

# Newsletter

## GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE JUNE 2010 Edition

**Dr. Andrew Seymour**

**LMC Chairman**

[Andrew.Seymour@glos.nhs.uk](mailto:Andrew.Seymour@glos.nhs.uk)

**Shelina Jetha**

**LMC Manager**

[shelina@gloslmc.com](mailto:shelina@gloslmc.com)

**Mike Forster**

**LMC Lay Secretary**

[mike@gloslmc.com](mailto:mike@gloslmc.com)

**Sue O'Sullivan**

**Administration**

[sue@gloslmc.com](mailto:sue@gloslmc.com)

LMC Website: <http://www.gloslmc.com>

**Tel: 01452 310706**

**Fax: 01452 386503**

June is a great month. Socially it is marked by Royal Ascot where ladies try to make a big impression with their hats and men pretend the Edwardian era still lingers on. Politically it is the month when LMC



representatives converge with sharpened minds and metaphorically sharpened knives on London for the LMC Conference. They take off their jackets and usually find catharsis by planting their metaphorical knives in the notional backs of those who have annoyed them over the previous year. They then direct the GPC towards great things to strive for in

the coming year. However this year's prospective target was no longer in power. There was thus cautious optimism that the new coalition government might be one that the GPC could do business with. A report on the Conference is at Annex A.

### EMERGENCY BUDGET

The need to retrench in public services has been recognised by the Chancellor of the Exchequer in his Emergency Budget. The BMA's response to the budget was that:

"Doctors understand that these are difficult times and we accept the need to be reasonable and responsible about future pay rises. However, we are seriously concerned that the Chancellor has overridden the whole negotiation process between the BMA and the independent review body and imposed a two-year pay freeze for the majority of public sector workers.

"The public sector did not cause the financial crisis and should not be singled out as the main vehicle for dealing with it.

"The BMA will cooperate fully with the forthcoming review on public sector

pensions. However, the NHS scheme underwent a major review in 2008 and the BMA will take all possible steps to protect the value of current and future pensions."

Those cursed with more than ordinary tenacity and an unquenchable thirst for knowledge can learn more about the budget at:

<http://www.info4local.gov.uk/content-by-topic/june2010budget>

### ACCESS TARGETS

The following indicators have been removed by the Government:

- Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours
- Patient experience of access to primary care (and supporting measures)

The question is, 'what effect will that have on the monies paid for that

performance under the contract?' The best steer that we have been able to get so far is that although DH is no longer going to be performance-managing PCTs on these indicators they remain part of the contract until that contract is formally modified, so the money should continue to be paid. The GPC clearly has some quick negotiating to do.

### QOF AND QMAS

Some small end of year increases in the Raw and Adjusted National Prevalence figures are inevitable as more practices tidy their EOY data and new patients are found. But this year, in addition to the usual statistical anomalies in Mental Health and Dementia that put nearly everyone on the 5% cut-off, there are other genuinely unbelievable changes in the Adjusted National Prevalence figures. Hypothyroidism is an example. In hypothyroidism the Adjusted National Prevalence changed overnight on 31 March 2010 from 0.03039 to 0.05067, despite the National Raw Prevalence only increasing from 0.02880 to 0.02933. One practice reports their Prevalence Factor being reduced from 1.26 to 0.98 as a result, and therefore suffering a reduction in their achievement payment (i.e. a pay cut in that area) of over 20%. This cannot be right, and the GPC are looking into it and similar instances most urgently.

### VETTING AND BARRING SCHEME

In case you missed the announcement, voluntary registration with the Scheme had been due to start on 26 July, though limited to new employees and job-movers working or volunteering with children or vulnerable adults. This voluntary registration has been halted. The Government has made clear its intention to bring the criminal records and vetting and barring regimes back to common sense levels. Until this remodelling has taken place those aspects of the new scheme which are already in place will be maintained, but no further elements will be introduced.

