premises. Alarm systems should be tested on a regular basis. When refitting the premises or developing new services, consider whether the existing alarm system is adequate for the new security requirements and seek security advice if necessary.
* Fire alarms should be fitted in all areas and regularly tested. Fire doors and automatic and manually operated fire control systems all help to prevent the spread of fire.
* Physical keys should be issued on a need-to-have basis, and a degree of inconvenience may be preferable to having many duplicate keys. Electronic keys can be cancelled with relative ease, but it can be time-consuming and expensive to change locks on doors. A record should be kept of keys issued for long-term use and staff should be briefed on the importance of reporting lost keys. A log should be maintained and procedures adopted to ensure that keys have been returned when staff members have left employment.
* Staff should be encouraged to clear their desks (including dispensing benches) of all sensitive and confidential information when it is no longer required for the task in hand and to ensure that such information is locked securely away overnight. Staff should also be shown how to use a password-protected screen saver on their computers if they need to leave their machine unattended.
* There should be an assessment of physical security. This should examine the premises as a whole, considering legitimate entry and exit points, areas where forced entry is possible and any unstaffed parts of the building(s). Having identified any areas of risk, the risks should be weighed against the likelihood of the threats occurring. For example, the assessment may identify a risk of burglary; the question to be asked is whether this a high-risk, medium-risk or low-risk likelihood.
* Physical security should be regularly risk-assessed, and updated guidance/ procedures issued to reflect new risks to the premises due to new ways of working or the purchase of new equipment. There should be checks that staff members are complying with the procedures, e.g., by reviewing burglar alarm logs. Awareness and training should be provided to all new staff as part of their induction, and existing staff should be provided with regular updates, as necessary.

## Intranet and social media acceptable use policy

The internet, intranet and social media platforms associated with the organisation are provided to enable staff to carry out their roles effectively, whilst also enhancing the level of service provided to the patient population. All staff always have a responsibility to adhere to this guidance to ensure the appropriate usage of the equipment. Inappropriate use is considered a serious disciplinary offence and will be treated as such. It is therefore imperative that staff understand the difference between acceptable and inappropriate use.

For further detailed information, see the organisation’s Communication Policy.

## Managing incoming pathology results

High-quality communication is critical to patient safety. The processing of test results is an important element of communication between the organisation and the patient. Failure to adhere to internal processes will undoubtedly contribute to unsafe patient care, leading to sub-optimal outcomes. Staff must ensure that they adhere to the processes outlined in the policy mentioned below to ensure that a high standard of patient care is always delivered.

The document sets the standard for clinical and administrative staff regarding their involvement in the processing of pathology results. This includes clinicians giving patients sufficient, clear information about their test results and follow-up arrangements, if applicable. It is to be read in conjunction with the below referenced material and local directives.

Additional information can be found in the organisation’s Managing Incoming Pathology Results Policy. Furthermore, guidance on the tracking, recording and processing of test results can be found in CQC [GP mythbuster 46: Managing test results and clinical correspondence](https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-46-managing-test-results-clinical-correspondence).

## National Data Opt-Out

Full information on the National Data Opt-Out (NDO-O) can be found in the NHS E document titled [National Data Opt-out Operational Policy Guidance Document](https://digital.nhs.uk/services/national-data-opt-out/operational-policy-guidance-document).

## Patient social media and acceptable use

This organisation’s Patient Social Media and Acceptable Use Policy has been produced to help all staff and patients recognise the need to understand and uphold obligations as deemed appropriate and in accordance with the [NHS Constitution for England](https://www.gov.uk/government/publications/the-nhs-constitution-for-england).

All staff have an obligation to inform the organisation of any untoward postings on social media that could affect the reputation of the organisation or any of its staff members. It should be expected that, from time to time, patients may be discontented with the level of service that they have received. Following any such concern, should the patient wish to make a complaint, then the appropriate and standard process should always be followed.

Whilst it is acceptable for a patient to record a consultation, considering doing so should involve a discussion between the patient and their clinician. While this is a matter of courtesy, it will also confirm the necessity to do so and establish whether further support is required such as the need for a Subject Access Request.

## Portable devices

Portable devices are a valuable tool to support staff working outside the organisation’s premises as part of the performance of their daily duties. Effective security and the correct use of such devices will enhance ways of working and ensure that confidentiality is always maintained. For further detailed information, see the organisation’s Portable Device Policy.

## Privacy notices

The UK General Data Protection Regulation (UK GDPR) requires that data controllers provide certain information to people whose information (personal data) they hold and use. A privacy notice is one way of providing this information. This is sometimes referred to as a fair processing notice.

A privacy notice should identify who the data controller is, with contact details for its Data Protection Officer. It should also explain the purposes for which personal data is collected and used, how the data is used and disclosed, how long it is kept, and the controller’s legal basis for processing. All privacy notices should be available on the organisation’s website and in hard copy if requested.

The first principle of data protection is that personal data must be processed fairly and lawfully. Being transparent and providing accessible information to patients about how their personal data is used is a key element of the General Data Protection Regulation.

The ICO has provided a privacy notice checklist which can be used to support the writing of the organisation’s privacy notices. The checklist can be found by following this [link](https://ico.org.uk/media/for-organisations/documents/1625126/privacy-notice-checklist.pdf).

The following privacy notices are available at this organisation:

* Privacy Notice – Candidates Applying for Work
* Privacy Notice – Easy Read
* Privacy Notice – Practice
* Privacy Notice – Employee

## Random spot checks

It is recommended that organisations conduct regular spot checks in relation to data security. Following the spot checks, an audit should be written in accordance with the data security standards.

A declaration is required within the DSPT that these audits have been undertaken throughout the year.

