

PRYING INTO PATIENT DATA

Think again before
consulting medical records
without a legitimate cause

DATA PROTECTION OVERHAUL

What is GDPR and why do
you need to know about it?

OVERTIME... AND HOLIDAY PAY

Landmark case decided
on voluntary overtime and
determining holiday pay

A FAMILY AFFAIR

MEET THE TWO SISTERS
BEHIND AN AWARD-WINNING
EDINBURGH DENTAL PRACTICE



SAFE AND SECURE
PROTECTING STAFF AND PATIENTS FROM
CRIMINAL OR "CHALLENGING" BEHAVIOUR

MDDUS
UK INDEMNITY, ADVICE & SUPPORT



JOURNALISTS, politicians and the like often enjoy bandying about acronyms like passwords to some exclusive club. A new one now gaining currency is GDPR. No doubt many practice managers will now or soon know this stands for General Data Protection Regulation. This is an overhaul of European data protection law which comes into effect on 25 May 2018.

Practices are being advised to start taking preparatory steps now as the changes will require time and effort to ensure compliance. On [page 12](#) of this issue MDDUS risk adviser Lindsey Falconer offers advice on the HR implications of the new regulations.

On [page 8](#) Daniel Kirk of the law firm Capsticks addresses practice security. Are you confident about your practice's ability to protect staff from stalking and other aggressive

behaviour by patients or their family members – be it on the premises or online via social media or other digital means?

This issue's profile ([page 10](#)) is of an innovative Edinburgh practice first set up as an NHS "squat" by a young dentist and her even younger sister acting as practice manager. Southside Dental Care recently won Practice of the Year at the 2017 Scottish Dental Awards, and on a recent visit Jim Killgore discovered why.

Our regular Call log on [page 4](#) covers a range of queries as handled by our advisory team from a patient request to amend "inaccurate" records, to GPs offering medical advice to patients holidaying abroad, to HCAs carrying out flu jabs. The Risk column on [page 6](#) offers a reminder of the potentially serious consequences of prying into patients' medical records without legitimate cause, and on [page 7](#) Janice Sibbald discusses the implications of a landmark employment law case which established that voluntary overtime must be included in determining holiday pay.

And finally our case study on [page 14](#) concerns an HRT prescribing error that led to patient concern over an increased cancer risk.

★ **Helen Ormiston**
Editor

TEXT MESSAGING USEFUL BUT HAS RISKS

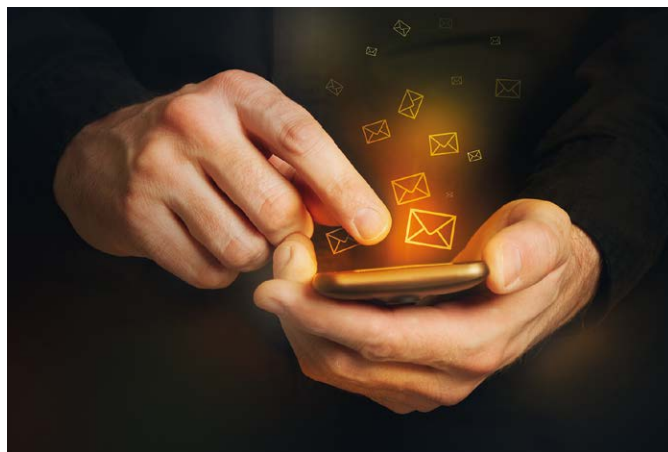
A STUDY of UK GPs has found that 38 per cent now use texting to communicate with patients.

An article published in the *British Journal of General Practice* reported on a telephone survey of 389 GPs to ascertain the prevalence of text messaging. This was followed by longer surveys with selected GPs who use text messaging and those who do not, and a patient satisfaction survey.

Time management was identified as the key advantage among the 80 per cent of GPs who used texting, and confidentiality was reported as the principal concern among the 69 per cent of GPs who did not. Most patients (99 per cent) were happy to receive text messages from their GP.

Data extracted from the IT systems of five consenting practices revealed that the number of text messages sent during the period from January 2013 to March 2016 increased by 40 per cent per annum.

Responding to the findings, Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, commented: "We recognise the potential security limitations of texting, especially to people who share their phones, and GP practices will only send text messages to patients if they have given us permission to communicate with them in this way. In the main, we find our patients welcome this approach."



COVER PHOTOGRAPH: SHANNON TOFTS



UK INDEMNITY, ADVICE & SUPPORT

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MDDUS RISK BITES

WANT to learn more about how to handle a:

- complaint
- significant event review
- negligence claim
- GMC investigation?

Tune in to the MDDUS *Risk Bites* podcast series. Each 20-minute episode offers a fascinating insight into the different ways two practices handle the case of Mrs Roberts, a 51-year-old patient diagnosed with breast cancer.

Learn how to minimise risk across key areas in your everyday practice and explore the latest advice and guidance with our expert risk team.

Find the podcasts at www.mddus.com in the Resources section.





"TELEPHONE FIRST" NO PANACEA FOR GP WORKLOAD

A "TELEPHONE FIRST" system in which GPs speak to all patients to decide whether problems can be resolved over the phone does not necessarily reduce workload, nor is there evidence it saves money, according to a study published in the *BMJ*.

Researchers from the Cambridge Centre for Health Services Research analysed routine health data from 147 English general practices adopting the telephone-first approach compared with a 10 per cent random sample of other practices in England. In a telephone-first system the GP decides whether a health issue can be resolved over the phone or if a face-to-face appointment might be more appropriate.

Adoption of a telephone-first approach led to fewer face-to-face consultations (reduced mean of 13 to 9 per day/1000 patients) and more telephone calls (increased mean of 3 to 12 per day/1000 patients), suggesting that a significant number of issues can be managed on the telephone. But there was an overall increase of 8 per cent in the mean time spent consulting by GPs (albeit with large uncertainty on this estimate).

Wide variation was found among practices in how well the system functioned, with some noting large reductions in workload and others reporting increases – though a telephone-first system was associated overall with an increased GP workload. There was also no significant associated reduction in attendances at hospital emergency departments.



RISE IN WRITTEN COMPLAINTS IN ENGLAND

WRITTEN complaints to GP and dental practices in England increased by 9.7 per cent in 2016/17 compared to the previous year, according to figures from NHS Digital.

Overall there were 208,400 written complaints received by NHS England during 2016/17, which is up 4.9 per cent on the previous year. This figure means that, on average, 571 written complaints were made every day.