### SESSIONAL GPs

The LMC Conference endorsed the GPC Sessional GPs Representation Working

Group Report in all its parts. In particular the report recommended:

- Delegating authority to the Sessional GPs Subcommittee of GPC (SGPS) so that sessional GP representatives act on matters wholly or primarily relating to sessional GPs.
- The size of SGPS will be doubled to 16 members.
- The formation of an SGPS executive committee, which will meet regularly and with the GPC's negotiating team when necessary.
- Four permanent seats on GPC for the SGPS executive committee, in addition to the sessional GPs already elected via regional and national elections.
- New guidance for LMCs to help them improve their representation of sessional GPs locally.
- A new strategy for communications aimed at improving the flow of information and discussion between the BMA and sessional GPs.

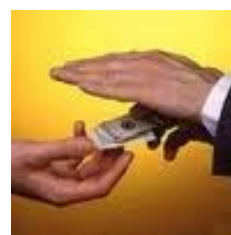
### SENIORITY FACTORS

The Technical Steering Committee has published the Interim Seniority Factors for GMS GPs in England and Wales for 2010/11. The figures are £95,802 for England and £85,690 for Wales.

### DANGER!

#### BRIBERY ACT 2010

With effect from 1<sup>st</sup> October (to be confirmed) the new Bribery Act 2010 comes into force. From a practice



perspective it seems unlikely that a GP would ever try to bribe anyone to do anything improper, but arguably they could themselves be accused of being bribed to do something improper. The only defence is that the practice has adequate procedures in place to prevent bribery. The receiving of gifts, corporate hospitality etc could be construed as bribery unless a written anti-bribery policy exists and the practice can prove it is being used. This would clearly be a sensible precaution, bearing in mind the size of the potential penalties. For more information see Annex B.

## REPORTS FOR PATIENTS CLAIMING BENEFIT

Practices are not obliged, either by statute or contract, to complete reports requested by organizations assisting people with their claims for benefit. Practices may choose to do so and may charge a fee. Welfare Rights and CAB usually say that they are not in a position to pay a fee. If a claimant is turned down for a benefit after making an application without a report from the GP, he or she can appeal the decision and if the appeal comes before a Tribunal and the Tribunal feels that it would be helped in its decision making by a report from the GP, the Tribunal is entitled to request such a report from the GP and will pay a fee.

## NEW TAX BRACKETS

We have raised before in our Newsletters the challenge that the new tax brackets will present to those whose income exceeds £100K annually. The GPC has now issued a revised *Focus on new tax brackets* which includes a spreadsheet showing the financial implications of taking on a salaried GP. See: <http://www.bma.org.uk/employmentandcontracts/tax/focustaxbrackets.jsp>

The whole thing is hedged with important legal caveats and disclaimers, but is still useful as an illustration. The general tenor is that it is generally cheaper to take on a new partner and 'spend more time with your family'.

In the light of the Emergency Budget the GPC is now re-examining this advice and will if necessary issue an amended version.

## SALE OF GOODWILL - DISPENSING

Where the dispensing rights have been granted to a GMS/PMS practice and form part of the NHS core services, they are intrinsically linked to the practice; then the practice cannot sell goodwill – it would be illegal. **It is imperative that practices do not fall foul of the Goodwill rules because by doing so, a breach in the regulations could result in a criminal offence.**

However, there are some circumstances where a practice has set up a pharmacy as a separate business (which is sometimes run from practice premises), which is almost like owning and running a

chemist's. It is not linked to the GMS/PMS agreement and can therefore be sold independently. In such cases it is thought that the Goodwill rules most probably do not apply.

The GPC would always advise practices who are unsure whether the goodwill rules apply or not, to check this with the Secretary of State.

## PATIENT SURVEY; CALCULATING ELIGIBILITY FOR QOF PE7 AND PE8

Full details of the patient survey results can be found at: <http://www.gp-patient.co.uk/surveyresults/>

PCTs will now use the patient access data in the survey for calculating practice payments under the QOF. As part of the H1N1 vaccination DES, those practices that meet the minimum target for vaccinations will receive a 10 per cent drop in the upper - and 20 per cent in the lower - thresholds in PE7 and PE8. Practices should be aware that the ImmForm Swine Flu data extraction programme, which has been used to assess uptake levels for the QOF easements, calculates the denominator on the age of the eligible patient population at the date of extraction, rather than the age of the patients at the time of vaccination.

