Practice Manager
AN MDDUS PUBLICATION
ISSUE 2

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MDDUS

Practice Manager

PHOTO: BILL BAIN

WELCOME AGAIN TO THIS SECOND issue of *Practice Manager*. I am sure you will all be interested, as I am, in reading the 'Doctors without borders' article on page 8. Currently there seem to be more questions than answers surrounding the issue of removing practice boundaries and it may be an interesting challenge to general practice in the future. It has certainly sparked strong reactions from all sides of the healthcare debate, but once again this brings into sharp focus the ever-changing environment which is general practice.

From here, the focus switches to the challenges of dealing with enquiries from the media in associate editor Joanne Curran's article on page 12. There are many reasons why a reporter might call at your practice and managers should be careful in how they respond as patient confidentiality is key.

We are all aware that a robust system for following up abnormal test results is vital in any practice, and on page 14 MDDUS risk adviser Alan Frame analyses the case of a young woman who fell victim to this type of system failure by her GP practice and family planning clinic. Our Call Log on page 4 highlights some common risk areas that have emerged in advice calls made by members to our team of advisers. Questions about disclosure of patient information and a delay in writing medical notes are a couple of the issues raised here.

In our Practice Profile on page 10, MDDUS editor Jim Killgore visits one of the UK's largest medical practices. General manager Lizzie Page discusses some of the challenges in running a practice which has 15 partners and serves more than 26,500 patients. Our employment law experts focus on the rights of employers and employees in drawing up flexible working arrangements on page 5, while on page 6 they highlight the health and safety issues surrounding sharps injuries.

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PM conference an "inspiring" success

ILM Diplomas in Healthcare Management were handed out to practice managers by MDDUS trainer Cherryl Adams at the Practice Managers' Conference. From left: Lynne Bolton, Frances Woods, Joanne Monaghan, Cherryl Adams, Lorraine Blunn and Karen Brown.

THE sixth MDDUS Practice Managers' Conference in February has been hailed a major success by delegates.

The event was held over two days at the Fairmont, St Andrews hotel and was a sell-out, attracting 205 managers from across the UK. Delegates praised the varied selection of informative workshops, thought-provoking speakers as well as the top class dinner and dance at the event.

Among those who travelled to St Andrews was Helen Dixon, practice manager at Kingsnorth Medical Practice in Kent, and her assistant practice manager Nicola McMinn. Ms Dixon told *Practice Manager*: "This is the first time we have been to a national practice managers' conference and it was really quite inspiring and gave us a lot to think about. It was great meeting up with colleagues from across the UK and we are keen to attend the next one. We do find MDDUS brilliant and when we call we always get the answers we need very promptly."

There was also positive feedback from managers for keynote speakers and aviation experts Phil Higton and Andy White from Terema whose fascinating take on "human factors" and risk was very well received. MDDUS staff also brought their experience to the conference, with medico-legal adviser Dr Anthea Martin leading a session on information governance while MDDUS' Training and Consultancy team – Liz Price, Cherryl Adams and Alan Frame – held workshops on various topics from managing patient aggression to influential communication.

Delegate feedback forms completed at the end of the conference highlighted just how well-received the event had been. The conference dinner and the grand finale of the mock fatal accident inquiry (FAI) attracted particular praise.

One delegate commented: "The FAI was excellent. This was a draw to my attending" while another said: "Another excellent conference, thank you MDDUS. [There were] useful workshops, good speakers – a superb environment for networking with colleagues." Managers of all abilities attended, with one commenting: "I am new to the manager's role and [the conference] gave me the opportunity to meet others in the same role and gain their knowledge and experience." Other comments included: "Very well put together, a great networking event and pertinent and topical material. Thank you."

Revised booklet on complaints handling

A REVISED edition of the MDDUS booklet on complaints handling in primary care has been published. The short guide is intended to provide practical advice on dealing constructively with patient complaints and in compliance with NHS and other regulations. *The Essential guide to complaint handling in primary care* can be found by searching online on our Resource Library at www.mddus.com. Print copies are available by contacting Karen Walsh at **kwalsh@mddus.com**

At last... MDDUS launches free employment law advice line

➔ PRACTICE managers within MDDUS group schemes or members who have employment responsibilities will soon be able to access a free helpline offering unlimited employment law and HR advice.

The new service will start in June with an experienced in-house team providing members with guidance on good HR practices and advice to those experiencing difficulties with employment matters. The service is intended to primarily operate during core hours but will be available 24/7 for urgent enquires.

Members will enjoy prompt advice via telephone or email on pressing matters and assistance in drafting or amending employment-related policies and procedures – all compliant with latest legislation. As the advice service is unlimited, members can speak with the team regularly for follow-up on developing situations.

MDDUS Training and Consultancy Manager Liz Price said: "Our managers have been asking us for a specialist employment law service for a long time – so we were happy to listen. I think this service will be invaluable for our managers."

The service will be available by calling 0845 270 2034 to speak directly with the team or by email at employmentlaw@mddus.com

ADDITIONAL SUPPORT

In addition to the helpline, MDDUS is also offering to Practice Schemes – where all employing GP/GDP partners are members of the Union – the option of a Legal Support, Representation and Indemnity package (LRI) which will be available for a small additional fee per head of employer. The LRI package provides access to assistance in matters that go beyond simple advice and guidance. It includes:

- Legal support and representation including costs.
- Employment tribunal award protection: in cases where an employee is awarded financial compensation following representation of a practice by our legal partners the settlement will be met on the practice's behalf by MDDUS. This is a significant benefit as disability claimants have been awarded in excess of £200,000.

The annual subscription for this LRI package is based on the number of sessions that the employing GP/GDP partners within the Group Scheme undertake on average per week.

For advice and also further information about the service call our Employment Law team now on **0845 270 2034** or email **employmentlaw@mddus.com**

New leadership programme aimed at PMs

➔ IN RESPONSE to the success of our leadership programme for doctors and dentists, MDDUS is launching an equivalent programme focusing on the unique challenges facing practice managers.

The Leadership in Practice Programme is the latest in our suite of partnership qualifications with the Institute of Leadership and Management (ILM). This course aims to provide a holistic development opportunity specifically for practice managers with the leadership challenge to drive positive change.

This programme will challenge you and help you positively change the way you manage your team. It will furnish you with the tools to ensure that you tackle change effectively and help you create interdependent, effective relationships in the workplace – helping you to recognise the impact you have on your colleagues.

Topics include:

- Understanding the management role
- Becoming an effective leader
- Building effective teams
- Understanding organisational behaviour
- Leading innovation and change.

Delegates attend five full day workshops which include a variety of creative learning/teaching techniques and – due to the small numbers admitted to the programme – are individual and group-based dependent on the topic. Sessions are very informal and responsive to group need within the agreed framework.

Completion of the programme leads to the ILM Level 5 Award in Management and delegates must submit three written assessments (two work-based assignments and a reflective review) to achieve the award.

Programmes will run in both London and Glasgow. Dates for the London programme have yet to be confirmed but in Glasgow the dates are 13th September 2010, 11th October 2010, 8th November 2010, 13th December 2010 and 10th January 2011

Fees are £749 for MDDUS DPS managers and £867 for non-DPS managers and include VAT, ILM registration fee and programme workbooks. For more information, contact Ann Fitzpatrick on afitzpatrick@mddus.com or call **0141 228 1261**.

