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Re-assess your strategy to use time and resources profitably

With the new financial year ahead, practices must be fully aware of contract changes and their impact. **Deborah Wood*** gives an expert commentary

From 1 April 2016 practices in England can expect a string of changes to their GMS contractual arrangements following NHS England's confirmation of the outcome of its contract negotiations with the BMA.

Contract uplift

There will be £220m investment into the core contract to cover:

- a 1% pay uplift for GPs
- increases to vaccination/immunisation payments
- QOF point values
- expenses increases including CQC.

Given a population total for registered patients across GP practices in England of 57.54m at 31 December 2015, this amounts to a total of £3.82 per patient.

Quality and Outcomes Framework (QOF)

There are no plans to change the arrangements for QOF points in 2016-17.

The value of a QOF point will be adjusted in 2016-17 to take into account population growth and relative changes in practice list size using data at 1 January 2016.

Based on the Health and Social Care Information Centre data at January 2016 compared to January 2015, there has been an increase in average list size from 7,233 to 7,461. This would suggest the value of a QOF point will rise from £160.15 to £165.20.

There will be no changes to QOF thresholds in 2016-17.

Enhanced services

The Avoiding Unplanned Admissions enhanced service has been extended into 2016-17 with a few minor changes.

The Dementia enhanced service will cease at 31 March 2016 and the £42m funding will be re-located into core funding (approximately £0.73p per patient). This will not be subject to any out-of-hours deduction.

All other enhanced services will continue unchanged.

Vaccinations and immunisations

All programmes will continue except:

Men B: catch up element ends at April 2016
Men C: the infant dose will be removed from the childhood immunisations from April 2016
Men ACWY: the vaccination for 18 year olds will be extended on an opportunistic basis for 19-25 year olds.

The item of service fee for vaccinations and immunisations will increase by 28% from £7.64 to £9.80.

Seniority

As previously agreed, seniority payments will cease on 31 March 2020 and there will be a 15% reduction in seniority payments year-on-year.

Those GPs being paid seniority payments on 31 March 2014 will continue to receive payments and progress as currently set out in the Statement of Fees and Entitlements (SFE) during the phasing out process.

A retrospective mechanism for achieving the 15% reduction has now been agreed. Where the rate of retirement in one year does not amount to 15% of the total remaining seniority funding, the pot (and therefore seniority payments for those still in receipt) will be reduced by the remaining amount.

Retrospective adjustments will be made to ensure that when this money is transferred into the global sum, no money that would have been received by the profession is lost. All of the money that would have been paid in seniority will be received by the profession via core funding.

The agreed mechanism meant that changes to seniority payment commenced in December 2015.

Patient online services

A whole raft of changes regarding patient online services is being introduced.

- aim to have 80% of repeat prescriptions via the Electronic Prescription Service (EPS) by 31 March 2017
- aim to have 80% of referrals via e-Referral by 31 March 2017
- aim to have 10% of registered patients using online services by 31 March 2017
- apps for booking appointments, ordering scripts, access to records will be validated and encouraged during 2016-17.

Summary care record, GP-to-GP, clinical correspondence, practice-to-practice, collaborative working and hospital-to-practice information sharing via online systems will all be improved.

Cyber security requirements will be put into place.

Personal Medical Services (PMS)

PMS reviews are now fully underway with transitional arrangements in place for clawbacks of PMS premiums over the next few years in line with MPIG withdrawal from GMS.

The GPC has successfully secured a commitment from NHS England that all the clawbacks from current PMS monies will be reinvested in primary medical services, subsequent to PMS practice reviews.

LMCs in some areas have been able to negotiate favourable transitional deals for practices to revert back to GMS.

Any changes announced to the core GMS contract are expected to be mirrored via PMS.

Premises

NHS England has previously announced that £250m a year is to be invested in GP premises for 2016-17 to 2018-19.

From 2016, funding for larger, more strategic activity – such as moving practices, constructing new buildings - is likely to be considered.

GP recruitment

NHS England has agreed to work with the GPC to explore radical new options for further support for GP recruitment and return to practice, funding for additional primary care staff and greater team working across individual practices.

GP superannuation

Tiered rate contribution levels have been set for the four years to 31 March 2019 as shown in Table 1.

