Practice Manager

ISSUE 1

Off the record

Patient record transfers between practices are still problematic

Thinking local

Has the Personal Medical Services contract lived up to expectations?

Authority gradients

Avoiding disaster in primary care is often a “simple” matter of speaking up

PROFILE: KINLOCH RANNOCH
UNIQUE CHALLENGES IN A UNIQUE LOCATION

MDDUS

Practice Manager

PHOTO: BILL BAIN

WELCOME TO THE FIRST EDITION of *Practice Manager* – a journal that we hope will be an informative and interesting resource to help you manage your medical or dental practice.

Almost everything we do in practice management is an assessment of risk in one way or another. How well we encourage our team, and ourselves, to identify and address these risks will influence how well we perform as managers and how safe and effective a service we provide for our patients.

In *Practice Manager*, MDDUS brings together a broad range of issues including medico- and dento-legal advice, employment law and statutory and regulatory issues. There will also be plenty of interesting and entertaining features offering a perspective on some of the hot topics in practice management today.

In this issue we look at the importance of communication within a team in Phil Higton's article on managing authority gradients on page 12. We examine the risks involved in medical records transfers on page 7, while on page 4 we explore some advice calls made by members to the MDDUS advisory team. In our profile on page 10, practice manager Karen Brown talks about the challenges of rural medicine in picturesque Kinloch Rannoch. Our employment law experts offer advice on tackling bullying in the workplace on page 5 and also highlight health and safety law on page 6. On page 8 we examine the impact of the Personal Medical Services contracts and how they have changed the job of practice managers.

Please get in touch with your comments about *Practice Manager*. We look forward to hearing your views and any suggestions or ideas that we could include in future editions.

Aileen Wilson
Editor

COVER PHOTO: SCOTT HUNTER / WWW.SHOT2STUN.CO.UK

Poor communication poses medication risk

PRACTICES and hospitals must communicate better to cut the risk of harmful drug reactions amongst patients, a study by the Care Quality Commission (CQC) has found.

The regulator discovered an increased risk to patient safety when drugs are prescribed following hospital treatment. Hospitals, they reported, often failed to fully pass on details of medication while practices often didn't share data when patients were first admitted. Incidents involving medication – including prescribing errors and failure to review medication after discharge – were the fourth most commonly reported to the National Patient Safety Agency in 2008.

The CQC visited 12 primary care trusts and surveyed 280 GP practices and highlighted four main risk areas. Their report reveals that patient information shared between GPs and hospitals is often "patchy, incomplete and not shared quickly enough".

Nearly half of all practices complained that it took too long for hospital discharge summaries to arrive, meaning patients were seen without a full set of records. The report called on trusts to do more to monitor and encourage hospitals and practices to ensure drug information is shared properly.

The study also revealed that nearly a fifth of the practices surveyed said the updating of GP records is not always carried out. This increases the risk of patients being prescribed incompatible medicines. Too few patients were also offered discussions with their GP about managing their medication. And the study found practices are not consistently reporting medication incidents and errors, and PCTs are not always monitoring them.

The CQC is recommending that all practices do more to tackle risks ahead of April 2010 when all trusts will be expected to meet new CQC standards.

Cynthia Bower, CQC's Chief Executive, said: "It is important that basic systems to share essential patient details are working effectively to get the right information to clinicians at the right time to minimise these risks. It is clear from this study that services have some way to go before this routinely happens in the way it should."

MDDUS

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Call for expanded practice nurse role

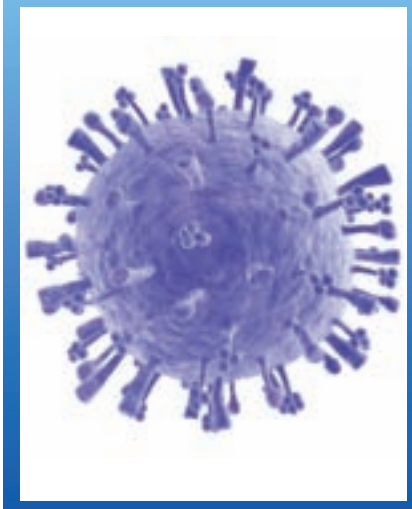
➔ PRACTICE nurses should be given greater responsibility to free up GPs to spend more time on patient consultations and 24-hour care, according to the chairman of the Royal College of General Practitioners (RCGP).

Professor Steven Field, speaking at an NHS Confederation conference last month, said: "[GPs] need to have consultations with our patients lasting around 15 to 20 minutes. We should focus on the whole of the patient and provide continuity of care".

He said that nurses could do many of the jobs currently undertaken by GPs in order to provide this extra care time for patients. But he added that "many GPs may feel threatened by this".

Professor Field called for the recruitment of more nurses and nurse practitioners in primary care and also announced that the RCGP will be setting up a practice nurse forum.

Flu vaccination cover



➔ MDDUS has had a number of calls regarding indemnity for healthcare assistants (HCAs) and practice nurses administering seasonal and H1N1 flu vaccinations.

The Union has confirmed that practice staff employed by MDDUS members are covered vicariously for administering vaccinations but GPs and practice managers should ensure that staff are properly trained and competent. Staff administering vaccinations should also be following DOH and any relevant local guidelines.

Should members be in any doubt, contact an MDDUS adviser.

Concerns over continuous registration

➔ PLANS to change NHS dental registration in Scotland could harm patient care, a survey has found.

Dentists fear proposals to introduce continuous registration sends out the wrong message to patients about the importance of regular check-ups. In a BDA survey of general dental practitioners across Scotland, 87 per cent of the 1100 who responded opposed the move. They voiced concerns that it wouldn't promote a strong patient-dentist relationship and could lead to a rise in undetected mouth cancer.

There were also fears the move could put a strain on NHS resources as some patients chose to attend less regularly. The BDA said irregular attendance often results in more complex, time-consuming treatment being required. There are also worries that practices could struggle to cope with more demand for emergency appointments which could in turn increase waiting times for patients attending regular appointments.

Colin Crawford, chair of the BDA's Scottish Dental Practice Committee, said: "This survey is an overwhelming vote of no confidence in the proposed change to continuous registration. Continuous registration... will create an illusion of growing numbers of patients accessing dentistry – but it doesn't genuinely improve patient care."

The BDA has written to the Scottish Government with its concerns over continuous registration. The new scheme would mean patients no longer have to visit the dentist within an agreed interval in order to remain a registered patient.

MDDUS offers local seminars

➔ MDDUS Training and Consultancy would be delighted to come to your locality and deliver management topics to practice manager groups. Topics we are frequently asked to deliver include: risk management, assessment of practice risks (prescribing, results, communication, confidentiality, information governance etc), understanding and managing change/emotions within the team, leadership, time management, assertiveness and managing conflict.

The sessions are tailored for each particular group dependent on learning needs identified. They are designed in workshop format with a little bit of background theory but the main focus is on facilitating discussion around practical application of the theory.