Around half (49.8 per cent) of resolved complaints made to primary care providers were upheld and 50.2 per cent were not upheld. Of the total number of primary care complaints involving a service area, 83.2 per cent related to GP surgeries and 14.6 per cent related to dental practices.

Complaints in secondary care rose by only 1.4 per cent in comparison and just over 64 per cent were upheld.

ADVICE ON EMPLOYING PHYSICIAN ASSOCIATES

A NEW guide to employing physician associates has been published by the Faculty of Physician Associates (FPA) at the Royal College of Physicians (RCP).

The guide is intended to enable healthcare providers (including acute hospital trusts, community trusts, and primary care organisations) to understand the role of the physician associate (PA), their scope of practice, and how to employ a PA. It provides advice on:

- the current education and regulatory framework for the profession
- employment and supervision
- tools to help guide appraisal, career and salary progression
- recommendations for continuing professional development (CPD).

Jeannie Watkins, president of the FPA, said: "The physician associate profession is a growing and evolving one. We estimate that there will be just under 600 qualified physician associates in the UK by the end of the year. This is expected to grow to up to 3,200 by 2020.

"Physician associates, in addition to existing members of the healthcare team, are here to add value, capacity and generalist skills to the clinical teams providing care for patients across primary and secondary care."

Access the guide at tinyurl.com/yaddhzrd

DEMAND FOR ACTION ON CHILD DENTAL STATS

NEARLY 42 per cent of children in England are missing out on free dental care, according to new statistics from NHS Digital.

Figures show that 4.9 million children did not attend for a free check-up in the 12 months to June 2017, down by 0.2 per cent on 2016 figures despite NICE guidelines recommending children should be seen by a dentist at least once a year.

Nearly half (48.6 per cent) of adults in England have not seen an NHS dentist in the last two years – a total of 21 million – a slight rise on 2016 figures (48.2 per cent).

Polling for the BDA has revealed major gaps in awareness among parents on eligibility for free dentistry, with one in four parents unaware that routine check-ups are free for children aged under 18. In the last *Adult Dental Health Survey*, 26 per cent of respondents reported that the type of dental treatment they opted for had been affected by cost – and almost one-fifth (19 per cent) said they had delayed dental treatment for the same reason.

The BDA believes these figures reflect a "continued failure" by government to deliver a coherent oral health strategy and effective public engagement. The organisation advocates a shift to a "genuinely preventive contract" for NHS dentists in England and a national programme to tackle decay, modelled on successful initiatives in Scotland and Wales.

Henrik Overgaard-Nielsen, Chair of General Dental Practice at the BDA, said: "The fact nearly 5 million children are missing out on free dental care is nothing short of a national disgrace."



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.

DISPUTED RECORDS

Q A disgruntled patient who has decided to leave our practice recently requested a copy of his medical records. We provided these and he has now submitted an angry written complaint over an entry made a year ago in relation to what the patient states is an erroneous diagnosis. He disputes the entry and wants it removed before his records are transferred. How should we respond?

A Both the Data Protection Act (DPA) and the General Medical Council (GMC) state that a doctor's clinical opinion should remain in the notes if it was a reasonably held belief at the time and is relevant to the patient's care. A patient who disagrees with such an entry is entitled to add their own annotation to the records in response. In this case a letter providing the patient clarification of your position on the matter and informing him of his rights in the matter would be reasonable. You should also advise the patient that if dissatisfied with your response he can contact the ombudsman or the Information Commissioner's Office, which handles compliance with the Data Protection Act.

DENTAL INDEMNITY EXCLUSIONS

Q One of our staff recently saw a notice from the BDA urging dentists to check the small print on their indemnity policies to ensure they are appropriately covered. The warning involved a recent GDC case in which the adequacy of a registrant's cover was questioned as the policy contained exclusions relating to the transmission of blood-borne diseases. Does your standard indemnity policy include such exclusions?

A We have been contacted by a number of dental members in regard to this issue.

The case apparently led a GDC panel to conclude that the registrant's policy did not fulfil Standard 1.8 within *Standards for the Dental Team*: "You must have appropriate arrangements in place for patients to seek compensation if they suffer harm". Our standard indemnity policies at MDDUS do not include exclusions for specific risks such as failure to prevent the transmission of blood-borne diseases.

FLU JABS

Q We have a large number of patients due to come in soon for their flu jab. One of our nurses has just gone off sick and is not expected back for a couple of months. Can our healthcare assistant (HCA) step in and help? She has the appropriate training.

A Many HCAs are well-trained and competent to administer vaccinations, but it is the prescribing of the vaccine, and the assessment of the patient prior to that, which is the issue. The majority of NHS flu vaccinations provided are prescribed via patient group directives (PGDs). These 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 an 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. This assessment should be documented and contemporaneous to the administration of the vaccine.

ADVICE FROM ABROAD

Q Our medical practice has been receiving an increasing number of calls from patients while abroad on holiday or business. We operate a triage system so patients are accustomed to telephone advice. Our policy has always been not to offer overseas call-backs on the grounds of cost but now calls to mobiles are no more expensive than those within the UK. However, we are still concerned that in advising patients not currently present in the UK we may be offering a service that is not indemnified. Can you advise?

A If a patient contacts the surgery for assistance whilst outside the UK, it is important to understand the associated risks. Administrative requests (such as for a repeat prescription due upon their return or for an appointment) can usually be responded to in the normal manner. But when a patient is requesting medical advice, it is very important to be aware of the obvious risks in being unable to assess the patient properly in order to make a diagnosis – and also the increased risks associated with treating



patients in other countries. MDDUS is a UK-wide indemnity organisation and provides assistance to members for actions raised against them within the UK. Members would NOT be represented if action was taken against them in another country where harm had arisen as a result of their provision of advice. Because of this, we would strongly advise that members do not offer any medical advice in relation to a non-recurrent illness to a patient who is overseas, but that they encourage that patient to see a local medical practitioner.

ACCESSING TWIN RECORDS

Q Our practice has two patients who are twin girls age 12. Mum and Dad are divorced but both share parental responsibility. We have received a request from Dad to come into the practice to view the twins' medical records. He has since remarried and wants to bring his new wife – a qualified nurse – with him to review the records. Are the twins old enough to consent to this or do we need to contact Mum for permission?

