UK200Group news

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Smailes Goldie Group
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GP practice mergers

Mergers between GP practices are becoming more commonplace. This trend is in part a response to the proposed developments to the NHS as set out in the NHS 'Five Year Forward View' published in October 2014. GP practices are being actively encouraged to work together, be it through practice federations, joint ventures, mergers, or other collaborative entities.

So what are the key drivers for GP practices considering a merger? Sometimes it can be down to circumstance where, for example, a senior partner of a two partner practice is about to retire and, due to GP partner recruitment difficulties, it makes it more practical to merge the surgery with a neighbouring practice in order to ensure the continuation of the surgery under a partnership structure. However, increasingly practices are reflecting on the direction of NHS reforms, with the move towards competitive tendering for contracts and the entrance of alternative (non GP partnership) service providers.

Merging two or more GP practices to form a larger single entity can potentially provide economies of scale and with the move towards increasing competitive tendering for services, this could improve the chances of securing new NHS contracts. Many analysts envisage an NHS in the future where numerous smaller GP practice providers will be replaced by a smaller number of large service providers. The coming together of these GP practices can potentially increase the bargaining power and influence of the merged entity.

However, practice mergers can also create challenges, particularly in the short term. It is likely that before economies of scale are achieved there will be a period of time where there is duplication of duties. It is possible that some redundancies might be required and the whole practice merger process can be stressful for both the staff and the GP partners, as change can cause fear of the unknown. There are also likely to be short term increases in legal and professional fees with the extra work that results from the coming together of two or more practices, such as having to draw up a new partnership deed and the practicalities of having to merge two computer systems and two bank accounts into one.

Potentially there may also be differences of working cultures to overcome in the merged practice and where one surgery is dominant over the other, it can sometimes feel more like a takeover than a merger, with the resulting loss of power, control and influence for some GP partners.

To ensure your merger goes smoothly it is essential to obtain the correct advice and guidance and I would recommend consulting trusted business and financial advisers to talk through the general procedure. If handled carefully, the increased capacity and flexibility that can result from a practice merger, with a wider skills base across the merged practice, can prove invaluable.

UK200Group Healthcare member

Healthcare UK200group

future of GP partnership model called into doubt

Professional journal 'Pulse' has questioned the future of the partnership model for general practice. According to senior journalist Sofia Lind, an increasing number of GP partners are concluding that life as an employee may be preferable to partnership. Ms Lind also reports that there are 'scores' of GP practices where all partners are planning to become fully salaried.

Of the 500 GP partners surveyed by 'Pulse' in May 2016, around half said they would consider becoming salaried if offered the right deal. GPs who had already made the switch from partner to employee reported benefits such as less paperwork, more time to spend with patients and a reprieve from the pressures of running a business. Just one in five respondents to the 'Pulse' survey believed the partnership model for general practice will still exist in 2026.

GP partners accounted for 55% of England's GPs in September 2015 compared to 69% in September 2009, and the proportion of GPs drawing a salary increased from 21% to 24%. According to Ms Lind, NHS England's 'Five Year Forward View' is 'quietly driving a move among practices to hand back their contracts'. In Wales and Scotland, local health boards are reported to be taking over practice contracts from retiring GP partners and employing remaining practice staff. The new voluntary contract for general practice services in England will be available to various provider models, including GP federations, when it is rolled out in April 2017.

Almost four in ten GPs surveyed by the British Medical Association in April 2015 worked in a practice that belonged to a network or federation, and almost two-thirds of locum and salaried GPs questioned said they did not envisage seeking a partnership in the future.

Read more about the future of GP partnerships at:
http://bit.ly/2c1wYLn

independent reports into patient data security published

In July 2016, two separate independent reports on patient data security were published. 'Safe Data, Safe Care: Data Security Review' was authored by the Care Quality Commission (CQC) and examined whether health and social care providers are using patients' personal information safely and protecting it appropriately. 'Review of Data Security, Consent and Opt-outs' is Dame Fiona Caldicott's long-awaited National Care Guardian for Health and Care review of NHS patient data security. Both reviews set new security standards and Dame Fiona's review also resulted in the closure of care.data, NHS England's flagship information-sharing programme.

