

THIS WON'T HURT A BIT

Are your healthcare assistants okay to administer flu vaccinations?

SPOTTING THE SIGNS

A new programme in Scotland is helping tackle domestic violence

NOT A MINUTE MORE

Sadly it's impossible to make time but you can better manage it



CQC APPROVED

WHAT DOES IT TAKE FOR A PRACTICE
TO BE RATED "OUTSTANDING"?



PARTNERSHIP AGREEMENTS
PRIMARY CARE IS CHANGING AND SO TOO ARE
YOUR LEGAL OBLIGATIONS





OVER 1,700 GP practices and out-of-hours services have been inspected by the Care Quality Commission, according to a recent statement by chief inspector of general practice Professor Steve Field. Of those, 84 per cent have been rated "good" or better, though only a small proportion achieve an "Outstanding" rating.

On [page 10](#) Jim Killgore visits one such practice - Orchard Court Surgery in Darlington. Here he meets PM Karen Fuat to discuss what set the practice apart and how she prepared for the ordeal of a CQC inspection. She says: "Every general practice in England knows that at some stage they are going to be visited by the CQC. You know more or less what they are going to be asking for. You just have to be organised and methodical."

How many partners or PMs out there can instantly lay hands on their partnership agreements? Often these are filed away and never consulted unless there is a dispute of some kind. Solicitor Mark Jarvis argues ([page 12](#)) that practices should view these as "living documents" to be reassessed on a regular basis.

Flu season is again upon us with vaccination clinics on the go. Are you certain of the basis on which your healthcare assistants and PNs are administering flu jabs? Do you know a PGD from a PSD? On [page 6](#) I provide some guidance.

Employment law adviser Janice Sibbald offers a quick primer on practice equality issues on [page 7](#). Suspected domestic abuse is the subject of our regular risk column from Alan Frame ([page 8](#)) and Allan Gaw offers an alternative perspective on time management for the busy PM ([page 9](#)).

Our regular call log on [page 4](#) features member queries on covert recording, the family of a violent patient wanting to re-register, the transfer of medical records abroad, an elderly patient driving with dementia and other topics. And our case study ([page 14](#)) features a questionable referral to child services.

Helen Ormiston
Editor

COVER PHOTOGRAPH: SIMON RYDER

NEWS

Over a quarter of GP appointments avoidable

A NEW report has found that over 27 per cent of GP appointments could potentially be avoided if there was more coordinated working between GPs and hospitals, greater utilisation of primary care staff, more effective use of technology to streamline administrative burdens and wider system changes.

The report by the NHS Alliance and the Primary Care Foundation found that a significant amount of GP time could be freed up if family doctors spent less time rearranging hospital appointments and chasing up test results. The report also estimates that one in six patients could potentially be seen by other primary care staff, such as clinical pharmacists, practice nurses or physician assistants, or they could be supported to meet their own health needs.

The study argues that the reduction of bureaucracy in general practice should be made a national priority. In particular the report calls for streamlined payment systems and to simplify and speed up the time practice managers spend on entering data.

Dr Jonathan Serjeant, GP and national lead for NHS Alliance's Accelerate programme, said: "GPs and their colleagues are experts in listening, supporting and diagnosing their patients. This is what we've been trained to do, and what we want to do."

"If applied quickly, the recommendations set out in this report, particularly those around extending the GP team to incorporate other health professionals, will help reduce the current levels of bureaucracy GPs face on a daily basis. The end result is that GP time is freed up, and people have access to all their information whenever they need it."



Interactive module on dental complaints handling

MDDUS members can now build their knowledge of dental complaints handling with a new interactive module from our Risk Management team.

Aimed at dentists and practice managers, the module is CPD-verified and offers a wide range of information and advice on best practice. It takes around 45 minutes to complete and covers:

- the common reasons patients complain
- the requirements in relation to handling complaints
- professional guidance on acting on patient concerns
- how you can review your own practice processes, roles and responsibilities in relation to complaints
- how you might investigate and respond more effectively
- strategies to minimise complaints in dental practice.

Members can login using their surname and MDDUS membership number. Find out more on the Interactive modules page in our Risk Management eLearning centre at mddus.com

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RCGP predicts challenging years ahead

OVER one million more patients will be living with two or more serious long-term, life-threatening conditions by 2025, according to new analysis by the Royal College of General Practitioners (RCGP).

The additional care will cost the NHS up to £1.2 billion per year. At the recent RCGP conference Chair Dr Maureen Baker highlighted the "paradoxical situation" that delivering complex care to patients with chronic conditions is "most cost-effective in general practice yet the bulk of NHS money continues to go into hospital care".

The RCGP has pointed out that currently 90 per cent of NHS patient contacts are made in general practice yet it only receives 8.33 per cent of the NHS budget.

Dr Baker said: "It is a great testament to modern medicine that nowadays we are much more likely to prevent or treat diseases that in the past killed people so early in their lives. GPs have played a pivotal role in this transformation.

"But this success has brought with it a whole new set of challenges to which the NHS is currently struggling to respond... We need an NHS that's properly set up to meet the complex clinical needs of people in the 21st century."



Fair and accurate job references

PRACTICES should ensure that any references they give for ex-employees are as fair and accurate as possible.

At MDDUS, we are frequently asked by practices what their obligations as employers are in relation to giving out information about ex-employees in references. Employers are not legally obliged to give a reference (unless stated in the contract) but if they do it should be done fairly and in good faith. In most cases, it would be appropriate for practices to provide a reference, and the criteria and format should be applied consistently.

Practices should consider including the employee's length and dates of service, positions held and key responsibilities. Employers should not ask for personal information and the reference should focus on the candidate's performance in their previous job.

Prospective employers must only approach a job applicant's current employers with the candidate's permission. Absence or disciplinary records do not need to be disclosed

with the reference but practices should consider whether omitting information would result in an inaccurate and misleading reference. In a situation where a former employee posed a risk to patient safety then the practice should disclose the relevant information.

If any disciplinary matters are to be included in a reference, then the correct process would need to have been followed at the time to ensure that any formal warnings issued were done so legally and in compliance with the Acas code of practice.

Employees can request to see a copy of any reference and can attempt to claim damages in court if they believe that a reference is false or misleading. The worker must be able to show that the information was misleading or inaccurate and that they have suffered a loss such as withdrawal of a job offer.

Supplying references can be a difficult area so practices should contact the MDDUS employment law team if they want to discuss any specific aspect.

Dental practices confused over data protection

CONFUSION exists over when a dentist is required to register with the Information Commissioners Office (ICO) in compliance with the Data Protection Act, according to a recent report.

The ICO visited 21 dental practices across the UK and conducted an online survey in order to understand the information risks and challenges that dentists face. It found there was confusion over data protection requirements, with some dentists registering with the ICO when it is not necessary and others not registering as required.

