# Primary Care Guide to Indemnity

# Introduction to HLP Workforce Programme

## Our vision

Our vision is to support the development of a modern health and care workforce in London which is trained, focused and supported to deliver the best care for patients now and in the future.

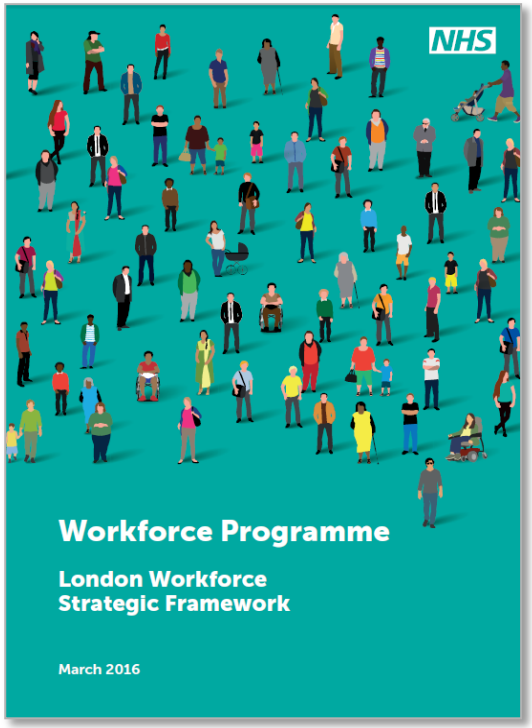
This vision is informed by Better Health for London (October 2014), and the Five Year Forward View (October 2014), which identified the need to focus on developing a modern NHS workforce that will support the effective delivery of new models of care.

## Who we are

To enable the delivery of this modern NHS workforce in London for Londoners, a collaborative workforce transformation programme has been established on behalf of London's clinical commissioning groups (CCGs) and NHS England (London) (Healthy London Partnership) together with Health Education England (HEE). This programme of work is a recognised enabler to mitigate existing service workforce challenges, and ensure the successful delivery of new models of care across London.

For latest the latest updates and available resources please visit:
https://www.myhealth.london.nhs.uk/healthy-london/workforce

# London Workforce Strategic Framework Outline




The London Workforce Strategic Framework establishes a coherent voice around the most pressing workforce priorities in London. It is made up of six chapters and outlines eight workforce findings.

By gaining consensus with stakeholders across London on the key workforce priorities for the capital, clarity will be achieved on what actions need to be taken in the short-term (1 – 2 years) and beyond (3 – 5+ years).

## The 8 Key findings

These eight key findings provide a guide to those areas of focus where action is required to ensure the NHS develops and delivers the health and social care workforce to meet the needs of patients now, and in the future.

# 01

# Regional and National Support for Indemnity Issues

- **HLP Support Products for Indemnity Issues**
- **DH / NHS England Support for Indemnity Issues**

# HLP support products for indemnity issues

## Completed and available on the HLP website

**Product 1**

### Primary Care Guide to Indemnity

Case for change/challenges, education pack to understand indemnity in general practice, claims trends, understanding memberships costs, myth busting e.g. CNST not free, data on NHS LA trends, myth busting crown indemnity why not have, explain occurrence, tail/run off, corporate and private market, student indemnity, training guides, events, ooh - what's included in general policies/USP

**Product 2**

### Mapping range & context of issues emerging from New Care models

Mapping live example of indemnity issues – Erewash, London, clinical pharmacists, ANP, PAs, ball park GP figures, change over the last two years, OOH example, capturing issues consultants in community, working at federation levels – link to MDO discussions below. Understand CNST – what includes and excludes/map to solutions (see below)

## Future products

**Product 3**

### MDOs on new models of care and new workforce roles

Event and get together with actions following, scoping of what new models asking to indemnify and joint working on solutions – plan jointly with NHS England and the New Care Models Team.. Agenda – event outline. – given what learnt today what do next?

**Product 4**

### Research to inform national review of indemnity

International models, options available, learnings from the new care model examples, understanding costs and challenges, perspective of MDOs and broader market – summarise outputs and issues from products above. Resource library.

