Practice Manager
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ISSUE 18

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TECH SAVVY

PROFILE: AN ABERDEEN PRACTICE PILOTING AN ONLINE TRIAGE AND CONSULTATION SYSTEM

GIVING VOICE

#METOO HAS RELEVANCE IN ALL WORKPLACES – MEDICAL AND DENTAL PRACTICES INCLUDED

Practice Manager

THE "casting couch" may be a Hollywood cliché but it's clear that sexual harassment is a serious issue in many workplaces – healthcare being no exception. Two in five women in the UK say they have experienced unwanted sexual behaviour at work but only a quarter reported it, according to a recent BBC survey. And the issue does not only impact women; 18 per cent of men stated that they too have been harassed at work.

In this issue (page 12) employment law adviser Janice Sibbald looks at some recent tribunal cases and offers advice on dealing with inappropriate behaviour at work and the importance of ensuring that employees are aware of how they can raise concerns and feel supported doing so.

Our usual Call log is on page 4 and on page 6, risk adviser Alan Frame asks: are your paper-light document-capture processes adequate to avoid risk? On page 7, we address the temptation to use Google or other popular social media platforms to assess potential employment candidates.

Solicitor Daniel Kirk of Capsticks LLP (page 8) considers the value of practices having an up-to-date partnership deed in light of a recent Court of Appeal case. Uncertainty over partnership terms can lead to additional cost and risk in a dispute or a partner leaving.

On page 10 Jim Killgore visits an Aberdeen medical practice trialling an innovative online triage system offering patients an alternative to traditional face-to-face GP consultations and access to practice services. "We feel it's the way to go… the way of the future," says PM Fiona Paterson.

Do you demand rigid adherence among staff to practice policies? On page 13 Alan Frame considers how being too rigid can add risk. Sometimes a more flexible approach is required – and this is especially true in enforcing a "late policy" for practice appointments.

Our case study on page 14 concerns a delayed insurance medical report with dire potential consequences and Diary (page 15) offers the usual items of questionable relevance.

Scott Obrzud
Editor

COVER: NEWSLINE MEDIA

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GMC RESOURCE ON TRANS HEALTHCARE

ONLINE guidance on providing healthcare to trans and non-binary people is now available on the GMC website.

Advice and information is offered on general trans health, ensuring confidentiality and equality, prescribing and mental health issues. There is also a video with tips on putting the guidance into practice and respecting the rights of trans patients.

Access at **tinyurl.com/yd75ppm2**.

FIT FOR WORK SCHEME SCRAPPED

PRACTICES are reminded that the government's flagship fit for work scheme is to be scrapped due to low referral rates.

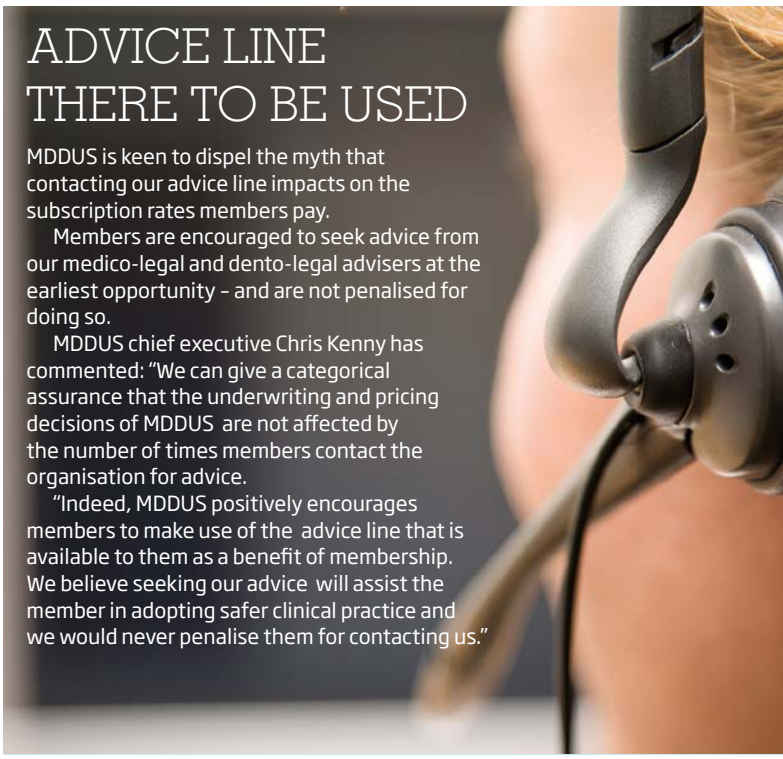
The Department for Work and Pensions (DWP) scheme was abolished at the end of March in England and Wales and will go at the end of May in Scotland. The helpline will remain for employers, employees and GPs to seek general guidance on health and work.

At MDDUS, we regularly handle calls from practices on how to deal with long-term absence and it was hoped that this scheme would provide more transparency and guidance for both employers and employees.

The initiative was introduced in September 2015 to help get employees back to work by providing free expert and impartial advice, including occupational health assessments and general health advice to employers and employees. However, a survey in September 2017 by *GPonline* found that two-thirds of GPs had not referred anyone in the last year and 60 per cent of those questioned were unsure how effective the initiative was at reducing long-term sickness levels.

The employer's ability to claim back statutory sick pay (SSP) was changed with the introduction of the scheme to aid funding, and the government has announced a consultation over any further changes now that the scheme is being abolished.

ADVICE LINE THERE TO BE USED



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

Members are encouraged to seek advice from our medico-legal and dento-legal advisers at the earliest opportunity – and are not penalised for doing so.

MDDUS chief executive Chris Kenny has commented: "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 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."

ADVICE ON ONLINE CONSULTATIONS

A GUIDANCE document "with questions to ask" when considering the provision of online consultations to patients has been launched by the Royal College of General Practitioners (RCGP).

The guidance (**tinyurl.com/ycnvwhtj**) comes as a growing number of services offering consultations online, most commonly via smartphone apps, are hitting the market. Whilst many of these are private, some have developed partnerships with GP practices in order to deliver NHS care (see page 10 of this issue).

Professor Martin Marshall, Vice Chair of the RCGP and author of the guidance, said: "Online consultations can seem like a very convenient option for accessing general practice services... But the ways some online services are provided raise patient safety concerns – people need to be aware of these, and properly understand what they are signing up to."

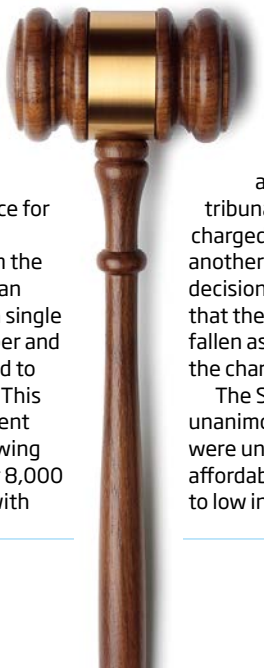
DUTY OF CANDOUR IN SCOTLAND

NEW duty of candour provisions in Scotland came into effect on 1 April.

The provisions, as defined in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill, set out a range of things that must happen when there has been an unexpected event or incident resulting in death or harm during health or social care.

Principles of candour exist in many organisations and professional codes of conduct but the Act introduces a statutory organisational duty on health and social care services in Scotland. The government has produced a guide on the new provisions and a set of factsheets to help understand what is required (**tinyurl.com/ke3f7qb**).

SURGE IN TRIBUNAL CLAIMS



THERE has been a substantial rise in employment tribunal (ET) claims following the Supreme Court ruling that employment tribunal fees were unlawful and prevented access to justice for workers.

The latest figures from the Ministry of Justice reveal an increase of 90 per cent in single ET claims between October and December 2017 compared to the same period in 2016. This follows an initial 64 per cent surge in new claims following the July 2017 ruling. Over 8,000 single claims were filed with the tribunal system over the three months to 31 December, a 16 per cent increase on the previous quarter.

