Practice Manager
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ISSUE 19

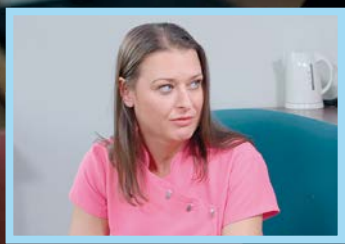
WATCHING THE WATCHERS
Do you make use of video surveillance in your practice and are you data compliant?

REVIEW NOW DUE
Ensure your practice has effective and robust patient call/recall systems

A DIFFICULT TASK
Dealing with disciplinary matters is never easy - read our quick primer

LEADING THE WAY

HOW A RURAL PRACTICE IS HELPING RESHAPE NHS CARE IN ENGLAND



BLEAK PRACTICE
IT'S BACK!

Practice Manager

EVERYONE appreciates a good story – or almost everyone. Here at MDDUS we often find that some of the most effective learning points come out of "scary stories" based on real cases – the admin blip leading to a prescription error, the "buried" test result, the patient in rapid decline not scheduled for a home visit. No wonder then that our own fictional medical surgery in *Bleak Practice* has proved so enduringly popular, with disaster after disaster played out on a video screen.

In this issue (page 12) Joanne Curran visits the set of the latest instalment of *Bleak Practice* (now in post-production) and learns more about the genesis of this ingenious learning tool and how it's put together.

Do you make use of video surveillance in your practice? On page 6 we look at the ICO's revised CCTV code of practice and changes to consider in addition to requirements from the GDPR. On page 7 Liz Symon offers a quick primer on practice disciplinary procedures.

Senior risk adviser Liz Price provides some tips (page 8) on ensuring your practice has effective and robust call and recall systems in place. What can you do when a patient in need of review "blanks" all contact?

On page 10 Jim Killgore profiles a rural Somerset medical practice at the heart of an NHS England vanguard programme working to dissolve the "traditional divide" between primary care, community services and hospitals. The Millbrook Surgery is part of the Symphony Programme, named Primary Care Team of the Year at the BMJ Awards back in May.

A summary of some recent advice calls to MDDUS can be found in our Call log on pages 4-5, and the case study in this issue (page 14) concerns an admin error resulting in a clinical negligence case involving the death of an elderly patient. Our Diary on page 15 offers the usual dose of absurdity with an added sprinkle of irony.

Helen Ormiston
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HARASSMENT WIDESPREAD

A REPORT has been published by the House of Commons Women and Equalities Committee (WEC) calling on the government to take action in relation to sexual harassment in the workplace.

It claims that sexual harassment at work is still widespread and that the government, regulators and employers are failing in their responsibility to tackle the issue. A BBC survey last year found that 40 per cent of women and 18 per cent of men have experienced some form of sexual harassment in the workplace.

The report states that, while there is widespread knowledge about workplace sexual harassment, employers should have greater and clearer responsibilities for protecting workers and greater awareness about the extent of the issue in their organisation.

PRACTICE PHARMACISTS PROVE BENEFIT

A STUDY has found that specialist clinical pharmacists working with 16 urban practices halved GP time spent on key prescribing activities.

In the research published in the *British Journal of General Practice*, GPs working in the Inverclyde Health and Social Care Partnership in Scotland recorded the time spent dealing with special requests, immediate discharges, outpatient requests and other prescribing issues for two weeks. This data was then compared to that from two equivalent periods in which specialist clinical pharmacists performed key prescribing activities to release GP time.

The researchers found that the time spent by GPs on key prescribing activities was reduced by 51 per cent, which equated to 4.9 hours per week per practice. Not only did this free up GP capacity but the practices also reported improvements in patient safety, positive effects on staff morale and reductions in stress.

The researchers concluded: "Specialist clinical pharmacists are safe and effective in supporting GPs and practices with key prescribing activities in order to directly free GP capacity.

"However, further work is required to assess the impact of such service developments."

NEW RISK TRAINING COMING SOON

MDDUS' Training and CPD team will soon be announcing a range of new webinars and training events focusing on key risks in medical and dental practice management. Topics include GDPR/data protection, complaints handling, managing conflict and social media.

Signing up couldn't be easier as most of our events offer online booking.

To find out more and to suggest a topic you would like to feature in a training event, email **risk@mddus.com** You can also browse the Training & CPD section of **www.mddus.com**

TELL US WHAT YOU WANT… REALLY

OUR MDDUS Training and CPD team are busy planning a packed programme of upcoming events, including our 2019 Practice Managers' Conference (date soon to be confirmed). Now is your chance to let us know what you would find useful in the way of conference sessions, stand-alone courses or webinars. Just contact **risk@mddus.com** with your topic ideas.

Members can also request a speaker or training event in their local area. Select a topic of your choice – from confidentiality and complaints handling to risks in general medical/dental practice. Local training courses can be delivered for a daily fee or for a per-delegate rate based on your preferences and available local arrangements.

We also consider all requests for MDDUS speakers as part of a local, regional or national conference or training event.

Go to **www.mddus.com/training-and-cpd/events/2018/tbc/request-a-speaker-or-training-event** or contact **risk@mddus.com**

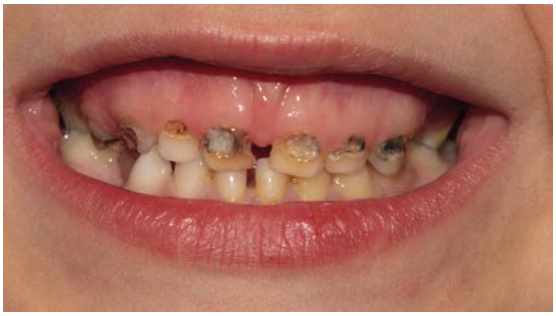
SHARED GP APPOINTMENTS

GP appointments involving up to 15 patients have been trialled in practices in England according to reports from the recent RCGP conference.

Group appointments of patients with the same condition, such as asthma, diabetes or pregnancy, have been piloted in GP practices in Slough, London, Birmingham, Manchester, Sheffield, Newcastle and Northumberland.

SMAs (shared medical appointments) are normally around 90 minutes with a multi-disciplinary team of healthcare professionals, says Dr Rob Lawson writing on the RCGP website. "The primary aim of the model is to improve patient health and wellbeing and to empower patient self-management. The additional aims are to increase patient and clinician satisfaction and to reduce waiting times and return rates."

