Professional support and expert advice for GP partners and practice managers

MPS

Practice MATTERS

VOLUME 3 ISSUE 1
JUNE 2015

UK

PRACTICE PROFILE

One Medical Group
The Light, Leeds

Page 10

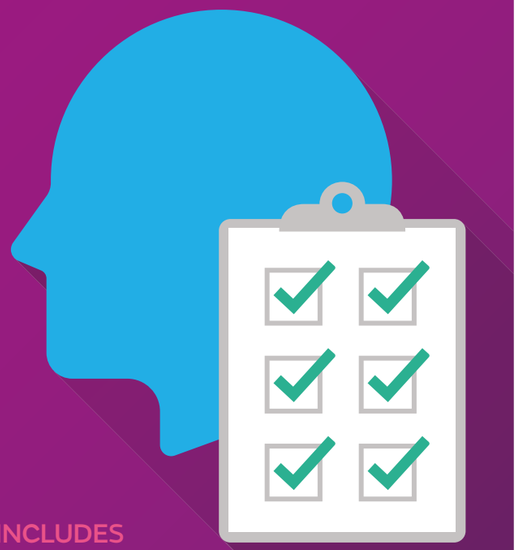
INSIDE...

MPS MORE THAN DEFENCE

SUPPORT FOR CQC

PRACTICES IN ENGLAND

You can access a range of support that can help your practice meet the new CQC fundamental standards.



THIS INCLUDES

- Workshops
- Risk assessments
- In-house practice seminars
- Factsheets and articles
- Video guides and podcasts.

If you are part of an MPS Practice Xtra group scheme then you can benefit from much of this support provided free of charge.

FIND OUT MORE

www.medicalprotection.org/cqc

1799: 05/15

The Medical Protection Society
Victoria House
2-3 Victoria Place
Leeds LS11 5AE
United Kingdom

Please direct all comments, questions or suggestions about MPS service, policy and operations to:

Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

chief.executive@medicalprotection.org

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

UK medicolegal advice
Tel 0800 561 9090
Fax 0113 241 0500
querydoc@medicalprotection.org

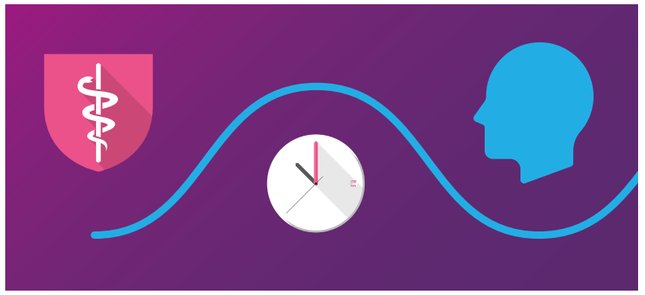
UK membership enquiries
Tel 0800 561 9000
Fax 0113 241 0500
member.help@medicalprotection.org

www.medicalprotection.org

Practice Matters (Print) ISSN 2052-1022
Practice Matters (Online) ISSN 2052-1030

Cover: © MPS/Paul Cliff

What's INSIDE...



We welcome contributions to ***Practice Matters***, so if you want to get involved, please contact us on 0113 241 0377 or email: sara.dawson@medicalprotection.org

Get the most from your membership...

Visit our website for publications, news, events and other information: **www.medicalprotection.org**

Follow our tweets at: **www.twitter.com/MPSdoctors**

Top tips in the palm of your hand – download the free MPS Advice app on the App Store or Google Play

NOTICEBOARD

Welcome

Welcome to this edition of *Practice Matters*. The magazine has been relaunched and is now aimed primarily at GP partners and practice managers – supporting you to support your GP practice team.

How you handle complaints is an important part of general practice, and in this issue we present a case study reflecting what could happen if you don't follow procedures and guidelines, along with learning points.

Flexible working is a hot topic on the Croner employment advice line; they have written up their frequently asked questions from practices across the UK on pages 6 and 7.

On pages 12-14, GP and popular author Dr Tony Males talks about how to consult over the telephone effectively and ethically. Consulting by telephone carries risks, and managing the risks is necessary to safeguard patients and your professional position.

