

# INSIGHT



PRIMARY

**Featuring:** Making SEA work for you / Dealing with aggressive patients / Texting pitfalls / Ethics: It's the small things



**DIY  
health**

An award-winning project providing parents with the knowledge and confidence to manage minor ailments in under-fives

# Welcome

Dr Greg Dollman  
Editor



WELCOME to the first issue of *Insight Primary Care* — one of three new quarterly magazines we are launching at MDDUS to broaden the scope of content we produce for all our medical and dental members (see **page 3**). I am excited to take on the role of editor and hope you

find this inaugural issue both interesting and useful. All comments and suggestions are most welcome.

Significant event analysis is not easy to get right and many of the SEAs we see at MDDUS are more description than analysis. On **page 10** of this issue, Liz Price offers tips on making SEAs more than just simple box-ticking exercises.

On **page 6** we look at how to deal with aggressive patients while ensuring practice staff are kept safe, and our regular risk column on **page 7** concerns the use of texting to contact patients and the data protection implications. In our profile feature on **page 8**, we hear about a programme helping to ease pressure on GP practices in Tower Hamlets London by promoting self-care among parents of children aged 0-5. 'DIY Health' so impressed the judges at the 2019 BMJ Awards that it was named Primary Care Team of the Year.

Professor Deborah Bowman offers a personal perspective (**page 13**) on how even "small things" can reflect ethical choices when it comes to dealing sensitively with patients.

Our Call log on **page 4** features common (and not so common) advice requests from GPs and practice managers, and our case study on **page 12** concerns allegations of delayed diagnosis of appendicitis in a patient with abdominal pain.

Addenda on **page 14** includes some curious cardiac imaging, reviews of Bill Bryson's brilliant new book *The Body* and the corporate crime film thriller *Dark Water*, along with a vignette of Dr Margaret Fairlie — pioneering obstetrician and gynaecologist, and the first professorial chair in Scotland.

Dr Greg Dollman  
Editor

EDITOR  
Greg Dollman

MANAGING EDITOR  
Jim Killgore

ASSOCIATE EDITOR  
Joanne Curran

DESIGN  
Connect Communications  
0131 561 0020  
www.connectmedia.cc

EDITORIAL DEPARTMENTS  
Medical: Dr Richard Brittain  
Legal: Joanna Jervis

MDDUS  
Mackintosh House  
120 Blythwood Street  
Glasgow G2 4EA

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

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# INSIGHT Briefing



## GP APPOINTMENTS

### Million missed monthly

MORE than one million people fail to attend GP appointments every month in England, costing the NHS £200 million a year, according to analysis of latest figures from NHS Digital published by *The Times*.

In the period from June to November 2019, 7.8 million patients in England "did not attend" (DNA) — an average of 42,822 per day. Around half of the appointments were to see doctors, with the rest for nurses or other healthcare professionals.

The NHS has no formal national policy for dealing with persistent non-attenders. Most surgeries use a range of tactics to tackle the problem, including text reminders, emails or letters, but some may issue warning letters. The RCGP said that the reasons for non-attendance may be complex and practices must be given the resources for patient follow-up.

## WELLBEING

### What about you?

PATIENT care may come first for medical professionals but how do you look after your own wellbeing? A 2019 British Medical Association (BMA) report found that nearly nine out of 10 GP partners are at high or very high risk of burnout — and all staff are under pressure with increasing demand. MDDUS has produced some guidance and resources for members on keeping well and avoiding burnout. To access the *Member wellbeing and mental health* page go to the Advice and Support section of [mddus.com](http://mddus.com)





## Go digital

Read, see and hear more content including coronavirus updates by accessing the premium digital version of *Insight Primary Care*. Go to Resources > Publications at [mddus.com](http://mddus.com) and click on **View this issue via digital reader**



### WORKFORCE

## RCGP sets roadmap

GENERAL practice is “running on empty” with ever increasing patient demand and falling GP numbers, says the Royal College of General Practitioners in a statement setting out a new Workforce Roadmap.

The plan details what must be done to ensure general practice has enough GPs and practice staff to deliver safe, high-quality patient care if the Government is to achieve its manifesto pledge of 6,000 more GPs and 50 million more patient consultations. The RCGP points out that from September to November 2019, GPs in England undertook 41.9 million patient consultations, which is 450,000 more than the same period in the previous year - this despite a drop in the number of full-time-equivalent GPs.

RCGP chair Professor Martin Marshall said: “Unfortunately, general practice has been running on empty for too long... The impact of these measures will be to significantly improve the access to our service and the quality of the care we can give to our patients.”

**42m**  
GP CONSULTATIONS



### INDEMNITY

## Extended cover for practice staff

MDDUS can provide extended indemnity, legal support and advice/assistance to non-GP practice staff in England and Wales for activities and risks not covered under new state-backed schemes. Under our **Primary Care Team Professional Advice Protection** plan all non-GP members on the practice team can enjoy access to expert advice and support with complaints arising from clinical practice indemnified by state-backed schemes in England and Wales (CNSGP and GMP, respectively). In England this includes NHS primary medical services delivered on behalf of the Primary Care Network.

The plan is provided free to practices where GP partners are all MDDUS members. In practices where all GP partners are not in MDDUS membership there will be an annual charge of £50 per regulated team member. Non-regulated staff (e.g. HCAs) will be covered free of charge.

MDDUS also offers an essential extension to the above plan for individual regulated non-GP staff. Find out more at [tinyurl.com/y4a2cogl](http://tinyurl.com/y4a2cogl).



## An *Insight* for primary care

LAST year we launched the first edition of a new digital *Insight*, generated using the premium digital magazine platform, Foleon. The switch to digital was part of a larger initiative to reconsider our publication programme and how best to communicate with members going forward in 2020.

We have now decided to broaden the scope of the content we produce for medical and dental members. Starting this month we will replace

our current range of magazines (including *GPST* and *Practice Manager*) with three branded quarterly digital and print magazine titles.

*Insight Primary Care* is the first of these magazines with a secondary care publication launched in April and a dental in May. All the *Insight* titles will be generated using Foleon and sent out via an email link, but those existing members who opted for print will still receive a hard copy in the post.