This is likely to have a minor impact on the number of patients in the six months age range because those who were previously not eligible, will now appear as eligible. This is not expected to be a large number and will mainly impact on those practices that are close to the 50.7 per cent target.

Practices who do not believe that the figures are an accurate reflection of their eligible patient population can, with the agreement of their PCT, perform a manual calculation to work out whether they have qualified for the patient experience easements.

Practices can use the data extraction report as a template to perform this calculation. An example of the report and details of the formula to be used, are available in Annex 4, page 15 of the H1N1 vaccination DES guidance, available here:

[http://www.bma.org.uk/images/panfluqpguidance\\_tcm41-191608.pdf](http://www.bma.org.uk/images/panfluqpguidance_tcm41-191608.pdf)

VALEDICTORY –  
SIR LIAM DONALDSON

In one of his last letters before leaving the post Sir Liam wrote:

*'The response of the NHS to the first pandemic of the 21<sup>st</sup> Century was excellent. As you know, this is my last week as Chief Medical Officer and I take this opportunity now to thank you for all your fantastic work and support, both during this pandemic and over the past decade in general. Whilst officials in the Department and I try our best to provide guidance and direction, you deliver the outstanding care the public rightly expects.'*

BUYING GROUP OFFER – MIAB

We recently circulated to practice managers an offer from MIAB to do with insurance against the costs of:

- Locum cover while those in the practice who fail revalidation are studying or retraining;
- Legal fees, covering a multitude of types of case, both for the practice and its partners, staff and their families, and in the case of partners – partnership disputes.

MIAB have asked us to make sure that the information has actually reached the GPs themselves and has not just been filed in the practice managers' office...

MAX'S MUSINGS

Under the influence of global warming all sorts of nastiness are said to be heading our way. Hornets the size of a finger and

capable of beheading 40 bees a minute have been seen in Brittany. The Scientific American magazine attributes to Dr Volker ter Meulen, EASAC chairman, the statement that rising temperatures in Europe would provide new habitats for a mosquito that transmits yellow fever,



West Nile virus, dengue fever and encephalitis. The same mosquito has been linked to over 200 European cases of

chikungunya, a virus that causes fever and destruction of the joints. And what about our old imperial enemy: malaria? Gin and tonic may yet come back into fashion again.

But the day may also come when the peculiarly French affliction of 'heavy legs' or 'jambes lourdes' may cross the English Channel, probably starting in Dover but spreading across the country with the speed of a pandemic. It is a mysterious



condition, and may even be genuine for all I know, but it seems startlingly rare outside France. The symptoms are surprisingly vague so we may have difficulty making our first

diagnosis. I await my first case with eager anticipation. Perhaps my CPD budget would run to an educational fortnight on the Loire? I could become a national expert and be able to diagnose the condition in almost anyone. Vive la France! Vive la galère!

And finally:

*'Examination reveals a well-developed male lying in bed with his family in no distress.'*

*'I saw your patient today, who is still under our car for physical therapy.'*



**This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office**

## **LMC CONFERENCE 2010 - REPORT**

Keynote Speech. Dr Laurence Buckman, Chairman of the GPC, said that national efforts to economise would be bound to affect the NHS. He had a number of wasteful policies he felt the Secretary of State should be urged to cut: the Private Finance Initiative, management consultancies, the internal NHS market, excess tiers of management and patient surveys. There were several others he might mention: NHS Direct, Choose and Book, Summary Care Records, Walk-in clinics and Darzi centres and compulsory polyclinics. Above all he wanted the service to be patient-led rather than target-driven.