RCGP Chair, Professor Helen Stokes-Lampard, commented: "The feedback has been very positive… However, this approach will not work for everyone and GPs will know what best suits their patients and practices – and there is no pressure on patients to participate if they would prefer to continue seeing their GP in a one-to-one consultation."



REDUCING CHILD TOOTH DECAY

HOSPITAL admissions in England for tooth decay in children aged 5-9 have increased for the second consecutive year but have dropped among ages 1-4 years and 10-14 years.

A total of 26,111 5-9 year olds were admitted for tooth decay in 2017-2018 compared to 25,923 in 2016-2017, according to data published by NHS Digital. This is more than double the number of children in that age group admitted for tonsillitis, and extractions to treat tooth decay remain the number one reason that 5-9 year olds are admitted to hospital.

Hospital admissions for tooth decay in other age groups have decreased in the last year, with admission among 1-4 year olds falling by 7.4 per cent and among 10-14 year olds falling by 3.3 per cent.

Last month NHS Digital data showed that 31.5 per cent of 5-9 year olds did not visit an NHS dentist in the 12 months leading up to 30 June 2018.

Professor Michael Escudier, Dean of the Faculty of Dental Surgery, commented: "When you consider that tooth decay is 90 per cent preventable and NHS dental treatment is free for all under 18s, it is disgraceful that so many children in their early years of school are suffering time away from class to have teeth removed."

GUIDANCE ON 'BELIEF' DISCRIMINATION

ACAS has published new guidance aimed at preventing religion and belief discrimination at work.

The guidance came into effect in May this year and offers employers advice on how to comply with the Equality Act (2010) by protecting employees against such discrimination.

The ACAS guidance highlights recruitment as a key area where employers should take care to ensure they avoid discrimination. It advises that job adverts should be publicised widely and it is almost always better if employers don't mention religion in the posting.

It also advises that training and development opportunities that help employees gain promotions should be organised so employees don't miss out due to religious observance.

Employers should take a flexible approach to dress codes where possible and consider requests to use annual leave for religious reasons carefully and sympathetically. They should also understand that fasting can impact on performance, so employers should try to be understanding in line with business needs.

Practices can conform to the law in terms of equality by having an up-to-date equality and diversity policy that is integrated into the key HR functions, with staff suitably trained.

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

VAPING IN THE SURGERY

Q A nurse has advised us that an associate dentist in our practice has been vaping in the consulting room between patients. Are we allowed, on legal grounds, to demand that she stop this behaviour?

A UK law prohibits cigarette smoking in enclosed public places and workplaces but the laws do not cover vaping. Organisations are free to make their own policy on the use of e-cigarettes on their premises. The practice should have a non-smoking policy in place and this could be extended to cover vaping. If you have no policy on smoking, a good place to insert one is in the drugs and alcohol policy. Any changes to the existing policy should be communicated to practice staff in writing. Practices should also ensure that their smoking policy is kept separate from the employment contract and details are provided in an employee handbook. This will allow the policy to be amended without having to get employees' agreement to amend their contract. Public Health England has published framework advice for businesses and employers to help create policies on the use of e-cigarettes. Access at **tinyurl.com/jsf6wcr**

PRE-ADOPTION RECORDS REQUEST

Q We have a three-year-old patient whose adoptive mother would like to access his pre-adoptive medical notes to obtain information relating to complications during pregnancy and childbirth. She is keen in particular to gain further information about alcohol consumption during the pregnancy. The mother states she was not provided a medical history for the child from social services.

A Adoptive parents take on parental responsibility and can therefore request access to a child's medical notes. The adopted child will be given a new NHS number and all previous medical information relating to that child is put into a newly created medical record. The new medical record should therefore contain all relevant information about the child's previous treatment in primary and secondary care but must not contain any information relating to the identity or whereabouts of the birth parents. The pre-adoptive information is regarded as confidential and any relevant medical information should have been shared with the new parent by social services during the adoption process. The scenario set out here presents a difficult situation for both the surgery and the mother and you may wish to emphasise the importance of keeping the pre-adoption notes confidential. You should urge the mother to discuss her concerns with social services who may be able to access the information she desires without breaching the birth mother's confidentiality. The adoptive mother should also be encouraged to discuss any concerns about the child's health or development with the GPs in the practice for further advice and assessment.

STUDENT NURSE INDEMNITY

Q Our practice has agreed to take a student nurse on placement from a local university. The individual will be monitored by our practice nurse and will only consult with patients under supervision. We are an MDDUS discount practice scheme. Can you confirm your position regarding indemnity for the student nurse?

A A student nurse acting in accordance with the duties delegated by an employee of the practice will have access to indemnity through the vicarious liability of MDDUS GP partners. MDDUS does not indemnify individual student nurses and it is possible that they could be sued in their own right and may consider obtaining personal indemnity for complete peace of mind. The university or employing trust is likely to retain a degree of vicarious liability for the student nurse and MDDUS would reserve the right to pursue any third party for a contribution if we consider it appropriate.

CASH DONATION

Q Last year a 91-year-old female patient of the practice left an envelope at reception containing £500 in cash. An accompanying note said the money was a donation to help spruce up the waiting area for other patients. Apart from some minor memory issues there appear to be no acute concerns regarding the patient's capacity. The practice accepted the gift and used it to repaint the reception area. Recently she left another envelope, again with £500. Should we keep accepting these donations?

A The GMC states in *Good Medical Practice* that a doctor may accept unsolicited gifts from patients or relatives but should consider whether by doing so they are altering their relationship with the patient, and also how this may be perceived by the public in general. The regulator provides supplementary guidance in regard to financial and commercial arrangements and potential conflicts of interest, which is available at **www.gmc-org.uk**. The practice should be satisfied that all actions taken are in accordance with such guidance and must be prepared to explain and justify any decisions made and actions taken. The acceptance of gifts by general practitioners is also subject to statutory and contractual regulations. The General Medical Services Contract Regulations highlight that a register should be kept of gifts received of a value in excess of £100, unless the gift is unconnected with their professional services. This register should include details of the donor and the nature of the gift, including whether it was given to the practice or an individual.

