Practice Manager
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ISSUE 16

TRANSGENDER PATIENTS

Ensure you offer care sensitively and in compliance with the law

DIFFICULT DECISIONS...

...are not always the important ones. Allan Gaw talks life, death and toothpaste

A REDUNDANCY SITUATION

Keeping within the law when it becomes necessary to make staff redundant

IN AT THE DEEP END

INTEGRATING HEALTH AND SOCIAL CARE AT THE GRASSROOTS

A STEP TOO FAR?
WHEN IT'S NOT ACCEPTABLE TO HAVE A PATIENT AS A 'FRIEND'

Practice Manager

IT has been estimated that around one per cent of patients identify themselves as transgender. This may not seem so surprising to practice managers, as most will be aware of at least one or two patients who are transgender.

These patients can sometimes find it difficult to confide in doctors or other healthcare staff. It is important to be sensitive and supportive, as well as fully aware of the legislation set out to protect the rights of 'trans' patients, while also recognising that practice staff may feel out of their depth in this area. On page 12 of this issue Liz Price offers advice on best practice in the care of transgender patients.

On page 8 medical adviser Dr Naeem Nazem considers the professional and ethical obligation to maintain appropriate boundaries with patients – and looks at a few testing scenarios in which healthcare staff might overstep the mark.

Dr Allan Gaw talks life and death and toothpaste on page 6 in his article on decision-making. Just because a decision is difficult doesn't always mean it's important. And on page 7 employment law adviser Janice Sibbald offers guidance on how to keep within the law when it becomes necessary to make staff redundant.

In our profile on page 10 Jim Killgore visits an inner-city practice in Glasgow that is seeing tangible benefits in integrating health and social care. Garscadden Burn Medical Practice belongs to a group of 100 practices at the "deep end" – serving the poorest populations in Scotland. A pilot programme employing a "links practitioner" who provides social prescribing and non-clinical advice is yielding surprising results.

Our regular Call log on page 4 covers a range of issues including staff adoption leave, wrongful access to patient records, accepting gifts and disposing of complaints files. The case study on page 14 concerns a mistaken disclosure of a child protection issue that leads to anger and conflict among an extended family.

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PRACTICES PLAYING MUSIC "MUST BUY A LICENCE"

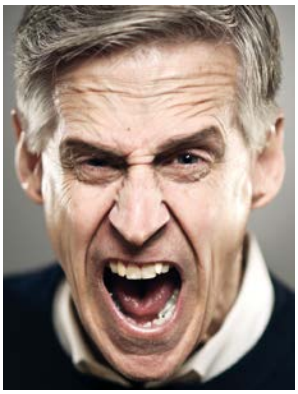
PRACTICES playing the radio or other forms of music in public areas must buy a licence or risk legal action.

A recent media report suggested dental surgeries may be paying "unwarranted" fees to collection agencies PRS for Music and PPL to listen to music in waiting areas or consulting rooms.

The article cited a decision made by the European Court of Justice in 2012 (*Società Consortile Fonografici v Marco Del Corso*) which found that broadcasting music within private dental practices in Italy did not require the purchase of a licence. But a PRS for Music spokeswoman has confirmed that the ruling "concerns specific types of rights and remuneration which are not relevant in UK law or to PRS for Music".

She said: "The law in the UK clearly provides that the performance and playing in public of works, sound recordings, films or broadcasts, is an act restricted by copyright and exercisable only with the consent of the copyright owner. Therefore, PRS for Music has the right to license businesses who use PRS members' musical works in this way."

A PRS licence for a practice waiting room, she added, costs from £84.13 a year. Practices may also require a PPL licence. Find out more at **www.prsformusic.com** and **www.ppluk.com**



RISE IN ABUSE FROM PATIENTS

PRACTICE managers are most likely among all primary care staff to experience patient abuse, with only nine per cent reporting *not* having been abused in some form over the last 12 months, according to a report from *Pulse* publisher Cogora.

Over 2,000 primary care workers were surveyed for the report – entitled *Primary Concerns* – which also found that 66 per cent of GPs experienced abuse over the period, a rise of seven per cent over the previous year. This included four per cent of GPs reporting physical violence from patients and 61 per cent having been verbally abused. However, compared to other primary care staff, GPs remain less affected by abuse.

Reported abuse of practice managers rose by 17 per cent in the year and there was a particular spike in written abuse, including online messages and on social media, which increased from 10 to 44 per cent.

The survey found that across all primary care workers, the numbers experiencing abuse were reported as:

- Verbal - 64 per cent (up from 54 per cent)
- Physical – 6 per cent (unchanged)
- Written – 24 per cent (up from 12 per cent).

Surprisingly, the effect on morale was not as great as might be expected. The authors of the report state: "Physical abuse from patients was rated as having no effect on morale, whereas verbal abuse from patients seemingly had a greater impact. While this only had a moderate effect on GPs, it was rated more highly by practice managers – the professional group most likely to receive this form of abuse."

GPC deputy chair Dr Richard Vautrey commented: "It is very concerning that any patient feels that they can act in this way when GPs and their staff are doing their best to help and care for them.

"The NHS must not only adopt a zero tolerance policy to abusive behaviour but must also back up practice staff when they are subjected to these types of incidents."

Source: *Pulse*

NEW COMPLAINTS PROCEDURE IN SCOTLAND

A NEW complaints handling procedure for the NHS in Scotland came into effect in April of this year.

The new *NHS Scotland Model Complaints Handling Procedure (CHP)* is intended to be used by all NHS service providers, including GPs, dentists, opticians, pharmacists, as well as other contractors such as cleaning or catering providers. The model CHP is designed as templates for NHS bodies and primary care service providers to adapt and adopt – and there is also an implementation guide available.

The revised two-stage procedure is intended to support a consistent person-centred approach to complaints handling across NHS Scotland, and bring the NHS into line with other public service sectors. Stage 1 allows five days for early local resolution of a complaint. Should a complainant remain dissatisfied this can be escalated to a 20-working-day Stage 2, providing for a more "thorough and robust" investigation. Complex complaints where an early outcome is unlikely can be handled directly at Stage 2 of the procedure.

NHS Scotland says that the model CHP has been structured with as much flexibility as possible, while still providing standardisation across NHS service providers. Details about how to make a complaint should be widely publicised, simple and clear, and made available in all areas of service provision.

