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## Lockharts Seminars and Events

Lockharts are pleased to announce that we will be holding a seminar day in association with Henry Stewart. Speaking on *'The different models of practice and their strengths and vulnerabilities'* with particular reference to the Health and Social Care Bill 2011. If you would like to attend or simply wish for more information please contact us at [csd@lockharts.co.uk](mailto:csd@lockharts.co.uk)

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### 1. Conflicts of interest

A considerable number of column inches have been written in the last months to cover, and more particularly express concern, about commissioners being

beneficially involved in provider organisations - Pulse reporting on a number of occasions that one in ten putative commissioners has such an interest in provider companies. This is a percentage that is likely to increase as more and more GPs, and indeed Consultants, look for ways to supplement their static, or in real terms, decreasing income.

Far less however has been said about the much more fundamental conflict that will affect not one in ten commissioners but every single commissioner. It is possible that after the present Government "pause" some GPs may be able to opt out of commissioning but this is unlikely to exempt them from the scrutiny of their peers if alleged "performance" failings are believed.

At the core of this conflict is the requirement set out with complete clarity in each of the GMS and PMS regulations that GPs providing essential services to registered patients, temporary residents and, where required, persons needing immediately necessary treatment owing to accident or emergency, must make available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services provided under the National Health Service Act.

If treatment or referrals are improperly provided or made there are systems in place to consider the position but ordinarily the GP's decision is made solely on what he or she considers best for and appropriate for the patient. That the PCT may not be able to afford the cost of the referral is not a matter directly for the GP, whose clear duty is to act as the advocate of the patient and

to do his or her best in the treatment and/or referral.

If it is the case that all GPs are to be required to take their commissioning responsibility into account on each occasion they treat a patient there can be little doubt that there will have to be a change in the contractual obligations for GPs that have existed in the GP's terms of service since the inception of the NHS in 1948.

What will replace these time honoured provisions is unknown to the general public but the author's view is that any diminution of this essential obligation may, at a stroke, finally sell down the river the NHS and practitioner responsibility.

It is clear that the country cannot afford every available drug and every available treatment but to restrict what is available is the responsibility of a fully mandated Government.

The Guardian of 6th April carried an excellent article under the heading "How do you want your GP to see you – as a patient or as a consortium cost?" At Lockharts my colleagues and I have spent a great deal of time since the publication of the Health White Paper last year advising putative consortia on their constitutions and the complexities of federation working in areas such as risk sharing and major cost contracting, but there is nothing we can do to help practitioners who may, when their terms of service are changed, as they will surely have to be, from failing their patients and losing the key element of trust on which a successful National Health Service should be based.

We will do everything we can to help putative consortia through difficult and uncharted waters but we fear that patients being a "consortia cost" may be the real outcome of the reforms and not the required savings that could come about from proper and effective



commissioning and procurement.

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## 2. Practice dilemma: Breach of Patient confidentiality

What action can be taken if an ex-staff member breaches a patient's medical confidentiality? Our legal expert advises.

GMC guidance states that doctors responsible for the management of patient records or information should make sure the data is held securely, and any staff you manage understand their responsibilities.

Practices should have a confidentiality clause in their staff contracts, worded to cover employees both during their employment and after they have left the practice. When staff come to the end of their employment at the practice, it is helpful to remind them of their duty to maintain patient confidentiality even after they have left. Most staff follow this as a matter of course, but there can occasionally be problems when staff forget or deliberately breach this duty.

If you are aware of an allegation that an ex-employee has breached patient confidentiality, you should investigate further to establish the facts. If it is clear that a previous employee has breached confidentiality, you should seek appropriate advice.

The first step is likely to be a firmly worded letter from the practice reminding the individual of the confidentiality clause and its extension beyond the end of their employment. The ex-employee should also be informed of their responsibility for any

financial damage done to the practice from a breach of the terms of their contract. Such financial loss to the practice may result from a claim for damages against the practice for breach of confidentiality, or a fine from the Information Commissioner's Office as a result of failure to comply with the Data Protection Act 1998. Financial loss through damage to the practice's reputation may also be a consideration but is likely to be very difficult to prove.

If the ex-employee is a professional regulated through a body such as the Nursing and Midwifery Council or the General Medical Council, and the breach appears to be deliberate, then reporting the individual to the relevant body could be considered. If you are aware of ongoing and purposeful breaches of confidentiality by an ex-employee, it is possible for the practice to seek legal advice with view to obtaining an injunction from the court to prevent any further breach.

