



# Practice MATTERS

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UK



## RISK WARNING ANTICOAGULANT MONITORING AND DOSING

We've teamed with NHS Improvement for a new series of risk warnings. First up we tackle medication errors associated with anticoagulants

Page 8

### INSIDE...

#### PRACTICE PROFILE: PROVIDENCE SURGERY

A look into how they achieved an 'Outstanding' rating from the CQC in their most recent inspection

#### IN THE HOT SEAT WITH IAN WILSON

An interview with one of the GMC's regional liaison advisers

#### END OF LIFE CARE

How to put the recent CQC recommendations into practice



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# What's INSIDE...



Every issue...

## 04 Noticeboard

Snippets and hot topics from Medical Protection's general practice team.

We welcome contributions to *Practice Matters*, so if you want to get involved, please contact us on **0113 241 0377** or email: [publications@medicalprotection.org](mailto:publications@medicalprotection.org)

## 04 Noticeboard

Snippets and hot topics from Medical Protection's general practice team.

## 06 FAQs – Pensions auto enrolment

With the deadline for pension auto-enrolment fast approaching, HR experts Croner answer your questions about it.

## 08 Risk Warning – Anticoagulant monitoring and dosing

Medical Protection has teamed with NHS Improvement for a new series of articles based on data from the National Reporting and Learning System (NRLS). In this issue we tackle the most commonly reported incident type; medication errors associated with anticoagulants.

## 11 Top 5 social media dilemmas

Medicolegal Adviser Dr Gordon McDavie answers some of the most common social media queries we receive from practices.

## 12 End of life care

A recent report from the CQC has highlighted where general practice could improve in the provision of end of life care. Dr Rachel Birch offers advice on how to put the CQC recommendations into practice.

## 15 In the hot seat with Ian Wilson

Ian Wilson, Regional Liaison Adviser for the GMC, discusses how the Regional Liaison Service can help doctors in general practice understand GMC guidance.

## 16 Practice Profile: Providence Surgery

The CQC recently visited Providence Surgery and rated them outstanding. Kirsty Plowman looks into how they achieved this rating and finds out what advice they have for other practices.

## 18 From the case files

A case that demonstrates some of the potential pitfalls in anticoagulant management that members will want to avoid.

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# NOTICEBOARD

## WELCOME



elcome to this edition of Practice Matters, our magazine for GP partners and practice managers.



One of the highlights of this edition is the launch of our new partnership with NHS Improvement. We are working together to bring you a new series of 'Risk Warning' articles based on data from the National Reporting and Learning System (NRLS), the NHS's national database of patient safety incidents in England and Wales. This is an exciting development for members as you will be amongst the first to be made aware of the most commonly reported incident types in general practice, and you will also receive advice on how to tackle these risks.

For the first article in the series we take on medication errors associated with anticoagulants, you can find this on page 8.

Another big subject in this edition is that of end-of-life care. A recent report from the CQC has highlighted where general practice could improve in this area and on page 12 we offer advice on how to put the CQC recommendations into practice.

We also have another excellent practice profile for you, this time looking at Providence Surgery in Boscombe, near Bournemouth. Despite being located in an area that is in the top 1% of the most deprived areas in the UK, it was recently rated 'Outstanding' by the CQC. On page 16 we examine how they achieved that rating and share their advice for other practices.

As usual, Croner are back with more HR advice, this time tackling the subject of pensions and auto-enrolment on page 6. We also answer some of the most common social media queries we receive on page 11.

I hope you enjoy this edition. We welcome all feedback, so please contact us or if you have any ideas for topics you'd like us to cover.

**Dr Rachel Birch**  
Editor-in-Chief and Medicolegal Adviser

## EDITOR'S RECOMMENDATION



he *British Journal of General Practice* recently published this interesting article – 'Missed opportunities for diagnosis: lessons learned from diagnostic errors in primary care'.

It highlights the importance of GPs learning from diagnostic errors in order to reduce the occurrence of these events and for this to be incorporated into GP training. It concludes that at a practice level, these experiences should be discussed more frequently; and more should be done to integrate these lessons nationally to understand and distinguish diagnostic errors.

To read the article visit: [bjgp.org/content/65/641/e838](http://bjgp.org/content/65/641/e838)

## UPDATE ON SPIP



n the previous edition of Practice Matters we introduced the new online version of the NASGP's Standardised Practice Induction Pack (Spip). This allows practices, GPs and nurses to keep up to speed with ever-changing local health information.

Since then, Spip has been renamed and is now known as the Standardised Practice Information Portal. A video which is available on the NASGP website provides an excellent overview of the device; a valuable tool for risk management and patient safety.

Practices can sign up to Spip FREE for the first sixth months, following which it costs £36 a month. Medical Protection Practice Xtra members retain their FREE subscription for two years. To find out more and sign up visit: [nasgp.org.uk/spip](http://nasgp.org.uk/spip)

# HOT TOPIC

**A**t the start of April 2016 a new system for firearms licensing was introduced to improve information sharing between GPs and police and to reduce the risk that a medically unfit person may have a firearm or shotgun certificate.

## NEW GUIDELINES

- Police will ask every firearm applicant's GP if the patient suffers from specific health issues, such as depression or dementia.
- GPs will be asked to place a firearm reminder code on the patient's record. This means the GP will know the person is a gun owner, and they can inform the police licensing department if the patient's health deteriorates after the gun licence is issued.
- New guidance will be published to help GPs and police operate the new system. Responsibility for deciding if a person is suitable to hold a firearm certificate remains with the police.
- Practices should be satisfied that they have the patient's consent before releasing any information from their medical record in regards to their firearms application.
- Information should be limited to what is relevant and necessary for the purposes of the police being able to determine the appropriateness of issuing a licence.
- If a GP becomes concerned about the health of a patient with a firearm reminder code in their record they should consider notifying the police of this concern. In keeping with current GMC guidance they should still seek consent to disclose this information (unless there is a reason not to, for example putting the patient or others at risk of serious harm to their mental or physical health).
- If the patient withholds consent the GP could still consider disclosure in the public interest. All discussions and reasons behind this decision should be documented.

## ACTION POINTS FOR GP PRACTICES

We recommend practices ensure that all GPs and staff are aware of the new system, how the firearm reminder code works and their responsibilities regarding this.

GPs and staff should also be reminded that this new system does not override their responsibility to follow GMC guidance on confidentiality. This means:

To read the full guidance on the Firearms Licensing Law, visit [gov.uk/government/publications/firearms-law-guidance-to-the-police-2012](http://gov.uk/government/publications/firearms-law-guidance-to-the-police-2012)

If you find yourself in this situation and need advice or guidance you should contact our team of expert medicolegal advisers on **0800 561 9090** or [querydoc@medicalprotection.org](mailto:querydoc@medicalprotection.org)

## BEHIND THE SCENES OF A GP CLAIM

We are proud of the work we do to support you. As a mutual organisation we are accountable to you and we want to give you more information on how we help you when you need us.

Many of you may never have experienced a claim, and those of you that have, may have been shocked and unsure what to do when you first received a claim. We want to provide you with some clarity and reassurance, so if the worst should happen, you understand what a claim is, what you should do if you receive a claim and how we can support you at every step.