Access at **tinyurl.com/ke3yrr3**

GMC REVISES CONFIDENTIALITY GUIDANCE

NEW guidance on confidentiality for doctors practising in the UK came into effect in April.

Confidentiality: good practice in handling patient information is the result of an "extensive consultation exercise" and the revised guidance provides additional clarity on topics such as the public protection responsibilities of doctors, including when to make disclosures in the public interest, and the importance of sharing information for direct care.

The new guidance is available at **www.gmc-uk.org**

PLANS FOR MORE IN-SURGERY PHARMACISTS

NHS England plans to introduce new, surgery-based clinical pharmacists to over 700 more practices in order to help free-up GP time.

In-surgery clinical pharmacists working as part of the general practice team provide expertise on day-to-day medicine issues and consult with patients directly on a range of issues. These include management of long-term conditions such as high blood pressure, providing advice for patients on multiple medications or offering better access to health checks.

The aim is to deliver enhanced access to clinical advice for patients and allow GPs time to focus on patients with more complex needs.

NHS England has pledged over £100m of investment to support an extra 1,500 clinical pharmacists to work in general practice by 2020/21. This is in addition to over 490 clinical pharmacists already working across approximately 650 GP practices as part of a pilot.

Dr Arvind Madan, GP and NHS England Director of Primary Care, said: "The clinical pharmacist programme is a clear win-win for patients and GPs. The pilots have shown GP workload to be eased while patients have the convenience of being seen by the right professional in a more timely way."

ORAL HEALTH TOOLKIT NOW UPDATED

AN updated version of the *Delivering Better Oral Health* toolkit from Public Health England (PHE) now includes new patient factsheets and guidance on alcohol and nutrition.

The evidence-based toolkit (**tinyurl.com/p8sw4d4**) is designed to help dental teams support patients in improving and maintaining their dental and general health. It was developed with input from a working group, including the BDA.

The information has been revised to reflect new healthy eating advice and guidelines on lower-risk drinking. The alcohol section is supported by an online training module and the toolkit also includes new factsheets summarising key actions for oral health improvement in adults and children.

BOOK NOW FOR PM CONFERENCE

THE popular MDDUS Practice Managers' Conference is being held this year at the Fairmont Hotel in St Andrews on Thursday 30 November and Friday 1 December.

Delegates attending the conference can enjoy interactive workshops covering a broad range of topics throughout the day on Thursday, plus additional sessions on Friday morning. These will focus on areas including recurrent risks associated with employing GP locums, and the dangers associated with poor patient communication.

There will also be an exclusive first screening of the fifth instalment of our film series, *Bleak Practice*, which promises an entertaining way to learn key risk lessons in general practice. Places are limited so contact the Risk Education team now on **risk@mddus.com** to book your place. Early bird rates are available until 30 June.

Download the flyer at **tinyurl.com/m7jmlem**

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

PATIENT GIFT

Q A GP in our practice has cared for an elderly gentleman for the last few years while under treatment for cancer. He is now receiving palliative care. Last week the GP received a watch in the post with a note thanking him for all he had done for the patient. An enclosed receipt revealed the watch cost over £400 pounds. The practice partners are happy for the GP to keep the watch and the patient would be upset if it was returned. Are there any probity issues in accepting the gift?

A GMC guidance states that accepting a gift is allowed, provided it does not affect or appear to affect the way a patient is treated and there has been no influence applied to pressure the patient into offering the gift. It cautions in general that any doctor receiving a gift or bequest must always consider the potential damage this might cause to the patient's trust in the doctor or the public's trust in the profession. Doctors should refuse gifts or bequests where they could be perceived as an abuse of this trust. Given these requirements are fulfilled, accepting the watch as a genuine token of gratitude could be reasonable. The only other matter to consider is registering the gift in line with Performers List regulations. Gifts with a value of over £50 should be entered on a practice gift register along with the name of the patient, doctor and approximate value.

INAPPROPRIATE DETAILS

Q A patient with mental health problems has attended the practice several times in the past few months for consultations with our nursing team. On the last three occasions he has spoken in detail about his sexual activity and it is upsetting our nurses, so much so that they are very uncomfortable about seeing him again. We are considering removing him from the practice list – what steps should we take?

A Removing any patient from your list is an emotive issue and one that requires careful consideration. In its guidance, *Ending your professional relationship with a patient*, the GMC advises: "You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient." This may occur where the patient has become violent, abusive or threatening, or has made sexual advances. Before making a decision, the regulator sets out four steps to follow: warn the patient you are considering ending the professional relationship (a formal written warning would be appropriate); do what you can to restore the relationship; explore alternatives to ending the professional relationship; and discuss the situation with an experienced colleague or your employer/contracting body. It would be useful to discuss the issue as a practice, noting what is said and what decision is made. Perhaps you might explore other options with the patient such as agreeing conditions in which a chaperone is present – but if you decide to remove the patient ensure this is in full compliance with GMC guidance. Be prepared to justify your decision and ensure prompt arrangements are made for the patient's continuing care.

ADOPTION LEAVE

Q One of our receptionists is planning to adopt her grandson. She has been with us for four years and works two mornings per week so her salary is below the Government's lower earnings limit of £112 per week. Is she entitled to adoption pay or leave?

A Adoption leave/pay does not apply in situations where a family member (or indeed a stepchild) is being adopted, so in this instance your receptionist would not be eligible. In addition, to qualify for statutory adoption leave, employees must earn on average at least £112 per week (before tax).

STAFF SMOKING

Q A couple of our staff members are smokers and sometimes choose to smoke in the practice car park. This looks unprofessional – can we tell them to stop doing this, or are they entitled to smoke outside where they like?

A The short answer is yes, you can tell them to stop smoking in the car park. The law entitles employees to an uninterrupted rest break of 20 minutes when their daily working time is six hours or more. But employers are not obliged to provide smoke breaks or outside smoking areas. It may be useful to have a policy stating where smoking is allowed on practice property (perhaps in the rear of the premises). Any policy would of course be in addition to the relevant government smoke-free legislation that applies in your area. Generally, this prohibits smoking in wholly or substantially enclosed public places. Try to be positive in seeking solutions, balancing the need to encourage healthy behaviour with possibly alienating valuable staff.