SISTER ON THE LIST

Q Our practice is in a rural area and it has recently come to my attention that the practice nurse has a sister who is registered as a patient. The nurse has assured me that she is aware of the legal requirements in regard to patient confidentiality and that she would never access her sister's medical records inappropriately. What is the legal/ethical position on having family members of staff registered at the practice?

A The Nursing and Midwifery Council Code states that nurses should "stay objective and have clear professional boundaries at all times with people in your care". GMC guidance (*Good Medical Practice*) is more specific on the treatment of family members, stating that: "Wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship". It would be preferable for the sister to be registered elsewhere but if this is not possible then the practice should ensure that the nurse is not providing direct care and also that a strict policy with regard to accessing medical records is adhered to by all employees to ensure confidentiality. Patient systems can also be set up to alert the PM to staff accessing particular records – e.g. those designated as family members at point of registration.

SAFEGUARDING CONCERNS

Q A child from a large family in our practice recently died in an accident. The local child death co-ordinator has now requested that the practice disclose the child's medical records (including concerns about safeguarding) to the safeguarding team. The team have not obtained parental consent for the release of the records as they are relying on the provisions of the Crime and Disorder Act 1998 in order to prevent serious harm to a child or young person. We are aware of no concerns regarding the safety of the other children in the family and are thus unsure why the disclosure is necessary. Can you advise?

A The GMC states that doctors must co-operate with any investigations regarding the safety or welfare of a child or young person. Perhaps the safeguarding team is investigating factors leading to the child's death, as well as further concerns for the safety of the other children in the family. In any case it would be helpful for the practice to have more information. A data controller is entitled to request this in order to be satisfied that disclosure in the absence of consent from a personal representative of the deceased is appropriate. You should reassure the safeguarding team of your willingness to co-operate in the investigation but state that you also require sufficient details to determine what information sharing is appropriate. If the safeguarding team believes that parental consent is not required they would need to explain why consent has not been sought. Should you judge that disclosure of the information requested is in the public interest, this disclosure should be of the minimum necessary and relevant to the purpose. Your local Caldicott Guardian may be able to advise you with any further concerns.

EXTREME SPORT

Q A 52-year-old patient has been in touch with the practice asking for one of the GPs to fill in a medical certificate. She plans to take part in a charity challenge which includes cycling over rough terrain for several days and needs to be certified fit. We are worried about being held liable should anything go wrong.

A Doctors must be cautious when completing fitness certificates. Even if the patient has been thoroughly examined, appears healthy and has no history of health problems that would cause concern, this is no guarantee of future fitness. The GP must be sure to act within their expertise and knowledge and be able to justify what they have written should they later be questioned. It may be advisable to make a broad statement along the lines of: "Based on the information available in the patient's medical notes, there appears to be no contraindication to exercise but, given the nature of the event, a sport medicine specialist with knowledge of the event would be better placed to comment on the specific query raised".

REFUSING TO PAY

Q We have a patient who is dissatisfied with her upper partial denture after having consented to treatment and costings. She is now refusing to pay though seems happy enough to keep the denture. Our experience in chasing such patients has been singularly unsuccessful and I have advised the dentist to let it go but he is adamant we pursue the debt. Would it be wise to chase and how can we prevent this from happening in future?

A Pursuance of outstanding payments can be a long and frustrating business but writing off such debts is equally disappointing. You might consider contacting the patient again to offer a further review to discuss any problems and make adjustments. You could also instigate the normal practice protocol of reminder letters before consideration of forwarding to a debt collection agency for recovery of the money. To prevent this happening in the future you might consider instigating staged payments each time the patient attends for treatment, thus making sure that a significant amount is paid before treatment is completed.

Watching the watchers

Do you make use of video surveillance in your practice? The ICO has revised its CCTV code of practice and these changes must be considered in addition to requirements from the GDPR and the Data Protection Act 2018

MDDUS receives regular calls from members in relation to the use of video surveillance within their premises. Requests for advice range from members wishing to monitor the waiting room or staff areas – because they have a specific suspicion about bad (or even criminal) behaviour or simply as a precaution – to requests for third-party access to CCTV or video surveillance footage after an incident has occurred.

The Information Commissioner's Office (ICO) has significantly revised its CCTV code of practice (**tinyurl.com/n3r38k2**) in recent years and these changes must be considered in addition to data protection requirements and developments in the technologies by which CCTV can be delivered.

The underlying principles of data protection legislation in relation to video surveillance remain the same – for example the need for transparency about camera position/use, security and rights of access. However, practices will need to demonstrate that they comply with:

- more prescriptive transparency requirements
- security protocols in the light of more stringent obligations, particularly around breach notification.

The ICO advises that a data protection impact assessment (DPIA) will be required before implementing video surveillance within your practice. Developing a DPIA in relation to installing video surveillance is the most effective way to comply with obligations and also to demonstrate that appropriate measures have been undertaken to ensure compliance.

Practices already using video surveillance tools should also consider undertaking a DPIA now. Normally these will be conducted before implementing any new method of processing personal data, but they should be treated as a continual process and updated throughout the lifecycle of a project, especially if there are any significant changes to procedures.

WHAT IS REQUIRED IN A DPIA?

- A description of the method of video surveillance and its purpose. This should include what the project aims to achieve and what the benefits will be to the practice, patients and staff. This will identify the 'legitimate interests' of the practice in implementing this form of data processing (a legitimate interest is a business interest which has been balanced against the interest of the individual(s) concerned).
- An assessment of the necessity and proportionality of the processing (e.g. video surveillance) in relation to the stated purpose. The views of individuals should be taken into consideration (e.g. a patient participation group/employees as relevant), including expectations about how their data will be used and whether it will have unjustified effects on them.
- An assessment of the risks to individuals and the measures in place to address these risks. Measures are likely to include information to patients and staff, and security safeguards, storage, access and reasonable retention protocols which are directly aligned to their purpose.

For further assistance, see the ICO's code of practice on data protection impact assessments (**tinyurl.com/ybakw8x6**).

In relation to mitigating the risk of a security breach, it is also important to update your practice on the notification requirements in relation to data breaches. Under the DPA 2018, practices are required to report a personal data breach of sensitive patient information to the ICO no later than 72 hours after having become aware of it. If in doubt, contact the ICO and/or MDDUS for advice if a breach occurs.

