The Governance Handbook

The essential guide to governance in primary care

139 pages covering everything you need to know

PRACTICE INDEX PLUS

www.practiceindex.co.uk

The Governance Handbook

Version:	Review date:	Edited by:	Approved by:	Comments:

Contents

1 Introduction

1.1 What is governance?

In short, governance is all that we do and it is essential that any organisation has robust governance to ensure that its day-to-day activities are compliant.

Here is a definition of governance that is used by various sources:

> *"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".*

At this organisation, we have established robust processes to ensure that, holistically, all aspects are safe, sound and compliant.

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

1.2 How this *Governance Handbook* works

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

These four areas of governance are defined as:

a. Clinical
b. Corporate
c. Financial
d. Information

Each of these broad, umbrella headings has its own chapter which is made up of all the areas of that particular activity and supported by a policy. Throughout this handbook, these policies are also linked to the actual policy.

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

Any organisation needs to be governed, and all aspects will ultimately fall into one of these four areas, to form the overarching *Governance Handbook*.

It should be noted that references and links throughout the handbook support practices in England. However, the *Governance Handbook* can also be used as an essential guide to support practices in Scotland, Wales and Northern Ireland. Furthermore, this comprehensive handbook is in lieu of a policy and will be updated as and when changes to legislation occur.

It considers all aspects of governance to support this organisation's compliance. All staff at this organisation have a responsibility to ensure that compliance is met and to understand the rules and regulations as detailed within 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. We must all strive towards this expected standard, and be proud and feel comfortable to recommend this organisation to a friend or family member.

Within this organisation, we do provide a safe and effective service. We do care about our patients and what we do, we act in a manner that is responsive to our patients' needs, and as such, we all should believe that we treat others to the best of our ability.

> There are several areas within this handbook that are supported by HUB courses that can support staff learning and development of the subject.

CLINICAL

1.3 Status

This organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the Equality Act 2010. Consideration has been given to the impact this handbook and its referenced policies might have regarding the individual protected characteristics of those to whom it applies.

This handbook and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

2 Clinical governance

2.1 Definition

Clinical governance is defined as "*A framework 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*".[1]

Clinical governance is often thought of in terms of seven pillars. However, at Practice Index, it is felt that having an eighth pillar that incorporates 'Strategy' reflects clinical governance more appropriately, coupled with providing an additional level of oversight and safety that supports practice service users and staff.

- Staff management
- Patient involvement
- Risk management
- Clinical effectiveness
- Education and training
- Information management
- Audit
- Strategic approach

The BMJ states that:

"Clinical governance is doing the right thing, at the right time, by the right person. It is the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. It also ensures that an individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes".[2]

Clinical governance is crucial to improving standards of care and treatments that patients receive. It is a continuous cyclic process of improving, controlling and monitoring clinical care provided for the betterment of patients.

It is important that organisations work in partnership with patients and carers. This includes gaining a better understanding of the priorities and concerns of those who use services by involving them in the organisation's work, including policy and planning.

To satisfy the Care Quality Commission and to show inspectors that clinical governance is given significant priority, organisations must demonstrate that:[3]

- Information about people's care and treatment, and their outcomes, is routinely collected and monitored. This includes assessments, diagnosis, referrals to other

[1] Public Health England - Clinical Governance Guidance
[2] www.bmj.com
[3] CQC GP Mythbuster 65 - Effective clinical governance arrangements in GP practices

services and the management of people with chronic or long-term conditions. This information is used to improve care.

- Quality improvement activities, including clinical audits, are carried out and involve all relevant staff.

- We participate in relevant local audits and other monitoring activities such as reviews of services, benchmarking, peer reviews and service accreditation.

2.2 Why is there a need for clinical governance?

Clinical governance 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 throughout 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 just tripped in it. She has sustained a nasty gash to her knee and is very upset.

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

- Provide any first aid measures

- Apologise to the patient and reassure her that you will advise everyone of the potential risk and that you will look at repairing the car park as soon as possible

- 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, but it is an incredibly useful tool that, if used correctly, will 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 kept, although removed to the Retired Issues Log.

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

   Note the word *'occurred'* (see above) as this is detailed later in the explanation of the difference between a risk and an issue.

Section 2.9 provides further insight into issues management and also the Risks and Issues guidance document.

2. Significant Event Log

Next, a significant event needs 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 in order that patient safety is maximised. Furthermore, as this incident may also result in mitigation, ~~so~~ having a robust SE Log detailing all actions would be useful for any insurance claim or, in a worst-case scenario, the practice needing to defend itself in court.

All significant events are to be detailed in the SEA Log. 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 within CQC GP Mythbuster 24 – Recording patient safety events with the Learn from patient safety events (LFPSE) service.

As there has been cold weather, discuss this SEA in your ICB/PCN and/or wider PM group as other local practices' car parks might also have sustained the same frost damage, potentially resulting in the same outcome.

Refer to GP Mythbuster No 3 – Significant Event Analysis (SEA). Additionally, the Significant Event and Incident Reporting Policy (England) details this subject in greater detail.

3. Risk Register

As further patients could also 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, etc.

A Risk Register should also have a Retired Log for any risk that has been completely mitigated. Section 2.9 provides further insight into risks management, coupled with the Risks and Issues guidance document and Risk assessment guidance document.

There are numerous practice-based risk assessment templates available on PLUS.

4. Communication and minutes

In addition to initially advising partners and staff, any SEA would need to be discussed at the various meeting and incorporated in any 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 Communication Policy.

5. 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.

Further reading can be found in the Clinical Audit Policy and CQC GP Mythbuster No 4 - Quality improvement activity.

6. 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 in accordance with the Complaint procedure (England).

This log details dates of receipt, acknowledgement and completion and should be used as evidence-gathering for the annual K014b complaints return to NHS England.

All complaints, written or verbal, should be added to the organisation's Complaints Log. Further reading can be sought within CQC GP Mythbuster 103 – Complaints management.

7. 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 management of training within any organisation could include:

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

Further reading can be found in the Staff Development Policy – Mandatory training guidelines and CQC GP Mythbuster No 70

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.

There are several tools within the HUB that can support these areas of clinical governance.

2.3 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.

Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm the improvement in healthcare delivery.[4]

The purpose of completing a clinical 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 undertaken and the overall aim of which 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

[4] NICE Principles for Best Practice in Clinical Audit

- 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

The following policies have audits included:

- Clinical audit
- Referral Choice Audit
- Caldicott and Confidentiality
- Cervical Screening Programme
- Cold Chain
- Infection Prevention Control
- Safeguarding
- Prescribing (England)

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 to appreciate the root cause
- Fishbone to understand cause and effect
- Process mapping for general improvement

The full NHS England list of quality, service improvement and redesign (QSIR) tools can be found here.

2.4 Clinical effectiveness

Clinical effectiveness means that any treatment modality you choose to perform on the patient must provide the best outcome for the patient. That 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, our 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:

- Clinical supervision for nurses and HCAs
- Clinical Supervision Policy
- Evidence-based Practice Policy
- Quality Assurance Policy
- The use of NICE guidance

2.5 Duty of candour

Organisations must fulfil their obligations to satisfy the ‘statutory duty of candour’ as part of 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.

It is also intended 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 England/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

CQC inspections will report on duty of candour under the Key Line of Enquiry (KLOE), a Question of Safety. For further detailed information, see the organisation's Duty of Candour Policy.

Duty of Candour e-learning training is available in the HUB.

2.6 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 that 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.

  Amidst the typical characteristics of ambiguity and uncertainty in the leadership space, coaching can achieve clarity and direction.

  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 one 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.

- **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
  - Including 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 the 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 and Salaried GPs Handbook.

- **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 is not 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 show the type of training delivered and that staff fully understand how to operate the device which the training covered.

On occasions, it may be necessary to loan certain medical devices to service users (patients, carers, or their relatives) as part of their ongoing care needs. All equipment loans should be coordinated by the organisation, ensuring that the device is serviceable and ready for use by the end user.

For safety, it is essential that service users being loaned the device are deemed competent to use and maintain the device and agree to return it in the same condition.

The duration of the loan will depend on several factors and will be agreed with the recipient at the time of issue who will liaise with the clinician requesting the loan.

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 that is needed 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 the 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 detailed information, see the organisation's Preceptorship Policy and the Preceptorship Framework 2017.

- **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 practice.

- **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.

  GPs undertake this process with an e-profile but need to keep you abreast of when they have undergone revalidation, and it would be helpful to them for the manager to be alert to SEAs and complaints which they might find it useful to include in their appraisal and revalidation portfolio.

  Revalidation, and thereby continued inclusion on the GMC register, is an area inspected by CQC so each organisation should check online annually that every partner and salaried GP is still on the GMC List and without any restrictions on their practice. The reason for this check is that from time to time the GMC will discipline a doctor for a misdemeanour committed while working for another employer (e.g., OOH providers) or for an incident that occurred before they started working in the organisation, and you may never find out about it because neither the doctor nor the GMC will have advised you.

- **Nurse revalidation**

  Every three years, all nurses and midwives are required to apply for revalidation using NMC Online; this is a secure system which enables nurses and midwives to manage their registration online. The NMC has stipulated seven requirements which nurses and midwives must meet to revalidate:[5]

  - A minimum of 450 practice hours
  - 35 hours of Continuing Professional Development (CPD), of which at least 20 hours must be participatory learning
  - Five pieces of organisation-related feedback

[5] NMC Revalidation – Employers' guide to revalidation

- Five written reflective accounts on their CPD and/or organisation-related feedback and/or an event or experience in their practice, and how this relates to the Code
- Reflective discussion with another nurse (or midwife)
- Health and character declaration
- Professional indemnity arrangement

The NMC has produced a guidance document for nurses and midwives, explaining how to use NMC Online.

Detailed guidance has been designed to support employers and line managers in understanding how nurses and midwives can meet the seven requirements. This information is available in the Employers' Guide to Revalidation, starting on page 15, accessible via the hyperlink at footnote 5.

For further detailed information, see the organisation's Nursing Staff Revalidation and Appraisal Policy.

- **Training and development**

Different staff members have different training requirements, and these should always be based on the role that 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 which highlights due dates for retraining.

Many organisations now use online systems for training provided by the NHS or a commercial company such as Practice Index and the 120+ courses that can be found on Learning Manager. These online services often provide a management facility that records successful training sessions and automatically flags up retraining dates. Intranet programmes and back-office software may also provide the same function. It would also be prudent to keep a record of partners' as well as employees' training to ensure they do not miss retraining opportunities, particularly during extended absences such as maternity or sick leave.

For further detailed information, see the organisation's:

- Staff Development Policy – Mandatory Training Guidelines
- Training Evaluation
- Training Needs Assessment
- Training Costs Agreement

2.7 Indemnity

From the 1 April 2019 NHS Resolution is 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 1 April 2019. CNSGP provides a fully comprehensive indemnity for all claims within its scope.

The What's covered by CNSGP? 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, agency workers and other organisation staff.

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 place where activities are carried out, the status of the person carrying out the activity, the form of the entity responsible for the provision of the NHS services in question and the individual circumstances of the patient concerned are not relevant to the scope of CNSGP. The question is whether the services provided are NHS primary medical services, and where they are not NHS primary medical services, whether they are NHS services provided by general practice (namely, by a provider whose principal activity is to provide NHS primary medical services). This means that different kinds of organisations are covered under the scheme for activities they carry out which are in scope of the scheme.

Claims made against GP organisations or other organisations providing NHS primary medical services or ancillary health services are covered under the scheme. This includes claims made in respect of liabilities that arise because of the acts or omissions of employees and others engaged to carry out activities connected to the provision of such 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 1 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 – Clinical Negligence Scheme for General Practice.

2.8 Patient and carer experience and involvement

If the organisation is to offer the highest quality care, it is important 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.

We actively encourage patient participation and have a few initiatives such as the Friends and Family Test, online forums, and patient participation groups (PPGs) to gather feedback with a view to enhancing the services offered. There are mechanisms in place to empower patients to make informed decisions about their healthcare and the services provided.

- **Friends and family test**

The revised FFT was implemented from the 1 April 2020 and organisation must ensure the changes have been actioned.

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.

A minimum of five responses is required by NHS England. Remember should there be no FFT data submitted for three consecutive months, the organisation will be in breach of the contract and risk having a breach notice issued.

The FFT is not a one-off exercise. It is an ongoing commitment that is written into the practice contract. Monthly submissions of the data collected from FFT must be submitted on the 12th working day in the month after the data is collected.

To comply with contractual obligations, organisations must:

- Afford patients and service users the opportunity to provide feedback using the FFT
- Use the revised, standard FFT question and response wording
- Include a follow-up question, offering a response in free text format
- Submit the necessary data in the specified format to NHS England monthly
- Publish results locally, including free text comments (so long as the participant has not opted out of having their comment published)

The collection of data should not be a cumbersome process; in fact, NHS England stipulate that it should be flexible whilst “aiming to create as little burden as possible for providers and their patients”.

Data may be collected as follows:

- Handwritten, i.e., postcard format

- Telephone
- Tablet
- SMS/text message
- Via an app or online
- Any other method agreed in the organisation

Data is to be submitted to NHS England at the end of each month for that calendar month of data collection. It is to be submitted by using the Calculating Quality Reporting System (CQRS). Access to CQRS is achieved by users logging in by using their unique username and password. Guidance on submitting data can be found here.

The following information is to be submitted:

- Total number of responses for each response category
- The collection method of each response
- The number of responses per each collection methodology

For further detailed information, see the organisation's Friends and Family Test Policy and NHS Improvement Guidance – Using the Friends and Family Test to Improve Patient Experience.

- **Patient Participation Group (PPG)**

Since 1 April 2015, it has been a contractual requirement for all English organisations to form a Patient Participation Group (PPG) during the year ahead and to make reasonable efforts for this to be representative of the organisation population. Generally made up of a group of volunteer patients, the manager and one or more of the GPs from the organisation, they meet on a regular basis to discuss the services on offer, and how improvements can be made for the benefit of patients and the organisation.

In practice, PPGs can play several roles, including:

- Advising the organisation on the patient perspective
- Organising health promotion events
- Communicating with the wider patient body
- Running volunteer services and support groups to meet local needs
- Carrying out research into the views of those who use the organisation (and their carers)
- Influencing the organisation or the wider NHS to improve commissioning
- Fundraising to improve the services provided by the organisation

The PPG's agenda and minutes should be made available to all patients and the organisation website is a good vehicle for this purpose.

Terms of reference should be available for the PPG as there is a danger that the group or some individuals may feel they are the final decision-making authority for the services the organisation provides. A PPG, nonetheless, is a valuable tool for demonstrating responsiveness for the CQC.

The PPG may wish to join the National Association for Patient Participation (NAPP) to widen its knowledge and usefulness. To support the PPG, NAPP have produced a

resource guide to help PPGs to work effectively. The guide was commissioned by NHS England and can be found here.

Other useful guidance on PPGs can be sought from The Patients Association or Healthwatch and within the Patient Participation Group (PPG) Policy.

- **Patient surveys**

The GP Patient Survey is an independent survey run by MORI on behalf of NHS England. 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 an issue 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 now may carry out a survey designed by the organisation, with the help of the Patient Participation Group, and publish the results on the organisation 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.

Organisations are also expected to carry out the Friends and Family Tests. The organisation needs to discuss the findings with the PPG and record those discussions as effective use of surveys is an area where the CQC expects to see organisations responding to concerns and issues.

- **Shared decision-making**

Shared decision-making is a process in 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.

The NHS Long-Term Plan states that personalised care will become "business as normal" across the health and care system, based on what matters to the patient and their individual needs.

Shared decision-making is important as:

  - It can create a new relationship between individuals and professionals based on a partnership
  - People want to be more involved than they currently are in making decisions about their own health and healthcare
  - Both individuals and clinicians tend to consistently overestimate the benefits of treatments and underestimate the harms
  - It has the potential to enhance the way resources are allocated and reduce unwarranted clinical variation

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 the 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.

2.9 Risk and incident management

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

How can one manage risks?

- By identifying what can and does go wrong during treatment
- Understanding the factors that may influence risks
- Learning from previous mistakes and adverse events
- Immediate action to prevents such mistakes and events
- Putting systems in place to reduce risks
- Knowledge of management of medical emergencies in dental clinics
- 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. The NHS risk matrix is used when discussing risks.

We have a robust system in place to manage all health and safety matters, with a nominated HASAW representative who ensures that the practice adheres to extant legislation and the environment is safe for both staff and patients alike.

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 into a Risk Register as detailed at Section 2.2.

HUB Risk Register Manager is available as part of the Compliance Package in the HUB.

Further reading on the management of risks can be sought at:

COSHH risk assessment guidance document
Risk and issues guidance document
Risk assessment guidance document

- **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) 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, etc.) or there is no access to IT. The plan must contain details of 'buddy' organisations, relocation venues and essential contact details for key staff and services. Remember that the security of the personal data of staff and essential external personnel is required by the Information Commissioners no matter where or how it is held, so hard copy must be locked away and information held on data sticks or other digital formats must be password secure.

  - 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 had to evacuate the building. A pro forma sheet for consultations is part of this stock and once there is online access to the clinical system, the consultations can then be retrospectively input – it will be a matter of organisation policy whether this is done by the completing clinician or as an admin task.

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

  HUB In support business resilience, Tabletop Exercises (TTX) – An introduction is available in the HUB.

