Practice Manager
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ISSUE 21

RECORDING CONSULTATIONS
Are patients within their rights to video or audio record consultations with a clinician?

ACTIVE MANAGEMENT
We are all project managers no matter what our role - but how effective?

WORKFLOW OPTIMISATION
It has been shown to ease GP workloads but there are patient safety considerations

GOING FOR GROWTH

AN INNOVATIVE GP GARDEN PROJECT BLOOMS IN LAMBETH

WHAT'S UP WITH WHATSAPP?
MANAGING RISK IN GROUP 'CHAT'

Practice Manager

AT the start of my introduction it is my very sad job to announce the death of my colleague and joint editor of *Practice Manager* magazine, Scott Obrzud. Please see our tribute to him on the page opposite.

Social prescribing in general practice seems to come in all varieties now – from Parkrun to bird watching – and the benefits do seem obvious for those who choose to engage. In our profile on page 10 we hear about an innovative GP garden project helping patients in Lambeth, south London.

An increasing number of patients are now asking to record their own consultations. On page 6 Alan Frame argues why it is best to try and accommodate such requests within reason – not least because they might just do it anyway without your knowledge and be within their rights.

On page 7 employment law adviser Liz Symon offers some points to consider when agreeing a phased return to work for an employee coming back from a long-term absence.

Workflow optimisation or correspondence management has been shown to ease GP workloads in some practices but concerns have been raised that it may put patient safety at risk. On page 8, risk adviser Kay Louise Grant investigates and provides some helpful action points on implementation.

No matter what our role, we are all project managers – and on page 12 Alan Gaw offers some tips on keeping your project on track. WhatsApp was not designed to be used in the workplace but many primary care staff in MDDUS report being included in practice group chats or wider clinical groups. Does this bring risks? What about "banter" and "crossing the line"? Liz Price ponders these and other questions on page 13.

Check our regular Call Log on pages 4-5 with advice on DNACPR forms, photocopy charges, confidentiality after death and more. Our case on page 14 concerns a missed warning on a medication allergy.

Helen Ormiston
Editor

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ENGAGEMENT IS EVERYTHING

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REQUEST A SPEAKER OR TRAINING EVENT

THE MDDUS Training & CPD team hold events in our Glasgow and London offices on a range of key topics. We also often work with partner organisations such as the Royal College of GPs and the law firm Capsticks to deliver relevant workshops across other areas of the UK. You may not realise that we can often bring training workshops to your local area on request.

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

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

Email **risk@mddus.com** to find out more.

EXTENDED COVER FOR PRACTICE STAFF

MDDUS has launched a new product in England and Wales to provide practices and practice groups with peace of mind that non-GP staff are properly protected and have advice and support for the work that they undertake.

Primary Care Team Professional Advice Protection (PCT-PAP) provides non-GP members of practice teams in England and Wales access to advice and support with complaints in respect of clinical practice indemnified by state-backed indemnity schemes (CNSGP and GMPI). PCT-PAP offers support for practice nurses, nurse practitioners, paramedics, physiotherapists, HCAs, phlebotomists, emergency care practitioners and administrative staff.

PCT-PAP also provides regulated non-GP members of the team with access to indemnity for a defined range of non-NHS work undertaken on behalf of the practice with registered patients and NHS patients within your primary care network. Activities include travel clinics, insurance reports and more.

The cost is free to practices where all GP partners are MDDUS members; otherwise £50 per regulated team member. Non-regulated staff (HCAs, phlebotomists, etc) are covered free.

More details on this new product and how to apply are available at **www mddus com/join/primary-care-team-protection---england-wales**

ACTION URGED TO IMPROVE VACCINATION UPTAKE

ONE in seven five year olds in England may not be fully up-to-date with routine immunisations, according to Public Health England (PHE).

That figure could be as high as one in four children in London.

These estimates were released as part of the PHE campaign – Value of Vaccines – to highlight that many children are starting school at unnecessary risk of serious diseases. The intention is to prompt a call for parents to check their child's Red Book to ensure they are up-to-date with scheduled immunisations.

There has been a small but steady decline in vaccination coverage in recent years, which means that the UK has now lost its 'measles-free' status with the World Health Organisation (WHO) three years after the virus was eliminated in the country.

Dr Mary Ramsay, Head of Immunisation at PHE, said: "We're particularly concerned about children being at greater risk of measles. We're continuing to see outbreaks of the disease occurring in communities across the country, many linked to visiting European countries over the summer holidays."

MDDUS RISK WEBINARS

LEARN how to manage key risks in general practice by accessing a range of webinars from the MDDUS Training & CPD team. Exclusively for members, our webinars are available to access both as live events and pre-recorded resources that can be watched at a time and place to suit you.

Hot topics for 2020 include:

- Reflective practice for dentists
- Confidentiality in GP practice
- Managing data security breaches.

Check out the Training & CPD > Training > Webinars section of **www mddus com** to find other pre-recorded and future webinars, or email **risk@mddus.com** for more announcements on topics such as complaints handling, confidentiality and managing social media risks.

BIG CHANGES FOR 2020

THERE are some big employment law changes planned from April 2020 under the government's new Good Work Plan.

Under the legislation, every new employee and worker will have the right to receive a statement of written particulars from day one of their employment. The penalty for failing to provide the statement will be two weeks' pay. Agency workers will need to be provided with a key information document that includes details about pay, costs, benefits, deductions and fees.

The reference period to take an average for holiday pay for those with varied hours will increase to 52 weeks from 12 weeks.

Other changes include:

- The Swedish derogation law regarding agency workers is to be scrapped in a bid to encourage employers to take on permanent employees.
- The threshold required for a valid request to set up information and consultation arrangements will be reduced from 10 per cent to two per cent of employees. The requirement for the request to be made by a minimum of 15 employees remains.
- Confidentiality clauses in contracts or settlement agreements preventing disclosure to the police, regulated health or care or legal professions is to be prohibited.

We are still waiting for confirmation on the following proposed changes:

- Right for workers with varying hours and shift patterns to request a more predictable and stable contract after 26 weeks employment.
- Redundancy protection for new parents to be extended.
- Extension of shared parental leave to grandparents.

SCOTT OBRZUD

IT is with great sadness that we have to inform you of the death of our dear colleague Scott Obrzud, who passed away in October.

Many of you will know Scott or will have spoken to him on the advice line. He had a tremendous passion for his job and viewed himself very much as a champion for the members. He always approached his work with professionalism and diligence and took great pride in what he did.

Scott began working at MDDUS as a practice adviser in 2013 and helped to pioneer the development of the role. He graduated from Napier University as an RN in 1997 and worked as a surgical nurse in the Royal Infirmary of Edinburgh for five years. He then spent seven years working as a practice nurse in general practice. In 2010 he successfully completed the NES PMVTS for Practice Managers before becoming a practice manager. Scott chaired his local managers' group for two years prior to joining the MDDUS.

For his colleagues and friends, the office is a much quieter place. Scott had a sharp wit and a real sense of fun (mischief!) and his laughter could be heard across the corridors. He was also very caring, looking out for his colleagues and for members. He was always ready to listen to members' concerns and do all that he could to assist them. Scott paid attention to all the small details, from the advice he gave, always checking legislation and guidance was clear, to the layout of the office, where he would rearrange the stickers on the year planner and line up his shoes perfectly!

