

Volume 4
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MDU

Good Practice



Is your complaints
procedure up to scratch?

in this issue

Profile

03 Medicine in the raw

News in brief

- 05 MDU helps make tax less taxing
- 05 Excellent service from the MDU – it's official
- 05 MDU proudly supports new Best Practice Conference

Features

- 06 Is your complaints procedure up to scratch?
- 08 What do you need to know about CQC inspection?
- 11 Revalidation – your questions answered
- 16 A holiday mishap

Membership

- 10 Calculate your sessions
- 14 Family-friendly childcare vouchers

In focus

- 19 Reform is needed now

Claims analysis

- 20 Aortic aneurysm

Advice line dilemma

- 22 A complaint to the Ombudsman

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editorial

April saw many changes for GPs. PCTs have disappeared, CQC inspections have started to take place and the revalidation cycle has begun.

I outline what you should expect from a CQC inspection on page 8, and the preparation you can do when you're told of an impending CQC visit. Dr Udviha Nandasoma answers common questions about revalidation on page 11, and dispels any myths that you may have heard.

Also in this issue, the MDU chief executive draws attention to the rising cost of damages awards. This is a cause of increasing concern to us because it has implications for our members, for the medical profession and for society as a whole. There are a number of factors driving the spiral in compensation payments, not least an anachronistic law that needs urgent review. We need to act now before medical practice and patient access to healthcare is compromised. You can read more about this cause on page 19.

In our main feature on page 6, Dr Wendy Pugh suggests ways to improve complaint handling in your practice and puts forward some valuable tips.

I hope you enjoy reading this issue of *Good Practice*. As always, we welcome your feedback.

Dr Michael Devlin

Interim medical editor

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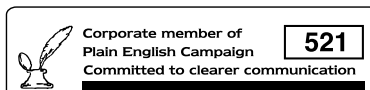
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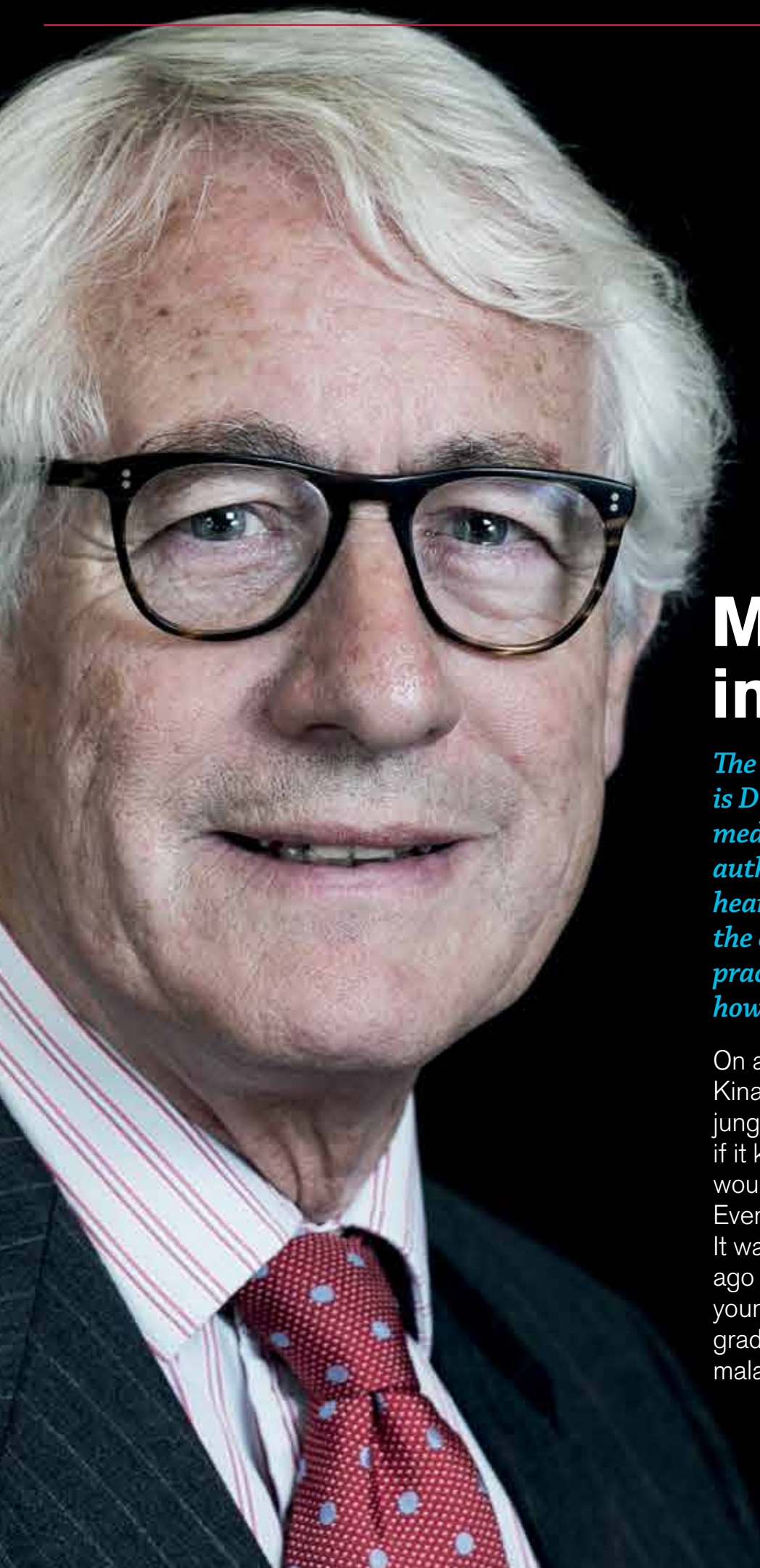
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Medicine in the raw

The MDU's new president is Dr Peter Williams, GP, medico-legal expert and author. A generalist at heart, he always relished the challenges of family practice. But that wasn't how his career started.

On a remote slope of Mount Kinabalu in the Borneo jungle, lives a rare snail which, if it knew it had a name, would be proud to be called *Everettia corrugata williamsi*. It was discovered 44 years ago by Peter Williams, a young Cambridge zoology graduate specialising in malacology. ▶



Peter was part of a post-graduate expedition to collect new species and climb the mountain by a new route. He was sampling the David Attenborough life, with a view to making it his career. But the experience changed his direction forever.

'When we emerged from the jungle, covered in slime and clothes stinking, I knew it wasn't the life for me. But we had spent two months guided by natives with whom we could barely communicate yet were completely reliant on. It was that experience that made me realise how interesting the human animal is.'

It was an unorthodox start to a long and illustrious medical career as a general practitioner that has now culminated in his appointment as president of the MDU. He returned to Clare College to take a one-year MB, then moved to University College Hospital and became one of the first vocational trainees in general practice. 'I was always single-minded about being a family doctor. I liked treating all sorts of people, of all shapes and sizes. It is medicine 'in the raw'.'