Workers in the UK had been charged a fee to bring a claim to an employment tribunal. A further fee was also charged if the claim was heard and another fee was levied to appeal the decision. However, statistics revealed that the number of tribunals had fallen as much as 70 per cent since the charges were introduced in 2013.

The Supreme Court ruled unanimously that tribunal fees were unlawful and not reasonably affordable for households on middle to low incomes.

NEW GDPR RESOURCES

GET ready for the new GDPR data protection rules with a range of practical resources from the MDDUS Risk Education team.

Members can login to a new topic area within our popular GP risk toolbox to access checklists, guidance sheets and articles designed to help you navigate this challenging new practice risk area.

Visit the GP risk toolbox in the Training & CPD section of **mddus.com**.

FACTORS IN MISSED GP APPOINTMENTS

AGE and socio-economic status were significant factors in the one in five patients missing more than two GP appointments, as observed over a three-year period in a recent study published in the *Lancet*.

Researchers in Glasgow and Lancaster analysed a data set of over 500,000 GP patients in Scotland and found that patients aged 16–30 or over 90 years and of low socio-economic status were significantly more likely to miss multiple appointments. The study (**tinyurl.com/y7az7xxp**) also found that urban practices in affluent areas with waiting times of two to three days were most likely to have patients who serially miss appointments.

Dr Richard Vautrey, BMA GP committee chair, said: "Missed appointments do result in valuable time and resources being wasted, but we do need to understand the reasons why this occurs... [Patients] from lower socio-economic backgrounds are more likely to miss appointments and many of these patients are often under pressure financially or in other parts of their lives, factors that often contribute to their non-attendance.

"It is important that the government and NHS works with GPs to find positive ways to encourage appropriate use of GP services and through education campaigns reinforces the importance of attending booked appointments, as well as the negative impact missing appointments have on other patients."

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.

COPYING CHARGES

Q Can you advise whether our practice can charge for photocopying patient records that have been requested by court order but via a solicitor's office?

A practice complying with a court order to supply copies of patient records is not allowed to charge a fee for photocopying. This applies irrespective of whether the order is received directly from the court or via a solicitor. However, the solicitor is obliged to supply the practice with a copy of the court order so you should make sure you are in receipt of this before sending the photocopied records.

ACCESSING DECEASED RECORDS

Q The daughter of a deceased patient has written to the practice requesting a copy of all notes relating to her mother's care during the final 12 months of her life. We are unaware of any instructions from the patient with regard to access to her records after death and she had not appointed a personal representative. We have discussed the request with the patient's two other daughters and they have no objections. Should we comply?

A It would be advisable to consult the General Medical Council's guidance on *Confidentiality* regarding disclosing information after a patient has died. The guidance advises that in these circumstances you should consider whether disclosing such information would likely cause distress to the patient's partner or family and whether there are any concerns over a breach of third-party confidentiality. Among the circumstances in which the GMC states you should usually disclose relevant information about a deceased patient is when "someone close to an adult patient asks for information about the circumstances of that patient's death and you have no reason to believe the patient would have objected to such a disclosure". This may apply in this particular case, and consideration should be given to which records might be relevant to disclose.

NURSE INVESTIGATION

Q We have received a request from the Nursing and Midwifery Council (NMC) for access to the full records of two patients. They say they need the files as part of an investigation into the conduct of a nurse who worked at the practice up until six months ago. Am I allowed to hand over the records without asking the patients' consent?

A Ordinarily, before disclosing identifiable information you would be expected to first seek express patient consent. In this case, the NMC has a statutory power to request information for the purposes of their investigation, so patient consent is not strictly necessary if the NMC states that they are relying on these powers. That said, the GMC's *Confidentiality* guidance states that, whenever practicable, you should inform patients about such disclosures unless that would undermine the purpose, even if their consent is not required. It also states that disclosures should be kept to a minimum so it is worth confirming with the NMC whether the full patient records are required, or if specific information can be supplied.

INSURANCE CLAIM

Q The sister of one of our patients has attended the practice asking one of our GPs to fill in a travel insurance form on behalf of her brother, Mr B. She wants to claim back the cost of a holiday that he was forced to miss due to ill health. Mr B no longer has capacity to make decisions for himself and is unable to communicate. What should we do?

A The first thing to do is to clarify whether Mr B has appointed a power of attorney (POA) or deputy to make health and welfare decisions on his behalf. If the sister has the relevant POA then this would permit your GP to complete the travel insurance form on Mr B's behalf. In addition to this, you should check whether there is anything in Mr B's records to indicate that he would not want this information disclosed. If there is POA in place, be sure to comply with relevant capacity legislation and act in the patient's best interests. If you do decide to complete the form, be sure to disclose only the minimum amount of information necessary.

CHECKING UP

Q The mother of a five-year-old patient has called up asking if we can confirm that her estranged husband attended with their son for his dental check-up this morning. We know she has parental responsibility and isn't on speaking terms with the dad. Are we allowed to confirm this information for her?

A Dealing with the estranged parents of a child patient can be a difficult situation for practices as emotions often run high. In this instance, it may be best to phone the mum to discuss her request and any concerns she may have about her son's ongoing care. As she has parental responsibility and if it is in the child's best interests, she would be entitled to know

whether or not her child attended for his appointment. You may wish to consider reaching an agreement regarding the child's dental care arrangements in the future to avoid the practice being placed in a difficult position between two estranged parents.

ONLINE PRESCRIPTIONS

Q Our practice offers patients an online service for requesting repeat prescriptions but despite promoting this extensively on our home page and with posters and leaflets in the waiting room, uptake remains below 10 per cent. Can we adopt a policy prioritising online repeat prescriptions with a five-day notice period for manual requests?

A The answer to your query may depend on your usual practice regarding prescriptions. If you currently require all patients to give five day's notice for repeat prescriptions then it may be acceptable to process electronic prescriptions quicker than this as an incentive, but you should consider how this may disadvantage some patients. Certainly, if your current policy calls for repeat prescriptions to be returned within 48 hours it could be seen as discriminatory to delay processing of manual prescriptions from patients who may lack access to the internet or the skills/confidence to use the online service. Practices should seek contractual/policy advice on the issue from their health board or CCG. There is also RCGP guidance on encouraging patients to take up on-line services. Go to **tinyurl.com/y74sh9nb**

BAD WEATHER

Q During a recent spell of severe weather, some members of our practice team were unable to attend work for two days. Some of the team were able to make it in, so it seems unfair that I should have to pay the ones who didn't. What am I legally allowed to do in this situation?

A There is no statutory obligation to pay staff if they cannot attend work due to the weather conditions. However, the practice may have contractual obligations or have custom and practice arrangements in place from previous years. You also need to consider health and safety obligations, as you have a duty of care to your employees. Common sense should be applied. Where there is a Met Office warning to avoid travel, then it is not reasonable to be encouraging employees to come to work. Few contracts will include a clause allowing the practice to deduct a day's pay if an employee cannot make it in and employees also have a statutory right protecting them against unlawful wage deductions. So, if the practice does not have the contractual right to deduct pay and the employee does not consent to the deduction, a complaint could be raised. Therefore, it is important for the practice to be flexible. How such matters are handled can often affect morale and productivity so it is advisable to introduce a bad weather policy that should be clearly communicated to all employees and applied consistently.

DENTIST WITH A SPECIAL INTEREST

Q One of the dentists in our surgery has been undertaking orthodontic cases having worked part-time in a local orthodontic practice for the past three years and also being halfway through an MSc in the subject. She is not on a GDC specialist list and we obviously cannot advertise her as such on our website. Would it be okay to refer to her as a dentist with a special interest in orthodontics?

A The General Dental Council states in its *Standards for the Dental Team* that "you must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading and complies with the GDC's *Guidance on Ethical Advertising*". The regulator is very strict when it comes to misusing the term 'specialist'. This is reserved only for dentists who have completed a GDC-approved specialist training programme and have been awarded a certificate of completion of specialist training (CCST), and who are listed on one of the GDC specialist lists. However, given the historic evidence of the dentist's commitment to orthodontic practice and her additional training and experience, it would be fair to describe her as a dentist with a special interest in orthodontics.

