Spring 2016

SUMMONS

AN MDDUS PUBLICATION FOR MEMBERS

• Curbing legal costs • Q&A: Professor David Haslam • Dentists and the DPA •

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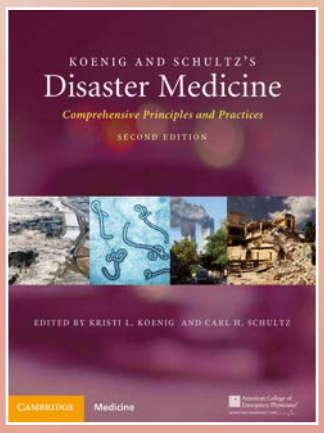

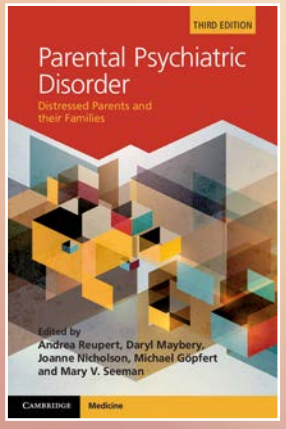

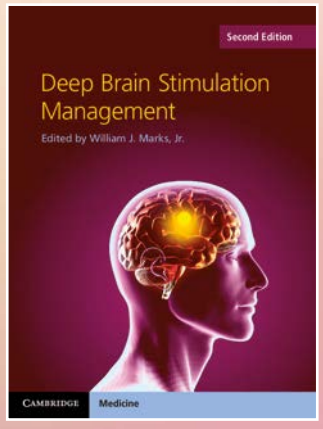

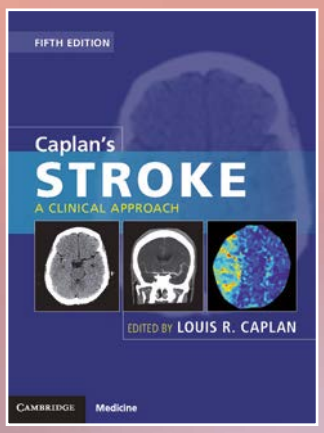

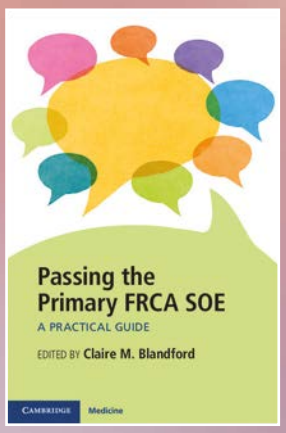

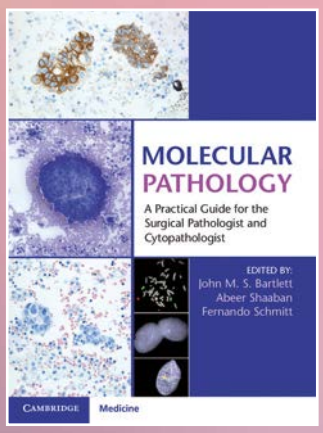

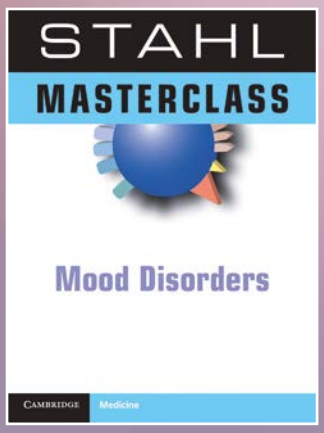

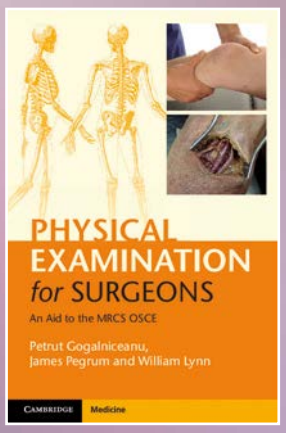

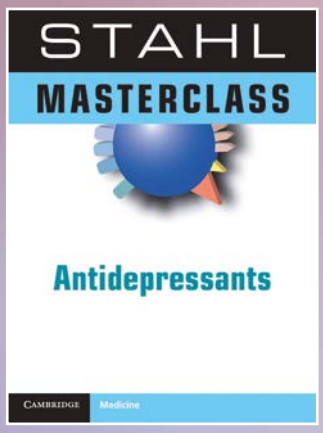

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FROM THE EDITOR

"IT WAS the worst thing anyone would want to hear." This is how Martin Bromiley recalls the moment he was told that his wife was in intensive care after a routine sinus operation went tragically wrong. Elaine Bromiley died two weeks later.

What happened next was entirely unplanned but had much to do with Martin's training as an airline pilot. In the aftermath of the incident he applied his experience of human factors training in the aviation industry to try and make sense of what took place – and this effort eventually led to the establishment of the Clinical Human Factors Group (CHFG), a charity dedicated to reducing the incidence of human error in healthcare. On page 14 he tells journalist Adam Campbell his story.

NICE is not without its critics, with some GPs in particular accusing the organisation of being detached from the everyday reality of primary care in some of its guidance. In our Q&A on page 10, NICE chair Professor David Haslam addresses some of these criticisms and discusses other challenges facing the organisation in the future.

An estimated £1.4 billion will be paid out by the NHS Litigation Authority in the coming year in claims to patients in England – with over a third of the NHSLA budget going to the legal profession and most of this in so-called "adverse costs" to claimants' lawyers. MDDUS is also seeing an ongoing rise in litigation and associated legal costs, with a 17.9 per cent increase in claims intimated against medical and dental members across the UK over 2014.

On page 12 MDDUS CEO Chris Kenny sets out his strong support for Government plans to impose fixed recoverable costs for lower value clinical negligence claims to help reduce the rise in medical indemnity costs.

Dr Barry Parker

Cover image: **Impruneta 12.14, 12th June, James H. Fairgrieve**. Acrylic, 1976.

James Fairgrieve studied at Edinburgh College of Art between 1962 and 1968. After some time in London he returned to the college to teach from 1969-1998. Nature is a strong theme in his work, and he has exhibited many times over the years.

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit www.artinhealthcare.org.uk Scottish Charity No SC 036222.

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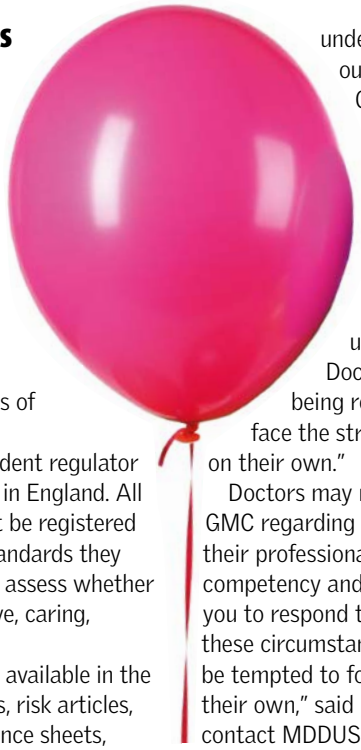
MDDUS launches CQC "toolbox"



A NEW CQC "toolbox" is now available on the MDDUS website to help members comply with quality and safety requirements. GPs and practice managers can browse a wide range of resources organised around the Care Quality Commission's five key lines of enquiry (KLOEs).

The CQC is the independent regulator for health and social care in England. All practices in England must be registered and meet the essential standards they have set out. Their KLOEs assess whether a practice is: safe, effective, caring, responsive and well-led.

Amongst the resources available in the toolbox are video modules, risk articles, practical checklists, guidance sheets, podcasts and interviews with experts.

New director of development at MDDUS, Mr David Sturgeon, said: "MDDUS is delighted to be able to provide our members with this toolbox to assist them in ensuring they meet the essential standards of the CQC inspection regime. The mixture of expert knowledge and practical checklists will help ensure a successful outcome and a positive message to patients of the quality of care provided by the practice."

Browse the CQC toolbox at **www.mddus.com**, within the Risk Management section. Members-only content will require log in with surname and membership number.

Don't face GMC complaints alone

Doctors facing a GMC complaint are urged to seek the guidance and support of MDDUS at the earliest opportunity.

"Being on the receiving end of a GMC complaint can be extremely stressful and it is natural for doctors to fear the worst," says MDDUS Joint Head of Medical Division Dr Anthea Martin. "While it is understandable to worry, in our experience very few GMC cases make it beyond written correspondence."

"Our team of medical advisers and lawyers has vast experience in assisting doctors with the stresses of being under investigation. Doctors are renowned for being resilient, but should not face the stresses of a GMC complaint on their own."

Doctors may receive a letter from the GMC regarding allegations made about their professional conduct or clinical competency and the regulator may invite you to respond to these allegations. "In these circumstances, doctors should not be tempted to formulate a response on their own," said Dr Martin. "They should contact MDDUS without delay; it is crucial that doctors seek advice before responding to the letter."

Of the 8,884 complaints received by the GMC in 2014, 30 per cent (2,750) went to a full investigation but, of those, more than half (51 per cent) were closed with no further action. For all the other complaints (6,134) dealt with by the regulator, 89 per cent (5,500) were closed immediately.

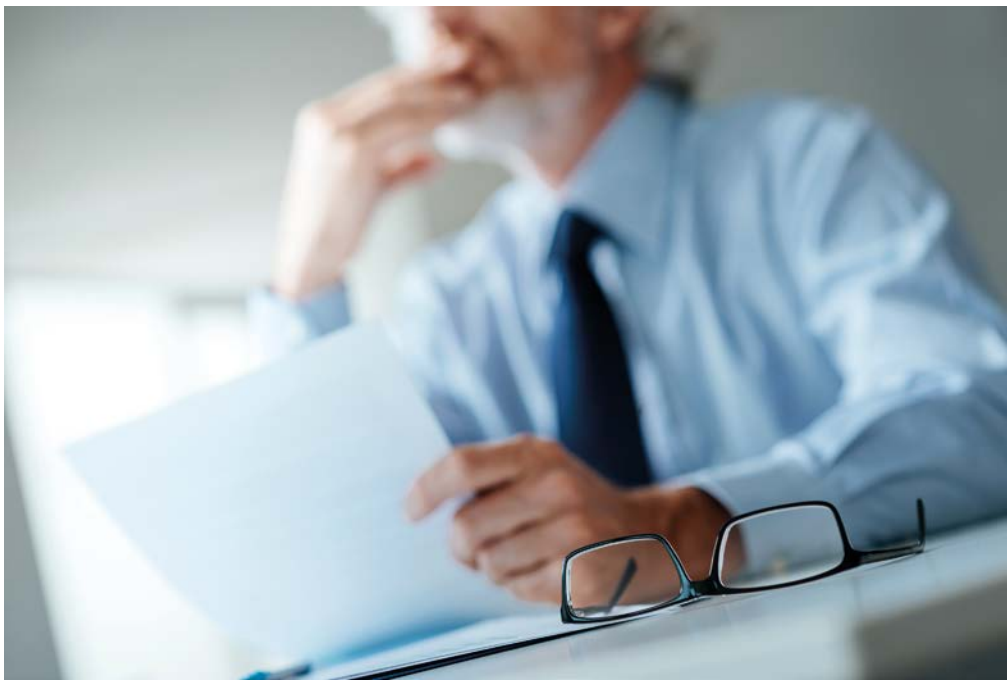
GDC challenged to turn aspiration into action

MDDUS welcomes the GDC's plans to improve the current complaints system and reform fitness to practise procedures for dentists facing investigation.

The GDC announced a three-year strategy entitled *Patients Professionals Partners Performance*. The document sets out a number of key objectives to improve dental regulation.