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### 3. Agency workers regulation

The Agency Workers Regulations 2010 (the Regulations) are due to come into force on 01 October 2011.

Briefly, the Regulations give agency workers the same basic working and employment conditions as employees.

An agency worker is defined in the Regulations as an individual who (a) is supplied by an agency to work for a hirer; and (b) has a contract of employment with the agency.

A hirer is an individual to whom individuals are supplied to work on a temporary basis under their supervision.

Pursuant to the Regulations an agency worker shall be entitled to the same relevant terms and conditions that are

ordinarily included in a contract of employment of the hirer for a comparable employee. A comparable employee is an employee of the hirer who works under the hirer's supervision and is engaged on the same or broadly similar work to the agency worker.

The agency worker would be entitled to the same following relevant terms and conditions:

- (a) Pay (including fees, bonus, commission, holiday pay and other emoluments).
- (b) Duration of working time.
- (c) Rest periods.
- (d) Rest breaks.
- (e) Annual leave.

It does not include:

- (a) Occupational sick pay.
- (b) Pension.
- (c) Maternity leave, paternity leave or adoption leave.
- (d) Redundancy pay.
- (e) Rewards.
- (f) Expenses.

An agency worker is entitled to the above after having been in the same role with the hirer for 12 continuous weeks ("qualifying period").

A break in the assignment for example for maternity leave may still require the time worked prior to the break to count toward the qualifying period.

The rights acquired by the agency worker continue until he is no longer working in the same role with the hirer. If however, the worker has completed two or more assignments with the hirer whether or not this has been in the same role the agency worker may still be entitled to the rights.

Further, agency workers have the right to be treated no less favourably than a comparable worker in relation to the

use of the facilities and amenities of the hirer:

- (a) Canteen.
- (b) Child care.
- (c) Transport facilities.

Agency workers also have the right to be notified of vacancies with the hirer so that they have the right to have the same opportunities as an employee of the hirer and find permanent work with the hirer.

The rights to access facilities and to job vacancies apply from the commencement of the work.

Where an agency worker believes their rights have been infringed they may make a request to the hirer (or alternatively the agency) to provide a written statement.

The hirer has 28 days to reply with a written statement setting out:

- (a) All relevant information regarding the rights of a comparable worker; and
- (b) Their particular reasons for the treatment of the agency worker.

The response provided must not be equivocal or evasive otherwise this will permit a tribunal to draw inferences, including the inference that the hirer has infringed the right of the agency worker.

Where an agency worker is dismissed for bringing such a claim or requesting such a statement they can be regarded as unfairly dismissed and a tribunal may award compensation of up to two weeks pay or where this is not just and equitable up to a maximum of £5,000.

It is expected that these Regulations will greatly impact on the health sector.

Where practices use agency workers, an assessment should be carried out of the workings of the practice and the impact that these Regulations will have.

Practices should also consider which agency workers may be covered by the Regulations and which basic working and employment conditions will need to be compared.

Practices will also need to be prepared to permit access to all agency workers to their facilities and job vacancies.

Practices should also review their agreements with the agency.

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#### **4. The implications of the new DES**

GPs will be required to gain the formal approval from patient groups before making any 'significant changes' to the services they provide, under the terms of the new £60m patient participation DES.

The terms of the DES stipulate that practices must fulfill a range of criteria to qualify for payments, including establishing a patient representative group, agreeing issues to priorities, carrying out local patient surveys each year, and agreeing action plans to tackle any issues raised in those surveys.

When making any major changes to the services they provide, such as altering opening hours, practices will be required to gain the formal approval from patient groups in order to qualify for payment under the DES.

If practice and patient groups cannot agree about any changes, then the plans have to be referred to the PCT for their sign-off.

In order to implement the Patient Participation Directed Enhanced Service under the DES Directions the BMA and NHS in their recommendation set out a number of key steps (mainly annual) to tackle:

1. Develop a structure that gains the views of patients and enables the practice to obtain feedback from the practice population, e.g. a PRG
2. Agree areas of priority with the PRG
3. Collate patient views through the use of survey
4. Provide PRG with opportunity to discuss survey findings and reach agreement with the PRG on changes to services
5. Agree action plan with the PRG and seek PRG agreement to implementing changes
6. Publicise actions taken and subsequent achievement

Lockharts provide a variation notice, which your PCT may use, if you have any questions about or would like further guidance on the points mentioned above please don't hesitate to contact us.

