IN THE DARK

RISKS OF TELEPHONE CONSULTATIONS

PAGE 4
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Inside this issue of Sessional GP...

Medicolegal features

4 Telephone consultations
Consulting on the telephone requires a different skill-set to normal practice, says Dr Tony Males

7 Revalidation watch
Dr Rachel Birch is in the first wave of GPs going through revalidation; she shares her experiences

8 Home visits
The art of telephone triage is ascertaining what really does require a home visit. Dr Zaid Al-Najjar explains how to get the balance right

10 Don’t miss the signs
The GMC’s latest child protection guidance has ushered in new obligations for all doctors. Charlotte Hudson explores all guidance surrounding child protection

Practical problems

12 How to create a patient safety culture
MPS risk manager Julie Wilson discusses how to build a patient safety culture in primary care

14 From the outside looking in
Terri Bonnici, general practice complaints manager, highlights the locum’s role in the complaints investigation process

Working life

16 In the hot seat: Dr Susan Stone
Dr Susan Stone shares her battle plans for getting commissioners to engage with sessional GPs

18 Final thought – The irony of complaints
Blogger and locum GP Dr Euan Lawson says that when it comes to complaints we should be grateful that thorns have roses

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Welcome

Consulting by telephone is commonplace in modern primary care and out-of-hours services. Sessional GPs are likely to have experienced many different models of telephone triage in the different practices they have worked in.

Consulting patients on the telephone lacks the nuances and richness of face-to-face consultations, so a full clinical assessment is not possible. In his article ‘In the dark’ popular writer and sessional GP Dr Tony Males says that if the limitations of the telephone consultation are recognised, and a careful history is taken and documented, patients can be managed in a reasonable, appropriate and safe way.

A key part of telephone triage is getting the balance right, so that the correct decisions are made about what can wait for a visit to the patient’s own GP and what requires a home visit. Medicolegal adviser Dr Zaid Al-Najjar writes in his article on home visits that although the decision about whether or not to visit is a clinical one, there are clear medicolegal implications of opting for the wrong choice.

He stresses that GPs should explore why a caller is requesting a home visit, even if it is seemingly for minor symptoms. If you are unsure about how to proceed, take the caller’s number and say that you will call them back to discuss it further.

We hope you enjoy this issue.

Dr Richard Stacey – Editor-in-chief
MPS Medicolegal Adviser
Consulting by telephone is commonplace in contemporary primary care and has evolved in order for practice teams and out-of-hours providers to adapt to increasing patient demand. Practices differ in their use of telephone consultations and sessional GPs will experience a variety of models. Requests for urgent appointments may be triaged at an administrative or clinical level, with call-backs made by nurses, nurse practitioners or duty doctors.

Routine care can be provided by telephone and calls may be initiated by the patient, for example, in wanting to find out and discuss the results of investigations, or by the clinicians, such as in the follow-up of a long-term condition. Thanks to the practically universal ownership of, or access to, telephones, this medium of communication is equitable and efficient, language barriers notwithstanding. It is absolutely imperative that we make telephone consultations medicolegally and clinically safe and effective.

Risk management
It must be acknowledged that telephone consultations lack the nuances and richness of the face-to-face consultation. The doctor is therefore deprived of the non-verbal cues that become apparent the moment the patient enters the consulting room. A full clinical assessment is therefore not possible, but if the limitations of the telephone consultation are recognised, and a careful history is taken and documented, patients can be managed in a reasonable, appropriate and safe way.

It is important to remember that you must put yourself in a position to justify the diagnosis and management plan you make in the context of a telephone consultation, and if there is any doubt then a face-to-face consultation should be arranged. Remember that consultations with third parties further amplify the pitfalls of telephone consultations and introduce extra dimensions relating to consent and confidentiality.

Features of a successful telephone consultation include:

- Identifying oneself and the caller, the latter being the patient whenever possible
- Gathering information from speech (content, rate, rhythm, tone and emotion) and non-speech sounds (cough, wheeze, background noises)
- Addressing both the clinical history and patient’s perspective, including the social and cultural context
- Giving a diagnosis or interpretation of the patient’s problem with an explanation or a summary
- Signposting the point at which a triage or management decision must be made
- Negotiating the outcome with acknowledgement and sharing of the risks. If it is agreed that no face-to-face meeting is necessary, then appropriate advice must be given and you should ensure that the patient is content with the suggested management plan
- Making follow-up arrangements and providing safety-netting advice
- Making a thorough, contemporaneous note, including the telephone number that was used in the consultation.

In the dark
Risks of telephone consultations

Consulting on the telephone requires a different skill-set increasingly relying on common sense and improvisation. Learning how to do this effectively is necessary to safeguard patients, says GP and popular author Dr Tony Males
Recording calls
Some practices and out-of-hours providers record incoming and outgoing telephone calls. These electronic sound files form part of the patient’s records and can provide useful information in the event of a complaint or claim. Such recordings must be made, stored and disclosed under the provisions of the relevant legislation, which includes putting the patient on notice of the fact that the call is being recorded.

Under the provisions of the Data Protection Act (1998), patients have a right to be provided with copies of information that is held about them and this would include recordings of telephone consultations. The General Medical Council have produced some helpful guidance about the recording of patients in their publication entitled Making and Using Visual and Audio Recordings of Patients, which states that you must not make secret recordings of calls from patients (paragraph 56).¹

In the context of a complaint or claim, a recording may provide information beyond what is in the records that can be of assistance to the doctor, but this is not always the case. MPS recently dealt with a case of a sessional GP working in the out-of-hours setting who accidently prescribed penicillin to a penicillin-allergic patient. Unfortunately the patient had an anaphylactic reaction which required in-patient hospital treatment and a claim ensued.