- **Significant event reporting**

  CQC GP Mythbuster 3: Significant Event Analysis should be read in conjunction with this section

  - Whilst the practice does have a Risk Register, another useful tool is active participation in Significant Event Analysis (SEA) reporting.

  - SEA should act as a learning process for the whole practice. Individual SEAs can be shared between members of staff, including GPs, and should 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 – but more importantly, learn from such occurrences.

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

The outcomes of SEAs are to be routinely forwarded to Learning from patient safety events or LFPSE and as detailed within CQC GP Mythbuster 24 – Recording patient safety events with the Learn from patient safety events (LFPSE) service

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

- **Audit**

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

Section 2.3 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.

Section 2.6 details staff training needs and requirements.

2.10 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 boost outputs by staff. 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.

The practice operates within a no-blame learning culture to encourage teamwork and to promote a positive working 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 and retention
- Appraisal
- Performance management
- Workforce development

For further detailed information, see the following:

- Management by Objectives Policy
- Management Policy and Procedures
- Performance Management - Capability Procedure
- Performance Appraisal Policy

2.11 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**

  Current BMA recommendations are that organisations should provide 72 GP appointments per 1,000 patients per week.

  NHS England has been collecting data from general practice appointment systems and publishing it, collated formally by CCGs 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.

  During the COVID-19 emergency, organisations have had to rapidly change their working patterns. This has highlighted to NHS England that not all clinical interactions with patients are recorded in the appointment book, although current NHS England data shows that appointment activity is now greater than pre-COVID times.

  It is suggested that this may result in an under-recording of the activity taking place in general practice. In turn, that may lead to under-reporting in the NHS England GPAD data publication. This is potentially giving a false picture of overall activity and workload in general practice. It is in everyone's interests to capture accurately the full scale of activity that general practice is providing for patients.

  NHS England suggests the following:

What constitutes an actual appointment has not been well defined and well understood as it could be by all the different health and care professionals involved in providing general practice.

To ensure consistency in counting actual appointments, the following definition has been agreed therefore, discrete interactions between a health or care professional and a patient, or a patient's representative.

This definition excludes:

- *Purely administrative interactions between practice staff and patients e.g., practice manager meeting a patient to complete a subject access request or a receptionist answering a query about opening hours*
- *Non-clinical triage or administrative signposting*
- *Online requests that do not result in an interaction between the patient and a health or care professional, for example automated online triage*
- *Work undertaken by a health or care professional that does not involve patient contact e.g., multi-disciplinary team meetings, case conferences, palliative care list reviews, referral letters, writing repeat prescriptions, reviewing results*
- *All clinical administration activity including audit, training, supervision*
- *Interactions with patient participation reference groups*

This guidance reconfirms that the definition of an appointment includes:

- *All relevant staff. Discrete interactions carried out by any health or care professional, including all roles in the Additional Roles and Reimbursement Scheme*
- *All modes. Discrete interactions that are delivered by all modes – face-to-face, by telephone, via video and online*
- *All settings. Discrete interactions in any primary medical care setting (including the practice, patient's home, community, care home, group consultations, local GP extended access hub*)*

Did Not Attend (DNA) appointments should continue to be recorded and as detailed within the Did Not Attend (DNA) Policy.

NHS England and NHS Improvement, in partnership with NHS Digital, have introduced a new set of GP appointment categories to better capture general practice workload and demand. These new GP appointment categories will be a superset of the existing 'slot type' field and it is now a contractual requirement for organisations to record all appointments in line with the Standardised GP Appointment Categories for 2021/22.

Additional detailed guidance is available on the NHS England webpages: Improving GP appointment data.

- **ePACT2 data**

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 easy-to-use analysis, reports and dashboards including the ability to:

  - Interrogate prescription data
  - Create data visualisations using interactive reports and dashboards
  - Look at high level data summaries down to individual prescription item detail
  - Export data from reports and dashboards
  - Access whole country data
  - View patterns of prescribing at patient level

Registrations for ePACT2 can be made here.

- **NHS Digital/NHS X**

NHS Digital and NHS X are now part of NHS England following a merger along with Health Education England. This new single organisation is collectively known as NHS England and will remain as the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

As previously, this organisation works with partners across the health and social care system to ensure information flows efficiently and securely.

They manage such services 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

There remains an NHS Digital webpage, although some of the information is now archived following the merger on 1 February 2023.

- **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) at NHS England, 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.

If effective, risk stratification, used as a part of a wide care model, can have a range of benefits[6]:

- Case finding can ensure that individuals at risk of an adverse event can be offered an intervention designed to reduce that risk. This means that it could support a reduction in a wide range of 'triple fail' outcomes (such as emergency admissions, premature nursing home admissions, falls, or bed sores) that are simultaneously high cost, low quality, and represent a poor patient experience

- In stratifying a population by risk, it can also be used to identify and target appropriate proactive interventions. It can ensure that the highest-risk patients receive appropriate care for their needs (such as the input of multi-disciplinary teams); medium-risk patients might be referred to a lighter touch intervention (such as social prescribing); and lower-risk patients could be managed through usual care and self-care

- It can also be used as a population health planning tool, enabling commissioners and providers to gain a detailed picture of the future risk profile of its population, allowing them to design care pathways and target funds and interventions appropriately

3 Corporate governance

The Audit Commission (2002) defined governance within the NHS as: "The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives and by which they relate to their partners and wider community".

The Department of Health 2006 defined integrated governance as: "Systems, processes and behaviours by which organisations lead, direct and control their functions in order to achieve

[6] NHSE - Risk Stratification: Learning and Impact Study

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 the Care Quality Commission (CQC) and other external audits

3.1 Annual declaration

The electronic practice self-declaration (eDEC) is a mandatory collection which all GP organisations in England must complete every year.

The eDEC covers eight areas to be completed:

- Organisation details (such as name and address)
- Organisation staff
- Organisation premises and equipment
- Organisation services
- Information about the organisation and its procedures
- Governance
- Compliance with Care Quality Commission (CQC) registration requirements
- General practice (GP) information technology (IT)

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.

NHS England regional teams will use the information GP organisations provide to check GP organisations are fulfilling their contractual requirements.

Integrated Care Boards (ICBs), which commission primary care services under formal delegation from NHS England receive information from the annual electronic organisation self-declaration that they need to support their delegated functions.

The CQC use it to check that GP organisations meet the CQC registration requirements, including complying with the law and in particular the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended). The answers to the questions relating to CQC's regulatory requirements will form part of their pre-inspection documentation, to reduce organisation workload in line with our commitments in the General Practice Forward View.

A senior member of the organisation's staff, for example the manager or senior partner, should complete the eDEC. 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). Organisations will need to have:

- The correct permissions set by the data collections service
- An NHS England single sign-on (SSO) account

Most participants will already have these set up and will get an invitation email. You should then follow the instructions in the email to access SDCS.

For further detailed information, see the NHS England Guidance – General Practice Annual Electronic Self-Declaration (eDEC).

3.2 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 Care Quality Commission (CQC) will want to see evidence that the organisation is adhering to the 'safe' KLOE. Organisation are appointing prescribing advisers to help manage prescribing across the primary care network.

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 is the only tool that 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.[7]

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 Clinical Audit Policy and Referral Choice Audit Policy. Furthermore, refer to GP Mythbuster 4 - Quality improvement activity.

[7] NHS E Joint guidance on the use of e-RS

3.3 Business planning

The organisation's Business Development Plan (BDP) should detail strategic goals for the forthcoming three-year period and 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
- Skill mix across the multi-disciplinary 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.

3.4 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 within 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.

3.5 Corporate manslaughter

The organisation should take every opportunity to incorporate the principles of the Corporate Manslaughter and Corporate Homicide Act 2007 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 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 the organisation's Corporate Manslaughter and Homicide Act Policy.

3.6 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:

- 1 January - 31 March
- 1 April - 30 June
- 1 July - 30 September
- 1 October - 31 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.

On navigating to the Close Quarter Notifications, in the right-hand pane, and selecting the required close quarter notification, any outstanding transactions will be displayed on the Outstanding Transactions tab.

All outstanding transactions in the GP links Outbox and GP links Inbox should be processed. Click Accept on the ribbon. The Accept option will be disabled (greyed out) until all outstanding transactions have been processed.

When this has been completed the quarter has been successfully closed and the close quarter notification will be removed from the GP Links Inbox.

3.7 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 and applies to individuals employed within organisations or 'corporate' services that provide a regulated activity.

A Fit and Proper Persons Policy will detail the compliance needed to meet these current regulations when employing a fit and proper person at partner or director level. Not all organisations need to conform to this as it is only relevant for to those organisations that do not form part of the traditional GP partnership model. Therefore, this requirement is for (but not limited to) the following models who operate within a regulated service:

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

3.8 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 health and safety policy and all relevant information should be held in the health and safety files which should be easily accessible – either in hard copy, on an intranet or other software back-office programme.

The areas where the organisation will need to evidence their procedures and assessments are:

• Access for people with a disability	• Legionella/safe water
• Accident reporting	• Liquid nitrogen
• Asbestos	• Lone working
• Blinds and blind loops	• Manual handling
• COSHH	• Medical gases
• Display energy certificate (DEC)	• Pandemic management
• Display screen equipment (DSE)	• Panic alarms
• Electrical and emergency lighting	• PAT testing
• Emergencies	• PEEP and GEEP
• Fire and fire marshal	• PPE

• First aid and medical emergencies	• Premises/slips, trips and falls
• Fixed wire testing	• Risk assessments and planning
• Fridge temperature logs	• Security
• Gas safety	• Sharps handling and needlesticks
• Health and safety	• Spirometry
• Home working	• Waste management
• Infection control	• Working at heights

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 (HSIER) to display the approved poster in a prominent position in each workplace or to provide each worker with a copy of the approved leaflet, Health and safety law: What you need to know, that outlines British Health and Safety law.

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

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

- Health and Safety – A Short Guide
- Health and Safety Made Simple

Additionally, refer to the Health and Safety Policy.

HUB Health and safety training is available in the HUB including:

- Accident and Incident Reporting
- Basic Life Support Adults (BLS)
- Basic Life Support Paediatrics (BLS)
- COSHH
- Display Screen Equipment (DSE)
- Infection Control (Clinical)
- Infection Control (Non-Clinical)
- Moving and Handling (Clinical)
- Moving and Handling (Non-Clinical)
- Preparing for a Pandemic

- Office, Electrical and Fire Safety
- Working at Heights

3.9 Insurance

The topic of insurance for a GP organisation can easily be confused with “indemnity” and it is necessary to draw the distinction.

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, its contents and then, both employee and public liability.

Key staff cover is not often found and needs to be carefully considered when the cost of taking on a locum manager or advanced nurse practitioner can be costly. As such, 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, organisation 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.

3.10 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 under the partnership agreement.

3.11 Organisation area

A GP medical organisation has a defined organisation 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 organisation list size. The

organisation usually has a copy of this in each reception area for reference and it should also appear on the organisation 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 England before doing so. Organisations are now being afforded the option of providing limited services to patients who live outside their organisation area.

3.12 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 where there is no agreement in place, or it is badly written!

Partnerships can be disbanded for many reasons, and this does put the organisation into significant problems regarding who may take it over, who will provide patient services, who might run the premises and even will NHS England 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 practice 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 ensures that the Partnership Agreement is both 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 which may be contrary to the partner's wishes.

A Green Socks clause in GP Partnership Agreements allows a partner to be expelled on 'no fault' grounds.

Standard expulsion clauses in Partnership Agreements commonly provide for a partner to be expelled if they are significantly in breach of the Agreement, if they are suspended or removed from the Register, or if they become bankrupt.

However, there are many reasons why an organisation may wish to expel a partner which are not covered by standard expulsion clauses. Examples include personality clashes, a partner who has had long periods of time off due to ill health, or a partner who is considered by the other partners not to be 'pulling their weight' (e.g., administrative or regulatory duties).

It is also possible for a partner to be under-performing in a clinical sense, without necessarily being in breach of any of the expulsion provisions. Having an under-performing partner who cannot readily be expelled under the terms of the Agreement can sap morale amongst other partners and employees and can severely hamper the effective running of a practice. The partners are of equal standing when agreeing that a Green Socks Clause should be included within a Partnership Agreement, so there is no reason why it should not be effective in law.

However, it is important to note that a partner who is being expelled under such a clause could potentially still be able to bring a claim for discrimination.

Therefore, it is worth seeking legal advice to explore whether taking action to expel a partner is discriminatory in some way before seeking to invoke the provision.

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 organizational area
- Provisions for payments during sickness and/or maternity, paternity, adoption, and study leave
- Provisions for retirement of a partner
- Arrangements for annual accounts, accountant etc
- Responsibility for signature of 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 on what the agreement should cover but care needs to be taken when making changes to ensure 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 upon 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 etc.

For further detailed information, refer to the New Partnership Guidance.

3.13 Partners' appraisals and revalidation

Every licensed doctor who practises medicine must revalidate every five years. All doctors with a licence collect examples of their work to understand what they are doing well and how they can improve. An important part of this is checking what their patients think about the care they give. Doctors collect:

- Feedback from their patients and from people they work with
- What they have learnt from training they have completed
- What they have learnt if something has gone wrong
- Any complaints about them.

GPs undertake this process with an e-profile but need to keep the practice management abreast of when they have undergone revalidation, and it would be helpful to them for the manager to be alert to SEAs and complaints which they might find useful to include in their appraisal and revalidation portfolio.

Revalidation, and thereby continued inclusion on the GMC register, is an area inspected by the CQC so each organisation should check online annually to ensure that every partner and salaried GP is still on the GMC list and without any restrictions on their practice. The reason for this check is that from time to time the GMC will discipline a doctor for a misdemeanour committed while working for another employer (e.g., OOH providers) or for an incident that occurred before they started working in the organisation, and you may never find out about it because neither the doctor nor the GMC will have advised you.

Further detailed guidance is available from the NHSE web pages.

3.14 Partners' contracts

Organisations are entitled to make their own appointments to partnership organisations. They can choose to appoint a salaried doctor or engage a locum if additional help is required in the organisation. The organisation receives a Global Sum Budget to run the organisation which does not take account of the number of doctors working in the organisation. Payments generally are now related to the overall weighted list size and to the type and volume of enhanced services provided.

On admission to the Medical List, the GP can start working for the medical organisation either as a salaried doctor or partner. For salaried doctors, the British Medical Association recommends the content of a contract of employment.

For a GP, the BMA model contract is available here.

A new doctor taking up a contract should agree his/her own working arrangements, hours of availability, days of work and number of sessions worked, and this is set down in a Job Plan appended to the BMA contract and reviewable yearly.

See GMS Contract section.

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 structure of the organisation often dictates whether doctors are on contract (usually larger organisations running multiple premises or part-time doctors providing additional sessions in a partnership) or are partners (the most common model). Partners are not on contract but could be either 'equity' partners (taking a share of the profit agreed between them as their salary) or salaried partners (paid a fix amount each month and not dependent on the profits).

3.15 Partner resignation or retirement

Normally unless partners agree otherwise, a doctor is required to give a specified notice of the intention to resign or retire. That being agreed with NHS England and the organisation, the remaining partners are entitled to be regarded as 'logical successors' to the outgoing partner's list of patients. NHS England will ask to whom the patients should be transferred, and the senior partner will need to sign a logical succession form setting how the patients are to be distributed. You will need to inform PCSE of the resignation by completing the relevant forms.

On the retirement or resignation of a member of the organisation, the new 'organisation' will need to agree the name of the senior partner and allocate new partnership shares and complete and sign a shares distribution form for NHS England. The senior partner and new member of the partnership need to sign a Declaration of Partnership which needs to be a formal legal document.

Understanding how 24-hour retirement works is useful. A policy should be implemented to ensure that all staff to whom 24-hour retirement applies understand how 24-hour retirement affects both the individual and the organisation.

CQC will be required to be informed following any change to the Partnership as this is one of the statutory notices. Refer to www.cqc.org.uk for further advice on statutory notifications.

Further guidance can be found in the Partners Joining and Leaving Guidance.

3.16 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).

3.17 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, 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.

- **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. This equipment includes:

  - Audiology equipment
  - Blood pressure devices
  - Diagnostic ECG
  - Infusion and syringe pumps
  - Patient monitoring equipment
  - Suction, oxygen, and therapy equipment
  - Scales
  - Spirometry

Tests should be carried out by adequately trained and appropriately qualified engineers. In line with CQC inspection requirements[8], good records are important in effective device management and should provide evidence of:

  - What the device is
  - Where it came from
  - Both serial or batch number
  - A maintenance record of the device
  - Any training carried out on how to use it properly

Further detailed information is available by reviewing the Managing Medical Devices – Guidance for Healthcare and Social Services Organisations (MHRA) and Devices in Practice: Checklists for using Medical Devices (MHRA)

- **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

[8] CQC GP Mythbuster 52: Portable Appliance Testing and Calibrating Medical Equipment

and Use of Work Equipment Regulations 1998), 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 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 (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.

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[9].

Organisations must ensure staff have access to resuscitation and emergency advice, training and that emergency equipment is checked. In respect of emergency equipment, the organisation should have a defibrillator, oxygen, and pulse oximeter on-site.