It was an honour and privilege to work with him and he is greatly missed.

Helen Ormiston, practice adviser

Call log

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

DO NOT RESUSCITATE

Q We are a practice based in Scotland and an elderly but otherwise healthy patient has sent in a letter requesting to formally record that if he should stop breathing he does not wish to have CPR. He wants to complete a DNACPR (Do not Attempt CPR) form to go in his medical records. Is this appropriate?

A DNACPR forms reflect a clinical decision, not necessarily a patient's request. The patient should be advised to complete an advance directive (also called an advance decision in England and Wales). This could be a detailed document setting out the patient's wishes regarding future treatment, including decisions over the provision of CPR. The patient must have capacity to make such decisions. If an appropriate advance directive is in place then, arguably, a DNACPR form is not required but may be helpful to indicate to other healthcare professionals that the advance directive should be abided by.

PHOTOCOPY CHARGES

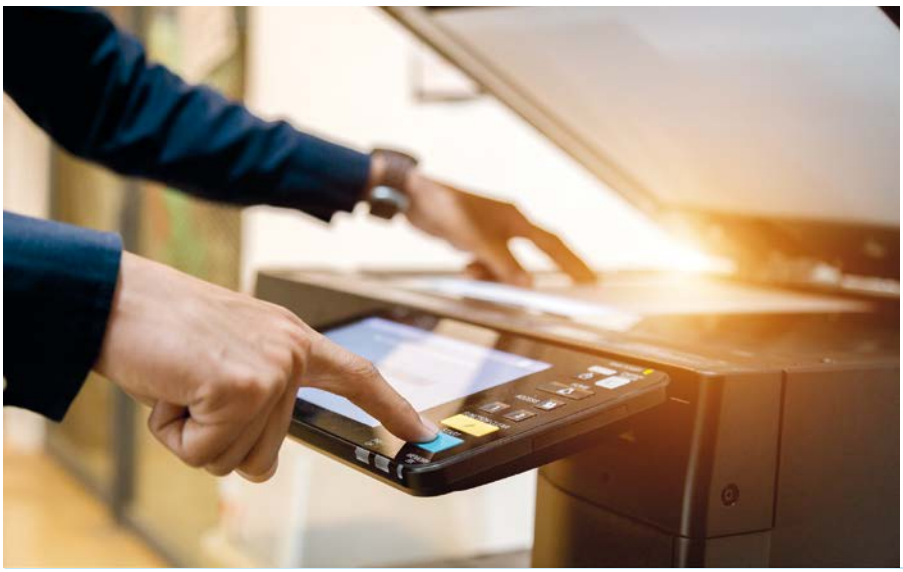
Q A patient has asked for copies of her full medical records, and claims that under the new GDPR our practice can no longer charge for this. Does this really mean we have to print out all notes for any patient without covering our costs?

A Under GDPR you are not allowed to charge patients for access to medical records apart from in exceptional circumstances. The regulations stipulate that a reasonable fee can be charged if a request is unfounded or excessive but these circumstances are likely to be rare: for example, a patient who makes repeated requests for the same information. In general, your patient is correct and you cannot charge for disclosures. The ICO (tinyurl.com/y43yappl) offers advice in relation to GDPR.

FACTUAL ERROR IN NOTES

Q A 19-year-old patient has contacted the practice asking for a correction on her medical records. She applied to join the army but the recruitment office suspended her application upon reviewing her medical records and noting a "two-year history of back pain". The patient claims she presented to the doctor twice in a two-month period and the reference to the "two-year history" was after the second consultation. She claims that this is clearly an error and would like to have it corrected. She also requests that the practice forward the amended records to the recruitment office with a covering letter pointing out the error. What would you advise?

A The practice should first investigate the matter in discussion with the consulting GP. The Data Protection Act (DPA) requires that data controllers ensure that the information they hold is accurate, and it also permits data subjects to request amendments to their records. Such requests usually relate to the correction of factual inaccuracies. In cases where both the doctor and patient agree that the recorded information is factually inaccurate, the record can be amended The original information should be able to be viewed and accompanied by an explanation of why there has been an alteration to the record. Should there be disagreement over the accuracy of an entry, the patient is entitled to include a statement in the record to this effect. In this case, it may boil down to a dispute of fact as to the duration of the symptoms and the practice would need to consider the evidence that is available and make a judgment on how to proceed. Be prepared to explain and justify that decision and the action taken, and ensure this is recorded in the notes.



CONFIDENTIALITY AFTER DEATH

Q The husband of a recently deceased patient has attended the practice requesting access to his wife's medical records. When asked the purpose and timeframe of the disclosure he admitted that he suspected his wife had terminated a pregnancy a number of years ago and he wants to check. He has now provided evidence that he is the executor of his wife's estate. Should we comply with this request?

A The duty of confidentiality extends beyond a patient's death and the presumption should be that personal information remains confidential unless there is a good reason for disclosure. The GMC provides guidance on the disclosure of records (*Confidentiality*) and paragraph 35 describes circumstances when you may disclose relevant information about a patient who has died. Such instances are when required by law or when necessary to meet a statutory duty of candour. In other circumstances, the extent of the personal information disclosed will depend on the facts of the case. A patient may have asked that certain information remains confidential and you should usually abide by those wishes. Otherwise, you should take into account whether disclosing the requested information is likely to cause distress to, or be of benefit to, the patient's partner or family – and the purpose of the disclosure. A person with right of access to a deceased patient's records under the Access to Health Records Act 1990 can include a personal representative or executor of the patient's will – but the Act does not guarantee full unredacted access to the records should there be third-party or potentially harmful information. In this particular case, the practice will need to decide whether providing the husband with details of a previous termination would have been what the patient would have wanted. You should consider the nature and purpose of the request and avoid providing information which may cause serious harm. In this case, there may be an argument that, given the patient has not previously disclosed this sensitive information, she may have wished it to remain confidential after her death. If information is not disclosed, the decision can be challenged in court.

RUMOUR OF ILLEGALITY

Q The practice has received an anonymous letter claiming that a patient has been selling on their prescription medication. A GP has discussed the matter with the patient who denies the allegation – however the doctor remains suspicious. How should we proceed?

A This is a difficult situation as the claim is hearsay and cannot be substantiated. You should consult GMC guidance on *Confidentiality*, which states: "Doctors owe a duty of confidentiality to their patients, but they also have a wider duty to protect and promote the health of patients and the public." The guidance goes on to explain that there can be a public interest in disclosing information to protect individuals or society from risks of serious harm. "Such a situation might arise, for example, if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person." The practice should consider trying to seek consent to disclose the concern raised (although this is clearly unlikely to be given). The conversation will, however, prompt a discussion about this issue and may help clarify whether the patient is using the medication appropriately. If the practice considers that a serious crime may have occurred or might occur in the future, there could be a public interest to disclose the minimum information necessary to allow the police to initiate an investigation. The patient should be informed of this intention to disclose, unless doing so would increase risks to any individual or compromise the investigation. If the public interest is not outweighed by the patient's duty of confidentiality and the information is not disclosed, this should be documented, along with the rationale.