The sessional GP had not recorded a history of allergy, but was adamant that their usual practice would have been to enquire about allergies before issuing a prescription and that the patient must not have given any indication that they were allergic to penicillin. The triage telephone recordings were reviewed, from which it was clear that the patient (without any prompting) volunteered that they were allergic to penicillin and on this basis the claim was settled.

Common pitfalls
The key stages in the telephone consultation are prone to error and are information gathering, making a decision and giving advice. Studies in the USA in the 1970s identified deficiencies in information gathering by trainee paediatricians conducting simulated telephone consultations.² ³ ⁴ ⁵ ⁶ For example, they missed out questions about medication given to the sick child, allergies and immunisation history. They failed to explore how well a child with a cough was breathing, or how well hydrated a child was with diarrhoea. The use of protocols improved the standard of history taking, but did lead to a higher number of patients being invited to attend the emergency department.

Two phenomena have been identified in telephone consulting that affect our interpretation of information and the subsequent decision-making process. In other studies involving simulated cases of sick children, nurses and doctors seemed to ignore additional information offered or concerns expressed beyond the point at which the clinician made a diagnosis or a decision about what to do.⁷ ⁸ ⁹ When GPs and community-based paediatricians were compared with hospital-based colleagues, the severity of a dehydrated baby’s illness was underestimated. The primary care doctors were described as having a wellness bias, as they were used to operating in a context with a low prevalence of serious disease.

Therefore we must be aware of making premature decisions in telephone consultations, keeping an open mind throughout and being willing to change our mind or management plan. We should include rare or serious conditions in our differential diagnoses, while we are listening to our patients’ histories, and be prepared to convert our calls into face-to-face consultations if we pick up symptoms, or cues, that deviate from the common pattern.

Giving advice is a communication skill that is just as important as listening. It is amenable to being structured through checklists and protocols and can be backed up by written information that can be posted to the patient or accessed online. Resources such as the Minor Illness Manual are valuable for all clinicians in primary care.¹⁰

Good advice empowers patients and enables them to learn from one episode of illness to the next and may reduce their need for professional help. More advanced and unlikely to be provided by practices are decision-support software packages that support telephone triage by prompting clinicians to give comprehensive advice on conditions that may not need a face-to-face assessment. NHS Direct and some out-of-hours providers use these packages.

Ethical considerations
Ethical issues arise when one considers that healthcare delivery by telephone is prone to error compared to its gold standard counterpart, the face-to-face consultation. What is the balance between the advantages and disadvantages to the patient?

How can the rights of the patient be reconciled with the duties of the practitioner? Beauchamp and Childress’ “four principles” ethical framework helps in the analysis of ethical questions from four different viewpoints: beneficence (doing good), non-maleficence (avoiding harm), autonomy and justice.¹¹

In circumstances when a patient or carer specifically requests “telephone advice”, you must not assume that the request can be managed by way of a telephone consultation. How can the rights of the patient be reconciled with the duties of the practitioner? Beauchamp and Childress’ “four principles” ethical framework helps in the analysis of ethical questions from four different viewpoints: beneficence (doing good), non-maleficence (avoiding harm), autonomy and justice.¹¹

In circumstances when a patient or carer specifically requests “telephone advice”, you must not assume that the request can be managed by way of a telephone consultation. Conversely there may be occasions when you initiate a telephone consultation in relation to a routine matter that it may become apparent that a face-to-face consultation is required. A frequent cause for complaint is when a patient or carer calls and requests a home visit, but instead receives a telephone call. It may of course be entirely reasonable to manage the problem by way of a telephone consultation, but if there is an adverse outcome then this is frequently construed as a refusal to visit.

The avoidance of harm has long been a central tenet of medicine. Both patient and health professional are at greater risk of harm through telephone consultation compared to the face-to-face encounter. The patient is vulnerable to the adverse health
outcomes associated with an inadequate or inaccurate history, “wellness bias” and premature decision-making. The health professional who does not put herself in the best possible position to make a diagnosis and therefore provide appropriate treatment and advice is vulnerable to complaints and litigation if the patient suffers as a result of her negligence.

Telephone medicine can both enhance and undermine patient autonomy. For callers with symptoms strongly suggestive of a minor, self-limiting illness or injury, telephone consultation helps to empower the patient or carer to manage the situation without hands-on involvement by a health professional. Both autonomy and self-efficacy are enhanced and the experience of overcoming a health problem with some timely advice may affect the individual’s future help-seeking behaviour. However, patients may be denied their ability to choose their preferred form of medical attention by virtue of decisions made in the interests of demand management.

Justice is a utilitarian concept that has enduring relevance in healthcare systems. Making the most of resources, both human and financial, is the shared responsibility of both practice teams and out-of-hours providers. The increase in resources in the NHS has not kept pace with demand and so initiatives that increase efficiency and cost-effectiveness to maximise the benefit to the greatest number are required for the sake of fairness. Because the principle of autonomy focuses on the individual and justice on the population, the two often conflict.

Clinician-initiated telephone consultations
Clinician-initiated telephone contacts cover a wide range of situations, including:

- Monitoring of long-term conditions (cancer, heart failure, COPD, sometimes supplemented with data from assistive technology)
- Follow-up of acute conditions, e.g. after home visits or after hospital discharge
- Informing patients of abnormal investigations and sharing the decision about further management
- Follow-up of patients who are quitting smoking
- Inter-professional conversations with primary care team members, hospital colleagues or professionals from other health or social care organisations.