# CALL LOG



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

## Consulting via social media

**Q** I have a patient being treated for a chronic condition and we recently discussed switching medication and agreed to do some baseline bloods first before changing the prescription. The patient has now sent me a friend request via LinkedIn with a link to an article assessing a possible alternative medication. Is it okay for me to reply to this message with a link to another article showing there is no conclusive evidence supporting increased efficacy in the suggested drug? LinkedIn is a “professional” platform and the question is treatment related.

**A** It's best to be cautious about this type of communication with patients. GMC guidance on *Doctors' use of social media* highlights that boundaries can become blurred when communicating through sites such as LinkedIn. It states: “If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile”. The guidance also states: “social media sites cannot guarantee confidentiality whatever privacy settings are in place”. We would advise that you inform the patient that you do not use LinkedIn or any other social media platform for clinical communication and provide a range of options to contact you via the practice.

## Access to teen's records

**Q** A 13-year-old patient at our practice has fallen out with his mother and is now living with his father. The mother has recently been in touch with the practice in regard to an ongoing health issue with the boy – but he no longer wants her to have access to his healthcare information. What is our legal position?

**A** Given the age of the boy it is possible he would be judged Gillick competent with capacity to refuse disclosure of his personal medical information. We advise that the practice writes to the mother stating that, in order to consider whether information can be disclosed to her, the boy would need to be assessed by a GP regarding whether he is competent to make this decision for



himself. It may be the mother would not want her child to be informed of her request. If she is content for this assessment to be undertaken and he has capacity but refuses, this would ordinarily be definitive. If he does not have capacity and the mother maintains parental responsibility, the key issue is what is in the child's best interests to disclose.

## Keeping insurance records

**Q** How long is our practice required to retain copies of completed medical insurance reports?

**A** Insurance forms are covered by the Access to Medical Reports Act 1988 and this allows for patients to request to see a report or have a copy of a report up to six months from the date of it being written – thus the practice would be expected to keep copies of these documents for a minimum period of six months. Principle 5 of the Data Protection Act 2018 is also relevant here, stating that personal data processed for any purpose shall not be kept for longer than is necessary for that purpose. Compliance with this legislation would suggest a practice policy of safely disposing of insurance forms after six months. MDDUS advises filing such reports independently of medical records so they can be easily reviewed and kept for no longer than is necessary in compliance with Data Principle 5.

## Intoxicated patient

**Q** An elderly patient recently attended the practice for an appointment having come from the pub. He was clearly inebriated, smelling of alcohol, stumbling and slurring his words. The GP refused to see the patient and asked reception to make another appointment for later in the week. The patient was clearly not happy and made a fuss in the waiting room. He is registered with the practice and has no history of alcohol dependence. Are we allowed to refuse to see an intoxicated patient in such circumstances?

**A** Conducting a consultation with an inebriated patient would clearly affect your ability to obtain a detailed history and perform an appropriate clinical examination. In such circumstances it would be appropriate to make an initial assessment of the patient to consider whether other issues are the cause of the patient's presentation and whether it would be unsafe to allow him to leave the practice in this state. It may be advisable to discuss the matter with practice colleagues to determine whether the patient may require further assessment/treatment for potential alcohol dependency. In the event that the patient displays abusive behaviour, you may wish later to issue a formal warning that such behaviour will not be tolerated and could lead to removal from the practice list.



## Work-shadowing

**Q** I'm a GP partner at a practice and have been asked by a friend if his daughter can shadow me for a few sessions. She is in her final year at school and is applying for medicine at university. Is this problematic?

**A** Work-shadowing arrangements are not uncommon but there are a number of issues to consider. First a risk assessment should be performed and recorded prior to such an attachment to ensure that the work environment is safe for a visiting pupil. The Health and Safety Executive has published guidance related to work-experience pupils ([tinyurl.com/uo65xfu](http://tinyurl.com/uo65xfu)). It is also crucial to consider issues of confidentiality and consent. The pupil should be required to sign an agreement and given firm guidance that personal patient details (even the fact that someone has attended the surgery) are entirely confidential. Patients must be asked for consent in advance (preferably in writing) for a school pupil to be present during a consultation and should also be advised that they may change their mind at any time. Notices in the waiting room to indicate that school pupil placements may occur are also helpful. Pupils should be informed that they cannot expect hands-on experience and will only be observing on a limited basis (e.g. no examinations). Finally, it is important that the whole practice team are comfortable with the arrangements to ensure the pupil is appropriately supported and supervised.

## Probationary employment

**Q** We hired a medical receptionist on a six-month probationary basis but there have been a number of issues arising in that period. These include not complying with practice protocols and procedures despite being given repeated training. She has also stated that she will not be available to cover annual/sickness absence which was clearly outlined in her interview. I have discussed these concerns and informed her that at present we will not be offering her a permanent employment contract. Are we within our rights?

**A** An employee with under two years' service does not have unfair dismissal rights. As long as there are no protected characteristic issues (such as disability, sex,



race, pregnancy etc), it should be straightforward to advise the employee that her probationary period has not been successful. She should be given her notice – which can be worked or paid in lieu – along with any accrued outstanding holiday pay up until the termination date. MDDUS members can request a template letter by emailing [advice@mddus.com](mailto:advice@mddus.com).

## Cc'ing the GP

**Q** Our practice is trying to reduce workload and one thing that crops up repeatedly is consultants copying the GPs in on bloods/histology results that they (the consultants) have requested. Can we assume that the consultant will follow-up on results if abnormal? Could the practice be held liable for failing to inform the patient of an abnormal result for a test that we did not request?

**A** The doctor who initiates an investigation is ultimately responsible for following it up and advising the patient accordingly (or making clear alternative arrangements) but there are often cases in which continuity and coordination of care are required. The GMC highlights that in delegating care you must ensure that you "share all relevant information with colleagues involved in your patients' care within and outside the team". In the circumstance described, the consultant initiating the investigation is likely to be responsible for reviewing the patient. However, as this information is being provided to a GP in the practice it should not be simply ignored – especially if urgent action is required. It would be difficult to defend adopting a specific policy not to review copied correspondence. Ultimately, if there is any confusion, it would be necessary to clarify with the originating



healthcare professional what are the follow-up arrangements for the specific patient. You could also discuss this matter further with your LMC, who may have a policy on the matter or would be able to advise you if similar instances have occurred with other practices.