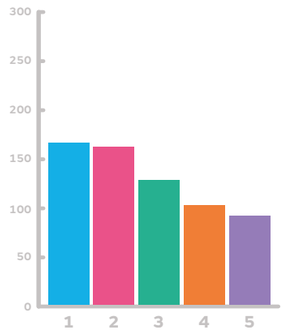
I hope you enjoy this edition. We welcome all feedback, so please contact us or if you have any ideas for topics you'd like us to cover.

Dr Rachel Birch
Editor-in-chief and MPS medicolegal adviser

TOP FIVE CHALLENGES FOR PRACTICE MANAGERS

1. Meeting CQC compliance (163)
2. Keeping up with legislation and protocols (159)
3. Deadlines from CCGs and local area teams (126)
4. Maintaining practice morale (100)
5. Ensuring systems are robust within practice to maintain patient safety (90)

These figures are the results of an MPS survey of more than 316 practice managers, who were asked to highlight their current top three challenges.



We have created a tailored resource for practices advising on the CQC's new fundamental standards and how we can help.

View the new section: www.medicalprotection.org/uk/for-members/general-practice/practice-xtra/cqc-inspections

PPGs now a contractual requirement

Since 1 April 2015 it has been a contractual requirement for all English practices to form a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population. Having a PPG is expected for CQC inspection.

Read our article on how to set up a PPG: www.medicalprotection.org/uk/practice-matters-issue-1/how-to-set-up-a-patient-participation-group

Forced data audits for GP surgeries

GP surgeries can now be forced by the Information Commissioner (ICO) to be audited for compliance with the Data Protection Act. The audits will review how the NHS handles patients' personal information and can review areas including security of data, records management, staff training and data sharing.

Read the full article: www.medicalprotection.org/uk/data-audits

MPS EXCLUSIVE FREE FOR LIFE OFFER – iWantGreatCare FFT SOLUTION

We are delighted to announce that the iWantGreatCare GP FFT solution is completely free to MPS practices, for as long as they remain a member of MPS.

Key benefits:

- Unique webpage for your surgery and GPs
- Save time: iWGC manage processing and transcription of feedback
- Guaranteed to be fully compliant with CQC and NHSE requirements
- Ready-made reporting, including monthly NHSE submission
- FREE for life.

For MPS members already using iWantGreatCare, reports can now be downloaded from your online account. Reports are fully formatted, ready for submission to CQRS.

iWantGreatCare

Register your surgery today at www.iwantgreatcare.org

NEW *PRACTICE MATTERS XTRA* E-BULLETIN

We have recently launched a new e-bulletin for GP partners and practice managers, *Practice Matters Xtra* – bringing timely news and information direct to your inbox. We'd love to hear your views; let us know what you think by emailing sara.dawson@medicalprotection.org.

SEPSIS-RELATED PATIENT SAFETY INCIDENTS

GP practices can now report sepsis-related patient safety incidents through the new National Reporting and Learning System (NRLS) e-form for general practice. There are an estimated 31,000 deaths per year due to sepsis, an estimated 10,000 of which are avoidable. Improvements around initial assessment, recognition of critical illness, and timeliness of treatment could positively impact on patient outcomes. Practice staff are encouraged to use the new e-form to report all incidents and near misses, increasing opportunities for the NHS to learn and take action at a national level to prevent identified patient safety risks.

Source: NHS England

View the e-form: www.england.nhs.uk/ourwork/patientsafety/general-practice

Croner
a Wolters Kluwer business

FLEXIBLE WORKING: YOUR QUESTIONS ANSWERED

HOME

Flexible working was introduced to help employees achieve a better 'work-life balance'. Croner frequently answer questions on their advice line from practices about flexible working

Q CAN WE REFUSE A FLEXIBLE WORKING REQUEST?

A Yes you can refuse a request, however there are limitations. An employer can only refuse a flexible working request for one or more of the following eight permitted reasons:

1. A burden of additional costs
2. A detrimental effect on ability to meet customer demand
3. An inability to reorganise work among existing staff
4. An inability to recruit additional staff
5. A detrimental impact on performance
6. Insufficient work during the hours the employee proposes to work
7. Detrimental impact on quality
8. Planned structural changes.

The reason(s) why the request is being rejected needs to be clearly stated in a letter to the employee informing them of the outcome of their request. The employee will then be able to lodge a written appeal if he or she chooses if the decision isn't in their favour.

