

## GETTING THE RIGHT RESULT

The best time to start  
preparing for a CQC  
inspection is now

## PATIENTS AS EMPLOYEES

What are the clinical and  
legal risks in employing a  
patient on your team?

## CONFIDENTIALITY AFTER DEATH

Advice on right of access  
to the medical records of  
deceased patients

# MEDICINE ON THE STREETS

PROVIDING PRIMARY CARE TO THE HOMELESS AND OTHER VULNERABLE PATIENTS



**POSITIVE PATIENT ENCOUNTERS**  
HOW RECEPTIONISTS CAN TRANSFORM THE  
WAY PATIENTS VIEW YOUR PRACTICE





PRACTICE receptionists make easy targets when it comes to complaints. They lack the professional mantle of doctors or dentists or practice nurses; there is no Royal College of Receptionists. Yet their role in healthcare provision is both important and at times fraught with complexity. Telephone encounters with patients can be particularly tricky.

On [page 8](#) in this issue senior risk adviser Liz Price looks at research on patient satisfaction related to initial telephone encounters with receptionists and considers how practices can enhance the experience while also reducing risk.

Requests for access to the medical records of deceased patients often cause anxiety and confusion for practice managers in regard to "who" has the right to access "what". On [page 6](#) practice adviser Scott Obrzud offers some

guidance. On [page 7](#) employment law adviser Janice Sibbald considers why it is generally not a good idea to have practice employees as patients.

On [page 10](#) Jim Killgore visits Bevan Healthcare CIC – an innovative practice in Bradford that provides primary care exclusively for the homeless, refugees and asylum seekers, and others who have difficulty accessing healthcare. Much of its service is delivered out on the streets and in shelters across the city. CQC chief inspector Steve Field described it as "an utterly outstanding practice".

MDDUS has recently formed a partnership with the law firm Capsticks providing GP and practice manager members in England and Wales discounted legal advice on non-indemnity issues. On [page 12](#) Capsticks partner Ian Cooper offers advice on ensuring your practice is prepped for a CQC inspection.

Our regular Call log on [page 4](#) covers a range of issues including patient preference for email contact, flexible working and caring for transgender patients. The case study ([page 14](#)) concerns a receptionist providing telephone advice beyond her competence – taking us back again to the importance of ensuring your reception team is fully supported.

★ **Helen Ormiston**  
Editor

COVER: TIM SMITH

### MDDUS encourages members to use advice line

MDDUS is keen to dispel the myth that contacting the organisation's advice line impacts on the subscription rates members pay.

Members are encouraged to seek advice from MDDUS' highly-skilled team of advisers at the earliest opportunity – and are not penalised for doing so.

MDDUS chief executive Chris Kenny said: "As we have repeatedly made clear to the BMA and a number of LMCs who raise this issue, we can give a categorical assurance that the underwriting and pricing decisions of MDDUS are not affected by the number of times members contact the organisation for advice."

"Indeed, MDDUS positively encourages members to make use of the 24-hour advice line that is available to them as a benefit of membership. We believe seeking our advice will assist the member in adopting safer clinical practice and we would never penalise them for contacting us for advice."

Each year MDDUS handles many thousands of calls to our advice line and emails from members on topics ranging from patient complaints to confidentiality to practice risk.



### Call for longer, fewer GP consultations

THE BMA is calling for the standard 10-minute GP consultation to be increased to 15 and the total number of consultations per day limited to 25 rather than the 40 or more per GP seen in some surgeries.

These are among proposals published in a BMA report – *Safe Working Levels in General Practice* – which looks at measures to help tackle the "rocketing workload" in the specialty.

The report considers the potential impact of 'locality hubs' where demand, patient lists and safe working limits could be managed for a number of local practices with GPs benefiting from greater integration, collaboration and flexible employment patterns. This hub model was featured in plans outlined in NHS England's *GP Forward View*, which included £500m of recurrent funding to provide extra primary care capacity and a £171m one-off investment by clinical commissioning groups from 2017/18 for practice transformational support.

BMA GPs committee executive team member Dr Brian Balmer said: "More GPs must be put in front of patients so that the number of consultations per GP a day falls to a sustainable level. We need to learn from best practice across the UK and look at options, where appropriate, for organising GP practices into hubs, where knowledge and resources can be shared."



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## Half of adults in England avoid dentist

NEARLY half of adults in England have not seen a dentist in the last two years according to data from NHS Digital.

The data also shows that 42 per cent of children (4.9m) in England have not had a check-up in the 12 months to June 2016, despite NICE guidelines recommending children should be seen by a dentist at least once a year.

The British Dental Association has expressed concern that rising charges (five per cent last year) are discouraging patients in need of care and driving an estimated 600,000 people each year to GP practices for treatment, despite doctors being neither trained nor equipped to provide dental care.

Dental leaders have urged government to deliver a coherent oral health strategy and effective public engagement.

Henrik Overgaard-Nielsen, Chair of General Dental Practice at the BDA, said: "It's clear we have a problem when more than one in three children are missing out on free dental treatment. We need a concerted effort to get parents, health professionals and government on the same page."

## Capsticks offers discounted legal advice on practice business matters

MDDUS has announced a partnership with law firm Capsticks that enables GP and practice manager members in England and Wales to access a free 20-minute legal consultation and ongoing discount rates on non-indemnity issues.

Capsticks Solicitors LLP will provide MDDUS GP and practice managers with a host of benefits including up to 20 minutes of free business and corporate legal advice, as well as access to a full range of practice and business legal services at specially discounted rates.

Sam Hopkins, partner at Capsticks and head of the GP legal support team, said: "We are very excited to be working in partnership with MDDUS and look forward to supporting their GP and practice manager members with their non-indemnity legal issues during what is a particularly challenging time."

## Dentists not taking sufficient breaks

A SURVEY of dentists found that less than 40 per cent take a lunchbreak and over 60 per cent take no small breaks at all.

Income protection insurance provider Dentists' Provident undertook an online survey earlier this year which also found that 60 per cent of respondents did not exercise. The survey revealed that 70 per cent of the dentists drank only half a litre of water a day or less, and over 50 per cent said they didn't drink anything else during the day.