Table 1: GP (and non-GP provider) tiered contribution rates from 1 April 2015 to 31 March 2019

	Total Pensionable Income	Contribution Rate
1	Up to £15,431.99	5%
2	£15,432.00 to £21,477.99	5.6%
3	£21, 478.00 to £26,823.99	7.1%
4	£26,824.00 to £47,845.99	9.3%
5	£47,846.00 to £70,630.99	12.5%
6	£70,631.00 to £111,376.99	13.5%
7	£111,377.00 and over	14.5%

The employer rate is 14.3%. The thresholds may change each year in line with national pay awards.

CCG co-commissioning

Co-commissioning refers to the process whereby CCGs are being given the opportunity to assume greater powers to directly commission primary medical services and performance manage practices but not individuals.

Under plans released in early November 2014 in the report *Next Steps Towards Primary Care Co-commissioning*, NHS England offered each CCG across England the opportunity to adopt one of three commissioning models should they wish to take on-board greater powers.

The *Next Steps* report made it clear that CCGs are not obliged to apply for any of the co-commissioning models and may continue to operate under their existing arrangements.

Co-commissioning is considered by NHS England to be a key enabler of the *NHS Five Year Forward View*: both to implement the new deal for primary care, and to support the development of new models of care. From 1 April 2016 over half of CCGs will have delegated responsibility in 2016-17.

In 2016-17, NHS England will be exploring options for the possible expansion of co-commissioning into wider primary care areas, with full and proper engagement of CCGs, NHS Clinical Commissioners and the relevant professional groups.

This includes community pharmacy, where scoping work will focus upon how partnership working between NHS England and CCG commissioners can be strengthened.

Other 2016-17 changes

MPIG will continue to be reduced by a further 1/7th and will be recycled back into the global sum.
The GMS income per weighted patient is expected to reach £78.66 by 1 April 2021, excluding any inflationary rises as a result of the withdrawal of MPIG.

Statistics published for 2013-14 in September 2015 on the HSCIC website show that average expenses are increasing faster than gross income and so average net income is continuing to decrease.

Expenses increased by 2.4% while gross income increased by only 0.7%. The expenses to income ratio rose by 1% to 63.5%. The core payment needs to adequately reflect this from April 2016.

Locum payments in excess of indicative maximum guidelines will have to be recorded.

Arrangements will be developed to record access to healthcare by European Health Insurance Card (EHIC), S1 and S2 patients.

NHS England and the BMA/GPC have further work to do to reduce bureaucracy, assist with workload management and agree a methodology for reimbursing expenses via future pay awards.

There will be a national scheme to promote self-care and appropriate use of GPs.

The above information relates to contracts in England only.

Scotland

In Scotland the powers that be are forging ahead towards a new contract from April 2017 so 2015-16 is seen as a transitional year and the final year of the three year 2015-17 arrangements.

All remaining 659 QOF points will be retired and the funding transferred into a core standard payment within the global sum.
There will be no additional out of hours' deduction attaching to that sum.

The value of the new core standard payment will be determined by averaging achievement points over the past three years, against which the 2015-16 prevalence and a pound per point rate of £133.47 will be applied (unchanged over the three years).

Before the measurement deadline of 31 March, many AISMA practices were reviewing their clinical disease registers to ensure these were as complete

Table 2: NHS Pension Scheme (Scotland) contributions from 1 April 2016

	Total Pensionable Income	Contribution Rate
1	Up to £16,128	5.2%
2	£16,129 to £21,817	5.8%
3	£21,818 to £27,360	7.3%
4	£27,361 to £50,466	9.5%
5	£50,467 to £72,050	12.7%
6	£72,051 to £112,490	13.7%
7	£112,491 and over	14.7%

as possible to maximise future core funding once the remaining 659 points are 'locked in'.

The payment will be amalgamated with the existing organisational and clinical core standard payments into a single 'core standard payment' which will in future be uplifted in line with global sum uplifts.

Of this funding approximately 25% will be specifically designated as Continuous Quality Improvement Funding to support the Transitional Quality Arrangements (TQA).

From April 2016, the monthly aspiration payments will increase to 100% of the 2015-16 achievement points, meaning that practices will receive a twelfth of the total QOF amount each month.

In June 2016, practices will receive the balance of the 2015-16 QOF achievement payment. This should be the last time the achievement payment will occur.