## Non-clinical chaperones

**Q** Our practice recently discussed the possibility of chaperone training for non-clinical staff. Is it a legal requirement to undertake DBS checking for prospective staff wishing to act as clinical chaperones?

**A** In the first instance it would be important to consider whether it is appropriate for a non-clinical staff member to act in this role. GMC Guidance on *Intimate examinations and chaperones* states that a chaperone "should usually be a health professional and you must be satisfied that the chaperone will:

- be sensitive and respect the patient's dignity and confidentiality
- reassure the patient if they show signs of distress or discomfort
- be familiar with the procedures involved in a routine intimate examination
- stay for the whole examination and be able to see what the doctor is doing, if practical

- be prepared to raise concerns if they are concerned about the doctor's behaviour or actions."

The guidance also states that a "relative or friend of the patient is not an impartial observer and so would not usually be a suitable chaperone, but you should comply with a reasonable request to have such a person present as well as a chaperone". MDDUS would suggest that you review the guidance as a whole to assist in your decision making in this matter – but should the practice still wish to consider the use of a non-clinical chaperone it is important that you are able to clearly explain and justify this decision. We would also advise that you ensure the person is appropriate and reaches the above standards. Most health professionals will have already undergone DBS checking and we would anticipate that non-clinical chaperones would also require vetting.

# AVOIDING WORKPLACE VIOLENCE

**Helen Ormiston**

Practice adviser at MDDUS

**T**HERE has been much discussion in primary care around zero tolerance policies and the uneasy line between meeting the needs of the patient and the legal obligation to provide safe places of work for staff. As attacks on healthcare staff increasingly make their way into news headlines, it is important that managers are proactive in reducing the potential risks facing employees.

From a health and safety perspective, every practice should have a comprehensive policy setting out the identified risks to staff (and the public), what steps have been taken to eliminate or minimise them, and who is responsible for overseeing the safety of all those within the practice.

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 others. The Health and Safety Executive (HSE) has specific guidance on assessing workplace violence within a health and social care setting.

The following areas are likely to be relevant when undertaking a risk assessment for GP premises.

## PHYSICAL ENVIRONMENT

- Are access ways well-lit and visible? Are there good lines of sight? One study reported a 50 per cent reduction in violent incidents in A&E as a result of design and signage changes.
- Consider the height and width of reception desks and whether patients can reach over to staff.
- CCTV cameras in the surgery and surrounding the buildings can act as a deterrent and recordings can be used as evidence if needed.
- Are telephone calls recorded? Call recording may substantiate an employee's concerns about an abusive caller. Recordings can also be used in staff training to review whether a call may have been handled differently.
- Is the reception desk visible to or within earshot of other staff, who may be able to provide support if necessary?
- Review the layout of consulting rooms and select furniture and fittings that are difficult to use as weapons. Explore whether staff are able to leave the room quickly if needed, and how best to do so.

## LONE WORKING

Do you have staff working alone in the surgery or conducting visits unaccompanied? If so, it is important to consider what reasonably practicable measures can be put in place to address additional risks. For example, if staff work alone during extended hours, can these appointments be bookable only in advance? The use of security cameras at the surgery entrance may be useful, and consider also door security so patients cannot walk in unexpectedly. In addition, would it be possible to limit known aggressive patients from accessing these appointments? Review proposed home visits where possible to try to ensure they are allocated to appropriate clinicians (trainees may build up their experience before visiting more difficult patients) and act on MAPPA (multi-agency public protection arrangements) warnings. Do clinicians need to attend in pairs or liaise with police or other agencies before undertaking a home visit?

## TRAINING

Do staff receive appropriate training, including basic techniques in managing challenging behaviour or de-escalation, with greater training for those in higher risk situations? Use protected time sessions to update training.

This training could include causes of violence, recognising warning signs, interpersonal and communication skills, de-escalation techniques and incident reporting procedures.

## POLICIES AND PROCEDURES

Are there appropriate policies and procedures in place for handling incidents, emergencies and particular high-risk patients, and dealing with threatening patients? These may include the use of warning letters and acceptable behaviour agreements. Any warning or behaviour contract should always be made based on an individual patient's specific needs and not just as a blanket policy. GP practices are often tolerant of unacceptable behaviour from patients because they are unwell or frightened — but do not wait until behaviour escalates before proactively addressing the concerns. It is not unusual for non-clinical members of staff to bear the brunt of a patient's unhappiness; ensure staff are fully supported when they raise concerns about aggressive or abusive behaviour.



## TECHNOLOGY

Is appropriate equipment available, such as panic buttons or alarms? Ensure that all staff understand how the alarms work: for example is the alarm audible or silent, does it alert the police directly when activated or must a member of staff contact 999? Ensure alarms are tested and serviced in the same way as fire alarms.

## ACTION POINTS

- Adopt a risk assessment approach to the management of workplace violence and aggression that takes into consideration the individual circumstances of a case.
- Ensure that all incidents of work-related violence are recorded and reported through relevant health and safety systems and, if appropriate, to the police. You may need a police incident number to refer a patient to the challenging behaviour unit.
- Have a clear and comprehensive policy in place for dealing with aggressive or violent patients, including the steps to be taken when considering removing such patients from a practice list. Review the GMC's guidance and your contractual obligations regarding ending a professional relationship with a patient. Take care with documenting an incident — keep to the facts and maintain a professional tone in all descriptions.

# DATA CONCERNS WHEN TEXTING PATIENTS

**Alan Frame**

Risk adviser at MDDUS

**T**EXT messaging patients has become almost routine in healthcare today. Even the GMC now recognises that texting “can be convenient and supports effective communication between doctors and patients”. However, robust processes are still needed to monitor and control both message content and intent, as well as protect patient confidentiality.

Enactment of the General Data Protection Regulation (GDPR) has raised concern among GPs about what exactly is permissible to send to patients by text. Text messages are transmitted on public phone networks and are therefore potentially insecure. They can also be read by unintended others. A clinician may not be responsible for a message once received by a patient but it is useful to remind and encourage patients to ensure their phones and devices are only accessible by individuals with permission to view their personal sensitive information.

