



A TRUSTED VOICE

MEET RADIO DOCTOR FIONA KINNON

ALSO INSIDE

04 10 MINUTES
IS IT LONG ENOUGH?

06 HEALTH LITERACY
MAKE YOURSELF UNDERSTOOD

AN MDDUS
PUBLICATION

MDDUS
UK INDEMNITY, ADVICE & SUPPORT



Welcome to your GPst

WITH more than 300 languages spoken across the UK, society is more multicultural than ever. This means GPs are increasingly likely to see patients with so-called "limited English proficiency". My article on [page 12](#) offers advice on overcoming communication issues and potential cultural differences with this growing patient group.

Understanding healthcare information isn't just a challenge for non-English speakers. Poor health literacy affects nearly half the population and GP Graham Kramer shares ways doctors can "make it easy" for patients on [page 6](#).

Is the traditional 10-minute consultation fit for purpose? Dr Roopinder Brar discusses the need for longer appointments at a time of intense pressure on practice resources on [page 4](#).

On [page 10](#) GP Fiona Kinnon talks about life in the media spotlight offering advice on a

phone-in radio show.

Saying sorry is regarded by some doctors as an admission of guilt or a sign of weakness. But in many cases a sincere apology is not only the right thing to do, it can help resolve complaints early and prevent them from escalating to a negligence claim. Find out more in our article on [page 7](#).

Names such as Victoria Climbié, Daniel Pelka and Baby P are familiar to many and serve as a stark reminder of the work that needs to be done to keep children safe. Our career article on [page 8](#) looks at how GPs can develop an interest in safeguarding children and young people.

And in our case study on [page 14](#), an asthmatic smoker presents with a persistent cough and a dark spot on his lung.

• **Dr Susan Gibson-Smith**
Editor

COVER PHOTOGRAPH: AMIE IGOE



EDITOR:

Dr Susan Gibson-Smith

ASSOCIATE EDITORS:

Joanne Curran
Jim Killgore

DESIGN:

Connect Communications
connectmedia.cc

CONNECT
ENGAGEMENT IS EVERYTHING



When you have finished with
this magazine please recycle it.

GPst is published by The Medical and Dental Defence Union of Scotland, Registered in Scotland No 5093 at Mackintosh House, 120 Blythwood Street, Glasgow G2 4EA. The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Articles of Association.

The opinions, beliefs and viewpoints expressed by the various authors in GPst are those of the authors alone and do not necessarily reflect the opinions or policies of the Medical and Dental Defence Union of Scotland.

PRINT:

21 Colour
21colour.co.uk

CORRESPONDENCE:

GPst Editor
MDDUS
Mackintosh House
120 Blythwood Street
Glasgow G2 4EA

t: 0333 043 4444
e: jcurran@mddus.com
w: www.mddus.com



EXPANDED ROLE FOR PHARMACISTS TO EASE BURDEN ON GPs

PLANS have been unveiled to ease the burden in both primary and hospital care delivery in Scotland by further enhancing the role of pharmacists.

Achieving Excellence in Pharmaceutical Care sets out the Scottish Government's priorities for a new national framework.

Scottish Health Secretary Shona Robison said the strategy would enable more people to be treated at home or in the community and ease pressure on other services. She pledged that every GP practice will have access to a pharmacist with advanced clinical skills by 2021.

Among other commitments set out is a planned expansion in the number of community pharmacists undertaking independent prescribing and advanced clinical skills training. It will widen a national minor ailments scheme (MAS) to cover more conditions such as impetigo, uncomplicated urinary tract infections in women and shingles, following a pilot scheme in Inverclyde during 2017.

A chronic medication service will be further developed to incorporate a more formalised role for community pharmacists in managing people with long-term conditions, building in medication review, prescribing, monitoring and dose titration.

The strategy also includes plans to transform the delivery of hospital pharmaceutical services and care during weekdays and at weekends, and improve all pharmacy-related aspects of the hospital discharge process utilising integrated models of care.

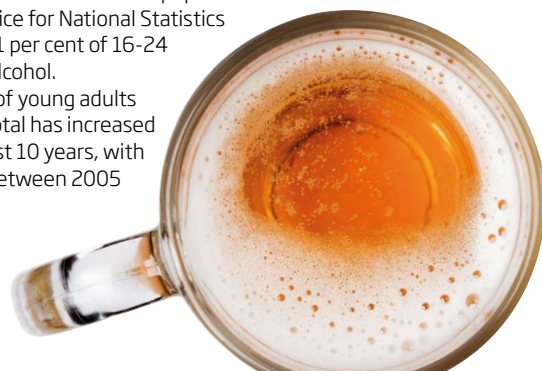
QUARTER OF MEDICAL STUDENTS TEETOTAL

NEARLY a quarter of UK medical students asked about alcohol consumption claimed to be teetotal in an average week.

An online survey sent to *BMJ Student* subscribers asking about health and lifestyle habits found that among the 823 respondents just over 10 per cent consumed more than the recommended maximum 14 units per week.

Drinking was found to be heavier in the early years at university but the survey also found that 23.8 per cent of medical students reported that on average they drank no units of alcohol each week. These findings correspond with data from the wider population compiled by the Office for National Statistics which found that 21 per cent of 16-24 year olds drink no alcohol.

The proportion of young adults claiming to be teetotal has increased steadily over the last 10 years, with a 40 per cent rise between 2005 and 2013.



REDUCE YOUR RISK WITH MDDUS PODCASTS

LEARN about key risk areas like complaints handling and negligence claims by downloading the MDDUS *Risk Bites* podcasts.

Each 20-minute episode offers a fascinating insight into the different ways two practices handle the case of a 51-year-old patient diagnosed with breast cancer. The series also highlights the latest advice and guidance to help you reduce your risk in daily practice.

Find the podcasts in the Resources section of mddus.com.



SUPPORT TO HELP MORE DOCTORS BECOME GPs

HOSPITAL doctors and overseas GPs wanting to work in general practice in England will be given extra support under new plans from Health Education England.

Doctors from other specialties who are interested in transferring to general practice would be offered training targeted to their specific requirements, taking into account their previous experience and training. They could then have their training shortened after a 12-month performance review.

Non-EU overseas GPs will also be offered an easier path. Those who have been identified by the General Medical Council as requiring additional training in order to meet UK competences will no longer be required to enrol as a GP trainee in order to access training.

The proposals – designed to boost GP numbers – are among a raft of measures set out by HEE in their consultation outcome report *Targeted GP training proposal including changes to extensions to training*.

Other proposals include enabling the re-entry to training for those who failed to successfully complete one part (out of three) of the MRCGP qualification within the time permitted. It is also proposed to allow extensions to GP training for some trainees.

The RCGP estimates that around 250 doctors could be eligible for targeted GP training under HEE's proposals. Chair Professor Helen Stokes-Lampard added: "Compared to the thousands more GPs we need in the workforce, this is a modest number and it is important that we do not generate false hope for these 'targeted' candidates, as these proposed new measures would not guarantee their success."

