The power is in your hands

What the introduction of CCGs means for GPs

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Read about the recent changes concerning medical devices

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The risks of delegating immunisations to HCAs

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Delayed diagnosis among the most common claims

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

Guidance update

The General Medical Council (GMC) has updated its prescribing guidance for doctors. Good Practice in Prescribing and Managing Medicines and Devices broadens the current advice to include medical devices. The guidance widens the definition of prescribing to include:
- Advising patients on the purchase of over-the-counter medicines and other remedies.
- Providing written information (described as information prescriptions) and advice given.

The guidance also covers:
- Unlicensed medicines – the guidance refers to the fact that there may be circumstances when it is necessary to prescribe an unlicensed medicine and provides guidance as to what steps to take in such circumstances.
- Prescribing for self and family – the guidance reiterates the guidance in Good Medical Practice in stating that wherever possible doctors should not prescribe for themselves or anyone with whom they have a close personal relationship. The guidance places doctors under an additional obligation to make a clear record (which should include your relationship with the patient and the reason why it was necessary to prescribe) and to inform their own or the patient’s GP unless (in the case of prescribing for somebody close to them) they object.

Cosmetic treatment – you must not prescribe drugs, such as Botox or other similar injectable cosmetics, by phone, email, video-link or fax.

Adverse incidents – you must report any adverse incidents involving drugs, medical devices – such as x-ray and other imaging equipment – pacemakers, artificial joints and anaesthetic equipment.

The new guidance came into effect on 25 February 2013.

FROM PRACTICE TO PLANET

A GP has become a YouTube sensation, clocking thousands of hits with his weekly health videos. Dr Ricky Gondhia, a salaried GP, at Crayford Town Surgery in London, fronts the One Click Clinic. His most popular video-sharing advice on cold and flu has clocked up 12,114 hits since it was uploaded in December.

TOP CALLS TO MPS

Top ten calls from GPs in 2012
- General advice
- Complaints
- Issues around confidentiality
- Disclosure of records
- Claims
- Writing reports
- Clinical judgment
- Inquest
- Consent
- Adverse incident reports
MPS policy update – online records

Allowing patients to view their medical records online is reminiscent of opening a ‘Pandora’s Box’, whereby patient confidentiality could be compromised, says MPS. MPS is concerned that when access is granted, it could have unintended and severe consequences, such as sensitive information being accessed by a patient’s family members.

An MPS survey revealed that this is a view shared by both the public and doctors:
- 58% of the public would be concerned for the security of their medical records
- 86% of MPS members would be concerned for the security of patients’ medical records if they become accessible online.

MPS wants a firm commitment from the government that the information strategy will not compromise patient confidentiality – because once the contents of ‘Pandora’s Box’ have been released into the wrong hands, the damage cannot be undone.

MPS will share these findings at a Parliamentary Reception on 30 April 2013.

Research update

GPs refer more than 80% of suspected cancer cases within two consultations, according to a report in the British Journal of Cancer, which used data from the English National Audit of Cancer Diagnosis in Primary Care 2009-2010. The data covered 13,035 people with any of 18 different cancers.

The researchers found:
- 58% of patients were referred after the first consultation
- 25% were referred after two
- 5% were referred after five or more
- Patients with multiple myeloma and lung cancer had high proportions of three or more pre-referral consultations (46% and 33% respectively)
- Breast cancer and melanoma patients were generally referred sooner

Source: British Journal of Cancer

Say what?

IBM has unveiled a super-computer, capable of sorting through millions of pages of medical research and 600,000 pieces of medical evidence in order to diagnose cancer symptoms. Known as ‘Watson’, the mighty machine speeds up the way data is analysed to make the best diagnosis and find the optimal treatment.

Watch this space

An increasing number of GPs are requiring pastoral support, LMC leaders have claimed. Figures from one LMC show a four-fold increase in the numbers of GPs presenting to pastoral care services in the first half of 2012 compared to the same period in 2011, and a doubling of the numbers overall. An LMC-run survey of 2,700 GPs across the South West found half were considering quitting general practice and two thirds believed their practice would struggle to remain viable due to the government’s planned contract changes.

Medicines update

The MHRA has opened new Twitter channels, including one for medicines and devices safety updates.

- @MHRamedicines lists medicines information and safety alerts
- @MHRadevices lists devices information and safety alerts
- @MHRaherbals lists information on the safe use of herbal remedies

For more information visit www.mhra.gov.uk/Stayconnected/Twitter/index.htm.
In April the clinical landscape of the NHS will undertake the biggest change since its inception in 1948. In his analysis of the changes, Dr Simon Abrams raises concerns over potential conflicts of interest.

On 1 April this year a national experiment in health redesign will take place. Every birth and death and every healthcare intervention will be affected as accountability for commissioning health services will pass from managers to clinicians for the first time. It begs the question: will the changes in the Health and Social Care Act move healthcare forward in this country?

The birth of CCGs
Most CCGs have been authorised. For many this authorisation demanded a real change in primary care involvement. Clinical engagement is a precondition and when it is not there the National Commissioning Board has demanded better.

As never before, GPs’ email boxes are full of regular updates, information about healthcare changes, requests for agenda items for neighbourhood practice meetings – all calling on frontline GPs to involve themselves in the wider issues of local healthcare. CCGs are meeting to identify healthcare priorities using public health data.

General practice is being asked to examine its performance from the inside out. Why are diabetes complications high? Why are spirometry levels low? Why are alcohol-related admissions high? More importantly, doctors are being asked what can be done about it. CCGs are working with GP colleagues to reduce inappropriate referrals, leading to healthcare savings.

Opportunity or black hole?
Historically, doctors are more interested in looking after patients than health politics. These changes will create opportunities and risks. Under the previous system, NHS managers were accountable to their line managers, then to the NHS Executive and central government. A command and control system was in place where health service policies were decided centrally and implemented. CCGs are now accountable to grassroots GPs.

The BMA called for GPs to closely scrutinise the constitution. That scrutiny needs to continue to ensure that CCGs make decisions that lead to improved patient care. If local GPs are concerned that their CCG is making the wrong decisions, they must hold them to account. The opportunities are there for local GPs to seek health service changes relevant to their population. If CCGs want to maintain their authority they must commission health services along lines that maintain local GPs’ confidence.