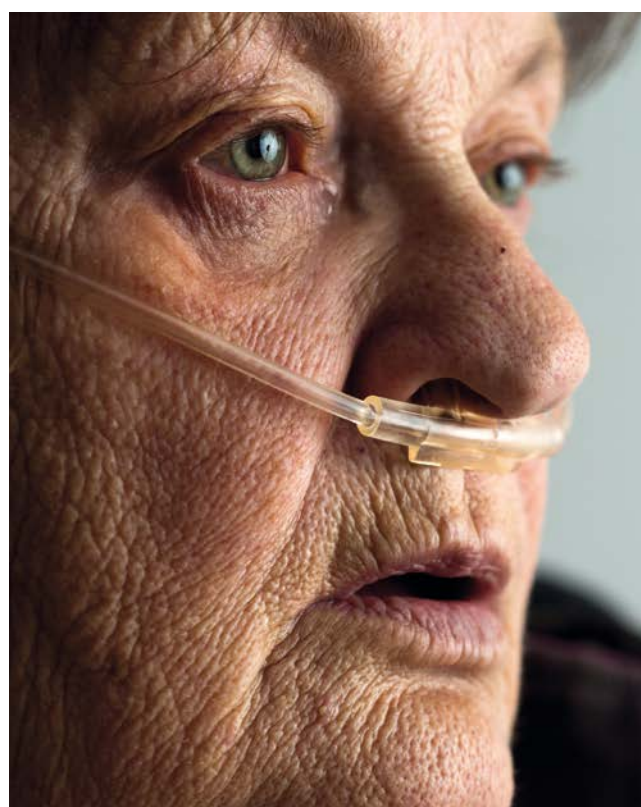
Dentists' Provident advises that dentists should take a short break every hour to ensure that mind and body can rest and recover. "Doing this as a matter of routine could help to prevent a variety of health conditions."

## New sepsis toolkit launched by RCGP

A NEW sepsis toolkit to support GPs and healthcare professionals to identify and manage the condition in patients has been launched by The Royal College of General Practitioners.

The toolkit ([tinyurl.com/hgsbb53](http://tinyurl.com/hgsbb53)) has been developed in partnership with Health Education England and NHS England and provides educational materials, up-to-date guidance and training resources. It also incorporates information for patients, carers and parents, including an adult and child sepsis 'symptom checker' illustrating signs and symptoms to look out for.

RCGP's Clinical Lead for sepsis Dr Simon Stockley, who developed the toolkit, commented: "Sepsis is responsible for 37,000 deaths a year in England alone. Recognising sepsis at an early stage among the huge number of ordinary infections can be a challenge even to experienced clinicians."



## New NICE guidance on multimorbidity

NICE has issued a new guideline setting out ways to tailor care for adults with multimorbidity.

The new guidance ([www.nice.org.uk/guidance/ng56](http://www.nice.org.uk/guidance/ng56)) aims to optimise care for patients with multiple long-term conditions by identifying ways of reducing treatment burdens (such as polypharmacy and multiple appointments) and unplanned or emergency care. It promotes shared decision-making based on asking patients what is important to them individually in terms of treatments, health priorities, lifestyle and goals. The guideline also sets out which people are most likely to benefit from an approach to care that takes account of multimorbidity.

The term multimorbidity refers to the presence of two or more long-term health conditions. A 2012 report by the Department of Health estimated that caring for more people with multiple health conditions, coupled with an ageing population, could require an extra £5 billion in spending by 2018.

Many of the conditions common in multimorbidity are covered in other guidance notes but NICE points out that evidence for recommendations on single health conditions is mostly drawn from people without multimorbidity and fewer prescribed medicines.

Professor Mark Baker, director of the centre for guidelines at NICE, said: "Our guideline brings an important perspective to light - that it's our responsibility as healthcare professionals to deliver person-centred care, not disease-focused treatment."



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

#### EMAIL CONTACT

**Q** A few of our patients have stated recently that they would prefer to communicate with the practice by email rather than by post. Is this something we are allowed to do? I'm worried about confidentiality.

**A** Email is a convenient way to keep in touch with people but you rightly raise issues of data security. In the first instance, get in touch with your clinical commissioning group (CCG) or health board and find out if they have a local policy about communicating with patients in this way. It is advisable to proceed with caution. While the practice will likely have robust IT protection in place for their email and computer system, the patient may not. Any message you send to them could, unless encrypted, be intercepted and this should be made clear to the patient. Another risk area would be if an email account is shared/accessible by a number of family members. A good way to minimise risk generally would be to avoid including very sensitive information in email exchanges – perhaps limiting it to matters such as appointment scheduling. Fully explain all these issues and ensure the patient also knows email should not be used to request urgent medical attention. This can be emphasised via an automated email acknowledgement. Similarly, ensure all relevant email accounts are monitored during staff absences.

#### FLEXIBLE WORKING

**Q** One of our admin staff recently asked about flexible working and whether she could vary her working hours slightly. I'm not sure this would fit with what the practice needs. She's only been with us for eight months and doesn't have children to look after. Can I just tell her no?

**A** Since 2014, all employees who have worked in an organisation for more than 26 weeks have had the right to request flexible working under the Children and Families Act. Previously this right only applied to people with children or caring responsibilities. ACAS has published guidance which states employers are obliged to consider requests in a reasonable manner and meetings should take place as soon as possible. Ask your employee to put her request in writing, stating what changes she would like to make to her working arrangements. She can make one request in any 12 month period and you have three months from receipt to give a decision. Be aware that you must have a sound business reason for rejecting her request – this

includes issues such as the burden of additional costs, an inability to reorganise work amongst existing staff, a detrimental impact on quality or performance, or a planned structural change to the business. More detailed guidance is available on the ACAS website and you can access an MDDUS employment law factsheet on our website at: [tinyurl.com/jjrpf5t](http://tinyurl.com/jjrpf5t)

#### TRANSGENDER CHANGES

**Q** We are based in the north of England and one of our male patients has been transitioning to female over the past year, with support from the practice GPs. He has now called up asking for his personal details to be changed on his medical record to reflect his new name and change of



gender. Can we do this at his request or should he provide some kind of formal certificate or authorisation first?

**A** You should ask the patient to submit a signed request in writing. He is not required to provide a Gender Recognition Certificate or updated birth certificate in order to have his record amended (this applies in Scotland too). You should then inform your CCG of the new name and gender (with the patient's consent). If the patient wishes to be issued with a new NHS number then this can be taken care of by the CCG who will ensure his records are transferred to his new identity. You should explain to the patient he may not be contacted for current or future screening programmes associated with his sex at birth and explain the implications of this. Decisions about screening should be made in the same way as any other decisions about his health (ensuring informed consent is in place). Don't forget to change the gender marker, pronouns and names on all the patient information that you hold. The GMC have published guidance on trans healthcare on their website which contains further information including the process for changing name, title or NHS number across the UK ([tinyurl.com/hg1l6su](http://tinyurl.com/hg1l6su)). Note that it is a criminal offence to share knowledge of a gender reassignment without the subject's consent.

## DECLARING INDEMNITY

**Q** I've heard about the recent changes the General Dental Council have introduced about declaring indemnity for our dentists and dental care professionals. Is this a new requirement we need to worry about?