CONFLICTS OF INTEREST STATEMENT FOR HEALTHCARE PROFESSIONALS

DOCTORS should refuse "all but the most trivial gifts" from patients, according to a joint statement on conflicts of interest.

Healthcare professionals are advised not to accept a gift if it could be interpreted as an attempt to gain preferential treatment or would contravene their professional code of practice.

They are also expected to be open about any conflicts of interest and formally declare them as early as possible. They should put the interests of patients ahead of their own interests, or those of any colleague, business, organisation, relative or friend.

The guidance comes in a joint statement signed by nine regulators including the General Medical Council, the General Dental Council and the Nursing and Midwifery Council.

It says: "Conflicts can arise in situations where someone's judgement may be influenced, or perceived to be influenced, by a personal, financial or other interest."

The statement is intended to support the standards or code for each profession and any additional guidance they may have. These professional standards, codes and additional guidance, it explains, should be the over-riding consideration for professionals.

FIT NOTES FOR MENTAL HEALTH MOST COMMON

MENTAL health and behavioural conditions were the most common "known" reasons for fit notes being issued by GPs in England between December 2014 and March 2017, according to new figures from NHS Digital.

Such conditions accounted for 31 per cent of all fit notes where the diagnosis was known, and around one in five were issued for a period of absence of more than 12 weeks.

Data on more than 12 million fit notes issued by GPs over a 28-month period was

analysed, of which around 5.8 million had a known diagnosis.

Around 1.1 million fit notes relating to musculoskeletal and connective tissue disorders were issued over the period – making this the second most common category.

The number of fit notes written for anxiety and stress related conditions increased by 14 per cent between 2015/16 and 2016/17, and January 2017 saw the highest number of fit notes issue in one month (556,000).

INTERNATIONAL RECRUITMENT DRIVE FOR GPs EXPANDED

HUNDREDS more GPs are to be recruited from abroad as NHS England steps up its campaign to boost workforce numbers.

A revised target to hire 600 overseas GPs has been set for 2017/18 and for a total of at least 2,000 by 2020/21. That compares to the initial target of just 500 doctors by 2020/21.

NHS England is calling on recruitment firms to join a framework to support the programme and has published a tender on the *Official Journal of the European Union* (OJEU).

The move is part of measures to fulfil the pledge in the *General Practice Forward View* report to recruit 5,000 more GPs and 5,000 more medical professionals into general practice by 2020.

NHS England said any doctors recruited would be expected to meet "the highest standards of practice", including being able to speak good English. Support would be given to ensure this as well as help to relocate their families.



MAKING TIME

Most practices offer standard 10-minute appointments – but as patients' needs become increasingly complex, **Dr Roopinder Brar** asks whether these short slots are still fit for purpose?

THE job of a GP can be rewarding and satisfying but with rising workloads and diminishing resources it has never been more demanding. As many practices struggle to meet patients' needs, some are questioning the merits of the traditional 10-minute consultation.

Most GPs will tell you about the challenges of trying to fit everything into a single 10-minute appointment. Ten minutes to manage a suicidal patient or a worried mother who presents with her sick baby. Ten minutes to break bad news or deal with the complex needs of someone with multiple comorbidities. Sometimes, well actually most of the time, 10 minutes just simply isn't long enough.

There has been much debate about how to tackle this issue. Some say slots should be extended to 15 minutes or want a daily set target number of consultations. Others argue for a limit of one problem per appointment.

Resource pressures

There is no legislation or guidance which stipulates that practices must offer 10-minute appointments, and practices could in theory increase their length, but that may not be as simple as it seems. Royal College of GPs chair Professor Helen Stokes-Lampard argues: "Offering longer appointments means offering fewer appointments, and due to the intense resource and workforce pressures currently facing general practice, our patients are already waiting longer than they should be for routine appointments." In the current set-up, most practices would be unable to offer this.

Equally, limiting patients to raising only one matter at a time may only exacerbate the problem as many would simply book in for second or third appointments to discuss unresolved issues. For some, waiting this extra time could make their health condition worse.

Despite these time pressures, doctors still need to ensure safe practice. Complaints and claims against GPs are rising and not having enough time to properly assess a patient isn't a valid defence. GPs need to explore practical solutions and work with patients to find a system that eases time pressures on the practice while still allowing them to offer safe care. There are a few things that practices could consider which may ease some of this burden.

Multi-disciplinary team

Patients and practices should make the most of the full healthcare team. Let your patients know which member to consult, and when: whether it's the pharmacist, nurse practitioner or healthcare assistant. Display this information clearly in the practice or on your website, and ensure reception staff know how other team members can help.

There are some clinical tasks that are best carried out

by a GP, but don't be afraid to delegate (provided team members work within their level of competence and area of expertise). This not only ensures that the patient is dealt with appropriately but also frees up GPs to help those with more complex needs.

GPs also work very closely with their secondary care colleagues and good communication is vital. Patients seen by secondary care or other community teams should understand what treatments are being provided, who is monitoring these and who is responsible for any follow-up care. This will minimise the number of patients contacting their GP just to seek clarification on care offered by other team members, saving vital consultation time.

Telephone consultations

Some problems do not require a face-to-face appointment and can be effectively resolved via a telephone consultation. However, it is crucial that these are used only when appropriate and not just to address resourcing pressures. Telephone consultations have their limitations and patients who need to be examined in person should be offered a face-to-face appointment to ensure GPs continue to deliver safe care.

