



The 12 risks of Christmas

*We share the risks in
general practice during
the festive season*

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Top tips on how to prepare your
practice for an inspection

END OF LIFE CARE

Professor Sir Peter Rubin highlights
what GPs should be aware of

INFECTION CONTROL

Managing infection control in
general practice

FROM THE CASE FILES

A locum GP raises concerns about
patient safety

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Dr Richard Stacey
Editor-in-chief and MPS medicolegal adviser

Welcome

From 1 April 2013 all GP practices had to register with the Care Quality Commission (CQC) and inspections started at the beginning of May; in this edition we profile a practice that had their inspection and offer some hints and tips on how to get through your practice's CQC inspection.

Another topical subject is the government plans for patients to have online access to their medical records by 2015. This has the potential to transform patient care, but in order to realise the advantages great care needs to be taken to manage the associated risks. Successful roll out of online medical records will require the engagement and participation of individual doctors and patients across the country. In Dr Amir Hannan's practice they have already successfully rolled out online records for patients; on pages 10 and 11 he tells us how it's going and how his patients responded.

Christmas can be a challenging time in general practice. On pages 14 and 15, Dr Rachel Birch, MPS medicolegal consultant and salaried GP, advises on how to survive the festive season.

We hope you enjoy this edition of *Practice Matters* and would be interested to hear your comments, as well as any topics you would like us to feature in future editions.

Richard Stacey

A round-up of the most interesting news, guidance and innovations

Prescriptions – guidance on prescription direction

The Pharmaceutical Services Negotiating Committee (PSNC) has issued a joint statement with the British Medical Association (BMA) on prescription direction. It reminds pharmacists and GPs of existing guidance about prescription direction, which can occur where a patient is being directed by their GP practice to a certain pharmacy to have their prescription dispensed.

The statement includes a list of activities to avoid in order to maintain good practice, including: providing a practice endorsement for a pharmacy, and suggesting that the practice, GP or member of staff would like a patient to use a particular pharmacy.

It states that where there is a financial link between a pharmacy and a medical practice, it is particularly important to ensure that appropriate procedures are in place to prevent prescription direction. A nominated partner and the superintendent pharmacist should oversee this, and ensure that everyone working in the pharmacy and medical practice is aware of their responsibilities.

If GP practices or pharmacies become aware of cases of prescription direction, there may be a role for LMCs and LPCs to intercede in the first instance to resolve a problem at a local level.

MPS policy update – HCA home visits

HCAs who are named Associate members on your Practice Xtra package may now perform tasks applicable to MPS associate grades 1-3, including blood testing and blood pressure monitoring, in patients' homes.

HCAs and other unregistered staff employed by your practice must always work under the supervision of an appropriate clinician. In respect of home visits, this means that a doctor or nurse must be present in the practice and available to respond to issues of concern and to review patients at the practice or at their home.

MPS will expect members to ensure clear protocols and guidance are in place, requiring HCAs to refer any clinical queries to a doctor or appropriately qualified and experienced nurse.

Are you a GP innovator?

The RCGP is looking for GPs with innovative ideas for improving patient outcomes, transforming GPs' working lives or the delivery of primary care. GPs are being invited to bid for posts that would allow them one day a week of paid sessional time plus a £3,000 'innovation fund' and access to other RCGP support.

The programme was designed to support GPs with great ideas who are being held back by a lack of time and funding shortages.

Find out more: www.rcgp.org.uk/clinical-and-research/innovation-fellows.aspx



GUIDANCEWATCH

NICE guidance relevant to primary care: January to March 2014

January

Clinical guideline

- Prostate cancer (update)
- Head injury (update)

Quality standard

- Peripheral arterial disease

February

Clinical guideline

- Osteoarthritis (update)
- Psychosis and schizophrenia in adults

Public health guidance

- Domestic violence and abuse - identification and prevention

Quality standard

- Anxiety disorders
- Faecal incontinence

March

Quality standard

- Neonatal jaundice

Note: These anticipated publication dates are subject to change. To keep up-to-date visit www.nice.org.uk/GP or follow NICE on Twitter (@NICEComms)

NEWS IN BRIEF

Department of Health – Guidance

The Department of Health has issued updated guidance on *Implementing the overseas visitors hospital charging regulations*. It includes information about the interface between primary and secondary care and the responsibilities of GPs in this regard (paragraphs 5.11 to 5.14).

Source: *Department of Health*

NHS England – increased openness and transparency

NHS England has announced new measures aimed at increased public participation as part of its ongoing pledge to openness and transparency. The new commitments include:

Extending the Friends and Family Test – The programme will cover GP practices from December 2014 and all other NHS services by 2015.

Linking clinical data from GPs – By June 2014 the data from GP practices will be linked to data from all hospitals.

Source: *NHS England*

Care.data – Guidance for GPs

NHS England and the Health and Social Care Information Centre (HSCIC) have set out the next steps they intend to take to raise public awareness about care.data – a programme that will use information to improve the safety and care of patients.

NHS England and the HSCIC have issued *Additional Guidance for GP Practices on Care.data*. It provides information to GPs about their responsibilities under current legislation and the action they should now be taking with regard to informing their patients.

Source: *NHS England*

How to employ shared staff

Some practices are looking at sharing staff with a neighbouring practice in order to cope with the workload implications of rising demand and bidding for LESSs and DESSs.

The BMA has produced guidance for GP practices on how to employ shared staff. It covers secondments, joint employment, VAT considerations, alternative arrangements and managing change. It discusses the benefits and pitfalls of various ways of sharing staff between practices.

BMA, *Guidance to practices on how to employ shared staff* (October 2013) – <http://bma.org.uk/practical-support-at-work/gp-practices/how-to-employ-shared-staff>

Upcoming events

Event	When	Where	What	Useful Links
MPS Practice Management Seminars	Throughout the year	Across the UK	These seminars have been developed to help guide you through the minefield of patient safety and complaints. The day will be very practical and interactive, giving you the tools to take back to your practice.	www.mps.org.uk/PMSeminars
Commissioning LIVE	26 March 2014	London	Commissioning LIVE provides a unique forum for all stakeholders to hear the latest policy developments, share experiences and ensure that they are able to wield their new leverage to the best effect.	http://commissioning-live.gpbusiness.com/
SSPC Annual Conference	25 April 2014	Glasgow	This conference brings together a broad range of healthcare practitioners, researchers and academics from all over the world and offers an impressive range of national and international speakers.	www.mps.org.uk/PMSeminars
Pulse Live	29-30 April 2014	London	This year's agenda provides a stimulating mix of plenary and keynote sessions and three conference streams tailored to the learning needs of GPs and practice managers.	www.pulse-live.co.uk
MPS Primary Care Workshops	Throughout the year	Across the UK	With the aim of minimising risk and delivering improved patient care, MPS workshops are focused on advice and practical tools and tips. Workshops include Understanding Human Error and Medical Records for GPs.	www.mps.org.uk/workshops

How to survive a CQC inspection

The words CQC and inspection can strike fear into the hearts of practices; what can your practice do to get through this daunting time?

Charlotte Hudson investigates

All general practices will be inspected by the CQC every two years, in most cases focusing on a minimum of five of the 16 essential standards. Preparation is key; if you regularly monitor your practice's compliance with the CQC's essential standards, there should be no need for last minute panic. Your practice can actually use the inspection as an opportunity to promote the standard of care that you provide to your patients.

There are three kinds of CQC inspections of general practices:

Scheduled inspections – a standard routine inspection to check that you are meeting the essential standards of quality and safety

Responsive inspections – these are usually unannounced and made when the CQC has concerns about the quality or safety of a service

Themed inspections – where the inspector will look at a specific area in health and social care.

The CQC give practices 48 hours' notice of an inspection, unless it is a responsive inspection.

During the inspection the inspectors will talk to patients and staff, and they may also speak with members of your Patient Participation Group if your practice has one. The inspectors will cross-check what they see and hear against other evidence such as records, schedules and protocols. They will look for evidence that the regulations are not being met.