"MDDUS welcomes the GDC's commitment to a faster, more streamlined and transparent service," says MDDUS chief executive Chris Kenny. "We will work with the GDC to help them deliver a regulatory system that better serves patients and dentists.

"Complaints continue to rise and we agree that wider reform is needed to improve efficiency, transparency and



IN BRIEF

● **LEADING THROUGH UNCERTAINTY** Places are still available on MDDUS Risk Management's popular Leading Through Uncertainty course, developed specifically for doctors with management responsibilities. The week-long programme will run from May 9-13, 2016 (inclusive) at the MDDUS Glasgow office. The cost is £495 for members and £595 for non-members. Contact the Risk team at 0845 270 2034 or **risk@mddus.com**

● **NEW EPISODE OF BLEAK PRACTICE** The third instalment in our popular video learning module is now available to MDDUS members. It follows on from the characters and events introduced in the first two modules – this time focusing on risks in prescribing. A downloadable discussion guide is available to help PMs and GPs take their team through the risk areas. Members can access the video in the Risk Management section at **www.mddus.com**

Complaints from grieving relatives

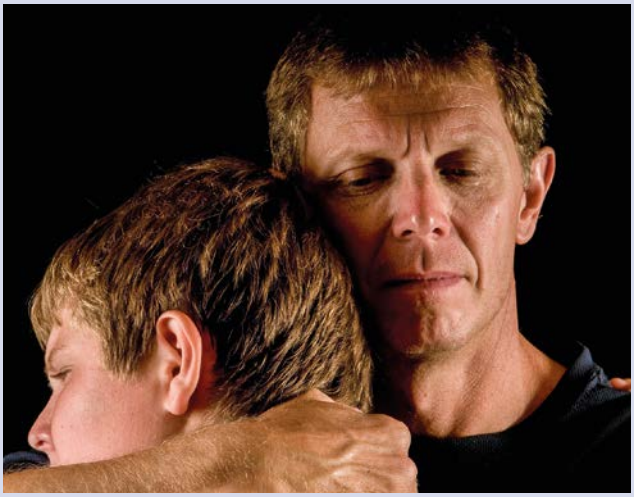
COMPLAINTS are an everyday fact of life and at MDDUS we assist thousands of members from all areas of practice with advice about the most appropriate way to move forward. Complaints from grieving relatives can be among the most difficult to respond to. These may involve individuals who you have not encountered before, challenging the care and treatment of their loved one and making allegations about your standards of practice. Not having an existing relationship with the complainant can compound difficulties in an already emotionally charged situation.

Poor handling of such complaints is likely to lead to protracted correspondence, failure to resolve the issues, escalation of the complaint and missed opportunities to improve practice. Responses require sensitivity and tact, thorough investigation and clarity in replying. Many practitioners can feel very defensive when dealing with such cases and their own emotional response can interfere with their engagement in the process. In some cases, respecting the confidentiality of the patient can also be a barrier and this aspect needs careful handling.

When formulating a response there are some basic steps to consider. The opening must be polite and conciliatory. Put yourself in the position of someone who is grieving and has concerns about a loved one's care. What reply would you expect to receive? The first paragraph will probably have the greatest influence on the reader. The complainant may have had no prior knowledge of the practice or the doctors being complained about – their main impression may be determined simply by the tone of the reply letter.

In regard to content, it is essential to identify all the issues the complainant wishes to have addressed. If in doubt, list the issues you have identified from the complaint and then detail the steps taken to investigate these issues: for example, a review of medical records, discussions with staff, the obtaining of reports, etc. These should be clearly described. All of the issues identified in the complaint must be addressed. If a numbering system has been used in the initial identification of concerns, it is helpful to use the same numbering system for the response. This aids clarity and avoids errors in omitting to comment on pertinent matters. Increasingly, significant event review (SER) forms part of an initial investigation and there are many templates available online which are clear and straightforward to follow.

Be aware of the emotions of the complainant throughout your response, including the potential impact of terms and expressions used. It is best to write in full and proper English;



avoid using "medical speak".

Some of the draft responses we see at MDDUS can be too defensive: for example, they focus on statistics which show how good the practice is, or counter negative comments about members of staff by stating that no one else has ever complained. Complainants who are already upset at having lost a relative or friend may become even more distraught if a response does not deal with the issues raised. Any reply which appears to avoid answering difficult questions will only inflame matters further.

Responses should always include an offer to meet with relevant practice staff – or to discuss alternatives to a meeting if this is not practical because a complainant lives in another part of the country. All responses should also inform the complainant of their right to raise concerns with the ombudsman (along with contact details) if they are dissatisfied with the practice response.

Time and effort spent on an initial reply is more likely to resolve a complaint. A hasty or incomplete investigation – revealing a lack of proper attention to detail – may compromise early resolution and increase the likelihood of extensive corrective recommendations from the ombudsman and risk escalation of the complaint to the GMC. It is noteworthy that a significant number of GMC cases arise where there have been communication difficulties between doctors and grieving relatives.

Members should seek MDDUS advice where a complaint requires significant investigation.

Dr Gail Gilmartin is a senior medical and risk adviser at MDDUS

decision making in their fitness to practise process. The challenge now is to turn aspiration into early action in order for the plan to be credible and effective."

MDDUS has seen a significant increase in the number of members subject to investigation by the GDC in recent years (up 37 per cent in 2014), the vast majority of which lead to no action.

"The often unjustified threat of regulatory action can destroy careers and reputations. We support steps that will make the process less stressful for dentists and reduce the number resulting in a final hearing," says Kenny.

RAISING SAFETY CONCERNS
Explore the issues around raising concerns over patient safety in this new video module. Senior risk adviser Liz Price examines the duties set out by the GMC and GDC, and reviews commonly raised issues. She goes on to explore why raising concerns is still so difficult despite all of the protections in place. Members can access the film in the eLearning centre in the Risk Management section at **www.mddus.com**.

BMJ AWARDS SHORTLIST
The shortlist has been published for the 2016 BMJ Awards, held in association with MDDUS. There are 14 categories recognising excellence and innovation in patient care delivered by teams across the UK, with MDDUS sponsoring the Primary Care Team award. Winners will be announced at a ceremony on May 5 in London. Read the full list of nominees in each category at **tinyurl.com/hld8llg**

Report urges better recognition of sepsis

AN NHS England report into the death of a young boy from septicaemia following a chest infection is urging better recognition of signs and symptoms of the condition by NHS staff.

The report on the 2014 death of William Mead from Cornwall identified numerous missed opportunities to diagnose his condition by GPs and NHS 111 advisers.

Lindsey Scott, director of nursing with NHS England in the South West, is quoted on the *BBC News* website, saying: "Everyone involved in this report is determined to make sure lessons are learned from William's death, so other families don't have to go through the same trauma."

She added that staff at the local NHS 111 service had since been given extra training to recognise when cases might be more complex and need referring up.

A range of clinical toolkits for doctors and other healthcare professionals can be found on the UK Sepsis Trust website. New NICE guidelines on the recognition, diagnosis and management of severe sepsis are due out in July 2016.

Tighter EU rules to bar "rogue" professionals

NEW rules governing the free movement of health professionals within the European Union have come into effect, including a warning system to guard against "rogue" doctors and dentists practising in the UK.

Healthcare regulators across the EU will now have to warn all other member states when a health professional is banned or their practice restricted. The new rules are intended to prevent "rogue" professionals from "job shopping" around Europe.

The Mutual Recognition of Professional Qualifications (MRPQ) Directive also introduces stronger language controls and updated minimum training requirements for healthcare practitioners. The updated legislation, which governs the free movement of professionals around the EU, will make it easier for qualified healthcare professionals to practise in other member states, while ensuring they are competent to do so through appropriate checks and procedures.

The Department of Health is currently considering new UK law which will underpin these changes.

Elisabetta Zanon, Director of the NHS Confederation's European Office, said: "More than any other country in the EU (with the tiny exception of Luxembourg) the UK relies on doctors, nurses and other health professionals trained elsewhere. We couldn't run the NHS without them. So we welcome moves to cut red tape and encourage people to relocate.

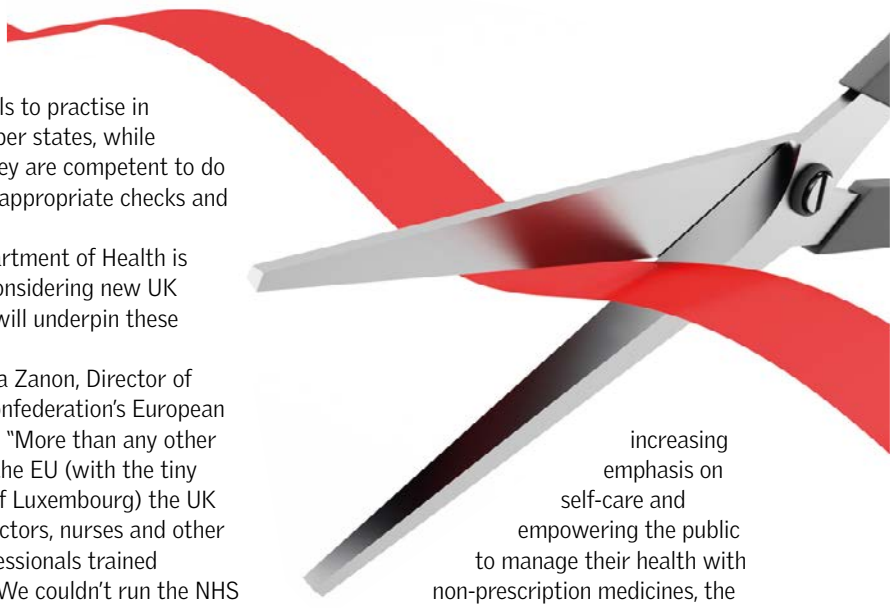
"It's vitally important that patients are protected from unsafe practitioners as people's lives are in their hands. That's why the NHS European Office fought hard for this legislation to include a warning system. It means that, in future, regulatory bodies across the EU will have to alert each other within three calendar days about any registrant who has been banned from practising, even temporarily."

Vigilance needed in non-prescription medicines

A RECENT study has highlighted the need for clinicians to be mindful of the potential abuse of non-prescription medicines (NPMs), particularly among patients with chronic pain.

Researchers in Aberdeen surveyed 1,000 individuals and found a lifetime prevalence of NPM "misuse" of over 19 per cent and "abuse" at 4 per cent. Predicative factors for misuse/abuse of NPMs were younger age, long-standing illness requiring regular NPM use and ever having used illicit drugs or legal highs. Dependence was reported with analgesics, sleep aids and nicotine products.

The study published in the *Journal of Public Health* concluded: "Given the increasing emphasis on self-care and empowering the public to manage their health with non-prescription medicines, the findings highlight the need for improved pharmacovigilance of these medicines to maximise benefits with minimal risk."



GDC reforms aim to reduce stress and cost

THE introduction of case examiners in dental fitness to practise procedures should lead to reduced stress for some dentists and dental care professionals (DCPs) subject to GDC complaints. This is the intention behind planned reforms by the regulator now out for consultation.

Case examiners will be empowered to agree undertakings with some dentists and DCPs where this is proportionate and in the public interest, thus avoiding full practice committee hearings. Such undertakings might involve an agreement to help a registrant meet the required standards through additional training, allowing the person to practise under supervision of another registered dental professional or by allowing them to work if they meet certain conditions.

Applicable cases will still be subject to hearings but the GDC estimates that reducing the number of such cases could generate savings of £1.8 million per year.