Be prepared

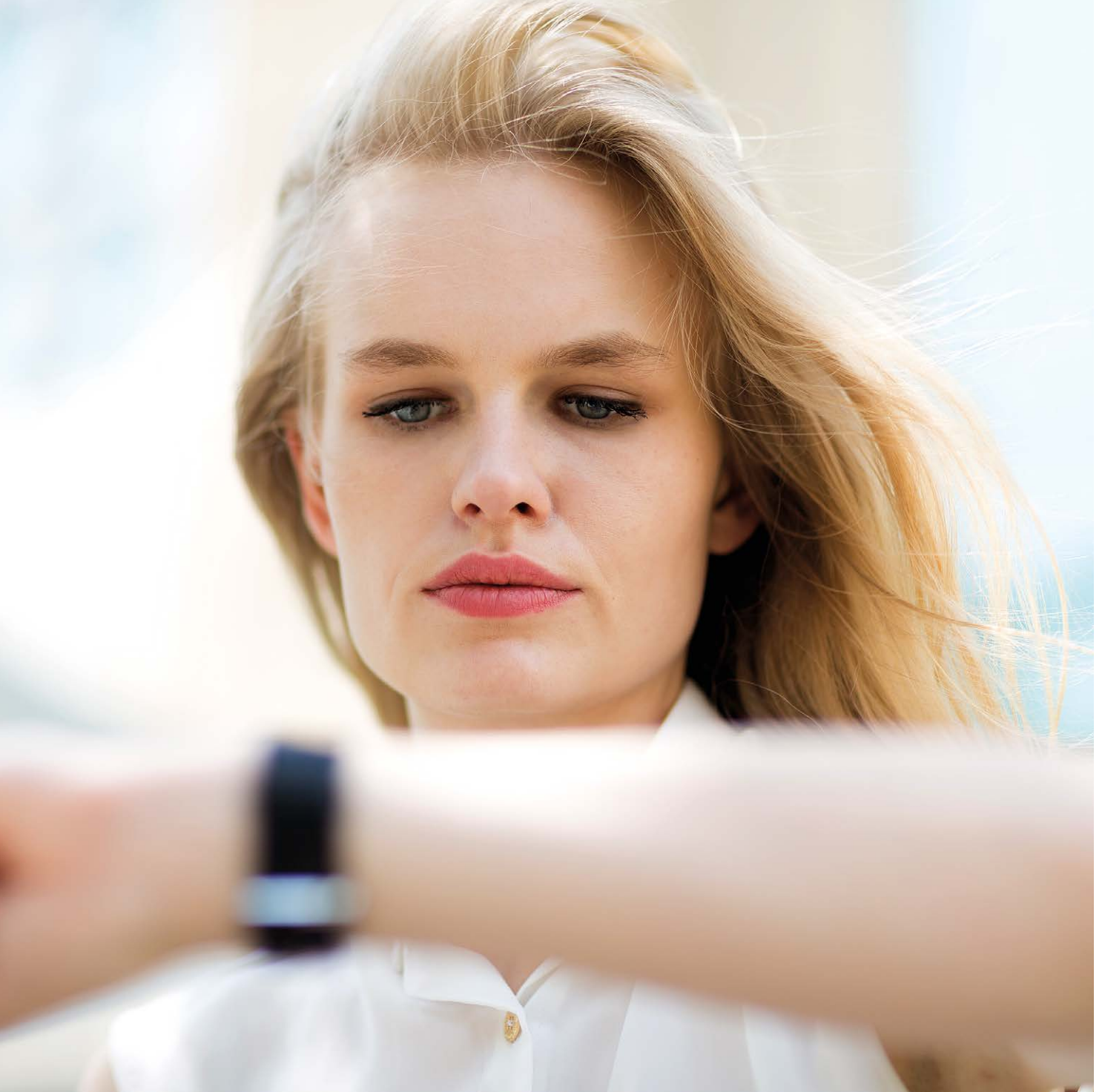
Time pressures can sometimes leave doctors feeling like they barely have time to draw breath, with as many as 40 or 50 patients coming through their door each day. One option is to set aside protected time prior to the surgery starting for GPs to look through notes and familiarise themselves with the patient. This may seem impractical but it can save time during the actual consultations where the doctor may be asked to look up test results, provide advice following a recent outpatient appointment or even follow-up care after a course of treatment by another GP or healthcare professional.

Be realistic, be safe

GPs usually try to deal with as many of a patient's problems as they can in one appointment. However, it is important to recognise that sometimes this is neither practical nor safe. Be clear and honest about what you can realistically achieve in the allocated time. Patients are less likely to become frustrated if they understand why you are unable to deal with all their concerns in a single appointment and consider other options you have to address their concerns.

GPs must use their professional judgement, work within their competence and never take shortcuts as a way of dealing with workload pressures. Offering extended/double appointments for those with complex problems is another option. Patients should also be reminded that urgent, same-day appointments are available for more serious issues.





No jargon

The consultation process is based around effective communication and working in partnership with the patient, involving them in making decisions about their care. A full and frank discussion is more likely to ensure a positive patient experience and outcome. Time constraints should never compromise this and it is common for patients to re-attend if they are unsure about any advice given to them. The use of clear, simple and consistent language and avoiding complex explanations or medical jargon can help. It can be worthwhile checking a patient's understanding of the advice given and plan agreed. This can be particularly helpful when safety netting to ensure they understand the next steps or implications of any red flag symptoms.

Good record keeping

As always, GPs should keep clear, accurate and contemporaneous patient records. Good medical records can ensure that patients receive continuity of care and provide important information to others sharing that patient's care. Medical records may also be required for legal purposes and are essential in successfully defending medical negligence claims.

Burnout

Dealing with stress and being overworked may be an accepted fact of life for doctors, but there is a tipping point. Burnout can affect a doctor's judgement, concentration and productivity. All of which can lead to mistakes. General practice cannot afford to lose any more GPs so it is important to recognise factors contributing to burnout and how these can be remedied. Practices should support their GPs but there are other resources out there. MDDUS recently supported the RMBF's *What's up doc?* campaign to help stressed doctors. Find out more at www.rmbf.org/about/our-campaigns/whats-up-doc/

Adapt and change

GPs work extremely hard and the pressures they face are very apparent. It may be time to bid farewell to the 10-minute consultation but making this a reality will not be easy. In the meantime, GPs will have to keep on being their resourceful selves in seeking out ways to continue providing safe, high quality patient care.

Dr Roopinder Brar is a GP and telephone adviser at MDDUS



MAKING IT EASY

GP **Graham Kramer** takes a closer look at the hidden problem of health literacy

IMAGINE there was a health problem that affected nearly half the population. Those worst affected, if aged over 50, have double the chance of dying over the next 10 years. Those with diabetes have double the risk of developing complications. We would expect medicine and pharma to pull out all the stops to find a solution.

However, this health problem isn't fixed with a pill. It's a problem we call health literacy – a difficulty of making sense of health issues and healthcare. This leads to insufficient confidence, knowledge, understanding and skills to cope with the demands and expectations that health and healthcare places on people, making it hard for them to safeguard their own wellbeing and those they look after.

We don't make it easy for people. Studies have shown that the information on a bottle of paracetamol, to calculate a childhood dose, is pitched at a literacy and numeracy level that would stretch 43 per cent of working age adults. As doctors, we unwittingly talk in words and use technical terms (jargon) that many of our patients are unfamiliar with, so that, on average, only half of what a person hears in a consultation is remembered and only half of that is understood.

This is particularly challenging for those with low educational attainment, the elderly, where the professional and patient don't share the same first language, those in pain, unwell or just frightened. People are too polite or ashamed to admit they don't understand and as doctors we consistently overestimate people's health literacy. As George Bernard Shaw famously said: "the single biggest problem with communication is the illusion that it's taken place".

This can have a massive impact on the safety and effectiveness of healthcare, makes shared decision making and informed consent a real challenge, undermines self-

management, and raises significant rights, health equity and medicolegal issues. Responding to people's health literacy needs is an important aspect of person-centredness and a challenge for us all. It's no coincidence that it is a significant theme in *Realising Realistic Medicine*, the Chief Medical Officer for Scotland's annual report for 2015/16.

Between 2011 and 2016, I was privileged to work on this agenda within Scottish Government. Scotland was becoming one of the first countries in the world to see health literacy as a significant priority. Working with some inspiring pioneers we developed an action plan, called *Making it Easy*. This aimed to increase awareness amongst health professionals to meet people's hidden health literacy needs whilst building their capabilities to respond. We developed a website, the Health Literacy Place, which has useful evidence, tools and resources.