**A** The GDC has made it clear that this is not a new requirement as dental professionals have always been required to have appropriate indemnity in place. All that has changed is that dentists and DCPs will be asked to "declare" this indemnity when they register/renew their registration. Dentists will make the declaration during the annual renewal period (deadline December 31) which can be done on the eGDC portal. The same applies to DCPs but their deadline is July 31. In relation to dental nurses' declarations, your employing principal should reassure the employed nurses that they have access to adequate and appropriate indemnity vicariously through the employing principal's membership with MDDUS. This applies to employed dental nurses only (not locums) where the employing principal is an MDDUS member. The nurses must also ensure they act within their skill set and competence and under the direction of a dentist. More detailed information is available on the GDC website at [tinyurl.com/gurs7la](http://tinyurl.com/gurs7la)

## FOI REQUEST

**Q** A patient has submitted a request under the Freedom of Information (Scotland) Act asking for various pieces of

information about how the practice works, including how it manages its budget. Is this something we are obliged to give him?

**A** The 2002 Act gives members of the public the right to access information held by public authorities, including GP surgeries. (The Freedom of Information Act 2000 applies in England, Wales and Northern Ireland and differs slightly from that north of the border). The practice should already have a publication scheme in place which can be a useful means of displaying (often on the practice website) the types of information the practice holds and how it can be requested. Typical publication schemes may include details of the practice's contract, the services it provides, policies/procedures, the names of the doctors practising there and any costs associated with FOI responses. The scheme should also detail the types of information that the GP holds but cannot make available, and why. The issue raised regarding budgetary management might need a specific answer as disclosing practice finances can be sensitive and may indirectly contravene data protection rights of employees and partners. Data protection rules would apply to any FOI request and the practice must not release any personal or clinical information that the recipient is not entitled to. Patients seeking personal information about themselves can do so via a written subject access request under the terms of the Data Protection Act 1998. FOI requests should be in writing and the practice has 20 working days from receipt of the request to respond. More detailed information can be found on the Information Commissioner's Office website.

## OVER DEMAND

**Q** We are an English general medical practice and in the past we have not been strict about patients remaining on our list after moving outside practice boundaries. But in recent years our list size has nearly doubled and we are now struggling to meet demand. Consequently we have begun to request that patients living outside practice boundaries register with another GP closer to their home. One patient who has been registered with the practice for 10 years has now written to complain that this will jeopardise his continuity of care. Are we within our rights to ask this patient to register elsewhere?

**A** It is normal practice to ask a patient who moves out of the practice area to re-register with their local GP. NHS regulations state that a patient may be removed from a practice list if they have moved out of the area but have not deregistered. The patient should be allowed 30 days to make alternative arrangements. In this specific case we advise that the patient should be written to with an explanation behind the decision. Should there be further objection it would be up to the practice to judge whether deregistering without permission would be in this

individual patient's best interests – but such decisions should be consistent to avoid any claim of discrimination.

## REMOVING CLINICAL DETAILS

**Q** A patient at our practice recently had breast augmentation surgery at a private clinic and requested that the hospital not send correspondence to us regarding the procedure – but we had already received a letter regarding the treatment. The patient is now insisting this be removed from her records. What should we do?

**A** This is relevant clinical information and as such should not be removed from the patient's records. It might be reasonable to code it as low priority so that it would not appear on referrals. The information might also be marked confidential to ensure it would not be revealed to any other party who may have consent to access her records. Should the clinician judge that this information would be relevant to a specific referral this should be discussed first with the patient.

## READ CODE CHANGES

**Q** A practice nurse has discovered that some of the IT read codes in one particular patient's records are incorrect and do not reflect his medical condition. Is there any legal risk in just correcting these?

**A** It would be appropriate to amend the read codes as information within the patient's records should be accurate. However, we would advise that there is a clear audit trail in relation to this change, including when/why the information was amended and by whom. You may want to contact the providers of your IT clinical system for advice on how this is best achieved. For more guidance see our RCGP-accredited interactive module on good record keeping for GPs in the eLearning centre of Risk Management at [mddus.com](http://mddus.com)

## BUDDY SYSTEM UNPOPULAR

**Q** Our practice is reconsidering the system we use for managing incoming blood results. It is obviously impractical for the requester to take sole responsibility for their own results as this does not allow for sickness or holiday leave. Currently our GPs use a "buddy system" but this is not popular. What do you suggest?

**A** An alternate solution would be for all blood results to be dealt with by the duty doctor of the day – or to distribute results equally among all the clinicians with immediate and urgent prescriptions dealt with by the duty doctor. Any protocol will have positives and negatives but it is important to ensure that whichever one is adopted is documented and explained fully to practice staff so that no test results are left waiting for a clinician to return from leave. See our risk checklist on record keeping and workflow processes in the eLearning centre of Risk Management at [mddus.com](http://mddus.com).

# Confidentiality

## after death

Practice adviser **Scott Obrzud** offers advice on right of access to the medical records of deceased patients

**A** COMMON enquiry received by the practice advisory team at MDDUS concerns requests for access to the medical records of deceased patients. Such requests often cause anxiety and confusion for managers in regard to “who” has the right to access “what”.

The relevant legislation to consider is the Access to Health Records Act (AHRA) 1990, which – as a starting point – provides no automatic right to access a deceased person’s medical records. Practices and other healthcare organisations have an ongoing duty of confidentiality to patients, even after death.

### WHO CAN REQUEST

The AHRA allows for a personal representative of the deceased patient to apply in writing to the record holder for access. A “personal representative” is an individual entitled to administer the estate of the deceased by virtue of a grant of probate (if a will was left) or by letter of administration if the patient died intestate (no will is left). This term is effectively synonymous with “administrator” or “executor” and it refers to a specific individual; practices should therefore be cautious as this may not necessarily be a surviving family member or next of kin. The applicant should provide proof that they have the right of access as a personal representative.

An application to access can also be made by an individual who is not the deceased’s personal representative as long as it can be proved that they have a claim resulting from the death. A “claim” is not defined by the Act, however it is something that should have resulted from the patient’s death and would include claims for clinical negligence, life insurance and travel insurance.

The applicant should be required to provide evidence that their claim is legitimate, including all relevant details and any substantiating documents.

On occasion relatives may wish access to records to investigate whether

a deceased patient had capacity when changing their will. If the personal representative is making the application, this would be allowed by the AHRA. If someone other than the personal representative is applying, then this may not qualify as a claim resulting from death. This is a disputed point that causes much discussion but to MDDUS’ knowledge has never been tested in court. In these circumstances we advise seeking the consent of the personal representative before disclosing to other family members for this purpose. If it is not possible to gain the personal representative’s consent, practices should call MDDUS to discuss the matter.

In preparing copies of medical records, check whether the deceased asked for certain information to be withheld and ensure there are no references to third-party information. The applicant (someone other than the personal representative) should only be provided with the information they requested, rather than simply handing over the entire record for the sake of ease.

Similarly, it is important to withhold any information that is likely to cause serious harm to a member of the family or third person.

### “CLOSURE” AND OTHER REASONS

Requests to access a deceased’s medical records can be made for many reasons but the majority tend to be from relatives wanting to understand what happened to their loved one prior to death to help them come to terms with their loss.