MDDUS practice schemes

➔ Practice managers are reminded that MDDUS Practice Schemes exist for financial savings, ease of administration and continuity of renewal. If your practice already has Practice Scheme Membership, we would remind you that the majority of the GPs or GDPs in your practice should be MDDUS registered to maintain the benefits of scheme membership. Further details regarding MDDUS Practice Scheme membership are available from our Membership Services Department on **0845 270 2038**.

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.

AN ACADEMIC REQUEST

Q A primary school contacts the GP of a seven-year-old boy who has a poor attendance record. The boy's mother has kept him off school several times in the past year and tells the school her son has been absent again because of a doctor's appointment. The school asks the GP if they can confirm the mother's story. The GP knows the boy has not attended any appointment and phones MDDUS to ask if he can give the school this information.

A The short answer to this query is "no". Doctors cannot usually or normally disclose any patient information without first getting the patient's consent, or in this case, consent from a parent. The school may argue the information relates to their concerns over the child's welfare, but the GP is bound by strict confidentiality rules and cannot release any information without permission. Only in serious cases, where you believed the child is a victim of neglect or abuse and is unable to consent to disclosure, could you consider releasing this information without consent.

A FORGOTTEN VISIT

Q A GP makes a home visit to an elderly patient while he is on his way home at the end of a Thursday surgery. The patient had been receiving treatment for a heart attack two months earlier which had initially been misdiagnosed by one of the practice doctors. The GP is not due back in the practice until the following Tuesday and forgets to write up his notes on the consultation. The patient subsequently requests a copy of her notes and the GP discovers his mistake. He asks MDDUS for advice on how to proceed.

A An MDDUS adviser told the GP he should write up a note in the patient's records for the visit now, but clearly sign and date the entry to indicate when it was written and include a brief explanation of why it was entered late. He was also advised to apologise to the patient and ensure the practice has a robust system in place to record home visits promptly. This is particularly relevant for any doctor who goes on a home visit directly before taking time off, or for locum GPs who may not be scheduled to return to the practice in the near future.

DRUGS POSSESSION

Q A GP's patient has been arrested by police on minor drugs possession charges. The patient denies any wrongdoing and claims his GP prescribed the pills. The police later contact the GP and ask her if she did indeed prescribe the drugs. She tells police she did not prescribe them but later contacts MDDUS concerned that she has made a mistake.

A The GP did not have the patient's permission to disclose confidential medical information to the police and should not have done so. Doctors are entitled to disclose personal information about a patient to police only under certain circumstances, for example if it is in the public interest or if police are investigating a serious crime, such as assault or murder. In this particular case, the charges appear to be minor and would not give the GP the right to disclose without the patient's consent. The GP is advised that if the patient in this case complains, an apology would be appropriate. Practices should always refer to GMC guidance on making disclosures to the police and call MDDUS for specific advice.

PARENTAL ACCESS TO RECORDS

Q A father contacts a surgery in England where his child is a patient. He and the child's mother are unmarried and now separated, and he wants access to the child's medical records. The mother also contacts the surgery to ask he not be allowed access. The practice manager calls MDDUS asking for advice how to proceed.

A It transpires that the father is recorded on the child's birth certificate and the date of birth is in August 2005. This means that by law he does have a right to access his child's medical records (note the location and DOB are important here as specific legislation varies among home countries). The mother is informed of this and insists that her own address not be disclosed in the records. MDDUS advises that this and any other potentially sensitive third-party information is redacted from the notes before being released to the father.

SCANNING PATIENT RECORDS

Q A practice contacts one of our dental advisers about a project to scan old patient records onto disk for uploading to the practice system. The plan is to contract the project out to a third party company specialising in this type of work. The company has reassured the practice that any work they do is fully compliant with the Data Protection Act (DPA) and that patient confidentiality will be strictly maintained. Can they contract the work?

A The adviser explains that the onus will be on the practice to scrutinise any contract with the company in order to ensure that the work would be done in compliance with all relevant legislation – namely the DPA. Ultimately it is the responsibility of the practice to ensure patient confidentiality so it is important to be perfectly satisfied that any third-party contractors are completely trustworthy and professional.

The 'work-life' dilemma

A WIDESPREAD myth seems to persist among employees in regard to 'flexible working' – namely that "if I need to change my hours to suit my domestic commitments, my employer needs to accommodate me – on pain of a complaint to the Employment Tribunal, if they refuse".

And the mythology is not limited to employees. Many employers feel under great pressure to accommodate changes to working arrangements asked for by staff – fearing that refusal will find them in court, even when the demands are wholly unreasonable or impractical.

While enabling staff to find a 'work-life balance' can be an important element of successful people management (and, indeed, may make the difference between retaining a valued member of staff and losing them to another employer), the needs of the practice must also be considered in such cases. The law is of some assistance to both employers and their employees in this regard – but not without some caveats.

The fundamental principle is that employees have the right to request (not demand) flexible working for certain (limited) purposes and their employer has a duty to consider these requests in good faith and without discrimination in their decisions.

Many employers choose to go beyond their statutory duty in response to staff requests, but it is important to understand what the law actually says here.

If a request is made in writing from an employee, who has at least 26 weeks' service, stating that they wish to vary their contractual hours or working arrangements permanently in order to care either for a child or dependant adult, then the employer must meet promptly with the staff member to discuss their request.

Employees have the statutory right to ask if they:

- have or expect to have parental responsibility of a child aged 16 or under or a disabled child under 18
- are the parent/guardian/special guardian/foster parent/private foster carer or the spouse, partner or civil partner of one of these and are applying to care for the child
- are a carer who cares, or expects to be caring, for an adult who is a spouse, partner, civil partner or relative; or who, although not related to them, lives at the same address as them.

The employer must seriously consider any application made, and only reject it if there are good business reasons for doing so. It is worth noting that, no matter how outrageous the request might be, the employer will risk a complaint to the Employment Tribunal if the request is not considered in strict accordance with the law – even if it is eventually rejected.

The written application should be made well in advance of when the employee wants it to take effect. It must state that the application is made under the statutory right to request a flexible working pattern and give details of the flexible working pattern they are applying for, including the date from which they want it to start.

Importantly, the employee is required to explain what effect they believe the new working pattern would have on their employer and how any such effects might be dealt with. Finally, an employee who has made such a formal request must wait 12 months before presenting another request.

If the request complies with the above conditions, the employer should arrange a meeting with the employee within 28 days of receiving their valid application. If it is difficult to arrange a meeting within this period, seek the employee's agreement to extend it.

Failure to hold a meeting within the 28-day period or any extension, without the employee's agreement, will be a breach of the procedure. The employee has the right to be accompanied by a work colleague or certified trade union representative at the meeting.

You must notify an employee of your decision within 14 days of this meeting.

As we said above, good business reasons can be advanced by the employer for rejecting a request. These are defined in the legislation as follows:

- planned structural changes
- the burden of additional costs
- a detrimental impact on quality
- the inability to recruit additional staff
- a detrimental impact on performance
- the inability to reorganise work among existing staff
- a detrimental effect on ability to meet customer demand
- lack of work during the periods the employee proposes to work.

In the event of a refusal of a flexible working request, you must explain in writing why the grounds for refusal apply in your particular circumstances.

If a staff member understands why a business reason is relevant, they are more likely to accept the outcome and be satisfied that you have considered their application seriously – even if it isn't the outcome they wanted. An appeal against the decision must be allowed and heard by someone other than the original person who decided the matter.