As GPs, what practical things can we do to be responsive to people's health literacy needs?

- 1. Preparing people before consultations.** It's difficult for people to take in information and then be expected to reach a shared decision at the same consultation. Giving people the same information that you have about them, in meaningful formats (lab results, blood pressure readings, correspondence etc) a few days before a consultation is very valuable. This is a key principle of care and support planning for people with long term conditions and helps engagement, understanding and improves outcomes.
- 2. During consultations.** Encourage a family member or friend to attend the consultation (with the patient's consent). Use simple, jargon-free (or clarified jargon) language. Check the person's understanding by using "teach back." This

is where we ask the patient in a non-stigmatising way to explain to us what they have understood in the consultation. It can be highly informative. Often, they have understood and explain back in everyday language. It also gives you instant feedback about your own communication skills. People feel more confident they have heard you correctly if you have checked their understanding. Sometimes it's clear the person hasn't understood and a signal they will need more time and help. Use "chunk and check", this is where we break down information into bite-size concepts and then check understanding using teach back before moving onto another concept.

- 3. After the consultation.** If people go home with a summary of their consultation, or even an audio recording, it helps understanding and confidence. Written information such as patient information leaflets have proved disappointing for people with poor literacy so signposting them to sources of support such as other members of the team, peers and self-management support can be helpful.
- 4. Organisationally.** Review your practice systems. Giving people forms to fill in can be challenging, particularly for those with basic reading and writing difficulties. Ask your receptionists to routinely ask if they would like help to fill in forms. Use patient volunteers to sense-check information in your waiting rooms or letters you send out. Use few words and keep it visual.

Good health literacy practice can be hugely illuminating and rewarding. It lies at the heart of engaging and enabling our patients to be in the driving seat of their health.

Dr Graham Kramer is a GP principal in Montrose and former Scottish Government national clinical lead for self-management and health literacy

Links:

- *Making it easy* – tinyurl.com/yaz38msm
- The Health Literacy Place – www.healthliteracyplace.org.uk

A PATIENT – Mr C – attends his local surgery complaining of weight loss and pain on urination. A GP examines him and orders blood tests but there is no obvious explanation and over the next 11 months the symptoms persist with the patient attending the surgery numerous times. Mr C is then referred to hospital for GI investigations but no cancer is found in the bowel or stomach. Another six months pass before the GP detects a large swelling in Mr C's abdomen. He is offered a non-urgent referral for a CT scan which leads to a diagnosis of kidney cancer.

Mr C writes to the practice complaining about his clinical care and the attitude of the GP. The practice investigates but the GP insists that no mistakes were made. The complaint response is later characterised as "lengthy, cumbersome and defensive". An apology of sorts is offered but caveated with the phrase: "although ultimately we are all humans with human frailties". Mr C receives the response two days before he dies.

The patient's wife then complains to the practice and the reply is again highly factual with no mention of regret for her loss or acknowledgment of any mistakes – nor even condolences.

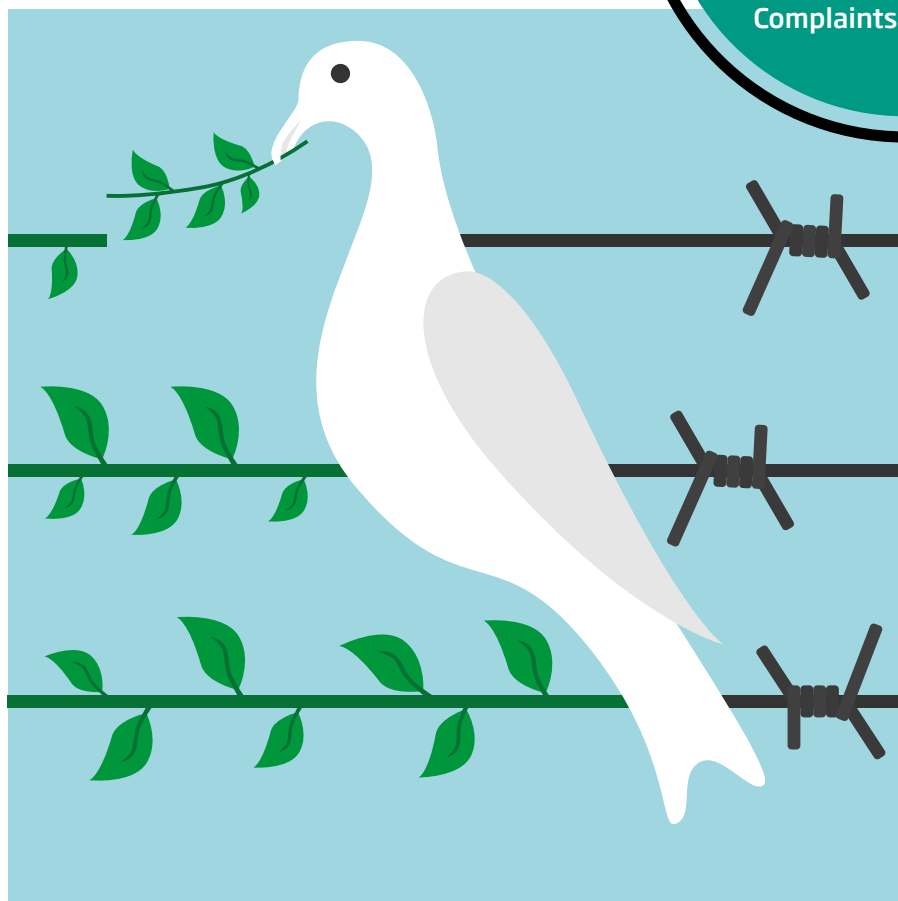
This case was highlighted in a 2016 report by the Parliamentary and Health Service Ombudsman (PHSO) on how some GP practices handle complaints. An analysis of 137 closed complaint cases by PHSO investigators rated complaint handling in 36 per cent as "Needs improvement" and in 10 per cent as "Inadequate". In a third of cases practice staff did not provide an adequate apology where appropriate, and apologies when offered were not always sincere.

Receiving a complaint from a patient is the most common reason doctors seek advice from MDDUS and this accounts for around a fifth of all the contacts we receive. Many of these complaints could be resolved with an apology and an honest and direct explanation.

Some doctors, however, are reluctant to apologise, believing that saying sorry is an admission of guilt or liability in any potential negligence claim. This is not the case. The Compensation Act 2006 states: "An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty".

Nor is offering an apology a sign of weakness. In fact, at times, not only is it the right thing to do, it is also a doctor's duty. There is both professional and statutory guidance on when and how it is appropriate to apologise. The GMC's *Good Medical Practice* provides general guidance to doctors in regards to the professional conduct expected of them. This includes saying sorry when appropriate and providing a full and timely explanation in a manner suited to individual concerns. NHS complaints procedures in the various UK countries impose a similar obligation on doctors.

