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This issue of Good Practice centres on two themes: meningitis claims and raising concerns.

Meningitis is, fortunately, relatively rare and most GPs will only see one or two cases in their career. But it is notoriously difficult to distinguish from other illnesses, and we see many claims arising from delayed diagnosis. On page 16, Dr Sharmala Moodley, deputy head of claims, offers valuable insight into the incidence and outcomes of meningitis claims, and looks at the experience of members who have faced a claim.

When is it right to breach patient confidentiality and raise a concern? Test yourself with our raising concerns quiz on page 8. The advice line dilemmas on page 14 and 15 examine the ethical issues and importance of raising concerns when dealing with young patients, and provide some useful learning points.

Also in this issue, our newest member of the medical claims team, Dr Nicola Bailey, reflects on her experience as a GP and examines the potentially devastating consequences that small, apparently insignificant errors can have. Elsewhere you can find advice on ethical social networking and protocols for keeping a wholly professional relationship with patients. We look at the recent GMC social media guidance, and provide an essential dos and don’ts guide.

I hope you enjoy reading this issue of Good Practice. As always, we welcome your feedback.

Dr Catherine Wills
Interim medical editor
Social networking may have transformed your professional and personal life but your ethical responsibilities still apply online, as recent GMC guidance makes clear.

Dr Wendy Pugh, MDU medico-legal adviser, outlines the professional dos and don’ts for the social media age.

**DO respect patient confidentiality**
You wouldn’t share information about patients or those close to them where you might be overheard and the same principle applies in online communities. The GMC’s guidance, *Doctors’ use of social media* states that publicly accessible social media sites should never be used to discuss individual patients or their care. You should also be extremely cautious when using membership-only professional sites to seek advice in specific circumstances. Even if you are careful not to divulge too much information in a single post, there is a risk of identification if the details in multiple posts can be pieced together to form a clear picture of the patient.

**DON’T blur professional boundaries**
We are notified of between 10 and 30 cases each year where patients have made romantic advances, most commonly to GPs. Five years ago it was more common to receive a handwritten note but today doctors are more likely to be contacted on a social networking site.

A ‘friend’ request on Facebook, or other site, is outside the boundaries of your professional relationship and should not be encouraged, however impolite it might seem to ignore or decline the request. If a patient contacts you through your private profile, the GMC says “you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile”.

It’s also important to check your privacy settings regularly but as the GMC points out “social media sites cannot guarantee confidentiality, whatever privacy settings are in place”. With this in mind, consider how you would feel if a patient or colleague could see any personal details or images you share because once posted, these can be difficult to remove and may be distributed by other users. If you regularly ‘check-in’ or post images when out socialising or with your family, ask yourself if you really want others (who may include your patients) to know your whereabouts.

**DO be open about conflicts of interest**
When posting material, the GMC states that you “should be open about any conflict of interest and declare any financial or commercial interests in healthcare organisations or pharmaceutical and biomedical companies” and follow its guidance in *Financial and commercial arrangements and conflicts of interest (2013)*.

**DON’T make abusive or gratuitous comments about individuals online**
Many people use social media to let off steam after a difficult day but you should avoid making it personal. The laws of defamation also apply to online posts and the GMC states: “You must not bully, harass or make gratuitous unsubstantiated or unsustainable comments about individuals online”.

Even if you believe your words can’t be taken seriously, others might have an entirely different view. It’s far easier to accidentally give offence when you cannot pick up the visual cues from your audience and online arguments can quickly escalate.
DO identify yourself by name when posting as a doctor on publicly accessible social media

This is because the GMC considers that “any material written by authors who represent themselves as doctors is likely to be taken on trust and may reasonably be taken to represent the views of the profession more widely”.

If you would not be comfortable making a comment in your professional career offline, do not use social media to do so anonymously. Be aware that apparently anonymous posts can usually be traced to the user’s IP (internet protocol) address.

DO use appropriate channels to raise concerns rather than social media

Social media is unlikely to be an appropriate forum for discussing concerns about patient care. Instead, this should be done through local procedures in the first instance and then through the regulator if appropriate action is not taken. The GMC says concerns should only be made public if you have tried these options and still believe patients are at risk. It adds that you should not breach patient confidentiality and should seek advice before making a decision of this kind.

Case scenario

A newly-registered patient visited her GP after twisting her ankle while running a few days before. The GP mentioned in passing that he was also a keen runner and the patient asked him to recommend a couple of local running groups as she had just moved to the area. The consultation was otherwise uneventful and the patient left with a prescription for a non-steroidal anti-inflammatory gel.

A week or so later the GP received a friendship request from the patient on his Facebook account. He unthinkingly accepted the request but quickly regretted his decision after the patient posted flirtatious comments underneath several photos on his page. The GP tried to ignore this but a few weeks later the patient made another appointment, this time complaining of breathlessness. The GP found nothing amiss on examination and when he asked her about her symptoms she was evasive. The patient later messaged the GP, confessing the appointment was a ruse to see him and suggesting that they meet for a drink.

Our advice

When the GP contacted us, he was advised not to respond online and instead to write to the patient explaining that the relationship between them was purely professional. He also needed to ‘unfriend’ her in order to avoid further blurring the professional boundaries. The GP followed this advice, apologising to the patient if he had inadvertently given her the wrong impression.

Shortly afterwards the patient unfriended the GP and he later discovered she had registered with another practice.

References

1. GMC, Doctors’ use of social media (2013), paragraph 11.
2. GMC, Doctors’ use of social media (2013), paragraph 8a.
3. GMC, Doctors’ use of social media (2013), paragraph 19.
4. GMC, Financial and commercial arrangements and conflicts of interest (2013)
5. GMC, Doctors’ use of social media (2013), paragraph 15.
6. GMC, Doctors’ use of social media (2013), paragraph 17.
A GP practice is taking action to improve the way it protects patient information after a breach of the Data Protection Act 1998 led to a warning by the Information Commissioner.

The breach occurred when the practice used a free web-based email account to inform patients of upcoming smear test appointments. Patients later received an email from hackers using the same email account, posing as a doctor and asking them to give their bank account details. The practice was alerted, and the email account was closed.

