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SOUTH STAFFORDSHIRE LMC NEWS

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MEDICAL INDEMNITY FOR EXTENDED HOURS, WINTER PRESSURES AFTER 6.30 PM AND FOR ACUTE VISITING SERVICE

The view from the Defence Unions (the MDU in particular) is that work carried out by GPs under the extended hours scheme would not require additional indemnity cover. This includes weekend working, as long as GPs are seeing their own registered patients.

However, the MDU recognises the fact that the NHS landscape is changing (seven day working, collaborative working, federations etc) and again, as long as GPs have access to patient notes and are using shared computer systems, this should not ordinarily affect the indemnity cover, but in the latter case they do currently expect to be informed in order to obtain a view from the underwriting team (i.e.; case-by-case basis).

Their general advice though, is for GPs to contact them for further guidance if there is a significant change in circumstances, including average number of hours worked.

Please note the difference between occurrence-based policies and claims-based policies.

Liability insurance policies are either "occurrence-based" or "claims-based." An occurrence-based policy provides insurance coverage for a loss that "occurred" during the policy period, no matter when the claim is brought against the insured. A claims-based policy provides coverage for a claim that is brought within the policy period, no matter when the loss occurred.

Claims based policies tend to be cheaper whilst you are working because occurrence based policies (e.g. the more traditional MDDUS, MDU or MPS policies) cover you in retirement for activity that took place whilst you were still at work (and paying premiums) but where the claim came in after you stopped work and paying premiums.
If you have a claims based policy you have to continue paying in retirement (i.e. run off) because each year could produce a claim about work done pre retirement. As fewer than 50% claims come in within 5 years of the incident, and some over 20 years later the cost to us and our heirs of a claim out side the cover period needs to be covered or we/ they may be required to defend it.

"Buy cheap, buy twice."

The GPC will be considering this and issuing guidance.

REMINDER ABOUT SENDING PATIENT IDENTIFIABLE INFORMATION (PID) TO CCGs

A recent incident where in all good faith a colleague sent PID to his CCG merits remembering that the CCG cannot be in receipt of any PID unless with the explicit consent of the patient.

The exception is for those Medicines Optimisation Team CCG staff members or practice pharmacists who are seconded into the practice (acting to all intents and purposes as part of the practice's Direct Care Team) to receive PID within the confines of the practice and subject to the clearly-defined parameters of the secondment agreement between the CCG and the practice.

The CCG has a certain duty of membership protection to work with the practice to inform them of any breach and to explain what they must do to prevent these recurring. But these are practice breaches and they are the liable party should fines ever be levied by the Information Commission Officer (ICO) (if the repeat breaches were of significance or

systematic/enduring enough).

Please note that even an NHS.net to NHS.net communication containing PID is a breach unless the practice can append to that email a scanned PDF or other format document to fully show that the patient has given their explicit consent for their PID to be shared with the CCG (whether that be staff at the HQ dealing with soft intelligence or even the Medicines Optimisation Team working offsite from their assigned practice); and with a note kept in the patient's practice held medical record. Individual funding requests are an example of sharing PID with explicit patient consent.

If patient information is requested by a clinician then this must be sent via NHS.net. The practice must be assured that this kind of communication is 100% for direct care related purposes only. The practice is then using "implied consent" as part of the direct clinical care given to their registered patients to inform colleagues of the pertinent clinical matters needing the patients' PID to be shared. This is a lawful use of PID for a stated purpose under the Data Protection Act.

SMS MESSAGING

The LMC would like to remind you of the existence of SMS messaging. All four CCGs will continue the funding albeit some have decided to produce a policy for equitable use and future affordability.

SUBJECT ACCESS REQUESTS (SARs) FOR INSURANCE PURPOSES

You will have received the GPC Focus on Subject Access Requests for Insurance Purposes.

It remains a right for anyone to request a SAR directly or through an agent. The Information Commission Officers' view was that the original GPC guidance suggested that GPs should refuse to provide a SAR.

The current GPC guidance, whilst more complicated, recognises that patients have this right, but that in view of concerns raised by the ICO it is more appropriate for the SAR to be sent to the patient rather than directly to the insurance company.