No doubt it can be stressful receiving a complaint but you should avoid acting defensively. An open and honest approach can help resolve complaints at the earliest possible stage and prevent them from escalating into



HONEST REGRETS

A sincere apology can often accomplish more than a roomful of lawyers

negligence claims or a matter for professional regulators.

Professionalism requires doctors to be honest and responsible and act with integrity. You should show empathy and respond objectively after consideration of the patient's point of view. A sincere expression of sorrow or regret should be offered at the earliest opportunity, as well as an explanation of what went wrong.

You should use appropriate language and tone, and avoid medical jargon. In our experience, most patients who complain are not interested in pursuing long and drawn-out formal complaints. Often just listening and understanding their concerns can defuse a situation.

Even if you don't believe a mistake has been made, it is still helpful to adopt a conciliatory tone and express regret that the patient is dissatisfied. Patients want to know that their doctor cares and understands their concerns. They want their doctor to be honest and responsible.

It is also important to try to learn from complaints, reflecting on what has happened and identifying any changes in individual

practice or systems that may be required. Changes of this kind may also be shared with the complainant to demonstrate that the matter has been taken seriously. Patient safety can be improved if you have a system in place to review and learn from mistakes.

The GMC's *Openness and honesty when things go wrong: the professional duty of candour* provides further guidance to doctors about saying sorry. It also reminds doctors not to be formulaic in their responses, as an apology has value only if it is genuine.

In the case of Mr C, highlighted above, the complaint from his wife was escalated to the PHSO which found that numerous opportunities had been missed to refer the patient for appropriate investigations that might have led to an earlier diagnosis. It also criticised the practice and GP involved for the handling of the complaint. In the end the practice acknowledged and apologised for its failings and paid Mrs C £1,500 for the impact. It also produced an action plan to show what it had learned from the complaint.

Dr Greg Dollman is a medical adviser at MDDUS

PROTECTING OUR FUTURE

We look at how GPs can develop an interest in safeguarding children and young people

NAMES such as Victoria Climbié, Baby P, Daniel Pelka and Liam Fee will be familiar to many and serve as a stark reminder of the vital work that needs to be done to keep children safe.

They are just a few high-profile cases of child abuse in the UK that have come to light over the past two decades, highlighting the continuing need for robust and wide-ranging safeguarding systems.

Much of the focus (and often the criticism) has fallen on the shoulders of social work professionals, but doctors also have a key role to play.

The Royal College of GPs has long advocated a strong role for the involvement of primary care. The College points out that a quarter of a GP's patients are under 19 with more children and young people seen in general practice than in any other part of the health service.

For this reason, the RCGP has recommended that all practices in England have a GP lead for child safeguarding and a deputy lead. This advice is underpinned by legislation (Section 11 of the Children Act 2004 England) and by Care Quality Commission regulatory requirements. In addition, most clinical commissioning groups in England also choose to employ a "named GP" for safeguarding children to support GPs in their area.

Arrangements in the rest of the UK differ, with doctors in Scotland, for example, working in line with the *Getting it right for every child* (GIRFEC) scheme.

Training options

GPs in England with an interest in this field may follow a formal training pathway with a view to applying for the post of "named

safeguarding GP". According to the RCGP/ NSPCC *Safeguarding Children Toolkit for General Practice*, the named safeguarding children GP should be "an experienced GP of good professional standing with extended knowledge and skills in the care of children and young people". This would be evidenced by a higher qualification in child health such as a diploma in child health (DCH) or MSc, and/or experience working in delivery of child health services within community paediatrics, schools or secondary care.

GPs may also have developed expertise through a range of other activities, including education, research, involvement with service development and management. This can include experience or working in relevant departments and professional specialties, for example attachment to a community paediatric unit under the supervision of a specialist practitioner.

Other options include self-directed learning, attendance at recognised meetings/ lectures/tutorials on specific relevant topics, a recognised university course or successful completion of a diploma or equivalent. Such courses are offered by the likes of the University of Kent, University of Greenwich, the University of Central Lancashire, University of the West of Scotland and Birmingham City University amongst others. GPs may also opt to work under the supervision of a specialist clinician in relevant clinical areas.

The job

Many GPs are actively engaged in programmes and schemes across the UK aimed at safeguarding children and young people.

In England, this is likely to involve working as a named safeguarding GP or as a GP lead/

deputy lead for child safeguarding in a practice.

Named safeguarding GP

GPs in this role would be employed by NHS England or a CCG to support all activities necessary to ensure the organisation meets its legal responsibilities to safeguard/protect children and young people. They have inter-agency responsibilities, participating in the health group and other subcommittees of the local safeguarding children board (LSCB)/the safeguarding panel of the health and social care trust/the child protection committee.

They advise local police, children's social care and other statutory and voluntary agencies on health matters with regard to safeguarding/child protection. They offer advice to the board of the healthcare organisation and offer advice to colleagues on the assessment, treatment and clinical services for all forms of child maltreatment including neglect, emotional and physical abuse, fabricated or induced illness (FII), child sexual abuse, honour-based violence, child trafficking, sexual exploitation and detention.

The role also includes a clinical element (where relevant) in supporting and advising colleagues in the clinical assessment and care of children and young people where there are safeguarding concerns. They help to coordinate safeguarding across the health community: agreeing and supporting training needs and priorities, and helping monitor the effectiveness and quality of services.

Practice GP lead

The practice GP lead for safeguarding has a number of duties including ensuring practice child protection policy and procedures are developed, implemented and regularly monitored



Q&A

Dr N Vimal Tiwari, Named Safeguarding GP Herts Valleys CCG

- What attracted you to develop an interest in safeguarding children and young people?

I have a strong interest in child health and was pulled into safeguarding while working in community paediatrics. GPs, as the first point of contact for most health-related problems, may be the only professional to realise when a family or parent is running into difficulties which could place a child at risk but can find such problems very challenging.

- What does your role involve?

I support GP colleagues by offering practice visits, educational seminars and sessions and advice on safeguarding issues. I meet with health colleagues regularly to discuss policy and practice and attend multi-agency forums to learn about safeguarding initiatives, achievements and concerns of other agencies such as education, the police and social care.

- What do you enjoy most about the job?

Meeting many hard-working conscientious GPs who care deeply about their patients and are eager to do their best despite time constraints and resource issues. It is deeply rewarding to see major improvement in the way practices now approach their safeguarding duties.

- Are there any downsides?

Child protection reviews centre on desperately tragic events involving the death or serious injury of a child which can be traumatic for all involved. Support from colleagues is vital when involved in writing reports for case reviews.

- What do you find most challenging?

The few GPs who cannot accept that child maltreatment exists. They are unwilling to participate in child safeguarding activities and refuse to provide essential information for child protection purposes.

- What about the role has surprised you?

Many GPs already possess a deep instinctive knowledge of the subject although they may not always be able to articulate their worries. Small changes can be enough to increase confidence and improve practice.

- What is your most memorable experience so far?

The 'light-bulb' moment in an educational session when a GP suddenly realises that a series of apparently inexplicable events or a perplexing presentation in a consultation is related to child abuse or neglect.