PATIENT MEDICAL HISTORY

Q Our dental practice asks patients to complete a medical history form at every six-month check-up. At visits in between, our clinicians only ask if there have been any changes in the medical history. One of our dentists feels this is not sufficient and believes important information might be missed. He would prefer patients to fill in a new PMH form at every visit. What is most appropriate?

A MDDUS advises that patients should complete a new medical history every six months, signing and dating it as appropriate. The practice should have a system in place for checking patients attending in between the six-month timeframe. This should refer to the uploaded form and prompt the dentist or DCP to verify the information and ask about any changes, particularly in medication. Any changes should be noted, the form dated and initialled by the patient and the treating clinician (or by other means on an electronic form).

VOICEMAIL MESSAGES

Q Can you provide some clarification regarding the question of confidentiality when leaving messages on patients' voicemail? Some partners at our practice leave messages asking a patient to contact the surgery but others will leave no message at all. What is best practice?

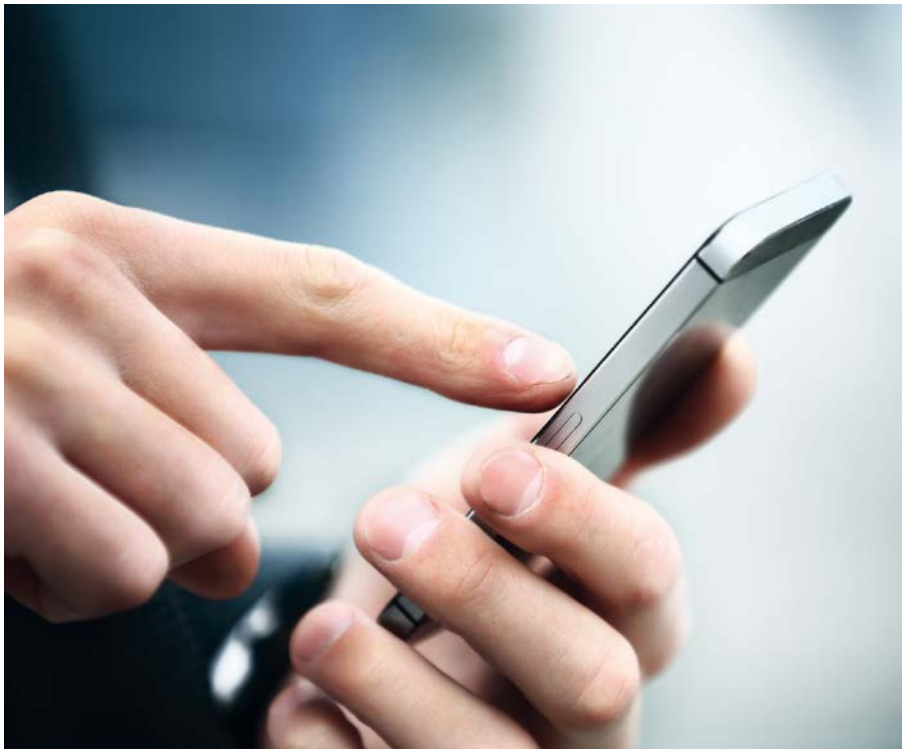
A It would be appropriate for your medical/nursing colleagues to use their discretion regarding leaving a message. There may be consent in place to do so, or they may have significant concern for the patient's health and wellbeing. Leaving a message on a patient's voicemail in such circumstances could certainly be justifiable. If there is no clinical need to leave a message and doing so might disclose information to someone other than the patient, it is not usually appropriate nor necessary to record such a message.

CLINICAL IMAGES VIA SMARTPHONE

Q Clinical staff in our practice are using mobile phones to photograph patient wounds in order to assist with ongoing care. These photographs are being emailed and then uploaded to the patient records. Concerns over data protection have been raised by some staff. Where do we stand?

A The GMC provides guidance on *Making and using visual and audio recordings of patients* which states that any recording made as part of the patient's care forms part of the medical records and should be treated in the same way as written material in terms of security and disclosure. The patient must agree to this way of monitoring their condition (i.e. informed consent must have been obtained). Confidentiality must also be safeguarded, with digital photographs safely stored and secured. The Information Commissioner's Office (ICO) provides guidance in regard to the use of personal devices by staff and the practice should consider which types of personal data may be processed by staff on their own mobile phones. A mobile phone issued by the practice for general use would clearly be preferable, and you may find that your LMC has considered the practicalities of this issue. The *NHS Information Governance Toolkit* advises that data on portable devices should be encrypted and this may not be the case with a personal phone used to record patient images. How the images are relayed to the practice is also important, as using personal email might raise significant concerns with the GMC and the ICO. Any images of patients should be deleted from the portable device as soon as practical. They should also not be inadvertently uploaded to cloud storage and the information processing must meet GDPR requirements. Overall, it is probably more appropriate for a secure and practice-based system of clinical image capture and storage to be used.

Finger on the button



Are patients within their rights to video or audio record their consultations with a clinician – covertly or not?

THE widespread availability of smartphones with high-quality audio and video recording apps has led to an increasing number of patients asking to record their own consultations. Such devices are easily activated without a clinician realising. Even hand-held games consoles can record conversations. We are aware of a case where a GP discovered that a child had inadvertently managed to capture a consultation with his mother – on audio and video!

The headline message is: "patients don't need consent to record their own consultation". Under UK data protection laws, the personal information contained in such a recording belongs to the patient and, providing no other patient is involved, they have the right to use that information as they choose.

This means that while the data is confidential to the patient, it is not to the clinician. There is no law against the patient doing with it as they please – including disclosing it to a third party or even posting it on the internet (except in extreme cases, such as where potentially obscene images may be included).

Clinicians do have privacy and data protection rights in relation to their own personal information. However, a consultation is focused on the patient's medical care and does not require a clinician to disclose any of their own personal information. As such, there is no legal prohibition to a patient recording a consultation, even covertly, but more on that later.

This realisation can certainly be unsettling for some healthcare professionals, but it is important to avoid becoming overly defensive when dealing with such requests. The reality is that recording consultations is now a product of the digital age. Indeed, the GMC has stated that: "While the idea may be daunting at first recordings can be a great tool for doctors and patients looking to overcome barriers to communication and understanding".

There are a variety of reasons why patients might wish to record a consultation, and most of these are non-controversial and do not suggest an absence of trust or "ulterior motives". A patient might not fully understand what is being explained during a consultation, or may be unable to recall what was discussed. Recording a consultation can provide the means to process and reflect on often complex medical information.

The GMC encourages discussion with patients to fully understand the reasons behind such requests. A clinician who feels uncomfortable at the prospect of being recorded should be open and honest with the patient and explain why. Doing so may encourage understanding and possible compromise. For example, the patient might agree to an audio rather than video recording, or to avoid filming faces.

It is important to remember that any recording is likely to support and confirm the actions of a clinician and may be admissible in court, demonstrating professional practice (or the lack of) in any complaint or claim.

What about covert recording? MDDUS recently assisted a member following a consultation with a patient who had previously expressed dissatisfaction with various treatment options and had undertaken her own research on online chat groups. The GP discovered that she had covertly video recorded a consultation and posted it on her Facebook page. He felt that this had been a betrayal of their trust and therapeutic relationship.