MEDICAL REPORT BACKLOG

Q We are currently dealing with a backlog of insurance reports in our medical practice and recently an insurance company wrote to inform us that should something dire happen to a patient without life insurance then the practice would be legally at fault. Is this true?

A Receipt of a medical report can be an obvious rate-limiting step in securing insurance and a patient and their family could be left seriously compromised if such a report is not provided in a timely manner. Were a complaint or claim to be made on such a matter, the outcome would depend very much on the extent of and reasons behind the delay but the practice could be at risk of breach of duty of care. It is hard to be more precise in this matter but with any undue delay it is best to inform the requesting organisation so that they are on notice that a report may take some time to complete (see case study on p. 14).

EXEMPTION FROM JURY DUTY

Q A patient in our Glasgow medical practice has been called up for jury duty. She suffers with moderate to severe multiple sclerosis and is requesting an exemption on the basis of her condition. What are our responsibilities and how do we process such a request?

A Potential jurors who are too ill to attend court must provide the clerk of court with a medical certificate. In general a medical certificate should set out the date on which a medical practitioner last examined the patient, the exact nature of the patient's condition and (if not self-evident) why this would make attendance at court difficult. Note that medical certificates which are requested from GPs for the purpose of jury service are exempt from payment as set out in the terms of The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. In England patients wishing an exemption from jury duty are directed to write to the Jury Central Summoning Bureau including evidence in the form of a "letter from your doctor". Certificates to establish unfitness for jury duty must also be supplied free of charge under GMS Regulations.

Scan, **shred**, repeat

Are your paper-light document-capture processes adequate to avoid risk?

CONSIDER this recent case dealt with at MDDUS.

A patient made a complaint against a GP for failing to accurately communicate outcomes in a letter from the pathology lab. The system in place within the practice was for all incoming letters to be date-stamped on the reverse on receipt, and the doctor reviewing the letter would handwrite there any required actions. By the time this complaint was raised, the patient had moved to another practice and the original doctor involved could not recall from memory what had happened on receipt of the letter.

The patient's new practice, on receipt of paper records from the old practice, scanned them onto their electronic files and then shredded the originals. Unfortunately, they did not scan the reverse of correspondence and so critical information regarding how the original letter had been actioned was lost.

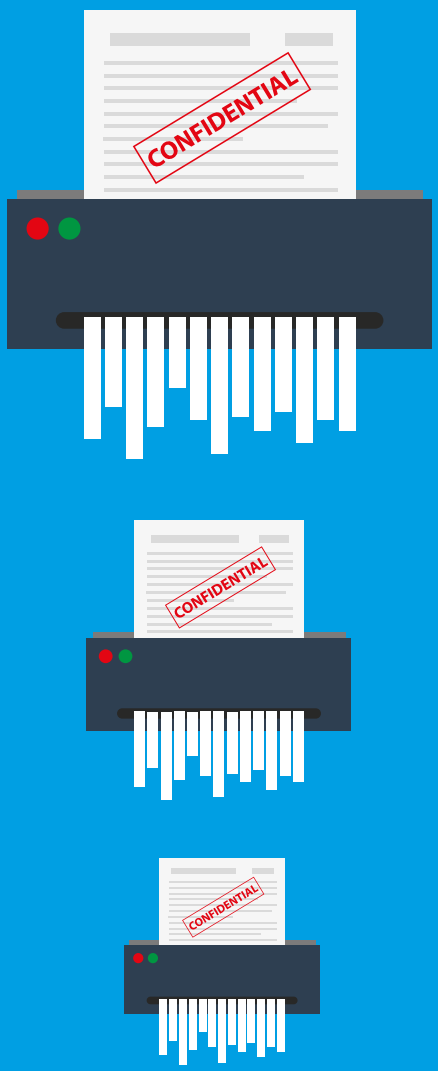
The circumstances in this case raise some interesting questions for all primary health care providers about the robustness of arrangements for accurately scanning and shredding incoming clinical correspondence and ensuring that important clinical information is not lost to follow up. For example, should information be retained in its original form rather than (or as well as) scanned electronically and then the original shredded?

The Records Management Code of Practice for Health and Social Care (2016) is a useful source of reference and guidance. It applies in England to all patient health records – electronic or paper-based – within general practice and hospital specialties. In regard to scanning records it states: "Where scanning is used, the main consideration is that the information can perform the same function as the paper counterpart did and like any evidence, scanned records can be challenged in a court. The legal admissibility of scanned records, as with any digital information, is determined by how it can be shown that it is an authentic record."

The key message here is that it is essential that practice procedures on the processing and scanning of paper records are adequate and applied consistently in order to be relied upon both clinically and in a legal context.

Another helpful document produced by the Department of Health, the BMA and the Royal College of General Practitioners is *The Good Practice Guidelines for GP electronic patient records*. It stipulates that following scanning and "once backed up, the original documents may then be shredded, within some safety and legal constraints, saving space and removing the need to file the paper into a patient record". The guidelines also offer advice to "paper-light practices" on establishing safe processes for the scanning and destruction of original documents.

Adequate paper-light working normally requires the practice to utilise a document management system (DMS) to handle correspondence. This will consist of a document scanner and associated software. Clerical staff must obviously be aware of the basics of document handling, filing items accurately and chronologically and complying with folder structures.



Staff should ensure scanned documents are legible and complete and know what to do when a document has failed to properly scan. Documents are normally scanned in black and white or greyscale, but colour can sometimes be important to the meaning so staff should know how to override default settings to create a colour scan.

The guidelines recommend a crosscut shredder for use in destroying paper records, although there is no NHS required standard. Some local primary care organisations may provide a document destruction service and there are commercial operators offering secure disposal.

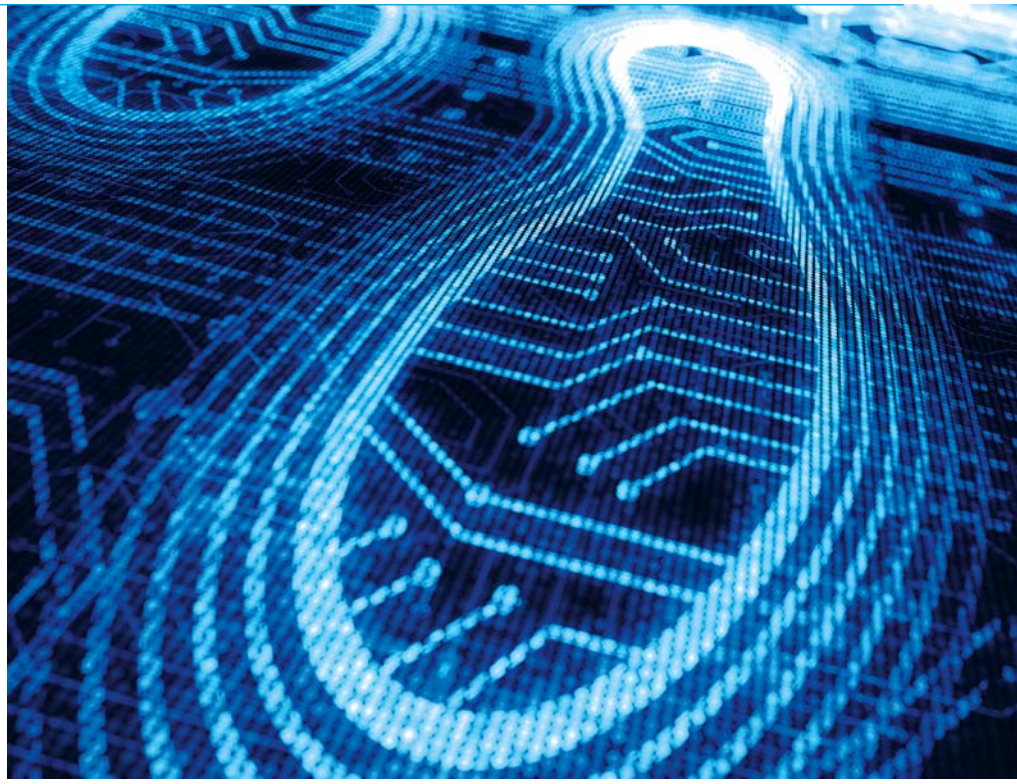
Provided that such policies and procedures are in place it would be difficult to criticise a practice in relation to document capture. Evidence of having followed appropriate guidance should be sufficient enough to demonstrate that an electronic copy is a true copy of the original.