As digital cameras become more prevalent, more information will be sent and received via the internet. Backups can be located in local or cloud storage and can be available to users over the web. Whilst many systems provide opportunities for enhanced and often automatic protocols – including auto-deletion after specific periods, audit trails of individual access, and encryption and pseudo-anonymisation techniques – the associated risks must be documented and mitigated. Risks include unauthorised access, the ability to disable cameras remotely and failure to ensure appropriate security updates are installed. If a third-party organisation is contracted to manage your system, a robust data-sharing agreement should also be in place. Guidance on this is also available from the ICO.

> "IF A THIRD-PARTY ORGANISATION IS CONTRACTED TO MANAGE YOUR SYSTEM, A ROBUST DATA-SHARING AGREEMENT SHOULD BE IN PLACE"

Practices will need to be transparent about the uses of video surveillance. It should be clear to individuals – in this case mainly patients or employees – where, when, how and by whom their data will be processed. This can be achieved with the use of clear signage and privacy notices, which will need to include details such as:

- What information is being collected?
- Who is collecting it along with contact details?
- How and why it is being collected?
- How will it be used?
- Who will it be shared with?
- How long will it be retained?
- Whether the data will be transferred outside the E.U. (e.g. for cloud hosting).
- Individual rights to access personal information/raise a complaint about how information is handled – and how to do so.

Liz Price is senior risk adviser at MDDUS

A difficult task

Liz Symon offers a quick primer on practice disciplinary procedures

DEALING with disciplinary matters is certainly among the most difficult and stressful challenges faced by practice managers. Such matters usually involve either misconduct (deliberate or wilful acts) or performance issues, such as lack of competence or capability.

Misconduct must be investigated thoroughly, including collating evidence and, where applicable, gathering witness statements. Any investigation should take place promptly but care must be taken to ensure it is also thorough. It should concentrate on gathering the facts and not be a "fishing exercise". Ideally, the person conducting the investigation should not be part of the disciplinary process and thought should be given in advance to who is the right person for each stage of the process.

Depending on the nature of the alleged misconduct it may be reasonable to suspend the employee during the investigation. Suspension should only be used in serious circumstances and should be paid and as short as possible. The employee should be called into an investigatory meeting to discuss the evidence and be given an opportunity to explain any mitigating circumstances.

Once the investigation is complete, all the evidence should be reviewed, a decision made regarding further disciplinary action and the employee advised.

In regard to performance issues, it is important to review required standards regularly to ensure that these are achievable and applied consistently. Practices should use regular feedback meetings to keep the employee on track. Should performance start to slip, an informal meeting (with examples) should be organised to discuss what can be done to achieve the required standards. It is important to tackle problems early and decisively, as avoiding difficult conversations will only store up problems for the future.

In dealing with conduct or performance issues it is essential to review practice disciplinary policy and ensure that this is followed, or that at least the ACAS code of practice is being met. Any employee subject to a disciplinary hearing should be informed in writing and the letter should set out:

1. The place and time for the meeting
2. Who will be in the meeting and their role
3. The issues that will be addressed
4. In cases of potential gross misconduct – the employee should be advised that the outcome of the hearing may lead to their employment being terminated.

Any supporting documentation, including investigation notes, should be included with the invite letter and the employee should be given sufficient notice to allow time to prepare. Employees have the right to be accompanied at the hearing by a work colleague or trade union representative, who will be allowed to take notes, confer with the employee and address the hearing but cannot answer on the employee's behalf.

Make sure at the hearing that you are thoroughly prepared with the facts and a list of questions you want to ask and ensure that there is sufficient opportunity for the employee to have their say. Focus on the behaviours or actions that you are concerned about, providing clear examples. Ask the employee if they require further support or training or if there are obstacles to improving performance and the reasons behind the behaviours in question.

Give yourself sufficient time to make a decision after the hearing. You may want to adjourn until the next day and this would certainly be the recommendation if considering a dismissal.

Should the outcome be a warning, this should be confirmed in writing to the employee, including the level of warning being given, how long it will stay on file and the right to appeal the decision. The employee should be advised that future issues may result in another disciplinary hearing and further warnings being issued. Any appeals should be heard within a reasonable timescale and someone impartial should conduct the hearing, with the result confirmed to the employee in writing.

Employees with less than two years' service do not have unfair dismissal rights; however they can bring a discrimination claim if they feel that their dismissal is linked to a protected characteristic (e.g. age, disability, gender reassignment, race, etc) or if they have raised a statutory provision issue. They also do not need two years' service to make a claim for wrongful dismissal, which is when the terms of an employee's contract are broken in the dismissal process.

To avoid such a claim, the practice should ensure that the disciplinary process is not included in or attached to an employee's contract. Wording in the disciplinary policy should also state that the practice has the right not to implement the disciplinary process in the first two years of service. Best practice for those employees with under two years' service would always be to have at least one disciplinary hearing and to give the employee a final warning and a chance to improve before dismissal.

Employees with over two years' service have the right to make a claim for unfair dismissal, and failure to follow the ACAS disciplinary process could result in an award being increased by up to 25 per cent – so it is important that you ensure the correct process is being followed.

Liz Symon is an employment law adviser at MDDUS

Review now due...

Senior risk adviser **Liz Price** offers tips on avoiding "lost" patients needing recall

ENSURING your practice has an effective and robust call and recall system is essential for a variety of reasons – most particularly for the safety of your patients. In our experience practice managers or GPs tend to conduct routine chronic disease management recall well but may struggle with the more ad hoc examples illustrated below:

- **Prescribing where a drug is normally contraindicated.** In this case the GP may wish to monitor the patient closely, for example via blood or urine samples, to keep an eye on whether they are experiencing an adverse effect.
- **Results follow-up.** A patient may need a repeat test in a couple of weeks or several months' time to check if they require further investigation or follow-up after an abnormal reading.
- **Hospital discharge.** A patient may have been discharged from secondary care either with a request from the specialist for the practice to follow-up monitoring or to consider re-referral at local level in the case of a DNA (did not attend). In our experience these letters can sometimes be filed with no action reminder set or clinical decision taken regarding active follow-up. The frequency of this could increase as practices try to improve workflow efficiency by utilising receptionists to review and direct incoming correspondence.