The report also found that dentists do not always have written contracts with external suppliers containing appropriate clauses about information security, particularly with IT contractors. The ICO also found that some practices utilising new technologies, such as mobile and personal devices, were not appropriately controlling associated risks.

There was also a lack of clarity in some practices over retention policies (to determine when records, both physical and electronic, should be destroyed). Retention periods were not always clear, and not generally applied to electronic records.

Investigators found that overall dentists are "not always engaged with sources of best practice and new guidance in relation to information governance".

The report states: "Dentists operate within a number of different complex structures, including individual practices, partnerships, expense-sharing arrangements, limited liability companies and dental corporates. This has led to some confusion about the circumstances in which a dentist is (or is not) a data controller, responsible under the DPA for patient data, and also for registration with the ICO."

It encourages practices to visit the ICO website (www.ico.org.uk) where there is a self-assessment tool and also specific dental practitioner FAQs. You can also phone their registration helpline at 0303 123 1113.

Access the report at <https://goo.gl/SieQq8>



National living wage to be introduced

EMPLOYEES over 25 who are currently on the national minimum wage will get a pay rise in April 2016 with the introduction of a compulsory national living wage.

Starting at £7.20 per hour, with the aim to increase to £9 by 2020, it will effectively replace the existing minimum wage for over-25s and is expected to boost the income of six million people.

The national minimum wage increases to £6.70 as of October so next year's change will see a 7.4 per cent wage increase for those affected.



These cases are based on actual advice calls made to MDDUS advisers and are published here to highlight common challenges within practice management. Details have been changed to maintain confidentiality.

SECRET RECORDING

Q I was chatting to a patient this morning and she mentioned in passing that she recorded her last consultation with the dentist as she wanted to keep track of what was discussed. Surely she should ask permission before doing this?

A The increasing use of smartphones and tablets makes audio/video recording much easier and increasing numbers of patients (both medical and dental) are taking advantage of this in consultations. Despite what you may think, patients do not need to ask permission before taping a consultation, as section 36 of the Data Protection Act 1998 considers that the information in the recording belongs to them. Conversely, the dentist would not be allowed to record without the patient's permission. MDDUS experience suggests most patients make these recordings for positive reasons (i.e. to help their understanding of health advice) rather than to challenge their clinician. Dentists acting professionally should have nothing to fear. As ever, by keeping clear, comprehensive and accurate records of consultations, dentists can justify their actions in court if necessary.

ACCESS AFTER DEATH

Q The daughter of one of our elderly patients who died last month has been asking questions about the nature of the care provided before her mother's death and has now requested access to her mother's medical records. Am I allowed to provide this to her?

A Requests for access to a deceased person's records are covered by the Access to Health Records Act 1990. The GMC's Confidentiality guidance is also a

useful reference (paragraphs 70 to 72). After death, access may be granted to the deceased's personal representative (i.e. the administrator or executor of their will) or to anyone who may have a claim arising from the death. Before disclosing, first check whether the patient had specifically requested her records remain confidential after her death and be sure to comply with her wishes (unless there is an overriding public interest in disclosing). Then confirm with the daughter the nature of her request as she should only be supplied with relevant information. Make sure you do not disclose any information in the record that may cause mental/physical harm to anyone, and remember to redact any third party information.

TRANSFER OF RECORDS ABROAD

Q A family in our practice has moved abroad and is requesting that full medical records be sent to their new practice. Should the records be sent via an "International Signed [for]" service to ensure secure delivery and can we charge for the extra postage?

A Subject access requests from patients abroad would not differ from those made within the UK under The Data Protection Act. The maximum amount that can be charged for copies is £10 for computer copies and up to £50 for paper copies or a mixture of the two. This figure would include postage. It would be reasonable to be able to show that you have made every effort to ensure safe delivery should a complaint arise later – thus an International Signed [for] service may be advisable. But you may also wish to advise the patients that the practice is no longer responsible for the records once they have been posted. Remember that all requests for medical records should be made in writing and signed – and you should take all reasonable steps to ensure you have checked the identity of the patients (or parental guardians) requesting the records. In this case, a signed request and copy of passports showing the signature would be reasonable.

REQUEST TO RE-REGISTER

Q A former patient has contacted our practice wanting to re-register her, her husband and her children. The family had previously been registered but moved to another practice after the husband was removed from our list for verbally threatening reception staff. The partners have met and decided that the practice would be willing to take on the patient and her children but do not want to allow the husband to re-register. We would also want assurance that the husband would not accompany her or the children to the practice, nor be present if a home visit was required. Is this reasonable?

A It would be reasonable to re-register the former patient and her children but to stand by your original decision and refuse to take the husband back on the list. However, it may be difficult to enforce the condition that the husband not be allowed to accompany the children or be present during necessary home visits as there may be circumstances when this is not possible, particularly in medical emergencies when the practice would be in no position to



refuse treatment. Thus, this would be best framed as a request rather than a condition of re-registering the family.

COPYRIGHT ON PATIENT DATA

Q A partner in our practice has been requested to complete an army medical form and he wants to include a copy of a CAMHS (Child and Adolescent Mental Health Services) assessment letter – but the letter includes a note stating: “Not to be copied without permission of the author”. Can we copy and send the letter without permission of the author?

A Once a document is placed in a patient's records it becomes available for the patient (or a representative acting with the patient's consent) to see or allow disclosure upon request. If it contains third-party information or anything the clinician believes could cause serious harm to the patient then this should be redacted. Letters from specialists or other health professionals do not count as third party and therefore anything they have written that is held in the patient records can be disclosed. Thus, it would be reasonable for the GP partner to send a copy of the letter. GMC guidance states that doctors should be honest when writing reports or signing forms and “must not leave out relevant information”.

GP SUPERVISION

Q Our practice is considering setting up a private clinic to administer travel vaccinations. The plan is to have our practice nurse carry out the injections – would one of the GPs have to be present while she does this?

A The key issue to consider when delegating is whether the person who will be carrying out the task is competent to do so. The practice must be confident that the staff member administering the vaccines has the qualifications, experience, knowledge and skills to provide the treatment. For example, would she be competent to deal with a potential anaphylactic reaction to a vaccination? The GMC states clearly that: “Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate.” When delegating, doctors must always pass on enough information about the patient and the treatment they need. Ultimately, if the GPs are satisfied these requirements can be met, then they can go ahead with their plans for the nurse to work in the clinic without direct supervision.

PHOTO CONCERN

Q A police officer has contacted the practice following a report from one of our patients who claims she was secretly photographed by another patient while they were both sitting in the waiting room. The officer wants access to the consultation list

to see who was booked in for an appointment at the time of the alleged incident. When I asked, he said he had not yet secured a court order for the disclosure. Should I give him this information?

