Practice Manager
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ISSUE 12

A WATCHFUL EYE

Is CCTV surveillance the best way to monitor staff or address security concerns?

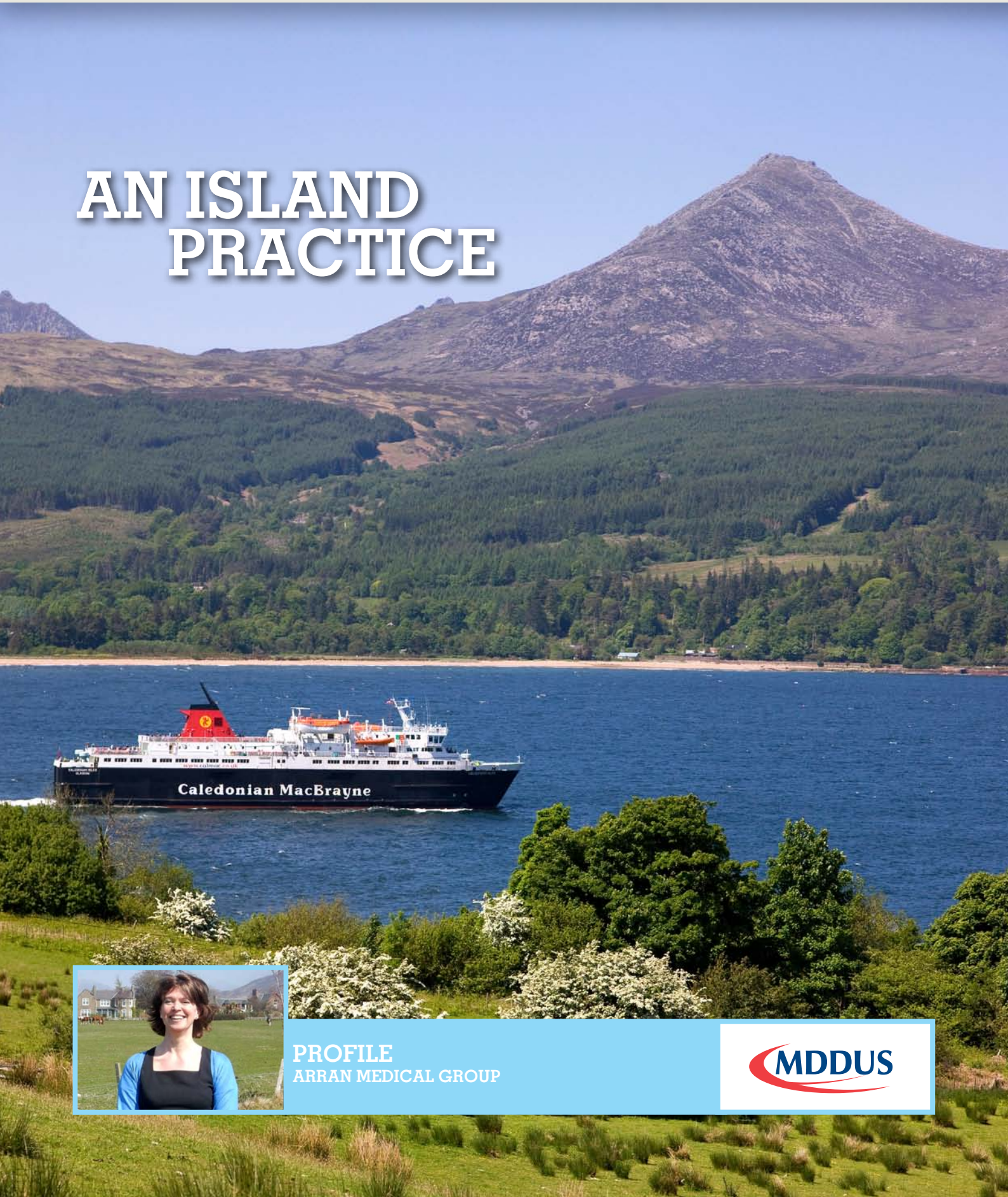
PAPERWORK PITFALLS

Filling in patient forms can at times seem mind-numbing – but therein lies the risk

UP IN SMOKE

Have you incorporated the use of e-cigarettes into your practice smoking policy?

AN ISLAND PRACTICE



PROFILE
ARRAN MEDICAL GROUP

MDDUS

Practice Manager

ARRAN is said to be a microcosm of Scotland – with mountains and beaches, castles and prehistoric stone circles, all on an island 10 miles by 20. It also shares the same challenges as other remote and rural areas in providing adequate healthcare in an isolated setting. On **page 10**, Jim Killgore pays a visit to Shiskine surgery – one of three main health centres making up the recently merged Arran Medical Group. Here he meets practice manager Ruth Betley and learns more about her unique role on the island.

Dealing with requests for patient reports is a daily routine for most practices. Recently MDDUS conducted a case analysis that identified the extent to which failures in the processing of patient reports can lead to complaints and even claims for negligence. On **page 12**, senior risk adviser Liz Price looks at some of the common pitfalls that emerged from this analysis.

On **page 6**, I look at a common area of angst and confusion among practice managers – dealing with parental access to medical records of children and more particularly requests from fathers who do not live with their children.

Are you considering the need for CCTV on your practice premises? Liz Price offers some important advice and a few caveats on **page 7**. Employment law adviser Janice Sibbald looks at emerging changes in smoking policies with the rise of the e-cigarette (**page 8**). And on **page 9** Allan Gaw asks is your practice research "ready and willing" to further knowledge in primary care?

Our regular Call Log on **page 4** summarises advice requests regarding dental tunes, power of attorney, fitness for work and a large bottle of malt whisky, among other topics. And our case study on **page 14** deals with a dispute over idle gossip in a small village leading to an alleged confidentiality breach.

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Be clear on dental treatment costs

A RECENT report from the Parliamentary and Health Service Ombudsman has highlighted the need for dental practices to be clear with patients on treatment costs.

The report identified 27 cases over the last two years where confusion about dental charging was an issue and found that the current system is confusing for both patients and dentists. Furthermore, it found that some practitioners fail to share treatment plans with their patients, despite an obligation to do so.

MDDUS dental adviser Doug Hamilton suggests that, while the vast majority of dental practices would never intentionally misinform a patient over treatment options and costs, there seems to be an increasing number of complaints arising from fee-related misunderstandings.

"Many of these disputes can be avoided by the provision of a cost estimate to patients prior to dental treatment being provided," says Hamilton.

"Practitioners have an ethical obligation to ensure patients have clear information on charges, including the need to provide a revised estimate if at any point the proposed treatment plan requires to be amended. Failure to comply will not only undermine any attempts to rebut a patient's complaint, but may also lead to investigation by the GDC."

Patient complaints can also arise where there is confusion over whether the treatment is carried out privately or on the NHS. Says Hamilton:

"If all or part of this treatment is to be carried out privately, then this must be stipulated in the treatment plan and then be signed by the patient. Any recommendation of private care to NHS patients must be delivered upon sound ethical and clinical reasoning and not any financial consideration of the dentist."

Practice and corporate scheme membership

MEMBERS who have Practice or Corporate Scheme Membership with MDDUS should note that it is their responsibility to ensure that membership is being adequately maintained.

This is generally done by the staff member responsible within the practice for the administration of the scheme, such as the practice manager. Failure to maintain adequate cover, for example failing to inform us of a return to work following maternity or paternity leave, cannot normally be rectified retrospectively.

Contact our Membership Team on 0845 270 2038 or via email at **membership@mddus.com** if you have questions or if you want to check the current status of your membership scheme.

Risk podcasts now online

MDDUS Risk Management is pleased to announce the launch of a new Risk Bites podcast series.

