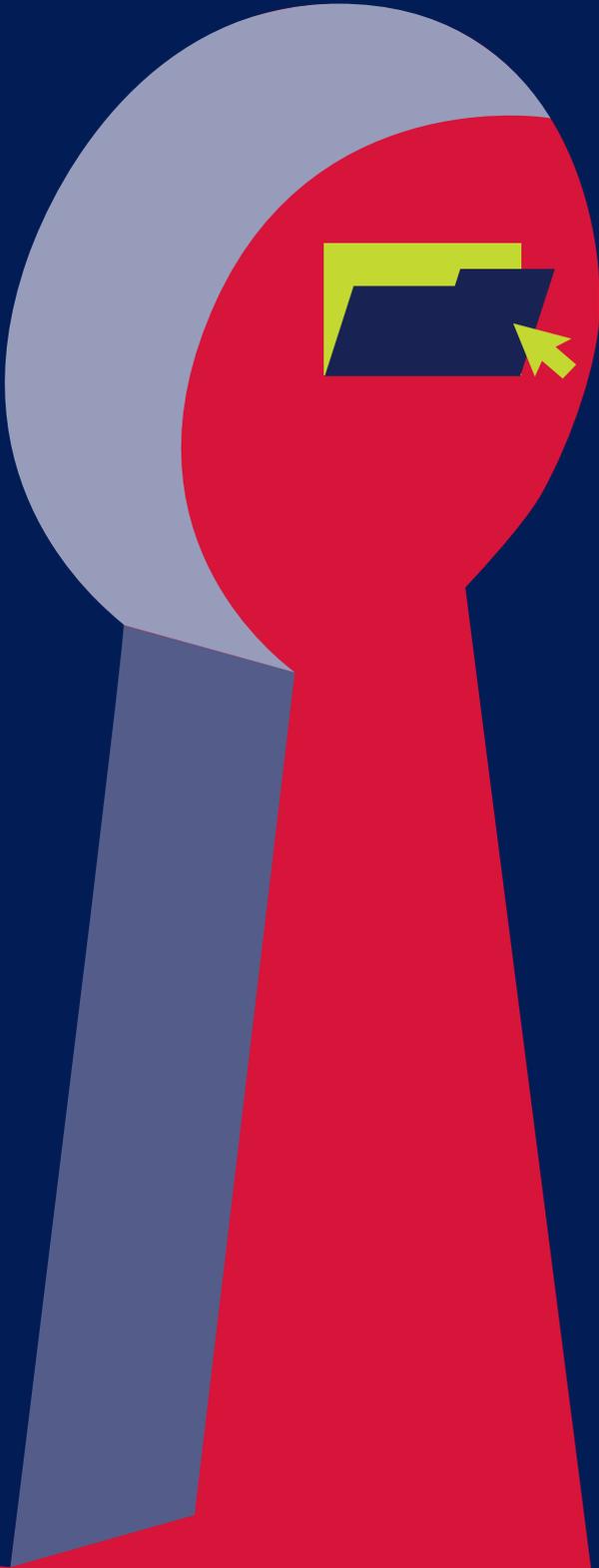


MDU

in·practice



Rights of
access

Volume 9
Issue 2
December 2013

in this issue

Features

04 Rights of access

11 Blurred lines

Membership

07 Meet Jane, GP liaison manager

07 Calculate your GPs' sessions

Quiz

08 Everyday decisions

News in brief

10 Medication error cases increase

10 DoH confirms delay in mandatory indemnity for nurses

10 CCTV in healthcare

Advice line dilemmas

06 Disclosing records to family members

12 Disclosure to the police

14 Sickness absence due to stress



Medical editor
Dr Beverley Ward



Managing editor
Nishma Badiani

Feedback

Please write to:

The editor, *inpractice*
MDUSL

230 Blackfriars Road
London, SE1 8PJ.

Or via our website:

themdu.com/feedback

ISSN 1749-3595

This is the fifteenth issue of *inpractice*, published for members of the MDU in the UK. The medico-legal advice in *inpractice* is for general information only. Appropriate professional advice should be sought before taking or refraining from action based on it. Opinions expressed by the authors of articles published in *inpractice* are their own and do not necessarily reflect the policies of the Medical Defence Union Limited.

The MDU always seeks to offer attractive benefits as part of membership and as such, from time to time, may add, withdraw or amend benefits at its discretion. Visit themdu.com for the latest information of the benefits included in membership.

