Practice Manager
AN MDDUS PUBLICATION

ISSUE 4

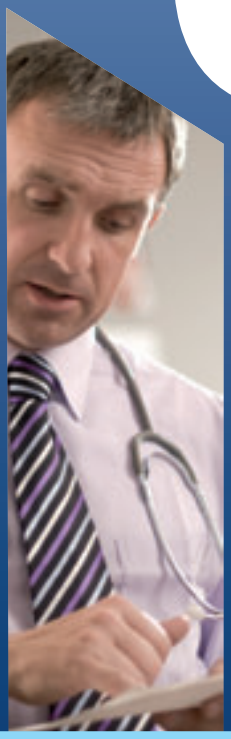
DEALING WITH CHANGE
Staff 'buy-in' is more important than any number of colourful Gantt charts

JUST A MINUTE OF YOUR TIME
The new UK Bribery Act means an even closer eye on the cherished freebie

NEED TO KNOW
Improper disclosure of patient records can be both distressing and expensive

Healthcare REFORM

WE MEET A PRACTICE MANAGER ON THE FRONT LINE



PROFILE:
STEVE POWELL,
WEEPING CROSS HEALTH CENTRE

MDDUS

Practice Manager

PHOTO: BILL BAIN

THERE IS A SAYING THAT THE only thing that remains the same is change. As managers we cope with change constantly. It is our ability to manage change, and how we present it to our teams which may measure how successful we are. Continuing professional development is vital in how we deal with the challenges our practices face. Cherryl Adams highlights this very effectively in her article on change management on page 7.

One practice accustomed to change is Weeping Cross Health Centre in Stafford, which is at the frontline of NHS reforms in England. Practice manager Steve Powell is chairman of the local Pathfinder consortium and talks to MDDUS editor Jim Killgore on page 10 about how practice management might evolve under new government plans.

The major changes afoot in the health service may well have increased stress levels in practices up and down the country. The costs of stress can be high, so Law At Work's article on page 6 offers valuable advice on how managers can tackle the issue.

The Bribery Act comes into force this year and MDDUS HR adviser Janice Sibbald offers advice on page 8 on what this means for practices in dealing with gifts or hospitality. The important HR issue of short term absence is tackled by Law At Work on page 5 while the tricky matter of disclosing medical and dental records is looked at by MDDUS solicitor Lindsey McGregor on page 12.

The Call Log on page 4 highlights calls made to MDDUS advisers, with advice on topics such as data protection, consent and patient harassment. The case study on page 14 analyses a case involving an incorrect test result in a warfarin patient.

Aileen Wilson
Editor

MDDUS practice manager workshops

MDDUS is pleased to present a series of workshops on a range of key topics in medical and dental practice management.

The programme launches on 24 August, 2011, with a workshop entitled 'Leadership and Developing your Team', which will help managers understand leadership qualities, evaluate their own style and understand factors affecting individual and team motivation.

The next session takes place on 13 September on the topic of 'Change Management'. This focuses on understanding the forces for change in an organisation and the effects of change on people.

Sessions continue with an 'Introduction to Risk Management' on 26 October, which looks at risk management, assessment, perception and treatment. This is followed by a workshop on 'Recruiting, Selecting and Inducting New Staff' on 12 January, 2012, while the fifth session on 21 February explores the topic of 'Assertiveness.'

Delegates are welcome to attend all five days or to select individual workshops to suit their needs. All workshops will be based at the MDDUS offices in Glasgow and run from 10am to 4pm. They cost £20 for members and £40 for non-members, with fees covering administration and lunch costs only.

For more information or to book a place contact Ann Fitzpatrick, Course Administrator, on **afitzpatrick@mddus.com** or **0845 270 2034**.

Guidance on new rights for agency workers

NEW regulations giving agency workers rights to the same basic employment and working conditions as permanent employees will come into effect later this year and the government has published guidance to help employers comply with the changes.

The Agency Workers Regulations implement the EU Agency Workers Directive as agreed in 2008 and will come into force in the UK on 1 October 2011. This means that agency workers will have rights to the same basic employment and working conditions as if they had been recruited directly by a company, if and when they complete a 12-week qualifying period in a job.

Key changes also cover elements of pay, duration of working time, night work, rest periods and breaks, annual leave and paid time off for ante-natal appointments.

Access the guidance for Agency Workers Regulations at **http://tinyurl.com/66uszcm**

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Early bird discount for 2012 PM conference

➔BOOK your place now to attend the sixth MDDUS Practice Managers' Conference being held 1-2 March 2012 at the Fairmont, St Andrews.

Book before September 30 and take advantage of our early bird offer.

The full programme is currently being finalised but there has already been strong interest from managers across the UK. Delegate places are limited so secure your attendance now and take advantage of our recession-busting rates.

For more information email **kwalsh@mddus.com** or phone Karen Walsh on **0845 270 2034**.

NICE web resource for general practice

➔AN online resource has been launched to help staff in general practice access National Institute for Health and Clinical Excellence (NICE) guidance.

GPs, practice managers and practice nurses helped create the web-based tool (**www.nice.org.uk/GP**) that offers solutions to enable the uptake of NICE and other national primary care guidance. There is also a section aimed at helping GP consortia.

The resource – part of the NICE website – allows users to quickly access relevant guidance and information, offers tips to ensure the practice team is up-to-date and has advice on how to further their continuing professional development. GPs can view the top 10 NICE guidelines along with summaries of the key points for general practice as new guidance is published each month.

The web tool has been welcomed by RCGP chair Dr Clare Gerada. She said it could become "an invaluable new resource" for those working in general practice, adding: "It can be a real challenge to keep up-to-date with NICE guidance, but this new resource will help GPs and their staff develop a systematic approach to identifying and using NICE guidance."

Online guide on treating migrant patients

➔A FREE guide to assessing and treating migrant patients has been launched online for GPs.

The *Migrant Health Guide* is published by the Health Protection Agency and offers a "one-stop-shop" of information about caring for patients who have moved to the UK from abroad. It recognises the fact that migrants often have more complex health needs than UK-born patients.