A six-year stint as a partner at the James Wigg practice in Kentish Town crystallised his interest and he became an active advocate of GP training, particularly in psychological issues. Now with a young family, he moved to Oxford and joined a teaching practice attached to the university. Within a few years, he was the GP course organiser in the Thames Deanery where he was able to promote his ideas, including the notion of family therapy within general practice. He published a book on the subject, *Family Problems*. 'My practice served both the university and a council estate, and the range of family problems that presented was wide. It was obvious to me that treating one family member wouldn't necessarily solve deep-rooted issues so there were many occasions when I offered psychological help to the whole family.'

A successful career in general practice and teaching might have continued uninterrupted had Peter not been

approached by a friend who was a clinical negligence defence solicitor who asked if he was interested in writing medico-legal reports. Always keen to try something new, he agreed. 'I was really thrown in the deep end though. My very first case ended up in court, which is really quite rare,' he says.

Undaunted, he carried on writing expert reports until, one day, a request arrived from the MDU, the company he had joined as a student for his indemnity. Within two years, Peter was invited to join the MDU's Cases Committee and Council, both of which sit regularly to discuss the complex clinical and medico-legal issues of cases involving our members. It wasn't long before he was also asked on to the MDU Board and for the last five years he has served as vice president under Dr Chris Evans, who stood down last September.

Using funds wisely

The transition from clinical practice to business and management was intriguing. He was struck immediately by two things. First, the quality of the people in the MDU, not least their willingness to engage in members' problems and their care and thoroughness in their dealings with members, and second by the extent to which decision-making is driven by providing good service. 'As a not-for-profit organisation, the MDU has to use members' funds wisely and take decisions for the benefit of all members. If it had been a 'for profit' company, I would have been far less interested. The interests of members always come first.'

As president of the MDU, Peter will be a wise guide for the executive team, listening to staff and directors and suggesting areas for attention or improvement. His focus will be on quality of service and meeting members' needs in a changing professional environment.

'Life is hard for doctors at the moment,'

he says. 'GPs now have to commission care for their patients. Revalidation affects everyone. Complaints against doctors rise every year; so do referrals to the GMC.'

'Twenty years ago, trainee doctors had no thought about cases or GMC complaints. These are now major

I was always single-minded about being a family doctor. I liked treating all sorts of people, of all shapes and sizes. It is medicine 'in the raw'.

concerns. In matters of consent, what the doctor advised often went unchallenged and the consenting process rarely featured on any curriculum. I have witnessed a huge rise in part-time doctoring. This has had its downside in that it has eaten into continuity of care and, where that continuity breaks, errors can creep in. Discontinuous care is a common thread in cases we see. We will never go back to full-time working, but as a profession we must take steps to prevent or reduce risk in the everyday management of individual patients.

'The MDU and other medical defence organisations have done a great deal to raise awareness of medico-legal risk factors, which has helped doctors understand how to manage those risks.'

'My hope is that being a member of the MDU allows doctors to practise the best medicine their knowledge and skills allow, knowing that the MDU is by their side. And if something does go wrong, they can be sure they will receive a first-class service.' ■



Dr Peter Williams and a carving of the rare snail he discovered

News in brief

MDU helps make tax less taxing

The MDU has developed an e-learning tutorial about tax in collaboration with HM Revenue & Customs (HMRC) which includes modules on tax allowances, business expenses and National Insurance.

You can work through the tutorial in your own time and return to it as often as you like. And if you want more information on any particular areas, there are links to other HMRC tips and tools to help. To access the tutorial visit themdu.com/learn

Excellent service from the MDU – it's official

The MDU's membership team has achieved the Customer Service Excellence Standard (CSE), a recognised independent benchmark of excellent service. The Standard tests in depth the areas that research shows are important to members – timeliness, accuracy, professionalism and staff attitude – and places great emphasis on how well the MDU understands its members' experience of service.

David Cardno, head of membership, said: 'The service innovations and focus on quality we have introduced over the last two to three years were critical to gaining accreditation.'

Following the accreditation, the MDU also went on to reach the finals of the UK Customer Experience Awards 2012, in both the Overall Customer Experience and Training categories.

MDU proudly supports the Best Practice conference 16-17 October 2013, NEC Birmingham

Develop your skills in successful practice management at the keynote primary care event – Best Practice (produced in partnership with the NAPC).

The MDU is proud to support Best Practice, the primary care show for those who are actually doing it. Don't want another conference full of tired top-down policy? Best Practice provides expert case study based educational seminars, innovative new learning formats, and practice-based speakers. Our expert speakers have "been there and done that" and will help you with:

- managing your practice finances
- navigating your practice through CQC
- surviving revalidation
- understanding what can be achieved with good PR
- the latest developments in the wellness agenda
- how to make patient engagement a reality
- how to get the best out of the relationship with your CCG
- turning tele-health from "luxury" to "can't live without"
- accredited clinical education stream.

The event is free for NHS professionals.

To find out more, visit bestpracticeshow.co.uk



Is your complaints procedure up to scratch?



Dr Wendy Pugh, MDU medico-legal adviser examines your practice's complaints handling process and suggests ways to improve complaints handling.

The Health Service Ombudsman for England received 2,951 GP complaints during 2011-12. This is an increase of 18% from the previous year¹. Most complainants were advised that they first needed to complain to their practice, but, of the 65 cases the Ombudsman investigated, 80% were upheld.

Once you've received a complaint, whether oral or written, it is important to deal with it in accordance with your complaints procedure and respond appropriately. A dismissive or unprofessional response could result in failure to resolve the complaint and possibly in negative publicity for your practice or criticism from the Ombudsman.

Your existing complaints procedure

In the MDU's experience, over 90% of GP complaints are resolved locally. Your ability to manage complaints effectively depends largely on your practice complaints procedure. If you have not reviewed your procedure for some time, it's worth assessing it critically. Consider the last few complaints your practice received. Did following the procedure make you feel comfortable and in control, or at the mercy of the complainant? Did anything occur that wasn't covered in the procedure? Did

staff understand the procedure and how it applied to them? And most importantly, did it help you to resolve the problem to the patient's satisfaction? If the answer to any of these questions is no, it may be time to make some changes.

Suggestions for improvement

Your complaints procedure should follow the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (or the equivalent regulations in Wales, Scotland and Northern Ireland). Based on the most common queries from MDU GP practice members, we suggest it includes the following points.

Identify responsibility for complaints

Identify a complaints manager and a responsible person (usually a senior partner) for handling complaints. The responsible person must ensure the practice complies with the complaints procedure and signs off complaint responses. This can be the same person as the complaints manager, but ideally the roles should be kept separate.

Assess the validity of complaints

If someone makes a complaint on the patient's behalf, such as a family member

or friend, the procedure should outline how to check they have the authority to do so. If the patient lacks capacity to consent, their representative must be able to demonstrate sufficient interest in the patient's welfare and be an appropriate person to act on their behalf. The procedure should emphasise the need for flexibility. For example, although complaints should usually be made within 12 months of the event that gave rise to the complaint, you should consider complaints outside this time limit or talk to the complainant about what steps you can reasonably take to address their concerns.