We've built a dedicated webpage that walks members through the process. To find out more, visit: [medicalprotection.org/behind-the-scenes-of-a-gp-claim](http://medicalprotection.org/behind-the-scenes-of-a-gp-claim)

# FAQs

# PENSIONS AUTO ENROLMENT:

## YOUR QUESTIONS ANSWERED

Under the Pensions Act 2008, every employer in the UK must put certain staff into a pension scheme and contribute towards it. Whether you're a hairdresser, an architect or a partner in general practice, if you employ at least one person you are an employer and you have certain legal duties.

With the deadline for small businesses, a designation which many GP practices fall under, to enrol their employees fast approaching, Croner provides answers to some of the pressing questions

### **I AM A PARTNER IN A GP PRACTICE, WHEN DO I NEED TO ENROL WORKERS BY?**

Small businesses (those with fewer than 30 individuals in a PAYE scheme on 1 April 2012) must, during 2016–17, automatically enrol their workers into a qualifying workplace pension scheme or the “default scheme”, the National Employment Savings Trust (NEST).

### **WHAT IS MY STAGING DATE?**

Auto enrolment duties apply from a specific date depending on the description of the employer. This is called the employer's staging date. For example, employers with fewer than 30 individuals, with the last two characters in their PAYE reference numbers 30–37, 6A–6Z, L1–L9 or LA–LZ have a staging date of 1 August 2016. Employers with a single PAYE scheme can enter the scheme reference at [www.thepensionsregulator.gov.uk](http://www.thepensionsregulator.gov.uk) to establish their staging date.

### **WHY SHOULD I NOMINATE A PRIMARY AND SECONDARY CONTACT?**

Nominate a primary and secondary contact within the business so these individuals can receive regular information from the Pensions Regulator in the lead up to the actual staging date. In a GP practice the primary contact is likely to be a partner, with the secondary contact the person responsible for the setup and management of auto enrolment, ie. the practice manager. The two contacts should be appointed up to a year before the staging date to create an action plan. This will involve allocating routine tasks and identifying where extra resources are needed.

### **WHO DO YOU CLASS AS AN “ELIGIBLE JOBHOLDER”?**

“Eligible jobholders” are individuals:

- not already in a qualifying workplace pension scheme;
- with qualifying earnings over the “earnings trigger” (£10,000 per year in 2016–17);
- aged between 22 and State Pension Age (60+ for women, 65 for men);
- working under a UK employment contract.

Other workers to consider are:

- “entitled workers” (those aged 16–74, working in UK and earning below £5824 per year in 2016–17) who have the right to join a pension scheme (not necessarily a qualifying scheme), but no right to benefit from employer contributions; and
- “non-eligible jobholders” who may opt in into the pension scheme and receive an employer contribution. Non-eligible jobholders are workers:
- aged 16–21 or above state pension age — 74, working in the UK, with annual earnings above £10,000;
- aged 16–74, working in UK, with annual earnings between £5824 and £10,000.



## WHAT ARE THE LIKELY COSTS OF AUTO ENROLMENT?

Auto enrolment introduces a new definition of pensionable earnings, called qualifying earnings (salary, commission, bonuses, overtime and statutory payments but not benefits in kind).

Minimum contributions are payable on workers qualifying earnings over a lower band of £5824 per year up to an upper band of £43,000 per year in 2016-17. Up to 5 April 2018, there is a total minimum contribution of 2%, of which 1% must come from the employer, with 0.8% payable by the employee and 0.2% in tax relief received from the Government.

There may also be one-off costs to consider, such as setting up the pension scheme, changes to payroll software to manage the auto enrolment process and any independent advice taken, e.g. from a business adviser.

Ensure the payroll system is compatible with employer duties under auto enrolment six months before the staging date, so the right data can be extracted, in the right format, in order to submit the right information to the pension provider, at the right time. Payroll software should flag key age-related dates and where the earnings trigger will be exceeded by a worker in a particular pay reference period, to see if anyone who was not initially eligible for auto enrolment has since become eligible.

## IF I ALREADY HAVE A PENSION SCHEME IN PLACE, WILL THIS COVER THE REQUIREMENTS?

If a pension scheme is already in place, make sure it is suitable for auto enrolment. Qualifying workplace pension schemes are pension schemes registered with HMRC that meet a minimum standard set out in pension law. If an eligible jobholder is already an active member of a qualifying pension scheme on the staging date, employers only need to provide information about the pension scheme and confirm in writing that it meets the minimum standards.

If your scheme is not appropriate for auto enrolment, choose a different pension scheme. The Government has set up a pension scheme specifically for auto enrolment, called NEST, primarily for use by small employers but any employer can use NEST. Independently reviewed schemes and those listed by industry bodies may also prove suitable. If a new scheme is set up to satisfy auto enrolment duties it should be easy to administer, cost effective, suitable for low earners and work well with current employer processes and systems.

## WHAT INFORMATION DO I NEED TO PROVIDE TO WORKERS?

At the staging date, employers must enrol all relevant workers into the pension scheme. Employers must provide the eligible jobholder with information about what auto enrolment means, their right to opt out and opt back in, and where to find further information about pensions by the end of the "joining window" (within six weeks of the employer's staging date).

By the end of the "joining window" eligible jobholders must be made active members of a qualifying workplace pension scheme and be issued with relevant pension information by the pension provider.

## WHEN DO I NEED TO REGISTER BY?

Employers must complete the registration process within five calendar months of their staging date or face a fine.

## WHAT HAPPENS IF A WORKER WANTS TO OPT OUT?

After relevant workers have been auto enrolled, employers may receive a request from the individual to "opt out" of the pension scheme. The employer must then stop deductions of contributions and make a refund to the worker of contributions paid to date. The refund date is one month after the date the valid opt-out notice is received.

Any pension contributions deducted from any worker in the three month period from the start date of active membership must be paid to the trustees or managers of the pension scheme by the 22nd (electronic payments) or 19th (cheque payments) of the month after the last day of that three-month period. For example, any pension contributions deducted from 1 July to 30 September must be paid by 19/22 October.

If an employer does not comply with their duties under auto enrolment, the Pensions Regulator can issue compliance notices and penalties. Employers must comply within 28 days of receiving a notice or be faced with a fixed penalty fine of £400. If payment is not made within the specified time (minimum of four weeks from the date notice was issued) an escalating penalty may accrue at a daily rate of £50 to £10,000 (based on number of payees in PAYE scheme), until compliance is achieved. In the most serious cases, the employer may be prosecuted.

Failure to pay contributions by the due date can result in the employer being fined up to £50,000. Employers must not make pension membership part of any selection criteria for recruiting workers; otherwise, a fixed penalty may be imposed based on the size of the employer's PAYE scheme.

## FIND OUT MORE

Croner is the UK's leading provider of information, advice and support in the areas of employment law and health and safety. Their qualified specialists have the experience to fully understand the issues and concerns you face working in general practice.

## 24-HOUR ADVICE

All Practice Xtra members can benefit from free access to the Croner helpline, for legal advice and support with matters including pensions and payroll. Whatever you need to know they will provide you with information you can trust, whenever you need it.

