



Practice MATTERS

VOLUME 3 ISSUE 2
OCTOBER 2015

UK



CQC SPECIAL

How to achieve 'outstanding'

INSIDE...

HOW WE SET SUBSCRIPTIONS

How we calculate subscriptions

NURSES AND DELEGATION

How to protect nurses

FAQS – SICKNESS AND ABSENCE

Top calls from our
employment helpline

MAKE SURE YOU'RE REVALIDATION READY

We can help you make sure you've got your appraisal covered. Our new revalidation guide provides support for GPs linked to the GMC's appraisal and revalidation framework.



- ✓ Education and resources for each requirement
- ✓ Learn for free and claim up to 50 hours CPD
- ✓ Practical tips to help you plan and prepare

View the revalidation guide today and find out how you can keep your appraisals on track.

medicalprotection.org/revalidationguide

The Medical Protection Society Limited (MPS) is a company limited by guarantee registered in England with company number 36142 at 33 Cavendish Square, London, W1G 0PS.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS is a registered trademark and 'Medical Protection' is a trading name of MPS. 2065: 10/15

EDITORIAL TEAM

Dr Rachel Birch
EDITOR-IN-CHIEF



Sara Dawson
EDITOR



Sam McCaffrey
WRITER



CONTRIBUTORS

Hannah Dryden, Marika Davies, Sam McCaffrey, Kate Taylor, Croner

PRODUCTION

Philip Walker, Conor Walsh, Lucy Wilson

MARKETING

Michelle Buckingham, Deborah Cardingley, Beverley Hampshaw, Claire Haworth, Judith Richards

EDITORIAL BOARD

Gareth Gillespie
COMMUNICATIONS MANAGER



Antony Timlin
HEAD OF CORPORATE COMMUNICATIONS



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

medicalprotection.org

Opinions expressed herein are those of the authors. Pictures should not be relied upon as accurate representations of clinical situations. © The Medical Protection Society Limited 2015. All rights are reserved.

GLOBE (logo) (series of 6)® is a registered UK trade mark in the name of The Medical Protection Society Limited.

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

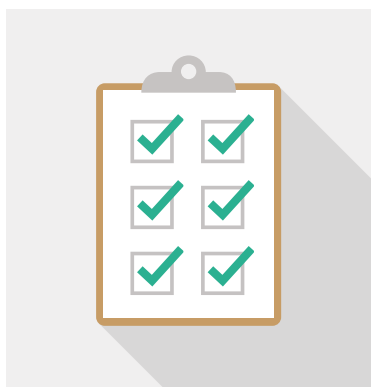
The Medical Protection Society Limited (MPS) is a company limited by guarantee registered in England with company number 36142 at 33 Cavendish Square, London, W1G 0PS.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS is a registered trademark and 'Medical Protection' is a trading name of MPS.

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

Cover: © Alex Orrow

What's INSIDE...



Every issue...

04 Noticeboard

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

08 CQC Special

How to achieve 'outstanding'

FEATURES

05 Blog – How we set subscriptions

Chief Executive Simon Kayll explains how we assess those risks and calculate GP membership subscriptions.

12 Risk Alert – Nurses and delegation

With complaints against nurses increasing, Clinical Risk Manager Kate Taylor, shares tips on how to decrease risks associated with delegation.

16 From the case files

Brain cancer accounts for a quarter of all childhood cancers, yet many GPs may still not have experience of the condition. Dr Rachel Birch outlines a case where a diagnosis could have been made earlier.

18 How to... deal with trivial requests by patients

Medicolegal Adviser Dr Marika Davies explains how to maintain professionalism when dealing with trivial requests from patients.

PRACTICAL PROBLEMS

06 Top tips to create a great GP job advert

GPJobs.org Site Editor Hannah Dryden shares her top tips for creating a great GP job advert.

14 FAQs – Sickness absence

Last year more practices called the Croner employment helpline for advice about managing sickness and absence than any other topic. Here are the most frequently asked questions.

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: medicalprotection.org



Follow our tweets at: 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

HOT TOPIC

Parental access for under 16's online medical records is a hot topic on the phones. We have received more than 800 calls from GPs seeking advice in this area in the last five years. Here's our quick guide...

THE ISSUE

The Information Commissioner's Office states that parents can make subject access requests on behalf of their children who are too young to make their own request.

A young person aged 12 or above is generally considered mature enough to understand what a subject access request is; however, each case must be judged on its own merits. They can make their own request and would need to provide their consent to allow their parents to make the request for them.

The law states that the mother of the child has parental responsibility and, therefore, has a right of access to their records. However, a partner's access to a child's records can be less straightforward.

YOUR ROLE

You must use your judgment to decide whether a young person aged 12 or above is mature enough to make their own request, as they do not always have the maturity to do so.

Remember any parental access to a child's records must be in the child's best interests.

WHERE IT GETS COMPLICATED

Fathers with parental responsibility may exercise a child's right to make a subject access request.

In some cases you might consider that it would be in the child's best interests to allow the father access to the notes even if he does not have parental responsibility. If the child's parents are divorced or separated, parental responsibility is not affected.

However, if this is the case, although there is no absolute obligation to do so, you may wish to consider informing the other parent that an application for access has been made, so that they can seek their own advice.

REMEMBER

The interests of the child are paramount. It is vital that GPs do not become embroiled in any family disputes, although this can be especially difficult when both parents are patients at the practice. In most cases the request for access is well-intentioned and reasonable, but it is important that all requests for access to a child's records are dealt with fairly and in line with the relevant professional guidance and legislation.