The guide provides advice on assessing the health needs of new migrant patients and explaining the NHS and entitlements to care. It covers language interpretation and cultural competence and understanding, as well as various health issues including infectious diseases like TB and HIV which are more common in other parts of the world.

HPA developed the guide in collaboration with a team of clinical and public health experts as well as primary care practitioners and carries the endorsement of the RCGP and the RCN. Access at **www.hpa.org.uk/migranthealthguide**

Revised booklet on consent

➔A REVISED edition of the MDDUS booklet on the basic principles of consent has been published. The short guide is intended to provide practical advice for healthcare professionals to ensure they obtain valid consent from patients prior to any medical or dental intervention.

The *Essential guide to consent* 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**

MDDUS publications **now online**

➔YOU can now access all MDDUS print publications online by going to our new Publications page on the MDDUS website.

Web versions of selected articles and PDFs of the full issues are available for:

Summons - main membership journal

Practice Manager - aimed at medical and dental practice managers

FYi - magazine for final year medical graduates and foundation year doctors

SoundBite - publication for final year dental graduates and postgraduate trainees

GPST - publication for GP specialist trainees

Essential Guides - booklets on core medico/dento-legal topics

Find articles on specific topics by searching our Resource Library at **www.mddus.com**.

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.

GOOD INTENTIONS

Q A practice nurse gets into a heated argument outside her son's school with the mother of a classmate. They row over an alleged bullying incident between the two children and exchange insults before the nurse walks away. The nurse recognises the mother as a patient at her medical practice. She looks up her clinical records the next day, notes her phone number and calls to apologise. But the woman is furious that her personal details have been accessed in this way, especially as her phone number is ex-directory. She makes a complaint and the practice manager calls MDDUS for advice.

A An advisor confirms that the actions of the practice nurse, while understandable, were indeed improper – practice records should be accessed for medical purposes only. The manager was advised to write to the patient to apologise for this error and perhaps also explain that it resulted from a genuine desire to resolve the earlier disagreement at the school. The letter might further state that a practice meeting will be held in order to clarify confidentiality obligations and to update practice policy.

ISSUE OF CONSENT

Q A police officer arrives at a dental practice seeking access to the clinical records of a six-year-old patient. She says she is investigating a case of suspected child neglect and needs to see the records urgently but cannot provide evidence that valid consent has been obtained. The practice manager is worried about breaching the Data Protection Act.

A An MDDUS adviser explains that confidential information contained in dental records should not normally be released to a third party without explicit patient consent. Where the patient is a child under the age of legal capacity, consent from their parent/court appointed guardian is usually required. Practices must exercise caution when authorities such as the police ask for the notes of a child who lacks capacity. In this case, it's reasonable to ask to see written consent from an adult with parental rights and responsibility. However, the police could object to this on the grounds that it may prejudice their investigation, and the matter would seem to constitute a "serious crime". The urgency of the situation could also be questioned, as the police should normally operate through recognised local child protection arrangements, which may not be being followed in this case. Disclosure could be justified by the production of a court order or, if the request is pursuant to a statutory power, then this must be specified before disclosure. In any case, any information subsequently disclosed should be the minimum required to meet the purpose being requested. Assure the officer you are keen to cooperate and consider offering to contact the parent yourself to secure consent.

PATIENT HARASSMENT

Q A young receptionist complains to the practice manager because a patient has been making comments to her that she is too young to have the job. The receptionist is upset and asks if something can be done to stop this harassment from continuing.

A The new Equality Act 2010 means the practice is potentially liable for harassment of employees by a third party – which includes patients. This covers harassment on the grounds of sex, age, disability, gender reassignment, race, religion or belief and sexual orientation. Employers have a duty to protect staff, to thoroughly investigate any claims and to take reasonable steps to prevent further harassment. An MDDUS adviser recommends the manager speaks to the patient and tells him his behaviour is not acceptable. If necessary, this can then be followed up with a written warning to inform the patient that if his behaviour continues he may be removed from the practice list. The practice manager should tell the receptionist what action she has taken and advise her to speak to her again if the patient makes any more inappropriate comments.

DENTAL MAILSHOTS

Q A dental practice manager plans to send out a mailshot to patients informing them about the new treatments available at the practice. But he is worried about breaching data protection rules and calls MDDUS to ask if he needs patients' consent to send them this information.

A Practices should only use patient names and addresses to provide them with dental care or to inform them of the services a practice provides. If this information is used to tell patients about non-dental products, meetings or services then this could be a breach of the Data Protection Act 1998 (DPA). Breaching the act risks court action, a fine of up to £5,000 and could jeopardise professional registration. An MDDUS adviser tells the practice manager he must also ensure the mailshot is not sent out to former patients.

CIVIL PARTNERSHIP

Q A patient comes in for a consultation with one of the practice GPs and is angry that the doctor is unaware she is a lesbian in a civil partnership. She asks for this to be recorded in her notes but the only place the doctor can find to record it is under a section named "Problem". The patient says this is discriminatory so the GP asks the practice manager to call MDDUS for advice.

A Not all practice software is capable of recording all types of patient information but failure to record a patient's status within a civil partnership could constitute unlawful discrimination under the Equality Act 2010. An adviser recommends the practice manager approach the software company to find out if the computer system can be updated to provide a way of recording same sex civil partnerships. The practice should consider checking with patients in future if they would like their sexual orientation noted in their clinical records. The manager should also ensure that literature relevant to lesbian, gay, bisexual and transgender health issues is made available in the practice.

Absent friends

PERSISTENT short-term absence from work is a difficult management issue for most smaller employers. If you offer a generous employer's sick pay scheme there is a fair chance that there will be little financial motivation for staff to return to work speedily or, indeed, to think twice about taking a sick day or two.

The disruptive effect of the same colleague being off sick on a regular basis can create some strong feelings amongst their colleagues – who often end up covering for their absent colleague by working harder or for longer hours. This potential ill-feeling towards the absentee can also be directed at a line manager who is perceived by the rest of the staff as "letting them away with it". The resentment may exist even if the manager is discussing the absence regularly with the absentee – because these discussions are, by definition, confidential and therefore cannot be shared with the rest of the team.