- What advice would you give to a trainee GP who is interested in this field?

An interest in child health is essential because a knowledge of normal child development/behaviour is required to identify variation from the expected. Curiosity about mental health and human behaviour is useful as the causes of child maltreatment remain poorly understood and under-researched.

and updated. They will have regular meetings with others in the primary healthcare team and personnel from other agencies such as health visitors, school nurses, community children's nurses and social workers to discuss any concerns about vulnerable children and families.

A key focus of the role is ensuring the practice fulfils its obligations in a variety of areas such as statutory responsibilities; contractual guidance; national/local regulatory requirements and inspection requirements in relation to information sharing and record keeping. When new staff are employed by the practice, the lead must make sure safe recruiting procedures have been followed and that the relevant vetting and barring checks have been carried out.

A GP safeguarding lead will also provide valuable advice and support to colleagues, helping them with child protection referrals and ensuring requests for child protection reports are responded to fully and promptly.

GIRFEC

In Scotland under GIRFEC, the plan is for a "lead professional" to be appointed for children who need extra support – a role which can be taken on by a doctor, teachers, health visitors and social workers. The Scottish Government describes a lead professional as "someone who helps to organise support for a child and their family" and who "makes sure all the people who support a child work well together". For doctors, this is commonly someone who holds consultant status or equivalent who has undergone higher professional training in paediatrics. However, GPs with dual qualifications in other specialties such as public health, forensic medicine or psychiatry may be able to demonstrate the required competence to undertake the role. The lead professional would help organise a "Child's Plan" (due to be launched in 2018) detailing information about the child's wellbeing needs and services that will provide support.

TRUSTED



"This was an opportunity to get involved in something outside clinical practice to keep me refreshed"

VOICE

GP **Fiona Kinnon** talks about life in the media limelight offering advice on a phone-in radio show

MATERNITY leave for any doctor is a chance to take a step back from clinical life, but for one GP it marked the birth of a successful media career.

Six months after the arrival of her first child in 2010, Dr Fiona Kinnon was approached at her Glasgow medical practice by a radio producer and asked if she'd like to contribute to medical items on BBC Radio Scotland broadcasts.

Fiona jumped at the chance and soon became one of the main GPs on BBC Radio Scotland's morning shows, earning a regular monthly slot in December 2015. As her profile – and popularity – increased, she made appearances on news programmes and even a ground-breaking documentary.

It's a varied schedule that provides a welcome counterpoint to the challenges of her day-to-day general practice.

Fiona says: "I love being a GP but you deal with a lot of heavy emotional issues. This was an opportunity to get involved in something outside clinical practice to keep you refreshed and invigorated.

"It has kept my knowledge of new research up-to-date and had many other side benefits. It has never, ever been about fame or fortune or ending up on television. But being Dr Fiona is great fun."

Being 'Dr Fiona'

While awaiting the arrival of her second child (now three), she agreed to return to work on the radio phone-in shows. Committed to the end, she even completed a live radio broadcast while having contractions.

She says: "The *Good Morning Scotland* team phoned me the night before my due date and asked if I would go in and discuss the growing epidemic of loneliness in the elderly. I agreed and fortunately 'junior' didn't put in an appearance for a few more days, but I was having twinges on air.

"I continued to do occasional items over the phone when Euan was born and during one broadcast on the national review of asthma deaths, you could quite clearly hear him waking up and whimpering in the background!"

For Fiona's typical regular radio slot, she emails the producers a few days before broadcast to decide on topical health stories

to discuss. The range is diverse, from whether we should ban skinny models, to dietary prevention of gout, to a new app to help asthma sufferers.

A brief is sent out to Fiona the afternoon before broadcast, and she will spend that evening researching the topics. But it is not uncommon for a health news story to break overnight, requiring some last-minute research.

As 'Dr Fiona', the GP has been a trusted voice across the airwaves, encouraging those who may not have sought medical attention to do so, including one woman who hadn't been to see her GP in more than 30 years.

Quick thinking

As well as discussing topical stories, listeners phone, email or text in with health-related queries – ranging from simple problems to serious mental health issues. And with no advance notice of the queries, the busy GP must think on her feet.

"There is no advance warning, but that's one of the joys of the job," she says. "In an average day I can go from breaking news of a terminal diagnosis, to a patient telling me they're pregnant; to dealing with disabling anxiety and depression, so I am used to changing gear mentally quite quickly.

"It's a bit of an adrenaline rush being live on the radio. Of course there are times that things flummox me, but you have to act with honesty and integrity – which are of course some of the deep-rooted principles of good medical practice. I would always admit if I didn't know what to advise."

Fiona, 40, began running her own practice with 1,600 patients at the age of 31, so she knows all about the challenges and risks facing GPs today. But during a live radio broadcast, with no access to medical records and scant information (often by text message), these risks multiply.

"It's so important as a GP – and especially when broadcasting live across Scotland – to ensure that you signpost patients to other relevant health professionals," she says. "I'm always careful to highlight 'red flag' symptoms for which urgent help should be sought, and provide safety-netting advice, i.e. telling people what to do if symptoms don't resolve as expected."

Dr Fiona's radio slot caught the eye of another well-known BBC star: *Newsnight* anchorwoman, Kirsty Wark. The veteran journalist asked Fiona to provide a

medical perspective for her recent BBC documentary, *The Menopause and Me*. It was an experience a rather starstruck Fiona describes as "beyond her wildest expectations". Other brushes with fame include meeting former *Great British Bake Off* presenter Mel Giedroyc, who was at BBC Radio Scotland HQ for an interview, and securing CBeebies goodie bags for her two sons.

Making regular radio and television appearances has not just had a positive impact on Dr Fiona and the BBC audiences, but on her patients too, especially given her involvement in the menopause documentary. "It's been a great way to help educate the public," she says, "and I now have a huge number of menopausal women coming to me for advice and saying 'I know I am not alone' and 'I know that you understand'."

Seeking variety

A varied career has been a goal for Fiona since she qualified from the University of Glasgow in 2000. As a junior doctor she worked on a P&O cruise ship for a year. The role took her across the Atlantic, to the Caribbean, through the Panama Canal and beyond, treating 1,000-plus crew members and many more passengers along the way.

In addition to her GP practice, Fiona also works as a GP appraiser, is a cluster quality lead for seven practices in North West Glasgow, she works occasional out-of-hours sessions, and has various media commitments. With supportive husband Conor by her side, Fiona balances this with being a mum to Leo, seven, and three-year-old Euan. However, she has recently taken steps to reduce her hectic schedule.

"My work/life balance was at risk," she says. "Part of my role as a GP appraiser is to help GPs recognise when they are doing too much and reaching a point of stress: I recognised that it was a danger in myself, and I stepped back from it."

Although the busy mother-of-two is preparing to take a short break from her media work, she hopes to return to the airwaves when her youngest son starts school. She says: "I'm happy where I am. I have done more as a GP than I could have ever dreamed of."