Previous attempts to engage clinicians in strategic planning had limited success – for example, the professional executive committees of the PCTs. Once on the respective professional executive committee, many GPs lost contact with their professional colleagues.

Whilst they often did good work, primary care did not move with them. Clinicians with operational experience who move to strategic positions on the CCGs, whilst at the same time remaining accountable to their primary care colleagues, is a cause for relative optimism.

Conflicts of interest need to be managed effectively by Clinical Commissioning Groups (CCGs). For a GP a conflict of interest may arise when their own judgment as an NHS commissioner could be, or could be perceived to be, influenced by their own concerns and obligations as a healthcare provider. However, with good governance and planning CCGs should be able to mitigate these risks.

If GPs are concerned that their CCG is making the wrong decisions, they must hold them to account.
Handling conflicts of interest
Will the relationship between leading and following GPs stand up? Will it turn into an “us and them” view? A major factor will be the handling of conflicts of interest. Those in a CCG are GPs with enthusiasm and drive to make a difference; these people have opportunities to both commission and provide, so conflicts of interest are inevitable and need to be managed effectively by CCGs. For a GP a conflict of interest may arise when their own judgment as an NHS commissioner could be, or be perceived to be, influenced by their own concerns and obligations as a healthcare provider.

Avoiding accusations of conflicting interests will require a declaration, both through a register of interests, and appropriate behaviour when commissioning decisions are being made. With good governance and planning CCGs should be able to mitigate these risks. Conflicts of interest do not in themselves suggest impropriety. It is the impropriety that is the problem. CCG members must remember that impropriety must both be avoided and seen to be avoided.

Impact on secondary care
What about secondary care? One piece of advice was about the number of conversations between primary and secondary care clinicians. Before Choose and Book, lifting the phone to discuss management of a complex patient was not unusual. The practice has diminished. The anonymous referral is standard. Choose and Book provides email advice services, but anonymity of professionals remains. GPs no longer attend grand rounds. Yet the subtleties of healthcare are better communicated in dialogues between GPs and consultants. Implementing more community-located consultant clinics might contribute to the re-establishment of the dialogue, and as part of the out-of-hospital strategy, will be a natural way to progress.

Regulation
The changes have led to new statutory bodies responsible for different parts of the NHS, with the NHS Commissioning Board as the main overseeing body. Decision-making processes of old have gone and new ones are yet to be set up. For some this will mean inertia and limit progress. For the dedicated innovators, opportunities will arise to do things differently and more effectively.

The Health and Social Care Act established Health and Wellbeing Boards. Their role is to implement the Joint Strategic Needs Assessment of the local population including both health and social care. It is taking a while for them to apply their influence, but this may change in the future.

Privatisation
A concern over the White Paper was privatisation damaging healthcare. The Francis Report has shown that excessive focus on targets can also cause damage. Bringing the private sector into health has led to the development of a series of vibrant social enterprise services. Currently 46% of patients in England and Wales have out-of-hours primary care delivered by social enterprises. Despite early criticism there is growing evidence that many of these providers are performing at a standard higher than daytime general practice. They certainly work to more stringent performance requirements.

The future
The Francis Inquiry recently identified endemic problems in the health service that will fluently cross the switch from PCTs to CCGs and remain unless addressed. Such problems include the silo working that enabled poor practice to be ignored by some professional groups, the culture of gagging those who want to speak out and the problems of services being run by staff for the benefit of the staff rather than patients. An NHS accountable to GPs at the frontline of care should be able to recognise what is good and develop it and what is not working and change it. The process should be approached with cautious optimism.

Dr Abrams is a GP in Everton, Liverpool, Medical Director of Urgent Health UK, Federation of Social Enterprise Out of Hours Services and Secretary of the Family Doctor Association.

GP VOX POPS
In the short term the introduction of CCGs will be perceived to worsen patient care, but in the long term essential elements will improve
We have more to fear from the new contract than clinical commissioning
The quality will be fragmented, varying greatly with different CCGs and different services within CCGs
CCGs are under pressure to squeeze primary care and it does not appear they really have any say in what matters, 111 is a typical example of an unrealistic idea mandated to CCGs
Concern about conflicts of interest will have to be carefully monitored and resolved
We are like turkeys voting for Christmas, we have taken on this role and it will all be our fault when the NHS folds due to government cutbacks

The future
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Dr Abrams is a GP in Everton, Liverpool, Medical Director of Urgent Health UK, Federation of Social Enterprise Out of Hours Services and Secretary of the Family Doctor Association.

What effect do you think the introduction of Clinical Commissioning Groups (CCGs) will have on patient care?
- I expect it will improve patient care – 29.61%
- I expect it will worsen patient care – 27.86%
- It won’t affect patient care – 15.03%

What are your concerns about the introduction of CCGs?
- Budget restrictions – 79.74%
- Time constraints – 66.36%
- Conflicts of interest – 58.85%
- Quality of care – 31.9%
- Other – 14.3% (including practice workload increase, fragmentation)
Ask the expert

Some years ago we teamed up with the UK’s leading provider of workplace advice to provide the Croner helpline to our Practice Xtra members. Louise Barnes, Senior Employment Consultant at Croner, reveals the top five workplace issues.

AT A GLANCE

Practices mostly call about:
- Absence and sickness
- Conduct
- Terms and conditions
- Disciplinary
- Grievances

1. Absence and sickness

In 2012 absence and sickness was the main area of concern for members. Calls to the helpline mostly involve employees who have been absent from work for significant periods of time with illnesses so debilitating that they are unlikely to return to work. Where an employee has been absent for more than six months and they are able to obtain a medical report confirming that they are unlikely to be able to return to work within a reasonable amount of time, the employment relationship could be brought to an end.

The helpline consultants can offer advice on satisfying the various conditions and procedural requirements that need to be fulfilled before the employee can be dismissed from their employment, and support employers to ensure they satisfy the obligations and requirements set out in law to prevent an accusation of disability discrimination by the employee.