There is a popular myth amongst employees that "They can't sack me for being off sick, if it's genuine or at least certificated". But this is a misconception if based on a belief that the law protects employees from dismissal for short-term sickness absence. Sickness, whether a single long-term absence or a series of persistent short-term absences, can lawfully form the basis of an employer's reason for dismissal. The law refers to the "capability... of the employee for performing work of the kind which (he or she) was employed" being a potentially fair reason for dismissal (Employment Rights Act 1996).

However, in order to avoid or defend a claim of unfair dismissal, the employer will have to show that the employee was aware that, if their persistent absenteeism continued, their job was at risk. Normally this will be achieved through the use of formal warnings to the employee, delivered after a formal disciplinary interview process.

Clearly, it would be preferable to avoid getting to the formal warning stage with an employee who seems to be building up a higher than average pattern of absences. For example, this might be achieved by a review process which is triggered when an individual reaches a certain level of absences in a defined period (e.g. so many instances of absence or so many accumulated days off in a rolling 12-month period). This review should ideally be conducted by their line manager and be separate from any return-to-work (RTW) interview relating to a specific absence.

The review should provide an opportunity to discuss the reasons for the absences, any common denominators that are obvious (dates, health reasons given, days of the week, etc.) and any underlying health or disability issues that are known to the employee. It may even be helpful to make a referral to an occupational health adviser – in order to identify underlying conditions or lifestyle issues which might usefully be discussed with the employee.

It is of course quite possible that, if the absences have been for a short duration and have therefore not required the employee to obtain a fit note, the employee may not have sought the advice of their GP about these problems. A GP's report might therefore be unproductive for absence management purposes as the GP will probably not have clapped eyes on their patient for some time and will not be able to usefully comment on their general health.

A problem issue which Law At Work clients have identified with this approach is that of consistency of treatment of their employees by different managers. Clearly it will be problematic for an employer if an employee can show that had they worked in a different location or team or department, their manager there would not have issued a warning to them about absence (or, even worse, would not have dismissed them). The way to avoid this problem is to ensure that the practice manager is involved in all such review interviews.

Finally, one consideration when warning staff about persistent absence is the presence of an underlying disability. It may be reasonable, for example, to remove from cumulative monitoring any absences which can be attributed to a disability. This presupposes, of course, that the staff member has told the practice about the disability and that it is possible to say that a particular instance of absence was attributable to that disability.

The hope is that, through a combination of return-to-work interviews, review interviews, medical assessments and, if absolutely necessary, formal warnings about the risk to the staff member's employment, the problem will be brought within 'normal' limits. However, if the employee fails to respond to this approach, a dismissal with notice can be fairly carried out through a formal interview process. ❋

Ian Watson is training services manager at Law At Work

LAW AT WORK

Law At Work is the primary supplier of employment law and health and safety services to MDDUS members. For more information and contact details please visit **www.lawatwork.co.uk**

Under pressure

HEALTH professionals deal with stress, day in and day out, advising and treating patients suffering from a variety of conditions ranging from mild anxiety through to major depression. The most recent UK statistics indicate that mental health is one of the top two reasons for absence from work, vying for first place with musculoskeletal disorders and accounting for more than 50 per cent of GP appointments.

Recent research also showed that NHS staff were four times as likely to be absent from work because of stress compared with other occupations, and that nurses were particularly at risk. The costs of stress can be high and, on top of sickness absence, can show up as high staff turnover, reduced work performance and poor timekeeping. And one employee's stress can trigger stresses for their colleagues.

In any of its forms, poor mental health is a combined challenge for employers and employees alike. It is a complex health and safety issue as well as a human resources and employment law matter. Handled badly it can lead to personal injury claims, as well as allegations of disability discrimination and unfair dismissal.

No kind of workplace or work is immune from stress, but some, including healthcare settings, face particular risks if stress is not identified quickly and dealt with effectively. In a busy GP or dental practice, a stressed member of the administrative staff might fail to book appointments properly, record patient details incorrectly, forget to secure the premises when leaving or omit to transfer the telephone line to the out-of-hours service at the end of the working day.

Much more serious errors can be made by stressed practitioners, including mistakes in diagnosis, commencing inappropriate treatment, failing to interpret test results accurately and prescribing (and sometimes dispensing) either the wrong medication or the wrong dosage.

There is no such thing as a 'pressure-free' job. Every job brings its own set of tasks, responsibilities and day-to-day problems, and the pressures and demands these entail are an unavoidable part of working life. Staff are, after all, paid to work and to work hard, and to accept the reasonable pressures that go with that.

And some pressure can be a good thing. It is often the tasks and challenges we face at work that provide the structure to our working days, keep us motivated and contribute to a sense of achievement and job satisfaction. But people's ability to deal with pressure is not limitless. Excessive workplace pressure and the stress to which it can lead can be very harmful.

Unhealthy stress can involve physical effects, such as raised heart rate, increased sweating, headaches, dizziness, blurred vision, aching neck and shoulders, skin rashes and a lowering of resistance to infection. It also leads to increased anxiety and irritability, a tendency to drink more alcohol and smoke more, difficulty sleeping, poor concentration and an inability to deal calmly with everyday tasks and situations.

From a legal perspective employers have a duty to ensure employees are not made ill by their work. The Health and Safety Executive's management standards are applicable to stress at work. They should be used to analyse work from six angles, as follows:

1. Demands – including issues such as workload, work patterns and the work environment.
2. Control – how much say the person has in the way they do their work.
3. Support – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
4. Relationships– this includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.
5. Role – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles.
6. Change – how organisational change (large or small) is managed and communicated in the organisation.

The enforcement authorities expect employers to meet their legal duties by implementing a five step process:

1. Identifying the risk factors.
2. Identifying who is potentially at risk.
3. Carrying out a formal risk assessment.
4. Recording the findings of the assessment.
5. Reviewing the issues periodically.

Staff themselves can provide a very useful view about the stress they are experiencing and the impact it is having on them, and many employers use anonymised questionnaires to gather this information. Even allowing for rogue results most staff will take this kind of exercise seriously and can alert management to issues they are unaware of.