Each GP practice is the “data controller” for information held by them about their patients under the Data Protection Act 1998. Data controllers have obligations in respect of data, particularly sensitive personal data. One obligation is that information is held securely and appropriate measures are in place to guard against accidental, unauthorised or unlawful loss of data. The Information Commissioner’s Office (ICO) is the independent organisation that upholds information rights and can investigate complaints about how data controllers handle information.


Since 1 April 2013, when PCTs ceased to exist, patient complaints which would formerly have been made to the local primary care body should now be directed to the commissioner of services – that is, either NHS England or the local Clinical Commissioning Group. The complaint will then be passed to a Local Area Team (LAT) which will seek consent from the complainant before contacting the practice for comments. At this stage, in order to preserve the professional relationship between the practice and the patient, we usually advise the practice to offer to respond direct. In cases where the complainant does not want to deal directly with the practice, the response can be sent to the LAT which will then draft a response. However, most complainants are happy for the practice to respond to them, with a copy to the LAT.

If the complainant is not satisfied with the response, they can refer their complaint to the Ombudsman. NHS England is not able to respond to complaints where the practice has already provided a response.

Exceptionally, a complainant might not allow the LAT to contact the practice but in such cases any response the LAT could provide would be limited by lack of information.
**New president of RMBF**

The Royal Medical Benevolent Fund (RMBF), the UK’s leading charity for doctors, medical students and their families has welcomed a new President and a new Chair of Trustees.

The RMBF’s new President, Parveen Kumar, is Professor of Medicine and Education at Barts and the London School of Medicine and Dentistry, Queen Mary, University of London; and honorary consultant gastroenterologist and general physician at Barts and the London NHS Trust and the Homerton University Hospital Foundation Trust. Parveen is a former President of the Royal Society of Medicine and the BMA. She is currently chair of the BUPA Foundation and a trustee of other charities.

The new Chair of Trustees is Roger Jones, Editor of the British Journal of General Practice, Emeritus Professor of General Practice at King’s College London and Provost of the South London Faculty of the RCGP. He was formerly Dean of Teaching for the Health Schools at King’s College London, Dean for External Affairs at Guy’s, King’s & St Thomas’ School of Medicine and Executive Director at the Centre for Caribbean health.

RMBF CEO Steve Crone said, “We’re delighted to welcome both Parveen and Roger and I look forward to working with them. Demand for the RMBF’s services has increased dramatically over recent years so our new President and Chair join at an exciting and challenging time for the charity.”

Find out more by visiting [rmbf.org](http://rmbf.org)

**Managing performance concerns of doctors on the Performers List**

NHS England has published two guidance documents¹ to help NHS England Local Area Teams (LATs) manage concerns about GPs on the Performers List in a consistent, reasonable and proportionate way.

When concerns are raised about a GP’s performance, an NHS England senior manager responsible for quality and performance will undertake a preliminary investigation to establish the facts. Their report is then considered by a Performance Screening Group, which decides if there is a case to answer.

If there is a case, the concerns can still be dealt with locally. But if the concerns are serious or local support mechanisms have not resulted in improvement in performance then a doctor can be referred to a Performers List Decision Panel.

The final stages in the procedure are remediation and closure. There is also guidance about liaison between organisations investigating the same facts (e.g. LAT and GMC). The documents emphasise the importance of the role of Responsible Officers, who are accountable for effective governance systems that allow the identification, management and support of doctors about whom there are performance concerns.

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¹ References

NHS England, Policy for the identification, management and support of primary care performers and contractors whose performance gives cause for concern (2013) [http://bitly/goodpractice40](http://bitly/goodpractice40)

NHS England, Procedure for the identification, management and support of primary care performers and contractors whose performance gives cause for concern (2013) [http://bitly/goodpractice41](http://bitly/goodpractice41)
Causes for concern?

GPs have a duty to raise concerns but there may be times when you may need to balance your duty to protect confidentiality against your duty to protect patients and the public at large. Test your knowledge of this difficult ethical area with this quiz.
You are a GPST. During a check-up, a woman confides her fears about her daughter’s new boyfriend. She tells you he has a short temper and her young grandson is afraid of him. She asks whether you had noticed any problems when her daughter attended the previous month and begs for advice. How do you respond?

A. Explain that you can’t discuss the welfare of another patient and tell her that there is probably nothing to worry about. Her grandson probably resents having a rival for his mother’s affection.

B. You know that children living with their natural mother and a boyfriend are at greater risk and you decide to report the matter to social services straight away. There is no time to lose so you do not seek advice or talk to the child’s mother first.

C. After explaining to the grandmother that your duty of confidentiality prevents you from discussing another patient, you seek advice from your trainer because you are worried about what you have been told. With their agreement, you invite the daughter to visit the surgery. When she attends, you ask her about her situation and explain your concerns about her child. She eventually gives her reluctant consent for you to speak to the local designated person for child protection.

Correct answer: C

You have a duty to act on any concerns you have that a child may be at risk. The child’s interests should take precedence over those of parents or carers. If a child is at risk or is suffering abuse or neglect, it will usually be in their best interests to disclose information.

The GMC’s guidance Protecting children and young people: The responsibilities of all doctors¹, says that you would be justified in taking action, as long as your concerns are honestly held and reasonable and you take action through appropriate channels. You are not expected to investigate the concerns yourself; indeed this could be counterproductive.

Your duty of confidentiality means that you should usually ask for consent to share information unless there is a compelling reason not to do so, for example if it would put the child at further risk.

While providing locum cover, you are asked to attend a nearby NHS care home for adults with learning disabilities where several patients are suffering from gastroenteritis. During your visit you notice an unpleasant smell and discover that one of the patients is lying in her own excrement while patients in the communal areas appear listless and unkempt. When you speak to the manager, he does not seem shocked. Instead he tells you that his staff are very busy but they will get to the patient as soon as they can. What do you do?

A. Conclude that the staff are probably overstretched because of the outbreak of sickness and decide to ask one of the other practice GPs to visit later that week to check things are back on track.