Clearly, the ideal situation is one in which flexible working arrangements are discussed in a spirit of compromise and good faith on both sides. However, there is no right to demand flexible working in any circumstances and staff need to grasp this before starting the discussion process. ❋

Ian Watson, Law At Work

At the sharp end

EXPLETIVE deleted! We've all done it; pricked a finger while sewing on a button, mending a seam, or carrying out one of a myriad of everyday household tasks using a needle or other sharp implement.

But while the vast majority of these accidents are inconsequential and can be dealt with using water, pressure and occasionally a plaster, it's completely different for healthcare workers.

Healthcare professionals use syringes, scalpels and a variety of sharp implements on a daily basis in the course of their work. Whether it's taking blood, giving a vaccination, a pain-killing injection, or carrying out a major operation, doctors, dentists and nurses are at significant risk of serious injury and illness throughout their working lives.

European estimates indicate that more than one million needle-stick injuries take place in a medical setting across Europe each year. Of these, UK trade unions estimate that 100,000 UK healthcare workers are injured each year. Any such injury can result in the injured party contracting one of more than 20 life-threatening viruses, including Hepatitis B, C and HIV.

Reducing the number of injuries from needle-stick and sharp instruments has been on the European Union's agenda for the last 10 years. The EU's concern culminated in March 2010 with the passage of a European Directive requiring member states to take action by 2012 with the aim of cutting sharps injuries in healthcare by 25 per cent. The directive focuses on practical steps which employers will be required to implement in order to achieve the target. It makes clear that risk management is the key to reducing injuries from sharps.

That means making sure that the equipment supplied is the safest available, that a full risk assessment has been carried out to identify any dangers which can be reduced or eliminated, that work procedures are designed to keep the workforce as safe as possible, that appropriate arrangements are in place for the safe disposal of used sharps and, crucially, that staff are fully trained in the safe use of sharp instruments.

It is estimated that around 40 per cent of injuries take place during a medical procedure, and a further 40 per cent after the procedure has been carried out. The key causes include:

- recapping, bending, or breaking needles
- inserting a needle into a test tube or specimen container and missing the target
- injury from a person carrying unprotected sharps
- sharps that are present in unexpected places, such as linens
- during complex surgical procedures
- handling or disposing of waste that contains used sharps
- patients moving suddenly during injections.

The EU is particularly concerned with the recapping of needles, especially when two hands are used for the procedure. It proposes that recapping should be banned immediately. Two-handed recapping is more dangerous because of the co-ordination required, and the possibility of one or other hand or arm being nudged. Single-handed recapping is safer because only one limb is involved, and a nudge or bump will affect the whole movement.

The directive also requires workers (including students) who are at risk of sharps injury to be offered free vaccinations where a vaccine is available. Given the concerns over the safety of some vaccines, those being offered vaccination will also have to be given a full explanation of the pros and cons of vaccination.

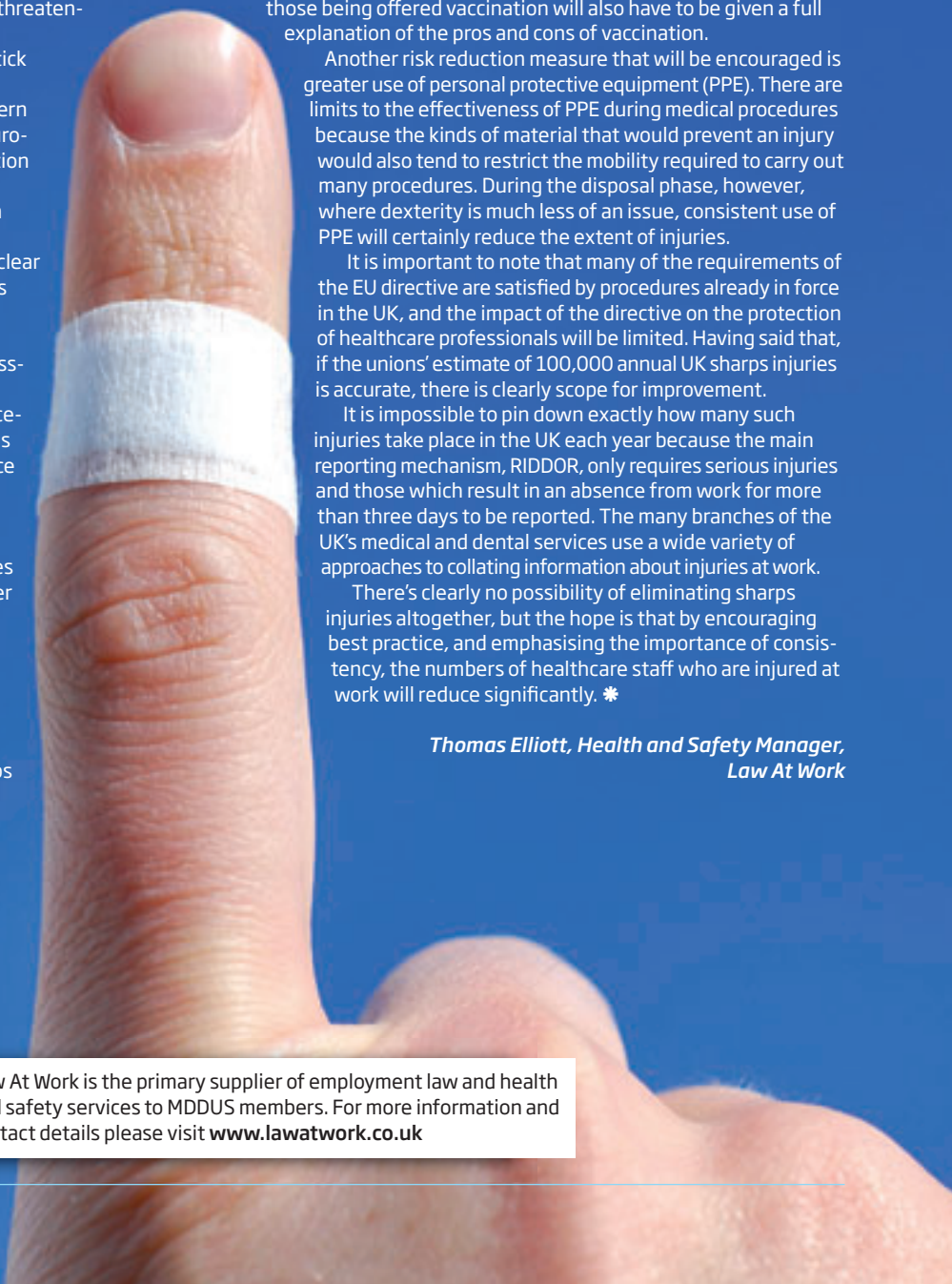
Another risk reduction measure that will be encouraged is greater use of personal protective equipment (PPE). There are limits to the effectiveness of PPE during medical procedures because the kinds of material that would prevent an injury would also tend to restrict the mobility required to carry out many procedures. During the disposal phase, however, where dexterity is much less of an issue, consistent use of PPE will certainly reduce the extent of injuries.

It is important to note that many of the requirements of the EU directive are satisfied by procedures already in force in the UK, and the impact of the directive on the protection of healthcare professionals will be limited. Having said that, if the unions' estimate of 100,000 annual UK sharps injuries is accurate, there is clearly scope for improvement.