The first two episodes are now available on the MDDUS website and accessible to all web users on the Podcasts page, in the Risk Management eLearning centre (**www.mddus.com/risk-management/elearning-centre**).

The podcasts focus on a fictitious 51-year-old patient, Mrs Roberts, who is diagnosed with breast cancer by her GP. MDDUS advisers consider the scenario in two very different practice settings. Both practices see the same clinical outcome but the series explores how they are able to respond differently to the case as it progresses from an adverse incident, to an NHS complaint, a claim of negligence and lastly a referral to the General Medical Council.

You can follow the discussion by downloading the patient's medical records to see the different clinical notes recorded at both practices. The podcasts explore and discuss a wide range of key risk areas for general practice.

Report finds significant non-adherence to prescribed medicines

An estimated 30 to 50 per cent of patients don't take medicines as prescribed, according to a new report.

Failure to adhere to prescriptions can render treatments ineffective and can cause serious harm in some cases. Wasted medicines are also thought to cost the NHS in England around £300 million a year, in addition to the knock-on costs of avoidable illness, further treatment and hospital admissions.

The figures were published in a summary of a meeting held by the Academy of Medical Sciences and the Faculty of Pharmaceutical Medicine.

Meeting chair Sir Alasdair Breckenridge said: "The fact that only one third to one half of patients take their medicines as prescribed should be a major wake up call to the healthcare profession. We need to determine why this is the case and develop better ways to help people take the medicines they are offered."

The report called for a co-ordinated response from both healthcare professionals and patients.

Physician associates offer valuable asset

PHYSICIAN associates (PAs) provide a same-day consultation service comparable to GPs and at a lower cost, according to a new study published in the *British Journal of General Practice*.

Researchers from Kingston University and St George's University of London made a comparative observational study of 2,086 patient records detailing same-day appointments in 12 general practices, comparing PA consultations with those of GPs. After adjusting for case-mix, there was little difference between PA and GP consultations in the rate of investigations, referral to secondary care, prescriptions issued or the rate of patient re-consultation for the same or a closely related problem within 14 days. Both PA and GP consultations scored high levels of patient satisfaction, with the average PA consultation longer and cost per consultation lower.

Physician associates (known as physician assistants in the US) are not doctors but have been educated and trained to diagnose, treat, and refer autonomously within certain boundaries. Physician assistants have been practising in the US for the past 50 years but the role is relatively new in the UK, with training courses producing the first graduates in 2009.

Dr Helen Stokes-Lampard, Honorary Treasurer of the RCGP, commented: "GPs are highly trained medical doctors, and our skills at being able to diagnose and treat the 'whole person' through initial consultation and the unique relationship we build up with our patients over time cannot be substituted.

"But there are many tasks that take up a huge amount of GPs' time that PAs can do, thus enabling family doctors to spend more time with patients with multiple and complex needs, for whom the standard 10-minute consultation is not enough."

Receptionists managing access to clinicians

AN interactive risk exercise focusing on the receptionist's role in managing patient access to clinicians is now available on the MDDUS website.

It's designed for practice managers and GPs to use with reception and admin teams and includes a case study, with associated group discussion points. The aim is to enable teams to explore the risks associated with the receptionist role in managing access to clinicians. A discussion guide is included which also provides advice on common risk areas. Download the *Access to clinicians* exercise in the Risk Management section at mddus.com (or go to **http://goo.gl/7lKlQo**).

Fit for Work roll-out

PRACTICES are reminded to update their sickness absence policies to reflect the new Fit for Work scheme currently being rolled out across the country.

The government is in the process of a phased launch of the new system which is expected to be fully operational from May. The purpose is to provide occupational health assessments and general advice to employees, employers and GPs, with the aim of helping individuals stay in or return to work. There are two elements to the service:

- Assessment – once the employee has reached, or is expected to reach, four weeks of sickness absence they will normally be referred by their GP for an assessment by an occupational health professional, who will look at issues preventing the employee from returning to work.
- Advice – employers, employees and GPs will be able to access advice related to the scheme by phone or via the website.

Following an assessment, employees will receive a return-to-work plan and information on how to get appropriate help and advice. Details of the scheme can be found at **www.fitforwork.org** (England and Wales) or **www.fitforworkscotland.scot**/ (Scotland).

Call log

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

POLICE REQUEST

Q Two police officers turned up at our medical practice this morning and informed the receptionist that they know a patient is attending an appointment later today and asked if she could confirm this is the case. They would only say that it relates to an investigation into minor thefts in the local area. What should we do?

A The decision to comply with police requests for information can be a tricky one and each case has to be assessed on its merits. Generally, confidential patient information should not be released without patient consent, unless in the public interest. That is, does the benefit of disclosure outweigh the general benefit to the public of maintaining confidentiality? In its guidance *Confidentiality*, the General Medical Council states: "If a patient refuses consent, or if it is not practicable to get their consent, information can still be disclosed if it is required by law or can be justified in the public interest." If the police can produce a court order or evidence of the patient's consent, then disclosure can be made. Otherwise, the GMC states that it could be justified in serious cases: "for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person." In this case, it would appear that this "serious crime" threshold has not yet been met and you could not justify disclosing the information without consent.

DENTAL TUNES

Q Our dentists like to have the radio on in the surgery while they treat patients and the TV is usually on in the waiting room. Does this mean we need a special music licence?

A Whether it's the radio, TV, CD, MP3 or other formats, any business that plays recorded music in public is legally required to have the relevant licence, including dental (and medical) practices. Licences are required to protect the copyright of those who create, produce and publish the music or performances. Your practice will likely need a licence from both Phonographic Performance Limited (PPL) and the Performing Right Society (PRS for Music). Those who fail to obtain the correct licence face legal proceedings for copyright infringement. More information is available on the PPL and PRS for Music websites.

KEEPING IN TOUCH

Q One of our receptionists is due to return from maternity leave in a few months and during a recent meeting she explained she was very nervous at the thought of coming back to work, as she had not had much contact from colleagues. While I would be happy to keep employees on leave up-to-date with practice news, I am wary of this being perceived as "harassment".

A The law allows employers to keep in "reasonable contact" with employees on maternity leave. This would certainly include internal matters such as practice organisational changes, staffing issues, promotion opportunities, job vacancies and any planned reorganisations or redundancies. Contact can be maintained informally via email, text, a pre-arranged phone call or even a letter, and notes from staff meetings could be sent. Some organisations use a 'buddy' system, where someone in the practice is chosen to keep the employee updated on events and changes. Each employee is different and it is worth agreeing with them in advance about the level of communication they would prefer. A more formal arrangement is by using Keeping in Touch (KIT) days – up to 10 days can be used during an employee's maternity leave period. KIT days cannot be enforced and must be agreed by both the employee and the practice, as there is no obligation for the employee to work them or for the practice to offer them. KIT days can be used for undertaking work, attending meetings, conferences or training. There is no set rate of pay for such days and this should also be mutually agreed. Discuss with each employee how they would like to proceed. An informal home visit towards the end of leave can also be useful.

POWER TO DECIDE

Q The son of an elderly female patient has complained to a practice (in Scotland) about the the number of visits she is receiving from the district nurse. He believes that his mother requires additional support. The son says he has the right to make this request because he has power of attorney for his mother's affairs.

A There are two important elements to clarify. First, what is the nature of the power of attorney held? These can be for financial or welfare decisions, or both. In terms of medical decisions, only a welfare power of attorney is relevant. Secondly, does the patient lack capacity to make decisions regarding the relevant issues? If not, then the power of attorney does not apply and the usual procedure for informed patient consent should be followed. If the patient does lack capacity (and her son has welfare power of attorney) then it may be useful to invite her son to discuss her care and make every attempt to reach a consensus on how best to proceed. If agreement can't be reached, then consider involving an independent advocate, obtaining a second opinion, holding a case conference or using local mediation services. The Mental Welfare Commission (Scotland) may also assist (law is different elsewhere in the UK). If all of this fails, you may wish to seek legal advice on applying to the appropriate court or statutory body for review or an independent ruling.