Vickie Wilkes, Regulatory Policy Manager at the CQC, has provided some tips for practices ahead of their inspection:

1. It is important to ensure that someone is there at the practice to meet with the inspectors. A key person to co-ordinate the day, introduce the inspectors to patients and staff, and provide the inspectors with somewhere they can sit and do their work, is essential. This is usually the practice manager.
2. All staff, from the receptionists to the GPs, should be made aware that we are coming and be prepared to talk to the team, answering questions about how they work, etc. It's all well having a policy in place but that on its own is not enough; testing staff is far more important for us, to find out what staff would do personally in situations.
3. The practice needs to be honest and upfront with us. If they're not fully compliant it is much better to acknowledge this and tell us. Don't try to hide it because it could make it worse for your practice. As long as you show how you are planning on improving practices to be compliant you will be fine.
4. Don't listen to the myths about the CQC inspections. Two common ones are if the reception desk is too high you will fail, and you're not allowed toys in waiting rooms.
5. Focus on the CQC documents to help prepare your practice for an inspection.

What's new?

Over the past 12 months the CQC has been undertaking a full review of how effective its inspections are and how they need to change. David Behan, Chief Executive of the CQC, said that an assessment of how the leadership of an organisation can set the culture around quality and safety will be built into the inspections it carries out.

He continued: "Our objective is to make sure that the people who use health and social care services receive high-quality, compassionate care which is also safe and effective. We encourage services to improve so that they can be the best they can be.

"In order to do this we are changing quite radically the way we inspect care and health services. Each service is different – for example, how you inspect a large multi-site intern teaching hospital and how you inspect a three-bed care home for people with autism needs to be different."

As part of the new approach, the CQC will ask

five questions about services that will be the basis of their inspections.

1. Are services safe?
2. Are services effective?
3. Are services caring? (Will I be treated with compassion and dignity?)
4. Are they well-led?
5. Are they responsive to people's needs?

"Question 4 is an important one because the link between the leadership of an organisation and the quality of care is now well established, and Robert Francis highlighted this in his inquiry report in Mid Staffordshire," explained Mr Behan. "How the leadership of an organisation sets the culture around quality and safety is something we want to assess as part of our inspection programme."

The CQC has started rolling out the new approach to inspections in hospitals first (from September to December 2013), and 18 hospitals in total will be asked these five questions.

Mr Behan's advice for GP practices

"My advice for GP practices is to not be fearful of the inspection. The questions are designed to be helpful and to lead to your practice improving the way you offer services to your community and the people that you're there to serve. Ask yourselves the questions: are services safe, effective, caring, responsive, and are they well-led?"

Listen here to Mr Behan's podcast:
www.medicalprotection.org/uk/podcasts/david-behan-on-the-future-of-cqc-inspections

An inspector calls at... Cross Hills Group Practice in Keighley, West Yorkshire

Cross Hills is a semi-rural practice on the edge of the Yorkshire Dales, located between Keighley and Skipton. Part of the Airedale Wharfedale and Craven Clinical Commissioning Group, it is a training practice with just over 12,000 patients, ten GPs, one Registrar, two advanced nurse practitioners and a full practice nursing team, as well as dedicated admin support staff.

Their CQC inspection took place at 9am on Wednesday, 11 September 2013.

Charlotte spoke to the Head of Operations, Belinda Seth, to find out exactly what happened...

How did you receive notice of the inspection?

Well it was classic: I was at my desk, 9am on the Monday morning when I took a phone call and a rather sombre voice spoke: "This is the CQC calling...I am ringing to give you your 48 hours' notice of inspection." It was the sort of call that would strike dread into any practice manager's heart, especially on a Monday morning, because of course I had my whole week ahead planned (in so far as you can plan in this job!).

What was your initial reaction to the call?

I notified the partners and pulled all the staff together for a short briefing to explain what was going to happen. I also put up notices around the building to make sure everyone was aware that the inspectors would be arriving 9am

Wednesday. I tried to put people at ease. My aim was to get across to staff not to be worried because we're doing a good job and the inspectors are not here to catch us out.

How did you prepare for the inspection?

I was less than six weeks into the role when I received the call from the CQC but the interim practice manager had done a lot of work within the practice since registering with the CQC. She had made sure that we had good controls to monitor performance against the CQC outcomes, defined process ownership and documented up to date protocols which had been discussed and cascaded throughout the organisation. We use one of the available CQC toolkits, which helps to structure and identify which protocols are relevant

and what actions you need in order to be able to satisfy the different outcomes. This was helpful when it came to sourcing relevant documentation for the inspectors to look at and to focus staff's attention prior to their arrival.

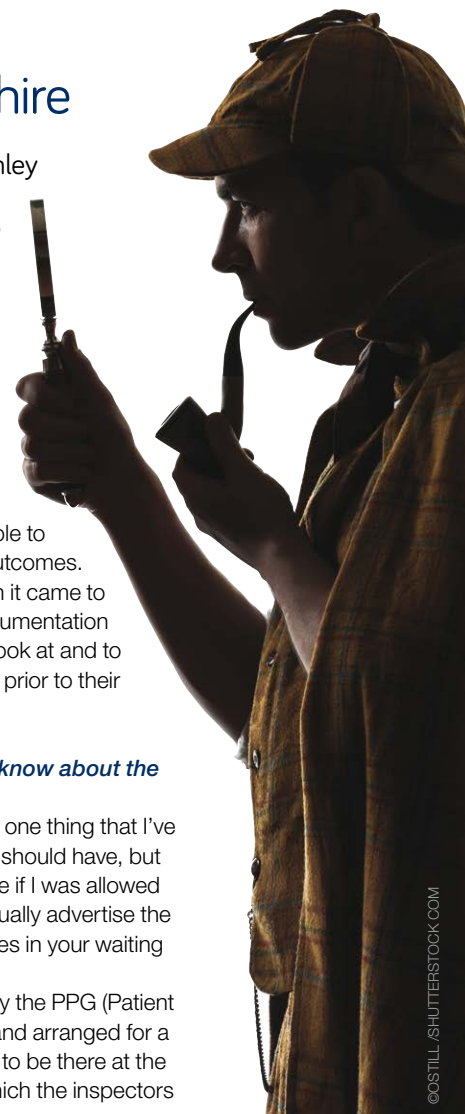
Did you let patients know about the inspection?

No I didn't, and this is one thing that I've learnt from because I should have, but wasn't sure at the time if I was allowed to or not. You can actually advertise the fact, and put up notices in your waiting room.

That said, I did notify the PPG (Patient Participation Group) and arranged for a member of the group to be there at the time of inspection, which the inspectors found helpful.



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CONTINUED OVERLEAF

Did the inspectors speak to patients?
Yes, there were two inspectors: the main inspector and an accompanying expert. They were understandably very keen to get the patient point of view supporting the concept that the CQC isn't about ticking boxes, it's about making sure that practices are delivering a high standard of care in a safe environment that meets patient needs, and clearly this can only be determined by speaking to patients directly.

What were the inspectors like? Did they share information about their background?
They were very friendly, professional and keen to put people at ease. They said very early on, we are not here to catch you out. I think one inspector was a former nurse who had a keen interest in our advanced nurse practitioners and how we were using that role within the practice, and the other was a practice manager.

How did you feel during the inspection?
Having been in the job less than six weeks it was a bit of a shock but, actually, because I'm an ex-auditor (though not connected with the NHS), I'm very familiar with the auditing process. Also, being new into the job I was secretly pleased that they were coming so soon after I'd started because that would help me to identify anything that I could improve upon very early on so I chose to see it as an opportunity.

What areas of the practice were inspected?
The inspectors were here from 9am until approximately 2pm and they inspected five outcomes:
Outcome 1: Respecting and involving people who use services
Outcome 7: Safeguarding people who use services from abuse
Outcome 8: Cleanliness and infection control
Outcome 14: Supporting workers
Outcome 16: Assessing and monitoring the quality of service provision
They did look a little bit at complaints but only reported on the five outcomes.

Did you feel well prepared?
Yes, I'd looked at the outcomes beforehand and tried to take a little bit of control of the process, by scheduling time in with key people within the practice who I felt would be able to give the inspectors the information they needed for those outcomes.