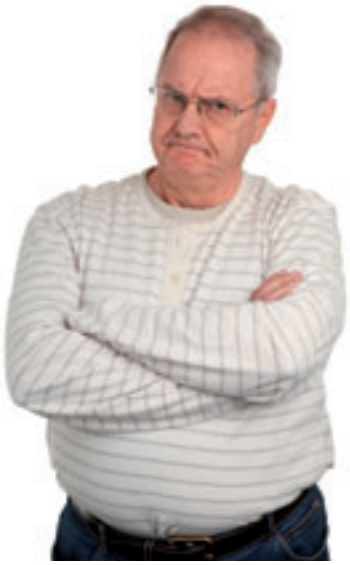
It is impossible to pin down exactly how many such injuries take place in the UK each year because the main reporting mechanism, RIDDOR, only requires serious injuries and those which result in an absence from work for more than three days to be reported. The many branches of the UK's medical and dental services use a wide variety of approaches to collating information about injuries at work.

There's clearly no possibility of eliminating sharps injuries altogether, but the hope is that by encouraging best practice, and emphasising the importance of consistency, the numbers of healthcare staff who are injured at work will reduce significantly. ✱

Thomas Elliott, Health and Safety Manager, Law At Work



Troubled or just troubling?



WHEN someone mentions the phrase "heartsink patient", are there many among us who could not picture at least one or two people who fit that description?

These challenging patients present in a variety of ways and chances are they take up a disproportionate amount of your team's time. This makes it an issue where the practice manager may need to get involved.

For many problems in general practice there are solutions that can be worked out pragmatically and implemented, such as with a system or process which needs "fixing". This is far from the case when dealing with difficult patients. Each is unique and may be of any age, sex, background, education or class. It is also worth bearing in mind that someone who is regarded as one doctor's heartsink, may not be another's.

It is well established that a small proportion of patients can generate a disproportionate amount of work. In 2001 the *BMJ* published that the top 3% of attenders generate 17% of a GP's clinical workload.

> "THESE PATIENTS HAVE AN EFFECT ON THE WHOLE PRACTICE, SO A TEAM APPROACH IS REQUIRED"

So how do you deal with these patients to minimise their impact on your GPs or GDPs?

Difficult patients may cause problems in many ways. They may be rude, unreasonable, demanding or aggressive. They may simply waste a huge amount of time by persistently not attending appointments. They may be suffering from some mental health problem or be in real pain, and this could affect their normal judgement. They may be dissatisfied or unhappy due to previous bad experiences and it might even come down to the patient just having a really bad day.

Whichever way these patients present they have an effect on the whole practice, so a team approach is required. Calling a meeting with all the GPs or GDPs to discuss these patients as they are identified can be a good place to start. Each difficult patient will need to be managed in an individual way to maximise the impact that might be made upon their behaviour.

Identifying the behaviours which the team agree are unacceptable is very important. Discuss a general approach to the patient taking into context their individual circumstances. You might decide to initially write to the patient, or it may be more effective or appropriate to ask the patient to come along to the practice and discuss their behaviour with the GP or dentist with whom they have had most contact and possibly yourself. But make sure that no one is left to deal with the patient on their own. It may be an idea to minute this discussion or produce action points, at least to begin with.

If this helps to change behaviours it may be all that the practice needs to do to effect change. If not then a series of meetings may be needed to ensure that the patient understands what is expected of them. Consider drawing up a behavioural contract to detail formally what behaviours will be acceptable to all parties. A contract will only be effective if it is signed up to – especially by the patient. PCOs often have designated groups to manage difficult patients. It may be well worth contacting your local group to get advice or support.

A few years ago one of my practices had significant interactions with a gentleman who not only was a frequent attender but was also having a fairly major impact on our out-of-hours service. We sat down as a practice along with our local pharmacist, community psychiatric nurse, out-of-hours service and a representative from our CHP. We drafted a contract and met with the patient to clarify all views and expectations. All services which this patient accessed then had a clear understanding of the issues, and were in effect "singing from the same hymn sheet". This did not allow the patient to play one service off another. The approach was initially very effective and did indeed change behaviour. However, it required quite a bit of monitoring to ensure that the contract was adhered to. It didn't solve the issues for the practice but did make the situation more workable for the GPs, who are now much more comfortable dealing with this man.

Whichever way your practice decides to manage difficult patients it may only be effective if reviewed regularly. There's a saying that you may not win every battle, just as long as you win the war. So there will be successes and failures.

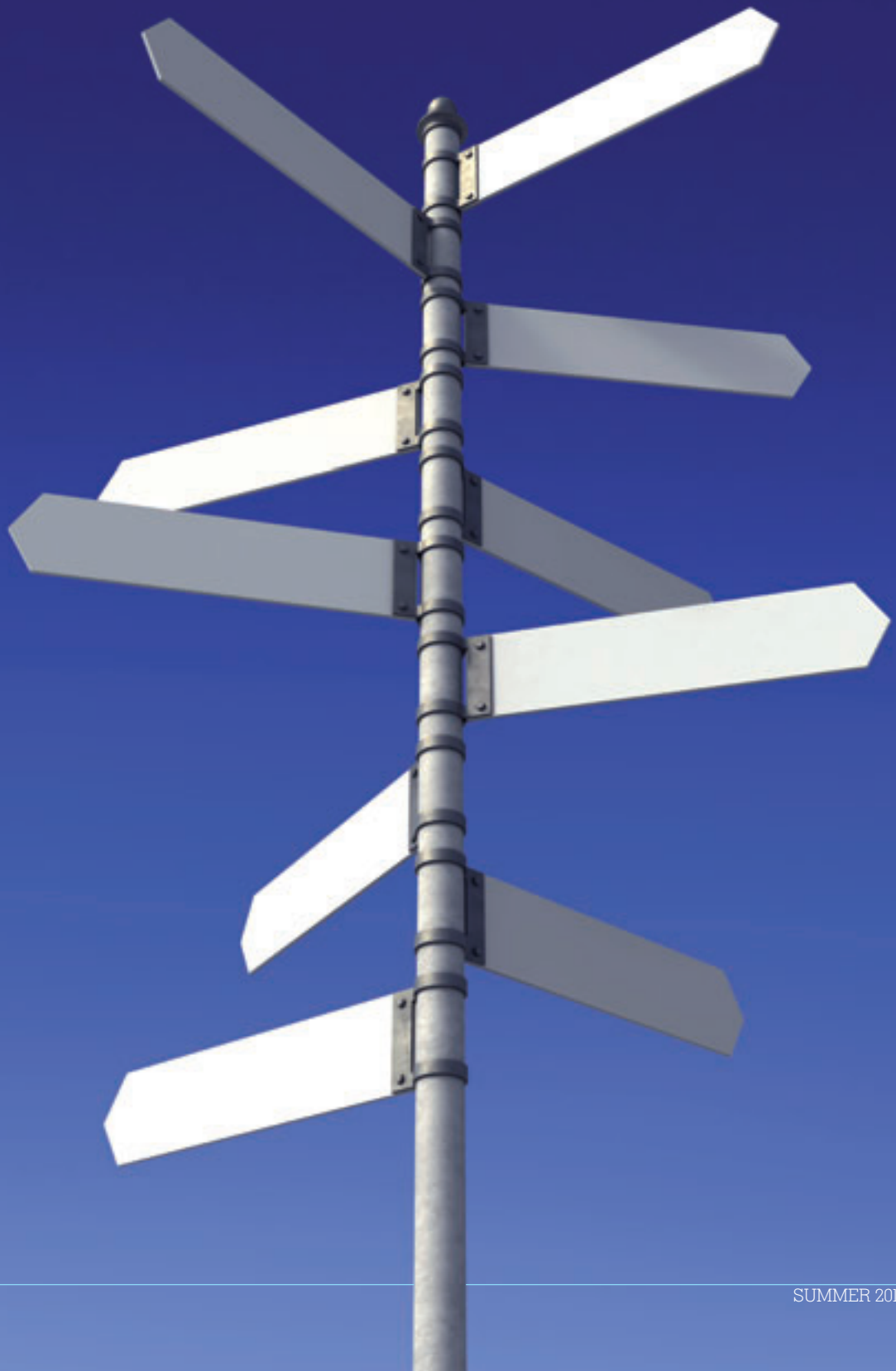
Ultimately the patient relationship may deteriorate to such a significant degree that a practice may have to consider removing a patient from their list. This should be the last resort when all other options have been ineffective. Clear guidance on this process has been published by the General Medical Council in *Good Medical Practice*, and by the Royal College of General Practitioners in *Removal of Patients from GPs' Lists*, which sets out the circumstances under which it is acceptable to remove a patient from your list. This can include a patient being violent towards you or your team, stealing from the premises or persistently acting inconsiderately or unreasonably. Similar guidance would apply to dental practices but check local regulations, especially with the recent introduction of continuous regulation for NHS patients in Scotland.