A All children with "capacity to consent" have the right to allow or prevent access to their medical records. In England there is a presumption of capacity at the age of 16 but children will often have capacity for many decisions before this age. You should first establish if either of the twins has the capacity to decide whether their father and, secondly, their stepmother can have access to their notes. We would suggest you talk to both girls separately to determine whether they understand the nature of the disclosure, its purpose and any possible consequences. A child will have capacity if they are able to understand and retain this information, weigh it up and then communicate their decision. Should each individual girl be judged to have capacity and agree to her notes being disclosed to her father and stepmother then you may do so, subject to redaction of third party or significantly harmful information. Should either girl refuse to consent you should respect her wishes, unless you feel she or someone else would be at risk of serious harm if you did not disclose relevant information. In the latter situation we would recommend seeking further and more specific advice from MDDUS prior to disclosure.

NURSE RECEPTIONIST

Q Our receptionist is a former dental nurse and, because of her experience and knowledge, she is able to respond to some dental queries from patients. Should she be registered with the General Dental Council?

A Registration with the GDC is only required for those who wish to work as a dentist or dental care professional in the UK. This would not normally include the work of practice receptionists. However, you should have clear policies and protocols that detail what she can and cannot say to patients so that she does not stray into what could be classified as the practice of dentistry.

ABUSIVE PATIENTS

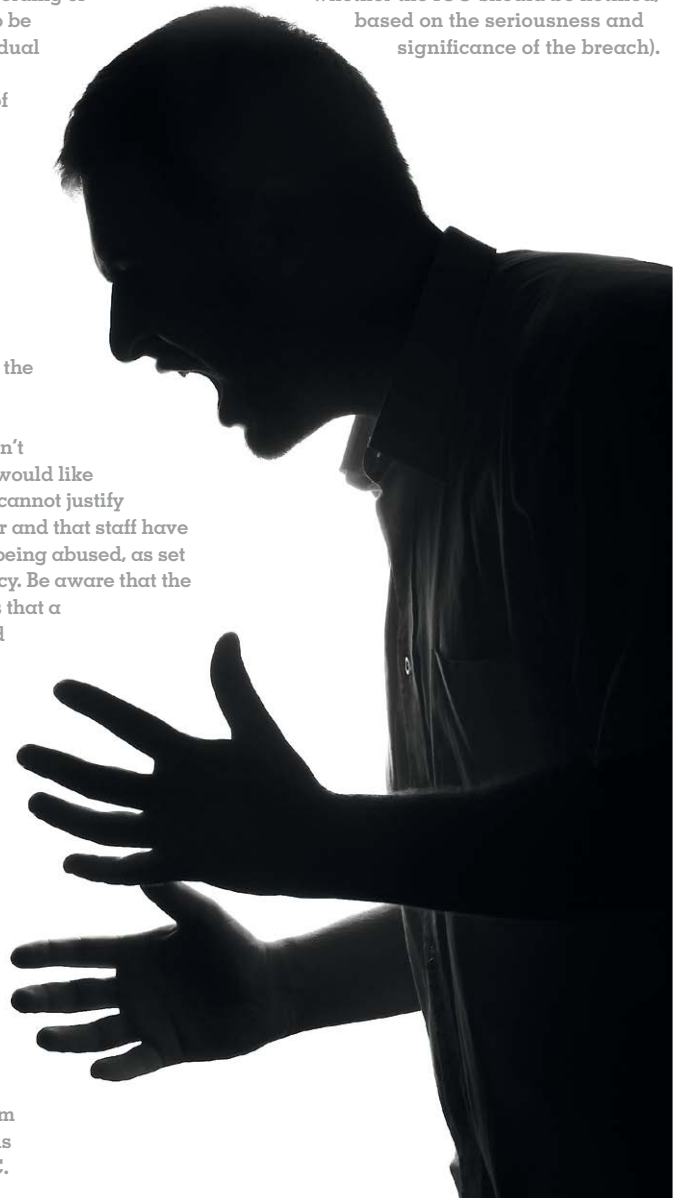
Q Our practice has in recent years seen a rise in incidents involving rude and abusive patients. Could you advise on a standard template letter we could send to such patients setting out our zero tolerance policy and with a warning about possible removal from the patient list?

A In recent years, use of the term 'zero tolerance' has come under increasing criticism in the NHS, as it does not take into account behaviours that may be explained or mitigated through mental illness and other disorders, challenging behaviours in learning disabilities and other contributory factors. 'Zero tolerance' approaches may also fail to consider personal thresholds for unacceptable behaviour. What may be offensive or unacceptable to one member of staff may be viewed as understandable or tolerable by another. What's important is that organisational policy recognises that it is the individual's perception of what is acceptable or unacceptable that is important. We would suggest using different terminology in referring to your policy, such as 'unacceptable behaviour'. In regard to warning letters we would advise that the wording of warning letters needs to be considered on an individual basis depending on the patient and the nature of the inappropriate behaviour. Warning letters should be detailed, setting out the specific issues, incidents and dates involved. It would also be reasonable to acknowledge that there may be some reason for the patient's behaviour: e.g. "I understand it may be frustrating when you don't receive the service you would like but..." adding that this cannot justify inappropriate behaviour and that staff have a right to work without being abused, as set out in your practice policy. Be aware that the GMS contract stipulates that a patient should have had a warning in the last 12 months before being removed to give them a chance to change their behaviour. Exceptions to the need for a warning include patients moving out of the practice area or if it is considered that a warning may put the patient or others at risk. The letter should also set out steps for the provision of alternative care in the event of removal from the list. More guidance is available from the GMC.

WRONG PATIENT

Q A patient came into the practice yesterday to pick up a prescription but later discovered she had been given one belonging to someone else. She has made a complaint about it. What should I do?

A The first step would be to draft an appropriate response, including an apology for what is clearly a breach of confidentiality. An MDDUS adviser can offer detailed advice on the wording of the response, but you should explain how the incident occurred and set out the steps the practice will take to ensure it does not happen again. It may be advisable to conduct a significant event analysis to review what happened and highlight any weak points in the practice's processes that need to be addressed. You should also contact the patient whose prescription was disclosed in error to inform them of the breach, offering a similar apology, explanation and details of how the practice will change. The breach should be recorded through the NHS Digital Toolkit as is required for general practices in England (elsewhere the practice should consider whether the ICO should be notified, based on the seriousness and significance of the breach).



Prying into patient data

A SPATE of recent cases has prompted the Information Commissioner's Office (ICO) to remind all NHS staff about the potentially serious consequences of prying into patients' medical records without a legitimate reason. The most recent case to be highlighted is one of five ICO prosecutions involving staff illegally accessing health records.