For more information on available topics and how to go about inviting us to your area, please contact Ann Fitzpatrick on **0845 270 2038** or email **afitzpatrick@mddus.com**

Ensure dental registration

➔ DENTAL practice managers must take care to ensure that their dentists, dental nurses, hygienists and other professional staff maintain their registration with the General Dental Council in order to avoid a situation where staff are working illegally.

The GDC recently removed over 4,000 dental care professionals from its register for failing to pay the annual retention fee (ARF) on time. Many were working for a two-week period unaware that they were not registered. By law, all dentists and DCPs who provide dental care in the UK must be registered with the GDC.

The GDC advises registrants about one month before their existing registration is due to expire and provides a direct debit form to eliminate the risk of registration being overlooked at time of renewal. There is also an opportunity to pay online via the GDC website.

Aubrey Craig, head of the dental division at MDDUS, said: "There are various reasons why so many have been removed from the register – including being unaware of the procedure, not being able to afford the fee, leaving the profession or taking a career break.

"However, maintaining registration is applicable to all registrants. Registrants must inform their regulatory body if they change address, change bank details, leave the profession etc. A direct debit mandate is the securest method of ensuring continuing registration".

MDDUS encourages all members to ensure practice staff details are correct with the registrar to prevent removal and possible investigation for unlawful practice by the GDC.

Call log

These cases are based on actual advice calls made to MDDUS advisers and are published in the magazine to highlight common challenges within practice management. Details have been changed to maintain confidentiality.

CONFLICT WITH RIVALS

Q There are two practices in a health centre and Practice A have started mailshotting established housing estates in the hope of attracting some of Practice B's patients. Practice B are angry at this campaign and contact MDDUS to ask if their rivals are acting unethically and can somehow be stopped. They intend to write to Practice A about their actions and ask MDDUS for advice.

A MDDUS agreed with Practice B that common, courteous practice would be to only mailshot new housing estates where residents may not be aware of the existence of particular GP services in the area. However, Practice A are entitled to mailshot any group of potential patients, provided they stick to clear guidelines. These are set out by both the BMA and in the GMC's *Good Medical Practice* regarding probity which states: "If you publish information about your medical services, you must make sure the information is factual and verifiable. You must not make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients. It must not offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge. You must not put pressure on people to use a service, for example by arousing ill-founded fears for their future health." Any correspondence with Practice A must be very carefully worded and avoid unfounded accusations about their actions.

DIFFICULT RELATIONSHIP

Q A receptionist within a medical practice is having an affair with a patient, Mr B. Mrs B is also a patient at the same practice and is furious when she discovers her husband's infidelity. Mrs B complains to the practice manager and raises concerns over the confidentiality of her personal details and medical records, to which the receptionist has access. Mrs B demands the receptionist be dismissed or, at the very least, disciplined and denied all access to her personal records. The practice value the receptionist highly and do not want to terminate her employment. They are unsure how to respond to Mrs B's complaints and what appropriate action, if any, should be taken regarding the staff member.

A An MDDUS adviser spoke to the practice manager and advised her to assess whether limiting the receptionist's access to Mrs B's records would be practically possible. If so, the practice should write to Mrs B suggesting this course of action. If this wasn't possible, Mrs B should be advised of this along with her right to register with another practice. Disciplining the receptionist would have to be undertaken in line with the terms and conditions stated in her contract of employment. Dismissing the worker would only be an option if her behaviour amounted to 'gross misconduct' as defined in her contract.

A MATTER OF DATA PROTECTION

Q A practice is asked by a patient, Mr G, for access to his medical records. The patient is adopted - and is aware of his adoption - but his records detail significant third party information with regards to this. The practice ask MDDUS how to deal with Mr G's request and how they should handle the sensitive information.

A We advised the practice that they are bound to comply with the Data Protection Act which means any third party information in Mr G's file must be removed or redacted before he is allowed access. Particular care must be taken if sending an electronic copy of records to the patient as these may be difficult or even impossible to redact. MDDUS advised the practice to print off the records, redact or remove the third party information and then invite Mr G to come to the practice to collect his records. A GP could then go through the records with Mr G to discuss any sensitive issues, medical terminology or other matters arising. Should Mr G question why parts of his records are redacted, the practice should explain they have done so to comply with the Data Protection Act. If the patient is still unhappy, or believes information has been held back inappropriately, he can be referred to the Information Commissioner's Office at **www.ico.gov.uk** for further advice.

PATIENT DECEPTION

Q A patient is found to have forged a sick note to his employer claiming to be from Dr J at the patient's medical practice. The practice have asked MDDUS how to handle this deception and whether they are entitled to remove him from the practice list.

A An MDDUS advisor discussed the matter with the practice manager and advised that she consult the RCGP's guidance, *Removal of Patients from GPs' Lists*. The RCGP states that "unacceptable behaviour such as... crime and deception such as lying to a doctor to obtain a service" is grounds for removal. Patients must always be given a reason for their removal from a practice, except in "very exceptional circumstances". The practice's contract also requires patients are sent a written warning if they are about to be removed or if they face the risk of removal, should the inappropriate behaviour be repeated. MDDUS advised the practice to use their judgement as to whether to remove the patient in this instance or simply warn him of the consequences of any repeat behaviour. The GMC's *Good Medical Practice* also advises doctors to make a "fair" and justifiable decision. If a patient is removed, the doctor must make prompt arrangements for the patient's continuing care by contacting the PCT or health board in the usual way.

Indignity at work

DR HENRY is a stickler for accuracy and runs a tight ship. He expects the staff in his practice to put in that extra bit of effort. He doesn't suffer fools gladly. He gives 110 per cent and expects his staff to do likewise.

Mary works in Dr Henry's practice as a receptionist. She finds his micro-management style oppressive, his personal manner demeaning and his attitude to non-medical staff dismissive and patronising. The practice manager Grace has struggled for years to protect her staff from Dr Henry's excesses but has now been handed a formal grievance from Mary complaining about Dr Henry criticising her in front of other staff for a mistake she made with an appointment for a patient. Mary says that she made the appointment in good faith but Dr Henry accused her of not checking his diary before making the appointment. According to him, she would then have discovered that he was away from the practice that afternoon.

Whether Dr Henry's behaviour is bullying or merely 'firm management' is a moot point for this practice. Certainly, our experience at Law At Work is that many employees tolerate eccentric, discriminatory and potentially intimidating behaviour until they are pushed over the edge or have an ulterior motive for dragging the behaviour into the open.

The problem for practices is that they are potentially vicariously liable for the unlawful behaviour of staff/partners. Practices may find themselves the object of discrimination claims (for harassment), constructive dismissal claims (for bullying – not related to a personal characteristic of the victim) or personal injury claims (for physical or mental injury resulting from such delinquent behaviour). The practice may be cited, alongside the harasser/bully, as responsible for their unlawful actions. Recent cases have also involved employers paying criminal damages to victims of bullying in their employment under the Protection from Harassment Act 1997 – the anti-stalking legislation.

