AISMA Doctor Newsline

A helpful resource for the practice business

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Cash in now on the CQC's long hold up

Save time and money by using your extra year to get your registration ready. **Martha Walker** shows how

Amid all the changes and reflective processes within the NHS, the much talked about Care Quality Commission (CQC) registration plans for NHS GPs are also undergoing some changes.

Originally due for April 2012, NHS GP registration has been pushed back to April 2013 following protests from GP leaders that resulted in the CQC acknowledging that it is looking at ways to 'ensure registration is more closely aligned with accreditation schemes.'

It is also using the extra year to give itself more opportunity to embed compliance monitoring in the sectors it already regulates. The CQC may be buying catch-up time but it will still register NHS GPs. It is just a question of when.

NHS GPs are understandably unhappy about registration and what they quite rightly view as another tool from another external body to measure performance and compliance.

Last year the country's dentists felt exactly the same and before them so did the NHS hospitals. And back in the early 2000s the clinics and hospitals in the independent healthcare sector were subject to complying with standards that changed on what seemed like a weekly basis.

The attitude of the then Healthcare Commission was 'We are here to stay, so you had better accept it'. Fortunately the regulatory body has improved its relationship with doctors over the last decade and has moved towards a more positive liaison with

providers.

CQC information and guidance devised for the dental profession is a vast improvement on what it gives to the independent medical sector so hopefully it will build on this, move forward and streamline the information NHS GPs will be asked to deliver as part of their registration process.

CQC registration comes in two parts.

Part one - The registration of the provider:

- Completion of the provider application.
- Completion of the registered manager application.
- Writing the Statement of Purpose.
- The declaration that you comply with the 16 essential standards of the Care Quality Commission (Registration) Regulations 2009.

The regulations describe the essential standards of quality and safety that people who use the services have a right to expect.

Part two - Ongoing compliance:

- Demonstrate that you continue compliance with the essential standards year on year.

Registering with the CQC will cost time and money – the registration fee for NHS primary care providers is yet to be announced. So how can an NHS GP practice ensure the registration process does not become a costly exercise and consume everyone's time at the expense of patient care and practice development?

While there is a pause in the registration process use this time to prepare and gather evidence to demonstrate compliance. You can complete the application forms for registration at a later stage.

By gradually introducing CQC into the practice calendar it won't suddenly consume a vast amount of time when practices have to complete the registration process in the timeframe allocated to them. Exactly how and when practices will be told when to submit their registration applications has yet to be confirmed.

Getting started

As with anything new, preparation is the key to successful registration and ongoing compliance.

Although your practice manager will undoubtedly oversee and most probably undertake the lion's share of the work involved it is important that the GPs at least have an overview of what is happening.

Consider one of the GPs working with your manager to understand what is required. Later the GP partnership will have to designate one or more 'nominated individuals' as part of the registration requirements.

But initially if one GP and the manager work together to get a clearer understanding of the process, they can present to the rest of the GP partnership and the whole practice team how preparation for CQC registration will affect them and the part they will all play in it.

Doctors in the independent sector, and more recently the dentists, have discovered that by involving all practice team members, clinicians, nurses, administration and housekeeping staff, the compliance process is not as much of a headache as originally perceived.

Make ongoing compliance part of the practice calendar. Find ways to promote the practice positively with staff and patients. Use audits and surveys looking at such things as having a clean building, patients recommending the practice and short waiting times. Implement innovative suggestions from staff or patients.

But to start, both the manager and the GP need to familiarise themselves with the CQC information manuals including:

- Guidance about compliance: Essential standards of quality and safety.
- Guidance about compliance: Summary of regulations, outcomes and judgment frameworks.

These are part of a wide range of guidelines available on the CQC website (cqc.org.uk/guidance for professionals). The website is updated regularly so make a point of visiting it at least fortnightly and sign up for CQC e-newsletters.

A useful tool from the CQC

Emphasis now is much more on the provider - here the NHS GP practice - demonstrating compliance with the essential standards through the patient experience, rather than inspectors sitting in an establishment and spending most of the time reading through endless policies.

With this in mind the most valuable tool the CQC has introduced is the Provider Compliance Assessment (PCA). Originally this online self-assessment tool was used very successfully by independent healthcare providers under the Healthcare Commission. It is likely the CQC will follow in its predecessor's footsteps and use the PCA as a tool to assess the ongoing compliance of all providers (including NHS GPs) once registered.