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited, registered in England 3957086. Registered Office: 230 Blackfriars Road, London SE1 8PJ

© 2013 JNL204-1312 - *inpractice* journal
December 2013

Contact us

UK

Advisory

0800 716 646

Membership

0800 716 376

From a mobile
or overseas

+44 (0)20 7022 2210

Email

membership@themdu.com

Website

themdu.com

Ireland

Advisory

1800 535 935

Membership

1800 509 132



@the_mdu



Available on the
App Store



ANDROID APP ON
Google play



Corporate member of
Plain English Campaign
Committed to clearer communication

521



MIX
Paper from
responsible sources
FSC® C105395

Introduction from the medical editor

One of the reasons practice managers say they enjoy their jobs is because of the hugely varied nature of their work. Unfortunately, this means that you need to have extensive knowledge of a wide range of subjects both related to your role in helping care for patients, and also in your role as employers.

A common theme in the queries we receive from practice managers relates to requests for access to records or information about patients. This can be a complex area, and so we always encourage you to contact us whenever there is doubt about how to proceed.

In this issue, medico-legal adviser Dr Shelagh Turvill explains how to deal with requests by patients to access their own records, as well as factors to consider when a request is made to access the records of a deceased patient. Dr Turvill outlines the limitations, timescales, charges and extent of disclosure of the records.

Another medico-legal adviser, Dr Kathryn Leask, describes a common scenario, when the police approach a practice asking for patient records. Turn to page 12 to find out about the advice we gave and the learning points for this scenario.

As part of your knowledge on a wide range of subjects, practice managers need to know about employment law, which can often be a complex area. Test your knowledge with a quiz, written by Nicola Mullineux from Peninsula Business Services, as well as a helpful dilemma about dealing with sickness absence relating to stress on page 14.

For doctors, treating work colleagues is generally discouraged, for sensible reasons, as lines can become blurred. Dr Sally Old explains the issues and pitfalls to avoid.

I hope you enjoy reading this edition of *inpractice*. Of course we always welcome any feedback you might have. ■

Dr Beverley Ward

Medical editor



Rights of access



GP practices need a consistent approach to requests for clinical records from patients and their representatives, says Dr Shelagh Turvill, our medico-legal adviser.

A patient's legal right to apply for access to their medical records has long been established but practices are not always confident about how they should respond, particularly when the request is from a third party or if the patient has died.

They are not alone. The Information Commissioner's Office (ICO) says that "many organisations still need to improve their processes for dealing with [access] requests"¹. As well as publishing a code of practice on responding to requests for personal information², the ICO is now reviewing the information organisations provide on their websites about access requests. It plans to publish its findings next year.

If you are a data controller, we advise you to check that your practice's policy on records access is easily accessible on the practice website and available to any patient on request. This is in line with the Care Quality Commission's *Essential standards of quality and safety* (for England only) which says that those using a service should be confident that "they, or others acting on their behalf ... can access, and where appropriate, contribute to the record"³.

Here are some of the areas that your access policy needs to cover to help ensure your practice complies with its legal and ethical obligations (and avoid complaints). We also recommend you regularly review the policy and ensure staff understand and follow the procedures it sets out.

Records ownership

Patients do not own their medical records and are not entitled to keep the originals but under the Data Protection Act 1998, they do have the right to view their records and have copies of them.

Who makes the request?

In most cases this will be the patient but you will still need to confirm their identity to ensure you do not breach patient confidentiality.

If a third party submits an access request on behalf of a patient (such as a solicitor), they should be asked for evidence of their authority to act for the patient. This includes the patient's written consent or the necessary legal authority, for example a certificate of Lasting Power of Attorney. Where someone with parental responsibility submits a request for the records of a

competent child, the child's consent should be sought.

Access limitations

Access can be limited or denied if it would be "likely to cause serious harm to the physical or mental health or condition of the data subject or any other person", unless it is information of which the patient is already aware. In such cases, there must first be an assessment by the doctor responsible for the person's clinical care and we advise you to make a record of this in case the person requesting access later makes a complaint to the ICO or applies for a court order. In circumstances like this, you can seek advice from our medico-legal advice line.

Timescales

You should respond to subject access requests within 40 days of receiving them or sooner if possible.

Charges

You can charge a maximum of £50 for copies of paper records or £10 for electronic records (including postage). Ensure patients are aware of charges before proceeding. However, it should be free for patients to inspect medical records which are held manually if they have been updated in the last 40 days.

Confidentiality

If a copy of the record is requested, this should be sent by secure means such as recorded delivery.

If the patient or their representative wants to directly inspect the records, it's sensible to consider whether this should be supervised by a health professional or administrator to protect the confidentiality of other records.

The extent of disclosure

You can 'black-out' part of the record or withhold specific documents which relate to third parties, unless you are able to get consent from the person named. Information about the patient written by other healthcare professionals involved in their treatment may be disclosed. This can be a complex area and you can seek advice

from our medico-legal advice line before proceeding with the request.