B. You are upset by what you have seen and not satisfied by the manager’s response. After discussing the matter with a colleague at the practice you decide to report your concerns about the lack of care directly to the Care Quality Commission (CQC) or the local equivalent. The CQC makes an unannounced inspection several days later and takes enforcement action.

C. You are so appalled by the neglect that you decide to research the home during your lunch break. When you discover a local campaign group has been calling for the home to be shut down, you contact the group’s organisers and pass on your concerns.

Correct answer: B

If you believe that patients are not receiving the basic care to meet their needs, the GMC expects you to immediately tell someone who is in a position to act straight away². As you are not satisfied with the manager’s response and there is an immediate risk to patients, you would be justified in contacting a body with the authority to investigate (which may be the CQC for practices in England, or the local equivalent).

Only consider making your concerns public if you have done all you can to raise the matter through the appropriate channels and have good reason to believe patients remain at risk. Before taking this step, the GMC says you should get advice from your medical defence organisation or one of the other organisations listed in Raising and acting on concerns about patient safety. You can also seek advice from the NHS and Social Care Whistleblowing Hotline on 08000 724 725 (open 8am until 6pm, Monday to Friday).
A long-standing patient has recently been diagnosed with Alzheimer’s disease. When she attends for review you discover that she drove herself to the surgery. You are concerned about the risk she poses to other road users but you also know she lives alone and wants to remain independent as long as possible. What should you do?

A. Talk to the patient about your concerns and explain that she has a legal duty to inform the DVLA that she has a condition that might impair her ability to drive. When she refuses to accept this, you offer to arrange a second opinion but tell her that she should not drive in the interim and make a note of your advice. Warn her that if she does not inform the DVLA and continues to drive against your advice you will have to do so yourself.

B. You warn the patient that she might have to give up driving but because she is in the early stages of the disease, you decide she doesn’t actually pose a risk. You have a quiet word with the patient’s daughter who is also a patient and ask her to keep an eye on her mother.

C. You believe that the patient is a danger to others if she continues to drive and you inform the DVLA because you cannot trust her to do so.

**Correct answer: A**

It is for the DVLA, not a GP, to determine whether a person is medically unfit to drive but you do have a responsibility to warn the patient if their condition may affect their ability to drive. The GMC says that in these situations you should make every reasonable effort to persuade patients to stop driving, including discussing your concerns with family members, with the patient’s agreement. If the patient continues to drive despite your advice you would be justified in informing the DVLA but you should try to tell them of your intentions and notify them in writing afterwards. You can disclose relevant medical details to the DVLA’s medical advisers in confidence.

You may also find it helpful to review the following guidance:

Dr Emma Sedgwick is a director of Healthcare Performance Ltd, who run a number of workshops for the MDU, including effective patient and colleague communication and medical ethics and law. Find out more by visiting themdu.com/learn

The MDU medico-legal advice line is available to answer any questions you may have about raising concerns. Call 0800 716 646 between 9am-5pm Monday to Friday. For medico-legal emergencies, or urgent calls, the helpline is available 24 hours a day, 365 days a year.

**References**
Information the GMC holds about complaints

The GMC uses its website and other material to inform doctors of the way it uses information, but from our conversations with members and representative organisations, we believe many doctors do not know that it may hold information about them.

The GMC closes less serious cases after initial assessment, but holds information about the doctors concerned indefinitely. The doctors involved will not usually be notified that there has been a complaint.

The complaints in question are those which the GMC decides do not raise a concern about fitness to practise. The GMC does write to the doctors involved if it decides not to investigate allegations relating to something that took place more than five years ago. It must have the complainant’s consent to do so.

However, it does not tell doctors about the other cases it closes after initial assessment. Looking at the GMC’s figures for 2012 alone, this would include many of the 6,240 cases that were closed at this stage.

Under current arrangements, details of these complaints are kept on file indefinitely. The GMC consulted last year on changes to its policies about how long it keeps information. Under those proposals, in future this information will be kept for four years, at which time the original record will be destroyed but the GMC will keep a summary record indefinitely.

The summary record will contain the complainant’s name, the doctor’s name, the date of the complaint, a brief description of the issue and the reason for closure. The GMC says its purpose for keeping this information is to enable it to respond to future enquiries about whether it had received specific complaints.

The GMC would not normally disclose information about cases closed after initial assessment but says there may be circumstances where it would consider it appropriate, for example, in response to a public enquiry about subsequent serious concerns.

We have raised concerns with the GMC about the practice of retaining a summary record. As the complaints have not been investigated, the GMC has no way of knowing whether the allegations in the summary record are accurate. The doctor is unaware of the complaint and has not been given an opportunity to comment on the factual accuracy of the information held, or any other aspect of it.

In support of this policy, the GMC has said it is satisfied it is not breaching the data protection requirements in respect of doctors whose information it is processing in this way. Under the Data Protection Act 1998 doctors can request access to any information the GMC holds about them, including a summary record, if one exists. The GMC would also have to disclose such a complaint if it wished to use it because it was considered material to a further investigation about the same doctor. The GMC consulted on both aspects of this policy during 2012 and the majority of respondents supported it.

For the MDU’s part, we can see that seeking consent from around 6,000 complainants and then writing to around 6,000 doctors in circumstances where the complaint is not being pursued would have considerable financial and administrative implications. The GMC needs to consider the potential impact on registration fees, and the effect on individual doctors of knowing that a complaint has been made.

However, we cannot support the practice of making a summary record after four years and keeping the information indefinitely. We believe the information should be destroyed at that stage. We are bringing this to members’ attention because the information retained might be about you, and we want to make sure you know what is happening.

Dr Mike Devlin
Head of advisory services

Reference
1. GMC, Report on the Outcome of the Consultation on GMC’s Records Retention Policy, (5 December 2012)
An apparently uneventful consultation can come back to haunt doctors, sometimes many years later. Dr Nicola Bailey, our newest member of the medical claims team and former GP, explains to interviewer, Susan Field, why nothing can ever be routine in general practice.