What can a doctor do about this? The answer lies in considering the type of harm, if any, suffered. In this scenario, the patient had the right (under existing legislation) to post her personal medical information (i.e. the consultation) on social media, and it would be difficult to pursue any action for the manner in which she handled her information. The doctor could reasonably ask the patient to remove the recording but there is no legal obligation on her part to do so.

Had she added inappropriate comments or altered the recording to render it a misrepresentation of what transpired, then this could call into question the therapeutic relationship of trust

One way to avoid such situations arising is to focus on good communication. A patient who is engaged and reassured is probably less likely to feel the need to covertly record a consultation. It is also worth bearing in mind that if a doctor were to refuse a reasonable request to record a consultation, the patient may be more inclined to do so covertly in future.

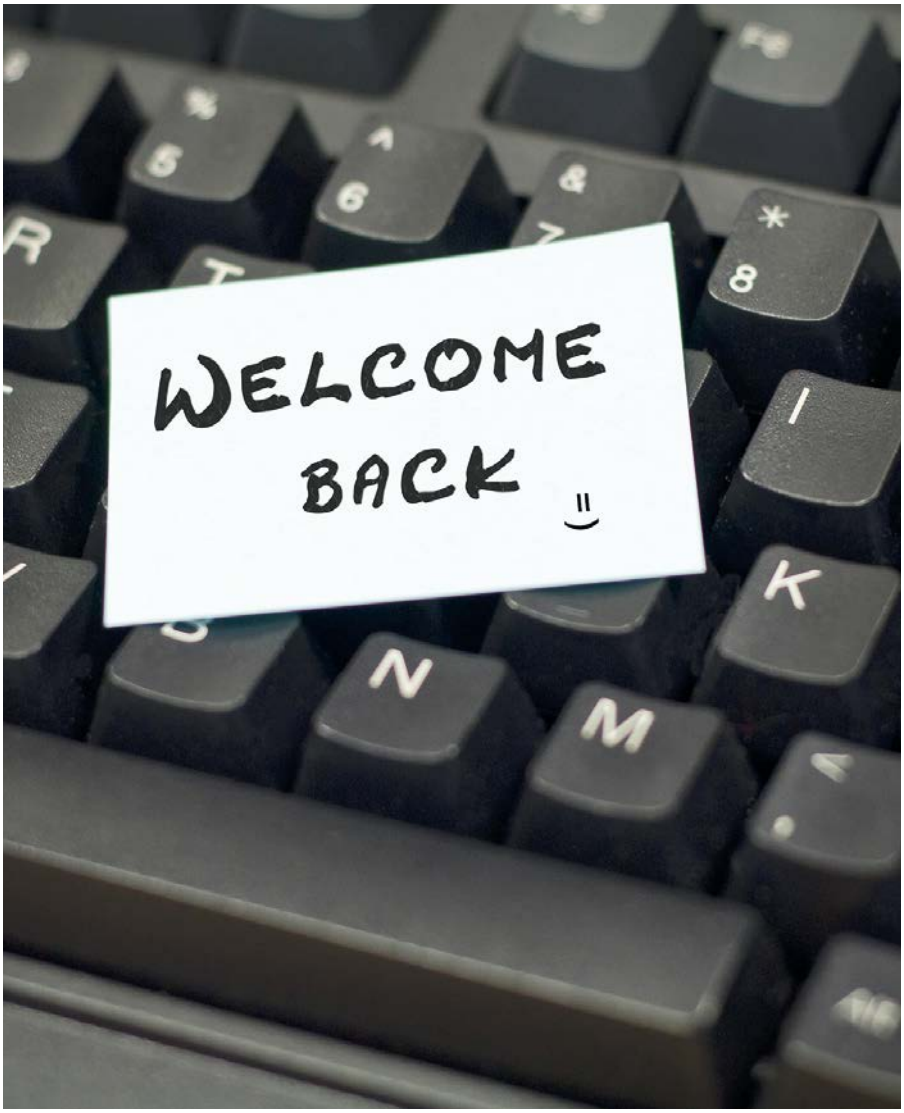
MDDUS advises that any doctor concerned about allowing a patient to record should consider efforts taken to properly understand the request. Has the patient been offered alternatives, such as bringing a family member or carer along to the consultation? Could you provide a copy of the consultation notes or other written guidance to help the patient reflect on the issues discussed?

Allowing patients to record consultations could be viewed as an opportunity in a more transparent health service. In any event, it is not something that can be easily policed or prevented – even if a patient is confronted with their finger on the record button!

Alan Frame, risk adviser at MDDUS

Phased return

Liz Symon offers some points to consider when agreeing a phased return to work for an employee on long-term absence



DEALING with staff absence is a common challenge in healthcare practice today, with UK employees taking an average of 4.1 sick days in 2017. During this year, sickness absence rates stood at 1.7 per cent for the private sector and 2.6 per cent for the public sector. Health workers had the highest rates in the public sector at 3.3 per cent.

Employees who have been on long-term sick leave may be advised to return to work on a phased plan. This can allow an employee to get back to work at an earlier stage of their recovery by providing adjustments, such as reduced hours and/or modified duties. In this way an employee can gradually build back up to their normal routine. A phased return may not be required by all employees, even if they have been on a long period of absence.

Recommendations regarding a phased return can be made by a GP or an occupational health (OH) provider but these are for guidance only and employers do not need to accommodate such requests. That said, a practice will need to be mindful about the legal obligation to make reasonable adjustments in disability cases.

There is no set timescale on how long a phased return should last, but the norm is usually between four to six weeks, with an agreed plan setting out how the phased return will work, how the hours will be built up and over what period.

One question often asked on our advice line is what the employee should be paid during a phased return. There is no legal obligation to pay an employee for their full hours, only for the hours they are working. However, the practice may want to consider this as it will want to encourage the employee to return to work rather than remaining off and getting full contractual sick pay. Consider offering full pay for a week or two, or maybe discussing taking holidays that have accrued. This way the employee will be using accrued annual leave and can still receive their full pay during the phased return to work. It also has the benefit of the employee not then being left with too much annual leave to take later in the year.

It is worth highlighting that an employee will continue to accrue annual leave during their sickness absence. If it is during the current holiday year, annual leave will accrue at the employee's normal contractual rate. Holidays only accrue at four weeks if it is in the previous holiday year.

With regards to pay during a phased return, it is also important to check the absence policy in case it refers to this situation. If it is not mentioned in the policy, consider what the practice has done previously with regard to other employees during phased returns. If it is common practice to pay an employee for any hours not worked throughout a phased return then it is important that all employees are treated fairly and consistently.

The practice should meet with the employee prior to their return to work to discuss and agree the detail of the phased return plan. The plan should include details of both parties' agreed expectations, including any amended duties, reduced hours, gradual increase in worked hours and over what time period. Review dates should be established, along with the date by which it is anticipated that the employee would have returned to their normal hours and duties. The agreed plan should then be followed up in writing to the employee.

Once the employee has returned to work, it is important to regularly review how things are going so the plan can be assessed and anything further done to support the employee to remain at work.