SICKNESS SCHEME

Q One of the receptionists has been off sick for three weeks for the second time in six months which is putting a lot of pressure on the rest of the staff. I have heard about the government's new Fit for Work scheme. Can I make her undergo an assessment to help get her back to work?

A The Fit for Work scheme, funded by the Department for Work and Pensions, is being rolled out across the UK and should be fully operational in Scotland, England and Wales later in 2015. It provides an occupational health assessment and general health and work advice to employees, employers and GPs with the aim of helping individuals stay in or return to work. Crucially, employees must give their consent to take part in the scheme, so you can't "make" your receptionist participate. Under the scheme, once the employee reaches four weeks of sickness absence, they can be referred by their GP for an occupational health assessment to examine the issues preventing their return to work. Fit for Work will then create a return-to-work plan including recommendations to help them get back to work and information on where to find further advice. Free advice is also available to employers, employees and GPs by phone or on the Fit for Work and Fit for Work Scotland websites. It would be advisable to update your practice sickness policy to reflect the new scheme.

CARELESS MESSAGE

Q One of our dental patients owed the practice £500 following private treatment to root treat and place a crown on one of his teeth. We have sent out several written reminders in recent months but only a third has so far been paid. A few days ago the dentist left a message on the patient's home answering machine asking him to call the practice about the unpaid bill. The patient has since complained about a breach of confidentiality because his wife heard the message and did not know about the debt.

A Patients should only be contacted by phone if they have given their express consent for you to do so. Even then, sensitive patient information should never be disclosed in telephone messages due to the potential for a third party to intercept them. In this case, confidentiality has been breached and the patient should be sent a written apology acknowledging the mistake and offering reassurances that it will not be repeated. Practice systems regarding confidentiality should be reviewed and details of how procedures have been improved should also be outlined in writing to the patient. It would be worth considering waiving the outstanding debt in recognition of the distress caused.

AN APPROPRIATE GIFT

Q A long-standing patient who is recovering from cancer has recently come into the practice to give her GP a large bottle of malt whisky and an expensive box of chocolates to thank him for the care he has provided over the past few months. The patient insists it is nothing more than a sign of appreciation for all that the doctor has done, but I am unsure whether it is appropriate to accept such a gift.

A The issue of accepting or refusing a patient gift is a difficult one. Sometimes there may be no harm in accepting a small token of gratitude, but other gifts may represent something more. The GMC's *Good Medical Practice* advises doctors not to "ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgement," adding that doctors "must not encourage patients to give, lend or bequeath money or gifts that will directly or indirectly benefit you." A strict "no gifts" policy may be difficult to enforce but you must consider whether accepting a gift could be seen to influence the doctor's decision-making, and you should be able to demonstrate that it hasn't. Consider discussing the offer of a gift with the patient and make it clear that their gesture will not have any impact on the care they receive. There is often concern about insulting or upsetting a patient by not accepting a gift but you should respectfully refuse/return anything that you feel is inappropriate. A practice gift register may be a helpful way of noting correspondence or conversations surrounding the offer of a gift, as well as reasons for accepting it.

DATA CHECKS

Q I have heard the Information Commissioner's Office will be carrying out checks on GP practices. Can they come into our practice without asking us first?

A Since February 2015, the ICO has been able to enter premises – including GP practices – without consent to carry out compulsory data protection audits. Consent was previously required for audits within the NHS, but this rule no longer stands. The ICO plans to use its powers to target poor performing parts of the health sector and act before a breach occurs. Practices should have a robust system in place to ensure patient data is stored and shared securely. Ensure your practice has appropriate security arrangements in place and consider the potential for data breaches in all electronic communications involving confidential patient data. Encryption can reduce some risks, identifiable data should never be stored on personal computers, and sufficient IT training and support should be available to staff. The ICO has powers to impose monetary penalties, issue undertakings or even launch criminal proceedings in organisations failing to protect private data.

A child's best interests

Scott Obrzud provides guidance on the sometimes tricky issue of parental access to a child's records

ONE common area of angst and confusion among practice managers phoning the MDDUS advice line relates to requests from parents to access their child's medical records – particularly requests from fathers who do not live with their children or were unmarried at the time of the birth.

Often when addressing a request to view the contents of a child's medical records there is confusion over the "residential status" or "access" arrangements relating to the child: interestingly, a parent's rights in regard to records relates to neither of these issues. When processing a request from a parent there are four main issues to consider before the information is provided:

- parental responsibility (PR)
- age of the child
- third-party information
- best interests of the child.

PARENTAL RESPONSIBILITY

PR refers to the powers, rights and duties that the majority of parents hold in respect of their own child, for example the authority to consent to treatment on behalf of their child. PR also affords a parent the statutory right to apply for access to their child's health records. While the law is recognised in all UK legal jurisdictions, there are subtle differences between countries.

In Scotland a birth mother automatically has PR unless this has been removed by a court, and a father will have PR if he was married to the mother at the time of the child's conception or after. An unmarried father will have PR if his name appears on his child's birth certificate and the child was born on or after 4 May 2006. An unmarried father can also be granted a PR order by a court or can obtain a PR agreement with the mother of his child.

In England and Wales the law differs slightly in that a birth mother automatically has PR (unless removed by a court) but a father will have PR only if married to the mother at the time of the child's birth. An unmarried father will have PR if his name appears on his child's birth certificate and the child was born on or after 1 December 2003. Just as in Scotland, a father can also obtain a PR order from a court or by agreement with the mother.

In Northern Ireland, a father will have PR if married to the mother at the time of the child's birth or after – if living in Northern Ireland at the time of the marriage. An unmarried father will have PR if his name appears on his child's birth certificate and the child was born on or after 15 April 2002 – and again a father can also obtain PR by court order or by agreement with the mother.

AGE OF THE CHILD

A child can be judged mature enough to be competent to consent to (or refuse) disclosure of their own records. The General Medical Council states in their guidance booklet *0-18 years: guidance for all doctors* (2007): "Young people with capacity have the legal right to access their own health records and can allow or prevent access by others, including the parents. In Scotland, anyone aged 12 or over is legally presumed to have such capacity. A child might of course achieve capacity earlier or later. In any event you should usually let children access their own health records." It would be advisable that a child's views should be sought and respected if they are deemed to have capacity, unless there is a strong public interest reason to override their views.

THIRD-PARTY INFORMATION

When preparing medical records for disclosure, care should be taken to remove any information relating to a third party to ensure the practice adheres to data protection laws. Third-party information can be particularly sensitive in the case of acrimonious separations: for example, details such as the mother's current address and contact details could inadvertently be disclosed to the father or vice-versa.

Practice managers often ask us if consent is required from both parents when one seeks access to a child's records. In their 2008 document, *Parental Responsibility*, the BMA advises that when practices receive a request from a parent with PR for access to medical records, there is no obligation to gain consent or inform the other parent. But it encourages practices to consider doing so if judged in the child's best interests. Of course, should the child be judged to have capacity you would need their consent.

BEST INTERESTS

Parents hold PR to protect the health, welfare and development of their child. In the majority of cases it is reasonable for a parent to argue that it is in their child's best interests that they have access to their medical details, but this may not always be the case, particularly in complex child protection situations. If in any doubt about the best interests of the child, the practice should consider seeking advice from others, for example social work or child protection colleagues.