Q HOW FAR DO WE HAVE TO LOOK IN TO THE POSSIBILITY OF FLEXIBLE WORKING WHEN AN EMPLOYEE MAKES A REQUEST?

A Employers should consider all flexible working requests carefully, document the thought process and considerations undertaken of every single one in case the decision is challenged at either an internal appeal or in a tribunal claim.

You should look at the benefits to the employee and your business to compare these with any negative effects that might impact the business. Also, given that refusing a flexible working request could give rise to an indirect sex discrimination claim it is imperative that employers give proper consideration to requests. As fewer women than men are able to work full time due to childcare commitments, there is a risk that refusal to agree to a request could amount to indirect sex discrimination.

However, indirect sex discrimination can be defensible if the employer can objectively justify why the request cannot be agreed to.

In assessing this, a Tribunal will consider the discriminatory effect on the employee compared to the reasonable needs of the employer. A Tribunal is unlikely to find that it is reasonable to refuse a flexible working request because the employer would prefer that the employee keep their hours as opposed to it being a genuine business necessity. Therefore, employers faced with a flexible working request should explore, among other things: whether a job share could be accommodated; if existing staff are willing to alter their hours; or the possibly of recruiting new staff.

Q WHAT EVIDENCE DO WE NEED TO SUPPORT A DECISION TO REFUSE A FLEXIBLE WORKING REQUEST?

A Employers should document the approach and considerations they carried out when considering a flexible working request. For example, this might include evidence of the unreasonably high costs which would be incurred if new staff were recruited to cover hours the employee had asked to drop; whether or not it would be possible to recruit a new employee to cover the hours the existing employee no longer wanted to do; or evidence of discussions with other staff to see if they could absorb those hours.

Q CAN WE HAVE A TRIAL PERIOD?

A If an employer is unsure of what the impact will be they can suggest a trial period to the employee. Following the meeting at which the flexible working request is discussed, the employer must write to the employee as soon as possible with their decision. In the letter the employer should also clearly state:

- That a decision about the flexible working request will be made after the trial period
- There is no permanent right to the employee to work the trial period hours
- The date on which the employee will revert back to his or her original hours if the employer refuses his or her flexible working request.

Q WE HAVE HAD A NUMBER OF PEOPLE ASKING TO WORK FLEXIBLY, WHO TAKES PRIORITY?

A Each flexible working request should be assessed on its own merits. The employer should have regard to the business case for whether the request can be granted and the impact of refusing a request.

Other factors employers could take in to account include:

- Who made the request first? However, you will not always be able to use this to make a decision as consideration must be given to the reason for the request.
- Have any of the employees made a flexible working request in the last 12 months? If so, they can't make another flexible working request until a full year has passed.

Q WE HAVE RECEIVED SOME CONFLICTING FLEXIBLE WORKING REQUESTS, HOW SHOULD WE DEAL WITH THEM?

A All requests for flexible working should be assessed on their own merits. When considering requests employers should consider the benefit to the employee in agreeing to his or her request and also the impact that a refusal may have, ie, that the employee could no longer continue to work for the employer.

Employers should also be mindful not to discriminate against employees on the basis of any protected characteristics. For example, only agreeing to flexible working requests from heterosexual parents so they can look after their child could lead to a discrimination claim from a gay or lesbian employee if they believe they are being treated less favourably because of their sexual orientation.

Q THE NEW LEGISLATION SAYS WE HAVE TO DEAL WITH REQUESTS IN A "REASONABLE MANNER", WHAT DOES THAT MEAN?

A The legislation does not define what is meant by "in a reasonable manner". However, the ACAS guide on handling requests to work flexibly in a reasonable manner seems to suggest that following a fair and transparent procedure will satisfy handling requests in a reasonable manner. This would include:

- Having a flexible working policy in place
- Arranging to discuss an employee's request with them as soon as possible after receiving it
- Allowing an employee to be accompanied by a colleague or a trade union official to the meeting if they wish
- Informing the employee of a decision on their request as soon as possible in writing setting out the right of appeal if the request has been refused
- Concluding the process, including any appeal, within three months.

Q WHAT WILL HAPPEN IF I DON'T FOLLOW THE CORRECT FLEXIBLE WORKING PROCEDURE?