2. Conduct

Members frequently seek advice from an employment law perspective for issues relating to misconduct or gross misconduct. For example, serious allegations relating to sexual harassment from members of staff of the opposite sex because the behaviour has caused offence and created an intimidating, hostile and degrading working environment.

In this instance a full and thorough investigation has to be undertaken (which would likely include the suspension of the employee). If the employer is satisfied that the evidence they have gathered demonstrates that there is reasonable belief that the employee has been acting in a manner which would amount to sexual harassment, then they can be taken through a disciplinary procedure and dismissed without giving notice.

3. Terms and conditions

It is common for employers to want to make changes to an employee’s terms and conditions, either for an individual or the whole practice.

Whatever the change and the justification behind it, the simplest way to achieve any change to terms and conditions is with the consent of the affected individuals. For this reason, changes that are beneficial are often accepted and are easy to implement, while changes which employees might consider to be detrimental require discussion and negotiation. Quite often an incentive will go some way towards encouraging acceptance.

Employers need to be mindful of the numbers affected, the business reason and nature of the change, as these factors will affect the best way to approach and manage the process in a way that is fair and will achieve the desired result.

4. Disciplinary

Matters relating to the poor performance and misconduct of employees require disciplinary procedures to be followed and these can be both time-consuming and difficult to manage. However, it is essential employees are treated consistently, fairly and, most importantly, reasonably.

Where an employee is underperforming or commits an act of misconduct it is often appropriate to issue a warning in the hope that this will act as a deterrent and prevent any repeat of the issue at hand. All practices are expected to have an internal disciplinary procedure, which should outline the process they will follow when managing an employee’s poor performance or misconduct. In the absence of such a procedure the law expects employers to act in a specific way and follow a statutory code of practice.

The employment experts on the Croner helpline can guide you through those legal requirements and ensure that any disciplinary procedures comply with the law and ensure you are in the best possible position to achieve the desired result.

5. Grievances

Internal conflicts between members of staff are increasingly common. If these are not managed and resolved informally in the early stages, ill-feeling can fester, and what starts as a relatively minor disagreement can be blown out of all proportion. All practices should have an internal grievance procedure and in most instances they would encourage conflict resolution informally at the earliest opportunity. Where this hasn’t happened, or the situation becomes more serious, one or more employees might wish to raise a formal grievance.

Upon receipt of a grievance the practice is expected to write and invite the employee to attend a grievance meeting, which gives the employee the opportunity to discuss their concerns in order that the chairperson of the meeting can investigate and respond to the individual’s points. Following a full and thorough investigation a timely response should be provided that will either uphold the grievance, in full or in part, or not uphold the grievance. Irrespective of the outcome the response should be given in writing and the employee offered the opportunity to appeal. There may also be practical recommendations arising out of the process – for example, offering mediation or further training to help to encourage a positive working environment.
In this alert Julie Price, MPS’s Clinical Risk Programme Manager, highlights the risk of healthcare assistants performing immunisations.

Our team has identified the use of Healthcare Assistants (HCAs) Undertaking immunisations in general practice as a risk area. There is no definitive list of tasks that an HCA can undertake. Whatever task is delegated to an HCA, the healthcare professional or registered clinician must ensure that the HCA is trained and has the necessary knowledge, skills and competence to undertake the tasks delegated to him/her, and that accountability is clear.

The Nursing and Midwifery Council states that: “The delegation of nursing or midwifery care must be appropriate, safe and in the best interests of the person in the care of a nurse or midwife. The decision to delegate would be judged against what could be reasonably expected from someone with their knowledge, skills and abilities when placed in those particular circumstances.”

In many practices GPs delegate the task of administering certain injections to HCAs – for example, flu and pneumococcal vaccinations and vitamin B injections. Some HCAs are now being asked to administer pertussis vaccination for pregnant women.

During our CRSAs (Clinical Risk Self Assessments) we identified that this is being undertaken on occasions by the HCAs without the HCA having Patient Specific Directions (PSDs) in place.

The Nursing and Midwifery Council states that: “A patient specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient.”

Prior to administration of any vaccine by an HCA to a patient, the HCA must obtain a signed authorisation (such as, patient list signed by GP or independent prescriber) to administer the vaccine and complete the vaccination record sheet that details the patient name, date of birth, vaccine given, dose, batch number and expiry. This is a legal requirement under the Medicines Act (1968). Where an HCA is unsure about any aspect he/she must refer to a clinician for advice before administering the vaccine.

The PSD must:
- state the name of the patient
- state the name and dose of the prescription only medicine to be administered
- show evidence to confirm that the patient has been considered as an individual.

The use of a template may assist for this purpose, for example:

A PSD for vitamin B injections could state: name, DOB, medication, dose, frequency of administration, review date, and be signed by the independent prescriber/GP and HCA, then scanned into the record.

The flu vaccinations could have a PSD attached to the list of patients signed by the independent prescriber and the HCA. For pertussis vaccination there should be a signed PSD for each patient.

Patient Group Directions (PGDs) that were introduced in August 2000 constitute a legal framework which allows certain healthcare professionals, eg, practice nurses, to supply and administer medicines to groups of patients that fit the criteria laid out in the PGD. HCAs cannot and should not vaccinate or administer immunisations on the basis of a PGDs, PGDs are only to be used by qualified healthcare professionals.

Within general practice, HCAs are required to work in situations where constant close supervision is not always possible. This means that HCAs need to be able to share the responsibility for working safely and correctly. Education, training and assessment will help to give them the confidence to do this successfully.

Employing GP partners are vicariously liable for the acts and omissions of the HCA. All HCAs should have adequate indemnity arrangements in place for the task they undertake. It is essential that practices inform MPS of tasks that the HCA is undertaking to ensure that adequate indemnity arrangements are in place.
Out and about
Highlights from MPS events across the UK
MPS has a unique insight into why things go wrong. By sharing this insight at conferences, seminars and workshops, doctors and healthcare professionals will learn how to better manage the risks that exist in day-to-day general practice.