There are, of course, risks whenever information is 'copied', with the potential for data loss. Where significant clinical data has been lost, practices will have to give serious consideration to reporting a "data security breach", both to the ICO (Information Commissioner's Office) and the patient concerned. This would be particularly important if the loss of clinical data impacted on the "rights and freedoms" of the individual as defined by the new General Data Protection Regulation (GDPR; coming into effect on 25 May) or placed the patient at risk due to missing clinical information.

The patient in our scenario above should have been made aware of the missing pathology results at the time as this could have had an adverse impact on their planned care and treatment. Even if a decision is made not to report an incident, practices will have to maintain a log of data security breaches together with any insight and learning from such incidents.

MDDUS has produced guidance notes for data controllers on preparing for GDPR and one specifically on reporting data security breaches. These can be accessed under the Training & CPD tab at **www.mddus.com**.

Alan Frame is a risk adviser at MDDUS



Employment law adviser **Janice Sibbald** urges caution in using Google to assess potential job applicants

Digital footprints

EMPLOYERS are increasingly using social media as part of their recruitment process and to advertise roles. There are many ethical and legal aspects to this but it is essential that prospective candidates and medical and dental practices move with the times and are aware of this additional tool in the recruitment of staff.

E-recruitment – or using the internet to aid conventional recruitment processes – has a number of advantages. It is particularly appealing to so-called 'millennials' who have grown up using a wide variety of social media platforms. E-recruitment also has the advantage of attracting the attention of "passive" job seekers, i.e. those who are currently employed but are open to learning about new job opportunities.

But there are also some risks to both employees and employers.

HERE COMES THE RAIN...

When was the last time you actually "Googled" yourself? The last time I did I found my Twitter account was open, there was a video of an Annie Lennox song being murdered by me on karaoke, along with many personal pictures of my family. I had no idea how they had got there and certainly hadn't given my permission for them to be there. Any potential employer would know I was a mother of two children (with questionable music taste) among other details. Would this have made a difference to any job I might apply for?

Your social media footprint is the trail that you leave behind for others to find every time you upload a photo on Instagram, check in on Foursquare, share anything on Facebook, tweet on Twitter, pin on Pinterest boards, publish videos of yourself on YouTube, get tagged in a Flickr photo or add jobs and education info onto a LinkedIn profile.

Our advice to practices previously has been never to use the internet as part of recruitment and selection processes – this for a variety of reasons. However, we do know from feedback from our members that this advice is frequently ignored in reality! An ACAS survey in 2013 established that the vast majority of employers did not have a formal policy covering the use of social media when recruiting staff.

ASK SOME QUESTIONS

First, have you asked for permission or are the candidates even aware that you will be carrying out a search on them? Although not legally necessary, it would be good practice to let them know that this is a part of your recruitment process. More and more employers use online sites to check if there is a reason to believe that a candidate is not being truthful in their job application.

Secondly, could this open the practice up to potential discrimination claims? For example, if a candidate was open about their sexuality on their Facebook profile and they knew you had viewed this, they may challenge whether this was the reason that they were unsuccessful in applying for a role. The skills and experience that a candidate has in relation to the job description is primarily what a candidate should be assessed on. The Equality Act 2010 protects candidates from discrimination on grounds including age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

Relying on social media or Google may also mean you are not reaching potentially good candidates who do not have ready access to computers or use social media. Is it fair to compare candidates by looking at those who do have social media profiles against those who do not? It is also worth noting that if you are recruiting low-skilled workers they may be less likely to use social media in their current roles or have access to it at home.

Other disadvantages include doubt over whether the information an employer finds online is actually accurate in the first place, and also perceptions of invasion of privacy by the applicant who may feel that it is unfair for you to access any online information about them. The least risky approach would be to refer only to sites such as LinkedIn, which are widely accepted as professional networking and job-hunting sites.

To conclude, we suggest that great care is taken when using social media in recruitment. Employers are advised to provide relevant training and information to managers who use social networking for recruitment, and in particular it is important to ensure that all information gleaned about candidates is accurate and handled in a responsible way.

If you wish any further information on this please contact MDDUS employment law advisers on 0333 043 4444.

Janice Sibbald is an employment law adviser at MDDUS

DEED OR

Solicitor **Daniel Kirk** considers the value of having a partnership deed in light of an English Court of Appeal case involving a dispute among GPs

A GP partnership is a formal business arrangement and the terms under which it operates should be clearly documented. A recent English Court of Appeal case has highlighted the risks that can arise when a GP partnership does not have an up-to-date partnership agreement in place.

In the particular case described below, the lack of an agreement meant that there were very limited rules governing the partnership, including how it could be ended. The legal interpretation in each situation will depend on the specific facts, and specialist advice should be sought. However, the Court's judgment provides an interesting overview of key issues and reinforces the strong recommendation to have a current partnership deed in place, reflecting any changes in the partnership.

SETTING OUT TERMS

Disputes within a GP partnership can arise for many different reasons. Common causes include conflict between property owning and non-owning partners (landlord/tenant disputes) and when partners retire or are removed from the partnership.

A signed and up-to-date partnership agreement or partnership deed is a key document to record the terms on which a GP partnership operates. It sets out the arrangements between the partners and what should happen in a range of scenarios, such as when a dispute arises or a partner leaves.

However, the reality is that many GP partnerships change and develop without having a current, or indeed any, partnership deed in place. This can arise when new incoming partners are negotiating over appropriate terms or, simply because limited available time and the demands of the 'day job' mean that a partnership deed was not considered or completed.

A partnership agreement should be seen as a "living document" and kept up-to-date with all changes affecting the partnership. Having a deed in place does not prevent disputes occurring but it reduces the risk by giving greater certainty about the agreed terms within the partnership.

CHEEMA V JONES: BACKGROUND

Although most partnership disputes do not end up in court, they can nevertheless be time consuming, costly and stressful for those involved. The lack of a partnership deed made this even more so in the case of *Cheema v Jones*. A summary of the case is interesting as it shows how things developed into a significant dispute due to a lack of clarity on partnership terms.

Dr Cheema, a salaried partner, was invited to join a partnership with Dr Jones when another partner retired. They signed a written partnership agreement on 8 April 2016. Dr Cheema and Dr Jones then discussed taking on three new partners to expand the practice. There was one formal meeting between four of the five proposed partners on 21 April 2016 and solicitors were instructed to prepare a draft partnership deed.

The GMS contract was varied to a partnership of five with effect from 1 July 2016 and the GPs started working at the practice but the draft partnership deed was not finalised. Partnership meetings were held in July and August with all five partners but in August 2016, Dr Cheema and Dr Jones fell out over allegations concerning Dr Cheema's fitness to practise. He was refused access to patients and sought a court injunction to allow him to return to work. The relationship between Dr Cheema and the other partners broke down.

A dispute arose over the nature of the partnership in place. Either that: (i) the Dr Cheema and Dr Jones partnership of 8 April 2016 remained in place; or (ii) a new partnership between the five GPs arose as a 'partnership at will'.

A 'partnership at will' can arise where the partners have not agreed other terms. Here the Partnership Act 1890 applies and incorporates very limited terms into the partnership, such as any partner can

NO DEED?

terminate the partnership on notice and all profits and liabilities are shared equally. In this case, it meant that Dr Jones could, without Dr Cheema's agreement, terminate the partnership at will to remove Dr Cheema.

A partnership at will does not cover the wide range of provisions that a standard GP partnership deed will include. It is not a suitable basis for a GP partnership and practices are much safer having clear agreed terms in place.

The trial took place in March 2017, with judgement being given in May 2017. All five GPs gave evidence at court, including being cross-examined by the barrister representing Dr Cheema. In this case the practice manager did not give evidence although the court could have compelled testimony.

