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1. Just around the corner

Although no date has been fixed, we understand that at some stage next week the Health and Social Care Bill 2011 will be laid before Parliament. Albeit in outline, the paper *Liberating the NHS: Legislative Framework and Next Steps*, presented to Parliament on 15 December, summarises the Government's view on the consultation exercises carried out in connection with the White Paper proposals and trails a number of matters which will be covered in the forthcoming Bill. It will, however, be very interesting to see exactly how the White Paper proposals are to be translated into legislation.

On 15 December, both Sir David Nicholson and Dame Barbara Hakim wrote

to colleagues outlining some of the provisions in the White Paper response and fireside/bedtime readers may find it much easier to grasp where matters stand at present by reading the two letters rather than delving deeply into the White Paper response and a further paper also published on 15 December being the Operating Framework for 2011/12.

Throughout the consultation process, Lockharts have been working on the development of model documentation for pathfinder consortia and our team is starting to visit different parts of the country with a comprehensive presentation setting out the nuts and bolts of what consortia commissioning will actually mean to GPs. In the next couple of weeks, Andrew Lockhart-Miramis will be visiting Gloucestershire, Kent and



Lincolnshire and arrangements are in hand for some ten or twelve further county wide visits in the near future. If members of putative pathfinders are interested in presentations of this sort, please contact us.

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2. Data protection

GP practices are reminded they must take steps to ensure patient information is secure, following the first fines by the Information Commissioner under new data protection legislation.

Two organisations were found to have breached the Data Protection Act and were given fines by the Commissioner using new powers gained in April.

Hertfordshire County Council was fined £100,000 for faxing sensitive information regarding a child abuse case to the wrong recipients, and an employment agency £60,000 for losing an unencrypted laptop containing personal information about 24,000 people.

The organisations involved were unrelated to the NHS, but the Medical Defence Union warned of the risk to GPs: 'Any organisation which handles highly sensitive patient information, particularly when held electronically, may be vulnerable to such losses.'

'For example, in September this year East and North Hertfordshire NHS Trust was found to have breached the Data Protection Act 1998 after a junior doctor mislaid an unencrypted USB stick which held details of patient's conditions and medications.'

Dr Beverley Ward, a medico-legal adviser at the MDU, said: 'The Commissioner expects data controllers, such as GPs, to take reasonable steps to prevent such breaches of the Act, such as carrying out a risk assessment or having a policy in place to encrypt all portable devices including laptops.'

The Government says it estimates that the Information Commissioner will need to use his new powers in around eight medical related cases a year. Safeguards have also been introduced to ensure that penalties are administered fairly.

What can you do to protect your practise?

Reasonable steps include carrying out a risk assessment or having a policy in place to encrypt all portable devices including laptops. In particular there may be greater potential for loss of data that is held electronically because it is more easily transmitted and more portable. With this in mind, the MDU advises doctors to:

- Avoid inputting patient-identifiable data on to personal mobile devices such as memory sticks and PDAs
- Ensure you have an information security policy in place, covering issues such as the use of laptop computers, and that all staff are aware of and follow it
- Never put patient data on your personal computer – it could lead to confidentiality breaches and it is notoriously difficult to erase some information permanently from a hard disk
- Consider taking advice from IT specialists about ensuring the security of practice computer systems
- Be aware of GMC and NHS guidance on this issue. For example, Connecting for Health's Good Practice in Mobile Computing, covering the secure use of laptops, PDAs and other mobile devices (February 2008)
- Report any loss of data to the nominated senior person within your practice, so that action can be taken and affected patients and the information commissioner informed if appropriate

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3. Protecting your practice from Locum GP's

Locum GPs are often the mainstay for many practices, allowing them to fill a short-term gap in their provision of medical care without taking the step of bringing on board another partner, or securing a salaried GP.

In most cases, locum GPs are themselves only too happy to 'job' between different practices, earning very substantial revenues, and accept that reduced job security is part of the deal.

However, recently there has been a spate of cases where GP employers have found themselves hit with a legal action after terminating a contract with a locum GP –

potentially facing legal bills running into five figures.