TOP TEN CHALLENGES FOR PRACTICE MANAGERS

THIS LIST IS BASED ON A MEDICAL PROTECTION SURVEY OF PRACTICE MANAGERS

- 1 Meeting CQC compliance
- 2 Keeping up with legislation and protocols
- 3 Deadlines from CCGs and local area teams
- 4 Maintain practice morale
- 5 Ensuring systems are robust within practice to maintain patient safety
- 6 Staffing issues; absences, sickness, etc.
- 7 Dealing with patients' complaints
- 8 Federating
- 9 Ensuring health and safety procedures in the practice
- 10 Employment issues; redundancies, recruiting, etc.

Find out more about the benefits of being a Practice Xtra member here:
medicalprotection.org/uk/for-members/general-practice/practice-xtra

For more advice visit our factsheets homepage: medicalprotection.org/uk/resources/factsheets

Book on our FREE Medical Records in Primary Care workshop here:

medicalprotection.org/uk/education-and-events/workshops/primary-care-workshops/medical-records-in-primary-care



BLOG

HOW WE SET SUBSCRIPTIONS

General practice is an increasingly challenging and high-risk environment in which to practise medicine. Chief Executive Simon Kayll, explains how we assess those risks and calculate GP membership subscriptions

Medical Protection is a not-for-profit organisation that exists purely for the benefit of our members, with no shareholders to pay dividends to. All subscriptions go towards helping you deal with the challenges that you face in your professional practice. The discretionary nature of our membership also means that we may be able to assist in unusual circumstances that could fall outside of a standard contract.

More UK primary care claims were reported to us in 2014 than ever before. While some of these claims will run into thousands of pounds, others will involve millions, which far outstrips the amount a GP will pay for professional protection over the course of their entire career.

We share your concern about the cost of clinical negligence. On your behalf, we continue to challenge the Government to consider action to reduce this, as it negatively impacts the level of member subscriptions and, as far as the costs incurred by the NHS are concerned, it diverts funds away from patient care.

Your membership is 'occurrence-based', which means that it allows you to request assistance with a claim or complaint that was caused by an incident that occurred during your time as a member - even if you only became aware of it much later and after your membership ended.

This is helpful because the nature of negligence claims means that it can often be years before a case is brought and fully resolved. Our current experience is that it takes, on average, over seven years.

We respond to this in how we calculate membership subscriptions. A lot of detailed and robust actuarial work is undertaken, assessing trends in the size of claims and in the likelihood of claims for your area of practice. We build this into subscriptions so that we have enough funds set aside as reserves for claims as yet unreported, as they fall due in future years. This means we can be confident of being there for you, as we have been since 1892.

As a GP you can also receive much more from us by getting together with colleagues and joining our Practice Xtra group scheme, which combines a discount on membership with a range of added-value education and risk management services.



READ THE FULL BLOG HERE.

[medicalprotection.org/uk/for-members/general-practice/gp-articles/gp-articles/how-we-price-membership-subscription](https://www.medicalprotection.org/uk/for-members/general-practice/gp-articles/gp-articles/how-we-price-membership-subscription)

Read about Medical Protection's not-for-profit status here:

[medicalprotection.org/uk/about-mps/organisation-and-finance](https://www.medicalprotection.org/uk/about-mps/organisation-and-finance)



TOP ADVICE FROM MEDICAL PROTECTION

You can access our most popular advice as factsheets on our website. Here is a list of our most popular factsheets:

1. Access to health records
2. Mental Capacity Act (2005) Assessments under the deprivation of liberty safeguards
3. Assessing capacity
4. Confidentiality – disclosures without consent
5. Mental Capacity Act – General principles

For more advice visit our factsheets homepage:
[medicalprotection.org/uk/resources/factsheets](https://www.medicalprotection.org/uk/resources/factsheets)

Follow us on Twitter

If you use Twitter in a professional capacity, why not follow [@MPSdoctors](https://twitter.com/MPSdoctors)?



TOP TIPS TO CREATE A GREAT GP JOB ADVERT

GPJobs.org Site Editor **Hannah Dryden** shares her top tips for creating a great GP job advert



Recruitment is becoming harder these days so to attract the best staff it's worth spending a bit of time to write a great advert for your vacancy.

If you create a template, some information will stay the same no matter what role you are advertising. Each time you need to recruit a new member of staff, you can simply slot the job specific information into your existing template.

1 PRACTICE NAME AND ADDRESS OR LOCATION

Putting your practice name and address or location at the top of your advert is really important as it helps create a good first impression and makes it very clear where the job is.

Imagine meeting someone and not introducing yourself until the end of the conversation – it doesn't make sense. It also means that the people who want to work in your area are immediately attracted to reading more about your practice and the role you have available.

2 JOB TITLE AND HOURS/SESSIONS

By putting the role(s) you are advertising and the hours or sessions near the top of the advert, candidates quickly gain an overview of the role. This allows them to decide early on whether they are interested or not.

Providing as much information is important, for example, if the advert says at the top that the role is full-time and someone is looking for part-time work, they may not bother to read to the end of your advert where it mentions that part-time applicants will be considered.

3 PRACTICE DESCRIPTION

Give a brief overview of your practice to allow candidates to imagine what it might be like to work there. For example:

Our thriving, semi-rural GMS practice comprises five GP partners, three salaried GPs, highly-skilled nursing staff and efficient admin and reception team. We operate from modern, purpose-built premises and provide high quality care to over 7,000 patients. We are a high achieving, well-organised practice and use SystemOne. We are also a teaching practice for medical students.

In just a few sentences, you can provide a lot of useful information that gives candidates real insight into your practice and hopefully encourages them to apply.

4 WHAT YOU ARE LOOKING FOR

Next you could state what you are looking for in an ideal candidate. This could include relevant skills, experience and qualifications as well as personal attributes. Many adverts include generic terms such as 'dedicated' and 'hard-working' as if to put off potential applicants who are uncommitted and lazy!

It is important to be as specific as you can about any additional skills required for the role, for example, an interest in teaching is required as you are a training practice. Similarly, if you require the successful applicant to provide cover for other team members and be flexible about their hours, this is also worth mentioning and will help ensure the candidates who apply have what you are looking for.