A If an employer fails to follow the correct flexible working procedure, the employee could:

- Raise an internal appeal against the employer's decision regarding their flexible working request
- Raise a grievance
- Submit a claim to an Employment Tribunal. If the employee was successful, the Tribunal could award up to eight weeks' pay for failure to comply with the procedure. The employee could also pursue a claim for discrimination, for which compensation is uncapped.

HOME

POOR COMPLAINTS HANDLING

The key to resolving many complaints is handling them early on at a local level. *Terri Bonnici*, MPS medical complaints adviser, presents a case study showing what could happen if you don't get to grips with a complaint in the early stages

CASE STUDY

Mr X had seen a GP about a long-standing problem with his bowels and had asked to be referred to the hospital for investigations as he didn't feel he was getting any better with the medications he had been prescribed. His GP was reluctant to do the referral as he felt the patient should try other treatment options first, as well as change his diet, but eventually relented.

He promised the referral would be done that week but when Mr X had not heard anything for several weeks he called the surgery back to find that the GP had dictated the letter, but the secretary had gone on leave and forgotten to send the referral off. A new referral was sent, but when he called the hospital was told they had not received it. Mr X called the surgery back to be told it had been faxed and they would call the hospital. On doing so they were told they had received it and had written to the patient with an appointment. Mr X was adamant he had not received anything and on closer looking it was established the hospital had written to a patient with a similar name but different address.

Mr X was eventually seen, but he was very unhappy with the way he was treated in that his colonoscopy procedure was delayed on arrival because they could not find his notes. He was also made to feel he was a nuisance when he verbalised his dissatisfaction about how he was being treated.

THE COMPLAINT

Mr X made a complaint against his practice and the hospital about the care and treatment he received.

HOW THE COMPLAINT WAS HANDLED

The practice did not address his complaint properly, which included failing to provide a timely and full response to all his questions.

They did not have a discussion with him to talk about how the complaint would be handled, who would be involved, negotiate a timescale within which a response would be forthcoming, or establish what outcome he was looking for – this is called the **planning stage**.

They also failed to inform him at any stage that he could contact the NHS Complaints Advocacy Service if he needed help with his complaint.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 state in Section 9.1(b) that:

> *If it appears to the first body that the complaint contains material which, if it had been sent to another responsible body, would be a complaint which would fail to be handled in accordance with these Regulations by the second body" then (9.2) "the first body and the second body must co-operate for the purpose of co-ordinating the handling of the complaint and ensuring the complainant receives a co-ordinated response to the complaint.*

The practice overlooked this at the **planning stage** when the complaint was first made, when they should have discussed the patient's wishes with regards to what he could expect from the investigation. Therefore they missed an opportunity to obtain comments from the hospital departments involved.

They also failed to provide him with information about the next stage of the complaint process should he remain unhappy with the outcome of local resolution. This meant that it was not clear that local resolution had ended and he did not know where he could take his complaint next.

CONCLUSION

The practice's handling of Mr X's complaint did not meet the requirements set out in the NHS Complaints Procedures and guidelines. The information given by the practice was vague and they failed to provide open and honest answers to his questions. On top of this, failure to involve other NHS organisations caused unnecessary stress to Mr X at what was already a difficult time for him.

Therefore, Mr X was left not knowing what had gone wrong with his care and wondering whether his condition could have been avoided or at the very least treated earlier.

Learning points

- It is important to keep in mind that all complaints should have a planning stage to discuss and agree with the patient/complainant how a complaint is going to be managed. This gives a focus on the investigation and reassures the patient the matter is being taken seriously.
- It is important to review your complaint procedures to ensure that they meet the current set of guidelines and regulations to avoid possible criticism from the Ombudsman, which has in some cases attracted financial remedy in favour of the patient.
- It is important for all staff to be trained on your practice complaints policy and procedures as you will be measured on this not only by the Ombudsman but also the CQC.

YOUR COMPLAINTS PROCEDURES PLAN SHOULD INCLUDE:

- Summary of complaint with dates of incidents
- List of issues to be investigated
- Outcome the complainant is seeking
- Agreed investigation plan (eg, use of conciliator, who is doing the internal investigation, who is doing the external investigation)
- Consent to share information with those involved in the investigation, including other organisations
- Agreed timescale for a response
- How the practice will provide the response
- Details of source of advocacy suggested
- A copy of the plan sent to the complainant so they can confirm they agree with how the matter will be investigated.