Managers can also contact the advisory team at the MDDUS to discuss individual cases either by telephone (0845270 2034) or via email at **advice@mddus.com**

Scott Obrzud is a practice adviser at MDDUS and co-editor of Practice Manager

A watchful eye

Is a practice CCTV surveillance system the best way to monitor staff or address safety concerns? MDDUS senior risk adviser Liz Price advises careful consideration

FIGURES suggest there could be as many as one CCTV camera for every 11 people in the UK, making ours among the most monitored societies in the world.

Electronic surveillance has proved an invaluable tool for law enforcement organisations in recent years – but is it a solution medical and dental practices should consider?

Advice calls to MDDUS on the use of CCTV have been increasing. Typical queries from practices considering installing a system include: "We think a staff member is stealing from our petty cash – can we install CCTV to catch them in the act?" or "We have a number of known violent patients registered with the practice and we would like to install CCTV in the waiting room to deter them".

Practices that have systems already installed most commonly contact us for advice on whether or not to disclose information captured on film. For example: "There's been a bump in the practice car park – can we share CCTV footage with the affected party and/or police?" or "The police are investigating a rumour that a patient is dealing drugs in our waiting area and want to see our footage for last Wednesday".

The decision to install electronic surveillance within your practice premises requires careful consideration. Is it necessary and proportionate to resolve the identified need? How will the data be stored, accessed, processed and by whom? What footage must or should be shared? These are all important points to consider before installation to avoid breaching data protection legislation.

The Information Commissioners Office (ICO) recently updated their guidance in this area (**http://tinyurl.com/n3r38k2**) in light of technical developments and to ensure that those who use surveillance cameras to collect personal data stay within data protection and privacy legislation. Practices who have or are considering CCTV should ensure they comply fully with the requirements.

HAVE YOU IDENTIFIED A NEED FOR SURVEILLANCE?

It is important to consider whether use of CCTV is justified. What is the purpose and is it a necessary and proportionate measure to meet that need? Could there be other more appropriate measures? For example:

- installing enhanced lighting in an area prone to vandalism
- repositioning a receptionist so patient areas can be monitored
- purchasing a secure cabinet for important documents and items
- limiting access to certain areas of the premises.

Before installing a CCTV system practices must also take into consideration GMC/GDC guidance on patient confidentiality – and also your responsibilities as an employer, particularly where you plan to use CCTV in staff areas. Just because you have information doesn't mean that you will be able to share it.

Ensure that any planned systems and procedures comply with your legal obligations. Is the CCTV sited to only collect the necessary information required? It should not cover areas that are not of interest, as this breaches the principle that the information collected should only be that which is necessary for the identified purpose.

Is there a policy for securely storing and handling the information? How long do you keep the information? Retention times should be reasonable, based on the purpose for which it is being used.

Access to data should be limited and authorised staff should be made aware that it is a criminal offence to misuse the information. They also must be competent to access and edit or extract information where disclosure is appropriate, as there may be a requirement to obscure the identity of individuals.

Patients and staff must be made aware of their right of access to footage which contains their images – so the practice will have to inform individuals that the CCTV is in place and for what purpose. Notices and social media can be used for this and signage should include details of who to contact for more information, for example the practice manager. A maximum of £10 can be charged in response to a subject access request.

Clear policies should be in place for responding to requests for access to footage, including when it is likely to be appropriate to make a disclosure and when it is not.

When deciding to disclose footage that shows others, consider the expectations of those individuals involved, regulatory responsibilities and legitimate public interest in the information. As above, you may have to take steps to disguise the identity of third parties captured in any footage, for example through the use of pixelation technology. When a disclosure is made you should record the date of the disclosure along with details of who the information has been provided to (the name of the person and the organisation they represent) and why they required it.

DO YOU ALREADY HAVE CCTV ALREADY IN PLACE?

Practices should ensure they have notified the ICO that this type of data is being collected, and you should regularly review whether use of CCTV is still necessary and proportionate. Check that policies and procedures are in place as above and that proactive checks are ongoing to ensure compliance with procedures around security and processing.

Liz Price is a senior risk adviser at MDDUS

Up in smoke

Janice Sibbald advises on developing a practice policy on e-cigarettes

E-CIGARETTES and personal vaporisers are battery-operated devices now marketed not just as a "healthier option" to traditional cigarette smoking but also as lifestyle accessories, like the latest smartphone or tablet computer. They produce a vapour including flavoured aromas either with or without nicotine, but also with fewer toxicants than cigarette smoke. The number of people who use electronic cigarettes in the UK has tripled over the past two years to 2.1 million, according to estimates by the health charity ASH.

One might assume that e-cigarettes would be covered under existing smoking policies and legislation; however, this is not the case, as tobacco is not actually being lit and burnt. So what does this mean for employees and employers where e-cigarettes are being used?

In a nutshell, employers can choose whether to let their employees use these devices at work or not; the key thing is making this clear to them and incorporating it into a smoking policy. If you don't have a policy on smoking, a good place to insert one is in your drugs and alcohol policy.

KICKING THE HABIT

It may be argued that a responsible employer should encourage employees to give up smoking and therefore promote the use of these aids where possible (although it's fair to point out that not all users see e-cigarettes as a means to quitting). Giving up smoking can be hard, as nicotine is highly addictive, and employers may wish to promote access to NHS smoke-free services or even pay for private hypnotherapy or counselling. There is a huge host of services provided by the NHS to support employees, including the use of NRT (nicotine replacement therapy), group counselling sessions, as well as access to specialised telephone advice.

If an employer decides to allow employees to use e-cigarettes, they must also consider the effects on other staff members. Currently the long-term effects of e-cigarettes are unknown, as are the potential impacts of the vapours emitted from these products. E-cigarettes could add to an unpleasant working environment and it might also be considered unsightly in customer-facing roles. Patients or visitors to the practice may mistakenly think employees are smoking tobacco.

Allowing the use of e-cigarette smoking in the workplace might also land you in an argument with other employees as to why real cigarettes are not permitted too!

CASE LAW

Employers should ensure that the same smoking breaks apply to e-smokers and you are within your rights to ask employees to take time off their lunch hour, for example, if breaks aren't normally given. Employees should be informed of the location of designated smoking areas but employers are under no obligation to provide a smoking shelter. However, if a shelter is provided, there are other legal requirements to be considered.

A recent employment tribunal decision highlighted the need to ensure that e-cigarettes are included as part of a practice smoking policy. In the case of *Insley v Accent Catering*, an employee resigned and pursued her employer for unfair constructive dismissal following attempts to discipline her for smoking an e-cigarette at work.

Ms Insley was a catering assistant at a school and was allegedly seen smoking in front of pupils. She was invited to a disciplinary hearing which she never actually attended and then resigned claiming that her actions had not been enough to warrant a dismissal. But as she was never actually fired, the claim was dismissed.

However, the tribunal then turned their attention to the school's no-smoking policy. It ruled that if she had been dismissed for smoking an e-cigarette the dismissal would have been unfair as e-cigarettes were not included in the schools no-smoking policy. The case highlights the need for e-cigarette smoking to be explicitly referred to in no-smoking policies.

It's also important to outline to employees the repercussions of non-compliance, which will most likely be dealt with under the practice's disciplinary procedures. Practices should remind employees that it is in fact a criminal offence (which will attract a fine) to smoke in a designated smoke-free public area.

As with any policy, you should ensure that you keep your smoking policy separate from your employment contract and provide details in an employee handbook. This will allow you to amend or change the policy without having to get your employees' agreement to amend their contract – to do so without following the agreement to the letter could put you in breach of contract.

We will be watching with interest how case law evolves in this area.

Janice Sibbald is an employment law adviser at MDDUS

Research ready – and able?