Summary
Telephone consultations are an integral part of contemporary practice and form a useful tool for the assessment and management of both acute and chronic conditions. Telephone consultations have inherent risks, but as long as you are aware of these, have a low threshold for arranging a face-to-face consultation, put yourself in a position to make the diagnosis, make thorough records and ensure that the patient is content with the proposed management plan then these risks can be minimised.

Dr Males is the author of the popular book *Telephone Consultations in Primary Care*. It can be bought for £24.95 from the RCGP bookshop. Visit: www.rcgp.org.uk. Dr Males has created an exclusive podcast on managing telephone triage, listen to the podcast here – www.medicalprotection.org/uk/podcasts/Telephone-triage-managing-uncertainty.

REFERENCES
1. GMC, Making and using visual and audio recordings of patients (2011) www.gmc-uk.org/guidance/ethical_guidance/making_audiostream.asp
Revalidation watch

Sessional GP and MPS medicolegal consultant Dr Rachel Birch is in the first wave of GPs going through revalidation; she shares her experiences.

My heart sank as I opened the email from the medical director – he was informing me of the local arrangements for revalidation and had the pleasure of telling me I was to be one of the lucky doctors to undergo revalidation in the first wave.

This was back in April, and I must say that for the first few weeks I behaved in an ostrich-like fashion. I went through denial, panic and self-pity before deciding that it was not going to go away.

I started looking into what was required for revalidation in my two professional roles, as a salaried GP and also as a medicolegal consultant for MPS. After emails to the local GP appraisal lead, extensive reading of GMC and RCGP websites and talking to my MPS mentor, I am now officially ready.

What is revalidation?
Revalidation is likely to have been lurking at the back of every doctor’s mind since it was first proposed by the GMC in 2000. Over the past 12 years the subject has rarely been out of the medical press. Varying models have been proposed and pilot studies conducted, but it is now on the brink of launching.

The GMC have confirmed that revalidation is expected to start at the end of the year. Revalidation is defined as the process by which licensed doctors have to demonstrate to the GMC that they are up to date, fit to practise and complying with relevant professional standards. Following a successful recommendation to the GMC by their responsible officer, doctors will have their licences to practice renewed. Each NHS performers’ list will have a responsible officer allocated.

The plan is that responsible officers will undergo revalidation by the end of March 2013. One fifth of licensed doctors will then undergo the process between April 2013 and the end of March 2014. Most doctors will be through the process by the end of March 2016 and the remainder by the end of March 2018. A five-year rolling rota will then follow.

GPs in some parts of the UK do not yet know in which cycle they will undergo revalidation. It is expected that from December 2012 this information will be provided.

How does it work?
All qualified GPs should be participating in annual appraisal and collecting supporting information. For revalidation this information will be submitted to responsible officers who will make their recommendations to the GMC.

What supporting information is needed?
■ Evidence that you have participated in annual appraisal, at least one of which has Good Medical Practice at its focus.
■ Supporting information that has been discussed at annual appraisals.
■ That there are no ongoing concerns about you as a doctor.
Although it is recognised that most GPs will have supporting information from the past five years, the GMC has outlined the minimum requirements for the first revalidation cycle as follows:
■ Documentation of personal information, personal development plans (PDPs), previous annual appraisals. Probity and health declarations signed at the latest appraisal.
■ A minimum of 50 CPD learning credits for the 12-month period prior to the last appraisal.
■ At least two significant event analyses (SEAs) in the previous 12-month appraisal year. Most GPs will have documented SEAs for previous years too, as this has been a contractual requirement.
■ A full-cycle audit completed within the previous five years before the revalidation date.
■ Completion of a colleague multi-source feedback (MSF) within the five years before the revalidation date.
■ A patient satisfaction survey documented within the five years prior to revalidation.
■ Description of any formal complaints and the response in the 12-month appraisal period.

If GPs ensure that they have this minimum supporting information prepared for this year’s appraisal and for every future appraisal too, they should be ready for revalidation whatever date they are allocated.

What you should do
Ensure that you have been allocated a responsible officer. Your appraiser will know who this is. Otherwise inform the GMC.

Take part in annual appraisals. Forms may have changed locally in line with the requirement to do appraisal based on Good Medical Practice – check the situation locally well in advance of your next appraisal.

Register with and start using an online portfolio so that you can store the supporting information required for revalidation. Examples are the RCGP revalidation e-portfolio, or for GPs in Scotland, the Scottish online appraisal resource (see references),

Start using the RCGP’s credit system to record all educational activities (including hours and impact).

Plan to have at least the minimum supporting information by your next appraisal.

Talk to your appraiser about the colleague MSF and arrange to review the results at your next appraisal.

If you do other work apart from GP work discuss this with your appraiser now. It may be able to be covered within your annual GP appraisal. If not, talk to your employer about revalidation arrangements. If in doubt, contact the GMC.

USEFUL LINKS
■ RCGP, Guide to Revalidation for GPs, version 7 (June 2012) – www.rcgp.org.uk
■ GMC, Ready for Revalidation: Supporting Information for Appraisal and Revalidation (March 2012) – www.gmc-uk.org
■ RCGP revalidation e-portfolio – www.rcgp.org.uk
■ Scottish online appraisal resource (SOAR) – www.scottishappraisal.scot.nhs.uk
■ RCGP CPD credits scheme – www.rcgp.org.uk
Home visits

The art of telephone triage is identifying what does require a home visit, and what is inappropriate. Dr Zaid Al-Najjar explains how to get the balance right.