The GPC agreed with the need to improve access but would need to discuss any removal of practice boundaries most carefully. Similarly, there was nothing intrinsically wrong with GPs being involved in commissioning (in-hours or out-of-hours) but the GPC would never accept GPs being the providers of last resort of OOH cover.

He mentioned, again, the obsessive and unfair attacks on the profession, not least by the Daily Mail. He stated that GPs work hard for their money and he was not ashamed to be there. On balance, so far, he felt that the new government was one the GPC could do business with, but the GPC would remain ready, willing and able – either to co-operate with wise government or to oppose any foolish policies.

Looking Back. The Pandemic Flu scare was examined and the part played by GP practices commended. However, despite all the advance planning there had still been times when policy was being made on the spur of the moment; lessons had to be learned and funding earmarked for future events.

Homeopathy. While some felt that homeopathy was cheap, safe and needed for some difficult patients, the general view was that there was insufficient clinical evidence to justify NHS funding for homeopathy clinics.

Discussion – the Future of General Practice. Professor Chris Ham, Chief Executive of the Kings Fund, introduced a discussion on the future of General Practice. There were factors that would drive change: an ageing population requiring ever more help; an increase in chronic conditions, and over-reliance on acute hospitals; the need to make significant savings, and the rise of a culture that stressed prevention in preference to treatment. A tide was already flowing in favour of the formation of networks, federations or groupings both between practices and with the social services, although whether to base such groupings on geographical location or like-mindedness was not clear. Also solutions in rural areas would inevitably differ from those in urban areas. GPs would be likely to take on a measure of budgetary control. Both these major changes would require rigorous piloting as they would require a reduction in centralised targets, and an increase in local powers, choice and competition and a need to grow a collaborative approach between all involved. There were dangers. Unbridled choice produced waste. For example, reduced waiting times were a benefit produced under the last government – but how could these times be kept low without targets? If patient choice became a tenet for the future, what could be done for those professionals who lose out as a result of that choice being exercised? Conference unanimously demanded evidence that polysystems provided a better way to deliver health care. They were also unanimous in stating that abandoning practice boundaries would be expensive and unaffordable, and put GP home visiting at risk. There was also a strong feeling that it would put at risk those personal relationships with patients that lay at the heart of general practice, and an influx

of patients to popular practices would not be supported by funding for premises enlargement.

Commissioning.

- PBC. Avon LMC likened PBC to a beautiful bird which had never flown as it should because it had been nailed to a perch inside its cage, and it only looked alive now because it was still nailed to the perch. There was general agreement, although in some areas of the country PBC was said to have had the occasional flutter. The alternative – to provide GPs with real (rather than indicative) commissioning budgets – needed to be looked at carefully, and GPs should only get involved on a voluntary basis. It should not provide inducements to treat patients less well.
- Referrals. Both primary and secondary care should remember that referrals exist to improve the treatment of the patient – not to provide a funding stream for clinicians.
- Secondary or Primary Care? A statistic frequently quoted during the conference was that GPs do 86% of the NHS's work for 23% of the funding, and thus provide outstanding value for money. As such it was likely that work would continue to move from secondary to primary care, but Conference insisted that any such move should be properly resourced (probably through enhanced services arrangements), and premises improvements or extensions made as required.

Contracts. One GP graphically likened those practices that had originally gone over to PMS as being mice tempted by cheese into a trap. Now however they were being called 'fat cats' caught in the same mousetrap because they had given away their right to have a national body negotiate for them. That said, the GPC was always ready to support all practices – and did so. Many PCTs had been and still were reviewing PMS contracts and the GPC intended to offer every support to PMS practices and LMCs during this period, short of actual negotiation.

DDRB Award. There was general condemnation of the last government's unilateral capping of the DDRB recommended award to impose a '1% saving'.

Locum Pensions. The conference unanimously agreed that locums should be allowed to pay superannuation contributions by direct debit or standing order with a reconciliation at the year's end.

GP Education. There was a general feeling that improvements could be made to the training of GP trainees, particularly to fit them for running a business as well as the clinical side. There was, however, great opposition to the tendency to micromanage practices by PCOs, and to their fixation on certified mandatory additional training.