Investigate and respond

If the matter cannot be dealt with there and then, the complaints procedure should stipulate the need for a clear investigation plan for each complaint. This should include:

- the complaint
- the outcome the complainant expects
- an estimate of the timescales reasonably required to investigate and respond.

The complaints manager must acknowledge written complaints within three working days, explaining how the complaint will be investigated and where

At-a-glance tips for responding to complaints

The MDU offers the following tips for managing complaints:

1. Publish information for patients about the complaints procedure. Explain to patients who wish to complain how they can do so and where they can find help.
2. Talk to complainants about the outcome they expect and agree how long you will take to investigate and respond.
3. Offer to meet complainants, and consider whether a conciliator may help. In some cases, it may be appropriate to consider seeking an independent clinical opinion, if the complainant agrees.
4. Try to remain objective. If possible, someone who is not the subject of the complaint should review complaint responses.
5. Involve your medical defence organisation early. We will guide members through the complaints procedures to help prevent the complaint escalating and can review your written response.
6. Take account of the seriousness of the concerns and the lessons learned and ensure that the response is balanced and appropriate. Use clear, everyday language in your written response and try to resolve any misunderstandings the patient may have.
7. Be honest and acknowledge any mistakes that your practice has made. Where appropriate, offer a clear and unambiguous apology. Avoid false apologies such as 'I'm sorry you feel the care wasn't good enough'.
8. Have a system in place for reviewing and learning from complaints and inform the complainant of any action taken.
9. Monitor complaints and produce annual reports on them, recording the lessons learnt.
10. Removing a patient from your list is an action of absolute last resort. In most cases, the patient should have received a warning before removal, and this is a contractual requirement for most GPs.

the complainant might seek independent advice (such as through Independent Complaints Advocacy Services).

A comprehensive account should be sent to the complainant after investigation. If there is a delay of more than six months, the reasons for the delay should be shared with the complainant.

Written responses must be signed off by the practice's responsible person or another senior member of the practice not involved in the substance of the complaint. The response letter must be open and honest. You should acknowledge mistakes, apologise where appropriate and inform the complainant of any action taken as a result of the complaint. You should also inform the complainant of their right to request a review by the Ombudsman if they remain dissatisfied.

Keep a record

Your complaints procedure should stress the need to keep detailed records of complaints received, such as the:

- name of the complainant
- subject matter
- date of complaint
- correspondence to complainant
- action taken.

The records can help you manage the complaint and provide evidence of effective complaints handling. You are advised to keep complaints records separate from patients' clinical records.

The complaint's legacy

The complaints procedure should not end when you have responded to the complainant. Practices also need to demonstrate they have learned lessons and, if appropriate, adopted changes aimed at improving patient care and safety.

Under the Regulations, you need to produce an annual complaints report, which should be available on request and sent to your commissioning body. It should give details of:

- the complaints received
- those which you decided were well-founded
- any lessons learnt
- any patterns of complaints in a reporting period
- and details of complaints referred to the Ombudsman. ■

Reference

1. *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12*, Parliamentary and Health Service Ombudsman, 8 November 2012



Since April 2013, all practices in England registered with the Care Quality Commission can expect a visit from the CQC's inspectors. Dr Michael Devlin explains what to expect.

There are three kinds of CQC inspections:

- **scheduled inspections** check that you are meeting the essential standards of quality and safety¹
- **responsive inspections** are usually unannounced and made when the CQC has concerns
- **themed inspections** look at a specific area in health and social care.

Preparation

You will usually have 48 hours notice before a scheduled inspection. If you regularly monitor your practice's compliance with the CQC's essential standards, there should be no need for last minute panic. However, the following tips may help you give inspectors the right impression.

- If you are a **GROUPCARE** practice and have taken advantage of our interactive *MDU Guide to CQC*, you can review the action plan to check there are no outstanding items.
- A critical walk through the practice could help identify any potential hazards, such as trip hazards or

blown light bulbs, that might mar an otherwise good inspection.

- Allocate a room where the inspectors can work undisturbed.
- Ensure the practice manager is available to show inspectors around, introduce them to staff and patients and be ready to produce any documentation requested.
- Explain to all staff what the inspection will involve and that the inspectors may want to speak with them about their understanding of the essential standards.
- Consider a notice in the waiting room or on your website to tell patients that an inspection is taking place and inspectors may want to talk to them. It's also a good idea to warn patients of the CQC's statutory right to inspect medical records, although it has said it will only obtain personal confidential information when necessary and will try to involve patients.
- Read the CQC's guidance for GPs, *What to expect from a CQC inspection*², which is available on its website.

What do you need to know about a CQC inspection?

Inspection day

The inspectors will explain which of the essential standards they will be checking. In some cases, they may be accompanied by a professional adviser or a person with in-depth experience of using GP services ('an expert by experience').

Don't imagine inspectors will spend their time looking at paperwork. Their priority will be speaking to patients, their families and carers – an important part of the inspection will be tracking a patient's route through the service and asking them about their experience. However, they will want to cross-check what they have been told against your policies and procedures.

Inspectors will usually give feedback at the end of their visit but they may also ask for additional information which you must provide within 48 hours.

Post-inspection

You will receive a copy of the draft inspection report within 10 working days for comment, before the final version is published on the CQC website.

In most cases, you will need to address any areas of non-compliance within a reasonable agreed timeframe, but if this does not happen or the failure is judged to be sufficiently serious, CQC has powers to begin enforcement action. This means it can issue a warning notice; impose or change a condition of registration; or suspend or cancel registration. ■

Contact the MDU advice line on **0800 716 646** if you have any specific concerns about a CQC inspection.

MDU **GROUPCARE** scheme members can access the *MDU Guide to CQC* by visiting themdu.com/cqc

If you are not currently a **GROUPCARE** scheme member but would like to benefit from the *MDU Guide to CQC*, please visit themdu.com/groupcare or call **0800 012 1318** for details on how to set up a scheme.

GROUPCARE Premium practices can benefit from an on-site risk assessment, subject to availability, contact your local GP liaison manager for more information at themdu.com/gplms

Reference

1. *Essential standards of quality and safety*, CQC, March 2010
2. *What to expect from a CQC inspection*, CQC, <http://bit.ly/goodpractice34>

Calculate your sessions

to ensure you pay the right MDU subscription



Not all MDU subscriptions are based on the sessions you work but, if yours is (this can be checked on page 3 of your renewal letter), please read the following information carefully.

If you do more than one type of GP work, each type of work should be shown on your renewal documents.

GP principal/partner/non-principal/salaried

Your subscription is based on the number of sessions you are contracted to work. If you work outside of, or in

addition to, your contracted sessions you should calculate the average number of additional 4 hour sessions worked per week and add this figure to your contracted sessions (see the above calculation on how to do this.)

If you have a substantial amount of time away from the practice through extended holiday, sabbatical, study leave or other reason, you should calculate the number of sessions based on the formula above.