These are serious matters from a legal, PR and expense point of view. Practice managers will need to develop policies and guidance for staff and partners explaining what is meant by bullying and harassment and why it is prohibited in the practice. Briefings for staff may be required to make it clear that bullying and harassment is unacceptable. Staff should be directed to raise any concerns they may have about such incidents through the practice's grievance procedure or, if necessary, in confidence to a partner. Staff also need to be told that bullying and harassment may constitute gross misconduct and could result in dismissal of the perpetrator.

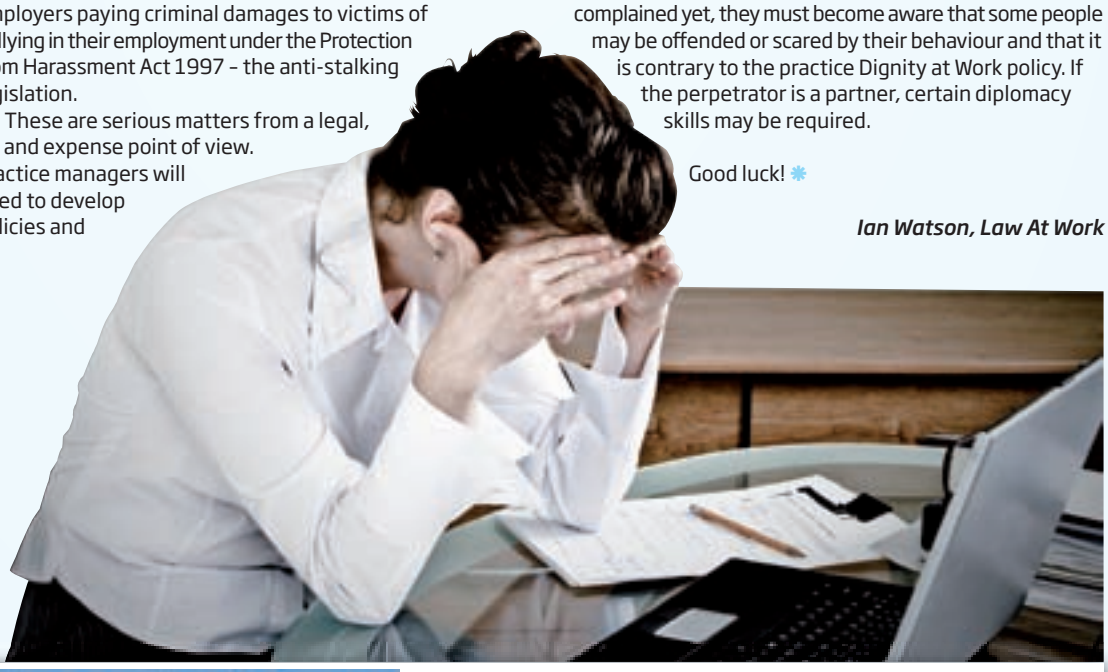
The key to success here is demonstrating to the court (if necessary) that action was taken to prevent the delinquent behaviour from happening - rather than reacting when it was complained about. So waiting for someone to complain is not a risk-free option for employers.

➔TASKS FOR PRACTICE MANAGERS:

- Develop or review a Dignity at Work policy – outlining what constitutes bullying and harassment, explaining that such behaviour is prohibited and stating what avenues of complaint are open to victims.
- Amend any staff handbook or disciplinary policy to ensure that bullying and harassment are shown as examples of gross misconduct.
- Arrange a briefing to tell staff and partners about the new policy and clarify any questions they may have about the issues.
- Be aware that delinquent behaviour may have become the norm in certain workplaces. This may mean that a 'quiet word' may be required with the main perpetrators. They need to be warned that, although no one may have complained yet, they must become aware that some people may be offended or scared by their behaviour and that it is contrary to the practice Dignity at Work policy. If the perpetrator is a partner, certain diplomacy skills may be required.

Good luck! ❋

Ian Watson, Law At Work



Happy birthday H&S

THOUSANDS of people owe their lives and millions more owe their health to a piece of legislation which celebrated its 35th birthday this year.

The Health and Safety at Work Act came into force in July 1974 and has been the keystone in driving down fatal workplace accidents from around 1000 a year to fewer than 200 in 2008. Over the same period serious accidents at work – those which resulted in more than three days' absence – fell by around 70 per cent from 336,000 in 1974 to around 100,000 in 2008.

These achievements are even more remarkable given that the workforce grew over that period by more than 25 per cent to around 30 million people. While the improvement partly reflects the changing nature of work since the 1970s, including the dramatic reductions in coal mining, shipbuilding, manufacturing and heavy industry, official estimates suggest that around half of the lives saved and injuries prevented are down to better health and safety practices.

The Act stemmed from the 1972 Robens Report which called for a complete overhaul of health and safety law. The new framework placed responsibility on businesses to identify and reduce risks to their workforces. The need for a fresh approach was underlined by the enormous explosion in June 1974 – weeks before the Act came into force – at a chemical plant in Flixborough, Lincolnshire, in which 28 people died and a further 36 were seriously injured.

But legislation alone cannot prevent every accident; there have been several subsequent work-related disasters. Among those best remembered are the Moorgate tube crash in 1975 which left 43 dead, the 1988 Piper Alpha explosion in which 167 people died and the Stockline plastics factory explosion in Glasgow in 2004 which caused nine fatalities and 33 major injuries. The real impact of the improved regime post-1974 is almost invisible: the media don't report accidents that didn't happen, and fatalities that didn't occur.

Robens' aspiration of a massive reduction in legislation has not been realised although the law itself is now simpler. But his other goal of creating a legal framework setting out broad requirements and the principles of how safety should be achieved by managing risks has become a reality. Risk assessment and control is now at the heart of health and safety. Every employer with five or more employees is legally obliged to have a written health and safety policy. That policy should identify who is responsible for the health and safety of the workforce and the arrangements that have been put in place to ensure this.

A typical policy will include a number of risk assessments addressing each hazard that staff are likely to encounter and safe working practices to be followed to keep the risk of accidents as low as possible. Where necessary, training arrangements will be included and these should be supported by written records of staff training. The effectiveness of the policy should be tested regularly by an auditing process and whenever weaknesses are discovered, a plan should be prepared to address them.

But even an excellent policy will not prevent occasional accidents and dangerous incidents. When one occurs, depending on how serious it is, it should be reported to the authorities if necessary and investigated as thoroughly as possible to find out what caused it. Lessons learned should be disseminated throughout the workforce and the policy adapted if necessary to minimise the risk of recurrence.

In retrospect, Robens' recommendations look like common sense and one wonders how it was that a system had emerged prior to his report comprising 30 major Acts of Parliament and more than 500 sets of Regulations. But if you think the position was, or still is, complicated in the UK, have pity on US employers who were at one point subject to no fewer than 140 sets of regulations about wooden ladders alone, including one which specified the grain of wood. At one point the US designated bricks as toxic substances and employers were required to advise staff how to recognise a brick and notify them of a brick's boiling point (above 3,500 degrees Fahrenheit in case you're interested).