You are a GP undertaking a telephone triage/base session one Saturday afternoon. Your colleague Dr F has just hung up and in anger tells you that a patient, Mrs R, wants to speak to another doctor. Dr F refused her request for a home visit to assess her and her 17-year-old daughter for a cough and flu-like symptoms. Dr F tells you that he really does not feel it is indicated and that it would be a waste of the car doctor’s time, given that it is a busy Saturday afternoon. The mother and daughter say that they have already been to a walk-in centre that morning, but are now feeling worse and do not feel well enough to make it to the treatment centre, where you are based.

The decision about whether or not to visit is a clinical one; however, there are clear medicolegal implications of opting for the wrong choice. GPs should explore why a caller is requesting a home visit, even if it is for seemingly minor symptoms. It may be helpful to explain that visits are usually only thought appropriate for people who are unable to get out of the house, or the elderly who may be more vulnerable getting out and about late at night. Most patients are reasonable and will often come around to the idea of coming in to see you for a consultation.

Consider whether, in actual fact, an ambulance may be more appropriate, ie, if the call is actually an emergency and an urgent visit just will not cut it. Many callers do not understand that the GP service is not an emergency service and that a home visit may not occur for at least an hour or two, even if it is triaged as ‘urgent’.

Is it appropriate?

During out-of-hours telephone triage sessions, there will often be a request for a home visit that the doctor does not feel is necessary or indicated or just plain inappropriate. For example, the inebriated patient who would like a doctor to visit to examine their sore throat, because they are over the limit and cannot drive into the base for a consultation; or the mum with three screaming children, whose partner is nowhere to be found, and has no way of bringing all of them in so that you can examine the painful ear of her eldest. It is frequently tricky and therefore the art of telephone triage is ascertaining what really does require a home visit, and what is inappropriate.

Local policies

Often, out-of-hours providers have policies regarding home visit requests and you should make yourself familiar with yours. If there isn’t one available, then you may wish to speak to your medical director about setting one up.

Communication

The decision about whether or not to visit is a clinical one; however, there are clear medicolegal implications of opting for the wrong choice. During most out-of-hours telephone triage sessions, there will often be a request for a home visit that the doctor does not feel is necessary or indicated or just plain inappropriate. For example, the inebriated patient who would like a doctor to visit to examine their sore throat, because they are over the limit and cannot drive into the base for a consultation; or the mum with three screaming children, whose partner is nowhere to be found, and has no way of bringing all of them in so that you can examine the painful ear of her eldest. It is frequently tricky and therefore the art of telephone triage is ascertaining what really does require a home visit, and what is inappropriate.

Seek advice

If in doubt, and you are unsure about how to proceed, take the caller’s number and say that you will call them back to discuss it further. You can then discuss it with a GP colleague to gain an impartial view, particularly if it has been a difficult consultation. You may even want to ask a colleague to take over the case and call them back – there is no shame in this as all of us have been there.

Documentation

One of the most important parts of the decision making
process, having discussed it with the patient, is to document what you have decided and why, along with any safety netting advice. If a home visit is not required at the point in time that you talked to the patient, make sure they know who to call and when, should things develop, or if they are unsure. If you triage a call as a home visit, make sure they know who to call, if their situation deteriorates between the time you take the call and the time the visiting doctor arrives. It may be that 20 minutes later, their cough develops into an asthma attack and they actually need to dial 999.

Frequent flyers
‘Frequent flyers’ are also mentally taxing for the out-of-hours GP. What do you do about the elderly lady who frequently calls requesting a home visit when in actual fact she is just anxious and needs a bit of company? Consider whether the out-of-hours service needs to be liaising with these patients’ GPs to ensure that there is a file note available for when they call in. An agreed action plan with the patient’s own GP is often helpful; however, you should be wary of dismissing the patient who cries “wolf”, when in actual fact, it is a new problem they are calling about.

USEFUL LINKS
- MPS has produced factsheets on unscheduled care; visit: www.medicalprotection.org.uk/england-factsheets
- MPS is hosting an out-of-hours and unscheduled care conference in April 2013. Visit: www.mps.org.uk/events

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The GMC’s latest child protection guidance has ushered in new obligations for all doctors. Charlotte Hudson explores all guidance surrounding child protection

Do’t miss the signs

Child abuse hit the headlines almost 40 years ago when the death of Maria Colwell shocked the nation, after which there were several high profile cases, including Heidi Koseda and Jasmine Beckford, before the Victoria Climbie findings generated the government legislation Every Child Matters. But children are still being put at unnecessary risk because professionals involved in their care do not recognise the signs, or fail to take appropriate action.

The most prominent recent case was that of Baby P who was killed by his mother, her boyfriend and his brother after months of abuse, in 2007. All the healthcare professionals involved in Baby P’s care were scrutinised, including Baby P’s GP. He was found guilty of a serious breach of professional duty for missing the signs of abuse, when he failed to properly examine Baby P or refer him for an urgent assessment after finding bruises on the child’s head and chest after apparently falling down the stairs. Had he taken the appropriate steps such appalling abuse – and his death – could have been prevented.

An Ofsted report released in 2011 looked at hundreds of cases in which babies and young people suffered death or serious injury at the hands of their parents – known as serious case reviews, between 2007 and 2011.

In one case, a depressed mother suffocated her baby, after doctors and health workers had been so worried about protecting her privacy that they failed to report that she could be a risk to her child.

The inquiry found “repeated examples of agencies underestimating the risks from parents’ background and lifestyle”, including drug or alcohol misuse and being abused as a child.

New guidance from the GMC, Protecting children and young people: The responsibilities of all doctors (2012), states that if doctors are treating an adult patient, they must consider whether the patient poses a risk to children or young people, and they must be able to identify risk factors in a patient’s environment that might raise concerns about abuse or neglect.