The Court of Appeal confirmed the decision that the GPs had not agreed the draft partnership deed and were not bound by it. Instead a 'partnership at will' had replaced the 8 April 2016 partnership deed, allowing Dr Jones to terminate the partnership to remove Dr Cheema. The judge commented: "The dispute that has arisen is as a result of the failure of the parties to enter into a written partnership… or to reach agreement on all the terms…".

Interestingly, NHS England sought to terminate the practice's GMS contract as a result of this dispute and the dissolution of the partnership arising from these court cases. The remaining four GPs successfully challenged the attempted termination of the contract under the NHS Dispute Resolution procedure and at the high court.

NO DEED?

The exact legal interpretation of a partnership, where it is disputed, will very much depend on the factual background, such as the terms of any previous partnership deed, the content of emails, partnership meeting minutes and conversations between the parties. In the Cheema case, the court reviewed emails and minutes of meetings between the partners in determining the relevant facts on which it made its decision.

Broadly, depending on the specific situation, where there is no signed up-to-date partnership deed, the following could apply:

- the terms of a previous partnership deed remain in place
- there is a partnership at will with very limited terms
- other terms apply which may be disputed.

MEDIATION

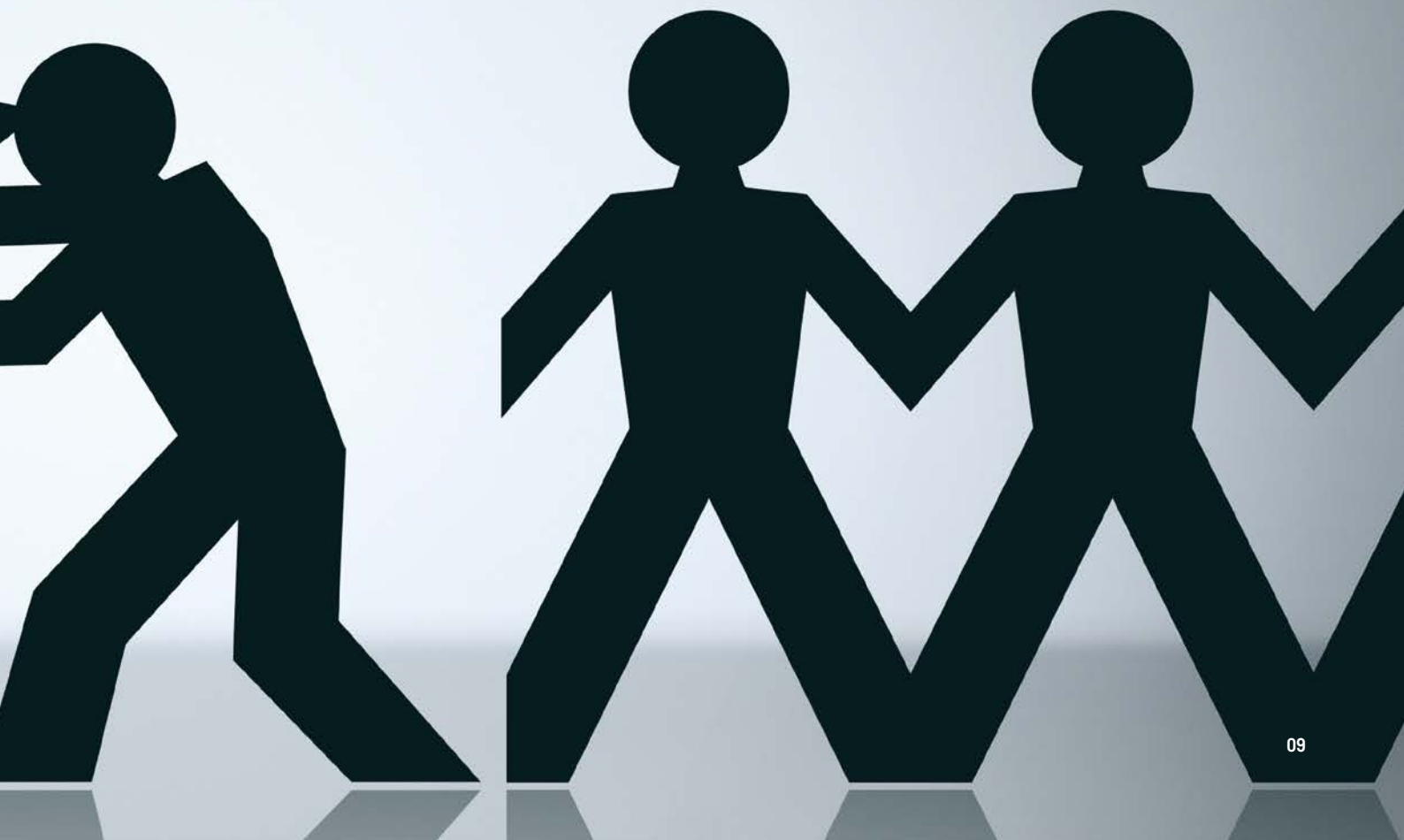
A partnership deed can contain a dispute resolution process setting out the steps that partners should take before issuing court proceedings. This can require a 'without prejudice' meeting to try to reach a settlement or mediation, where an independent mediator, often a lawyer, will try to facilitate an agreement. Mediation has a good success rate and lower costs and risk than pursuing a court claim. Court should be the last resort. Seeking advice early and planning a strategy can help resolve a dispute cost effectively.

WHAT TO TAKE AWAY

This case highlights some key principles in managing a GP partnership:

- Uncertainty over the terms of the partnership can lead to significant additional cost and risk in the event of any dispute or a partner leaving.
- The partners can protect themselves with a clear, signed partnership deed, updated to reflect changes in the partnership. The same principle applies to having a documented lease in place where required.
- Try to resolve disputes early and amicably before they escalate.
- Correspondence and records of meetings will be important evidence.
- Court proceedings may be required as a last resort but other cost effective methods for dispute resolution exist.

Daniel Kirk is an associate in the litigation division and member of the dedicated GP team at Capsticks Solicitors LLP, who provide discounted business and corporate legal advice to GPs and practice managers in MDDUS (England, Wales and Channel Islands only)



Jim Killgore visits an Aberdeen medical practice chosen to trial an innovative online triage and consultation system

DIGITAL DOCTORING

PHOTOGRAPHS: NEWSLINE MEDIA

AN ESTIMATED one in five GP appointments is for minor conditions that could be managed with advice and self care, according to a 2016 report by the Local Government Association. Another report by the NHS Alliance argues that 27 per cent of GP appointments could potentially be avoided if there was more coordinated working between GPs and hospitals, wider use of other primary care staff and better use of technology.

Certainly something needs to be done to help address rising patient demand for primary care services across the UK, attributed in part to a growing elderly population and associated co-morbidity, but also the crisis in GP recruitment. One potential time-saving solution that has emerged over the last few years is the use of online patient triage services for general practice.

In 2014 the Scottish Centre of Telehealth and Telecare (SCTT) set out to investigate the technology available to facilitate online triage. Ten Scottish GP practices were selected to trial an online "first click approach" to patient consultation. A range of urban and rural practices were approached and among those selected was the Old Machar Medical Practice in Aberdeen. I recently visited the practice and spoke with manager Fiona Paterson and GP partner Dr David Cooper.

ONLINE CONTACT

Old Machar is among Scotland's largest GP practices with over 18,000 patients cared for at two branch surgeries – one in Eastern Aberdeen, an area with high levels of deprivation, and the other in the more affluent north suburb of the city. The practice has five full-time and seven part-time partners, along with over 30 admin and nursing staff.

It's perhaps not so surprising that Old Machar was selected for the e-consultation pilot as David Cooper has a keen interest in information technology, being an executive member of the Scottish National Users Group and involved in numerous IT steering and advisory groups.

"I always dread when he comes back from a meeting saying I just said 'yes' to something," Fiona jokes.