# DH / NHS England Support for Indemnity Issues

**Stage 1**

Until summer Recess

a) Assess the different impacts on GP partners, Salaried GPs, Locums, Trainee GPs etc. Consider the impact of different professionals moving into clinical roles within general practice; how to risk assess new roles and predict their impact on indemnity costs.

b) Develop and assess options
Develop a “long list” of options ranging from ‘do nothing’ to the more innovative changes.

c) Produce proposals for publication
Undertake an initial options analysis, taking into account the impact and risks for each option, to create a “short-list” of viable options to include in the final proposal;

The outcome of Phase 2 will be a recommendation to Ministers and NHS England that identifies “Quick Wins” that can be taken forward straight away, together with medium or long-terms options to include in the proposal.

**Stage 2**

By end of 2016

Put into place action plans to drive forward the “Quick Wins” highlighted in Stage 1;
Engage with stakeholders to stimulate debate on the proposal

Following wider stakeholder engagement, carry out a full appraisal for each option, including a risk assessment and equality / impact assessments, identifying financial, legal and commercial issues.

The outcome of Phase 2 will be a recommendation to Ministers and NHS England for a programme of work that will bring the cost of indemnity provision for GPs to a sustainable level.

# Primary Care Guide to Indemnity

Product 1

June 2016

# 01
# Context

- What is Medical Indemnity?
- National Developments – The GP Forward View
- Medical Defence Organisations in the UK
- Alternatives to Medical Defence Organisations
- Types of Policies

# What is Medical Indemnity?

**Indemnity:**

*"To compensate for loss or damage; to provide security for financial reimbursement to an individual in case of a specified loss incurred by the person."*

**Medical indemnity in Secondary Care**

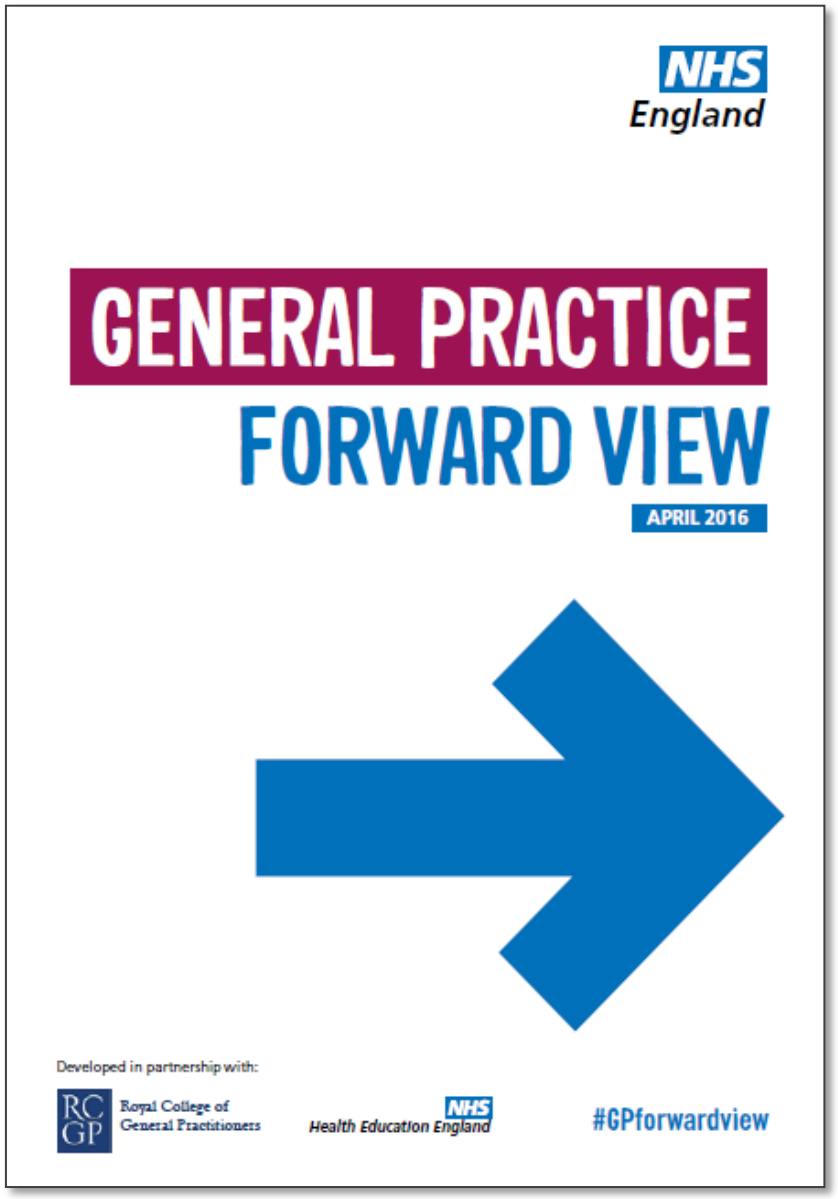
- The **Clinical Negligence* Scheme for Trusts (CNST)** (administered by the NHS Litigation Authority) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Membership is voluntary but all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme
- From 1st April 2013, **independent sector providers** of NHS care have been able to join CNST and cover under CNST was extended to include the cost of representation at inquests