NSPCC statistics reveal that there were 50,552 children on child protection registers or the subject of child protection plans in the UK as at March 2011.

If doctors are treating an adult patient, they must consider whether the patient poses a risk to children or young people
There are a number of physical signs that may indicate abuse, including unexplained bruising, marks or injuries on any part of the body or human bite marks. Changes in behaviour can also indicate physical abuse, eg, flinching when approached or touched.
Despite the dismal weather we have experienced this summer, 2012 has been an exciting year. Team GB excelled during the Olympics, winning a total of 65 medals, of which 29 were gold; the British cycling team alone won seven golds. How did they do this? Did they have ‘magic wheels’ as suggested by the French team? Of course not – the British cycling team is an example of a team working well together, who have developed a culture of success.

Unfortunately, England fared less well in Euro 2012. A result that many supporters expected as England is often knocked out early in many major tournaments. There is even a book written about why England lose. The team is made up of a number of talented, experienced footballers, but why is their record poor? Perhaps the answer is that they do not work together as a team and maybe the leadership has been questionable?

In healthcare
How does good teamworking translate into general practice? Perhaps it is striving together for high quality and a safe service. Quality starts with safety – let us not forget the Hippocratic principle: “First, do no harm”. How do you achieve this? As we can see from the England football team, practices may have fantastic individuals, but to meet these aims practices must have a team safety culture.

What is a safety culture?
It is increasingly recognised that safety within a healthcare organisation is dependent upon its safety culture; a concept that was first coined by the nuclear power industry in the aftermath of the Chernobyl accident in 1986. The Chernobyl plant blew up on 26 April 1986, following an error during the testing of a reactor, discharging a radioactive cloud and contaminating much of Europe – an estimated 15,000 to 30,000 people died in the aftermath.

Of course, first thoughts are to blame the plant operators – they made a mistake – but as with most disasters when things go wrong it is rarely because of a single isolated event; errors and incidents occur within a system and usually there is a sequence of events that occur before an accident happens. In the Chernobyl accident investigators found that the disaster was the product of a flawed Soviet reactor design coupled with serious mistakes made by the plant operators. It was a direct consequence of Cold War isolation and the resulting lack of any safety culture.

For example:
■ The reactor was operated with inadequately trained personnel.
■ The team was not competent to do the job; they were electrical engineers rather than specialists in nuclear plants.
■ There was poor communication between the team and managers.
■ The nuclear reactor was housed in inappropriate premises.

The Advisory Committee on the Safety of Nuclear Installations 1991 stated that: “The safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to an organisation’s safety management.”

Developing a safety culture
Learning from other industries can be translated into the context of healthcare, ie, a safety culture in primary care has been described as possessing the following characteristics:
■ Individuals and teams have a constant and active awareness of the potential for things to go wrong.
The systems approach to safety acknowledges that the causes of a patient safety incident cannot simply be linked to the actions of the individual staff involved.

- A culture that is open and fair and one that encourages people to speak up about mistakes – being open and fair means sharing information openly with patients and their families balanced with fair treatment for staff when an incident happens.
- Both the individual and organisation are able to acknowledge mistakes, learn from them and take action to put them right.
- It influences the overall vision, mission and goals of the team or organisation, as well as the day-to-day activities.

The systems approach to safety acknowledges that the causes of a patient safety incident cannot simply be linked to the actions of the individual staff involved. All incidents are also linked to the system in which the individuals are working.

What should you do to build a safety culture?
- Undertake a baseline cultural survey of your practice.
- Undertake a risk assessment to identify potential risks to patients and staff.
- Appoint a risk manager for the practice.
- Develop effective leadership, i.e., lead by example, perceived as sincerely committed to safety.
- Encourage team working – build ownership of patient safety at all levels and exploit the unique knowledge that employees have of their own work.
- Develop a structured approach to safety.
- Ensure effective communication with the team and patients.
- Learn lessons from complaints and mistakes – remember we will all make mistakes (to err is human) but the key is to learn from those mistakes and ensure that systems are robust so that errors are less likely to happen.
- Ensure that staff are trained to competently undertake the roles assigned to them.

Summary
The correlation between safety culture and patient safety is dynamic and complex. Healthcare is not without risks and errors and incidents will occur; general practice should work to minimise those risks by ensuring systems are robust and that when things do go wrong, lessons are learnt and appropriate actions taken. By developing a team approach to patient safety it will in turn develop the safety culture of your practice and improve the quality of care provided. So, in this challenging year in general practice, ensure that you and your team achieve gold and develop a patient safety culture in your organisation.

REFERENCES
3. NPSA, Seven Steps to Patient Safety in Primary Care (2006) www.nrls.npsa.nhs.uk/resources/?EntryId45=59804

Staff Survey on Patient Safety Culture

**GENERAL PRACTICE**

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The purpose of this survey is to ask for your opinion about patient safety issues, clinical error and event reporting in your practice and will take about 5-10 minutes to complete.

An ‘event’ is any type of error, incident, accident or deviation that could cause patient harm, ‘Patient safety’ includes the administrative and clinical systems and procedures designed to prevent patient injuries or adverse events resulting from the processes of health care delivery.