These pages showcase highlights from top MPS conferences. In this issue we shine a spotlight on the MPS General Practice Conference 2012: Where the Risks Lie, which took place last year.

More events...

**MPS Practice Management Seminars**
These seminars have been developed to help guide you through the minefield of patient safety and complaints. The day will be practical and interactive.

*When:* Throughout 2013  
*Where:* Across the UK  
*More at:* [www.mps.org.uk/PMSeminars](http://www.mps.org.uk/PMSeminars)

**MPS Out of Hours Conference**
Learn about new approaches for reducing risk and how to make out-of-hours safer for patients and clinicians.

*When:* 25 April 2013  
*Where:* The Kings Fund, London  

**GP Tutors’ Annual Conference**
Hear about the latest assessment and technology news for GPs.

*When:* 26 April 2013  
*Where:* London  
*More at:* [www.ucl.ac.uk/pcph/events](http://www.ucl.ac.uk/pcph/events)

**Pulse Live**
This two-day event offers attendees 14 CPD hours for participating and is supported by a lively, interactive exhibition.

*When:* 30 April 2013 – 1 May 2013  
*Where:* Birmingham  
*More at:* [www.pulse-live.co.uk](http://www.pulse-live.co.uk)

**Commissioning Live**
Learn about commissioning and share best practice.

*When:* 11 May 2013  
*Where:* Birmingham  
*More at:* [www.commissioninglivebirmingham.com](http://www.commissioninglivebirmingham.com)

**Management in Practice**
Attend this free event and further your knowledge about healthcare management.

*When:* 4 June 2013  
*Where:* Manchester  
*More at:* [www.managementinpractice.com/manchester](http://www.managementinpractice.com/manchester)

**MPS General Practice Conference 2013**
MPS’s 2013 annual general practice conference will take you back to basics to identify the key medicolegal and ethical issues that will help safeguard you and your patients.

*When:* 19 and 26 June 2013  
*Where:* London and Manchester  
Rising nurse claims

MPS has seen a steady rise in the number of claims involving practice nurses, with ‘delay in diagnosis’ being the most common type of claim. Kate Taylor, Clinical Risk Manager, MPS Educational Services, reveals more.

Understanding the common claims facing nurses can help nurses to ensure that they employ risk management strategies and efforts to reduce risks.

A study of general practice claims opened by MPS over the period 2007 to 2011, where practice nurses/nurse practitioners were involved in the care of patients, identifies that 33% of cases related to a delay in diagnosis. Further analysis of these claims identifies that nurses are seeing patients with more acute presentations, who perhaps historically would have been seen by a GP. Many of these claims involved nurses not referring the patients’ care onwards either to a medical colleague or a specialist healthcare professional.

Key contributing factors include:
■ Failure/delay to refer patient to GP/specialist
■ Inadequate assessment of the patient’s condition
■ Inadequate monitoring of the disease progression.

Common claims

While missed diagnosis was the most common, the penultimate most common claim was chronic disease management, with 16% of claims during the four-year period relating to this. Chronic diseases include diabetes, asthma, coronary heart disease and hypertension. Chronic disease management is a huge part of the nursing role within general practice, so the risk it presents needs to be tackled.

Key contributing factors include:
■ Failure/delay to refer patient to GP/specialist
■ Inadequate assessment of the patient’s condition
■ Inadequate monitoring of the disease progression.

Common claims against nurses in general practice

[Diagram showing common claims: Delay in diagnosis 33%, Chronic disease management 16%, Immunisations 9%, Wound care 7%, Ear syringing 7%, Contraception 7%, Medication 6%, Minor surgery 4%, Miscellaneous* 11%]

*Includes: infection control, medical records, phlebotomy, joint injections

NB, this information is based on MPS claims for the period 2007-2011.
The study shows that 9% of claims involving nurses working in general practice relate to issues associated with immunisations, be it childhood immunisations, flu vaccinations or travel vaccinations.

Key contributing factors include:
- Administration of the correct drug/dose
- Method of administration including technique
- Schedule of vaccinations, ie, travel vaccinations.

Why are nurse claims increasing?
The role of nurses working within general practice is ever-changing, with an expectation that they take on additional responsibilities and increased autonomy; ranging from chronic disease management clinics, nurse triage, family planning, and immunisation clinics alongside the introduction of the advanced nurse practitioner role, healthcare assistant and nurse prescribing. With this expansion of the nursing role comes the increased risk of clinical negligence claims from patients.

Across all providers healthcare litigation is increasing with patients being more aware of their rights, and MPS remains concerned that as nurses’ autonomy increases so does the risk of litigation.

The Nursing and Midwifery Council Code of Conduct (2008) states that nurses must recognise and work within the limits of their competence; therefore it is imperative that nurses ensure that they have received the appropriate training and skills to undertake their role.1

Risks of nurse triage
Nursing roles are increasingly being developed to undertake triage of appointments; this way of prioritising patients helps to identify the patient’s problems and directs them to the most appropriate care pathway, eg, urgent appointment, routine appointment, telephone consultation, and self help.

Nurse triage tends to be provided over the telephone and should be supported by practice guidelines/protocols. Nurse triage is not without risk; MPS claims data identifies a number of cases whereby assessment of the patient’s needs has been inadequate, resulting in an adverse outcome. Nurses undertaking triage need to be supported by guidelines and protocols and ensure that they work within their own sphere of competency. It is also vital that the reception staff who are responsible for referring patients for nurse triage are supported with guidelines; this will help to reduce the risk of nurses seeing patients inappropriately and will also ensure that the patient sees the most appropriate clinician.

In recent years within general practice there have been examples of titles being used by nurses that infer levels of clinical expertise that could not be verified.

Advanced nurse practitioners
In recent years within general practice there has been a random use of titles by nurses that infer levels of clinical expertise that could not be verified; the subsequent development of the advanced nurse practitioner course has helped to overcome this and has added an additional layer of monitoring of appropriate competency, education and tangible evidence-based practice (RCN 2012).2 In MPS experience, advanced nursing roles are increasing; nurses working within these advanced roles must also recognise their own limits.