Assistance

You will need to make a reasonable adjustment for disabled patients who find it impossible or unreasonably difficult to make a subject access request in writing, for example, by accepting their verbal request.

The ICO also expects you to help patients understand the contents of their records. For example, you may need to spell out acronyms and be prepared to explain diagnoses and treatments in more detail.

Correcting factual errors

Patients can question the content of their records but an entry should not be amended simply because they do not agree with or like it. If factual corrections are made, it should be immediately obvious who made the amendment and the time and date it was changed.

Requests relating to deceased patients

These usually relate to concerns about the treatment the patient received (if you suspect this is the case then contact our medico-legal advice line), an insurance company investigation or where there is a dispute about the patient's will and their testamentary capacity.

Rights of access to the records of deceased patients are covered by the Access to Health Records Act 1990 and the Access to Health Records (Northern Ireland) Order 1993 rather than the Data Protection Act 1998. The right to make a request under the Act applies to the deceased's personal representative, the executor or administrator of their estate, or any person who may have a claim resulting from their death. Applicants should be required to make their request in writing, providing evidence of their identity and in support of their claim.

Other access requests will need to be considered on a case-by-case basis, bearing in mind the patient's right to confidentiality extends beyond their death. If the patient had previously asked that access should not be given,

a note should have been made on their records and their wishes should usually be respected. However, in many cases the patient will not have left any indication of their wishes and you will need to make a judgement based on the content of the record, the reason and source of the request, and your knowledge of the patient's wishes. It's also important to consider the extent of the disclosure. For example, where the applicant has a claim arising from the patient's death, access should be limited to relevant information. As with other medical records, the practice may need to withhold information if it might cause serious harm to an individual or if it relates to a third party other than a health professional who has not consented. ¹

Call our medico-legal advice line

Our medico-legal team are on hand to advise you with queries regarding disclosing records.

Call **0800 716 646** or email us at advisory@themdu.com

Lines are open 9am-5pm Monday to Friday. We provide an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.

References

- 1 ICO, *New ICO subject access code of practice helps organisations give people control over their data* (8 August 2013). <http://bit.ly/inpractice24>
- 2 ICO, *Subject access code of practice* (August 2013). <http://bit.ly/inpractice25>
- 3 CQC, *Essential standards of quality and safety*, (March 2010) page 172. <http://bit.ly/inpractice26>

Disclosing records to family members

A practice receives a call from the father of a 21-year old patient with a history of drug addiction who recently died following an overdose. He wants access to her medical records because he is convinced his daughter had sought help with depression from her GP and claims the practice failed her. Records show that the patient had had a termination when she was 16 and she had specifically requested that no one should be told about this. The practice manager rings us for advice.

Our advice

The practice has a duty of confidentiality to the patient which continues after her death. While the Access to Health Records Act 1990 makes provision for access by the patient's personal representative, this is not an absolute right.

In this instance, the father should not be given access to information which the patient would not have expected or consented to be disclosed. This includes details of the termination but may also include information about her mental health if it was considered this might be related to the termination procedure. Nor could he be given access to any information which might allow others to be identified without their consent, e.g. the person who supplied her with drugs.

You therefore need to decide whether the father could be given access to the records with this information 'blacked out' or if it would be better to invite him to meet the patient's GP first to discuss her care, making clear that the patient

herself wanted some information in her records to remain confidential. This would also be an ethical response as the GMC states that doctors "must be considerate to those close to the patient and be sensitive and responsive in giving them information and support" (*Good medical practice*, 2013, paragraph 33) and that they "should not refuse to listen to patients' relatives on the basis of confidentiality" (*Confidentiality*, 2009, paragraph 66).

You should also bear in mind that the patient's death is likely to be the subject of a coroner's inquiry (or a fatal accident enquiry in Scotland) and that the practice will have a statutory obligation to disclose relevant medical information if ordered to do so. It may be a good idea for the GP to explain this to the patient's father and make clear that the practice will be co-operating with the coroner's investigation which will look into the circumstances of the patient's death.

The outcome

The practice manager arranged for both parents to visit the practice and speak to the patient's GP about their concerns, with the GP's agreement. They knew about their daughter's addiction and he was able to answer their questions about the treatment she received. He explained that the coroner was investigating the patient's death and would be looking into the background, including whether she was suicidal and if anything could have been done to prevent it.

The coroner reviewed the patient's records and obtained statements from the GP and the patient's addiction counsellor. He concluded that she had not taken drugs for several months before relapsing and she had not appreciated that her tolerance had diminished during that time. He recorded a verdict of accidental death which her parents accepted.

This is a fictional case compiled from actual cases from our files.