Commenting on the plans, Director of Fitness to Practise at the GDC, Jonathan Green, said: "The consultation is a further

IN BRIEF

● **SCREENING IN BOWEL CANCER** Bowel cancer is more likely to be detected early by screening than with GP referral or as an emergency presentation, according to a new study published by Cancer Research UK and Public Health England. It was found that 37 per cent of cases picked up by bowel screening were caught at Stage 1 with eight per cent at Stage 4. This compared to 22 per cent of diagnoses being Stage 4 after referrals from GPs and 40 per cent at Stage 4 on emergency presentation. Access the full study at **tinyurl.com/h87w9by**

● **BRUSH TIME** A new programme to teach proper tooth brushing technique to nursery and school children has been launched by the British Dental Health Foundation. Brush Time has been developed to help nursery and school staff teach children how to brush their teeth correctly and offer effective oral health lessons. Access at **www.dentalbuddy.org/**

step to modernise the way we run our fitness to practise caseload.

"When someone is being investigated by the GDC, we recognise this places the person under considerable stress and anxiety. While we absolutely have a duty to protect patients by taking swift action against those who should not be practising dentistry, we must make the entire process as efficient, seamless and timely as possible by providing the necessary support.

"Introducing case examiners with a power to agree undertakings with practitioners means that we will see more complaints dealt with without the need for a practice committee hearing. This should lead to significant reduction in stress for practitioners, as well as ensuring that suitable cases are resolved earlier and with less expense."

It is expected GDC case examiners will start making decisions in late summer 2016. Go the GDC website to access the consultation which runs until 14 March.

Dentist sanctioned over counterfeit equipment

SEIZURE of more than 100 counterfeit and non-compliant items of dental equipment has landed a dentist in front of a GDC fitness to practise panel.

An investigation by the Medicines and Healthcare products Regulatory Agency (MHRA) found that a West London dentist had purchased and permitted the use of the illegal dental equipment at 14 dental practices.

The findings of this investigation were subsequently referred to the GDC and in a public hearing held on 18 January a Professional Conduct Committee (PCC) found the dentist's fitness to practise impaired by reason of his misconduct.

The MHRA has been working with the British Dental Industry Association (BDIA) and the GDC to monitor the use of substandard, counterfeit and illegal medical equipment and to promote awareness of the dangers that they present to patients and operators.

Alastair Jeffrey, Head of Enforcement, MHRA said: "Dental patients are entitled to expect quality care, including the standard of the instruments and devices used by dental professionals.

"It is vital that dentists and dental staff buy equipment from bona fide suppliers and avoid unapproved or counterfeit devices. I urge all dental professionals to be cautious of seemingly cheap devices which may be unfit for purpose and potentially dangerous to patients and the staff that use them."

Tailored advice needed on sunlight exposure

NEW NICE guidance published last month highlights the need for balancing risks against benefits when advising patients on exposure to sunlight.

Sunlight exposure – risks and benefits **acknowledges that communicating this balance poses a challenge to healthcare professionals. Exposure to the sun can boost vitamin D levels but too much time spent in the sun increases the risk of skin cancer.**

NICE has made 18 recommendations including the need for professionals to offer one-to-one advice tailored to an individual's level of risk and the creation of effective national and local media campaigns to emphasise how the risks and benefits of sunlight will vary depending on a range of factors.

Professor Gillian Leng, deputy chief executive and director of health and social care at NICE, said: "How much time we should spend in the sun depends on a number of factors including geographical location, time of day and year, weather conditions and natural skin colour.

"People with lighter skin, people who work outside and those of us who enjoy holidays in sunny countries all have a higher risk of experiencing skin damage and developing skin cancer. On the other hand, people who cover up for cultural reasons, are housebound or otherwise confined indoors for long periods of time are all at higher risk of low vitamin D levels.

"We need to better identify groups at risk of over or under exposure to sunlight and give them better understanding of why they may need to modify their behaviour and how."

Access the new guidance at www.nice.org.uk/guidance/ng34

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brushtime/

- **ALCOHOL-RELATED DEATHS** The UK saw only a slight rise in alcohol-related deaths in 2014 to 14.3 per 100,000 population but this is still almost double the number recorded in 1994, according to figures published by the Office for National Statistics. There were 8,697 alcohol-related deaths registered in 2014 compared to 8,416 in 2013. Over 65 per cent were among males with rates highest among 55 to 64-year-olds.
- **COST-SPECIFIC TEXTS** Patient reminder text messages highlighting the specific cost of missed appointments helped reduce non-attendance by almost a quarter, a Department of Health study has shown. Telling patients how much money would be lost proved most effective. Almost 10 per cent of outpatient appointments are missed in England every year costing the NHS up to £225 million.

PRESCRIBING SYSTEM ABUSE

Gail Gilmartin

FOR most patients, obtaining a prescription is a straightforward and simple matter. Indeed for the most part it is also a simple matter for a practice to produce prescriptions. However, on closer examination, prescribing systems can be highly complex. Taking care not to make accidental errors is repeatedly emphasised but less attention is paid to the risk of abuse of a system – be this by patients or staff. Unfortunately, abuse of prescribing systems is not rare and in some instances such abuse can go on for a significant time before coming to light.

Prescribing a medication can be split into five steps: source, generation, transmission, dispensing and delivery. Prescription requests are generated from a variety of sources including direct requests, from a list of repeats, from hospital letters or during consultations. They come in different forms and may be handwritten or electronic, transmitted by staff, patients or others, and dispensed and delivered by a variety of different methods and individuals. At any one of these stages the system can be abused by staff, other colleagues, patients or anyone acting on their behalf.

When staff members are involved it may be opportunistic, for example when medicines are handed back in by patients and kept for personal use rather than being properly disposed of. In other cases there may be a clear and systematic approach to obtaining prescriptions/medicines by deceit.

Such abuse, once discovered, can have a major impact on a practice. Falsified medication records can result in significant adverse consequences for both patients and professional staff, with regulatory investigation (and possibly suspension or erasure) or even police involvement. Misuse of the system necessitates investigation and review which can be very time consuming and distressing.

Examples of cases handled at MDDUS typically involve:

- lack of a process to properly identify those requesting or picking up a prescription/medication
- staff adding medication to patient records then keeping it
- doctors using medication issued in patient names
- patients/relatives altering a prescription by adding more items.

Points to consider

In prescribing, as with many practice systems, much depends on goodwill and trust. Imposing strict restrictions and checks may not be practicable – but it is essential to have proper processes in place. Here are some points to consider:

- How are anomalies highlighted?
- Is there robust incident reporting?
- Is there a clear policy regarding SEAs and is this used for prescription incidents?
- What if prescriptions go missing?
- Is there any audit of errors identified by the pharmacy?
- Are prescription pad serial numbers logged?
- Do staff pick up prescriptions for patients? Is there a protocol for this in your prescribing policy?
- Are repeats still issued when review dates are passed?
- Can the computer be overridden? Is this logged with reasons?
- Can repeats be initiated by admin staff? Are there controls in place?
- Do the same controls apply to nurse-generated prescriptions?

Every practice should have a written prescribing policy that is properly implemented and reinforced with adequate staff training at all levels. Any anomalies should be audited and, where appropriate, a significant event review should be undertaken, again to include all staff. In this way policies can be emphasised and reviewed with everyone. Intermittent audits of prescribing trends can be a useful way to monitor prescribing and can pick up unusual patterns.

Health matters

Cases where staff misuse prescribing systems can often trigger complex medico-legal investigations, notably involving the regulator. In many cases the misuse will have continued for considerable periods of time without being picked up. Usually this will be the result of underlying ill health where medication is obtained under false pretences – perhaps first to control symptoms then leading to dependency and addiction. It is worth noting here that if a GMC/GDC investigation is in relation to a health matter solely this cannot result in the erasure of the doctor/dentist.

Practices are always concerned to note the duration of the misuse – and how long they have been unaware. In many cases a controlled prescribing system, involving audit, would have picked up anomalies. Early detection is in everyone's interest.

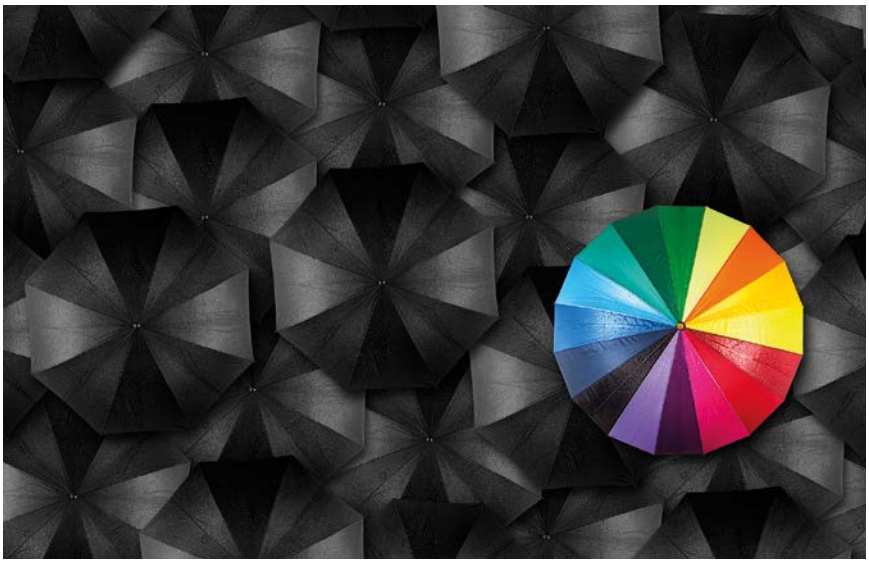
In summary, consider two questions: if someone is misusing your prescribing system would you know, and can you closely monitor how well it is working?

In any case of doubt MDDUS advisers are happy to offer advice and guidance to our members – be they responsible for the prescribing system or if they find themselves in personal difficulties.

■ ***Dr Gail Gilmartin is a senior medical and risk adviser at MDDUS***

IDEAS ABOUT IDEALISM

Deborah Bowman



"Advice for aspiring medical students often cautions against unmitigated idealism"

THE question of idealism in healthcare in general, and in relation to its moral content in particular, has been preoccupying me. It is an ambiguous, slippery and yet recurrent concept in healthcare. The ways in which idealism is understood, represented and experienced are fascinating. There is, it seems, an ambivalence about idealism which is both surprising and somehow also inevitable.

From the earliest stages of a medical career, the delicacy of idealism and its "push-pull" place in healthcare are evident. Applicants to medical schools and to other healthcare courses will be asked about their motivations for wishing to join their chosen profession. They are expected to demonstrate compassion, empathy and a facility for care. Yet, they are also warned not to be too idealistic. The successful candidate balances idealism with realism. At my own institution, we explore whether an applicant appreciates the disadvantages and difficulties of embarking on a career in medicine. There are sound reasons for doing so: no one should embark on training without understanding the challenges of working as a doctor.

However, there is something else at play in the dance with idealism at which applicants must excel. Advice for aspiring medical students often cautions against unmitigated idealism, warning that the candidate may be perceived as insincere, naïve or clichéd. Applicants are urged to balance their commitment to care with a clear-sighted account of the challenges of healthcare in the 21st century. Is it possible to be idealistic and realistic? Are they qualities that can be held in tandem or does one preclude, or at least inhibit, the other?

Further insights into the curious place of idealism in healthcare can be found by looking at what happens to students and junior staff. The literature suggests that many commonly experience the diminution of their ideals and ethical standards in their training and/or clinical practice. This phenomenon is well-described and has been observed in different countries, healthcare systems and stages of training. It is an experience that students often discuss informally in ethics sessions, sometimes with considerable emotion. They recognise that there has been a change in them. They struggle with the tension between what they believe they should do and what it is possible to do within the constraints of the system. It can be painful and lead to moral distress if there is no one to support them as they navigate the demands of systemic pragmatism during the long years of education and training. In contrast, for some, the diminution of idealism is something of a badge of honour denoting experience and someone who knows whereof he or she speaks.