The organisation should also have a small stock of common medicines for emergency use and CQC advice is that the following list is the most justifiable:

Drug	Indication
Adrenaline for injection	Anaphylaxis or acute angio-oedema
Antiemetic such as cyclizine, metoclopramide or prochlorperazine	Nausea and vomiting
Aspirin soluble tablets	Suspected myocardial infarction
Atropine (for practices that fit coils or where minor surgery is performed)	Bradycardia
Benzylpenicillin for injection	Suspected bacterial meningitis
Chlorphenamine for injection	Anaphylaxis or acute angio-oedema
Dexamethasone 5mg/2.5ml oral solution	Croup (children)

[9] CQC GP Mythbuster 1: Resuscitation in GP Surgeries

Requires date opened sticker and new expiry once seal broken (or soluble prednisolone – NOTE off-label use)	
Diclofenac (intramuscular injection)	Analgesia
Furosemide	Left ventricular failure
Glucagon (needs refrigeration) GlucaGen® Hypokit® has an 18-month expiry out of fridge – should be labelled with new expiry date) Or alternative medicine to treat hypoglycaemia	Hypoglycaemia
Glyceryl trinitrate (GTN) spray or unopened in date GTN sublingual tablets	Chest pain of possible cardiac origin
Hydrocortisone for injection and/or soluble prednisolone	Exacerbations of asthma, severe or recurrent anaphylaxis
Midazolam (buccal) or diazepam (rectal)	Epileptic fit
Naloxone (dependent on whether opiates are kept at the practice)	Opioid overdose
Opiates – diamorphine, morphine or pethidine ampoules for injection. (Water for injection may be required to reconstitute)	Severe pain including myocardial infarction
Salbutamol, either nebules or inhaler with volumatic and ipratorium bromide (children) – consider strengths stocked	Asthma

Notes:

1. The above list is not exhaustive and additional medicines may need to be added depending on the needs of the local population and local arrangements for services e.g., district nurse, palliative care and substance misuse.

2. Naloxone is a medicine used to reverse the effects of opiates. Organisations that stock opiates (either in the practice or in the doctor's bag) should also stock naloxone.

   A risk assessment may be needed based on the patient group. For example, patients with addiction or those patients who present with opiate related problems.

3. The CQC would expect to see evidence that an appropriate risk assessment has been conducted. This is to identify a list of medicines that are not suitable for a practice to stock and how this is kept under review.

4. There should be a process and system in place to check that drugs are in date and equipment is well maintained.

5. All emergency drugs and equipment need to be readily available. That does not mean that they are kept in a room that is in clinical use, where in an emergency a staff member would need to interrupt a consultation or procedure.

6. Keeping emergency-use equipment/drugs in a safe place where they cannot be accessed by non-staff but can be grabbed at a moment's notice is the only option. In a cupboard in a constantly staffed reception back office or in a corridor cupboard fitted with a combination padlock and an alarm that goes off when it is opened (if out of direct sight of staff) would satisfy all the requirements.

7. All emergency drugs should be monitored accordingly, and a policy should be in place which details the monitoring arrangements at the organisation. The emergency equipment/drugs/doctors' bags must be checked every month and a checklist completed. Checklists must be filed and retained for six years until the time for any likely legal action has passed.

8. Emergency equipment contained in any doctor's bag should mirror that which is held in the organisation where it is appropriate (i.e., there would be no usual requirement for a defibrillator or oxygen to be carried.

9. Advice on what should be should be kept in a clinician's emergency bag can be found here.

For further detailed information, see the Clinical Guidance Document – Medical Emergencies and also the DNACPR Policy for those patients that may not be considered for cardio pulmonary resuscitation.

- **Keyholders**

The arrangements will differ according to the ownership and operation of the premises but in organisation-owned premises the main keyholders to the property are usually the partners and the 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 they comply with the directions that follow:

- The safekeeping of the key(s) will ensure that they are not given to any unauthorised personnel without the express permission of the manager.

- Should it be necessary for the nominated keyholder to transfer the key to a delegated individual (delegated keyholder), they must ensure that the delegated keyholder fully understands their individual responsibilities.

- The nominated keyholder will report the loss of any key(s) to the manager immediately to ensure that the security of the organisation, or areas within it, are not placed at risk.

- The nominated keyholder or delegated keyholder accepts that they may be charged for any lost key(s).

- The nominated keyholder or delegated keyholder will report any damage to the appropriate manager immediately.
- The nominated keyholder or delegated keyholder will ensure the safekeeping of the key(s) in their possession, preventing unauthorised individuals from accessing the key(s) and/or gaining access to the organisation.
- Upon termination of their contract, or upon request, any keyholder will return all keys in their possession to the appropriate manager.

In some areas the keyholding function might be outsourced to a contractor – usually the same one who provides the organisation intruder alarm – so a clear Service Level Agreement and regular monitoring of who comes in and out of the premises when it is closed is preferred.

For further detailed information, see the organisation's Key Security and Keyholder Agreement.

- **Maintenance**

In accordance with The Workplace (Health, Safety and Welfare) Regulations 1992, 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.[10]

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 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.

The issue for organisations, regarding making improvements, is the change that may follow with respect to the cost or notional rent reimbursement so NHSE approval may be needed and may not always be forthcoming!

For further detailed information, see the organisation's Risk Assessment and Control Form – Locking and Unlocking premises, External Inspection of Premises Checklist and Internal Inspection of Premises Checklist.

- **Music licence**

Under the Copyright, Designs and Patents Act 1988, permission is needed from the copyright holders, generally those who create, record and publish music, to play or

[10] HSE Workplace health, safety, and welfare

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 in 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 the 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 re-apply for TheMusicLicence online.

- **PAT testing**

The Electricity at Work Regulations 1989 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 which will enable compliance with the requirements of testing at "regular" intervals.

Formal inspection and testing includes:

  - Formal visual inspection for signs of damage and deterioration
  - Electrical testing using a calibrated PAT device

Details of equipment inspected and tested will be recorded and the equipment labelled as "passed" with the test date clearly visible.

All equipment to be tested will be made accessible (if necessary, in advance) to ensure the person conducting the testing and inspection can complete the programme. Any equipment used off site will be returned to the organisation for the day during testing.

Any preliminary arrangements to manage the inspection and testing programme will be communicated. Such arrangements will include:

  - Date of testing and accessibility of equipment
  - Power down arrangements for computer and office equipment

The CQC expect GP organisations to provide assurance that they have carried out risk assessments to identify all risks associated with their premises and that they are managing these risks.[108] Effective record keeping is essential.

For further detailed guidance, see the organisation's Portable Appliance Testing (PAT) and Calibration Testing Policy.

- **Refrigerators**

The vaccine fridge should have the sole purpose of storing vaccines. It should not be used for the storage of any other products.

In particular, the fridge should:

Be clearly identified as a vaccine fridge	Undergo regular Portable Appliance Testing (PAT)
Have a functioning locking mechanism or be stored in a locked room	Be clean, sited appropriately and not overfilled
Have an external maximum–minimum thermometer in place, as well as the integrated thermometer	Undergo a regular servicing programme that is auditable
Be defrosted (if an icebox is fitted) regularly and this information recorded for audit purposes	Have an uninterrupted electricity supply (switchless socket) or, where necessary, have the socket clearly labelled “vaccine fridge; do not turn off”

- **Recording of temperature**: In accordance with the Green Book[11], fridge temperatures should be recorded at least once daily. A log can be found within the Vaccines Toolkit.

  CQC GP Mythbuster 17: Vaccine storage and fridges in GP practices and the Green Book, the recording process is formed of four stages and the four Rs.

  Make sure that the person making the recording of the fridge temperature:

  - **Read** it at least once every day during the working week and signs the temperature record sheet
  - **Record** it in a standard fashion and on a standard form to include current, maximum, and minimum temperature readings
  - **React** immediately if the temperature falls outside +2° and +8°C
  - **Reset** the thermometer after each reading

  Ideally, use a second thermometer that is independent of the integral thermometer in the vaccine fridge. This is to:

  - Cross-check the accuracy of the temperature
  - Monitor the temperature if the electricity supply to the vaccine fridge is interrupted

[11] The Green Book

If you do not use a second thermometer, calibrate the integral fridge thermometer as frequently as the manufacturer recommends. Records of fridge temperatures must be retained for a period of 12 months.

- **Data loggers**: To provide assurances that the cold chain is being maintained when a data logger is used in the vaccine fridge, each working day the logger must still be read and temperatures on the integral fridge thermometer recorded (minimum, maximum and current) then the min/max thermometer reset. Failure to do so runs the risk that, should the data logger or battery be faulty, this would result in a breach of the cold chain and all the fridge contents potentially having to be destroyed.

  The benefit of a data logger over the reliance upon a fridge alarm system is that the data will be stored, and the cold chain confirmed even should there have been a power outage for several hours over a prolonged period, such as a weekend. The standard fridge alarm may sound whilst out of temperature range but cease to sound once temperatures return to normal.

  Additionally, on some fridges, there may be no warning lights to advise of any temperature spike.

- **Actions in the event of fridge failure**: Staff responsible for the monitoring and storage of the vaccines should know what to do in the event of a fridge failure or loss of power.

  Initial actions should be to:

  - Keep the fridge door closed to retain the temperature
  - Review the overall incident, establish how long the fridge has been without power and determine the last reliable temperature
  - Isolate affected vaccines until they are deemed safe to use
  - Contact manufacturers to determine the feasibility of using the vaccines
  - Maintain an accurate record of the incident
  - Dispose of vaccines if rendered unusable

  Should the manufacturer deem the vaccines safe to use, normal cold chain management should be restored. If it is thought that vaccines may have been administered that were outside of the parameters, advice should be sought from the local area team, in conjunction with the manufacturers and, if necessary, patients recalled.

  For further detailed information, see the organisation's Cold Chain Policy.

- **Shredding**

The Secretary of State for Health and all NHS organisations have a duty under the Data Protection Act 2018 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 the provider chosen to carry out offsite destruction is fully compliant and accredited as follows:

- BS EN 15731:2009 in the role to undertake shredding and disposal of confidential paper waste offsite
- ISO 15489-1:2016 standards
- ISO 9001 (UKAS approved) certificate of compliance

ISO 9001 confirms that the contractor, as a member of the British Security Industry Association (BSIA), has obtained the required quality management systems plus can evidence that these standards are both monitored and maintained.

For further detailed information, see the organisation's Confidential Waste Policy and Waste Management Policy.

- **Waste management**

Organisations will need to apply to the Environment Agency every three years for registration as a producer of controlled waste where they dispose of clinically contaminated dressings, speculums, sharps, etc. This can be done online here.

In premises where there are other clinical staff employed by community providers, etc. who also produce controlled waste, it is important that it is not mixed up with that from the organisation and is collected and labelled separately.

The reason for this is that the organisation is responsible for all problems that may arise and which are traceable back to them. Should a community nurse inadvertently place an unsheathed sharp in a plastic bag which has the organisation identity label attached, and that results in a needle-stick injury to the waste carrier, it will be the organisation that is prosecuted.

For the same reason, it is highly inadvisable for the organisation to accept any clinical waste, particularly sharps, from patients (diabetics, etc.) and it is the responsibility of NHSE and the ICB to have arrangements in place for the collection and disposal of patient-produced hazardous clinical material.

Clinical waste must be stored in a clearly labelled facility, preferably away from any public areas and only collected by a licensed waste carrier – who will be contracted to NHSE depending on the delegation of role that exists in individual areas.

Healthcare waste is a particular problem for organisations as it impacts both on Infection Control and Health and Safety. Waste is broadly classified into three types. The first is general domestic/commercial waste and typical examples in the organisation would be discarded paper/ envelopes and waste from the kitchen that poses no obvious risk to anyone encountering it.

Secondly, you may find healthcare waste classified as clinical waste, which unless handled in a safe manner is a hazard to any person meeting it. It is any waste that may be contaminated with human tissue, blood or other body fluids, excretions, medicines/injections, dressings, or swabs used in cleaning wounds or syringes, needles, or other sharp instruments.

This includes other waste arising from the provision of treatment, such as disposable gloves or aprons, towels or any other waste that may carry an infection risk to any person coming into contact with it. Being hazardous, it may also be harmful to the environment.

For specific COVID-19 guidance for healthcare waste refer to the NHS document titled: COVID-19 waste management standard operating procedure

Clinical waste can also be anything that is not necessarily infectious, as can be seen from the examples above, but can prove to be a chemical risk to persons coming into contact with it. Organisations often, and increasingly so, as patients are more frequently being seen outside the hospital environment need to administer cytotoxic or cytostatic injections which carry risks.

The carrier must provide the organisation with a statement of what it collects each time and those receipts must be kept for future inspection, if required.

All personnel, when involved in the handling of clinical waste, should use the correct PPE; it is essential that staff have received IPC training before handling clinical waste. The minimum PPE requirements when handling clinical waste are gloves and an apron.

Clinical waste bins must be emptied on a daily basis and bags must not be filled more than three quarters full. Waste must be placed in the correct receptacle whilst awaiting collection.

For further detailed information, see the NHS property service poster titled Disposing of clinical and non-clinical waste which is also in the Infection Prevention Control Handbook and the guidance available at the following gov.uk websites:

- Hazardous Waste
- Hazardous Waste: Consignment Note Guidance
- Classification of Types of Waste

3.18 Procedural guidance for staff

The organisation should have a readily accessible directory of policies and protocols that all staff can get to when needed.

Topics include:

- Clinical
- Medicines and prescribing
- Finance
- Health and safety
- Human resources
- Information governance
- Information technology
- Patient administration
- Practice business administration
- Premises
- Quality
- Strategy

They can be retained within the organisation's intranet or on a shared drive on the main server. In this latter instance, it will need to be well constructed in a logical format to be properly effective. In exceptional cases an organisation may keep hard copy policies, but it is important in all cases for the copy that is accessible to be the most up-to-date version.

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 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 to spot when operating issues change and a digital filing system/software should prompt when review dates are due.

Further support including a list of commonly required policies that the CQC will expect an organisation to have can be found in the CQC Handbook at Annex B.

Additionally, to support document control, Policy Manager is available in the HUB.

3.19 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) 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, 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.

  To satisfy the Care Quality Commission (CQC) and to show inspectors that quality improvement is of significant priority, organisation's should show that they are focused on the three domains of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

The CQC will look at quality improvement under key line of enquiry[12] (KLOE) E2: How are people's care and treatment outcomes monitored and how do they compare with other similar services?

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 which 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 Quality Assurance Policy and GP Mythbuster 4: Quality improvement activity

- **Risk assessment**

Risk assessments are often perceived as being complicated and very time consuming. The organisation's Risk Assessment Guidance Document assists 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. It will be of huge benefit to adopt a systematic approach to the identification, assessment and management of risk which will enable a much better understanding of what needs to be managed and to what extent.

Risk related information is broadly set against the standards promoted by organisations such as the Institution of Occupational Safety and Health (IOSH) and the International Institute of Risk and Safety Management (IIRSM). The general requirements to undertake risk assessments are set out in the Management of Health and Safety at Work Regulations 1999 (MHSWR) and its Approved Code of Practice (ACOP) which take precedence.

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) using available resources.

[12] CQC Key lines of enquiry, prompts and ratings

For further detailed information, see the Business Risk Assessment Guidance Document, Risk and Issues Guidance Document, Risk Assessment Guidance and Risk Assessment Toolkit.

- **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.

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 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. As such, the following are considered key components of the register:

- Reference number
- Risk description
- Consequence
- Approach
- Residual likelihood
- Residual risk rating
- Date added
- Numerical priority (current risks)
- Risk category
- Likelihood
- Risk rating
- Description of mitigating actions/control measures
- Residual consequence
- Owner
- Date updated
- Date closed (retired risks)

For further detailed guidance, see the organisation's Risk and Issues Guidance document.

3.20 Security

The organisation faces several risks which 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 are to always wear their NHS identification badge when on the premises.

- **Staff access**

All staff are permitted to access all areas within 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 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 no obstruction 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 following supporting documentation can be used for visitors:

Third party confidentiality agreement - Incorporating fire safety and risk awareness for visitors

- **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 are to then:

  - Deactivate the alarm
  - Conduct a walk around the organisation, turning on corridor lighting, etc.
  - 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, etc.

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 regarding 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, i.e., 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 Security and Risk Assessment Policy and Risk Assessment and Control Form – Locking and Unlocking premises

- **CCTV**

See the CCTV 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.

For further detailed information, see the organisation's range of Corporate Guidance documents.

4 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.

4.1 Accountant

The organisation should appoint an accountant who prepares the formal annual accounts and deals with the partners' tax returns for submission to the Inland Revenue. 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 often this will be the case. The annual accounts are later presented to the partners at a business meeting which may take place two or three months after the year end.

For further detailed information, see Choosing an Accountant.

4.2 Accounts

These days, accounts are generally kept in a computer format. Iris GP Accounts software complements the Iris Payroll package, but organisations may also use other software such as Sage, Quicken, Xero or Microsoft products. Software packages are made secure by setting a password and this is an essential requirement in the interests of financial security and confidentiality.

Most products are cloud based so there is no need to be concerned with lost data, however those packages that are not cloud based should be regularly backed up at regular intervals, at least each month or quarter end, and certainly at the end of each financial year.

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.

It can be useful to set up categories to keep track of expenditure on expensive items such as printer cartridges. It is also useful to keep additional 'accounts' (not bank accounts) for all NHS income as well as petty cash. It is also important to keep track too of any private income received in the form of cash, cheques, or direct credits.

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 before the VAT Return is made, should the practice or organisation be VAT registered.

The formal year end for the preparation of the organisation's annual accounts is the date when business accounts close.