Learning points

- Your practice's records access policy should be easy to find on your website and available on request.
- Check the identity of those requesting records. If not the patient, they should have their written consent or the necessary legal authority.
- Respond to access requests within 40 days and ensure patients who want copies are aware of charges.
- Ensure someone is on hand to answer any questions when patients are inspecting their records.
- Unless they relate to healthcare professionals, get consent before disclosing entries which concern third parties or black these out.
- Factual corrections can be made at the patient's request but it should be clear who made them and when.
- The records of deceased patients can be requested in writing by those with a claim arising from their death or the patient's representative or executor. Consider other requests on a case-by-case basis.

Meet Jane, GP liaison manager

Which areas do you cover?

I have taken over Chester, Crewe and North Wales from my colleague Chris Hall. The other areas that I'll be looking after are Dudley, Telford, Stafford, Shrewsbury, Walsall and Wolverhampton.

What is your typical day like?

My typical day consists of seeing our members face to face in their own practices. I cover quite a large area, and am kept busy with delivering free seminars to the whole practice or meetings with practice managers to discuss MDU benefits.

Usually I'll grab lunch on the go, and will often eat it in the car.

Some of my day is spent following up from practice visits, which includes a fair amount of phone calls and emails.

If you were a practice manager, which MDU benefit do you think you would regularly use?

It would have to be the practice seminars, which I regularly give. They are packed with up-to-date guidance

and information and are available free to **GROUPCARE** practices.

What has been the highlight of your role so far?

The company ethos. Our members are at the forefront of everything we do and being part of a company that delivers on its promise is extremely rewarding.

What do you like about working for the MDU?

The thing that struck me immediately is that they constantly strive to achieve, and adapt where needed.

Tell us three facts about yourself...

- When I was growing up, my passion was horses.
- I am a trained actress. I trained in London when I left school.
- My favourite pastime is property renovations.



If you're a member in Jane's area you can contact her to discuss MDU membership, **GROUPCARE** benefits or even horses! Jane's details can be found on themdu.com/liaison

Calculate your GPs' sessions

to ensure you pay the right MDU subscription



Not all MDU GP subscriptions are based on the sessions worked but if they are (you can check this on page 3 of the GP's renewal letter) please read the following information carefully.

If the GP does more than one type of GP work, each type of work should be shown on the renewal documents.

GP principal/partner/non-principal/salaried

Subscriptions are based on the number of sessions a GP is contracted to work. If they work outside of, or in addition to, the contracted sessions they should calculate the average number of additional 4 hour sessions worked per week and add this figure to the contracted sessions.

If a doctor has a substantial amount of time away from the practice through extended holiday, sabbatical, study leave, parental leave or other reasons, the above formula should be used to calculate the number of sessions.

Include both scheduled and out-of-hours (OOHs) care for patients registered at the practice when calculating the average number of sessions.

If the doctor is doing different types of work, please inform us of the number of sessions for each type of work so the subscription can be calculated correctly.

GP locum

The locum category is for GPs who do not typically work at one fixed practice, but undertake temporary contracts, sometimes but not always via a locum

agency. They are self employed and pay their own tax. Private GP work also belongs in this category. The subscription is based on the average number of sessions worked per week during the membership year.

Out-of-hours GP

This category is appropriate for any primary care services provided on an ad-hoc basis for patients not registered with the practice providing the service. Examples of work which fall into this category include: deputising services, GP co-operatives, walk-in centres and minor injuries/illness units.



For any membership queries call **0800 716 376** (8am to 6pm Monday to Friday, except bank holidays)

Everyday

decisions

Employment law may be a daunting aspect of managing a practice. But knowing how to apply the laws and regulations can support your everyday decisions and reduce the risk of an employment tribunal. Nicola Mullineux, research co-ordinator from Peninsula Business Services, puts your knowledge to the test.

Q1

A receptionist who has been with your practice for four months has had a significant amount of sick leave. Your practice hasn't been able to cope with the high level of absence. When you speak to the employee, she tells you that she suffers from chronic fatigue syndrome. How do you respond?

- A** You start the dismissal proceedings. You cannot continue to put up with the uncertainty her absences are creating; the receptionist is pivotal to the efficient running of the practice.
- B** Tread more carefully than you would when dealing with other types of absences, as she has highlighted an ongoing health problem. You look into how you can help her.

Q2

One of your staff who has young children tells you that she needs to change her working hours and would prefer to work part-time. She tells you that she has a right to change her hours because she is a parent and would like to start the new arrangement from next month. How do you react?

- A** She is not automatically entitled to change her hours but you follow the statutory request procedure and hold a meeting with her, before you decide whether to allow the change.
- B** You reluctantly agree to the change. It leaves you in a difficult position because you will have to reorganise her work between the remaining staff.