## TIME-SAVING RESOURCES

Practice Xtra Gold members can benefit from free access to the Croner-i Professional Practice Manager website. It's a resource for everyday management, with a range of templates you can download and customise for your needs including model policies, 'how to' guides, sample letters and forms.

For more information about using Croner services visit [medicalprotection.org/uk/croner](https://medicalprotection.org/uk/croner)

For more information about joining Practice Xtra visit [medicalprotection.org/practicextra](https://medicalprotection.org/practicextra)

# RISK WARNING – ANTICOAGULANT MONITORING AND DOSING

We have teamed up with NHS Improvement for a new series of risk warnings based on data from the National Reporting and Learning System (NRLS), the NHS's national database of patient safety incidents in England and Wales. Each article will tackle a different risk commonly reported to the NRLS. In this issue we tackle a commonly reported incident type, medication errors associated with anticoagulants

## Dr Martyn Diaper, Head of Patient Safety (Primary Care) at NHS Improvement



NHS Improvement is excited to have teamed up with Medical Protection to bring you this series of articles, highlighting the most common risks reported to the NRLS.

We recently launched a new reporting tool – the GP eform, designed to make it quick and easy for GPs and the entire practice team to report patient safety incidents for national and local learning. It also provides evidence of reporting and reflection. Key features include the facility to:

- receive a bounce back email with national reporting trends;
- share the incident with the local CCG and NHS England team;
- save the incident report as evidence for CPD, appraisal, revalidation and CQC inspections.

Early adopter practices have reported over 2,000 incidents in the first year since the GP eform was launched. From these reports medication-related incidents were identified as the most common incident type, making up around 50% of the total. Of these, around 10% relate to anticoagulants, predominantly warfarin. Emerging themes relating to warfarin incidents include:

- **Failure to monitor** – for example, patients continuing to receive prescriptions for warfarin without having their INR levels monitored for many months; or not undertaking the required additional monitoring when another medication is prescribed that concomitantly affected INR levels.
- **Wrong dose/strength** – for example, a patient having been prescribed both warfarin 5mg and 0.5mg strengths and then inadvertently taking the wrong strength.
- **Contraindications** – for example, a patient prescribed another medication that interacts with warfarin (e.g. miconazole oral gel).
- **Communication issues across care settings** – for example, incomplete/unclear discharge planning information when discharged on warfarin from hospital.

Patients vary in how they respond to warfarin. This, and a narrow therapeutic range means it's a fine balance between achieving the right INR to prevent thrombotic events while avoiding the risk of excessive bleeding. It is therefore imperative that we report incidents nationally and learn from things that go wrong, so that lessons can be learnt locally to improve safety and support colleagues who undertake prescribing, monitoring, dosing and supply of warfarin.

## Julie Price, Head of Risk Management and Education Consultancy at Medical Protection

Around one billion prescription items were issued in primary care in 2015, costing around £9.3 billion<sup>1</sup>. According to the PRACTiCe study 2012<sup>2</sup>, one in 20 prescription items was associated with a clinically important error and one in 550 was associated with a serious error. Prescribing errors in primary care can cause considerable harm, with adverse drug events accounting for around 7% of hospital admissions in the UK, and half of these are judged to be preventable.<sup>3</sup>

Evidence from a systematic literature review<sup>4</sup> revealed that 47% of all serious medication errors were caused by seven drugs or drug classes:

- methotrexate;
- warfarin;
- nonsteroidal anti-inflammatory drugs (NSAIDS);
- digoxin;
- opioids;
- aspirin;
- beta-blockers.

To access the GP eform, visit  
[report.nrls.nhs.uk/GP\\_eForm](https://report.nrls.nhs.uk/GP_eForm)





The PRACtice study<sup>2</sup> also found that simvastatin, warfarin, ramipril and bendroflumethiazide accounted for over 60% of drug preparations associated with monitoring errors.

As seen from the evidence above and from the incidents reported to the NRLS, warfarin accounts for a substantial proportion of medication errors.

### HOW CAN A PRACTICE PREVENT A POTENTIAL ERROR, ASSOCIATED WITH WARFARIN, OCCURRING?

The NRLS identified emerging themes for incidents reported. Below is risk management advice for each theme:

#### Failure to monitor

- It is essential that a practice has a robust monitoring system in place and always checks the current INR result and any untoward INR trends before generating repeat prescriptions for warfarin.
- The practice should also implement appropriate strategies to ensure non-attendees are identified and monitored. If a patient fails to attend for a blood test or is not at home (for a domiciliary visit), the practice should schedule a new appointment within a set time, perhaps one week.
- If no result is available, eg, the patient has undergone the test in the hospital clinic and no result is available, the GP should telephone the clinic to request the result. It may be helpful to discuss with the hospital warfarin clinic how INR results could be delivered in a timely way to the practice prior to the practice issuing a prescription.
- The National Patient Safety Agency (NPSA) states: "Ensure that before issuing a repeat prescription for anticoagulant medication, the GP checks that the patient's INR is being monitored regularly and that it is at a safe level for the repeat prescription to be issued. The easiest way to do this is to ask to see the patient-held INR record, which may be in the form of a single printed sheet, a small booklet or another format used locally."<sup>5</sup>
- The patient's yellow warfarin booklet should be updated at every INR test. If this booklet is not available, a temporary record booklet must be completed and given to the patient. The patient should be encouraged to take the booklet to every appointment.

#### Wrong dose/strength

- The NPSA states in Patient Safety Alert no. 18: "It is essential for the safe use of anticoagulants that patients and carers receive adequate verbal and written information about their treatment. This information should be provided before the first dose of anticoagulant is administered, and reinforced at hospital discharge, at the first anticoagulant clinic appointment, and when necessary throughout the course of their treatment. It is important that the healthcare practitioner who first provides this information records in the patient's healthcare records that this information has been supplied."<sup>6</sup>
- NHS Cumbria in Warfarin Management Guidelines (para 16.3) states that: "Wherever possible the patient should not be provided with more than two strengths of warfarin. Tablets should be routinely supplied in 1mg and 3mg strengths to ensure a consistent approach across primary and secondary care and minimize the risk of confusion. In exceptional circumstances eg, high warfarin sensitivity or high dosage requirements, warfarin may be prescribed in 0.5mg or 5mg strengths. In these instances the prescription must indicate the strength prescribed in both numbers and words ('half mg' or 'five mg') to ensure that the correct tablet is given. The patient should be supplied with the least number of different strengths of tablets possible."<sup>7</sup>

#### Contraindications and interactions

- It is important that prescribers consider interactions between warfarin and commonly prescribed medicines or complimentary medicines. It is important not to overlook over-the-counter and herbal products; certain food substances can also interact with prescribed medication. Prescribers should refer to latest BNF for a list of drugs known to interact with warfarin.
- Advise the patient to inform a healthcare professional (including anticoagulant clinic staff, GP, dentist, pharmacist, or nursing staff) of changes to their lifestyle, for instance if he/she starts, stops, or changes the dose of other medications. Other medicines include not only prescribed drugs, but also products that may be bought without prescription, such as aspirin and medicines containing aspirin, vitamins, food supplements, and herbal or homeopathic remedies.<sup>8</sup>

#### Communication issues across care settings

- Discharge arrangements for warfarin monitoring should be clearly established and documented. Responsibility for the discharge arrangements lies with the clinician referring the patient. Patients should remain the responsibility of the hospital team until arrangements and agreement have been made with the GP to take over.
- The front of the patient's yellow warfarin booklet should be completed to include indication of treatment, INR target range and duration of treatment, person with clinical responsibility and emergency contact number. The patient's GP should contact the initiating hospital if any of these details are omitted.