The PCA goes through each 'essential standard' and allows the provider to assess if they have the relevant evidence to demonstrate compliance with the requirements of each standard and an action plan template to use if they need to work on improving a standard.

The PCA can be downloaded and started at any time. Once the practice manager is familiar with the 'essential standards' and their intended outcomes, completing the PCA is the ideal way to record and consider the evidence the practice holds.

PCA completion relies on the gathering and listing of compliance evidence. With this is mind the first thing to remember is all practices will have most if not all the information, processes, governance

systems and data collection already in place to demonstrate compliance to the essential standards. It is mainly a case of knowing where it is, making sure it is up to date and above all keeping it relevant to patients' needs.

The most successful way to complete the PCA is for the manager to delegate different standards to each of the practice teams to assess and collate evidence for. With the PCA completed and action plans created to fill in any gaps, the whole practice will be in a strong position to complete the registration application whenever the time comes.

Timely planning means registration, and demonstrating ongoing compliance, should not be an all consuming event that detracts from patient care.

Martha Walker has over 20 years experience running independent medical practices and has successfully registered and overseen continued compliance of clinics in the independent sector since 2003.

She advises and assists doctors in the NHS and independent sector on CQC registration, and mentors practice managers and their teams. Martha also runs workshops and presentations on CQC compliance. Email: info@cqcconsultancy.co.uk Telephone: 07974 756 189, cqcconsultancy.co.uk

GPs risk new legal traps from registration

CQC registration could have some serious partnership implications, warns Andrew Lockhart-Mirams

Under CQC registration each provider of a regulated activity has to be registered before that activity can be carried out.

Failure to register is a criminal offence carrying a maximum fine of £50,000 or a prison sentence.

Where a stable practice, for example of four partners, seeks to register for the first time this should present no undue difficulty and once completed the registration stays in place subject to the payment of the annual fee.

But there are considerable problems where a new partner is to join the practice.

At present registration can take up to 120 days and this lead time is going to make it very difficult to deal with partner appointments - particularly if a new partner is joining in order to preserve the existence of a GMS contract on the retirement of an existing single-handed contractor.

The new partner cannot provide the services until registered and, as noted, commits a criminal offence in doing so.

And there may be considerable time pressures to bring new partners in and if existing partners do so without the registration of the new partner then they will be putting themselves at considerable risk.

Almost certainly they will be aiding and abetting the commission of a criminal offence. They will risk proceedings before the General Medical Council for practising with an unregistered person and, most probably, they will be putting their professional indemnity policies into jeopardy.

Are there ways round this? Regrettably not. The offence is absolute and the only answer is carefully planning ahead of time.

If a new partner is to start on 1 May, one month after the registration requirement starts, an application - given the present time lag - will have to be made before the end of the preceding December and this requires the identification of the new partner, with advertising, interviews and the like to be commenced many months before this.

Even then, the partnership commencement date will be subject to registration being completed. If a practice leaves the whole appointment process too late, the putative partner cannot start work other than as a salaried doctor covered by the partners' registration. This is hardly an ideal start for a new enthusiastic

partner.

Other practical issues that arise relate to practices that a PCT is running and then puts out to tender, or new services that the PCT wishes to put out to tender.

In the first case, these are likely to be failing practices that the PCT has taken over on a temporary basis. There are probably not a great number in the overall scheme of things but this does happen.

The large majority will be for new APMS contracts for the provision of both core services and other services such as triage services operating before patients reach A&E.

Where the PCT runs a service, it will become a service provider and registration delays could substantially hinder any takeover. Where contracts are being put out to tender, the new contractor will be required to register with the CQC.

They cannot realistically seek to do so before the contract is awarded as they do not even have a 'subject to contract' interest in the business. Normally after a tender has been awarded, PCTs like to get the new service up and running within a month or so but the lead time will create problems.

And these are problems which will only worsen if the winning applicant encounters obstacles to registration, such as difficulties with the mandatory CRB checks.

At some stage during the course of 2012-13 there will be changes to the existing regulatory system and at present proposals are being consulted on with a closing date of 7 October 2011. Parliamentary time will then be needed to bring the changes into effect.

