Practice Manager
AN MDDUS PUBLICATION
ISSUE 3

STUCK IN THE MIDDLE
How mediation skills can help restore harmony in a divided practice

POSITIVE FROM NEGATIVE
Top tips on making patient complaints handling an opportunity for improvement

SAFE FROM HARM
Healthcare professionals risk violence every day - so how best to keep staff safe?

"FIRST IMPRESSIONS ARE IMPORTANT"

PROFILE: DUNCAN SMITH DENTAL PRACTICE

MDDUS

Practice Manager

PHOTO: BILL BAIN

DEALING WITH CONFLICT, whether it be internal staffing issues or unhappy patients, can be very challenging to us as managers. However, the rewards for seeking resolutions to these types of situations are great. One such challenge being presented to us currently comes in the shape of the new Equality Act and its practical implementation. The art of practice management is not in knowing everything (a myth, I know!), but knowing where to access expertise and advice to allow us to do our jobs effectively. This is borne out in the steady increase in the number of contacts the MDDUS employment law and HR advice service is experiencing on a range of topics, as highlighted on page 3 of this issue.

On page 8 we look at the issue of workplace disputes and offer some practical advice on the role of mediation in resolving them. Conflict can arise in various areas of day-to-day practice, so on page 6 Thomas Elliott looks at ways of minimising the risks presented by aggressive patients. Meanwhile on page 14 MDDUS risk adviser Alan Frame continues that theme with a case study about a violent patient who was refused a prescription.

Our Call Log on page 4 offers advice on risk areas such as informing the police about a missing person and unintentional disclosure of confidential information. In this edition's Practice Profile on page 10, MDDUS editor Jim Killgore visits a dental practice which prides itself on excellent customer service.

On page 12 Dr Sandy McKendrick offers some valuable advice on resolving patient complaints while our article on page 5 discusses what questions prospective employers can ask about candidates' health in the wake of the new Equality Act. And finally, MDDUS dental adviser Doug Hamilton focuses on the risks associated with allowing work experience students into your practice on page 7.

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Flu season Yellow Cards

MANAGERS are being asked to be vigilant for any vaccine or antiviral treatment side-effects in the approaching flu season.

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued a Yellow Card Scheme Update asking practices to report any suspicious side-effects – in particular febrile seizures occurring in children within 72 hours of receiving flu vaccines.

The update reminds practices that the Department of Health has advised against the use of two particular brands of seasonal influenza vaccine in children younger than age 5 years: Enzira and CSL Biotherapies generic influenza vaccine. Recent use of these vaccines in Australia was associated with an increased risk of febrile convulsions. Children older than age 6 months and younger than 5 years who are in clinical risk-groups should be administered alternative vaccines as recommended by the Department of Health.

The MHRA is also urging practices to report suspected side-effects to the antivirals Tamiflu (oseltamivir) and Relenza (zanamivir), and the swine flu vaccines (Celvapan and Pandemrix). Report online at **www.yellowcard.gov.uk** or by post (paper Yellow Cards are available at the back of the British National Formulary) or call **0800 731 6789**.

Patient satisfaction unreliable measure

PATIENT satisfaction surveys may not be a reliable way of evaluating GP practice performance, new research has suggested.

Specific questions about patients' experiences – particularly access to care – are a more accurate measure of performance than questions about patients' general satisfaction.

Researchers from the University of Bristol analysed data from 4,573 patients who consulted 150 different doctors at 27 general practices in England. They wanted to find out whether responses to survey questions reflected differences between the practices, the doctors or the patients themselves.

They found questions asking about patient experiences were a better indicator of performance because of differences in people's perceptions and random error. Responses also varied according to the patients' race, gender and age but adjusting for these characteristics made little difference to practices' scores or individual rankings.

The research found that: "Surveys of patients' satisfaction fail to distinguish effectively between individual doctors because most of the variation in doctors' reported performance is due to differences between patients and random error rather than differences between doctors."

The report concluded by supporting the concept that questions about specific experiences of care provide a more discriminating measure of a practice's performance than subjective questions about general satisfaction. The team also called for their findings to be replicated in a larger sample of practices.

High demand for employment law advice

➔MDDUS has seen a steady increase in the number of calls and emails to its employment law and HR advice service in the five months since being launched.

The new service provides practice managers within MDDUS group schemes or members who have employment responsibilities free unlimited access to advice from an experienced in-house team of HR and employment law advisers. The service has seen a month-on-month increase in the volume of contacts with the top three topics being contractual issues, work absence and disciplinary cases.

The helpline is open for calls during core work hours but 24-hour assistance is available for urgent enquires.

"Advice calls and emails have been increasing as members become more aware of the service and use us," says adviser Liz Symon. "Often these involve continuing discussions with practices as many of the cases are ongoing. This is the great advantage of an unlimited service."

A significant number of practices have also signed up for the Legal Support, Representation and Indemnity (LRI) package. The package provides access to assistance in matters that go beyond simple advice and guidance and is available to practices where all employing GP/GDP partners are members of the Union. It is available for a small additional fee per head of employer and offers legal support and representation including costs along with employment tribunal award protection.

MDDUS Training and Consultancy Manager Liz Price says: "It's gratifying to see that we are serving a clear need among our managers as evidenced in the growing number of calls. I have no doubt the service will continue to grow, as will uptake of the LRI package."

The MDDUS HR and Employment Law team will be running a series of employment law workshops in the MDDUS Glasgow and London offices over the next few months. We are also able to offer bespoke workshops direct to GP/GDP and practice manager groups by arrangement. For more details and to book a place on one of our practical workshops, phone Ann Fitzpatrick on **0141 228 1261** or email **afitzpatrick@mddus.com**

Are you a training practice?

➔MDDUS has launched two new publications aimed at GP specialist trainees and trainee dentists.

We would like to hear from managers who know of trainees who would be interested in reading these magazines.

GPST launched in September 2010 and is packed with practical articles and features aimed at doctors embarking on a career in general practice. Advice focuses on improving areas such as communication skills, while general features offer a perspective from working GPs.

Final year dental students and dentists in their first two years of post-graduate training should find our new dental magazine *SoundBite* a valuable source of practical advice on how to improve professional skills. It also includes careers information and general interest features from around the dental world.

To request copies of *GPST* or *SoundBite* contact Karen Walsh at **kwalsh@mddus.com**

New equality laws come into force

➔TOUGH new laws to combat discrimination have come into force and will have an effect on employment practices.