David laughs. "Keeps the staff on their toes. But I'm really not techy at all. My interest is more along the lines: does the technology work? Is it what people want? How does it fit in systems-wise? Making it work is someone else's problem."

The system they were asked to make work for Old Machar was eConsult – an online triage tool developed by a group of London-based GPs along with a team of IT experts. eConsult bolts onto an existing practice website and invites patients to fill out an online form that captures symptoms associated with over 100 common clinical conditions. The tool is already in use in NHS England and Old Machar agreed to participate in a three-year trial starting in August 2016.

"We saw this as possibly the wave of the future and so we wanted to get in there early to see what it's like, with no risk from a funding point of view," says David.

Patients visiting the homepage of the Old Machar Medical Practice can access an e-consultation via a pop-up panel which asks them to input details on an online form. Among the options presented are help for a specific problem/condition, general advice on symptoms, or administrative requests such as test results, sick notes or a medical report. Patients are also advised of other ways to get advice either via the NHS 111 service or self care using the NHS Choices website.

Before being allowed to start an online consultation, patients are asked to confirm their problem is not an immediate emergency and that they are over 18 and consulting for themselves (not a child). The form then records patient details and takes the user through a series of questions to explore the nature of the complaint, capturing the symptoms using standard diagnostic scoring where possible.

"It starts with red flags," says David. "Say the patient has low mood. It asks: Are there any suicidal-type thoughts? In which case, it does not allow the patient to go any further. It says you should phone the practice immediately."

WORK FLOW

Information gathered using the online form is then output to a PDF document with a standard format so that clinicians can quickly review

Dr David Cooper and practice manager Fiona Paterson

for the relevant information needed to treat the patient. At Old Machar the PDFs are received in the practice Docman system and admin staff forward them to the appropriate person – be that a doctor, nurse or other staff. These are then apportioned to appointment slots for review.

"Staff check the mailbox first thing in the morning and e-consults are already on appointment screens as soon as the doctors come in," says Fiona. "The inbox is checked again at lunchtime and then about four o'clock – maybe three or four times a day."

"We decided it shouldn't be extra work; this is *instead of* work," says David. "So essentially if you have three e-consults to do that day then you will have fewer urgent patients."

The doctor then inputs a response into the Docman workflow and an administrator phones the patient back and reads out the advice and/or alerts them that a prescription is ready for collection, or to arrange an appointment for a face-to-face consultation. Some of the advice (including safety netting) can be pre-populated with existing text for common complaints such as viral-type infections. Advice and treatment are promised within two working days (or sooner if urgent).

"It's always a phone back," says David. "In order to close the loop, to be 100 per cent sure the patient and only the patient has got the info, you need a phone back."

The practice is currently averaging around 50 e-consults per week which amounts to about five per cent of all practice consultations. A report by NHS Scotland covering a four-week period in 2017 found that Old Machar had saved 60 face-to-face appointments using e-consultations – the second highest in the pilot. Overall most e-consultations in the pilot were to do with administrative requests (test results, referral letters, etc) or general advice on a pre-existing problem. Common conditions included back pain, cold or flu, coughs and earache. Just over 40 per cent in the pilot practices resulted in face-to-face appointments and 11 per cent were dealt with by telephone consultation, 12 per cent with advice and 21 per cent were provided prescriptions.

> "WE NEED TO ADJUST SERVICES TO MEET CHANGING NEEDS. THAT'S HOW MANY YOUNGER PATIENTS WANT TO COMMUNICATE – TEXT, EMAIL, VIDEO"

"We've found that most problems turn out to be fixable without an appointment," says David. "We probably only have to see about 20 per cent of the patients who complete an e-consultation."

FUTURE PROOF

Most of the patients using the eConsult service at Old Machar fall within the early 20s to mid-40s age group, with the oldest user so far being 92. It has proved very popular with patients and the practice has seen "exponential" growth over the last year.

"The more people use it, the more people find out about it," says Fiona. "We have loads of repeat users because it works for them."

That isn't to say there has not been some resistance. "Just as you would expect in any practice we have GPs who prefer to see patients face-to-face, and patients who prefer to be seen face-to-face," says David.

It's also not suitable for every patient and this is why the practice chose not to make it a "blanket" access system. Says Fiona: "This would create huge health inequalities at our King's Street branch because not all our patients have computers."

Overall the practice is very positive about e-consultations and expects to invest in some form of online system when funding for the current pilot ends in July of this year. Old Machar has also recently expanded patient access with the option of video consulting using the Attend Anywhere platform.

"We feel it's the way to go," says Fiona. "We need to adjust services to meet changing needs. That's how many younger patients want to communicate – text, email, video. What we are doing is just in line with that – the way of the future."

Jim Killgore is managing editor of MDDUS Practice Manager

As the #metoo movement continues to make headlines, **Janice Sibbald** offers advice on tackling inappropriate behaviour at work

GIVING **voice**

HE IS the brains behind some of Hollywood's biggest movies, but Harvey Weinstein stands accused of a catalogue of claims of sexual harassment against actresses and female employees spanning the last two decades.

A renowned film producer, Weinstein allegedly used his position of authority and power to sexually harass women. Not long after these accusations emerged, the "#MeToo" movement spread virally across social media encouraging women to speak out about their own experiences of inappropriate behaviour.

It is clear that sexual harassment is very much an issue in many workplaces. Two in five women in the UK say they have experienced unwanted sexual behaviour at work but only a quarter reported it, according to a recent BBC survey. The issue does not only impact women, with 18 per cent of men stating that they too have been harassed at work.

WHAT IS IT?

Sexual harassment is unwanted behaviour of a sexual nature that:

- violates your dignity
- makes you feel intimidated, degraded or humiliated
- creates a hostile or offensive environment.

It can be broadly categorised into three groups: verbal, non-verbal and physical. It can happen to women and men and can occur between people of the same sex or the opposite sex.

Examples of verbal harassment include comments about appearance, body or clothes; indecent remarks; and questions or comments about your sex life. Non-verbal harassment may involve looking or staring at a person's body; displaying sexually explicit material such as photos or magazines; or sharing emails with sexual content. Physical harassment can range from physically touching, pinching, hugging or kissing to assault and rape.

Harassment can be subtle and you don't have to have previously objected to someone's behaviour for it to be unwanted. Even if the person didn't mean for it to be perceived that way, it can still very much be classed as harassment.

We frequently get calls from practices about "banter" in the workplace. After all, it is just a bit of harmless fun isn't it? Bear in mind that what one person may deem as "joking around" or light-hearted fun might be perceived by another as sexually inappropriate.

CASE LAW

The employment tribunal cases described below provide useful learning points to any employer tempted to dismiss or fail to take seriously complaints of harassment from employees.

In the case of *Austin v Samuel Grant (North East) Ltd*, a heterosexual male employee won a harassment claim on the basis of sexual orientation and religion or belief. The employee was referred to as "homosexual" and "gay" by colleagues because he had told them that he didn't like football. He had filed a grievance but the HR director rejected it on the basis that the remarks were simply "office banter".

In *Furlong v BMC Software Ltd*, a tribunal upheld an employee's claim that she was subjected to sex discrimination and sexual harassment, including an incident where a senior manager groped her bottom and told her "he would like to eat her like a marshmallow". As well as upholding the employee's claim, the tribunal made recommendations to the employer to review their equal opportunities policy and training to management.

Harassment of a sexual nature is one of the most common forms of harassment and is specifically outlawed by the Equality Act 2010.

TAKING ACTION

Employers can prevent or address this issue by having an up-to-date and relevant policy that you may wish to display in the workplace. It should include:

- a statement of commitment from senior management
- a clear statement that bullying and harassment is unlawful and will not be tolerated
- examples of unacceptable behaviour
- a statement that bullying and harassment may be treated as disciplinary offences
- reference to confidential routes for complaints
- protection from victimisation
- how the policy is to be implemented, reviewed and monitored.