What questions did they ask?
They kind of trawled the whole practice; as well as basing themselves in the waiting room and talking to patients, they also went into the office and selected a few members of staff



Far left: Belinda Seth with staff at Cross Hills

at random and they were asking them, for example, whether the practice had a process for safeguarding and what they understood by safeguarding – it was quite thorough. We have a GP lead for safeguarding so I made sure that she was available between certain times to speak to the inspectors; for the 'supporting workers' outcome they ask how you induct new employees, how you appraise them and develop them, etc, and one of our advanced nurse practitioners had only recently joined the practice and therefore that experience was fresh in his mind, so again I scheduled time with him. Likewise I blocked some time with the practice nurse because of the focus on infection control – they wanted to look at the treatment rooms, etc – so the practice nurse lead for infection control was available to assist.

Did the inspectors have any specific concerns?
We were found to be compliant in all of the outcomes they inspected. They gave little hints and tips along the way but they were very clear from the outset that it was not within their remit to offer advice. They would say things like "some practices have found it useful to do X,Y,Z" but they weren't recommending specific actions.

How long after the inspection did you receive the report?
They issued a draft report to us on 19 September, eight days after the inspection, and we were given the opportunity to make amendments or add comments to it.

How did the visit end?
Once the inspectors had finished interviewing and looking through documentation they retired to a private room, which we'd set aside for them. They spent about 40 minutes going through everything, before having a 30-minute wrap-up meeting at the end with me, where they outlined what they'd done, what their findings were and gave verbal confirmation that we had been found to be compliant, which was helpful.

What is your advice to other practices facing an inspection?
1. Be prepared – expect the unexpected but don't worry about it; I don't feel that they're

looking for perfection, what they're looking for is an understanding of the CQC requirements and for you to have a mechanism for evaluating and improving your performance on an ongoing basis. If you're not the best you can be now and you don't have every schedule and every protocol perfect, I don't think it matters, providing you can demonstrate that the bones are there and that as a practice you are looking at the outcomes and making progress, and have a process for capturing that.
2. Make it as easy as you can for the inspectors to get the information they need. I'm an ex-auditor and I know that any kind of inspection is not an easy job as you have to navigate round different organisations and interrupt people's work. Giving them access to a range of people, who are relevant to the outcomes they are looking at, and who can talk to them in an informed way, is helpful to them. It's in our interests to make it easy for the inspectors and you can take steps to manage the process to minimise disruption to your practice.
3. Get your PPG involved. It is important to get the patient opinion across because at the end of the day unless you subscribe to a very cynical view, CQC inspection is about improving the quality of service and care to patients.

What is your practice doing going forward?
Even though I am delighted that we've been found to be compliant on the five outcomes, that doesn't mean we can become complacent. There are many more outcomes than those they inspected and if CQC inspection stands for quality assurance, designed to prompt improvements to service and the processes that underpin them, then that's the spirit we take it in. We will continue to review what we're doing, to ensure all practice staff understand what is required of them and to make improvements where we can and where it is in patients' interests to do so.

USEFUL LINKS

- CQC, *What to expect from an inspection: GPs and other primary medical services.*
- CQC, *Guidance about compliance – Essential standards of quality and safety.* Visit: www.cqc.org.uk

Hot Topic

End of life care



In the third part of his series exploring elements of the new *Good Medical Practice*, Professor Sir Peter Rubin, chair of the GMC, looks at end of life care

Talking to someone about their end of life care is never easy. Proper palliative care and considered communication are vital if a patient is to have the "good death" that we would wish for ourselves.
However, our reluctance as a society to talk about death means that too few patients get the opportunity to experience this. As doctors, though, we must work in partnership with patients, and those close to them, to provide the best possible care. This is why the GMC has published clear, concise guidance to help doctors navigate the complex decisions and ethical dilemmas that can arise when patients are approaching the end of life.
Doctors must take the lead on this. We need to create opportunities for patients to talk about their death, where they want to die, and any other wishes or concerns they may have. We need to explain what options are available to them, and what each may mean in terms of burden, benefit and risk. We also need to allow for their plans to alter as their condition progresses.
And this partnership goes beyond

patients. We need to communicate with all those involved in treatment and care, and assume responsibility if and when patients move between their own home, care home, hospital and hospice. Crucially, we need to acknowledge the roles and responsibilities of those close to patients. This is particularly true when capacity is impaired: we must ensure they are given the time and information they need to reach consensus. The GMC's guidance offers clear decision-making models to assist on this, as well as further case studies.
I don't underestimate the difficulties that can and do arise. End of life care is one of the most challenging areas of practice. But, since Dame Cicely Saunders founded the hospice movement, the UK has, albeit quietly, led the world in this area. Every day doctors are having hard conversations with patients and their families and helping them make incredibly difficult decisions. This guidance, with its emphasis on partnership, on conversation, is there to support us as we do that, and ensure more patients experience a "good death".

USEFUL LINKS

- GMC, *Consent: patients and doctors making decisions together* – www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
- GMC, *Treatment and care towards the end of life: good practice in decision making* – www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

Locum apathy



Dr Euan Lawson, portfolio GP in Cumbria, explains how a little bit of apathy goes a long way

We all need a little bit of apathy. I'm not advocating idleness: one still has to see the patients, hack through the path links, sign the scripts, and offer sacrifices to the great GMC God of Revalidation. I mean a version of purposeful apathy; the kind of apathy that gives you a chance of surviving a career in the NHS. Take my NHS smartcard. I've tried, admittedly half-heartedly, to get one over the years, but the system barely acknowledged locums. I could have wallowed in some existential angst; instead I have let the snub wash over me and I remain, chaste and proud, a Choose and Book virgin.
I have revelled in being apathetic when it comes to commissioning. When I enter any meeting where commissioning is being discussed I feel like a slug crawling into a bag of ready salted crisps. My soul shrivels and my face twists. It's not pretty: think tetany; think bulldog licking a nettle. You get the idea. It's not just apathy, it is simple self-preservation.
I'm sure that many partners have embraced purposeful apathy. Our local RCGP faculty board meetings consist of GPs who are retired or sessional in some capacity. No one else has the energy. I was texted by one partner still seeing patients at 8pm who had to go home to prepare for the CQC visit the next day. Later he told me the practice got a 'good' with the rider 'could be excellent', which seems somewhat damning in a Jim Bowen, look-at-what-you-could-have-won, kind of way. Turns out that the staff toilet training wasn't quite up to mustard. Or something. I forget. To be honest, he lost me at CQC.
There are now just two kinds of GPs. Those above a certain age where the years to retirement are in single digits. (You'll know who they are – they'll tell you.) For the rest of us retirement is still receding into the distance and it's no longer visible on the horizon. Something to do with the curvature of the Earth I think. For both groups I maintain that purposeful apathy is the best answer. I'm a little prone to ranting and raving at the best of times. If I got riled up over every flaw in the system I'd be dead by the end of the average day. A little bit of apathy goes a long way.

Dr Euan Lawson is a portfolio GP in Cumbria, also working at Lancaster Medical School and as Deputy Editor of the BJGP.

Online medical records

All GPs will be expected to provide patients with online access to their medical records by 2015, but not everyone believes it is a good idea. *Dr Amir Hannan* shares how Houghton Thornley Medical Centre approached online access to records and how their patients responded

A patient in his mid-50s, Mr P, came to see me. Mr P had just had a routine check-up and had been diagnosed with high blood pressure by the practice nurse. I advised him to have fasting blood tests, provide a sample for urinalysis and have an ECG. I also invited Mr P to consider getting a blood pressure machine so that he could monitor this himself. After confirming Mr P had access to the internet I agreed to obtain access to his medical records and the hypertension care on the practice website, to help him understand his care so that he would be better informed. I explained to him that he could come back to the practice at any time, as we support his needs, but he does not have to wait for us.

On a return visit Mr P commented that he felt safer knowing what to expect going forward and when to seek help. This is evidence of a partnership of trust between a patient and a clinician supported by an IT system that is shared with patients.

Mr P is not alone. We started offering online access to records in 2006 – more than seven years ago. Now more than 2,260 patients at our practice have signed up for online access to their records – that’s 19% of the patient population, and the numbers are rising as the word spreads among patients.