A short article of this kind cannot go into the detail of how to keep on the right side of the law, but Law At Work will be delighted to provide healthcare employers with some peace of mind by helping to plan and implement a risk management process to deal comprehensively with the hazards of stress.❋

Thomas Elliott is health and safety manager at Law At Work

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Time for a change

THE Greek philosopher Heraclitus once noted that "Nothing endures but change", while renowned political author Arthur Koestler remarked that "The only thing which likes change is a wet baby." These two quotes seem to capture the general attitude to change – it's inevitable but few people like it!

With massive changes afoot in the NHS, managers face great challenges, from increasing patient expectations, tightening budgets, changing roles within general practice and the prospect of GP commissioning.

How then does a manager steer a team through an eternally shifting environment? The first step is recognising that change is not simply an organisational transition, but a process that involves each individual within the organisation adopting those changes and modifying their day-to-day working.

As a change leader you are effectively asking each team member to engage and change, not simply running through a process of adjusting procedures around your team. Change can have a significant psychological effect on both individuals and the team as a whole. Some may start to behave differently, boundaries become fuzzy, and people often have to rediscover their identity within the team. It's important to account for these psychological and emotional reactions rather than only planning for the hard, quantitative outcomes.

> "BE SURE TO ADDRESS ANY RESERVATIONS YOU MAY HAVE BEFORE TRYING TO PROMOTE A CHANGE TO YOUR TEAM"

Be prepared to manage people through their experience of change. There may be resistance from some and morale may drop, but you should create an appealing vision of the future and develop a strategy for making it a reality. Consider ways of maintaining motivation within the team and be prepared to help steer them through it to give them the incentive to move forward. Individuals can sometimes find their own way but sometimes they need guidance.

Research suggests that the biggest cause of change failing is that people do not understand why they are being asked to change. Organisations will often efficiently take care of the 'how' element of change management – hard measures and outcomes, financial forecasting, Gantt charts coming out of their ears – but neglect the 'why'. Team members will usually be concerned with a number of issues:

- Why are you asking me to change?
- Why are the skills that I have developed with the existing system now no longer required?
- What benefits will this change bring?
- How will I gain the skills and knowledge needed to feel okay with this new system?
- Can I visualise how I will fit into the new picture?

Addressing these questions early in the change process can enable individuals to understand their thoughts surrounding the changes, the vision of where and why the organisation is changing and how they are going to cope and fit in with these changes. This involves the singularly biggest element of successful change management: communication. That means explaining where we are now, where we need to get to and why, and how we are going to get everyone there.

An inclusive way of managing change is to have managers paint the broader brushstrokes of where the practice has to get to, and in what timescale, and enlist the help of those who are directly involved in the transition to fill in the steps required to get there. This method takes some of the pressure off managers and allows the people who will be using the system to feed their invaluable knowledge into the process and understand what the end result should look like, whilst also addressing the practical day-to-day issues. This addresses another of the biggies in change management: participation. It is vital to not only plan and monitor change, but to gain the commitment of those who will be affected by it. If a team member has contributed to the new system, and has practical input, then there is more opportunity to feel engaged and have a sense of ownership over the initiative.

Another important factor in leading your team through change is understanding how you feel about it. Incremental changes which are internally generated through recognising how systems and processes can be improved will have a different impact than changes introduced through an external influence where the practice has little choice. This may be the introduction of a new IT system or the practice entering the world of GP commissioning. Understanding how you feel about it on an emotional and practical level will provide great insight into how you will lead your team through it. Be sure to address any reservations you may have before trying to promote a change to your team as it will make for a more authentic communication strategy – personally and organisationally.

Leading a team effectively through change requires an understanding of all the management 'tools' – effective leadership, open communication strategies, problem-solving skills and ultimately an understanding of your team and your own strengths and challenges. Change should not happen in an uncontrolled way so be sure to create a good plan, communicate your vision of change, engage individuals and recognise what needs to happen to support them – i.e. training sessions or team meetings. Make sure the change is adopted consistently by everyone in the practice – particularly those at senior levels – and above all be sure to communicate effectively with everyone involved. ❋

Cherryl Adams is a trainer and risk facilitator with MDDUS Training and Consultancy

Just a minute of your time

2011 will see the new UK Bribery Act come into force, meaning an even closer eye on the cherished freebie. Here MDDUS HR adviser **Janice Sibbald** looks at some of the implications

AN OFFER of free centre court tickets at Wimbledon might not be easy for anyone to turn down. So it proved when drug reps for the pharmaceutical giant Abbott Laboratories invited a group of London doctors to enjoy "full hospitality" at the tennis tournament in 2004.

An anonymous whistleblower triggered an investigation by the Association of the British Pharmaceutical Industry (ABPI) who later ruled that the company breached industry code of practice. The company also faced accusations that it had treated doctors to greyhound racing in Manchester as well as a night out at a lapdancing club for one hospital consultant.

Such activities are strictly forbidden by the ABPI code which was adopted by the pharmaceutical industry to police its own conduct. But offering expensive freebies may in future lead to worse penalties than industry censure. The Government have announced that the new Bribery Act 2010 will come into force on 1st July 2011, making it a crime to offer financial or other advantages with the intention of inducing a person to perform an "action improperly". The Act goes even further making it illegal for healthcare professionals to request, agree to receive, or accept an inducement.

The Act significantly reforms outdated laws on bribery, some dating back to 1889. Importantly, it creates a new offence for any business failing to prevent bribes being paid on its behalf, quite a significant change in direction. It will give the UK some of the strictest anti-bribery sanctions in the world, increasing the maximum penalty for bribery from seven to 10 years imprisonment with an unlimited fine.

That's not to say that prosecutors are out to get doctors or practice managers – the Act is aimed mainly at major corporate corruption. But it is important that medical and dental practices have "adequate procedures" in place to prevent bribery.

➔WHAT IS AND IS NOT ACCEPTABLE?

In March the Director of Public Prosecutions and the Director of the Serious Fraud Office issued joint guidance for prosecutors in England and Wales on the new Act, stating: "Hospitality or promotional expenditure which is reasonable, proportionate and made in good faith is an established and important part of doing business. The Act does not seek to penalise such activity."