**Medical indemnity in Primary Care**

- **GP contractors, locum GPs and salaried GPs** employed by practices **are not indemnified by the NHS scheme** and therefore require **personal medical indemnity**
- Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, **all registered healthcare professionals** are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK
- Indemnity cover for Pharmacists working in clinical settings is provided under 5 main providers.

*Clinical negligence is defined as a "breach of duty of care" owed by the health care professional to the patient.

# National Developments: The GP Forward View




**Chapter 1 Investment: Tackling rising costs of indemnity includes plans to:**

- Consult the profession and others on proposals to tackle indemnity costs in general practice by July 2016
- Consider how personal costs of indemnity and clinical insurance can be contained, provided certain clinical governance standards are met – with the objective of reducing the overall costs to the individual
- Reducing indemnity costs for individuals in particular circumstances, such as GPs who wish to remain in the workforce on a part-time basis past a certain age
- Enabling new models of care such as **Multispecialty Community Providers (MCPs) to take on corporate indemnity**, freeing up individuals working in those new models from the burden of personal indemnity costs

# Medical Defence Organisations

- There are three Medical Defence Organisations (MDO's): Medical Defence Union Limited (MDU), The Medical Protection Society (MPS) and The Medical and Dental Defence Union of Scotland (MDDUS).
- MDO's are mutual non-profit making organisations, owned by their members.
- The primary function of MDOs is to indemnify doctors for incidents arising from their clinical care of patients and to provide members with 24-hour access to advice and assistance on medico-legal issues arising from clinical practice.
- The membership benefits of the MDOs differ, it is important to consider each one carefully before making a choice (please see appendices for further information).

MDU

http://www.themdu.com

MDDUS

http://www.mddus.com

Medical Protection

http://www.medicalprotection.org/uk

# Alternatives to Medical Defence Organisations

- The private insurance market provides medical indemnity insurance which is an option for GPs unable or unwilling to obtain medical indemnity through one of the MDOs.
- The premiums may be similar or higher than the subscriptions charged by the MDOs.
- The level of cover may also not be sufficient to allow an individual to remain on the medical performers list.
- NHS England expects all GPs on the England National Performers List who are insured to have minimum personal liability cover of £10 million for 2016, but this will need to be reviewed annually.
- If purchasing private insurance, all GPs are strongly urged to check that the personal liability cover is sufficient before committing to payment.
- Check with NHS England and the LMC if in doubt.

# Pharmacy Defence Organisations

The main Pharmacy Defence Organisations are as follows:

- National Pharmacy Association (NPA)
- The Pharmacists' Defence Organisation (PDA)
- Private Insurance Agency
- Guild of Healthcare Pharmacists (GHP)
- Other private insurance companies

# Types of Policies

### "Occurrence"

- An **Occurrence** policy protects you from any covered incident that "occurs" during the policy period, regardless of when a **claim** is filed.
- An **occurrence** policy will respond to **claims** that come in – even after the policy has been cancelled – so long as the incident occurred during the period in which **coverage** was in force.

### Considerations:

- Can be reported years later, key is when it happened
- Can be more valuable as responds to claims years after the event

### "Claims Made"

- **Claims-made** policies provide coverage for claims only when BOTH the alleged incident AND the resulting claim happen during the period the policy is in force.
- Claims made policies provide coverage so long as the insured continues to pay premiums for the initial policy and any subsequent renewals.