Whatever the reasons, the GMC is clear that "before you end a professional relationship with a patient you must be satisfied your decision is fair" and you must be prepared to justify that decision. However, with effective intervention, such a drastic step will hopefully not be necessary. ❋

Aileen Wilson is editor of Practice Manager and has been a practice manager for 14 years. She is based in the north-east of Scotland

Doctors without borders

Are plans to abolish practice boundaries practical and achievable?



MODERN consumers are used to being able to pick and choose whichever service they want based on what suits them best.

If your hairdresser gives you a bad cut, then you can easily try another salon. Or if there's a pub close to your work you might decide to go there on a Friday night rather than one near your home.

It now seems this level of consumer choice has reached general practice. The previous Labour government announced plans last September to abolish practice boundaries in England by October 2010, giving patients the right to register with whichever GP they choose. Commuters, for example, could register with a GP near their workplace rather than being restricted to a doctor close to home. And patients who were unhappy with their medical care would easily be able to switch to an alternative practice that may offer more or different services.

Even the newly formed Conservative-Liberal Democrat coalition government is unlikely to kill-off these plans. New health secretary Andrew Lansley made his feelings clear when he branded practice boundaries "a solid wall of defence against real choice" in a statement last June.

The Lib Dems also favour the policy, so the scrapping of practice boundaries looks almost inevitable. But the proposals have sparked considerable concern amongst healthcare leaders, GPs and practice managers.

This is despite former health secretary Andy Burnham putting forward a strong argument in favour of the changes when he launched a 12-week consultation on the proposals in March, entitled *Your choice of GP Practice: A consultation on how to enable people to register with the GP practice of their choice*. He acknowledged that the majority of patients are happy with their current GP practice but said a "significant minority" would like to change their GP.

Launching the consultation at Wandsworth Medical Centre, the former health secretary said "it is the right move at the right time". "We know that to make this work some changes will be needed, for example how we organise home visits for those people who choose to register with a practice further away from where they live."

His sentiments were echoed by Wandsworth Medical Centre's managing partner Dr Seth Rankin who said many patients would "really appreciate" having a greater choice of GP services. He added: "If the problems of home visiting patients living long distances away can be worked out, it is an exciting new challenge for general practice which we look forward to."

➔CONCERNS EXPRESSED

Mr Burnham and Dr Rankin's views, while positive, touch on just one of the numerous areas of concern raised by groups including the British Medical Association's GP committee, the RCGP and the NHS Alliance.

Many believe that abolishing boundaries would raise serious questions over funding arrangements, continuity of care when managing home visits, the risk of mismanagement and clinical error as well as the potential for health inequalities. Mr Burnham also admitted the boundary changes would likely increase pressure on A&E departments for patients who don't understand how the new home visiting system works. There would also be a greater requirement for shared medical records for patients registered with a second, 'distant' GP practice. This underlines the need for improved IT systems and for the roll-out of the Summary Care Record scheme – due for completion in 2011 – to be a success.

The BMA set out its own proposals for altering boundaries in *Reforming General Practice Boundaries* published in January. It said removing practice boundaries could incur a "huge cost and upheaval" and offered a different solution, just short of completely free registration.

Dr Laurence Buckman, chairman of the BMA's GP committee, said: "Complete free choice of registration is a good idea in principle. However, we don't want it to come at the expense of continuity of care or for it to lead to increased risks for vulnerable patients and a widening of health inequalities."

The BMA called for current IT projects, such as the electronic patient record transfer projects, to be accelerated so GPs could have access to full patient records in order to make safe clinical decisions. They highlighted the risk of widening health inequalities which could happen if some patients were unable to travel to practices further away while others can.

Systems would need to be put in place, the BMA said, to monitor "at risk" patients who are regularly re-registered at practices beyond their social services boundary and funding arrangements for GP practices would have to be reformed to ensure all practices were treated fairly. The BMA also called for more help for popular practices who are pushed to full capacity to improve premises to meet patient demand.

They have suggested a series of "local solutions" that would accompany a national change in the current "temporary resident" arrangements. They propose widening practice boundaries in urban areas, making more use of technology such as webcams and videophones for consultations and allowing patients who move outside a practice boundary to stay with their GP.

RCGP chairman Professor Steve Field has been less supportive, spelling out his concerns over the proposals in press reports last November. He said the college was "open to discussions" on how to resolve the issue of patient access but said: "I do not support the abolition of practice lists or practice boundaries." He added: "It would be crazy – if you don't have a boundary, how can you be a leader in a local community?"

➔OPPOSITION WITHIN THE PROFESSION

Echoing these concerns, more than two-thirds (68 per cent) of managers and clinicians from GP practices and PCTs said they were against extending practice boundaries, according to a poll conducted by NHS Alliance. The survey also found that 77 per cent of the 47 respondents believe more funding would be required if boundaries were extended. And a resounding 91 per cent said that practice catchment areas should continue to be used to identify patients for whom the practice has a duty to provide home visits.

Michael Dixon, NHS Alliance chairman, said: "Abolishing practice boundaries altogether... could lead to some practices having to close their lists for local patients and, for those who can register with local practices, there could be a danger that personal care and continuity for those that most need it – the elderly, the long-term ill and the very sick – is fractured."

General manager Lizzie Page from Brookside Group Practice near Reading (see p. 8) said removing practice boundaries posed a "real problem for continuity of care". She said: "If patients are registered a distance away and their practice is unable to visit them at home, then it would fragment their primary care services. This is particularly worrying for terminal care patients." There are other difficulties she adds: "Doctors already get called out in the middle of surgeries, so how can they go out with a waiting room full of patients and then return in reasonable time if your practice boundaries are not fairly curtailed?"

The government's preferred option is for practices to retain responsibility for home visiting for local patients, but for PCTs to take on responsibility for home visits for patients who register further away from home. Other options include making practices responsible for arranging home visits for all patients on their list, regardless of where they live, or allowing people to register with two practices, although this option is likely to prove too costly.