The ICO warning came after a former midwifery assistant at Colchester Hospital University NHS Foundation Trust, who described herself as "nosy", was ordered to pay a total of £1,715 in fines and costs after pleading guilty to offences of unlawfully obtaining and disclosing personal data. A local investigation was prompted following a patient complaint, which established that she had accessed the records of 29 people, including family members, colleagues and others, over a two-year period using her trust's electronic patient record system.

Some of this information was found to have been shared with others and came to light when someone discovered their medical records had been seen by an ex-partner. This was not only a breach of patient confidentiality but also of the Data Protection Act 1998.

The Head of Enforcement at the ICO Steve Eckersley said: "Once again we see an NHS employee getting themselves in serious trouble by letting their personal curiosity get the better of them."

"Patients are entitled to have their privacy protected and those who work

Alan Frame offers a reminder of the potentially serious consequences of prying into patients' medical records without legitimate cause

with sensitive personal data need to know that they can't just access it or share it with others when they feel like it. The law is clear and the consequences of breaking it can be severe."

Other recent cases include:

- an administrative employee of a general practice in Wales who was prosecuted for accessing the sensitive medical records of two patients without consent
- a former clerical officer employed by Portsmouth Hospitals NHS Trust who accessed the sensitive medical records of two estranged family members on numerous occasions over a five-month period, obtaining new addresses
- a former nurse prosecuted for accessing the sensitive medical records of over 3,000 individuals, which included the records of hospital staff.

All of these constituted offences under section 55 of the Data Protection Act and resulted in significant fines and a criminal record for the individuals concerned.

This warning serves to highlight that all personal information contained within a medical record is classified as "personal sensitive data" under the act, which means that all data controllers and their employees and representatives must take particular care to safeguard this data.

The ICO can take action to "change the behaviour" of organisations and individuals that collect, use and keep personal information improperly. This includes non-criminal enforcement and audit, or criminal prosecution. At present the ICO also has the power to impose a monetary penalty on a data controller of up to £500,000.

It's also apparent from the outcome of these recent cases that the offenders were subject to disciplinary action by their employers, with the possibility of scrutiny by regulators. Indeed, the GMC states in its new *Confidentiality* guidance: "You must not access a patient's personal information unless you have a legitimate reason to view it." MDDUS also reminds members that in any criminal prosecution under section 55 of the Data Protection Act 1998 it is unlikely that they would be indemnified under the terms and conditions of their membership.

ACTION

- Medical records must never be accessed without a genuine clinical or administrative reason. With modern electronic patient management systems, a clear audit trail is present which can be examined to determine who has accessed a patient record and when.
- Practices and other data controllers must ensure that they have clear policies for employees in relation to accessing medical/dental records on a need-to-know basis. Providing access to regular knowledge updates and training in this area is an important way to mitigate organisational risk, ensuring staff are reminded of their responsibilities.

**Alan Frame is
a risk adviser
MDDUS**

at



Overtime and holiday pay calculations

Janice Sibbald reports on a landmark case establishing that voluntary overtime must be included in determining holiday pay

EMployees in most practices are contracted to work a set amount of hours in any week, but the reality is that when cover is required for periods of sickness or annual leave, staff regularly work additional hours. So is it fair or even illegal that annual leave calculations do not reflect actual working time or pay?

A recent landmark case before the Employment Appeal Tribunal (EAT) addressed this issue and held that any payments for voluntary overtime should be included in holiday pay calculations if they are regular enough to constitute "normal pay".

In the case - *Dudley Metropolitan Borough Council v Willetts and Others* - five employees brought a tribunal claim against their employer on behalf of 56 other employees. The workers were employed to repair and maintain council houses and were contracted to work a set number of hours (usually 37). In addition they undertook extra voluntary duties, such as working out-of-hours standby shifts, attending call-outs and voluntary overtime. These voluntary payments, however, were excluded from calculations of holiday pay and the workers argued that this was contrary to the Working Time Regulations 1998 (WTRs).

The EAT ruled in the workers' favour, confirming that amounts over and above normal pay should be included in calculations if they are 'intrinsically linked' to performance of the contract. The tribunal accepted that staff could "drop on and off the rotas to suit themselves whether day by day, week by week, month by month or permanently"

and additional work was "almost entirely at the whim of the employee, with no right to enforce work on the part of the employer".

This case has provided employers with some clarity over the position of voluntary overtime, although what constitutes "regular" is still rather muddy! We suggest that practices may want to look back every 12 weeks to overtime records to enable them to calculate additional holiday pay for those employees that work regular overtime.

OTHER RELEVANT CASES

A few other recent cases are also relevant to the area of holiday pay. In *Williams and others v British Airways plc*, the European Court of Justice held that holiday pay should include not just basic salary but remuneration linked to the performance of tasks that a worker is required to carry out in their contract of employment. In this case the calculations must include 'flying pay' and 'time away from base sums'. Whilst this may not be relevant to a medical or dental practice it further demonstrates the complexity in this area.

More helpful guidance came in *Lock v British Gas Trading* when it was decided that

sales commission should also be included in overtime calculations. Mr Lock, a sales consultant with British Gas, claimed in an employment tribunal that he was owed money on the basis that his holiday pay did not reflect what he would have earned from commission. On top of his basic pay, he was paid monthly commission which fluctuated based on his sales and this was to be included in the calculations.

The case of *Fulton v Bear Scotland* concerned overtime that a worker is obliged to work when available but which is not guaranteed by the employer. The EAT held that such "non-guaranteed compulsory overtime" constitutes part of the worker's normal remuneration and as such should be included in calculating the worker's holiday pay.

WATCH THIS SPACE

The position of voluntary overtime remained unclear until we had the ruling of *Dudley*, however the EAT cautioned that each case must be determined on its own facts and it is up to employment tribunals to determine whether or not overtime payments are sufficiently regular and settled to require inclusion in holiday pay. So watch this space for further clarity as more cases come through the courts.

If you need any further guidance on this complex area of employment law, then please contact one of the employment law advisers at MDDUS.

Janice Sibbald is an employment law adviser at MDDUS

“AMOUNTS OVER AND ABOVE NORMAL PAY SHOULD BE INCLUDED IN CALCULATIONS IF THEY ARE 'INTRINSICALLY LINKED' TO PERFORMANCE OF THE CONTRACT”

Ensuring a safe and secure work place

Solicitor **Daniel Kirk** explores the steps practices can take to protect staff and other patients from criminal or "challenging" behaviour

RECENT research published by the *BMJ* shows a nine per cent increase in recorded crimes on GP premises and health centres. This is against a backdrop of a rise in overall recorded crime of ten per cent and so is not, in itself, a cause for undue alarm. It is, however, a timely reminder to think about what appropriate action should be taken to ensure safe practice premises for staff and patients.