### Considerations:

- Claim has to take place both whilst there is a current policy and there has been continuous cover since the time of the incident
- No "tail coverage" which means the policy does not cover any historic claims arising from a policy which ceased to be in effect

# 02

# Issues and Challenges

- **Indemnity in the National Press**
- **National Indemnity Issues**
- **Case Study Example: The Healthbridge GP Federation**

# Indemnity in the National Press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Health

**NHS negligence claims bill tops £1bn**

17 July 2015 | Health

Clinical negligence cost inflation 'astonishing' - MDU

NHS Boss under pressure from Derbyshire doctor over soaring GP costs


PULSE At the heart of general practice since 1960

OPINION Do we really

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**Retired GP faced with legal claim after 40 years as cases jump 15%**

Nurses advised to check indemnity cover in wake of new law


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February 9, 2015 2:52 pm

**Medical negligence costs 'threat' to National Health Service**

Sarah Neville and Alistair Gray

**Negligence claims costing NHS £4.4bn**

NHS sets aside quarter of its budget for medical negligence claims

The health service has set aside £26bn to cover medical negligence claims against NHS hospitals, it has emerged

Soaring medical indemnity costs force GPs to cut out-of-hours shifts

By Nick Bostock on the 19 August 2015

One in three GPs say medical indemnity fees have risen 20% in five years

**English GPs move north of the border due to spiralling indemnity fees**

20 May 2016 | By Alex Matthews-King

NHS negligence claims rise by 20 per cent in just one year

Claims against the NHS for medical negligence have risen dramatically following a succession of hospital scandals.


PULSE At the heart of general practice since 1960

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**GP 'quoted £30,000' for annual indemnity insurance**


theguardian website of the year

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NHS

NHS sounds compensation alarm after £120,000 lawyer bill for £5,000 claim

# National Indemnity Issues

Indemnity costs for GPs and clinical staff in practices has escalated due to rising negligence claims and advisory costs. The reasons are as follows:

## Rising Claims

Causes and Statistics:

- RCGP figures show a 19% increase in the number of GP consultations from 304 – 361 million from 2008/9 to 2013/4
- Greater awareness of the options to claim clinical negligence or complain. In 2013, an MDO was notified of 358 claims from GP members who had never had a claim in 20 years of membership
- Although the majority of claims do not succeed in compensation for the claimant (75-80% of medical claims between 2010-4), there are still costs associated with defending medical claims and this may include an early settlement
- With improving standards of care and increasing longevity, compensation for costs of care in successful claims are also escalating
- The reported claim numbers to the NHS LA have increased yearly with liabilities standing at £28.3 billion (NHS LA accounts 14/15). The annual costs have risen substantially with a 35% increase to CNST to £1.4 billion

## Legislation

- Section 2(4) of the Law Reform (Personal Injuries) Act 1948 means that defendants who are providing compensation for future healthcare must pay for such care on the presumption that it will be provided by the independent sector when NHS treatment is available leading to “double recovery”
- There is no limit on the number of years to claim
- The assessment for speculative loss of earnings is limitless, other countries like Australia limit this to annual salary per year

# National Indemnity Issues

Indemnity costs for GPs and clinical staff in practices has escalated due to rising negligence claims and advisory costs. The reasons are as follows:

Higher costs equals higher premiums

**The Medical Defence Organisations identify the following areas as higher risk resulting in higher premiums**:

- Unscheduled GP care sessions (if you provide these services to your own patient population subscriptions should not increase as much)
- Private GP sessions or treating non-NHS patients
- Undertaking Forensic or Police Physician (FME) work
- Work in a private travel clinic or a private walk-in centre
- Working across multiple sites within a GP network or federation
- Undertaking occupational health physician work
- Performing cosmetic surgery procedures
- Employing new workforce roles including Physicians Associates, Advanced Nurse Practitioners and Clinical Pharmacists
- Sports medicine

Assessing Risk

- The MDO's estimation of risk associated with the new care models and new workforce roles is high due to their infancy
- There are difficulties in estimating risk due to there being no limits on the number of years to claim
- Lack of transparency on data and claims from the personal medical indemnity market mean it is difficult to identify and address trends