ACTION POINTS

In dealing with a phased return:

- Consider if a phased return is suitable.
- Consider if further medical information needs to be sought from a GP/OH.
- Arrange a meeting to discuss the details with the employee.
- Consider any suggestions the employee may have.
- Consider if there is a legal obligation to make reasonable adjustments.
- Record the details of any meetings and phased return plans.
- Consider what the employee will be paid.
- Set review times.

Liz Symon is an employment law adviser at MDDUS

Workflow optimisation has been shown to ease GP workloads but concerns have been raised that it may put patient safety at risk

TIME SAVING OR

ALL across the UK practice managers are feeling the pinch with growing patient lists, reduced resources and staff shortages – this is not exactly news. Neither is the increasing administrative burden faced by GPs.

One practice in Brighton and Hove piloting a scheme to improve the way they process their administrative work found that a "significant number" of letters required no clinical input. Dr Paul Deffley told *Pulse Online* that he spends approximately 40 minutes each day processing mail, of which 80 per cent could have been dealt with administratively.

New frameworks to help ease GP workloads are being developed at various sites and many include a process known as workflow optimisation or correspondence management. NHS England has identified this as a priority and within the *GP Forward View* looks to overcome the administrative burden. Correspondence management strategies are intended to encourage practices to train non-clinical staff to process and action practice mail, freeing up GP time to spend on more complex patient issues.

Workflow optimisation has been shown to work but concerns have been raised that the process may in some circumstances be putting patient safety at risk.

NO ACTION REQUIRED

A large proportion of mail received by practices can be identified as 'low risk', with GPs happy for staff to send straight to file with no action required. An example of correspondence requiring no clinical input would be a discharge letter from an accident and emergency department where the patient has attended for a minor injury, such as a sprain or strain, or an acute medical condition such as sore throat. Usually the patient receives sufficient treatment and/or advice that requires no further action for the GP and therefore the letter can be sent straight to the patient's notes with no further action.

Another potential "low risk" example could be a letter from secondary care informing a GP that a patient did not attend an appointment. This can be frustrating for hospitals with buckling waiting lists but there are many reasons why a patient might fail to attend an appointment. From a risk perspective, it is important to consider the patient as an individual and, in particular, whether they have capacity and fully understand the reason for the referral along with the consequences of not attending – or if they are vulnerable in some way.

A recent call to one of our advisers from a concerned practice manager highlights this issue well. A patient diagnosed with dementia had been referred by a GP for a secondary care opinion, but after the hospital had sent her three offers of appointments with no attendance or response she was discharged back to the GP. A letter detailing the patient's failure to attend was sent to the GP and this was filed straight into the notes without being highlighted to the doctor.

The patient's condition deteriorated and it was some months later, when a related acute problem arose, that the GP became aware she had not been reviewed at hospital and had likely disposed of the letters without carers or family being aware. Had the 'DNA' letter been actioned or recorded in a way that highlighted this to the GP, it is likely the patient would have been followed up, preventing a worsening of her condition.

CLEAR GUIDELINES

Workflow optimisation can help provide GPs the time to focus on work that only they can do. But to ensure that new ways of working are safe, it is imperative that practices agree and provide clear guidelines to staff on which patients fall under the umbrella of vulnerability. Indeed, many practices have created ways of flagging these patients so that non-clinical staff can direct mail to the referring GP in order

RISKY BUSINESS?

that a clinical view can be taken on the need for follow-up. Vulnerable patients might include:

- children
- older patients who are physically or mentally frail
- patients with learning disabilities
- patients with certain mental health conditions, such as dementia
- the homeless.

Once safe systems are agreed and staff trained, it is important to consider what safety nets the practice could implement to ensure that mail is being correctly actioned. Should there be a GP lead and are practices regularly auditing this activity? One solution adopted by some practices is to nominate a 'safeguarding officer' to whom this sort of mail may be directed to follow up with the patient.

Another increasingly common issue in general practice is returned referrals. This can occur for various reasons: the referral may be missing important information or the department may require other tests to be carried out before the patient can be seen. Practices also often see urgent referrals returned with the instruction to resend as a routine referral. A secretary or administrator may follow this instruction with the best intentions, wanting to prevent any further delay. However, these should usually go back to a GP to review (preferably to the original referrer) as they may be aware of further information that requires the patient to be reviewed more urgently.

Practices contacting patients needing bloods or to provide a sample should keep a record of how and when that contact was made. In making such an appointment, a note can be added to say that it was doctor-initiated so that if the patient cancels or DNAs, staff are prompted to make further contact. Good documentation is also key in supporting the clinicians involved, should any medico-legal issues arise as a result of a patient DNA.

A basic incident reporting system should be in place to identify any problems or patterns of concern. The practice manager can then review these to determine whether a significant event analysis (SEA) would be helpful to "tweak" the protocols.

ACTION POINTS

- Identify low-risk correspondence that may have further implications if not reviewed clinically and create a process that safety nets your workflow optimising procedure.
- Ensure non-clinical staff are trained in new processes and are aware of the associated risks and know who to approach for advice if concerned.
- Implement quality assurance of systems to ensure patient safety is not compromised and that staff continue to be competent in delegated tasks.
- GPs should ensure patients are fully informed about the reasons for referral and consequences should they not attend. This discussion should be documented within the record.
- Good documentation will support the clinician in any potential medico-legal issues arising as a consequence of a patient failing to attend for further care.
- When processes are up and running, it is important to ensure that the protocols/policies are reviewed regularly so that any issues arising can be fixed promptly.

Kay Louise Grant is a risk adviser at MDDUS

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Sowing the seeds for good health

GROWING vegetables is not the usual scope of practice for a GP, so when NHS educator Ed Rosen approached a group of clinicians with his 'gardening for health' idea, he was met with some scepticism. However, six years (and one Royal visit) later, his ground-breaking food co-operative project is flourishing.

Today, 15 gardens have been created in the grounds of doctors' surgeries across the South London borough of Lambeth, growing everything from beetroot and mushrooms to herbs and potatoes. In these green spaces, patients and healthcare teams come together to cultivate crops as well as relationships.

Alongside the more obvious practical lessons on gardening and healthy eating, the project has provided a lifeline for those affected by loneliness, depression, anxiety and chronic conditions such as diabetes and arthritis.

Ed, a self-confessed "novice gardener", is the director and driving force behind the Lambeth GP Food Co-op (LGPFC). So far the project has engaged with more than 400 patients, many of whom suffer from multiple long-term conditions and who live in high-rise tower blocks with no access to green spaces. The gardens provide an ideal, informal setting to highlight the importance of eating well and to offer nutritional advice.

Ed says: "Dieticians and nutritionists from St Thomas' Hospital and Kings have come out, rolled their sleeves up and planted alongside patients. In doing so, they have spoken to patients about the nutritional value of what they are planting. They are low-key health conversations whilst they are collaborating in planting courgettes or pumpkins.

"It does improve the quality of life for some of the most vulnerable people in society."

An innovative project building gardens in GP practices is transforming patient care

PIONEERING WORK

One local GP surgery actively involved in the food co-op is The Grantham Practice, which has a list of around 10,000 patients with over 60 ethnicities. Jonathan Wilmshurst is the former practice manager and now patient liaison at Grantham.

"Our practice decided to do this not really knowing how popular it would be," says Jonathan. "We started out with just two planters at the back of the surgery and that turned into six and then we moved to a bigger site and it's just grown from there really.