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## 5. CQC regulations

Each practice is facing the nightmare prospect of designing nine separate care pathways under the latest QOF changes, with no new resources with which to do it.

So it is impossible to imagine a worse time for GPs to be confronted with a new wave of bureaucracy, in the form of the Care Quality Commission's compulsory practice registration scheme.

The CQC, mindful of its own workload, decided not to try to roll out registration across health and social care all at once.

On this occasion, general practice has been spared the role of guinea pig, with that honour going to dentists instead. It's fair to say they have not enjoyed the experience.

The British Dental Association says preparing for last week's registration

deadline has been 'shambolic' and caused its members 'severe stress'.

Some dental practices have been setting aside half a day a week for six months as they attempt to meet a host of registration standards across 21 separate categories, on everything from infection control, to criminal record checks, to their managerial structure.

It probably doesn't help that they have had to pay for the privilege, even if the CQC has reduced dentists' fees from £1,500 to £800, presumably to avoid mutiny.

Just like revalidation, it's difficult to remember exactly what CQC registration is for. If 300-page guidance documents and more than 90 hours' preparation are the answer, then what was the question, and why did it scare the Department of Health so witless?

It's not that GPs will be opposed to the principle of having their practices and premises given the once over. Given the risks when medical care goes wrong, it is possible to make a case for almost any system of scrutiny, if taken in isolation and applied proportionately.

CQC registration, though, does not exist in isolation – but in a world of appraisal and revalidation, balanced scorecards,

QOF assessments and NHS Choices ratings, with more on the way when the new health and wellbeing boards start showing their teeth.

And there will be nothing proportionate about the new system, if the BDA's stark warning is anything to judge by.

One function of CQC registration is to give practices, and private firms the quality stamps they need to be any willing providers under the new world of GP commissioning. But any consolation GPs may feel at the thought that at least the CQC will help keep private

firms in check will surely be dispelled when the inequities dawn upon them.

A private company, perhaps running GP practices and Darzi centres right across the country, will surely be far better equipped to cope with the bureaucracy of registration than a GP practice, just as large practices will cope better than small ones.

The CQC must surely implement a system that takes into account these disparities in resources. Otherwise, in the process of measuring everything about general practice, it will damage much of what makes it so valuable.

CQC registration and many other practice challenges will be on the agenda at this year's NAPC conference: [pulse-seminars.com](http://pulse-seminars.com)

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## **6. Concerns raised over GMC procedures for non- UK doctors**

Doctors who qualified outside of the UK are more likely to be suspended or erased from the medical register, says a study that raises questions about the GMC fitness to practice process.

The authors of the study - published in the British Medical Journal - found a discrepancy between the rate of serious action by the GMC on UK and non-UK trained doctors and concluded it may be due to GMC processes discriminating against non-UK trained doctors.

The research was led by Professor Charlotte Humphrey and found that at the initial GMC stage 29% of inquiries concerning UK qualified doctors had a high impact decision compared with 43% for EU doctors and 46% for non-EU doctors.

At the next stage they found that 1% of UK qualified doctors were erased or suspended from the medical register

compared to 4% of EU doctors and 3% of non-EU doctors.

Professor Humphrey said that although there is no clear reason why overseas doctors do worse in GMC fitness to practise processes. She argues that either 'real differences exist in fitness to practise between groups of doctors who are referred to the GMC' or 'that the GMC processes tend to discriminate against certain groups of doctors.'

GMC chief executive Niall Dickson, said they still did not fully understand why doctors from outside the UK are more likely to be suspended or removed from the register.

'We do not believe there is any firm evidence that our procedures unfairly discriminate against doctors from overseas and we are committed to ensuring that our processes are fair to everyone,' he said.'

The report comes after the GMC called for a major crackdown last month on the standards of GP training across Europe. They urged all 27 EU member states to bring in checks on national medical qualifications to prevent migrant foreign doctors working outside their own country, in health systems they may not be familiar with.

Today the NHS Confederation has also called for better checks on migrant health workers. Elisabetta Zanon, director of the NHS Confederation's European Office said: 'There is a tension that needs resolving between the European Commission's aim to simplify and speed up the recognition of professionals and making sure the right checks and balances are in place to protect patients from dangerous care from health professionals.'