Please indicate your agreement or disagreement with the following statements by placing the number that best matches your views on your practice. Your answer is anonymous and your individual responses will be treated in absolute confidence.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The leadership of this practice is committed to improving patient safety.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Staff medical and training are congruent in this practice.</td>
<td>1 2 3 4 5</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. I always report any patient safety concerns I might have.</td>
<td>1 2 3 4 5</td>
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<td>4. The levels of nursing care are sufficient to manage the workload safely.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>5. It makes a thought to difficult to diagnose in an inpatient.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>6. Staff in this practice often report being unhappy with tasks allocated.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>7. Staff in this practice believe their patients are being heard.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>8. There is a culture of teamwork throughout the practice.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>9. The organisation is often overworked in this practice.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>10. Regular training is provided throughout the practice.</td>
<td>1 2 3 4 5</td>
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<td>11. I feel that an assessment of patient safety would be taken seriously.</td>
<td>1 2 3 4 5</td>
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<td>12. In my primary care, clinical errors can be explained by clinical understanding.</td>
<td>1 2 3 4 5</td>
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<td>13. Our systems and procedures are good at minimising errors.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>14. Staff in this practice are trained to competently undertake their roles.</td>
<td>1 2 3 4 5</td>
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<td>15. The learning from any incident or personal development activity is used.</td>
<td>1 2 3 4 5</td>
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<td>16. All staff have such frequent office hours that they are not overloaded with work.</td>
<td>1 2 3 4 5</td>
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<td>17. If the leadership is to relieve wrongs then there is a system within the practice.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>18. Staff in this practice believe their patients are being heard.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>19. We normally have the appropriate processes put in place to deal with complaints.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>20. I would suggest changes to improve our understanding of the role at this practice.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>21. We communicate effectively with our patients.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>22. The practice is doing more to improve patient safety than it did a year ago.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>23. This practice can usefully build ownership of the safety culture.</td>
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</tbody>
</table>

MPS SURVEY TOOL

MPS Education and Risk Management developed a survey tool for general practice and out-of-hours (OOH) service providers to assess the opinion of the clinical and non-clinical staff towards the patient safety culture in their organisations. The tool yields anonymised data that enables organisations to benchmark its safety culture with other practices and target areas for improvement. It consists of a 23-question survey, which is sent to all staff working for the organisation prior to an MPS clinical risk self-assessment.

So far more than 600 organisations in the UK and Ireland have taken part in the survey, with more than 15,000 forms completed.

MPS CLINICAL RISK SELF ASSESSMENTS (CRSA)

MPS’s CRSA is a unique tool that has been developed to offer an opportunity for all the general practice team to work together, talk openly and develop practical solutions to promote safer practice. This is an approach that delivers results and gets all staff committed to making changes happen. As part of the CRSA, we undertake a baseline assessment of the patient safety culture of the practice. For more information visit www.medicalprotection.org.uk/education-and-events/clinical-risk-self-assessments-for-GPs
As a locum you are often distanced from the complaints process and may be informed of an adverse event sometime after an investigation has begun. The danger here is that this can prevent you from providing your comments and ensuring that your contribution has been accurately reflected, which in turn can escalate the matter. As one locum recently pointed out: “Practices simply don’t tell us that we’ve had a complaint.” This can lead to a situation that leaves not only locums, but patients in the dark.

The current system
The NHS and social care complaints system aims to be more open and accountable, fair and proportionate and above all patient-focused. Practices must involve locums in handling complaints from the outset, even if they have left the organisation.

If a patient cannot resolve their complaint locally, they can take it forward to the Parliamentary Health Service Ombudsman (PHSO). Often a doctor will only learn of a complaint once it has escalated to PHSO. This is when they contact us for advice.

Handling complaints
At some point in your career you may find yourself the focus of a complaint from an aggrieved patient or member of their family. You should familiarise yourself with the practice’s complaints procedure. There should be one person within the practice who administers the procedure.

The complaints manager
The complaints manager’s role is to ascertain the facts relating to a complaint, assess the evidence and report the findings. Complaints should:
- Normally be acknowledged within three working days
- Be handled flexibly and responsively in consultation with the complainant if possible
- Be investigated and resolved as speedily as possible, giving the complainant a full, clear explanation and, if mistakes have been made, an apology
- Feed into clinical governance and service improvements.

The complaints manager will prepare a report on the findings. In the document, Listening, Responding, Improving: A Guide to Better Customer Care, the Department of Health states that the manager should have an open dialogue with both parties, so that their final report does not surprise anyone involved.

According to the Department of Health: “Before the report is finalised everyone involved should be given the chance to give their views on what has been said.” So if a complaint concerning your practice is being investigated, the complaints manager should seek your views if possible, whether you are a locum or a partner. This will probably involve being asked to write a statement or attend a meeting to discuss what happened. If you find yourself in this situation stick to the facts and avoid offering opinion, speculation or defensive justifications.

We would encourage you to see a draft copy of the reply the practice intends to send to check it for factual accuracy.

The locum’s role
At MPS we understand that handling complaints can be time-consuming and stressful for doctors. However, a prompt, well-balanced response to a complaint is often enough to defuse the situation and to prevent it escalating further.
Practices must involve locums in handling complaints from the outset, even if they have left the organisation.

In *Good Medical Practice*, the GMC says patients “have a right to expect a prompt, open, constructive and honest response, including an explanation and, if appropriate, an apology”. An apology is not an admission of liability so be prepared to meet with the patient, or complainant, and liaise with the complaints manager. See it as an opportunity to listen to the patient, understand the reasons for the complaint and to ensure the relationship can be improved and any similar problems avoided in the future.

MPS has produced six booklets on complaints handling; one of them is a case study and takes you through the steps for successful complaints resolution – a link to this can be found at the end of this article.

Most complaints are an opportunity for learning, so practices often hold a significant event audit (SEA). If you are involved in the complaint, suggest being involved in any subsequent SEA meetings. This will offer a chance to liaise with the practice team and learn from the complaint.