"What we've found is that patients who have taken part visit their doctor less. If they don't get out much and they're quite lonely, it gives them the opportunity to mingle and create friendships as well as a little community. And that's a good thing. Not everything can be sorted out in the four walls of a consulting room."

Indeed, Lambeth food co-operative is something of a pioneer in the movement towards more widespread 'social prescribing' (where clinicians direct patients to a variety of cultural and community activities to improve quality of life). The initiative was established well before the UK government unveiled its "loneliness strategy" in 2018, which called on GPs to engage in more social prescribing.

NHS national clinical lead for social prescribing Dr Michael Dixon has praised their work as "a model of social prescribing in action". At the same time, in February 2019, the food co-op received Royal recognition when Camilla, Duchess of Cornwall, visited the LGPFC garden at Swan Mews in Lambeth for their sixth anniversary.

And as Lambeth's co-op goes from strength to strength, other healthcare providers are taking note. A food garden has been built at the Pulross Centre in Brixton, a 20-bed unit which cares for patients with MS and who have suffered from stroke and other conditions.

Ed says: "The OTs and physiotherapists are planting and growing vegetables with patients, many of whom have lost limbs and are in wheelchairs. That is a really important model as we continue our journey in the acute sector and the community centre."

PHOTOGRAPHS: DAN WELLDON/JIM WINSLET

Opposite page and left: Jonathan Wilmshurst and garden volunteers. **Below:** Camilla with project director Ed Rosen (holding blue folder) and Jonathan behind the cake he baked

SCALING UP

Ed has ambitious plans for the longer term, including building gardens on hospital roofs and other unused spaces in the community. He also hopes to work with NHS catering companies so that the food grown in the grounds of local surgeries by local patients can be served in local hospitals, like Kings.

However, at present, the volumes required to make this happen are just too high, as Ed explains: "If we were able to grow one tonne of mushrooms they would buy the whole crop and make mushroom soup for staff and patients. It's not that far down the line but it requires a slightly different model of growing compared to what we have at the moment. I can't ask people who are not well to work their socks off, but we are looking at new technology for growing at scale. I think over the next five years, if we get the investment, we can do this.

"In terms of what we are doing just now, it is very timely and very relevant."

The Lambeth co-op has also published its first recipe book (available via its website for £7), with a second due to be published in time for Christmas. It features a selection of healthy recipes submitted by patients, GPs and nurses, including red onion marmalade, spring green miso noodle soup and roasted butternut squash.

MODEL FOR SUCCESS

It all seems a far cry from that initial scepticism Ed faced in 2013, and is testament to his determination to make the project a success. He is magnanimous and clearly passionate when asked what he would say to all those who doubted the garden project would ever succeed.

> "WHAT WE'VE FOUND IS THAT PATIENTS WHO HAVE TAKEN PART VISIT THEIR DOCTOR LESS"

He says: "I would say to them 'would you like to make a financial contribution?'! No, seriously, I would invite them along. We have demonstrated that the concerns, reservations and anxieties were not grounded in the reality of developing the project. It is possible to do it and it works. It may not cure cancers but it improves the lives of some of the most vulnerable people in our communities."

Support for the food co-op comes from many different areas and is increasingly high profile. GP and media doctor Jonty Heaversedge, London regional medical director for primary care and digital transformation, has spoken of the positive impact the project is having on patients. He says: "The Lambeth GP gardens help people feel less isolated and improve the health of local people living with long term conditions across the borough."

Aidan Cleasby, Trust community facilities lead for Guy's and St Thomas' adds his support, saying: "Patients can get outside, particularly in the spring and summer months, to plant, water and prune the plants, which is much more stimulating than sitting on a hospital ward. This complements their recovery process and enhances their wellbeing.

"Once the planters are in place it's just a case of refreshing the area every year with top soil, plants and seeds. There is very little impact upon the environmental footprint and the benefits to our patients are huge. We are very proud of that."

● Find out more at **lambeth.gpfoodcoop.org.uk** or follow the project on Twitter **@GPFoodCoop**

Kristin Ballantyne is a freelance writer based in Glasgow

Putting it all together

Allan Gaw offers some invaluable tips on effective project management

THEY say that no matter what our role is, we are all project managers – but no one ever says that we are all equally good at it. The reality is that many projects fail to complete on time and on budget, and some may struggle even to get off the ground.

In considering how to be an effective project manager, it is useful to define very broadly what we mean by a 'project'. Yes, it includes those specific pieces of work that we are allocated or get caught up in by chance, but it also includes almost every one-off thing we do – installing a new computer system, arranging for a consulting room to be redecorated or even organising a staff party. All are projects and all can succeed or fail.

Here are my top tips for ensuring your project, whatever it may be, will get started, get finished and engender as little stress as possible.

ACTIVELY MANAGE

We know that dinners don't cook themselves, buildings don't build themselves and similarly projects don't manage themselves. All successful projects need to be actively managed, so the first key to success is simply the recognition that you need to take a very active role. This requires effort, attention to detail and often simply being around to ensure the pieces are fitting together as they should.

PLAN WELL

The first step in all project management is the planning stage. To plan well, you need to know where you are going and what is it you are trying to achieve. This may be easy and well-defined, but often it can be vague, especially if you are trying to put into action someone else's idea. If the latter is the case, then the first job is to formulate a clear objective. As one wag put it: "If you don't know where you're going, you'll probably end up somewhere else."

SMART OBJECTIVES

You may be familiar with the little acronym SMART, standing for Specific, Measureable, Attainable, Relevant and Time-bound. Put simply, unless your objective is SMART – as specific and measureable as possible and with a clear time-line attached to it – it is unlikely ever to come to a successful conclusion. Many people have vague wish-lists – think about your New Year resolutions – but how many of them ever come to fruition? That's not the approach we should take in successful project management.

RESOURCES, QUALITY AND TIME

In planning and carrying out your work, remember that in every project there is a tension between the amount of time you have to do it, the available resources you have to complete it and the desired quality of the outcome. Change any one of these factors and it affects the others. For example, if you suddenly find you have less time, this may impact upon the quality of what you can achieve, or if the quality cannot be compromised, force you to look for additional resources – often more money or more staff.

TIME MANAGEMENT

Especially with longer and more complex tasks, you may have to put particular efforts into keeping the project running on time. It may help to use scheduling tools such as Gantt Charts and approaches such as critical path analysis, but most of the time it involves much simpler strategies. These invariably include making sure you have the bigger picture in mind while also attending to the details, and simply keeping a close eye on the project, especially if you are relying on other people to help out.

MANAGEABLE PARTS

How do you eat an elephant? One spoonful at a time. No matter how big and daunting the task in hand is, by breaking it down into smaller and smaller steps we can tackle just about anything. And if you're working in a team, having a series of discrete tasks is always easier to allocate and monitor.

OPPORTUNITY COSTS

Sometimes when we are planning a project, we delude ourselves into thinking something or someone we plan to use is free, just because the resource is already in place and available. But someone is paying for that piece of equipment or that staff member, so to cost a project accurately we need to recognise this and be familiar with the notion of opportunity costs. What else could you have spent that money on, or used that equipment for, or had that staff member working on?