That pragmatism supersedes idealism is not surprising nor is it necessarily problematic. In any role or job, as one becomes experienced, one has to find ways in which to cope with the demands and competing priorities of the role. Few positions exist in optimal conditions in which to work: our professional lives are inevitably shaped by imperfect systems, professional frustrations and difficult choices. However, it is important to reflect on where idealism fits into our professional lives and we do it too rarely. That we choose not to reflect on, or discuss, idealism as often as we might is perhaps because we sense its capacity to influence the quality of our work and we fear the effects of its loss both on us and on those whom we serve.

I was particularly struck by the ways in which clinicians recognise the power and significance of reflecting on, revisiting and even reclaiming idealism at two events for doctors at which I was a speaker. One was a day-long conference with the theme of compassion held at the Royal Society of Medicine in London and the other was the innovative DotMED conference. Each meeting was oversubscribed and populated with delegates from a wide range of backgrounds and locations. On each occasion, I was struck by the number of times I heard individuals speak about the restoring effect of attending those meetings. Many said that they had been motivated to attend because they wanted, or even needed, to be reminded of what had originally brought them into medicine or dentistry or nursing. These were individuals who recognised that something had changed or was at risk of changing, and they were seeking to protect themselves against its effect both for them and their patients.

Of course, we all function on a spectrum ranging from idealism to cynicism, with pragmatism and realism somewhere in between. We will probably move back and forth on that spectrum depending on what is happening in our lives and where we are working. But it is worth keeping an eye on the direction of travel and remembering where we began our professional journeys. In an ideal world, obviously.

■ ***Deborah Bowman is Professor of Bioethics, Clinical Ethics and Medical Law at St George's, University of London***

Working within limits

Professor David Haslam talks about the challenges of his role as chair of NICE and his belief in the importance of individualised, patient-centred care

PROFESSOR David Haslam's career has spanned five decades and has seen him take on some of healthcare's most high profile leadership posts. He practised as a GP in Cambridgeshire for almost 40 years and took on the role of chair and then president of the Royal College of GPs, as well as vice chair of the Academy of Medical Royal Colleges. He was president of the British Medical Association before moving in April 2013 to his current post as chair of the National Institute for Health and Care Excellence (NICE). His commitment to medicine and healthcare was recognised in 2004 when he was awarded the CBE.

Much of the 66-year-old's work has been in shaping medical education, including two years as chair of the Modernising Medical Careers Programme Board from 2007. A prolific writer, he has authored 13 books and well over a thousand articles for both the medical and mainstream press. He lives in Dorset with his wife, and has two children and three grandchildren.

What do you think NICE does well as an organisation?

The critical thing for an organisation like NICE is that people should trust us. I think we generally achieve that by being as transparent as we can be, by involving patients and the public, working with professionals and using evidence. Most people understand that in every healthcare system in the world there are limits to what it can afford and there will always be more demand than resources to pay for it. This is an incredibly difficult situation in an area such as health but NICE has a reputation for taking some of these issues on in a way the public and professionals can trust.

In what areas could NICE be improved?

One growing problem area we have identified is patients with numerous healthcare problems. We are currently working on guidance on managing multimorbidity that will be published late 2016. We've already produced guidance on medicines optimisation, for people on numerous medications. For those with multiple health problems – maybe as many as eight or nine long-term conditions – it's not just a question of adding all the different guidelines together, you have to work with patients using professional judgement and shared decision-making. Personalising care for the individual is critical.

What are the main challenges of leading an organisation such as NICE?
The initial challenge was understanding the full breadth of what NICE does. We deal with everything from drugs for ultra-rare conditions, to technology appraisal work looking at new treatments, right through to social care quality. I hadn't realised how great NICE's international reputation was and how much other countries are interested in what NICE does. I was also pleasantly surprised at our relationship with the pharmaceutical industry. I think most now trust and respect the way NICE works, even if they sometimes disagree with us.

How do you respond to criticism of NICE for its refusal to approve certain treatments?
I completely understand how emotive this area can be but I'm also very aware that with extremely expensive treatments the money can only be spent once and if you spend it in one way, it cannot be spent in another. It's very important that in any system money isn't reserved for the people who make the most noise. We have to look after people with a full range of conditions. We are a rational organisation, rather than a rationing organisation.

You have held talks in recent months with GP leaders on ways to make NICE guidelines easier to deliver in primary care. How can improvements be made?
Coming from a lifetime as a GP, I completely understand some of the issues raised. Not only am I holding meetings with representatives from general practice to look at how we can best support GPs, but we've had a lot of feedback about the need for simple summaries that can be used rapidly. I am keen on NICE guidance being adapted for use within decision-support software and clinical software used by GPs – not in a way which templates or forces GPs to work in a particular way, but provides them with the necessary information in a straightforward manner. When we put draft guidance out for consultation we do genuinely want feedback. Sometimes our stakeholders tell us they don't agree with us, at which point, where appropriate, we will change. Sometimes the media calls that a U-turn but I call it doing our job properly.

Some critics have accused NICE of being detached from reality in some of its guidance. Is that unfair?
I understand the frustration. I think sometimes people get irritated through a misunderstanding of what we have said. For instance, with the statins issue [in 2014 when NICE lowered the risk threshold for prescribing] the threshold change came about because the price of statins dropped very considerably, so the point at which it was cost effective to offer statins changed. Our guidance emphasises the importance of doctors talking with their patients about lifestyle issues such as smoking, exercise and alcohol. If having done that, at certain risk levels if their patient still thinks they would like to take statins then, because of the change in price, the threshold has changed. That absolutely isn't what some newspaper headlines reported at the time. The change of the threshold was applying to people with pre-existing hypertension and diabetes where they are already coming for check-ups. This was not a question of NICE saying "one in 10 of the population must now attend their doctor."

Is NICE doing its best to engage with GPs?
I try to speak to as many GP conferences as I can, write articles

"We are a rational organisation, rather than a rationing organisation"

for general practice, take any criticism on the chin. If we're getting it wrong I need to know. I believe we are making a difference. A lot of problems tend to come down to misunderstandings. I know general practice is under incredible pressure at the moment and anything that seems like advice about something else to do is the last thing people want. Fundamentally, what NICE does is look at all the research and evidence available on a given topic and presents that in a way that will be helpful to practitioners. If NICE wasn't there, somebody else would need to do it.

How can NICE encourage more GPs to work on guidelines panels?
One of the first things I did as chair of NICE was to increase the reimbursement but I completely understand how busy GPs are. We do get a lot of GP representation on our committees and I find it slightly frustrating when doctors say to me "yes, but they're not real GPs". It's almost as if becoming interested in either an academic focus or working with NICE makes them inappropriate to represent GPs. There's a real catch-22 there.

You are often named amongst the most influential figures in the NHS. What are your priorities in using that influence?
Again, for me the critical areas relate to multimorbidity and patient-centredness. We're really working in that direction and I'm very positive about it. If we manage to achieve a balance between the best of evidence-based medicine and the best of person-centred medicine then that will make a fundamental difference.

What has been your proudest professional achievement so far?
Up until I stopped practising as a GP about four years ago, I must have carried out about 250,000 consultations. For me, they are my most important achievement.

■ *Interview by Joanne Curran, associate editor at MDDUS*

MDDUS Chief Executive Chris Kenny *urges support for Government proposals to curtail rising legal costs in clinical negligence claims in England*

Taking action on spiralling

THE UK is becoming more litigious – there is no disputing this fact. We are seeing not only a rise in the number and value of clinical damage claims but also in associated legal costs.

Last year the NHS Litigation Authority (NHSLA) paid over £1.1 billion in claims to patients in England and this year it will be an estimated £1.4 billion. Over a third of the NHSLA budget is paid to the legal profession and most of this as so-called "adverse costs" to claimants' lawyers.

MDDUS is also seeing an ongoing rise in litigation with a 17.9 per cent increase in claims intimated against medical and dental members across the UK over 2014. Subscription rates and the cost of indemnity are directly affected by the uncontrolled growth in adverse costs levied in claims by claimant lawyers. These are often more than six times those of defendant costs and in some cases 10 times.

Fixed recoverable costs

Last December I wrote to the Parliamentary Under Secretary of State for Health, Ben Gummer, in advance of a proposed consultation to impose fixed recoverable costs for lower value clinical negligence claims. The Government is proposing to introduce fixed recoverable costs for all cases where a letter of claim is sent after 1 October 2016 and this would apply in clinical negligence cases possibly up to a value of £250,000 in damages. A recent pre-consultation document reported that claimant legal costs for cases managed by NHSLA in 2014/15 amounted to 83 per cent of damages awarded for claims between £50,000 and £100,000, and nearly 300 per cent of damages awarded for claims between £1,000 and £10,000. That's a lot of money being diverted from patient care – and from the wallets of MDDUS members.

In my letter to Mr Gummer I expressed our strong support at MDDUS for the early implementation of fixed recoverable costs and indicated our full commitment to ensure that money expended in compensating for clinical accidents should, as far as possible, find its way to the injured patient and not disproportionately to the lawyers supporting those patients' claims. MDDUS General Counsel Simon Dinnick and I reinforced these points when we met Mr Gummer at the end of January and felt that we had a good hearing.

More than half our members are GPs, GDPs and private practitioners working in England and Wales. Their subscriptions and their cost of indemnity are directly affected by the uncontrolled growth in adverse legal costs. This, in turn, adds to pressure on health expenditure generally with no discernible benefit to the bulk of patients. The pressure may be more visible in relation to the costs of hospital services via the Clinical Negligence Scheme for Trusts (CNST) but it is also a real issue in relation to primary care, a fact of which we know Government and NHS England are acutely conscious.

We have long believed that the object of a fair system for resolving clinical negligence claims should be timely, proper and just compensation for those wrongly damaged. We have had concerns for some time that the distortion in the ratio between damages and claimant costs levels is having an adversely disproportionate and harmful effect, particularly, but not exclusively, in lower value claims.

MDDUS' experience in this field mirrors the published data from the NHSLA, both as to increasing claims frequency and the ratio of costs to damages. It is by no means unusual for costs to exceed damages by a very substantial degree, even if the claims are promptly settled with the minimum necessary investigation. This is due to the very considerable front-loading of legal costs by claimant lawyers before a claim is even intimated to the practitioner. There is no opportunity to control this cost despite robust case management by the courts and strong claims-handling procedures, proactive acceptance of liability where intimated and considerable risk management and educational work in the wider field by indemnifiers and the NHSLA.

We can quote examples of cases where claimant lawyers' bills

legal costs

have vastly exceeded damages awarded. In one particular case of alleged delayed diagnosis of breast cancer, we negotiated a settlement on behalf of our member for the sum of £35,000 but the claimant submitted costs of over £200,000, which was eventually settled for £170,000. In another case involving a poor outcome from mastopexy, we settled for £3,000 but the claimant costs amounted to £118,000, of which solicitors' costs were in excess of £70,000. These are but two of many examples.

"We acknowledge the need for fairness and access, especially in more complex higher-value claims"

Jackson reforms and LASPO

MDDUS recognises that other reforms have begun to address some of these issues. In April 2013 the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 took effect in response to proposed reforms in civil litigation costs by Lord Justice Jackson. LASPO abolished the recoverability of "success fees" from defendants where the claimant entered into a conditional fee agreement (CFA) or so-called "no win, no fee" arrangement. Now it is the claimant who must pay the success fee and this cannot exceed 25 per cent of the damages (excluding damages for future care and loss).

MDDUS believes that such reforms – although welcome – are unlikely to achieve the necessary controls on unwarranted cost. Moreover, LASPO has in one important respect made the situation worse by introducing qualified one-way costs shifting (QOCS). This allows a claimant to recover costs from a losing defendant but bars a successful defendant recovering costs from a losing claimant. QOCS means that the NHS and defence organisations like MDDUS cannot reclaim the costs expended on rebutting wholly spurious claims.