IMPROPER DISCLOSURE

Q One of our patients transitioned to female last year. She recently came into the surgery complaining of ear pain and was referred to ENT for further examination and treatment. Details of her gender surgery were automatically included in the electronic referral, which she was very unhappy about. How should we handle referrals like this in future?

A It is unlawful in some circumstances to disclose a patient's gender history without their consent. GMC guidance advises healthcare professionals they must make sure any personal information held about patients is effectively protected at all times against improper disclosure. You should respect the wishes of any patient who objects to particular personal information being shared with the healthcare team or with others providing care, unless disclosure would be justified in the public interest. The regulator goes on to say that, when communicating with other

health professionals, gender history need not be revealed unless it is directly relevant to the condition or its likely treatment. In the case of ear pain, it would not be appropriate to disclose details of gender surgery. Practices must always be wary of electronic referral templates that automatically include high-priority clinical information and be prepared to manually remove anything that is not relevant (or which the patient has asked not to be disclosed). More information is available in the *Advice for doctors treating transgender patients* section of the GMC website – and see also the article on page 12 of this issue.

SAR CHARGE

Q A patient has submitted a subject access request (SAR) for information that was added to her record three weeks ago. As the information is currently only in electronic form, are we obliged to supply it to her for free or are we entitled to charge a fee?

A According to the Information Commissioner's guidance *Subject access code of practice* (**tinyurl.com/oksakle**) you may charge a fee of between £10 and £50 for complying with a SAR relating to health records. The exact amount depends on how the health records are held. In this case, the guidance states you may charge up to £10 for complying with a SAR relating to health records if they are held only electronically. This would cover, for example, the costs of printing out the requested information. The higher charge can be made for records that are held either wholly or partly in non-electronic form. Be sure to also comply with standard Data Protection Act rules relating to issues such as non-disclosure of third party information or information that could cause serious harm.

WRONGFUL ACCESS

Q We recently hired an admin assistant who lives in the local area. During routine checks we discovered she has accessed the health records of her uncle and we suspect also a number of her friends. She has been dismissed and we have informed her uncle about the incident. Should we also inform the other data subjects that there has been a possible breach?

A It would be advisable for senior practice staff to hold a significant event analysis (SEA) meeting as soon as possible to review what happened. You should carefully review relevant guidance – for example, the Information Commissioner's Office (ICO) website has a section on health which provides useful information on responding to data breaches across all four UK countries. This includes information and links on how to report incidents. In England, healthcare organisations must now use the IG Toolkit Incident Reporting Tool which will report all information governance serious incidents requiring investigation (IG SIRIs) to NHS Digital, the Department of Health, the ICO and other regulators. In Scotland, Wales and Northern Ireland reports are submitted to the ICO using its security breach notification form. You can contact the ICO helpline to discuss the incident and for guidance on whether you should inform the patients whose records have potentially been breached. As always, you should carefully document all discussions, including rationales for decisions that are made.

COMPLAINT FILES

Q How long is our general practice required to keep paper records of old resolved patient complaints and should these be stored separately from the medical notes?

A NHS guidance states that a formal patient complaint file in England should be stored 10 years from the date of resolution and then reviewed to determine if no longer relevant before being destroyed. In Scotland a complaint file should be stored for seven years and, in children, until the patient is age 16. Complaint files are normally stored separately and only information that is relevant to ongoing care should be copied into the clinical file – but there should be a reference (flag) that a complaint folder exists.

DELEGATING INR MONITORING

Q We are a DPS (discount practice scheme) practice with MDDUS. A number of our patients are on warfarin and we would like to know if it would be appropriate for our healthcare assistants (HCAs) to use a portable INR monitor and advise patients on doses based on the results.

A Practice staff in discount schemes are normally vicariously indemnified but MDDUS expects that for any appropriately delegated tasks, HCAs will be adequately trained and supervised and adhere to best practice and guidance. Monitoring of INR and warfarin dosage can be complicated and getting it wrong can have serious consequences for patients and for the practice with the risk of a claim or GMC referral. Monitoring by HCAs might best be restricted to confirming stable INR status and a continued warfarin dose. Any change in INR should normally be referred to the prescriber – be that a practice nurse or doctor – for assessment of possible dose change and to instruct on scheduled review. The GMC makes clear in its guidance on *Delegation and referral* that: "When you delegate care you are still responsible for the overall management of the patient."

Decisions, **decisions**

Just because a choice is difficult, doesn't mean it's important. **Dr Allan Gaw** talks life and death and toothpaste

EVERY day we make hundreds of decisions – many are small and apparently insignificant, some seem to have more recognisable consequences and very occasionally we find ourselves confronted by the momentous. Our ability to make all these decisions easily and fluently often means the difference between a stressful, unfulfilling day and one where we can go home with our to-do list ticked off.

But how do we make those decisions? Are you the logical kind of decision maker who carefully tallies up the pros and cons and after a little mental arithmetic computes the "best" decision? Are you the type that goes with their gut, not really knowing how the decision has been reached but feeling that this is the "right" choice? Or are you the kind of person who, before making a decision, asks questions such as: is this the way we should do things, is this what I ought to do? Rather than trying to pigeon-hole yourself into one of these categories you should realise that we are all a complex mixture of different decision-making styles. And, moreover, we tend to use different approaches for different kinds of decisions.

Some decisions benefit from the logical approach. For example, choosing a new bank account where you can readily access all the features of the different options and work out which is the best for you. But, while a pros and cons list might be good for making a financial decision, it rarely works for choosing whom to fall in love with. There our guts, or should it be our hearts, have the upper hand. The same is true of buying a new house. The average Briton takes just 21 minutes to choose a new home, while it takes us 284 minutes to decide on which new TV to buy. We use our guts to "just know" whether the house is right, while we use our heads to calculate the best television.

The reason it takes more than 10 times longer to pick the TV is, however, largely due to the overload of information we have to deal with, and there is a lesson to be learned here. We tend to regard important life decisions as difficult decisions – and one important consequence of this is that we have the unfortunate habit of also inferring that difficult decisions must be important. That's where it all goes wrong: just because a decision is difficult does not mean it's important.

Ironically, this seems to happen when we are confronted with a decision that is unexpectedly difficult – one that we thought should have been easy. It's almost as if we think: "Oh, I thought this was going to be simple, but it's not, so that must mean I've misunderstood its importance. I'd better work at this. It needs more time, more effort."