Q3

An employee who is on long-term sickness absence contacts you asking to take the next two weeks as annual leave. How do you respond?

- A** You automatically say no and question the appropriateness of asking to take time off when she is already on sick leave.
- B** You weigh up the pros and cons of agreeing to the annual leave request and allow her to take it as you are uncertain as to your legal position.

Q4 A disagreement between two employees is now affecting morale among the rest of the staff. The two employees involved refuse to talk directly to each other and resolve the situation. How do you deal with it?

- A** You ignore the situation. Your employees are paid to work and you are their manager, not their parent.
- B** You ask each party for a meeting, to confront the issue and look for a resolution.

Q5 You are in an appraisal with a 63-year old member of staff. You don't want to ask them about their future plans because they might think you are enquiring about retirement. How do you approach the situation?

- A** You loosely ask the employee about the rest of their career, and hope that you have done so in a tactful way.
- B** Avoid asking them anything at all about the future, you would rather avoid the subject to stay on the safe side.

Q6 An employee discloses that he feels he is being bullied by another member of the team, but refuses to name the perpetrator. Every time you approach him to discuss it further he looks nervous. What will you do about it?

- A** You don't progress the situation so he won't feel uncomfortable. He hasn't formally raised a grievance to you in writing, so you won't be able to investigate the options.
- B** You speak to the employee again the next day and ask if he wants to take it further. You are concerned about whether this will affect his performance at work.

1-3 questions correct

Your decisions may not be compliant with employment laws and regulations. This may put you in a position where you are taken advantage of or are vulnerable.

4-6 questions correct

You have a good basic knowledge of how to implement practices in your workplace to keep yourself on the right side of employment law. Your approach is correct, you face staff issues head on rather than allowing them to fester and potentially turn into larger problems.

Keep up-to-date with the latest employment law advice by visiting the legislation website <http://bit.ly/inpractice30> or visit our employment law tool on <http://bit.ly/inpractice36>

Q1 – correct answer b

Although the receptionist has only worked for you for four months and doesn't have the length of service to claim unfair dismissal, she has raised a health concern that is legally classified as a disability. The employee is protected by the Equality Act 2010, which states that it is against the law for employers to discriminate against an employee because of a disability.

You must assess her responsibilities and ensure that she can cope with her workload. Read more about the government's Disability Act by visiting <http://bit.ly/inpractice27>

Q2 – correct answer a

You should not be forced into agreeing to her proposal, and you cannot automatically decline. You may refuse the request for flexible hours because of the difficulty in reorganising her work.

The employee must follow a procedure to request flexible working. The government website outlines the following procedure to request flexible working:

1. The employee writes to the employer.
2. The employer should request a meeting within 28 days to discuss the application.
3. The employer must make a decision within 14 days of the meeting and tell the employee about it.
4. If the employer agrees to flexible working they must give the employee a new contract. If they don't agree the employee can appeal.

Find out more visit <http://bit.ly/inpractice29>

Q3 – correct answer b

The employee is entitled to take annual leave during her sickness absence, so you should consider authorising the request. If her absence continues into the following holiday year, it is likely that

the employee would be able to carry the annual leave over and therefore be paid in lieu of it if her employment is terminated. Letting her take the leave now will reduce any potential termination payments.

Q4 – correct answer b

If disputes arise in the workplace, it is in your best interests to help smooth the dispute and find a suitable resolution. Mediation can help to encourage the employees to confront each other in a safe environment and find an adequate solution. The steps involved are as follows.

- Arrange for a confidential meeting room with the parties involved.
- Set agreed objectives for the meeting, and the agenda.
- Talk through any issues, state the facts and discuss how the situation can be improved.
- Agree on key action points.

Q5 – correct answer a

The tactful way to approach this situation is by asking the employee freely about what they want to achieve from the rest of their career. You have asked this question to all of your staff and have therefore not treated this member of staff any less favourably than the others.

Q6 – correct answer b

Bullying in the workplace can affect an employee's morale and job satisfaction, and could lead to sickness days or ultimately resignation. If an employee is affected by bullying, and it impairs their job satisfaction, you can treat the conversation as a formal grievance, regardless of the fact that they did not raise it in writing. You can remind him that substantiated bullying is not acceptable and that you will take steps to eradicate it.

News in brief

Medication error cases increase

Medication error cases reported to us by GP members have increased by nearly 60% over five years, according to our new study.

However, the increase is likely to be driven by the increase in GPs' prescribing workload, rather than a fall in medical standards.