Sessional GPs. Conference discussed sessional GPs at length. There was a strong feeling that unity was strength. The GPC Sessional GPs Representation Working group Report had just been published (and a copy was given to each attendee). The Conference welcomed the report and endorsed it in all its parts: the doubling in size of the Sessional GPs Subcommittee to 16 and delegating power to them to deal with particular Sessional GP business, the formation of a Sessional GP's Executive Committee, and the creation of 4 new seats on the GPC for members of the Sessional GPs Subcommittee. Appendix 2 of the Report specifically addresses how sessional GPs can get involved with LMCs and how LMCs can support Sessional GPs:

- To ensure that 'Chinese Walls' arrangements exist whereby different LMC members/ different staff members support employer and employee in any dispute, if necessary calling in support from a neighbouring LMC.
- How to get in touch with sessional GPs.
- How to encourage them to stand at elections.
- What services LMCs can/should provide for sessional GPs

Partnerships. There was strong support for the system of partnership practice, and several suggestions were made for its survival. However the conference did not agree that GPs should never be employed for more than 5 years without being offered a partnership, as it was recognised that some GPs would never wish to make the move from salaried status to partnership and it would be wrong to put them under pressure to make that change.

Extended Hours. While a broad majority believed that Extended Hours had been a political whim, only a 57%:38% majority felt that the extra appointments were being attended by those who could have attended normal appointments. So the system was providing some benefits to patients.

Out-of-Hours. There was only a bare majority (52%:47%) in favour of GPs taking a central role in commissioning OOH services but all were emphatic that even if they got involved in commissioning the service this would never equate to GPs being the providers of last resort. There was a statement that the doctors involved in OOHs work are of two sorts, the tired and the retired, which at least raised a laugh.

#### Performance Management.

- Balanced scorecards came up for discussion again. Conference felt they had value for developmental purposes but should not be the basis for financial penalties or meaningless league tables.
- There was unanimous agreement that practice registration with the Care Quality Commission should not impose a financial or bureaucratic burden on general practice.
- Conference also voted unanimously in favour of overseas doctors coming over to practice in UK for short periods being able to speak English, knowing how the NHS works, having broadly comparable skills, training and knowledge, and being governed by the normal regulatory processes.
- There was general distrust and dislike of patient surveys as they were currently constructed and used. There was an erudite but sadly incomprehensible exposition on why the survey could at once be statistically valid (which it was) and yet give a very distorted picture of primary care (which it did), paradoxically reducing practices' ability to improve access by reducing the funds needed to do so.

Dispensing. There was an impassioned explanation by a dispensing doctor from Cornwall that there were some 80 drugs where the funding regulations assume that the doctor is given an 11% discount when he buys the drug, so that amount is clawed back – but the discount is no longer given. So for some drugs the dispensing is done at a loss. This does not apply to pharmacists, who are refunded the cost of drugs without clawback. Combined with the predatory applications of pharmacists and the current rules on whether a practice can dispense or not depending on its location relative to a pharmacist there is a severe risk that patients in rural areas will soon no longer be able to enjoy the current dispensing service. Conference unanimously deplored this situation.

The Mid-Lothian Question. There was a decisive vote against English matters being voted on only by English LMCs.

GP Defence Fund. Dr Brian Keighley is not standing for re-election as Treasurer of the GPDF. He leaves it with the overall worth of the fund having increased slightly to £5.9M and with recent refunds given to LMCs when it was clear that the GPDF would not need all the money collected in-year.