And for any trainee GPs interested in following in her media footsteps, she adds: "Go for it! News stations are always looking for contributors, so just email them to ask about any openings. If you don't ask, you don't get."

Kristin Ballantyne is a freelance writer in Glasgow

As increasing numbers of UK patients speak little or no English, **Dr Susan Gibson-Smith** offers advice on bridging the language divide

THE number of languages spoken across the UK is thought to be more than 300, with hotspots in cities such as London, Birmingham, Sheffield and Glasgow.

Society is more multilingual than ever, which means GPs are increasingly likely to have patients with what is known as "limited English proficiency". Add to that potential cultural misunderstandings and effective communication and shared decision making suddenly become more challenging. Complicating the situation further is the issue of increasing practice workloads and diminishing resources.

So how can we ensure we provide a high standard of care to this patient group?

Consider the following scenario:

The patient, Mrs W, was booked for a routine 10-minute appointment. She had recently moved to the area and was accompanied by her husband. I asked if she minded him being in the room. He answered 'no', his wife did not mind as he went everywhere with her to translate because she spoke no English. I asked what the problem was and the husband explained she had been very tired and unhappy recently and had stomach pains. I asked Mrs W a few questions, all of which the husband answered, sometimes with a brief word to her in their language but usually without conferring with her at all. I was becoming increasingly frustrated that I was not able to communicate effectively with Mrs W.

I asked if I could examine her abdomen. Her husband said yes and I invited her up on to the couch. She did not seem to understand what was happening and I asked him to explain what I was doing. The examination was normal apart

from some epigastric tenderness. I then suggested some routine blood tests. The husband said that would be fine but did not translate what I had said to his wife about my management plan and what was happening. I arranged an appointment to see them with the results in 10 days. The patient and her husband both seemed pleased with the outcome and smiled as they left however I felt very unsatisfied with the consultation which had taken 25 minutes. What could I do differently the next time?

Best care

Demand for GP appointments is extremely high and most practices still schedule standard 10 minute slots. This can be tricky to manage at the best of times, but particularly when treating a patient with poor English. However challenging this is, doctors cannot allow it to affect the care they provide. As RCGP chair Professor Helen Stokes-Lampard says: "GPs will always strive to deliver the best possible care to all of our patients, regardless of their nationality or ability to speak English. GP practices that serve a population where a lot

of patients might not speak English as their first language will take the need for longer appointments and translators into account when planning their services."

Consultation tips

Translators

It is important to note that any translator must be reliable and appropriate. There is a clear need for one in our scenario and whilst it may not have been possible in the first appointment it would be important to book one for all future appointments, attending either in person or assisting by phone. Check arrangements with your health board/trust/CCG. Some practices place a flag on the patient records so the receptionist knows an interpreter is required when the appointment is booked. This allows a longer appointment time to be arranged and for the translator to be booked in advance.

When using a professional translator, ensure they are qualified and appropriate for the consultation. Note their details in the patient record and explain at the start that you must hear all the information offered by the patient. Maintain eye contact with the patient and speak



MULTILINGUAL MEDI



MULTILINGUAL CINE

clearly, avoiding jargon or complex phrases.

If a professional is not available, other options include a multi-lingual healthcare professional or 'ad hoc' interpreter such as a friend or relative. Remember that there is no guarantee how effective an ad hoc interpreter will be and it is unlikely they will have the relevant experience of medical terminology as a professional would. Ensure the patient can speak freely and comfortably in front of the translator, particularly regarding more sensitive health issues.

Open questions

It is crucial to use open questions rather than closed ones when speaking to patients with poor English. Remember the five 'Ws': what, where, when, why, who and how/how often. These will help avoid basic yes/no responses and the answers should help you understand more about the patient while being reassured they understand you. Speak slowly and in short sentences and ask the patient to do the same.

Cultural differences

Doctors must also take into account potential

cultural differences. A patient who is afraid to cause offence may simply say 'yes' even if they haven't understood you. In some cultures, nodding your head is a gesture of respect to show the person is listening and not necessarily a sign of understanding/agreement. Similarly, the patient may have no intention whatsoever of complying with the recommended treatment for cultural reasons that were never discussed.

At the end of the consultation, ask the patient to summarise their understanding of the problem and agreed treatment plan, including how to take any medication.

Consent

This is a key risk area for patients with poor English. In our scenario it could be argued the patient was not properly consented for her abdominal examination (although fortunately no complaint was made). According to the GMC's 2013 guidance *Intimate examinations and chaperones*, an intimate examination includes those of the breasts, genitalia or rectum, but for some patients it may involve simply touching them or even being close to them.

It is essential to obtain informed consent before carrying out an intimate examination and to record that consent. The patient must understand why the examination is being carried out and how it will be conducted. What part of the body will be examined? Will there be any discomfort?

A chaperone may be able to confirm that an examination has been conducted in a professional and appropriate manner but cannot ensure that it was consensual. To avoid any misunderstanding a trained medical interpreter is desirable when dealing with non-English-speaking patients in order to avoid potential complaints or medico-legal claims. It is preferable to have the interpreter present during physical examinations if the patient is agreeable. Otherwise extra care must be taken to explain beforehand and via the interpreter exactly what will happen during the examination.

Leaflets can also be very helpful and some practices routinely have their practice leaflet printed in several languages depending on the practice demographic. The website **patient.info** has some useful resources.

Conclusion

So, back to our scenario. A telephone translator was booked for the next appointment and 20 minutes was allowed. The husband was present but the wife spoke freely with the translator's assistance and a diagnosis of gastritis was made. The doctor explained how to take the medication, checked the patient's understanding, and Mrs W left satisfied with an information leaflet in her own language.

Dr Susan Gibson-Smith is a medical adviser at MDDUS and editor of GPST



DIAGNOSIS

SUSPECT SPOT

DAY ONE

MR J is a 53-year-old smoker with a history of asthma. He attends his local surgery complaining of shortness of breath, wheeziness and a persistent cough along with a fever. The GP - Dr L - examines the patient and refers him to A&E. Later that day Mr J has a chest X-ray and is discharged with antibiotics.



WEEK THREE

A letter is received at the practice from the hospital indicating that a review of the X-ray revealed an opacity adjacent to the right hilum. The letter states that this is likely to be due to infection but the practice should arrange a follow-up X-ray for Mr J in about six weeks. The letter is stamped and a tick is made against Dr L's name suggesting that he has seen the letter - but the follow-up X-ray is not actioned and the letter is scanned and filed.



MONTH EIGHT

Mr J is back at the practice again complaining of severe shortness of breath and a persistent cough. A two-week course of antibiotics offers no improvement. Dr L refers the patient to hospital for another chest X-ray which shows a 6 cm mass in the upper right lobe. Mr J is admitted to the chest unit and a CT scan and bronchoscopy with biopsy confirm non-small-cell bronchial carcinoma. The tumour is considered inoperable due to its position abutting the mediastinum just above the right bronchus. The CT also reveals some nodal spread and the patient is referred for chemotherapy.