Thomas Elliot, Health and Safety Manager, Law At Work

COMPUTERS were supposed to simplify the complicated world of medical record-keeping.

Out would go all the dusty, cumbersome old files that fill entire rooms, to be replaced with easy-to-access computer files that take up a tiny amount of space and can be easily transferred to wherever they are needed. But many practices across the UK still seem to be waiting for this time-saving, electronic revolution to hit its stride. Instead, they continue to manage the myriad of different practice software and computer systems currently in use – many of which still aren't compatible with each other – as well as the steady stream of paper files that need to be scanned, copied, redacted or archived.

According to the Scottish Clinical Information Management in Practice (SCIMP) *Good Practice Guidelines for Electronic Records 2006:* "The transfer of paper GP records alongside electronic ones will continue for the foreseeable future." This is because patient records are made up of so many different parts – the A4 folder, historical paper notes and Lloyd George envelope – and, amongst other factors, not all UK practices fully use electronic records for direct patient care. Generally, the main pitfalls in transfers involve sending incomplete information, disclosing confidential patient information or disclosing third party information.

> "THE TRANSFER OF PAPER GP RECORDS ALONGSIDE ELECTRONIC ONES WILL CONTINUE FOR THE FORESEEABLE FUTURE"

PRACTICE TO PRACTICE

When a patient decides to leave your practice, their complete medical records should go with them. Practices will often be able to send on records electronically (provided both practice computer systems are compatible), but managers must be sure that any remaining paper documents not included in the electronic records are also sent on in due course. If it's not possible to send records electronically, the practice would have to arrange for them to printed and sent to the new practice.

Under the Data Protection Act (DPA), information should not be held for longer than necessary. This would normally mean that when a patient leaves a practice and registers elsewhere, the records held by the former GP should be destroyed. But GPs have been exempted from this element of the Act because the audit trails within the GP clinical system record and electronic records can't be transferred between practices. The General Practitioners Committee and Information Commissioner agreed the exemption will remain in place until audit trails can be transferred.

PATIENT REQUESTS

The DPA allows patients access to their full medical records. Practices must comply within 40 days and can charge £10 to patients who wish sight of their records or a maximum of £50 to provide a copy. Practices must be careful, however, that the records don't contain third party information or information that could be deemed detrimental to the patient's physical or psychological wellbeing. Files should usually be printed and any sensitive information redacted before the patient sees the records. Such information might, for example, refer to another individual's medical history, detail allegations of abuse by a parent or spouse or other confidential third party information.

REFERRALS AND OTHER REQUESTS

A transfer of medical information is also necessary in GP referrals to hospital specialists. The risks here may seem low but there are pitfalls. In providing patient referrals, doctors should only include personal information relevant to the medical condition being treated. Inadvertent inclusion of personal details that a patient may not want disclosed in a referral is a much greater risk today with most patient information now being held in easily transmissible electronic form. It is important that practice systems for referrals take account of this risk. Disclosure of confidential information unnecessarily or improperly can expose practitioners to possible civil actions or disciplinary proceedings, or prosecution under the DPA.

The same principles apply when dealing with legitimate requests from insurance companies or other health professionals such as occupational therapists. Any sensitive/third party information must be redacted before files are sent. Doctors must also remember that, while the DPA may allow for the disclosure of certain information under certain circumstances, GMC guidelines may not. Doctors must be prepared to answer to the GMC should they disclose information in a way that conflicts with the council's guidance.

MIND THE GAP

Patients returning to a practice after a period elsewhere also require careful consideration in regard to medical records. While the practice may hold past records, practices must take care as the record will be out of date and there will be a gap in clinical and prescribing information. If a patient re-registers with the practice and the patient record is reactivated, then the record must be updated once the information is received from the sending practice.

Members who are unsure when to redact, delete or disclose information should contact the MDDUS for advice.

LINKS

- Department of Health's *Good practice guidelines for general practice electronic patient records*: **http://tinyurl.com/nchork**
- SCIMP have just published advice for practices regarding system migration; moving to paperless working; and back-scanning patients' paper notes at: **http://tinyurl.com/yhvdq9n** ✱

Joanne Curran is an associate editor at Practice Manager


Flexibility
Responsibility
Security
Autonomy
What does PMS mean for PMs?
Debt Recovery
guaranteed income
Opportunity
Financial Reporting

Thinking local

The new Personal Medical Services contract promised great things for GP practices when it first launched. **Joanne Curran** looks at its impact.

A FEW decades ago the Edinburgh Access Practice might not have existed. This primary care service for the homeless is based in two clinics in the city and is run by a management team with all staff employed by NHS Lothian. Here patients have 'drop-in' access to GPs, nurses, midwifery services, mental health nursing, dental and podiatry clinics, drug and alcohol support as well as shower facilities and a repeat prescription service.

The practice operates under the Personal Medical Services contract which was first piloted in 1997 and made permanent in 2004. PMS has been hailed by supporters as an efficient means of boosting career satisfaction, slashing bureaucracy and improving patient care in one fell swoop. It also brings greater job security, a guaranteed income for GPs and other healthcare professionals and a flexible approach to the types of services provided for patients.

Over 40 per cent of GP practices in England – more than 16,000 practitioners – held purely PMS contracts last year while around 10 per cent of Scottish practices are PMS. There are no PMS practices in Wales and Northern Ireland.

FLEXIBLE APPROACH

The contract is seen by the Department of Health as a flexible approach to delivering primary care services in a departure from the traditional General Medical Services agreement. It has been used to develop new services for specific populations such as the homeless and ethnic minority communities, to attract doctors and nurses into deprived areas and to improve services for patients. The DoH and the Scottish Government have been keen for greater numbers of practices to sign up to the contract as part of their plans to modernise the NHS.

Kirsty Hogg has been with the Edinburgh Access Practice since 1999. She says: "Flexibility is a positive feature of PMS as our clinicians can spend significantly more time with patients – an average 14 minutes - than might be possible in a non-PMS practice. And due to the drop-in nature of our surgeries, patients are usually seen by a GP or nurse on the day they attend."

Unlike GMS, PMS contracts are negotiated locally between the PCO and the practice, and are not subject to direct national negotiations between the DoH and the General Practitioners Committee of the BMA. A PMS contract pays GPs on the basis of meeting set quality standards and the particular needs of their local population. It offers the security of salaried positions for all healthcare staff in practices that have chosen to be directly employed by their PCO. Salaries are not reliant on hitting targets, allowing practice staff to concentrate on treating patients, rather than worrying about other demands such as QOF. As PCO employees, staff are entitled to the pay, terms and conditions dictated by 2004's Agenda for Change, including generous annual leave, educational leave, maternity and paternity leave. They must also be treated in line with the PCO's HR policy.

But PMS does not always mean a switch to salaried status. Practices can retain their independent contractor status and negotiate a PMS contract tailored to their patients' specific needs and there are also a number of other options open to PMS practices.