A Whenever police ask for access to confidential patient information there are a number of key issues to confirm. One of these is a court order – if this is in place, then you are required by law to disclose the necessary relevant information. Without such an order, you must exercise your professional judgement. Ideally, no disclosure would be made without first securing consent from the patient(s) concerned, but you should check first with police whether doing so would undermine their investigation. You should also be satisfied that seeking consent would not put you or others at risk of serious harm. Without either a court order or patient consent, you must consider whether disclosing could still be justified. The GMC recognises that there can be a public interest in disclosing information without consent where it is in the public interest “to protect individuals or society from risks of serious harm, such as... serious crime”. Having considered all these factors, if you feel disclosure would not be justified in this case (without consent) then the police would have to seek a court order.

followed all the necessary steps so far in discussing the issue with the patient and highlighting his legal obligations. As the patient is still driving, it would be advisable for his GP to meet with him again – ideally involving his daughter/another family member – and inform him that if he continues to drive then the doctor will report it to the DVLA in the public interest. Details of the discussion should be noted in the patient's record and a letter sent to him outlining any action taken. See GMC guidance - *Confidentiality: reporting concerns about patients to the DVLA or the DVA*.

NEGATIVE FEEDBACK

Q Our receptionist has informed me that one of our patients has posted a number of negative and derogatory comments about the practice on Facebook. She is not happy about the treatment she has received and she claims our dentists and staff are incompetent. This is very unfair and makes the practice look bad. How should we respond?

A Firstly, however unfair this seems and however much the practice wishes to defend itself, you should resist the urge to reply directly (and publicly) to the comments via Facebook. This will not help and will likely make matters worse, as well



DEMENTIA DRIVER

Q A patient who was recently diagnosed with dementia was seen arriving in the practice car park this morning in his car. He has been told on two occasions he is not fit to drive and that he must inform the DVLA of his diagnosis. His GP has discussed the matter with the patient and his daughter, but to no avail. What should we do next?

A All drivers have a legal obligation to alert the DVLA if they suffer from one of a list of conditions, including dementia, cognitive problems and other related conditions. It would appear the practice has

as potentially breaching patient confidentiality. Instead, consider contacting the patient to let her know you are aware she is unhappy about certain aspects of her dental care and invite her to come into the practice to discuss it. Advise her about the practice complaints procedure which could give her a constructive means to air her concerns and allow you to respond accordingly. It is important to make sure that any written communication is carefully composed and should not contain any warnings or threats to deregister her. (It has been known for such letters to also find their way onto Facebook.)

THIS WON'T HURT A BIT

Helen Ormiston addresses confusion over the necessary requirements for healthcare assistants administering flu vaccinations



WITH the flu season now underway, questions regarding healthcare assistants (HCAs) administering flu vaccinations are being raised on a regular basis with the MDDUS advisory service.

Currently there is no specific list of appropriate tasks that HCAs can perform. It is a matter for the practice to decide what training and supervision is appropriate for their HCAs. The General Medical Council does offer the following advice regarding the delegation of clinical care:

"When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised. When you delegate care you are still responsible for the overall management of the patient".

Many HCAs are well trained and competent to administer vaccinations and this enables them to carry out the task of immunising patients. However, it is the prescribing of the vaccine, and the assessment of the patient prior to that, which may raise concerns and has led to confusion in some practices.

PGD V PSD

A majority of flu vaccinations provided by the NHS are prescribed via patient group directives (PGDs), which are written instructions for the supply and/or administration of a named licensed medicine for a defined clinical condition to groups of patients, who may not be individually identified before presentation for treatment.

PGDs are not a form of prescribing but provide a legal framework for nurses and certain other registered healthcare professionals to administer a medicine directly to patients under a specified criteria, without the need to see a doctor or other qualified prescriber.

However, please note that HCAs may not administer drugs or provide treatment under a PGD. For a HCA to be involved in flu immunisations it must be via a patient specific directive (PSD). A PSD is a written instruction from an independent prescriber (doctor, dentist or independent nurse prescriber) to another healthcare professional, to supply and/or administer a medicine directly to a *named* patient or to several *named* patients.

PSDs are used once a patient has been assessed by a prescriber (who may be a doctor or independent nurse prescriber), and that prescriber instructs another healthcare professional in writing to supply or administer a medicine directly to that named patient or to several named patients. This could be in the form of a written template, a prescription or a simple written or electronic instruction in the patient's notes.

A PSD must state the name of the patient, the name and dose of the prescription-only medicine to be administered, the name or initials of the authorising clinician and "show evidence to confirm that the patient has been considered as an individual".

The key issue is the assessment of the patient, which should be contemporaneous to the administration of the vaccine. In this context practices may also wish to refer to GMC guidance in paragraph 14 of the 2013

supplementary document *Good practice in prescribing and managing medicines and devices*. In this guidance the GMC states that in providing clinical care "you should prescribe drugs only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs".

ENSURING COMPLIANCE

So how might this be set up within the practice to allow HCAs to be involved in the flu vaccination programme? Practices across the country will run their programmes differently but here are a couple of ways that practices could utilise their HCAs and remain compliant with GMC guidelines.

Opportunistic vaccination. When a patient is in consultation with a doctor or an independent nurse prescriber who is in a position to assess the patient, they can issue a PSD and the patient can then be asked to see the HCA to have the vaccination administered.

Prearranged clinics. In this set-up an HCA may work in tandem with a clinician, where the clinician can assess the patient and the HCA administers the vaccination. They may work in the same room or in a separate room close by.

The practice should be confident that the HCA is trained and competent to complete the task and any training and supervision that has taken place should be documented and kept on file.

Helen Ormiston is a practice adviser at MDDUS and editor of Practice Manager

EQUALITY DIVERSITY AT WORK

PREVENTING discrimination and managing equality are ethical and legal requirements that impact organisations, both large and small.

We work in a world of changing population dynamics. We have more women in the workplace, more ethnic minorities as well as an increasingly ageing population, and it is important that no one feels that they are being treated unfavourably in having what we call in employment law terms a “protected characteristic”. Encouraging greater awareness and understanding of protected characteristics, as defined by the Equality Act (2010), can only help in reducing the likelihood of discrimination claims.

So what are protected characteristics? They take in age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

How can you ensure your practice conforms to the law in terms of equality and protected characteristics? First it is essential that any practice has an up-to-date equality and diversity policy that is integrated into the key HR functions such as recruitment, pay and training opportunities. But it's simply not enough just to have a policy; staff must be informed and trained in the policy and its meaning. The commitment to the policy also needs to be demonstrated “top-down” by partners, salaried GPs and GDPs, and managers within the practice.