#### Information Technology.

- Choose and Book. Conference agreed that providers should be forbidden from managing demand by removing their option from C&B. Similarly, C&B was seen as an extra service, not as part of the core contract.
- IT Systems. Besides asking for secure remote access to clinical systems there was also a lot of complaint about slow N3 access. There was unanimous disapproval of letting other agencies have access to GP computer systems.
- Summary Care Record (SCR). Despite the suggestion that the end was of unproven value, and thus the means to that end were questionable at best, Conference fought shy of suggesting that SCR should be abandoned (50%:43%). However they insisted that the GPC should be negotiating for explicit consent and that the concepts of implied consent and 'opt-out' were not acceptable. Furthermore the extra work involved in implementing SCR should be rewarded. The new Minister of State for Health, Mr Simon Burns, had just written to the GPC stating his government's position and the letter was read out in full. In summary:
  - Patients and clinicians alike need to see the electronic record.
  - The SCR process was to be reviewed.
  - Data security is paramount.

Primary Healthcare Teams. Many regretted the 'gadarene rush' to 'transform community services' by use of vertical integration.

#### Primary Care.

- Conference agreed that an independent body should publicly report on the cost effectiveness of Darzi clinics, and that the cost effectiveness of APMS contracts should also be open to FOIA enquiries.
- An aging population will require proportionately more care, which will equate to more GPs being needed. Although the need, and probably the supply, are identified the resources are not. The future funding of General Practice, and its scope vis-à-vis secondary care, need to be settled.
- Conference unanimously agreed that community nursing services should be fully integrated with general practice, and that midwives and health visitors should be formally attached to practices.
- Lack of premises funding was identified as a major obstacle to progress, and should be put right, and that if a practice should fail CQC assessments over premises issues the PCT should be required to resource the actions to put that right.

Revalidation. There was general disquiet that the RCGP was designing a system without securing the necessary funding, particularly what the cost of remediation would be and how it was to be paid for. Further, the role of the responsible officer implied that he (or she) should be a practising GP, should not be accountable to

the PCO in any other capacity, and that GPs should be able to choose between at least 2 responsible officers in case of personality clashes. The motion was passed, but the GPC negotiators doubted much would come of it, particularly with the difficulties faced in recruiting responsible officers.

PCOs. Conference voted that there should be a 'practitioner experience questionnaire' from GPs on the PCT's performance, which would be included in balanced scorecards which PCTs would have to publish annually, and that GPs should be given a choice of which PCT they wished to be administered by. Some of this may have been tongue-in-cheek, but there was serious antagonism to:

- The hiring by PCTs of outside management consultants.
- Inaccurate administration of regulations.
- Excessive demands for information.
- The making of service decisions that clinicians would judge detrimental to patients.

and there was a feeling that NHS managers should be accountable for any harm to patients arising from their actions or decisions.

GPC Negotiators Question Time. Main points raised:

- Real Commissioning Budgets. The negotiators clarified that they would only agree to arrangements that kept practice income and commissioning moneys clearly and entirely separate. Questions raised the risk of loss of economies of scale if PBC budgets became actual (or 'hard'). While recognising this risk, it was a factor that would encourage the federation of practices. The negotiators would certainly be pushing hard for these budgets (if they came about) to be professionally supported, properly funded and carrying power as well as responsibility.
- Fees. They were asked, again, whether the collaborative fees could be re-set.
- The Contract. The Government had not expressed the intention since coming to power of renegotiating the current contract.
- The Role of LMCs if PCTs were to be Reorganised. No change: LMCs were the representatives of GPs, statutorily appointed, and that role would remain however the NHS organised itself.
- Pensions. They confirmed that all NHS work (including appraising) is superannuable.

Soap Box Session. Major issues raised were:

- There was concern that the standards set for hospitals by CQC were aimed at acute trusts, but that community hospitals would be subjected to the same standards, perhaps inappropriately.
- Bradford (understandably) had produced a language tool that they would be keen to make available to others.
- Misdirected communications from hospitals. One practical solution had been found: sending a copy with a suitably printed label to the chief executive of the trust every time it happened.
- E-mail fatigue. (No practical solutions raised)

## **THE BRIBERY ACT 2010**

[http://www.opsi.gov.uk/acts/acts2010/ukpga\\_20100023\\_en\\_2](http://www.opsi.gov.uk/acts/acts2010/ukpga_20100023_en_2)