## Nominated anticoagulant lead for the practice

Practices should consider nominating a clinical member of the practice staff to be responsible and oversee the provision of the warfarin monitoring services. The nominated person should understand the whole care pathway and review this periodically to identify potential problems. In particular, the nominated clinical person should ensure:

- There is a system for identifying all INR test results, which includes patients seen on home visits;
- There is a failsafe system which ensures all results are received and appropriate action taken;
- Patients are aware of how they will be informed of their INR result, dosing instructions and recall date;
- Patients with specific needs are identified and appropriately managed, ie, where there are communication problems, patients in social care settings, patients using Monitored Dosage Systems etc.

In addition a GP should be available at all times for advice when warfarin monitoring services are offered to patients by the practice.

## Delegation of anticoagulant monitoring to other healthcare professionals

In our experience GPs frequently delegate the role of anticoagulant monitoring (and sometimes dosing) to other healthcare professionals, eg, practice nurse, practice pharmacist, healthcare assistant. Practices may use a computer decision support system for monitoring and dosing patients on warfarin.

In Good Medical Practice<sup>9</sup> the GMC makes clear that if a GP delegates this task to another healthcare professional the GP must ensure that the healthcare professional is trained and competent to undertake the tasks delegated to him/her, and that accountability is clear. He/she should be supervised and work to practice protocols.

It is important to have a robust protocol in place for monitoring those patients who are taking warfarin. This should be reviewed regularly, and issues raised about the system in place addressed. Please see Box 1.

The protocol should be available to all staff, including locums, be signed and dated by staff and reviewed on a regular basis. Warfarin clinic practitioners should also follow other the relevant protocols including infection control, needlestick injuries, venous sampling, disposal of clinical waste and spillages.

## EXAMPLE OF WHAT TO INCLUDE IN THE PRACTICE WARFARIN PROTOCOL

A warfarin clinic protocol for another Healthcare professional (HCP) including HCA, should address requirements for safe practice such as history taking, record keeping and 'safety netting'. They should include:

- The name of the nominated anticoagulation lead for the practice (usually a GP);
- The minimum frequency of face to face review by the supervising doctor and the information to be recorded at a review (preferably using a computer template);
- The training that the HCP should have completed initially and the required regular update training;
- The written information that must be provided to patients about issues such as interactions, lifestyle restrictions while taking anticoagulants and symptoms that might indicate dangerous dosages;
- The history items to be recorded by the healthcare professional at each encounter (preferably using a computer template);
- How patients' responses to questions and their concerns should be recorded and dealt with by the Healthcare professional;
- Circumstances that must immediately and invariably be reported to the supervising doctor by the HCP;
- What the HCP should do if an INR is outside normal limits at the time of testing;
- Who is responsible for action if a patient cannot be contacted by phone by the doctor;
- Procedures to prevent patients being 'lost to follow-up' if they miss an appointment with the HCP (some INR monitoring computer packages have a specific facility to flag non-attenders);
- Audit arrangements for monitoring the clinic.

## REDUCE YOUR RISK

Medical Protection has a series of resources to help practices reduce their risk and avoid complaints and claims.

### WORKSHOPS

Our workshop *Medication Errors and Safer Prescribing in Primary Care* is free to members and is designed to enhance your understanding of errors in the medication process, and provide you with some practical tips and strategies to help you prescribe more safely. To find out more and book a place visit: [medicalprotection.org/education](http://medicalprotection.org/education)

### RISK ASSESSMENTS

Why not try one of our Clinical Risk Self Assessments (CRSAs)? This unique consultancy programme has been designed especially for primary care and involves the whole practice team. This risk assessment will help you:

- Meet national standards;
- Improve a practice's systems, the quality of care provided and clinical risk management
- Reduce the risk of harm to patients;
- Reduce the likelihood of complaints and claims;
- Improve communication within the team.

CRSAs are FREE for Practice Xtra Gold members and half price for Practice Xtra Silver members.. To find out more and make a booking visit: [medicalprotection.org/crsa](http://medicalprotection.org/crsa)

### REFERENCES

1. Health and Social Care Information Centre, Prescription cost analysis (2016) <http://www.hscic.gov.uk/article/2021/Website-Search?productid=20437&q=prescriptions&sort=Relevance&size=10&page=1&rea=both#top>
2. Avery et al, Investigating the prevalence and causes of prescribing errors in general practice: The PRACtICE study. (2012) Commissioned by GMC <http://www.gmc-uk.org/about/research/12996.asp>
3. Stock S et al, Examining variations in prescribing safety in UK general practice: cross sectional study using the Clinical Practice Research Datalink (2015) *BMJ* 2015;351:h5501 <http://www.bmj.com/content/351/bmj.h5501>
4. Saedder et al, Identifying high-risk medication: a systematic literature review (2014) *Eur J Clin Pharmacol.* 2014 Jun;70(6):637-45. doi: 10.1007/s00228-014-1668-z. Epub 2014 Mar 27. <http://www.ncbi.nlm.nih.gov/pubmed/24671697>
5. National Patient Safety Agency, Anticoagulant therapy: information for GPs (2007) <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59814>
6. National Patient Safety Agency, Patient Safety Alert no 18 (2007) <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59814>
7. NHS Cumbria, Warfarin Management Guidelines (2014) <http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/Warfarin%20management%20guidelines.pdf>
8. National Institute for Health and Care Excellence (NICE) Anticoagulation – oral. Scenario: Warfarin (October 2015) <http://cks.nice.org.uk/anticoagulation-oral/#scenario:3>
9. General Medical Council, Good Medical Practice (2013) [http://www.gmc-uk.org/guidance/good\\_medical\\_practice/continuity\\_care.asp](http://www.gmc-uk.org/guidance/good_medical_practice/continuity_care.asp)

# TOP 5 SOCIAL MEDIA DILEMMAS



Medicolegal Adviser Dr Gordon McDavid answers some of the most common social media queries we receive from practices

1

## HOW CAN A PRACTICE DEAL WITH ABUSE FROM PATIENTS ON SOCIAL MEDIA?

Abusive behaviour by patients must be handled in a robust yet considered manner, ensuring compliance with the practice's obligations as a healthcare provider and as an employer. Unacceptable communication via social media may feel like a nightmare scenario for any practice. However, as with any challenging patient situation, a good starting point is to try to achieve open communication with that patient.

The approach to managing patient behaviour will depend upon the particular circumstances and it is important to try to aim for a mutually acceptable resolution of the patient's concerns. For example, if the patient has made a complaint about the practice, it may be preferable for the practice to address this under their complaints procedure. Practices may wish to ensure that the patient understands that abuse (in any form) is unacceptable. Most social media providers will have a mechanism for reporting abusive comments and this should be considered.