Discrimination can take various forms and in some ways may not even be intentional. To be safe, practices should ensure that they have a robust set of HR policies and procedures to support their decision-making and reduce the likelihood of an employment tribunal claim. Below are some areas where an equality policy can impact a practice.

ADVERTISING JOBS

Steer clear of using terminology that may potentially discriminate against certain groups of people. Examples of this might include “mature individuals only” or “young graduate” or “female preferred”. Ensure that the advert details what the main duties and responsibilities are and use these as the key criteria for shortlisting in the next stage of your recruitment process.

RECRUITMENT

Ensure that you assess the candidates against the job requirements equally. Candidates should have the same opportunity to answer the same questions. In any recruitment process there will be an element of bias, so to help reduce this you should have two people involved in the interview process when possible.

Although it may be more commonplace than in the past, take great caution in checking social media sites to see how candidates

Janice Sibbald offers some advice on ensuring your practice avoids discrimination in all its various forms

present themselves to the outside world. If a decision not to carry a candidate forward to the next stage isn't based on their match to the skills and experience of the job, then you could be opening up your practice to a discrimination claim. Apart from a few exceptions, the Equality Act (2010) makes it

illegal to ask about an employee's health and absence records prior to offering a job so this topic should be avoided.

TRAINING

Access to training and development opportunities should not exclude a specific person or group of people, and access to training should not be influenced by a certain protected characteristic or whether staff are in full or part-time employment. Everyone should have the same opportunity to apply for training and you should be able to justify your decision as to what training is granted.

RELIGIOUS PRACTICE

It is important to be mindful and sensitive to employee's religious practices and beliefs. An example of this might be that in planning events you ensure there are vegetarian or halal food choices, as well as non-alcoholic drink options. You may be in a position to offer a place for prayer but smaller practices may find accommodating this too difficult. There is nothing in employment legislation to state that you have to give time off or facilities for religious practice but it is important to try and be as flexible and accommodating as possible.

DISMISSAL

An employee must have two years' service with a practice before being allowed to take an employer before a tribunal for unfair dismissal. However, it is important to note that if they believe that they have been dismissed because of a protected characteristic then they qualify for this right from the day that they join the practice. For example, if you wish to dismiss a poorly performing employee who you know is homosexual, you would have to be able to justify this on grounds of performance and be able to prove that the dismissal was not related to their sexuality.

To conclude, do ensure that you treat all people with equity and respect, and that you have a robust set of HR policies and procedures to protect your practice from claims of discrimination. If you think that your practice would benefit from an up-to-date equality and diversity policy, please contact us at employmentlaw@mddus.com and we will be happy to email you a copy.

Janice Sibbald is an employment law adviser at MDDUS



Spotting the signs

Alan Frame looks at an innovative scheme to help healthcare professionals address domestic violence

PRACTICE managers will know that domestic violence and the signs of physical or psychological abuse in patients are often hard to detect, and even more difficult to address when suspected. A new initiative has been launched in Scotland with the aim of overcoming some of these obstacles.

The Ask, Validate, Document and Refer (AVDR) programme proposes to equip dentists, doctors, firefighters and even veterinarians and hairdressers to recognise the signs of this crime. The programme will develop and deliver domestic abuse training throughout Scotland, teaching professionals how to look out for the signs of domestic abuse and offer guidance on further support to victims.

AVDR was devised jointly by the doctor's group, Medics Against Violence (MAV), and the Scottish police Violence Reduction Unit. To date, around 2,000 dentists, doctors, vets, firefighters, hairdressers, dental and medical students have taken part in the programme and new funding means that it can be rolled out across the whole of Scotland, reaching an estimated 100,000 professionals.

The scheme was originally developed from an American model by Dr Christine Goodall, a lecturer and consultant in oral surgery at the University of Glasgow and founder of MAV. She began working on the project after many years studying links between facial injuries and violence. MAV have expanded membership to include veterinary surgeons, as a link was identified between animal cruelty and domestic abuse, with hurting

animals often being used as a means to coerce or punish human victims.

THE FOUR STAGES

It is not the intention of this article to provide a tutorial or critique of the AVDR programme itself, but it is perhaps worth taking a few moments to summarise what each of the four stages of AVDR relates to:

- **Ask** – ask questions of the suspected victim in an empathetic, non-judgmental manner.
- **Validate** – provide validating messages to the suspected victim.
- **Document** – note presenting signs and symptoms of abuse in the medical record and any specific disclosures by the victim.
- **Refer** – refer the suspected victim to appropriate resources and authorities.

Clearly, the first two stages are concerned with communication, trust and empathy and involve specific skills in which all doctors and other healthcare professionals may benefit from specialised training, such as that provided in this initiative.

Stages three and four, however, begin to raise other medico-legal and ethical considerations which clinicians in particular will have to take on board. By contrast, hairdressers are not bound by professional codes of conduct and a duty of confidentiality to their clients, and in this respect any decision to report or escalate suspicions of domestic violence will largely be taken on individual moral grounds, or to do what "feels right".

DUTY OF CONFIDENTIALITY

It may be worthwhile, therefore, to remind ourselves what considerations need to be taken into account by any healthcare

professional who may be faced with a case of suspected domestic violence. The GMC, for example, make it clear that the doctor-patient relationship is based on openness, trust and good communication, which allows doctors to work in partnership with patients in order that individual needs can be addressed.

To fulfil this role the doctor must respect a patient's privacy and right to confidentiality. The patient can expect that information about them will be held in confidence by their doctor, which normally means that such information can only be disclosed to a third party with the patient's express consent.

If we look at a scenario where a patient has fully disclosed to her doctor or other healthcare professional that she has been subject to domestic violence but expressly requests that this information is held in confidence, then the dilemma is probably more straight-forward. Unless the doctor considers that what has been disclosed constitutes a "serious crime" or there is real concern about the patient's or wider public's safety, then the circumstances should be fully documented and the patient's right to confidentiality honoured. Suspected abuse of a child within the home would be an exception and should be reported to the appropriate agency.

Greater difficulty may arise when the doctor has suspicions that domestic violence is involved, but the patient is unwilling to confirm or is reticent to provide sufficient details to base a decision on. What to record in the patient's notes now becomes a dilemma, never mind consideration whether it should be escalated to another authority.

This can be a complex area and practice managers are reminded that doctors should seek advice at an early stage from MDDUS.

Alan Frame is a risk adviser at MDDUS



goals, as well as others that are far from obvious. As an individual, you first need to look at your job and decide what needs to be done in the short, medium and long term to achieve your professional objectives. This will include what has to be done today, this week and this month, as well as those longer-term plans, such as gaining a new qualification, getting that promotion or even shifting careers. Whatever it is, it forms part of your self-appraisal and will help inform your objectives.

WHAT'S IMPORTANT?