For further detailed information, refer to the Data Security and Protection Toolkit Handbook and the Staff Monitoring Policy. The latter includes an audit template on how to undertake spot checks.

## Records management and retention

The [Records Management Code of Practice](https://transform.england.nhs.uk/information-governance/guidance/records-management-code/) is a guide for organisations to use in relation to the practice of managing records. It is relevant to organisations working within, or under contract to, the NHS in England. The Code also applies to adult social care and public health functions commissioned or delivered by local authorities.

The Code provides a framework for consistent and effective records management based on established standards. It includes guidelines on topics such as legal, professional, organisational and individual responsibilities when managing records. It also offers advice on how to design and implement a records management system including organising, storing, retaining and deleting records.

It applies to all records regardless of the media on which they are held. Wherever possible, organisations should be moving away from paper towards digital records.

All organisations need to enable staff to conform to the standards contained in this Code. This includes identifying organisational changes or other requirements needed to meet the standards – for example, the people, money and correct tools required. Information governance performance assessments, such as the [Data Security and Protection Toolkit](https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit), and our organisation management arrangements will help to identify any necessary changes to current records management practices.

The organisation’s Record Retention Schedule also includes the NHS E information in addition to key HR-related record retention.

## Remote access to IT

Remote working enables staff to work from home on a regular or ad hoc basis or because of the organisation’s business continuity plan (BCP) coming into effect such as in the event of the loss of premises or a pandemic.

It is essential that staff work in accordance with the guidance contained within the BCP and the referenced policies thereby ensuring that data security is at an optimal level at all times and patient information is protected.

For further detailed information, see the organisation’s

* Access to Medical Records Policy
* UK GDPR Policy
* Cyber Resilience Policy
* Communication Policy
* Portable Device Policy
* Homeworking Policy and Procedures

## Smartcards

Smartcard users have access to sensitive patient data and efficient access controls are vital to maintain the security of such data. All staff must ensure that they conform to the guidance detailed within the organisation’s Smartcard Policy to ensure that clinical and personal information is only accessed by those personnel who have a valid reason to do so.

The NHS smartcard is required to use the e-referral online systems and to deal with patient registrations, to allow the transfer of records between organisations electronically. In addition, NHS smartcards are used in electronic prescribing. The GP clinical system will need to be switched on at each user terminal for these services to be used.

Should a smartcard need to be updated or reactivated, this can be done online via the NHS E guidance titled [New self-service smartcard unlock application launched](https://digital.nhs.uk/services/care-identity-service/latest-news/new-self-service-smartcard-unlock-application-launched). For further detailed information, see the

## System administration

The purpose of a System Administrator declaration is to establish the organisation’s expectations for the employees who have administration and access rights to the electronic communications, files, systems or documents of the organisation and have administrator-level access.

A System Administrator Policy (refer to the organisation’s Access Control Policy) and the System Administrator Declaration Template (Annex D of the Access Control Policy) are both requirements of the Data Security and Protection Toolkit evidence at Assertion 4.3.1.

Note, by signing the declaration, employees confirm that they have complied with the requirements and affirm that they will conduct their duties to the highest standard of care.

Further reading and guidance on the completion of the DSPT, can be found in the Data Security and Protection Toolkit Handbook.

## Telephone recording

Telephone communication is a fundamental element of general practice. Communicating effectively with patients will ensure that the expected level of service is delivered, and the appropriate level of care offered in a safe and effective manner.

It is important to ensure that prior to/during any telephone conversation, incoming or outgoing to/from the organisation, that there is a statement made by the member of staff undertaking the telephone conversation that calls are recorded for training, monitoring and dispute resolution purposes.

For further detailed information, refer the Audio, Visual and Photography Policy.

## Third party confidentiality and risk awareness for visitors

All contractors and visitors to the practice should have a basic understanding of the organisation’s confidentiality requirements and, therefore, are required to agree to the standards and expectations needed to protect the confidentiality of patients, staff and the business.

Additionally, this is an opportunity for any visitor to be advised of any risks that may affect their visit, and the immediate actions that are required to be taken in the event of a fire.

It is the responsibility of the front-office team to ensure that contractors and visitors have signed the visitors’ book upon arrival and departure.

For further information, refer to the organisation’s Third Party Confidentiality Agreement Incorporating Fire Safety and Risk Awareness for Visitors document.

## Transport of confidential records

The [Public Records Act 1958](https://www.legislation.gov.uk/ukpga/Eliz2/6-7/51/contents) requires that all public bodies should have effective management systems in place to deliver their functions. Personnel required to transport patients’ health records between organisations are required to ensure the safe transportation of these records and to minimise the risk of any data breach or loss of sensitive information.

For further detailed information, see the organisation’s Transportation of Confidential Records Policy and the Health, Safety and Risk Management Handbook.

## UK General Data Protection Regulation

The UK GDPR came into effect on 1st January 2021, replacing the EU GDPR which had been in place since 25th May 2018. The UK GDPR is now incorporated in the Data Protection Act 2018 (DPA18) at Part 2.

For further information, refer to the organisation’s UK GDPR Policy.

## Use of NHS numbers

Effective patient care is heavily reliant on the information held about them. Using the NHS number helps to identify the person and reduces the risk of confusion between patients’ healthcare records. It will enable records to be kept up to date with accurate information whilst permitting the appropriate archiving and destruction of paper health records.

The NHS number is a unique and consistent identifier used in health and social care. It is a mechanism used for ensuring that patient records are linked to the right person, reducing risk and confusion. Staff are to ensure that all correspondence for patients includes the correct NHS number.

The organisation’s Use of NHS Numbers document provides guidance on this subject.

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