5 WHAT YOU CAN OFFER

Again, in order to attract applicants, you should set out what you are willing to offer the successful candidate. This might include salary and benefits, annual leave entitlement, development opportunities but also the type of working environment on offer, for example, a practice that values a good work-life balance, flexible working or a supportive working environment.

You can also include whether you are a GMS/PMS practice and if you offer the BMA model contract. Some practices include humour to make their advert, and their practice, stand out. This advert is a great example.

For more information visit: gpjobs.org/jobs/minion-for-gp-partnership-of-evil-geniuses-6-sessions-polegate-east-sussex

6 WHO TO CONTACT FOR MORE INFORMATION

Providing a named person and their contact details is a great way of encouraging informal contact before a candidate applies. Many practices also encourage prospective applicants to visit the practice before applying so this can also be mentioned in this section.

7 IMPORTANT DATES

Many good adverts fail to include a closing date, which can make it difficult for candidates to know whether it's worth applying or not. You may also find that your advert is listed after the closing date and you continue to receive applications for a vacancy that no longer exists.

Providing the closing date, interview date and ideal start date can help candidates plan and be prepared, meaning that they are more likely to be available if they are invited for interview.

8 HOW TO APPLY

Giving clear details for candidates on the application process is vital. Some practices prefer a handwritten covering letter, others are happy to receive applications by email. If your interview process includes anything additional such as simulated consultations then include this information here. Make it clear and wait for applications to flood in.



CQC SPECIAL

CQC compliance topped a recent Medical Protection survey of practice managers' main concerns. We profile a practice who were recently inspected by the CQC, and interview two inspection managers about how practices can prepare for the process



HOME

BACKGROUND

A recent Medical Protection survey of practice managers identified that their main challenge is complying with the Care Quality Commission (CQC).

The Health and Social Care Act (2008) introduced the CQC's fundamental standards. These new standards came into force for general practices on 1 April 2015 and replaced the CQC's Guidance about Compliance Essential Standards of Quality and Safety and its 28 outcomes.

The new fundamental standards incorporate the previous regulations and are not too dissimilar; however they do include new regulations:

- the duty of candour
- the fit and proper persons requirement for directors
- the requirement to display performance assessments

PRACTICE PROFILE – CUCKOO LANE SURGERY, LONDON

The CQC recently visited Cuckoo Lane and rated them outstanding. Sam McCaffrey visited the practice to find out why.

Tucked away in a quiet corner of the Hanwell Health Centre in London is a small general practice that is making a big name for itself. Cuckoo Lane Surgery is certainly not your average GP practice-it is an alternative provider of medical services run by nurse practitioners. While standard GP appointments are available, the vast majority of patients are seen and treated by nurses.

It was also recently rated outstanding by the CQC.

In its report the CQC found Cuckoo Lane to be outstanding for being well-led and providing responsive and effective services. The inspectors also found that the care provided to older people, people with long-term conditions, families, children and young people, people living in vulnerable circumstances and people experiencing poor mental health, including people with dementia, was outstanding.

HOW DID THE PRACTICE ACHIEVE THIS?

Carol Sears, nurse practitioner and one of the two directors of Cuckoo Lane, believes that being outstanding is all about going the "extra mile".

"I think if you want to be outstanding you first have to be good," she said. "To be outstanding you have to do extra. You have to be able to show you're auditing your care, that you're looking at your patient population and asking what they need and then putting that in place."

At Cuckoo Lane they go an extra three or four miles. Among their successes, they were instrumental in establishing an area-wide approach to the three-tier model of shared care for diabetes; they provide spirometry tests, and a weekly clinic for patients registered at other practices, which has resulted in a 25% reduction in hospital admissions for COPD patients; and they are involved in a vanguard for whole systems integrated care.

COMMUNICATION

The practice was particularly praised for being well-led, with the CQC report saying that the practice had a clear vision and strategy and a clear leadership structure, with staff feeling supported by management. It added: “Staff told us that there was an open culture within the practice and they were happy to raise issues at team meetings.”

Julie Belton, nurse practitioner and the other director of the practice, said that the key to achieving this was good communication.

“ ”

“Every day prior to morning surgery and afternoon surgery we have a ‘five-minute huddle’ where we discuss points of communication – they can be operational, clinical or strategic. The summary of what is said is then written up and immediately sent to the whole team.”

She added: “We have an open culture; doctors will consult with the nurse practitioners about cases and vice versa. We also have weekly clinical meetings and monthly multidisciplinary meetings in the wider community.”

This view was consistently echoed by the staff working at the practice. Practice manager, Myo Swe, said:

“We talk to each other all the time, we don’t have that segregation you see in other practices where clinicians, admin and practice managers don’t mix. We all work together here; nobody can do their job without the others.”

Julie Belton added that a big part of creating an open culture was treating complaints and things going wrong as learning opportunities.

“It’s not a blame culture. It’s a culture of finding different ways to do things and improving. That is how we achieved outstanding. There’s not a day that goes by where we don’t see two or three issues where we say ‘We can do this better’, and we sit down and come up with a way of doing it differently.”

THE INSPECTION

Perhaps the toughest part of CQC compliance is the inspections. Even for ‘outstanding’ practices they find the ratings process difficult.

“It was very tough,” Julie Belton said. “We really didn’t get a chance to show a lot of the good things we are doing, but I think in hindsight they were pushing us because they could see so much good work and they had to get the evidence.”



Myo Swe



Carol Sears



Frances Dallin



Dr Adebowale Adesanoye



Julie Belton



Photography: Alex Orrow



On the day of the inspection the team arrived at 9am and stayed until 8pm. There were four inspectors, two full-time GP practice inspectors, an expert GP and an “expert by experience”. First the practice had to give a presentation on their work and then the inspectors spent the rest of the day reviewing records, policies and procedures; interviewing patients and interviewing every member of staff at work that day.