Conclusion
In conclusion, increasingly nurses are at risk of clinical negligence claims from patients; however, understanding the common pitfalls and employing appropriate risk management strategies will reduce the risk of such claims. It is also essential that practices ensure that they have appropriate indemnity arrangements in place for all employed staff.

REFERENCES
In the wake of the Francis Report, we wholly agree with those areas for action, which create a culture of openness, transparency and candour, but strongly disagree that a legislated duty is the way of achieving this. A statutory duty might seem like a ‘quick win’, but this blunt instrument approach would cut across the whole idea of building a supportive and open environment to raise concerns and could instead invite ‘gaming’ and only doing the minimum necessary.

In the US there are certain states that have introduced mandatory disclosure (to communicate details of adverse events with affected patients and their families), but whether transparency with patients has been achieved, is still highly questionable. We believe that you cannot legislate to create a culture of openness; only fearful behaviour is created in this way.

We strongly agree with the focus on training and education for health professionals, but would go further by saying that an understanding of errors and high quality communication skills should be embedded as a core part of medical training.

There also needs to be more done to eliminate the barriers that doctors face in being open. In a survey of MPS members, 91% of doctors identified that time was a key barrier to them being open with patients, and 70% identified a lack of support as a barrier.

GPs might well be concerned by the reference to them playing a ‘monitoring role’ on behalf of their patients when it comes to outcomes of secondary services. For those involved in commissioning, this might be a natural fit, and having greater transparency of performance information could be useful to inform their commissioning decisions.

For the day-to-day GP however, we will be watching closely to see how the government responds to this recommendation – GPs have an ever-increasing number of expectations placed upon them, but we need to ensure they have the tools and support to meet these expectations.
How to…
Set up a Patient Participation Group

Stephanie Varah, Chief Executive of the National Association for Patient Participation (NAPP) shares the benefits of building a partnership with your patients

What?
PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs – this unique partnership between patients and their practices is essential to achieving high quality and responsive care. Groups either meet face-to-face with practice staff at mutually agreed intervals or ‘Virtual PPGs’, which operate alongside ‘real’ groups, facilitating dialogue with the whole patient population through email networks, online surveys and social media.

Why?
PPGs can bring significant benefits to the practices who have them: reducing costs, improving services, allowing resources to be used more efficiently and, most importantly, developing mutually supportive networks outside the GP or nurse appointment. Groups help the practice by enabling GP teams to be proactive in providing services that truly reflect what patients want and need. Some PPGs aim to benefit wider patient care within a practice – for example, by arranging transport for older or disabled patients, or by running self-help and wellbeing activities, such as weight management sessions, walking groups, etc. Patients are encouraged and supported by PPGs to take more responsibility for their own health by increasing health literacy, raising awareness of lifestyle options and promoting self-care, particularly for minor everyday illnesses.

PPGs become active advocates for the practice and the services provided – practices that have a PPG are increasingly being viewed by patients as an indicator of them being a high-quality caring practice and becoming a differentiator for patients between practices in their area.

Having a PPG will also assist practices to meet new policy requirements. Practices with a PPG will demonstrate a high level of commitment towards meeting the Care Quality Commission essential standards as the new primary care regulatory framework rolls out.

How?
Experience tells us that excellent practices and effective PPGs go hand-in-hand. Starting a group, however, may be unfamiliar territory for GPs and their staff. The most effective model for a practice is the combination of face-to-face meetings with a ‘core group’ of patients; this may vary in numbers depending on the size of the practice and patient population, supplemented by feedback gathered by email and through online surveys from the virtual group.

The building blocks of a good PPG are:
- Inclusive and representative membership
- Clear mutual understanding of purpose and role
- Effective and sustainable operation
- Strong, supportive relationships and culture within the practice.

Members can be recruited by holding open meetings, which any patient may attend, by contacting individuals directly who are patients at the practice, and by creating an email list of patients willing to help practices by giving their views electronically.

Where?
To ensure clear understanding of the role and purpose of the group, patients and practices need to mutually agree ‘Terms of Reference’, which set out what the group will do, and ground rules for how meetings will be run. Together these agreements will provide a framework within which the group can operate, ensuring effective management of expectations and objectives.

The NAPP ‘Getting Started’ guide provides comprehensive details on setting up and running successful PPGs. NAPP is the only UK-wide umbrella organisation for patient-led groups within general practice, with over 30 years’ experience in promoting, supporting and developing PPGs, working closely with GPs, practice teams and patients. A registered charity, NAPP has a membership representing more than ten million patients – www.napp.org.uk.

Did you know?
- The first Patient Participation Group (PPG) was started in 1972 by GPs
- Over 50% of practices in England now have a PPG
- There are now PPGs in dental practices and pharmacies.
Communication

In this series we explore the key risk areas in general practice

At a glance
In general practice communication has to extend to a greater number of people, so there are more opportunities for it to fail. Communication between primary, secondary, voluntary and social care should be viewed not as a chain, but as a communication net.

Colleagues
You and your colleagues should be aware of who is doing what, and understand the part they play. This will involve sharing patient information, which is entirely appropriate as long as continuity of care is balanced with the need to maintain confidentiality and patients are aware of how the information will be shared within the team.

If you are a locum GP, your colleagues should provide all the relevant details of the patients for whom you are responsible. Practices should have protocols in place for the transfer of relevant information between doctors. However, many do not cater for the nuances of working as a locum, so locums should have their own systems in place to ensure adequate clinical handover.

Consultations
Good communication with patients during a consultation is your first line of defence in warding off complaints and potential clinical negligence claims. Effective interpersonal skills are particularly important for locum GPs because they often have only one chance to make a good impression.

Patients who are denied the opportunity to explain their concerns or reasons for presenting may feel alienated, frustrated or resentful. Patients who are kept informed about their condition, and who are actively involved in deciding on the appropriate treatment, are more likely to comply with suggested treatments and are less likely to complain if things go wrong.

Tips for an effective consultation

- Let the patient talk first. An uninterrupted history aids diagnosis.
- Use non-verbal communication to encourage patients to talk, eg, nodding, making and maintaining eye contact.
- Well-aimed open questions can help “lead” the consultation.
- Allow patients enough time to ask questions and clarify things.
- If there is a lot of information for patients to digest, use patient information leaflets or factsheets.