CQC registration is not an easy topic and specialist advice is strongly recommended.

Andrew Lockhart-Mirams is senior partner at Lockharts Solicitors

OPINION

Take this chance for a life-saving look after 'home'

Mike Gilbert, past chairman, AISMA

The summer inevitably brought a period of quiet but the pressing issues affecting medical practice have not gone away.

Clinical Commissioning Groups (CCGs) and the Health and Social Care Act are getting closer by the day. But until we have an Act the Government is not prepared to negotiate a new unified contract. This seems to suggest we might have at least two years of status quo for GP funding.

Pensions have become a hot topic in that the breaching of the annual allowance and lifetime allowance can bring severe tax charges, not to mention an imminent and substantial increase in employee contributions. GPs are advised to obtain a copy of their dynamising record from the NHS Pensions Agency and then seek appropriate financial advice.

All these issues are undoubtedly urgent but GPs must also turn their attention to important issues such as running their own practices. AISMA's annual survey into GP earnings highlights one clear fact – the top 10% of GP earners work 'on' as well as 'in' the practice, whereas the bottom 10% merely work 'in' the practice.

High GP earners are generally good at time management whereas the low earners are not. They run the practice as a 'business', unlike the low earners. So what should GPs be doing this autumn to look after 'home'?

With a view to creating 'time' I suggest the following checklist:

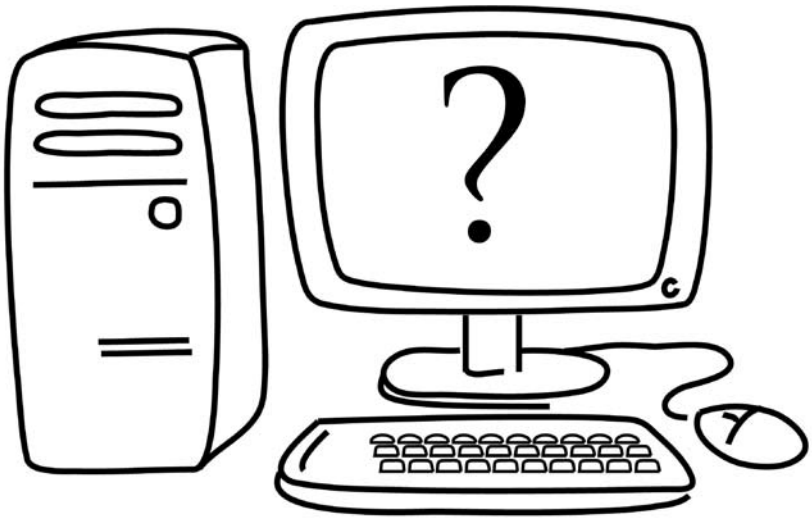
- Redraw your organisation chart with clear lines of responsibility.
- Review all of your systems and procedures and modify as necessary.
- Review job specifications and training needs.
- Check you are properly managing patient demand.
- Review partners' roles in the current climate and make sure they are appropriate.
- Hold monthly partners' meetings which are properly minuted and acted upon.
- Hold 'all hands' meetings with all staff quarterly and create team spirit.
- Write and buy into a procedures manual.
- Plan an 'away day' and get it facilitated, if appropriate.

There is no doubt that an efficiently run practice improves time management which in turn creates more enjoyment leading to financial reward.

But if you do not look after 'home' you could well commit financial suicide. That is simply defined as doing nothing and expecting a different outcome.

Get IT right or pay the price

Your next computer change may have to be for life so consider the costs and implications as carefully as a surgery move, says **Kathie Applebee**



It is difficult to decide which creates the greater upheaval for practices: moving premises or changing computer systems.

But anecdotal evidence indicates practices may spend more time preparing for a move of home and so experience fewer costly organisational problems and regrets later than those changing IT systems - where the bulk of the work ends up being done retrospectively.

As with all major projects, practices need to prepare detailed business cases to establish the pros and cons of such changes. Changing premises tends to involve a lengthy decision-making process and careful examination of the financial and long-term implications.

Changing IT systems, although it impacts on every area of the practice for years to come, does not always get the same degree of scrutiny. It may be done on the basis of a single local recommendation or because a solitary enthusiast pushes through a change based on personal preference – or even because the existing system is not being utilised properly.