“It was very professional. At the end of the day there was some feedback, but there was no telling what they were thinking,” Julie Belton said.

Carol Sears added: “Although they were rigorous it was professional and not aggressive. They seemed gentle and our staff said it went better than they expected. It wasn’t an unpleasant experience.”

PREPARATION

When preparing for the inspection most staff at Cuckoo Lane said there was not a great deal of extra work to do as the practice always made an effort to keep records and protocols up to date.

Salaried GP Dr Adebowale Adesanoye said: “We’re well organised and don’t leave things for the last minute, so there wasn’t much extra work to do for the visit, we just needed to check everybody was up to date.”

Carol Sears said most of the time was spent preparing the staff. “We made sure the members of the team knew the sorts of questions they would get asked. We went through our mission statement and made sure members of the team understood it. We checked we were talking the talk and walking the walk, making sure we were actually doing our mission statement.”

HINTS AND TIPS

When asked what advice they have to other practices on how to achieve outstanding, Myo Swe, the practice manager said: “Don’t panic. Use it as a learning experience, if they say something is missing ask how do we do this? And then get better.”

Julie Belton said communication is key. “Making sure every member of your team is in the know and up to date. I’ve worked at some practices where the doctors will talk about clinical care and not invite the nurses. I think it’s about making sure every member of staff is keyed up about every aspect.”

Meanwhile Carol Sears advises practices not to be afraid to stand up for themselves, and defend the way they do things. She cited the experience of defending Cuckoo Lane’s lack of written protocols to the GP expert, as they had an alternative system which integrated national guidance into their IT system and clinical templates.

She said: “Initially the GP who interviewed us didn’t like how we did it, I argued strongly and sent evidence afterwards that this was a better way of working. In the end that was one of the things they liked and said we were outstanding on so I’m glad I stuck to my guns.”



ADVICE FROM THE CQC



Claire Martin, Inspection Manager for General Practice in Surrey and Sussex, and **Nicola Cecil**, Inspector for General Practice, at the CQC share how practices can prepare for their inspection

MP What can a practice do right now to make sure they're ready for their inspection?

NC Before we inspect a practice we review all the information we have about that practice; from QOF data to patient surveys and information on NHS Choices, any information we can get our hands on. We also look at the practice's website. In terms of advice, practices should make sure their website is up to date for things like opening times and who their staff are – information we would expect patients to need to know.

Another important thing for practices to check is how they are registered with the CQC; what their regulated activities are, who their partners and who the registered manager is. A lot of times this information can become out of date, for example, sometimes a practice might not have provided a family planning service, but then they employ a doctor to take on that role and they might not have updated that regulated activity with us.

The other big one we find are partnerships; we look to see who they have registered as a partner and sometimes we find some partners leave or new ones join and they may not have put in all the relevant forms needed.

CM We also have mythbusters, which are produced by Professor Nigel Sparrow at the CQC. These are designed to ensure practices understand key elements of what we are looking for. Practices can find these on our website.

MP What should practices do once you've notified them you're coming to inspect them?

NC They should look at things like their policies and procedures and make sure their team understand what the policy means, what the procedures are. They should also look through their training and make sure people are up to date. I personally think that if you have ten days' notice, one of the things I would be looking at if I was a practice manager was whether I had done an Infection control audit recently.

CM They should make sure they are aware of the regulations, of the provider handbook and appendices, and the mythbusters.

As Nicola says there are some key elements that we will be looking at; have they done a fire risk assessment, have they got an evacuation procedure? Very simple things they should already be doing, but it's being able to demonstrate that you've done it.

MP What separates an outstanding practice from a good practice?

NC We say that to achieve outstanding a practice needs to be innovative and creative, constantly striving to improve. It should also be open and transparent. For good, we'd say a consistent level of service, people have a right to expect robust arrangements are in place for when things do go wrong.

CM In practical terms, for an outstanding practice, we might be looking at ways that they really address the needs of the practice population. For example, with long-term conditions, there are expectations about the basic level of service, but what are they doing that is different to other practices and is it really meeting the needs of the patient population groups? If you look at the provider handbook it will give you some key characteristics that you might find useful.

MP What else should practices know about CQC inspections?

CM There is a view that the CQC is looking for bad. That's not true, we like to see good and we're delighted if we see outstanding. We want to celebrate good practice, we want to inform GP practices what is going on out there that is really brilliant.

The other thing to say is we also allow the LMC to attend our inspections if they wish. Practices are always advised if this is going to happen and have the opportunity to say if they don't want the LMC to come along, but usually the practice find their presence reassuring.

FIND OUT MORE

Medical Protection's website has a dedicated page offering support to help practices meet the CQC's fundamental standards:

[medicalprotection.org/uk/for-members/general-practice/practice-xtra/cqc-inspections](https://www.medicalprotection.org/uk/for-members/general-practice/practice-xtra/cqc-inspections)

CQC Mythbusters resources: [cqc.org.uk/content/mythbusters-and-tips-gps-and-out-hours-services](https://www.cqc.org.uk/content/mythbusters-and-tips-gps-and-out-hours-services)

RISK ALERT – NURSES AND DELEGATION

With complaints against nurses increasing, clinical risk manager **Kate Taylor** shares tips on how to decrease risks associated with delegation



Within a climate of stretched resources and increasing demands on general practice, practice nursing roles are taking on more patient care that traditionally would have been managed by GPs.

However, complaints against nurses are on the rise with the number of referrals to the Nursing and Midwifery Council (NMC) rising by 36% from 2009/10 to 2013/14. In this increasingly challenging environment it is important to be aware of the risk management issues relating to delegation, nursing responsibilities and accountability.