Next we have to consider all the things we have on our plates and prioritise everything on that long-to-do list. Some things we assign ourselves are undoubtedly important and will help us directly or indirectly to achieve our goals. But, other things, often many other things that we spend our time doing, neither contribute to the everyday workload nor to our longer-term ambitions.

As everything we do, every resource we expend, including our time, has an opportunity cost, we must carefully weigh up our actions. Put simply, if we spend our time doing one activity, we cannot use the same time on another - we get to use our limited time only once.

To help us deal with this, a simple, cheap but effective strategy is to keep a to-do quadrant rather than a to-do list. Draw a box and then with two more lines divide the box into four equal quadrants. The top left quadrant is where we place anything we have to do that is both important and urgent, the top-right quadrant is where we put the important but non-urgent, the bottom-left is where we put the non-

Not a **minute** more

Allan Gaw says good time management is mostly about knowing what you want

TIME flies like an arrow...and, according to Groucho Marx, fruit flies like a banana. Even if we don't appreciate the joke, we can probably all sympathise with that feeling of time speeding by too fast for us to do all the things we need to do. We even talk of "time management" as if it can be managed, perhaps even slowed down. Unfortunately, it cannot.

Time simply is an inelastic, non-negotiable 24 hours a day, and not a minute more. We cannot find time that is not already there, and we cannot make time, even with wishful thinking. The time famine we then experience brings with it anxiety and enough stress to spoil a job we might otherwise enjoy.

Any busy professional feels this and none more so than those managing a modern primary care service. But if time cannot be managed, what can we do to solve this apparent shortage of time? The simple answer is that we must manage ourselves. Good time management is really about self-management - how we use the limited time we have most effectively - and that is all about the personal decisions we make on a daily basis.

WHAT ARE YOUR OBJECTIVES?

Much has been written about time management, but all the self-help wisdom in the world will not make you any more efficient unless you are willing to change what you do. What exactly we need to change and how we do it depends entirely on what we want to achieve, and that is where good time management must begin - with an honest appraisal of our objectives.

In any professional setting there will be a number of clearly set out

important but urgent and the bottom-right is the home for the neither important nor urgent.

Anything that is placed in the important and urgent box needs to be done. Anything in the important but non-urgent box can be deferred. We should focus our energies on those things that are important, and by important we mean important and relevant to helping us achieve those professional goals, which may be as simple as getting today's staff rota completed or as complex and long-term as helping us achieve that promotion within the next five years.

The bottom two boxes are where we place those things that are unimportant to us, but which are also either urgent or not. The unimportant but urgent should be delegated and the non-important and non-urgent should be dumped. This system of deciding, based on importance and urgency, whether something should be done, deferred, delegated or dumped will make much better use of your time. It will force you, as you make your to-do lists, to actively prioritise as you go and to recognise that some things should never have been on your list in the first place.

NEED A REBOOT?

There are many different strategies advocated as time-management tools but all should involve an appraisal of our personal goals and a prioritisation of the various tasks we think we need to do. If you feel your time management needs a reboot, try setting your goals and using a to-do quadrant to help you prioritise. You have a simple strategy that will cost you nothing and all that is needed is for you to put it into practice and hopefully reap the rewards.

And, of course, the best way to get something done is to start.

Dr Allan Gaw is a writer and educator in Glasgow

What 'Outstanding' looks like

Jim Killgore visits a Darlington GP practice among the select few to have been awarded a top rating on inspection by the Care Quality Commission

IT'S HARD to say what I was expecting on my visit to Orchard Court Surgery. Certainly not the ordinary one-storey brick building I arrive at by taxi, hidden among almost identical houses in a tightly packed residential area of Darlington.

Inside the waiting room it's bright and pleasant but again little different from a hundred other GP practices across England – and yet this somehow makes it seem even more extraordinary given that Orchard Court was in May of this year rated "Outstanding" by the Care Quality Commission (CQC).

Sue McMillan, CQC deputy chief inspector of general practice, said: "The care we observed at the practice really was excellent. It sets a high standard that every GP practice should seek to attain."

I have come to meet practice manager Karen Fuat to try and discover what has set Orchard Court apart in the eyes of the regulator – and also to ask how the practice prepared for the ordeal of a CQC inspection.

COMETH THE INSPECTORS

Karen has worked at Orchard Court for over 27 years, joining first as a young receptionist. Today it has a medium-sized list of around 7,700 patients, reasonably distributed over age ranges and with deprivation levels lower than the national average.

The practice is unusual in having seven doctors, all but one of them part-time (making rotas tricky). There are also three practice nurses, a practice assistant, a secretary and no fewer than seven part-time receptionists. Karen also works with a deputy manager.

Certainly her long experience in primary care has been an important factor in the success of the practice.

"I know general practice inside and out. I have been there and gone through all the changes," she says.

First hearing that the practice was to be inspected by the CQC was a bit unnerving, admits Karen. "You get notified a fortnight in advance. All of Darlington were told they would be visited – and we were going to be

the first. But I didn't feel scared because I was organised. I think if you weren't organised it would be a bit of a nightmare."

In fact Karen had been anticipating this day ever since the practice first registered with the CQC. She had read all the information available on the CQC website, highlighting what was required and working through training slides with practice staff.

"Every general practice in England knows that at some stage they are going to be visited by the CQC. You know more or less what they are going to be asking for. You just have to be organised and methodical."

First thing that Monday morning after learning of the inspection Karen began gathering the evidence required by the CQC in advance of the inspection. All of this had to be compiled as email attachments: practice statement of purpose, minutes of PPG (patient participation group) meetings, patient surveys, SEA reports, clinical audits, complaints audits, recruitment and training policies, induction checklists and more.

"I also had to do an essay," says Karen. "They wanted to know evidence and examples of the quality of care provided for six specific population groups."

In preparation she met with her deputy, the GPs and other practice staff and ran through a standard set of key lines of enquiry (KLOEs) which the CQC use to help rate practices. These relate to five key questions – are services safe, effective, caring, responsive and well-led.

INSPECTION DAY

On the appointed day three CQC inspectors arrived at 8:30am. The team comprised a CQC lead inspector, a GP and practice manager. Karen first gave a 30-minute presentation setting out the philosophy at Orchard Court: "we aim to provide accessible high quality healthcare to all patients in a friendly, open, non-judgemental and professional atmosphere." She then explained how this was reflected in the practice culture and its management and approach to patients



– and particularly in relation to the five key questions. The inspection team then split up to focus on different aspects of care such as treatment and outcomes, infection control, governance and HR policies.

"The practice manager [inspector] walked around the waiting room looking at all our posters, seeing if they were relevant," says Karen. "She talked to patients, interviewed my healthcare assistant. She then interviewed a member of our PPG."