The Equality Act 2010 aims to protect the rights of individuals and promote equality by updating and strengthening existing legislation. It is made up of a number of different provisions which will be introduced in stages to allow individuals and organisations time to prepare.

The vast majority of the act's provisions came into force on October 1 when the various pieces of discrimination legislation were brought together into one law. The act extends its provision to:

- Third party harassment
- Associative discrimination
- Perceptive discrimination
- Indirect discrimination.

The changes mean employers face increased responsibilities to protect their employees from harassment on the basis of "protected characteristics" which relate to race, disability, religion, sexual orientation, gender or age. The government has described the laws as "a simple, modern and accessible framework of discrimination law" but practices may find them challenging to implement.

Under the new rules employers will be responsible for protecting employees from harassment from a third party. This could be an individual who is not an employee such as a locum GP. Employers will also have to be aware of rules over discrimination by association where they must protect employees from being harassed or bullied about someone associated with them. This would mean an employer being held responsible if, for example, someone makes jokes about the age of an employee's partner.

Indirect discrimination also now covers disability and gender reassignment, while perceived discrimination extends to employees who are perceived as having a protected characteristic.

The Equality Act also aims to make it more difficult for disabled people to be screened out when applying for jobs by restricting the circumstances in which an employer can ask about disability or health issues (see page 5 in this issue).

For more information on the Equality Act log onto **www.tinyurl.com/2gyrk5n**

For further guidance on HR and employment law issues, contact the MDDUS Employment Law Team on **0845 270 2034.**

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.

PUBLIC INTEREST?

Q The police have asked a practice manager to help them trace a missing person who is a patient at the practice. The officer told the manager that the young woman has been missing for two weeks and her family are desperate to get in touch with her. The manager has since heard that the missing woman has made contact with a practice five miles away, who have never treated her before. The practice manager asks MDDUS if she should alert the police.

A In general, the police would only be entitled to access confidential patient information in the prevention or detection of a serious crime. In this case, however, there may be a public interest in the practice alerting the police about the missing woman. An MDDUS adviser explains this to the manager and recommends contact is made with the other medical practice and that the practice use their clinical judgement in deciding whether or not to inform the police. The GMC guidance *Confidentiality* also covers this subject.

CLINICAL RECORDS ONLY

Q A practice is being sued for damages by a patient who alleges medical negligence against one of its GPs. Solicitors acting for the patient request copies of all relevant medical records. The practice manager sends full copies of the record but only later notices that included among the documents is correspondence between the GP and a medico-legal adviser from MDDUS which refers to the original patient complaint and the likelihood of a negligence claim. The practice manager is worried about his mistake and calls MDDUS for advice about how to store such documents in future.

A It is essential that a patient's medical or dental records are used to keep clinically relevant information only. Storing non-clinical information here risks improper disclosure of non-relevant information or breaching third party confidentiality. Documents like medical reports for insurance companies, DWP reports, case conference meeting minutes regarding issues of child protection or a vulnerable adult and correspondence relating to patient complaints should be maintained in a separate patient file. If the patient leaves the practice then this separate file can be sent, where appropriate, in a separate envelope or folder clearly marked as 'non-clinical' or 'medico-legal information'.

A SIMPLE DISCLOSURE

Q A GP is contacted by the headteacher of the village primary school who asks about one of her patients, an eight-year-old boy. The teacher wants the GP to confirm where the child lives and explains that he suspects the boy's parents are using a bogus address in order to get him into the school. The GP believes the family do not actually live in the school catchment area and wonders if there is any harm in confirming the headteacher's suspicions.

A An MDDUS adviser told the GP that even confirming whether or not the address held by the school was the same as the one held by the practice would violate patient confidentiality. The GP would need consent from the child's parents before releasing any information – even if she knew the headteacher's suspicions were well-founded. Only if the disclosure was made in the public interest, in accordance with GMC guidance *Confidentiality*, could a doctor consider disclosing without consent.

COURT ORDER FOR RECORDS

Q A general practice in Scotland contacts MDDUS in regard to a court order to surrender a patient's records for use in criminal proceedings. The question is whether the practice has to provide the original documents or would a photocopy be sufficient?

A It is often assumed that police require original documents for evidential purposes but this means that a practice may be deprived of an original patient record for months or even years in some criminal cases. An MDDUS adviser is able to provide the practice with a copy of a document setting out an agreement between NHS Scotland and the Crown (via the Procurator Fiscal Service) that states that in the first instance "clearly authenticated copy medical records" can be provided in all cases unless the patient is deceased. The Crown reserves the right to request originals in certain circumstances (e.g. where the writing is difficult to read or there are concerns that the record may be incomplete). The document also provides a template for a certificate of authorisation which must be completed and attached to the record copy. Access at **www.tinyurl.com/2u8eloe**

HOME VISIT DEMAND

Q A mother phones a general medical practice in regard to her child who has been vomiting all night and may be dehydrated. The mother lives relatively nearby but refuses to bring the child into the practice and insists on a home visit. The practice is extremely busy at the time and the practice manager phones MDDUS to ask if the mother can be refused a home visit and compelled to bring the child in.

A A medical adviser speaks with the manager and first clarifies that MDDUS cannot provide specific clinical advice on the case. But she points out that the practice has a duty of care to its patients and obligations as part of the General Medical Services contract, and the doctor on call will have individual responsibility as set out by the GMC in *Good Medical Practice*. Should the mother not be persuaded to bring the child into the practice it would be wiser on risk grounds that the practice accommodate her request for a home visit. In the end it is a matter of clinical judgment but better safe now than sorry later.

In sickness or in health

IT MAY be tempting for some employers who are looking to hire new staff to try to identify the candidates who seem the most physically and mentally fit – and who will therefore be least likely to go "on the sick".

But while some questioning by prospective employers along these lines may have been tolerated in the past, new legislation introduced on October 1, 2010 has changed employment practices. Employers are now banned from asking questions about candidates' sickness records and existing health conditions, before they have decided to offer them a job.

This provision of the new Equality Act 2010 is one of the most significant developments in employment law this autumn and is intended to protect disabled candidates from having their applications binned before they have even had a chance to demonstrate their suitability for the job on offer. There is research evidence to suggest that this has been a fairly widespread practice in the past – to the extent that the Chartered Institute of Personnel and Development (CIPD) and many other organisations supported this change to the law, as now enshrined in the new Act.

We are aware of a number of Law at Work clients who have had bad experiences with high levels of staff sickness absence in the past and who have introduced sifting mechanisms to gather information from job applicants about their past job history. They have done this simply in order to avoid wasting time and effort - having followed a long recruitment process only to find that the successful candidate goes off sick shortly after starting the job and quickly becomes a problem attender.