Given the thousands of patients visiting GP premises and health centres every day, the actual numbers of recorded crimes are relatively low. In 2016/17, there were 2,147 incidents, 339 assaults, 55 cases of harassment and 321 public order offences such as threatening behaviour. For the individual victims, of course, the effect may be life-changing. Managing difficult patients can also be challenging for a practice but there are effective ways to help protect staff.

LEGAL OBLIGATIONS

The obligations on a practice to address such issues will arise from various sources and from its roles as employer, service provider and owner (or tenant) of a premises.

Key relevant legal obligations include:

- ensuring as far as is reasonably practicable the health and safety of employees, patients and visitors to the premises (Health and Safety at Work etc Act 1974)
- security arrangements to make sure that people are safe while receiving care (CQC Fundamental Standards Regulation 15)
- sufficiently trained staff (CQC Regulation 8).

RISK ASSESSMENT

As with many health and safety obligations, the starting point in addressing required and recommended actions is to conduct an adequate risk assessment. The basic purpose of the risk assessment is to identify hazards, evaluate risks and implement, monitor and review measures to reduce the risks – in this case potential aggressive behaviour to staff and other patients. The Health and Safety Executive (HSE) even has specific guidance on assessing workplace violence in a health and social care setting.

The followings areas are likely to be of note in a risk assessment for GP premises:

- The physical environment. Are access ways well-lit and visible?

Are there good lines of sight? There is various guidance showing how the impact of colour palette, signage and layout can help reduce and better manage the risk of patient violence. One study reported a 50 per cent reduction in violent incidents in A&E as a result of design and signage changes.

- Do you have lone workers or those conducting visits? What reasonably practicable measures can be put in place to address additional risks?
- Do staff receive appropriate training, such as basic techniques in managing challenging behaviour or de-escalation, with greater training for those in higher risk situations?
- Are there appropriate policies and procedures in place for handling incidents, emergencies and particular high-risk patients, and dealing with threatening patients, such as warning letters and acceptable behaviour agreements?
- Is appropriate equipment available, such as panic buttons or alarms?

SERIOUS CONSEQUENCES

Failure to have adequate systems in place can have serious consequences. For example, a staff member injured by a patient could bring a claim for financial compensation for harm, or in an employment tribunal. The employer could also face a health and safety prosecution.

Although a criminal prosecution normally follows an incident in which someone is harmed, an employer or service provider can be charged for simply creating a risk of harm. Following a change in sentencing guidelines, fines for health and safety breaches are now based on an organisation's turnover and can, in certain circumstances, run into hundreds of thousands of pounds. There have been a number of prosecutions, for example, of NHS trusts failing to take adequate steps to protect staff who have then been the victim of serious, or even fatal, injuries from patients.

Commonly, issues arise from the systems around assessment or treatment of mental health patients. Whilst the risks may be less prevalent in general practice, isolated violence and sustained aggressive behaviour do occur.

DEALING WITH SERIOUS THREATS

Cases of stalking of a GP by a patient are thankfully rare but not unknown. In recent years a male patient was imprisoned for a campaign of harassment against a female GP which led to serious mental health consequences.

A common sense approach to dealing with violent incidents includes contacting the police as a first port of call. It is also important to keep a log of events in case the acts become repeated by a particular individual and evidence is needed to pursue formal action, or patterns emerge which can be assessed to help reduce risk.

Interestingly, the Criminal Justice and Immigration Act 2008 created an offence and power to remove from certain NHS premises those creating a nuisance. The legislation does not cover GP premises but rather hospital and other facilities operated by an NHS Trust or Foundation Trust. Options that GPs do have include removing an individual from the practice list if certain criteria are met. There is a careful process to follow but violent or threatening behaviour can be grounds to justify removal of a patient from the list.

Practices should have a policy on dealing with difficult behaviour, such as escalating correspondence and setting out how decisions will be taken, including clinical input. These steps often act as a pre-cursor to removing a patient and help establish a clear and reasonable process for the practice to follow.

In cases of harassment or violence, the police have a range of powers that can be used and there are various criminal offences. Liaising with MDDUS and police would be the first recommendation. In certain circumstances, a practice might consider taking action itself. The Protection from Harassment Act 1997, which creates a criminal offence of harassment, also gives a civil court the power to issue an injunction (a court order) preventing someone from carrying out acts of harassment against other specified individuals.

The threshold for acts that constitute harassment is relatively high and to obtain an injunction it is necessary to show a course of conduct causing alarm or distress. In 2012, that Act was updated to include specific offences and remedies in relation to stalking. Whilst seeking an injunction from the court comes as something of a last resort, Capsticks have successfully obtained them: for example in regard to the release from a psychiatric unit of a patient known to be fixated on a former healthcare professional still living in the area.

WHAT TO TAKE AWAY

Here are some key tips to consider for protecting practice staff and complying with legal obligations:

- Have the environment and staff procedures been risk assessed and identified actions completed?
- Can the physical environment be adapted to be safer?
- Ensure policies are up-to-date (dealing with violent patients, lone working etc).
- Make sure staff are trained in how to respond.
- Are appropriate equipment and safeguards in place?
- Keep a record of any incidents that take place, and consider 'debriefing' staff.
- Where appropriate, report incidents to the police.
- Seek further advice if necessary.

Daniel Kirk is an associate in the litigation division and member of the dedicated GP team at Capsticks Solicitors LLP



SISTER ACT

Jim Killgore visits an award-winning Edinburgh dental practice that is truly a family affair

IN 2008, Leanne Branton opened a “squat” NHS dental practice in a former GP surgery in Edinburgh. Starting such a business from scratch would be a daunting prospect for any dentist but for a 27-year-old only five years out university it seemed particularly audacious.

Leanne had been working as a part-time associate dentist at Optical Express but also doing sessions for the prison service and as a civilian dentist for the army.

“I had decided that I wanted to own a practice and just kind of rolled with the idea and it snowballed,” she says. “I soon realised that I had the dental skills but very little management skills. It’s an area I’d not done any training in; there’s not an awful lot of it in dental school.”