Prescribing
Good communication is particularly important when it comes to prescribing. Patients need to be made aware of, and recognise, adverse side effects. It is vital that prescriptions are written clearly and accurately, and computer-issued prescriptions are properly checked. It is also important that the patient understands clearly what the medication is for, and how they should take it.

Check what other medication the patient is taking, and whether there are any contraindications with the current prescription.
Telephone consultations

Studies show that public satisfaction with telephone consultations is high, and patients increasingly wish to have this option. Talking to a patient on the phone, however, exaggerates the difficulties of a face-to-face consultation because there are fewer cues to pick up on.

Tips for an effective telephone consultation:

■ Remember not to break confidentiality – be cautious about revealing your identity until you have confirmed that you are speaking to the patient. You should only discuss details with a friend or relative if you are sure that the patient has given their consent.

■ Empathise with the caller.

■ When gathering information on the caller’s problem, make sure you: ask some open questions and closed questions, ensure that you are in a position to reach a sound clinical judgment, agree a plan of action with the patient, and check that they agree with it and understand it.

■ Ask the patient to repeat the advice given several times throughout the consultation.

■ Document the consultation accurately.

■ Follow-up: check existing medication when prescribing new medication, explain to patients what they should expect by way of improvement, ask about significant symptoms to report, and advise when to phone back if they are not getting better.

Using computers

It is important that the patient feels that they are receiving your full attention. Two helpful approaches are:

■ Listen – if the patient speaks, stop what you are doing and turn your attention to them – providing a useful opportunity for the patient to reflect and tell you any information they have forgotten.

■ Explain – tell the patient what you are doing.

You should ensure that other people cannot overlook your screen and make sure that when you are talking to a patient you have their records displayed and not someone else’s. There is nothing to prevent you letting a patient see their own records, unless these display harmful information relating to a third party.

Being open

Sometimes, in spite of your best efforts, patients will be unhappy with the care they have received. The General Medical Council (GMC) emphasises that patients who have lodged a complaint deserve a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology.

USEFUL LINKS

■ GMC, Good Medical Practice, www.gmc-uk.org/guidance/good_medical_practice.asp

■ GMC, Confidentiality (2009)

■ MPS communication courses and workshops, www.medicalprotection.org/uk/education-and-events/courses-and-workshops

■ MPS E-learning platform, www.medicalprotection.org/uk/education-and-events/elearning: Work through interactive case reports and earn CPD points, too!


The Apprentice

Dr Laura Davison, a GP registrar from Milton Keynes, shares her thoughts on topical issues facing GP trainees. Here she explores how to break the ice in general practice.

I read a troubling article in the newspaper recently. The UK is reportedly still lagging behind in global cancer survival rates because of the British attitude where people feel like a burden to their doctor, thus preventing early detection of cancer or increasing the loss of follow up.

As a trainee GP continually looking for ways to develop, I wondered how this attitude could be prevented by what I do during a consultation. I want my patients to feel valued not burdensome. Ok, I know what you’re thinking, and we all do it at times: “Why did they bother coming in with that?” Well maybe that’s the question we need to start asking ourselves, and the patient. Don’t be shy or British about this, ASK what they were worried about, and then take the opportunity to educate them for next time. This is not a waste of your time or theirs. Burden banished! It’s such a small simple change, but is a demonstration of personalising the consultation, shows interest in the person and the comforting ability to make this anxious experience for patients a positive one. There’s some truth behind the phrase “It was all very clinical” and pure focus on the medicine can leave patients feeling cold and uncared for. You can really listen, are key. It takes nothing to ask about their job, or the family, or even make a simple comment on the weather to break the ice and provide a more positive experience. The aim is to relax a patient’s attitude and experience the patient remembers, not the management of their time or theirs. Burden banished! It’s such a small simple change to your practice.

As doctors we often forget the experience of visiting us can be a nerve-wracking one for many patients. Praying it’s nothing, but yet hoping it’s not a waste of time. The dismissive manner of some GPs can consolidate this belief. From observation, the highest patient satisfaction scores come when the GP appears to have a genuine interest in the patient and the comforting ability to make this anxious experience for patients a positive one. There’s some truth behind the phrase “It was all very clinical” and pure focus on the medicine can leave patients feeling cold and uncared for. You can be Cambridge-Calgary perfect, but it’s the human experience the patient remembers, not the management you planned. The simple art of small talk, inquisitiveness scores come when the GP appears to have a genuine interest in the patient and the comforting ability to make this anxious experience for patients a positive one. There’s some truth behind the phrase “It was all very clinical” and pure focus on the medicine can leave patients feeling cold and uncared for. You can be Cambridge-Calgary perfect, but it’s the human experience the patient remembers, not the management you planned. The simple art of small talk, inquisitiveness scores come when the GP appears to have a genuine interest in the patient and the comforting ability to make this anxious experience for patients a positive one.

The rote robotic phrase, used by the majority of clinicians for the traditional consultation sign off, is: “If it’s not better in six weeks, come back.” Patients don’t. They feel dismissed. The phrase is reeled off to everyone, whatever the complaint. Next time try: “I WANT to see you in six weeks, if it’s not better.” It’s a simple change, but is a demonstration of personalising the consultation, shows interest in the person and lessens the anxieties of reattending. You want to see them. They are not a burden.

Is this simplicity enough to improve the likelihood of patients attending the surgery for follow-up, or improving the chances of picking up a cancer earlier by reducing the British fear of burdensomeness? Surely it’s worth a try.
There are 10,000 associates in training (AiTs) in the UK, translating to a quarter of the RCGP membership. Dr Brown has an important job to make sure that all members are represented effectively. One way is by representing AiTs in all major departments on the RCGP Council. In November last year the Chair and vice Chair of the Committee were given voting rights, meaning they are now allowed to vote on the various aspects of policy. “Not all other Royal Colleges extend this responsibility to their trainees – so it’s quite a big deal,” explains Dr Brown. “I think it’s a testament to the College itself, that senior officers really value the trainee voice and input.”