With regard to payment, the insurance company should pay.

CQC DUTY OF CANDOUR

The CQC Duty of candour came into effect for all GP practices on 1 April 2015.

This is covered by Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out all of the fundamental standards. It aims to ensure that providers are open and honest with people when something goes wrong with their care and treatment.

When a service is meeting the duty of candour patients should expect:

- A culture within the service that is open and honest at all levels;
- To be told in a timely manner when certain safety incidents have happened;
- To receive a written and truthful account of the incident and an explanation about any enquiries and investigations that the service will make;
- To receive an apology in writing;
- Reasonable support if they were directly affected by the incident.

If the service fails to do any of these things, **CQC can take immediate legal action against that provider.**

It is recommended that members read the mythbuster on the Duty of candour.

REGISTERED MANAGER RESPONSIBILITIES

A GP colleague has raised important legal aspects about registered manager responsibilities which need clarifying with respect to practice structures, agreements and deeds. The LMC Secretary has contacted the GPC who have requested formal advice from the GPC legal team.

OVERSEAS VISITORS AND REGISTRATION REQUIREMENTS

The GPC is aware of concerns about the lack of clear advice from NHS England about the obligations of practices with regard to registration and they are taking urgent steps to ensure NHS England produces clear and definitive guidance to resolve this uncertainty. They have been consulted on guidance which they have insisted should be published as soon as possible. In the interim the LMC reminds practices that people applying for registration cannot be turned down for reasons relating to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Practices should not refuse registration on the grounds that a patient is unable to produce evidence of identity or immigration status or proof of address; there is no contractual duty to seek such evidence. Anyone who is in England is entitled receive NHS primary medical services at a GP practice.

GPC WEBSITE

Please note the link for the GPC on the BMA website.

http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee

Dr David Dickson
LMC Secretary

DATES OF NEXT MEETINGS

24th Sept	Edric House, Rugeley	**LMC**
5th Nov	Hill Street Health & Wellbeing Centre, Burton	**NHSE**

The meetings with the **LMC** are for the full committee of LMC members without NHSE.

The meetings with **NHSE** are for the LMC Executive and NHSE alone.

LMC MEMBERS

The following is a list of current members of the South Staffs LMC

Dr D Dickson (Secretary)	01283 564848
Dr V Singh (Chairman)	01543 870580
Dr P Gregory (Executive member)	01543 682611
Dr G Kaul (Executive member)	01543 414311
Dr P Needham (Executive member)	01283 565200
Dr T Scheel (Executive member & Treasurer)	01283 845555
Dr M Bermingham	01785 822220
Dr O Barron	01889 562145
Dr J Eames	01785 815555
Dr E Odber	01827 219843
Dr A Parkes	01827 68511
Dr A Selvam	01543 571650
Dr A Yi	01543 870590
Dr H Zein-Elabdin	01922 702240

DR V SPLEEN

Dear reader

Undervalued

I note an anonymous posting on the BMA communities forum from a doctor considering a post abroad:

This is not a decision I have taken lightly – I love my country, I have been a passionate believer in the NHS all my adult life … but I cannot and will not continue to be exploited, undermined and demeaned at every turn by the Government, by NHS management and by the British media. As far as I can tell, Britain alone expects doctors to work long hours, plus many more unpaid and unacknowledged, while simultaneously subjecting them to pay cuts, pension raids and systematic attacks on their professional status and standing in the public arena.

Feelings of being undervalued, vilified by the media and attacked by the Government were prevalent throughout other comments on the forum. Some wondered what can the NHS do to retain its doctors? One response was:

The system is broken. It's not working. The amount of administration and paperwork is phenomenal compared to what a doctor in Australia has to do. Younger doctors don't want to own a practice or manage a practice. They just want to do the clinical work and have nice working conditions where you have the time for appointments with patients and can manage them well with easy access to investigations and treatments.

It is my view that until doctors feel respected, listened to and in control of their working lives in the UK, the exodus will continue.

Venture

The views expressed in this column are those of the author and not necessarily those of the LMC.