But it just so happened that help was close at hand. Leanne was then sharing a flat with her younger sister Aimi, who had a background in hospitality and retail management and at the time was running a nightclub. Together they hatched a business plan that was to evolve into Southside Dental Care – a mixed NHS and private practice which in 2016 was awarded Best Team, Best NHS Practice and Practice of the Year at the Dentistry Scotland Awards.

Leanne is the owner and sole trader of the practice which employs five associate dentists and six dental nurses and a hygienist. Aimi is practice manager.

I visited with the sisters recently at the practice which is located in a converted Victorian villa in the leafy Mayfield district of Edinburgh. Speaking nearly 10 years since opening they still seem genuinely amazed at what they’ve achieved.

“It was a steep learning curve,” says Leanne.

“Very steep,” echoes Aimi. “We were a bit ambitious because we opened our doors with three dentists and no pre-existing patient list. We did a lot of flyering, a lot of ground work in the six weeks leading up to the practice opening, building up the books and getting patients booked in and ready and waiting.”

Managing the refurbishment of the building before opening was an even wider family enterprise involving their father – a chartered surveyor.

“It took six months to get the building in shape,” says Leanne. “It was much harder in retrospect than it would have been to build from scratch. We had to respect a lot of the original features, but it does create a lovely clinic.”

Having no experience running a dental practice, Aimi had to quickly get to grips with day-to-day issues such as implementing standard HR and health and safety policies, understanding NHS reimbursement and developing an ongoing marketing plan to name but a few.

“I had done policies in my previous job but this was all new. The BDA is a wonderful resource – and the NHS practice support manual.”

Leanne adds: “We were also very fortunate to have advice from some of my previous employers who were actually very supportive, sharing policies and guidelines.”

VISION

From the start Leanne and Aimi were determined to run a mixed NHS and private practice very much focused on quality patient care across the board.

Says Leanne: “I had the privilege of working in a really busy NHS practice as a VT and a learning associate. It was fantastic. Then I went into private dentistry – and enjoyed that as well. But I just felt there



Practice manager Aimi Branton-Bouglas (left) and dentist and owner Dr Leanne Branton

PHOTOGRAPH: SHANNON TOFTS



had to be a halfway point that at that time didn’t really exist. It does now – and I think it is becoming much more common.”

Aimi adds: “We offer the same level of service regardless of whether you are spending £10.88 on a scale and polish or £2,500 on an implant. We treat all our patients with the utmost respect and care. It’s a lot more personal as well.”

They attribute the steady growth in patient numbers to this emphasis on a quality personal service – building relationships with patients and focusing on the “patient journey” from first contact on the phone or via Facebook to walking through the door to dental examination and treatment to follow-up.

“I think that’s why we’ve grown so quickly,” says Leanne. “We spent a lot of time in the beginning forming these relationships with the patients. The fact that so many are still with us and that we are still growing reflects that.”

The practice currently has over 9,500 patients on its list. In order to accommodate the demand they run three surgeries on two six-hour shifts: 8 to 2 and 2 to 8. “We are getting pretty tight now,” Leanne admits.

In addition to standard care Southside Dental offers implant treatment with Leanne undertaking basic cases and a visiting implant surgeon handling the more complex ones. Two associates do facial aesthetics, marketed under the separate name of Southside Skin Clinic. The practice also offers a special service for nervous patients, including the option of conscious sedation for those with serious dental phobia.

DRIVE

Another unusual aspect of the practice is the fact it is almost entirely female. Leanne insists this is not by design but mainly because they see a much higher proportion of female applicants for training posts.

“It’s unclear whether they are personally targeting the practice or just because now there’s a greater number of female graduates. But in the seven years we have been training the ratio has hugely changed. And the females are very strong candidates. There’s no doubt. They seem very driven.”

It may also reflect the fact that Leanne and Aimi are clearly very driven – and yet in conversation there is none of the tension you might expect from siblings, both of them quick to laugh and constantly interrupting each other. So what about the pitfalls of working with family?

“Everybody asks that,” replies Leanne. “But to be honest I wouldn’t have it any other way. It works for us and it always has. We never saw it as an issue.”

Aimi is quick to agree: “There’s nobody I trust more than Leanne. Having clinical and admin sides we mesh well together; we kind of form that one unit.”

“Trust is a huge issue,” Leanne adds. “For example, going off on maternity as a practice owner is incredibly scary. Knowing that you are leaving it in the hands of someone you trust is fantastic.”

QUALITY CARE

Whatever the formula, it is clearly working. Winning the three gongs at the 2016 Dentistry Scotland Awards was a total surprise, says Leanne. And last year they won another one for Practice of the Year at the 2017 Scottish Dental Awards.

“I think it comes down to the team,” says Leanne. “That’s the crux of it. We have a great team that have worked together for a long time and who have a wide variety of skills... We have a real focus on consistency of patient care. And I think we are constantly trying to push as well. That’s a big thing. We’re not complacent. We know we have to change to keep up with the times.”

Leanne says they would like to expand the business, even though they are now struggling with limited space at the clinic. Both sisters also have young families which makes work-life balance much more of a challenge.

“But I am always looking at how we could grow this business and potentially open other clinics,” says Leanne. “Because we do love it.”

Aimi then laughs and adds: “We still have time. We’re older but not finished yet! Maybe once the kids are at school.”

Jim Killgore is managing editor of Practice Manager

GDPR may sound more like a name for the new high-speed rail link but be assured it will be arriving at organisations across the country on 25 May 2018 and everybody will have to get on board.

The GDPR or General Data Protection Regulation is an overhaul of data protection law, which hasn't been updated since the Data Protection Act came into being in 1998. Practices are being advised to start taking preparatory steps now as it will require time and effort to ensure compliance. Perhaps the first and most important step is to make sure that your partners and all levels of management in the practice are aware that the law is changing and what likely impact this is going to have.

Much of the focus in primary care thus far has been on the changes applying to patient records, but practice managers must remember that the new regulation also applies to the information you hold about your employees. So what is GDPR going to mean for you and the way you handle your employee data?

PRACTICAL IMPLICATIONS

The GDPR will apply to "personal data", meaning information that relates to an identifiable living person. The definition is broad and, in the employment context, will include personnel records including sickness absence, performance appraisals, recruitment notes and any other information held about your staff.

The regulation is concerned with the "processing of data". For example, this could be running the monthly payroll or using an employee's data to refer them to occupational

storing it (the more personal data you have the greater the risk of a breach)?

- Who am I sharing that personal data with? This information would form the basis for your "privacy notice" (see panel opposite).