We have paid around £5million in compensation and £400,000 in legal costs over the period, with an average compensation award of just over £58,000 for GP cases. The largest compensation payout made on behalf of a GP member was £1.2 million to a patient who was left severely disabled after a failure to monitor levels of a long-term prescription for lithium resulted in lithium toxicity.

Find out more
<http://bit.ly/inpractice33>

DoH confirms delay in mandatory indemnity for nurses

Although it was widely believed that mandatory indemnity had to be in place by 3 October 2013 (in order to comply with the EU cross border directive) the Department of Health (DoH) has now delayed this requirement until 2014.

To find out more visit
<http://bit.ly/inpractice34>

CCTV in healthcare

In a recent question in the Scottish Parliament, an MSP asked whether there was a legal impediment to installing CCTV cameras in hospital wards to monitor patient safety¹. Coincidentally, the Care Quality Commission (CQC) in England suggested that hidden cameras could form part of its new approach to inspecting social care services.

CCTV cameras are now a widely used crime prevention and security measure. The use of surveillance in healthcare settings is problematic however, because of the need to protect patients' confidentiality and privacy. A number of GP practices have sought our advice concerning the medico-legal implications of CCTV, such as whether they could disclose CCTV images from waiting room cameras if a crime takes place to the police.

If you are planning to install CCTV at your practice, consider the following learning points.

- Record your reasons for installing CCTV and ensure they are proportionate and legitimate e.g. crime prevention. The Information Commissioner's Office says the use of CCTV should be reviewed each year. Seek advice from your local Caldicott Guardian, if necessary.
- Ask one person within the practice, ideally the data controller, to be responsible for ensuring your CCTV system complies with the law and your ethical duty to protect patients.
- Seek professional advice about the most appropriate surveillance technology, the location of cameras, facial recognition, time/date stamps etc. As with any third party supplier, ensure you have a contract which includes guarantees about



such issues as security and patient confidentiality when processing images.

- Install clearly visible signs which state that CCTV cameras have been installed.
- Restrict access to stored CCTV images and only view them in a secure area. Do not retain images for longer than necessary, unless they are needed as evidence.
- Do not disclose images of patients without consent except in exceptional circumstances when this can be justified in the public interest. Where other people are recorded on the same footage, their image should be blurred to protect their confidentiality.
- Produce a practice policy covering the installation of cameras, the safe storage of images, retention periods, disclosure to the police and subject access requests.

Reference

- 1 Rise of CCTV in 'Big Brother' Scotland, The Scotsman, 8 April 2013
<http://bit.ly/inpractice31>

BLURRED LINES

People who don't work in general practice might be forgiven for thinking that one of the perks of working for a GP is having swift access to medical attention. But treating work colleagues is generally discouraged, for sensible reasons. MDU medico-legal adviser Dr Sally Old explains the pitfalls.

Treating colleagues is tricky for GPs because a close personal relationship with patients makes it very difficult to maintain clinical objectivity, subverting the normal doctor-patient relationship. For instance, would a GP be able to put their irritation aside when seeing a receptionist who had attracted several complaints about her attitude? If an employee has taken sick leave, might they be tempted to provide treatment that they would not usually provide in order to help them return to work?

For their part, employees may also find it more difficult to talk openly about their health with someone they see every day in a different capacity, not least because of concerns about confidentiality.

There is also the potential for conflict within the practice if concerns are raised about an employee's performance, especially where there are health implications. It is difficult to approach employment issues objectively if a GP is aware of relevant information that they learnt in a private consultation. Equally, a GP's ethical duty of patient confidentiality means this cannot be

considered without the patient's consent. Any breach of the employee/patient's confidentiality could prompt a complaint to the GMC or a claim to an employment tribunal.

Informal prescribing to colleagues

GPs who prescribe medication for their practice colleagues on an informal basis are also taking a significant professional risk with implications for their practice colleagues who would have to pick up the pieces.

The GMC has long discouraged doctors from treating anyone with whom they have a close personal relationship, and recently tightened its guidance¹ which now states: "Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship." Controlled drugs must not be prescribed to those with whom the doctor has a close relationship except in exceptional circumstances such as where it is necessary to save a life or alleviate uncontrollable pain or

distress. The GMC expects doctors who prescribe for someone close to them to make a clear record justifying why there was no alternative, and also inform the other person's GP about which medicines have been prescribed, unless the other person objects.

No alternatives

Of course, there may be practices, such as those in remote rural communities where employees do not have easy access to alternative medical care. If treating employees is unavoidable, the practice should ensure they are aware of the potential pitfalls that such arrangements might create, including difficulties with confidentiality and remaining objective.

Practices in this situation can seek specific advice on the ethical implications from us. Our medico-legal team is available between 9am-5pm Monday to Friday and provides an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.