> *We have found that poor complaint handling itself constituted maladministration or service failure leading to an injustice or hardship for the complainant. This was so even in cases in which we did not uphold the original complaint*

(The Parliamentary and Health Service Ombudsman, *Principles of Good Complaint Handling*)

*Please note: This is an English case study, and whilst many of the principles apply to good complaint handling across all the jurisdictions, please refer to the MPS factsheets on our website for advice specific to Scotland, Wales and Northern Ireland.

THE LIGHT – GROUP PRACTICE

Charlotte Hudson, deputy editor of *Practice Matters*, interviews *Nick Giles*, area operations manager for the One Medical Group – The Light, Leeds, about the secret to the practice's success

Q What is the practice's demographic?

A The Light has a very young, working population; we have very few elderly patients. This means that our GPs don't have to do many home visits, and most visits to the surgery are for acute illness as opposed to chronic illness. The male to female split is 50/50 and there are a number of child patients. Patients don't have to live in the city centre to register with us, we have patients who live in Bradford but work in Leeds so it's easier for them. We are open from 7am until 8pm on some days so this suits a lot of people working in the city centre.

Q How many patients do you have?

A We currently have 11,500 patients, and this is growing by an average of 1,000 patients per year. We get an influx of between 700 and 800 new patients when students move into the area in August/September. We promote the practice to new students by attending the halls during move-in and handing out promotional materials.

Since working at The Light I've done three presentations, for the 9,000th patient, 10,000th patient and 11,000th patient. We call them up, invite them into the practice and invite the local paper down if they're happy to be photographed.

Q How long have you worked for the practice?

A I've worked for the group since November 2012. I used to work at Abbey Medical Group in York, and prior to that I was the regional director for a number of food retail companies. The NHS was all new to me when I got the job in York.

Q Why the One Medical Group?

A I liked the idea of looking after numerous sites, being able to share best practice, and also transferring my years of experience to the NHS. I feel that the NHS has not always been very business-focused, so I found the job attractive because I can look at how we can be more efficient and cost-effective.

Q Tell me about your PPG...

A We've had a PPG for about two years – it works well but it is difficult to engage with patients. We have ten patients on the list and hold quarterly meetings, usually with two or three different patients each meeting.

The PPG has been instrumental in making a number of improvements in the practice. We've had real problems with women not coming in for their cervical smears, so we did a survey and got the PPG involved, asking patients when the best time would be for them to come in for their smears. We had two results – lunchtime drop-ins and Saturday mornings. Saturdays were very successful.

The PPG also helped with the Friends and Family Test – patients can either fill in cards, give feedback via text, or use the iPad that is on the reception desk, which we think is quite innovative. The majority of patients say they would be extremely likely to recommend us. Our response rate is currently 14%, which is an achievement in itself, because most practices have an average response rate of about 4%.

Q It is now a requirement for GP practices to provide online access for patients. How has The Light implemented this in the practice?

A We have provided online access for two years. We have 1,800 patients signed up now, which is around 14% of the population. This list is growing all the time. Patients can also download our app from the website.

Q Have you developed a 'safety culture' in preparation for a CQC inspection?

A Because we have a number of sites that have already had an inspection, we have a good idea of what to expect. During the inspections you basically have to be honest – talk about what's good, what's bad and how you're going to fix any problems. They are very interested in hearing about how you're going to resolve issues. We have a very good safety culture in practice. We hold a clinical meeting once a month, made up of all clinicians, and we also have a lead GP and a group medical director who he reports to. All significant event reports are submitted online, and once submitted, they go into the minutes of the next clinical meeting, are discussed and learning points made so it doesn't happen again.

© MPS/Paul Cliff

The Light Surgery, run by the One Medical Group, is the first and only NHS GP surgery in Leeds city centre. Based in The Light Shopping Centre, it is situated in a prime location for local working professionals and students. Nick Giles looks after six sites in total, which make up just part of the One Medical Group.

Q What are the challenges for the practice? How are you overcoming them?

A We don't have enough doctors, nurses or appointments. Patients are more demanding now; they want more access, they want it quickly, and they want what they *want* and not what they necessarily *need*. To get around this we try to be very efficient.