In October 2016, the correctly calculated core standard payment will be paid as part of the Global Sum total and the Practitioner Services Division (PSD) will make whatever adjustment is required for the first six months. The QOF aspiration payment will also stop.

TQAs will be put into place at cluster level or at practice level where clusters are slow to get off the ground.

Data extraction monitoring will be set up to provide assurance and support peer review around maintaining quality processes.

Each GP practice via its practice quality lead will engage in a local cluster group. A nominated GP from the cluster group will have a leadership role as Cluster Quality Lead (CQL).

CQLs will have a mandate to improve quality in the wider health and social care system.
Funding for envisaged time input for these roles is partly to come from time freed up from the QOF burden. But some funding will be separately agreed at a local level. Assessment of time commitment will be reviewed at the end of the year.

For members of the NHS Pension Scheme (Scotland) from 1 April 2016 contributions will be as shown in Table 2.

These rates are applicable for four years to 31 March 2019, but the thresholds are adjusted each year in line with national pay awards. The employer's contribution is 14.9%.

Additionally, a £20m short term package of support for the next 12 months includes:

- £11m to uplift GP pay by one per cent and uplift GP expenses by 1.5 per cent. The Scottish Government said this also includes funding to cover the costs of population growth in 2015-16.
- £5m to fund a GP from every practice in Scotland to take part in fortnightly sessions on cluster working - designed to develop their role in quality and leadership in the local health and social care system
- £2m to improve or upgrade IT infrastructure in GP practices
- £2m on three specific support measures called for by the Scottish GPC - funding a new rate for backfill cover for GPs taking maternity, paternity or adoption leave; developing occupational health services for primary care staff; and supplying every GP practice in Scotland with oxygen cylinders for use in emergencies.

Wales

Practices in Wales are about to enter the second year of a two year contract deal. This aims to cut bureaucracy and free up GP time by developing GP clusters to deliver patient care in the community.

The agreed commitments for 2016-17 include:

- completion of the review of the care homes enhanced service, diabetes enhanced service and of the IOS fees for vaccinations and immunisations
- consideration of the removal of the exception reporting requirement for three patient invitations in QOF
- working to develop a cluster network peer review programme in collaboration with the Welsh Government and Health Boards
- consideration of any new clinical QOF indicators

recommended by NICE
- necessary revisions to the QOF cluster network development domain including a revised GP practice development plan, a revised cluster network action plan, revised clinical governance assurance arrangements and a review of the participation in the general practice national priority areas.

In Wales core contract funding will increase by 2.2% from April 2016, an investment of £10.5m, of which £7.02m is intended to cover increased expenses including employers' superannuation, national insurance, indemnity and also covers the changes arising from the movement in the QOF contractor population index. The other £3.48m is intended to cover pay.

Northern Ireland

In NI there will be a £7m uplift to core funding from April 2016 and a further £10m of investment in the form of a premises and infrastructure loan fund.

The core funding includes £2.55m to fund pharmacists in practice, where there is an intention to have 300 in post by 2020/21, and £2m from the transformation fund to assist with ageing demographics and staff needed to support long-term conditions in the elderly.

The transformation fund of £30m in total had been announced previously and from this £1.25m will be allocated to district nurse and health visitor services. As with the other countries the funding is intended to deliver a 1% pay uplift.

Final thoughts

As ever practices have to be fully aware of these many changes and the impact they might have on practice funding and workload.

For advice on the future strategy for your practice talk to your local AISMA accountant.

OPINION

Time to change your shape in general practice?

Bob Senior, AISMA chairman

Over the last few years various surveys, including those run by Pulse and Lloyds Bank, have shown a consistent theme - many GPs expected the shape of general practice to change quite significantly 'over the next five years'.

We are now well into that five year period since some of those surveys and sure enough general practice today is very different to where it was in 2011.

In the last year some 200,000 patients found themselves being forced to find a new doctor following practice closures.

According to the BMA, over 800 practices - about one in ten - is now at the point of closure due to being financially unsustainable. Both those situations would have been unthinkable in 2011.

Potentially the one practice in ten at the point of closure does not include those which are still financially sustainable but where the doctors are at the point of collapse due to their problems with workload and recruiting new doctors.