Case scenario

A practice receptionist sought urgent advice from a GP colleague because she had an attack of cystitis, including traces of blood in her urine and she was unable to concentrate because of the pain. The receptionist revealed she had had cystitis before so the GP advised her to drink plenty of water, take some painkillers and suggested she might also need a course of antibiotics to clear up the infection. Explaining that she didn't want to take time off work to attend her own doctor, the receptionist persuaded the GP to prescribe amoxicillin.

Unfortunately, the receptionist developed a rash and it was discovered she was allergic to penicillin. The receptionist was embarrassed at not remembering she could not take penicillin and did not want to make a complaint.

When the incident was investigated within the practice, it was agreed it wouldn't have happened if the receptionist had attended her own practice where the GP would have had access to her notes. The practice manager and senior partners agreed

to implement a policy requiring staff members to see their own doctor if they were unwell.

Reference

- 1 GMC, *Good practice in prescribing and managing medicines and devices* (31 January 2013), paragraph 17-19. <http://bit.ly/inpractice32>

This is a fictional case compiled from actual cases from our files.

Disclosure to the police

A practice manager was approached during a busy morning surgery by a police officer who was requesting information about a patient of the practice. The patient was currently being held in custody. The police officer told the practice manager that the patient had committed a serious crime, which had resulted in harm to another person, and they needed a copy of the patient's clinical records.

The practice manager rightly asked the police officer whether he had consent from the patient authorising disclosure of her records. The officer explained that he had been unable to get consent and quoted section 29(3) of the Data Protection Act 1998 (DPA), stating that this waived the need for patient consent.

She rang us for advice.

Our advice

Our adviser explained to the practice manager that section 29(3) of the DPA meant that information could be disclosed, without a breach of the Act occurring, but it did not compel disclosure.

The adviser referred to the GMC's guidance on confidentiality particularly in relation to disclosures in the public interest. Paragraph 37 states that personal information can be disclosed in the public interest without consent, or if consent has been withheld, if the benefits to society outweigh the patient's interests in keeping the information confidential.

Due to the ethical duty of confidentiality owed to the patient, consent should be sought in the first instance, particularly as the patient was in custody and did not pose a threat to the public.

Our adviser suggested that the practice manager speak to the police officer again to establish why they could not get consent and why they specifically needed information from the clinical records. This would hopefully enable the practice to make an informed decision as to whether or not they could justify disclosure of the records.

The outcome

The police officer informed the practice manager that the patient was unable to consent as she lacked the mental capacity to do so due to what appeared to be a mental health problem. The Forensic Medical Examiner (FME) had assessed the patient and found that she was very distressed and appeared psychotic. The FME had requested the records so that he could establish what her medical and drug history was in order for him to provide her with appropriate care and treatment.

Based on this information, our adviser suggested that one of the GPs

in the practice who was familiar with the patient speak directly to the FME to provide him with the appropriate information. If, after this conversation, it was felt that any medical records needed to be disclosed these should be only those that the GP felt were relevant and should be disclosed directly to the FME, rather than to the police officer.

The practice manager proceeded on this basis and the patient's GP spoke to the FME who was then in a position to provide appropriate treatment to the patient.

Learning points

- It is not unusual for the police to request information about patients from their GP. Under normal circumstances it is important to ensure that you have the appropriate consent from the patient which specifies what disclosure can be made.
- The police may quote section 29(3) of the Data Protection Act 1998 with the suggestion that due to this legislation, consent is not required. However, a doctor has an ethical duty of confidentiality and must be able to justify a decision to disclose information without the patient's consent.
- Even when a patient has been accused of committing a serious crime, if they are in police custody and therefore not a risk to the public, their consent should be sought if possible. If the patient refuses to consent the police may be able to get a court order compelling disclosure of certain information. Only that information which is specified in the court order should be disclosed.

Dr Kathryn Leask
Medico-legal adviser

References

- Data Protection Act 1998
- GMC, *Confidentiality* (2009)

This is a fictional case compiled from actual cases from our files.



Set up a childcare voucher scheme at exclusive rates

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

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.

A finance officer from a **GROUPCARE** practice from Yorkshire says:

“ We have 41 staff members at the practice, 13 who are parents. The scheme is seen as an extra benefit by our employees and the best thing is that it doesn't cost us anything. The vouchers are a valuable benefit of employment and seen as vital. It was easy to transfer our existing scheme over, and we had fantastic communication with Computershare, they pulled out all the stops to ensure we were set up correctly. The contact even called me back on his way to the ferry to go on holiday to make sure we were set up! ”

GROUPCARE

Multiply the benefits

GROUPCARE members benefit from preferential rates.