The General Medical Council emphasises that the duty of confidentiality continues even after the patient’s death (see GMC guidance *Confidentiality* at [tinyurl.com/6cy4zam](http://tinyurl.com/6cy4zam)) but they do allow for disclosure of relevant information where a “partner, close relative or friend” asks for information about the circumstances of the death. Under the terms of such a disclosure, doctors can consider having a “discussion” with a relative or loved one, however care should be taken to ensure only “relevant information” relating to the circumstances of the patient’s death is provided. Again, check whether the deceased had previously asked for any information to be withheld.

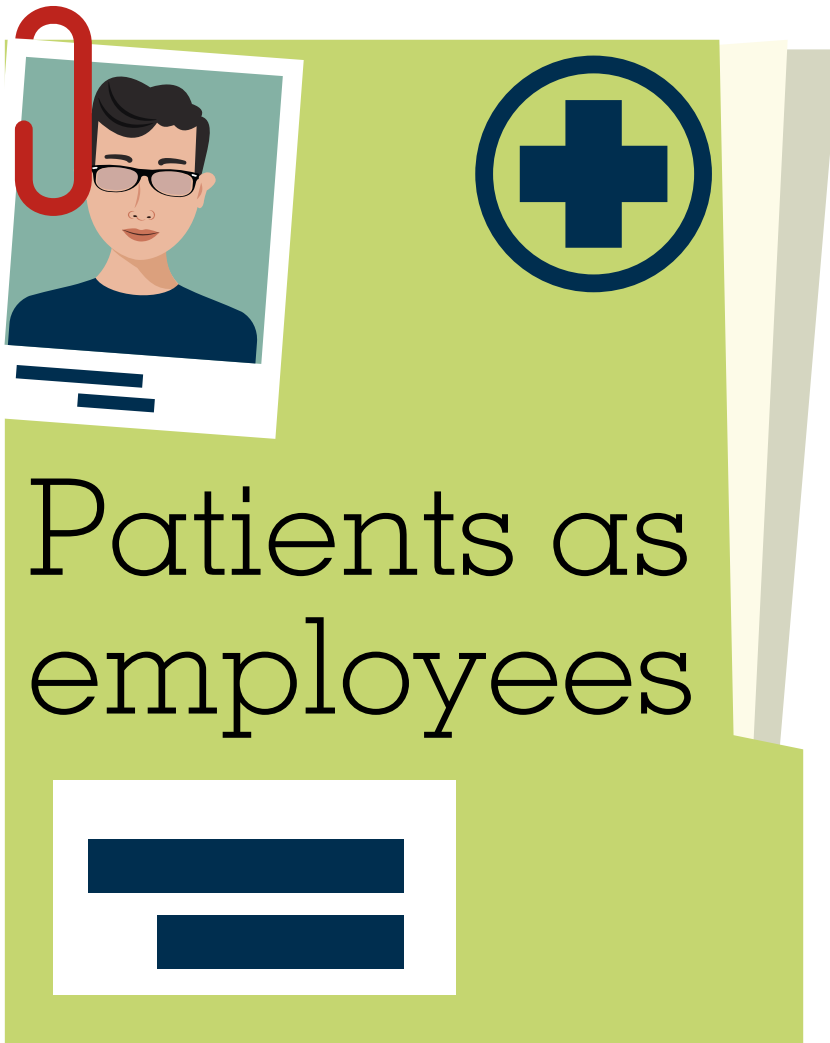
The coroner in England, Wales and Northern Ireland or the procurator fiscal in Scotland may legally request a full copy of the deceased person’s records in order to investigate their death. The request may come via a police officer acting as an agent for the coroner or procurator fiscal, and disclosure in these circumstances would also be considered acceptable.

There are other circumstances in which disclosure may be required in the public interest. This could be in the event of an official public inquiry or if the police are investigating a serious criminal offence. The normal rules of disclosure and co-operation in those circumstances would have to be addressed.

Should you have more specific questions in regard to disclosure of medical records please do not hesitate to contact the advisory team at MDDUS who are happy to assist either by telephone on **0333 043 4444** or by email to [advice@mddus.com](mailto:advice@mddus.com)

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





Is it risky to employ a patient on your team?  
Janice Sibbald offers a perspective

**S**HOULD new employees at a GP or dental surgery be asked to register at another practice as part of their job offer or do they have the right to join any practice that they wish? This is a common question put to the employment law advisory service at MDDUS. And what happens if prospective employees are already patients at the practice? Can you ask existing employees to move?

These are interesting questions and not as straightforward as you may think. Employing a staff member who is a patient at the same practice can potentially cause a myriad of problems. There is the obvious conflict of interest when providing care to a patient with health issues while also dealing with them as an employer. Do you use your insight into their health problems to ensure they are kept at work for operational reasons? It might be tempting to suppose that a health condition is not genuine or being "over played" while at the same time having the responsibility to provide a fit note to certify absence from work.

#### INSIDE KNOWLEDGE

In cases where employees are regularly absent with no apparent underlying health

conditions, the disciplinary process may be invoked which can be unpleasant all round. A frequent reaction to an employee being challenged at work for absence, performance or conduct is for them to be signed off sick, but you can see the conflict here if the practice is aware of the reason why the employee is being disciplined at work. In some long-term absence cases, it may be necessary to refer the employee to occupational health to gain an objective and independent view so that again the practice is not seen to be "trading on" its inside knowledge as healthcare provider and employer.

There are also important clinical reasons to keep the doctor-patient relationship separate from work. For example, employees may be embarrassed to share essential information or undergo an intimate examination with a doctor at the same practice, or they may worry that health concerns might raise questions of their capacity to do their job.

Doctors treating staff colleagues may also be put in a difficult professional position and patient care can be compromised. GMC guidance states doctors should "wherever possible avoid

providing medical care to yourself or anyone with whom you have a close personal relationship."

#### BE CLEAR FROM THE START

Our advice is that you should inform prospective employees at interview that a stipulation of any job offer is that they move to another practice - or even flag this up earlier in the application process. This should ensure that it is no surprise when the candidate finds that they are required to register with another practice as a condition of employment. The only exemption to this policy would be if your practice is in a remote setting, such as an island, where there is no alternative primary healthcare provider available for prospective employees to register.

Asking current staff to change practice is not so straightforward as there is no obligation for them to comply. Some patient-employees may feel a strong tie to their practice and to a specific doctor or dentist who is familiar with their clinical history. Discuss fully with staff the reasons behind the request - the potential conflicts of interests and clinical risks - but make it clear that you cannot force them to move. It may be more effective to address the issue with the practice as a whole and then offer individual follow-up meetings for employees who have personal concerns they would like to discuss. Hopefully staff will see that the policy is in their best interests.

Another approach used in some practices is to have one doctor allocated as "staff partner", who is ultimately responsible for decisions regarding staff but does not routinely see employees in the capacity as patients.

#### MAKE IT POLICY

To conclude, it is best practice if prospective employees are asked to move to another practice at the point of job offer where possible to avoid any potential conflicts. You can also ask current staff to move although you cannot force them to do so. We would also advise that whatever policy is adopted is added to your employee handbook.