ACCOUNTABILITY

The Royal College of Nursing and General Medical Council (GMC) are clear in their respective guidance for nurses and doctors that practitioners have a duty of care and a legal liability with regard to patients.

According to the GMC's Good Medical Practice: "When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient."

If a GP or a registered nurse delegates a task they must ensure that the task has been appropriately delegated, meaning:

- the task is necessary and delegation is in the patient's best interest
- the nurse or support worker delegated the task understands the task and how it is to be performed
- the nurse or support worker has the skills and abilities to perform the task competently
- the nurse or support worker accepts the responsibility to perform the task competently.

The GMC is clear that when you delegate care you are still responsible for the overall management of the patient.



Each individual nurse will adopt his/her own safeguarding processes prior to delegation

Within general practice it is the responsibility of the employing GP partners to ensure that the persons to whom practice nursing teams may delegate tasks have the appropriate education, training and skills to carry out those tasks delegated to them.

NURSE RESPONSIBILITIES

The NMC Code of Conduct summarises the accountability of a nurse delegating a task:

"If the nurse or midwife is delegating care to another professional, health care support staff, carer or relative, they must delegate effectively and are accountable for the appropriateness of the delegation."

Translating this to general practice means ensuring practice teams have appropriate systems and processes in place to safeguard the delegation of any nursing activities.

Each individual nurse will adopt his/her own safeguarding processes prior to delegation; however it is useful to consider a structured approach. The RCN sets out clear guidance on key questions to consider when delegating to another member of the team:

CASE STUDY

Patient X had been visiting the practice nurse three times a week for the management of a burn on her left leg following an accident in the home. Patient X's wound was healing slowly but was showing signs of improvement; therefore the practice nurse thought it appropriate to delegate future dressing changes to the health care assistant (HCA).

Subsequent dressing changes were managed by the HCA. Some weeks later the HCA was on holiday and so Patient X was seen by the practice nurse. As she began to remove the dressing the practice nurse noted an odour from the wound and that the dressing was particularly wet with exudate. On completely removing the dressing she discovered that Patient X's wound had deteriorated considerably. The practice nurse re-assessed the wound and determined that it was probably infected; she took a wound swab and asked the duty doctor to review it. Patient X was started on a broad spectrum antibiotic. The practice nurse redressed the wound and advised Patient X that she would now need daily dressings until an improvement was noted.

The practice nurse documented her findings, assessment and treatment plan in Patient X's medical notes. At this point she also noted that the HCA's documentation of previous dressing changes

was sparse with no reference to the deterioration of the wound.

Patient X completed the course of antibiotics and within a few weeks the wound was completely healed. The practice nurse recorded the incident as a significant event and a subsequent investigation revealed the following learning points:

- The practice nurse failed to assess the HCA's competency in wound care
- The HCA had not had specific training in wound management
- The practice nurse had not written an appropriate care plan for the wound management, detailing when the HCA should seek further support or advice
- The HCA had inadequate support from the practice nurse-several weeks had gone by without a review of the wound by a registered nurse
- The HCA medical records were inadequate, identifying that the HCA had not undergone any specific training in medical records
- Discussion at the practice team meeting raised the question about whether this had been an appropriately delegated task.

- Is the delegation in the best interest of the patient?
- Is the person you are delegating to suitably trained and have they been assessed as competent, preferably with written evidence of the assessment?
- Are there clear and robust protocols and guidelines in place?
- Does the task form part of the member of staff's job description?
- Do the members of the team know this task has been delegated?
- Is there sufficient supervision and support available?
- Is ongoing training and development available to ensure the member of staff remains competent?
- Has a risk assessment been undertaken?

the same rule also began to apply to doctors who want to register with the GMC.

Ten per cent of practices visited in 2014 as part of Medical Protection's Clinical Risk Self Assessment (CRSA) programme were unsure of their indemnity arrangements. As it is a legal requirement, it is vital that registered healthcare practitioners working in general practice are clear about their indemnity arrangements.

As nurse roles grow in scope, claims against nurses have increased. It is therefore important that nurses are on the correct grade for the work that they undertake. Medical Protection offers three grades of nurse membership:

- Level 4 – basic practice nursing duties only
- Level 5 – Prescribing (repeat) and basic practice nursing duties
- Level 6 – Clinical assessment or management of patients presenting with acute or undiagnosed conditions, beyond initial triage. Repeat and acute prescribing and basic practice nurse duties

Healthcare workers below Practice Nurse level are likely to be supervised, working under appropriate delegated authority to practice protocols and not making standalone clinical judgments, so are unlikely to hold individual indemnity protection in their own right. It is possible that clinical negligence claims are made against the practice as a result of the negligent acts or omissions of healthcare staff working at all levels; please check the type of Medical Protection membership you hold to ensure that it provides suitable protection in the context of your practice's specific mix of staff.

Delegation is a professional skill requiring GPs and nurses to match patient needs with the appropriate level of skill to ensure that patient care needs are in no way compromised. The current health care system continues to work under pressures and will inevitably make the need to delegate even greater. As doctors and nurses working in general practice we must be mindful of this and ensure safe high quality patient care.

INDEMNITY

From 17 July 2014, it became a legal requirement for nurses and midwives to hold an indemnity arrangement in order to be registered with the NMC. In September 2015

PRACTICAL TIPS FOR SAFE DELEGATION

- Ask: is the delegation appropriate?
- Identify any training needs
- Identify support available
- Following training, assess competencies in relation to knowledge, skills and experience
- Ensure robust quality assurance, for example by peer review or performance review
- Ensure that the practice has a system for reporting if things go wrong, to include the sharing of lessons learnt with the whole practice team
- Ensure that all health care professionals have appropriate indemnity arrangements
- Ensure a robust practice protocol in place for any delegated tasks including when to escalate and refer onto a more senior member of the practice team

FIND OUT MORE

To protect our members we provide ongoing learning and development opportunities to help you avoid complaints, claims and litigation. Visit: medicalprotection.org/uk/education-and-events

1. Nursing and Midwifery Council Annual Report and Accounts 2009-2010, http://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/nmcannualreportandaccounts2009_2010interactive.pdf
2. Nursing and Midwifery Council Annual Report and Accounts 2013-2014, http://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/nmc-annual-report-and-accounts-2013---14.pdf
3. NMC (2015) The Code; professional standards of practice and behaviour for nurses and midwives.
4. Royal College of Nursing (RCN) 2011. Accountability and delegation: what you need to know.