Following a busy morning surgery, GP Nicola Bailey was on her way out to make a home visit. As she left a receptionist asked if she could spare a moment to sign a prescription for co-codamol*, a drug the patient had been prescribed before for her back pain.

She remembers: “Although it sounded OK, for some reason an alarm bell went off in my head and I decided to go back and check the patient’s records. It was only then I discovered she had picked up a two-week supply of co-codamol just a few days before. There could have been a reasonable explanation but it was also possible that the patient was overusing because she was unable to control her pain or more ominously she might be depressed which would make it dangerous for her to have that amount of the drug in her possession. If I had signed the prescription without checking, I could have put the patient at risk and put myself in a terrible position.”

The incident shows how easy it is for an apparently innocuous encounter to have potentially dreadful consequences, something that has been brought home to Nicola during her first few weeks in the MDU’s claims team.

The former GP partner in Greater Manchester had long been interested in medico-legal work but despite her knowledge of the legal process, Nicola’s introduction to the world of clinical negligence has changed her perspective on her own career in general practice.

She says: “I always assumed that if I received a claim it would be for a terrible mistake with immediate repercussions for the patient but since I began my training at the MDU it’s been brought home to me how many seemingly ordinary jobs have the potential to go wrong without my even noticing.”

Take the routine task of reviewing blood tests. Nicola recalls she used to check up to 60 results each day: “The lab had a fail-safe system so anything outside certain parameters would prompt a phone call to the practice. When a blood count did not trigger the fail-safe but was still outside the normal range, it was up to us to spot it and check the patient’s records. I used to take a break if I felt I'd begun to work on autopilot but it’s easy to imagine a situation where I had become distracted for a moment, pressed return and brought the next record up. What if that split second’s inattention meant that I had missed a case of anaemia in an elderly patient, something which might easily be a symptom of bowel cancer? That might have caused a delay in reaching the correct diagnosis and adversely affected the patient’s prognosis. It could also have left me vulnerable to a clinical negligence claim.”

Diagnoses
Allegations of delayed diagnosis and referral are actually one of the most common reasons for claims against GP members. Between 2008 and 2012 we paid out over £28million on behalf of GP members to settle 17 negligence claims involving delayed diagnosis of meningitis. But as Nicola explains, while meningitis is thankfully rare, the early features are often the same as those of minor viral illnesses which require no treatment. “A GP might only see one or two cases of meningitis in a lifetime of practice but they will see large numbers of feverish children and adults. Making the wrong call could be devastating for the patient, potentially causing serious irreversible injuries such as brain damage and the loss of limbs. It is also likely to result in a claim.”

* Details changed to preserve confidentiality.
Minor mistakes with devastating consequences

“Failure to diagnose a patient's condition is not necessarily negligent”, she adds, “unless the GP is unable to demonstrate their management was of a reasonable standard. That's why it is so important to keep a full clinical record of all interactions with patients, whether in person or by telephone or email. A note of your differential diagnosis, management plan and what you advised the patient is important for patient care and far better than relying on your memory or usual practice, especially as you might not receive a claim until many years after the consultation.”

Dr Nicola Bailey, MDU claims team

That is also why the MDU has called for a cap on future care costs and loss of earnings awards among a package of reforms to the civil claims system.”

GP's at greater risk
This is more important than ever because in the last decade, the MDU has seen the number of claims against medical members rise sharply – new claims notifications increased by 15% in 2012 alone although there is no evidence that clinical standards have slipped.

For Nicola, becoming a member of the claims team is a chance to defend and support hard-working GPs who are often shocked and distressed to receive a claim. "When I first qualified as a GP," she remembers, "I was distantly aware of the risk I could receive a claim but sadly this has almost become an everyday hazard for the profession. Yet it's also true that many of the incidents which prompt claims rarely stand out as significant moments in a GP's day and I'm sure that like me, many GP members might experience an uncomfortable twinge of recognition when they hear about the circumstances and understand that it could easily have happened to them.

It seems to me that the key to avoiding becoming one of the statistics is being aware of the potential risks in everyday situations and taking steps to address them, from implementing systems which flag up missed reviews and high risk medication to ensuring that lessons are learned from every significant event.

Clinical negligence is a highly specialised and complex area of law and certainly not something that doctors would ever want to face alone, quite apart from the eye-watering sums involved. So if the worst does happen remember to alert the MDU’s claims team straight away for expert support and advice. After all, it is what we are here for.”

GPs at greater risk

Nicola has been surprised at the size of the claims she has seen in her first few weeks at the MDU and suspects GP members would be alarmed to hear that awards of £5million or more are not unusual. This is because in addition to general damages for pain, suffering and loss of amenity arising from the injury or illness, the claimant is entitled to special damages for the financial consequences such as loss of earnings and the cost of care over their projected life span. The MDU's largest ever pay-out for a GP member was for a delayed diagnosis of meningitis in a child under one year old who required a high level of long-term care. It was settled for £6.8million in 2009.

However, even if the MDU and the member agree that a claim should be settled, Nicola and her colleagues still need to negotiate with the claimant's lawyers to determine a level of compensation which is fair to both parties. She reflects: "Negligently damaged patients should be compensated but we must try to ensure the level of compensation is appropriate in the interests of all our members and the public. After all, it's not in anyone's interest for claims awards to inflate beyond society's ability to pay for them.
A GP had recently joined a practice. One of her first appointments was seeing a 14-year old boy who presented with oedema. He had recently suffered nephrotic syndrome and, following discharge, had been well for several weeks until the oedema returned. The GP found that, although his blood pressure was satisfactory, a urine dipstick test showed the presence of protein. There were letters from the consultant paediatrician in the notes indicating that the boy had been followed up for some time in the paediatric clinic and then discharged with a recommendation that he should have his blood pressure and urine tested every fortnight at the GP practice. That had not happened.

The GP made an urgent referral back to the consultant paediatrician. The GP was concerned that the recommended testing had not happened at the practice and she mentioned her concerns to a senior colleague. After some weeks nothing had happened, so she contacted us for advice.