And if you don't believe this happens, think back to the last time you were standing in a supermarket aisle buying toothpaste. A "simple" task but now you see there are 50 different varieties to choose from. Some have fluoride, some don't; some whiten your teeth, some don't; some are for sensitive teeth, others aren't. Suddenly, what should have potentially been a trivial decision is elevated by its apparent complexity into a difficult and therefore an important one, worthy of time and attention. But it isn't. They're all toothpastes after all; they all clean your teeth and in the big picture of your life it really doesn't matter which you choose.

And in life there are many toothpaste decisions like that, where we agonise over the trivial, thinking that the very complexity of the decision means that it's important. Once you realise that this is not the case, indeed is hardly ever the case, you can turn your attention to those decisions that do matter.

Our ability to make effective decisions is undoubtedly important. Indeed, Napoleon said: "Nothing is more difficult, and therefore more precious, than to be able to decide." But, he was talking about deciding whether to invade a country and not which brand to buy in Tesco. Beware of the trivia and beware of the procrastination that can sometimes occur as a result of our inability to decide.

"In any moment of decision," said Teddy Roosevelt, "the best thing you can do is the right thing, the next best thing is the wrong thing, and the worst thing you can do is nothing."

Sources

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- Sela A, Berger J. *Journal of Consumer Research*, August 2012

Dr Allan Gaw is a writer and educator from Glasgow

A redundancy situation...

How do you keep within the law when it becomes necessary to make staff redundant? Employment law adviser **Janice Sibbald** offers some guidance

A FREQUENT call we receive from practice managers is in regard to advice on how to effectively make an employee redundant as the result of a job no longer existing. This can be for various reasons such as a practice closing down or patients moving to another practice or the requirement to reduce the number of employees, possibly after a merger of two practices.

So what are the legal framework, legislation and processes around carrying this out correctly and how can you minimise any potential future problems or risks to the practice?

Before we get into the detail, let's take a step back.

POINTS TO CONSIDER

The first question you should ask yourself is do you intend to replace the individual once you have made them redundant? If the answer is 'yes' then this may indicate that it's the person not the position you wish to no longer be part of your practice. Redundancy cannot be used as a means of terminating the employment of a poorly performing staff member – a thorough performance management process should be used instead.

Other areas to think about (although I am certain you will have by this point) – are there any ways to avoid redundancy? Some measures might include limiting any recruitment activity and stopping or reducing overtime, laying off temporary or agency staff, offering voluntary redundancy or offering flexible working such as part-time to staff members in an attempt to reduce the overall wage bill. Also think about natural wastage – not replacing staff planning to leave the practice.

The law dictates that there are two processes to support redundancy: one where you are making more than 20 employees redundant at the same time and one where it is fewer than 20 employees being made redundant.

In the majority of practices it will be the latter, so we can focus on that but just be aware of the difference.

CONSULTATION

Employees should always be consulted prior to any redundancies taking place, including briefings as to why the redundancies are necessary, any alternatives to making people redundant, fair selection criteria and what if any suitable alternative employment is available. Consultation can either be done on an individual or collective basis (although this must be collective if over 20 employees are being affected).

It's not legal to simply choose the people that you wish to make redundant; there should be a fair process in place using fair selection criteria such as attendance, disciplinary history, skills and experience and performance. Take caution, however, to ensure that any information that can be linked to either an employee's disability or pregnancy is not taken into account.

NOTICE AND PAYMENTS

Once the relevant people have been selected and consulted, you are required to let them know what notice will be given to them, usually after referring to their contract of employment. In the absence of this, statutory notice periods will apply.

An employee may be eligible for redundancy payments if they have worked with the practice continuously for two years or more, and statutory redundancy payments take into account an employee's age, length of service and weekly pay.

The above only discusses the process; one must keep in mind what an emotive, difficult and personal experience it can be for the employees and also the managers dealing with the redundancy process. The employment law advisers at MDDUS will be able to give you advice and guide you through any process.

Janice Sibbald is an employment law adviser at MDDUS

A STEP TOO

Maintaining appropriate boundaries with patients is a key obligation for doctors and other healthcare professionals – but would you recognise a GP overstepping the mark? **Dr Naeem Nazem** offers some advice

HEALTHCARE professionals should always be aware of their privileged position in society. There are few professions in which you can question an individual on the most personal aspects of their life, let alone examine them or perform invasive procedures. People allow their doctor or dentist or practice nurse this liberty in order to receive appropriate treatment. In return they trust professionals not to abuse their position. And therein lies the cornerstone of any patient relationship: trust.

Below are some points to consider when establishing practice policies which support maintaining appropriate boundaries with patients.

A FRIEND IN NEED

Any doctor would help a stranger on the street suffering a medical emergency and MDDUS provides access to indemnity for such "Good Samaritan acts". And if a non-patient arrived at the practice door needing immediate assistance, the practice should at minimum assess their need and treat/signpost as appropriate. However, what happens when the situation is not as clear?

Consider the scenario: a GP meets up with a friend on a Friday evening. The friend is going on holiday on Monday and forgot to pick up her repeat prescription for thyroxine medication, which will now run out during the trip. Her practice is closed for the weekend so she asks her friend to write the prescription. What should the GP do?

The GMC states that doctors should, wherever possible, avoid providing medical care to friends or relatives unless in an emergency. But does this scenario qualify as an emergency? After all, the friend is unable to collect the prescription before going on holiday so it is an urgent situation for her. Or perhaps it could be argued she is just a friend and not someone "close" to the GP?