FAQS- SICKNESS ABSENCE

Last year more practices called the **Croner** employment helpline for advice about managing sickness and absence than any other topic. Here are the most frequently asked questions...

HOME

SICKNESS ABSENCE DURING A CAPABILITY PROCEDURE

Q: We have written to invite a member of staff to a formal capability hearing after a period of informal professional support. He is now off work sick. What is the appropriate course of action for us?

A: As a general principle, sickness should not unnecessarily delay a capability procedure. It is wrong for a member of staff to be absent just to slow down the procedure. However, each instance of absence needs to be assessed on an individual basis.

In this case, it may not be possible to continue with the procedure without your colleague being present. In some cases, the formal procedure may be so advanced that it can reach an outcome in the member of staff's absence. Check the capability procedure to see if it gives guidance. If the absence becomes long term, you will need to apply your sickness absence procedure.

MANAGING ABSENCE

Q: An employee has a fit note/medical certificate and has been off for an extended period of time; can I do anything about this?

A: The existence of a fit note/medical certificate does not exclude you from managing the absence of an employee. When considering your approach, you should give consideration to the nature of the condition and the likelihood that a return to work might be possible in the near future.

Care should be taken to identify whether the condition might fall within the definition of a disability in accordance with the Equality Act 2010. Again, this does not exclude you from managing the situation, but it does place a requirement that you give full and proper consideration to making reasonable adjustments to the workplace and to the job role in order to accommodate the individual requirements. This must be considered on a case-by-case basis.

Regular contact with the individual during the period of absence is recommended — case review meeting agendas may include a number or all of the following: update on condition; timescale of when a return to work may be envisaged; reasonable adjustments; phased return; access to medical records request; availability of alternative employment on either a short-term or permanent basis.

The case review meeting is not about questioning the validity of the illness/condition (except in very exceptional circumstances where evidence exists to this effect). Your role is to consider whether the individual levels of attendance are satisfactory for the needs of the business, and how we can support this individual to facilitate a successful return to work. In some instances it may be appropriate that the individual's employment is terminated, but you must be able to demonstrate that this was only considered as a last resort.

HOLIDAYS WHILE ON LONG-TERM SICK LEAVE

Q: A member of our staff who is on long-term sick leave is planning to go away on holiday. Is this acceptable and, if not, what steps should we take?

A: It is reasonable for you to expect staff not to go on holiday during sickness absence without first obtaining approval. Your absence management procedure should make this clear and should also include arrangements for regular contact between you and members of staff during long-term absence. Approval for a holiday need not, therefore, be a formal procedure.

Whether you decide to give approval or not will depend on the circumstances. In most cases, it will be self-evident that a holiday will assist the recovery to full health. However, a holiday could include activities that are clearly at odds with the nature of the illness and likely to affect recovery. If unsure, you should accept advice from the member of staff's GP or from the occupational health service, where appropriate.

SICKNESS ABSENCE AND THE NEW 'FIT-FOR-WORK' SCHEME

Q:

I understand that, in future, an employee's GP may be able to refer the said employee to the Government's Fit-for-Work service for a health assessment and development of a Return to Work Plan if he or she takes sick leave. What is this, and are employers obliged to abide by such a plan?

A:

Under the UK Government's Fit-for-Work scheme, GPs will, from the autumn of 2015, have the option to refer patients (with their consent) to the Fit-for-Work service if they have been, or are likely to be, off work for four weeks or more.

Fit-for-Work has been instigated to assist GPs, employers and employees manage sickness absence and provides access to work-related health advice via a website, advice line and free referrals for an occupational health assessment, which in most cases will be via telephone, although face-to-face assessments may also take place. The assessment will seek to identify all potential obstacles preventing the employee from returning to work (including health, work and personal factors) and involve agreeing a "Return to Work Plan" designed to advise and make recommendations for interventions to help the employee return to work more quickly.

When deemed appropriate by a case manager and the employee's consent is given, employer occupational health services or other employer representatives will be consulted during the formation of the Return to Work Plan and when discussing the recommendations within the finalised Plan.

The Return to Work Plan will be shared with the employee and, with their consent, also with their employer and their GP. Employers and employees will receive Return to Work Plans via email, or where appropriate by post. It is not mandatory to progress the interventions recommended by Fit for Work, unless this is required to meet employers' obligations under the Equality Act 2010.

Guidance from the Government clearly states that the decision about whether to implement any recommendations made in a Return to Work plan remains for the employer and the employee. Employers will continue to have responsibility for managing absences and hence decide if the interventions/adjustments are reasonable and affordable.

PHASED RETURN TO WORK PAYMENTS

Q:

A member of staff has been off sick for three months but has now been signed as fit to return to work, albeit on a "phased return". While we acknowledge we have to make reasonable adjustments and this is something we can accommodate, the employee is demanding a full week's pay when she will only be working three days per week. Do we have to pay her a full week's pay for three days worked? She is currently in receipt of SSP.

A:

Unless the employee's contract states that this is the case or custom and practice within the company suggests otherwise, you can pay the employee normal pay just for the days worked. As she has not exhausted SSP she would be paid this for the two days she is not working, during which time she will be considered absent from work due to sickness.