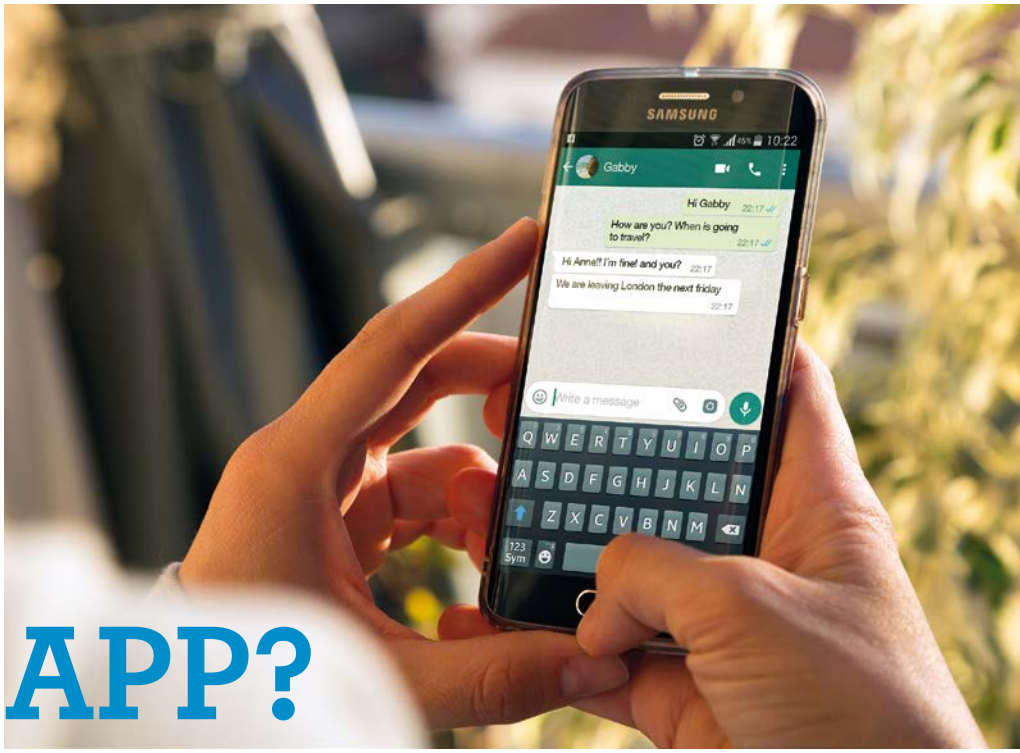
BE REALISTIC

This last point is probably the most important and tends to come with experience, often painfully so. The knowledge that almost everything you'll ever do will take longer, use more resources and cost more than you originally planned will allow you to make better, more realistic plans and ultimately help you complete your projects.

Allan Gaw is a writer and educator in Scotland

Managing risks in the group chat app

What's up with WHATSAPP?



TEN years may seem a lifetime in online technology – but growing a business from zero to over one and a half billion users in a single decade still boggles the mind. Such has been the success of WhatsApp, now a fixture in many people's lives, both as a one-to-one messaging service and as a 'social media' tool through the use of group chats.

WhatsApp was not designed to be used in the workplace but many primary care staff members in MDDUS report being included in practice group chats or wider clinical groups, management team groups, admin or nursing groups and also social activity groups. There are also group chats for clinical trainees or local PM groups which cross practice boundaries.

In our experience, these groups are thought (for the most part) to be incredibly useful – allowing team members to interact more freely and encouraging open communication and engagement. However, PMs and partners/principals, as employers, should consider these benefits against the known risks. Consider the following scenarios:

- You find out from your deputy that one of your healthcare support workers has been sending messages to the admin team WhatsApp group complaining about the way one of the doctors has been speaking to her. The consensus within the group is that the GP is being a bully.
- Your trainee discloses that he has inadvertently sent a screenshot of a patient record to his trainee WhatsApp group for advice without cropping the identifiable patient details. The image ended up on the iPad of the husband of another trainee – this being initially shared back to the group as a "funny" story.
- One of your nurses has shared a meme within your social group chat after a night out which you feel is very likely to be offensive to a certain member of the team.

From a management perspective, having a WhatsApp group could be considered invaluable, particularly across larger practices – say to share early absence or practice disruption information or indeed to create a sense of team around social events where some employees are part-time.

Certainly encouraging communication within the team is important, and taking too strict an approach to policing WhatsApp use could end up having a damaging effect on interpersonal relations. So is there anything you should or could be doing to prevent or restrict individuals from using it inappropriately?

In reality, it can be difficult to police online activities within working time, let alone outside practice hours. The best way to approach the issue is to have some reasonable ground rules. An "acceptable use" policy can be integrated with existing policies on social media or mobile phone use in the workplace, and it can be useful to include examples highlighting behaviours which could result in disciplinary action.

If the practice creates a WhatsApp group (for staffing/briefings, etc), it is worth considering whether you or the partners are (even indirectly) encouraging communications about work outside practice hours. Individuals could end up feeling that they are expected to respond to non-urgent, work-related messages when not at work.

There is evidence that, as the use of virtual groups increase, individuals become less guarded and more informal in their communications. The risk here is that 'work' groups may transition into the social sphere where 'banter' arises – to the amusement of some and more than likely not others. It becomes detrimental to the purpose of the group and individuals may be tempted to 'mute' streams of communication intended to pass on necessary or urgent information.

Groups created within the practice (for a work purpose) should have a clear purpose agreed in advance to guide the tone and nature of interactions. An example might be: "this group is to alert staff to absences or other important business continuity changes".

WhatsApp is widely perceived to be secure as it is promoted as "encrypting", but shared images can automatically 'default' to the recipients' camera roll and perhaps other devices. WhatsApp messages are also easy to access and scroll through if a member of the team leaves their device unlocked in a public environment.

So-called 'funnies' or 'banter' may also be problematic as it can be difficult to determine when a message or image has "crossed the line", even when the intent to be controversial or cause offence is absent. Most social media policies will include a statement making it clear that no offensive material, arguing or heated conversations will be tolerated.

Staff should be encouraged to raise any relevant grievance in person and within the terms of practice policy (rather than in a forum). It should be made clear that any posts including divisive comments or views which could be expected to offend a member of a protected category within the terms of the Equality Act must be avoided and may lead to the practice taking disciplinary action.

As practice manager, you cannot control the actions or words of your individual team members but you can set out clear expectations about what is acceptable within the work environment.

Liz Price is senior risk adviser at MDDUS

Allergy **alert**

Day one

A 26-year-old with severe asthma – Ms B – is going on holiday to Brazil in two weeks and attends the pharmacy at her GP practice to collect an emergency travel pack put together by the in-practice dispenser – Ms K. In addition to her regular medication Ms B is provided with an emergency supply of steroids (prednisolone) and a seven-day dose of amoxicillin.

Day 10

Four days before her holiday Ms B speaks to the practice nurse in regard to the emergency pack. The nurse provides instructions on use but advises Ms B to attend a local clinic for any urgent health concerns.