# Pharmacists Working In Clinical Settings

| | |
|---|---|
| **Pharmacy Defence Organisations** | • National Pharmacy Association (NPA)<br>• The Pharmacists' Defence Organisation (PDA)<br>• Private Insurance Agency<br>• Guild of Healthcare Pharmacists (GHP)<br>• Other private insurance companies |
| **Issues** | • Sharp rise in costs as move from community to clinical pharmacy role<br>• Increase in costs from £300 to £1700 when moving from a community setting to more formal clinical setting<br>• The defence organisations will not cover primary diagnosis or where there is not a clearly defined role in primary care<br>• The Clinical Pharmacists in General Practice Pilot job description does not include primary diagnosis but there is a recognised need for fluidity |
| **Recommendations** | • Need to await the outcome of the PDA Consultation ending on 31st May to understand the updated position<br>• The position of each defence organisation regarding primary diagnosis requires further research and needs to include Pharmacists working in care homes<br>• Further discussion is required on the difference between the Clinical Pharmacists in General Practice Job Description and the need for fluidity |

# Case Study Example: The Healthbridge GP Federation

The Healthbridge GP Federation is a group of GP practices in Redbridge and linked with The Barking and Dagenham, Havering and Redbridge (BHR) System Resilience Group which is an Urgent and Emergency Care Network.

**Indemnity Challenges have included:**

Unaffordable costs for **Advanced Nurse Practitioners** working in the out of hours setting given the higher assessment of clinical risk associated with the setting and type of role meaning significant recruitment and retention issues.

The NHS Winter indemnity scheme which was developed with the Medical Defence Organisations (MDOs) to offset the additional indemnity premium for GPs who wish to work additional sessions for their **out-of-hours (OOH)** providers only applied to work carried out within a recognised out of hours provider which meant significant costs were still incurred and therefore deterred GP's from taking on extra sessions.

**Clinical Pharmacists** working under the Pharmacy Practice Pilot are employed by the Federation and deployed into practices. The Pharmacists have their own personal insurance plus additional Federation insurance. NHS England are satisfied with this arrangement but the Practices under the Federation are concerned that this may not be enough.

# Pharmacists in Clinical Settings
# Case Study Example: Hall Green Health, Birmingham

Hall Green Health is a practice in Birmingham taking part in the national Clinical Pharmacists in General Practice pilot.  Three clinical pharmacists have been recruited in total, one has already started and 2 are due to start at the beginning of June.

**Indemnity Challenges have included:**

The companies indemnifying the pharmacists (PDA and NPA) are asking for an additional premium of £ 1700 per annum for the pharmacist if they are involved in triaging patients for minor ailments or make new diagnoses of chronic diseases or acute conditions. The significant increases in fees  are anticipated to significantly effect the budget for supporting the pilot.

The Pharmacists are covering their own indemnity fees currently. One of the roles that had been identified was to include managing minor ailments and triage medication queries over the phone for urgent care patients. Part of this may involve making a new diagnosis of an acute of chronic condition which could make the costs unaffordable.

# Pharmacists in Clinical Settings
# Case Study Example: Erewash Federation

Erewash GP Federation is located in Derbyshire between Ikeston and Long Eaton.

## Indemnity Challenges have included:

The Pharmacist employed by the Practice contacted the PDA regarding indemnity cover. The cover provided was a basic policy for one month. The policy allows the Pharmacist to look at records, adjust medications and prescribe but does not cover for diagnosis or treatment. The PDA stated that they are currently revamping the primary care indemnity and will have 4 levels; Intern, basic, advanced and specialist. The criteria asks Pharmacists to demonstrate three things which impact on the decision on cover. The criteria includes the number of years worked in Primary Care, qualifications, and area of expertise within competency. The length of Primary Care service meant the Pharmacist could not apply.

## Developments

The underwriters for the PDA have now responded to say they recognise the years of pharmacy experience and will insure the Pharmacist as an independent prescriber; running clinics and for differential diagnosis. The policy will not cover the 'first diagnosis' so acute clinics will be out of the question initially but it may follow at a later date.

# 03

# Dispelling the Myths

- **Myth 1: Private sector employers and GPs would not be vicariously liable and therefore I have to provide my own cover**
- **Myth 2: Private sector employers and GPs would not be vicariously liable and therefore I have to provide my own cover**
- **Myth 3: CNST should be applied to primary care**
- **Myth 4: Indemnity cover for Out of Hours is always more expensive**
- **Myth 5: Indemnity cover for Out of Hours is always more expensive**

# Myth Busting

**MYTH 1**

## Private sector employers and GPs would not be vicariously liable and therefore I have to provide my own cover

No, this is not true.
Employers cannot choose whether they are vicariously liable. All employers are by law vicariously liable for the actions of their employees. This means they are responsible for what you do in the course of your employment, including where you make a mistake. All organisations involved in the provision of healthcare, both inside and outside the NHS, will be vicariously liable for the actions of their employees. This includes voluntary organisations.