Does your practice aspire to furthering healthcare through research? Getting involved is often a simple matter of attitude, says Allan Gaw

IN healthcare, research matters to everyone. Even if your practice has never been actively involved in a research study, you are, on a daily basis, consuming the fruits of other people's research. Modern medical practice is built on decades of carefully conducted research from around the world that tells us, in any clinical situation, what to do and how to do it. And the more we are all involved in research, the faster we can push back the current limits of healthcare.

Many practices in the UK are accredited as 'Research Ready' and are actively involved in research, but many more would like to be. Sometimes, though, it can seem a daunting prospect to make the staff and the facilities ready. Sometimes, the complex regulatory maze we have to navigate to get involved may seem more trouble than it's worth. But, often it comes down to a simple matter of attitude. How should we approach research, how important is it to have the right mindset and what are the principles that underpin it?

As soon as you contemplate being a research active practice, you will meet a set of standards called GCP or more fully, 'good clinical practice'. What is that all about?

WHAT IS GCP?

Unfortunately, the term 'good clinical practice' is just about the worst possible name for what we are talking about. Actually, it has nothing to do with clinical practice – good or otherwise. Rather, it is a set of principles that we apply to the conduct of clinical research. Although these principles had their origins in the pharmaceutical industry back in the 1990s, they are now internationally recognised and have come to be regarded as the gold standard not just for the conduct of drug trials but all research studies involving people.

All those involved in designing and conducting clinical trials are expected to be familiar with these principles and to work in accordance with them. There are many opportunities to attend courses or participate in online training for GCP, but in many ways these principles represent a way of thinking about research that everyone should acquire.

> "OUR RESEARCH PARTICIPANTS ARE NOT NAMELESS NUMBERS BUT PEOPLE WITH RIGHTS AND DIGNITY"

And that state of mind revolves around three main concepts – safety, quality and respect.

SAFETY, QUALITY AND RESPECT

Above all, when conducting any form of clinical research we must have the safety and well-being of our patients or healthy volunteers at the forefront of our mind. We should design our studies and carry them out with the participant in mind, always asking the question: is what we are doing as safe as it can be?

The end result of any research project is of course a set of results that we hope will help us change clinical practice for the better. We will only be able to do that though if we have taken all the care necessary to ensure that our results are accurate. The quality of our work is therefore of great importance, and GCP has a lot to say about how we should go about gathering and assessing our data. At the core of this is the call for good documentation. Of course, this is important in healthcare generally, but it is even more so in research, where the basic motto of the various regulatory agencies who govern research is: "if it isn't documented, it didn't happen".

And we should never forget that we are working with people. Our research participants are not nameless numbers but people with rights and dignity, and everything we do in research should be done with respect. That respect will be evident when we involve our participants fully in the study process and view them, not as research subjects, but as the most important members of our research team. When we take the time to explain our projects to prospective participants and seek their truly informed consent we are putting that respect into practice.

So, if we are involved in research we should always ask ourselves three questions: is what I plan to do as safe as possible, will it produce the highest quality results, and is it respectful? If the answer to all three questions is yes, then we can be sure that we are working very much to the spirit of GCP and the other regulatory frameworks that govern the conduct of research in the UK. However, if there is any doubt in our minds, we should pause for thought and think how we might do it better.

Getting involved in clinical research for the first time can be challenging, but the rewards can be considerable both for the practice and its patients. We are expected to understand and follow the principles of GCP, but often this amounts to everyone in the practice having the right attitude to research and never forgetting the importance of safety, quality and, above all, respect.

Dr Allan Gaw is a writer and educator in Glasgow

An island practice

Jim Killgore travels to the Isle of Arran for a perspective on the challenges of remote and rural primary care

THE SEA is calm the day I make the short ferry crossing to the Isle of Arran from the North Ayrshire port of Ardrossan. Standing on deck I am even lucky enough to see a dolphin break the placid surface as the granite peak of Goatfell comes into view above the low cloud. Lying only 40 miles southwest of Glasgow as the crow flies and only 14 miles from the Scottish mainland the island does not seem as remote as I had imagined.

Less than an hour later I sit in the meeting room of the local GP surgery in the small village of Shiskine. I have come to meet the practice manager of the Arran Medical Group (AMG) – Ruth Betley. The Arran Medical Group was formed in 2012 with the merger of the three main practices on the island. It serves a resident population of over 5,000 people but that can increase fourfold in the summer months when the island is swamped by holidaymakers.

Ruth explains that, even with its close proximity to the populous central belt of Scotland, Arran faces the same challenges typical of remote and rural practices across the UK. Not least recruiting and keeping staff with a skill set to serve the broad needs of an isolated population.

"When you have lots of water between you and the mainland, GPs here will do many things that other GPs would send on to secondary care," she says.

Ruth is responsible for the overall management of three base surgeries (at Brodick, Lamlash and Shiskine) and three branch surgeries with 30 staff – all part-time – in addition to six GP partners, two salaried GPs and one rural fellow. She is supported by three team leaders for on-site management of the base surgeries and also a business manager. In addition to delivering primary healthcare on the island, AMG also provides a range of additional services including out-of-hours care, medical input to the local Arran War Memorial Hospital, accident and emergency cover, BASICS prehospital care and police surgeon work.

"It's quite a large area, geographically. You are 56 miles all around the island," says Ruth. "I actually work in each of the main sites. I move around a lot. That's the only way you can do it. You need to be there and see how people are getting on."

A NEW PROJECT

Ruth is originally from Yorkshire and moved to Arran nine years ago. She and her husband had been coming to the island for holidays and decided to make a lifestyle change. She had worked in health administration all her career, first in hospitals and then as a director of a primary care trust near Halifax.

"The director's job was quite long hours and difficult. And then an opportunity came up in Arran," she says. "The existing surgery in

Clockwise from main image: Isle of Arran ferry; rescue helicoper above Cir Mhor; Ruth Betley, practice manager, AMG

> "IT'S QUITE A LARGE AREA, GEOGRAPHICALLY. YOU ARE 56 MILES ALL AROUND THE ISLAND"

Shiskine was one of the last to be located in a private house. They had plans approved to build a new surgery and I thought this would be quite an interesting little project for me to do part-time on Arran. I had just had a baby."

They made the move to the island and bought a house just outside Shiskine, with Ruth's husband – also a former NHS administrator – embarking on a major renovation.

"I worked on the project a couple of days a week until the surgery was finished but then the new GP was keen that I become a practice manager at Shiskine. So I took that on part-time."

In 2011 an urgent clinical review of medical services on the island was undertaken. This was in response to problems not unique to Arran but symptomatic of rural practice across Scotland. A recent paper published by a strategy group of the RCGP Scotland concluded that remote and rural healthcare in Scotland is experiencing a deepening crisis and is in urgent need of review and reshaping. Rural practices have in recent years suffered from ongoing cuts in funding, along with rising costs and patient expectation. Recruiting GPs and other staff willing and able to work across the spectrum of rural general practice – including out-of-hours, emergency and hospital work – has become increasingly difficult.

"The review covered the hospital, the GP practices, the nursing staff, plans to introduce NHS 24. We looked at nurse skill mix at the hospital, we looked at an ENP service," says Ruth.

"The aim was to try to make Arran sustainable into the future. And the merger of the practices was a product of that. We were already going to do it – to be fair. It was already a plan. Because once you pool that clinical team it just makes things so much more efficient. All the GPs working together [off one rota] has been a major efficiency."

A year later the Arran Medical Group was formed, unifying primary care on the island under the one service and Ruth was appointed overall practice manager – no doubt in part due to her experience in senior healthcare management. Merging of staff and resources has allowed economies of scale and integrated work patterns that avoid duplication of services and have led to a more financially viable primary care service.