Before examining specific GDPR considerations, it is important to reinforce that care should be taken with any text messages that contain sensitive clinical information. This may relate to the type of information being transmitted (e.g. a specific clinic appointment or mention of a condition) but it also requires

consideration as to what may happen if the information is misused. Some clinical information by nature is especially sensitive, such as issues relating to sexual or mental health, and in any case all health information is classified as “special category data” under GDPR, which demands even greater security measures to be in place.

The Information Commissioner’s Office (ICO) has produced general guidance that health professionals should consider and follow in the provision of a text messaging service to patients. Specific advice can also be obtained by phoning the ICO advice line on 0303 123 1113.

The starting point for data controllers is to identify a lawful basis under GDPR for the processing of all personal information, as well as the “special category condition” for health information. Once established it should be set out in a privacy notice and publicised widely within the practice, on its website and social media pages, as appropriate. A practice intending to use text messaging to contact patients must clearly set this out in its privacy notice in a “granular” and “meaningful” way. This means clarifying the specific purposes for which you intend to contact patients and not deviating outside those communicated parameters.

If the above process is followed, there is no additional requirement under GDPR to obtain individual patient consent to send patient-specific text messages. However, the ICO confirms that obtaining such consent would still be regarded as “good practice”, and this is more aligned to current regulatory guidance from the GMC.

Looking at some specific advice requests that MDDUS has received since the introduction of GDPR can hopefully provide clarity on complex issues that might be open to testing and interpretation.

**Is it acceptable for a practice to send appointment reminders and other patient-specific information, such as a chronic disease recall alert?** The answer here is ‘yes’, as long as the message is patient specific and a “reminder” rather than “promoting a service”, which may come under the category of direct

marketing, where explicit consent from the patient would be required (see below). A results notification would also be legitimate but only the fact that a result is now available. Transmission of actual test results by text and other specific clinical information is possible but the practice would have to identify a specific “special category condition” for processing and communicate their intention under a published privacy notice or statement. The ICO also emphasises that attaining individual patient consent to send actual test results would be “good practice”, paying particular attention to accuracy and security, and taking reasonable steps to ensure that mobile numbers are kept up to date. Otherwise a foreseeable data breach could occur.

**Can “service update” messages be texted to all practice patients?** This could include, for example, “the clinic will be closed for training next Tuesday afternoon” or “the practice will now be open until 7pm on weekday evenings”. Although not patient-specific, such texts would be viewed as service update messages and therefore permissible. The intention is to inform patients about important service changes or updates to prevent inconvenience and maintain the smooth operation of the service. While specific patient consent would not be required, the ICO advise that a descriptor of such types of communication should also be included in your privacy notice.

**What is considered direct marketing under GDPR?** This is defined as the “promotion of a service, whether for profit or not” and under GDPR will require explicit opt-in consent by recipients. Some examples of what could be construed as direct marketing include setting up and advertising a new diabetes clinic for all patients on the practice database with this diagnosis, or promoting a travel clinic to provide holiday/travel advice and vaccinations.

It is again also important to remember your professional obligations when it comes to protecting patient confidentiality and to review appropriate guidance, including the GMC’s *Confidentiality: good practice in handling patient information*.





# DIY HEALTH

An award-winning project aims to help ease demand on an overburdened healthcare system — and much more

**T**OWER Hamlets in London faces some tough challenges when it comes to healthcare. This inner city borough has the highest rate of child poverty in the capital at 43 per cent. Healthy life expectancy in men is among the lowest in the country at 61.3 years compared with 63.1 years nationally. The borough also has high premature death rates from circulatory disease, cancer and respiratory disease, along with high rates of diabetes, particularly among its Bangladeshi community.

Addressing these challenges on a daily basis is Bromley by Bow Health (BBBH) — a partnership of three surgeries located in the heart of Tower Hamlets. It is affiliated with the pioneering Bromley by Bow Centre: part church, part charity, part community hub, with a reputation for innovation and experimentation in social care.

It was here in 2013 that Dr Khyati Bakhai started her career as a GP partner, nine months into a Darzi Fellowship for clinical leadership. An ideal choice, as this would prove the genesis of an innovative new programme that could in future help ease the burden on primary care provision across the UK.

## SELF CARE

Just after starting at BBBH's St Andrew's Health Centre, Khyati noticed that parents of children under the age of five were frequently reattending for minor ailments that could easily be dealt with at home, such as diarrhoea, fever and viral coughs and colds.

"I started enquiring about this with some of the patients," says Khyati. "And they said either they didn't have the knowledge or the confidence or just someone else to speak to about these issues, and this was what was often driving them to come and see the GP."

This led Khyati and her colleagues to recognise that more needed to be done to help parents and carers manage their children's health at home and to know when to seek further help. It's a challenge reflected across UK healthcare.

A significant proportion of primary care demand comes from patients attending for self-treatable conditions. An estimated 27 per cent of patients seen in GP appointments could actually be getting necessary advice elsewhere. Figures from 2016 show that minor conditions and illnesses were responsible for approximately 57 million GP consultations and 3.7 million A&E attendances, costing the NHS more than £2bn — resources that could be better employed elsewhere considering the increasing demands of an ageing population with complex morbidities.

Khyati discussed the issue with her practice partners. "Looking on a borough-wide level we found children nought to five were behind some the highest spend in A&E attendances and the majority of these were for minor ailments. But when we looked at the wider data we found it wasn't just a local problem but a UK issue. So we decided to create something that could be used nationally and replicated in different settings."

## CO-PRODUCTION

In her project work as a Darzi Fellow, Khyati employed a development methodology known as co-production. Rather than simply consulting on what's needed, co-production involves users (patients) directly in the design, delivery and evaluation of a service. It places them in partnership with professionals using "participatory action learning techniques" to ensure the effective transfer of knowledge, skills and capabilities. The method has been shown to improve outcomes and intervention effectiveness.

"The partnership supported the facilitation of focus groups and we worked with patients at the outset to determine exactly what was needed and in what context," says Khyati. "The patients themselves then helped us pitch for funding."