The GP has a duty to act if she believes patients are at risk because of inadequate policies or systems. Rather than simply telling her colleague what has happened, she should use the established practice procedures for reporting adverse incidents and near misses, in line with the GMC’s guidance in *Raising and acting on concerns about patient safety* (2012) and the obligation set out in *Good Medical Practice* (2013) to “contribute to adverse event recognition” (paragraph 23b). She should also keep a record of her concerns, relevant conversations, correspondence and the action she has taken for future reference. In the circumstances, the practice will probably hold a significant event audit to investigate why the patient had not been regularly tested in accordance with the recommendations by the consultant paediatrician.

Our advice

The GP spoke to the practice manager who asked her to complete a significant event incident form. The case was discussed at the next practice significant event audit meeting where it was decided that the system for reviewing hospital letters needed to be improved. Following the practice’s established significant event procedures, the incident was logged with the National Reporting and Learning Service.

Outcome

The GP spoke to the practice manager who asked her to complete a significant event incident form. The case was discussed at the next practice significant event audit meeting where it was decided that the system for reviewing hospital letters needed to be improved.

Other sources of help include the NHS whistleblowing helpline (08000 724 725), the GMC’s confidential patient safety helpline (0161 923 6399), or the charity Public Concern at Work (020 7404 6609).

**Learning points**

- If you have a concern about patient safety, it’s your responsibility to raise this immediately using your practice’s policy.
- Put your concerns in writing and record the steps you have taken to resolve them.
- Establish that appropriate action has been taken to investigate and act on your concerns. If you believe patients are still at risk, consider taking the matter further.
- Contact the freephone medico-legal advice line about escalating your concerns, on 0800 716 646. Our medico-legal team is available between 9am - 5pm Monday to Friday and is available for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.
- Other sources of help include the NHS whistleblowing helpline (08000 724 725), the GMC’s confidential patient safety helpline (0161 923 6399), or the charity Public Concern at Work (020 7404 6609).
Self-harming teenage girl

A 14-year old girl visited her GP because of headaches. When she rolled up her jumper sleeve so he could take her blood pressure, he noticed superficial cuts on her upper arm and some scarring. When asked about this, the patient admitted she had been cutting herself for the past six months because it seemed to help with the pressure she was under at school. She begged the GP not to tell her parents as she was worried about their reaction. However, he was worried the girl was at risk and contacted us for advice.

**Our advice**

If the teenager has capacity to make this decision, then the GP owes the same duty of confidentiality to her as to her adult patients. If the patient was unable to trust him not to disclose information without her consent, it may deter her from seeking help in future and, given her already vulnerable state, this could be detrimental to her health.

In line with the GMC’s 0-18 years: guidance for all doctors, every reasonable effort should be made to encourage the patient to involve her parents. The guidance also says that doctors should usually respect a young person’s decision not to do so if they have capacity.

Doctors can only disclose information about a competent young patient without consent if required by law, if there is an overriding public interest which outweighs their right to confidentiality or where disclosure is in the best interests of a young person who does not have the maturity or understanding to make a decision about disclosure.

In this case, sharing information with the girl’s parents may be in her best interests because it would enable them to understand the pressure their daughter is under and provide support.

The GP would be wise to assess the young patient’s capacity, the level of risk to her and discuss the case with a specialist or a child protection lead before deciding whether to disclose information.

If he decides that disclosing information to the girl’s parents without her consent is justified in her best interests, the GP should still tell her of his intentions, unless that would undermine the purpose of the disclosure or put her at increased risk. He should also record the decision and the reasons for it in the patient’s notes. The disclosure should be made promptly and be the minimum necessary for the purpose.

**Outcome**

The GP asked the patient to return to the surgery the following day for a further consultation when he explained to her why he felt it important to involve her parents. The patient reluctantly consented and the GP arranged a home visit to talk with the family. With the support of her worried parents, the girl was referred to the mental health team for treatment.

**Learning points**

- Young patients with capacity have the same rights to confidentiality as adults but it is usually in their best interests to involve their parents if the patient consents.
- Decisions about the best interests of young patients are often best made with others. If you are not sure whether to raise concerns about a young patient, seek advice from the local child protection lead or an experienced colleague with appropriate expertise.

**References**

Meningitis is a rare disease and notoriously difficult to distinguish from other illnesses in its early stages. Dr Sharmala Moodley, deputy head of claims at the MDU, discusses the incidence and outcomes of meningitis claims.

With an incidence of approximately three cases per 100,000 people each year, meningitis will present just once or twice in the average GP’s career. Successful immunisation campaigns have reduced its incidence further, and it is conceivable that in future many GPs may never see a case in their clinical practice.

However rare the condition, a failure to diagnose can have devastating consequences. The patient may not survive, and many who do suffer catastrophic brain and limb damage.

This is one of the main reasons negligence claims involving meningitis are brought, and compensation can run into millions of pounds, especially where a young child requires life-long care.

General practitioners see a large number of febrile young children and unwell adults. The early features of meningitis are often the same as those of minor viral illnesses, of which children are likely to develop several in the first two years of life. By the time a doctor sees the patient, the symptoms may still be indistinguishable from other more common conditions and these diseases do tend to progress very rapidly.

The warning symptoms and signs differ depending on the age of the child. It is because the outcome for the patient is so devastating that there can be a tendency to assume, with hindsight, that it could have been different. Our experience of defending meningitis claims is that information in the records is often incomplete and there is generally a dispute of facts.

In a review of selected settled meningitis claims against our members, the principal conclusion is that a fuller clinical note of the history and examination findings along with documentation of the follow-up advice given may make it easier to defend a claim.

In the cases reviewed, the factual dispute always related to the clinical condition of the patient at the time they were seen by the doctor. Other areas where the doctor was vulnerable to criticism included:

- note keeping, in particular failure to record negative findings, including state of alertness and photophobia
- failure to document the patient’s temperature
- lack of safety netting advice.

Without these vital pieces of information, it becomes difficult to establish the exact clinical sequence of events, which in turn impacts on the determination of breach of duty and causation, as the case studies that follow show.

Practitioners often note that a child is well. This is a subjective assessment. In clinical negligence cases, experts and judges prefer a more objective analysis.