Further specific advice and support on this issue is available from the employment law team by calling **0333 043 4444**.

*Janice Sibbald is an employment law adviser at MDDUS*

**Liz Price** looks at how receptionists can transform the way patients view your practice

**G**Ps may complain about bad press – but consider the lot of the medical receptionist. Perhaps no other figure in healthcare is more unjustly demonised for being rude, obstructionist or even ignorant.

In August the press highlighted yet another study examining how receptionists interacted with patients over the telephone, with the *Times* declaring: “Abrupt GP receptionists are suspected of filling up A&E”.

It was reported that researchers at Loughborough University found a strong correlation between decreased practice satisfaction scores and patients feeling that their initial telephone requests were unmet: that they were “left hanging” or had to “push” for an alternative solution. The most effective receptionists (receiving high patient satisfaction scores) made alternative offers when the initial request could not be met, and in addition left the patient feeling clear about what would happen next.

It should be better recognised that the role of receptionist is a difficult one. Having to balance patient demand in an environment where free appointments are often scarce, while ensuring that patients feel that their personal needs are being met, and providing options and reassurance (without increasing risk) is not easy.

Telephone encounters with patients can be particularly fraught with jeopardy.

### CHALLENGE AT BOTH ENDS

A significant proportion of patients who telephone a practice are likely to be fearful, worried about their symptoms, concerned that they might not be taken seriously and fully expecting to have to convince the receptionist that they are ill in order to secure an appointment. Ideally, they want



# POSITIVE PATIENT ENCOUNTERS

the receptionist to ask what assistance they require, listen to their request and provide what they are asking for or something very close to this – but they probably expect the opposite.

On the other end, the receptionist may:

- have very few options available in terms of appointments or clinician availability
- fully expect that when they listen to what the patient wants they will be unable to satisfy those needs
- have just rung off from another difficult call where a patient expressed their dissatisfaction
- be aware that other patients are trying to get through on the phone – or indeed tapping their foot at the reception desk – meaning time pressure to get off the phone as quickly as possible. This can of course leave the patient feeling they have been dealt with abruptly.

Depending on the time of day, the receptionist's ability to easily and positively

deal with a patient request may be even more diminished.

Reduced patient satisfaction or even formal patient complaints are not the only risks when practice access systems fail. MDDUS has dealt with cases where a receptionist's action or inaction has led to allegations of clinical negligence. These usually involve receptionists being unable to offer timely appointments or being unable or unwilling to access advice from a clinician even when the patient is persistent.

Receptionists who are not adequately supported by the clinical team may end up being drawn into giving advice to patients or indeed turning patients away who should have been seen by a doctor. This can lead to delayed examination, investigations or diagnosis and a subsequent claim against the practice.

### SOLVING THE PROBLEM

The best way to achieve increased patient satisfaction and reduce the risk of a claim related to clinician access is via a team approach. This requires good leadership,



“THE MOST EFFECTIVE  
RECEPTIONISTS MADE  
ALTERNATIVE OFFERS  
TO THE PATIENT”

may be juggling other patient contacts and feeling pressured to end the call. At this point, agreed mechanisms for gaining advice from a clinician are essential to ensure patient safety is maintained. The receptionist should know the options available to them and should provide the patient with clear information on what will happen next and when.

Risk management accessibility in your practice by taking time to ask your team which types of encounters are most difficult for them to deal with positively under pressure. Encourage them to imagine being in the shoes of the patient in order to identify practice-based, team solutions.

### FINAL THOUGHTS

Interestingly, one mechanism many practices have put in place to increase the efficiency of receptionists could result in decreased patient satisfaction. Electronic patient check-in systems are intended to reduce the need for receptionists to interact with patients attending for appointments and allow them to answer calls faster. But practices should remember that for many patients a positive “live” contact with a member of the team can make them feel valued. Ensuring the team take time to nod or smile at patients when they enter or leave can be just the thing to bump up your scores!

If you would like to explore risks around access to clinicians with your team, a case study and discussion guide is available in the Risk Management section of [mddus.com](http://mddus.com) (access at [tinyurl.com/hsk59zq](http://tinyurl.com/hsk59zq)).

*Liz Price is a senior risk adviser  
at MDDUS*

a supportive team culture, effective problem solving in both planning and facilitating access, and encouraging staff to engage in empathetic and positive communication skills.

MDDUS has long experience in assisting practices with patient complaints and claims and my top advice would be to urge practice managers to spend time in reception to increase their understanding of how often receptionists encounter difficult patient interactions. Do your team members answer each call in a positive, welcoming tone? How often are the team quick to say things like; “I’m sorry I can’t...” or “I’m afraid we have nothing available...” or “No, I’m not able to...”?

It is important for the team to address the patient’s non-clinical (human) needs as well as their clinical needs. A positive tone, asking the patient how they can help and listening properly to the request are important to ensure the patient feels valued.

Research shows that in most cases, a positive experience for the patient from the start of an encounter can influence the way the patient feels at the end of the encounter

- even when they have not been able to get exactly what they wanted.

If the receptionist cannot meet the patient’s need (for example in providing “an appointment today”) they should offer an alternative - for example: “I can offer you an appointment on Wednesday for Dr Smith.” It is important that, if the patient expresses concern about a delay, the receptionist should be able to address that concern - for example: “If you can tell me more, including why you feel this cannot wait, I can ask the doctor if she is able to speak to you today?”

It is important that the receptionist does not offer health advice in lieu of an appointment and that they listen to the patient’s concerns. Nor should the receptionist attempt to triage the patient if an acceptable solution cannot be found initially.

It is their job to stay in the encounter until a solution is identified and to take responsibility for passing concerns on to a clinician so that a decision can be made about what to do. This can be particularly difficult at busy times when the receptionist

Jim Killgore visits an innovative practice in Bradford offering healthcare exclusively to the homeless and vulnerable

# Medicine on the streets



**M**IKE was living out on the streets of Bradford when he was first approached by the Street Medicine Team run by Bevan Healthcare CIC – a local primary care provider in the city.

“We could clearly see that he had a lot of problems but he wasn’t having anything to do with us,” says Gina Rowlands, managing director of Bevan and also a practising nurse.

“It took a considerable amount of going up and speaking to him to get some sort of engagement. Initially he wouldn’t say anything; then he started to tell us where to go! Then I actually asked him: what is it you really want? And he said: ‘I want a haircut.’”

So the practice organised for a support worker to take Mike (not his real name) along with £3.50 to a local barber.

“That’s all it took for him to engage,” says Gina. “He started to speak to the team. We built up trust – it was a mutual thing. Eventually he registered at the practice and started coming along. Things are not perfect for him but it was a huge step forward. And it was just something as simple as a haircut.”

Gina can tell many such stories from the more than 10 years she has worked at Bevan House. Recently I visited Bradford to chat with her about the unique and innovative primary care service the practice provides exclusively for local homeless people, those living in temporary or unstable accommodation, refugees and asylum seekers and others who have difficulty accessing healthcare.