Day 28

Ms B enjoys her holiday without incident but five days after returning she phones the surgery from home feeling unwell. She has a telephone consultation with a GP – Dr J – and reports having green catarrh and chest pain/tightness. She is also suffering with low back pain/urinary frequency and thinks it might be a UTI. Dr J offers advice on adjusting her asthma medication and asks what medications she has to hand in her unused emergency pack. The GP suggests starting the prednisolone and amoxicillin and attending the practice for review after the weekend if no better.

Later that day

Ms B is taken to hospital by her boyfriend with vomiting, sweating and tongue and lip swelling – and she later faints in the emergency room. The symptoms occurred almost immediately after taking the antibiotic. It transpires that Ms B has a known allergy to amoxicillin and should have been provided clarithromycin in the emergency pack. She is treated for anaphylaxis and spends the next three days in hospital.

A LETTER of claim is received by the practice alleging clinical negligence in the misprescribing of amoxicillin to Ms B. Solicitors acting for the patient claim that the practice failed to dispense the correct medication despite being aware of her amoxicillin allergy. It is also alleged that Dr J failed to provide competent medical advice in the telephone consultation and neglected to enquire about known allergies/contraindications before advising she take the antibiotic.

The resulting anaphylaxis led to hospital admission and a life-threatening medical condition with considerable pain and distress. Ms B reports recurring panic and low mood.

A primary care expert is instructed to provide a report on the case. In his formal opinion the expert notes a clear failure by the dispenser (Ms K) to check the patient's allergy history and prescribe the correct antibiotic. It is an obvious system failure that the practice has already addressed in a significant event analysis (SEA) – and one for which all the practice partners are vicariously liable.

The expert is sympathetic in regard to Dr J's actions, as the GP did not prescribe the antibiotic but only suggested the patient take what had already been provided by the practice. In such circumstances there would have been no call to check an allergy history. However, Ms B's decision to take the amoxicillin was based on the GP's advice to treat an undiagnosed UTI, which was a different reason for which the drug was originally prescribed.

MDDUS agrees to settle the case on behalf of and in agreement with the practice partners.

KEY POINTS

- Ensure allergy/contraindication alerts are working on practice systems and are properly actioned.
- Prescribing staff should routinely check for allergies before prescribing an antibiotic.
- Give careful consideration to examining a patient before diagnosis and treatment.
- Conduct an SEA to ensure practice prescribing procedures are failsafe.

Diary

SO MUCH absurdity, so few column inches. Welcome back to Diary where we ask for interesting and entertaining medical anecdotes from our readers, get nothing in reply and so make up our own. But let us not be bitter...

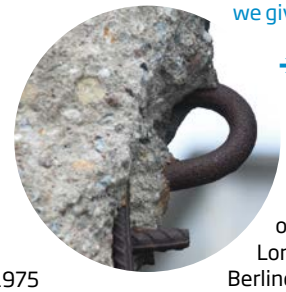
➔ **JAB! SLICE! SUCK! DRILL!** Maybe best to skip the sound effects – but it's been found that a comic-book approach to getting informed surgical consent can improve comprehension and reduce anxiety in patients facing complicated procedures. Researchers in Berlin developed a 15-page comic-style booklet to help inform patients undergoing cardiac catheterisation and stent insertion. A total of 121 patients were then recruited, with some undergoing standard consent only and the rest being additionally provided with the 'comic'. The researchers found that the latter scored better on a short recall test and also reported feeling less anxious and better prepared for cardiac catheterisation. Dr Anna Brand, one of the lead investigators, said: "We want to use future research to test whether similar positive effects can be achieved in patients undergoing other medical procedures." Source: *OnMedica*

➔ **VICTORY...ALBEIT BELATED** It only took 150 years but seven female Edinburgh University students have finally been awarded their medical degrees. In 1869, Sophia Jex Baxter and six other women were allowed to enrol in medicine at the university but had to endure fierce hostility, not only from the public but from fellow male students, culminating in the Surgeon's Hall Riot in November 1870 when they arrived to take an anatomy exam facing a mob and were pelted with mud and worse. Later the so-called Edinburgh Seven were refused graduation and forced to study elsewhere in Europe. This summer seven current female medical students at Edinburgh University accepted degree certificates on behalf of these pioneering women. Better late...

➔ **AMAZING DOCTOR AMAZON** Diary has special pity for anyone this century with the misfortune to be named Alexa. Imagine the constant quips: *Alexa, where's my stuff? Alexa, play Rick Astley. Alexa, have you ever had sex?* Add now to that requests for health advice. The NHS has announced plans to team up with Amazon to provide voice-assisted technology employing algorithms that tap into information from the NHS website to provide answers to questions such as: *Alexa, how do I treat a migraine?* or *Alexa, what are the symptoms of flu?* The aim is to help patients, especially the elderly, blind and those who cannot access the internet through traditional means, to get professional, NHS-verified health information using simple voice commands. The Government says: "It is hoped the technology will reduce pressure on the NHS and GPs by providing information for common illnesses." Just remember to shut the windows at night to keep out the surgical cyberspiders.

➔ **WEAPONISED TICKS** It may sound like the ultimate fantasist "told you so" but the US House of Representatives has ordered the Pentagon to conduct a review of whether the defence department experimented with using ticks and other insects as biological weapons. The review was demanded by New Jersey Republican Chris Smith and prompted by "books and articles" exploring research carried out at a biological research unit on Plum Island, which lies across a narrow stretch of water from the community of Lyme, Connecticut. Here in 1975 a cluster of paediatric arthritic illness was later associated with infection by the spirochete *Borrelia burgdorferi* and thereafter commonly referred to as Lyme disease. Smith wants to know if medical entomologist (and *B. burgdorferi namesake*) Wilhelm Burgdorfer may have worked for the US Government, breeding ticks and injecting them with various pathogens. Nice. Source: *BMJ*

➔ **CHOICE WORDS** A recent study by linguists at Lancaster University used computer software to analyse over 29 million words used to describe various healthcare professionals in comments posted by patients on the NHS Choices website. Surgeons came out best being described by positive words 98 per cent of the time ('brilliant', 'outstanding'), followed by dentists 96 per cent ('great', 'the best'), midwives 93 per cent ('amazing', 'exceptional') and nurses 90 per cent ('lovely'). Not surprisingly receptionists in the firing line fared less well, attracting positive terms only 57 per cent of the time, along with some choice negative words, including 'useless, rude, unprofessional, unhelpful, arrogant, patronising, aggressive and terrible.' Lead researcher Professor Paul Baker, commented: "Rather than suggesting that receptionists need retraining or that surgeons deserve pay rises, we instead noted that feedback is very much linked to expectations and constraints around different staff roles...In other words they [receptionists] are often taking the flak for things that are not their fault but actually are indicative of patient frustration at bigger systemic issues – fewer appointments and longer waiting times are more likely to be the result of funding shortages that are beyond the receptionist's control." So how about we give them a break!



➔ **WALLBEING** In his new book, professor and researcher of complementary medicine Edzard Ernst describes a treatment offered by a pharmacy in London, known as "Murus Berlinensis" – a diluted solution of ground concrete from the Berlin Wall mixed with alcohol and water, aimed at people with symptoms of depression and asthma. A 100 ml quantity with "medicating potency" sells for £64.50. Ernst comments: "People tend to think homeopathy is based on natural substances, but Berlin Wall shows that it's not true. It's not only bonkers but ineffective." Source: *BMJ*

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