In each of these situations – and I'm sure you can think of others – there is the potential for the patient to get 'lost', resulting in the practice facing medicolegal action when that patient suffers harm and subsequently claims that they were not properly informed of the need for follow-up or the risk associated with not attending. Ensuring that a conscious decision has been made in partnership with the patient to follow all or some of the steps below – depending on the level of clinical risk if the patient defaults – will help to demonstrate that the practice has acted reasonably.

DOCUMENT PATIENT INSTRUCTIONS

The patient should understand follow-up requirements and be made aware of the risks associated with failure to attend for testing or review, so that future recalls from the practice are taken seriously. In all scenarios, specific communication about the clinical reasons for follow-up should be unambiguous and also documented in the record so that, if an adverse event arises, the practice has an audit trail which will support their position. Instructions from clinicians via a non-clinical member of the team

to patients should be clearly documented and specific.

BOOK ADVANCE APPOINTMENTS

The longer the time between the initial test and the follow-up, the more onus there is on the practice to have resources and systems available to keep track of the actions required. It is best if your system allows a member of the team to book an appointment in advance for the patient, including details of which clinician initiated the review (and why) within the appointment slot. Should the patient call to cancel or fail to attend there should be a clear flag for the receptionist to re-book another date while the patient is on the phone or (for DNAs) to check with the instigating clinician whether the patient requires further follow-up.

URGENCY AND FEEDBACK

Decide on the level of effort to be expended and whether feedback is required. At the initiation of any call for follow-up, or even more importantly after the patient defaults from an initial call, it is essential that the clinician is clear with non-clinical staff about the urgency of the action and the timeline within which the patient should be reviewed. Do they need to speak to or see the patient that same day or within a couple of weeks? Do they need to know that the patient has not been contactable within an agreed period? Any attempts to contact the patient by non-clinical staff should be documented within the record and GPs should be clear in advance on whether and how they expect to receive feedback on the success or failure of any attempts to make contact with the patient.

> "ANY ATTEMPTS TO CONTACT THE PATIENT BY NON-CLINICAL STAFF SHOULD BE DOCUMENTED WITHIN THE RECORD"

WRITE TO THE PATIENT

If you are unable to get the patient on the phone, a letter is often the next action on the list. Please remember here that detailing specific points about the importance of review for an individual patient within a letter is more effective than sending one with a generic, bland statement about making an appointment. Being more specific about the possible consequences of non-adherence can also provide evidence of the clinician ensuring that the patient has been made aware of the risks. You may wish to consider using recorded delivery, particularly where the clinical risk of non-adherence is high. It is not advisable to adopt a 'three letters and then nothing' approach, and asking the patient to sign a disclaimer is much less useful than taking the opportunity to have (and document) a face-to-face chat when the patient is in front of someone!

PLACE AN ALERT

If the situation is not urgent, an alert can be placed in the patient's record so that, should they attend for another reason, the clinician seeing them can take the opportunity to conduct (and document) a face-to-face conversation with the patient to reinforce the importance of review and to attempt to get to the bottom of any difficulties or worries the patient might have about attending appointments. In the best case scenario, the clinician can undertake the review themselves, there and then.

"ENCOURAGE" ATTENDANCE

You should take steps which encourage the patient to attend. If the patient is on repeat medication, consider whether you could include a message about the need for review with their prescription. Depending on the level of severity associated with the situation, a prescriber could decide to reduce the amount of or withhold a patient's prescription until they are seen by a GP. Be aware though that there are risks associated with this strategy and therefore it should be used with care – and only after other attempts to engage the patient have failed.

TAKE ADVICE

When you have exhausted the range of options available to you and the patient is still refusing to attend, it can be useful to discuss the situation with an MDDUS adviser. We can help to ensure that you have done enough to communicate to the patient the dangers which they are exposing themselves to by not attending – and whether further action might be taken to ensure you are unlikely to suffer criticism should the patient come to harm.

Liz Price is senior risk adviser at MDDUS

FORWARD THINKING

Jim Killgore profiles a rural Somerset practice that is part of a quiet revolution in UK healthcare

MAIN PHOTOGRAPH: LATITUDE PHOTOGRAPHY

"ENGLAND is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'."

This uncharacteristically poetic quote comes from NHS England's *Five Year Forward View*, launched by chief executive Simon Stevens to much fanfare in October 2014. The document set out an overarching aim to dissolve the "traditional divide" between primary care, community services and hospitals – largely unaltered since the birth of the NHS – and introduce more personalised and coordinated care for NHS patients.

To this end the NHS invited organisations and partnerships to apply to become 'vanguards' in the development of new care models to act as blueprints for the NHS moving forward. Fifty such vanguard programmes now operate across England with enhanced funding.

The Symphony Programme is one such vanguard, set up as a collaboration between South Somerset GP Federation (19 practices), Yeovil District Hospital, Somerset Partnership NHS Foundation Trust and Somerset County Council. Together they serve a population of around 200,000 patients. One rural practice in the scenic market town of Castle Cary – Millbrook Surgery – has become an exemplar of the programme and the vanguard initiative.

I spoke recently to practice partner Dr Steve Edgar and manager Georgina Ball about the transformation taking place at Millbrook and in healthcare across the region. Steve has been actively involved with the Symphony Programme from the start and is currently its Chair.

"We're a PACS vanguard [Integrated primary and acute care systems]," says Steve. "Working together with the hospital as a whole to help improve the healthcare system but not limited to that, so including social services, voluntary care and the wider community.

"A lot of what we're doing is about putting back some of the good stuff that has been removed by the market changes. The ability of GPs in primary care to talk to their hospital consultant colleagues without somebody saying 'who's billing who'. Trying to reduce that payment by item, by item and actually have people working for the system as a whole, and as a result working for that patient as a whole."

The Symphony Programme also aims to recognise "evolving needs", including rising patient numbers and a growing percentage with complex long-term health issues putting a strain on existing resources and services. Research by the Centre for Health Economics at York University in 2013 found that just four per cent of the population – those with multiple and complex conditions – account for 50 per cent of health and social care spend.

HEALTH COACHING

One innovation introduced by the programme to address these challenges has been the employment of "health coaches" to work alongside primary and secondary care in supporting people with complex needs. Health coaches are non-clinical practice staff who concentrate on prevention, care coordination and developing patients' skills and confidence in self-management. This allows GPs to focus time more exclusively on clinical work.