Some employers ask a question on their application form about the level of sickness absence the candidate has had in the last year. Others ask applicants to complete a checklist confirming particular medical conditions that they have had or still have. Many ask candidates questions at interview about their medical history. But these practices will now have to stop or employers will risk being challenged in an employment tribunal for disability discrimination.

Of course, candidates can lie about their medical history and the only vaguely reliable way to ascertain the true position is to ask their former employer, in a reference, for information about their former (or present) employee.

As practice managers will know, references are not the most reliable source of information – but they are often the only way of checking the candidate's statements on the subject.

Under the Act, the recruiting organisation can still ask the successful candidate about their medical history, but only at the point that a conditional offer of employment is made. This is to avoid any suggestion that disabled applicants have been disadvantaged up to that point in the process.

There are, however, exceptions in the Act which permit employers to ask questions about disabilities or medical conditions at an earlier stage in certain circumstances. These are:

- To establish whether adjustments need to be made for interview and selection
- For the purpose of equality and diversity monitoring
- If there is an 'intrinsic' feature of the job which requires a check about whether the candidate has a particular condition – for example, for safety or insurance reasons
- Where a job interview guarantee scheme, or similar positive action, is in place for disabled candidates
- Where having a disability is an occupational requirement of the job.

If you have an application form with medical questions or a checklist or follow the practice of asking interview questions about health matters, you need to get advice about how, or indeed whether, these should now be used.

There is more information about the Equality Act on the Government Equalities Office website at **www.tinyurl.com/eqa2010** ❋

Ian Watson is training services manager at Law At Work

Safe from harm

MEDICAL and dental surgeries are usually more associated with healing than violent crime. But as attacks on healthcare staff increasingly make their way into news headlines, it is important that managers are aware of how to minimise the risks facing practice employees.

A survey by the British Medical Association in 2008 revealed one in three doctors had been physically or verbally attacked at work in the previous year, although many doctors didn't report it to police. Junior doctors were most likely to experience violence, followed by GPs. The BMA raised concerns of "an increasing acceptance of violence" and underlined the need for a zero-tolerance approach to violence against healthcare staff.

Medicine, aggression and violence are far from uncommon bedfellows. Emergency departments deal with a daily stream of injured patients, many under the influence of alcohol or drugs, who have been involved in violent incidents.

Patients' needs sit uneasily alongside the legal obligation on practices to provide safe places for staff to work. Short of introducing metal detectors at the surgery door, there is nothing to prevent patients bringing weapons onto the premises. And as some recent cases have shown, violence and aggression are not restricted to practices in economic and social deprivation hotspots.

From a health and safety perspective, every practice should have a comprehensive policy setting out what risks to staff (and the public) have been identified, what steps have been taken to eliminate or minimise them, and who is responsible for managing practice safety.

In the event of a serious injury or dangerous incident, the enforcement authorities will want to see what the practice has done to identify, assess and manage the risks. This will include an inspection of the paperwork and records of training supplied to staff both when they start employment and on a continuing basis. Specific training should be undertaken following each incident and health and safety should appear regularly on practice meeting agendas.

A degree of physical separation of staff and patients is another good security measure. Reception and ancillary staff should normally work in an area to which the public do not have easy access. But separation should not impede communication. When patients enter the waiting room they should be able to see and talk to staff without raising their voice.

Practices should consider installing panic buttons in all rooms where staff and patients come into contact, especially in consulting rooms. The panic button can either set off a buzzer in the reception area or set off an alarm which can be heard throughout the premises, and can also be connected directly to the local police station. Where possible, consulting rooms should have more than one exit, enabling staff to escape easily if need be.

> "JUNIOR DOCTORS WERE MOST LIKELY TO EXPERIENCE VIOLENCE, FOLLOWED BY GPs"

Staff who carry out home visits – whether during the day or out of hours – should always carry a mobile phone and a personal alarm. They should also ensure that someone knows where they are going, and when they expect to return.

Potentially dangerous equipment and medicines stored on the premises should normally be kept under lock and key. In particular, syringes, needles, other sharps, and patella hammers should not be left lying out in consulting rooms. Greater security, particularly for staff working in the evenings and weekends, can be achieved by installing a buzzer controlled entry system, ideally in conjunction with CCTV, while motion triggered external lights can mitigate the dangers of long winter nights.

Despite the headlines, it's important to remember that the majority of unpleasant encounters are verbal. Few result in violence and only a tiny minority result in serious injury. Setting the tone is important and the practice should make clear what the rules are. A notice should be prominently displayed explaining that the practice does not tolerate physical or verbal abuse of staff by the public, or vice versa.

Good communication is also important in helping to avoid confrontations, so make sure all staff, doctors included, undertake regular training in communication skills. It is important to be aware of how to calm down a frustrated, worried, or disturbed patient rather than aggravating them further.

If you are faced with an implacable patient, you can explain to them how to make a complaint, or warn them that if they persist in behaving disruptively, the police will be called. And while following the guidelines set out above will not guarantee staff safety in all circumstances, it will go a long way towards controlling the risk of a serious incident.✱

Thomas Elliott is health and safety manager at Law At Work

Work shadowing – the risks

GIVING older pupils the chance to experience what life is like in the world of work has become a core part of the school experience.

Participation can enhance a young person's CV and help them choose the right career. And for those whose ambitions lie in the fields of medicine or dentistry, gaining a first-hand insight into these professions is even more significant. Evidence of such work placements can be an important part of any application to an undergraduate medical or dental programme, and some institutions, such as Glasgow Dental School, refuse to interview candidates who have not 'work-shadowed' in a practice.

This means it is highly likely that your practice will at some time be approached by pupils hoping to clock-up the requisite experience. Mindful of their own tribulations in gaining that much coveted university place, many practitioners will be eager to help. And laudable as this may be, MDDUS would advise managers to be aware of the various medico-legal implications that this entails.

➔HEALTH AND SAFETY

In the first instance, it must be noted that anyone who is participating in work experience is regarded as an employee for the purposes of health and safety legislation. This means the practice's level of employers' liability insurance will have to be checked and, if necessary, increased. It's also worth remembering that certain health and safety requirements – such as the need to record risk assessments in writing or have a qualified first-aider – become active above a threshold number of employees, so the addition of students to the workforce could have quite onerous practical implications.