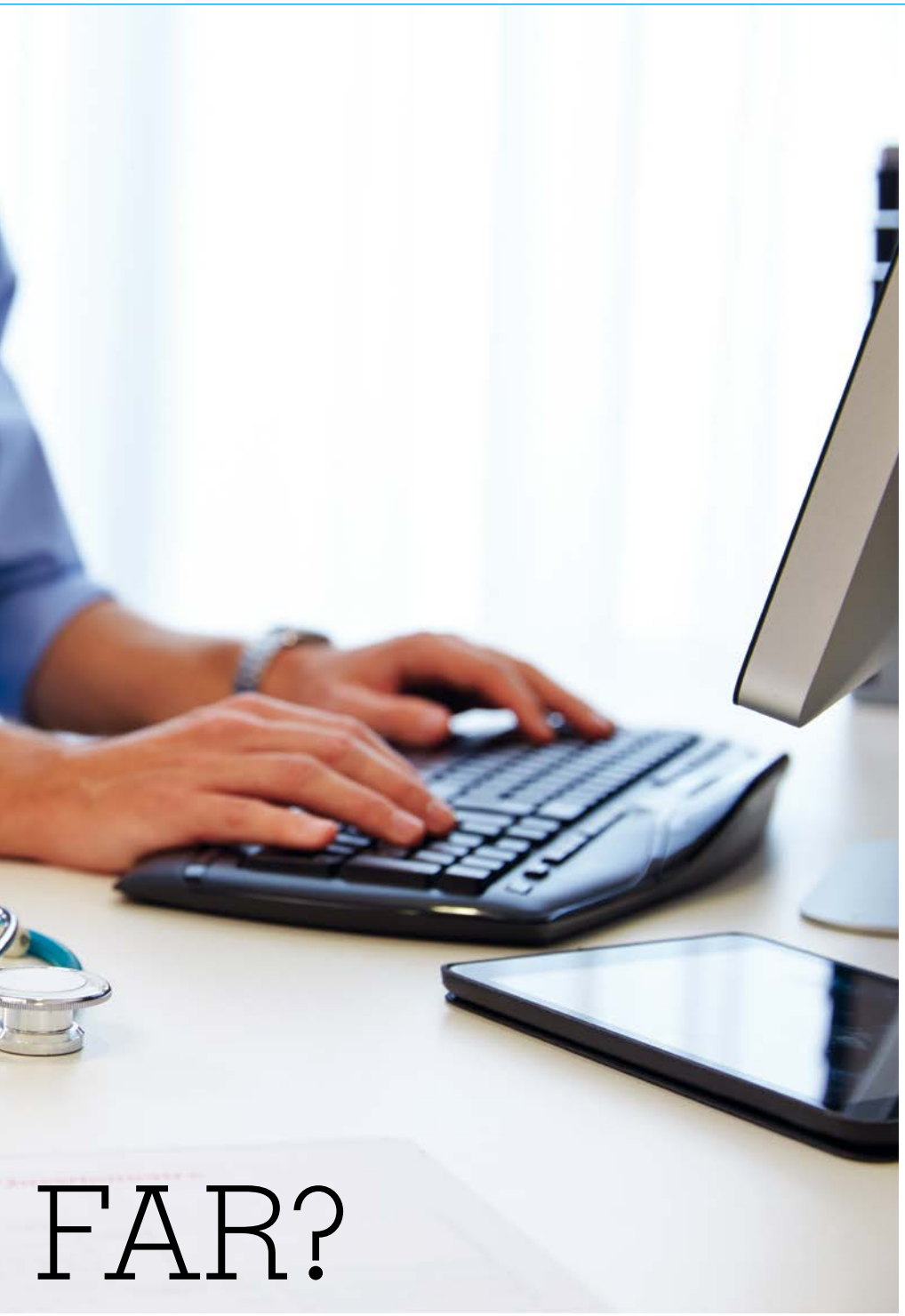
Although one or more of the arguments above may seem persuasive, the GMC's guidance does start by saying "wherever possible", implying that a GP should exclude all the other possibilities before making a decision to treat or prescribe. In this case there are lots of other options available. For example, the friend could attend one of the many walk-in centres in the UK that are open at weekends. Or she could see a doctor in the country she is visiting and obtain a local prescription. In this case, by issuing the prescription, the GP is likely not only to fall foul of the GMC's guidance, but also local prescribing policies and restrictions.

A FRIEND REQUEST

When it comes to maintaining boundaries, another important risk area is social media. Patients can often form close bonds with their doctor or dentist and many are tempted to look them up on Facebook and may even send a friend request. So what should a GP or dentist do upon receiving a request from a patient? Is it okay to accept? Or should these be declined even if it leads to potentially awkward moments later?

Declining a friend request may be awkward but how might a doctor or dentist feel knowing a patient had seen personal photos and details of friends and family – or that they had read personal comments posted or received on Facebook? Would it make discussing treatment plans or delicate decisions more difficult? Would it impact the level of professional trust?

The GMC's guidance *Doctors' use of social media* advises that using social media creates risks, "particularly where social and professional boundaries become unclear". It



FAR?

goes on: "If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile".

MDDUS recommends that doctors and dentists decline friend requests and, if the matter is raised by a patient, offer a polite explanation of the importance of maintaining a strictly professional relationship. If a patient persists in seeking to engage via social media it may be helpful to discuss the matter with the practice team. As with nearly all difficult situations, it is also essential to keep a clear record of everything that is happening at the time it happens. It is also worth highlighting to clinicians and other practice staff that they can take steps to minimise the chances of patients making contact via social media. Offering guidance to ensure privacy settings are as secure as possible and trying to keep a clear line between professional and personal pages are important.

MORE THAN A FRIEND

Another dilemma for some practices is whether it is ever appropriate for a doctor or dentist to become romantically involved with a patient, either past or present. As highlighted at the outset, trust is the foundation of any patient relationship. The GMC is clear that a personal relationship with a current patient is never acceptable. Doctors must never use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. GMC guidance *Maintaining a professional boundary between you and your patient* also states that doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them.

> "THE CORNERSTONE OF ANY PATIENT RELATIONSHIP: TRUST"

The GDC in its *Standards for the Dental Team* also states: "You must maintain appropriate boundaries in the relationships you have with patients. You must not take advantage of your position as a dental professional in your relationships with patients."

But is it ever appropriate for doctors or dentists to become involved with former patients? There are no answers or set time limits in such situations and clinicians must always exercise their judgement. The GMC explains that the more recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate. The duration of the professional relationship may also be relevant. For example, a relationship with a former patient treated over a number of years is more likely to be inappropriate than a relationship with a patient seen in a single consultation. Much also depends on whether there could be any perceived abuse of position. Factors to consider include the amount of time since the patient was last seen in a consultation, whether they are vulnerable and whether family members are still under treatment.

IN SUMMARY

Having practice policies in place can help highlight and reduce risks associated with these types of situations. In addition, practice managers can play a role in ensuring a practice culture exists in which staff are able to discuss openly any concerns they have about relationships with patients and approaches from patients, knowing that they will be supported in how to deal with these mindfully and safely.