If we then consider the Government's aim of providing '8 to 8' access to a GP seven days a week it is hard to see how the recruitment crisis is going to be solved any time soon.

In some areas, the merging of practices into larger units is one direct result of the recruitment problems. Those mergers often have the aim of eventually closing many smaller surgeries to improve operating efficiency.

These mergers can help with GP workload if the opportunity is taken to change working practices. But simply merging and then carrying on exactly as before is unlikely to produce any significant benefits.

Many practices have been using nurse practitioners within their teams for years. The effects have been very mixed with some practices achieving great results but others feeling that although they have put extra capacity into the system, the doctors' workload has not reduced.

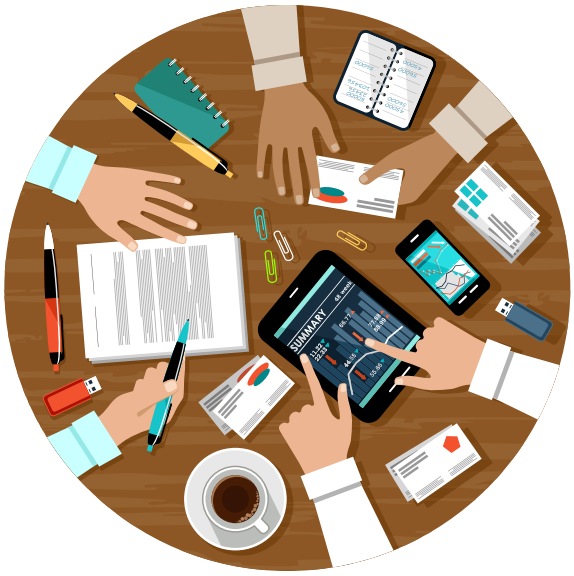
In the last year or so we have seen further developments with practices using paramedics, physician associates and pharmacists to handle a wide range of tasks – freeing up time for GPs to deal with more complex cases.

GPs need to bear in mind that developing such structures may not work immediately so they may need to continue to adjust them until they do achieve the desired result.

Simply trying something once, finding it did not achieve what was hoped for, then immediately going back to the way things were will not achieve anything.

Many will have come across the famous line from Henry Ford: 'If you always do what you've always done, you'll always get what you've always got.' While that quote may be old it is nevertheless true.

What it perhaps fails to point out is that if what 'you've always got' is no longer sustainable then you really do need to do something different.



Help your accountant help you

Your annual accounts meeting helps your accountant help you. **Luke Bennett**** gives some top tips for getting the most out of it

It is normal practice to meet your accountants after the draft accounts have been prepared.

Then you can discuss them, resolve any queries so they can be finalised, and consider financial matters likely to arise in the coming year.

But of course it is important to get the most from your meeting.

So here are some top tips to make sure it is one really worth having.

1 Get a date in the diary early.
The larger the partnership the more difficult it is to get everyone together, so give plenty of notice for the meeting.

2 Be realistic about start and finish times. If the morning surgery finishes at 12.00, do not arrange a meeting to start at 12:00. There is no way everyone will be there on time.

3 Read your copy of the draft accounts before the meeting. And if you have any queries ask the practice manager to raise these with your accountant before you get together.

4 Bring your copy of the draft accounts with you to the meeting.

5 If there is some information required before the accounts can be finalised, give the practice manager time to find this out before you meet up.

6 For larger partnerships, a prior meeting with the accountant, practice manager and finance partner is often sensible because it can enable detailed queries to be resolved. The meeting with all the partners can then concentrate on the bigger picture and strategic issues.

7 If you have individual queries to raise about your personal affairs, and a lot of GPs have, then arrange a time to discuss these either before or after the main meeting.

8 Look at your current account – are your monthly drawings too high or too low?

9 Are there any changes in the partnership – sessions or partners, potential mergers or federations - that will impact on profitability and drawings?

10 Take the opportunity to update your accountant on practice plans for the future – for example changes in staff structures, new services to be offered, or capital expenditure.