We are in the process of setting up a central hub, made up of a bank of secretaries, note summarisers, read coders and letter readers. This central hub of staff will handle all work across all sites that make up the One Medical Group, filling the gaps that occur when staff are absent, ensuring the quality of service to patients. We are lucky because it's not something you could do unless you have got a group structure.

For example, if a doctor goes on holiday or phones in sick, one of our doctors can log in to the system remotely and do telephone appointments, sign prescriptions electronically, do pathology, etc.

Q What do you like most about your job?

A I like developing staff and seeing them improving what they do. I also like communicating with people, sharing best practice, and seeing results of where we have done things differently. My role is a good mix of business and looking after people.

Q What is the secret to your practice's success?

A In order to be successful you need to surround yourself with good people that can do the job, create a nice working environment for staff, and reward them properly. Good communication is vital and getting staff to buy-in to what you're trying to achieve is important.

Be innovative – do something different that makes you stand out from others. Offer patients what they want – for example, our opening hours and drop-in sessions are there as a result of feedback from patients.

Key achievement:

DNAs at the practice are at 4%, when they were once at 15%. This has been helped by 91% of patients giving us their phone details, which enables us to contact them via phone-call and text message – and for patients to reply by text message.

Find out eight ways to streamline your appointment system, written by Nick, here: www.pulsetoday.co.uk/your-practice/eight-ways-to-streamline-your-appointment-system/20005729.article

RISKS OF TELEPHONE CONSULTATIONS

Consulting on the telephone requires a different skill-set, relying on common sense and improvisation. Learning how to do this effectively is necessary to safeguard patients and your professional position, says GP and popular author *Dr Tony Males*

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

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

RISK MANAGEMENT

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

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

FEATURES OF A SUCCESSFUL TELEPHONE CONSULTATION INCLUDE:

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

PRESCRIBING BY TELEPHONE

Whether prescriptions should be issued on the basis of a telephone history alone is a personal matter for individual practitioners and a policy issue for practices and out-of-hours service providers. The GMC states in its guidance that:

> *Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent…*[1]

The guidance also states that you must prescribe only when you have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs.

SOME GENERAL PRINCIPLES THAT SHOULD BE CONSIDERED IN TELEPHONE PRESCRIBING ARE:

- The prescriber should ensure that the patient is content with the proposed management plan
- The regular medications (including over-the-counter medications) taken by the patient and any drug sensitivities should be known or elicited by the clinician
- The rationale for treatment should be explained together with its risks, benefits and burdens
- Adequate provision for follow-up in the event of no improvement, worsening symptoms or side effects should be made
- The patient or a carer should be in a position to attend a pharmacy, surgery or out-of-hours centre to obtain the prescribed item
- The drug prescribed should be efficacious, cost-effective, prescribed at appropriate dose and in the appropriate quantity
- For infections for which there is equivocal evidence for the effectiveness of antibiotics, the prescriber should consider the option of issuing a "delayed" prescription that can be redeemed by the patient at a future date should symptoms not improve spontaneously
- Controlled drugs should not usually be prescribed on the basis of a telephone consultation alone.

COMMON PITFALLS

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

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

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

Giving advice is a communication skill that is just as important as listening. It is amenable to being structured through checklists and protocols and can be backed up by written information that can be posted to the patient or accessed online. Resources such as the *Minor Illness Manual* are valuable for all clinicians in primary care.[10] Good advice empowers patients and enables them to learn from one episode of illness to the next and may reduce their need for professional help. More advanced and unlikely to be provided by practices are decision-support software packages that support telephone triage by prompting clinicians to give comprehensive advice on conditions that may not need a face-to-face assessment. Organisations offering health advice and out-of-hours providers use these packages.

INFORMATION GOVERNANCE WITH RESPECT TO TELEPHONE RECORDINGS

Some practices and out-of-hours providers record incoming and outgoing telephone calls. These electronic sound files form part of the patient's records and can provide useful information in the event of a complaint or claim. Such recordings must be made, stored and disclosed under the provisions of the relevant legislation, and the patient must be informed of the fact that the call is being recorded.