In addition, the extended transition period for LASPO changes has had the effect of increasing the volume of tendentious and poorly prepared litigation in the short-term, an effect totally at odds with Parliament's intent in passing the legislation. We can see a similar effect starting to happen in relation to the proposed new changes, so it will be important for Government to implement quickly and cleanly to stop a similar bubble of dubious claims emerging again.

MDDUS therefore strongly supports the introduction of a fixed recoverable cost scheme, especially for lower value claims. We acknowledge the need for fairness and access, especially in more complex higher-value claims in which costs restrictions might provide a disincentive for solicitors to offer services in clinical negligence and thus restrict access to justice for patients. But excessive outlay in claimants' costs needs to be curtailed. Access to justice should not be confused with unlimited licence to lawyers.

Wider reform

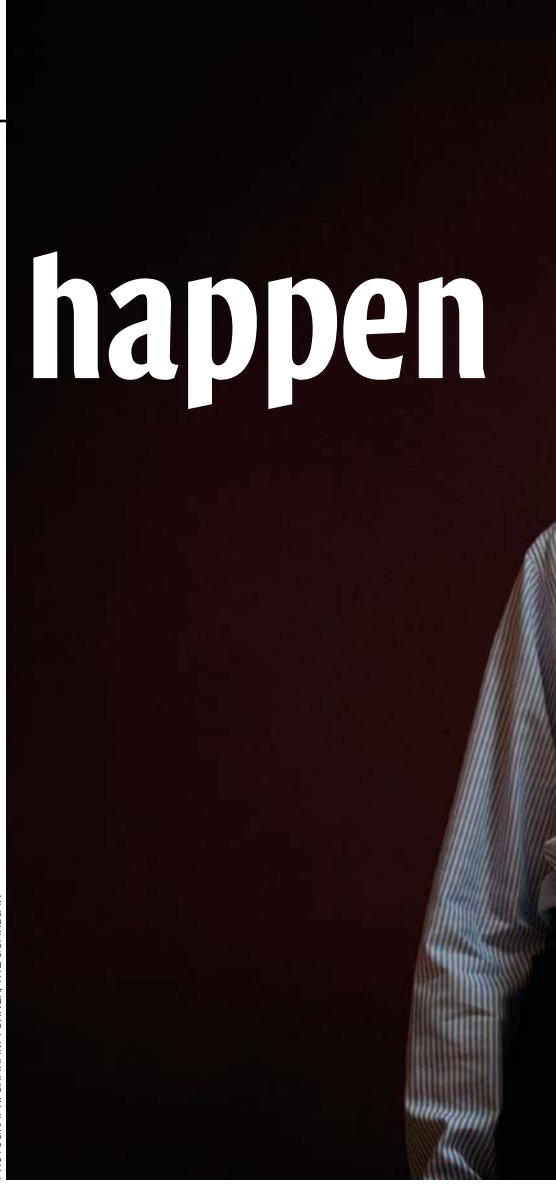
Fixed recoverable costs for lower value claims is just one measure among others. At MDDUS we are doing what we can to curtail escalating legal costs, including more robust case handling, rejecting claims that have no merit and challenging legal costs. We are also committed to promoting greater risk awareness and education among our members to reduce patient harm, and better communication and complaint handling to prevent patients feeling that their only recourse is through the courts.

MDDUS also believes there is a case for wider reform in civil litigation and we are urging Government to explore further legislative means to prevent the continued escalation in legal costs – but this current vital step regarding fixed recoverable costs should not be delayed whilst a more comprehensive package is prepared.

■ *Chris Kenny is CEO of MDDUS*

Accidents will happen

Adam Campbell *learns how personal tragedy led airline pilot Martin Bromiley to found a charity dedicated to reducing the incidence of human error in healthcare*



PHOTOGRAPH: GRAHAM TURNER/THE GUARDIAN

"IT WAS the worst thing anyone would want to hear," says Martin Bromiley, recounting the moment he was told his wife, Elaine, was in intensive care. Only a few hours earlier he had dropped her off at a private hospital for a routine sinus operation. An airline pilot, Martin says that after the initial shock he very quickly went into "pilot mode".

"I thought the important thing now is that Elaine's life is saved. My focus for three or four days was very much about being there and doing the best I could to make sure that whatever could be done was done," says the 52-year-old.

It was 29 March 2005. Earlier that morning, at 8.35am, Elaine had been anaesthetised in preparation for the operation. Almost immediately things started to go wrong. Increased tone in her jaw muscles was preventing insertion of the laryngeal mask airway. Four minutes later her oxygen saturation had deteriorated to 40 per cent and attempts to ventilate her lungs continued to be unsuccessful. The consultant anaesthetist tried a tracheal intubation but this too failed.

By this time there were two anaesthetists, an ENT surgeon and at least three nurses in the room. Shocked at Elaine's vital signs and colour, one nurse went out and booked an intensive care bed. Another asked her colleague to fetch a tracheostomy set. Both of these measures were considered over-reactions by the consultants as they continued to attempt intubation. The bed was cancelled, the tracheostomy set unused. When an intubating laryngeal mask was finally inserted at 9am, Elaine had already gone 20 minutes with severe oxygen starvation.

At 11am, Martin got the call to say Elaine had been admitted to intensive care at a nearby NHS hospital. On arrival he was told she might have significant brain damage. A few days later, confronted by the reality of her situation, the decision was made to switch off her life support.

What happened next – a journey that would lead to the setting up of the Clinical Human Factors Group (CHFG), a charity dedicated to reducing the incidence of human error in healthcare – was entirely unplanned but had much to do with Martin's training as a pilot.

Not about blame

First there was his discovery that there was no plan to investigate the incident. The very idea was anathema to someone from the aviation industry. So he pressed the case, while making clear to the director of the private clinic: "this is about learning; it's not about trying to blame anybody. My thought at the time was that the clinicians did absolutely everything they could and that there might be some small lessons that could be learned".

The investigation and the subsequent inquest, however, highlighted numerous areas where things should have been done differently. Generally, there had been a loss of awareness of time, of the seriousness of the situation, a breakdown in the decision-making processes and in communication among the consultants. The nurses said they knew what was supposed to happen but they didn't know how to broach the subject.

Clearly, thought Martin, there were some rather large lessons that needed to be learned. "I recognised that here were failings that had to do with human factors and non-technical skills," he says – human factors being all the things that make people different from logical, predictable machines.

As a pilot, he was used to an industry where technical skills were rarely taught without an element of the non-technical. So that when pilots are taught about a new piece of equipment, for example, there will also be a discussion regarding why they might choose not to use it in an emergency, and how colleagues can help to make sure it is used effectively. "I suddenly realised that here was a safety-critical environment which doesn't seem to work in the way that other safety-critical environments work."

Spreading the message

With two small children to look after on his own, Martin decided to cut his flying time by 50 per cent. This meant he had the odd afternoon here and there, and he kept coming back to this question of human factors in healthcare. So he began talking to people about it – academics, policymakers, clinicians.

"I didn't really have a plan but over two years I built up a picture of some really good work going on in health. But these were really tiny pockets of work, and they weren't connected."

He'd seen a human factors group involving policymakers, academics and pilots develop in aviation in the 1990s, starting almost as a hobby, and eventually become part of the Royal Aeronautical Society, so he decided to organise a meeting in London. Perhaps testament to his powers of persuasion, 45 people from his list of 80 names turned up.

After that first meeting, it was suggested that if they were to keep it up they would need some kind of capacity for booking meeting rooms, paying expenses, and that

logically they should set themselves up as a charity. And so, with a £5,000 grant secured by Martin from the Health Foundation, the CHFG was born.

After discussions with his employer, he decided to continue flying at around half the time and dedicate the remainder, in an unpaid capacity, to spreading the clinical human factors message.

That was nine years ago, and in the intervening period the number of active supporters has grown to around 3,000 people across the UK. The CHFG run free seminars and conferences, publish guidance documents and illustrative health stories, and generally do their utmost to promote dialogue and sharing of their ideas across the healthcare spectrum. Their goal is to show that a better understanding of the role of human factors can have a significant impact on safety, quality and productivity.

In day-to-day terms, Martin explains, it's about encouraging a system that, for example, makes it difficult to give someone the wrong drug – through better labelling and more standardised storage procedures – and more acceptable to double-check with colleagues that it's the right drug, at the right dosage and by the correct route, even under pressure of time.

At bottom, he says, it's about having multiple lines of defence that take into account that "no matter how good or intelligent or knowledgeable you are, you can still get it wrong".

The NHS is a many-headed behemoth, of course, and the greatest challenge is altering policy. "A lot of my time is spent trying to persuade people at policy level about ways they can redesign the system to do it better. I'm not an expert, but what I can do is at least overcome some of the inertia and provide some motivation for people to go out and get that expertise."

There has been change over the years. Whereas at the beginning he would find about one per cent of clinicians had heard about human factors, nowadays it's a majority, even if they don't understand what it is. "The teaching of it is much more widespread, but we're still a long way from embedding it."

Thank you for speaking up

Embedding a human factors approach on the personal level, says Martin, begins by clinicians asking themselves: what can I do with my behaviour that's going to encourage people to be safe around me? One answer, he suggests, is to ask open questions. "You might walk into a situation and know exactly how to deal with it. But you should stop yourself and ask a more junior colleague, how do you think we should deal with this? It not only helps to develop them, but more importantly they might well see something you don't."

Another is to thank people for speaking up. "That encouragement is so important. I've had people saying to me when I'm flying, Martin, don't forget such and such. Half the time I think, yes, well I was going to do that anyway. But I say thank you, because I know that next time I might genuinely have forgotten and be about to make a complete idiot of myself.

"It's about humility because we are all so capable of screwing up. Safety in a complex world cannot be delivered by just one person, it has to be delivered by a team."

■ ***Adam Campbell is a freelance journalist and regular contributor to MDDUS publications***

Find out more about the Clinical Human Factors Group at ***http://chfg.org***

Lyme borreliosis –

Dr James Douglas *provides a useful summary of this rare but often debilitating condition*

LYME borreliosis (previously Lyme disease) is caused by a tick-borne spirochete and is an important zoonosis seen with increasing prevalence in Scotland and parts of England, including the New Forest. Primary Lyme borreliosis can easily be prevented by tick removal and the rash cured with antibiotics but the secondary disease has a gathering clinical reputation as a rare multi-system mimic.

Lyme disease was first described as an outbreak of juvenile arthritis in Lyme, Connecticut, in the USA in 1975. It has subsequently become widely prevalent across Northern Europe along with other tick-borne diseases, including viral tick-borne encephalitis (not yet reported in the UK). In Scotland approximately 200 people per year have new positive serology[1] but there is a much greater disease burden being reported by GPs who make the clinical diagnosis of erythema migrans (see image on page opposite). The exact prevalence of erythema migrans[2] is uncertain because the Lyme serology is negative. GPs, A&E, out-of-hours and relevant specialists all need to be aware of the presentations of Lyme borreliosis.

Prevalence and ecology

A survey of Scottish blood donors (n=1440) showed 4.2 per cent positive Lyme serology[3], although with regional variations in prevalence north and west. Highland has the highest percentage of seropositive donors at 8.6 per cent. The interpretation of these data is difficult but may indicate recovery by human host immunity in the healthy population of Scottish blood donors, who may be more likely to engage in outdoor activities. There are no case reports worldwide for transfusion transmitted Lyme borreliosis.

In Scotland, the Ixodes ricinus ticks transmits the Borrelia spirochete by attaching to the human host and injecting its stomach contents over about 24 hours. The tick can be widely distributed in affected areas including moorland, gardens and picnic sites[4]. It lives at ground level in bracken and grass, being passed around by rodents, birds, deer and sheep. The ticks attach themselves to humans on legs, behind the knees, in groins, armpits and the natal cleft; thus the patient may not recall a tick bite or rash. There is seasonal prevalence with peaks in spring and autumn. The ticks have a two-year life cycle.