This kind of legal action can be prevented by carrying out a 'health check' on your contracts with locums. This article will explain how.

On what basis could a locum launch legal action?

Employees are those who enjoy what is called a 'mutuality of obligation' between themselves and their employer: in other words, the employer is obliged to provide work, and the employee is obliged to accept it.

This is typically not the case for locum GPs, as they are self employed and can refuse sessions if they wish. Practices may have a locum contract with the locum GP that accepts each party can refuse to provide or accept work, but problems can start to arise if, in reality, the surgery does rely on the locum doctor and, in turn, the locum doctor relies on the surgery for certain fixed sessions.

If this is the case, then a locum doctor may be able to claim they are more an 'employee' of the surgery as opposed to being self-employed, and can launch costly and time consuming proceedings through an Employment Tribunal.

What is the risk of this happening?

This typically occurs when a locum applies for partnership and is rejected, or their contract is terminated with a practice after a long period of time.

Since locum doctors are relatively well remunerated, a claim of unfair dismissal that might follow from the termination of the surgery's contract with the locum can relatively easily reach the current statutory maximum for compensation for unfair dismissal, which is £65,300.

Even if the surgery succeeds in demonstrating that the locum cannot have been an 'employee', the locum can still

argue that he or she was a 'worker' within the meaning of Section 230 of the Employment Rights Act 1996, namely 'someone that undertakes to do or perform personally any work or services for another party to the contract whose status is not by virtue of the contract that of a client or customer of any profession or business undertaking carried on by the individual'.

If the locum GP succeeds in arguing that he or she is a 'worker' within the meaning of the Act, then the practice could find itself liable for paying holiday pay to the locum doctor.

How can I prevent this?

Practices are able to protect themselves with a clause in their locum GP contract that says although they reasonably expect that specific locum doctor to turn up for the agreed sessions, the locum may also sub-contract the work to another doctor, with the surgery's prior agreement.

If it is well-drafted, then this so-called 'substitution clause' removes the possibility that the locum was a worker, as it dispels the notion that the locum doctor is personally required to provide the service. It does not have to have ever been invoked to still hold legal force.

In addition to this, ensure that you review your arrangements with locums. Is the expectation that the locum will do a fixed number of sessions each week or month, but is the timing of those sessions left to the locum? Does either party envisage paying or receiving holiday pay?

Ensure there is an understanding that the locum send in a replacement if he or she is not able to attend and that there is provision for this in any contract between the surgery and the locum.

Also look at the arrangements governing the locum's availability outside of his or her normal times of work at the surgery – is this a formal arrangement or is it more casual?

It is important to emphasise that every situation is different, and each surgery will contract with locums in a unique context and subject to unique demands made by either of the parties. Expert advice is therefore a sensible option once the above have been considered.

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4. How far can you enquire into a persons health background during recruitment

Your practice is recruiting a new healthcare assistant, can you make enquiries about their health in the recruitment process?

It is common for employers to want to make enquiries into a person's health during the recruitment process. However, this should be done with caution to avoid discriminating against individuals because of a disability, or their age.

The issue of pre-employment questionnaires has been specifically addressed in the Equality Act, which came into force last month.

This Act replaces harmonises and strengthens previous legislation on discrimination. Under the Act an employer must not ask about the health of an applicant before short-listing them, or offering work except where:

1. It is for the purposes of identifying whether any reasonable adjustments need to be made for the recruitment process.
2. To establish if the individual will be able to carry out a function which is intrinsic to the work concerned.
3. For monitoring diversity.

Unfortunately, there is little guidance on how far questions can go and where the line between necessary and unnecessary questions should be drawn will only be addressed in litigation in due course. Until then, you should proceed with caution,

especially with regard to past health problems (which are unlikely to be seen as relevant to current capabilities) and limit questions about their current health to where these are necessary to make adjustments in the recruitment process (e.g. arrangements for the interview) or where health is clearly intrinsic to the role in question.

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5. Can you amend a patients medical records?

A patient treated for depression when they were a teenager wants this diagnosis removed from his medical record. The patient – now in their thirties – has had no recurrence of depression, but what should you do?