"To start with it was difficult. Some of the decisions we made left patients very unhappy. We centralised the phones to one particular site and that went down like a lead balloon," says Ruth.

"It's still an issue. People know the staff in their surgeries; they have a really good relationship with them and that's something we wanted to value and keep. But at the same time things move forward and modernise. It's been a balance."

Overall the merger has been judged a success and the Arran model is now being looked at by other rural primary care services in Scotland facing similar challenges. AMG is also a training practice, currently with three GP trainees and is accredited by Dundee University to take on medical students for work experience.

"All of this is very important in terms of succession planning and sustainability of services in remote and rural practices," says Ruth.

VISITORS AND RETIREES

Arran does however come with its own unique challenges – being popular both with visitors and retirees.

"Our population is skewed – the over-65 population is very high," says Ruth. "In mainland Ayrshire it's 19 per cent of the population but for Arran it's 27 per cent, with many frail elderly people over 85. So you can imagine the pressures on social and healthcare services are significant."

GPs on the island deal with a high degree of chronic co-morbidity and there is a high incidence of cancer – again with an elderly population. "So there is lots of palliative care, but we do have a good district nursing service."

Holiday time brings added challenges with the tourist season lasting from April to October. Traffic jams on the island are not that unusual in July.

"Our population goes up to about 20,000 in the summer. So there is a significant increase in activity," says Ruth. "People falling off bikes – a lot. Walkers falling down hills – a lot. Holidaymakers with jelly fish stings, ticks – that sort of thing. So in the summer time it gets much busier for staff."

A GOLDFISH BOWL

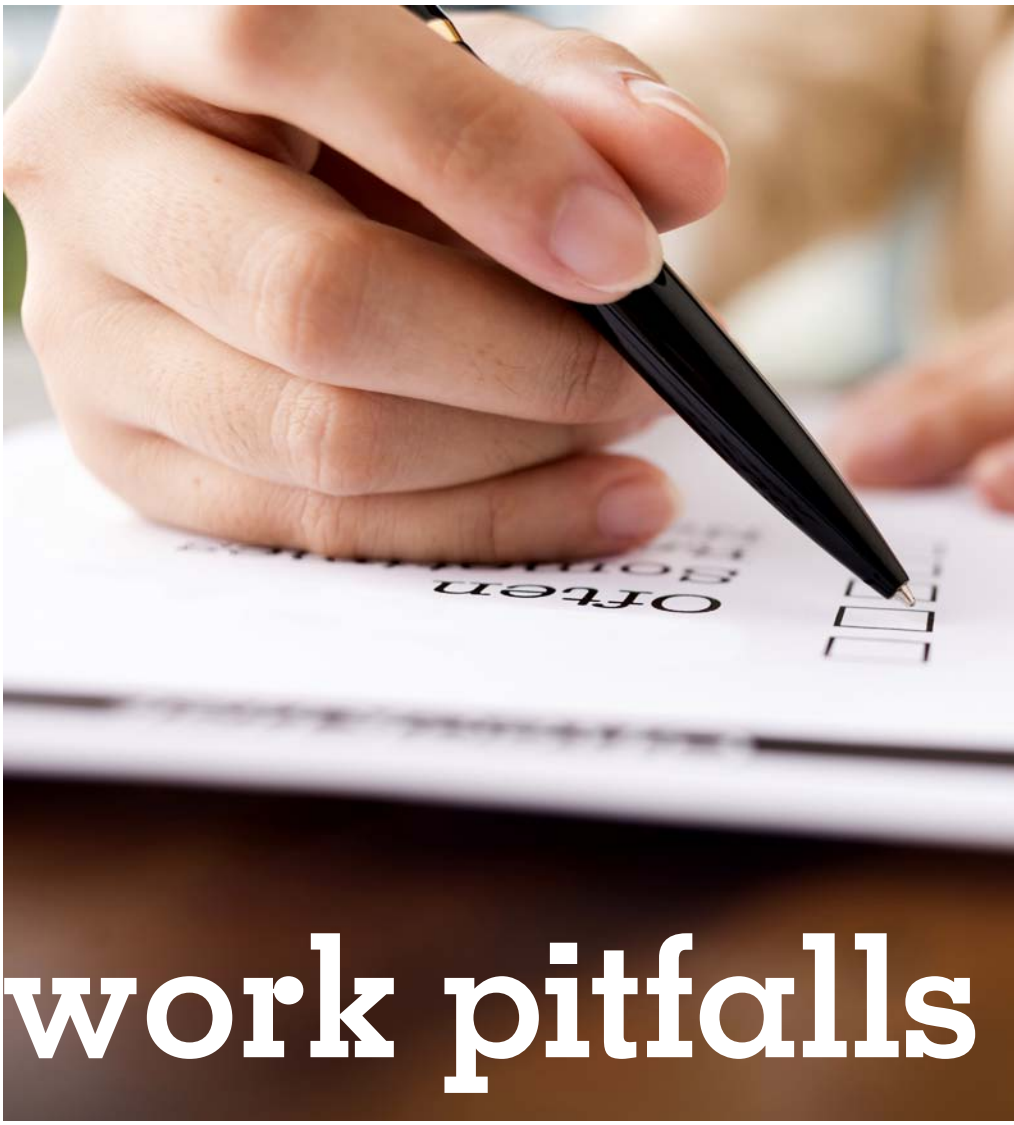
But even with this annual influx of visitors, Arran remains a collection of small tight-knit communities and Ruth says there can be an element of "living in a goldfish bowl" when you have such a recognisable job. There is also the issue of confidentiality.

"Sometimes people ask you questions or comment on someone's health and you just have to say – 'Oh, I don't know'," she says with a laugh. "No one on our staff knows anything about anybody. That's how it works."

But the trade-offs of living and working in a remote setting have been well worth it as far as Ruth and her family are concerned. Just as I'm leaving Shiskine we discuss her local running circuit which takes her past the prehistoric stone circles at Machrie Moor and along the coastal path to King's Cave.

"We live in a lovely place," she says. "I feel very privileged."

Jim Killgore is associate editor of MDDUS Practice Manager



Senior risk adviser **Liz Price** offers guidance on managing risks in the processing of patient reports

Paperwork pitfalls

PRACTICES receive requests for patient reports from a variety of organisations, including employers, insurance companies and government agencies – and as such they are part of the daily routine. But a recent analysis of GP cases conducted by MDDUS has identified the extent to which failures in the processing of patient reports can lead to complaints and sometimes claims for negligence.

Here I will explore some of the things that can go wrong when managing requests across the full multidisciplinary process from request to completion.

REQUEST RECEIVED

When a request for a patient report arrives at the practice it is important that patient consent is attached. Under the Access to Medical Reports Act (1988), companies must ask a patient's permission to request a medical report from their doctor. Patients may also choose to see reports before a practice submits it to the company.

Important points to check at this step are:

- Has the patient consent form been signed recently (less than six months prior to the date of request)? The older the consent is, the less valid it becomes (unless of course the request for a report comes as the result of a patient's death and relates to a life insurance policy). If consent is not recent, the patient should be contacted to confirm that they are happy for the practice to comply with the request.
- Does the information requested in the report go beyond the remit of the statement the patient has signed? For example, the information requested may appear to be more extensive than the patient is likely to have anticipated based on the consent given, or the doctor may find information in the medical record that the patient might not realise could be detrimental if disclosed. If in doubt, check with the patient before complying with the request.