This was followed after lunch by a three-hour meeting in which the inspector asked Karen to run through all the practice policies and procedures. "She basically sat in my office and asked can I have a look at this and a look at that. And I had everything to hand."

The visit finished later that day with a meeting in which the inspectors provided some immediate feedback to the senior practice team. In the case of Orchard Court it was almost all positive. Says Karen: "It was great to get feedback. We all work hard and it helps to be told once in a while that you are doing a good job."

THE REPORT

Twelve weeks later when the CQC published its report Karen was both shocked and delighted. "We weren't really expecting Outstanding. We know we are good. We always aim to be very good but we didn't expect to be Outstanding."



Left and far left: PM Karen Fuat. Above: staff at Orchard Court Surgery



“WE KNOW WE ARE GOOD. WE ALWAYS AIM TO BE VERY GOOD BUT WE DIDN'T EXPECT TO BE OUTSTANDING”

She shows me her copy of the report which bristles with multi-coloured sticks. “I went through it with a fine tooth comb as you can see.” The report found the practice Outstanding in four categories: safe, caring, responsive and well-led, and it was rated Good in providing effective services. Orchard Court also demonstrated “elements of outstanding practice” across six main population groups: older people; people with long term conditions; families, children and young people; working age people; vulnerable people and people experiencing poor mental health.

Among some of the highlights the inspectors praised the practice for its “open culture” in which safety concerns raised by staff and patients were integral to learning and improvement.

“People here do feel comfortable about raising issues,” says Karen. She puts this down in part to an egalitarian spirit among staff. “I am the manager but I don’t think I’m any more special. We are all on an equal level – doctors, nurses, cleaners. I can’t do their job and they can’t do mine.”

The inspectors also cited specific safety

initiatives such as a “buddy system” in which when one GP is away from the practice another takes responsibility for their letters, results and queries, and actions them.

The report also praised the “patient-centred culture” at the practice, stating: “We found many positive examples to demonstrate how patients’ lives were supported through the caring and supportive actions of staff.” These included a scheme to support diabetic Muslim patients during Ramadan and another dealing with recently bereaved patients and families in which a GP makes contact and a condolence card is sent.

“I think absolutely everyone in this building goes over and above what we are asked to do,” says Karen.

The inspectors were also impressed with the rapid and flexible appointment system at Orchard Court – and how the practice coordinates their appointments to reduce the number of times a patient has to attend. Karen explains: “If someone is seen by a GP who then wants some blood tests. They don’t go to the desk and make another appointment. The patient will have the blood test done right then by an HCA. Our GPs don’t

want an 80-year-old lady having to come back the next day.”

Many more examples of outstanding care at Orchard Court can be found in the full inspection report at <http://goo.gl/VmiOIR>


It is evident that much of the success at Orchard Court is down to good teamwork and the leadership provided by Karen and her partners. The report commented: “The cohesiveness shown amongst the whole team was remarkable... There was a high level of constructive engagement with staff and a high level of staff satisfaction.”

Karen was pleased that this was so evident in the inspection. “I am very close to my staff. They never need an appointment to see me. My door is always open.”

So what is her advice for other practices contemplating their turn with the CQC?

“You know at some stage they are coming. They have been coming for the last two years,” she says. “Start getting organised now. It’s not going to take that long – and all the information is there on the website.”

Jim Killgore is an associate editor of Practice Manager



Mark Jarvis of Capsticks LLP considers the changing primary care landscape in England and Wales and the need for revised partnership agreements to reflect the move toward federated practices

Future proof your partnership

A FIRM foundation is essential for any business venture and as we progress down the road set out by Simon Stephens in the *Five Year Forward View*, we are seeing a wide range of flexibility in approaches towards new models of care.

With a strong emphasis on integration between primary care, community services and hospitals, the new models of care envisage GP practices working together with a range of other providers. Such arrangements may be complex and involve several layers of governance and representation. The multi-specialty community provider (MCP) models envisage GP practices working in federations to realise this.

Federating itself is being driven by a range of motivating factors, whether these are to achieve economies of scale, to bid for new services with an integrated function, to provide staffing support, to share a premises solution or to achieve any number of benefits from collective working. The message of “form follows function” has been key to GP practices intending to work collectively – the aim being to get prospective federating practices to sit and consider what their business plan is to enable an appropriate federating vehicle to be formed around that business plan.

Key amongst all of this is governance – ensuring the intentions

of the parties are properly and comprehensively documented. The relationships, liabilities, decision-making, exit strategies and more will all need to be agreed on and documented. Federating groups have been keen to ensure the robustness of collective working arrangements; however, the foundations of these federations and new models of care will be the GP practices themselves. What hope then for collective working if the foundation itself lacks governance?

GP PARTNERSHIP DEEDS

For the majority of GP practices, ensuring appropriate governance is in place will mean a well-drafted and comprehensive partnership agreement. However, surprisingly large numbers of GP practices operate without a partnership agreement or one that is up-to-date.

The absence of any written agreement doesn’t mean there is no agreement at all. Instead it means the agreement that does exist will be governed under the Partnership Act 1890, which can have entirely undesirable consequences. For example, this will include immediate dissolution of the partnership on notice of death, and capital and profits being shared equally (regardless of contribution). This can have disastrous consequences for the primary care contract that underpins the practice. It should also be noted that where a partnership holds



a GMS contract, it is a requirement on the contractor that any person who becomes a member of the partnership after that contract has come into force is bound automatically by it whether by virtue of a partnership deed or otherwise.

Those working collectively in MCPs or federations (and indeed lenders to them) will want to ensure that every practice has its "house in order" such that internal issues do not spill over and adversely affect the functioning of the collaboration.

Whilst a benefit of having a written agreement is to reduce the scope for costly litigation, it is important to ensure that this is kept up-to-date. An outdated partnership agreement can have a contrary result to the original intentions and this can also lead to costly disputes.

Practices participating in collaborative arrangements may be doing so on a practice representative basis and it would be sensible for parties to include appropriate provisions in their partnership agreements dealing with this role, its extent and its power to bind the partnership, as well as providing appropriate indemnity should liabilities fall on that partner as a result of that role. The deed may also need to ensure that income derived from a collaborative arrangement is properly considered in constituting core practice income or perhaps should be apportioned differently between partners based on participation.

CHANGES IN LAW

Of course, aside from ensuring they properly reflect involvement in collaborative arrangements, partnership deeds should be kept up-to-date with any changes in legislation. The drive to ensure efficiency and achieve outcomes means that the NHS has undergone a number of reforms in the past decade alone. With the arrival of co-commissioning, the division of commissioning responsibilities leading to practices holding primary care and community services contracts means that practices should ensure that their deeds do not leave this to assumption. Partnership deeds may well apportion income streams differently between former enhanced services and the provision of core essential services, and it is important the provisions of the deed remain relevant today.