"The idea was that they are people people," says Steve. "Closer to the demographic of the population than the professional might be so as to be able to facilitate communication. The reality is that a lot of the successful health coaches have been recruited from the HCA or the practice admin workforce. They've got a good understanding of the system already but want to take on more.

"Let's say I see someone and they are going to start some medication. 'Here are the tablets; see you in a month's time.' This person might need help with that treatment plan. We want it to stick; we want them to be more plugged into it. The health coach will go over it with them and then follow-up on a two-week interval. Bring them back in if there are any problems and just facilitate the plan so it makes a difference."

Health coaches also allow the practice to focus more resources on preventative care.

"We try to be as proactive as we can," says Steve. "That's one of our metrics: how much of our care is because we initiated it. So with a health coach review – maybe it's every two or three months – we call the patient and arrange a review, not waiting until something has gone wrong with them and then we are just playing catch up and firefighting."

Currently over 50 health coaches are now working across the Symphony Programme in 17 GP practices, supporting around 11,000 patients.

TEAM HUDDLE

Another aim of the Symphony Programme is to encourage more collaborative working, not just among practice staff but with the wider health and social care community. To this end, around three times a week, the practice convenes a "huddle" where the healthcare team discuss particular patient issues such as urgent care or emergency admissions, or "soft intelligence" such as missed appointments or other changes in a patient's behaviour. All of the practice staff attend, as well as "outside" participants, including local "complex care teams" established to provide specialist care for patients with multiple and/or long-term health conditions.

"It's a regular group of people but can be flexible and include hospice staff, mental health nurses or representatives from local

PRACTICE MANAGER GEORGINA BALL OF MILLBROOK SURGERY AND **(BELOW)** PRACTICE STAFF WITH DR STEVE EDGAR

voluntary organisations," says PM Georgina. "The huddles are completely health-coach-led. I don't initiate the agenda at all. They have a database of patients on their radar, some who may be having interactions with the complex care team or have recently been in hospital. We talk about their care needs. We talk about shared learning. We talk about successful cases or perhaps things we could do better the next time."

Steve adds: "It really fosters a team ethos. It's not just the GP's job to do the work; it's the whole team, led by the health coaches who reach into the hospitals. Some of our patients may be in hospital but they're still our patients. We're involved in their ongoing care."

Millbrook Surgery has three health coaches working with the GPs and practice staff, serving a growing list currently of around 5,500 patients. Another innovation at Millbrook aimed at fostering a team ethos is an open-plan office design where admin and clinical staff, health coaches and GPs all work next to each other, "hot desking" consulting rooms to see patients.

"Rather than the GPs being behind closed doors and the admin team hovering about trying to get an answer, we all work collaboratively together," says Georgina.

The practice also operates a unique appointment system called GP Access. They offer no pre-bookable GP appointments which puts the doctor completely in control of their day. Says Georgina: "patients can phone in and get an appointment and speak to a doctor on the day. This means our DNA rate is practically non-existent."

> "THE TEAM HUDDLES ARE COMPLETELY HEALTH-COACH-LED. I DON'T INITIATE THE AGENDA AT ALL"

SCALING UP

The changes implemented by Millbrook and the other practices in the Symphony Programme have yielded measureable improvements. In the last year, hospital overnight admissions in the region fell by 7.5 per cent, emergency bed days by 15 per cent and non-elective admissions from nursing homes by 50 per cent.

In May of this year the Symphony Programme was named 'Primary Care Team of the Year' at the BMJ Awards. The judges were impressed by the positive impact shown on developing patients' skills, knowledge and confidence in self-management, and the programme team were praised for their focus on relationships, commitment to patient partnerships and strong measurable outcomes.

Now the task of the vanguard is to scale up the learning and the experience, says Steve. "To take some of the positive things we've managed to create and do that at a bigger scale so that it has a greater impact across the Somerset healthcare environment.

"When you talk about investment in primary care and bottom-up change it takes time to change and one of the lessons we've learned is to allow that to happen."

Jim Killgore is managing editor of MDDUS Practice Manager

BLEAK BY DESIGN

Joanne Curran goes behind the scenes during filming for the latest episode of GP drama series *Bleak Practice*

I TIPTOE in the back door of the medical practice just as an anxious patient is telling his GP about a recent trip to hospital with chest pains. The doctor shifts uneasily in his seat as the man reminds him he has sought advice from him on a number of previous occasions for the same issue. The look of mild panic on his face suggests the GP is wondering whether he missed a diagnosis. Should he have referred the patient for specialist help sooner?

It's a tense scene but rest assured that no patient confidentiality was breached during the writing of this article. The anxious patient, Mr Martin, and his GP Dr Wright are two central characters in the forthcoming sixth episode of MDDUS' flagship GP drama series *Bleak Practice*, an online risk learning resource that has proved immensely popular amongst UK medical practices. Exclusively for MDDUS members, each 15-minute instalment focuses on key risk areas in day-to-day clinical practice and is accompanied by a discussion guide that lets teams work through the films in their own practices at their own pace.

SETTING THE SCENE

Filming for this latest drama-packed instalment takes place over two days at a real GP practice in Glasgow while it is closed for the weekend. I arrive just as the scene is finishing another take, being careful not to make any noise that could be picked up by the microphones placed around the consulting room by sound recordist Alan Henry. Director Brendan Smith, of video production company Enterprise Screen, is keeping a close eye on the action alongside producer Gavin Hopkins.

The small consulting room is filled with expensive-looking lighting, cameras, monitors and sound equipment and the actors and crew gingerly step around the coil of wires and tripod legs dotted across the floor. Just outside the doctor's office is MDDUS risk adviser and *Bleak* scriptwriter Alan Frame, who carefully listens for any inaccuracies or inconsistencies in dialogue. Senior risk adviser Liz Price also stands quietly in the hallway, overseeing the whole project with the help of team administrator and chief organiser Ann Fitzpatrick.

Ann is well acquainted with Dr Wright, having had the dubious pleasure of dying in episode two as 'Mrs Hicks' after the GP failed to check her test results. Indeed, being such a small production with a tight budget (the actors apply their own make-up and supply their own non-medical costumes), many MDDUS staff have served as extras and supporting characters over the years alongside the cast of paid actors. The films are truly a team effort.