You should also be aware that the law defines those under 18 years of age as 'young people' and, as such, their employment must be preceded by a risk assessment which takes into account their lack of maturity, knowledge and ability to recognise danger. It is generally advisable to record the results of this assessment. Indeed, in circumstances where prospective work-shadow students are under the age of 16, the findings must be written down and passed on to their parents or legal guardians.

All hazards, even the apparently mundane ones such as those posed by surface cleaning products, should be assessed with a view to eliminating or at least minimising the risks they pose. Clearly dental and medical surgeries are fraught with potential dangers unique to the clinical setting and will therefore demand careful attention. The hazard presented by contaminated sharps, for example, is particularly relevant to dental surgeries where many of the instruments which have been in contact with the patient's blood and saliva could cause a penetration injury. It is good practice for managers to ensure all practices have strict protocols in respect of this issue.

Students will probably not have started a hepatitis B vaccination programme, and safe systems of work must be in place that prevents contact with sharp instruments. The Health and Safety Executive also has an advice booklet called *The Right Start. Work experience for young people: Health and safety basics for employers* available at: **www.tinyurl.com/pm-rightstart**

➔CONFIDENTIALITY

Before beginning their placement, any student working in a clinical setting must be made aware of the fundamental importance of never divulging confidential patient information – including the mere fact of a patient's attendance. This should be reinforced by a confidentiality agreement, to be signed by the student, which makes clear that the work placement will be terminated if the agreement is broken.

It is also strongly advised to get express consent from patients before they are treated or examined in the presence of a student, perhaps even in writing. Patients should be told they can change their minds at any time, in which case the student should leave immediately and without protest. Consider putting up an information poster in the waiting room to allow patients to consider this issue before being approached individually. Where possible, it is advisable not to take on work experience students who live in the local area to minimise the risk of them recognising a patient.

> "WORK EXPERIENCE STUDENTS ARE REGARDED AS EMPLOYEES IN TERMS OF HEALTH AND SAFETY LAWS"

➔HANDS OFF

If a practice decides to accept a request for work shadowing, it should be made clear that there will be no opportunity for 'hands-on' experience. Students will be present in a purely observational capacity, and will be expected to conduct themselves in a proper manner. This means clean smart attire, a professional attitude and respect for the other staff members.

It is unfortunate that such acts of kindness towards the doctors and dentists of tomorrow carry with them so much statutory and medico-legal baggage. But for those who do decide to take the necessary measures, they can at least draw satisfaction from the fact that the young person involved should have a safe and enlightening experience, for which they will undoubtedly be grateful. ❋

Doug Hamilton is a dento-legal adviser at MDDUS

Stuck in the middle

IN AN ideal world everyone would work well together, respect their colleagues and get the job done as one big happy team.

But for many managers, the reality of day-to-day practice can be a challenging mix of differing personalities and working styles that sometimes leads to conflict. And while some level of conflict is normal in any workplace, it is vital that problem areas are addressed in the right way to prevent issues escalating to the point where the running of your practice, and its staff, suffer.

Disagreements can be caused by any number of issues, both major and minor. Often problems can build up over time before eventually boiling over into a full-blown dispute. As practice manager you may find yourself stuck in the middle when working relationships begin to break down, fielding complaints and comments from all sides.

A crucial skill for any manager in successfully resolving conflict is learning how to mediate. This means being able to identify problems early and tackle them swiftly and effectively. Mediation is a flexible, confidential process that involves an impartial third party – which may be you, the practice manager – helping people who are in dispute to reach an agreement.

Practice disputes can centre on various issues, from financial disagreements over budgets or locum costs to workplace problems like bullying and harassment. Partners, for example, may disagree over how much money should be invested in the practice in terms of employee salaries, patient services or even in how much should be spent on the upkeep of the premises.

The BMA strongly recommends that GPs draw up a written partnership agreement and seek legal and accountancy advice in doing so. This can help avoid many practice disputes which focus on financial or other partnership issues. The BMA guidance document *Medical partnerships under the NHS* offers more advice on this.

A breakdown in communication will often be at the heart of a workplace conflict. GPs or GDPs may feel they are not being listened to by their partners or that their decisions are being ignored or undermined. The balance of power within a practice is another common source of conflict. The senior partner who insists "what I say goes" can cause simmering resentment among partners and staff, as can a lack of clear responsibilities. For example, the staff member who protests "I do all the work around here and he does nothing" could have a valid complaint that, if ignored, may eventually escalate into a full-blown dispute.

➔SWIFT ACTION

Whatever causes conflict in the practice, it is important that practice managers recognise the warning signs early.

Hugh Donald is a trained mediator with the firm Core Solutions and has more than 25 years' experience in the medico-legal field. He says: "These can be small things like noticing that certain GPs, GDPs or staff members are not contributing during practice meetings or are avoiding the meetings altogether. You might notice certain individuals are avoiding each other in the break room or hear of complaints about the way the practice is run. Whatever you do, don't ignore it."

The longer a problem is ignored, says Hugh, the more likely it is that entrenched positions will form on either side of a conflict, which may make finding a solution more difficult. He says: "The best approach tends to be a collaborative one which encourages people to work together to identify the cause of the conflict and find ways of addressing it. Collaboration is what takes you into the mediation process."

➔FIRST STEPS

Once you notice there is conflict in the workplace that needs to be

addressed, it's important to begin the mediation process early and with an open and objective mindset. Mediators should first make contact with the parties involved individually to find out their concerns and needs.

Liz Price is the training and consultancy manager at MDDUS and has considerable experience in helping practices manage workplace conflicts. She says: "Ask each party what they would like to happen in order for the problem to be resolved. Really listen to what is being said and remember not to take sides. You may need to go back and forth between the parties a few times, noting what they say and listing possible solutions."

Using open questions such as "So what's been happening?" or "Can you tell me more about…?" can help identify the main issues before you go on to explore possible solutions. You should ask people what they need from the other parties rather than what they think of them. This might present an early solution as you may be able to change the way the practice works, for example, or simply help someone understand why a colleague behaves the way they do.

Some issues will be more difficult to deal with than others. Liz explains: "You can get conflicts charged with emotion, usually where people feel they are being bullied or discriminated against. These can be more challenging to resolve, but it's important for a mediator to acknowledge and understand the emotion, then to strip the emotion out and to really identify the core issues. Emphasise the fact that whatever is said is confidential, and that you are not there to take sides or judge."

➔MOVING FORWARD

Once you are confident that you have identified the issues and that the parties have solutions in mind, the next step is to hold a (voluntary) joint meeting. Ground rules must be set about how the process will work and the mediator should make sure all sides are given a chance to speak. It's important to carefully examine the options going forward rather than jumping to solutions too quickly. Break big problems down into small ones and highlight what could happen if the dispute is not settled.