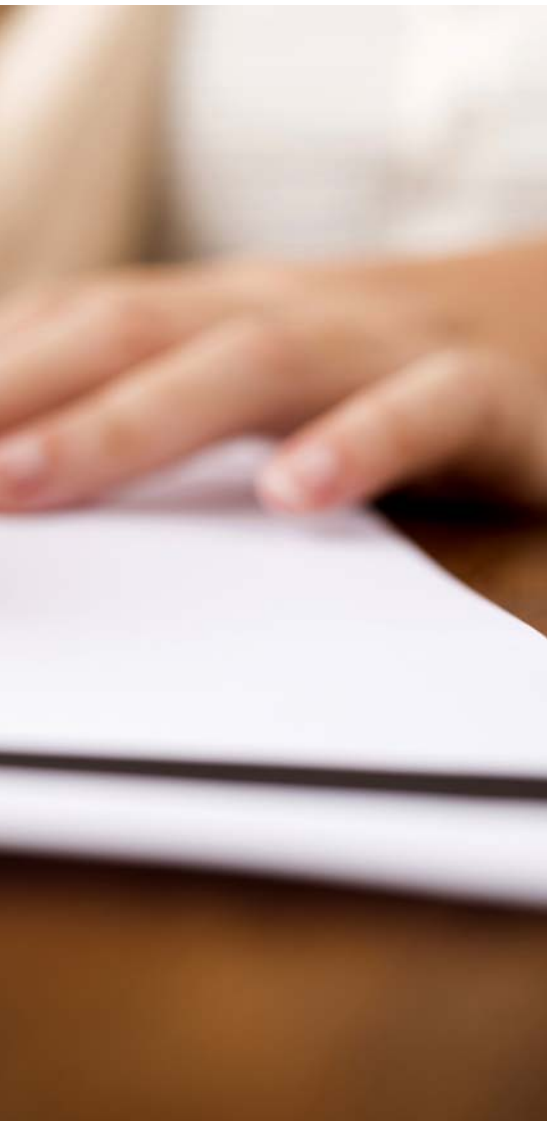
It is essential that you only provide information that the patient has consented to but it is also important to ensure that any additional checks do not cause unnecessary delay in complying with the request. If a doctor chooses to withhold information which does not fall within the scope of patient consent, ensure that the person(s) requesting the report are informed of this.

Some types of report allow for patient review prior to submission, such as those covered by the Access to Medical Reports Act (e.g. insurance reports). It is important to be aware that there could be a conflict between the interests of the patient, the requirements of a third party and the obligations of a doctor to provide accurate information. Some types of report do not require patient consent, specifically where the doctor is legally obliged to produce the information, but it is good practice to inform the patient, where possible.

WORK-FLOWING THE REQUEST

Careful consideration should be given to practice policies around the allocation of a doctor to complete a patient report. Whilst it is important not to overload any particular doctor with such requests, systems which simply use an allocation rota could cause difficulties. An important consideration here is whether any of the doctors know the patient.

If a patient is known to a doctor this could assist in completing the form more efficiently



and accurately. The doctor may be more aware of the patient's attitudes around sensitive information, the disclosure of which falls within the scope of the consent provided. In some cases, the patient may have wished the doctor to restrict the extent of information provided.

It is also important to note any special need to expedite the request. This may affect who can complete the report as a doctor may be on leave, or may not have current capacity to comply within the required timescale.

AUDIT TRAIL AND MONITORING

In order to avoid complaints and claims associated with delays in complying with requests, it is essential to maintain an administrative log of each patient report.

Useful information to record might include:

- date of request and related patient
- company or person(s) requesting the report
- nature of the report requested and whether the practice can/should comply
- whether appropriate consent is included
- whether the patient is allowed/has requested to review the report before submission
- a record of the agreed fee for completion and who is liable to pay this (advice on fees is available from the BMA)
- the urgency of the report and required completion date
- which doctor has been allocated the report
- agreement from the allocated doctor (it may be that – after discussion with the patient – completion of the report may not be in their best interests or the doctor may not feel equipped to provide the required information)
- expected date of completion.

Practice managers should have knowledge of each doctor's workload and capacity in relation to completion of patient reports. It can be helpful to agree an informal standard for timescales. This can help the administrative team deal with any enquiries on completion dates and ensure that consistent failures to meet timescales are addressed – or indeed that the timescales for completion should be reviewed. It may be helpful to diarise a reminder for the doctor, with their prior agreement, so that the agreed deadline for completion is not passed.

> "HAS THE PATIENT CONSENT FORM BEEN SIGNED RECENTLY? THE OLDER THE CONSENT IS, THE LESS VALID IT BECOMES"

ACCURACY OF INFORMATION

Accurate completion of requests for patient reports and forms is essential. Several recent claims for negligence have arisen due to a loss of earnings or a delay in pay-outs on insurance claims – many relating to doctors making errors on insurance reports and DVLA forms and reports. The latter are likely to attract claims where the patient requires a current /appropriate driving licence to carry out their job; a large proportion of these are linked to HGV reports and solely relate to a doctor ticking the wrong box on a form.

When completing forms, doctors should ensure that they read each statement carefully. Some questions can move from negative to positive wordings which may be confusing, particularly if the doctor is under time pressure.

Some patient systems are able to produce editable template information for inclusion in patient reports. This can be helpful; however, the quality of information extracted is directly proportionate to the quality and consistency of input information. Where information is automatically extracted, it is important to review this from two angles. Firstly, what has been missed and, secondly, what has been included that is excessive, irrelevant or outside the scope of the request.

A further area of risk is overreliance on a previously completed patient report. Whilst it may be tempting to use existing information as a starting point – or indeed the core section of a new report – this strategy can lead to the perpetuation of a previously missed error.

Doctors should stick to facts rather than personal opinion when completing reports and if the requested information is outside their sphere of knowledge or competence, the doctor should state this where relevant, or even advise that another party may be better qualified to supply the information required. Doctors withholding any patient information in a report should include a statement to this effect: for example information which may be harmful to the patient or a third party.

COMPLETING THE PROCESS

Any expected delay in the completion of a report should be communicated proactively to the person(s) requesting it. This can help to manage expectations and prevent complaints.

Patient requests to review a report before it is sent should be facilitated where appropriate. A patient who does not agree with information included within a report has the right to ask for it to be amended – or for a statement of their objections to be included with the report. The patient also has the right to ask for the report not to be released and this should be communicated promptly to the company or person(s) requesting the report.

And it goes without saying that when sending out patient reports ensure the mode of transfer is secure – be it paper or digital.

Liz Price is a senior risk adviser at MDDUS

Village gossip

Day one

A GP – Dr K – is a partner in a small village practice and is at home on an afternoon off when the receptionist calls from the surgery. A patient – Mr L – has phoned the practice wishing to speak with him in regard to an urgent personal matter. The receptionist passes on a contact number and the GP phones Mr L, whom he knows well both from the surgery and through casual contact in the village. Mr L is very angry. Just that morning he was phoned by a good friend who had been in the local pub the night before and heard it discussed that Mr L's daughter was in rehab for a drug addiction. Dr K says he is sorry to hear this but asks how it is a "personal matter". Mr L states that his daughter – though a registered patient – is rarely in the village, and no-one locally could know about her drug problem apart from Dr K. He accuses the GP of either discussing the matter at home or elsewhere in the village and that this constitutes a serious breach of confidentiality. The GP comes off the phone very upset and calls the senior partner.

Day two

Mr L phones the surgery again and asks to speak to the practice manager – Ms D. He repeats his allegation of breach of confidentiality and states that he wants to make a formal complaint. The practice manager asks Mr L to put this in writing so the matter can be investigated. Ms D then speaks with Dr K and the receptionist who took the initial message, asking them to write a statement setting out their versions of the events. Dr K is adamant that he never discusses matters involving patients outside of the surgery – and working in such a small community makes him even more scrupulous.