**The new offences** The four new offences can be summarised as follows:

1. **Bribing Another Person (active):** offering or giving a financial or other advantage to a person
  1. intending to induce (or to reward) them, or another person, to perform improperly a public function or business activity, or
  2. knowing or believing the acceptance in itself would constitute improper performance;
2. **Offences Relating to Being Bribed (passive):**
  1. requesting or accepting an advantage or reward intending personally, or through another, to perform improperly a public function or business activity;
  2. requesting or accepting such advantage when the request or acceptance would constitute improper performance of a public function or business activity, or
  3. improperly performing such a function or activity in anticipation of receiving such an advantage;
3. **Bribery of Foreign Public Officials:** offering or giving to (or with the assent of) a foreign public official any advantage that is neither permitted nor required by the written law applicable to that official intending
  1. to influence them in their capacity as a public official, and
  2. to obtain or retain business or business advantage;
4. **Failure of Commercial Organisations to Prevent Bribery: The 'Corporate Offence':** a commercial organisation or a partnership will be guilty of an offence if an associated person (including an employee, agent or subsidiary providing services for the organisation) bribes another person intending
  1. to obtain or retain business for the organisation, or
  2. to obtain or retain an advantage in the conduct of business for the organisation.

### **The adequate procedures defence**

Where an organisation (e.g. a practice) might be liable because an associated person has committed a relevant offence, the sole defence available to the practice will be for it to show that it had in place "adequate procedures" to prevent bribery. The Act, therefore, places the onus on organisations to ensure that their own procedures (and where necessary those of their associated persons) are adequate. Policies alone, without policing of actions, are unlikely to be enough.

### **Compliance procedures**

Government is expected to issue guidance on the standard to be achieved and the Act contemplates that the Ministry of Justice will issue such guidance before the Act comes into force. However, that guidance is expected to be principle based, rather than prescriptive, and it seems unlikely that it will be capable of direct implementation. Instead, organisations will be expected to develop and refine procedures appropriate to their own circumstances and will be well advised to use

the period before the Act comes into force to undertake a root and branch review of their business practices and reassess whether the protective measures and compliance procedures now in place are appropriate, given the nature of the risks faced.

Looking forward, organisations will also have to ensure they have the necessary resources to implement their procedures and it will certainly not be sufficient for large commercial organisations to simply produce written policies and compliance programmes without effective implementation and record keeping.

Good anti-corruption policies will involve tailored risk analysis, clear and cogent strategies and training to combat specific risk, and evidence of careful and committed monitoring with rigorous enforcement at all business levels.

### **So what should your practice be doing?**

Consider the following when developing or enhancing your procedures to prevent bribery:

- Procedures to assess the likely risks of bribery arising in the practice's business;
- A clear and unambiguous code of conduct including appropriate anticorruption elements, which is publicised internally and externally and applies right across the practice;
- Employment procedures involving pre-employment vetting, express anticorruption obligations in employment contracts and clear disciplinary consequences for breach of those obligations;
- A programme of anti-corruption training and guidance for staff;
- Formal whistle-blowing procedures for staff to report corruption;
- Formal procedures for suitably qualified persons to investigate and report on allegations of corruption;
- Undertaking due diligence on any proposed new business relationship, both as to counterparty and geographical risk of corruption; and
- Using procurement and contract management procedures to minimise the opportunity for corruption by agents, partners and sub-contractors of the business, and to require them to reflect your own anti-corruption policies and procedures in their own businesses.

In the unfortunate event that you discover a corruption issue in your practice, you should seek prompt independent legal advice to ensure that the way the issue is investigated and handled minimises the resulting legal consequences and damage to reputations.

### **Conclusion**

Incidentally, the World Bank estimates that over \$1 trillion is paid annually in bribes. With governmental guidance on the scope of the 'adequate procedures' defence expected shortly, it is imperative that all organisations meet the standards expected under the Act as soon as they are reasonably able to do so. If they do not, they may find that they are too late to avoid being penalised with the harshest of penalties.