2

## WHAT CAN STAFF DO ABOUT PATIENTS TAKING PHOTOS IN WAITING AREAS AND POSTING THEM ON SOCIAL MEDIA?

This tricky scenario is becoming all the more commonplace with the increasing use of camera phones. Practices should have a policy in place in relation to photographs being taken on-site. It might be to prohibit patients taking photographs, particularly in clinical areas or waiting rooms.

A photograph in which an unsuspecting patient is inadvertently pictured attending surgery, could be considered a breach of confidentiality – particularly if that photo then finds its way online and is published on social media. This could cause distress to patients and could invite a complaint.

Banning photographs can be a challenge. A practice would be expected to take reasonable steps to enforce their policies, for example, empowering staff to politely interject if a patient is observed taking photos, or displaying clear notices in public areas. These notices should make specific reference to the fact that no photographs should be published online.

3

## WHAT SHOULD A SOCIAL MEDIA CLAUSE WITHIN A STAFF CONFIDENTIALITY STATEMENT INCLUDE?

It is important to include a social media clause in the staff confidentiality statement. In relation to social media particularly, the following comments may be helpful:

- It is wholly inappropriate for a GP or member of staff to post derogatory comments about a patient on social media sites. The healthcare regulators, such as the GMC, would take an extremely strict line in this regard.
- It would be also inappropriate to discuss posts on social media in the context of a consultation.
- It is also not appropriate for staff to discuss the practice or staff members on these sites. A clause could be included in a staff member's contract.
- We understand that such sites often have a quick means by which abusive comments can be reported.
- Medical Protection takes the view that GPs and practice staff should avoid accessing patients' personal social media sites, or at least avoid adding patients as friends.

The social media clause should state that staff members should act, on social media, with the conduct that would be expected of a practice employee. It should state that patients, consultations or desk enquiries, even anonymously, should not be discussed on social media sites. Aspects of the day-to-day running of the practice or reference to colleagues should not be discussed.

4

## IS IT OK FOR A PATIENT TO TAKE A SELFIE DURING MINOR SURGERY?

This sounds a bit unusual but at Medical Protection we've heard this is becoming an increasingly common request, especially in practices that deal with a high student population. If a patient were to ask to take a selfie photograph, it is worth discussing this with the patient to explore the reasons for the request. If the reason is innocent enough and you have no concerns about the patient taking such a photograph, there is no reason to refuse to allow this. However, if the picture could potentially capture something it shouldn't, such as another patient in the background or confidential information, then it would be your duty to intervene. Practices may wish to consider a policy in this regard and may elect to have a blanket protocol to prohibit all forms of photographs.

5

## MY NURSE HAS BEEN CRITICISED ON OUR PRACTICE'S FACEBOOK PAGE – WHAT SHOULD I DO?

It is important to open the lines of communication with the person expressing unhappiness and to deal with such a situation as any complaint would be managed.

The optimum strategy would depend on the particular circumstances but contacting the patient directly and offering to look into their concerns is likely to be a helpful first step. Such action provides a means to look into the allegations and a forum to be able to respond to the criticisms, whilst also steering the patient away from voicing their negative views online.

You also need to keep in mind your obligations under the relevant complaints regulations for your area. For more information read our advice booklet *A guide to effective complaints resolution*, available on our website: [medicalprotection.org](http://medicalprotection.org)

## MORE RESOURCES

Medical Protection has a factsheet on the use of social media. To access it visit: [medicalprotection.org/factsheets](http://medicalprotection.org/factsheets)

# END OF LIFE CARE

A recent report from the CQC has highlighted where general practice could improve in the provision of end of life care. Dr Rachel Birch, Practice Matters Editor-in-Chief, offers advice on how to put the CQC recommendations into practice

**M**any patients choose to spend their last days of life at home. GPs have an essential role to play in ensuring that patients die with dignity and choice, with minimal distressing symptoms and with good care and support for both patients and families.

Whilst many GPs may feel that they are already doing their best for patients at the end of life, the CQC has recently published a report that suggests there is still room for improvement.<sup>1</sup>

## THE CQC REPORT

The report found that patients from certain groups in society may sometimes experience poorer quality care at the end of their lives, because health professionals may not always understand or fully consider their needs. As part of the review, investigators spoke with patients in these more vulnerable groups to seek their experiences of end of life care.

The review focussed on the following ten groups of patients:

- people with conditions other than cancer;
- older people;
- people with dementia;
- people from Black and minority ethnic (BME) groups;
- lesbian, gay, bisexual and transgender people;
- people with a learning disability;
- people with a mental health condition;
- people who are homeless;
- people who are in secure or detained setting;
- Gypsies and Travellers.

The review looked at four particular aspects of care:

1. Identification of people likely to be in the last 12 months of life, and communication with these people and those important to them.
2. Coordination of care, particularly for people with complex needs or vulnerabilities.
3. Timely and equitable access to good care, including 24/7 support.
4. Care in the last days and hours of life that delivers the five priorities for care of the dying person.

The report found that health professionals did not always have conversations with people early enough about their end of life care. It also stated that in some situations an equality-led approach was not being taken and the needs of the above groups of patients were not being fully identified and met.



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## GP RECOMMENDATIONS

The CQC has recommended that GPs:

- assess and understand the end of life care needs of their local population;
- fulfil their duties under the Equality Act 2010;
- ensure practice staff have appropriate knowledge, skills and support;
- follow national guidance on quality end of life care;
- ensure that everyone with a life-limiting progressive condition has the opportunity to have early and ongoing conversations about end of life care;
- provide every patient with a named care coordinator to coordinate services (eg, GP, district nurse, specialist nurse).

At future CQC assessments, the CQC intend to:

- assess the quality of end of life care provided by practices, ensuring it is meeting the needs of all patients, including those from equality groups and vulnerable patients;
- seek evidence that early conversations are being held with all patients to ensure coordinated end of life care.





# HOW CAN GPs PUT THE CQC GUIDANCE INTO PRACTICE?

Although CQC guidance only applies in England, their recommendations are relevant to practices across all four UK jurisdictions. Their recommendations are consistent with existing guidance. NICE outlines the importance of early recognition of, and communication with, patients approaching the end of their lives<sup>2</sup> and specifically refers to a “comprehensive holistic assessment with the development of a personalised care plan”.

## RECOGNISING PATIENTS AT THE END OF LIFE

One of the biggest challenges for practices may be identifying patients who may be nearing the end of life. This will depend on several factors, including how well the patient is known to the practice, what condition they have and whether it is possible to pinpoint when a chronic disease has entered its final phase.

It might be easy to recognise patients in nursing homes or perhaps those with end stage chronic renal disease. Harder to spot may be people with slow-developing dementia or those with mental health problems who do not consult on a regular basis.

The General Medical Council (GMC) states<sup>3</sup>:

“Patients are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions;
- general frailty and co-existing conditions that mean they are expected to die within 12 months;
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
- life-threatening acute conditions caused by sudden catastrophic events.”

GPs may wish to use the Gold Standard Framework Prognostic Indicator guidance<sup>4</sup> to identify patients who may be approaching the end of life.

Since primary care is multidisciplinary in nature, there may be several health professionals who contribute to an individual patient’s care. GPs, practice nurses, healthcare assistants, district nurses and health visitors may be treating the patient for a range of different conditions. Whilst individually they may not have identified concerns, taking all their experiences together, it may be possible to identify vulnerable and deteriorating patients.