**MYTH 2**

## Private sector employers and GPs would not be vicariously liable and therefore I have to provide my own cover

Claims made insurance can be cheaper in the first few years because the indemnity it provides is limited in terms of money and time. However, this means that doctors seeking indemnity for claims that are not within the policy's limits will be un-indemnified and patients will go uncompensated.

Insurance companies can charge lower premiums than MDO subscriptions when they enter the market on a claims-made basis because incidents that occur during the term of the policy, but which are not reported during that term, will not fall to be paid under that policy.

MDOs state *'We are all non-profit making mutual organisations, owned by our members. The income generated by subscriptions is held in the mutual fund to provide the benefits of membership. Mutual organisations exist solely for the benefit of their members and no dividends are paid to shareholders.'*

# Myth Busting

## MYTH 3 — CNST should be applied to primary care

The current difficulty with this is that the NHS Litigation Authority has suggested that it cannot afford (and does not have the experience or expertise) to indemnify individual GP practices as currently structured.

They argue that Hospital trusts, being larger organisations, can conform to much tighter corporate policies, protocols and guidelines around avoiding clinical negligence, potential litigation and handling patient feedback and experiences.

The potential for variation across multiple smaller organisation such as GP practices is perceived by the NHS LA to present too great a risk. The introduction of large primary and community care organisations, such as GP networks or federations, vanguard sites, multi-specialty community providers etc. may provide opportunities for the Litigation Authority to consider providing similar indemnity to that currently enjoyed by trusts, although this is not a short term solution and is unlikely to be a primary reason to form such groups.

There could also be drawbacks to the above model. MDOs are constituted in such a way as to support GP members as individuals, with attention to their personal interests, whereas the NHS LA would have to manage claims on behalf of Trust members and liaise with the Trust management, rather than the individual doctors. Such a system would not reduce the amount or the cost of claims either, so they would still have to be paid for. Transferring the risk will not diminish it.

# Myth Busting

## MYTH 4 Indemnity cover for Out of Hours is always more expensive

The NHS Winter indemnity scheme which ran from December to March 2016 was developed with the Medical Defence Organisations (MDOs) to offset the additional indemnity premium for GPs who wish to work additional sessions for their out-of-hours (OOH) providers. This was to help GPs cope with extra demand over the winter period by reimbursing the indemnity costs for out-of-hours sessions. Feedback on the NHS Winter Indemnity Scheme included that it was only valid for GP's working for a recognised Out of Hours provider.

MPS published new guidance on their classification of scheduled and unscheduled hours in February which means sessions that were previously defined as Core Hours and Out of Hours will now be classed as Scheduled Care sessions and Unscheduled Care sessions.

**Scheduled Care** is undertaken during the scheduled opening hours of the practice (within 8am-8pm, 7 days a week) where registered patients are seen by appointment and where staff have access to the patient's full general practice records.

**Unscheduled Care** is any work that falls outside the Scheduled Care criteria, such as sessions undertaken at any time of day in walk-in/urgent care centres.

**You are advised to check with your MDO regarding their classification of Core Hours and Out of Hours**

# Myth Busting

## MYTH 5

## Nurses are covered by the Royal College of Nursing Indemnity Scheme

In January 2012, the Royal College of Nursing (RCN) made changes to its nurse indemnity scheme. RCN members currently working in GP practices no longer receive indemnity as part of their membership benefits. Ten per cent of practices visited in 2014 as part of Medical Protection's Clinical Risk Self Assessment (CRSA) programme were unsure of their indemnity arrangements.

It is vital that registered healthcare practitioners working in general practice are clear about their indemnity arrangements. GPs are advised to check their indemnity arrangements to ensure that work carried out by their practice nurses and all practice staff is appropriately covered.

**GPs should also note the following:**

The Nursing and Midwifery Council (NMC) advises that all registered nurses should have professional indemnity insurance and that while employers have vicarious liability cover 'it is the individual's responsibility to establish their insurance status and take appropriate action'.

All nurses are advised to retain their membership of the RCN or similar organisation to support them in any non-indemnity issues, including claims made against them by the NMC.

**Please see the appendices for further advice from the MDO's.**

# Myth Busting

## MYTH 6

### Indemnity cover for Out of Hours is always more expensive

Members may from time to time wish to look at the terms and conditions provided by other MDOs in case these are more favourable.