Hurdles

People often ask: “Were you not worried about harmful or third party data? What about security?” Whilst these are legitimate concerns, so is the need for patients to understand what is happening to them and to be able to follow it, learn from it and share it with whom they like.

Confidentiality

Many patients understand that there may be security risks, but no system is perfect – even paper records can be inappropriately shared. However, a balance needs to be reached on the appropriate levels of security, whilst recognising the needs of the patient and their right to determine what is right for them.

Ten stage approach to online records access

1. Listened to patients and began to realise that enabling online access could help patients manage their own care and better, supported by us.
2. Created a set of rules with our local Care Record Development Board, which agreed principles based on the available evidence from patients, clinicians and managers from the local health and social community. We also referred to the guidance from the RCGP for giving patients access to their records.
3. Adopted an open policy with patients and used patient testimonials describing the benefits of the system. We also gave patients time to determine what was right for them; some patients needed reminding several times before they made their decision.
4. Asked patients what online services they wanted, eg, ordering repeat prescriptions and booking appointments.
5. Worked with patients to develop a valid consent process.
6. Standardised procedures so that staff knew how to give patients access to their records and what to do when they encountered problems.
7. Built a practice-based web portal for patients and staff that signposted users to the relevant information. We use the website to publish data. Visit: www.htmc.co.uk.
8. Created a local EMIS code, such that the system clearly states that a patient has access to their records, called Patient Access to E-Health Record.
9. Set up a patient participation group (Houghton Thornley PPG), to give patients a united voice, and networked with other practices and other CCGs.
10. Used social media to promote what we can offer patients. I publish our activities on Twitter (@amirhannan) to inform patients and share ideas.

Personally

I have ankylosing spondylitis with associated iritis and now have persistent atrial flutter. I take immuno-suppressants, steroids, anti-coagulants and heart regulating drugs. Wherever I travel I carry three passwords with me on a card – they grant access to all my health information.

I have just had an ablation procedure at a London hospital and as I live in Manchester, had my pre-op consultation by telephone. I could give the nurse all the information she needed by logging on and she had no need to contact the practice except to arrange an MRSA swab.

Advantages

1. Ordering repeat prescriptions is simple. A few clicks and the practice sends the script to the pharmacy.
2. Family members in other countries can monitor the health of their relatives and give support (this would be of course, subject to the provision of consent from the patient).
3. Ability to print out previous correspondence if away from home or in another country.

4. It’s easy to check blood tests. The patient is aware that their doctor is monitoring the results and will let them know if an abnormal result needs to be dealt with.
5. The information is always to hand and very accessible.

Going forward

We are in the process of building a strategy in the CCG that supports the needs of patients and the variety of information systems that are needed. We are starting to develop other online services, such as Instant Medical History – this enables patients to contribute to the record and not just access it.

I believe that when published media meets social media it furthers the partnership of trust, meets the challenges of today and tomorrow and enables more people to learn quickly how to support themselves. I hope that in the future many more patients will have the benefits that I enjoy and be empowered to participate more fully in decisions concerning their precious health. Welcome to the Digital Age!

For more information visit: www.htmc.co.uk or email htmcpatient@nhs.net.

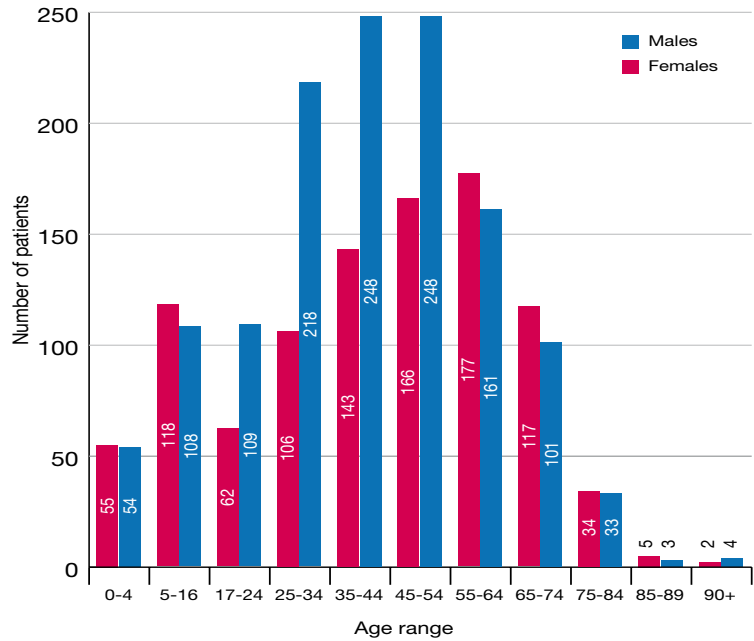
Figure 1

The following table contains figures, correct on 29 June 2013, showing how many patients have access to their records according to the medication they are on or what condition they suffer with.

Patients with Diabetes (Type 1 and Type 2)	189/769	24%
Patients with Type 1 Diabetes	18/69	26%
Patients with Ischaemic Heart Disease	101/503	20%
Patients with Obesity	105/288	36%
Patients with Rheumatoid Arthritis	23/77	29%
Patients with Asthma	399/1739	22%
Patients with Low Back Pain	609/2302	26%
Patients with Chronic Obstructive Pulmonary Disease	67/344	19%
Patients with Depression / Anxiety with Depression	494/1303	37%
Patients with Cancer confirmed	61/237	25%
Patients with a Deep Venous Thrombosis	29/122	23%
Patients with a Pulmonary Embolus	22/69	31%
Patients with Chronic Kidney Disease	58/376	15%
Patients on anti-coagulation therapy ie warfarin, sinthron	25/277	9%
Patients on Thyroxine	124/459	27%
Patients on Methotrexate	9/25	36%
Patients on Cyclosporin (immunosuppressant)	4/4	100%
Patients who were Pregnant from 10 months ago	80/350	22%
Patients on Learning Disability register	6/46	13%
Patients who have ever had a URTI or viral infection	1253/6247	20%
Bengali patients with access to their records	216/1528	14%
Current patients who have ever Ordered Prescriptions Online	629/11882	5%
Patients at Houghton Vale Surgery	775/5562	13%
Patients at Thornley House Medical Centre	1493/6282	23%
Number of patients with access to their GP electronic health records	2272/11882	19%

Figure 2

Patients with access to their GP electronic records at Houghton Thornley Medical Centre 29 June 2013
2,272 patients with access to records
Total 985 males; 1,287 females; 19% of total patient population – 11,882 patients



What has MPS been doing on your behalf?

MPS asked you how you wanted to see medical records used and accessed in the future and the challenges in giving patients online access to their records.

You told us:

- **Doctors and patients need more support.** Ninety-two per cent of you said you needed more support facilitating the introduction of online records. Eighty-six per cent of you also said that the public will need more information about keeping records secure and 71% that this should be provided centrally by government.
- **Expectations need to be set carefully.** From what you said we think there is disparity between the services that patients expect they will have through online access to their records and what you think is realistic in the immediate term. Care is needed to ensure patients are not promised something by government they will not get.
- **There will need to be changes in culture and mindset.** You think there are advantages to be gained from online records and other digital innovations, but that patients will need help to understand the

critical role they will play in their own healthcare and how they can use their own information safely and appropriately.

MPS has highlighted your concerns in public debate on this issue, drawing on our international experience. We have shared with politicians, key decision makers and the RCGP working group your view that patient access to online health records has the potential to transform patient care, but that in order to realise the advantages great care needs to be taken to manage the associated risks.

It is not enough to just equip patients with the ability to access their medical records online and inform them of their rights; patients also need to be supported and informed about how to understand and use their information safely, appropriately and effectively. We think more consideration needs to be given to getting these support needs right.

For more information read our full report *Online medical records and the doctor-patient partnership* on our website: www.medicalprotection.org/uk/policy/reports.



Infection control

Kate Taylor, MPS Clinical Risk Manager, highlights the importance of infection control in general practice



It's a busy Friday morning and as the practice nurse you have a full childhood immunisation clinic. While treating patients you inadvertently sustain a needle stick injury – how do you deal with this situation? Does the practice have policies and procedures in place to manage it?