The DoH has offered its reassurance by saying that practices pushed to capacity could be given extra cash to expand their premises. It also insisted that scrapping boundaries "should not have an adverse impact" on commuter-belt practices who may lose patients following the change. But the DoH also said the GP funding system means that "the funding associated with patients leaving the practice would follow them to their new practice".

It remains to be seen what unique view the new government will take on the proposals and their possible implementation. ❋

Joanne Curran is associate editor of Practice Manager

PHOTO: DAN WELLDON/WWW.DANWELLDON.COM

Bigger can be better

Jim Killgore visits a 15 partner general practice in Wokingham with a unique approach to management

LIZZIE PAGE has a surprisingly modest office for the general manager of one of the largest GP practices in England. The Brookside Group Practice serves over 26,400 patients at three sites in the borough of Wokingham, near Reading.

Lizzie works at the main surgery in Earley and her office is a small narrow room with a single Velux window looking out over the rooftops. In the office door is another thin window with a curtain she keeps open to let the staff or doctors know when she is available to talk.

"The curtain is only closed if I'm doing salaries or if someone is crying," she says.

Chatting with Lizzie you soon understand why a grand office would not fit in with her management philosophy. Despite a team of around 130 people Brookside seems refreshingly democratic (though in a loose sense of the word).

"We work on a matrix structure where everybody has a say," she says. "I don't think I could bear to work in a hierarchical structure."

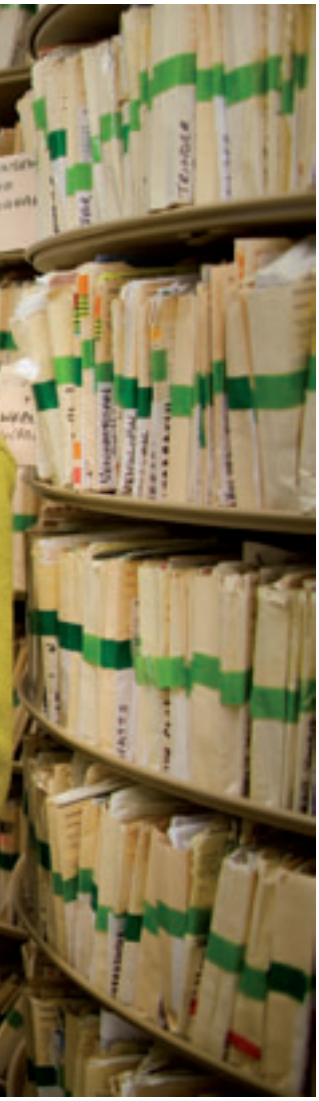
Lizzie describes Brookside as a "relational organisation" and in practice this means 18 separate management groups with staff at all levels contributing to decision-making on a variety of issues including medical records, finance, staffing, QOF, patient education, training and communication. The partnership deals with major management decisions under the guidance of an executive subcommittee but many of the day-to-day decisions are devolved to those most involved in outcomes.

"We do everything in groups," says Lizzie. "Nobody ever works alone; you are always in a 'we'. It's resource hungry but I feel it's the most effective way of doing things."

➔GROWTH AND DISLOCATION

This is just one of many unique aspects of the Brookside Group Practice. It was established in 1977 when Dr Derek Munday took over a single-handed practice in Earley. That same year a private housing estate at Lower Earley was constructed which effectively doubled the local population – now said to be one of the largest such estates in Europe. This led to a rapid expansion in local primary healthcare demand.

In the intervening years Brookside has grown from one to 15 GP partners with five associate doctors and an ever-expanding staff of practice nurses, healthcare assistants, patient services and support staff, district nurses, health visitors, midwives, dieticians, smoking cessation advisers, physiotherapists and counsellors. Brookside doctors see



General manager Lizzie Page of the Brookside Group Practice

an average of 1,900 patients per week while the practice nurses consult with roughly 750 patients. Each month over 200 new patients register with the practice. Lizzie feels the practice may now be nearing the limit in terms of size.

"I imagine we could get bigger and more efficient but I'm not sure the patients would feel better served," she says. "The same goes for our staff. I feel if a member of staff doesn't feel individually known and significant they are never going to pass that on to a person they are speaking to or treating."

> "BROOKSIDE DOCTORS SEE AN AVERAGE OF 1,900 PATIENTS PER WEEK WHILE THE PRACTICE NURSES CONSULT WITH ROUGHLY 750 PATIENTS."

Certainly the sheer scale of patient contacts at Brookside poses many unique challenges to the practice. Just managing the telephone lines requires a staff rota of six answering phones in a call centre monitored by specialist software.

"Calls for all three sites come into the centre," says patient services manager, Julie Maughan. "On Monday mornings in the first couple of hours we handle something like 500 calls."

These include patients arranging appointments, worried about symptoms, calling for test results and countless other reasons. All have to be answered or routed to the correct extension. It's a balance of efficiency and ensuring a personalised service to patients. And Lizzie is convinced a personalised service is vitally important to the unique patient community Brookside serves – lying as it does within the vast commuter belt of London.

"We often deal with households where there is no extended family, no grandparents, a husband commuting. It can be very isolating. We have a lot of mental health problems, depression. There can be a real sense of dislocation. People will come to the doctor because they don't have anywhere else to go. An inner-city practice might have more problems but we've got a lot of worried well."

INNOVATING TIPS

But in general, the healthcare and social challenges at Brookside run the gambit. Just as in most practices urgent appointments are available on the day and routine or non-urgent appointments are bookable up to four to six weeks in advance. These include consultations for chronic conditions such as asthma, diabetes or hypertension – and likely to be with one of the specialist practice nurses.

"We believe that while doctors are best at making diagnoses, practice nurses can be very good at management details – routines and protocols," says Lizzie. "We have some specialist doctors but you don't always want all the diabetics seeing a diabetic GP specialist because you end up deskilling the other doctors and you also lose continuity of care. Continuity of care is absolutely essential."

This constant consideration of the way service is delivered seems typical of Brookside and has led to a number of innovations over the years. The practice has recently introduced a texting service where patients can be reminded of pre-booked appointments or can be recalled for reviews. Another example can be found in the waiting areas. To avoid breaching confidentiality by calling out names, each patient is given a coloured disk with a number at reception and can watch a screen to see when their appointment is about to be called.

Such ideas often come out of the regular staff team meetings or from practice-wide training sessions known as TIPS or 'time to improve patient services', an initiative started nearly 10 years ago throughout the PCT. TIPS are conducted four times a year and are themed to cover a particular topic such as dealing with bereaved patients or improving doctor-patient communication.

"At exit interviews often people say that TIPS were what they enjoyed best working at Brookside," says Lizzie.

Another key factor in the apparent success at the practice is a strong team ethos among the staff – this being a particular challenge with such a large number of employees spread out over three different sites. Brookside encourages staff to work at different sites whenever possible. Doctors do all their 'lates' – late and Saturday sessions – at the main Earley practice. Other staff will move between sites to cover absences. Each Friday all the partners meet for lunch and twice a year there is a full staff social event.

PURPOSE AND VISION

Recently at one of the TIPS meetings Lizzie conducted a session on what makes practice staff happy, using a survey tool from the *BMJ*. To her surprise 'financial remuneration' came in at fourteenth on the list. Good relationships and a clear sense of vision were the main issues that emerged. To provide this vision the practice established a statement of purpose which is given out to all new staff in the form of a laminated card:

"Together to further the health and wholeness of the community we serve through providing and developing primary health care services."