The purpose of the National Care Guardian review was to examine models for patients to consent to or opt-out from their data being shared. Although Dame Caldicott was not asked to look at care.data, she recommended that the Government consider its future 'in the light' of her work. NHS England's decision to scrap care.data was announced on the same day as the review was published. However, data-sharing work is being continued, and privacy campaigners such as medConfidential have expressed concern that care.data may carry on in a diluted form.

The National Care Guardian review sets out ten new data security standards to be upheld by healthcare providers. It also introduces a new opt-out procedure to make it clear to patients how their information will be used and in what circumstances they can prevent it from being shared. A consultation on the review's implementation closed in September 2016.

The CQC review sets out six recommendations for providers. For example, the senior management of health and social care providers should 'demonstrate clear ownership and responsibility for data security'. According to the CQC, the new data security standards will result in 'more stringent CQC inspections'.

For more information about the reviews, go to: http://bit.ly/2bXNMnK

To read the review, go to:
http://bit.ly/2bNqjTX

in brief...

NHS England steps up measures to remove ghost patients from GP lists

The match funding requirement has been removed from NHS England's Vulnerable Practice Programme. Since April 2016, GP practices are now able to apply for funding from the programme without being required to directly match the funding. Instead, applicants now only have to demonstrate how the funding will be matched in kind, for instance by guaranteeing that GP practice staff will dedicate a specified amount of time to projects funded by the programme. However, an NHS England spokesperson has claimed that this 'basically means they just have to state the number of days of GP and practice time available and that this is proportionate to the support on offer and achievable for the practice to provide'. According to the General Practitioners Committee, the requirement to match funds was 'clearly a barrier' to GP practices accessing support. http://bit.ly/2bYMUxh

Welsh GP practices helped by 'rapid response' teams

Two local health boards in Wales have set up 'rapid response' teams to help GP practices facing closure. Cwm Taf Health Board's Primary Care Support Unit comprises salaried GPs and practice managers, as well as other healthcare workers depending on the needs of the practice it is supporting. The team has managed nine practices that returned to independent status, and supplied nurses, advanced nurse practitioners and other health and care support workers to ten practices. The make-up of Hywel Dda Health Board's Primary Care Support Team also depends on the practice in difficulty and may include clinical pharmacists, advanced paramedic practitioners and occupational therapists. Read more about the teams at: http://bit.ly/2bQqKCZ

Funding requirement for vulnerable practice programme removed

The match funding requirement has been removed from NHS England's Vulnerable Practice Programme. Since April 2016, GP practices are now able to apply for funding from the programme without being required to directly match the funding. Instead, applicants now only have to demonstrate how the funding will be matched in kind, for instance by guaranteeing that GP practice staff will dedicate a specified amount of time to projects funded by the programme. However, an NHS England spokesman has claimed that this 'basically means they just have to state the number of days of GP and practice time available and that this is proportionate to the support on offer and achievable for the practice to provide'. According to the General Practitioners Committee, the requirement to match funds was 'clearly a barrier' to GP practices accessing support. http://bit.ly/2bYMUxh

One-third of worst-rated CCGs granted full control of primary care

NHS England has rated 26 of England's 209 clinical commissioning groups (CCGs) as 'inadequate' and a further 91 as 'requiring improvement'. Just 10 CCGs were rated 'outstanding' and the remaining 82 CCGs were rated as 'good'. Of the CCGs rated as 'inadequate', one-third had been awarded full responsibility for primary care commissioning and nine shared this responsibility with NHS England. However, the majority of CCGs with the lowest overall rating received a 'good' rating for their handling of the primary care commissioning functions that were delegated to them. Of the 91 CCGs requiring improvement, 40 had sole responsibility for primary care commissioning and 41 shared their responsibility with NHS England. http://bit.ly/2bQqrrN