A six-month pilot was costed as part of the Tower Hamlets CCG Innovation Bursary Fund. Khyati worked with Patient First manager Emma Cassells, parents and other



stakeholders to implement a peer-to-peer learning programme. This was the genesis of DIY Health: 0-5.

DIY Health is delivered in eight to 12 two-hour sessions, catering for up to 12 parents per session. Topics covered include management of fever, diarrhoea and vomiting, skin conditions, coughs and colds, ear pain and feeding. The programme also utilises play specialists to involve the children and ensure childcare is not an issue.

Over 300 families have taken part in DIY Health since 2013 and the scheme has also trained several parents who can now facilitate the programme.

Says Khyati: "Once we piloted the programme we started seeing huge benefits and not just in children's health. It reduced isolation and parents were able to talk to each other about their own wellbeing. It addressed problems that we had not even necessarily identified."

Evaluation of the next phase conducted in partnership with the Anna Freud Centre and Professor Monica Lakhnapaul and Carol Irish working with UCLPartners showed an increase in knowledge, confidence and skills to manage a wide range of health issues for all parents involved, and high levels of co-production throughout the programme. Quantitative results revealed a 36 per cent reduction in attendance for minor ailments to GPs, emergency departments, out-of-hours clinics, and walk-in centres in the 12 months following the programme.

Reducing the burden on primary care





Main picture: Dr Khyati Bakhai and Nasim Hafezi. Below: DIY Health team attending the BMJ Awards (from left): Nasim Hafezi, Surayia Uddin, Clara Barai, Khyati Bakhai and Emma Cassells



MAIN PHOTOGRAPH: DOMINICK TYLER; INSET: HARRY RICHARDS

services has been an important outcome of the programme but was not the prime motivation for Khyati. “The aim is to get people the most appropriate help in the most efficient way. We have seen a change in people in that they are more confident accessing resources online and minor ailments schemes directly through the pharmacy.”

### SPEAKING THE LANGUAGE

Another unique characteristic of the programme is its multidisciplinary approach. Says Khyati: “It started off with medical professionals, then health visitors and now we have non-clinicians facilitating these sessions. We are giving our non-clinical staff a wider role in improving people’s health — and this improves staff satisfaction.”

Nasim Hafezi joined BBBH four years ago,

working as a patient assistant in reception.

“An email went around the practice to see who might be interested in DIY Health,” she says. “I was a bit bored with what I was doing to be honest. Something about it really interested me.”

Nasim worked at first with a nurse but now co-facilitates DIY Health sessions with other non-clinical staff.

“In a way I think it’s better to be non-clinical because you speak the same language. You’re not making everything clinical. But if there’s any problem, if I’m not sure how to answer a question, I know there’s a clinician I can go to. That’s never an issue.”

“It’s a very informal session. Not us standing in front of a blackboard and saying you must do this. It’s the parents who decide what topics they want to discuss for the following week.”

Nasim also insists the programme is

**“We found children nought to five were behind some of the highest spend in A&E attendances and the majority of these were for minor ailments”**

not just about health but also community — about helping each other. “Most of the parents know what they are supposed to do but just need some reassurance. It’s about sharing other parents’ experiences, their stories — especially now in this day and age when people may not have family nearby.”

“One of our parents said to me: ‘this is the only place where I feel I can talk about my children without being judged’. That is so important.”

It’s these wider benefits that contributed to DIY Health being honoured in the 2019 BMJ Awards as Primary Care Team of the Year. The judges said they were particularly impressed by the way in which the project empowered and connected local parents. “There were obvious immediate benefits for parents, their children and health providers. And also a long-term ripple effect into the local community.”

BBBH are keen to spread the DIY Health ethos of co-production and participatory learning across the UK and have produced a free toolkit (available at <https://uclpartners.com/diy-health-toolkit>).

Khyati says her top advice for anyone undertaking a similar approach is not to start from scratch but to reach out.

“Get in touch with us or anyone who is doing something similar. Start from a point they have left off so that we are not all reinventing the wheel.”

Khyati can be contacted via email at [k.bakhai@nhs.net](mailto:k.bakhai@nhs.net)

Jim Killgore is managing editor on *Insight Primary Care*



# MAKING A SEA CHANGE

Is your practice truly learning from adverse incidents?

MDDUS senior risk adviser **Liz Price** offers some reflections on SEA

**S**IGNIFICANT event analysis (SEA) is now (hopefully) embedded as an ongoing process which supports complaints handling and acts as a collective learning exercise within general practice. But when was the last time that you took stock of how much value your practice is getting out of the process?

Many of the SEAs we see at MDDUS in our role assisting members with potential medicolegal cases are more of a description than analysis. A lack of analytical rigour in SEAs, if routine, can lead to poor engagement in the process with much less learning and a reduced impact on patient safety. If your practice is sleepwalking through SEAs, consideration of the following can help.

## HOW ARE EVENTS TARGETED FOR ANALYSIS?

Factors at play here include the use and effectiveness of your incident reporting processes. Does the team understand what to report? Are low level incidents, near misses and 'good catches' being collected as well as significant incidents for thematic review? There is some evidence that unless there is a significant proportion of these incidents reported, it may be that your processes are not sensitive enough.

Among additional benefits in capturing lower level but repetitive incidents is the identification of training needs and also a reduction in unnecessary follow-up activities. Practices should also consider who reports incidents. Are the same people putting forward the same events for discussion or do SEAs cover the full range of services/activities undertaken by the practice? Does your organisational culture support self-nomination? Staff who feel unsupported are unlikely to report an incident in which they were involved.

It can be helpful to nominate a member of the team to review all reported incidents on a regular basis in order to identify themes. Particular systems or protocols associated with lower level incidents can then be targeted for analysis, and solutions presented for a sense-check at team meetings. Highlighting efficiencies

and safer protocols adopted as a result of such reporting can encourage future engagement. Reviewing the ease of reporting is also important: achieving a balance between simplicity and gathering appropriate data is crucial.