Since the national AiT Committee was founded in 2007, it has helped to shape many areas of the RCGP by providing ideas, suggestions and plans from a trainee point of view. As a result of this work the MRCGP is a very different assessment.

The AiT Committee also sit on other major committees and discuss topics including the curriculum, examinations and ethics. Externally they represent the College by sitting on committees, such as the BMA GP Trainees Subcommittee and the Academy of Royal Colleges Committee. Dr Brown’s predecessor was invited by RCGP Chair Dr Clare Gerada to give evidence at parliament when the Health and Social Care Bill was going through. The RCGP have new offices at 30 Euston Square, which Dr Brown is keen to tell us about: “The new offices hold a Knowledge Resource Centre where members can visit and there is also a new examinations department. In line with this new department, the CSA is going paperless. Instead, iPads will be used, making the exam more life like than ever by using computer-based notes instead of paper. I would encourage all trainees to go and have a look around the new building and its facilities – they’re really impressive.”

Dr Brown moves on to talk about the enhanced GP training bid that was approved by Medical Education England in September 2012. GP training is currently three years, making it the shortest training for GPs in Europe. In the coming years, this should be extended to four years and there are going to be some added changes, which will improve the robustness and quality of GP training, better equipping GPs for the future, he says. “One of the aims of enhanced GP training is to provide more exposure to GP trainees in specific areas. The training will involve more time in general practice, which should equate to two years over the four-year training. In the fourth year we are looking at innovative ways to develop leadership skills and help GPs implement service improvement projects.

“Getting involved with the AiT Committee is a real way to effect positive change for GP trainees on a national level. From a personal development point of view you find out how general practice, the College and the wider health system works, and you will learn how to manage yourself and a team,” says Dr Brown.

Elections to become an AiT representative are held regionally and will next take place in November. The term of office on the Committee is currently one year, which Dr Brown felt was too short, so will be extended to two years from November.

“If you want to get involved you should put yourself forward for the elections for the new committee, otherwise you could wait up to two years to get involved again,” he explains.

The Committee also has a scheme where any trainees in the UK can come and observe one of their meetings, and if you want to get involved locally with what your rep is doing then you can also contact them through their website – www.rcgp.org.uk/membership/join-rcgp-trainee-gps/ait-committee.aspx.
Spinal abscesses are not common and may be
Mrs S had been experiencing an intermittent
In any patient with a persistent fever you should
If a patient has existing neck pathology it is a
Do not hesitate to reconsider your diagnosis if the
Ensure that in any patient with neurological

Forty-nine-year-old Mrs S visited her
GP, Dr Y, with a recent onset of pain in the middle of her back extending down her right shoulder. She had also been suffering from a recent flu-like illness. She had a 15-year history of chronic neck and left arm pain due to cervical spondylosis.

Dr Y documented that she had a worsening pain and a pain over her left breast, where she had had pleurisy in the past. Her chest was clear on examination and he advised physiotherapy.

Mrs S’s pain worsened and she attended the local Emergency Department (ED) where she was diagnosed with a chest infection and discharged with antibiotics.

Five days later Mrs S had developed numbness in her right arm, the pain had become more severe and she was experiencing fever and night sweats.

Dr O visited her at home, found her to be pale and clammy with a pulse of 100, but normal blood pressure. He documented no tenderness between the scapulae or over her cervical spine, power in her right arm was noted to be 4/5, bronchial breathing was present at the left base. He changed her antibiotics and arranged to review her in the morning.

The next day, Sunday, Mrs S was starting to feel better and her observations were normal. Dr O reviewed Mrs S on Monday; she told him that the pain was still severe between her scapulae, but that her right arm was improving. She requested an HIV test. Dr O noted that her chest was clear and arranged a full blood count and plasma viscosity in addition to the HIV test. He asked her to attend the hospital for a chest x-ray and cervical spine x-ray.

Dr O reviewed the patient the following Monday. Mrs S continued to complain of severe pain between her scapulae and of right-arm numbness. She also told Dr O that her right hand was clawing although this is not documented in the records. Dr O wrote that the chest x-ray showed chronic inflammation within the lungs and the spinal x-ray demonstrated chronic osteoarthritis in the cervical and thoracic spine. Dr O did not examine Mrs S but arranged more blood tests. Two days later Mrs S awoke with severe leg pain and called an ambulance. She was seen by Dr C in the ED who discharged her advising an MRI scan would be arranged by her GP.

Later that day, Mrs S awoke to find that she was experiencing paralysis from the waist down and had been incontinent of urine. She was taken by ambulance back to ED where an MRI scan revealed the presence of a spinal abscess at C6/7.

Mrs S was transferred to the regional neurosurgery centre where she underwent an emergency laminectomy the following day. Unfortunately, neurological damage had already occurred and for two months she was paralysed from the chest down. Her legs improved but Mrs S continued to have problems with her mobility, only being able to walk short distances. She had to be re-homed since her current house had steep stairs. Her right arm remained painful and weak with little function and she experienced episodes of urinary incontinence and had to self-catheterise. Mrs S made a claim against Dr O and Dr C.

Expert opinion
Although a spinal abscess may be difficult to diagnose, Dr O could be criticised in relation to his standard of care. Dr O’s record-keeping was felt to be inadequate, and he should have carried out a comprehensive neurological examination on that second Monday, including testing the power and sensation in all limbs and palpating the spine for tenderness. Had Dr O done so he would have detected abnormalities and the patient should have been urgently admitted to hospital that day.

Expert neurosurgical opinion was that early diagnosis would have led to a better outcome, and the patient may have preserved most or all of her function. The hospital care in the ED was also criticised. The claim was settled for a large sum, apportioned between the hospital and Dr O.