Infection control in general practice is not just related to preventing sharps injuries; it covers much more. All staff working in general practice play a vital role in infection prevention and control.

Care Quality Commission (CQC)

As infection control is one of the Care Quality Commission's *Essential Standards*, general practice teams need to ensure that they have suitable arrangements in place to ensure patients experience care in a clean environment and are protected from acquiring infections.¹

The Health and Social Care Act 2008 *Code of Practice on the prevention and control of infections* and related guidance became effective from April 2013, and sets out the criteria that registered providers of healthcare should follow to ensure compliance with the CQC's registration requirements for cleanliness and infection control.²

Risk associated with infection control

MPS undertakes Clinical Risk Self Assessments (CRSAs) of general practices – this is a systematic approach to identifying risks and developing practical solutions to ensure quality of practice, and preventing harm to patients.³ MPS has conducted in total more than 1,000 CRSAs in practice. We analysed data obtained from more than 120 CRSAs conducted during 2012 – the results revealed that 85% of practices visited had issues regarding infection control. A further analysis of these risks is detailed in Figure 1. We'll now explore some of the key areas.

Cleaning of premises

Of the practices visited in 2012, 41% had risks associated with the cleanliness of the premises; this did not relate to the effectiveness or efficiency of those undertaking the housekeeping roles, but rather the schedule of cleaning for each individual practice.

Practices should ensure that they have a regular planned and monitored cleaning schedule, which provides details on the environment and when equipment, such as chairs, examination couches and toys, should be cleaned and how frequently.

Floor mops should be regularly washed and changed periodically. Mops and buckets should be colour coded and different mops should be used to clean clinical and public areas. Mops should be hung to dry and should not be left wet in buckets.

Specimen handling

How often do reception staff handle specimens within your practice? Are patients experts in ensuring sample bottles are not contaminated? Almost 44% of practices visited in 2012 had risks associated with specimen handling.

As part of the practice's infection control policy, reception staff should not touch patient specimens, and samples in inappropriate containers should not be accepted. GPs should ensure that they issue the patient with a labelled specimen container when requesting a specimen; this should reduce the number of specimens being presented in unsuitable and unlabelled containers. It will also prevent the need for decanting samples. A box could be provided at the reception desk for patients to leave their samples, which can then be passed directly to the nursing staff.

Hand washing

Almost a quarter of those practices visited had not provided staff with training on hand washing. Ensure that all staff receive appropriate training and use the six-step technique before and after direct contact with a patient in accordance with NICE guidance.⁴ Replace any cloth hand towels with paper towels, as cloth towels are a recognised source of cross infection. Staff should also have access to suitable personal protective equipment, such as gloves, aprons and eye protection.

Clinical waste/sharps

Of the practices MPS visited, 5.8% had risks associated with clinical waste and the management of sharps. For example not using pedal operated clinical waste bins, clinical waste bins not being provided in the consulting room and inappropriate storage of clinical waste awaiting collection.

Practices must ensure they comply with the Control of Substances Hazardous to Health (COSHH) Regulations 2002, ensuring that all staff are instructed how to dispose of waste correctly and safely.⁵ All hazardous liquids such as bleach should be stored in a lockable cupboard.

COSHH also states that staff should ensure that needles are disposed of in the sharps containers at the point of use.

Dealing with spillages

Spillage kits were not available in 26.7% of the practices visited. Ensure that the practice provides spillage kits, either purchased or made up in-house, for dealing with spillages such as body fluids, blood and mercury (if applicable). Contact your local infection control nurse about requirements for the safe cleaning of hazardous substances. It is also good practice for staff to be offered hepatitis B immunisation.

Training

Just under 32% of practices visited had not provided staff training on infection control. MPS experience of CQC inspections leads us to understand that training records provide key evidence to demonstrate compliance.



Toys

In MPS experience many waiting room toys are not cleaned routinely. Soft toys are hard to disinfect and tend to rapidly become re-contaminated after cleaning. Conversely, hard toys can be cleaned and disinfected easily. MPS advises the use of a bead frame or activity table that can be easily cleaned.

Summary

Today, patients have increased and differing expectations of their healthcare needs and requirements, none more important than the expectation that healthcare providers will meet standards of hygiene. A key component to achieving this is to ensure effective infection control and prevention systems within your practice.

Top tips for ensuring compliance with CQC registration

1. Ensure the practice has a nominated lead responsible for infection control issues
2. Make sure the premises are clean, with a designated person responsible for cleaning
3. Provide accurate information for patients about infection control
4. Provide accurate information on infections to all persons providing support or nursing/medical care
5. Patients who have infections should receive appropriate initial advice and treatment
6. All staff in the practice should receive appropriate infection control training
7. Provide adequate isolation facilities for patients presenting with an infectious condition
8. Secure adequate access to diagnostic, microbiology and virology laboratory services
9. Discuss and maintain infection control policies, such as safe handling and disposal of sharps, aseptic technique, decontamination of instruments etc
10. Ensure healthcare workers are protected from exposure to infections.

USEFUL LINKS

How can MPS help your practice?

MPS has developed an interactive workshop that will give general practice teams a clear understanding of the importance of infection control, providing you with the skills to manage and reduce infection in your practice.

Visit here for more information: www.medicalprotection.org/uk/education-and-events/infection-control-for-primary-care

MPS also offers an **Infection Control Risk Assessment Workshop**. This involves a two to three hour practice visit by one of our expert facilitators.

During the visit the facilitator will:

- review your current approach to infection control
- undertake semi-structured interviews with key practice staff
- identify areas of risk within your practice relating to infection control.

Visit here for more information: www.medicalprotection.org/uk/infection-control-gps

REFERENCES

1. CQC, *Essential Standards of Quality and Safety* (2010) – www.cqc.org.uk/
2. Health and Social Care Act, *Code of Practice on the Prevention and Control of Infections* (2008)
3. MPS, CRSAs – www.medicalprotection.org/uk/education-and-events/clinical-risk-self-assessments-for-gps
4. NICE, Clinical Guideline 139, *Prevention and Control of Healthcare Associated Infections in Primary and Community Care* (2012) – www.nice.org.uk/guidance/CG139
5. *Control of Substances Hazardous to Health* (COSHH) – www.hse.gov.uk/coshh/

The 12 risks of Christmas

“On the first day of Christmas my practice manager said to me...”

Christmas can be a challenging time in general practice. *Dr Rachel Birch*, MPS medicolegal consultant and salaried GP, advises on how to survive the festive season

“12 patients waiting...”

With staff on holiday and the practice closed for several days over the festive fortnight, there may be a great demand for appointments. Patients often wait to attend their own health centres rather than the out-of-hours service.

Top tips:

- Ensure you have sufficient time to plan the staff rotas and consider making contingency plans in case of staff illness.
- Offer influenza vaccinations to all staff members.
- Make all the appointments “on the day” and ensure you have adequate time for house visits, as elderly patients may be housebound if the weather is bad.
- If you are employing locums, provide them with a good induction.

“11 fairy lights flashing...”

Whilst a well-decorated and cheery waiting room can put a smile on everyone's face, remember that there may be risks involved with festive decorations.

Top tips:

- Consider an artificial tree to avoid the risks of pine needles.
- When decorating the waiting room beware of trailing cables and wobbly ladders.
- Ensure you have followed the relevant safety legislation.
- Arrange for power cables and fairy lights to be checked for safety in accordance with Electricity at Work Regulations (1989). Always use surge protector sockets.
- Ensure baubles are child friendly and not made out of glass.
- Keep any waiting room Christmas music at low volume.

“10 doctors leaping...”

Whilst everyone may be looking forward to the staff Christmas celebrations, remember that patients place a lot of trust in their healthcare team to look after them and behave appropriately.

Top tips:

- Ensure that you act professionally at all times.
- Be aware of the effects of tiredness and alcohol on performance.
- When in a holiday mood and discussing Christmas plans with patients, do not forget your duty of confidentiality.

“9 results a waiting...”

Hospital laboratories may have a reduced collection and results schedule. This coupled with the Christmas post may lead to delays in the usual services.

Top tips:

- Try to make referrals electronically, where possible, from mid December, so that they are not subject to postal delays.
- If a test result is essential, request it urgently so that it is phoned back to the practice the same day.
- Arrange for important tests, such as INRs, to be done a few days before the long holiday period.