LEGITIMATE PROCESSING

To be able to process your employees' data legally, you have to be able to show that there is a legitimate basis for doing so. An example of this could be that it is necessary to process the data for "compliance with a legal obligation". An illustration of that would be sending information to the HMRC after each pay run.

The processing principles of the GDPR all existed under the Data Protection Act (DPA) 1998 but some have been refined. The Information Commissioner's Office (ICO) has said that if organisations have been complying with best practice under the DPA then they probably won't have too much work to do. However, as an employer, you are responsible for showing compliance with the principles and are therefore accountable in the eyes of the ICO.

The overriding principle in dealing with any personal data is that you are fair and

What is GDPR and why do you need to know about it? Risk adviser Lindsey Falconer offers some answers on new data protection regulations

from the practice system or send personal emails from their business account? Do you have a fair use policy which outlines when staff can access the internet for personal use (e.g. at lunchtime) and are staff aware that you can monitor their usage and the sites they access through their computer's IP address? Can they access personal email accounts and online banking from their work PC? If you have call recording, do staff know that you might use this for training and assessing their performance?

Why would you want to monitor these things? You could argue that you have a legitimate interest in protecting your business: for example you have the right to try to prevent viruses from coming into your IT system. However, you also need to respect the personal privacy of your staff. It's a balancing act between a legitimate interest in monitoring and the right to privacy for staff.

Data subject access rights is another area that has small but significant changes to it. Currently, the Data Protection Act 1998 enables employees and ex-employees to ask to see the information that you hold about them. You would currently have to comply within 40 days. Once the GDPR is in place you will have to comply "without undue delay" but definitely within one month. You will also no longer be able to charge a £10 fee.

The points above give a flavour of the things that practices need to start thinking about. Check the ICO website as it is continually being updated with information about the GDPR as it becomes available.

Note that the penalties for breach of the regulation are high - up to 4 per cent of turnover or £17.8m (€20m) - whichever is

Protecting emplo

health. This applies whether the practice is private or NHS. Be aware that job applicants will also be covered by the same legislation. Even though they are not employees, you are still processing their personal data.

So what are the practical implications for employers? As a starting point to compliance with the GDPR it would be useful to start thinking about the following:

- What categories of personal data do I process as an employer of staff?
- What do I do with that personal data?
- Why do I do this - what is the legal basis for processing it?
- Is it necessary for me to be processing all the personal data that I have and/or

transparent in what you do with it. The GDPR increases this transparency by making it obligatory for practices to inform employees about what they do with their data, including any relevant data retention policy.

This would take the form of a privacy notice. It is a requirement that the privacy notice is concise, intelligible and easily accessible (see the panel opposite for help on how to create a privacy notice).

OTHER IMPLICATIONS

Among other practical implications for consideration is how you monitor staff activities. Do you have CCTV in staff areas? Do you allow staff to make personal phone calls

higher. So thinking and planning now about GDPR is certainly an investment worth making.

Action points

- Examine your existing data systems and the personal data you process.
- Review your current documentation relating to data protection and familiarise yourself with the requirements for privacy notices.
- Consider any practical ways that you monitor employees to assess proportionality.

Lindsey Falconer is a risk adviser at MDDUS



yee data

PRIVACY NOTICE CHECKLIST

The GDPR places emphasis on the documentation that data controllers must keep in order to demonstrate accountability. You should document what personal data you hold, where it came from and who you share it with. When you collect personal data you have to give people certain information, and in the context of personnel records you would have to provide that information to all of your employees. The following general checklist will provide a template for doing so. More information could be added if required.

What should be included?

- Who is collecting the information (i.e. the name of the data controller and the data protection officer)? Normally the data controller will be the legal entity, which would be the practice name. The data protection officer would be the named person who is the contact for queries; probably the practice manager or an identified GP.
- What personal information do you hold?
- How is the information collected?
- Why is it collected?
- How will it be used?
- Who will it be shared with?
- What will be the effect of this on the individuals concerned?
- Is the intended use likely to cause individuals to object or complain?
- What are you doing to ensure the security of personal data?
- Information about employee's right of access to their data.
- What is the retention period for the data?

How should the checklist be presented?

- Use clear, straightforward language.
- Adopt a style that your employees will all understand.
- Don't assume that everybody has the same level of understanding as you.
- Avoid confusing terminology.
- Be truthful.

Once you have your privacy notice

- Test your draft privacy notice with users.
- Amend it if necessary.
- Roll it out to everyone.
- Review and update as necessary.

The privacy notice doesn't have to be one big document. If it becomes too unwieldy, you might consider using a layered approach where key privacy information is provided immediately and more detailed information could be provided elsewhere, such as on your shared drive. The important thing is to make sure you have been transparent and provided accessible information to your employees, as this is a key element of the GDPR.

HRT error

Day one

MRS A is 52 years old and attends the surgery for a routine HRT check. She is seen by a GP registrar – Dr K. The patient has had menopausal symptoms for the last four years and has been taking Prempak C and wishes to continue with this medication. Dr K discusses the risks/benefits of continuing HRT and an informed decision is made to reduce the dose and monitor. Dr K enters the prescription into the system and Mrs A is provided with a script.



Month six

Mrs A returns to the surgery complaining of PMB (post-menopausal bleeding) and is seen by another GP – Dr S. Examination reveals no abnormalities and the patient is referred to the local gynaecology clinic for assessment. An ultrasound reveals a thin and regular endometrium, and the patient is advised to return to her GP if the bleeding continues.



Month 13

The consultant gynaecologist writes to both the practice and Mrs A about the long-term effects of unopposed oestrogen HRT with an intact uterus and advises that the risk of serious complications from the prescribing error is low but suggests an annual ultrasound scan to ensure that the womb lining remains stable.



Month 12

Another GP at the practice – Dr N – sees Mrs A who is still experiencing PMB. A transvaginal scan is arranged at the gynaecology clinic which shows a thickened endometrium. A biopsy is taken but the sample proves inadequate so a hysteroscopy is arranged. This reveals a normal-sized uterus with no polyps or fibroids but the histopathology report notes a proliferative polypoid endometrium consistent with ongoing oestrogenic stimulation, though with no evidence of endometriosis, hyperplasia or malignancy. The reviewing consultant gynaecologist suspects that this is indicative of the patient taking oestrogen-only HRT and on further investigation it is revealed that Mrs A has been mistakenly prescribed the unopposed oestrogen HRT Premarin rather than the combined oestrogen and progesterone medication Prempak C. Mrs A is advised by the practice to discontinue taking the Premarin and she opts to come off HRT entirely.