Where there is a factual dispute, the documentation of objective findings helps establish the clinical condition of the child at the time of the consultation.

Documentation of the patient’s state of alertness, colour, temperature, respiratory rate and capillary refill (as set out in the NICE feverish illness in children guidance), along with negative findings, may not assist in the diagnosis of meningitis but may help in the defence of a claim.

Consideration should also be given to recording negative findings and safety netting advice about follow-up arrangements.

Learning points
A 38-year-old patient contacted the out-of-hours service over a weekend. The triage notes indicated that the patient had a cold and a bad earache. An out-of-hours MDU GP telephoned the patient who gave a five-day history of cold symptoms, shivers, deafness in the right ear and left ear ache that had been eased by analgesia. The patient was advised to continue with the current treatment of analgesics and anti-inflammatories.

Ten hours after the first consultation the patient phoned back and was advised to attend the out-of-hours base. On arrival, she was seen by a second MDU GP who recorded a history of frontal, bilateral headache and 24 hours of throbbing ear pain and sweating. She had a temperature of 40° and a pulse of 112 beats per minute. The GP diagnosed acute left otitis media and prescribed erythromycin. The patient was advised to see her own GP the following day.

Twelve hours later, the patient was found collapsed at home and an ambulance was called. On admission to the emergency department with a GCS of 8/15 and a pyrexia, a diagnosis of pneumococcal meningitis was made. The patient suffered hemiplegia.

Some three years after the event, the patient brought a claim against the second GP, alleging that the doctor should have referred her to hospital immediately. The claimant’s solicitors advised that if she had been referred, a lumbar puncture would have been undertaken leading to the diagnosis and IV antibiotics would have been given earlier. With an earlier diagnosis, the claimant would not have suffered permanent neurological complications and would have made a full recovery.

The MDU asked an independent GP expert to advise on the GP’s standard of care. The GP expert advised that a pulse of 112 and a temperature of 40° are both abnormal to a degree that would be unusual for otitis media. The expert advised that it would be necessary to take care in assessing such a patient as the clinical signs were not sufficient to explain the earache and the bilateral frontal headache.

There was a factual dispute about whether the patient had neck stiffness and was drowsy. The GP member did not document the patient’s state of alertness nor whether she had neck stiffness or photophobia.

An expert opinion was also obtained from a consultant in infectious diseases who confirmed a clear association between acute otitis media and the local and direct spread of pneumococcal meningitis to the central nervous system. He advised that even with earlier treatment the patient would have still had neurological sequelae as a single dose of an appropriate IV antibiotic would have been insufficient treatment. The MDU instructed a consultant microbiology expert who agreed with this advice.

The claimant’s neurology expert said that if the diagnosis of meningitis had been made at the time of the consultation then it was likely that the patient would not have suffered permanent neurological complications. While pneumococcal meningitis is a severe illness with significant mortality and morbidity, the good prognostic factors in this case included the fact that the claimant was otherwise healthy.

A conference took place with the MDU barrister and the experts to review the merits of the claim. The barrister advised that the MDU member was vulnerable to a finding of negligence in view of the failure to record the negative symptoms and take account of the fact that the patient was systemically unwell. It was thought that the case on causation was finely balanced as to whether the patient would have avoided all of her neurological complications had she received antibiotics earlier.

The case was eventually settled for £250,000, a quarter of the damages originally claimed. There is an otitic aetiology in 30-50% of cases of pneumococcal meningitis. Hearing loss is a common finding and occurs early in the illness.
Case history

Child diagnosed with meningococcal septicaemia

A mother called her GP practice just after midday, requesting a visit for her two and a half year old son, who had a temperature of 41° with diarrhoea and vomiting. The mother had also noted spots on the child’s forehead. She was advised to bring her child to the surgery that evening.

Later in the afternoon, the mother called the practice again, making another request for a home visit, as she felt her child needed to be seen earlier. She told the receptionist her child was ‘flop and lethargic’.

An MDU GP member responded to this request and visited the child at home. She noted that the child had been unwell for 24 hours and had a temperature of 39°. On examination she found no abnormality, aside from a rash on the child’s limbs, which she thought was not haemorrhagic. The child remained pyrexial throughout the afternoon and continued to have diarrhoea and vomiting.

Some five hours after the GP’s visit, the parents called an ambulance and the child was taken to hospital where he was diagnosed with meningococcal septicaemia. Following intensive treatment, the child recovered, but unfortunately both feet and the tips of several fingers were amputated.

Five years later, a claim was brought against the GP member alleging that her assessment of the patient had been negligent. It was alleged that, at the time of the consultation, the child had photophobia, and that he was systemically unwell with a pyrexia and history of diarrhoea and vomiting. It was also alleged that as the child was lethargic and floppy, a greater level of care should have been given. It was alleged that had the GP referred the child to hospital, broad spectrum antibiotics would have been administered within 30 minutes and the child would have suffered no or no significant injury.

The MDU investigated the claim and obtained a number of expert opinions. A GP expert concluded that if a child was being described as unwell with a temperature of 39°; he would normally admit the child to hospital.

An expert in infectious diseases advised the MDU that septicaemia had probably started during the morning of the child’s illness. The crucial factor was the type of rash described by the mother. If the rash was haemorrhagic at the time the child was referred to hospital then, on the balance of probabilities, complications would still have developed but would have been less extensive. If the rash was non-haemorrhagic when the patient was referred and the child had received appropriate antibiotics, the septicaemia would have been controlled and the complications would not have developed.

An expert paediatrician concurred with this view and also commented that in about a third of cases of meningococcal septicaemia, the purpuric rash is preceded by non-purpuric, non-descript pink spots indistinguishable from many viral rashes that often accompany children’s illnesses. The experts agreed that the rash was non-haemorrhagic at the time of the GP consultation.

The GP member’s legal team advised that given the receptionist’s description of a lethargic and floppy child, the GP member’s note indicating that the child was unwell with a temperature of 39° and a rash, and the GP expert’s view that he would have admitted the child to hospital, it was likely that the claimant would succeed should the case proceed to trial. All experts agreed that, had the child been admitted, on the balance of probabilities he would have made a complete recovery.