“8 maids a milking...”

It can be fun to bring in ‘treats’, but make sure that you follow some basic rules to ensure the staff don't all become the patients.

Top tips:

- Check the sell by date on the milk.
- Ensure you follow basic food hygiene rules and do not reheat food more times than is recommended.
- If the cleaning staff are on leave take extra care to wipe surfaces with antibacterial fluids and do the washing up promptly.

“7 notices informing...”

It is surprising how many patients do not consider the altered surgery opening hours until it is upon them.

Top tips:

- Advertise the festive opening hours in good time and using as many methods as possible.
- Many regions publish lists of services and contact details for the festive periods – this may include OOH services, pharmacies, walk in centres, etc.
- Find out which hospital clinics may be closed, so you know where to direct patients should they require treatment.

“6 happy staff smiling...”

Christmas is a good time to show your staff how much you value their hard work during the year.

Top tips:

- Consider having a staff Christmas lunch or night out.
- Try to ensure that all staff get some time off, either at Christmas or New Year.
- Be aware that this can be a stressful time of year and offer support to your colleagues if needed.

“5 gold rings...”

Okay, we don't expect to receive gold rings as presents, but patients sometimes like to give gifts of chocolates, flowers, wine and fruit.

Top tips:

- Ensure the practice has a gift policy and maintains a register of all gifts received.
- Consider sending thank you cards to those patients who brought you presents.
- Inform the local commissioning body or health board if you receive any presents over the value of £100.
- Doctors should keep thank you letters from patients for their appraisals.
- Don't leave alcohol in consulting rooms as it may give the wrong impression to patients.

“4 snow storms...”

Practices could find themselves liable if patients injure themselves in the snow and ice.

Top tips:

- Fill up your grit bins and keep snow shovels in the practice.
- Draw up a festive rota for clearing snow. Provide training, supervision and provision of suitable equipment.
- Ensure that you have adequate public liability insurance.
- Keep the temperature of the surgery warm to prevent frozen pipes.

“3 winter bugs...”

Winter brings its own set of illnesses, including norovirus, colds and influenza.

Top tips:

- Encourage eligible patients to have their annual influenza vaccinations.
- Consider providing alcohol handwash stations in the waiting room and patient toilet areas.
- Be vigilant to the possibility of atypical presentations of serious illnesses such as heart attacks.
- Liaise with district nurses, social services and consider offering telephone support for vulnerable patients.
- Emotions may run high and if patients need admitting to hospital they may try to stay at home – try to offer the same advice to patients as you would at any other time of year.

“2 emergency prescriptions...”

It is amazing how many patients leave prescription requests until the last minute.

Top tips:

- Ask patients to request prescriptions in advance.
- Consider printing reminders on the right-hand side of prescriptions, advertising in the local newsletter and on notices, and consider sending text reminders.
- If sending text reminders, ensure you follow the guidance in the MPS factsheet “Communicating with patients by text”.
- Allocate extra time in the week to deal with extra prescription requests.
- Make sure the practice emergency cupboard is well stocked.

“And an ostrich in a Christmas tree...”

Don't be an ostrich and bury your head in the sand, or behind the sparkly Christmas tree baubles – be prepared.

TOP TIPS

This year surgeries will reopen on the Friday after Christmas, making it a potentially difficult day as there is only one working day before the weekend again.

Ensure you have adequate staff for this day, and the Thursday and Friday after New Year. Remember that the first full week following the holidays is likely to be busy too.

Good preparation should help you have a successful Christmas and a Happy New Year.

CORE SKILLS SERIES

Confidentiality - Disclosures about patients unable to consent

In this series *Charlotte Hudson* explores the key risk areas in general practice



At a glance

Confidentiality is central to the trust between doctors and patients. You owe a duty of confidentiality to all your patients, past or present.

The issue of confidentiality is a complex one for doctors, particularly with regards to disclosing patient information to third parties. The legal and ethical dilemmas of when you can disclose information, whose consent you need and in what circumstances are particularly tricky areas for doctors. The situation is even more blurred in scenarios where a person lacks the capacity to consent.

Working in general practice, you may be asked to provide information from the medical records of patients who are incapable of giving consent, are aged under 18, or have died. Or you may be asked by a child or young person to withhold information from their parents about their condition or treatment. How do you handle requests of this nature?

The GMC, in its *Confidentiality* guidance, states that when making decisions about whether to disclose information about a patient who lacks capacity, you must make the care of the patient your first concern; respect the patient's dignity and privacy; and support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

For consent to be valid, a patient must be competent to make a decision. Assessment of a person's capacity should be based on his/her ability to understand, retain and weigh in the balance the information relevant to a particular decision. The person must also be able to communicate the decision. The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.

Children and young people with capacity

Many young people have the capacity to consent to the disclosure of their medical records. If the child or young person (under 18 years of age) is able to understand the purposes and consequences of disclosure (Gillick competent) they can consent or refuse consent to the disclosure. You should discuss disclosing the information with them and release it only with the child or young person's consent. If a child or young person under 18 refuses consent, you should nevertheless disclose the information if it satisfies one of the circumstances below:

When should you disclose?

- If you consider the child or young person to be at risk of neglect or abuse
- To assist in the prevention, detection or prosecution of a serious crime
- Where the child or young person may be involved in behaviour that might put themselves or others at risk of serious harm, such as serious addiction, self-harm or joyriding
- For the purpose of a criminal investigation.

You should involve the child in the decision and ensure it is documented, including notes on how the decision was reached.

Confidentiality about treatment

As children grow older and become more competent to make their own decisions about treatment, they also become entitled to confidentiality about that treatment. Be aware that Gillick competent children may visit the surgery alone to talk about issues they want keeping confidential (such as family planning) but may still visit with a parent with other conditions. MPS frequently receives calls on the helpline in relation to matters regarding consent and confidentiality relating to children.

Children and young people without capacity

The overriding principle, when dealing with the disclosure of the medical records of children or young people who do not have the maturity or understanding to make a decision, is ensuring that you act in their best interests.

If the child or young person lacks the capacity to consent to the disclosure of information, those with parental responsibility

can consent on their behalf. The consent of only one person with parental responsibility is needed for consent for disclosure. Unless she lacks capacity herself, a child's mother automatically has parental responsibility. A father will have parental responsibility if any of the following conditions apply:

- He is married to the mother of his child (or was married to her at the time of the child's birth).
- He has made a parental responsibility agreement with the mother.
- He has obtained a court order granting him parental responsibility.
- The child was born after 15 April 2002 in Northern Ireland, 1 December 2003 in England or Wales, or 4 May 2006 in Scotland and the father is named on the child's birth certificate, regardless of whether married or not.

Other individuals or organisations (such as social services) may be given parental responsibility by court order, or by being appointed as a guardian on the death of a parent. There are also circumstances where parents might delegate parental responsibility to the child's grandparents, eg, so that they can attend the surgery on behalf of the parents.

The Mental Capacity Act 2005 and the Children Act 1989 can apply in young people aged 16-17, depending on the circumstances. In England, the MCA defines anyone of age 16 as an adult.

It is important to record any decision made in the patient's notes. This should include the information that was provided to the patient and the parents, and how the decision was reached.

Child abuse

The Children Act 2004 places a statutory duty on medical professionals to safeguard the wellbeing of children. The GMC also advises that if you believe a patient to be a victim of neglect, or physical, sexual or emotional abuse, and that they lack the capacity to consent to disclosure, you must give information promptly to an appropriate responsible person or authority, if you believe this is in the patient's best interests or necessary to protect others from risk of serious harm. You should usually tell the patient that you intend to disclose the information before doing so. Where

appropriate, you should also inform those with parental responsibility about the disclosure.

Adults lacking capacity

Under the Mental Capacity Act 2005, patients are assumed to have capacity, unless they have an impairment affecting their mind (eg, dementia), which means they are unable to make a specific decision at a specific time. There is also a requirement to ensure all practical steps have been taken to help the individual make a decision.