Remember to include any out of hours work you do for patients registered with your own practice when calculating your average number of sessions.

If you are doing different types of work, please tell us the number of sessions for each type of work so we can ensure your subscription is calculated correctly.

GP locum

Your subscription is based on the average number of sessions worked per week during your membership year.

This category is appropriate if you are a locum (or freelance GP) and do not work in one fixed practice, or have temporary contracts. You will also see the word 'locum' on your renewal documents if you do private GP work, or work for an out of hours provider.



For any membership queries call **0800 716 376**
(8am to 6pm Monday to Friday, except bank holidays)



Revalidation - your questions answered

Revalidation is now well underway and many doctors will already know their revalidation date. Dr Udvitha Nandasoma, MDU medico-legal adviser, addresses some of the most common revalidation questions received from MDU members.

Q What are the powers of a responsible officer?

A Responsible officers (ROs) are senior licensed doctors with more than five years' practice and will often be the medical directors of a designated body. Their main duties are leading clinical governance within their organisation, overseeing the appraisal process, completing revalidation schedules for doctors connected to their designated body and making recommendations to the GMC about doctors' revalidation. The GMC's decision to allow you to revalidate is based on your RO's

recommendation that you are up to date and fit to practise. Alternatively, your RO can request to defer the date of their recommendation, or notify the GMC that you have not engaged in the revalidation process. Strategic health authorities have provided training for ROs, and the GMC has published a detailed protocol and guidance to help them carry out their duties. ROs themselves are among the first to revalidate so they will have personal experience of the process.

Q I have just returned from working overseas and I don't have a designated body or RO. What should I do?

A If you have already secured a job in the UK, then your employer is likely to be your designated body. However, if you are in any doubt or have not yet found employment, the GMC website has an online tool to help. The GMC suggests that before using the tool you make a list of all the organisations you are employed by, have a contract with or work through (such as a locum agency) and consider where you spend the majority of your practice.

If you do not have a connection to a designated body, you need to inform the GMC by logging on to your GMC Online account, selecting the 'My Revalidation' tab and clicking on the 'I don't have a designated body' button. You will be asked for further information so that the GMC can advise you.

First in line

Dr Matthew Lee, director of professional services at the MDU, has been nominated to be the MDU's responsible officer and will oversee the appraisal of, and make recommendations to the GMC about the 50 or so doctors working at the MDU, including our medico-legal advisers, medical claims handlers and clinical risk managers.

He explains: 'While doctors working for the MDU may not treat patients, the advice and assistance we provide to clinicians on the frontline can have a direct impact on clinical decision-making so it is important to ensure that our doctors are giving advice that is accurate, comprehensive and up to date.

'We all, understandably, find the prospect of revalidation daunting but in the interests of patients it is hard to argue against the concept that all practising doctors should be subject to a degree of regular scrutiny and, as part of that, required to demonstrate that they are taking appropriate steps to keep themselves up to date in their chosen field. Of course, we will be doing everything we can to support members as they go through revalidation.

It's essential to prepare a portfolio of supporting information to demonstrate how your practice meets the GMC's standards.

Q What kind of supporting information will I need to present at my appraisal?

A Your ability to revalidate largely depends on the success of your yearly appraisals. So it's essential to prepare a portfolio of supporting information to demonstrate how your practice meets the GMC's standards. This can be discussed with your appraiser.

Supporting information includes detailed evidence showing how you keep up to date and evaluate your practice, and third party feedback. The GMC has set out six types of supporting evidence that doctors will be expected to provide at least once in each five year revalidation cycle:

- continuing professional development
- quality improvement activity (such as clinical audits)

- significant events
- feedback from colleagues (at least once every five years)
- feedback from patients (if applicable, at least once every five years)
- a review of complaints and compliments.

You will need to demonstrate that you have reflected on what the supporting information says about your practice and identified any areas for improvement. The GMC published detailed guidance in March 2012¹ which is available on its website.

Q Do I need to collect patient satisfaction data if I am not in a patient facing role?

A The GMC recognises it may not be appropriate for some doctors to collect patient feedback although it suggests that these doctors 'think broadly about who can give you this sort of feedback. For instance, you might want to collect views from people who are not conventional patients but have a similar

role, like families and carers, students, or even suppliers or customers.²

If it's not possible to collect feedback from patients, you should discuss this (as well as any alternative ways to engage with patients) with your appraiser.

Q I am under investigation following an allegation from a colleague although it's not related to patient care. Will this stop me revalidating?

A If the matter is still being investigated when your revalidation is scheduled it is likely that your RO will request that the date is deferred. In its protocol for ROs, the GMC says that deferral requests apply to doctors 'participating

in ongoing local HR or disciplinary processes, the outcome of which you will need to consider prior to making your recommendation.' Your RO will be asked to specify the length of the deferral, which can be up to a year.

i Reference

1. *Supporting information for appraisal and revalidation*, GMC, March 2012, bit.ly/goodpractice35
2. *Supporting information for appraisal and revalidation*, GMC, March 2012, bit.ly/goodpractice35

REVALIDATION AT A GLANCE

- ☑ Every practising doctor should be connected to a designated body (usually your employer or the employer for whom you do most work).
- ☑ If you do not know your designated body, the GMC has an online tool to help. It can be accessed from the revalidation section of the GMC website.
- ☑ If you are one of the small minority of doctors who does not have a designated body to connect to, you should let the GMC know so that they can advise you. Again, this can be done via your GMC account on the website.
- ☑ The responsible officer (RO) in your designated body oversees the local processes on which revalidation is based and will recommend to the GMC whether a doctor should be revalidated.
- ☑ Revalidation will be based on your annual appraisal.
- ☑ Doctors are expected to prepare a portfolio of different supporting information from every area of their practice.
- ☑ There are six types of supporting evidence you will be expected to provide at least once in the five year revalidation cycle: CPD, quality improvement activity, significant events, feedback from colleagues, feedback from patients (if applicable) and review of complaints and compliments.
- ☑ During your appraisal discussion, you will be expected to show that you are up to date and fit to practise, and that you have reflected on your practice, and identified any areas for improvement.
- ☑ Failure to engage in the revalidation process could mean your RO notifies the GMC and you may not be able to revalidate.

Q I object to the person who has been appointed to carry out my appraisal. Can I refuse to co-operate with him/her?

A Appraisal is seen by the GMC as one of the local processes which support revalidation. Refusing to co-operate will almost certainly rebound on you and could put your career at risk. Instead, you should raise the matter with your RO who is responsible for ensuring that appraisers are trained and competent and will need to decide whether your objection is justified.

If your RO believes there are no extenuating circumstances, he or she

may raise it with the GMC, either directly or through its regional Employer Liaison Advisers. The GMC could then write to remind you of your obligation to participate. If you still refuse to co-operate, it could bring forward the date of your revalidation which would enable your RO to formally notify the GMC of your non-engagement. The GMC will then begin the process of withdrawing your licence to practise, although you would have 28 days to appeal.