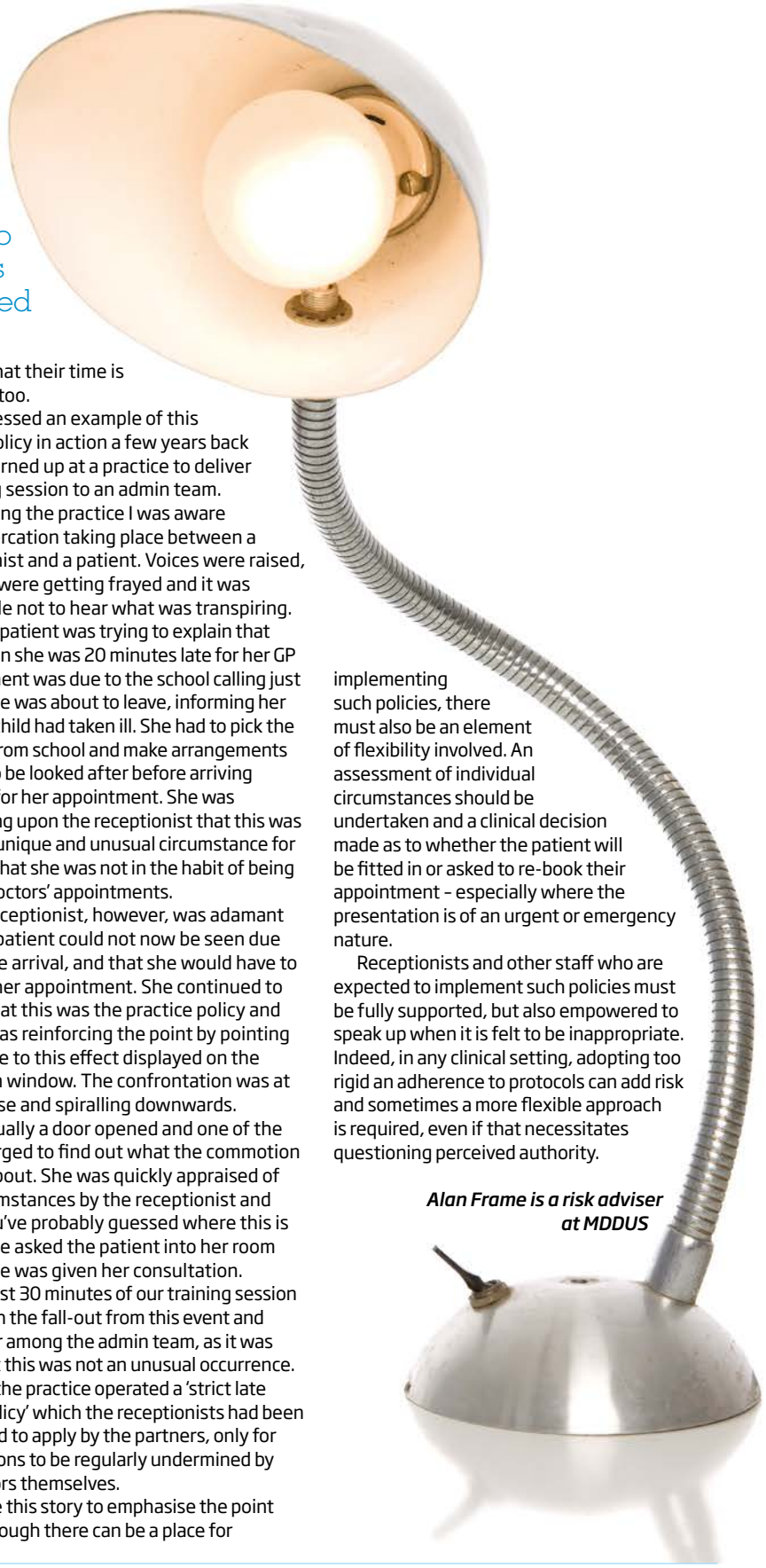
The important thing is to ensure that employees are aware of how they can raise concerns and that they feel supported in doing so. Complaints should always be taken seriously and handled fairly and sensitively. Some organisations suggest complaints are made in writing in the form of a grievance letter to the relevant supervisor (likely to be the practice manager). It may be helpful for the complainant to make notes about the incident in question, especially if recalling the incident is particularly upsetting. Remember to also offer support and sensitivity to the person accused of harassment as this can be a distressing experience for them too.

This is a sensitive and complex area of employee relations and if you need any support or advice please contact an MDDUS employment law adviser on **advice@mddus.com** or on 0333 043 4444. There is also useful information on the Acas website.

Janice Sibbald is an employment law adviser at MDDUS

The importance of being **flexible**

Adopting too rigid an adherence to protocols can add risk – sometimes a more flexible approach is required



A 42-YEAR-OLD man books an emergency appointment. He is suffering with nausea and abdominal pain but drags himself out of bed and is driven by his wife to the surgery. Traffic is bad and they arrive 20 minutes late for the appointment.

He explains the delay to the receptionist but is not reviewed or examined as the practice operates a strict policy whereby a patient more than 10 minutes late will be asked to re-book an appointment for the following day.

Later the patient is taken from home by ambulance to A&E and admitted to ITU with a ruptured appendix.

Such a scenario is all too plausible in our experience at MDDUS. Strict policies relating to patients arriving late for appointments are not uncommon in primary care. The reasons for taking such an approach may be understandable within a busy medical practice, for example to manage patients who habitually turn up late and cause significant operational problems.

A general observation about such an approach is that it can also impact on the majority of patients who usually turn up in good time but may sometimes be delayed due to unforeseen, unusual or unavoidable personal circumstances. The policy itself could therefore be viewed as a fairly 'blunt instrument' when applied rigorously and inflexibly, instead of addressing specific behavioural issues typical of only a small cohort of patients.

Enforcing such a policy without any built-in flexibility also carries significant risk – as may occur when turning away a patient who could be suffering from a serious medical condition that is then left undiagnosed and untreated, exposing the practice to potential criticism, complaint and even a medico-legal negligence claim in the event of an adverse outcome.

This type of regimented "10-minute-late" policy may also be viewed as somewhat ironic by patients who have turned up in good time for their appointment but are left waiting 20 or 30 minutes longer. Patients may recognise that their doctor's time is valuable and important but it could also be reasonably argued that their time is valuable too.

I witnessed an example of this kind of policy in action a few years back when I turned up at a practice to deliver a training session to an admin team. On entering the practice I was aware of an altercation taking place between a receptionist and a patient. Voices were raised, tempers were getting frayed and it was impossible not to hear what was transpiring.

A lady patient was trying to explain that the reason she was 20 minutes late for her GP appointment was due to the school calling just before she was about to leave, informing her that her child had taken ill. She had to pick the child up from school and make arrangements for him to be looked after before arriving overdue for her appointment. She was impressing upon the receptionist that this was a wholly unique and unusual circumstance for her, and that she was not in the habit of being late for doctors' appointments.

The receptionist, however, was adamant that the patient could not now be seen due to her late arrival, and that she would have to re-book her appointment. She continued to repeat that this was the practice policy and indeed was reinforcing the point by pointing at a notice to this effect displayed on the reception window. The confrontation was at an impasse and spiralling downwards.

Eventually a door opened and one of the GPs emerged to find out what the commotion was all about. She was quickly appraised of the circumstances by the receptionist and then (you've probably guessed where this is going) she asked the patient into her room where she was given her consultation.

The first 30 minutes of our training session dealt with the fall-out from this event and the anger among the admin team, as it was clear that this was not an unusual occurrence. In effect the practice operated a 'strict late arrival policy' which the receptionists had been instructed to apply by the partners, only for their actions to be regularly undermined by the doctors themselves.

I relate this story to emphasise the point that, although there can be a place for implementing such policies, there must also be an element of flexibility involved. An assessment of individual circumstances should be undertaken and a clinical decision made as to whether the patient will be fitted in or asked to re-book their appointment – especially where the presentation is of an urgent or emergency nature.

Receptionists and other staff who are expected to implement such policies must be fully supported, but also empowered to speak up when it is felt to be inappropriate. Indeed, in any clinical setting, adopting too rigid an adherence to protocols can add risk and sometimes a more flexible approach is required, even if that necessitates questioning perceived authority.