For this reason, good communication with all members of the primary care and community teams is essential. Practices may wish to consider arranging regular multidisciplinary team meetings, so that any concerns can be shared at an early stage.

The value of receptionists shouldn’t be underestimated either. Some receptionists have been at practices for many years and may notice subtle changes in patients that no one else has identified. If your receptionist is worried that a patient is “not as good as they were”, GPs probably should be too.

Encouraging communication with community psychiatry staff such as CPNs and psychiatrists for the elderly may help to identify potentially vulnerable patients at an earlier stage.

## GOLD STANDARD FRAMEWORK MEETINGS

The aim of the Gold standard framework<sup>5</sup> is to ensure that all patients nearing the ends of their lives, whether with a cancer diagnosis or not, receive “gold standard” care. It is good practice for all members of the patient’s multidisciplinary team to meet regularly to monitor, record and plan the patient’s care. Emphasis is placed on the control of symptoms, discussion and planning with the patient and their carers, carer support and good communication and coordination, including with other providers such as OOH.

All practice should ensure that they are holding regular Gold Standard Framework meetings and keep minutes of discussions held.

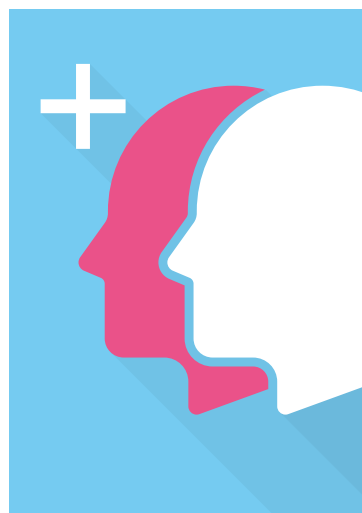


## COMMUNICATION AROUND END OF LIFE CARE

It can be difficult for any health professional to bring up the subject of end of life care with a patient. GPs are often the first point of contact at this sensitive time and may find themselves dealing with a variety of issues arising from the diagnosis.

At a new diagnosis, for example of metastatic cancer, this may be a huge shock for a patient and their family and it may take some time to come to terms with the diagnosis. It is helpful for GPs to make contact with patients when the initial diagnosis is made, as they are uniquely placed to coordinate care from the beginning and may already know the patient well and therefore be best placed to offer support. It takes sensitivity to get the timing right but, at an appropriate stage, GPs should ensure that patients are aware that their wishes are paramount in providing and coordinating good end of life care.

Equally challenging can be addressing the subject, with a patient with a deteriorating chronic condition, that they are nearing the final stages of that illness. GPs should be sensitive in their approach and ask the patient if they would like a family member present to support them.





## ADVANCE CARE PLANNING

The GMC's guidance three indicates that patients are likely to want the opportunity to decide what arrangements are made for the final stages of their illness. It also recommends that if a patient has a condition that might lead to a loss of capacity, their GP should encourage them to think about what they might want should this happen. In addition, doctors should consult patients, where practicable, about their wishes and feelings regarding CPR.

Early discussion about a patient's wishes may avoid misunderstandings, distress and potential conflict between healthcare professionals and patients. If the patient and family are aware that the GPs and nurses are "on the same page" then this can produce reassurance on any concerns they may have.

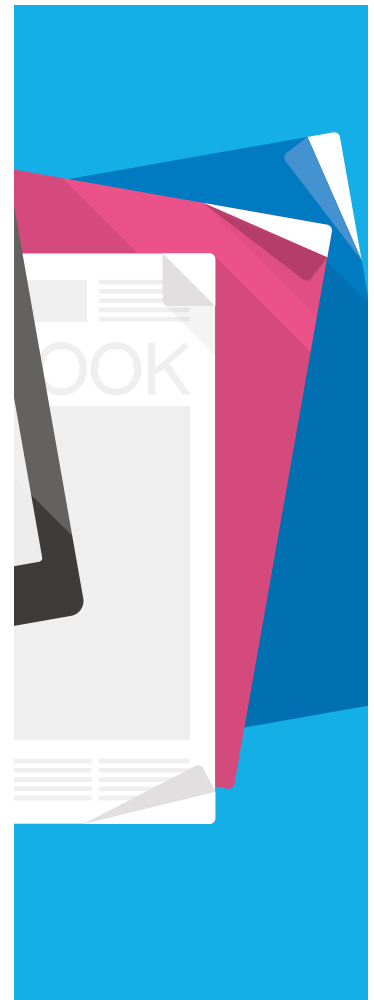
Patients may wish to discuss palliative care and how this will be organised. Discussions should cover the patient's wishes, preferences and fears about their future treatment care and treatment. If the patient wishes family members or legal proxies to be involved in discussions then this should be facilitated. Patients may specifically wish to express a preferred place of care, such as a hospice, and they may identify religious or personal support that they would like.

It is helpful to discuss interventions which may be considered in an emergency, or in the event of deterioration, such as CPR or antibiotics for life-threatening infection.

The GMC states that doctors must make a record of all advance planning discussions and decisions made. It is good practice to give the patient a copy of the advance care plan and all other professionals involved in their care. This is important so that it is clear what has been agreed.

In particular, if a patient makes an advance refusal of treatment, you should encourage patients to share this with those close to them.

Advance care plans should be reviewed and updated as the patient's situation or views change. In addition to clinical decisions, patients may wish to attend to other personal matters, such as appointing a lasting power of attorney or making a will. GPs may be asked to assess capacity for such decision making and, if they know the patient well, they are usually best placed to undertake such an assessment.



## TRAINING

Advance care planning is a key part of the Gold Standards Framework (GSF)<sup>5</sup>. It includes many elements to help people approach the end of their life and can be summarised as:

- what patients want to happen;
- what patients don't want to happen;
- who will speak for them.

The GSF offers a range of training programmes to healthcare professionals, aimed at enabling them to optimise the care they provide to patients at the end of life.

Practices should ensure that all staff receive regular training on how to support patients at the end of life. This may be in house or external, but should be documented in staff members' training files.

## GOOD END OF LIFE CARE

Although many GPs are already delivering high quality end of life care to their patients, it is important to ensure this good practice is documented. One way of doing so is to develop an end of life practice policy, which outlines the processes and systems in place to support patients and ensure their needs are met at this very important stage of their lives. The policy should include:

1. Early identification of patients.
2. Consideration of potentially vulnerable patient groups.
3. Coordinated care within the healthcare disciplines.
4. Early and regular conversations with patients and their carers about their wishes.
5. Training for all staff members.

## MORE SUPPORT FOR YOU

Conversations with patients around end of life care can often be difficult. Our FREE workshop on Mastering Shared Decision Making can help. Facilitating conversations effectively can result in more informed and appropriate decision making for patients. It can also increase a patient's sense of ownership of the decision leading to better acceptance of unexpected or unwanted consequences after an adverse outcome.