In April of this year the Care Quality Commission awarded Bevan House an Outstanding rating in all five of its key lines of enquiry (KLOEs). Professor Steve Field, chief inspector of general practice said: “I had the benefit of being part of the inspection team and I can vouch personally for Bevan House. If there is a better practice in England I look forward to visiting it... This is an utterly outstanding practice and just shows what can be achieved with excellent leadership and teamwork which includes the team and the patients that this practice serves.”

## AN INCLUSIVE MODEL

Bevan House is located strategically in Bradford city centre in a bright,

newly renovated Victorian building that would be the envy of many a GP surgery in the UK. The clinical team includes eight part-time GPs and two practice nurses, a vulnerable migrants nurse, a mental health nurse and a full-time health care assistant, supported by a team of administrative staff.

The practice is unique in a number of respects. It operates under an APMS (Alternative Provider Medical Services) contract which allows it to partner with other non-NHS bodies, such as voluntary or commercial providers to supply enhanced and additional primary medical services. Bevan Healthcare is also an independent community interest company (CIC) which is a type of social enterprise set up to use all profits and assets for the public good. This means the practice does not have partners; instead it has a board of non-executive directors with an executive management team.

“It’s a very inclusive model,” says Gina. “We are all salaried and any surplus we make at the end of the year goes back into the community. It’s also a really flexible model allowing us to bid for pots of money that probably regular NHS practices wouldn’t be able to do because of the way that they are structured.”

## TAKING CARE TO THE PATIENT

Speaking with Gina it’s hard to keep up with all the local initiatives the practice is involved with – the Street Medicine Team being just one of the more high-profile schemes. This is a dedicated service that operates at food drop-ins, night shelters and emergency hostels, and on the streets, bringing healthcare directly to homeless patients or those with inadequate housing. The team runs a Street Medicine Bus in which patients can see a doctor or nurse in privacy.

“It’s a motorhome which we managed to purchase with a bit of money from the lottery and some of our own funds,” says Gina. “It’s dead kitsch, about 25-years-old. At first people were a bit reluctant to get on it; they don’t like change. But it’s really quite cosy; it’s private and warm in the winter. There is a mental health worker who works with us; there’s also a housing worker. It just makes their lives a bit



“PEOPLE WHO ARE HOMELESS  
DIE OF OFTEN TREATABLE  
MEDICAL CONDITIONS – WHICH  
IS JUST UNACCEPTABLE.”

easier but it's also about engagement, building trust to encourage them to come to the surgery and register which then opens up a whole host of services.”

The bus operates on a set timetable, parking in different parts of the city on different days. “We learned a long time ago by trial and error that where there's food, there are our patients. So we go to a lot of the faith groups, churches that maybe run soup rooms or kitchens giving out meals.”

### KEY RELATIONSHIPS

Bevan works in partnership with numerous such voluntary and local government organisations. “If we didn't have those key relationships this model wouldn't work,” says Gina.

One initiative that particularly impressed CQC inspectors was a service run by the practice along with a local social housing provider. The Bradford Respite and Intermediate Care Support Service (BRICSS) comprises a residential 14-bed temporary unit offering accommodation for homeless patients who require medical care after being discharged from hospital.

“It really helps get people back on their feet in terms of housing and addressing health needs. It gets them moved on to a better place,” says Gina. “But it's also been successful in terms of helping some homeless people get access to palliative care. That's probably one of the best aspects. It's provided them with a dignified death.”

And death on the streets can be quick and untimely. The average age of death for a homeless woman is 42 and for a man it's 48, compared to age 86 and 88 respectively for a pensioner in Chelsea.

“Nobody dies of homelessness,” says Gina. “People that are homeless die of often treatable medical conditions – which is just unacceptable.”

Gina began her career working as a secondary care nurse in A&E where she often dealt with homeless patients attending for basic care such as epilepsy medication or asthma inhalers – treatments that should have been accessed via primary care. This was one motivating factor in her joining Bevan in 2003 as a practice nurse.

“These patients are often called ‘hard-to-reach’ groups,” she says. “But I don't think they're hard to reach. I think it's the completely wrong term to use. I think they are ‘easy-to-ignore’. They are often difficult to look after due to the chaotic nature of their lifestyles. They don't often fit into mainstream services. They may not have telephones or mobile phones to make appointments. They often have other challenges in their lives and pressures that stop them turning up for an appointment. If you say to some of our patients we would like to see you next Wednesday at three o'clock. That's absolutely setting them up to fail before they even get out the door.”

### ONE-STOP SHOP

It was this ethos of truly patient-centred care that also impressed CQC inspectors and recently won Bevan an Innovators of the Year Award in the 2015 General Practice Awards. It is also embodied in the physical layout of Bevan House which has been designed as a one-stop shop, hosting benefits services, refugee support workers, rape crisis, legal, housing, midwifery and health visiting teams.

Says Gina: “We wanted to create a hub with tenants who are like-minded partners. We also knew that we wanted to open a health and well-being centre and really go for the social prescribing model which is important for our patients.”

Patients also play an important role in how the practice is managed. Bevan has a very active patient participation group and also an experts-by-experience group, which is a small cadre of volunteers including people who have had experience of homelessness or have come to Bradford as asylum seekers or refugees. It meets every eight weeks and offers an invaluable service user perspective.

Staff motivation at Bevan is high given the unrelenting nature of the work. Gina puts this down to a common sense of purpose and belief and buy-in to practice goals which are reflected in the motto: “health, hope, humanity”.

“We are not evangelical about the model here, but we do feel enormously proud of what we've achieved.”

Ian Cooper of Capsticks solicitors offers advice on how to prepare for a CQC inspection

# GETTING THE RIGHT RESULT

**G**OING through a new-style CQC inspection can be a stressful and protracted experience, as those practices who have been inspected will know. It can take up to three months after the inspection to receive the draft report along with the proposed ratings. I am frequently contacted at this stage by practices who are of the view that the draft inspection report and ratings do not accurately reflect the standard of care they provide. What then follows is a process of challenge to the draft report which is finally published with an amended narrative and, very often, improved ratings.

However, the key question here is what can practices do to ensure that the draft report is "right" first time? There are a number of steps you can take to achieve this goal.

Understanding and complying with the CQC's 'fundamental standards' is essential and goes hand-in-hand with having sound governance and assurance arrangements to monitor ongoing compliance and act on any issues arising. This should form part of the everyday business of any practice.

## UNDERSTANDING THE BENCHMARK

In addition to understanding the legal requirements which make up the fundamental standards, practices need to keep up-to-date with how these standards are being interpreted and relevant inspection trends. Primary care organisations have secured the highest percentage of 'good' ratings among CQC-registered providers but there is no room for complacency. It is important for practices to keep up-to-date with published CQC reports and guidance to understand, for example, what makes the difference between 'requires improvement' and 'good'. By reflecting on these trends and benchmarks, practices will be able to ensure that they avoid common pitfalls and stay on the right side of 'good' in regard to all five of the key questions considered in CQC inspections: is your practice safe, effective, caring, responsive and well-led?