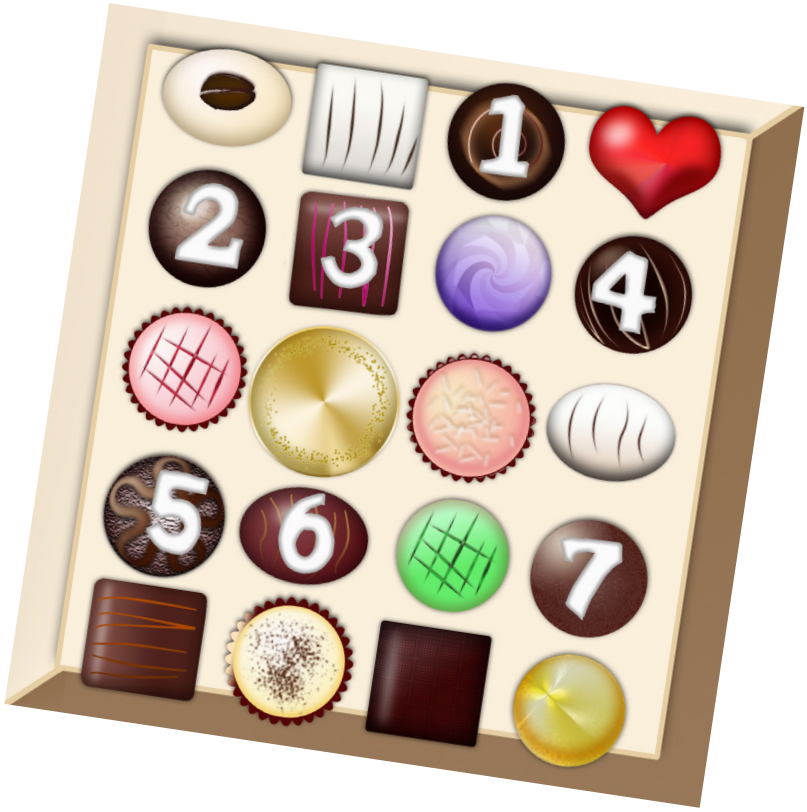
11 While your accountant should raise these sorts of issues to the meeting, you might prompt him or her to explain what changes are on the horizon in:

- Pensions allowances
- Tax rates or allowances, and
- Superannuation rates

And a last word - refreshments are always welcome, thank you. But it is difficult for your accountant to talk through the accounts and eat a hot bacon baguette at the same time. I have tried. And failed.

Seven deadly sins that will drain your profits

With practice profits under constant attack, **James Gransby***** shares some thoughts on temptations to avoid



1 Working harder but earning less

Some services and sources of other income come with disparate rewards for similar effort levels.

So with the new financial year upon us it is worth assessing your income streams and efforts involved. Then you can see whether you could generate higher earnings by dropping some optional services to concentrate on new ones.

Activity reviews can often unearth inefficiencies and missed opportunities - particularly if it has been some time since you did the last one.

Possibilities might include:

- renting out rooms when they are not being used by the practice
- placing a vending machine in the waiting room
- becoming a training practice if there is a partner who is willing and able to take on the responsibility and the surgery is set up sufficiently for this purpose
- maximising the income earned from writing medical reports
- advertising local businesses in your waiting room - this may be an option since a large volume of people pass through your doors annually
- becoming a dispensing practice if this is a viable option.

Keeping an eye on movements in funding for Enhanced Services is important too. For example while the 2016-17 contract continues with the Extended Hours, Avoiding Unplanned Admissions, and Learning Disabilities ESs for another year, the Dementia ES will have ceased on 31 March 2016.

2 Not talking to your neighbours

Team up with neighbouring practices to benefit from economies of scale.

A practical example of this is where a number of dispensing practices link together to create a central role of drug purchasing by a dedicated person/team who will research and negotiate with different suppliers.

Rather than each practice working it out themselves, a dedicated resource should achieve cost savings for those in the buying group and may be able to negotiate discounts. Non dispensing practices may also be able to tap into this resource for consumables, such as dressings.

Payroll is another example where practices can outsource to achieve an overall cost saving, particularly if one practice takes on the role for their local colleagues to earn a new source of income for them.

One step further is to federate or merge - a common topic in recent years.

3 Not having your head in the cloud

Get up there - move towards a Cloud-based system and encourage the use of technology.

Moving to an online appointment system and sending emails instead of letters and phone calls can improve efficiency, free up staff time and cut costs such as postage and phone bills.

Cloud-based systems are becoming increasingly part of everyday life. Practices can also consider moving their accounting systems to the Cloud with appropriate bookkeeping software which links to the practice's bank account. This enables a direct feed of transactions to the system, saving the time of manual inputs and reconciliations.