The accounts may comprise print-offs from the accounts software package, which could be filed in a ring binder. However, some accountants can accept digital transmission of the organisation accounts or a CD with the details as they have the accountant's version of the same software package as the organisation. It is good practice, in all cases, that a hardcopy folder should be kept for each financial year.

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.

This year-end process may mean entering all cheques issued and completing all auto-bank line payments and printing off payment schedules and remittances. It will also mean breaking down certain payments in more detail. For instance, any assets purchased, such as furniture and equipment, will need to be shown separately in the accounts. Computer hardware should normally be provided by the NHS IT provider without charge to the organisation. Office and medical supplies are broken down in more detail. For instance, drugs, vaccines, and medical consumables, such as minor surgery packs, should be shown separately.

The Bank Charge Projection tool can be used to forecast the organisation banking charges for each financial year.

Further detailed information, see the organisation's Financial Management Guidance Document and Business End of Year Planning Protocol.

4.3 Bank statement reconciliation

Bank statements issued by the bank can be received monthly, fortnightly, or as and when requested. The need for hard-copy bank statements has reduced as more and more clients use online banking services. Bank statements can also be viewed using password access. The bank reconciliation process requires that the entering of all income and payments is brought up to date. The following tips may need to be considered when balancing the books.

Reconciliation of all accounts needs to be undertaken before any VAT return can be calculated and submitted to HMRC online. 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.

Further detailed information, see the organisation's Financial Management Guidance Document.

4.4 Banking

An organisation's main business current and other accounts are usually placed with a mainstream 'high street' bank. Account transactions 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 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, etc. 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 should there be 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

– 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.

4.5 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 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 SSC 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

4.6 Claim process for activity undertaken

The organisation receives income from a variety of sources, some of which are paid for by Public Health, the Area Team, NHS England, or the ICB. 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 England, or another organisation, requests information about a particular GP service
- NHS England 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 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 is in their own clinical system
- If its 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! Organisations tend to experience significant problems with payments made through the NHS and the need to keep on top of what is owed and what is received is vital.

Organisations can login with an appropriate user ID and Password here and the user guides can be found via here.

4.7 Contracts

There are three different types of GP contract arrangements used by NHS Commissioners in England – General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS). The below is an extract from the Kings Fund document titled GP funding and contracts explained.

- The GMS Contract is the national standard GP contract. In 2018/19 around 70% of GP organisations operated under it.

  This contract is negotiated nationally every year between NHS England and the General Practice Committee of the BMA, the trade union representatives of GPs in England. It is then used by either NHS England and/or ICBs (depending on delegated powers) to contract local general practices in an area.

- The PMS Contract is another form of core contact but, unlike the GMS Contract, is negotiated and agreed locally by ICBs or NHS England with a general practice or practices. This contract offers commissioners an alternative route with more flexibility to tailor requirements to local need while also keeping within national guidelines and legislation.

  The PMS Contract is being phased out but in 2018/19, 26% of organisations held one.

- The APMS Contract offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third second providers) other than general practitioners/partnerships of GPs to provide primary care services.

  APMS contracts can also be used to commission other types of primary care services, beyond that 'core' general practice. For example, a social enterprise could

be contracted to provide primary health care to people who are homeless or asylum seekers. In 2018/19 19.2% of organisations held this type of contract.

A new Integrated Care Provider (ICP) Contract has recently been made available to allow for greater integration of services. This can offer an additional contracting route for general practice but there has been no uptake so far.

All types of contracts are managed by the NHS Commissioner (either NHS England or ICBs). Where contracts are negotiated locally, Local Medical Committees representing GPs may advise or participate in discussions alongside regional BMA representation.

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 and sets 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 (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) that vary by area.

General organisations 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 provide 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, 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

4.8 Direct 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 Managers Handbook.

4.9 Expenses

The organisation may have an Expenses Policy giving guidance on the payment of expenses that will apply 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).

This includes setting out:

- How to claim expenses
- Alternatives to travel
- Rail travel
- Taxis
- Use of own vehicle
- Meals and accommodation

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. For further detailed information, see the organisation's Expenses claim form.

4.10 Fraud

The NHS Counter Fraud Authority (NHSCFA) 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. By NHS fraud, this means any fraud where the NHS is the victim.

Types of fraud associated with general practice includes:

- Diversion of the global sum
- Treatment record/claims
- Capitation figures
- False claims
- Prescribing
- Inducements
- Conflicts of interest
- Disposal of drugs
- Prescription fraud
- Timesheet fraud
- Expenses fraud
- Invoice fraud

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. Staff can access the online reporting tool here.

Staff are not to be discouraged from reporting suspicions of fraud due to a lack of information. The role of investigating suspicions rests with the NHSCFA and suspicions of fraud should be reported at the earliest opportunity.

For further detailed information, see the organisation's Anti bribery and Counter Fraud Policy.

Fraud Awareness training is available in the HUB.

4.11 Global sum

Practices receive an amount of money per patient called the Global Sum, this is so practices can deliver the core parts of its 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 £102.28 per patient from 1 April 2023 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.

The exact amount of the global sum will depend upon the application of the allocation formula, as follows:

- An adjustment for the age and sex structure of the population, including patients in nursing and residential homes
- An adjustment for the additional needs of the population, relating to morbidity and mortality
- An adjustment for list turnover
- Adjustments for the unavoidable costs of delivering services to the population, including a staff Market Forces Factor and a rural factor.

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.

From October 2020, organisations have been required to support NHS England maintain an accurate and up-to-date list of patients.

For further detailed information, see the BMA Guidance on Global Sum Allocation Formula.

4.12 GMS contract

NHS England may have entered a General Medical Services 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 NHSE (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 that 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 NHSE, 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
- Seniority payments (ceased with effect from 1 April 2020)

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

For further understanding on the GMS Contract changes for 2023/24 see the NHSE guidance or this YouTube clip from eGPlearning.

4.13 HMRC

- **Annual returns**

The P32 return must be submitted to the Inland Revenue by 19 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. 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.

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 Inland Revenue 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 – each partner signs 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 partner's 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.

4.14 Income (including remittances)

NHS income is mainly received from three different sources: NHS England, the Integrated Care Board (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 which enables the organisation accountant to correctly attribute income at the year end. Income from the NHS – either directly through the current payment system or through an agency (presently PCSE) – may be very difficult to account for as the agencies seem to have their own referencing system that bears little resemblance to any invoices an organisation may issue.

4.15 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 England, 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.

4.16 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, a temporary employee.[13]

IR35 was implemented in April 2000 and is known as the intermediaries legislation. The responsibility of determining whether IR35 applies rests with the public authority or medium and large-sized organisation outside the public sector whereas previously it rested with the intermediary.

As an NHS provider, a primary care organisation is classed as a public authority and has a responsibility to determine if locum and agency workers fall within IR35.

To determine the employment status for tax of the individual providing the services, it is advised the Check Employment Status for Tax Tool is used to understand a worker's employment status. A determination, based on the information submitted, can be:

- Employed for tax purposes for this work
- Self-employed for tax purposes for this work
- Off-payroll working (IR35) rules apply
- Off-payroll working (IR35) rules do not apply
- Unable to determine – the tool will then give further information to help to reach a decision

For further detailed information, see the current governmental information and the organisation's IR35 Policy.

4.17 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

[13] IR35 Tax Legislation

specifications or be locally agreed although there is an expectation that ICBs review their existing LES portfolio and develop commissioning intentions for relevant community-based services to be commissioned using the standard NHS contract.

These current schemes could include:

Local Enhanced Services	
24-hour ambulatory BP monitoring	HRT
24-hour ambulatory ECG	Information management and technology
Administration of Denosumab	Minor injuries
Alcohol screening	Oral anticoagulation
Atrial fibrillation	Oral glucose tolerance test
Care homes	Phlebotomy
COPD	Shared care drug monitoring
Complex dressings	Treatment room services
Homeless outreach nurse	Special allocation scheme (SAS)

4.18 National Living Wage (NLW)

The National Living Wage (also known as the 'minimum wage') is the least amount that any employee can receive. Uprated from 1t April 2023, it stands at:

Age band	From 1st April 2021
Adult rate 23 and over	£10.42
Adult rate 21-22	£10.18
18-20	£7.49
Under 18	£5.28
Apprentice rate	£5.28

Organisations must ensure that none of the following payment mistakes are made and should any have occurred as the employer, the organisation could owe back pay.

- **Working overtime?**
  If an employee receives a higher hourly rate for overtime or working antisocial hours and is paid below the National Minimum or Living Wage 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.

  The ruling states:

  "Regular voluntary overtime must be included in the first four weeks' holiday pay. Allowances do not need to be factored into holiday pay for those employees who only worked voluntary overtime occasionally. For those employees who worked voluntary overtime on a regular basis, the overtime has become an intrinsic part of their jobs and should be taken into account when calculating their holiday pay (for the first four weeks' holiday required under EU law)"

To support planning, Holiday Manager is a free resource in the HUB. Furthermore, a holiday overtime pay calculator can be sought here.

- **Is the cost of your 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, etc., 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 your shift (e.g., should there still be patients 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.

Further detailed information is available from the gov.uk National Minimum Wage and National Living Wage rates guidance.

4.19 NHS statements (PCSE Online)

Open Exeter was the legacy system for NHS Payments. However, on the 1st June 2021 PCSE launched a new online service to help administer practice payments and GP pensions.

This system provides practices with the ability to submit claims for premises and locum cover online. Practices can submit claims easily online, with the added benefits of knowing there are checks in place for any missing information and the ability to easily track where all claims are in the process. Practice Statements will also be hosted by PCSE Online.

This toolkit hosts a suite of services and can be accessed here.

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
- Seniority 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

PCSE have provided several guidance documents to support the implementation of the new system and additional guides are available:

- Monthly Practice Statements
- Claims Portal Guide
- Optional Services

Access to the system is by NHS email via the login page. Further guidance can be obtained by contacting the PCSE Team at pcse.user-registration@nhs.net.

4.20 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. The organisation accountant will 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 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, etc.

4.21 Partners' earnings declaration

As from 1 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 the 30 April in the financial year beginning immediately after the end of the next financial year

The General practice pay transparency guidance from NHS E details the requirement further including the established thresholds for earnings as detailed in the below table.

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

Legislation surrounding this requirement has been included into The National Health Service General Medical Services Contracts and Personal Medical Services Agreements) (Amendments) (No 2) Regulations 2021.

Further reading into this requirement can be sought from BMA guidance here.

In addition to this, and as it is deemed that only a minority will meet the above thresholds, practices will continue to also 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 England 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.

Producing the final figures: Total relevant income/number of GPs = mean total

The mean GP earnings figure should include income for all contractors, salaried and locum GPs who worked full or part-time in the organisation for a total of six months or more within the financial year.

- For contractor GPs, the earnings should include income and expenditure for the area listed below.
- For salaried GPs, this should be the actual salary of staff which relates to the work areas listed below.

- For locum GPs, this should be the actual income of the locum.

All earnings should be pre-tax, National Insurance (NI) and employee pension contributions. For GP contractors, the figures should include organisation expenses incurred. This includes earnings from NHS England, ICBs and local authorities for GP services that relate to the contract, or which have been nationally determined.

Income to be included:

- Global sum (and PMS equivalent) - this should include the organisation's global sum income (considering any OOH deduction where the organisation has opted out) and MPIG correction factor payments, as well as any financial support in respect of the phasing out of MPIG
- Quality and outcomes framework - including both aspiration and achievement payments
- Item of service fees for specific vaccination and immunisations services
- Income from national enhanced services - local enhanced services should not be included
- PA reimbursement and fees, including reimbursement for PA drugs and PA fees
- Employee's superannuation

The items of income above should be minus the following expenditure costs:

- Organisation expenses - this includes staff costs, general running costs for the organisation and depreciation
- Personal/business expenses - transport costs for home visits, MDU, GMC and BMA subscriptions, mobile phone costs, capital allowances claimed on vehicles
- Any other expenses related to items which are included in the calculation
- With ref to ES and V&I - the costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs

For further detailed information, see the BMAs Publishing GP Net Earnings guidance.

4.22 Partners' personal expenses

Some or all 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.

4.23 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.

Between December and 29th February all practitioners need to have returned their forms to PCSE via the portal.

- GP Partners and non-GP (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 organisations 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 is similarly advised to NHSE.

4.24 Partnership superannuation returns

- **GP superannuation payments**

  NHS England 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. The highest percentage deduction is 14.5%. As at April 2023, the BMA advise that GP employers' contributions are 20.6% (England and Wales), 22.5% (Northern Ireland) and 20.9% (Scotland)[14].

  A pension guide for GPs is available here.

  It is important that organisations do not 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

[14] BMA

commencement in 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 England requires, showing the superannuable income for organisation partners. This certificate allows NHS England 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 income from outside the organisation (e.g., out-of-hours or locum fees) is included – and he/she 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 within the PCSE website.

4.25 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, and most, if not all accounts or payroll packages now have the facility for online submission of payroll data.

Therefore, it is recommended that should the payment be made by the 10th working day, this will provide adequate time for the payment to be received and allocated appropriately. If payments are made too early, or too late, HMRC may not correctly link the payments.

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, so remember that individual monthly payments need to be made.

Further detailed information is available on the gov.uk website – PAYE and Payroll for Employers guidance and Pay Employers' PAYE guidance.

4.26 Payroll

Iris Payroll also has a personnel record and an annual leave record, but other software may be employed for a similar purpose.
Probably the most widely used staff payroll software is Iris GP Payroll, which is updated several times a year to take account of tax changes and year-end processes. There is a maintenance fee, payable annually in March to Iris Software. The organisation will be able to regularly update the system online, when requested to do so and for the new financial year. At the year end, it is important to take a backup copy of the year's accounts before undertaking a close-down of the year.

Pay increases will usually be agreed with the organisation partners or executive management and should be added to the payroll system according to the organisation or company policy. Many organisations outsource their payroll to an agency or their accountants, so the system that might be found can vary widely. Annual increments need to be amended in the personal pay details of each employee. The Iris GP Payroll can also be used to keep personnel records, including sickness absences, appraisals, and personal details. Again, this will be according to what systems are in place in individual organisations.

Where payroll is outsourced, a monthly list of overtime, new starters, etc. is usually required by the agency who will use it 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 organisation accountants will be necessary in making pension and HMRC annual returns.

- **Salaries**

  The pay rates that the organisation uses which 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**

  Organisation 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 37.0 hours or 37.5 hours per week. 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? Statutory Sick Pay is due
- 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 are leaving during the month?
- Have staff claimed expenses, travelling, etc?

- **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. See the Pension Management – NHS section for further details on pension administration obligations for the employee and employer.

  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 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 gov.uk website – Tell HMRC about a new employee guidance and the HMRC 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. Payslips must now show:

    - Earnings before and after any deductions
    - The amount of any deductions that may change each time a payment is made, e.g., tax, national insurance, student loans
    - The tax code of the employee
    - The date of receiving the pay
    - The pay period
    - The number of hours worked and any overtime
    - The rate of pay
    - Deductions
    - Superannuation contributions

- **Payslips and P60s**

  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 are unique documents that shows the tax the employee has paid on their salary (6 April to 5 April). Employers must provide these to every employee employed in the organisation on the 5 April each year and the P60 must be provided by 31 May either on paper or electronically.

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

  The organisation's payroll software hopefully provides an effective wizard to make payments of statutory sick and maternity pay. It is important 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 as below.

  For statutory sick pay if an employee has had two periods of absence within 56 days, there are no waiting days for payment for the second absence as this is classed as a 'linked period' where they are unable to work. If an employee is sick and away from work on two or more occasions within a 56-day (8 week) period, then each period of absence is 'linked' and regarded as a single period of entitlement for the purposes of SSP. This means that the maximum payment of 28 weeks of SSP will be gradually used.

  If an employee is off sick after more than 56 days since the last period of absence due to sickness or injury, then this will be treated as a 'non-linked' period of absence and the period of entitlement will be 'reset' to 28 weeks.

  Further detailed guidance is available from the gov.uk website – Statutory Sick Pay (SSP) Employer Guide

- **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 and qualifying.

  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 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 are often reimbursed at the rate of 45p per mile. A GP registrar will be able to make mileage claims via the lead authority**.** 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 those costs.

For further detailed information regarding how to claim expenses, travel between main and branch surgeries, use of 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 gov.uk website – 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 on the gov.uk website – Make Debt Deductions from an Employee's Pay guidance.

- **Staff leaving**

  A P45 should be printed off and issued promptly to staff who are leaving. The payroll software or agency will be able to print a computer version of the required form. Part 1 will be sent or uploaded to HMRC. Part 1A, 2 and 3 is given to the leaving employee. Part 1A is kept by the employee. Parts 2 and 3 should be given to the new employer by the employee.

  Further detailed information can be found on the gov.uk website – What to do when an employee leaves.

- **Payroll enquiries**

  Occasionally the organisation, as employer, is asked to respond to enquiries on behalf of staff from the Department of Social Security, 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 take a backup to an external drive, to protect the payroll. Taking a backup to an external drive ensures that the payroll is saved elsewhere and can be used to reinstate the payroll if there is a PC breakdown or crash. It is strongly recommended not to make a backup to the C drive as this does not protect the payroll software and it is important not to decommission the payroll computer without transferring annual backups to any new computer.

4.27 Pension management – auto-enrolment

- **Auto-enrolment**

  Not all workers will automatically join the workplace pension scheme. For those that meet the eligibility criteria to join automatically, the member does not need to take any action if they wish to remain in the pension scheme. Other workers who may want to join a workplace pension scheme do need to act.