Having heard the legal team’s advice, the MDU member advised that she would prefer the case to be settled. The MDU then instructed experts in rehabilitation medicine, orthopaedics, occupational therapy, physiotherapy, assistive technology, accommodation and educational psychology in an attempt to quantify the claim.

The orthopaedic surgeon confirmed that the child would remain severely disabled and that further surgery was unlikely to help. It was agreed that allowances should be made for wheelchair provision throughout his adult life, together with new prostheses every few years until adulthood.

An accommodation expert advised that the child would require a bungalow with sufficient space to accommodate the use of a wheelchair and room to extend and it was agreed that he would also benefit from physiotherapy and occupational therapy.

Although the claimant would have physical limitations on what he could do, it was deemed that he could gain employment in the future. The claimants pleaded their case on the basis of a full loss of earnings and large care costs into the future – an estimated sum of £5.5 million. After negotiation, the case was settled for £3.5 million.

Learning point

A temperature of greater than 38°, with vomiting and diarrhoea, may indicate a diagnosis other than gastroenteritis. Not all meningococcal rashes are non-blanching.

Dr Sharmala Moodley
Deputy head of claims
Keep in touch sessions are becoming commonplace to help employees who are new parents keep up to date with their job. Keep in touch sessions are a great opportunity to ease new parents back into practice, and to re-familiarise themselves with the working environment after some time away. The sessions offer the chance to catch up with colleagues, learn about the latest developments in primary care and also to brush up skills and knowledge.

Doctors on parental leave who participate in ‘keep in touch sessions’ or do occasional unsupervised sessions (within the terms of their leave arrangements) may receive a concessionary rate from us depending on the work that they do. Ring our membership team on 0800 716 376 to keep us up to date. Lines are open 8am to 6pm Monday to Friday, except bank holidays.

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We’re making it even easier for you to stay informed, even when you’re on the go. The MDU mobile site offers everything you’ll find on our full site, but designed for your phone.

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‘Keep in touch sessions’

‘Keep in touch’ and catch up sessions are becoming commonplace to help employees who are new parents keep up to date with their job. Keep in touch sessions are a great opportunity to ease new parents back into practice, and to re-familiarise themselves with the working environment after some time away. The sessions offer the chance to catch up with colleagues, learn about the latest developments in primary care and also to brush up skills and knowledge.

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The annual GP Enterprise Awards aim to seek out and highlight some of the best initiatives developed in hard-working surgeries that are the backbone of the NHS. The awards are run by GP magazine in conjunction with the RCGP and are proudly sponsored by the MDU.

This year’s winners demonstrate the breadth and variety of general practice, adding up to a real celebration of innovation in the profession.

### Outstanding practice team

**Robin Lane medical centre, Leeds**

The Robin Lane medical centre implemented a proactive model of primary care focused on wellbeing. The practice launched various initiatives to help them achieve this:

- a wellbeing centre which contains a volunteer centre, café and an education programme led by clinicians
- a community eye clinic
- a community newspaper funded by advertising
- an urgent walk-in centre for registered patients, which reduced overall demand for appointments by 26% (which won the Improving quality and productivity award)
- a volunteer programme which co-ordinates self-help groups
- an education programme led by clinicians
- a smartphone app that allows patients to book appointments, order prescriptions, send secure text messages, and set appointment reminders.

A proactive care team was launched, employing a community matron and a healthcare assistant trained in intermediate care. This led to a reduction in hospital and practice visits. Overall, the practice saw reduced patient demand, increased list size, and freed resources to invest in new staff and services.

### Innovative clinical care

**Frome Valley medical centre**

The Frome Valley medical centre reduced the number of patients frequently attending the surgery with symptoms not easily related to an identifiable medical condition.

The practice used the BATHE technique (Background, Affect, Trouble, Handling, Empathy) to help these patients develop the skills and confidence to manage their own health. BATHE aims to identify the problem, why they are struggling to deal with it, and ways to improve their confidence in tackling the issue.

When a patient requested an appointment, they were telephoned by the GP to establish whether a face-to-face consultation was needed.

Patients were offered participation in a patient support group and a quarterly newsletter was implemented. After nine months, the programme had saved £18,986 in GP appointments, unplanned admissions and referrals to secondary care.
Feature

Caring for vulnerable groups

Padiham medical centre, East Lancashire

Dr James Fleming launched the Green Dreams Project to provide local, community-based solutions to unemployment, isolation and reduced quality of life among patients. Dr Fleming noticed that some patients had multiple problems such as substance abuse, educational difficulties, relationship problems, life crises, poor housing, financial troubles and low self-esteem. These factors were having a detrimental effect on their physical or mental health. Under the new project, patients are offered voluntary work that raises their self-esteem and provides a route to paid employment. Activities have included the development of derelict land and the creation of groups to tackle isolation.

The community interest company started in January 2011 with one project worker, and there are now five, handling referrals from nine practices across seven towns.

Some 27% of patients who engaged with Green Dreams have seen directly attributable benefit to their mental or physical health, and 20% have markedly reduced their GP appointments.

RCGP First5 award

Overall winner

Dr Neil Metcalfe, York

This award is given to an individual GP who, in their first five years since passing the MRCGP exam, can demonstrate how they have made a positive and innovative impact on the NHS, by working to improve clinical care, patient services or healthcare systems.

Winner Dr Neil Metcalfe led a group of auditors whose aim was to determine whether the Ayling Inquiry’s recommendations on chaperone policy in acute trusts had been implemented in England. This led to the publication of follow-up study of chaperone use by hospital consultants, which revealed inter-specialty differences for male intimate examinations despite national recommendations. It also highlighted the medico-legal danger of only a minority of consultants documenting the presence of a chaperone for intimate examinations.

Dr Metcalfe’s own audit of breast examination documentation at a GP surgery led to a 300% increase in such documentation.

He has published more than 20 articles on a range of subjects, including advice on diabetes pen injection techniques in the BMJ and a critical analysis of the MRCGP AKT as an assessment tool in Education for Primary Care.