CQC registration is also a pertinent issue for GP partnerships. As the registered provider of regulated activities, all of the partners will be jointly liable for meeting the legal requirements and for the relevant actions/inactions of all the other partners. A partnership deed can allocate and set out the responsibilities of a "registered manager" to a particular partner or a practice manager. It may also be appropriate to include an indemnity for any partner conducting this role on behalf of the partnership and in accordance with their joint instructions.

NEW PARTNERS

Another perhaps more common trigger for the need to update a partnership deed is the introduction of a new partner, which can be expected to void the existing agreement. Setting out a probation period and the consequences of completing the same are important considerations. However, there will be a range of other questions that partners should be considering. Will the new partner buy into the premises/capital and in what proportion and over how long? The introduction of a non-clinical partner may require more careful consideration of the provisions of the deed. Provisions on decision-making, partner obligations, etc may well require distinctions to be made between clinical and non-clinical partners. The CQC registration position will also need to be factored in as a prerequisite of the partner joining.

A new partner is a good opportunity not just to update the parties to the agreement but also to ensure that it still reflects the intentions of the partnership as a whole.

PROPERTY CHANGES

A change in the property position is another occasion which should trigger a review of the partnership deed. Many practices are looking to release equity by agreeing to a sale and leaseback of their practice premises. Federating drivers and premises funding opportunities have also seen practices looking to relocate with neighbouring practices, a collaboration which would be expected to require amendments to the partnership deed to reflect a change in the property position, as well as integration with a form of overarching property arrangement, for example.

Even where many of the property provisions are dealt with separately in a property deed, it can be expected that the partnership deed may need some adjustment to reflect this. It follows that property trust deeds should also be kept up-to-date and any new partner or partnership property acquisition is a signpost to review and update both arrangements.

Mark Jarvis is a senior lawyer at Capsticks LLP and a specialist in partnership arrangements

A neglected child?

Day one

Ms K is a newly registered patient and brings her three-year-old daughter Ruth into the surgery for childhood immunisations. She is seen by both the practice nurse and a healthcare assistant. Both are very concerned about the state of the young girl. Her skin is smudged with dirt and her clothes are stained and smelly. The child is also quiet and unresponsive, and something "seems amiss" between her and her mother. Ms K does not comfort the girl when she becomes upset after her jabs and is rough when putting the child's coat back on. Both members of staff are uncomfortable about what they have witnessed and report their concerns to the practice manager and one of the GPs. The GP decides to write to the local health visitor to see if they have any background information on Ruth.

Day five

An email response from the health visitor confirms that she last saw Ruth seven months ago and that there were no recorded issues. This presents the practice with a dilemma and it is decided to seek advice from local child services who decide there is sufficient cause for the practice to put its concerns in writing.

Day fourteen

An officer from child services informs the practice manager that they have spoken to Ms K and her former GP and health visitor and that no further action will be taken. Ms K had explained that at Ruth's nursery the boys and girls spend much of their time outdoors and parents are encouraged to dress their children in clothes that can get dirty. A phone call to the nursery confirmed that there have been no concerns over Ruth's home life or welfare.

Day twenty-five

Ms K asks to speak with the practice manager in regard to the report made to child services regarding Ruth. She is very upset that the practice did not contact her first to allow an explanation. She has taken legal advice and states the practice did not follow correct procedure in contacting social services without informing her of this action. In the meeting she asks why the practice staff did not raise their concerns at the time. Ms K admits that Ruth had been fractious that day as she did not want to get her jabs and both of them had been a little "on edge" - but she was devastated when contacted by child services to say she had been reported for suspected neglect. She wonders if it might have something to do with her being a single mother. Ms K is also concerned that the matter will now be recorded in her child's permanent medical records and she wants all reference to it removed. The practice manager asks how Ms K would like to take her complaint forward and it is agreed the practice will further investigate and respond in writing.



THE practice manager meets again with the staff involved and then drafts a letter of response. This is sent to an MDDUS adviser for review. The letter first expresses regret at Ms K's distress and acknowledges that child services now consider the concerns over Ruth's welfare are unfounded. She states that on reviewing the circumstances the practice still feels it acted appropriately in referring the matter but in hindsight should have informed Ms K of its actions. The PM also denies the decision had anything to do with Ms K being a single mother.

In response the practice states it will review its procedures and ensure that parents or care givers are routinely informed of any child welfare concerns and the intention to refer the matter to child services (unless doing so would increase the risk of harm to the child). In regard to the request to remove entries in the patient records the PM states that it cannot retrospectively alter medical details unless factually incorrect but that it would be possible for Ms K to review the records to check for inaccuracies in the entry. The PM or mother would also be

allowed to annotate the entries.

The PM offers to arrange a further meeting involving other practice staff if this is wished. The letter also states that if Ms K is not satisfied with this response she has the right to take her complaint to the ombudsman and an address is provided.

KEY POINTS

- Healthcare professionals have a duty to act on any concerns they have about the safety or welfare of a child or young person.
- You do not need to be certain that the child is at risk of significant harm in order to inform an appropriate authority.
- Inform children and their parents when you have concerns about abuse or neglect and how you will act on these concerns (unless doing so may put the child or anyone else at risk of harm).
- Patients have the right to check medical records and request that inaccuracies are corrected.

Diary



MORE random items of questionable relevance from the PM team...

➔ **MOST DENTISTS LOVE LIONS** Diary truly despairs of the state of things when a successful dentist is pilloried for exercising his right to travel the globe and commune with exotic wildlife down the sights of a high-powered hunting rifle. Such now is the sad reality for American dentist and big-game hunter Walter Palmer after "mistakenly" targeting much-loved Cecil the lion.



Even members of his own profession are distancing themselves and this includes staff at Bloomsbury Dental Practice. A patient recently contacted customer care manager Christopher Hall to ask

whether all dentists are like Walter Palmer. He replied: "No they are not!" Chris then spoke to his own dentists who were "quite shocked that people might think that". So he contacted the Born Free Foundation and the practice has now adopted three African lions just to prove it.

➔ **STAR-CROSSED CARE** Could the answer to the overuse of antibiotics lie in the ancient practice of astrology? Conservative MP for Bosworth David Tredinnick seems to think so. A supporter of complementary and alternative therapies, he was quoted in *Pulse* suggesting it could "certainly" be useful to GPs and could also help reduce the cost of the NHS as a whole. A keen student of the stars himself, the MP said astrology could help patients understand which pending health issues they should look out for. The signs of the Zodiac, he explained, have been associated with different ailments – Capricorn with knee issues, Aries the head and Pisces the feet. "Some people because of their astrological make-up

would be more susceptible to some ailments than others," he said. "It has been used for 3,000 years... and we need to be a bit more broadminded."