Each employer must review its workforce to identify which workers are eligible to join its workplace pension scheme. Workers may fall into one of four categories:

- **Eligible jobholders**

  Will be automatically enrolled into the workplace pension scheme, if they are not already active members of a workplace pension scheme that meets a set of minimum standards. The employer must make pension contributions to the pension scheme and the worker may also have to contribute. Workers who do not want to join the scheme may opt out for a three-year period. However, employers are required to continue automatically enrolling eligible workers who have opted out, every three years.

  Eligible jobholders are workers who:

  - Are aged between 22 and state pension age
  - Earn over the earning threshold, and
  - Work in the UK

  The earnings threshold is £10,000 per annum, but employees will be assessed for eligibility at each pay period. The earnings threshold will be pro-rated meaning the actual earnings threshold amount will differ if employees are paid monthly, four-weekly, fortnightly, or weekly. As employees are assessed for eligibility at each pay period it may be possible that employees are automatically enrolled if their earnings increase - if only for a short period.

- **Non-eligible jobholders**

  Non-eligible jobholders, who are not already active members of a workplace pension scheme that meets certain minimum standards, do not have to be automatically enrolled in the employer's workplace pension scheme, but do have the right to ask to join the scheme. They will also receive employer contributions.

  Non-eligible jobholders are workers who either:

  - Are aged either between 16 and 21, or aged between state pension age and 74
  - Earn over the earnings threshold, and
  - Work, or ordinarily work in the UK and have a contract of employment (i.e., so is an employee and not a self-employed contractor) or who have a contract to provide work and/ or services personally (so cannot sub-contract to a third party)

  Or:

  - Are aged between 16 and 74
  - Earn between the lower earnings amount and the earnings threshold; and

- Work, or ordinarily work in the UK and have a contract of employment (i.e., so is an employee and not a self-employed contractor) or who have a contract to provide work and/ or services personally (so cannot sub-contract to a third party)

The earnings threshold is the same as above.

The lower earnings amount is currently £6,136, but each employee will be assessed for eligibility at each pay period and the lower earnings amount will be pro-rated. As employees are assessed for eligibility at each pay period it may be possible that employees are automatically enrolled if their earnings increase - if only for a short period.

- **Entitled workers**

  Entitled workers, who are not currently members of a workplace pension scheme that meets certain minimum standards, have the right to ask to join a workplace pension scheme, but this does not need to be the same scheme as eligible jobholders and non-eligible jobholders. It could be a personal pension or another type of pension scheme. The employer is not required to make contributions to an entitled worker's pension scheme, although it may choose to do so.

  Entitled workers are workers who:

  - Are aged between 16 and 74
  - Earn less than the lower earnings amount, and
  - Work, or ordinarily work in the UK and have a contract of employment (i.e., so is an employee and not a self-employed contractor) or who have a contract to provide work and/ or services personally (so cannot sub-contract to a third party)

- **A worker who is not an eligible jobholder, non-eligible jobholder or entitled worker**

  A worker who is not an eligible jobholder, non-eligible jobholder or entitled worker does not have any rights to join an employer's workplace pension scheme but can save towards their retirement by taking out a pension scheme, such as a personal pension or stakeholder pension themself.

As an employer, organisations need to keep abreast of the information required to be sent to members of staff requiring opting in and opting out. Running a payroll service might be part of the work of an agency; otherwise, the organisation must be registered with the NHS Pension Authority (NHSPA) as an NHS pension provider and be issued with an EA number against which all pension deductions must be forwarded.

Employees must be registered with the NHSPA on taking up their role, and all enrolment etc. is done online using a form SD55. When enrolled, the employee will also be given an SD number to mark their inclusion in the scheme.

Although most staff will opt for the NHS pension, the organisation will need to be aware that it may need to offer an alternative private pension arrangement if requested, especially where a member of staff has taken their NHS pension and has returned to work.

For further detailed information, see the Pension Management - NHS and Pension Management – NEST sections.

- **Assess and enrol staff**

  Organisations will already have reached their staging date, (i.e., the date at which the organisation has been told it must start to offer a pension to staff), and everything should already be in place to enrol staff into the automatic enrolment pension scheme.

  This assessment continues to be undertaken at the end of each pay period.

- **Postponement**

  Organisations can choose to postpone automatic enrolment for up to three months for some or all staff on joining the organisation.

- **Write to your staff**

  After the staging date, the organisation must write to staff to tell them about the pension scheme and how automatic enrolment applies to them.

- **Your ongoing automatic enrolment duties**

  Once staff have been enrolled into the pension scheme, the organisation will have ongoing responsibilities. It is important to continue to pay contributions, keep records, and constantly review staff including new starters.

  It is against the law to try to influence any employee to opt out of the pension scheme. It is important the organisation complies with its ongoing responsibilities.

  - Keep records of how the organisation has complied with automatic enrolment duties, including:

    - The names and addresses of those enrolled
    - Records that show when contributions were paid
    - Any opt-in and opt-out requests
    - The pension scheme reference or registry number
    - Any information sent to the pension provider

    The organisation must keep these records for six years and opt-out notices for four years.

- **Monitor staff**

  The organisation must monitor the ages and earnings of its staff (including new starters) to see if anyone who was not eligible for automatic enrolment at the staging date has since become eligible. It is important to enrol and write to them within six weeks from the day they become eligible.

- **Manage opt-out requests**

  If any staff choose to opt out within one month of being enrolled, it is important to stop deductions of contributions and arrange a full refund of what has been paid to date. This must happen within one month of their request.

If you fail to complete your ongoing automatic enrolment duties, you could be fined.

Further detailed information is available from NHS Pensions Employer Hub, The Pension Regulator and The Pensions Advisory Service.

4.28 Pension management – NEST

While most employees will choose to enrol into the NHS Pension for its benefits, some staff may wish to enrol into another scheme, especially those who take 24-hour retirement to access their pension benefit. These employees could be eligible to continue to pay pension payments if they so request. They will not be able to re-join the NHS Pension.

Whilst NEST has been the secondary pension provider of choice for practices it is recognised that other providers are available, and it is matter for the practice when selecting a provider. NHSBSA provides further information with regard to stakeholder pensions here.

Auto-enrolment criteria still apply although the contribution rates are much lower than the NHS Pension. The legal minimum for job holders is currently 8% of their qualifying earnings. Of this, the employer will need to pay at least 3%. The remainder comes from the employee's pay (4%), which will be collected by the organisation and sent to Nest, and tax relief from the Government (1%). Nest will claim the tax relief on your workers' behalf.

Organisations can sign up for the scheme online and the management of the scheme works much the same as that of the NHS Pension.

For more detailed information, see the NEST Employers Guidance.

4.29 Pension management – NHS Pension

Extensive guidance for employers and employees is available on the NHS Pensions website and it is recommended that organisations refer to this. However, this section of the Handbook provides an overview of the guidance.

There are two parts to the NHS Pension scheme which consists of 1995/2008 Section and the 2015 Scheme. The 1995 and 2008 Sections are based upon final salary arrangements and the 2015 Scheme is a career average re-valued earnings (CARE) arrangement.

- 1995/2008 Section

For members in the 1995 Section the pension accrual rate is 1/80th of their highest years pensionable earnings (from their last three years membership) for each year of pensionable membership. For practitioners it is 1.4% of uprated pensionable earnings (i.e., dynamised) throughout their career.

The normal pension age (NPA) for members retiring in the 1995 Section is 60. Members with Special Class status and Mental Health Officers may be eligible for an earlier retirement age, from 55. This is subject to them meeting all relevant eligibility criteria at their chosen retirement date.

The minimum pension age for some members considering retirement in the 1995 Section is age 50. However, the minimum pension age increases to age 55 for those members who:

- join for the first time after 6 April 2006
- re-join after 6 April 2006 with deferred benefits prior to 31 March 2000
- left the Scheme before 31 March 2000 and have not re-joined (deferred benefits)

On 1 April 2008, a new section of NHS Pension Scheme (2008 Section) was introduced for new members and former 1995 Section members who were returning to the Scheme after a break in membership of five years or more. Members who were able to continue in the 1995 Section after 1 April 2008 were given the choice to move from the 1995 Section to the 2008 Section.

For members in the 2008 Section the pension accrual rate is 1/60th of reckonable pay for each year of membership they accrue. Reckonable pay is calculated as the average of the highest three consecutive years' pensionable earnings in the last 10 years of membership. For Practitioners it is 1.87% of total career uprated (i.e., dynamised) pensionable earnings.

The normal pension age (NPA) for the 2008 Section members is 65. Members cannot have more than 45 years membership in the 1995 or 2008 Section.

- 2015 Scheme

The 2015 Scheme commenced on 1 April 2015. Active membership of the 1995 or 2008 Sections ended on 31 March 2015 for those members who were not eligible for full or tapered protection.

Benefits in the 2015 Scheme are built up at a rate of 1/54th of actual pensionable earnings in each scheme year of active membership, which runs from 1 April to 31 March each year. This is known as the pension account or 'pension pot'. Each scheme year the pension account is revalued until 2015 Scheme membership ceases. The pension pot is revalued each year to ensure that the value of an active 2015 Scheme member's NHS pension is protected against inflation.

The 1/54th build up in the 2015 Scheme is the same for officers, organisation staff, non-GP providers, and practitioners.

There is no maximum limit on pensionable membership in the 2015 Scheme. The pension age in the 2015 Scheme is the later of age 65 or equal to the member's State Pension age. A member may continue active membership of the 2015 Scheme after their normal pension age.

Membership of the 1995/2008 Section and 2015 Scheme must cease at age 75.

- **Enrolment**

All NHS employers must enrol all eligible employees into the NHS Pension Scheme from their first day of employment. The Scheme is open to any NHS workers aged between 16 and 75 who are:

  - Directly employed by the NHS (this includes apprentices)
  - Medical, dental and ophthalmic practitioners and trainees who have a contract with the NHS
  - General medical organisation staff (from 1 September1997)
  - Eligible staff of independent provider/direction bodies which have specifically been granted access to the Scheme
  - Non-general practitioner providers
  - Freelance locum medical practitioners

A member of the 1995/2008 Section, and 2015 Scheme can be both an officer and a practitioner. Officer membership cannot exceed whole time.

When an employee is auto-enrolled, the organisation will be responsible for issuing a Member Guide each time the employee is auto-enrolled. Normal Scheme joiner procedures apply for auto-enrolled members and so a pension record should be set up immediately. You should not wait to see if the member will opt out.

Salaried doctors or staff joining the scheme will need to complete a joiner's form and be added to the scheme using the NHS Pensions website. For members leaving the scheme, the Pensions website will require amendment. Changes of name and address should also be notified on the website. The final salary payments made to members retiring will need to be submitted before a pension award application can be considered.

- **Scheme protection arrangements**

The 1995/2008 Section closed with effect from 1 April 2015 with the exception for some members who may be entitled to continue in the 1995/2008 Section under scheme protection arrangements. Members may be entitled to full protection, tapered protection, or no protection.

- **Types of members**

The NHS Pension Scheme has different types of members. They are:

- Officers
- Organisation staff
- Practitioners
- Non-GP providers
- Special class members
- Mental health officers (MHOs)
- Pension Credit members

Many organisational staff will be classed as organisation staff or practitioners. GP registrars (or GP trainees) are afforded Officer NHS Pension Scheme status.

A Type 1 medical practitioner is a GP provider (GP partner, single–hander, or shareholder, in a GMS (General Medical Services), PMS (Personal Medical Services), sPMS (specialist Personal Medical Services), or classic APMS (Alternative Provider of Medical Services) surgery.

A Type 2 medical practitioner is as salaried or long-term fee-based GP working in a GMS, PMS, classic APMS or SPMS surgery. This also includes GP retainers and any GP who works solely for an Out of Hours provider either on a salaried or fee-based arrangement.

Non-GP providers is a sole trader, shareholder, or partner in a GP (or APMS) who is not a GP. Non-GP providers always have whole time Officer status regardless of the number of hours they work, and they can only pension income from one post. If they are working in more than one NHS post concurrently, they must decide which post to pension. Their pensionable pay is their share of the organisation's profits unless they are a fixed salary partner.

Special class status is a historical provision of the 1995 section and is only relevant to members who were employed as nurse, physiotherapist, midwife, or health visitor on or before 6 March 1995. Subject to qualifying criteria being met, Special Class status allows a member to retire from the age of 55 without a reduction to their benefits. Special Class status was abolished for all new members who joined the 1995 Section after 6 March 1995 and for any members returning after a break in membership of any one period of five years or more.

- **Employee pension contributions**

The employer contribution rate for the period 1 April 2019 to 31 March 2023 increased from 14.3% to is 20.68% of pensionable pay for both the 1995-2008 Scheme and the 2015 Scheme.

The employer contribution rate is set through a process known as the scheme valuation. A scheme valuation is carried out every four years and it measures the full cost of paying pension benefits (to current pensioners).

Employers are required to pay a scheme administration levy, in addition to the employer contribution rate, to cover the cost of the scheme administration. This levy is 0.08 per cent of pensionable pay and will be collected at the same time and in the same way as

normal employer contributions. In practical terms, this means employers will pay 20.68% of pensionable pay.

Since 1 April 2019, employers are responsible for paying 14.38% of contributions with the remaining 6.3% being funded centrally.

When entering new staff in the payroll or increasing the pay of existing staff, it is important to check that the correct employee pension contribution is being levied. The employee's percentage rate deduction depends on the level of their **annual** salary. Employee pension contributions should always be worked out based on the whole-time equivalent. Check the NHS Pensions website for the correct percentage value.

A new member contribution structure came into effect on 1 October 2022, replacing the old structure that had been in place since 1 April 2015.

From 1 October 2022, three key changes were made:

- Member rates are determined using actual pensionable pay earned in the previous scheme year, instead of whole-time equivalent pay
- The new contribution structure will mean that many members will pay a different rate to what they previously paid in the old structure
- Going forward, the thresholds for each tier will be increased in line with the Agenda for Change pay award, which will reduce the likelihood of a member moving to a higher contribution tier as a direct result of a national pay award

The key messages to communicate to staff about the changes from 1 October 2022 can be found on our dedicated web page.

Member contribution rates:

Pensionable pay (WTE)	Phase 1 Contribution rate from 1 Oct 22 based on actual pensionable pay	Phase 2 Contribution rate based on actual pensionable pay
Up to £13,246	5.1%	5.2%
£13,247 to £16,831	5.7%	6.5%
£16,832 to £22,878	6.1%	6.5%
£22,879 to £23,948	6.8%	6.5%
£23,949 to £28,223	7.7%	8.3%
£28,224 to £29,197	8.8%	8.3%
£29,180 to £43,805	9.8%	9.8%
£43,806 to £49,245	10%	10.7%
£49,246 to £56,163	11.6%	10.7%
£56,164 to £72,030	12.5%	12.5%
£72,031 and above	13.5%	12.5%

Source: NHS Employers Pension Contributions and tax relief

Where an employee holds two job positions with the same employer, it is the employer's responsibility as to how they assess multiple employments for auto-enrolment. Examples of how this may work can be found on the NHS Employers website.

Where an employee has two different jobs with different employers, each having separate PAYE references, both employers must enrol the worker under automatic enrolment legislation.

In instances where an employee has pension arrangements elsewhere but not in a qualifying scheme, they must still be auto enrolled in the NHS Pension Scheme as this is the default pension scheme for eligible NHS employees.

- **Joiners to the NHS pension**

  Joiners to the NHS Pensions Scheme will need to be added to the Pensions website via Pensions Online portal and the payroll. The SS10GP form will need to be completed by the employee and retained in their HR file. The New Employee Questionnaire will also need to be completed and returned to the employer.

  Continuity of NHS employment will ensure the employee's membership service is enhanced.

  For further detailed information, see the NHS Pensions – New Junior Member Guide, NHS Pension Scheme – Joiners and Eligibility Guide for Employers and NHS Pensions – Capacity Codes List.

- **Opting out of the NHS pension**

  If a member decides to opt out of the Scheme, they will need to complete an application to leave the NHS Pension Scheme (SD502) and return it to you. Employers are not permitted to provide the form to their employees. However, if an employee does not have access to a personal computer/printer, you can supply them with access at work to obtain the form if you have facilities available.

  Once you have been handed the completed and signed form, please retain a copy and either upload the information from the form into Pensions Online or send the original to NHS Pensions. Any other form of request to withdraw from the Scheme (such as by letter, email or verbally) will not be accepted.

  These employees must still be added to the Pensions Online Portal as a new starter and then taken off again the following day. A pension payment should be taken from the payroll for this month and then refunded in the following month by the organisation.

- **Leavers from the NHS pension**

  For any employee wishing to leave the NHS Pension they must complete an SD502 form ensuring that both Part 1 and Part 2 have been completed. Contribution deductions should be ceased for the month in which the form is received. Following the last payment an SD55 form will need to be printed out from the organisation's payroll and the values submitted either via the Pensions Online system or forwarded to the NHS Pensions.

Further detailed information is available from the NHS Pensions – Application to leave the NHS Pension Scheme Guidance and NHS Pensions – Terminating a Period of Employment.

- **Refund of contributions**

The length of time between enrolment and the date a member opts out determines whether contributions can be refunded locally by the employer or whether the refund is paid by NHS Pensions. The application to leave the NHS Pension Scheme (SD502) and the accompanying completion notes provides details of the circumstances where a local refund can be paid. Typically, this is only possible where a member opts out within a month of enrolment. This is known as the 'opt out period'.