When professional relationships become strained, it often falls to the practice manager to find a way of restoring workplace harmony. **Joanne Curran** explores the role of mediation in resolving disputes

Everything should be written down and solutions will hopefully be identified and agreed upon. The parties can then sign an agreement and decide how to move forward, including how to monitor the situation and ensure bad behaviours do not return – or that any agreed changes to systems or communication are undermined.

Liz says: "At the end of these meetings you should have a clear list of what has been agreed and how that will be achieved. It's crucial to follow this up by arranging to meet again to monitor how things are progressing. You don't want people to just go back to the way they were behaving before. If that happens, then carefully remind people what was agreed during mediation."

Some managers may find mediating a conflict too challenging and may be reluctant to take action for fear of jeopardising their own role within the practice. Others may find they do not have the necessary skills to tackle a serious dispute. But help is available.

Liz adds: "Addressing conflict can be a daunting process, especially for those managers who don't have a strong influencing role within a practice. But try to deal with it early and seek support of other partners, GPs or GDPs to help you. If you still find it difficult, or if you think the problem is too complex for you to handle alone, then call MDDUS for advice or contact the BMA, BDA or a professional mediation service."

To find out more, the ACAS document *Mediation: An employer's guide* is available online at **www.tinyurl.com/2e3kk68** ✱

Joanne Curran is an associate editor of Practice Manager

Word of mouth

PHOTO: SCOTT HUNTER / WWW.SHOT2STUN.COM

Jim Killgore travels to Musselburgh in Scotland to visit a dental practice where success is measured in patient satisfaction

ON THE morning I visit the Duncan Smith Dental Practice I find myself wandering up a wide street in the Scottish east coast town of Musselburgh checking my map again to see if I'm in the right place. Soon though I spot a small brass plaque beside a modest entrance tucked between a mortgage centre and a private nursery.

Practice manager Andrea Smith greets me in a bright, sizable reception area just off the street. "Did you manage to find us okay?" she asks and then apologises. The week I have chosen to visit the practice is having large street-front signage installed to incorporate their new logo.

"First impressions are important," she says later showing me a drawing of how the new signage will look. It soon becomes clear that making and maintaining a good impression is a high priority to Andrea and her practice team.

Certainly on first entering Duncan Smith Dental there's a TARDIS-like sense of something much bigger on the inside. Andrea tells me there has been a dental practice at the site since 1933 though originally accommodating only one dentist working in a single surgery and small laboratory. Dundee dental graduate Duncan Smith – Andrea's husband – took over the practice in 1992 and expanded both the team and the office space so that now six dentists, a full-time hygienist and 12 staff work here.

Just under 7,000 patients attend the practice, most from in and around Musselburgh, which lies six miles from Edinburgh on the River Esk. It is said to be the oldest town in Scotland – dating to Roman times – and is also the site of the world's oldest golf course and the famous Musselburgh Racecourse. Over the years the population in the area has grown steadily being in a busy commuter belt.

One key factor behind the steady expansion of the dental practice has been its emphasis on quality treatment combined with attention to the whole patient experience and good "customer care". Or as Duncan Smith puts it: "Our aim is to keep the back door closed, if you like, so that once patients join the practice they stay with us for a long time."

Andrea also sees this as crucial in ensuring the continued success of the practice. She says: "It's important to focus on the whole management of the patient from the moment they first set foot in the practice – making eye contact, being courteous, acknowledging needs. All these things are important in making the patient feel it's a personal service; that they are not just another number but an individual."

➔MARKET DRIVEN

This focus on the "patient as customer" is becoming increasingly common among UK dental practices, driven at least in part by the growing number of dentists moving away from the NHS to offer private treatment. In an open marketplace, patients will vote with their feet so finding ways of attracting and keeping them becomes ever more crucial. Given now the emphasis on 'choice' throughout NHS primary care across the UK it's also something

general medical practices may need to pay increasing attention to in coming years.

Attention to the patient experience begins from day one at Duncan Smith Dental, as Andrea explains. Each new patient at the practice is presented with a welcome pack with information leaflets explaining the treatments and services offered. The pack also incorporates a statement of practice aims promising consistency, a relaxed and friendly environment and "our utmost respect at all times".

"I know it may sound like a cliché but we genuinely believe in these aims," says Andrea.

Patients are then given a "walk through" to get familiar with the premises before first meeting the dentist. Most patients will attend the same dentist, even for emergencies, says Andrea. So the stress of seeing someone unfamiliar is taken away.

Every aspect of the patient encounter is considered by Andrea and her staff in seeking to improve service levels. Two staff work reception at all times greeting patients and the practice recently installed a new telephone exchange with four incoming lines to reduce call waiting.

"We run a tight schedule so our waiting area is rarely busy," says Andrea.

To help personalise patient contacts the practice makes use of a pop-facility within the electronic records. Here relevant personal or health details are recorded and displayed whenever a patient's file is edited. These might include anything from a needle phobia to a recent bereavement. This way staff can be aware of a patient's particular circumstances.

HOW ARE WE DOING?

To drive improvements in patient-customer care the practice conducts patient surveys on an annual basis. Says Andrea:

> "IT'S IMPORTANT TO FOCUS ON THE WHOLE MANAGEMENT OF THE PATIENT FROM THE MOMENT THEY FIRST SET FOOT IN THE PRACTICE"

"We target 15 to 30 patients per dentist across the age-groups. Patients fill out forms in the waiting area. We then collate all the information and it's displayed in charts and graphs along with all the patients' comments."

Satisfaction is measured against numerous criteria including waiting times, staff attitude and facilities. The staff then meet to discuss the results and any potential improvements.

"For example, in the questionnaire we did two years ago it came to light that explanations of our costs weren't good," says Andrea.

"Patients were unsure what they were being charged for when they reached the front desk; it wasn't explained well. So we positively acted on this and put prompts on the monitor screen to remind us to check patients' understanding of treatment costs. Since then we've greatly improved in this area."

Another recent innovation was the installation of an automated text messaging service to remind patients of upcoming appointments.

"It's dramatically decreased the number of DNAs we have," says Andrea.

INTERNAL CUSTOMERS

Speaking to Andrea it becomes clear that she is a firm believer in a team approach to improving quality standards in the practice – the notion that staff are in effect "internal customers" that must be equally valued. She explains: "If your staff feels taken care of that naturally reflects in their attitude towards patients. If you have disgruntled staff, patients will pick up on that."