The growing interest in countryside pursuits such as walking and camping may have increased the prevalence of Lyme borreliosis in humans. Occupational groups including forestry, estate, ecologists and outdoor instructors are at particular risk of infection.

Prevention of tick bites is the best way of avoiding Lyme borreliosis and an important public health message. Walkers should be encouraged to stick to paths and dress well-covered to prevent access to skin (e.g. trousers tucked into socks). Both children and adults should be checked for ticks after outdoor activities, especially in the hair and behind the knees. Ticks should be removed promptly with a special plastic removal tool and not with fingernails or ordinary tweezers.

Tick bites do not always result in borreliosis: at worst only 10 per cent of ticks are affected. Proper and prompt removal effectively eliminates the chance of Lyme borreliosis.

Presentation and early management

A rash on the legs or arms after exposure to ticks may be erythema migrans. Urban GPs need to consider late Lyme borreliosis in people with neurological or joint symptoms having returned from UK or other Northern European hotspots. Around 70 per cent of patients will give a clear history of tick bite and rash.

The classic bull's-eye rash of erythema migrans can be seen but this will evolve over days to coalesce into a red area around the tick bite site and may persist or begin to fade. The patient may be unable to adequately see their rash behind the knees or in skin folds. Allergic reactions to flying insect bites will usually be raised in contrast to erythema migrans. Lyme serology is unhelpful in diagnosing erythema migrans which is an entirely clinical diagnosis.[2]

Antibiotics should not be prescribed prophylactically for a simple tick bite. However, give 2-4 week courses of doxycycline 100mg bd when the diagnosis is erythema migrans. Patients should be encouraged to take photographs of their rash and

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a tricky diagnosis

GPs should actively follow-up uncertain rashes with their own photographs. Doxycycline can be nephrotoxic with poor renal function and reference can be made to the current BNF for alternatives.

Secondary disease

In secondary Lyme borreliosis the diagnosis may be challenging. A clear history may be lacking apart from presentation of new central nervous system (CNS) or joint symptoms in someone who has been engaged in outdoor activity in an infected area. Brushing through bracken, kneeling in the garden or sitting in the grass in a picnic site should raise a clinical possibility. In contrast, where walkers have kept to hard surface paths, Lyme borreliosis is less likely.

New onset cranial nerve palsy including Bell's palsy should raise suspicion of Lyme borreliosis in Scotland or other hot spots. Swelling of the face and redness make infection more likely in facial palsy with positive serology. The fit elderly who garden or walk in affected areas have recently been giving unusual presentations of Lyme borreliosis and unexpected toxic confusion should raise the possibility in a differential diagnosis list.

Sensory and motor symptoms which suggest multiple sclerosis should also prompt consideration of Lyme borreliosis in the history and differential diagnosis, as should new onset mono-arthritis in knees, ankles or wrists which could be attributed to Lyme arthritis.

Blood tests can be difficult to interpret as they record previous exposure. However, a rise in titre might suggest a recent infection. Cerebrospinal fluid (CSF) can be tested using PCR techniques but there is a general acceptance that we need better tests for Lyme borreliosis.

Treatment of secondary Lyme borreliosis involves prolonged courses of IV antibiotics to eradicate the bacteria. However, profound tiredness and continued CNS symptoms seem to persist suggesting a prolonged inflammatory response in the body and CNS in particular. This can make patients quite challenging as they expect a cure and are typically previously healthy "outdoor people". They can feel angry with medical uncertainty.

Indeed, Lyme borreliosis often gets mixed up with chronic fatigue syndrome. Patients with secondary Lyme borreliosis have chronic fatigue but those with other causes of chronic fatigue syndrome may attribute their symptoms to the condition, with difficult histories and uncertain investigations.

The clinical management of Lyme borreliosis requires managing uncertainty with professional knowledge, confidence and a willingness to listen to patients and learn from them. There is a balance between under diagnosis and over diagnosis, and often with clinical and media pressure. Doctors need to facilitate the psychological healing required following secondary Lyme borreliosis. We need to shift our thinking and terminology from 'Lyme disease' to 'Lyme borreliosis' for the benefit of patients and doctors.

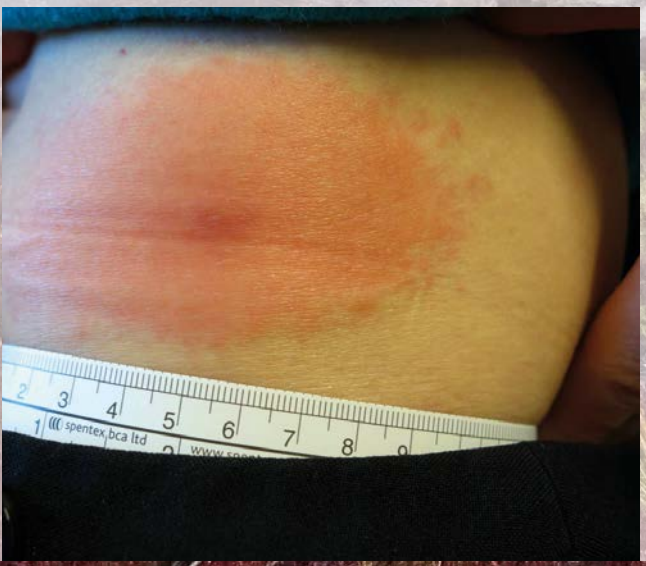
Medico-legal implications

Established GPs in areas affected by Lyme borreliosis are usually familiar and confident in the diagnosis and management. However, new doctors and locums may easily miss the diagnosis. Photographs of rashes in the patient record and coding on the computer, including 'suspected Lyme borreliosis' (by the patient or the doctor) will help document uncertainty in regard to the diagnosis.

In secondary Lyme borreliosis a diagnosis may be obvious with hindsight and blood tests but this represents considerable risk with regard to accusations of delayed diagnosis. Patients in at-risk occupational groups and those returning to urban GPs 4-8 weeks after a camping weekend need continued clinical vigilance.

■ *Dr James Douglas is a GP in Fort William in the Scottish Highlands*

Clockwise from main picture: Scottish moorland is the perfect habitat for ticks; a tick burrowing into human flesh; Erythema chronicum migrans



Dentists and the DPA

MDDUS information governance officer Alex Lyons *reflects on a recent ICO report on data protection in the dental surgery*

FIRST let me pose two questions: what is four per cent of your gross profit for last year and how easy is it to commit a criminal offence? I will get around to addressing these questions at the end of this article. Before that I would like to discuss the findings of a recent inquiry published by the Information Commissioner's Office (ICO).

The ICO is the regulator responsible for ensuring that organisations comply with the Data Protection Act 1998 (DPA) and for promoting good practice in information handling. The DPA sets out the core principles with which all organisations processing personal data must comply.

Between June 2014 and June 2015, ICO researchers visited 21 dental practices across the UK in order to understand the information risks and challenges that dentists are facing. They also conducted an online survey and held discussions with various organisations including the British Dental Association (BDA).

Their visits could only cover a small number of dental practices and were predominantly in England. Despite these limitations, they found some common themes and challenges faced by all dentists in complying with the DPA.

Am I a data controller?

Among the professionals questioned there was general confusion over the circumstances in which a dentist can be considered a data controller and responsible under the DPA for patient data and also for registration with the ICO. Some dentists were registered when not necessary while others were not registered as required. On this point the ICO does not offer a single rule that fits every situation but there are a number of questions that can help clarify whether a particular dental practitioner is a data controller.

1. Are you responsible for the control and security of patient records and do you have other responsibilities associated with the data?
2. Do you have a patient list separate from the practice and would those patients follow you if you left the practice?
3. Do you treat the same patient at different practices?
4. If a complaint was made by a patient or data was lost would you be legally responsible for dealing with the matter?

If you answer 'yes' to any of the above questions, you are likely to be required to register with the ICO by visiting their website (**www.ico.org.uk**). Bear in mind that failure to comply can result in criminal sanctions from the regulator.

Information security arrangements

Information security was another area of concern in the study. It is a wide-ranging topic that covers everything from physical security of records and premises, to using firewalls and anti-virus software, to training staff appropriately. Dental practices are subject to a number of requirements in relation to maintaining the security and integrity of records. In addition to the DPA, the General Dental Council publishes its own *Standards for the Dental Team* which requires dentists to "maintain and protect patients' information", and the CQC's outcomes framework outlines controls for record keeping against which dental providers can be audited.

The ICO points out that organisations are legally obligated to have appropriate security to prevent personal data being accidentally or deliberately compromised. In particular, the DPA requires data controllers to take specific steps when using a third party (a data processor) to process personal data on their behalf. Data controllers must:

- choose a data processor providing sufficient guarantees regarding information security
- take reasonable steps to ensure compliance
- have a contract in place, in writing, specifying that the data processor is to act only on instructions from the data controller and must comply with information security measures comparable to those in the DPA.

In many of the smaller practices the ICO visited, information technology support was provided by small-scale IT contractors. These arrangements were often informal without a written contract or nothing more than a small service-level agreement. They rarely included clauses concerning information security measures.

In some cases this was justified on the basis that the contractor was unlikely to have access to sensitive information (working with hardware under supervision or installing software only to new equipment) but with any such work it is possible that contractors could access personal data. The report recommends that dental practices consult the ICO website for guidance on applying information security principles.

Retention of personal data

Many respondents to the ICO survey did not know how long they were required to retain patient data, leading to wide variation in practice. The DPA states that personal data should be retained for no longer than is necessary but it does not go on to specify how long is necessary for different categories of data. The following questions therefore tend to be asked (in descending order of importance):

- Is there any other legislation that requires that personal data be retained (e.g. income tax purposes)?
- Are there any agreed industry standards for retention?
- What is your organisation using the records for and when is the soonest they will not be of any use?

In the case of dental records, the ICO report cites BDA recommendations that they be retained 11 years for adults, and 11 years for children or up to their 25th birthday (whichever comes first). This advice is based on various limitation periods for bringing legal claims for personal injury, clinical negligence or breach of contract, and it is reiterated in the NHS Code of Practice.

The ICO recommends that all dental practitioners implement a retention policy. This can be a short document or schedule that lists when personal data should be destroyed, based on the questions and industry standards discussed above.

Those practices in the ICO survey that had policies in place and followed them tended to destroy only manual or physical personal data. Most practices are now moving to electronic dental records but none of the respondents to the research disposed of electronic records or had the facility to do so.

Retention periods apply to both manual and electronic records. Inactive electronic records can be archived but they often remain intact and accessible at the push of a button. The report concludes that the dental sector must begin to consider the importance of securely destroying electronic records at the end of their retention period. Those practices without the technical capability to delete personal data due to system constraints should consult ICO guidance on how such information can be put "beyond use".

Wider information governance landscape

The report also stresses the need for all organisations to keep up-to-date with changing technology in order to ensure information is secure. Some practitioners are failing to adapt effectively to the increasing use of mobile and personal devices within the workplace and the report highlights the importance of being alert to guidance and advice about using new technology securely.

Dental professionals busy running practices can struggle to engage with more involved information governance issues. This is understandable as their focus is on delivering care to patients and it may not be possible to spend large amounts of time addressing complex information governance matters. The ICO is pragmatic about the requirements of running small businesses and recognises the need for additional channels of communication regarding information governance.

MDDUS can provide a number of checklists and practical guidance to assist members in achieving compliance. Don't forget also that our advisers are at the end of the phone and our website features a number of webinars in relation to subject access requests and data sharing to help you achieve compliance.

Some answers

Now back to my initial questions. In 2016, new data protection legislation will introduce a structure for monetary fines set to be agreed at 4 per cent of gross profit. I don't know what that would cost you but I'm sure your finance manager could give you a figure.