Q Last year, a patient I was treating died suddenly and his family complained, although this was eventually resolved. Will this count against me when I revalidate?

A Most doctors can expect to receive a complaint at some point during their five-year revalidation cycle. This should not count against you, provided you can demonstrate during your

appraisal that you have reflected on what happened and can discuss ways you modified your practice as a result.

Q I have retired from clinical practice but I am planning to do some expert witness work. Will I need to retain my licence to practise and revalidate or is it enough to remain on the register?

A The GMC does not require doctors who are not practising clinical medicine to have a licence to practise so you could relinquish your licence and remain on the GMC register.

You would not then be expected to revalidate. However, you might find it difficult to find work as a medico-legal expert because many solicitors,

insurance companies and others will require the doctors they instruct to have a licence and demonstrate that they are up to date in their relevant field.

If you decide not to retain your licence you would need to make your status clear to anyone who instructs you.

We are on hand to support doctors through revalidation. Speak to specially trained doctors and lawyers on our free 24-hour helpline. Over 30,000 members called us for advice last year alone. (Our medico-legal team are available between 9am-5pm Monday to Friday and provide an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year) ■



Family-friendly childcare

For working parents, one of the biggest headaches is the cost of good childcare. Now you can be a 'family-friendly' employer by offering tax-free childcare vouchers to eligible staff, all at no net cost to the practice.

The MDU has teamed up with Computershare Voucher Services to provide a childcare voucher scheme at exclusive discounted rates for **GROUPCARE** practices. The scheme can be offered as an attractive benefit to parents on your staff. It costs nothing to set up and both the employer and employees can make savings in tax and National Insurance (NI).

What are childcare vouchers?

Childcare vouchers are an employee benefit offered by forward-thinking practices to support working parents.

Employees can choose to spend up to £243 a month¹ of their gross salary, before tax and NI, on vouchers towards the cost of registered childcare. Both parents can join a scheme, increasing the value of the vouchers.

Vouchers may be paid automatically to the childcare provider. They can be used to pay multiple carers and for more than

one child. They can also be saved up to use when needed, such as during school holidays.

What can employees save?

There are attractive savings for the employee. For example, a basic rate taxpayer who requests the full £243 voucher value each month can save around £900 a year in tax and NI, depending on their circumstances.

Childcare vouchers – the benefits

Setting up a childcare voucher scheme:

- allows you to **access competitive rates** as a **GROUPCARE** practice member
- **improves your corporate reputation** as a family-friendly employer
- is relevant for **all staff with children under 15** (16 if the child is registered disabled)
- assists you in the **recruitment and retention** of staff
- helps **reduce absenteeism** of staff taking days off for childcare
- **improves staff morale** through recognising the need for a work-life balance.

GROUPCARE

Multiply the benefits

How can the vouchers be used?

The vouchers can be used for **all types of registered childcare**, including:

- childminders
- nurseries
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- crèches
- playgroups
- after school clubs
- holiday schemes
- qualifying childcare provided by schools
- activity clubs
- summer camps.

To be eligible, the employee must be the parent, legal guardian or a person with parental responsibility of at least one child aged between 0 and 16 years. The vouchers are valid until 1 September following the child's 15th birthday, or 1 September following the 16th birthday of a child who is registered disabled.

Setting it up is child's play

Setting up a childcare voucher scheme is easy with Computershare Voucher Services. **Download and complete the form on the MDU website themdu.com/groupcare** with your practice details, and email to mdu@computershare.co.uk. It's free to register for the Computershare voucher scheme.

- There is no net cost to you.
- Minimal ongoing administration.
- No hidden costs.
- Direct savings on NI payments - up to £402 per employee, per year.

What does 'no net cost to you' mean?

Computershare Voucher Services takes a percentage of each employee's monthly voucher value as a service charge. However, when an employee buys childcare vouchers from their gross salary, you don't need to pay NI on that sum each month.

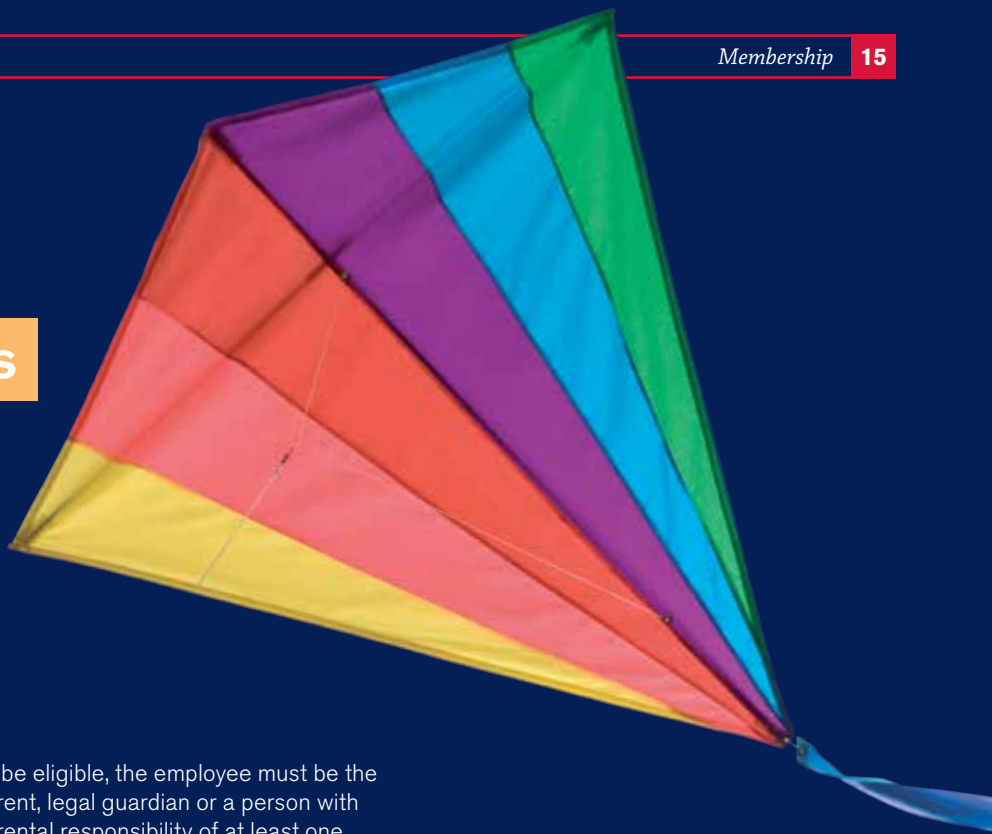
So, although you will be charged for the scheme, you will recoup that cost in National Insurance savings. In Computershare's experience, the NI savings made by the employer are always greater than the cost of the scheme.

Exclusive rates for MDU GROUPCARE scheme members

MDU **GROUPCARE** practice members win both ways, thanks to the exclusive discounted rates we have negotiated with Computershare Voucher Services. The higher the **GROUPCARE** tier, the more the practice can save.