To find out more and book a place, visit: [medicalprotection.org/workshops](http://medicalprotection.org/workshops)

### REFERENCES

1. CQC. A different ending: Addressing inequalities in end of life care (2016). <http://www.cqc.org.uk/content/different-ending-our-review-looking-end-life-care-published>
2. NICE. End of life care for adults. Quality standard 13 (2011). <https://www.nice.org.uk/guidance/qs13>
3. GMC. Treatment and care towards the end of life: good practice in decision making (2010). [http://www.gmc-uk.org/guidance/ethical\\_guidance/end\\_of\\_life\\_care.asp](http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp)
4. The Gold Standards Framework Prognostic Indicator Guidance (2011). <http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>
5. The Gold Standards Framework. <http://www.goldstandardsframework.org.uk/>

# IN THE HOT SEAT



*Medical Protection's Kirsty Plowman sits down with Ian Wilson, Regional Liaison Adviser for the General Medical Council, to discuss how the Regional Liaison Service can help doctors in general practice understand GMC guidance*

The General Medical Council's (GMC) Regional Liaison Service (RLS) operates as a frontline service to help doctors understand and apply GMC guidance to their everyday practice. The RLS supports doctors at all levels, patients, medical students, non-clinical staff and other groups across the UK.

The service provides:

- free interactive sessions to groups of doctors to improve their understanding of GMC guidance and explain what happens if a doctor falls short of these;
- support to doctors with sessions explaining revalidation;
- talks to medical students about professionalism and what will be expected of them as doctors;
- consultations to people who want to help shape GMC work and discuss changes that could affect them;
- a 'Welcome to UK Practice Programme' to doctors new to medical practice in England.

The interactive sessions are useful for all doctors and are tailored to the particular audience.

Ian Wilson, Regional Liaison Adviser for Yorkshire and Humber, believes all doctors should be taking advantage of the RLS.

"It is very much about providing frontline service for doctors to help them understand GMC guidance,"

he says. "We think there is a link to doctors getting into difficulty and the lack of understanding with GMC guidance. Our workshops address the types of behaviour that can get doctors into difficulties and ways of avoiding the pitfalls."

"They are very much about reducing the fear factor of fitness to practice investigations – ultimately, on an annual basis only a tiny proportion of doctors are removed from the register."

## WHAT FORMAT DO THE SESSIONS TAKE?

The regional liaison advisers travel to practices across the country to deliver the sessions face-to-face in a familiar setting to attendees. This can be in hospitals, general practice surgeries and clinical commissioning groups as an outreach service.

Ian says: "The sessions are very interactive and we encourage lots of audience participation. Most of our sessions involve playing a range of video scenarios that test a range of ethical situations. We often split into smaller groups and encourage discussions on what ethical issues are at play. The group then comes back together to discuss what GMC guidance says about the specific issues. They usually last between one and two hours."

## POPULAR SESSIONS

The service offers a wide range of topics aiming to look at all the issues medical practitioners could face. They include:

- The GMC – an update;
- Treatment and care towards end of life;
- Confidentiality;
- Raising concerns;
- Professional use of social media;
- Good medical practice;
- Revalidation and reflection;
- Consent;
- Personal beliefs;
- Maintaining boundaries;
- Leadership and management.

"The most popular session that I teach is 'The GMC – an update' which offers an overview of what the GMC and the RLS provides," says Ian. "But 'Confidentiality' is also popular as it encourages doctors to consider if they are doing enough to protect information and inform them about the exceptions of confidentiality particularly around public interest."

"Our session 'Raising concerns', which asks "what would you do if you felt patient safety was being compromised?", is of great interest to doctors and we're currently seeing a lot of interest for 'Revalidation and reflection' – this defines what revalidation means for doctors and helps them to sharpen their reflection skills for appraisals and training."

## EXTRA RESOURCES

The RLS sessions are intended to show that the GMC isn't just about fitness to practice. Ian explains: "The GMC deals with registration, education and revalidation, but right at the core are our standards, and those standards are about helping doctors with professionalism."

"That's why we have a GMC helpline and there are a number of online resources and services which help doctors with GMC guidelines and medical ethics."

For more information, visit [gmc-uk.org](http://gmc-uk.org) and enter "rls" into the search box - or call the GMC helpline on **0161 923 6399**.

## MORE ADVICE

Medical Protection's expert team of medicolegal advisers are available to assist you if you have received a complaint or a claim, or just need advice or guidance relating to any legal or ethical aspect of your practice. Contact them free on: 0800 561 9090 or [querydoc@medicalprotection.org](mailto:querydoc@medicalprotection.org)

# PRACTICE PROFILE

# PROVIDENCE SURGERY



The CQC recently visited Providence Surgery in Boscombe, Bournemouth and rated them 'Outstanding'. Medical Protection's Kirsty Plowman looks into how they achieved this rating and finds out what advice they have for other practices preparing for the process

**P**rovidence Surgery is located in Boscombe, a suburb of Bournemouth, Dorset. The practice has two GP partners and employs seven salaried GPs. In addition there are two practice nurses, two healthcare assistants, an operations manager and a team of administration and reception staff. The practice is a training practice for medical students and doctors training to be GPs and there is a branch surgery at Strouden Park Medical Centre.

The practice is situated in the top 1% of the most deprived areas in the UK and has a higher proportion than the national average of patients aged between 20 to 49 years of age. There is also a higher than national average incidence of recorded crime and patients who are of no fixed abode.

Providence has approximately 9,600 patients on its register, but is subject to a 30% turnover of patients annually. A total of 20% of the patients registered with the practice are known to misuse drugs and/or alcohol. There are 38 different languages spoken within the practice area and 20% of the population are unable to read or write well.

#### Why is the practice rated outstanding?

Under the Care Quality Commission's (CQC) new programme of inspections, all of England's GP practices are being given a rating according to whether they are safe, effective, caring, responsive and well-led. Inspectors rated Providence good

©ProvidenceSurgery



for being safe, effective and caring, while rating it outstanding for being well-led and responsive to people's needs.

Ruth Rankine, Deputy Chief Inspector of General Practice, said: "We found that Providence Surgery is providing an outstanding service, particularly for people whose circumstances may make them vulnerable and at risk.

We were particularly impressed with the practice's work to drive improvements to services for its patients and the commitment of all staff to continuously improve.



“The culture of the practice focused on community engagement and being central to community life. This culture benefited the emotional and physical wellbeing of the patients. In addition we noted many individual acts of care, compassion and kindness towards patients, by members of the practice team.”

#### The CQC found that the outstanding areas of practice at Providence included:

- All GPs had specialist training on substance misuse and detoxification protocols. Care for patients with mental health and/or substances misuse was shared with the mental health team and detoxification programmes were offered at the practice. This ensured consistency of care and consistent parameters for the type of care provided.
- The practice had “in-house” MRI scanning, X-ray and ultrasound facilities to enable patients to have examinations carried out promptly. The ultrasound service was developed and paid for by the practice and had a waiting time of one week for a scan to be done.
- A GP from the practice visited the local night shelter for homeless people on Monday to Friday to provide medical care.
- The practice worked with the local community, in particular the Boscombe Community Forum, to shape the future of the community. The forum’s purpose was to raise awareness of issues affecting the community and act as an information exchange of what services are available to people, such as local Healthwatch, Citizen’s Advice and Drug and Alcohol support.