However, the guidance does confirm that some forms of hospitality and promotional activity could form the basis of offences under sections of the act. It states:

"The more lavish the hospitality or expenditure (beyond what may be reasonable standards in the particular circumstances) the greater the inference that it is intended to encourage or reward improper performance or influence an official. Lavishness is just one factor that may be taken into account in determining whether an offence has been committed. The full circumstances of each case would need to be considered. Other factors might include that the hospitality or expenditure was not clearly connected with legitimate business activity or was concealed."

So practice managers should be aware of what is and is not acceptable in order to protect staff and the practice. Fortunately the ABPI code is already in place to help ensure that there is no direct bribery of doctors and medical practices. The code requires medical and dental representatives to maintain a high standard of ethical conduct. They must not use inducements or subterfuge to get into a meeting and this applies to what they say as well as the materials they use.

Reps should no longer be giving out expensive "freebies" to practices in order to curry favour and, in relation to conferences, companies should not provide hospitality to healthcare professionals except under the following conditions:

- The meeting/event must have a clear educational content.
- The venue must be appropriate and conducive to the main purpose of the meeting (lavish, extravagant venues must not be used).
- The sustenance associated with a meeting or event must be secondary to the nature of the meeting.
- Any hospitality provided must not extend to a spouse or other such person unless they are a member of the health profession or appropriate administration staff.
- Any air travel that is supported must be economy class and not business or first class.

It has been suggested that a company may perhaps pay for a member of staff to attend some specific training and this would still be acceptable under the Act. But you should ensure that you are not putting yourself or any member of staff under obligation to accept services or goods because of the promotional activities of a company.

Some patients may bring gifts such as wine, perfume or foods into a practice, perhaps as a thank you after a period of illness or for looking after a relation. As long as there is no preference given to these individuals then the Act allows for gifts. However, it may make sense to ensure that you have a policy that means that gifts are distributed among staff to ensure fairness.

Remember also that the GMC places obligations on doctors in regard to potential conflicts of interests. In supplementary guidance to *Good Medical Practice* it states that doctors "must act in your patients best interest when making referrals and when providing or arranging treatment or care. You must not ask or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe, treat or refer patients."

➔WHAT POLICIES SHOULD I HAVE IN PLACE?

It is strongly advised that practice managers have a clear and comprehensive gifts and hospitality policy in place and this forms part of the practice employee handbook. Ensure that when you have new employees joining that they are referred to it as part of their induction process and you may wish to make it a discussion topic at team meetings to ensure there are no awareness or interpretation issues. Ensure that not only staff but also doctors are aware of the law and their obligations. You may also want to add in a specific example of misconduct in regard to gifts and hospitality in your disciplinary procedures so that staff are aware of the repercussions of breaching the policy.

But the message is clear, be careful what you accept from any industry rep as it may prove a perk too far.

For more detailed guidance about the Act as well as a set of illustrative case studies, check out www.justice.gov.uk/guidance/bribery.htm You can also phone the MDDUS employment law and HR advice service on 0845 270 2034 or email: employmentlaw@mddus.com. ❋

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"THE MORE LAVISH THE HOSPITALITY OR EXPENDITURE THE GREATER THE INFERENCE THAT IT IS INTENDED TO ENCOURAGE OR REWARD IMPROPER PERFORMANCE"

Frontline reform

Jim Killgore meets a practice manager at ground zero of NHS reform in England

THE morning I travel to Stafford to meet Steve Powell he kindly offers to pick me up at the train station. In the email he says to look out for a slate grey Mercedes E Class Coupe and I do not have to wait long before he pulls up in what is a very nice car.

Steve is a busy man and it's clear that making time to meet with me has not been easy. He manages a group of three medical practices with over 18,000 patients – the largest in South Staffordshire – but this is only part of his current responsibilities. Steve is also Chair of the Stafford and Surrounds GP Commissioning Consortium which is one of the government's much talked about Pathfinder consortia at the heart of its controversial NHS reforms in England. Most of the lead executives in emerging commissioning consortia are GPs so Steve is the rare exception being a practice manager.

Our first stop of the morning is Beaconside Health Centre located in a new and spacious building on open ground adjacent to the campus of North Staffordshire University for which it serves as a student health centre. Beaconside was opened in 2005 as part of a planned expansion out of the original practice at the Weeping Cross Health Centre. Steve is clearly proud of the set-up as he tells me later in the large training and meeting room at the centre. He organised the construction of the new building – designed the layout and even chose the colours.

Steve is not only business manager of the group practice but also a partner. He says this "mature relationship" has allowed the practice to grow in a managed and innovative way.

"The GPs recognise that my skills are in business and finance and their skills are in medicine. Being a partner helps keep things on an even footing."

➔JOB CREATION

Steve joined Weeping Cross in 1994 having before studied business and finance and run his own successful catering business. Then it was a small practice of about 4,800 patients with only two GPs and had never before employed a practice manager.

"No one knew what a practice manager was meant to do," says Steve. "I was given a filing cabinet with about 20 years of paperwork and told to build my own job really. And I have been fortunate to be able to carry on doing that."

The Weeping Cross practice grew as residential development in the area expanded in the late 1990s with the patient population being within commuting distance of both Manchester and Birmingham. In the early 2000s the practice began providing services on the campus of the University and eventually purchased land to build the Beaconside Centre. This brought an additional 6,000 patients. Just recently the practice merged with a third practice – the John Amery Drive Surgery. The combined group now employs around 45 staff including 12 GPs.

In addition, five years ago Steve together with the other partners in the practice set up a separate private limited company called the Beacon Clinic Ltd offering a range of medical cosmetic treatments and travel medicine services as well as providing primary care services to the Ministry of Defence.

Steve does not see any conflict between being entrepreneurial and also providing care in a National Health Service. He says:

"Remember that GPs are independent contractors. I never describe myself as working for the NHS. I consider I work for a business that is owned by GPs and myself. And we follow the rules and principles of business and it just so happens that the product we deliver is quality patient care."

➔TAKING ON REFORM

Steve's interest and involvement in NHS reform began back in 2004 with the new GP contract and the introduction of practice based commissioning. In 2005 Weeping Cross joined with five other practices in an informal group which over the years evolved into the Stafford and Surrounds Practice Based Commissioning Consortium. It now includes 15 practices representing 145,000 patients with a budget of about £173 million. Steve has served as chair of the consortium since its inception.