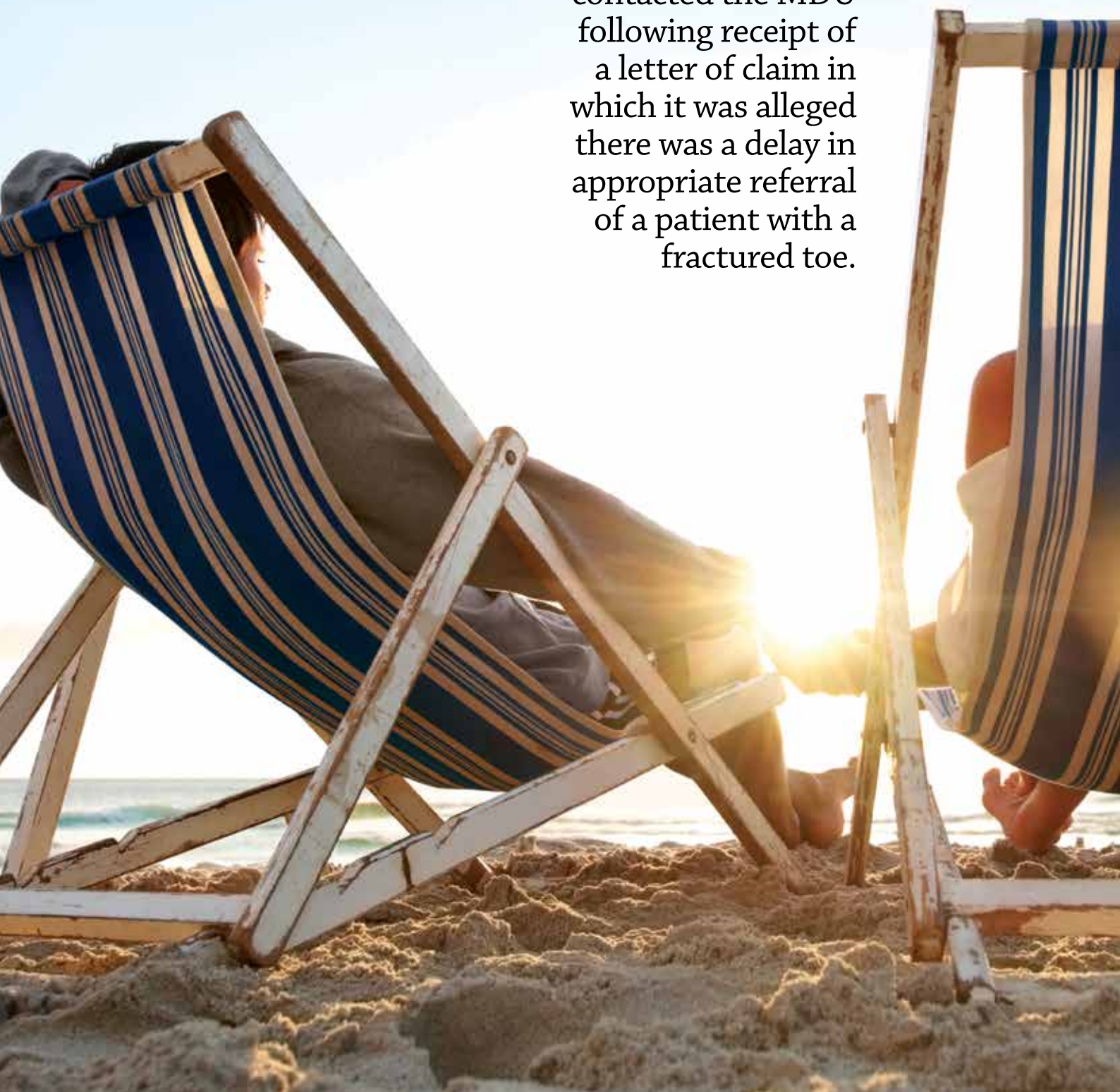
i Reference

1. Applies to basic rate taxpayers. Different limits apply to higher and additional rate taxpayers.



A holiday **mishap**

A GP member contacted the MDU following receipt of a letter of claim in which it was alleged there was a delay in appropriate referral of a patient with a fractured toe.



The patient had fallen and injured her foot while on holiday abroad. She had attended the local hospital where she was diagnosed with a fractured third toe. She was advised to buddy-strap the toe and to see her GP on her return home two weeks later, on 13 July.

According to the computerised records, the patient had a consultation with her GP, an MDU member, on 14 July. The computerised records did not say whether this was a telephone or a face-to-face consultation. The entry was brief, stating only that the patient had fractured a toe two weeks before.

The patient then did not seek further medical attention until three months later. She saw a different GP, who noted that her third toe was painful and was overriding the second, and referred her to an orthopaedic surgeon. X-rays revealed a healed fracture of the proximal phalanx of the third toe. The patient underwent surgery, which improved the alignment of the toe but it remained stiff and intermittently painful.

In the letter of claim, the claimant alleged that she had called the GP surgery on 18 July, and arranged a telephone appointment with the MDU member for later that day. It was alleged that during that telephone appointment the claimant told the GP about her injury and that her foot was very sore and bruised and she could not walk properly. She said the GP told her this was normal and that no further action was required.

The letter of claim also stated that the GP should have invited the claimant to attend the surgery for review, and then referred her to the fracture clinic. It was not alleged that surgery to the foot would have been avoided, but that had the referral been made earlier, the period of pain and suffering would have been shorter, and the outcome of the surgery better.

The crux of this case hinged on a dispute as to when the telephone consultation with the GP actually took place, and the advice given during that telephone call.

The claimant also provided a copy of her diary, showing an entry on 18 July with a time for an appointment with the doctor at 2pm. She alleged that this entry corresponded to the telephone appointment with the MDU member and disputed the accuracy of the GP computerised records in recording an appointment on 14 July.

The crux of this case hinged on a dispute as to when the telephone consultation with the GP actually took place, and the advice given during that telephone call.

The GP obtained the audit trails and screen shots from the computer system for the relevant period. These demonstrated that the initial consultation was by telephone on 14 July, during which the GP booked an appointment for the claimant for 18 July at 2pm. The same screen shot also showed that this appointment was then cancelled by the claimant on the day of the appointment.

The MDU member was also able to confirm that he had been on telephone triage duty on 14 July but not on 18 July, and therefore if the claimant had telephoned to speak to a doctor on 18 July, she would not have spoken to him.

The MDU member said that he could not recall the telephone consultation on 14 July, but that he believed the entry in the notes was brief because he knew he had arranged a face-to-face consultation for later that week, when a fuller history and examination would be undertaken, and a plan of management made. The MDU obtained advice from a GP expert. That expert advised that since the injury had been sustained over two weeks before the telephone consultation, that it was entirely appropriate to arrange face-to-face review within the week before deciding what, if any, further action was required.

The MDU denied breach of duty on the basis of the evidence from the audit trails and expert advice, providing copies of the relevant audit trails and screen shots as supporting evidence. As a result, the claim was discontinued against the GP.