He has worked as a peer reviewer for the BMJ, and is a reviewer of the RCGP’s e-learning modules.

Dr Metcalfe was a founder of a First5 GP group in York and regularly organises external speakers for the group and for local GP registrars.

He has completed the PGCME and runs two successful student selected components at Hull York Medical School.

Best use of media and technology

Summercroft surgery, Orpington, Kent

The practice introduced a barcoding system to streamline the administration of its flu vaccination clinics. Previously, the practice had posted personalised invitations to eligible patients for flu jabs, which included a tear-off slip that they would bring with them to the clinic for data entry.

By adding a barcode on the tear off slip with the patient’s NHS number which automatically updated a spreadsheet, the practice dramatically reduced staff time and cut costs – it took two hours for data entry instead of spending 40 hours manually typing it in.

Improving quality and productivity

Robin Lane medical centre, Leeds

This practice launched an urgent care walk-in service for their registered patients, reducing the overall demand for appointments by 26%.

The walk-in service runs from 8am to 12pm, as part of its strategy to move away from an appointment-based approach for urgent care. Patients are asked to complete a consultation prep form to describe their symptoms and what they would like to get from the consultation.

Practice business partner Methven Forbes said the system removed the patient’s anxieties about obtaining an appointment: ‘The patient simply turns up and is seen in about 10-25 minutes at the latest.’

As well as reducing the overall demand for appointments at the practice by 26%, the clinic has led to an overall reduction in A&E attendance by 10%, based on CCG figures. Patient satisfaction has also increased, with complaints now averaging less than one per month, and one per quarter regarding appointments.

We would like to congratulate all the winners of the categories on their hard work and inspiring ideas.
Internet consulting

A young GP was approached by an online pharmacy asking him to provide a remote consulting and prescribing service to its patients. He was told that many of the patients required treatment for erectile dysfunction and cosmetic imperfections.

The GP phoned the MDU to seek advice about the medico-legal implications of remote consulting and prescribing.

In 2013, the GMC published updated guidance on prescribing. The guidance states that “You should prescribe medicines only if you have adequate knowledge of the patient’s health and you are satisfied that they serve the patient’s needs”.1

Some medications must not be prescribed remotely without examination. The guidance states that “you must undertake a physical examination of patients before prescribing non-surgical cosmetic medicinal products such as injectable cosmetic medicines and must not therefore prescribe these by telephone, video-link, or online”.2

For other prescriptions, doctors prescribing remotely must consider:

a. the limitations of the medium through which you are communicating with the patient
b. the need for physical examination or other assessments
c. whether you have access to the patient’s medical records.3

Communication with patients is key because, in order to comply with GMC guidance, prescribing doctors should have sufficient information about each patient’s history including:

a. any previous adverse reactions to medicines
b. recent use of other medicines, including non-prescription and herbal medicines, illegal drugs and medicines purchased online
c. other medical conditions.4

Doctors should fully explain to patients the likely benefits and side-effects of the medicines, what to do if things go wrong, and what monitoring or adjustments are likely to be necessary.5

Communication with the patient’s own GP is also important. If a patient has not been referred by their GP, the doctor should consider whether they have sufficient reliable information to prescribe safely, and should ask for the patient’s consent to contact their GP if more information, or confirmation, is needed. If the patient objects, the doctor should explain that the prescription cannot be provided, and explain the options.6

Unless the patient objects, the doctor must also keep the GP informed about any new medicines, or changes to existing medications, with information about the proposed duration of treatment, any monitoring requirements, and any new allergies or adverse reactions identified.7

Finally, doctors prescribing online should take care to avoid prescribing via websites that breach advertising regulations and should be aware that some of their patients might be making contact from overseas. If so, doctors may need to consider whether there are implications for import/export requirements, whether the doctor needs registration in the country where the medicines are to be dispensed and additional indemnity requirements.8

If doctors cannot satisfy these conditions they should not use remote means to prescribe for a patient.

On reflection of the advice given, the doctor felt that it might be difficult to provide a safe remote consulting and prescribing service for these conditions. He was disappointed, but thanked the MDU adviser for the chance to talk through his concerns.

Doctors who wish to prescribe online and/or provide advice over the internet should contact our membership team on 0800 716 376 to keep us up to date. Lines are open 8am to 6pm Monday to Friday, except bank holidays.

Some conditions are unsuitable for remote consultations because of the inability to conduct a physical examination, to monitor treatment and to provide appropriate aftercare.

Doctors have an ethical and legal duty to ensure that personal data and communication systems are secure and protected from unauthorised access.

Doctors must ensure that patients understand the limitations of online consultations and give informed consent.

Doctors should only prescribe if they have enough information about the patient, and sufficient dialogue with the patient, to do so safely.

Doctors should only prescribe remotely if they can fulfil all the requirements of the GMC guidance.

References
Set up a childcare voucher scheme at exclusive rates

**What is a childcare voucher scheme?**
Childcare vouchers, provided by Computershare Voucher Services Ltd, are a tax-free and National Insurance (NI) exempt scheme that enables employers to offer cost effective support to working parents. The vouchers are an employee benefit which means the value of the vouchers is deducted from the employee’s salary (without any tax or NI contributions). The vouchers are then supplied electronically to the parent to pay their registered childcare provider. There is no net cost to employers to set up a scheme.

**GROUPCARE members can now set up a childcare voucher scheme at exclusive, favourable rates.**

**Setting up a scheme:**
- improves your corporate reputation as a family-friendly employer
- is relevant for all staff with children up to 15-16¹
- helps you achieve NI savings of up to £402² per employee, per year
- assists you in the recruitment and retention of staff
- helps reduce absenteeism
- improves staff morale through recognising the need for a work-life balance.

**GROUPCARE members benefit from preferential rates, so the higher the tier, the more the practice can save.**

¹ September following 15th birthday or 1 September following 16th birthday for children who are registered disabled.
²Annual Employer NI savings for a Basic rate tax-payer taking the full £243 voucher value. The maximum savings available will be less for Higher and Additional rate tax-payers.

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