"It's all very democratic. We have elections every year for clinical lead and chair. I've tried to get out of it several times now but I keep getting nominated and voted back in," he says.

"The workload is phenomenal. It started out at about four or five hours a week but now I probably put in 30 hours a week in GP commissioning. So that makes a 70-hour-plus week with my other responsibilities. It's virtually doing

PHOTOGRAPHY: GILL TAYLOR / WWW.GILLTAYLOR.CO.UK

two jobs and I'm happy to carry on as long as my health and enthusiasm hold out."

Should the NHS reforms go ahead, GP consortia like Stafford and Surrounds will in 2013 begin commissioning patient services directly from hospitals and other providers. Many of the Pathfinder consortia have already launched local commissioning initiatives.

In Stafford and Surrounds one of the most successful of a number of programmes has been the Greyfriars Therapy Centre. The consortium developed a detailed business case for the PCT to lease and adapt a new building in order to provide a one-stop shop for a range of local social and healthcare services including pain management, pulmonary rehabilitation, rheumatology, orthopaedic triage and out-patient general and dermatological surgery. It also gave the consortium the opportunity to start to integrate health and social care teams by co-locating them in the same building which is an important element in the government's reform plans.

"The benefits are several-fold," says Steve. "You don't want to go into hospital if you don't have to. The service is provided in a less daunting, less clinical environment. The quality of care is better than in a secondary setting and the risk of contracting a hospital-acquired infection is much less. It also falls within government aims of providing care closer to home and it saves the health economy a significant amount of money because it's done at 70 per cent of national tariff – that's a 30 per cent saving. And patient feedback has been fantastic – with 98 to 99 per cent satisfaction ratings."

CUTTING RED TAPE

The consortium has also delivered a number of other new initiatives in the past year including the expansion of its community ENT triage service, the launch of new services in stroke care and primary care mental health along with other projects in dementia, end-of-life care, diabetes and osteoporosis. Steve is an ardent supporter of GP commissioning.

"The one thing that irritates me more than anything is bureaucracy," he says. "I cannot tolerate pen-pushing and filling forms for the sake of it. What we have been able to see and do with PBC is cut through all the red tape and get things done a damn-sight quicker by driving it ourselves. Left to the PCT, I do not know if the local health economy would have achieved half of what's been accomplished by PBC."

But the devil is in the detail and Steve believes it is crucial that established Pathfinder consortia lead the way. He also sees an important role for practice managers in the success of GP commissioning.

"Practices will be taking responsibility for devolved budgets which will probably on average be around £8 million to £12 million a year. Practice managers will have to up-skill and start working smarter. The ability to prioritise and time manage will become crucial."

> "I NEVER DESCRIBE MYSELF AS WORKING FOR THE NHS. I CONSIDER I WORK FOR A BUSINESS… AND THE PRODUCT WE DELIVER IS QUALITY PATIENT CARE"

Steve even foresees the possibility of someday having specialised practice managers much as there are specialist GPs. "In a consortium you might have practice managers who specialise in finance or HR or health and safety or clinical policies. And the skill set might be interchangeable between practices."

Having some formal training in management and business will also become more important for practice managers. Steve recently undertook a Certificate in Healthcare Finance which included a module on GP commissioning and would recommend it to any practice manager seeking to enhance skills. His view is that GPs can provide the clinical drive in commissioning but it may largely be up to PMs to drive the management, administration and vision.

Steve has no illusions regarding the pitfalls and complexities facing the new NHS reforms.

"It's a mammoth task pulling practices together to work cohesively," he says. "But it's got to happen because the NHS as it is now is not sustainable."

Jim Killgore is an associate editor of Practice Manager

Need to **know**

MDDUS solicitor **Lindsey McGregor** offers some basics on the disclosure of patient records

TO DISCLOSE or not to disclose – that may be the question but what's the answer? Deciding how to comply with the numerous types of requests for access to medical or dental records from various sources is a regular feature of general practice today. Patients, police, lawyers, social workers, insurance companies – the list is endless. And some requests can be quite unusual and the appropriate response not entirely obvious.

At MDDUS our medical and dental advisers receive calls on a regular basis from practice managers or practitioners seeking advice on how to respond to such requests. We encourage members to get in touch with specific queries but it is helpful and important to have an overview of the legal framework behind records requests.

➔WHAT AND WHAT NOT TO DISCLOSE

The Data Protection Act 1998 gives all patients the right of access to all computerised and manual records which contain information about their physical or mental health. This Act will be very familiar to many practice managers and stipulates a 40-day turnaround from the request being received in writing by the data controller. But what are you to give access to? In the legal team we sometimes are provided with records which have been recovered by patients and handed over to their solicitors to commence a claim. In those records we will see documents which should not form part of the clinical record and may in fact be prejudicial to a claim. Only disclose records of clinical relevance and do not include:

- correspondence with the MDDUS medical or dental adviser
- GMC/GDC correspondence
- correspondence with solicitors/DVLA/insurance companies
- case conference notes.

➔AUTHORITY TO DISCLOSE

It's also important to know who has made the request and if they are authorised to do so. Requests do not always come from patients and it's important to check that the authorisation is valid and is signed and dated.

In requests for access to children's records, check that the person making the request has parental rights. Generally speaking parents can exercise their parental rights and responsibilities without the consent of the other parent and this would include access to records. However, some parents have had their rights restricted or removed and it's important to check that the request is valid. This is particularly the case with unmarried parents. If the father's name is not on the birth certificate and he has not been granted parental rights by agreement or by court order then he is not entitled to have sight of his child's records. Equally important is to consider the age of the child as he or she may be legally competent to consent to the release of the records.

Requests of course don't just come from patients. In our compensation culture solicitors will regularly write for either access to their client's records or for a report on their condition. Again the golden rule is carefully check the request and ensure you have a signed and valid mandate from your patient. Only provide what is requested and don't provide all the records if you are only asked to provide records from a certain date or relating to a specific illness or accident. If in doubt ask the MDDUS or consult your patient.