BLEAK BEGINNINGS

The idea of producing a filmed drama was first touted around five years ago when Liz Price and her risk education team received increasing numbers of requests from managers for learning resources they could access in their practices, at a time that suited them. Keen

OPPOSITE PAGE AND LEFT: THE ENTERPRISE SCREEN CREW ON SET FILMING EPISODE 6. **MAIN IMAGE:** WORRYING TIMES FOR MARGO AND **(ABOVE)** STAFF DEAL WITH ANOTHER CRISIS

to create something engaging and different, it was Alan Frame who first suggested a short scripted drama as an entertaining way of highlighting everyday practice risks.

With the help of risk advisers Cherryl Adams and Dr Gail Gilmartin, a story board, script and discussion guide were drafted. Enterprise Screen was brought on board to take care of filming and post-production and within six months the first episode was ready. The big premiere took place at the MDDUS Practice Managers' Conference in St Andrews in 2014, where it formed the basis of a varied programme of interactive risk workshops.The feedback was immediately positive and the risk education team have made new episodes every year since.

"We have been delighted at the positive reaction to *Bleak Practice* which seems to build in popularity each year," says Liz Price.

"The films offer a real team-building experience and practical learning for practices. It's also a plus that they can be accessed in different ways. Some teams work through a whole film over the course of an afternoon's protected learning time (PLT) while others break it down into sections and work through it scene-by-scene.

"Every episode has one main theme with a number of sub-themes so there are a lot of really practical learning points in there. The scenarios are all based on real MDDUS case files so the risks and mistakes are real – they just may not all take place in one practice in one day."

One important message Liz wants practices to take from *Bleak* is that risk comes from the entire healthcare team, doctors included.

"Many failures occur as a result of a failure across a multidisciplinary system and our experience shows that doctors are equally prone to making mistakes," Liz adds. "It is not just the PM or receptionist. That's why we encourage practices to work through *Bleak* with their entire team."

FANBASE

Since its premiere, *Bleak* has received a steady flow of positive feedback from practice managers. One manager who has worked through the episodes with her team during PLT says: "The staff really enjoyed the presentations. They could laugh at the blatant confidentiality breaches knowing that they would never do such silly things. However, the more subtle and seemingly innocent comments which could cause major issues struck a chord with many and made for interesting post-video discussion. Everyone is looking forward to the next instalment."

Many of *Bleak's* main characters have become familiar faces, including Dr Wright. He has featured in numerous episodes, having battled alcoholism and faced accusations of negligence. He is played by actor and former murder mystery business owner Peter Hammond.

But the character who enjoys most recognition is Margo, whose piercing blue eyes and wide range of pained facial expressions has earned the long-suffering receptionist something of a cult following.

She is played by Nicola Clark, a trained actress who had a brush with pop stardom in the 1990s after winning a competition to sing in a girl band managed by former *X Factor* judge Louis Walsh. While her music career never quite took off, she continues to fit in singing and acting around her day job for Transport Scotland.

As Margo, she will take centre-stage in episode six with her father Mr Martin. I speak to her as she is putting on her receptionist's uniform and preparing to film her first scene.

"This will be my sixth episode so for me coming to filming is like a big reunion," says Nicola. "It's great fun playing Margo. She means well but has a bit of a big mouth. I think a lot of people can relate to her – she shows that sometimes when you go out your way to help someone it can land you in trouble."

After two busy days of filming, *Bleak* 6 will spend a few weeks in post-production before a rough draft is released to Liz's team for approval and a final cut is ready for its big premiere.

● *Bleak Practice* episode 6 will be available for members under "team training" in the Training & CPD section of **mddus.com**

Joanne Curran is an associate editor of Practice Manager

Rapid decline

Scenario

Mr K is a frail 89 year old with a history of congestive heart failure secondary to calcific aortic stenosis. He also suffers from numerous other co-morbidities, including impaired renal function, type 2 diabetes, osteoarthritis and vascular dementia. Mr K has been recently feeling poorly and a home visit is arranged with his GP – Dr L. A discussion with input from the patient's wife reveals a two-week history of shortness of breath and a slight increase in leg swelling. Mr K also complains of a cough. Chest examination reveals crepitations in the right mid and lower zone and the left lower zone and there is bilateral pitting oedema up to the knees. Dr L prescribes amoxicillin for a presumed chest infection.

Mr K is already taking bumetanide 1mg twice daily and the GP adds an additional 500mcg on alternate days to treat a possible slight worsening of his heart failure. Dr L arranges for renal function to be checked after one week.

Day 10

Dr L makes another home visit for follow-up. Mr K's renal function had been found to be stable and the patient is feeling "much the same". Chest examination reveals some fine bilateral crepitations and further blood tests are arranged. The GP decides to discontinue the additional bumetanide dose as it appears to have produced no significant benefit. He records in the notes: "hold off further bumetanide".

Day 19

The local pharmacy receives a routine repeat prescription request for bumetanide (along with other medications) and a script is printed off for the half tablet on alternate days. Another GP – Dr O – is given this prescription to sign but notes the comment by Dr L in the records. Dr O asks an admin team member to inform the pharmacy that the extra dose of bumetanide is not to continue.

One month later

Dr L receives a phone call from Mrs K to say that her husband has been admitted to hospital with heart failure and that the bumetanide had not been in the medication dosette box. Dr L later notes that the bumetanide had last been issued over six weeks ago. Two days later Mr K dies in hospital with the cause of death certified as: 1.a. left ventricular failure and aortic stenosis with chronic renal failure under section 2.

A CLAIM for clinical negligence is received by the practice from solicitors acting on behalf of Mrs K. It alleges that the failure to prescribe her husband's normal dose of bumetanide was a clear breach of duty of care and led to his untimely death.

The practice undertakes a significant event analysis which finds that the pharmacist contacted the practice a month before the patient's death to query Mr K's repeat bumetanide prescription. In response, practice staff printed out the prescription for the half-tablet on alternate days. This was presented to Dr O who on seeing Dr L's note instructed that a change medication form be completed discontinuing the extra dose of bumetanide. Instead, a form was drawn up mistakenly stopping all bumetanide scripts, including the 2mg daily.