#### How did the practice achieve this?

GP Partner Dr Mufeed Ni’man and Operations Manager Chris Hughes established a business model for the surgery which focuses on developing Providence as a centre of excellence in patient care. Their aim was to expand and reinvest profits to increase patient numbers by offering unique services and diagnostics.

Dr Ni’man believes that Providence is outstanding because of the patient-focused services that the practice provides.

“My team try to develop a culture and environment of openness, learning and encouragement, where we don’t see a problem, we see a solution,” he said.

“We practise in a very deprived area and

have lots of vulnerable people here. After recognising that some of our patients do not have transport or money to go to hospital, we decided to do things differently by bringing services to them. I think what impressed the CQC was the drive and the vision we have to provide these patient services on-site.”

Mr Hughes also recognised the practice’s commitment to patient needs as one of the reasons for the successful CQC rating.

He explained: “Our primary focus is on the patient. Around that, we developed services that would minimise the patient’s pathway. For example, we self-commission our own ultrasound service and MRI service. A patient could come into the surgery on Monday and have the ultrasound on Tuesday. Patients are being seen promptly as we have brought these services closer to home.”

Providence was praised for the support it provides vulnerable patients. The practice actively encourages “at risk” groups such as the homeless to register in order to help resolve all health issues.

#### The inspection

Even for an ‘Outstanding’ practice, perhaps the hardest part of CQC compliance is the inspection. Mr Hughes said: “It was very demanding – at the start of the day we gave a presentation which outlined our vision then the inspectors conducted a series of audits on our policies and procedures.”

A team of five or six inspectors carried out the inspection which ran from 8am to 6pm. In addition to the presentation and the review of policies and procedures, patients and staff who were on-site on the day were interviewed.

Dr Ni’man added: “It was a stressful day, but we wanted our staff to express their views about anything – that’s the way we operate, we are open which is always the best way.”

#### Hints and tips

When asked what they would say to other practices on how to achieve outstanding Dr Ni’man said: “Be yourself – and be patient focused. Have a clear vision of what it is you want to do and what type of care you want to provide.”

Additionally, Mr Hughes said communication is essential: “I think transparency with staff and communication is key. You can have many policies and procedures in place but they need to be implemented on a day-to-day basis so it is very important to create a culture within the practice that generates lines of communication that enables the effective day-to-day management of patients.”

He added: “The personable touch is also

very important, but is difficult to create – it’s something that we are very absorbed in here at Providence. Always remember that it’s about being in tune with the patient.”

#### FIND OUT MORE

Medical Protection’s website has a dedicated page offering support to help practices meet the CQC’s fundamental standards. Visit [medicalprotection.org/cqc](http://medicalprotection.org/cqc)

A Clinical Risk Self Assessment (CRSA) for general practices is a unique consultancy programme provided by Medical Protection designed to identify potential risks within a practice and develop practical solutions to mitigate these risks. A CRSA aims to improve the quality of patient care and reduce a practice’s exposure to unnecessary risk, helping to assist practices in preparation for a CQC inspection.

To find out more and watch a video about what a CRSA can do for your practice, visit [medicalprotection.org/crsa](http://medicalprotection.org/crsa). To make a booking email [crsa@medicalprotection.org](mailto:crsa@medicalprotection.org) or call **0113 241 0359**.



# FROM THE CASE FILES



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When Mrs C, a keen golfer in her early forties, began to experience constant pain in her lower back, she consulted a GP at her local surgery. Dr P took a history of slow onset of pain with restricted mobility. He did not examine her, but prescribed an NSAID and advised Mrs C to return in two weeks if there was no improvement.

Over the following three months, Mrs C made five more visits to the surgery with the same complaint, seeing a different doctor on each occasion. On her fourth visit, when she consulted Dr L, she complained of numbness in her perineum and that her back pain was now radiating down both her legs. Dr L recorded these symptoms in her notes, but did not examine Mrs C. Her notes read: "lumbar pain for 10/52 now, getting worse. Saddle anaesthesia. Refer physio".

Dr L did refer Mrs C, but as there was a long waiting list for physiotherapy, Mrs C's first appointment was to be in six months' time.

In the meantime, Mrs C was becoming increasingly distressed as her symptoms worsened; she returned to the surgery, this time consulting Dr V. Again, saddle anaesthesia and bilateral sciatica were noted, but Dr V merely prescribed stronger analgesia and suggested that Mrs C perform daily gentle exercises. His notes mentioned that Mrs C was "highly strung", so he may have thought that she was overstating her symptoms.

Mrs C returned to the surgery two days later and was seen by Dr G. This time she had a new and distressing symptom to add; she had been incontinent of urine. Dr G, looking through her past medical history, observed that Mrs C's pelvic floor had probably been weakened by the five vaginal deliveries she had had during her twenties and thirties. He instructed her in carrying out pelvic floor exercises and arranged a gynaecology referral for assessment.

That evening Mrs C's back pain intensified to the extent that she was unable to walk. Her husband called for an ambulance and she was taken to the local A&E department. An MRI scan confirmed a massive central disc protrusion at L4/L5 and surgery was carried out as a matter of urgency to relieve the pressure on the cauda equina. Unfortunately, the discectomy did not have the desired effect. Mrs C was left with permanent neurological damage, unable to walk and doubly incontinent.

Mrs C brought a claim against her GP practice, alleging that the signs of cauda equina syndrome had been apparent during her consultations and that the GPs' failure to diagnose her condition had deprived her of timely treatment and the chance of a full recovery.

## EXPERT OPINION

In the opinion of GP experts, Dr P could be criticised for not examining Mrs C, but his treatment and advice were otherwise reasonable in the circumstances. They reserved their detailed criticism for Dr L, Dr V and Dr G who, they felt, had all delivered

substandard care. Mrs C had presented to each of them with clear warning signs of cauda equina syndrome and they should have referred her to hospital as a matter of urgency. Moreover, none of them had examined Mrs C to determine the extent of her problems.

On causation, an expert in neurosurgery concluded that Mrs C would have been left with "little or no" permanent neurological damage if she had been operated on within 48 hours of seeing Dr L. He thought that by the time she saw Dr V some permanent impairment had probably already occurred, but that she would have regained more use of her legs if intervention had taken place at that time.

The case was settled out of court for a substantial sum.

## LEARNING POINTS

- Although lower back pain is commonplace, it is still important that you take and record a proper history and examine the patient for signs of neurological impairment.
- Continuity of care can be difficult when patients consult a series of different doctors about an ongoing complaint. You should therefore refer to earlier entries in the patient's record especially when seeing someone for the first time.
- Cauda equina syndrome often has a chronic onset, so be alert to this when seeing patients making repeated visits for unresolved lower back pain.
- Familiarise yourself with the "red flags" associated with cauda equina syndrome and refer the patient urgently if these are apparent in association with

## RED FLAGS

- Bilateral or unilateral sciatica
- Bladder or bowel dysfunction
- Anaesthesia or paraesthesia in perineal region or buttocks
- Significant lower limb weakness
- Gait disturbance
- Sexual dysfunction

## FURTHER READING

1. Anthony S, *Cauda Equina Syndrome*, Casebook, 2003(1); 9-13

For more case reports from general practice visit:

[medicalprotection.org/uk/cases-GPs](http://medicalprotection.org/uk/cases-GPs)



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