This along with a set of stated values informs everything the practice does and reflects the "Christian foundation" of Brookside's founding partners – which is another interesting aspect of the practice. It must be one of the few GP practices in the UK to offer the services of a chaplain.

"We are in to whole-person care – and there is obviously a spiritual dimension to that. But it's not something we force on our patients or our staff," says Lizzie.

Indeed Lizzie's own background includes working for a church in addition to experience as a director of a large supply business. That she is enthusiastic about her role at Brookside is clear.

"I love the fact that we work as one team. Some practices have a coffee room for doctors and another for everybody else. Our doctors are just as much part of the team as anybody else. It's not a 'them and us'."

Only one thing stands out as a constant frustration in her job and that's the growing bureaucracy in general practice and the "increasing external demands for one-size-fits-all measures of success".

"So much of your time can just be taken up with filling in reports that nobody reads in order to prove that you do something well according to tick-box definitions of quality," she says.

"You need to keep your eye constantly on the ball and remember you are not here for the government or the PCT but for the patients."

Jim Killgore is an associate editor of Practice Manager

In the spotlight

Dealing with the media can be an unnerving and unpredictable experience, particularly for healthcare professionals. **Joanne Curran** offers some advice on how to handle the attention

HEALTH stories are big business for the media industry, with a seemingly never-ending supply of sensational headlines appearing every week.

From positive stories about medical miracles to more damaging tales about deaths caused by malpractice, there are many reasons why your medical or dental practice might attract a reporter's attention. And as a former national newspaper journalist, I have seen first-hand how the media machine works and the lengths to which they will go to get their story.

As practice managers, you are likely to find yourselves at the sharp end of media enquiries, so it is important to know what reporters want and what you can tell them. It is useful to bear in mind that a journalist who questions you may not be in search of large chunks of information. Even the slightest nugget of data – like confirming a particular GP is on duty that day – will fill gaps in their story. Always be careful about what you say.

Practice managers are also bound by strict confidentiality rules which limit what they can say. Patients have the freedom to talk freely about their healthcare to a reporter, but there is very little you will be allowed to say in return. And while the media all pledge to abide by the voluntary code of conduct set out by the Press Complaints Commission, it is not surprising to hear that these rules on privacy, harassment and underhand tactics are not always strictly adhered to. In all cases, members should contact MDDUS for advice.

To explore some of the risk areas surrounding media enquiries, it is useful to analyse common scenarios that practice managers might find themselves in.

→COLD CALLING

Imagine a practice manager receives a phone call from a newspaper reporter who seems to know all about one of her patients. That patient is a high-profile politician with a known health problem and the reporter says he knows the person is a patient and asks how the practice staff have coped in treating the person recently. How should

the manager respond?

The important thing about this scenario is that the reporter is very likely fishing for information in the hope that they will catch the manager off-guard. But patient confidentiality means you can't confirm or deny if anyone is a patient – so be careful not to imply anything. You should be polite and avoid being drawn into a conversation. A response like: "I'm sorry but we have a duty of confidentiality and cannot comment about any patient-related matters" should suffice. And avoid blurting out "no comment" as this can sound abrupt and rude.

The journalist may sound friendly but remember there is no such thing as "off the record", so don't say anything that you would not be happy seeing in print. It may be frustrating not being able to defend yourself, but the media is not the place to deal with patient issues and any statement you do make could be printed inaccurately or out of context.

The GMC has published guidance on this issue: *Confidentiality: responding to criticism in the press*. It explains clearly what can and can't be said and acknowledges that while criticism about your practice in the press can be frustrating, "it does not relieve you of your duty to respect your patient's confidentiality… You must not put information you have learned in confidence about a patient in the public domain without that patient's express consent."

➔ON YOUR DOORSTEP

High profile cases tend to attract even greater attention from the press. It may be that one of your GPs has made a controversial statement, for example, on assisted suicide. You turn up at work to find a large group of reporters and photographers gathered outside the practice. They ask you what you think about the GP's remarks and you notice some of your patients are being questioned as they approach the surgery.

So how should you handle the situation?

It's not advisable to speak there and then when you have been caught off-guard. Take the reporters' details and tell them you will call back. If they enter your practice you can ask them politely to leave but they are allowed to stand outside on the pavement provided they are not causing an obstruction.

They are also entitled to speak to your patients, but you should make it clear they must not harass patients and respect their privacy by not photographing them entering or leaving the practice without their consent. If they attempt to photograph you or your practice staff, you should resist the urge to run away and hide your face as this creates a negative image. It is good to have a clear policy in place for dealing with the media which has been approved and understood by the practice partners. In some practices a senior or administrative GP would take an active role. Once a policy is in place make sure practice staff are familiar with it.

➔AN UNHAPPY PATIENT

Patients who have a complaint about their medical or dental treatment can often phone a newspaper or broadcaster directly to talk about their case. So it is likely that the practice manager would in turn receive a call from the reporter to get the other side of the story.

Imagine a scenario where a newspaper has been contacted by the daughter of an elderly patient. The woman tells the reporter that one of your GPs missed a fracture in her mother's ankle causing weeks of suffering. The lady now needs surgery and plans to sue the GP. Two days later a negative story appears in the paper with the headline: "GP left me with broken ankle for two months". A picture appears alongside of the GP covering his face with his briefcase. What do you do?

The first move is to buy time by taking the reporter's details and calling her back. Don't be tempted to ignore the call as reporters will just keep trying. Call back even if all you are doing is reminding the reporter of your duty of confidentiality. You should not be tempted to try to justify the actions of your staff as this will breach confidentiality.

It is unwise to phone up the newspaper to complain because there is little you can do unless the story is significantly inaccurate. As the GMC's guidance explains: "Disputes between patients and doctors conducted in the media often serve no practical purpose; they can prolong or intensify conflict". If you deny allegations that appear in the press, the GMC warns: "You must be careful not to reveal personal information about a patient or to give an account of their care without their consent".

In some circumstances it can be helpful to contact the patient to make them aware of the practice complaints procedure and perhaps offer to meet with them to discuss their concerns further.

➔DIRTY TRICKS

Reporters have been known to go to extreme lengths to get their story, including pretending to be someone else on the telephone or by not identifying themselves in the hope of catching you off-guard. For this reason, you should always ask callers to identify themselves and, if in doubt, don't give out patient information. Genuine callers will not mind if you offer to call them back once you have verified who they are.

➔KEY POINTS

There are some basic points about handling media enquiries that practice managers should bear in mind:

- Always respect confidentiality
- Be polite and avoid an abrupt "no comment"
- Have a practice policy that all staff members are familiar with
- Always ask callers to identify themselves
- Don't ignore media calls
- If in doubt, do not comment and seek advice from MDDUS.

Joanne Curran is an associate editor of Practice Manager

A catalogue of miscommunication

The scenario below takes place over six years and involves the alleged failure of a GP and other healthcare professionals to arrange adequate follow-up after an abnormal cervical smear test.

Week one

1: A 35-year-old mother of four attends a local family planning clinic as she had been receiving intra-muscular injections of Depo Provera for contraception. A cervical smear taken at the clinic is reported as showing suspicious cells, and a note is made in the family planning clinic's records that the smear should be repeated in three month's time. A letter is sent to the general practitioner enclosing a copy of the cervical smear report, but indicating that this will be followed-up at the family planning clinic. No action is initiated by the GP at this stage.