If a local refund is paid, the employer contributions may be retained by the employer. If the refund needs to be made by NHS Pensions, you should submit the application for a refund of pension contributions form (RF12) to us. In this instance, employer contributions cannot be retained by your organisation.

Members will qualify for a refund of pension contributions if they:

- Have no continuing membership upon reaching normal pension age
- Have ceased membership of the Scheme in all employments
- Have less than two years qualifying membership in the Scheme (including membership in both the 1995 and 2008 Sections and any transferred in membership)
- Have not had a transfer in from a personal, money purchase or stakeholder pension
- Have re-entered pensionable NHS employment and had a break in NHS pensionable employment of 12 months or more (unless they have requested a transfer of this earlier membership to another pension arrangement within the transfer time limits)

Members will not qualify for a refund of pension contributions:

- If they opt out of the Scheme before the end of the pay period during which they were first included in the Scheme. They are then treated as having never been a member of the Scheme. Employers are responsible for returning these contribution
- If they have two years or more qualifying membership, including membership in both the 1995 and 2008 Sections and transferred in membership
- If they have already reached normal pension age during the period of membership for which a refund is being requested, a refund is not possible as entitlement to pension benefits will now exist. This still applies even though the member will have less than the normal two years qualifying membership required for deferred pension benefits

- If they have had a transfer of pension rights into the Scheme from a personal, money purchase or stakeholder pension

Further detailed information is available from the NHS Pensions – Refund of Pension Contributions Factsheet.

- **Administration of the pension scheme**

  The organisation, as employer, must administer membership of the scheme by notifying the authority (using the website) of staff who join or leave the scheme. Notification must also be made of changes in hours of work, part-time to full-time and vice versa. The NHSPA will need to know changes of address and marital status of both spouses prior to retirement.

- **Pension estimates for organisation staff**

  Active and deferred members of the NHS Pension scheme can access their Annual Benefit Statement through the Total Reward Statement portal. The service is free. Pension statements refresh yearly, based on the information supplied by the employer up to 31 March.

  Estimates can be requested through the appropriate forms here.

- **Annual returns**

  The annual individual returns (SD55s) for staff employed by the organisation who are members of the NHS Pension Scheme must be submitted using the Pensions Online website during the first week in April each year. A printed copy of the annual return can be provided to each member of the scheme with the April pay slip, along with the annual P60. A copy should be kept in the payroll records for the financial year.

  If there has been an increase in the employee's pay during the year it is appropriate to review the contribution rate and update this on Pensions Online in time for the next year contributions.

- **Monthly direct debit notification**

  Payments to the NHS Pension Scheme are collected by direct debit and need to be made by the 19th by submitting the amount to be deducted to the Make Contribution Payments (MCP) on the NHS Pensions website. It is again recommended that the payment is made on the 10th working day to ensure that the payment is received and allocated within the required timeframe. Contribution collection information can be found here.

  The GP1 form that is provided from the organisation's payroll has all the information required for uploading to the MCP portal. This will show the employee and employer contributions for the previous month. This information will also need to be entered into the organisation accounts.

Administration and interest charges were introduced on 1 April 2014 for all NHS Pension employers who pay their scheme contributions late.

- **NHS pension website access**

  The NHS Pension Agency allocates a user code along with a password to allow the employer entry to the website. The NHS email address of the authorised user should also be notified to the agency via the website.

- **Pension awards**

  An extensive NHS Pensions Retirement Guide is available to members of the NHS Pension Scheme.

  The employer is responsible for initiating pension awards once the appropriate form (AW8P) has been completed by the employee. The employee will need to produce their birth certificate and marriage certificate and various certificates and personal details of themselves, their spouse or civil partner and the bank details where they wish their pension to be paid. Care should be taken when filling in the award form as it might affect the accuracy of the pension award and it is a time-consuming and complex process.
  The NHSPA recommend starting the process at least three months before the pension date to ensure payment is made without any gaps after the last salary pay date.

  The employer will be asked to provide information about earnings over the actual final three years of employment. These figures will need to be calculated individually and it may be necessary to print off the last four years' annual pension returns for the member of staff concerned.

  Detailed guidance regarding how to apply, returning to work after receiving the NHS Pension, pension figures and retirement lump sums is available from the NHS Pensions website – Applying for your pension.

  For those staff members who are planning to retire, then return to employment, the NHS Pensions Retire and return guide should be consulted.

  Further information can be sought within the Retire and re-join guidance document.

- **Added years**

  - **Employees**

    The employer will need to process applications for added years, subject to a scheme being available, and apply the agreed percentage additional deduction from the employee's salary. The 'added years' contribution is paid to the NHS Pension Agency each month along with the employee's and employer's contributions and is a means for some employees to enhance their pension amounts.

- **General practitioners**

  Added years payments made by the doctors need to be attributed to their capital accounts. Applications for enhanced pensions or lump sums are dealt with by NHS England. Some doctors may be subject to an earnings cap on their pension contributions and may be entitled to a refund of overpayments of contributions.

  Further detailed information is available from the NHS Pensions – Added Years Guidance

- **Pension nominations**

  In the event of the employee's death, the NHS Pension Scheme may provide for their family or a person they have nominated. Employees can nominate someone to receive an adult dependent's pension and lump sum on death benefit it they die. Employees can also cancel or change a previous nomination. This form does not need to be completed if the employee is married, in a civil partnership or if the membership ended before 1st April 2008.

  Lump Sum on death benefit forms (DB1 and DB2), Partner nomination form (PN1), Existing nomination cancellation form (NOM1) and Allocation of Pension forms are all available on the NHS Pensions – Nominations Section.

- **NHS Pension Scheme contacts**

  The NHS Pension Scheme website is now the main method of communication with the NHS business services authority.

  Website: http://www.nhsbsa.nhs.uk/pensionsonline.aspx
  Employer's Helpline: 0300 3301 353

  Pensions Online Technical Help: 0870 011 7108
  Member Helpline: 0300 3301 346

  Stationery Order Line: 0300 123 1002
  Postal: NHS Pensions, PO Box 2269, Bolton. GL6 9JS

4.30 Petty cash

An Imprest system 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 amongst 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 an 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 Guidance Document.

4.31 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 where 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 England, 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 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 Guidance Document.

4.32 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 management team should agree on financial thresholds. For example:

- 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, see the Procurement Policy.

4.33 Purchasing

The organisation may be part of a buying group or other collaborative where 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 which are medical products such as drugs, vaccines, equipment, and dressings. They may sometimes be directly purchased from the manufacturer or through specialist pharmaceutical wholesalers.

PPA Manager that is available in HUB can help to identify costs savings and reimbursement figures.

4.34 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 also 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 NHSE Area Finance Team quarterly and once authorised 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 (maternity, paternity or adoption) or sickness leave, the organisation is eligible to receive funding towards the cost of cover for that GP.

This is an outline of the reimbursement schemes, as set out in the SFE (Statement of Financial Entitlements).

- **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 by either an external locum or another GP already employed in the organisation.

Under the SFE, organisations are eligible for a maximum of £1,143.06 (£1,113.74 in Wales) a week for the first two weeks and £1,751.52 (£1,734.18 in Wales) a week thereafter. If the full cost of the locum is lower than the maximum, the organisation will receive the invoiced amount.

Organisations should submit costs at a frequency agreed with the commissioner, or within 14 days of the end of the month for which they are claiming reimbursement. These payments will not be pro-rated in line with the working pattern of the absent GP. There are no timescales set out in the SFE for locum reimbursements for parental leave. We would expect payments to be in line with the length of maternity leave.

- **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.

Cover for the absent GP can be provided by either an external locum or another GP already employed in the organisation, provided they do not already work full-time. After the first two weeks of absence, organisations are eligible to receive up to £1,751.52 (£1,734.18 in Wales) per week. If the full cost of the locum is lower than this, the organisation will receive the invoiced amount.

Organisations should submit costs to their commissioner at the end of the month in which they were incurred. Payment should then be made to the organisation on the day that it receives its next global sum monthly payment. These payments will not be pro-rated in line with the working pattern of the absent GP.

Organisations should receive the full agreed amount for the first 26 weeks (six months) of leave, followed by 26 weeks at half that rate. This begins after the initial two-week qualifying period. Commissioners will account for any previous costs claimed for the absent GP in the same financial year, when calculating the number of weeks for which further payments can be claimed. For example, if a GP were on sick leave for six weeks during May/June and then had a further sickness absence in December, the four weeks of reimbursements claimed earlier in the year would be deducted from the 52-week annual total.

- **Payments for locums covering sick leave and phased return**

Organisations are entitled to be reimbursed for locum cover and returns to work on adjusted hours under the advice of a fit note.

- **GP partners**: The SFE makes no distinction on sickness leave (i.e., full and adjusted hours are viewed the same). This means the commissioner should continue to reimburse locum cover irrespective of the working arrangements of the performer.

- **Salaried GPs**: The SFE applies further requirements to qualify for reimbursement of locum cover. The requirement is for the contractor, as an employer, to pay statutory sick pay or the performer's full salary during sickness leave under the terms of their employment.

  However, a phased return arrangement may affect the contractor meeting these requirements. If the requirements are not met, the commissioner has the discretion to reimburse locum costs. If they are met, the commissioner should continue to cover the costs of locum cover as above.

  Regarding discretionary payments for covering an employed GP, if the SFE requirements are not met, the commissioner will make payments in these circumstances:

  - The employed GP performer's phased return arrangement directly follows sickness absence leave which attracted a locum payment under section 16 of the SFE.

  - Where the phased return or adjusted hours arrangement has been advised under a fit note (and only for the period that fit note covers or advises).

  - Where the contractor is paying the employed GP performer their full salary in respect of their phased return or adjusted hours arrangement, for example taking account of both working and sickness absence days/sessions.

- **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.

4.35 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.

4.36 Rent reimbursement and review

Organisations are eligible for rent reimbursements, with different terms depending on whether they own the premises or not. The Premises Costs Direction 2013 explain the areas that should be considered when considering an organisation's rent and how this should be calculated.

- If the building is owned outright by the Partners, then this is known as notional rent
- If there is a mortgage, it is known as cost rent or borrowing cost reimbursement
- If the partners are tenants in a property, they received leasehold cost reimbursements

- **Notional rent**

  The amount of notional rent to be paid to the contractor is based upon the CMR (current market rental) value for the property, as determined by a surveyor. The CMR is assessed based on notional lease terms, which assume *15-year term tenant internal repairing obligations* with the landlord responsible for external and structural repairs and insurance.

  Contractors who currently receive borrowing cost reimbursement can switch to notional rent payments.

  The Area Team must grant the application if the contractor chooses to switch from borrowing cost payments to notional rent. However, once the switch has been made, it is not possible to move back to borrowing costs.

These amounts will be reviewed every three years (or when the premises situation changes or if there is further capital investment in the premises which will be reflected in the payments the contract is receiving under its contract) by the District Valuer and the NHS may increase – or decrease – their reimbursement dependent on the assessment made. The organisation will need to complete a CMR1 form and submit it to the Area Team prior to the review.

Under the 2013 premises cost directions, when the CMR is to be reviewed, organisations are required to provide the area team with a rent review memorandum. This is a signed agreement between the tenant and the landlord stating any changes made to the level of rent being charged.

- **Cost rent**

  GPs who own their premises and have incurred costs, such as a mortgage or loan for repairs, may be eligible to have their borrowing costs reimbursed by the Area Team.
  The conditions attached to borrowing costs reimbursements are found in part 5 of the Premises Cost Directions.

  It is the responsibility of the contractor to notify the area team of any changes to the terms and conditions of the loan. Failure to notify the area team may result in them clawing back any overpayments received by the organisation.

  Borrowing cost reimbursements should only be in place for a finite period. Once the mortgage has been repaid, the organisation is no longer eligible for borrowing cost reimbursements and should notify the area team and switch to notional rent. When servicing their loan, organisations are expected to pay down the capital and interest of the loan. Organisations found to only be making payments on the interest of the loan may face NHS England sanctions.

- **Leasehold rent reimbursement**

  The level of leasehold rent that may be granted is determined by the CMR value of the premises, or the actual lease rent, whichever is lower.

  The CMR value of the premises is as assessed by independent valuation conducted by the district valuer, who must determine what might be reasonably expected to be paid for the premises.

  The level of leasehold rent reimbursement paid to the contractor must be reviewed when the landlord undertakes a rent review provided for in the respective lease. That is unless the review does not result in any change to the level of rent being charged.

Further information is available from the BMA Guidance – Rent Reimbursement for GP Practices.

4.37 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 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 on 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.

4.38 Service charges/sub-letting organisation space

Generally, if the organisation is receiving rent from those subletting, then it would be reasonable for the notional rent to abated. However, if this is not the case and the 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 little 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 within the National Health Service (General Medical Services - Premises Costs) (England) Directions 2004/2013, more commonly referred to as the 'Premises Directions'.

The commissioning of services by ICBs means that additional services can often be hosted within 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 Tenants 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 Contract and Premises Directions 2004/13.

- 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 England.

- There is an expectation that any charges made are reasonable. This will mean that Rental charges (where properly incurred) are in line with the Current Market Rent 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-rata that cost according to 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 photocopying.

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, the dementia workers and mental health workers.

  The organisation also may offer accommodation free of charge to a variety of others including the midwife, health visitor and others should the partners feel that it afforded a patient benefit and were 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 document.

4.39 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 service income from NHS England is covered under the medical exemption for VAT.

- **VAT allowance**

  NHS GPs are paid the cost of supplying the drugs and appliances which they both personally administer and dispense on 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 1 April 2006, the rules for paying the VAT allowance to doctors in England changed. From 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, telephones etc. 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, including doctors and nurses, is available from the gov.uk website – Health professionals and pharmaceutical products (VAT Notice 701/57).

- **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 that can be recovered is available on the gov.uk website – 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.

  All VAT-registered business should now be signed up to the Making Tax Digital for VAT returns and, as such, VAT returns cannot be uploaded via the HMRC gateway.

  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, see the organisation's range of Financial Guidance documents.

5 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 UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018, the NHS England Data Protection and Security Toolkit and elements of the International Standard for Information Security Management Systems – ISO27001.

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

Information governance training is available in the HUB incorporating:

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

5.1 Access to medical records

In accordance with the UK General Data Protection Regulation, 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
- 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 (governed by the Access to Medical Reports Act 1988)

As of April 2016, NHS organisations, as part of their contractual obligation, have had to provide patients with access to coded information held within their health records.

Such information includes:

- Allergies
- Demographics
- Immunisations
- Medication
- Other (ethnicity, QoF, etc.)
- Procedures
- Problems/diagnoses
- Results
- Values

It should be noted that the GP contract changed for 2022/23 and has now removed the requirement for practices to print and send copies of the electronic record of deceased patients to Primary Care Support England (PCSE)[15]. Consequently, as of 1 August 2022, 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 10 years after which time they will be destroyed as detailed within the Records Retention Schedule.

[15] NHS E and NHS I

Further detailed information is available within the Access to Deceased Patients Records Policy, the Medical Protection Society article titled Disclosures after death and within PCSE guidance here.

All patients should have online access to their full record, including the ability to add their own information, as the default position from April 2020, 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 Digital document titled Access to patient records through the NHS App advises that this change for prospective access was expected to be on 1 November 2022. This date was confirmed on in the NHS Digital document titled Offering patients access to the future health information dated 21 July 2022.

Prospective access to full records, is subject to the same safeguarding information requirements as applied to DCR access.

NHS England has published an information leaflet, Patient Online, which provides further detailed information about this obligation and how patients can access their health record online.

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. However, patients may request access to their health records informally.[16] Any such requests should be annotated within the individual's health record by the clinician dealing with the patient.

Requests may be received from the following:

- **Competent patients** may apply for access to their own records or authorise third-party access to their records.

- **Children and young people** may also apply in the same manner as other competent patients. The organisation should not automatically presume a child or young person has capacity under the age of 16. However, those aged 12 or over are expected to have the capacity to consent to medical information being disclosed.[17]

- **Parents** may apply to access their child's health record if it is not in contradiction to the wishes of the competent child.[18]

[16] How to get your medical records
[17] Access to health records
[18] Children and young people ethics toolkit

- **Individuals with a responsibility for adults who lack capacity** are not automatically entitled to access the individual's health records. The organisation should ensure that the patient's capacity is judged in relation to the decisions being made. Any consideration to nominate an authorised individual to make proxy decisions for an individual who lacks capacity will comply with the Mental Capacity Act in England and Wales and the Adults with Incapacity Act in Scotland.

- **Next of kin** have no rights of access to health records.

- **Police** are not able to access health records without first obtaining a court order or warrant. However, health professionals may disclose relevant information to the police if the patient has consented or if there is overriding public interest.

- **Solicitors and insurance companies** in most cases will provide the patient's signed consent to release information held in their health record. The BMA has issued guidance on requests for medical information from insurers.

The Information Commissioner's Office (ICO) refers to the use of SARs 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 when requesting a GP report and an appropriate fee should be charged.

In the case of **any** third-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, the 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 data subject must be informed and the reasons for the extension given.

Under The Data Protection (Subject Access Modification) (Health) Order 2000, the organisation must ensure that an appropriate healthcare professional manages all access matters. There are several such professionals and, wherever possible, the individual most recently involved in the care of the patient should review and deal with the request. If, for some reason, they are unable to manage the request, an appropriate professional should assume responsibility and manage the access request.