THE practice later receives a letter from solicitors on behalf of Mrs A intimating a negligence claim. It is alleged that, due to the prescribing error made by the GP registrar and the subsequent failure by the practice to detect the mistake, the patient has had to endure unnecessary invasive procedures and unpleasant symptoms including bleeding, hair loss, lack of sleep, abdominal and back pains. There is also concern over the ongoing risk of complications.

MDDUS undertakes representation of the GP partners in the practice; the GP registrar is indemnified by the NHS. A lawyer reviews all the relevant documents including the patient notes and a practice SEA (significant event analysis). The prescribing error is attributed to inexperience on the part of the registrar – but also in part due to the two medications being similar in name and appearing together on a drop-down menu in the practice system.

The SEA concludes that all future HRT prescribing should be double-checked to establish whether the patient has an intact uterus – and a further checklist should be implemented at each HRT review.

A GP expert report is deemed unnecessary in the case as prescribing unopposed oestrogen in these circumstances (and the failure to correct the error in review consultations) is clearly indefensible. A medico-legal expert in gynaecology is consulted

regarding the consequences of this incident. She states that it is clear the prescribing error would have led to a thickened endometrium and bleeding but this would not necessarily have required hysteroscopy/biopsy under general anaesthesia. This was primarily a result of inadequate sampling in the first referral.

In regard to ongoing risks the expert states that in her opinion there is no significant risk remaining now that the oestrogen-only HRT has been stopped. She also does not believe that the symptoms described by the patient can be solely attributable to the prescribing error as Mrs A had been complaining of menopausal symptoms for years before her consultation with Dr K.

MDDUS does, however, deem the case too risky to contest in court and decides to settle for a small sum in agreement with the members, along with a contribution from the NHS Litigation Authority in respect of Dr K's involvement.

KEY POINTS

- Ensure fail-safe systems in the prescription of HRT.
- Medication reviews should act as effective safety-netting.
- Be aware of common prescribing error risks such as drop-down menus displaying medications with similar names.

Diary



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

→ **HELLO HUG** A worrying report from the *BBC* suggests workplaces are seeing a rise in hugging culture. It seems the era of the polite nod or firm handshake could be coming to an end as increasing numbers of colleagues engage in physical greetings. The report cites a recent survey that found more than half of advertising and marketing executives said hugging was common, up from a third compared to a 2011 survey. Experts say the trend could be linked to more relaxed workplaces. However, there is hope for those who do not feel comfortable in the warm embrace of their workmates. Concerns over sexual harassment and a fear of accusations of inappropriate or unwanted contact could limit hug proliferation. Doctors also have an additional defence citing strict adherence to hygiene rules.

→ **PREHISTORIC PAIN RELIEF**

Neanderthals with toothache may have self-medicated using plants, according to research published in the journal *Nature*. Remains found in El Sidrón Cave in Spain showed that one Neanderthal with a nasty abscess appears to have eaten poplar, which contains the active ingredient of aspirin. His dental plaque also had a natural form of penicillin, 40,000 years before its discovery. Alan Cooper, professor at the University of Adelaide in Australia and co-author of the study, said: "Apparently, Neanderthals possessed a good knowledge of medicinal plants and their various anti-inflammatory and pain-relieving properties... The use of antibiotics would be very surprising, as this is more than 40,000 years before we developed penicillin." However, he cautioned that the Neanderthal could also have eaten the plants without knowing of their medicinal qualities. The samples used range from between 42,000 to 50,000 years old, making them the oldest dental plaque to be analysed genetically. *Source: CNN*

→ **LOVE IS ALL YOU NEED** Which? magazine recently interviewed 15 doctors for an article entitled "10 ways to get the best from your GP". Top of the list: "Love

your receptionist". The authors explained: "The old-fashioned view of receptionists acting as guard dogs to keep you away from your GP is outdated. Try to think of them as your ally in finding the person most skilled to help you... And don't hate them for asking 'is it urgent?'".



→ **SAVED BY A WHISKER** Beards it seems were once regarded as more than just a must-have hipster accessory. An article in *Smithsonian* magazine reports how a similar beard trend took hold in mid-1800s England. But rather than being grown just for show, they were seen as a means of keeping men healthy. Writing in his blog, award-winning historian Alun Withey says that in the 16th and 17th centuries beards were seen as a form of bodily waste. But by 1850 attitudes changed considerably and "doctors were beginning to encourage men to wear beards as a means of warding off illness." A thick beard, it was believed, would capture impurities in the air before they could enter the body. While it may seem far-fetched, pollution and poor air quality was a major issue in Victorian-era

England and facial hair was regarded as a protective barrier. Sadly research would suggest they only serve to increase risk as facial hair is more likely to trap bacteria and food, thus increasing the chance of infection.

→ **CAKE CAPITOL** With the *Great British Bake Off* back on our screens - sadly sans Berry - the Oral Health Foundation has taken the opportunity to remind us that all cake is *poison*. Not really - but it did recently offer a reminder that a single slice of cake can exceed half our daily recommended allowance of sugar (around 30 grams). The organisation also polled thousands of Brits to discover which UK city indulged most in baked goods. Starting with the most abstemious - only 46 per cent of Aberdeen residents admitted eating a slice of cake or a biscuit daily. Compare that to the UK's top cake-loving city, Belfast, where 83 per cent treat themselves daily. Not surprisingly that city also has some of the highest levels of tooth decay in Britain. Dr Nigel Carter, CEO of the Oral Health Foundation, commented: "We all love a sweet treat from time-to-time but having them too often can very quickly mean bad news for our health... We have to remember that every single case of tooth decay and every rotten tooth which is removed from our mouth is entirely preventable."

→ **LONDON WEIGHTING - FOR**

MILK TEETH No one is exempt from the influence of global economics - not even the tooth fairy. Research carried out by SunLife has found that in 2017 UK kids earned on average around £1.49 per tooth tucked under their pillow - which was a five per cent increase on 2016. Children in London get the most, typically receiving £1.88 on average per tooth, and those living in the South West earn the lowest amount - £1.18. But it's not all good news: children in Northern Ireland have seen an average reduction of around 44 pence in the amount they can expect following a visit from the tooth fairy - and kids in the North East and Scotland have also seen a similar drop in the value of lost teeth. Diary's own family tooth fairy - Peggy - was unavailable for comment.

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