MDDUS instructs an expert in primary care to review the case and she concludes that the medication error represents a clear breach of duty of care to the patient by the practice.

A consultant in cardiology is also asked to comment on the question of causation (consequences of the breach). He consults both practice and hospital notes in regard to the patient's care. On admission to hospital, Mr K was reported to have increasing shortness of breath with bilateral crepitation indicating fluid in the lungs. Blood tests showed moderate to severe renal failure with significantly elevated blood glucose and additionally a dangerously elevated potassium level. An ECG indicated left ventricular hypertrophy. Cardiology staff elected to manage the patient conservatively due to his age and parlous condition.

The expert concludes that the sudden removal of treatment with a powerful diuretic certainly contributed to the patient's rapid decline – although uncontrolled diabetes and renal failure were also significant factors in his hospital admission and death.

MDDUS offers to settle the case with the agreement of the practice partners.

KEY POINTS

- Ensure change medication forms are double-checked for errors.
- Breach of duty is not enough to establish clinical negligence – causation must also be established.
- Make sure the patient is aware of treatment plans – or their family/carer in cases of impaired capacity and with proper consent in place.

Diary

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

➔ **CEREAL KILLER** It might be churlish to take The Association of Cereal Food Manufacturers to task when they say: "Breakfast cereals are an important source of fibre, vitamins and minerals". More interesting perhaps is what they don't say. A recent study published in the *British Dental Journal* found that some top-selling UK breakfast cereals are 35 per cent sugar by weight. The packaging does recommend maximum portion sizes of 30g which is fine until – as the researchers observe – you look at the front of some cereal boxes with photographs of bowls "brimming to the top". Eating the estimated 90g of cereal in these images would lead to children aged 4 to 10 exceeding their daily limit of "free sugars" by 12.5 per cent with just a single bowl.

➔ **SORRY (NOT SORRY)** Practice managers are no strangers to email ping-pong and the delights of finding increasingly imaginative ways to politely chase someone for the umpteenth time. But it turns out all those pleasant sounding stock phrases fool no one. A survey by software company Adobe of 1,000 US workers found that the most-hated lines were those that tacitly imply a lack of response to a previous email. Giving off more than a whiff of passive-aggression is the classic opener: "Not sure if you saw my last email" (most hated by a quarter of survey respondents), followed by the abrupt "per my last email" and "per our conversation" (hated by 13 per cent and 11 per cent respectively). While maybe sounding innocent enough, "Any updates on this?" and "Sorry for the double email" also caused irritation. And let's not forget the quiet persistence of those who are "re-attaching for your convenience" in the hope of receiving a reply sometime this millennium. Adobe's director of email solutions Kristen Naragon says that, despite its speed and efficiency, expressing oneself clearly and politely via email can be tricky. "Emotion and intent are sometimes hard to convey via email, so [some phrases] can negatively impact productivity and culture." Happy to discuss.

➔ **IT'S SO BRACING** Time was, that lifestyle advice from your local practice amounted to "lose a few pounds and give up the fags". Not so in Shetland today where 10 GP surgeries have recently been authorised by their health board to issue "nature prescriptions" for patients with conditions such as diabetes, heart disease, stress or depression. The local Royal Society for the Protection of Birds has drawn up a list of walks highlighting particular bird and plant species with leaflets available at surgeries. Dr Chloe Evans, a GP who piloted the programme at Scalloway Health Centre on the west coast of Shetland's main island, told *the Guardian*: "People are always thinking at some level about their diet or exercise or stopping smoking but finding out what works for them is the key. The beauty about Shetland is it has this fantastic wild landscape." Diary advice: hold on to your hat.

➔ **ROCKY ROAD** Whoever said progress runs smoothly? Looking only to advance human wellbeing, lifestyle brand Goop (founded by Gwyneth Paltrow) has faced its share of setbacks. Coming hot on the tail of recent criticism over its DIY coffee enema kit, sceptics are now questioning the efficacy of its vaginal eggs. The jade (£51) or rose quartz (£42) stone eggs are claimed to boost sexual energy while balancing hormones, regulating periods and improving bladder control. The company has agreed to pay a $145,000 settlement over alleged unscientific claims about the eggs and a herbal essence said to help tackle depression and has also agreed to refund customers. In July, Paltrow announced that Goop had hired an in-house fact checker for its website. Not an enviable task.

➔ **GENDER CONTROL** And so to Japan where women account for over 40 per cent of the workforce but this year's 18 per cent pass rate for women taking the entrance exam to Tokyo Medical University proved something of a mystery. Was there a subtle cultural/gender bias at play? Not at all – a local newspaper found that administrators were simply marking down exam results by up to 10 per cent to keep the female student population down. This was deemed necessary (media reports have alleged) to prevent women undertaking medical training only to later quit in order to raise children. Head of the Japan Medical Women's Association, Yoshiko Maeda, was astonished. "Instead of worrying about women quitting jobs, they should do more to create an environment where women can keep working."

➔ **FAMOUS FINGERS** Prostate Cancer Canada has come up with a novel campaign to encourage men to undergo digital exams and other checks to test for the disease. "Famous Fingers" features 13 model hands wearing latex gloves – index fingers raised – inspired by historical and fictional figures including Sherlock Holmes, Abraham Lincoln, Winston Churchill and King Tut. "It's about normalising the conversation around prostate exams and stressing the importance of detecting prostate cancer early," said Peter Coleridge, President and CEO of Prostate Cancer Canada. "Any alternative to being examined by your doctor is quite absurd, which the campaign captures perfectly. Would you prefer to have your prostate checked by your doctor, or by Big Foot? We'll let you decide." Er... doctor please. **www.famousfingers.ca**

BLEAK PRACTICE is back!...

and all is not well

THE eagerly-anticipated sixth episode of our flagship drama is now online at **mddus.com**

Join us for another eventful day in the Wellnot Surgery – and also at a local hospital – as staff wrestle with a variety of challenges and risks around consent, referral systems, delegation, working collaboratively with colleagues and breaches of confidentiality.

Bleak Practice is a series of short dramatisations based on real MDDUS cases. The films are designed to highlight common areas of risk in general practice and include discussion guides to assist GPs and PMs in facilitating discussion within their own teams.

Members can login to access at Team Training in the Training & CPD section of **mddus.com**

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