Initially it would be advisable to see the patient to ascertain in more detail why the patient wishes this information removed from his notes. You should take the opportunity to reassure the patient of your confidentiality obligations and the limited access others would have to his notes without his consent.

Health professionals have a legal obligation to keep accurate and up to date information in medical records but patients do have the right under the Data Protection Act to request that a factual inaccuracy is deleted or changed. However you should only comply with this request if it is valid.

Good communication is required to explain that the information may be 'opinion' rather than 'fact', however previous opinions are important in understanding previous care decisions. In this case, unless you were the treating physician at the time of the entry it is unlikely that you can state that the entry is inaccurate.

If you decide the objection is valid you need to add an amendment, sign and date it. There are only rare examples when an entry can be deleted from a medical record. Even if you agree with

the patient that an entry can be removed you would need to explain that electronic records cannot be fully deleted because of the necessity to maintain an audit trail.

The patient may also need to be informed of any potential risk in removing an entry. A viable alternative to the patient may be the option of adding an addendum to the notes stating the patient's objection to the entry. More detailed guidance is available from the National Information Governance Board for Health and Social Care

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6. GP's should not be allowed to be the owners of their own premises

GPs should not be allowed to be owners of their premises under the Government's white-paper reforms, so they can more easily be removed if they are not up to scratch, according to the LIFT Council's official consultation response.

The council, which represents public-private venture companies that have invested more than £2 billion into GP premises in recent years, said ownership should be transferred to 'expert asset managers' at these organisations.

It warned allowing GPs to own and manage their own premises would 'frustrate' the Government's reforms, because it would limit the flexibility to replace failing services under the 'any willing provider' policy.

The news adds to the Council's already controversial proposals to 'refocus' its strategy for investments on improving existing premises, which provides that less money will be available for new buildings.

'Should providers own and manage the primary and community care estate, the Government's reforms will be frustrated,' the council said. 'Any willing provider necessitates changing providers when standards fall.'

It added that existing PCT assets should not transfer to providers when PCTs were abolished: 'Where a PCT has a LIFTCo, that PCT's residual estate should transfer to the LIFTCo unless there are clear reasons why that should not be the case.'

Chris Whitehouse, chair of the LIFT Council, said: 'LIFT represents the most effective way of managing the NHS estate with an ability to integrate services along defined commissioning pathways in the best interests of the patient.'

A Department of Health spokesperson said: 'We know how important it is to make sure local services can access high-quality facilities, and will say more in due course.'

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7. Cheque book experts

"In the last three months we have been asked on 3 separate occasions and each for around £12,000 if we would sponsor a "major" forthcoming medical healthcare event, mainly on the topic of GP Commissioning.

On each occasion we have declined not only because of the costs involved which would include very considerable "soft costs" in the form of conference support and staff attendance - probably several times the proposed fee - but because we feel that it is unhelpful for all our clients to have to absorb in our fee structure costs that can at best only benefit a very limited number of them.

Possibly as a development of the trend to invite solicitors to sponsor commercial events is a further approach we have received where, for a fee of £15,000, we would be promoted over a 12 month period in a medical healthcare magazine and on a website as the providers of information in an "Ask the Expert" series.

Whilst we genuinely believe that we have all the requisite skills and experience to carry out this role we are deeply troubled that commercial publishers are now

offering "Expert" slots on a cheque book basis."

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8. Superannuating locum income

GPs, where it applies, cannot superannuate GP locum income in a practice in which they are a partner.

Surprisingly some PCTs remain unaware of this and have allowed a few GPs to have the employer's 14% paid by the PCT rather than themselves, on their locum income. The notes accompanying the recently published 2009/10 pension certificate specifically indicate "this is strictly forbidden under the NHS Pension Scheme regulations". This is not a change to those regulations but has always existed. Let us hope that PCTs do not try to claw back the relevant employer's superannuation payments that should have been made.

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Finally we wish all our readers a very happy and prosperous New Year

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"Headed by Andrew Lockhart-Mirams, Lockharts advises over 1,800 GP practices, plus numerous dental practitioners, healthcare professionals and professional bodies throughout the country. The practice also helps to establish companies and LLPs tailored for the delivery of healthcare services"