**Record keeping**

You should always keep good medical records and this is particularly important if a complaint is made, as this will help you remember what happened and assist you in providing a clear explanation if asked for your comments. In *Good Medical Practice*, the GMC says: “Keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients and any drugs prescribed or other investigations or treatment.” In addition it is helpful to document any follow-up advice.

Good record-keeping is particularly important when you bear in mind that complainants now have 12 months from the occurrence giving rise to the complaint, or from the time that they become aware of the matter, to make a complaint. The complaints manager will retain the discretion to investigate complaints brought later than this if there are good reasons for the delay and it is still possible to carry out the investigation.

**Practising empathy**

Any complaint should be replied to empathically. Put yourself in the complainant’s shoes, and tailor your responses to their needs. Understand the emotional impact that the events leading up to the complaint may have caused, and be aware that emotions may be highly charged. Keep calm and keep body language neutral during any subsequent complaint meetings. The tone of any responses should be conciliatory.

**Claims**

While complaints may occur immediately after an adverse incident, claims often take longer to arise. For this reason it is more likely that, if you are involved in a claim, it will be connected with an incident at a previous practice that you worked at. We recommend that you contact MPS if this situation arises so we can help with writing a report or statement, and if you feel vulnerable about your involvement, do not hesitate to contact us.

**GMC**

You could receive a letter from the GMC about a complaint and again we advise you seek MPS advice before responding to any correspondence.

**Future complaints**

Only time will tell whether locums feel more involved in complaints handling, but the current system is tighter and less bureaucratic, and the additional guidance implies that complaints against locums cannot be handled effectively without gathering their input, where possible. One thing that is clear is that where a locum is involved in a complaint in an environment where regulators are pressing hard for increased communication, transparency and more accountability, the locum’s viewpoint becomes indispensable.
Q: Do you think sessional GPs are properly represented in clinical commissioning groups (CCGs)?
A: No, not at all. It stems from an historic issue that all GPs are not seen as equal – GP partners are seen as most skilled and senior, then salaried, then locums. Traditionally, everyone wanted partnerships and the best GPs got the roles so the ranking was logical, but nowadays many locums and salaried GPs do it as a lifestyle choice, a substantial number having been partners first. Some CCGs and some older GPs are yet to realise the landscape has changed. In the old PCTs, GP partners took on the roles, and as these evolved into the CCGs, the same old-school GPs continued at the top – and it is very hard for some of the people who are in control to shift their mindsets.

This cultural issue was one we were expecting when we started this project, but we found that this wasn’t the only problem. There was also a lack of confidence and a lack of encouragement for non-partner GPs to get involved. The top reason why sessional GPs aren’t engaged, however, was communication. The CCGs use practice lists as mailing lists which often misses salaried GPs and almost always misses locums. The sessional GPs aren’t receiving updates, meeting invites or job opportunities. Those that are proactive and contact their CCGs are in some cases actually turned away because in some areas all non-partners are excluded.

Q: How is your project trying to overcome these barriers?
A: The project is a multi-prong approach. It is backed by some very heavy hitters, the GMC, the BMA and the NASGP. We are trying to affect the authorisation process for the CCGs so that there will be a clause that says you have to engage your entire GP workforce.

We have been working with the GMC because when the CCG guidance was published, it was assumed that the partners were the only people to be involved – and in some areas it was thought that this excluded non-partners. The GMC and the BMA have both started rewriting this guidance to encourage practices to include all the GPs who work in the practice.

This year we are hopefully attending the Lib Dem party conference with Clare Gerada to talk about CCGs and how more sessional GPs should be involved. Currently we are attending as many conferences as we can to spread the word.

We have also approached a lot of the CCGs who are lagging behind, in a very informal way, sending emails offering support in areas such as recruitment. Communication needs to be improved – we have explored creating a single email list of sessional GPs so CCGs know who is out there, but issues around data protection mean that this is going to take time.

Q: Why should locum and salaried GPs get involved with commissioning?
A: When you see patients as an individual GP you might see and help 30 to 40 patients a day, but when you get involved in commissioning you can help thousands. If your driver is to help patients and you are frustrated by long waiting times, hate patients being passed around the system, and you can see unnecessary delays and duplication is happening to your patients – then this is a way you can fix the system for them. You can get involved in your areas of interest. My interest was MSK – I was sick of long waiting times for physios and clinic appointments in my area. I have now got the waiting times down from six months to about eight weeks. You can have a bigger impact than you might think.

A lot of GPs, although they love seeing patients, feel it can get exhausting and emotionally tiring, as they are often doing the same thing over and over. For those GPs who would like to do something a bit different, commissioning is the place to do it. I now understand project management and finance;
On my Twitter account GP partners express their worry about trusting sessionals to redesign their services, because they are not the ones at risk of losing money

I like stretching myself and learning new things. GPs get involved because they want to ask questions, understand how the NHS works; when you work at a CCG you can ask all these questions and get answers.

Q: To get involved would it be best to go directly to a CCG or a practice employer?
A: My advice would be – try everything you can. If you work at a practice regularly, approach them first. Ask if their practice is paired with a CCG, when the meetings are and can they keep you informed. If you show a genuine interest you are more likely to be selected to participate. If you are a locum it is slightly more difficult; if you work in a locum chambers, then get the word out there that you are interested.

Also, find out who your CCG is, find the contact details, and ask to be added to the communication list. Some CCGs email all GPs with an NHS.net account in the area, so it is really important you have an active NHS.net account to try and pick up communication.

Both salaried and locum GPs should be proactive; don’t be put off – take a role even if it is not ideal. Don’t be scared to give it a go; I think everybody worries that they won’t be good enough, they won’t have the skills, they won’t be able to do it; they’ll look stupid. In a CCG you’re not expected to know everything – all they ask is that you bring the clinical knowledge they lack and we can all do that.