New voluntary contract for GPs

The new voluntary contract for general practice services will have a 15-year term and may exempt GP practices from Care Quality Commission inspections and lower their medical indemnity costs. Default national terms will be published by NHS England in September 2016 and the contract rolled out across England from April 2017. The terms agreed by Manchester's local medical committee (LMC) are expected to closely mirror the default terms. According to Dr Tracey Vell, Manchester LMC Chief Executive, contracting organisations will be able to join 'up to varying levels' and GP practices may be able to keep their general medical services contract. Read more at: http://bit.ly/2bXOmBH

New social media guidance for dental professionals

The General Dental Council (GDC) has updated its social media guidance for its registrants. The guidance helps dentists and dental care professionals (DCPs) use social media safely, professionally, and in a way that maintains patient confidentiality. It also defines the boundary between patients and professionals, and dentists' and DCPs' professional responsibilities. The guidance covers all forms of social media, including blogs, forums and social networking platforms, as well as setting out a series of recommendations for dental professionals to follow when using social media. These include prohibiting dentists and DCPs from publishing information online that could identify patients, unless they have obtained their consent, and advising them to comply with their employer's social media policy. Read more about the guidance at: http://bit.ly/2cAUZOr

estimates of compensation payable for care already provided almost doubles

The amount that will be needed to pay for negligent care in NHS hospitals in England already provided has almost doubled in the last 12 months, according to NHS Litigation Authority (NHSLA) estimates. The NHSLA is the organisation responsible for compensating patients for negligent hospital care. It estimates that £56.1 billion will be needed to settle claims for negligent hospital care provided up to July 2016, representing an increase of 83% from last year's estimate of £30.6 billion needed to compensate for negligent care provided up to July 2015.

According to the NHSLA, these figures represent a 'ticking time bomb' in relation to the cost and availability of medical indemnity insurance cover. Although the figures relate to hospital care only, the Medical Defence Union (MDU) has warned that they are 'illustrative' of the rising cost of clinical negligence claims, which the MDU has also seen in medical negligence claims against GPs. Research carried out by GPonline found that over 90% of GPs were quoted a higher price for indemnity insurance in 2016 than in 2015. The MDU estimates that the cost of claims for medical negligence is increasing by 10% each year, 'outstripping' other forms of inflation. The NHSLA paid out £1.5 billion in 2015/16, an increase of around 36% compared to £1.1 billion in 2014/15. The number of new claims decreased by 4.6% over the same period, with the rise in compensation attributed to the high number of claims started in recent years that are now becoming payable. The overall amount of compensation awarded increased by 23% between 2014/15 and 2015/16 and costs awards rose by 43% during the same period.
Read more about the NHSLA figures at: http://bit.ly/2bNGDc9
Read more about the GPonline research at: http://bit.ly/2c5v3ap

GDC publishes duty of candour guidance for dental profession

The General Dental Council (GDC) has published guidance on the professional duty of candour for dentists and dental care professionals (DCPs). This applies alongside the GDC's existing 'Standards for the Dental Team', which requires GDC registrants to act honestly and with integrity and offer an apology and a practical solution if a patient makes a complaint. However, the duty of candour goes further by requiring dentists and DCPs to be open and honest with all patients regardless of whether a complaint has been made.

The duty of candour guidance was published on 1 July 2016 and it became applicable to GDC registrants immediately, despite a request from the British Society of Dental Hygiene and Therapy (BSDHT) for further consultation. The importance of dentists and DCPs being open and honest with patients is stressed throughout the guidance. To this end, they are expected to apologise as soon as possible when a patient suffers harm or distress due to something going wrong with their treatment.

According to the BSDHT, the guidance itself casts doubt on dentists' and DCPs' professionalism. BSDHT President Michaela O'Neill has pointed out that the GDC's standards already cover patient interaction and suggests that the guidance 'could be read as over regulation ... suggesting that some DCPs are dishonest and do not uphold these standards'.

The BSDHT also claims that requiring dentists and DCPs to inform patients that something has gone wrong places them at risk of legal action, as such communication could be interpreted by the patient as an admission of fault or negligence. However, the GDC explicitly states that 'saying sorry is not the same as admitting liability', adding 'the guidance is designed to emphasise this point'.

Read more about the guidance at: http://bit.ly/2bYMvuP

And: http://bit.ly/2bRk7NY

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