It is relatively unusual for a claim to be grounded in a dispute of facts which is capable of resolution solely with the use of information available from computer

systems. However, even if this is not the case, this type of information can be very helpful. Most computer systems will allow print outs of audit trails and screen shots, and these can provide very useful additional information, as can appointment records and records from internal memo systems. ■



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When claims severity and frequency threaten to compromise our members' practice and patients' access to healthcare, it is time to act. That time is now, says Dr Christine Tomkins, MDU chief executive.

England and Wales have amongst the highest level of personal injury damages awards in the world. Damages inflation far exceeds other inflation measures and now runs at about 10% a year. In each of the last three years, the MDU settled several claims at over £5m and higher. Claims frequency is also rising steeply: we opened 15% more medical claims files in 2012 than 2011.

The effect on subscriptions is self-evident, but there are less obvious implications. Ultimately, we are all paying for a system which awards damages at a level that outstrips society's ability to pay for it. Large sums of money are leaving the NHS to pay for clinical negligence claims – in 2011, £1.2bn was paid out and NHSLA total liabilities stood at £16.7bn, all funded by the taxpayer. Ever-rising medical defence subscriptions, needed to meet unrealistic claims payments, are already a significant factor in the economics of private and general practice and will eventually deter doctors from entering or staying in the specialties most affected.

It is not as if we have never seen this problem before. Australia faced a medical professional indemnity crisis in 2002 which resulted in wholesale reform of the way clinical negligence claims were dealt with. In Ireland, the government introduced caps on claims against private practitioners to ensure that private practice did not become unaffordable, thus placing an excessive burden on publicly-funded healthcare. In many US states, tort reforms have been introduced, differing from state to state, in response to a claims environment which was driving doctors out of practice and preventing patients from receiving the care they needed.

What can we in the UK do? Some answers lie in the way the law requires us to compensate for the cost of long-term future care and loss of earnings. Loss of earnings awards are based on an estimate of what the patient could have expected to earn, had the

negligence not prevented them from doing so. These can be very large sums. Some jurisdictions have capped loss of earnings to, for example, three times the national average salary, which might seem reasonable to most people. One way or another, everyone is paying for these awards.

Awards for long-term care costs are based on Section 2(4) of the Law Reform (Personal Injuries) Act 1948, which requires that 'there shall be disregarded, in determining the reasonableness of any expenses, the possibility of avoiding those expenses or part of them by taking advantage of the facilities available under the National Health Service...'. This might have made sense in 1948 when the NHS was new and untested, but makes no sense now.

The practical effect of the Act is that defendants who must pay for the future healthcare and treatment of negligently damaged patients must do so on the presumption that care will be provided by the independent sector, and ignore the fact that good NHS treatment may be available. This creates a classic vicious circle. Compensation is paid for out of NHS funds, diverting resources from NHS care. For every patient whose injuries are the result of negligent care there are many more with similar injuries, not caused by negligence, and the same requirements for future care. The current system means millions of pounds are diverted from the NHS to set up care arrangements for a tiny number of individuals at public expense. This in turn may encourage a perception that privately-funded care is superior, and also the incentive to seek access to privately-funded care through litigation.

If the money currently being diverted out of the NHS was used to set up specialised NHS care units and facilities, the resources could be retained in the NHS to allow an equal or better standard of care to be delivered than through private arrangements.



Reform is
needed
NOW

This does not mean that defendants should escape paying care costs in personal injury cases. Defendants should continue to meet the reasonable costs of negligently injured claimants. However, if legislation were introduced to ensure that the NHS and other public bodies could recover costs from defendants to fund public sector care packages as part of personal injury compensation awards, the money could be used by the NHS and local authorities to extend the provision of these services generally. Over time, there would be greater choice of public services available to claimants, as well as those many others who also need these services.

Changes to Section 2(4) and other tort reform measures will not be easy. Nor is it realistic to expect the NHS and other public authorities to be able to provide the necessary care immediately and consistently throughout the country. But those are not good reasons for allowing the current destructive system to continue unchecked. ■

Aortic aneurysm

Over a recent 10-year period, 328 cases featuring aortic aneurysm were reported to the MDU. These included both complaints and claims.

An analysis of the main reasons for notification to the MDU shows the diversity of difficulties that a doctor may encounter when a patient becomes very ill, or dies, as a result of aneurysmal disease. In many cases, disciplinary and legal processes arose from one incident. (This is known as 'multiple jeopardy'. An example may be a complaint, serious untoward incident and clinical negligence

claim occurring concurrently.)

In most cases, the doctor contacted the MDU when they received a complaint or notification of a claim. Members also requested assistance with serious untoward incidents and the coroner's process. Complaints from relatives, and in particular those made by relatives on behalf of a deceased patient, featured heavily in the notifications received.

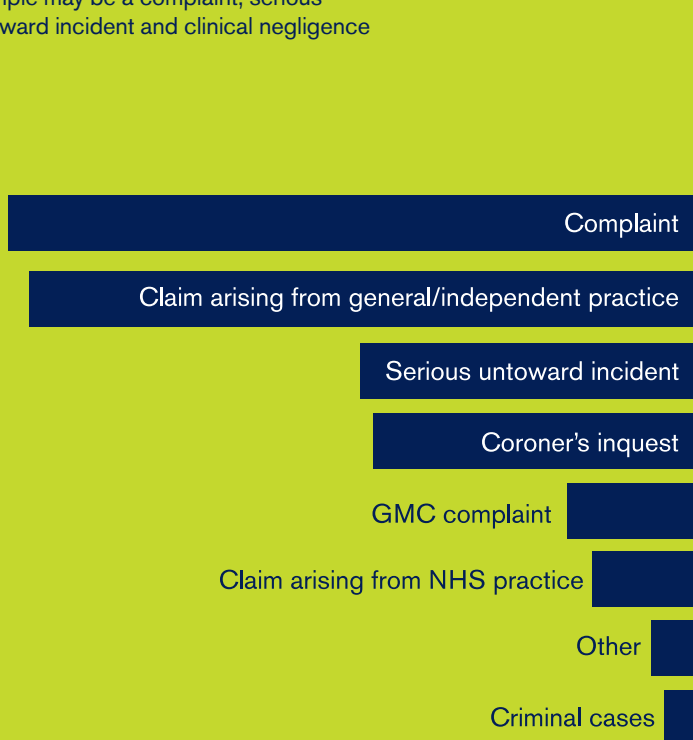


Figure 1a

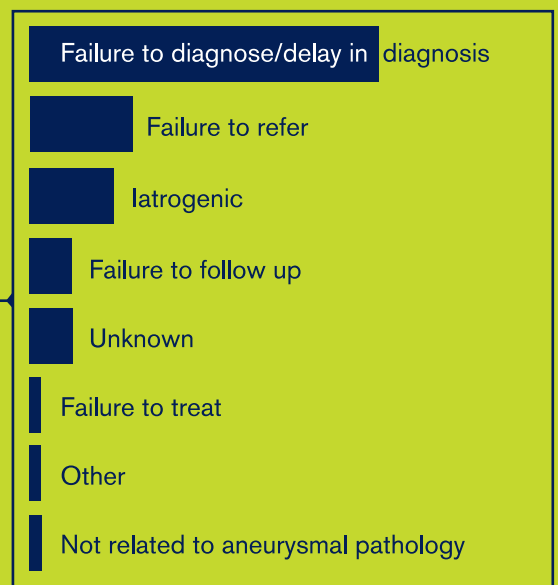


Figure 1b

The consequences of aneurysmal disease can be devastating for patients. A case can present to any clinician regardless of specialty or grade, as Dr Pierre Campbell, head of underwriting, found in an analysis

Reason for claim

Analysis of 85 claims arising from general and independent practice revealed a number of different reasons why they were pursued (see Figure 1b). In the majority of cases (54%) it was alleged that the clinician failed to diagnose aneurysmal disease (at all or in a timely manner). In 15% of claims, incidents relating to the iatrogenic formation of an aneurysm were reported. These usually followed vascular intervention such as angiography or angioplasty, or orthopaedic surgery.