The true costs and implications of changing GP IT systems are virtually impossible to calculate. But it is undeniable that virtually all working practices will need changing. Team members will require extensive training beforehand and support afterwards, and efficiency will be compromised by actions, formerly automatic, suddenly being slowed by lack of familiarity or expertise. Costly mistakes may also be made.

The GP market

The GP IT market has experienced a period of major upheaval in recent years due to certain imposed regional changes.

In Scotland, Vision and EMIS are now the two sole GP IT providers, and the many practices that used GPASS have had to change systems. In the CSC Local Service Provider (LSP) areas in Northern and Eastern England, funding has been made available for practices to move to a single system, SystmOne (sic), although many in these areas have opted to remain with their chosen suppliers.

Unlike in Scotland, in England the GP Systems of Choice (GPSoC) programme has allowed practices their choice of system, as long as it meets national accreditation standards, although it is unclear whether all practices are aware of this.

The previous Government's ill-fated NHS IT Plan which set out to create monolithic regional systems, has now given way to the more pragmatic and cheaper NHS Interoperability Toolkit (ITK) programme, a set of standards and frameworks for making IT systems interoperable. This resulted from the 'connect all' rather than 'replace all' strategy endorsed in the Equity & Excellence: Liberating the NHS White Paper.

In England, commissioning now brings its own requirements, and practices may find themselves coming under pressure to change to Clinical Commissioning Group (CCG) preferences.

While GPSoC is still in force, practices should step back from such pressures and consider the short-term costs and long-term implications of changing their systems. The main requirements for commis-

sioning are that practices are able to provide, analyse and exchange data, and most of the existing systems are able to do this. Cumbria and Liverpool are examples of areas where practices using different systems (Vision and EMIS) are sharing data with each other and with other healthcare providers.

Over a period of 30 years, the GP market has undergone a series of cyclical transformations. For example, iSoft, which is now fourth in the English leader board, led the market back in the late eighties when it was the Abies (and later the AAH Meditel) system. It has recently joined the CSC stable and may well benefit from a new lease of life.

One recent trend is that some moves appear to be driven by PCT and practice managers, with minimal clinician involvement. As the bulk of the data entry is done by clinicians during patient encounters, in order to demonstrate a sound and valid business case it is obviously essential that they are actively involved and are given access to all possible alternative systems in order to make informed choices.

This will help support any agreed change and ensure the long-term work of changing systems is clearly understood by all.

In the face of the changing economic climate, it seems self-evident that any practice switching systems from now onwards is unlikely to be funded.

So practices should consider the implications as carefully as a surgery move. At least they can extend, repair or redecorate the new building. But a new GP computer system, as the canine slogan points out, may now be one for life.

Kathie Applebee, is organisation psychologist for primary care, strategic management partner at Tamar Valley Health Group Practice, and chairman of the National Vision User Group

Top 10 employment law problems answered

Nearly half the calls from GP practices to an employment law advice line are contractual. **Janice Sibbald** gives advice in a rundown of the biggest worries

1 Performance issues

A good working relationship between employers and staff helps productivity and the general effectiveness of a practice - but what happens if there are performance issues and how can these be addressed?

If there is a workplace performance issue, you should discuss this with the member of staff, explaining your concerns about the standard of the employee's work, giving clear examples. Extra support and training should be provided to help the individual reach the required level expected within their role. A review period should be set and formal action can be taken if there is no improvement.

2 Short-term absence issues

Short-term absence accounts for around 80% of all absences, with the average worker absent 8.4 days a year.

While there are many common reasons for this, from toothache to migraines, some cases of absence may be because an employee feels stressed at work or is going through personal issues at home.

Short-term absences can place an extra burden on the rest of the staff because they are unplanned and need to be dealt with promptly and consistently. Attendance levels of all employees should be monitored and recorded. Formal action can be taken in most cases if there is no improvement.

When an absence is for less than seven calendar days, the employee can self certify. Beyond that timescale, as you know, a 'fit note' from their GP is required.

3 Long-term absence issues

Dealing with long-term absence requires balancing the employee's health needs while also trying to manage the practice's needs. It is usually related to one specific medical issue such as recovering from an operation or stress and depression.