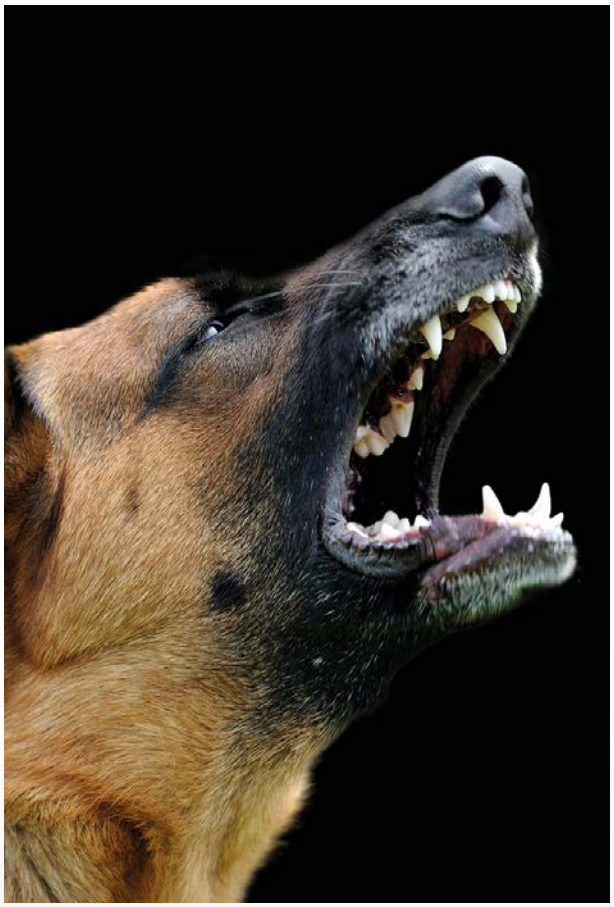
As to the second question: how easy is it to commit a criminal offence? The answer is "very" – processing personal information without registering with the ICO is illegal!

■ *Alex Lyons is a senior information governance adviser at MDDUS*

CASE studies

These studies are summarised versions of actual cases from MDDUS files and are published in *Summons* to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality

TREATMENT: INFECTED DOG BITE



BACKGROUND: Mr B attends his local A&E with a dog bite to his ankle. He is 18 years old and works in a kennel and had been bitten while cleaning a cage. He is seen by a specialist registrar who notes a 2cm incision on the internal aspect of the right ankle which does not appear infected.

Mr B is later reviewed by a consultant who advises that the wound be washed out and left open to heal. He is administered a tetanus (ATT) injection but is not given precautionary prophylactic antibiotics at this stage as a dog bite to the leg is regarded as low risk of infection. He is advised to attend his local GP surgery in two days to ensure that the wound is healing adequately – or sooner at any sign of infection.

Two days later Mr B makes an emergency appointment with his GP – Dr K. The bite has grown increasingly red and painful. Dr K examines the wound and notes cellulitis but no pus. She prescribes the antibiotic flucloxacillin and advises Mr B to re-attend if there is no improvement or the infection grows worse.

Three days later Mr B attends A&E. The attending nurse practitioner examines the patient's ankle which is painful, hot and swollen with some blistering. He refers Mr B to the on-call consultant who diagnoses an infected dog bite. He is admitted to hospital for treatment with intravenous co-amoxiclav. Three days later the wound is much improved and Mr B is discharged with oral co-amoxiclav.

In subsequent review a small area of superficial necrotic tissue is identified and Mr B is admitted for debridement. This requires further antibiotics and the patient is left with a significant scar.

A year later Dr K receives a letter from solicitors acting for Mr B detailing an allegation of clinical negligence in the treatment of his ankle. It states that in prescribing flucloxacillin Dr K departed from what would be considered appropriate treatment for an animal bite as indicated in the British National Formulary. This resulted in a more serious infection than Mr B might otherwise have suffered and a more protracted recovery and significant scarring.

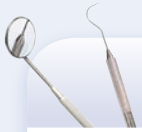
ANALYSIS/OUTCOME: MDDUS assists Dr K with the claim, assessing the solicitor's letter and associated medical records. Expert reports are commissioned from a primary care physician and a plastic surgeon. Both are critical of Dr K in her decision to prescribe flucloxacillin in this case as the British National Formulary states that in infected animal and human bites the appropriate choice of antibiotic is co-amoxiclav.

The plastic surgeon further comments on causation in the case stating that it is likely that given earlier use of the appropriate antibiotics to control wound infection there would have been no need for later hospital admission and further surgical debridement. Some scarring was inevitable but the tissue loss has made it more noticeable.

In light of these critical reports the decision is made to settle the case in agreement with the member.

KEY POINTS

- Double check to ensure treatment decisions are in compliance with accepted guidelines.
- Document your justifications for any clinical decisions that depart from appropriate guidelines.
- Keep up to date with most current guidelines, e.g. BNF, NICE, SIGN.



TREATMENT: LIP TRAUMA

BACKGROUND: Mr Y attends his dental surgery for a regular check-up. The dentist – Dr G – notes that a distal composite filling on the lower right canine needs to be replaced. The patient re-attends a few weeks later and Dr G administers local anaesthetic and uses cotton wool rolls to isolate the tooth and also reduce the risk of moisture contamination and to protect the soft tissue.

Clinical notes indicate nothing remarkable about the procedure and Mr Y leaves the surgery without complaint. Three days later he returns to the practice complaining of a large ulcer on the lip adjacent to the tooth that was filled. He claims to have become aware of "some injury" within an hour of having left the surgery when he tried to eat a bacon roll. Dr G suggests that the most likely cause was trauma from biting his lip before the anaesthetic had worn off. The dentist advises Mr Y to clean the ulcer with water and bicarbonate of soda and apply Corsodyl gel. He arranges to review the patient in a few days.

On the next visit the ulcer has completely healed. Mr Y states that he has sought the opinion of another dentist who suggested that the ulcer was caused by the tooth being pushed up against the lip and the spillage of acid etch gel. Dr G expresses his regret over Mr Y's suffering and explains the procedure that had been followed including the measure to protect against soft tissue damage. He also reassures the patient that he would have informed him of any trauma that had occurred during the procedure and the likely consequences.

Mr Y is not happy with this explanation and demands a refund for the cost of the treatment. Dr G later forwards a cheque as a gesture of good will.

A few months later the dental surgery receives an injury claim from solicitors acting on behalf of Mr Y. It alleges that Dr G acted negligently by not adequately protecting the patient's lower lip during the procedure. The letter claims that the lip was punctured and acid etch used in the procedure came into contact with the wound. Mr Y further claims that after the procedure he had to attend his GP for antibiotics and now suffers from dental phobia.

ANALYSIS/OUTCOME: MDDUS commissions an expert report from an oral surgeon, who notes numerous conflicting details in the patient's account of the treatment. Mr Y claims there was lack of protective measures to ensure against damage to the soft tissue yet in latter statements he claims to have felt a burning sensation to his lip when the cotton wool was removed without first being moistened.

The expert assesses the clinical photographs of the lesion noting that the wound is of uniform depth with an area of ulceration corresponding in size and shape to an injury from the incisal edge of a tooth. Detailed analysis of the images further leads the expert to discount the possibility of a burn, skin adhesion to cotton wool rolls, dental drill injury or rough treatment as the cause of the lesion. His view is that the ulceration adjacent to the incisal edges of the teeth suggests that the patient bit the inside mucosal surface of his lip – possibly when eating while the lip was still anaesthetised.

MDDUS writes a letter of response to Mr Y's solicitors repudiating the claim and the case is eventually discontinued.

KEY POINTS

- An expression of regret is not an admission of liability – nor is a refund for treatment.
- Even the most routine procedures can sometimes result in unexpected claims or complaints.

DISCLOSURE: AN ANXIOUS DRIVER

BACKGROUND: A 48-year-old farm worker – Mr L – attends his surgery in regard to on-going complaints of anxiety. In consultation with the GP – Dr T – he mentions that he recently began suffering unexplained blackouts. In one instance he fell without warning in his kitchen while making a cup of tea.

Dr T examines the patient but can find no abnormal signs that might explain the blackouts. She arranges for Mr L to have some cardiovascular testing and also makes a neurological referral. The GP explains to the patient that in the meantime he should not drive until the results of these investigations are known.

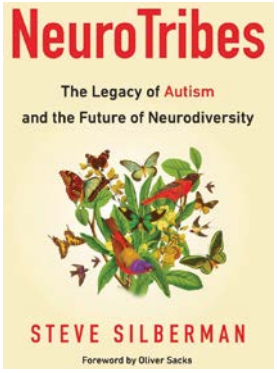
A few weeks later Dr T receives a letter from a cognitive behaviour therapist working with Mr L to manage his anxiety. In the letter the therapist expressed his concern that despite Mr L mentioning his blackouts he is still driving.

ANALYSIS/OUTCOME: Dr T contacts MDDUS for advice on the matter and is referred to GMC guidance which states that doctors are obligated to inform patients that any condition which may affect their ability to drive must be reported to the DVLA – and the patient should refrain from driving in the meantime. Should the doctor discover the patient is still driving against advice then the DVLA may need to be contacted immediately with disclosure of relevant details in confidence (also informing the patient of the disclosure).

Mr L re-attends the surgery after receiving a letter from Dr T in regard to the matter and is signed-off work pending results of the medical investigations.

KEY POINTS

- Disscussion with MDDUS is recommended given the complexities of these scenarios.
- Keep clear notes in the patient records of all decisions made in such cases.



Book review:
NeuroTribes – The Legacy of Autism and the Future of Neurodiversity

By Steve Silberman
Allen & Unwin; £11.89 Paperback
Review by Jim Killgore, managing editor, *Summons*

IN THE introduction to his book *NeuroTribes*, science writer Steve Silberman admits that prior to embarking on his research: "Everything I knew about autism I had learned from *Rain Man*, the 1988 film in which Dustin Hoffman played a Savant named Raymond Babbitt who could memorize phonebooks and count toothpicks at a glance."

The genesis of the book – which has won the 2015 Samuel Johnson Prize for Non-Fiction – was an assignment to cover a "Geek Cruise" for *Wired* magazine, in which Silberman spent a week sailing up the Alaskan coast with a group of top software coders or "digital natives with their own history, rituals, ethics, forms of play, and oral lore".

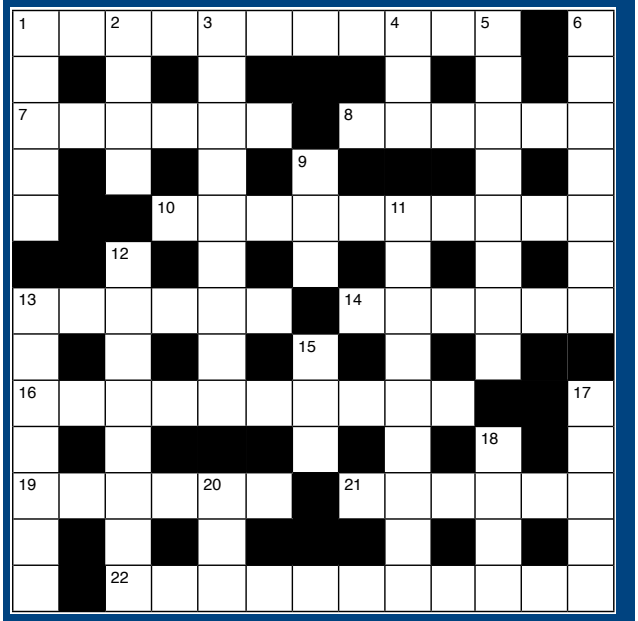
In the course of writing the article he encountered a curious phenomenon – an apparent "epidemic" of autism among children in Silicon Valley near San Francisco, the so-called cradle of the information technology industry. It had become cliché to joke that many of the programmers and engineers working at companies like Adobe or Intel were "on the spectrum". Indeed one supervisor at Microsoft told Silberman: "All my top debuggers have Asperger syndrome." Was there a connection between these observations and the higher incidence of autism among children in the Valley?