¹ 1 September following 15th birthday or 1 September following 16th birthday for children who are registered disabled.

² Annual 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.



Find out more
themdu.com/groupcare

Sickness absence due to stress

A practice manager receives a text message to say that the lead receptionist has a cold and will not be coming into work. The practice manager notes this in her files, and works out that it is the ninth sick day the employee has had in the last three months.

The employee has taken off more and more sick days recently. Four months ago, the receptionist had less responsibility and was a different person – she left work on time, and seemed chirpy and approachable in her manner. Since being put in charge of the practice's procedures and operations, she has complained about the amount of work she now has to do. As well as organising the rest of the receptionists in the large practice, she is also in charge of the practice's infection control measures, complaints, and is undertaking a project with the

practice manager to improve patient confidentiality and privacy.

The receptionist has mentioned that she feels stressed with the weight of her new responsibilities, and the practice manager suspects that the employee is taking a day off to recuperate from her busy workload.

So far, the practice manager has allowed for the receptionist to take some days off but the work carries on mounting, and with the possibility of a looming CQC inspection, he now needs to confront the problem.

Advice from Peninsula Business Services

Nine single days' absence within three months is certainly a trigger for alarm bells. The practice manager now realises that he must confront the issue, although action should have been taken from the day of the first absence. Employee issues can often be time-consuming and difficult, but the earlier you deal with them, the more control you will have over how they affect the practice.

It might initially be prudent to assume that stress is actually the cause of the employee's absence. There may be separate illnesses that have occurred at the same time. The key to identifying the cause is good communication. You must set up channels of communication with the employee and ensure that the employee feels comfortable using these channels.

Return to work interview

When the employee returns to work, you should set some time aside to speak to her. A return to work interview is a good opportunity for you to question the employee about their absence. Not only does this help you understand the cause, but also shows staff that you take absence seriously and that they will have to explain each occasion.

Although termed an 'interview', this meeting is an informal chat between you and the employee. However, you should keep a record of the date of the absence in question and the reasons. Make enquiries as to the cause of the absence and be intuitive with the responses you get. Some employees will relish the opportunity to offload about their problems but some won't. Avoiding direct questions and instead asking general wellbeing questions may elicit more truthful responses.

In this scenario, the employee's responses may tell you that her absence is not stress-related but down to other ailments such as migraines, colds or possibly backache. You should explain to the employee that the practice cannot accept such high levels of absence.

Disciplinary action

Disciplinary action at this stage would be difficult to justify as you will be imposing a sanction in relation to a time when the employee did not know she was being monitored. For disciplinary action, you will need further instances to build a case.

Work-related stress

If the employee's responses do lead you to believe that work-related stress is the cause of the absences, your response will need to be different. You have a duty to take reasonable care of the health and safety of your staff. Tribunals expect employers to support and assist employees who are suffering from workplace stress and to try to find ways of helping the employee overcome their problem.

Work together with the employee to look at which aspects of the job cause the stress. You could ask her to identify real examples and consider ways to reduce the impact on her. You may want to reduce some of her responsibilities, with her agreement.

You should endeavour to keep the employee informed at all times of the actions you are taking.

Your role as manager

Think about your role in this situation. In particular, consider whether:

- you could have done anything to prevent the employee from being overwhelmed by her responsibilities
- you gave full consideration to whether she would be able to cope with the extra responsibility
- you could have supported the employee with training
- you could have arranged for regular meetings with the employee to determine how she was dealing with the extra responsibilities
- you provided an opportunity to raise any concerns.

Prolonged periods of absence would ultimately require the intervention of an occupational health report, which will provide an opinion on the likelihood of the employee returning to work. **I**

Nicola Mullineux

Research co-ordinator at Peninsula Business Services

This is a fictional case compiled from Peninsula's actual cases from their files.

Learning points

- Implement a sickness absence policy. This will set expectations of what is required from the employee. It also reduces the likelihood of an allegation of discriminatory treatment in comparison with other staff.
- Don't ignore the first signs of a problem – if an employee tells you they feel stressed, ask them if they want to speak to you further about it.
- Monitor every occasion of sickness absence and record the reason. Look for patterns that may arise, for example, if absences always fall on days that important meetings are due to be held. You are within your rights to question the absence and ask for an explanation as to the pattern.
- If an employee mentions work-related stress or dissatisfaction, you should consider whether you can provide extra support and training.
- Communicate with the employee by involving them in decisions and providing an action plan.
- Consider external help such as an employee assistance programme. As an employer, you are not the employee's counsellor and therefore must take help from professionals if needed.

GROUPCARE members receive access to a free 24-hour employment law advice line. For more information on how to set up a **GROUPCARE** scheme, visit

themdu.com/groupcare



MDU