If a patient who lacks capacity asks you not to disclose personal information about their condition or treatment, you should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse, and you are convinced that it is essential in their best interests, you may disclose relevant information to an appropriate person or authority. In such a case you should tell the patient before disclosing the information and, if appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record your discussions and the reasons for deciding to disclose the information.

Remember that disclosure of confidential information should be made in the best interests of the person lacking capacity.

Confidentiality after death

Your duty of confidentiality continues after the patient has died. The GMC's *Confidentiality* (2009) states that a doctor does have discretion to disclose pertinent information after death, however this should be read in conjunction with the relevant legislation (the Data Protection Act [1983] applies only to living subjects, hence, the relevant legislation is the Access To Health Records Act [1990]). If the patient had asked that specific information remain confidential, their views should be documented, and respected, subject to disclosures that are required by law or justified in the public interest. There may be circumstances when disclosure may be justified, for example, the Access to Health Records Act (1990) allows either the deceased patient's personal representative (this would be either an executor of the will or the administrator of the estate) or anyone who may have a claim arising out of the death to make an application to access the part of the records that is relevant to their request.

Disclosure after a patient's death – Case study

By Dr Saheli Chaudhury, GP partner

Confidentiality is one of the cornerstones of trust that enables patients to be open with doctors about their symptoms and problems

Fred had been my patient for a few years but died in November 2011. Fiona, who is the eldest daughter of Fred, is also my patient and was her father's main carer. Fred was due to take a holiday over Christmas in 2011, so Fiona wanted to cancel the holiday and make a claim on the holiday insurance policy that Fred took out in December 2009.

Fiona had already forwarded the relevant correspondence to the travel insurance company with regards to the claim, but received a letter from them asking for her father's medical records for the two years prior to taking out the insurance policy. The company was refusing to pay until furnished with that information.

Fiona contacted the surgery requesting her father's medical records. She was concerned that if the insurers did not pay she would be £2,500 out of pocket. I knew she was a very caring daughter and had looked after her father well in his last months. He had fairly good health up to August 2010 but after several TIAs, developed vascular dementia.

Whilst mindful of the doctor-patient relationship between Fiona and me, I was unsure of the best way forward in this situation. I bought time and suggested I look into matters to see how best I could help.

Actions

There is guidance and legislation regarding disclosures after death; the GMC's guidance on confidentiality and the Access to Health Records Act 1990. As a general rule, you should seek a patient's express consent before disclosing identifiable information for purposes other than the provision of their care or local clinical audit, such as financial audit and insurance or benefits claims; however, this was not practicable in this case as Fred had passed away. Fred had not signed a consent form with his insurance policy, either.

My duty of confidentiality to Fred continues after he has died. The permission of a surviving relative or next of kin is not required and does not

authorise disclosure of confidential information, although the views of those who were close to the patient may help you decide if disclosure is appropriate. I chose to discuss this scenario with my GP partners at the practice and rang MPS for advice.

After discussion and in light of the guidance and legislation, I concluded that I could reasonably justify providing the relevant information on the following grounds:

- It could be reasonably stated that Fiona's request pertained to a claim arising out of the death (hence she would have a right to make an application for disclosure of the part of the records that was relevant to her request under the provisions of the Access To Health Records Act [1990]).
- I had no reason to believe that Fred would have objected to the disclosure (GMC, *Confidentiality*, paragraph 71[g]).
- The disclosure of information was likely to benefit Fiona (GMC, *Confidentiality*, paragraph 70 [a]).

All names and events in this case scenario are entirely fictional and are solely to demonstrate the ethical dilemmas often faced in day-to-day general practice.

Conclusion

Confidentiality is one of the cornerstones of trust that enables patients to be open with doctors about their symptoms and problems, and it is generally implied that when a patient consults a doctor, the information about the patient is kept confidential. There are, however, situations when you may have to disclose information about a patient when it is in their best interests, or the interests of the public, with or without their consent.

Ultimately, a doctor's primary concern is patient safety and ensuring that the patient is cared for. So long as your reasons for disclosing patient information are justified, you will be able to defend your actions.

The Apprentice

Can you keep a secret?

Dr Laura Davison



Following a number of practice meetings I had some real corks to tell from the "field" about dilemmas in discretion and confidentiality. I re-read the GMC guidelines on confidentiality to enable me to accurately pass on key points that came of the controversial stories but actually came to the conclusion that...I can't actually tell you anything. Nothing. Zip. Unless you don't mind reading a story about Mr X who came to see Dr Y about his disturbing A and Dr Y didn't know who to ask for help about A just in case B happened and confidentiality had to be broken. Or the other particularly tricky tale about Dr Z constantly complaining about Mr T to Dr M. Dr M knows all about Mr T and wants to help but can't because it breaches confidentiality of two parties; so instead is putting Mr T and Dr Z through the anxiety-inducing arduousness of P. You see the problem?!

Disclosing information, even for educational purposes, requires patient consent. You may anonymise cases for reports and no consent would be necessary, but seeing as you know my name, location, occupation and even what I look like, you could probably work out the cases' identities just through a quick Google if I included too many facts. And what if X, Y and Z read this article too?! Calamity.

The crux of my cases was really a predicament around patients that might be a risk to themselves or others. We discussed a particularly tricky case in one practice meeting. The debate raged on and on until the coffee and sandwiches ran dry. What counts as a "need to know" basis these days? And how do you control the disclosure once it's 'out there' with another party? The old "tap nose, wink wink" approach is no longer effective in secret keeping. There is a huge element of trust versus risk.

The GMC guidance has common themes on information keeping. It's patient interest versus public interest. Confidentiality is a legal requirement, but for both patient AND public. So which do you pick? Whose side are you on? Providing the care of your patient is paramount but then you have the responsibility to protect the public too. It's surely a Catch-22. One will not thank you for your decision whichever way you go. It's eternally debatable. In the end, our practice has chosen to keep our patients' trust for now. We felt as long as you can justify (and document!) your decision, you should survive these dilemmas with only emotional bruises rather than legal ones.

Is it just me that feels so encumbered by these confidential revelations that patients entrust to me? Can I tell a secret? Should I?

Dr Davison is a GP in Milton Keynes.

Sample AKT questions regarding confidentiality

with Dr Mahibur Rahman



1. One of your patients asks if her daughter has been prescribed the oral contraceptive pill. Her daughter is 14, and was seen on her own a week earlier, and prescribed the combined oral contraceptive pill by one of the other doctors in the practice. Which of the following is the most suitable action?

- A. Provide information if the mother has parental responsibility.
- B. Explain that you are unable to disclose information without the daughter's permission.
- C. Explain that her daughter is taking contraception but that you cannot divulge details of the exact prescription.
- D. Advise the mother to put in a request to access the notes in writing.
- E. Provide full details as the mother has a right to know.

2. Where a patient has a notifiable disease, doctors have a duty to inform the Proper Officer of the details of the disease even if the patient does not consent to the disclosure. Which ONE of the following is not a notifiable disease?

- A. Cholera
- B. Tetanus
- C. HIV
- D. Malaria
- E. Legionnaire's disease

3. You receive a request for a medical report based on a patient's notes from an insurance company. The request includes signed consent from the patient to allow you to provide this information. The patient contacts you asking to see a copy of the report before it is sent to the insurance company. The patient does not have any significant medical problems. What is the most appropriate way to deal with this request?

- A. Contact the insurance company and request their permission to give the patient a copy of the report.
- B. Tell the patient that he should request a copy from the insurance company.
- C. Tell the patient that it is not possible for him to see the report, but that he can request access to his own records.
- D. Provide a copy of the report to the patient before sending the original to the insurance company.
- E. Provide a copy of the report to the patient after sending the original to the insurance company.

For the answers to these questions see the *Practice Matters* section of the MPS website: www.medicalprotection.org/uk/practice-matters/issue-4/test-your-knowledge

Dr Mahibur Rahman is the medical director of Emedica, and works as a portfolio GP in the West Midlands. He is the course director for the Emedica AKT and CSA Preparation courses, and has helped hundreds of GP trainees achieve success in their MRCGP, AKT and CSA examinations each year.

USEFUL LINKS

How can MPS help your practice?