Learning points
- Spinal abscesses are not common and may be difficult to diagnose especially if a patient has coexisting neck pathology.
- Mrs S had been experiencing an intermittent pyrexia, which persisted despite treating her presumed chest infection with two courses of antibiotics. An intermittent pyrexia is suggestive of an abscess.
- In any patient with a persistent fever you should look for the cause of the fever and consider all presenting symptoms carefully.
- If a patient has existing neck pathology it is a common trap to assume that the new symptoms are a gradual progression of this. Try to avoid linking all the symptoms together and instead consider carefully whether something new might be occurring.
- Ensure that in any patient with neurological symptoms you take a good history and perform a full and comprehensive neurological examination. In this case the examination findings may have led Dr O to detect the evolving spinal abscess at an earlier stage, which would have led to a better outcome for the patient.
- Do not hesitate to reconsider your diagnosis if the clinical picture no longer fits this and always consider obtaining a second opinion from a colleague or telephoning hospital specialists for advice.
Mr P, a 56-year-old keen athlete, attended his GP, Dr M, with episodes of tight central chest pain while running. He was a non-smoker and had no family history of heart disease. He had a history of rectal carcinoma for which he had had a bowel resection four years previously.

Dr M arranged for bloods and an ECG and, in view of his previous cancer, a chest x-ray. The results of the bloods and chest x-ray were normal. The result of the ECG is not documented. Dr M arranged for Mr P to have an exercise ECG.

The exercise ECG was reported as normal by Dr H at the hospital. It was stated that Mr P did not develop any chest pain during the exercise ECG test. Mr P reported that his symptoms had almost settled. Dr M advised a trial of a proton pump inhibitor and documented that he felt Mr P had an element of anxiety about his cancer diagnosis and his stoma. However, Dr M stated that the patient would require cardiology referral if things did not settle.

Fourteen months later, Mr P presented to Dr M with right-sided chest pain on exertion and also at rest. Nothing else was documented about the nature of the pain, although it was so severe that Mr P had decided to stop exercising due to the pain. There was no dyspepsia, appetite was good and Mr P’s weight was stable. Dr M noted that Mr P’s chest was clear but did not document a cardiovascular examination. Dr M noted that the chest x-ray and ECG were satisfactory the previous year and advised a proton pump inhibitor.

Nine months later, Mr P attended Dr M to discuss the results of a recent colonoscopy for rectal bleeding. Dr M did not enquire about the chest pain. He documented that the patient was going to visit his family in Canada.

Two months later, Mr P passed away in Canada. At postmortem the cause of death was found to be myocardial infarction. Mr P’s widow made a claim against Dr M.

Expert opinion

Expert opinion was critical of Dr M for not referring Mr P to cardiology at the first presentation, even in the presence of a negative exercise ECG, as the history was suggestive of classical angina pain (and particularly in light of the fact that the exercise ECG did not provoke any chest pain). It was also felt that Mr P should have been actively followed up to assess his response to the proton pump inhibitor and a cardiology referral made if the pain did not settle.

At the second presentation Dr M’s record-keeping was criticised as there was poor documentation of the nature of the pain and no assessment of how effective the proton pump inhibitor had been in the past. Dr M ignored his previous plan in the records to refer to cardiology if the pain did not settle.

An expert cardiology opinion concluded that, on the balance of probabilities, if Mr P had been referred to a cardiologist at either the first or the second presentation, he would have been diagnosed with coronary artery disease and would have had treatment, either medical or surgical, to reduce the incidence of angina and the risk of myocardial infarction. The claim was settled for a moderate sum.

Learning points

- In any patient with chest pain, you should exclude a cardiac cause with a careful history, examination, investigation and ongoing referral to cardiology if there is any concern about the diagnosis.
- It is well-documented that exercise ECG tests may be unreliable. In this case Mr P did not experience chest pain during the test and it was therefore not possible to exclude angina on the basis of this test alone.
- Each time a patient presents with chest pain, you should make a note of the nature of the pain, its position, radiation and any relieving, precipitating or associated factors.
- Do not assume that the pain is the same pain as at the patient’s last presentation – pain should be reassessed at each presentation, especially if it is failing to settle.
- Be very cautious in attributing symptoms to anxiety and exclude all serious physical causes first.
- Follow up the patient after a trial of treatment, where the diagnosis is unclear, and consider referral to secondary care for advice or a second opinion if symptoms fail to settle.
- Consider putting reminders, such as “If symptoms do not settle refer cardiology” in bold in the records so they do not subsequently get missed.

The heart of the problem

Learning points

- It is well-documented that exercise ECG tests may be unreliable.
I wake up bolt upright at 5.30am. I look in the mirror and realise I’ve inadvertently left my false eyelashes on from the previous day’s telly. They hang rather precariously from my upper lids – my mascara is half way down my cheeks and my hair is doing a good impersonation of Jedward. My husband rolls over and states that I look like a drag queen and promptly falls back to sleep.

I nearly always wake up before both my husband and our alarm on a working day as I have a morbid fear of being late, probably a by-product of being schooled by nuns. Today is like most other days, I jump in the shower and then race round the house deciding on what to wear; this usually involves a lot of stamping, swearing and searching – yet in spite of this drama, I always end up in a little black dress.

Annoyingly on TV days colour is essential, and green has become my Embarrassing Bodies staple. Today, however, there’s a hem down, no wonder web and a baby to feed, so it’s back to black. I always try to snatch a cuddle from my baby before I leave.

Breakfast is normally two pints of tea – I don’t do food in the morning.

When I arrive in London I jump in a black cab; I’m not keen on the Tube, it’s not snootiness or perceived celebrity status, it’s the humongous escalators. On arrival in London I jump on the train and immediately hook up with my second husband – my iPad. I write for various women’s magazines so at every available opportunity I write something. Usually, I sit in a carriage of businessmen who spend the journey discussing the Yen and the Dow Jones, while I’m frenetically typing an article on farting – each to their own.

On arrival in London I jump in a black cab; I’m not keen on the Tube, it’s not snootiness or perceived celebrity status, it’s the humongous escalators. I have a recurring nightmare of falling down backwards and crushing everyone like a pack of cards.

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Day in the life of...

Dr Pixie McKenna

Medical celebrity and GP presenter of Embarrassing Bodies, Dr Pixie McKenna, shares a typical day.

I’m being a proper doctor tomorrow, so I need to get some shut-eye – there are no retakes in the real world.
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