For example, the table at the foot of the page contains a sample of the types of issues arising within the 'safe' domain.

It is equally important to keep an eye on what 'outstanding' looks like. So in the 'safe' domain, evidence of "an open safety culture" and "comprehensive systems to keep patients safe from harm" will score highly with the CQC who will want to see significant events reviewed on a regular basis internally and externally (by bringing external stakeholders and multidisciplinary teams into the review meetings) before awarding the highest rating available.

This exercise can be carried out across all five domains. For example, issues arising in the 'well-led' domain might look like this:

### KEY QUESTION: WELL-LED Vision, culture and communication issues:

- Lack of succession plans in place for key staff, such as the practice manager or lead receptionist
- Lack of a clear vision and strategy
- Failure to involve key staff such as the practice nurse in plans to introduce new clinics
- No clear leadership structure and no whole-practice meetings
- Not all staff had received regular performance reviews

### Engagement and patient involvement:

- No adequate patient participation in the practice and no mechanism to obtain feedback from patients
- No systems to use complaints to improve the service delivered.

### Governance:

- Absence of any recorded governance meetings
- No risk log or register to collate and mitigate relevant risk issues

KEY QUESTION	'Inadequate' or 'requires improvement' examples
<b>SAFE</b>	Lack of consistent systems for reporting, recording and monitoring incidents; staff not clear on threshold for reporting incidents
	Lack of robust safeguarding processes and gaps in staff training and awareness in this area (especially for reception and administrative staff and locums)
	Shortcomings in recruitment procedures and pre-employment checks (including DBS checks)
	No clear evidence of patients receiving a verbal and written apology in line with the Duty of Candour requirements.



- Policies undated/without a review date

As for the 'outstanding' benchmark in the domain of 'well-led', this requires clear evidence of innovation in terms of the manner in which high-quality care is delivered, for example the development of bespoke clinics designed to meet the needs of a practice with a high student population (sports injury clinic, weekly drop-in clinic for patients with mild to moderate eating disorders and an allied CBT clinic). It is also important for the inspectors to find evidence of a clear vision and strategy to deliver high-quality care and for staff to understand this vision and their responsibilities in relation to it.

### SUPPORT YOUR STAFF

It is clear from reading any CQC report that what staff say to inspectors carries a lot of weight and is frequently quoted in the inspection report. It is important to engage staff in the pre-inspection phase. They should all be clear about what a CQC inspection entails and have a high degree of familiarity with the five key questions and, ideally the key lines of enquiry (KLOEs) that underpin

the questions. Staff should be supported in this regard so that they feel confident when speaking to inspectors and can present the most accurate information. Well-prepared practices will have a clear idea of the types of questions that the inspectors will ask their staff and will be confident that the responses given reflect the true position of the practice.

Most practices will have elements of outstanding and innovative care but these will not feature in the inspection report unless your staff, firstly, recognise these elements as outstanding and, secondly, speak up about them during their time with the inspectors. Starting this dialogue with your staff well in advance of any inspection will generate confidence and improve your chances of securing the right outcome in the inspection reports. You should also engage your patients in the inspection process and encourage them to get involved and have their say.

### WORKING WITH THE CQC

The relationship you have with your lead inspector will be of fundamental importance in ensuring that the inspection process goes

smoothly and also that the post-inspection phase is handled as efficiently as possible. You should ensure that you have an open line of communication with your lead inspector so that you can address any immediate issues arising during the inspection and can anticipate when the draft report may arrive.

A vital part of securing the right result for your practice is to ensure that the draft reports are factually accurate. The practice will have 10 working days to consider the draft report and make any factual accuracy submissions to the CQC. The CQC encourage providers to go further than just pointing out minor errors in draft reports; they expect providers to help them publish an accurate and fair report. Therefore, the new template supplied by the CQC invites practices to submit comments about the following:

- Typographical or numerical errors
- Challenges to the accuracy of the evidence set out in the draft report (providing evidence demonstrating the inaccuracy) and also describing any impact on the rating(s)
- Additional evidence which the practice considers should be taken into account in the report.

If the practice is not happy with the ratings proposed in the draft reports and believes these are based on inaccurate findings then this is the time to make these points. In practical terms, it will be too late to raise these issues after the 10-day factual accuracy period has closed. Ratings have been changed by the CQC in approximately 90 per cent of cases where we have supported providers through the factual accuracy process. If used correctly, this stage of the process can therefore deliver real results and those practices who are concerned about the accuracy of the draft reports cannot afford to miss this opportunity to put things right.

Where fair and valid concerns have been raised by the CQC then it is important to respond to these promptly and in a manner which will give the regulator the confidence that the practice can improve and does not need to be subjected to escalating regulatory or enforcement action. Again, the relationship with the CQC will be key at this stage.

It can be daunting to face a CQC inspection but the suggestions above should help you to take control of the process and lead from the front.

*Ian Cooper is a partner at Capsticks solicitors, who have recently partnered with MDDUS to provide members with discounted legal advice on non-indemnity issues (see page 3 for more details)*

# Working within the limits

## Day one

A 72-year-old widow - Mrs T - has been unwell for four days with cough, congestion and fever. Her son is worried and takes time off work to look in on her. Mrs T is normally fit and active, spending most days in her garden or at her local bowling club, but on this morning she is still in bed looking pale and weak. Mr T phones the local GP surgery and speaks to a receptionist. He explains that his mother has a chest infection and wonders if she might need an antibiotic. The receptionist replies that there is a "viral flu" going about and the practice was not giving out antibiotics. She says it usually lasts about three days but when Mr T tells her that his mother had been unwell for longer she replies: "See how she is in the morning and then give us a ring back". Mr T repeats that he is really quite worried about his mother's condition and asks whether it might be best to take her to A&E. The receptionist replies "not really" as the hospital is also not handing out antibiotics for viral infections.

## Day four

Mr T phones the surgery again to say that his mother is no better. A GP - Dr K - sees her at home that evening. Mrs T is complaining of left-side chest pain on moving or coughing, such that she cannot clear the phlegm in her throat. She finds it difficult to sleep but seems well hydrated. Dr K finds the chest sounds are okay on auscultation but with transmitted bilateral rattling though no audible pleural rub. He diagnoses possible lower respiratory tract infection and prescribes amoxicillin and co-codamol, and advises Mr T to get back in touch if there is any change or deterioration in his mother's condition.



## Day eight

Mrs T's condition worsens and that evening she collapses on the ward and dies from cardiac arrest.

## Day six

Early on Monday morning Mr T phones the surgery again to say his mother seems worse. The receptionist tells him that they need to give the antibiotics time to "kick in" but in the afternoon he phones again to say his mother is now very poorly. That evening she is seen at home again by a locum GP - Dr P. Mrs T's temperature is raised and her BP is 200/84. The GP detects reduced right breath sounds and dullness. He arranges for an ambulance to A&E. She is admitted to hospital and placed on IV antibiotics.