4 Falling foul of inertia

It's all too easy to stick with a provider and overpay them after a contract ends. Consider switching providers when you come out of deals on phone lines or gas and electricity.

When contracts are nearing their end, mark it in the diary and make it best practice for someone to re-negotiate or adopt a policy of obtaining value for money by tendering. Get at least three quotes.

Be sure not to go too far the wrong way or you may end up losing out on quality, but a cost review should be carried out routinely.

5 Not being paid for work you are already doing

Make sure your practice does not lose out on claims it is entitled to. Not being paid for work you are already doing is particularly bad form. It usually indicates a failure in the reporting system, or miscommunication.

For instance, are all of the locums working at your practice well versed and up-to-speed with what is required of them while on your premises? If not then QOF points may be missed as a result.

Take note of what income has been received in the past. For example, at the simplest level if there is a monthly receipt for an income stream or reimbursement check that all 12 months have been received.

One potentially overlooked claim is where a partner is covering sessions for a fellow partner on maternity leave. There is reimbursement (albeit partial) available for this which should certainly be claimed.

Grants too - practices should be aware of future funding being made available. Ensure any funding bids are made early and there is contact with local CCGs.

Also take note of any correspondence from the NHS which might note criteria needed to secure new funding.

Not being on top of workforce changes

Paying attention to your workforce, and making sure the people employed match the roles they are engaged to do, is very important for GPs' profitability.

This comes under the following headings:

- Ensuring everyone is doing the correct work for their skillsets and is fully occupied.
- Reviewing long term locums to see if they can be either taken on as a salaried GP (which may be necessary anyway if they have become a more permanent fixture), or to see if a salaried GP can be brought in instead. Locums are commanding premium rates at present so this could work out to be a cheaper option.
- Considering not replacing leavers if others' roles can be changed to fill the gap, or any spare capacity redeployed. A pay rise for existing staff taking on additional roles will often cost less overall than employing a new staff member.

- For partners, a poorly planned holiday diary could lead to multiple partners being away at the same time meaning that locum costs are incurred when they could have been avoidable.

7 Closing your doors (patient list)

In recent years more income has been included in the global sum/PMS baseline figures with the migration of income away from QOF points, seniority, some ceased enhanced services funding and employer's superannuation on locum costs.

As this is linked to patient numbers then increasing the number of patients will raise income more now than in the past.

If you have a closed list then you are limiting your income earning potential. Opening a list when this could lead to patient dissatisfaction with service levels may be a concern here so consider how this could be addressed - perhaps by hiring new staff. Calculate how many extra patients would be needed to cover their salary, and if this is achievable.

And finally…

As always any options need to be considered with the wider picture of the effect on clinical offering and patient satisfaction in mind.

The most profitable practices will usually be the ones with the best staff, systems and communication and those that put thought to the factors affecting their profitability.

If you are considering the above then a strategy day could be arranged with your AISMA accountant to perform analysis and advice and to facilitate the discussion.

Safeguarding children: topical issues for GP practices

Local authorities have overarching responsibility for safeguarding and promoting children and young people's welfare - but many different organisations have duties too and a GP practice's role is crucial. **Alison Oliver** and **Jonathan Flower** examine some common issues surrounding GP practices' obligations

GP practices are often the first - and sometimes only - point of contact between children and young people who are at risk of significant harm. Their role in safeguarding is crucial.

Practices are obliged to:

- work in a way that safeguards children and young people
- ensure GPs and practice staff understand how important it is to identify children in need of safeguarding at the earliest possible stage
- ensure that suspicions or allegations of harm are dealt with appropriately and referred to Children's Services
- work effectively with multi-agency partners.

Practices are not responsible for investigating abuse or neglect. But they are responsible for sharing information, acting on concerns and contributing to processes for protecting children at risk of - or suffering - harm, abuse or neglect.

They must have safeguarding policies and procedures and a safeguarding lead and deputy. All staff, both clinical and non-clinical, must understand their respective safeguarding obligations and know what to do if issues come to their attention.

Risks to children are often dynamic, not static, and all staff should stay up-to-date with changes in guidance, law and procedure. For example, GPs need to be aware of more recent concerns such as risks of radicalisation, child sexual exploitation and cyberbullying.