Dr Naeem Nazem is a medical adviser at MDDUS

An inner-city practice in Glasgow is seeing tangible benefits in integrating health and social care

Changing primary care at the deep end

ANNETTE Fennell is perhaps not a typical medical receptionist. Four years ago she moved to the Glasgow area from Aberdeen where among other roles she worked with the church doing mental health visiting and counselling teenagers with drug and alcohol problems.

Joining Garscadden Burn Medical Practice in Drumchapel seemed fortuitous given its ethos of addressing head-on the challenges of social and health inequality that characterise this deprived area – but also considering the inclusive approach the practice takes when it comes to the strengths and interests of its staff.

Just over a year ago at the instigation of one of the GP partners, Annette began working with a small peer support group of patients who were affected by loneliness and isolation – calling themselves Promising Links. They meet every Tuesday morning to share coffee and cake and chat – as well as undertake activities in support of the local community.

Studies have linked loneliness to numerous health conditions including cardiovascular disease, mental health issues, high blood pressure and dementia. In areas of high deprivation, twice as many people report feeling lonely or living in isolation.

Typical of the group was one patient who spoke recently in a *BBC* interview. "When the day comes you don't want to go. So you're making all the excuses under the sun not to go." But the group has helped her gain the confidence to take part. "It's a lifeline," she says. "It brings you out yourself for two hours a week."

Annette is passionate about what has been achieved by this small initiative. "The change in people is astounding," she says. "They've gone from not wanting to come out of their house – real tears, real anxiety – to actually going to lunch… We've had a young man who was so anxious he was literally shut up in the family home for 10 years. He started coming to the group; he's now working. It's amazing."

Promising Links is just one of numerous initiatives attracting the attention of both media and politicians alike and recently resulted in Garscadden Burn being awarded Scottish Practice of The Year by the Royal College of General Practitioners.

Last month I visited practice manager Elaine Smith at Drumchapel Health Centre, an ageing NHS facility which Garscadden Burn shares with five other practices, each covering designated postcodes in the area. Here Elaine ensures the smooth running of the surgery with a list of 5,100 patients looked after by five GP partners and one salaried GP, two practice nurses, a healthcare assistant and five admin staff.

HEALTH DEPRIVATION

Garscadden Burn belongs to a group of 100 Scottish practices designated as General Practices at the Deep End. These serve the poorest populations in Scotland with 60 per cent of registered patients living in the 15 per cent data zones categorised as the most socio-economically deprived. Here healthy life expectancy for men is 18.8 years less than in more affluent areas – and 17.1 years less for women. Garscadden Burn is a typical "deep end" practice.

"Mortality is very high compared to Bearsden which is just a mile or so up the road," says Elaine. "Move over the boundary and you live nearly 20 years longer on average than the people here."

Studies have also found that practices in deprived areas like Drumchapel have 38 per cent more patients with complex health problems (five or more long-term health conditions) and twice as many with combined physical and mental health problems than in more affluent areas.

Dr Peter Cawston is a GP partner at Garscadden Burn and a founding member of GPs at the Deep End. He explains the ethos behind the group: "Back when we started, inequality was seen as a public health issue not a medical issue. So within general practice it was invisible. It was never really discussed. There was no recognition that there might be a different scenario for GPs working in highly deprived areas."

Today that has all changed with Scottish Government now having a legislated priority to integrate health and social care at a structural level. In 2013 a group of deep-end GPs submitted proposals to help achieve this goal at the grassroots and improve the provision of healthcare in the poorest areas of Scotland. Among the proposals was the creation of a new role known as a community links practitioner – someone whose job is to offer "social prescribing" and to improve links with other community resources and services. The proposal was picked up by Scottish Government and in April 2014 seven practices – including Garscadden Burn – began a pilot employing a "links worker".

PHOTOGRAPHS: SHANNON TOFTS

Practice manager Elaine Smith and below with Dr Peter Cawston

> "WE'VE HAD A YOUNG MAN WHO WAS SO ANXIOUS HE WAS LITERALLY SHUT UP IN THE FAMILY HOME FOR 10 YEARS. HE STARTED COMING TO THE GROUP; HE'S NOW WORKING. IT'S AMAZING"

"A great many health problems are caused by social conditions and GPs were being asked to address issues that were not medical and we weren't equipped to deal with in a very effective way," says Dr Cawston. "We strongly urged that the links worker should be part of the practice team and also that opportunity should be made for the whole practice to rethink how they approach social problems and become better at sign-posting – more aware of what's available in the local community."

ROLLER COASTER RIDE

Margaret Ann Prentice is the links practitioner at Garscadden Burn and is employed by the Health and Social Care Alliance Scotland with support from Scottish Government. She is also considered a full member of the primary care team, seeing patients in a consultation room and also in their homes. The job is not an easy one and in a YouTube video she describes her typical week as a "roller coaster ride" – helping patients with issues such as adult and child protection orders, bereavement, rent arrears or threatened eviction, dealing with police and social workers, mental health issues, as well as promoting healthy living, including organised walks, yoga and cookery classes. Annette Fennell acts as links administrator in the practice in addition to her role as receptionist.

Having a links worker has had a major impact on the practice, says Elaine. "On a Friday afternoon a GP might come across someone with no money, no food and three children. The GP can then say 'okay I'm going to refer you on to Margaret Ann' and she can take over that patient."

The scheme has also given GPs greater confidence to ask patients about underlying issues, such as debt or domestic violence, because they now feel able to offer an adequate response. So is it working? Evidence is due to be published later this year but from April 2014 and August 2016 there were 508 referrals to the links worker at Garscadden Burn and she was able to engage with 388 (76 per cent). A questionnaire sent to patients across the pilot found that 60 per cent of users reported improved wellbeing and 25 per cent reported significant improvement.

"A lot of patients we would see week in, week out – we now see less of because their problems have been sorted out by Margaret Ann," says Elaine. "They only need to speak with a doctor if they are genuinely ill."

Certainly evidence coming out of practices such as Garscadden Burn has convinced the Scottish Government. It recently published an action plan involving the recruitment of 250 community links practitioners to work with GP surgeries across Scotland. Dr Cawston has been asked to advise on the implementation.

"I think we are still a very ordinary practice with all the stresses and strains and failings of ordinary practices," he says "We don't claim to be special in any way. But we do feel in a better place both in terms of team dynamics and morale. We have also been able to see really quite visible improvements for patients, especially those at the most difficult end of social problems. And I guess the reason we come to work, the thing that improves our morale, is feeling that we can make a difference – not just keeping our heads above water. We are actually managing to do something positive."