Similarly, orders from the courts can require you to produce records. Read the court order carefully as there will be time limits and instructions as to how the records are to be disclosed and to whom. Make sure that you only provide the records which the order requests.

DENYING DISCLOSURE

Access can be denied to the records in some circumstances, particularly if:

- Disclosure would cause serious harm to the physical or mental health of the patient or any other person.
- Information was provided on the basis that it would not be disclosed to the person making the request.
- Information was obtained following an examination which the patient consented to on the basis that it would not be disclosed.
- Information is in the records which the patient has expressly indicated should not be disclosed.

REQUESTS BY POLICE

The police have specific powers to request records in terms of section 29 of the Data Protection Act when they are in the course of a criminal investigation. There is a tension here between the Act and the GMC advice which requires the crime to be "serious". It is unlikely in these circumstances that the police will agree to you seeking consent from the patient if you have a concern about whether the crime falls into the serious category. In such a scenario it would be important to keep notes of any discussions with the police, to contact the MDDUS for advice and to record this advice and then to comply with the request. As long as you have acted in good faith and taken appropriate advice, the GMC should be satisfied that you have complied with *Good Medical Practice*.

Remember that if you are in doubt about a disclosure request it's always better to ask for some guidance. Hefty fines can be imposed by the Information Commissioner if personal data gets into the wrong hands. Hertfordshire County Council were fined £100,000 for faxing information about a child abuse case to the wrong recipient.

Our advisers are only a phone call away.

Lindsey McGregor is a solicitor at MDDUS

CASE STUDIES

Below are examples of some typical disclosure requests.

1 *A practice manager contacts the MDDUS over a patient who died last year. The practice has received a request from the insurer of the trustee in bankruptcy to release the deceased's medical records.*

The Access to Health Records Act 1990 applies to the records of a patient who has died. Anyone who has a claim arising out of the patient's death including a trustee in bankruptcy may apply for access to the records. This would include an executor. However, there are exemptions on what can be disclosed and the practitioner must be satisfied that only information directly relevant to the claim is disclosed.

The following must also be considered:

- Did the deceased request non disclosure of the records?
- Are third parties identified?
- Will disclosure result in serious harm to a third party's physical or mental health?
- Was information provided on the basis that it was confidential?
- Do the terms and conditions of the insurance policy provide evidence of consent to release the records?

2 *A dentist, Mr B, contacts the MDDUS as he has been asked by the father of two patients aged 12 and 15 to disclose their records. The parents are separated with the daughter residing with the mother and the son with the father. The father anticipates that the mother will refuse to consent.*

The children in this scenario could request access to their own records and this might be one route to suggest, however this draws the children into a dispute which could arise between the parents. Given the father claims to have parental rights, Mr B does not require to seek the mother's consent but to be sure he could ask to see the birth certificates. Given the ages of the children Mr B should seek their consent unless there is a question of competence.

3 *Dr H receives a request for access to records of children by a father who is in prison, convicted of murdering his wife. He still has parental rights. However the maternal grandparents also have parental rights. One child is 15 but the other is 7.*

The GP practice confirms proof of parental rights from the grandparents and properly seeks their views in relation the younger child. The older child should be able to refuse on her own behalf if judged competent to do so. The GP could have also refused access on the basis of the serious harm test referred to earlier.

Warfarin dosing error

This fictional scenario is based in part on a real case in which simple human error could have led to fatal consequences.

Day one

1: A 78-year-old woman – Mrs B – attends her local surgery for a routine blood test. She is on long-term warfarin therapy after having suffered a pulmonary embolism. Staff at the practice monitor her INR (International Normalised Ratio) and adjust the warfarin dosage on the basis of a detailed programme implemented after consultation with the local haematology department. Frequent dose adjustments are required to maintain the therapeutic action of the drug and minimise side-effects. Under-anticoagulation can lead to thrombosis and over-anticoagulation to bleeding. The practice keeps a warfarin register with a page for each patient being treated with the drug. Each time a blood sample is taken one of the doctors enters the latest INR level along with the current warfarin dose and any necessary change that might be indicated. The patient is contacted with this information along with the date of the next test.

Day two

2: An INR result is received for Mrs B from the lab and the practice sends out a letter informing her that although her INR is near the upper end of the acceptable range there is no need to change her warfarin dose. Her next test is scheduled for two week's time

Day nine

3: An INR result is received in the practice for another patient with a similar name to Mrs B. One of the doctors mistakenly adds the result – which is just below the acceptable range – to Mrs B's page in the warfarin register.

Day ten

4: A practice nurse who monitors the register notices the low result for Mrs B and as per a set protocol phones Mrs B and tells her to increase her warfarin dose.

Day sixteen

5: Mrs B has missed her scheduled blood test due to a very painful leg. Later that day she asks for a home visit and the attending doctor diagnoses a large haematoma in her thigh. Back at the practice the doctor checks the original computerised lab results and finds the erroneous result added to Mrs B's page in the register. She is hospitalised and tests reveal a dangerously high INR and she is also found to be very anaemic. She responds well to treatment and fortunately makes a full recovery although with pain and inconvenience.

ONE month later a letter of complaint is received by the practice from Mrs B's son over his mother's treatment. The practice manager investigates the matter and with the advice of MDDUS frames a response letter in which she first apologises for the errors that led to Mrs B's condition and hospitalisation. She writes that the practice had been confident that the system used to monitor warfarin treatment in patients was foolproof but Mrs B's treatment had clearly demonstrated this was not the case.

A SEA (significant event analysis) is to be conducted and the protocol re-examined – with particular regard to the potential for human error – in order to ensure that such a mistake will not happen again to any patient at the practice. She offers to report on the outcome of the SEA and meet with the family along with the doctors to discuss the matter if desired. It is also pointed out that if Mrs B and the family are dissatisfied with the explanation provided they are "free to seek an independent review".

Mrs B's son replies to the practice manager thanking her for the full and frank response and states the family is satisfied now that it was simple human error and not a lack of care that led to the treatment failure. No further action is taken in the case.

KEY POINTS

- Ensure you have an effective results-handling process.
- Make sure systems are as 'fail safe' as possible.
- Anticoagulants are among the drugs most associated with fatal medication errors so take particular care with patients being treated with warfarin to ensure any changes in dose are based on sound protocols and are accurately and clearly communicated.
- Ensure careful sharing of responsibility for tests and results handling.