Fostering a team ethos is essential. Recently the practice was awarded membership of the BDA's Good Practice Scheme – a quality assurance programme demonstrating dental care provided at nationally recognised best practice standards.

"A lot of work went into achieving this and it had to be a team effort," says Duncan Smith. An important result of this was a shared sense of pride and to celebrate the entire staff was treated to a weekend at the Crieff Hydro near Perth.

But at the heart of the team is the partnership between Andrea and Duncan. Andrea never intended becoming a practice manager. She started out her professional career as a veterinary surgeon in a small animal practice and has also worked as a manager in her parents' retail business.

After marrying Duncan she took time out to look after their three children but as the practice grew and she saw how busy Duncan was it seemed only natural to help out with the business.

"Back then the practice wasn't computerised and I could see that overdue accounts were getting out of hand. And if there is one thing that annoys me it's money not coming in, people not paying their accounts."

So she set up an automated accounts system and her role grew from there. She enjoys working with her husband developing the practice.

"We very rarely have any arguments," she says. "Duncan is a bit less accepting of change but once he sees the benefits, he's fully onboard."

When I ask about the future of the practice the answer is surprising.

"We have no plans for physical expansion," says Duncan. "Our aim is to ensure we offer an increasing diversification of treatments for our patients, with an even greater emphasis on quality dental care."

To this end the practice is keen on improving preventative dentistry and has also expanded into other treatment areas such as cosmetic dentistry and implantology. Most new patients to the practice now come mainly from referrals – friends and family members of existing patients – and this suits Andrea just fine.

"I don't feel we have to spend a lot of money on advertising because the best advertising is word of mouth."

Jim Killgore is an associate editor of Practice Manager

Positive from negative

Dr Sandy McKendrick of the Scottish Public Services Ombudsman offers some top tips on resolving patient complaints

MOST OF US will have experienced that horrible feeling in the pit of the stomach upon hearing that a complaint has been made against the practice – and if not yet there is every chance that at some point in your career it will happen. However, viewed positively, complaints can lead to improvement.

➔NOT A HAPPY SITUATION

Anger is a common emotion at the first signs of a complaint – be it verbal or in writing. It is natural to want to ignore it or tear up the letter and throw it away. But perhaps the best advice to heed when faced with a complaint is to avoid being overly defensive. Try to focus on the best result which is a quick but fair resolution.

Someone not directly involved should be the main contact with a complaining patient. Usually, the best person to take on this difficult task is the practice manger, unless of course he or she is the subject of the complaint.

Everyone who has had contact with the patient should be asked to make a written statement as soon as possible regarding the incident. This can and should rely on the notes. Hopefully, the incident will not be so far in the past that staff have forgotten the details. If they have forgotten, then any notes made at the time will be useful and comments like "in these circumstances I normally do..." can help when an investigation gets underway.

The person dealing with the grievance should contact the complainant by phone or failing that by post. They should explain that the complaint will be investigated by someone who, as far as possible, was not involved in the case, although it will probably still be someone in the practice. They should also offer to meet the complainant to discuss the case and try and resolve it at that stage.

They should confirm that the initial investigation will be in the complainant's hands within a specified period (see national regulations for precise timescales). Early contact and a speedy response can often help resolve complaints quickly; for this to be successful, the complainant must realise that the practice is taking them and their complaint seriously.

➔INVESTIGATION

The main investigation and the letter explaining the practice's actions should be led by either the practice manager or another partner. The individual named in the complaint should not write to the complainant other than in exceptional circumstances and nothing should leave the surgery until it has been checked by another member of staff.

The practice should consider that the complaint is made against the team not just the named individual.

The investigation, like an SEA (significant event analysis), should be broad and far reaching. It is important to consider the reasons for everything that happened, including systems and processes within the practice, and not just the clinical aspects of the case. Sometimes the cause of an error or mistake can be found in the way the practice infrastructure is organised (e.g. the repeat prescription system or at what time the records from the OOH service are incorporated in the notes).

Good contemporaneous notes are the cornerstone of any investigation. The notes made by the doctor at the time are more likely to reflect the real events, as they will have been written before the complaint was laid and without the benefit of hindsight. Your IT person can help here because computer notes make it crystal clear who wrote what when.

Anyone looking at the notes in the course of investigating a complaint will rely on what was written on the date of the original contact as being the strongest evidence for a doctor taking or recommending a particular course of action. Full and accurate contemporaneous notes, especially computer-recorded notes, are therefore vitally important. Almost every other aspect of the

> PERHAPS THE BEST ADVICE TO HEED WHEN FACED WITH A COMPLAINT IS TO AVOID BEING OVERLY DEFENSIVE

complaint will be written some time after the contact or consultation leading to the complaint, when time and hindsight may have affected memory of the incident.

All organisations stress the importance of good notes – and this cannot be emphasised enough. Many complaints come down to the differences in memory of the parties to a particular incident, so the quality of practice notes is critical.

Once the facts of the case have been described then the investigator needs to come to some conclusion as to the validity of the complaint and the reasons for the actions taken by the practice. If something has gone wrong then it is important to be open about it.

LESSONS LEARNED

Even complaints where there have been no errors can be useful as a way of improving the practice both in terms of processes and systems and in clinical skills. So a practice meeting should be held to present all the facts pertinent to the complaint as discovered by the investigator. The format and rules of an SEA should be used. This should be written up and consideration given as to whether it should be shown to the complainant.

Identifying individual learning needs and discussing the complaint with an appraiser are valuable ongoing educational tools. The practice may need to organise a specific educational event for all its members, and a review date with perhaps a built-in audit should be incorporated in any plan.

RESOLVING THE COMPLAINT

Once the investigation is over, the results should be relayed to the complainant. This should be in writing but it may be preferable to also organise a face-to-face meeting with the complainant, including the individual who has been the main focus of the complaint (although some complainants will not want to meet). By this time tempers may have abated and reasonable discussion can take place. The complainant can repeat their complaint and the practice can try to explain what happened and present results of in-house discussions, what lessons have been learned and plans to change the way the practice is run as a result of the complaint.

It is important in any written response to a complainant to stress that the practice has taken the complaint seriously, that it is willing to apologise and that it has made plans to change its procedures and systems to try and avoid a repetition of the incident. Showing how the practice has responded to the complaint can be important in rebuilding the relationship with the patient.