Jim Killgore is publications editor at MDDUS

Liz Price offers advice on ensuring that transgender patients are treated sensitively and in compliance with current legislation

SUPPORTING TRANSITIONS

IT IS now estimated that around one per cent of patients are transgender, or more appropriately have 'gender incongruence' – a belief that true gender is different from how an individual physically appears or was assigned at birth. Our own experience at MDDUS is that most practices are aware of at least one or two patients who are transgender, and almost all can describe awkward or difficult encounters that with better preparation could have been avoided.

Patients can find it difficult to disclose feelings of gender incongruence to GPs and it is important to recognise that the risk of self-harm and suicide for transgender (trans) patients is significantly higher than that of the general population. With this in mind, it is essential for your patients to feel supported and not uncomfortable when accessing GP services and whilst awaiting a specialist referral.

As the regulatory guidance for supporting and treating trans patients evolves, it is important that practice managers review the ways their team cares for this cohort of patients – or might breach any legislation designed to protect them.

Consideration of the following aspects of the care and treatment will help you assess how well your team are providing services.

ASSESSMENT AND TREATMENT

The Royal College of Psychiatrists[1] provides guidance on the assessment and treatment of patients with gender dysphoria and you should ensure that all GPs in the practice are aware of what to do following diagnosis. The GMC has also issued specific guidance for doctors which includes directions on referral without delay, and steps to take whilst a patient is awaiting specialist review[2]. The GMC provides clear guidance on the responsibilities of GPs in tackling the risk of harm in relation to 'bridging prescriptions' by use of a clear set of criteria. This is where medication may be necessary before specialist input has been received and in particular where the patient is known to already be self-medicating from an unregulated source.

GPs can feel out of their depth in this area and may have concerns that they risk acting outside their level of competence and expertise. With this in mind, the Royal College of GPs has created an online CPD module to help GPs respond to the needs of adults and young people experiencing gender dysphoria[3]. It is important to note that a doctor cannot refuse to see or treat a patient because of their trans status as the Equality Act (2010) has clearly established this as a 'protected characteristic'.

MEDICAL RECORDS

There is no actual legal requirement for a patient to obtain a Gender Recognition Certificate in order to ask for their personal details to be changed by the practice. Neither are they required to provide evidence of an updated birth certificate for this. A signed request from the patient is sufficient to make such changes and the reception team must be prepared to deal with requests of this nature in a sensitive way and not appear to be obstructive.

The perception that a practice is being obstructive is most often the case when there is a lack of training in place, or staff are unaware of the patients' rights or the necessary actions. In addition, we have assisted practices where the patient's gender has been changed to 'indeterminate' (which is an available option within some clinical systems) in the absence of documentary evidence of a complete transition process rather than to the preferred gender stated by the patient. This could amount to indirect discrimination and the practice should always seek to accommodate patient preference.

Clear guidance is available online from the different NHS bodies on the process for changing name and NHS number, and links to these can be found within the new GMC guidance.

CONFIDENTIALITY

The Gender Recognition Act (2004) provides safeguards for transgender patients, and practices should note that this legislation makes it an offence to disclose protected information acquired in an official capacity. Protected information here can be that the person has changed from one gender to the other or is undergoing a transition process.

Receptionists must be careful to address patients with their preferred name and title, and if they are uncertain it is appropriate to discreetly enquire how the patient would like to be addressed. If this preference can be clarified within the bounds of a consultation by the patient's GP, the records can then be clearly amended to state these preferences. This is less intrusive and allows all staff to access the same information.

REFERRAL

Any clinical referral made by a GP must not include reference to the patient's gender transition/previous gender, unless:

- this has been discussed with the patient
- they have given consent to the disclosure
- the information is necessary for medical purposes.

Legal requirements around this are set out specifically within the Gender Recognition Act. This is reinforced in the GMC guidance which states that seeking patient consent

> "ALMOST ALL PRACTICES CAN DESCRIBE AWKWARD OR DIFFICULT ENCOUNTERS THAT WITH BETTER PREPARATION COULD HAVE BEEN AVOIDED"

DENTAL PRACTICE MANAGERS

Many aspects of this guidance are relevant to managers of dental practices, particularly regarding records, patient confidentiality and ensuring staff are provided with training in equality and diversity. There may also be a possibility that endocrine treatments prescribed to trans patients have an impact on dental care and so patients must be supported to feel comfortable updating their medical history to ensure any impact can be monitored appropriately.

before disclosure of information "shows respect, and is part of good communication between doctors and patients". Practices using referral software must ensure that any referrals are checked before sending to avoid an inadvertent breach.

SCREENING

Before issuing a patient with a new NHS number there is a responsibility for the GP to discuss the implications of this with the patient. For example, a consequence for a female transitioning to a male is that they would no longer be invited for (potentially necessary) cervical screening. The GMC states that decisions about screening should be made with patients in the same way as any other decisions about their health and to refer to their guidance on consent for more information.

TRAINING

As an employer, the practice has a duty to ensure that all practice staff receive training on the requirements of the Equality Act. This includes understanding of the needs of trans people. In England, CQC regulations require "that service users must be treated with respect… having due regard to any relevant protected characteristics".

Often things go most publicly wrong at reception and within our cases we see patterns of complaints arising where perhaps a member of staff has dealt badly with a call from a patient with a deep voice who identifies themselves as a female, or where they have called out a patient name as Mrs or Mr when the patient has expressed a preference for the other.

Being aware of relevant legislation and guidance should ensure your practice cares for transgender patients with sensitivity and understanding – but if members have any specific issues do not hesitate to call the MDDUS advice line.

Liz Price is a senior risk adviser at MDDUS

References

1. *Good practice guidelines for the assessment and treatment of adults with gender dysphoria* (RCPsych)
2. *Advice for doctors treating transgender patients* (GMC, March 2017)
3. *Gender variance* (RCGP Learning, May 2015)
   Also: *Focus on gender incongruence in primary care* (BMA, October 2016)

Sealed envelope

Day one

MRS B attends the local surgery with her young child who is suffering from an earache. A GP – Dr L – examines the child and offers treatment advice before Mrs B mentions another difficult matter she would like to discuss. Her sister-in-law – Mrs J – is also a patient at the practice and has two young daughters. Recently Mrs B has become concerned over her sister-in-law's excessive drinking in combination with the use of over-the-counter pain medication. On two occasions she has visited Mrs J in the middle of the day to find her "passed-out" in the bedroom with the two girls left unwatched and "filthy" with soiled nappies. Mrs B is worried the girls may someday come to harm.