Many providers require a 28 day notice period to allow for a “letter of good standing” from your previous provider.

If you do decide to change provider, ensure you have access to indemnity in case of a claim during the transition period and that you remain able to seek assistance with claims that arise from incidents that took place when you were with the previous provider but that are reported while you are with the new provider. This is particularly important if you seek cover from the private insurance market.

Also check carefully your benefits of membership or policy and that there are no gaps that might leave you vulnerable as an individual or a practice. This is especially important given the legal requirement to have adequate and appropriate indemnity for your practice.

Never cancel your indemnity arrangement with your existing indemnity provider until your new provider has confirmed that they have accepted you as a member of their mutual organisation or will cover you, and the date from which your membership or cover will commence.

# 05
# Solutions

- **Solutions for Reducing Primary Care Indemnity Claims and Costs**
- **Student Indemnity – Reducing the Risk for Student Nurses**
- **Student Indemnity – Reducing the Risk for Student Physician Associates**

# Solutions for Reducing Primary Care Indemnity Claims and Costs

**Medical indemnity corporate or group insurance policies**

- Ask the MDO's about a corporate or group membership for GP Federations or Super-Practices which could reduce (although not remove) the current costs of personal indemnity
- For example, all OOHs work would be covered by the provider and GPs would only have to pay indemnity for regular in-hours work
- GPs would be able to undertake OOHs and cover seven-day access sessions

**"Block" indemnity cover for general practice**

- Consider indemnity for the GP Federation so that there is less pressure on the individual GP with blended contributions from the provider
- Consider cover for other staff within the practice e.g. pharmacists, advanced nurse practitioners, physicians associates

**Risk management**

- Utilise the tools available from the MDO's in order to mitigate risk
- Invest in safe systems, improving communication skills and professionalism in an attempt to bring down claims in the first place

# Student Indemnity – Reducing the Risk for Student Nurses

Student nurses placements in general practice carries a very low risk if general practice professionals take the following steps:

1. Practice nurses acting as nurse mentors hold a mentorship qualification that meets the NMC guidelines
2. All clinical members of GP practice should have an indemnity cover for their work which will cover student nurses accordingly
3. GP practices should sign a Learning Development Agreement with relevant university to clarify what student nurses are able to carry out and at what stage of their study
4. An honorary educational contract should be signed between the student nurse and GP Practice/Nurse Mentors to clarify role and responsibilities for all parties (template available from Health Education Kent, Surrey and Kent)
5. It would always be recommended that student nurses (if they can afford) to purchase student nurses membership with the RCN which provides them with personal indemnity cover. We understand it is £10 per year and per student

# Student Indemnity – Reducing the Risk for Student Physician Associates

The physician associates students placements in general practice carries a very low risk if general practice professionals take the following steps:

1. GPs acting as clinical supervisors have been through appropriate training that meets the university and Health Education England guidelines

2. All clinical members of the GP practice should have an indemnity cover for their work which will cover PA students accordingly

3. GP practices should sign a Learning Development Agreement with the relevant university to clarify what PA students are able to carry out and at what stage of their study

4. An honorary educational contract should be signed between the PA student and GP practice to clarify roles and responsibilities for all parties (available from Health Education Kent, Surrey and Kent)

# 06
# Recommendations

# Recommendations

1. Contact your MDO if you have any questions regarding your existing policy or to ask about a change in cover
2. If you are developing a new care model such as a GP Federation, contact the MDO at the start of the process to understand the implications at the outset
3. Consider the range of memberships available from all the MDO's and check whether there are better options for cover
4. Utilise the tools and advice available from your MDO in order to mitigate risk
5. If you wish to change MDO provider, allow more than 28 days notice
6. Always consider the introduction of new workforce roles and check the appropriate indemnity arrangements are in place

# 07

# Contact Details & Additional Resources

# Contact Details and Additional Resources

Telephone: 0113 807 0161

Email us: England.LondonWorkforce@nhs.net

Post: Healthy London Partnership, 4th floor, Southside, 105 Victoria Street, London, SW1E 6QT

You can also follow us on Twitter at www.twitter.com/#healthyldn

Get involved with the Working Group

Visit the HLP website and you'll find all of the support packs
https://www.myhealth.london.nhs.uk/healthy-london-partnership