HOME



FIND OUT MORE

Croner is the UK's leading provider of information, advice and support in the areas of employment law and health and safety. Their qualified specialists have the experience to fully understand the issues and concerns you face working in general practice.

24-HOUR ADVICE

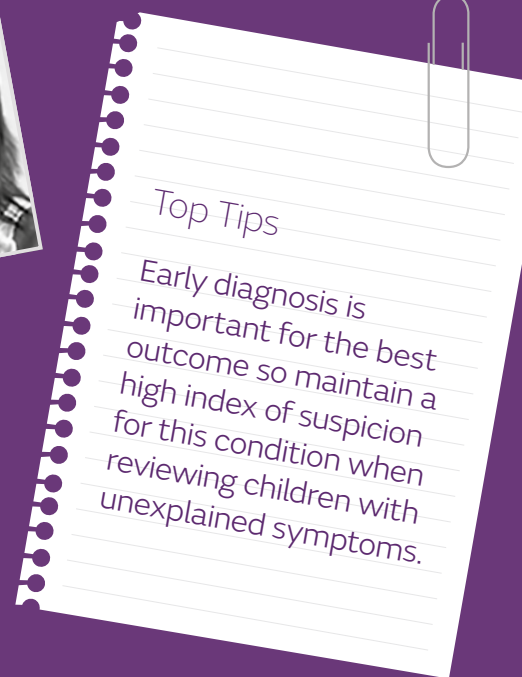
All Practice Xtra members can benefit from free access to the Croner helpline, for legal advice and support with matters including sickness and absence, holiday, pay and employee rights. Whatever you need to know they will provide you with information you can trust, whenever you need it.

TIME-SAVING RESOURCES

Gold Practice Xtra members can benefit from free access to the Croner-i Professional Practice Manager website. It's a resource for everyday management, with a range of templates you can download and customise for your practice. The absence and leave library includes model policies, 'how to' guides, sample letters and forms and factsheets for employers and employees.

Contact Medical Protection member services on 0800 952 0441 for more information about using Croner services or becoming a Practice Xtra member.

FROM THE CASE FILES



Brain cancer accounts for a quarter of all childhood cancers, yet many GPs may still not have experience of the condition. Dr Rachel Birch outlines a case where a diagnosis could have been made earlier

At presentation, Peter was 14 years old and had presented with migraines since the age of 8. He was taking Pizotifen and his headaches were well controlled. Over the past four weeks he had started getting headaches again. They were in a similar location to his migraines, but were different in nature – he couldn't put his finger on exactly how.

His mother took him to see Dr G who attributed his increased headaches to puberty and the fact that he had a new job doing a morning paper round. He advised better sleep hygiene and suggested that Peter use Sumatriptan when the headaches were severe.

Four weeks later the headaches were no different. In addition, Peter had started to feel sick a lot in the mornings and occasionally vomited. His mother told Dr G she was worried he had a brain tumour. In the consultation Peter admitted to feeling stressed about upcoming exams and was tearful, stating that he couldn't cope with the headaches any more. Examination was normal and Dr G felt that Peter was anxious. He arranged a CAMHS referral and agreed to see him again in two weeks.

After two weeks his mother attended with him and they saw the GP registrar, Dr W. Peter's mother was concerned that Peter was sleeping every evening for an hour after school and seemed lethargic and disinterested most of the time. She wondered whether Peter might be depressed.

Dr W questioned Peter further and found that the headaches were present on waking most mornings and that he had been sick on occasions at school break time. Neurological examination was normal.

Dr W was concerned about Peter's symptoms and arranged same day referral to paediatrics. The next day, following an MRI scan, Peter was diagnosed with a brain tumour. Subsequently this turned out to be a low grade astrocytoma and Peter underwent surgery a few days later.

Fortunately after six months, Peter is doing well, and the surgery is believed to be curative at this stage.

Peter's mother made a complaint to the practice about the six-week delay in his diagnosis. Dr G undertook a SEA with the practice team to review the case. He met with Peter and his mother, offered an apology and shared with them what they had learnt from the incident and what steps the GPs would take to raise their awareness of childhood brain tumours. Peter's mother was satisfied with this approach and no further action was taken.

Learning points:

- Always reassess a child with a history of migraine or tension headache if the headache changes.
- Suspect a brain tumour if there is a history of persistent headaches on waking for more than four weeks.
- Persistent vomiting on waking for more than two weeks should be considered a red flag.
- Lethargy is the commonest behavioural change associated with brain tumours.
- Listen to the parents' concerns as they know their children well and can pick up subtle changes in behaviour and health.

GUIDANCE

All GPs should be familiar with Brain Pathways Guideline developed by the Children's Brain Tumour research centre in Nottingham and is endorsed by the Royal College of Paediatrics and Child Health (RCPCH) and NICE*.

It advises that doctors should consider a brain tumour in any child presenting with:

- Headache
- New, persistent headache, for more than four weeks, occurring at any time (children under four may not be able to complain of headache – observe behaviour)
- Nausea and/or vomiting
- Persistent nausea and/or vomiting for more than two weeks
- Visual symptoms and signs
- Reduced visual acuity or fields
- Abnormal eye movements
- Abnormal fundoscopy
- Motor symptoms and signs
- Abnormal gait or coordination
- Focal motor weakness
- Growth and development abnormalities
- Growth failure
- Delayed, arrested or precocious puberty
- Behavioural change. Most commonly lethargy
- Diabetes insipidus
- Seizures
- Altered consciousness



RAISING AWARENESS – HEADSMART CAMPAIGN

By Sarah Mee, Head of Policy and Campaigns of The Brain Tumour Charity

We launched Headsmart to reduce the length of time it takes to diagnose brain tumours in children and young adults. Evidence shows that children in the UK with a brain tumour take longer to be diagnosed than children in other countries.