WEEK 12

Mr J later returns to the surgery complaining of breathlessness on minimal exertion. Dr L diagnoses infective exacerbation of chronic obstructive pulmonary disease (COPD) and prescribes ciprofloxacin and prednisolone. A review two weeks later finds Mr J improving.



WEEK EIGHT

Mr J attends the surgery again with a productive cough and shortness of breath. Dr L prescribes amoxicillin and tells the patient to re-attend if his symptoms do not improve.

A LETTER of claim is received by the practice from solicitors acting on behalf of Mr J alleging clinical negligence for the delayed diagnosis of his lung cancer. The main allegation is over Dr L's inaction in response to the letter from the radiologist advising a follow-up X-ray in six weeks.

MDDUS acting on behalf of Dr L reviews the relevant case documents, including a report from a primary care expert. A further expert report is obtained from a respiratory physician in regard to causation in the case.

In his statement Dr L confirms that the letter had been received in the practice and marked as read but the follow-up chest X-ray had not been highlighted and actioned. The letter was subsequently scanned and filed. The primary care expert concludes that the failure of Dr L to act on the advice of the letter - particularly when Mr J presented on several occasions with respiratory symptoms - fell below expected standards of care.

The respiratory physician is asked to assess causation in regard to two particular questions: was the abnormality detected on X-ray at the initial A&E visit likely to be the tumour subsequently identified and would the treatment and outcome have been different if a cancer diagnosis had been made after the intended repeat chest X-ray?

The expert finds that the rounded spiculated mass identified as the tumour is present in both X-rays and has enlarged over the eight-month period. A CT scan subsequently confirmed spread to the para-tracheal and mediastinal nodes.

In regard to the delay in the diagnosis the expert points out that in non-small-cell carcinoma, removal of the tumour offers the best cure. Radical radiotherapy (sometimes with the addition of chemotherapy) can also offer effective treatment - and the smaller the tumour the better the chances.

The surgeon in the case had judged that on

balance the tumour was not curable by removal due to its position, but the expert states that a lobectomy might have been possible had the tumour been diagnosed within six weeks of the initial X-ray presentation. Radical radiotherapy might also have been a more effective treatment option in a smaller tumour - enhancing the patient's chances of long-term survival.

Given the obvious breach of duty of care and the expert view on causation, MDDUS decides in agreement with the member to settle the case.

KEY POINTS

- Ensure fail-safe practice systems for actioning results and follow-ups.
- Significant event analysis can ensure key lessons are learned from adverse incidents.
- Evidence of breach of duty and causative harm is required to establish a claim.

Diary

SO MUCH absurdity, so few column inches. Welcome back to Diary where we ask for interesting and entertaining medical anecdotes from our readers, get nothing in reply and so make up our own. But let us not be bitter...

● **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 from their 2011 survey. Experts say the trend could be linked to more relaxed workplaces. However, there is hope for those who do not wish to get too close to 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 to bypass the germ-laden bear hug by citing their strict adherence to hygiene rules.

● **PRICEY MOULD** A "holy relic" of medical science was recently sold by Bonham's Auction House in London for £11,863 - a patch of mould. Not just any old mould though - it was grown by none other than Alexander Fleming 90 years ago. On the back of the glass encased disc holding the small white swatch is an inscription from Fleming himself reading: "the mould that first made penicillin". This may be stretching things as the scientist apparently often sent out samples of his mould to numerous dignitaries including the Pope and - oddly - Marlene Dietrich. Not quite a girl's best friend.

● **DOC DELIVERY** Inspired by the success of firms bringing pizza and sandwiches to the masses, one company now wants to deliver GPs to your home or workplace. Described by the *Daily Mail* as the "Deliveroo for doctors", the service promises "quick, convenient access to quality healthcare for families and business". They guarantee same day, face-to-face treatment with prices starting from £80 per month (although laboratory and diagnostic tests cost extra). It's the latest in a series of new private doctor services offering an "on demand service" in person or via smartphone app/video. But before you shut up your high street practice, there have been words of caution from some. The Care Quality Commission said it had "significant concerns" about some digital primary care services with its chief inspector of general practice Steve Field saying that "some services may be putting patients at risk" if they are not appropriately assessed or managed.


● **FORGET THE KRISPY KREME - HERE'S A NICE FRUIT PLATTER** Diary consumes only lukewarm distilled water when at work so we are thus unperturbed by the dietary strictures being promoted currently by Prof Nigel Hunt, Dean of the Faculty of Dental Surgery at the Royal College of Surgeons. He believes that a "cake culture" in offices and

practices is fuelling the current obesity epidemic. Speaking at a recent College dinner he said: "Managers want to reward staff for their efforts, colleagues want to celebrate special occasions, and workers want to bring back a gift from their holidays. But for many people the workplace is now the primary site of their sugar intake... Cake culture also poses difficulties for those who are trying their hardest to lose weight or become healthier - how many of us have begun such diets only to cave in to the temptation of the doughnuts, cookies or the triple chocolate biscuits?" Chastened dentists at the dinner were consoled over coffee with "mint panna cotta, British strawberries and chocolate soil".

● **SAVED BY THE BEARD** As we remain in the midst of a facial hair fashion frenzy, it seems beards 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. Others saw it as a means of relaxing the throat, especially for those whose work involved public speaking. 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.

● **FOR MEDICINAL PURPOSE ONLY** Debate continues over the harmful or helpful effects of moderate alcohol consumption with another recent study - this time by Cambridge University and UCL researchers - finding that one alcoholic drink per day was linked to a lower risk of some cardiovascular conditions. Medicinal justification for the daily tippie is nothing new: recently a photograph of an historical note appeared on Twitter written by a physician in 1932 on behalf of a prominent British MP travelling in prohibition America. It reads: "This is to certify that the post-accident convalescence of the Hon. Winston S. Churchill necessitates the use of alcoholic spirits especially at meal times. The quantity is naturally indefinite but the minimum requirement would be 250 cubic centimetres."





"Rising indemnity costs are a concern for all GPs ... I'm delighted that our newly qualified members can opt to benefit immediately from this discount scheme"

Professor Helen Stokes-Lampard,
Chair of the RCGP

RCGP FIRST5 PARTNERSHIP

MDDUS has teamed up with the Royal College of General Practitioners to offer GPs in the first five years after qualification access to a tailored indemnity package and a contribution towards their College membership. This partnership provides a new cost-effective route for new GPs to get all the benefits of belonging to two innovative and complementary professional bodies.

Newly qualified First5 GPs will be able to take advantage of a 75% contribution to RCGP membership fees, as well as a tailored indemnity product at a competitive price. This exciting new package can offer **overall savings in excess of £3,000**.

To find out more and take advantage of this offer go to **www.mddus.com/join/rcgp-first-5-partnership**. The 75% contribution to your RCGP fees will be applied after your membership application is approved.

Existing MDDUS members who are RCGP First5 GPs will automatically benefit from the contribution at their next renewal date.

Contact Mairi Dixon on **0141 228 1267** or **mdixon@mddus.com** for more information.