DOUBLE DUTY

Aileen Wilson, 42, a practice manager for 14 years, has a unique perspective on the ins and outs of PMS and GMS. For eight years she has managed a PMS practice in rural Portsoy, Aberdeenshire, as well as a GMS practice in neighbouring Aberchirder – a challenging role as each practice has a list of around 2600.

Aileen says: "The Portsoy practice went PMS about nine years ago because it wasn't financially viable to have as many GPs as patient demand required. Recruitment and retention was the main issue for us so we had little choice but to go down the PMS route. But I think it has worked out well. We are able to tailor the services to our patients in a way we feel is best through negotiating with our PCO and CHP."

Aileen spends around 21 hours a week at the Portsoy practice, where the medical team are all directly employed by NHS Grampian. She also spends around nine hours in Aberchirder, where the practice is run by independent partner GPs.

She explains: "Everyone has a guaranteed salary under the directly-salaried form of PMS. GPs get paid the same no matter what QOF targets they hit, so they don't have to get as deeply involved in the financial side unless they want to. But in Aberchirder there is a direct link with how well the practice does medically for our patients with the potential to earn additional income.

"Under PMS, a practice can, for example, make use of a GP with a special interest in a particular clinical area by negotiating with the PCO to fund a specialist service for patients of that practice and neighbouring practices."

But while the benefits seem clear for patients, GPs and other practice staff, what does PMS mean for practice managers? Aileen has found she has greater autonomy but initially found the change quite challenging, especially in terms of the financial management and HR.

She says: "There is virtually no difference for a patient walking into a PMS rather than a GMS practice. The fundamental difference is for the practice manager. In GMS you are part of a tight-knit operational unit, where you know exactly what you can expect at the end of the year. But with the directly-salaried form of PMS, you have to understand and integrate into a larger-organisation approach to finance. The financial reporting structure of PMS schemes like ours in Portsoy is completely different from my experience of GMS and the financial responsibility lies largely with the practice manager. The practice is allocated a budget which may take up to three months to be fixed. While there is no direct financial incentive for GPs to achieve QOF, the practice needs to do well in QOF for this to be reflected in our annual budget as this means more money to spend on other services for patients. Since moving to PMS, I feel that the role of practice management is the linch-pin between the practice team and the wider PCO.

"HR can also be more challenging because we must adhere to our PCO's stringent disciplinary and grievance policies and pay scales are dictated. To discipline a member of staff using the current policy available to me, it could take up to two years to reach the dismissal process. So this would be a longer process than under GMS. GMS practices, as private businesses, don't have that issue and don't have to implement Agenda for Change the way we have to as employees of our NHS organisation."

HERE TO STAY

The RCGP published its *National Evaluation of First Wave Personal Medical Services Pilots* in July 2002 in which it found PMS "can encourage innovation and act as a catalyst for change". It can "generate service change and benefit patients as a result of increased flexibility". It also found PMS had potential for "improving services for disadvantaged groups" and had a positive effect on recruitment and retention. Some drawbacks, as highlighted in *The Complete MRCGP Study Guide 2006*, include no agreement on pensions, funding growth is reduced for each new wave and the local contract is not aligned with national pay reviews.

Whatever practice managers make of PMS, former health minister John Hutton made it clear years ago that "PMS is here to stay".

Joanne Curran is an associate editor of Practice Manager

Dodging sheep and other hazards

MDDUS editor **Jim Killgore** visits a remote and rural medical practice in the Scottish Highlands

"SOME people joke we're on the road to nowhere," says Linda Entwistle.

And you can understand why in travelling the 'tourist route' to the village of Kinloch Rannoch in the Perthshire hills of Scotland. The narrow road off the A9 north snakes through the countryside for 15 miles before reaching the eastern shore of Loch Rannoch. Passing the village it twists another 15 miles to its terminus in the mountain wilderness of Rannoch Moor.

Linda is the healthcare assistant/receptionist at the Kinloch Rannoch Medical Practice and to her the isolation is part of the magic of the job. The practice is the most remote in the NHS Tayside region and also one of the most dispersed with a list of just over 600 patients in 250 square miles served only by B class roads.

PHOTO: JOHN MUIR TRUST

Most of these patients live in Kinloch Rannoch proper – a postcard Victorian village with an outlook dominated by the towering Munro (mountain over 1000 metres) of Schiehallion. Just leaving the village you pass a modern building on the right. This is the large new health centre and practice manager Karen Brown has worked here since it was built in 2003 and before when the practice occupied a small bungalow across the road.

Karen manages a staff of five, including Linda, as well as a part-time practice nurse and three part-time receptionists. Kinloch Rannoch has three doctors working sessions to provide 5-day single-handed GP cover. The nearest community hospitals are in Pitlochry and in Aberfeldy, both 20 miles distant, and the district hospital is in Perth although many of the services have now been centralised to Ninewells over 70 miles away in Dundee.

"And it's not just the mileage that makes things difficult but also the road –dodging timber lorries, tourists taking photographs, caravans, buses and sheep," says Karen.

The location presents some unique challenges for the practice not uncommon to many remote and rural practices in Britain – long tenuous transport links, the need for extended clinical skills in pre-hospital and emergency care, difficulties in arranging ongoing training and providing holiday and sick cover in a small part-time staff.

"I do enjoy my job. I really enjoy it. I don't wake up in the morning thinking – oh I have to go to work," says Karen. "But it's always busy. You can never just sit here and do your knitting."

Before 2006 Kinloch Rannoch was a single-handed GP practice with only one partner and a part-time associate. Together the two doctors provided GP cover 24/7 including on-call service. Before the retiral of the principal GP in 2008 NHS Tayside had begun to consider the position of single-handed GP practices in light of the new GMS Contract and the Shipman Inquiry. It was decided that having only one full-time doctor in the area was not safe.

Applications for the replacement of GP services were invited and a call went out for tenders to amalgamate the practice. Aberfeldy Medical Practice won the contract and Kinloch Rannoch became an affiliated sister practice. For Karen this meant that some of the financial decision-making as practice manager was taken away from her but she retains responsibility for much of the site management – HR, health and safety and IT.

"The change did cause a lot of consternation in the village because everyone thought at the time that they would close us down and patients would have to go across to Aberfeldy," she says. "But in the end I think it's worked out well with the majority of our patients hardly noticing any change at all."

➔A VILLAGE LIFE

Karen is in a good position to understand the concerns of her community. She first came to Kinloch Rannoch in 1977 from New Zealand on a six-month travelling holiday. She met her husband – a native of the village – while working in a local hotel and never left. For many years she was an assistant bursar at a local private school and when that closed she was hired as receptionist at the medical practice and stayed in the job until the acting practice manager retired.

"They asked me if I wanted to do the job and I said 'no'. And then they asked would I do if for just 6 months. Five years later and I'm still here."

Working in a small community medical practice presents some unique difficulties, says Karen.