## WHO DO YOU INCLUDE IN THE PROCESS?

Some clinical incidents may be too sensitive for discussion in a wider team setting, but should an SEA involve non-clinical systems it is essential that a suitable member of the admin team is involved to ensure that any changes are sensible and do not create additional risks. Alternatively, clinical SEAs or admin-only SEA outcomes can be briefed to the wider team at regular practice meetings. Either way it is important to ensure changes are properly understood (and embraced) by the wider team.


Routine SEA meetings involving the full team should include a range of topics or potential risks (errors) over a set period of time (e.g. a year cycle). This will ensure that no one group feels alienated or unengaged in the process.

## HOW IS THE SEA MEETING STRUCTURED?

Many practices use similar styled templates for structuring conversation and analysis around significant events. A structured approach is essential but it can often end up being used as a 'documentation' tool rather than an in-depth 'learning' tool. A highly structured conversation in the context of a busy agenda may disincentivise discussion after "high-level factors" are identified. Staff may be reluctant to address other contributing factors and may feel pressure to "move onto the next agenda item" or "wrap the conversation up". There may be a reluctance to express any implied (or implicit) criticism of others, or to draw others into the mix by expanding the depth or breadth of the analysis. A good chair should be able to manage the time spent on each agenda item, whilst ensuring that enough exploratory questions are asked in each area of analysis.

It's useful to collect as much information as possible





beforehand in relation to the event(s) in question, in order to maximise the quality of discussion. This could include more detailed written statements, copies of current policies or other records, as appropriate.

### IS THE MOST COMPREHENSIVE LEARNING EXTRACTED?

Often only superficial learning and training opportunities are identified through the SEA process. What went wrong may be put down simply to: “the process or protocol wasn’t followed” or “the person should have asked for advice from a colleague at the time of the incident”. Subsequent learning is then noted as: “the protocol should be followed in these circumstances” or “in future a GP should be asked to speak to the patient if they present in this way”. Such conclusions may be true but unless “why” questions are asked, many incidents are more likely to reoccur.

This is because in most scenarios there will be other underlying factors that contributed to the adverse incident. Such factors usually range across:

- People — the specifics of the patient or the team member involved.
- Activities — the task(s) or process that the individual (or team) were engaged in at the time.
- Environment — the setting or situation within which the incident occurred.

Asking “why” multiple times will help draw each strand of an investigation to its natural start point. Indeed there is evidence that asking “why” five times is the optimal strategy to achieve deeper learning and a root cause.

Exploring the contributory factors more fully should lead to findings such as: “the protocol was not followed because the individual was under too much pressure” or “the GP was not consulted for advice because the receptionist was too scared to approach them”. In the latter example, asking why is likely to identify whether the receptionist needs support to be more assertive, or whether the GP needs to adjust their manner or response to interruptions.

Identifying such underlying issues can often be uncomfortable and challenging to resolve. They may relate to deficiencies within practice management/ leadership or ingrained behaviours created by stress/ overload — but such causal factors will likely lead to future incidents if not recognised and resolved.

### ARE OUTCOMES BEING MAXIMISED?

To ensure that any lessons learned from incidents are cascaded properly, the practice should agree a mechanism by which staff not directly involved in an SEA still receive an update. Any amendments to protocols or practice systems should include clear information about the efficiency, effectiveness or patient safety gain from the proposed change, as this is likely to encourage compliance.

Sometimes, research or audit is required to assess the extent of any issues identified, or further training will be necessary to support improved practice. It is important to agree a timescale for completion, and an individual should be appointed to make sure it happens and is reported back.

At the end of the review, an anonymised written record of the analysis, including insights gained, lessons learned and actions agreed should be completed and retained securely. It is often useful to share an SEA with the patient as part of a complaint response to show evidence of quality improvement (e.g. as part of a CQC inspection under KLOE2). Where an event led or could have led to patient harm, an SEA can be used by GPs as evidence of reflective practice for the purposes of appraisal or revalidation.

Should you need assistance in reviewing your incident reporting system, members can access our incident reporting checklist in the training and CPD pages at [mddus.com](https://mddus.com). MDDUS advisers are also available to review anonymised SEA draft reports, once the investigation has been completed. Getting this right will set your efforts off in the right direction.

Liz Price is senior risk adviser at MODUS

# PERFORATED APPENDIX

## DAY ONE

A 19-year-old student, Daniel, presents at the campus surgery complaining of abdominal cramps and vomiting. His flatmates have recently suffered similar symptoms. He is attended by Dr J and reports having been sick around 10 times (but less frequently that morning), along with some episodes of diarrhoea. Dr J notes that the patient is afebrile with a heart rate of 68 and respiratory rate of 14. The GP examines his abdomen and notes: *Abdo – soft. Mild generalised tenderness.* Dr J concludes that Daniel is likely to be suffering from gastroenteritis and advises him to take paracetamol and drink plenty of fluids. He is also instructed to seek further medical care if the symptoms do not resolve or he becomes more unwell.

## DAY FOUR

Daniel is brought to A&E by his flatmates in "agony" and is diagnosed with appendicitis. A note of the initial assessment records a three-day history of abdominal pain, abdominal distension, generalised tenderness and absent bowel sounds.

## DAY FIVE

Daniel is taken to theatre and undergoes an open appendicectomy. The surgeon finds a perforated appendix with copious pus in the abdomen. Daniel has a difficult recovery with complications including a post-operative ileus, pleural effusion and hospital-acquired pneumonia.

## DAY 13

Daniel is discharged from hospital. His parents later contact a solicitor and a letter of claim is sent to Dr J alleging breach of duty of care in failing to consider a diagnosis of appendicitis. It is alleged that this led to a delay in referral for further assessment and treatment, resulting in a perforated appendix requiring invasive surgery and a risk of associated complications.



MDDUS seeks expert opinion on both breach of duty and causation in the case. In his response to the claim, Dr J highlights that he did in fact consider a diagnosis of appendicitis when Daniel presented with abdominal pain. He carried out an abdominal examination and checked heart rate, respiratory rate and temperature, as recorded in the consultation notes. Dr J's position is that he felt that a diagnosis of appendicitis was unlikely on the basis of these findings.