As can be seen from table 2, the site of the aneurysm in the notified claims varied considerably and broadly reflected the anatomical sites commonly seen in practice. The majority of claims related to intra cerebral aneurysms and in particular the failure to diagnose them.

Specialty

The analysis of members involved in these types of cases revealed that whilst general practitioners were involved in the majority of the cases (54%), the remainder were spread across many different specialties. As can be seen in table 1 below, almost any clinician could be expected to report this type of case.

Number of claims by specialty	
177	General medical practice
30	Accident & emergency
20	General medicine
18	General surgery
15	Cardiology
11	Vascular surgery
10	Anaesthetics
8	Radiology & imaging
6	Orthopaedic/traumatic surgery
6	Others
5	Neurosurgery
3	Cardiothoracic surgery
3	Neurology
3	Obstetrics
3	Urology
2	Ophthalmology
2	Paediatrics
1	Cardiology (proc)
1	Gastroenterology
1	Geriatric medicine
1	Intensive care
1	Maxillo-facial surgery
1	Nephrology
328	Total

Table 1

Cerebral	42
Abdominal Aortic	18
Popliteal	6
Thoracic Aortic	6
Femoral	5
Other Site	4
Site unknown	2
Carotid	1
Subclavian	1
Total	85

Table 2

Cost of claims

Claims involving aneurysmal disease can result in high damages awards and costs.

In the 10-year period under review, the highest payment made to a claimant was in excess of £415,000 in respect of both damages and costs. It should be remembered that the level of damages paid reflects the level of injury to the patient. In cases in which there is a catastrophic injury, the damages payment may run into many millions of pounds.



A complaint to the Ombudsman

An elderly couple, both registered with the same practice, frequently requested home visits. Although the wife was undemanding, the husband always rang for a GP to attend his wife and was often verbally aggressive if he was refused. Despite her medical problems, the wife was able to leave the house regularly for local shopping trips. The practice had spoken to the husband about requesting unwarranted home visits numerous times, but he did not stop.

Recently, the husband had become abusive and swore at the practice manager when demanding a home visit for his wife. Afterwards, the GP partners of the practice decided to remove the couple from their list and wrote to inform them of the decision.

On receiving the news, the irate husband responded by complaining directly to the Ombudsman, claiming that they had been removed because the doctors did not like visiting his wife.

The Ombudsman wrote to the practice asking them to investigate the complaint at a local level and respond in writing to the husband, with a copy to the Ombudsman. The practice was asked to justify the removal and to provide evidence of any previous warnings that related to the matter.

The senior partner of the practice phoned the MDU advice line to speak to a medico-legal adviser.

MDU advice

The adviser explained the relevant ethical and contractual obligations that apply to removing patients from GP lists. The doctor would have to have good reason to remove the patient from their

list, and should have taken the relevant steps towards removing the patient (such as issuing a warning and an explanation first). *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2010-11* states NHS contracts require GPs to give patients a warning within 12 months before removing them¹, except where this would pose a risk to health or safety or where it would be unreasonable or impractical to do so. The GMC states that where a patient is removed, the decision must be fair and the patient should be advised of the reason in writing. Arrangements must also be made for continuing care.²

The medico-legal adviser noted that the husband had never been formally warned about his behaviour or told that he was at risk of being removed. He also discussed the difficulty of justifying the wife's removal on account of her husband's behaviour.

The GPs addressed the complaint at a partners' meeting and subsequently drafted a response with the MDU's assistance. The response outlined the fact that the wife had been visited at home and, in the GP's opinion, her medical condition on some occasions had warranted this. The partners made it clear that the principal reason for removing the couple from the practice list was the husband's behaviour. They apologised for the distress that the removal had caused. The practice acknowledged that they should have formally warned the husband about his behaviour before taking the step of removing him. They also apologised to the wife for removing her and

acknowledged that this had been unfair and could not be justified.

On the advice of the MDU medico-legal adviser, the senior GP partners in the practice offered to meet with the couple to discuss whether they would wish to rejoin the practice list. It was emphasised that should they do so then this would be on the understanding that all future requests for home visits would be assessed on the basis of clinical need.

The outcome

The practice sent the response to the couple, and a copy to the Ombudsman. In fact, the couple had already registered at another practice. They chose not to meet the partners, nor did they rejoin the practice list. No further correspondence was received from the Ombudsman.

Learning points

- Ensure that all patient removals are in line with contractual and ethical obligations.
- Unless a patient has been violent, and the matter reported to the police, then there is a contractual obligation to give patients a written warning within 12 months of the date of removal.
- Even if there is a justifiable reason to remove a patient, this rarely justifies removing family members. ■

References

1. *The National Health Service (General Medical Services) Regulations 2004*, Schedule 6, Part 2, Regulation 20.
2. *GMC Good Medical Practice* (2006), paragraph 38.



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Are you thinking of establishing a company to provide clinical services?

Increasing numbers of our GP members are thinking about setting up a company to provide clinical services. Often this is a new venture involving many challenges, one of which is to ensure the indemnity risks their company faces will be appropriately protected. If this applies to you, the MDU's Corporate Business team is on hand to guide and support you.

While individual practitioners will have their own individual clinical indemnity arrangements in place; a company will also need clinical indemnity to protect it in the event of failure of clinical process or for its vicarious liability for the acts of its staff in providing professional services. Mistakes do happen - failure of a referral process or errors by clinical or administration staff can and do result in claims being made against companies.

The MDU's Corporate Indemnity Solution provides unique and comprehensive professional indemnity for a company for claims of clinical negligence made against it. Indemnity provided by the Corporate Indemnity Solution means a company can hold appropriate indemnity to meet NHS and CQC requirements.

Our Corporate Business team has a proven track record of supporting a wide range of businesses, from small companies to large groups, and would be happy to give you guidance with how best to develop an appropriate indemnity solution tailored to your company's needs.

We can also introduce you to an independent intermediary used by many of our corporate members to provide guidance about the other commercial insurances your company will need including Public and Employer Liability.

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