Furthermore, to maintain UK GDPR compliance, the data controller must ensure that data is processed in accordance with Article 5 of the UK GDPR and will be able to demonstrate compliance with the regulation. Data processors must ensure that the processing of personal data is lawful and at least one of the following applies:

- The data subject has given consent to the processing of their personal data for one or more specific purposes

- Processing is necessary for the performance of a contract to which the data subject is party or to take steps at the request of the data subject prior to entering a contract

- Processing is necessary for compliance with a legal obligation to which the controller is subject

- Processing is necessary in order to protect the vital interests of the data subject or another natural person

A DSAR form should be completed and passed to the data controller. The use of a form will ensure all appropriate information is provided by the requester at the outset however, it is not a legal requirement to use this method and organisations need to recognise that requests can be received via email, letter or verbally. All DSARs should be processed free of charge unless they are complex, repetitive, or unfounded. The UK GDPR states that data subjects should be able to make access requests via email.

Upon receipt of a DSAR, organisations should record the DSAR within the health record of the individual to whom it relates, as well as annotating the DSAR log. Furthermore, once processed, an entry onto the health record should be made, including the date of postage or the date the record was collected by the patient or authorised individual.

Individuals will have to verify their ID[19] and it is the responsibility of the data controller to verify all requests from data subjects using reasonable measures. The use of the organisation's Data Subject Access Request (DSAR) form supports the data controller in verifying the request. In addition, the data controller is permitted to ask for evidence to identify the data subject, usually by using photographic identification, e.g., a driving licence or passport.

Being the data controller, the organisation has the right to refuse any Subject Access Request, although any such refusal will be within the allotted timescale and reasons for the refusal will be given.[20]

A response letter detailing the reasons is to be provided and could include the following reasons for refusal:

- Manifestly unfounded (see below footnote for ICO explanation)

- Excessive request – is the insurer requesting a full copy of the medical records when this could be deemed to be unreasonable or excessive for the purpose?

- If the information required details a further third party, a separate SAR would be required

- Would this information be detrimental or cause harm to the requesting patient or any other person?

[19] NHS England Patient Online Services in Primary Care Good Practice on Identity Verification
[20] ico.org.uk

- It includes information about a child or uncapacious adult which would not be expected to be disclosed to the person making the request
- It is legally privileged information
- It is information that is subject to a court order
- Sharing the data would prejudice regulatory activities

Further reading is available within the Access to Medical Records Policy.

5.2 Access to online services

Patient Online was designed to support organisations in offering and promoting an online service to their patient population. The service is referred to as 'GP online services' and is offered to patients in addition to telephone and face-to-face interactions at GP organisations.[21]

Online access helps to improve access to care, improve levels of patient satisfaction and provide a more efficient delivery of services. Online services ease the administrative workload of the organisation, enabling administrative and reception staff to focus on providing higher quality services during face-to-face contact with patients.

The Access to Medical Records Policy and Consent Guidance outline the procedures to access online services.

Patients who wish to register for online services to book or cancel appointments, order repeat prescriptions, view summarised records and clinical correspondence online are to complete a registration form.

ID verification is required to ensure that access is granted only to the patient or their authorised representative(s). All patients will be requested to provide two forms of ID verification in line with the NHS Good Practice Guidance on Identity Verification[22], and the organisation should accept the following forms of ID:

- Photo ID (passport or driving licence)
- Proof of address (bank statement or utility bill)

Only the completed registration form should be scanned into the individual's healthcare record. Staff are to remind patients that GP online services are free and available to all registered patients.

Once a patient has registered and the request has been processed, they should be issued with a letter that includes their unique username, password, and instructions on how to access the online services.

As already mentioned, patients have the right to grant a carer, relative, responsible adult, or partner access to their online services. The patient can limit which online services they want

[21] NHSE About Patient Online
[22] Patient Online Services in Primary Care Good Practice Guidance on Identity Verification

the nominated individual to access. Patients are to be advised that they should not share their own login details with anyone. The nominated individual will be issued with separate login details to access the online services for their partner, relative or person for whom they are caring. To obtain proxy access a person must be registered for online access at the organisation where the patient they are acting for is registered.[23]

The nominated individual is to complete an online services registration form. Should the organisation opt not to grant the person access to the patient's record, then the patient will be contacted and advised of the reasons why this decision has been reached.

Parents may request proxy access to their child's detailed care records until the child reaches the age of 11, when this will automatically cease. Subsequent proxy access will need to be authorised by the patient (subject to a competency test). In addition, parental proxy access may be reinstated if, after discussion with the parent(s) requesting access, the child's GP believes that proxy access would be in the child's best interest.
It is difficult to say at what age the child will become competent to make autonomous decisions regarding their healthcare, as between the ages of 11-16 this varies from person to person. This is titled Gillick competence and as detailed within CQC GP Mythbuster No 8 – Gillick competencies and Fraser guidelines

In accordance with Article 8 of the UK General Data Protection Regulation (UK GDPR)[24] and Part 2, Chapter 2, paragraph 9 of the Data Protection Act 2018 (DPA 2018),[25] from the age of 13, young people can provide their own consent and will be able to register for online services.

The procedure for access is the same as other patients and the usual registration form is to be used.

5.3 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 requirement to inform the Information Commissioner's Office (ICO), to notify them of a breach, the data controller is to read this supporting guidance.

Breaches must be reported without undue delay or within 72 hours of the breach being identified.

When a breach is identified and it is necessary to report the breach, the report is to contain the following information:

- Organisation details
- Details of the data protection breach
- What personal data has been placed at risk
- Actions taken to contain the breach and recover the data
- What training and guidance have been provided?
- Any previous contact with the Information Commissioner's Office (ICO)

[23] RCGP Proxy access
[24] Article 8 UK GDPR
[25] DPA 2018

- Miscellaneous supporting information

The ICO data protection breach notification form should be used to report a breach. Failing to notify the ICO of a breach when required to do so can result in a heavy fine of up to £8.7 million or 2 per cent of your global turnover.

Further information can be sought from ICO document titled Personal data breach.

The data controller is to ensure that all breaches are recorded. This includes:

- Documenting the circumstances surrounding the breach
- The cause of the breach; was it human or a system error?
- Identifying how future incidences can be prevented, such as training sessions or process improvements

The data controller must notify a data subject of a breach that has affected their personal data without undue delay. If the breach is high risk (i.e., a breach that is likely to have an adverse effect on an individual's rights or freedoms), then the data controller is to notify the individual before they notify the ICO.

For further detailed information, see the organisation's UK GDPR Policy and DSPT Handbook.

5.4 Caldicott Guardian

All staff are to be fully conversant with this policy and are to understand the requirement for effective controls of personal confidential data (formerly patient identifiable information).

This policy is derived from the Dame Fiona Caldicott Information Governance Review in 2013[26] which forms the Manual for Caldicott Guardians[27] produced by the UK Caldicott Guardian Council in 2017.

Compliance will be monitored through annual audits and all staff will be briefed regarding the findings and subsequent recommendations.

The Caldicott and Confidentiality Policy and Employee Handbook provide guidance on:

- The Caldicott guardian's role
- Information governance lead
- Caldicott principles
- Compliance
- Data Security Protection Toolkit[28]

[26] The Information Governance Review (Information: To share or not to share?)
[27] A Manual for Caldicott Guardians
[28] DSP Toolkit

5.5 Clear desk policy

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 and post-It notes, all of which often contain confidential data. Regular audits are conducted by the management team and any considered a breach may result in disciplinary action.

For further detailed information, see the organisation's Confidential Waste Policy and the Employee Handbook.

5.6 Clinical photography

Audio-visual (AV) recording is a common and useful tool in primary care. While it can be used for training purposes, it has become more commonplace – especially since the COVID-19 pandemic began – for clinicians to use this as an alternative to face-to-face consultations. It is essential that staff adhere to the guidance outlined in this policy 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.

The purpose of the organisation's Audio Visual and Photography Policy will be twofold:

- To support the need for traditional uses of clinical imagery within primary care, such as training

- To provide 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

The policy aims to support clinicians in their use of all forms of audio-visual consultation and when using imagery in the course of their employment.

This document should be referred to by clinicians who are working in a formal training setting, and those who use AV consultations and/or photographs in their normal day-to-day duties as a primary care clinician.

The policy gives details guidance on:

- Compliance and guidance
- Consent
- Confidentiality
- Data protection
- Assets and security

Further reading can be sought in GP Mythbuster 100 - Online and video consultations and receiving, storing and handling intimate images.

5.7 Closed Circuit Television (CCTV) monitoring

CCTV systems are valuable tools which enhance the safety, security and wellbeing of services, staff and patients and are an increasingly common sight in GP organisations. This system should be installed and used in accordance with extant legislation – i.e., Equality Act 2010, UK GDPR (General Data Protection Regulation), Data Protection Act 2018 and Surveillance Camera Code of Practice (Amended) 2022.

The Surveillance Camera Code of Practice details 12 guiding principles which 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.

5.8 Communication

The internet, intranet and email systems used by organisations are provided to enable staff to carry out their roles efficiently and effectively whilst also enhancing the level of service provided to the patient population.

All staff members have a responsibility to adhere to this guidance. Excellent communication is something we must all strive to achieve, ensuring that our communication methods are consistently clear and concise.

Organisational policies must provide guidance on:

- Internal communication
- Communication with patients
- Videoconferencing
- Telephone messages
- Text messages
- Message taking
- Information from meetings

For further detailed information, see the organisation's:

- Communication Policy
- Access to Medical Records Policy
- Caldicott and Confidentiality Policy
- Managing Incoming Pathology Results
- Correspondence Management Policy
- Communicating Results and Medication Results to Patients

5.9 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.[29]

All staff are to adhere to the principles of confidentiality outlined in the NHS Code of Practice[30].

For further detailed information, refer to the Caldicott and Confidentiality Policy and the Employee Handbook.

These policies provide guidance on the following aspects of confidentiality:

- Good practice
- Breach recording
- Abuse of privilege
- Disclosure
- Audit

5.10 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.

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 regarding the use of their information.[31]

For further detailed information, see the organisation's Confidential Waste Policy.

The scope of this policy covers all forms of personally identifiable information, be it patient or staff and of a clinical, personal, financial, or commercially sensitive matter and relates to both electronic and hard copied confidential waste.

The policy provides guidance on:

- Legal requirements
- Associated policies
- Compliance requirements
- Regular disposal of confidential waste
- Working away from the office environment

[29] NHSE Confidentiality Policy v5.0 2019
[30] NHS Code of Practice 2003
[31] NHSE Confidentiality Policy v5.0 2019

- Auditing
- Data breaches and non-compliance
- Destroying and deleting records

5.11 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, and other customisation functions.

There are many types of cookies and the following information has been obtained from both About cookies and Age UK.

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 of the PECR that 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 is given the opportunity to refuse the storage of or access to that information.

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

To comply with the information requirements of 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 advise as to 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 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, for example, an organisation refuses to take steps to comply, or 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 ICO Regulatory Action Policy.

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

The policy provides guidance on:

- Understanding cookies
- Types of cookies
- Legal requirements
- Compliance including cookie consent, data analytics, cookie exemptions, opting out and consent
- Audit and non-compliance

5.12 Correspondence management

All staff who are expected to carry out correspondence management and 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.

For further detailed information, see the organisation's Correspondence Management Policy. This policy provides guidance on:

- Managing correspondence in general practice
- Training
- Workflow processes
- Clinical coding
- Scanning of documents
- Legal admissibility of scanned records

5.13 Cyber resilience

It is inevitable that the organisation will at some point be affected by an incident that is out of their 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 detailed information, see the organisation's Cyber Resilience Policy.

This policy provides guidance on:

- Resilience
- Data Security Standards
- Precautionary measures to avoid a cyber attack
- Response to a cyber attack
- Recovery of relevant data following a cyber attack

5.14 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, see the organisation's UK GDPR Policy.

5.15 Data Protection Impact Assessments (DPIA)

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 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.

5.16 Data Security and Protection Toolkit (DSPT)

The preservation of data and information security is crucial to maintaining the trust of the entitled patient population. All staff have a duty to ensure that 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 is a mandatory online self-assessment tool which allows organisations to measure their performance against the National Data Guardian's ten 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 information and data handled in line with the standards. Assessments are ordinarily submitted by 31 March annually, although post COVID-19 pandemic, this has moved to 30 June.

For further detailed information, see the Data Security and Protection Toolkit Handbook.

This handbook provides guidance on:

- Requirements of the DSP Toolkit
- National Data Guardian's expectations
- Data Security Standards
- NHS England resources to support the completion of the DSP Toolkit
- Accessing and registering the DSP Toolkit
- How to carry out an assessment and the assertions and evidence items required
- Assertions and evidence
- How to report an incident on the DSP Toolkit

5.17 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:

- Accurate
- Valid
- Reliable
- Timely
- Relevant
- Complete

The organisation's corporate objectives for data quality define a framework of management arrangements which 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 which 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:

- Quality Assurance Policy
- UK GDPR Policy
- Caldicott and Confidentiality Policy
- Cyber Resilience Policy
- Employee Handbook

5.18 Deceased patients' records access

Deceased patients retain the right of confidentiality. There are several considerations to be considered prior to disclosing the health record of a deceased patient. Such considerations are detailed in the Access to Health Records Act 1990. 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 Access to Health Records Act 1990 Chapter 23, 4(3). 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)

For providing a copy of a deceased patient's medical records, a fee not exceeding the cost of making the copy and postal costs may be charged. This fee must be reasonable and fully justifiable.[32]

For further detailed information, see the organisation's Access to Medical Records Policy.

5.19 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.

GP organisations should make decisions about which groups access their patient records. They should also consider which organisations in the local health community are providing care to their patients and whether information sharing would improve the delivery of care and is necessary for direct care.[33]

[32] BMA Guidance – Access to health records
[33] Principles for sharing and accessing local shared electronic patient records for direct patient care

For further detailed information, see the Access to Medical Records Policy.

The policy includes detailed guidance on:

- Sharing agreements
- Legitimate arrangements
- Access controls
- Privacy
- Consent
- Restrictions

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).

The policy includes detailed guidance on:

- Information sharing
- Information sharing agreements and an appropriate template

For further detailed information, see the organisation's Information Sharing Agreement.

5.20 Electronic transfer of and access to the healthcare record

In this digital age, it is vital that organisations offer an array of services to our patients to keep up with the demand for greater efficiency and, of course, for better healthcare. Systems such as GP online services, GP2GP and the SCR allow us to do this by offering swift, efficient, and secure processes which, in turn, result in safer, high-quality care.

GP online services support practices to offer and promote online services to patients. These services include:

- The booking and cancelling of appointments
- The ordering of repeat prescriptions
- The viewing of their clinical record (which includes coded information about allergies, immunisations, diagnoses, medication, and test results)

Digital technology has the power to change the relationship between patients and their GP organisations and patients who are informed and involved in their own care have better outcomes and are less likely to be hospitalised.

For further detailed information, see the organisation's Electronic Transfer of and Access to the Healthcare Record.

The policy provides detailed guidance on:

- GP online services
- Summary Care Record

- GP to GP record transfers
- Transfer of GP records to England from another country
- Summarising

5.21 Email and internet usage

All staff are allocated an NHS email address which is for the use of organisational business only and is one of the most common means of communication within the organisation.

Emails should be written in a clear and concise manner and should be relevant to the subject heading. The organisation standard signature block is to be used by all staff in all email correspondence and the font for emails is recommended as Arial, size 12, in black. Patients may actively and consistently use email as their preferred method of communication. It is imperative that the patient confirms their email address with the organisation enabling them to verify the accuracy of the information held.

It is the responsibility of the patient to ensure that they provide an up-to-date email address, and all patients must be advised 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 with the organisation so that confidential information will not be seen by family members. Additionally, patients are to be advised that internet email accounts are not secure and that there is a risk of their email being hacked (albeit a small risk). Again, the organisation will not accept any responsibility for the loss of confidential information should a patient's email account be hacked.

Staff are not permitted to use the intranet, internet, or emails for any of the following purposes:

- Pornography
- Gambling
- Promotion of terrorism and/or terrorism skills
- Cult-promoting websites

In addition to the above, access to any sites that are likely to cause offence is also strictly forbidden.

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.

5.22 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.

For further detailed information, see the ICO's What is the Freedom of Information 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 subject access request.

The policy provides detailed guidance on:

- Obligations under the Act
- The principles
- Information publication
- Classes of information
- Requests for information
- Responding to an information request
- Refusing a request

5.23 General Data Protection Regulation (GDPR, now UK GDPR)

With the completion of Brexit, the principles of GDPR are still relevant and continue to apply. These provisions have been incorporated directly into UK law at the end of the transition period and The UK GDPR came into effect as of 01 January 2021, replacing the EU GDPR which had been in place since 25 May 2018.

The UK GDPR is incorporated in the Data Protection Act 2018 DPA18) at Part 2. This comprehensive policy details how organisations can ensure they remain compliant with the UK GDPR.

Given the complexity of the UK GDPR, all staff must ensure that they fully understand the requirements within the regulation. Understanding the regulation will ensure that personal data remains protected, and the processes associated with this data are effective and correct.