The GP expert opines that it was reasonable for Dr J to conclude that Daniel's reported symptoms were consistent with gastroenteritis rather than appendicitis, and that the care provided was in keeping with that of a reasonable GP, exercising

reasonable skill and care.

The primary care expert does however comment in his report that a more detailed record of abdominal findings would have been ideal, such as whether there was any guarding and rebound tenderness in the right iliac fossa and whether bowel sounds were normal.

In regard to causation (the consequences of breach of duty), expert opinion from a general surgeon concludes that Daniel was in the early stages of appendicitis when he presented to Dr J but no obvious signs were likely to have been present at that point. The expert considers that appendicitis would not have been diagnosed at this stage, even if the patient had been admitted. As such, an open appendicectomy would have been

required in any event and the complications could not be attributed to delayed referral.

MDDUS prepares a letter of response repudiating the claim on the basis of the expert reports. Notice is later received that the patient has abandoned his claim and the case file is closed.

## KEY POINTS

- Ensure medical notes reflect key detailed observations upon which clinical decisions are based.
- Document significant differential diagnoses considered and why they have been discounted.
- Offer patients clear safety-netting advice on when to re-attend or seek emergency care.



# IT'S THE SMALL THINGS

**Deborah Bowman**

Professor of Bioethics, Clinical Ethics and Medical Law at St George's, University of London

**W**HEN I first became interested in medical ethics, it was an issues-led field that was predominantly concerned with 'big questions'. The relatively few books that existed had titles such as *Matters of Life and Death*. There were no syllabi nor any agreed curriculum content, but the lectures I attended were commonly concerned with a triad of abortion, euthanasia and reproductive ethics. These are, of course, important. Yet, early on, I became interested in the intersection of ethics and the small things. For example, those precious initial moments in an encounter that set the tone and allow for trust, dignity and humanity to flourish, how we adapt in pressured environments to queries or interruptions, how constructively we can disagree and the tone of our communication with others. I wrote a lot about the "ethics of the everyday", largely absent from curricula and textbooks, but integral to healthcare.

I have been thinking a lot about the small things and the big challenges that they can present for staff and patients. A few weeks ago, I received a letter from 'the NHS'. It advised that an appointment had been booked across the road from my office for breast screening. The letter explained why this appointment was valuable, talking about age, risk, early detection and improved prognosis.

As some readers will know, this letter was received by a woman who no longer has breasts and, so far, has received two and a half years of treatment for breast cancer. I was, in a response that is increasingly familiar when I think about illness, both rational and emotional. I appreciated that it was an automated letter and no one's fault or responsibility. I understood that for many, the letter would be welcome and the ease of a pre-booked appointment appreciated. In a complex and resource-constrained system, it isn't efficient or perhaps even possible, to identify those who might be considered exceptions.

Yet, I was also upset. The letter was a stark plunge into dark places. Its unexpected arrival was an unavoidable reminder that I was relatively young when diagnosed, that I had late stage disease with a poorer prognosis, that I was physically different from most women, that I was frightened about the future, that I felt ashamed about perhaps having 'missed something' before I was diagnosed and that maybe I should have been more



**"The letter was an unavoidable small thing; a consequence of the complexities and challenges of running a national screening system"**

alert to avoid being in this position in the first place.

I knew enough not to do anything immediately but to sit and process my response; to attend both to the rational and to the emotional. After a few days, I began to wonder about the member of staff who would take my call when I rang to explain that I would not be attending the appointment. He or she would have no idea about my circumstances, or that I have deliberately avoided having any clinical care at my own hospital. Rather, I'd encounter someone likely to be working in a pressured environment and juggling myriad demands.

I wanted to explain why I wasn't coming, but I knew I needed to do it in a way that was calm, factual and kind. I understood that the person I contacted was not responsible for, or even aware of, my personal response. I rehearsed the

conversation. I debated whether to go over to the Breast Centre and speak to them in person whilst at work, or whether it was better to make a telephone call from home. The task hung over me and I was apprehensive when I passed the unit as I walked through the hospital. I knew though that this 'small thing' was no one's fault and I had to acknowledge that truth in my response.

Eventually, I rang the unit. It was not the conversation for which I hoped. I was reminded by the staff member that screening slots are precious and, although it was a fortnight until the pre-booked appointment, asked why I had waited a few days to get in touch. I was asked twice if I was "sure" even as I explained that I have had a radical bilateral mastectomy. No one knew whom I should contact to avoid being invited to future screening in the hope that I could save the NHS time and resource by preventing further letters and pre-booked appointments.

When I put down the phone, I reflected on "the small things". The letter was probably an unavoidable small thing; a consequence of the complexities and challenges of running a national screening system. However, the response of another person to my call was a small thing that could have been different. The conversation, imbued with officiousness, irritation and misunderstanding, reflected ethical choices. It could have made all the difference. There was nothing "small" about it.

# Addenda



PHOTOGRAPH: WELLCOME

## OBJECT OBSCURA

### Heartstrings – digital image

THIS swirling arrangement of cardiac fibres in the left ventricle was produced using a type of MRI known as diffusion tensor imaging (DTI). The non-invasive technique tracks the diffusion of water molecules in the myocardium, revealing valuable information about the structure of the heart in a non-invasive way. It allows scientists to model the structure of cardiac muscle cells and how certain pathologies, such as ischemia, can cause this to change.

## BOOK CHOICE

### The Body: A Guide for Occupants. By Bill Bryson

Transworld, hardback, £25.00 2019

Review by Dr Greg Dollman, *Insight* editor

I MUST admit I was a little sceptical at first. How could anyone, even Bill Bryson, keep me engrossed throughout nearly 400 pages of a lay description of the human body? There are only so many “we blink fourteen thousand times a day” and “the body makes millions of red cells every few seconds, and discards one billion every day” facts that I could appreciate. I was wrong. Within the first few pages, Bryson describes the human body as “a warm wobble of flesh” and I was hooked.

The chapters whistle-stop their way through the anatomy and physiology of the body, reminding us how we come to be, what makes us who we are and how we live — marvelling at what ‘goes right’ and considering what can go wrong.