Later that day Dr L discusses the matter with the practice manager and a senior partner. A decision is made to report the concerns over Mrs J to social services as they judge that the practice has a duty of care to do so, regardless of the consent of the person who made the disclosure.

Two months later

A visit by social services results in Mrs J agreeing to get help with her addiction and a child protection plan is put in place. Mrs J is unaware how the situation was brought to the attention of social services and assumes it was a neighbour who reported it.

Six months later

Mrs J attends the surgery with one of her daughters who has been complaining over the last few weeks of a very sore tummy. Dr L decides to refer the child for emergency assessment and tries to contact the hospital numerous times without success. In the end she prints off the full consultation notes for the girl, places them in a sealed envelope and asks Mrs J to present them at the hospital. Before attending the hospital later that day Mrs J opens the envelope to read the referral letter and discovers the child protection disclosure naming her sister-in-law as the source. She phones the practice angry and upset that she had not been informed that the disclosure had come from her sister-in-law via the practice. She disputes the information in the notes and wants it removed.

THE practice contacts MDDUS for guidance on how to deal with the matter. First the practice is urged to contact Mrs B by letter informing her of the confidentiality breach and providing an account of the incident along with an appropriate apology. This should be followed by the results of a significant event analysis, including lessons learned and measures implemented to ensure such an incident does not happen again (i.e. new practice procedures and further staff training).

A written response to Mrs J should also include an apology for not first seeking consent before referring the matter to social services. This should be accompanied by an explanation of how the incident occurred and steps taken to tighten up practice procedures to ensure it will not happen again in future.

In regard to the disputed details, the practice is advised to inform Mrs J that these now form part of the permanent medical record for her child and should not be removed. Mrs J should be informed that she can annotate the records to set out her position.

The practice completes the NHS Digital Information Governance Toolkit regarding the data breach and goes on to inform the Information Commissioner's Office (ICO) of the issue. A few months later the ICO responds informing the practice that no further action will be taken at this stage. It takes the view that the GP acted reasonably in providing a hard copy of the notes given the circumstances – and that the mother should not have opened the envelope which was sealed and addressed to the hospital consultant. The ICO acknowledges that any inappropriate information should have been redacted from the records but it is unlikely that significant detriment has been caused to Mrs J by the disclosure as it may already have been known to her. The ICO does not comment on the impact of the breach on Mrs B.

Both parties express their deep dissatisfaction with the practice at the breach but the complaint is taken no further.

KEY POINTS

- When third parties provide information about patients, seek consent to disclose their identity to the patient (or patient's parent in this case).
- Should consent to disclose not be provided ensure that information which would reveal third party identity is redacted from disclosed patient records.
- Disputed details should not be removed from records but patients do have right of comment.
- Always consider consulting with parents before referring to external agencies in circumstances such as these.

Diary

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

➔ EMAIL MELTDOWN Cringeworthy though the recent Oscar envelope gaffe might be – pity the poor NHS worker who last November accidentally sent a test email to all 840,000 NHS staff, thus paralysing the system. A spokesman explained that the disruption was "due to an NHS Mail user setting up an email distribution list which inadvertently included everyone on the NHS Mail system". The problem was further exacerbated by some recipients clicking "Reply all" and further choking up the system.

➔ DOG DOSH A dog owner is pursuing her dream career in medicine after training her husky to pose for pictures. Grumpy Anuko's fur pattern gives him a natural steely glare and he has taken social media by storm, notching up almost 40,000 Instagram followers and millions of YouTube views. The three-year-old has been showered with gifts and is even in demand for modelling jobs. Owner and budding doctor Jasmine Milton, 21, of Shropshire, has so far coined in £20,000 which she is using to fund a place at medical school.

➔ ROBOT WARS Another day, another news story suggesting technology will soon be better at providing healthcare than actual human doctors. The *Telegraph* reports claims that robots will "soon be able to diagnose more accurately than almost any doctor". This suggestion comes from the founder of a private company bidding for contracts that would see patients encouraged to seek medical advice from "chatbots" rather than a living person. Diagnoses could also (seemingly) be offered via smartphone without ever having to see a GP. Patients could key in their symptoms and artificial intelligence would assess the urgency of each case, deciding whether users should be sent to A&E, a pharmacy or just rest at home. The Care Quality Commission has waded into the debate by urging consumers to be wary of online services after an inspection of two web companies found drugs were being handed out without checks on patient identities or side effects.

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

➔ FORGET THE KRISPY KREME – HERE'S A NICE FRUIT PLATTER Diary consumes only lukewarm distilled water when at work so we are thus unperturbed by the dietary strictures being promoted currently by Professor Nigel Hunt, Dean of the Faculty of Dental Surgery at the Royal College of Surgeons. He believes that a "cake culture" in offices and practices is fuelling the current obesity epidemic. Speaking at the College's annual dinner for dentists he said: "Managers want to reward staff for their efforts, colleagues want to celebrate special occasions, and workers want to bring back a gift from their holidays. But for many people the workplace is now the primary site of their sugar intake... Cake culture also poses difficulties for those who are trying their hardest to lose weight or become healthier – how many of us have begun such diets only to cave in to the temptation of the doughnuts, cookies or the triple chocolate biscuits?" Chastened dentists at the dinner were consoled over coffee with "mint panna cotta, British strawberries and chocolate soil".

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

➔ MUCUS TROOPERS ADVANCE Sickness absence among British workers is now at an all-time low – or at least since records began over 25 years ago. We were absent an average of 4.3 days which is the lowest rate since 1993 when it was 7.2 days. Minor illnesses such as coughs and colds accounted for almost 25 per cent of days lost, followed by musculoskeletal problems including back pain, neck and upper limb problems, accounting for 22.4 per cent. TUC general secretary Frances O'Grady believes the fall in the sickness rate shows that "it is a myth that UK workers are always throwing sickies". She commented further: "We are really a nation of mucus troopers, with people more likely to go to work when ill than stay at home when well."

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**

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