Alan Frame is risk adviser with MDDUS Training and Consultancy

Diary

GIVEN recent headlines Diary wonders if practice managers should be sharpening up their clinical skills. One front page article this month in the medical tabloid *Pulse* warned: 'NHS reforms push third of GPs to head for exit'. Are things really that bad? And more inside – 'Half of GPs suffer stress', 'GP workload on the rise', 'GPs spending less time with patients' and all illustrated with a depressing little histogram of survey findings that show how GPs feel they are worse off in terms of pay, working hours, autonomy, relationship with secondary care and ability to meet expectations. It might just be time to replenish the biscuit tin – maybe even with those Duchy Originals.

➔ ONE EAR TOO MANY Staying with the topic of *Pulse*, Diary was impressed by a recent exposé written by its editor Richard Hoey. In an online blog Mr Hoey described how he had arranged to have his ears syringed at his local London GP after many weeks of impaired hearing. "I was rather looking forward to being dewaxed," he writes. "The nurse though was having none of it, or rather, she was having exactly one half of it. 'We can only do one ear' she said, as soon as I sat down. I was rather confused by this, and it took me a while to say much in response. Apparently, the policy was that only one ear could be syringed in a 10-minute consultation. If I'd wanted two ears syringed, I should have specified this when booking my appointment."

➔ SNACK CUTBACK Alarming news has come our way courtesy of a random survey by workplace design firm Maris Interiors. Their researchers spoke to 185 people in February and concluded that the quality of sandwiches served at business meetings has fallen dramatically in the past five years. A shocking 80 per cent of participants thought the quality of their corporate snacks was on the wane with only four per cent noting an improvement. The statistics seem to bear out this worrying trend, with the average cost of business meeting sandwiches coming in at £5.91 per person in 2006 compared to just £3.80 in 2011. Back in the heyday of 2006, popular sandwiches boasted high-end fillings like crayfish and avocado, while in 2011's austerity Britain we're more likely to be served up tuna and sweetcorn. A sad sign of the times indeed.

➔ EAT BEER Just when Diary was starting to feel guilty about all those midweek glasses of wine, it turns out our attitude to alcohol might not be so far behind the times as some people. In Russia, beer is technically classified as a foodstuff and is apparently regarded by locals as little more than a soft drink compared to their national tipple, vodka. It's routinely sold in kiosks on almost every street corner with the 1.5 litre jumbo bottle a particular favourite. All that looks set to change, however, as legal moves are afoot to classify it as an alcoholic drink for the first time. New laws are currently making their way through parliament in a bid to cut underage drinking and alcohol-related deaths. Now, who's for a chardonnay?

➔ HEAD RUSH The next time you need to give yourself a boost under pressure, think twice before reaching for the coffee – unless you're a woman. Researchers from Bristol University studied 64 men and women and found that men's performance in set tasks was reduced if they drank caffeinated coffee, with impaired memory and slower decision-making. But the opposite was true for women who were able to complete tasks 100 seconds faster if they had been given caffeine. Source: *The Journal of Applied Psychology*.

➔ SNEEZE TIMEBOMB It's the kind of news that will have all practice managers reaching for the sanitiser spray. Scientists have discovered it takes just a single sneeze from a flu sufferer to spread germs around an entire room. And the tiny infected droplets can hang around spreading contamination all day. Breathing in these microscopic specks can infect a person within an hour. The findings from US researchers at Virginia Tech will surely make the prospect of working alongside all that coughing and spluttering all the more appealing. So long as you don't breathe, everything should be fine.

➔ BRUSH WITH BIEBER On now to an even more insidious viral agent – *Dentistry* magazine recently reported the launch of a Justin Bieber toothbrush collection. Sadly only available in the USA at present the brushes play Justin Bieber tracks such as *Baby* or *U Smile* for two minutes while brushing to encourage youngsters and adults to keep to the recommended time. Patients can also buy Justin Bieber dental floss. Diary suggests the products could be marketed in the UK under the slogan "Rot your brain, not your teeth" – or perhaps that's a tad curmudgeonly.

➔ GIVE THE BLACKBERRY A REST And on the topic of toothbrushes, Diary read recently on the BBC website that around the world mobile phones now outnumber toothbrushes two-to-one – a factoid disturbingly difficult to process. The point being that mobile technology has now enslaved us within a "culture of hyper-connectivity" which makes it difficult to switch off from work. Last year a Jewish non-profit group based in New York, called Reboot, decided that what the world needed most was a National Day of Unplugging or NDU to inspire us to recapture "real interconnections between people" amidst the "relentless deluge of information" in our lives. For this year's NDU in March Reboot handed out little sleeping bags for people to give their smartphones a rest. How cute is that?

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**

EARLY BIRD OFFER

MDDUS Practice Managers' Conference

Fairmont, St Andrews 1 – 2 March 2012

The SIXTH MDDUS Practice Managers' Conference is once again returning to the recently refurbished Fairmont, St Andrews (formerly known as St Andrews Bay Golf Resort & Spa) on 1 – 2 March 2012.

The full programme is currently being finalised but as delegate places are limited you can book **now** to secure your attendance and benefit from our recession busting rates.

Book before 30th September to take advantage of the early bird offer.

Conference fees (all prices include VAT)

Residential single room	**Early bird – DPS**	**£249**
	Early bird – non DPS	**£279**
	Standard fee – DPS	£279
	Standard fee – non DPS	£299
Residential double room	**Early bird – DPS**	**£219**
	Early bird – non DPS	**£239**
	Standard fee – DPS	£239
	Standard fee – non DPS	£259
Residential triple room	**Early bird – DPS**	**£209**
	Early bird – non DPS	**£229**
	Standard fee – DPS	£229
	Standard fee – non DPS	£239
Day delegate	**Early bird – DPS**	**£119**
	Early bird – non DPS	**£139**
	Standard fee – DPS	£139
	Standard fee – non DPS	£149

To receive your early bird application form, email kwalsh@mddus.com or call Karen Walsh on 0845 270 2034