UNRESOLVED COMPLAINTS

If despite your best efforts, you are unable to resolve the complaint, the complainant may appeal to a relevant national body such as the Scottish Public Services Ombudsman (SPSO) or Parliamentary and Health Services Ombudsman in England (PHSO).

This will involve further investigation but even if the complaint is upheld, the Ombudsman will look favourably on steps that the practice has already taken in response to the initial complaint. So it is worth noting the tips in the box below for successfully handling complaints.

TOP TIPS

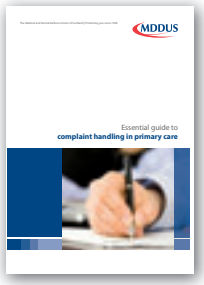
- Ask colleagues for support.
- If you are the person who is being complained about, make sure someone else in the practice deals with the complaint.
- Keep good contemporaneous notes – this is absolutely critical!
- Be open to accepting that something may have gone wrong.
- Share learning from complaints with the whole practice.

- Let the complainant know what the practice plans to do to put things right.

And finally, remember complaints are sources for learning and can be used to improve your knowledge and skills and to better your practice.

Dr Sandy McKendrick is a retired GP and part-time adviser to the Scottish Public Services Ombudsman (SPSO).
The SPSO is the final stage for complaints about the NHS in Scotland

Copies of the MDDUS guide to complaints handling can be ordered from **kwalsh@mddus.com**



The perils of saying "no"

This fictional scenario based in part on a real case involves an encounter between a young GP and an angry and subsequently violent patient

1: Mr G has been promised by GP partner, Dr A, that he will be given a prescription for Viagra following a face-to-face appointment to discuss the matter. The patient duly makes an appointment but is booked instead with a GP trainee, Dr T, without being told.

Mr G turns up for the appointment and explains his request to Dr T but as the consultation progresses the GP begins to doubt that the patient meets the criteria for a prescription of Viagra on the NHS. Dr T turns his back on the patient to search the internet for guidelines and does not notice from the patient's facial expression and body language that he is becoming very annoyed.

Dr T finally finds the guidelines and proceeds to ask some very intimate questions which make the patient feel more uncomfortable and his embarrassment leads to rising feelings of anger. Sure now of his facts Dr T informs the patient that he does not qualify for an NHS prescription of Viagra.

2: Mr G explodes with anger shouting that "Dr A said I could get it". Dr T responds by holding up and waving his printed guidelines on Viagra prescribing to justify his argument. The patient stands up and pushes over his chair, partially blocking Dr T's exit, but the GP manages to run past him into the corridor and shouts for help.

The patient then leaves the consulting room where he encounters the practice manager who is speaking with Dr T in the corridor. The patient offers an apology about his behaviour and asks if he can speak to another doctor about the matter. The practice manager informs the patient that his aggressive behaviour is completely unacceptable and if there is any repetition then the police will be called.

He is then asked to leave the premises and told that the practice will be considering removing him from their list in line with their new 'zero-tolerance' policy. Dr T then points to a 'zero tolerance poster' situated on the waiting room wall as the patient makes to leave.

3: Mr G turns suddenly and punches Dr T hard on the face several times, causing him to fall onto the floor banging his head. The patient then rips the poster from the wall and flings it at the practice manager before storming out the door.

Dr T is initially treated for facial injuries in the surgery but is later driven to A&E by a colleague and is found to have a broken jaw. The practice has to complete a RIDDOR report and the Health & Safety Executive later write asking the practice partners to respond with risk assessments and safe systems of work procedures.

4: The incident is reported to the police who arrest the patient. He appears at court from custody, pleads 'not guilty' and is released on bail pending a trial date being fixed. The next day the police call at the practice to take witness statements from the staff.

The patient is subsequently removed from the practice list and six months later, Dr T, the practice manager, four reception and admin staff, and three patients are called to give evidence at the trial. After two days of evidence and cross-examination, the defendant is found guilty and sentenced to 120 hours community service.

The Health & Safety Executive heavily criticise the practice's health and safety at work management, and issue an 'improvement notice' requiring immediate changes to their safe systems of work. Dr T has not yet returned to patient-facing medicine completely and continues to be traumatised by the whole event.

THIS scenario illustrates how a relatively simple disagreement over a clinical matter can escalate into a major incident with both tremendous personal cost and reputational damage for the practice concerned. There are failings and lessons to be learned before, during and after the event.

Pre-incident: There is communication failure within the practice between Dr A and Dr T over the initial consultation arrangements for the patient. Had Mr G been offered an explanation at the outset, he might not have reacted as adversely.

During the incident: Dr T may have acted with diligence but he failed to appreciate the effect of his decision on an already frustrated and emotional patient. By concentrating on his computer screen the GP also failed to observe and act upon the obvious non-verbal signs of the patient's rising anger and hostility. A powerful trigger for his initial outburst occurred when Dr T began to wave his documentation around in front of the patient. This was certain to further inflame the situation.

The encounter in the corridor also shows a lack of awareness, with the practice manager and Dr T failing to appreciate the seriousness of the situation and instead proceeding to point out various aspects of policy and procedures. This culminates in the most obvious trigger to actual violence – Dr T pointing at a 'zero-tolerance' poster as the patient is already about to leave.

Post-incident: This period illustrates the potential pitfalls that any employer can face following a serious assault in the workplace, as well as the huge potential personal costs to individuals involved. The practice can be subjected to intense scrutiny in a multi-agency dimension, leaving them open to censure, claims and even prosecution. This is the time where practice policies, risk assessments and safe systems of work will be subjected to maximum scrutiny and criticism. It is important to have policies and procedures in place to cover such an eventuality. See page 6 in this issue for some further guidance on ensuring staff security. ❋

Alan Frame is risk adviser with MDDUS Training and Consultancy

Diary

NOTHING better than a little greenery around the place or so we've been told – the only vegetation within Diary desk range being a few curious islands of blue-green fungus in an old Costa go cup.

➔ A RECENT report from the organisation Plants4Life suggests that houseplants in the workplace can boost productivity and slash sickness rates. The report cites a study of 51 offices showing that houseplants can reduce fatigue by 20%, headaches by 30%, coughs by 40% and dry facial skin by 25% through emitting oxygen and acting as natural air purifiers. They also have excellent listening skills – though not reported in this particular study.

Following an article on the findings, the magazine *Management in Practice* asked its online readers "Do you have plants in your surgery? Do they make a difference do you think?" One correspondent indentified only as Marie from Northwest England replied: "Yes we do, but they die a long, slow and dehydrated death as nobody ever remembers to water them. They also collect dust and no one cleans them." Maybe cacti would be a viable option?