"You do have to be very careful about confidentiality. It's a problem for all the staff. I can't say to my husband when I go home at night, oh I saw 'X' today. Or if there's a difficult situation, I can't discuss it because he'll know the people involved."

PHOTO: DOUGLAS MCBRIDE

Practice Manager Karen Brown in the dispensary at Kinloch Rannoch Medical Practice

There is also no such thing as anonymity and for Karen even less so as she is also the district registrar, recording births and deaths, and performing weddings, sometimes in a small conference room inside the health centre.

"At one time they were talking about sending the service off to Aberfeldy or Pitlochry but I felt it was important to keep it here. So I agreed to take on the job."

EMERGENCY AND OUT OF HOURS

Much of the year Kinloch Rannoch is a quiet place but in the tourist season the population can expand by up to 800 people with visitors staying in hotels, time-shares and the local caravan parks and camping grounds. One weekend in the summer an orienteering competition attracted 3000 participants. Most days the practice will see some TRs or temporary residents attending with hillwalking casualties, sprained/broken ankles, tick bites, infections or forgotten medication.

A great bonus to both visitors and residents is the fact that Kinloch Rannoch is a dispensing practice eliminating the need for patients to make a 40-mile round trip to get common acute and repeat prescriptions.

But perhaps the most challenging – and contentious – aspect of a remote practice like Kinloch Rannoch is out-of-hours (OOH) and emergency care. The practice has a transponder linked directly to the ambulance service and the doctors will often be the first on the scene at road traffic accidents.

"If there's an emergency, the doctors must drop everything and go, even if it's in the middle of a surgery," says Karen. "Fortunately our regular patients are very understanding about this."

The doctors all have special training in emergency care and the practice is kitted with a Sandpiper Bag as well as a defibrillator. Common emergencies include minor road traffic incidents, obstetric cases and suspected myocardial infarctions.

"We are one of the few practices in Scotland where doctors carry medications such as metalayse to help dissipate the effects of heart attacks."

Emergency and OOH care is also an issue that has recently thrust Kinloch Rannoch into the media spotlight. Back in May 2006 the practice opted out of OOH service provision and it is now provided by NHS 24 along with a call-out service from Aberfeldy and Pitlochry. The move caused anger and concern among some members of the community and has sparked some media attention in the newspapers.

Recently a local resident paid for an advert in *GP* magazine for a doctor to provide separate out-of-hours GP service for the area as it was felt that relying on a service based miles away was dangerous. The controversy is still boiling and Karen admits the loss of the practice OOH care has caused a "hoo-ha" in the community.

"But we see the other side of it. We used to have doctors on duty 24/7 for three weeks or more, being disturbed at night and sometimes for things that were not life-threatening – a stomach ache or diarrhoea. The doctors were not on the ball for the next day. It's much safer now."

Despite all the frustrations of her job Karen says she wouldn't change her situation or her role in the village.

"I grew up in a small town in New Zealand and both my parents were heavily involved in our community. I think I've inherited that mentality – what you put into a community is what you get out of it."

Jim Killgore is an associate editor of Practice Manager

Speak up

Risk training consultant and former pilot **Phil Higton** warns that failure to recognise and manage 'authority gradients' in your practice can sometimes have serious consequences

WHEN relationships are under pressure, communication is one of the first things to suffer. Communication failure is the highest-ranked contributor to risk, safety failures and significant adverse events. But creating an environment in which 'difficult' conversations can be made less threatening and more productive does not happen by chance – all the team have to play their part. Understanding how to manage the 'authority gradient', and being clear about what assertiveness is, are two elements of success. The high-pressure world of aviation offers important lessons.

Imagine the scene: a crew of professional and skilled pilots are picking their way around turbulent shower clouds as they descend towards the airport. The bright lights of the airport and the town are occasionally visible through the gaps in the cloud but the rest of the mountainous island is invisible. Some of the radio equipment at the airfield is not working which will make the approach more complex. Once below the cloud they can't see the town or the airfield and the first officer is worried. They are below the height of Nimitz Hill and not on the normal route.

There are two sides to this dilemma. The captain is working hard controlling the flight-path in difficult conditions. In an ideal world he would want the first officer to speak up with his concerns but, right now, being told that things are not going well could be heard as criticism and make a difficult situation worse. Meanwhile, the first officer has the constraints of junior rank and inexperience to overcome in addition to any social inhibition when making comments or contributions.

➔DILEMMA

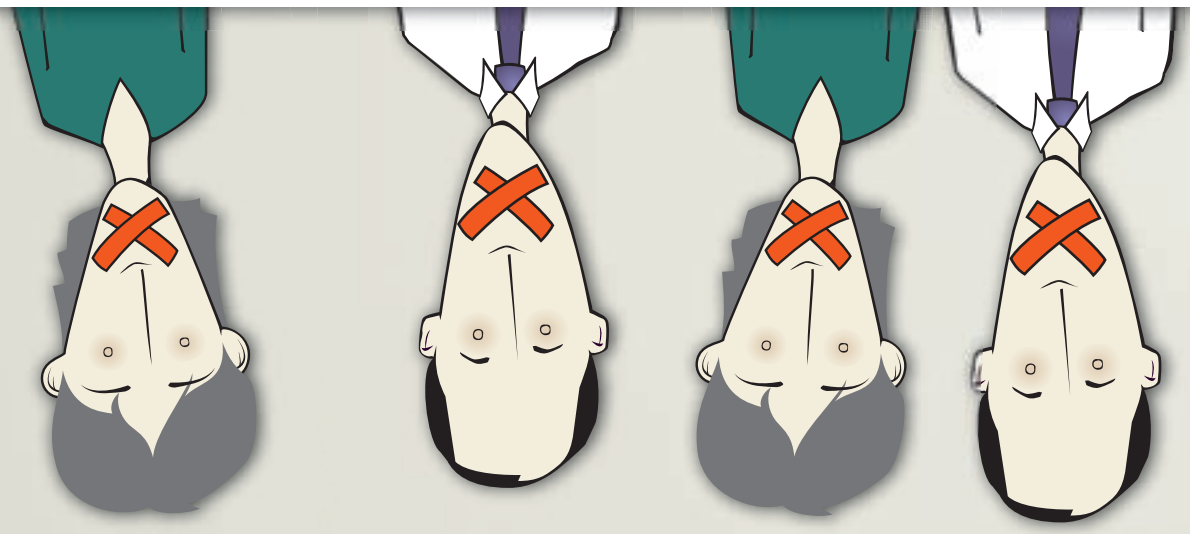
The issues facing the crew are repeated in high and not-so-high-risk environments the world over. Psychologists describe these issues as power/distance. In aviation we talk about this as the authority gradient, or the difference in authority between the senior and junior team members. If the gradient between them is steep, the boss will have a tight grip on proceedings and can appear decisive. Bosses often have high control needs and steep authority gradients are superficially effective in 'getting the job done'.

The down-side to this is that juniors may feel they are merely 'units of labour' and be reluctant to communicate or contribute observations and insights. Over time the juniors may lose the capacity to think for themselves and become dependent on the boss for even the most trivial decisions.