**A** FEW months later a formal letter of complaint is received in the surgery from Mr T. He expresses dissatisfaction with the way his mother was treated by the practice. In particular he questions how a receptionist was allowed first to diagnose a viral infection over the phone and then judge that an antibiotic was not necessary. He also questions why in a later phone call to the surgery he was advised by the receptionist to give the antibiotic time to "kick in" when in fact his mother was seriously ill and in need of hospitalisation.

Mr T states that he now finds it personally distressing that he did not demand more urgent treatment for his mother and he has been left wondering whether, if he had done so, would she still be alive today.

The practice manager phones MDDUS and is given advice on how to respond to the complaint. First she is urged to acknowledge the complaint immediately, expressing condolences on his loss and informing Mr T that an investigation will be undertaken and specifying when a response can be expected.

A significant event analysis is undertaken by the PM and the receptionist answering both calls is identified and interviewed. She is reminded that receptionists should never take it upon themselves to offer advice to patients or family unless that instruction has come

directly from a doctor or practice nurse. The PM raises the issue again in the weekly practice meeting and reminds all staff that they must work within their limits of competence.

The PM composes a letter of response expressing regret for the cause of the complaint and setting out the findings of her investigation into the matter. She explains that the receptionist in question has been spoken to about the incident and the importance of always deferring any advice on clinical matters to experienced and qualified members of staff. She also states that standard practice policies have been amended to highlight the issue and ensure that it does not happen again in future.

The PM offers to meet with Mr T to further discuss the matter if he wishes and she also explains how he can take his complaint further if not satisfied with the practice response - providing contact details for the health ombudsman.

### KEY POINTS

- Ensure that all staff realise the importance of working within the limits of their competence.
- Make sure non-clinical staff are clearly aware that all clinical judgements must be deferred to doctors or other qualified staff.

# Diary



**M**ORE random items of questionable relevance from the PM team...

➔ **ROOTIN TOOTIN SHOOTIN** Dental practice in the UK does come with its risks but thankfully these do not include patients packing loaded pistols. A 72-year-old man in Ohio is reported to have shot himself while being treated in a dental chair. He was under nitrous oxide sedation and thought he heard his mobile phone ring but reaching into his pocket grabbed his gun instead. The bullet went through his hand and grazed his stomach. Amazingly the man had a legal concealed carry permit although he may be charged with using a weapon while intoxicated. Sgt. Christina Evans-Fisher with the Clark County Sheriff's Office commented: "Going to a doctor's office where you might possibly be placed under some kind of medication that may alter your mental status at that point, you might not want to carry a weapon in there at that time." Diary heartily agrees - and does not think having to make such a statement is crazy at all.

➔ **HOPING TO NEVER RETURN** Diary has heard many tales in recent years of brave souls who have posted "hilarious" out-of-office email messages, but has never dared stray beyond a safe, functional alert. We could only dream of equalling the boldness of some of the employees whose comedy gold has featured in recent internet news feeds. The ill-advised notices include: "On holiday. Hoping to win the lottery and never return" and "I am away from the office right now. Unfortunately I will be back tomorrow." The love-my-job theme continues with "I've run away to join a different circus", while another cynic offers: "I am out of the office from dd/mm to dd/mm and will not be checking email. It's likely your note will be swallowed in a sea of inbox banality, never to be seen again. If you require a response, please re-send your email after dd/mm." And finally, winning the award for "most likely

to backfire" must surely be: "I am currently out at a job interview and will reply to you if I fail to get the position."

➔ **PASS THE PURPLE CRAYON** Looking for realistic solutions to the problem of low GP morale and burnout? In September it was revealed that the RCGP is considering issuing members with "well-being" packs including a bag of chocolate coins, some teabags, a "mindfulness colouring book" and a "gratitude journal" for noting down all the things GPs can be grateful for in their lives. The packs are purported to be intended mainly for AiTs (Associates in Training) and Dr Duncan Shrewsbury, chair of the RCGP's AiT Committee, said that the college is aware that this is not the only answer to the problems facing general practice and "in fact, this is clearly stated in the packs" - just in case you are not immediately swept away in a tide of warm well-being.



➔ **BASH BACK** GP bashing has long been a cherished sport among certain tabloid and broadsheet newspapers - not to mention names (... *Daily Mail*). But recent statistics released by insurers 1st Central reveal that doctors do a fair bit of bashing on their own, albeit of a different kind. Analysis of accident claims in 2015 ranks doctors at number three on the list of worst drivers by profession - just behind solicitors and accountants. No doubt it's with all that racing about in expensive high-powered cars bought with outrageous salaries...or so the trope goes, as opposed to doctors driving home while exhausted from overwork. So who are the safest drivers according to the analysis? Roofers top the list followed by farm workers and builders. Perhaps most worrying - number 10 on the worst list was train drivers.

➔ **CHEWING KALE** Health experts have railed against the Department of Health's "watered down" obesity strategy which asks the food and drinks industry to "work towards" lower sugar content in products. Hence the burden remains on healthcare professionals to encourage

healthy eating among patients - including advice on avoiding fad diets. To this end the British Dietetic Association (BDA) compiles a yearly five worst celeb diets to avoid. Here below Diary offers a pocket countdown of 2016. Trim Secrets (5): buy capsules to take three-times daily along with a 1,500 calorie diet and regular exercise (or skip the pills and lose weight anyway). Super Elixir (4): powder bought at £96 per month to regulate your body's acidity levels (or you could just eat a balanced diet with fruit and veg and trust your body to regulate acid balance naturally). Bulletproof diet (3): drink daily 'Bulletproof coffee', essentially black coffee with some added butter and MCT (medium-chain triglycerides) oil. Foods are classified in three categories - bulletproof, suspect or kryptonite - with rules on timing of meals. All-kale and chewing gum diet (2): that's it really; just eat kale and chewing gum (and be in close proximity of a toilet). No sugar diet (1): tall order unless this means processed sugar (not fructose, lactose, etc). BDA says: "It's not about a single food or nutrient, we advocate a whole diet approach." So forget the Donut Diet.

➔ **WINTER IS COMING** Rural Scotland needs GPs and the government has shown it is willing to pay. One hundred new GP training places were recently advertised and some with a £20,000 "Golden hello". The one-off bursary will be paid for posts that have "not been filled recently" - many of these in isolated rural communities. Diary suggests that NHS Scotland could also enhance the offering with a bumper supply of vitamin D. Recently the Scientific Advisory Committee on Nutrition (SACN) recommended that everyone in the UK take 10 mg daily supplements in autumn and winter to protect bone, teeth and muscle health. Given that in mid-winter the sun barely breaks the horizon in some northern parts we feel it only fair to equip eager recruits. Sadly whisky is no substitute.

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

# GP **risk** toolbox

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