It is important to keep in regular contact with the employee. Once they have been off for around six weeks or more, you may wish to ask their permission to contact their GP or refer them to occupational health. This can help determine a likely date of return.

When the employee returns to work, it would be advisable to agree a return to work plan - this could involve them working shorter hours or alternative duties.

If the employee is not deemed fit to work, you do not have to hold a role open indefinitely, but terminating the contract on the grounds of capability can be a long and sensitive process.

4 Bullying and harassment

These claims need to be handled sensitively, objectively and promptly as any allegation of harassment or bullying may cause tensions among colleagues. For those who are being bullied or harassed, it can be an extremely upsetting and stressful time. Every employee has the right to come into work in a safe environment.

Bullying and harassment is characterised as offensive, intimidating, malicious or insulting behaviour. Where it is possible and appropriate, the matter should be dealt with informally at first, as the alleged accused may be unaware that their conduct has caused offence.

If the situation cannot be resolved after a simple chat, then a more formal approach may be taken in the form of a grievance (see topic 10).

A practice should have a policy on bullying and harassment which sets out its commitment on how it will handle problems. This should include such details as what is considered unacceptable behaviour and how the practice will handle such matters.

5 Disciplinary

There are several steps you should take into account when carrying out a disciplinary hearing in order to make the process fair and legal. The facts should be established and an investigation carried out along with witness statements noted.

If a matter is deemed serious enough to be taken to a disciplinary hearing, ensure you give the employee all the information in writing before the hearing. The employee has the right to be accompanied at the hearing by a work colleague or trade union representative.

A hearing can result in no sanction awarded, verbal warning, first written warning, final written warning, dismissal or gross misconduct. After every formal stage, the employee has the right to appeal.

6 Discrimination

Everyone has the right to be treated with dignity and respect at work. There should be a level playing field where staff are treated the same in every aspect of the employee life cycle, regardless of age, sex, race, nationality and religion. The behaviour of practice managers and doctors is just as important as any formal policy. By setting a good standard and treating staff equally, discrimination problems within the workplace will be less likely.

7 Altering contracts of employment

The subject of changing terms and conditions can be a contentious one. It is very difficult, but not impossible, for an employer to alter an employee's terms and conditions of employment. Like all legally binding contracts, the terms of an employment contract can only be altered if both parties agree to the changes.

Take time to discuss with the employee why the contract needs changing, explaining the reason is due to genuine business needs, while listening to the employee's views and concerns.

If agreement cannot be reached, then one option is to impose the change upon staff. This may lead to a potential breach of contract claim or a risk that the employee raises a constructive dismissal.

Another option is to terminate the original contract, giving the proper notice, and offer the employee re-engagement under a new contract, with the revised working times. However, the termination of the old contract will be regarded as a dismissal and therefore will be open to a claim of unfair dismissal.

8 Redundancy

When faced with a potential redundancy, practices need to enter into a period of consultation.

It is important to explain to the affected employees the reason behind the situation, which parts of the practice will be affected, the impact of the redundancies on the workplace and the timescale involved.

The practice may have to draw up selection criteria to assess which employees are affected. Such factors as the employees' skills, experience and disciplinary records may be looked at when selecting staff for redundancy.

Obviously, this is a very stressful and emotional issue for employees so every care should be taken to carry out this process in a timely manner, professionally and sensitively. Staff should be fully informed throughout the process.

9 TUPE

TUPE is a very complex area of employment law involving the Transfer of Undertakings (Protection of Employment) Regulations. This could be a result of an employer selling or buying part of a business or when one business merges with another.

The purpose of TUPE regulations is to protect the employees' terms and conditions when a transfer takes place. Due to the complicated nature of TUPE, it is recommended that legal advice be sought.

10 Grievance

Grievance topics can range from a staff personality clash to something altogether more serious such as a sexual harassment claim.

Regardless of the subject, the practice manager should hold a grievance meeting with the staff member to clearly establish the facts and to gather relevant details such as dates, times, specific examples of the unacceptable behaviour and accounts from any witnesses. Any staff grievance must be taken seriously and dealt with promptly.

Depending on the outcome of any investigation, a disciplinary hearing may be required to address the misconduct.

Janice Sibbald is employment law adviser at the Medical and Dental Defence Union of Scotland

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