➔ IN THESE lean economic times, it's reassuring to see the NHS continue to invest in that great British institution – the cuppa. NHS Grampian in the north of Scotland has spent £75,000 buying 27 tea trolleys. Despite facing spending cuts of around £100million, the health board has given the go-ahead to pay £2,500 each for the trolleys which will serve patients with food and drinks. A spokesman for the board argued the move will yield important medical benefits, reportedly saying: "They are equipped with hot-water boilers which enable staff to safely provide freshly-made beverages to each patient, therefore improving fluid intake."

➔ AUSTERITY measures of a different kind have been affecting vending machines in Wales where health bosses have imposed a sugar ban, amid claims the substance poses a "risk to health". The order has gone out for coffee and tea machines in hospitals across the country to be cleared of sugar. And if that wasn't enough, the Welsh Assembly has banned fatty cheddar cheese sandwiches. Vending machines will instead be loaded up with healthy alternatives such as dried fruit, juice, seeds and water. An Assembly spokesman reportedly refused a compromise deal involving lower-calorie "Half Spoon" sugar and said hospitals should set an example for visitors.

➔ FOR those in search of more imaginative prescribing options, then Dutch scientists Simon Rietveld and Ilja van Beest may hold the answer. They recently won the Ig Nobel Medicine Prize at a glittering "bacteria"-themed ceremony at Harvard University where judges rewarded scientists for their weird work. The Dutch pair were honoured for their remarkable discovery that asthma symptoms can be treated with a rollercoaster ride – so could this pave the way for GPs to prescribe sufferers trips to Alton Towers? Other notable winners included British scientists who proved that swearing relieves pain while another team figured out the perfect way to collect whale mucus using a remote control helicopter. Nice.

➔ *BMJ* ONLINE recently ran a headline that caught Diary's eye – 'Study comes up with 41 definitions of what "having sex" means'. The article reported on a major survey of sexual behaviour among Americans involving nearly 6,000 men and women aged between 14 and 94. One finding was that there can be "great diversity" in a single sexual event among adults, with a total of 41 possible combinations of sexual behaviours represented. The study was funded by the Church & Dwight Company who make Trojan condoms, although researchers pledged that scientific integrity was maintained throughout the study.

Diary recently tried to come up with 41 personal definitions of what "doing work" means but only managed 11 and – reassuringly – there was no overlap with the American findings.

➔ THINGS are different in Britain when it comes to sexual behaviour – and especially up North where NHS Doncaster recently published a *Glossary of Yorkshire Medical Terms* to help European (and probably many UK doctors) interpret the local dialect and common phrases. Diary's favourite among many is "my husband is good to me" – translation being he doesn't expect sex.

➔ GPC CHAIRMAN Dr Laurence Buckman recently lamented the 'rabid' press coverage GPs get these days and commented on the worry that it may be eroding public confidence in the profession. "Of course GPs should reply to negative articles ... but there comes a point when you can't win with these people (newspaper editors)," he said. "It is very distressing to read that you are wicked, corrupt and bad at your job." Perhaps the cause wasn't helped when newspapers recently reported that 1,465 GPs make more than the Prime Minister and one male GP from Hillingdon in west London earned £475,500.

➔ DIARY has noticed a marked increase in the celebrity dental news content of the magazine *Dentistry* – typical in a recent issue it breathlessly reports how the X Factor timetable is so tight in the lead-up to the finals that contestants may miss out on tooth whitening. It seems that in the last series, top cosmetic dentist Mervyn Druian had 12 finalists of the TV talent show in his chair at The London Centre for Cosmetic Dentistry. But this year a spokesperson announced: "The X Factor has said that they are very tight on timings so they may not be able to get the finalists' teeth whitened at all." Such is our apprehension, Diary may not tune in at all.

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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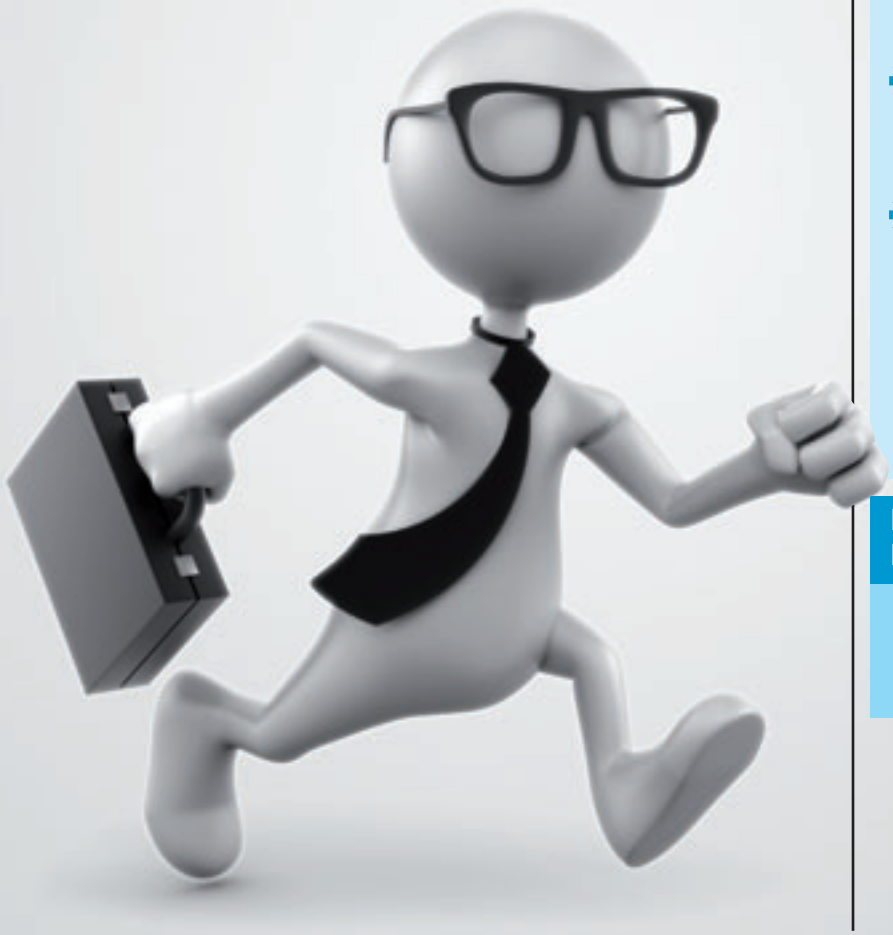

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