Since we launched the campaign it has reduced diagnosis times from 9.1 weeks to 6.7 weeks and we aim to get this down to five weeks or under to match Canada and the USA.

There are multiple factors affecting the time taken to reach a diagnosis; however, there is evidence that some children and young people with brain tumours are seen by healthcare professionals multiple times with symptoms that occur with the disease and are not appropriately referred or investigated.

We recognise that healthcare professionals have a difficult job to do in assessing children's health and making judgements about the appropriate course of action.

The initial symptoms of brain tumours often mimic those of more common and less serious childhood conditions and illnesses. We designed our website to assist in the diagnosis of brain tumours early on, identifying when they should be reassured, reviewed, referred and scanned.

Find out more

Access symptom cards with a list of warning signs for brain tumours and posters and leaflets through the charity. GPs can do an e-learning module on the HeadSmart website to improve their knowledge.
Visit: headsmart.org.uk



*The Brain Pathways Guideline: A Guide to Assist Healthcare Professionals in the Assessment of Children Who May Have a Brain Tumour (March 2011)



HOW TO... DEAL WITH TRIVIAL REQUESTS BY PATIENTS



Medicolegal Adviser **Dr Marika Davies** explains how to maintain professionalism when dealing with trivial requests from patients

HOME

Doctors are working under more pressure than ever, and on a busy day, it is understandable that a GP can feel frustrated when a patient presents with a seemingly trivial complaint.

Concerns about inappropriate use of primary care resources were recently raised by Resilient GP, an online support group for doctors in general practice.

Nearly 200 examples of requests that GPs thought were an inappropriate use of their time and skills were published online, including:

It ended up attracting media attention with headlines such as “I’m allergic to crisps.”

It may seem easy to be dismissive of a patient who presents with something

seemingly unimportant, and it is undoubtedly tempting to rush such consultations when the surgery is full of many other patients who genuinely need medical attention. In doing so however, doctors risk missing a potentially more serious diagnosis, a loss of trust in the doctor-patient relationship, or even attracting a complaint. GPs are well aware that factors such as education, genuine worry, a lack of social support or a poor understanding of the health care service can be the cause of such visits.

There is clearly a fine balance between being an approachable GP, always willing to listen to the concerns of your patients, and the risk of consultations being used inappropriately when time and resources in primary care are under increasing pressure. So what is the best way to handle consultations about seemingly small matters?



It ended up attracting media attention with headlines such as “I’m allergic to crisps.”

Visit: resilientgp.org/inappropriate-demands



I have had a mouth ulcer for 2 days



I have had a runny nose for the last half hour



I have a scratch on my arm



My baby’s snot is too green

1 MAINTAIN PROFESSIONALISM

No matter how trivial a query from a patient, doctors are well practised at maintaining professionalism, and know how important it is to avoid the temptation to be condescending or patronising. If a patient feels belittled or rushed, even if their problem has been dealt with appropriately, it could lead to a complaint. Dr Nik Kendrew, a GP in Kent, says, "It's all about how you deal with it, and making sure patients feel listened to." If concerns are not addressed, and a doctor is dismissive, patients may be reluctant to present in the future with something that could be more serious.

2 EXPLORE ANY UNDERLYING ISSUES

When dealing with minor symptoms, Dr Kendrew suggests taking a step back to look at the underlying problem. "These patients are genuinely worried," he says. "If they are coming in repeatedly with lots of trivial things you need to think 'why are they doing that?'" he says. Exploring with a patient why they are concerned about a seemingly trivial condition, such as a short history of a sore throat, can be helpful, for example, there may have been a death in the family from throat cancer. A pattern of insignificant complaints might also be a presentation of an underlying anxiety disorder.

3 EDUCATE

Educating patients is key to ensuring they use health care services appropriately. Once the problem has been dealt with, it is reasonable to politely point out to the patient if it has been an inappropriate use of the service, explain the reasons why and tell them where else they can obtain advice and treatment.

Dr Kendrew thinks some patients have lost the confidence to know what is and isn't serious, or when to see the doctor. "We should be educating the public about health, not just to stop the trivial things coming in but to teach people about red flags, so these symptoms aren't sidelined," he says. "It's about educating the right people to access services in the right way."

4 RULE OUT A SERIOUS MEDICAL CONDITION

The risk of not carrying out a full assessment is that a more serious diagnosis may be missed. It can be very frustrating for GPs when they are so busy, but going through a quick checklist to rule out anything of concern does not take very long. Conditions evolve - something may seem trivial to start with, such as a nosebleed, or indigestion, but it is important to bear in mind what else it might be.

5 REASSURE THE PATIENT

Once anything serious has been ruled out, give the patient a clear explanation and reassure them. Safety netting is an essential tool, and it is helpful to ensure the patient understands the parameters in which they should come back if something changes.

Dr Kendrew tries to empower patients to take the initiative, and to know if it is something serious in the future. "It might not be that problem, it might be something else, and what you don't want to do is to make them scared of coming to their GP because they are going to be laughed at or belittled. It's a really fine line, because equally you don't want to encourage somebody turning up unnecessarily."

HOME

**BETTER
PROTECTION
FOR THE WHOLE
PRACTICE TEAM**

PRACTICE XTRA

HOME

With everyone in your practice involved in patient care, a Medical Protection group scheme gives you extra peace of mind.

- ✓ **DISCOUNTS FOR GP SUBSCRIPTIONS**
- ✓ **FREE NURSE INDEMNITY**
- ✓ **PRACTICE REWARDS WORTH UP TO £4,000**

Call: 0800 952 0441

Visit: [medicalprotection.org/practicextra](https://www.medicalprotection.org/practicextra)

The Medical Protection Society Limited (MPS) is a company limited by guarantee registered in England with company number 36142 at 33 Cavendish Square, London, W1G 0PS.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS is a registered trademark and 'Medical Protection' is a trading name of MPS.

Medical
Protection