➔ **LIVERPOOL, KNOW THYSELF** Practices in Liverpool will no doubt be delighted to hear that the city leads the country in online self-diagnosis. Video service Push Doctor accessed data from 61 million UK internet searches for 160 leading health issues. It found that the trend for self-diagnosis has risen 19 per cent over the last year (with an average of an extra 848,000 searches each month). The share of health searches was highest in Liverpool (5.99 per cent), Cardiff (5.86 per cent) and Surrey (5.74 per cent). Fewest clicks on medical issues were in Hertfordshire (0.94 per cent), Milton Keynes (0.72 per cent) and York (0.64 per cent). Among other curious trends was that back pain and depression were the most searched for topics in Liverpool whereas in Shropshire it was diarrhoea. Go figure.

➔ **PRE-MORTEM** Diary recently had a nightmare that we consulted the Ubbie UK Longevity Explorer only to discover we are already dead. How welcome it was to awake Scrooge-like and realise there is still time to make a change. This apparently is a key motivation behind the development of the online tool which uses self-reported information to generate a score that predicts the risk of death within the next five years for UK people aged 40 to 70. It is based on research from the Karolinska Institutet utilising health data from nearly half a million adults held in the UK Biobank. Researcher Dr Andrea Ganna said: "Of course, the score has a degree of uncertainty and shouldn't be seen as a deterministic prediction. For most people, a high risk of dying in the next five years can be reduced by increased physical activity, smoking cessation, and a healthy diet." Diary will honour these resolutions in our heart and try to keep them all the year!

➔ **EXTREME MEASURES** Diary isn't certain whether a topless shot of health minister and GP Dan Poulter will help or hinder efforts to boost exercise uptake

among the general population, but we can only applaud his bravery. Earlier this year he announced that he (and two fellow MPs) had accepted an eight-week fitness challenge from *Men's Health* magazine in a bid to prove that even busy people have time to exercise. Two months of calorie controls and work with a personal trainer left the Tory politician 2.5kg lighter while his body fat dropped from 24 per cent to 18 per cent. Dr Poulter and his colleagues showed off the results of their labour with topless before and after shots in the magazine, whose editorial declared: "If they can juggle work and fitness, you sure as hell can too."

➔ **RE: YOUR CANCER** Some doctors can be reluctant to break bad news to patients – but in Oxford it may be far better for GPs to grasp the nettle. John Radcliffe Hospital is reported to be introducing a strategy where hospital administrators will inform patients they may have cancer if GPs have been less than explicit when using the two-week urgent referral pathway. This is to prevent patients from cancelling appointments or investigations for "trivial" reasons such as going on holiday. Oxfordshire LMCs' chief executive Dr Paul Roblin said: "I do sympathise with both sides, GPs need to play their part in informing patients, but the John Radcliffe has to deal with patients in a sensitive way."

➔ **FREE-FALL BURDEN** Diary has learned that the recent HEE recruitment campaign featuring a GP providing routine sky-diving consent for a patient has sparked reports from dozens of surgeries overrun with parachutists. One PM said: "Just last week our waiting room was stowed out. They turn up in their orange suits and demand emergency appointments. My staff can no longer cope." Another GP commented: "Sure. It's exciting for them but an administrative nightmare for us. No doubt there will soon be calls for a 7-day parachutist consent service."

CALL FOR DIARY ITEMS Do you have any tidbits, anecdotes or absurdities in a similar vein to the items above? Please write in or email them to PM@mddus.com

GP **risk** toolbox



GP's and practice managers can review key risk areas within their practice using the new GP risk toolbox.



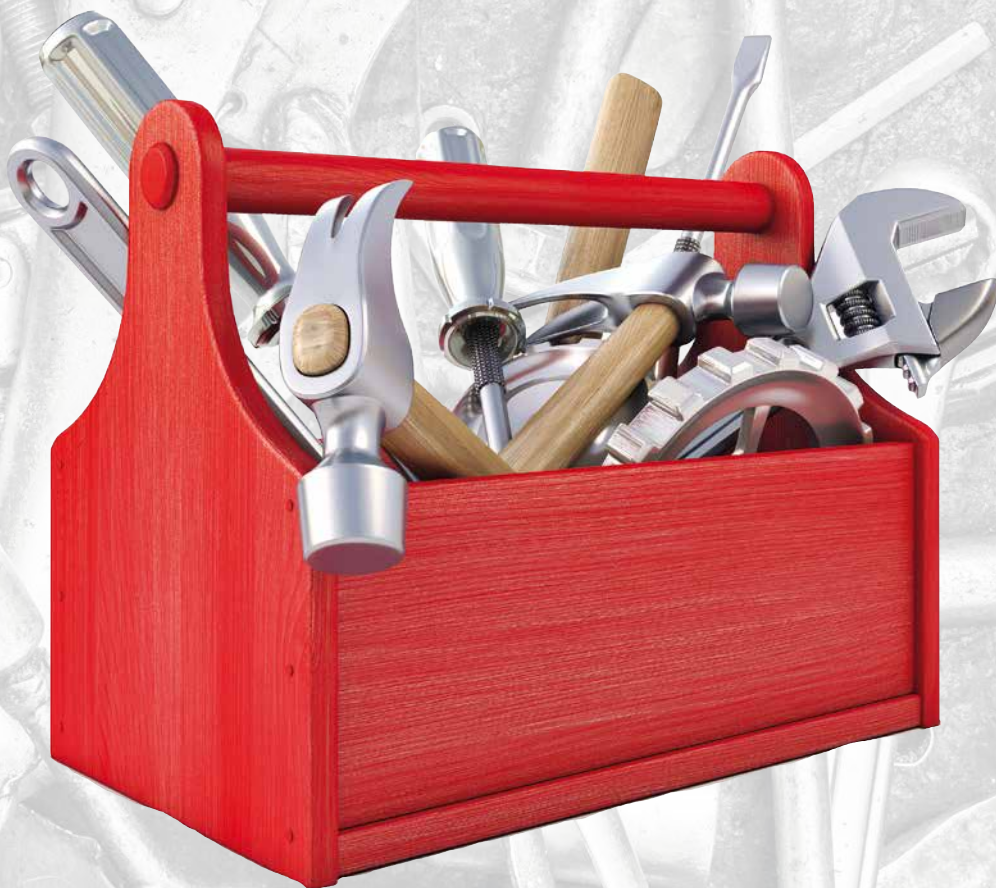
Access video presentations, checklists, eLearning modules, risk alerts, podcasts and more.



Browse a wide range of resources by topic, including confidentiality, results handling, prescribing and record keeping.



Find the GP risk toolbox in the Risk management section of mddus.com or email risk@mddus.com for more information



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