Shallow authority gradients have their drawbacks too. Giving every team member licence and opportunity to comment and contribute over every matter can slow decision-making or stop it altogether. Responsibility may become blurred. At the extreme, it may be that the nominal leader will carry the responsibility for a committee decision which they personally thought to be inappropriate or did not have the authority to implement.

➔MINIMISING RISK

There is no one-size-fits-all solution. Shallow gradients are good for team-building and generating solutions when either the nature of the problem is unclear or where the remedy is neither routine nor obvious. Steep gradients are often appropriate in a crisis or where immediate action is required but may add risk because the decision-maker is isolated from the insight of his or her team.



In the world of general or dental practice, partners are likely to have a bias towards independent decision-making (steep gradient). It is part of their professional training as most patients will expect a quick decision about their care. For other staff in the practice there is the impact of a distinct and long-standing professional hierarchy which can mean that many decisions are referred upwards. This is reinforced by the perceptions of the risk to patients if decisions are not sound. Over time, both the will and ability of more junior staff to make decisions, even in administrative matters, is eroded.

Taking decisions locally requires competence and confidence. Appropriate training can deliver competence but confidence can be reinforced or shattered by the working relationships. With pilots, a collapse of confidence often leads to a loss of competence. When this happens, an instinct of self-preservation is triggered which results in that individual saying and doing as little as possible (steep gradient). Other members of the crew take up the slack since the task has to be completed, but the individual feels marginalised, reinforcing the steep gradient.

The safety risk is increased if the decision-maker becomes overloaded. Overload is a killer. In aviation we say: "When I am overloaded I become incompetent (make unforced errors) and my judgement goes (make poor decisions)". Our single, limited-capacity brain has to control our movements and activity at the same time as making sense of what is going on and taking decisions. So, when demands in one aspect are high, performance in the other is compromised. The study of 'human factors' and the practice of Team (Crew) Resource Management, which is used in aviation, centres on creating an environment in which overload is proactively avoided.

Communicating effectively when the workload is high is critical to safety, but creating the appropriate environment and developing the necessary skills has to be undertaken before the workload increases. We need to be able to recognise the signs of overload in ourselves as well as in our work colleagues because this will be the time when our ability to communicate is most seriously compromised.

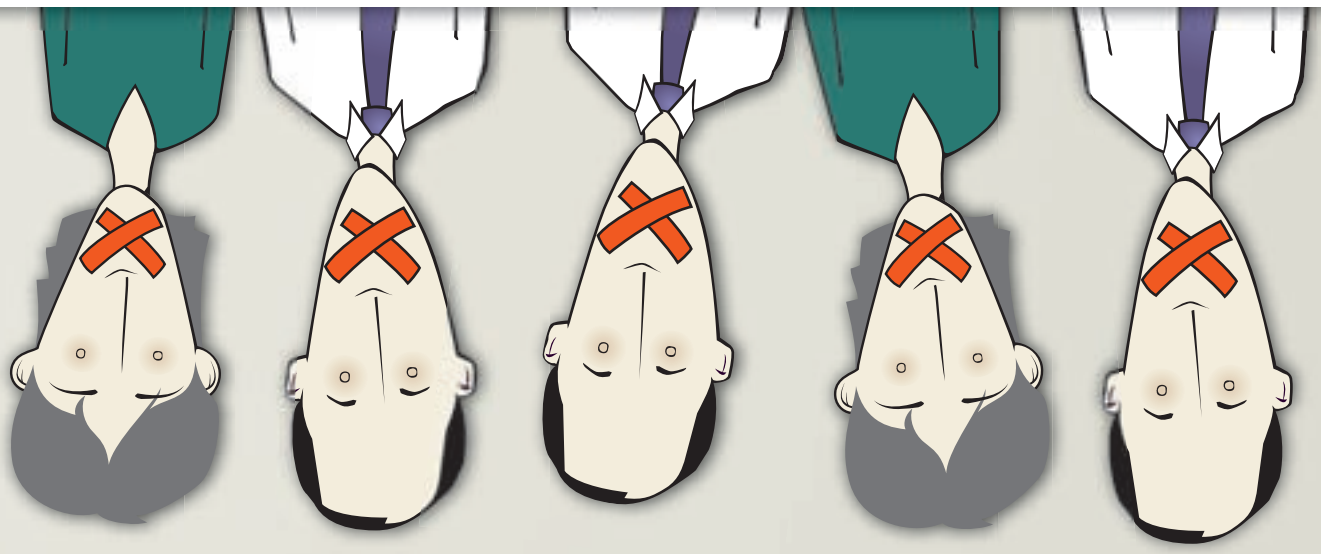
MANAGING THE AUTHORITY GRADIENT

Seniors must make themselves approachable and juniors must be competent and confident in their role. Seniors should invite juniors to speak up with their concerns or professional contributions and juniors must make those contributions clearly and professionally.

High risk often sits alongside high workload. Agreeing a small, appropriate group of phrases to be used whenever high workload or high risk is recognised is important. If anyone, particularly someone under pressure, has to interpret the nuances of what is said, a significant risk to safety is introduced. A professional language with agreed phrases is powerful in addressing this. Without it, we often fall back onto inhibited social language. We fail to 'talk straight'. We use hints and soften any statement which may be seen as a form of social challenge either to protect ourselves from retribution or to save face on of behalf our colleague. In protecting ourselves and our egos, we put others at risk.

In the aeroplane story, you may see all the possible inhibitions - social, professional and hierarchical - mixed with high workload and uncertainty. We have a cockpit recording which illustrates what happens in real life. The first officer's words of warning were: "The weather radar is our friend this evening". Precisely what he meant we will never know. The aircraft crashed into Nimitz Hill with no survivors.

Phil Higton is director of training with healthcare training firm Terema



A tragedy in four acts

The scenario below takes place over the course of a week and involves one patient and eight different members of a practice staff. There are 10 attempted and actual patient contacts. Can you see how the outcome could have been prevented?

The Previous Week

1: A patient who is feeling generally unwell attends her local GP practice. She consults with **GP A** who examines her and records 'No abnormalities detected'. He advises her to come back if not better in a couple of days.

Day one

2: The patient returns to the practice still feeling unwell. She has a sore throat and feels "fluey". This time the patient sees **GP B** who takes a blood sample and prescribes penicillin. He advises the patient to go home and take paracetamol to control her symptoms. **GP B** orders three blood tests: 1) FBC; 2) U&E; 3) glucose. The samples are sent off to the lab.

Day two

3: The results of test 1 (FBC) arrive back from the lab at 13:00 hours. Receptionist A passes the test results to **GP C** (duty doctor) who checks test 1 result against the consultation notes and advises "OK". There is a slightly raised WCC but nothing worrying. Medical records are updated and the patient then phones the surgery a short time later, to be told by receptionist A that her "blood test is normal".