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## **7. Government toughens revalidation to act earlier on failing GP's**

The Department of Health has pledged to tighten up revalidation procedures to intervene earlier and prevent GPs who cannot be brought up to scratch from practising further.

The move follows criticism from an influential group of MPs who claimed that revalidation focused too much on remediation, and not enough on removing potentially dangerous doctors from contact with patients.

Health secretary Andrew Lansley said that guidance will now be issued by the GMC to responsible officers detailing clearly which sanctions should be given when a doctor's performance is poor under revalidation, and when fitness to practise procedures should be triggered.

In January record numbers of GPs were referred for performance issues in trials of revalidation, with concerns raised for one in 10 GPs, despite being self-selected for their interest in appraisal.

The Government's pledge came in its response to the House of Commons' Health Committee report on the revalidation of doctors published today. The committee's report, published in February, criticised the existing plans for revalidation, saying they were too light a touch and did not do enough to protect patients from potentially dangerous doctors.

The Government's response says: 'The Department agrees there is a need for guidance that makes it clear to responsible officers and doctors when a doctor's conduct and performance can be considered to be below the level which is acceptable and fitness to practise procedures will be triggered.

'The Department also considers there is a need for guidance about the processes that will be in place when a responsible officer is unable to make a

positive recommendation about revalidation.

'Officials will be working with the GMC to ensure that this guidance is in place before the first recommendations are made.'

Health secretary Andrew Lansley said: 'For the vast majority of doctors, the more systematic annual appraisal will provide the basis for reflective practice and improvement, an essential developmental process.

He added: 'For the small proportion of doctors about whom there may be concerns, the strengthening of local clinical governance and a more objective annual appraisal provides the means for identifying problems earlier and either putting in place remediation or, if not possible, taking steps to remove them from clinical practice.'

The GMC has said that the revalidation changes will come into force from 'late 2012'.

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## **8. GPC: Take on a partner to reduce your tax bill**

New tax rules mean taking on a partner may be more cost-effective than employing sessional GPs, says the latest guidance from the GPC.

The guidance from the committee says recent changes to tax arrangements coupled with the continued squeeze on partner pay was providing an incentive for practices to share their workload and take on more partners.

The document comes after a similar forecasts from accountants, who said practices should be looking at taking on partners given that the pay gap between the two tranches of the profession is continuing to narrow.

Latest figures from the NHS Information Centre show that the average income before tax for GMS GP partners slumped by 1.2% between 2007/8 to 2008/9, whilst salaried GPs working in GMS practices saw their average income before tax rise by 3.4% in the same period.

In the document - Focus on GP Partners - the GPC said employing a salaried GP currently costs practices £90k per annum on average, but that the true cost could be up to 40% on top of the actual salary when taking into account other factors such as sickness leave and maternity cover.

It said the higher rate of income tax of 50% on total income over £150,000, coupled with the gradual withdrawal of the personal allowance for those whose adjusted net income exceeds £100,000 with no allowance after £112,950, had also made an impact.

The guidance also points out that 'reimbursements for locum cover from PCTs can be variable and do not necessarily cover the costs', and says taking on partners would benefit practices in terms of continuity, ownership, new skills and ideas, investment, recruitment, and working hours.

It recommends: 'There are many benefits in both becoming and taking on a new GP partner, such as continuity of care and a sense of ownership of the practice. Coupled with this, the new tax arrangements actually provide an incentive to GP partners to share their workload rather than paying high marginal rates of tax.'

'An alternative to paying such high marginal rates of tax could be for partners to improve their work-life balance by taking on more staff, reducing their income and time commitment to their practices.'

'Taking on a new GP partner is one way in which this could be achieved, and may well prove to be more cost effective than employing a salaried GP.'

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## Distribution of our Newsletters

We prepare newsletters for practitioners at approximately monthly intervals and occasional newsletters for LMCs. LMCs are welcome to distribute these to their constituents in their entirety.

If LMCs or other persons or bodies wish to circulate only part of our newsletters, we are happy for them to do so provided that the following acknowledgement and disclaimer are printed immediately below the relevant extract:

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Drawing upon its expansive commercial, litigation and property expertise, the team regularly advises on matters specific to the healthcare sector. "They have expansive knowledge, and advise with great sensitivity and patience"



"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"