Under the provisions of the Data Protection Act (1998), patients have a right to be provided with copies of information that is held about them and this would include recordings of telephone consultations. The GMC have produced some helpful guidance about the recording of patients in their publication entitled *Making and Using Visual and Audio Recordings of Patients*, which states that you must not make secret recordings of calls from patients (paragraph 56).[11]

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

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

ETHICAL CONSIDERATIONS

Ethical issues arise when one considers that healthcare delivery by telephone is prone to error compared to its gold standard counterpart, the face-to-face consultation. What is the balance between the advantages and disadvantages to the patient? How can the rights of the patient be reconciled with the duties of the practitioner? Beauchamp and Childress' "four principles" ethical framework helps in the analysis of ethical questions from four different viewpoints: beneficence (doing good), non-maleficence (avoiding harm), autonomy and justice.[12]

In circumstances when a patient or carer specifically requests "telephone advice", you must not assume that the request can be managed by way of a telephone consultation. Conversely there may be occasions when you initiate a telephone consultation in relation to a routine matter that it may become apparent that a face-to-face consultation is required.

A frequent cause for complaint is when a patient or carer calls and requests a home visit, but instead receives a telephone call. It may of course be entirely reasonable to manage the problem by way of a telephone consultation, but if there is an adverse outcome then this frequently construed as a refusal to visit.

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

CLINICIAN-INITIATED TELEPHONE CONSULTATIONS

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

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

SUMMARY

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

Dr Males is the author of the popular book *Telephone Consultations in Primary Care*. Visit: www.rcgp.org.uk/bookshop/eresources/telephone-consultations-in-primary-care. Dr Males has created an exclusive podcast on managing telephone triage, listen to the podcast on our website www.medicalprotection.org/uk/for-members/podcasts.

REFERENCES

1. GMC, *Good practice in prescribing and managing medicines and devices* (2013) – www.gmc-uk.org/guidance/ethical_guidance/14326.asp
2. Ott J, et al, *Patient Management by Telephone by Child Health Associates and Paediatric House Officers*, Journal of Medical Education (1974)
3. Brown S, Eberle B, *Use of the telephone by pediatric house staff: A technique for pediatric care not taught*, Journal of Pediatrics (1974)
4. Greitzer L, Stapleton F, Wright L, Wedgwood R. *Telephone assessment of illness by practicing paediatricians*, Journal of Pediatrics (1976)
5. Strasser P, Levy J, Lamb G, Rosekrans J. *Controlled Clinical Trial of Pediatric Telephone Protocols*. Pediatrics (1979)
6. Levy J, et al, *Development and Field Testing of Protocols for the Management of Pediatric Telephone Calls: Protocols for Pediatric Telephone Calls*, Pediatrics (1979)
7. Perrin E, Goodman H, *Telephone management of acute pediatric illness*, New England Journal of Medicine (1978)
8. Goodman H, Perrin E, *Evening Telephone Call Management by Nurse Practitioners and Physicians*, Nursing Research (1978)
9. Yanovski S, et al, *Telephone Triage by Primary Care Physicians*, Pediatrics (1992)
10. Johnson G, Hill-Smith, Ian, *Minor Illness Manual*, Radcliffe (2012)
11. GMC, *Making and using visual and audio recordings of patients* (2011) – www.gmc-uk.org/guidance/ethical_guidance/making_audiovisual.asp
12. Beauchamp TL, Childress FJ, *Principles of Biomedical Ethics*, Fifth Edition, Oxford University Press (2001)

MPS MORE THAN DEFENCE

MPS

MORE SUPPORT FOR YOUR PRACTICE

MPS members – The Light, Leeds

Did you know that we can offer you even more support and advice through our Practice Xtra group scheme?

FIND OUT MORE

For more details on Practice Xtra membership, or to request a quotation, please freephone: **0800 952 044*** or email: **gp@medicalprotection.org**

*Open Monday-Friday 08.00-18.30.

Calls may be recorded for monitoring and training purposes.

VISIT

www.medicalprotection.org

You could receive thousands of pounds worth of additional benefits and savings including:

- ☑ Discounted GP membership subscriptions
- ☑ Membership for practice nurses
- ☑ In-house medicolegal teaching sessions (including chaperoning and consent)
- ☑ HR and Health and Safety advice
- ☑ In-house risk assessments
- ☑ Online educational resources

PRACTICE XTRA | PRACTICE XTRA Silver | PRACTICE XTRA Gold

1798: 05/15