This question is the starting point for a fascinating and amazingly comprehensive overview of more than 70 years of autism research starting in the early 1940s when the syndrome was "first" identified serendipitously by two doctors on opposite sides of the Atlantic: Leo Kanner and Hans Asperger. The book also explores the desperate and heroic efforts of frustrated parents of autistic children looking for cures or simply the means to manage a debilitating condition among a morass of confusing research findings and often dubious theorising.

A central and recurring theme in the book is the notion that autism need not be regarded as a condition to be cured but as a naturally occurring "cognitive variation" with "distinctive strengths that have contributed to the evolution of technology". Surveying the history of science Silberman considers numerous examples of individuals who today would no doubt be diagnosed with Asperger syndrome, including the eccentric English physicist Henry Cavendish, who in 1797 used an ingenious apparatus of rods and lead balls to determine the mass of the Earth.

At the book's core is the idea that, given the right circumstances and support, many people "on the spectrum" can live happy, productive lives.

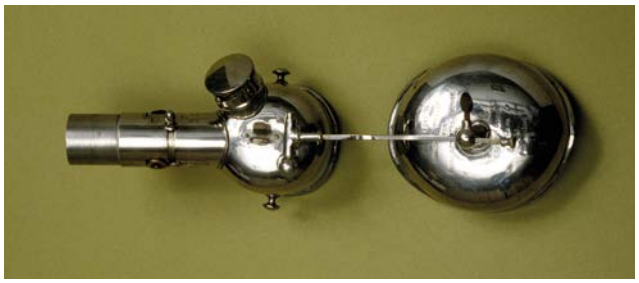
Crossword



ACROSS
1 Underwater naval personnel (11)
7 Flowers (6)
8 Abnormal desire (6)
10 Adherents of dogma (10)
13 Performed without stress (6)
14 Interstellar cloud of dust (6)
16 Examination of the nose (10)
19 Surprises (6)
21 Persuaded (6)
22 Horticulturalist in theatre? (4,7)

DOWN
1 Oily secretion (5)
2 Take technology to work (abbr.) (4)
3 Shelled mammal (9)
4 See (3)
5 Event or thing that evokes a reaction (8)
6 Speech and language disorder (7)
9 Relating to GP payments (abbr.) (3)
11 Defeat with superior strength (9)
12 Pursuer in claim (8)
13 Dead body (7)
15 Office of information commissioner (abbr.) (3)
17 Radioactive element discovered by Dorn (5)
18 ____ disease, infection from tick bite (4)
20 Biblical first woman (3)

See answers online at:
www.mddus.com/news/notice-board



PHOTOGRAPH: SCIENCE PHOTO LIBRARY

Object obscura:
DeFord anaesthetic inhaler

This inhaler from 1913 was used for dental anaesthesia with either somnoform or nitrous oxide. It has both an oral mask (right) and nasal mask (left) allowing administration of anaesthesia to continue while dental surgery was performed. Somnoform was a mixture of anaesthetic liquids and produced a longer lasting anaesthesia than did ethyl chloride alone but was more toxic and fell out of use by the late 1920s.

Vignette: Pioneering eye surgeon Sir Tudor Thomas (1893-1976)

IN THE autumn of 1934 at the American College of Surgeons meeting in Boston, Daphne Muir was the guest of honour. She was an English novelist who had been involved in a car accident nine years earlier that had left her blind. Both her corneas had been damaged in the accident rendering them opaque. Now, as a result of pioneering surgery, her sight had been restored. She had just become the first recipient of bilateral corneal grafts in London and had been invited to the American conference to share her experiences. The man responsible for her recovery was characteristically absent from the meeting, for he was a modest though brilliant surgeon – Tudor Thomas.

James William Tudor Thomas was born into a Welsh-speaking family in Ystradgynlais, Breconshire, but would spend much of his life in Cardiff and London and would be known throughout his career as, simply, Tudor Thomas. A distinguished student, he obtained his BSc in 1913 from the University of Wales before going on to study clinical medicine at the Middlesex in London. In 1916, he not only passed the London MB BS, but he also became the first person to obtain the MB BCh degrees from the University of Wales.

After his house jobs in Swansea, he served during World War I in the RAMC. During his service in Africa he encountered a number of young soldiers who had been blinded in action. It was perhaps this experience that led to his choice of specialty for when he returned to civilian life he trained as an ophthalmic surgeon at Moorfields and the Central London Ophthalmic Hospital before moving back to Wales. He would devote the rest of his career to research and clinical practice in this area.

Throughout the 1920s in Wales, while working at Cardiff Royal Infirmary, he performed a series of experiments on corneal grafting in rabbits, and in 1930 he presented his experimental findings in London. The same year he performed his

PHOTOGRAPH: THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

first corneal graft in man. Thomas was not the first to perform such a graft – that had been done in 1905 by the Austrian ophthalmologist Eduard Zirm – but he made significant contributions to improve the practice of keratoplasty, including developing novel suturing techniques and the improved preparation of the donor and recipient cornea. Indeed, the Medical Research Council, who were funding his work, noted in their annual report of 1931: "the experiments give hope of a radical cure by surgical means of blindness due to the opacity of the cornea".

His clinical work was performed partly in Cardiff, but also partly in London and it was there that he performed the series of corneal grafts in the early 1930s that brought him the attention of his peers from around the world. However, despite his interests in the scientific basis and surgical practice of keratoplasty, Thomas was also acutely aware of the broader issues of transplant surgery.

As with all human transplantation, the availability of suitable donor material was a serious obstacle in the field of corneal grafting. Before World War II, when he was working at the Central London Ophthalmic Hospital in charge of its corneoplastic department, Thomas developed the idea of a registration system for the collection and use of donor corneas. This concept would develop in the 1950s into the UK's first Eye Bank at the Queen Victoria Hospital, East Grinstead.

His pioneering work in the field of corneal grafting brought him many honours. He was elected to the Presidency of the British Medical Association in 1953, he received an honorary doctorate from the University of Glasgow in 1954 and he was knighted in 1956. In 1960, he received the prestigious Gold Medal of the Worshipful Society of Apothecaries in recognition of his contributions to corneoplastic surgery. With this award he joined a very distinguished company as previous recipients of the Gold Medal had been Sir Henry Dale, the pharmacologist and 1936 Nobel Laureate, Sir Alexander Fleming, the discoverer of penicillin and Sir Russell Brock, one of the pioneers of modern open-heart surgery.

But it was not the honours or awards that mattered – his lasting contribution would be the countless patients, like Daphne Muir, who owed their restored sight to the care and dexterity of this remarkable Welsh surgeon. At that surgical conference in Boston, she reported that the first words she had been able to read after nine years of near total blindness were, "very heaven". Words that doubtless felt appropriate to someone who had been led from darkness once more into the light by the expertise of Sir Tudor Thomas.

■ *Dr Allan Gaw is a writer and educator in Glasgow*

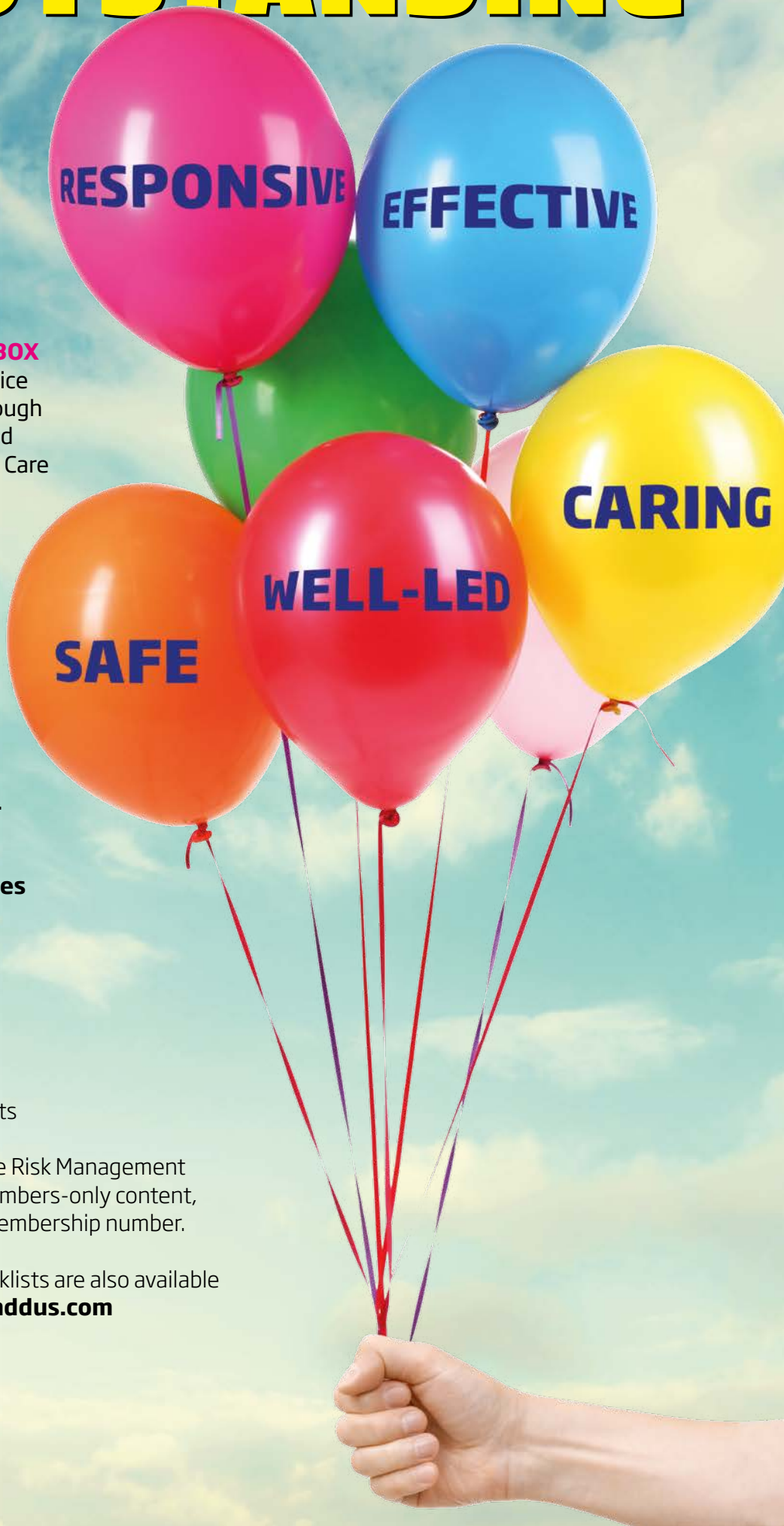
SOURCES

Chicago Tribune Oct 17, 1934

Obituary Brit J Ophthalmol 1976; 60: 309-10

Dictionary of Welsh Biography

BE OUTSTANDING



Check out our new **CQC TOOLBOX** designed to help GPs and practice managers in England work through many of the areas of quality and safety identified as core by the Care Quality Commission.

A combination of new and existing MDDUS resources are now available for members, organised under each of the five key lines of enquiry (KLOEs) focussed on by the CQC in practice inspections. KLOEs assess whether a practice is: safe, effective, caring, responsive, and well-led.

A range of targeted resources are available including:

- video modules
- risk articles
- practical checklists
- advice and guidance sheets
- podcasts
- video interviews with experts

To access the toolbox go to the Risk Management section at **mddus.com**. For members-only content, log in with your surname and membership number.

Editable versions of all risk checklists are also available to MDDUS practices via **risk@mddus.com**