Test 2 (U&E) returns from lab at 14:30 hours. Receptionist B passes the electronic test result to **GP B**; it shows a significantly raised K + level. He decides that the patient needs to be seen that afternoon and asks receptionist C to contact her.

Receptionist C attempts to call the patient twice by phone but with no success. Later that afternoon receptionist B also fails to contact the patient and informs receptionist D, who also phones the patient half an hour before closing, leaving a message asking the patient to contact the surgery, but giving no indication of any urgency. There is no subsequent contact with the patient and **GP B** is not reminded/informed of this before the surgery closes that evening.

Day three

4: Receptionist C notices that receptionists B and D had been unsuccessful in reaching the patient the previous day. She manages to contact the patient by phone and schedules an appointment with **GP B** that afternoon. **GP B** is then called away to an urgent home visit and the patient sees **GP D** instead. The doctor consults with the patient but only sees the results of test 1 which he does not find alarming. The results of test 3 (glucose) have now also been returned to the surgery and are viewed as normal. But the electronic result for test 2 had been temporarily saved as a blind communication between **GP B** and Receptionist B rather than embedded in the patient's record. **GP D** does not see the test 2 result and tells the patient that nothing is seriously wrong. She leaves the surgery.

Later updating the record he discovers the test 2 result and arranges for immediate hospital admission before ringing the patient. He gets no reply and leaves an urgent message. Time passes and **GP D** grows increasingly worried and drives to the patient's home only to discover the patient's husband has already taken her to hospital. Later that day the patient dies from cardiac arrest due to complications related to her blood chemistry.

THIS case highlights how both systems failures and human error can combine to provide the conditions for a tragic outcome. One key feature was the flawed 'communication chain' between the various GPs and receptionists tasked with passing on important and, in this case, life-saving information to the patient. Another failing was in the practice procedure for recording and communicating test results between staff. GP B correctly realised the significance of the U&E result and put in place a plan to contact and alert the patient. But due to the software interfaces of the results handling system, the electronic test result was temporarily saved as a 'blind communication' and this resulted in a potential lost opportunity on day 3 when the patient was seen by GP D.

Various other points in the chain of events offered opportunity to rescue the situation but these were missed. Chance also played a role as when GP B was called away on the urgent call at a crucial point.

Some important lessons can be drawn from this study. Practices should:

- Ensure they have a written policy on results handling.
- Establish clear responsibilities and protocols for ordering, logging and marrying up test results – including multiple results.
- Implement a system for clinicians to action results where indicated and order any subsequent actions required, as well as checking up if required actions have been undertaken.
- Be aware of and act on potential electronic system defaults, which could potentially lead to a result being overlooked.
- Ensure that there is an effective mechanism in place to check and manage abnormal results, including a practice protocol for contacting patients – balancing urgency against the risk of breaching patient confidentiality.

Alan Frame is risk adviser with MDDUS Training & Consultancy Services

Diary

LAUNCHING a new magazine can be a lonely business. You look up from your desk after a long day – weary and dispirited – and think to yourself: something's missing here. Then comes the realisation – that missing factor, dear reader, is you. In putting *Practice Manager* first to print there is no one yet to point out those 'its' versus 'it's' errors, no terse emails exposing our use of 'practice' instead of 'practise' (what was the difference anyway, must look that up again). So welcome now with hopes that next issue you'll be well onboard to keep us on our game – and also to provide some interesting items for this diary. Now on to important matters.

➔JUST in time for Christmas, toys have been banned in Wales. Well not in all of Wales, just in some practice waiting rooms – and for good reason. Dr Charlotte Jones, a GP in Swansea said: "I've had all the books and most toys removed from our surgery to reduce the chance of transmission of infections, such as swine flu and measles, after studies have shown they can be passed on through touching toys. We removed the magazines too because droplets can live on them for a few hours and they are a potential source of infection." Will such Spartan measures work? A consultant epidemiologist for the National Public Health Service for Wales isn't convinced. Dr Brendan Mason said: "The most important method of preventing the spread of the infection is to encourage frequent hand washing with soap and water and frequent cleaning of hard surfaces." One might also suggest banning patients – if that plan wasn't already well in hand.

➔MORE interesting news for the nation's children from experts at the University of Southern Denmark. Their report in *The Lancet* this month reckons British children born in 2007 have a 50 per cent chance of living until they're 103. And for those who baulked at the thought of the retirement age increasing from 65 to 66, spare a thought for these young folk who may have to work until they're 80 just to meet the financial burden that will inevitably be placed on the healthcare system. Mind you, enterprising scientists at the University of Leeds might hold the answer. They've just announced a £50 million, five-year programme to build human spare parts. Before you ask, this is not a hoax from someone who has watched too many episodes of *The Six Million Dollar Man*. If they're successful, we could one day be typing our emails using a bionic hand and walking around on a man-made hip joint that'll never wear out. Although, if all of that is just a ploy to keep us working until we're 80 then perhaps it's not such a good idea after all...

➔A TRUE sign that practices should never give up on a patient comes from 102-year-old Winnie Langley who has finally quit smoking – after a mere 95 years of puffing. The remarkable pensioner from Croydon, South London, had her first ciggie in 1914 and has apparently given up the habit because she just "didn't fancy it any more". That's a long time to wait to boost your QOF score.

➔NHS CHOICES has recently been trumpeting the success of its new online facility for patients to rate GP practices and provide feedback. The site received more than 1,600 comments within 24 hours of going live last month. Most patients (80 per cent) answered yes to a question asking whether they would recommend their practice to a friend. But that still leaves hundreds not so encouraging. Among the comments logged so far were: "I've experienced a broad spectrum of NHS primary health care. Without a doubt this practice is by far the very best..." But there was also: "The hellish combination of entering what feels like a portakabin to be welcomed by a sea of leaflets and posters which peer out from the low level lighting is enough to induce a feeling of dread on each and every visit". Dear me.

➔FOR those looking to brighten up their practice, perhaps think twice before encouraging staff to belt out their favourite chart songs. Shop worker Sandra Burt from Clackmannan near Stirling had a close call with the Performing Right Society (PRS) who decided her daily 'outbursts of joy' constituted live public performances and demanded she pay for a licence. They even warned she could be taken to court if she didn't stop serenading customers. Luckily they came to their senses and apologised for their over-zealous approach. But it might be worth warning any practice staff member who enjoys a sing-song to check none of the patients are PRS members.

➔AND FINALLY to a consultation document recently published by the Department of Health on proposals to give patients personal health budgets allowing them to spend NHS money on 'non-traditional' services such as complementary therapies, respite care, equipment or transport. Pilot schemes are expected to involve GPs across England helping patients draw up care plans to allocate money from the budgets. One curious item in the consultation states that the regulations should exclude direct payments being spent on "alcohol, tobacco, gambling or debt repayment". Perhaps it is best to make such minor caveats explicit.

CALL FOR DIARY ITEMS.

Do you have any tidbits, anecdotes or absurdities in a similar vein to the items above? Please write in or email them to **PM@mddus.com**

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