Day three

Mr L hand-delivers his letter into the surgery and the practice manager phones the MDDUS for advice. A medico-legal adviser asks her to forward anonymised copies of both the complaint and the GP's account of the events. He also advises Ms D that consent will be required from Mr L's daughter before the practice can respond to the complaint. Ms D acknowledges receipt of the Mr L's letter and sets out the need for patient consent.

Day five

MDDUS offers advice on the wording of the response to Mr L's complaint and Ms D drafts a letter for review. In the letter she expresses regret at what has transpired in regard to his daughter. She then provides details of her investigation into the alleged breach including discussions with the receptionist and with Dr K. She states that the GP is again adamant that he was not the source of the gossip circulating around the village. Having worked many years in a small community he knows how any discussion of patient details with family or friends can lead to confidentiality breaches – even if inadvertent. For this reason he is particularly scrupulous in not discussing patients outside the practice team. Ms D concludes the draft letter by stating that her investigation has led her to believe the information regarding Mr L's daughter must have come from another source in the village. She offers to meet with the patient and Mr L face-to-face, along with Dr K, and informs him that if they are not satisfied with the outcome of the complaint process it is their right to take up the issue with the ombudsman (and she provides contact details).

Day seven

The MDDUS reviews the letter and reminds Ms D that before she can send out the response she must obtain consent from the patient – Mr L's daughter. She advises the practice manager to write to Mr L informing him that the investigation is complete and that she would be pleased to forward it to him upon receipt of the signed consent.

A MONTH later Ms D contacts MDDUS to say that she has not yet received a letter of consent from Mr L's daughter permitting disclosure of the investigation, despite having written twice. The adviser replies that it is now reasonable to write to Mr L informing him that as consent has not been provided she is now required to close the complaint. But the practice manager is advised to ensure she keeps the papers in a complaints file as the usual timescale for raising cases under the ombudsman is 12 months after the incident, though this can be extended in extenuating circumstances.

KEY POINTS

- Maintaining patient confidentiality requires scrupulous professionalism especially in a small community.
- Ensure a third party has consent (or parental responsibility) to act on behalf of a patient in pursuing a complaint.
- Conduct a full investigation before coming to any conclusions over a perceived breach.
- Patient consent will also normally be required before the results of a complaints investigation can be shared with a third party.

Diary

Here we offer our usual collection of oddball items and gentle musings...

➔ WAITING ROOM SCIENCE Diary abhors thievery of any kind – even when it might offer a public service. Researchers from New Zealand have recently reported on the findings of an ambitious study designed to shine a light on the murky world of waiting room magazine theft. In the study, 87 magazines were placed in the waiting room of a general practice in Auckland. Titles ranged from high-minded magazines such as *The Economist* and *National Geographic* to 'gossipy' entertainment publications, defined as having five or more photos of celebrities on the cover. Twice a week the researchers checked back and within a month nearly half had disappeared including all but one of the 27 "gossipy magazines" – yet all 15 copies of *The Economist* remained. Research team leader Professor Bruce Arroll commented: "Quantification of this phenomena was urgently needed... Future research in waiting room science would include identifying who or what is responsible for the removal of magazines."

➔ MEDICAL EMERGENCY WITH A VIEW NHS Highland recently conducted a workshop considering innovative solutions to improve out-of-hours care in rural areas. The current service was judged to be too fragmented and lacking in flexibility to cross-cover, as well as being "extremely expensive". One solution floated was the use of "telebooths" which would allow patients to talk to GPs from remote locations. Diary was immediately put in mind of the lone red phone box in the film *Local Hero* – perched on the stone quay of the fictional Scottish village of Ferness. Maybe you could enjoy a lucky glimpse of the northern lights as you await the EMRS helicopter.

➔ CHEAPER BY THE BUNNY The Health and Social Care Information Centre has published figures on GP funding in England revealing that the cost of primary care was on average £136 per registered patient. Reporting on the announcement, the magazine *Pulse* helpfully pointed out that this amounted to less than an annual Sky TV subscription which costs £238 per year. The magazine noted that £136 also cannot get you the yearly rise in the price of a season train ticket from Guildford to London, a trip to the cinema every fortnight, one haircut per month or a daily Mars bar. An anonymous reader on the *Pulse* website further commented: "Just got a quote from PetPlan for a year's health insurance for a rabbit; £175.80."

➔ EMOTIONAL EXTREMES Diary is well aware of the benefits of encouraging positive emotions amongst team members and minimising moaning, but it can be taken too far. A prime example can be found at the New York customer service provider who allegedly forced employees to pray, thank God for their jobs and say "I love you" to managers and colleagues. Reuters reported that several of those who resisted the rather unusual requirements of the "Onionhead" spiritual belief system were fired, while others claim they were demoted. Details emerged in a recent lawsuit raised by the US Equal Employment Opportunity Commission against Long Island-based United Health Programs of America and its parent company Cost Containment Group. One worker who complained about the system (created by a relative of United Health's owners) was allegedly moved to an open plan area and a Buddha statue placed in her former office. In a statement, the companies said they were "caring, family-oriented businesses" and called the lawsuit "meritless."

➔ OUT OF BED AND BRUSH YOUR TEETH Diary applauds ongoing Department of Health initiatives to revise the dental contract to encourage and reward proactive efforts for promoting oral health. Perhaps the Government could go even further. It has been reported that in New Zealand a trial program was underway to remind the unemployed to clean their teeth. Text messages were sent daily asking whether recipients had brushed and requesting them to respond when they had done so.

➔ EVERYONE NEEDS A FAIRY GODMOTHER Even if he's called Ray. The small village of Prees in Shropshire was recently celebrating the opening of a new £1 million surgery built through the generosity of local businessman Ray Grocott. He stepped in to fund construction of the new Prees Medical Centre when the retirement of the current GP – who worked out of his own home – would have left the village without a surgery. Said Ray: 'I'm a chap who's lived in the village all my life, our family have been all born there, we're used to the proper GPs - the old original ones. We've had such good service and there's no way that I fancied all the village people having to travel to Wem or Whitchurch." No indeed not.

➔ WALK, SIT, CONSULT ON WATER. Diary has noted that the dwindling supply of willing GP trainees has lately been matched by ever more creative means to attract candidates. Forget sober adverts in the back of the *BMJ* – you need a You Tube video with a James Bond sound track and action shots (Arran) or a consciously (let's hope) cringe-worthy musical number on the attractions of primary care (West Sussex CCG). East Cumbria GP Training Programme has recently launched #GreatBritishConsultations as a way of getting noticed on social media with a series of eye catching photographs to attract attention – this one rather messianic. Good luck we say.

PHOTOGRAPH: STEVE RAZZETTI

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

MDDUS
Practice Managers' Conference 2015

Fairmont, St Andrews
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MDDUS Risk Management invites you to join us at the EIGHTH MDDUS Practice Managers' Conference returning to the Fairmont, St Andrews on 26-27 November 2015. Book now and benefit from our early bird rates

DAY 1: RETURN TO BLEAK PRACTICE
The 2015 conference will focus on another filmed dramatisation of events based on actual MDDUS cases. A programme of masterclass workshops will explore a range of medico-legal risk areas with a particular focus on prescribing – one of the largest sources of general practice claims. So just sit back, watch, analyse, share and be thankful it's not you!

DAY 2: INTERACTIVE WORKSHOPS
Delegates can select from a range of interactive workshops, and engage in discussion around a range of risk topics, relevant to your own practice. Each session explores a current risk area within general practice and will allow delegates to share best practice in order to mitigate these risks.

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- For further information visit Risk Management at mddus.com
- To book contact Ann Fitzpatrick on afitzpatrick@mddus.com or at 0845 270 2034
- Early bird rates – available until 30th June 2015