What is safeguarding?

Safeguarding legislation aims to allow the State to intervene in family life to protect vulnerable children from significant harm, abuse or neglect.

Harm can take many forms, including sexual, physical, emotional, verbal or psychological. It can result from both positive acts and from omissions, or failure to act. Children who see or hear domestic abuse are deemed to suffer harm.

Action taken is designed to promote children's welfare and protect them from harm. It broadly involves ensuring safe and effective care and preventing impairment to their health and development.

The aim is to identify any causes of concern at an early stage and provide support for children to remain in their family's care if at all possible. Working together with multi-agency partners across health and social care is a central aspect of the safeguarding system.

Local Safeguarding Children Boards (LSCBs) are responsible for developing procedures in their area.

All organisations that come into contact with children have a responsibility for safeguarding and must have their own policies and procedures. All aspects of the NHS have a key role in safeguarding, both as members of the LSCB and as partner agencies, working with Children's Services.

GPs' professional duties

GPs have specific responsibilities as professionals and the GMC has produced guidance on protecting children and young people.

Particularly complex issues for GPs include:

- identifying when children are at risk of, or are suffering from, abuse or neglect – this involves being aware of risk factors and having the skills to recognise signs and symptoms
- communicating effectively (both listening and speaking) with children of different ages and with parents
- balancing the duty of care owed to a parent or carer who is a patient against the duty of care owed to a child at risk of harm
- knowing what information can be shared with whom
- issues around consent, capacity and parental responsibility.

Let us explore the last two points in more detail:

Sharing information

GPs must inform Children's Services promptly if they believe a child is suffering, or is at risk of suffering, significant harm.

They should ask for consent before sharing confidential information unless there is a compelling reason not to. An example would be if the resulting delay would increase the risk of harm or if asking for consent in itself might increase the risk of harm – such as concerns around fabricated or induced illness.

Confidential information can be shared without consent if required by law, directed by a court, or if the benefits of sharing the information outweigh public and the individual's interest. A GP should explain to the individuals to whom the information relates why it was shared without consent.

Generally, parents should be kept informed of a GP's concerns about a child's safety or welfare and any decision to make a referral. Information should

only be withheld if the doctor believes that telling the parent might increase the risk of harm to the child or another person.

Information should only be shared with agencies or people entitled to receive it and to the extent necessary for the purpose of safeguarding the child.

Consent

Where consent is required (whether for sharing confidential information about a child or for a child protection examination or otherwise), the child themselves should provide that consent if they have capacity to give it.

Otherwise, it should be a person with parental responsibility. It is important that the practice knows who has parental responsibility for a child.

In all cases, practices should explain what information is being shared, who it will be shared with, how it will be used and where they can obtain independent advice and support. GMC guidance lists sources of advice and support.

Records

It is essential to keep meticulous records of all events and decisions relating to safeguarding matters. Records should be made promptly and include all concerns, consent obtained (or reasons for proceeding without it), details of action taken, information shared, decisions made and reasons for decisions.

If you have access to the parent's records, appropriate entries should be included in those, if necessary and proportionate to do so. Records can be produced in connection with court proceedings, police investigations, inquests and Serious Case Reviews.

Working with others

There are particular issues to consider when GP practices are working as part of multi-agency teams and participating in pilots for the new models of care which involve working with other organisations.

It is important for each organisation to comply with its respective professional and statutory safeguarding duties and that there are clear lines of accountability and procedures for when things go wrong.

Practices should be constantly mindful of their confidentiality obligations, particularly when working with personnel from other agencies and organisations.

It can be easy to become too relaxed about what information is shared when working with other agencies on a regular basis.

But – as mentioned above - this should only be shared where necessary, where the other organisation is entitled to the information and where this does not breach the practice's confidentiality and data protection obligations.

Safeguarding vulnerable adults

Many issues here are also relevant to safeguarding vulnerable adults, although there are some distinct differences in law, procedure and guidance, which are beyond the scope of this article.

Alison Oliver is an associate solicitor with top 100 law firm Ward Hadaway. She advises GP practices on a range of legal issues, including partnership agreements and disputes, contractual matters and federating.

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Disclaimer: This article is for information purposes only and should not be relied on as legal advice.

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