Q: Why is the RCGP’s sessional engagement project necessary?
A: CCGs are struggling to get GPs involved. A CCG will only be authorised if it has a certain number of commissioners working in it, and it will only be successful in improving patient pathways if new intelligence is brought into the system.

We want CCGs to succeed, we believe in the ethos of letting doctors sort out what patients need, we do not want to return to the old system. The only way to do this is to get a large number of GPs to take on small projects so that we see improvements. The CCGs struggle because everyone is daunted by commissioning and feel it is mixed up with the Health and Social Care Bill, when in fact commissioning has nothing to do with the Bill – it was around before and it will be around after.

A lot of GPs heard the kerfuffle surrounding the Bill and were put off getting involved so we started doing this to help GPs understand what commissioning really means and make it work. If a CCG only recruits GP partners they are not engaging 40% of their GP workforce. GP partners tend to work for the longest hours, whereas salaried GPs typically work part-time and locums can pick and choose their time; so the part of the workforce that CCGs are neglecting to invite in are the ones most likely to have the time, energy and enthusiasm to do the work.

Q: What can sessional GPs bring to the whole process?
A: Salaried GPs share similar views with partners, but they tend to have more time available to them and less management pressure; locum GPs are pretty unique in that they travel round a lot of different surgeries; this has become a real plus for our CCG because they have gathered information from a number of different surgeries, so our CCG has a much broader view of the area. If you have a mix of locums and partners you can confidently say that your whole area is covered.

Q: You described making the inclusion of sessional GPs compulsory for CCGs as a “bit of a dream”. Why?
A: It has been hard enough getting GPs to sign up to CCGs, never mind informing them that they now have to include all their locums and salaried GPs. On my Twitter account GP partners express their worry about trusting sessionals to redesign their services, because they are not the ones at risk of losing money. That is the dirty secret lingering in the background that nobody necessarily wants to acknowledge – GP partners are financially at risk if practice income falls, locums and salarieds aren’t. My challenge back to that is that I am spending three days a week working my socks off to make this work and I am not financially benefiting from improved practice profits, so the reason for doing this is not money. Commissioning is not about maintaining GP income; it is about patient services and patient care.

Q: Final words?
A: The RCGP project was given a set amount of funding, and that funding has not yet been renewed. As a group, we are trying to create as much noise as we can about the project and motivate people to get involved. This is how we are going to win the battle – by continuing to be proactive. All individuals need to take responsibility for clinical commissioning to succeed. It always makes me cross when GPs are passive about commissioning; this is our job now so like it or lump it, let’s make it work.

Words: Charlotte Hudson
Final thought: The irony of complaints

Blogger and locum GP Dr Euan Lawson says that when it comes to complaints we should be grateful that thorns have roses

Sometimes it feels like everyone is complaining. It’s natural for patients to complain. That’s what they do – their first concern is, after all, known as the presenting complaint. Patients don’t tend to come back to tell their doctors they have been cured. They sit at home, happy and well. We sit in the surgery, listening to a new batch of complaints. On occasions, patients may take it too far and complain about having to ring up for appointments in the morning, rather than being able to plan their illnesses for several weeks in advance. But, for sheer Olympic standard grumbling it’s hard to beat the doctors in the NHS. It just seems staggeringly difficult to persuade doctors that the NHS is anything other than hellbound – and the transport of choice is the handcart.

The patients who feel they should open the discussion with a declaration of their high pain threshold set my teeth itching. It seems that pain thresholds fall into the same category as intelligence – everybody thinks they are above average. Or the folk that ‘never bother the doctor’ really do, as it happens, bother me, quite a lot. Highlighting the fundamental discrepancy in their story, even as a joke, is not recommended. If they do possess any sense of humour it is likely to be because they are borrowing it for the day and have to return it later – preferably unused. The one defining feature of these patients is that they often give the impression that they have had a total irony bypass.

The patient type of which I’m most wary is the speed-dialler. This seems to be a problem unique to locums. Good-natured reception staff regard it as a personal failure to leave a locum with an unfilled slot. The speed-dialler calls and even normally slouch-like receptionists will scramble into action like a highly-drilled RAF groundcrew launching a strike jet. One moment I’m contemplating a quick break and within minutes the speed-dialler is jammed into my clinic a mere two hours after the onset of their tickly throat. The problem with diagnosing a mild flu-like illness so early is the possibility it is the product of something far more exotic and not just, well, flu. In the first two hours it could still be early meningitis, or, for all I know at that stage, rabies. The paradox of the speed-dialler is that so much safety netting is required it takes more time to deal with them than it would if they’d been ill for a week.

People don’t complain all the time and apparently, I’ve been told, some GPs are given gifts by their patients. One GP was recently telling me, with an admittedly jaundiced eye, of the dozens of bottles he had received last Christmas. That is not something your average locum has to worry about. And sometimes patients don’t complain when they should.

A number of years ago I was speaking to one old man who had lost the vision in one eye after getting some inappropriate steroid drops from a GP. He just shrugged stoically and pointed out, as if I wasn’t aware, that doctors were people too. Complaints seem to be an intrinsic part of human nature, but Alphonse Karr once said that some people will grumble that roses have thorns; I’m with him when he pointed out that we should simply be grateful that thorns have roses.

Dr Lawson is from Kendal. Visit his blog at http://euanlawson.com/blog
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96% of members said they would be likely or very likely to recommend MPS to their colleagues.

92% scored good, very good or excellent for the service they received from our medicolegal advisers.

94% scored good, very good or excellent for the service they received from our membership team.

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