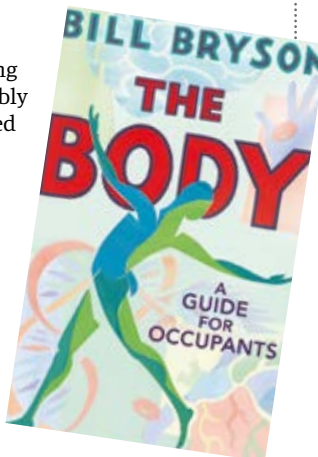
Bryson’s descriptions are witty and astute: he observes that, considering the nature of the skin’s stratum corneum, “all that makes you lovely is deceased”, and explains how we are infected with viruses and colds on being “exposed to others’ leakages and exhalations”.

*The Body* surely contains something for everyone. There are the bizarre facts (Bryson notes the difference in bowel transit times between men and women), the ‘pub quiz’

facts (the record for staying awake is 11 days, 24 minutes), the history lessons (pioneers of medicine along with the ‘firsts’), refresher courses on immunology, microbiology, nutrition (you name it, it’s mentioned) and of course the references (over 40 pages of them).

I anticipate that experts will note factual inaccuracies, unsurprisingly given the volume and detail within the book. Remarkably, however, Bryson provides considerable facts and figures, in a very entertaining format, for a non-medical audience.

*The Body* provides a comprehensive account of something that I know reasonably well and yet managed to keep me turning the pages — and smiling while I did (contracting the orbicularis oculi muscle in each eye to make them sparkle, as Bryson tells us).



## FILM CHOICE

### Dark Waters

Directed by Todd Haynes, UK 2020. Starring Mark Ruffalo, Anne Hathaway

A SHOCKING true story of corporate greed wreaking untold environmental damage is at the heart of this legal thriller. Ruffalo stars as real-life corporate defence attorney Rob Bilott, who went from advising businesses on how to pollute legally to suing one of the world’s largest chemical companies, DuPont, for dumping toxic sludge into a small town river.

Ruffalo puts in one of his best performances yet as the determined lawyer who responds to a plea for help from a West Virginia farmer whose cows have been dying in mysterious circumstances. At great personal cost, Bilott doggedly investigates DuPont and uncovers a corporate cover-up that is breathtaking in its disregard for the environment and the health of the town’s people and animals.

This is a story that deserves to be widely told and, while it is often intense and infuriating, director Todd Haynes never lets the story drag.



## VIGNETTE

# Margaret Fairlie (1891-1963)

## First female professorial chair in Scotland

DUNDEE prides itself as a city of discovery and in recent years has worked hard to honour those of its citizens who have contributed to that name. Today in Slessor Gardens, behind the imposing Caird Hall, you will find a walkway paved with bronze plaques. Amongst these is one to Margaret Fairlie. As well as a short biography, the plaque depicts less obvious clues about her life and career — a frame of sea holly and wheat, a glimpse of the Eiffel Tower and a stylised atomic structure of radium.

Margaret Fairlie was born in Angus and grew up on a farm near Arbroath —hence the plants framing her plaque. She studied medicine at the University of St Andrews and University College, Dundee, graduating during the First World War. After holding various clinical posts in Dundee, Perth and Edinburgh, she worked at St Mary's Hospital in Manchester, where she received much of her specialist training. She returned to Dundee in 1919, where she would spend most of her remaining career. There, she ran a consultant practice for gynaecology, and the following year started teaching at the Dundee Medical School.

In the mid-1920s, she joined the staff of Dundee Royal Infirmary and in 1936 was promoted to Head of Department of Obstetrics and Gynaecology. Her appointment, however, was not met with universal approval, and one male colleague was disgruntled that the post had been awarded to a woman.

Although a gifted and diligent teacher, she also pursued an active clinical career. In addition to her core work at the infirmary in Dundee, Fairlie was visiting gynaecologist to all the hospitals in Angus and in the north of Fife. Like all in her specialty, she

dealt with patients across a wide age spectrum and enjoyed all aspects of it. As an obstetrician, she helped set up Dundee's first antenatal clinic. One matron asked her: "Do you think if all the babies you delivered were laid top to tail they would reach from Dundee to Perth [some 22 miles]?"

"Yes — and heading for Scone [another 2.5 miles]!" was Fairlie's quick reply.

As for her interest in the novel treatment of gynaecological malignancy, this was sparked by her visit in 1926 to the Marie Curie Foundation in Paris where she learned about the clinical applications of radium — hence the Eiffel Tower and atomic structures on her bronze plaque in Dundee. On her return, she pioneered its use in Scotland and conducted careful long-term follow up of her patients. Thirty

**At the time of her retirement  
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professor**

years later she would remark: "One aspect of my work which has given me especial satisfaction and delight has been my continuity with the patients who attend the radium follow-up clinic... some of whom have been coming for twenty years... The atmosphere at this clinic is one of trust, gratitude and mutual affection."

Her students, her colleagues and her patients found much to praise, but perhaps her main claim to fame was to become Scotland's first female professor. This, however, was not straightforward. In 1936 her appointment as head of department

should have almost automatically made her eligible for the chair in obstetrics and gynaecology. However, it took the University authorities four years to come to terms with appointing a woman. Perhaps she was a victim of the political difficulties ongoing between Dundee and St Andrews Universities at the time, but it is also thought that the then Principal of St Andrews was particularly averse to the idea of a woman professor.

She was finally appointed to her chair in 1940, with the strong backing of the Directors of Dundee Royal Infirmary. At the time of her retirement in 1956, she remained the only female Scottish university professor. It would be another two years before the University of Edinburgh would appoint its first woman to a chair and a further 22 years before Glasgow would follow suit.

In her retirement Margaret was a keen gardener and an enthusiastic traveller. It was while in Florence in the summer of 1963 that she took ill for the last time. She returned home

and was admitted to her former hospital where she died soon after. Today there is that bronze plaque on Dundee's Discovery Walk, which includes words from one of her patients: "She gave me the will to live." Surely no higher tribute could be paid to a practitioner of medicine."

*Allan Gaw is a writer and educator from Scotland*

### SOURCES

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- Glasgow, 29 April; London 28 May
- GP risk training day – Glasgow, 12 May; London 10 June.

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or email [risk@mddus.com](mailto:risk@mddus.com)



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