Five months later

2: No further record appears in the family planning clinic notes until five months later when it is noted in the margin *"C/S Please"*. A further note some two weeks later reads: *"Unproductive domestic follow-up. Patient not in am and pm. Query letter to GP"*. A letter to the GP at that time indicates that the patient has not kept her appointment and that the clinic has been unable to follow her up at home. The letter concludes: *"If you are seeing her and we can be of any further help we shall be pleased to see her again"*. The clinic also notifies the cervical cytology laboratory that it has been unable to repeat the patient's cervical smear. No mention is made of further efforts to pursue the patient.

A nurse at the practice takes note of the failure of the patient to attend for a follow-up smear test and records this on the pink clinical continuation note sheet so that the next doctor to see the patient can advise her to attend a well women clinic to have a follow-up smear taken. No other action is taken by the practice after that entry.

One year later

3: The patient is now under the care of a consultant obstetrician and a smear is taken at an antenatal clinic and reported as 'suspicious'. A repeat smear is undertaken at the postnatal check and is reported as showing mildly atypical cells. No further records in the hospital case notes mention another smear being taken or any other follow-up arranged.

Four years later

4: No significant events are recorded (apart from missed appointments to the well woman clinic) until the patient attends the surgery four years later because of difficulties being experienced with an intra-uterine device. The GP has difficulty in replacing it and the patient is referred back to the family planning clinic. Unfortunately, the patient is reported as a new patient and no mention is made of the previous abnormal smear. The patient does not have a repeat smear taken as she is menstruating. She is invited to return to the clinic three months later but again fails to appear. A few months later the GP pays a home visit to the patient because of reported heavy vaginal bleeding. At this point she is referred to the hospital where carcinoma of the cervix is diagnosed leading to the need for radical surgery and radiotherapy. Solicitors acting for the patient launch a damages claim against the health authority and the GP.

MDDUS acts on behalf of the GP and commissions various expert reports. It is necessary to determine if the healthcare professionals involved demonstrated the skill and care of the ordinary competent professional, or did that care fall below standard?

The expert report commissioned by MDDUS takes the view that there was a distinct failure on the part of the family planning clinic to adequately inform the patient about the abnormal smear or to request follow-up by the general practitioner. The report also notes a failure in communication within the practice with the doctors not being alerted to the need for a repeat smear test. Nor was any action taken by the practice to inform the patient.

The case involves a catalogue of failures by the clinic, GP practice and hospital to take appropriate action on the possession of important information. The expert opinion concerning the hospital's responsibility states: "This is not so much to do with medical negligence of an individual or a department, but an all round catalogue of communication problems and difficulties culminating in this very important and distressing situation ..."

The case was eventually settled and damages paid at around £100,000. A few weeks later the patient died.

KEY POINTS

Some important lessons can be drawn from this study:

- Ensure your practice has a robust, fail-safe system for ensuring patient follow-ups.
- Better to persist with reminders to patients rather than risk anyone slipping through the net.
- Assume responsibility for continuity of care to your own patients – other services may not act with the same diligence.

Alan Frame is risk adviser with MDDUS Training & Consultancy

Diary

ELECTION over, credit crunch, swine flu, snow drifts now just dim memories and issue 02 of *Practice Manager* in the bag – it's all giddy optimism here at the Diary. Let's quickly dispel that.

➔WE love it when the English language is enriched with new words to describe stuff you might never have thought needed description. Here we would like to highlight a term encountered in a new report by The Work Foundation – 'presenteeism'. Think 'absenteeism' but imagine all those unwell people turning up for work anyway and "seemingly intentionally or through disengagement" not performing their best. It's also referred to as 'sickness presence' and is, perhaps unsurprisingly, more prevalent than absenteeism: "45 per cent of employees reported one or more days of sickness presence compared with 18 per cent reporting sickness absence over the same period". In fact I think I'll just put my head down now for a minute or two so you can read the report at **www.theworkfoundation.com**.

➔KEEPING to the topic of sickies – one half of Diary (at least) is gratified to report that the phenomenon known as 'man flu' is no joke. Researchers at the University of Cambridge are proposing that men have weaker immune systems due to evolutionary factors and hormonal differences. Their theory is that high levels of testosterone make males more susceptible to coughs and colds thus leading to a trade-off between a strong immune system and reproductive success. But a leading flu expert (probably a woman) says there is no difference in men's immunity.

➔TO COINCIDE with 'No Smoking Day' the Department of Health has launched an official NHS 'Quit Smoking' application for the iPhone. With a touch of the screen it provides daily hints and tips on how to manage cravings and keeps a running tally of how much money quitters have saved since kicking the habit. It also provides a direct link to a stop-smoking helpline for some instant encouragement. Let's just hope it's more successful than the NHS drinks tracker application released in December of last year. This was launched to allow iPhone users to keep track of drink consumed in alcoholic units so as to discourage people overindulging. Within days of the tracker being released it was being described on the internet as an "awesome game" with users trying to beat their "top score".

➔DIARY would like to extend congratulations to dentist Rob McNeil and his staff as music mogul Simon Cowell recently dedicated his gong for Most Popular Talent Show at the National TV Awards to "his dentist" – presumably because of his blindingly bright-white smile. Who says the man has the sense of humour of a spider.

➔A RECENT item on the *Management in Practice* website reported how a GP in Cumbria has appeared before a GMC disciplinary panel over claims he was aggressive and foul-mouthed to his practice manager and other staff – all women. A reader added her feedback below the article: "When I first came into the NHS two years ago one of my colleagues who had apparently regularly bullied the previous manager tried it with me in front of other colleagues. I pointed out that she was wrong (she was) and insisted that she yell her apology across the room as loudly as she had her abuse. I am a short mixed race woman in my late 50s, so have got used to dealing with would-be bullies. I always insist on an apology in the same manner as any aggro I get". Diary says "good on you"!

➔CLEVER new £1.5million plans to easily identify nurses in Wales seem to have backfired thanks to irritating new uniforms. Two health trusts decided to bring in colour-coded outfits to make it easier for patients to spot different grades of NHS staff. The only problem is the fabric has caused skin irritation in a number of wearers, meaning some of the shiny new clothing items might have to be abandoned in favour of alternatives. A Welsh Assembly Government spokesman described the development as "disappointing". And reports have since emerged of similar problems with new uniforms in Scotland. I suppose that's one way for patients to easily spot the nurses – they'd be the ones scratching those big rashes all over their arms.

➔RECENTLY Dr David Haslam had a few harsh words to say in regard to the system of paying GPs to compile lists of obese patients. He told the Tackling Obesity 2010 conference in London that the QOF meant he was "incentivised to identify fat people and make a list of them, and with the list do absolutely nothing – but when they come back a year later, weigh them to make sure they are still fat enough that I continue to get paid".

➔AND FINALLY – just having a data protection policy is sometimes not enough. A report on the Information Commissioners Office (ICO) website tells how a USB data stick used routinely to back-up clinical administrative databases went missing from Her Majesty's Prison Preston. A thorough search never turned up the data stick which held medical details relating to over 6000 patients who were or had been incarcerated at the prison. It later emerged that the data stick had indeed been encrypted but unfortunately the password had been attached to the device on a slip of paper.

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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