Alan Frame is a risk adviser at MDDUS

Policy delay

Day one

Mr B is 49 years old and married with two teenage children. He works for a large construction firm and has decided that he wants to start his own business doing smaller residential projects. Discussing the particulars with a financial adviser he agrees that extra life insurance would be wise and he contacts one of the major providers. He fills out a form and provides contact details for his GP surgery in order to request a medical report.

Day four

The surgery receives a request from the insurance company for a GP's report, with a form for completion. This is acknowledged by the practice administrator.

Day 12

A letter is received from the insurance company chasing the report. The administrator responds by email to say it is practice policy not to complete insurance reports until the fee has been paid. She attaches an invoice to the email. Notice of online payment is registered by the practice next day.

Day 26

An insurance agent phones the practice to chase the report and the practice administrator offers assurance that it has been allocated to a GP and the form will be returned in a few days. Over the next three weeks the insurance agent contacts the practice again numerous times via phone, email and letter chasing the completed form.

Day 49

Mr B collapses on a construction site, complaining of severe chest pain. He is taken by ambulance to the local A&E and admitted but later suffers a cardiac arrest and cannot be resuscitated. A post mortem indicates that the cause of death was myocardial infarction. It also emerges that Mr B had for a number of years suffered from chronic kidney disease (CKD).

Day 56

A report is completed by a practice GP and sent to the insurance company. It is noted on the form that the doctor had been requested to pay particular attention to Mr B's recent history of kidney disease and to forward all relevant specialist reports.

A CLAIM of negligence is received from solicitors acting on behalf of Mr B's wife in relation to the delayed insurance form. It is alleged that the practice was negligent in taking over 50 days to complete the insurance form, thus resulting in the policy not being issued and paying out on Mr B's death. This has left his family in serious financial difficulty.

MDDUS obtains an independent expert opinion from a GP. The expert agrees that the time taken to complete the report was not in keeping with usual and standard practice. He refers to an agreement between the BMA and the Association of British Insurers advising that a 20 working-day period is a reasonable time frame for medical reports of this nature.

But in regard to causation (consequences of the negligence) the GP expert concludes that even if the form had been completed and returned within 20 working days of the invoice being paid it is likely that the insurance company would have requested further assessment or comment in regard to the patient's history of CKD. Given the time required to do so – in addition to the insurance company's seven-day review period – MDDUS considers that on the balance of probabilities the policy would not have been issued before Mr B's death.

An MDDUS solicitor drafts a letter of response to the claimant solicitors denying liability. It is acknowledged that there was a breach in duty of care to Mr B and his family but causation is denied. Six months later MDDUS receives notice that the case will not be proceeding.

KEY POINTS

- Ensure awareness of and compliance with established service standards.
- Ensure practice systems trigger alerts for overdue tasks.
- Establishing clinical negligence requires proof of both breach of duty and causation.

Diary

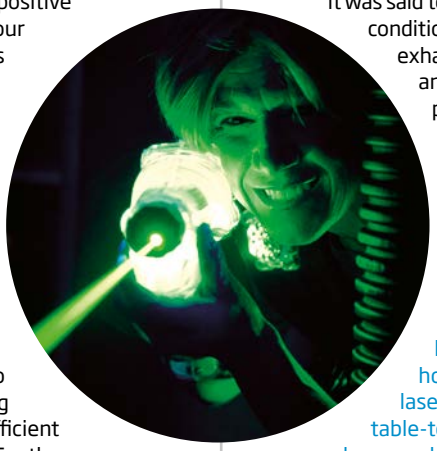
MORE random items of questionable relevance from the PM team...

➔ **BEYOND THE CALL...** Cutting nicely through the seemingly never-ending NHS-bashing headlines are some amazing tales of derring-do by practices caught up in this past winter's severe weather. A GP in Essex told *Pulse* how, with no buses running, one of his receptionists spent more than four hours walking to work in deep snow, while a practice manager elsewhere slept in the surgery to ensure services kept going. Another GP drove half way to his locum booking before completing his journey on skis. *GPOnline* reported that many practices had activated business continuity plans, with some closing early, switching to an emergency-only service or arranging for staff unable to travel to provide triage from home. One GP whose car wouldn't start walked to the nearest main road and hitched a lift in a passing 4x4 before trudging a mile and a half through the snow on foot. Dedication indeed.

➔ **ELBOW GREASE** British rock band Elbow have been unveiled as the latest weapon in the ongoing battle to boost the GP workforce. They have given permission for their hit single *One Day Like This* to be used in Health Education England's recruitment campaign, entitled *One career, endless opportunities*. The song forms the soundtrack to a video in which GPs and trainees talk about their experiences of life in general practice, and why they chose the specialty. As the chorus goes: "It's looking like a beautiful day... One day like this a year would see me right." A sentiment many hard-working GPs could no doubt relate to.

➔ **EQUAL OPPS FLU** The term "man flu" is so ubiquitous that it has been included in the Oxford and Cambridge dictionaries. Oxford defines it as "a cold or similar minor ailment as experienced by a man who is regarded as exaggerating the severity of the symptoms." So begins a research paper (published in the *BMJ*) by the University of Alberta's Dr Kyle Sue exploring whether "men are wimps or just immunologically inferior". He analysed available evidence to determine whether men really do experience worse symptoms and whether this had any evolutionary basis. His findings suggest that men may actually have weaker immune systems than women and that testosterone may act as an immunosuppressant while oestrogen works in the opposite direction. The rather tongue-in-cheek study was given some credence by RCGP chair Professor Helen Stokes-Lampard who said that, while flu "is not sexist", there is some evidence to suggest respiratory tract infections may present more severely in men than women. "Most people, whatever their gender, will recover completely within a few days," she added.

➔ **POWER OF POSITIVITY** It's official – a positive mindset is good for your health. Well, maybe. A British study has found that being in a positive mood on the day of your flu jab can increase its protective effect. It found happy patients developed stronger antibody defences than those who merely feel so-so. Fortunately patients do not have to be in a state of joy at the precise moment the needle is stabbed into their arm – just feeling upbeat that day is sufficient to reap the benefits. For those struggling to raise a smile, Nottingham University researchers said the best method is "a combination of comedy, uplifting music and a list of funny things people say."



➔ **BROWN BEAR BUSTED** A Sheffield GP – Dr Catherine Bell – has commented in the *BMJ* (albeit the Christmas issue) on the questionable practice of a certain ursine cartoon doctor appearing regularly in the popular children's TV programme Peppa Pig. Having observed questionable prescribing by Dr Brown Bear in three separate cases involving two piglets and a pony, Dr Bell concludes "exposure to Peppa Pig and its portrayal of general practice raises patient expectation and encourages inappropriate use of primary care services". The GMC has yet to respond.

➔ **THERE WILL BE BLOOD** Historical treatments for menstruating women included barber surgeons bleeding them from the ankle to draw the blood down and encourage smooth flow. Chinese medics suggested drinking yellow rice wine to harmonise the blood, while a special tonic laced with cocaine – called Hall's Coca Wine – was encouraged circa 1916 for "sickness, so common to ladies". Less appealing was hormone supplement Glanoid, produced from 1867-1930 by a meat-packing business. A more hi-tech solution came in the form of a battery-operated "electropathic belt" aimed at "suffering men and women". Marketed circa 1893 it was said to be effective for conditions such as nervous exhaustion, neuralgia and "ladies' ailments", promising wearers "new life and vigour". Source: Wellcome Collection.

➔ **WHO DARES WINS** A PM from Peterborough has recently described how her five to eight hours a week playing laser tag and fortnightly table-top war gaming has sharpened her management skills. Nicola Hewitson of Thorpe Road Surgery, interviewed in *Management in Practice* magazine, said: "Communication skills, tactical thinking, and coping well under pressure are all essential to a winning team... A team could have the best individual player, but if that team loses their medic or ammunition carrier, the best player's skills quickly become redundant because the team begins to run out of lives or ammunition." Diary assumes she refers here to laser tag and not morning surgeries in the zombie apocalypse.

GP risk toolbox

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