For further detailed information, see the organisation's UK GDPR Policy.
The policy provides extensive detailed guidance on:

- Data protection by design and default
- Roles of data controllers and processors
- Access
- Fees
- Responding to a data subject request

- Verifying the subject access request
- E-requests
- Third party requests
- Requests from insurers
- Data breaches
- Incorrect data
- Data erasure
- Consent
- Data Mapping and Data Protection Impact Assessments

5.24 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 components 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.

The Good Practice Guidelines for GP electronic patient records v4 (GPGv4 2011) should act as a reference source of information for all those involved in developing, deploying, and using general practice IT systems. GPGv4 was written and produced by the Department of Health (DH), the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA).

For further detailed information, refer to Good practice guidelines for electronic patient records.

5.25 GP2GP

As part of the General Medical Services Contract[34], organisations are required to transfer patient records using GP2GP; this supports the objective set out by the Department of Health, which was to ensure that the patient's digital record can follow them around the health and social care organisation.

NHS England advises that the integration process is to be carried out promptly, while degrades and medication authorisation 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 GP2GP Transfer Policy.

The policy provides detailed guidance on:

- GP2GP process overview
- Benefits of GP2GP
- Reports and tools
- Roles and responsibilities

[34] NHS Digital GP2GP

- Printing
- Data transfer
- Record sharing using CDs
- User guides

5.26 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.

The policy provides detailed guidance on:

- Eligibility for home working
- Equipment and materials
- Security and confidentiality
- Health and safety
- Mortgage, lease, and insurance
- Employer expectations
- Working hours
- Performance and sickness absence management

5.27 Information asset register

The organisation must ensure 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 that 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).

- **Information Asset Owners (IAO)**

  Information Asset Owners (IAOs) should be identified for every electronic system and networked folder held within the organisation. The IAOs will be responsible for understanding and addressing what information is held within their business area, what is added, what is removed, risks to the security and quality of data held within these systems including compliance with relevant legislation and adherence to national standards to provide the relevant assurances to the Caldicott Guardian and SIRO.

  An IAO will be responsible for an information asset in terms of:

  - Identifying risks associated with the information asset
  - Managing and operating the asset in compliance with policies and standards
  - Ensuring controls implemented manage all risks appropriately

- **Information Asset Administrators (IAA)**

  Information Asset Administrators (IAAs) work on a day-to-day basis with information contained in an information asset. They have day-to-day responsibility for the asset, and make sure that policies and procedures are applied and adhered to by staff and can recognise actual or potential security incidents relating to their information asset.

  The IAA is responsible for reporting such incidents to their IAO and consulting the IAO on incident management. It is possible that the IAO of an information asset is also the IAA of that asset.

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

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

5.28 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 walls and through your workforce. This includes limiting what data can be observed, stolen or accessed.

Policies do need to be put in place to ensure UK GDPR compliance, and this is an opportunity to think about overall premises security.

While the focus 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 comply 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.

5.29 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 Intranet and Social Media Acceptable Use Policy.

This policy provides all staff with the necessary information to ensure that when they access and use organisation intranet and social media platforms, it is done in a manner that conforms to extant legislative guidance in common with other NHS organisations.

The policy provides detailed guidance on:

- The principles of acceptable use
- General considerations including standard procedures and good practice

5.30 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 this policy to ensure that a high standard of patient care is always delivered.

The document sets the standard for both 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 referenced material and local directives.

For further detailed information, see the organisation's Managing Incoming Pathology results policy.

The policy provides detailed guidance on:

- E-results
- Cytology results
- Urgent pathology reporting
- Staff absences
- Unmatched results
- Tracking requests
- Communicating results to patients
- Recording information

Further guidance on the tracking, recording and processing of test results can be found at: CQC GP Mythbuster 46 - Managing Test Results.

5.31 National Data Opt-Out

The organisation's National Data Opt-Out guidance enables member organisations to understand the National Data Opt-Out (NDO-O) policy, with which primary care is now required to comply by 31 Jul 22 following several extensions.

Full information on the NDO-O from NHS England can be found in its document titled National data opt-out operational policy and guidance.

This covers the requirements and procedures that need to be in place to enable organisations to identify when patient data needs to be removed before it is disclosed to certain third parties. Additionally, it identifies the sources where they can access and download resources to enable them and their patients to understand and follow the guidance required to fulfil their obligations as required by the National Data Guardian.

It should be noted that this now replaces the previous Type 2 opt-out codes which can no longer be used, although any Type 2 opt-outs which have previously been submitted to NHS England have been automatically converted to national data opt-outs.

Organisations are required to ensure that any such data contained in a report or search generated by the clinical system or by any other means has the data removed which belongs to patients who have chosen to opt-out. Organisations will need to ensure that their privacy notice has been updated to reflect this process. For those patients who do not want their confidential patient information to be used for research and planning, they can choose to opt out by using one of the following:

a. **Online service:**

   Patients registering need to know their NHS number or their postcode as registered at their GP Practice

b. **Telephone service:**

   Contact 0300 303 5678 which is open Monday to Friday between 0900 and 1700

c. **NHS App**:

   Is for use by patients aged 13 and over (95% of surgeries are now connected to the NHS App). The app can be downloaded from the App Store or Google play

d. "**Print and post":**

   Complete this registration form

Photocopies of proof of applicant's name (e.g., passport, UK driving licence etc) and address (e.g., utility bill, payslip etc) need to be sent with the application.

It can take up to 14 days to process the form once it arrives at:

NHS
PO Box 884
Leeds
LS1 9TZ

Getting a healthcare professional to assist patients in prison or other secure settings to register an opt-out choice. For patients detained in such settings, guidance is available here.

The national data opt-out cannot be applied by this organisation.

5.32 NHS England data collection from practices

It was decreed that the NHS needs data about the patients it treats to plan and deliver its services and to ensure that care and treatment provided is safe and effective. The General Practice Data for Planning and Research (GPDPR) programme was established to help the NHS to improve health and care services for everyone by collecting patient data that can be used to do this.

For example, patient data can help the NHS to:

- Monitor the long-term safety and effectiveness of care
- Plan how to deliver better health and care services
- Prevent the spread of infectious diseases
- Identify new treatments and medicines through health research

However, following concerns from public, patient and professionals, this collection was not started as planned and as of summer 2021 the proposals to commence GPDRP were halted with further reading here.

GP practices already share patient data for these purposes, but this new data collection will be more efficient and effective. This means that NHS England can provide controlled access to patient data to the NHS and other organisations who need to use it, to improve health and care for everyone.

NHS England plan to collect, analyse, publish and share this patient data to improve health and care services for everyone. This includes:

- Informing and developing health and social care policy
- Planning and commissioning health and care services
- Taking steps to protect public health (including managing and monitoring the coronavirus pandemic)
- In exceptional circumstances, providing you with individual care
- Enabling healthcare and scientific research

Any data that NHS England collects will only be used for health and care purposes. It will never be shared with marketing or insurance companies.

Patient data will be collected from GP medical records about:

- Any living patient registered at a GP practice in England when the collection started - this includes children and adults
- Any patient who died after the data collection started, and was previously registered at a GP practice in England when the data collection started

NHS England will not collect patient demographic information. Any other data that could directly identify patients, for example NHS number, General Practice Local Patient Number, full postcode and date of birth, is replaced with unique codes which are produced by de-identification software before the data is shared with NHS England.

Pseudonymisation means that no one will be able to directly identify individuals in the data. NHS England will be able to use the same software to convert the unique codes back to data that could directly identify individuals in certain circumstances, and where there is a valid legal reason. Only NHS England has the ability to do this.

Type 1 Opt-outs were introduced in 2013 for data sharing from GP practices but may be discontinued in the future as a new opt-out has since been introduced to cover the broader health and care system, called the National Data Opt-out. If this happens people who have registered a Type 1 Opt-out will be informed

If a patient does not want their patient data shared with NHS England, they can register a Type 1 Opt-out with your GP practice. A patient can register a Type 1 Opt-out at any time, they can also change their mind at any time and withdraw a Type 1 Opt-out.

If a Type 1 Opt-out is registered after patient data has already been shared with NHS England, no more of the patient's data will be shared with NHS England. NHS England will however still hold the patient data which was shared with them before the Type 1 Opt-out was registered. If patients do not want NHS England to share their identifiable patient data (personally identifiable data in the diagram above) with anyone else for purposes beyond their own care, then they can also register a National Data Opt-out as described above.

Further detailed information is available from the NHS England's General Practice Data for Planning and Research (GPDPR) and their YouTube clip.

5.33 Patient social media and acceptable use

This document 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.

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 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.

For further detailed information, see the organisation's Patient Social Media and Acceptable Use policy for England.

The policy provides detailed guidance on:

- Patient access to information
- Social media contact by a patient
- Inappropriate postings by a patient
- Action against inappropriate postings
- Patients wishing to record their consultation
- Overt and covert patient recordings
- Use of audio-visual recordings within public areas of the organisation

5.34 Patient text messaging

Text, or SMS, messaging benefits both patients and the organisation alike. For patients, it helps to improve access to care and levels of satisfaction whilst providing a more efficient delivery of services.

Benefits to the organisation include easing the administrative workload whilst enabling staff to focus upon providing a higher quality service.

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

Understanding and respecting patient preferences means that patients need to understand the range of communication options available to them, to be informed of the potential risks of each communication format and indicate their preferences against each. Patients can also offer their preferences upon attendance or by completing a text messaging preference proforma. EMIS records will show any codes related to consent and dissent when sending a message. However, organisations should endeavour to code patients with an appropriate code to indicate that they give consent for communication or receiving results by text.

Following the implementation of the UK GDPR, re-consent does not need to be considered for those patients already receiving text messaging services.

Text messages should only be sent for the delivery and administration of health and care services. They must not be used for marketing third-party services or any other reason that a patient would not reasonably expect.

It is the responsibility of the patient to advise their primary care organisation should they change their mobile number or if it is no longer in their possession. In order to protect patient confidentiality, it is the patient's responsibility to be aware that others may have access to their mobile phone, that messages can be displayed on a mobile's locked screen which may allow others to read them, and that mobiles can be connected to other devices allowing messages to be received on them independently.

However, a patient's mobile number should be verified at any opportunity when speaking to a patient. All members of the team should opportunistically update mobile numbers, for example confirming a mobile number before sending patient advice at the end of an appointment.

Patients have the right to grant a carer, relative, responsible adult or partner access to the text messaging services by proxy access.

Children and young people may be keener for interaction via text message as this is more commonplace as their means of communication. However, with this comes greater challenges as, whilst children and young people may prefer to use SMS regarding their care, particular attention should be given to:

- Highlighting the ability for children and young persons to request that their contact details are used instead of their parents or carers

- Having the correct contact details
- What information is to be sent to them for specific episodes of care as their healthcare record may contain alternative contact numbers for both them and their parents or carers
- Children and young people may wish general care information to remain communicated to their parents, e.g., check-ups, service information, etc., whilst wishing for a particular test result to be texted directly and only to them
- It should not be presumed that one should automatically include parents or carers in any communication

It is difficult to say at what age the child will become competent to make autonomous decisions regarding their healthcare as, between the ages of 11-16, this varies from person to person. In accordance with Article 8 of the UK General Data Protection Regulation (UK GDPR) and Part 2, Chapter 2, paragraph 9 of the Data Protection Act 2018 (DPA 2018), from the age of 13, young people can provide their own consent and will be able to register for text-messaging services.

Care must be taken to determine who has parental rights for a child under 11 or a patient over 16 who is not competent to control access. Care must also be taken if a parent has no, or limited, legal right of access because they have been perpetrators of abuse and/or neglect.

Patients should be free to update and change their preferences at any time and expect those changes to be effective immediately.

For further detailed information, see the organisation's Patient Text Messaging (SMS) Policy.

The policy provides detailed guidance on:

- Responsible individuals
- Staff access
- Training and familiarization
- Managing patient communication preferences
- Data processing and UK General Data Protection Regulations
- Telephone number confirmation
- Message content, format, and usage
- Sending times and delivery reports
- Proxy access
- Children and young people's access
- Opting out of text messaging services

5.35 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.

The policy provides detailed guidance on:

- Portable device management including device issue, transfer between staff, security, data, encryption, and software
- Passwords
- Reporting the loss of a portable device and data

For further detailed information, see the organisation's Portable Device Policy.

5.36 Organisation 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 the organisation undertaking the telephone conversation that calls are recorded for training, monitoring and dispute resolution purposes.

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

This document has been produced to provide all staff with the information they need to ensure the effective use of the organisation telephone system, thereby enhancing the level of service offered to the entitled population

The policy provides detailed guidance on:

- Use of telephones
- Telephone triage
- Telephone consultations
- Communication failure
- Communicating using text messages

5.37 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 are collected and used, how the data are used and disclosed, how long it is kept, and the controller's legal basis for processing.

Everyone should be aware of the organisation's privacy notices and be able to advise staff, patients, their relatives and carers what information is collected, how that information may be used and with whom the organisation will share that information. 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.

For further detailed information, see the organisation's:

- Privacy notice – Candidates applying for work
- Privacy notice – Children (England)
- Privacy notice – Employee (England)
- Privacy notice – Practice
- Practice privacy notice (Scotland)
- Practice privacy notice (Wales)
- Practice privacy notice (Northern Ireland)

It should be noted that when further information is confirmed concerning the NDO-O, these privacy notices will be further updated.

5.38 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 for the DSP Toolkit that these audits have been undertaken during the year. For further detailed information, refer to the Data Security and Protection Toolkit Handbook and also the Staff Monitoring Policy as this includes an audit template to undertake a spot check to confirm staff compliance.

5.39 Records management and retention

The Records Management Code of Practice for Health and Social Care 2021 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, and our organisation management arrangements will help to identify any necessary changes to current records management practices.

NHS England are currently proposing to undertake a review into the retention time for de-registered GP records. 'De-registered' refers to when a patient is no longer on the GP practice system. It does not refer to patients who are still registered at a GP practice but have not needed to receive care. If a patient has moved to another practice, the record would be sent to the new provider. However, if the reason for de-registration is unknown, the digital record is printed off and sent in paper form to NHS England.

There is currently a proposal to review the retention time for de-registered GP records to ensure that the significant costs of retaining the records for 100 years are justified by the benefits they bring.

For further detailed information, see the organisation's Record Retention Schedule.

5.40 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 coming into effect such as in the event of the loss of premises or a pandemic.

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

For further detailed information, see the organisation's

- Access to Medical Records Policy
- UK GDPR Policy
- Cyber Resilience Policy
- Communication Policy
- Intranet and Social Media Acceptable Use Policy,
- Portable Device Policy
- Homeworking Policy and Procedures

These policies provide further guidance on:

- Definition of terms
- Linked policies
- Security standards
- Security essentials
- Reporting the loss of a device or data

5.41 Smart cards

Smart-card 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 in this document and the referenced material to ensure that clinical and personal information is only accessed by those personnel who have a valid reason to do so.

The NHS smart card 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 smart cards 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.

- **Issuing new NHS smart cards**

  The process for issuing smart cards involves completing an RA form which is signed by the applicant and the sponsor. The applicant will need to have a passport-sized photograph taken by an officer of the NHS IT Support Unit unless alternative delegated authority has previously been given to the organisation.

  Applicants will need to provide proof of identity.

- **Managing NHS smart cards**

  It is important that smart cards always work; any failure to function should be reported immediately to the practice/computer manager. The smart card needs to be updated or reactivated promptly and this can be done online via here.

For further detailed information, see the organisation's Smart Card Policy.

5.42 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 and/or declaration is also now a requirement of the mandatory Data Security and Protection Toolkit evidence, Assertion 4.3.1.

By signing the declaration, employees agree to comply with the requirements above and affirm that they will conduct their duties to the highest standard of care.

For further detailed information, see the organisation's Access Control Policy.

5.43 Third party confidentiality

The purpose of this document is to advise all contractors and visitors to the organisation of the basic requirements as to confidentiality and that they are required to sign the Third-Party Confidentiality Agreement to confirm that they understand the need to protect the confidentiality of patients, staff, and the business.

Additionally, this is opportunity for any visitor to the organisation to be advised of any risks that may affect their visit as well as the immediate actions to be taken should there be any need to escape due to a fire.

All contractors and visitors must sign the visitor's book on arrival and departure, and it is the responsibility of the receptionist on duty to ensure that this action has been conducted.

For further detailed information, see the organisation's Third Party Confidentiality Agreement incorporating fire safety and risk awareness for visitors policy.

5.44 Transport of confidential records

The Public Records Act 1958 requires that all public bodies 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.

The policy provides detailed guidance on:

- Requirements and responsibilities
- Transportation and packaging methods
- Privacy markings
- Health and safety
- Registrations and deductions

5.45 Use of NHS numbers

This document provides guidance on the use of NHS numbers at the organisation. 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.

For further detailed information, see the organisation's Use of NHS Number Policy.
The policy provides detailed guidance on:

- Format of the NHS number
- Use of the NHS number
- Significant of the NHS number

- Principles of the NHS number
- Tracing the NHS number
- Resolving issues with the NHS number

Additionally, see the organisation's range of Information Guidance documents.

6 Summary

Adherence to the information detailed in this *Governance Handbook* by all staff will ensure that the organisation remains fully compliant with recognised good practice, risk is minimised and there is a safe, consistent approach to governance and quality assurance at all times.

Practice Index Ltd
4th Floor
86 - 90 Paul Street
London
EC2A 4NE

T: 020 7099 5510
F: 020 7099 5585
E: info@practiceindex.co.uk

www.practiceindex.co.uk

PRACTICE INDEX