- MPS factsheet, *Confidentiality – Disclosures relating to patients unable to consent* – www.medicalprotection.org/uk/england-factsheets/disclosures-unable-to-consent
- GMC, *0-18 years guidance: Children and young people who lack capacity to consent* – www.gmc-uk.org/guidance/ethical_guidance/children_guidance_27_28_lack_capacity.asp
- GMC, *Consent guidance, Part 3: Capacity issues, When a patient lacks capacity* – www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_making_decisions_patient_lacks_capacity.asp
- GMC, *Confidentiality* – http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp



A day in the life of a rural GP...

Dr Andrew Murray

Endurance athlete and GP Dr Andrew Murray reflects on working in Mongolia and why he decided to run from Scotland to the Sahara



The sense of space is unparalleled. The sun-baked desert plains of Mongolia are only broken by the towering mountains 50km distant to the West, and Asia's highest sand dunes to the North East. They are interspersed with nomad villages and camels. I will always remember when I arrived in Mongolia; a young man gestured towards me, offering me what looked like cheese. My Mongolian and his English were limited but his smile drew me in. I remember thinking "what would it be like to live here?"

It turns out that Mongolia is an outstanding place to visit, but a more difficult place to live. It is the 19th largest country in the world, and the 146th most populated, giving it the lowest population density on Earth. Temperatures in the summer frequently top 45 degrees; whilst in the winter minus 30 Celsius is not unusual. There is little rain from one year to the next.

My new friend showed me round his house, a large

circular tent or Ger, where he and eight other members of his family lived. I started to feel slightly ill. It was not the 44km leg I had run that day as part of "the Gobi Challenge", but rather the realisation that this man that had so little was unfailingly generous, offering me a bed for the night, and food.

A fellow doctor, Duncan Goodall, and I decided to set up an impromptu clinic – true rural medicine with only two houses visible on the horizon. Even with a modest bank of patients, we saw an infected burn, ear infections, a small abscess, and were able to offer explanations via an interpreter for a healed fracture, and cataracts. The cataracts frustrated me.

I was in the Gobi desert to take part in a run, racing 250km across this region in six days. Fortunately, the race director Dave Scott is also the founder of the Yamaa Trust, whose sole aim is to ameliorate poverty in the Gobi desert, so I'd been able to offer a bit of

medical input at camp each evening. Dave explained the unmet need of this population, and that with funding it would be simple and cheap to provide a life-changing cataract operation.

Upon arriving back home after this amazing trip – a switch flicked. I'll do a big run. I like deserts. I'll run from Scotland to the Sahara desert, and raise money for the Yamaa Trust and come back to the Gobi.

Scotland2Sahara was worth it in so many ways. The human body has evolved perfectly over millions of years to cover big distances on foot, so I knew running 2,660 miles over the 11 weeks I had to complete the challenge was possible. There was a simplicity to it. Start at John O'Groats and put one foot in front of the other until you reach sand dunes and camels.

On the way I was passed at various times by a nine-year-old boy, by a donkey and had a few quite painful injuries – ilio-tibial band, Achilles tendinopathy, a hip flexor injury, and some fairly gnarly blisters. But the view coming over the High Atlas mountains with snow-capped peaks behind me and a green river of life dwindling down towards the Sahara was phenomenal.

I've since had the opportunity to compete in some incredible endurance challenges, and work in remarkable places. My doctor's bag at the North Pole was very different to the one I'd use for house calls in Edinburgh. Vital supplies included an inhaler (many visitors become wheezy due to the cold dry air), some warm gloves to avoid frostbite, and a gun to fire in the air should a polar bear fancy some ginger, Scottish dinner. Mongolia is still my favourite, and the opportunity to go back and share a visit with my wife Jennie offered a chance to see the sights and contribute medically.

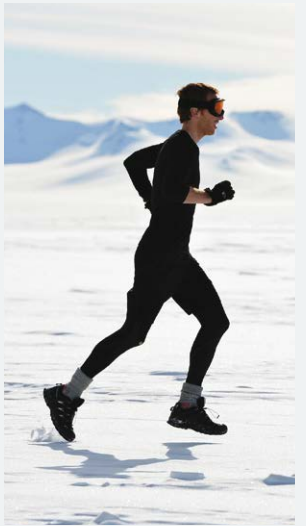
The Yamaa Trust have now funded a number of

cataract operations in the south Gobi, and this region opened my eyes. Despite its faults, we are a part of an NHS that offers a phenomenal service to the people of Great Britain. The paperwork drives me mad, but why is it that 99% of customers are satisfied, but 95% of press attention is negative? It also showed me that qualifying as a GP is a unique ticket to work in some amazing places, and gives us life skills that can make a difference in the UK and further afield.

Dr Murray works as a GP and Sports Medicine doctor with the European Golf Tour, and Scottish Rugby, as well as doing regular GP out of hours in Midlothian. He has worked on all seven continents and the North Pole.

His run from John O'Groats to the Sahara raised more than £79,000 for the Yamaa Trust. Since then he has gone on to complete many remarkable endurance challenges. He has also written a book called Running Beyond Limits. To donate to the work of the Yamaa Trust: www.justgiving.com/Scotland2Sahara.

For more information follow him on Twitter at @docandrewmurray or visit his website www.docandrewmurray.com.



From the case files...

Each issue the team that bring you *Casebook* share interesting general practice cases

An obligation to report concerns

In this issue we share a case where a locum GP raised concerns about patient safety in a practice he had worked at for three months

Dr V had recently finished training as a GP. He had just completed a three month locum at a practice in England when he contacted MPS for advice on handling concerns about systems failings at the practice, which he believed put patients at risk. He had discussed the issues in broad terms with his former trainer who agreed that the systems described were flawed.

Before leaving he had discussed his concerns with the senior partner who appeared receptive but he was later informed by the practice manager that it was not agreed that the risk to patients was significant. Dr V was uncertain to what extent his concerns had been shared with the other partners at the practice.

Dr V believed he had an obligation to report his concerns but he did not want to cause any difficulties for the practice and feared a negative effect on his career; moreover, he did not know how to go about it.

Dr V was told that he was correct in his assessment of his obligations and referred to the GMC guidance *Raising and acting on concerns about patient safety*.¹ By reference to this document, the options were discussed and the following actions were agreed.

First, he had only raised his concerns verbally so it was agreed that he should write to all the partners and the practice manager setting out his concerns in writing. As he was no longer at the practice it was reasonable to expressly seek a response and a tangible reassurance that action would be taken. The letter

would need to be carefully crafted to avoid appearing presumptuous and causing offence. MPS agreed to review the draft.

In the absence of a suitable response from the practice Dr V would need to consider escalating his concerns to the performance management group of the NHS England Area Team.

Having done this, he would, in all likelihood, have discharged his obligations as it was reasonable to expect the Area Team to take control of the situation. However, he would need to consider reporting the matter to the CQC and/or the GMC if he believed that the Area Team was part of the problem or he learnt that their response had been inadequate. It was pointed out that he had an obligation to report immediate and serious risks to patients to the regulator with a responsibility to intervene; in this case most probably the CQC. However, it was agreed that the risk identified did not reach that threshold.

MPS provided Dr V with advice in relation to the tone, style and content of his draft letter to the practice. Upon receipt of the letter the practice arranged a meeting with Dr V in order to discuss the issues that he had raised. The practice took a positive approach to the concerns that Dr V had raised and instigated an action plan to rectify the relevant issues. As a consequence of the action taken by the practice Dr V was sufficiently reassured and did not consider he had an obligation to escalate matters further.

Learning points

- A doctor has a duty to act where there is a risk to patient safety irrespective of any negative effects on themselves or of any loyalties.
- It is sufficient that a doctor reasonably believes that this might be the case. They do not need proof. In this case, Dr V discussed his concerns with his former trainer. This was very helpful but had he not been able to do so, he would have had to rely on his own honest assessment of the issues.
- Wherever possible, concerns must be raised following a stepwise process, usually starting with the doctor's immediate line manager, escalating internally to the individual responsible for clinical governance or in overall charge.
- Unless there is an immediate and serious risk to patients, external escalation will be to the Area Team in the first instance followed, in the absence of a suitable response, by involvement of the CQC and/or GMC.

REFERENCES

¹ www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp



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