Practice Manager
AN MDDUS PUBLICATION
ISSUE 5

ONLINE
OR OFF LIMITS?
A clear internet policy with regular reminders is a must for any practice

A VISIT
FROM THE POLICE
Not something a practice manager might relish but rarely cause for panic

BRIDGING
THE DIVIDE
Our ever-more culturally diverse society brings numerous challenges to general practice

Health CHALLENGES IN URBAN GLASGOW

PROFILE:
KATHLEEN DIAMOND, JANETTE MCMILLAN
THE KER PRACTICE

MDDUS

Practice Manager

PHOTO: BILL BAIN

ONE DEFINITION OF multiculturalism is "the appreciation, acceptance or promotion of multiple cultures". This will mean different approaches and ways of working for general practice, depending on where in the country you are. In my small rural practices in the NE of Scotland you may think that we have less of a migrant population than practices in Glasgow. And you would be right on the whole, but there is a very substantial eastern European population within the NE of Scotland. So no matter where you are, being mindful of the wide mix of cultures in your local area can make the process of managing patient expectations less challenging.

On page 12 Joanne Curran talks to practice managers who face the challenges of multiculturalism on a daily basis.

One practice at the frontline of multicultural care is The Ker Practice in Glasgow. In our profile on page 10, Jim Killgore finds out about the challenges facing Ker's managers as they deal with poverty and chronic deprivation in a mixed patient population.

The secret to successful practice management is discussed on page 8 where MDDUS trainer Cherryl Adams looks at the importance of having a clearly defined vision of where your practice is going and how a SWOT analysis can help you get there. Leading the way for dental PMs is Jill Taylor who talks about her new role as president of ADAM in our page 7 Q&A.

Few managers would relish a visit from the police, but it need not be a cause for undue panic. MDDUS risk adviser Alan Frame offers advice on how to handle such a situation on page 9 ,while the case study on page 14 provides a relevant example.

Regulating employees' internet use is a growing challenge and on page 5 MDDUS employment law adviser Janice Sibbald discusses the importance of having a clear policy, while on page 6 Law At Work offer a sensible guide to risk management in health and safety. And the Call Log on page 4 highlights advice provided on topics such as disability discrimination and parental access to children's records.

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Indemnity for practice staff

A RECENT letter from the Royal College of Nursing (RCN) regarding indemnity for some of its members has been causing concern among practice managers and staff. The letter informed RCN members that from 1 January 2012 indemnity cover for work undertaken in general practice was being removed from the range of RCN member benefits.

Some practice managers have expressed concern that this means practice nurses may no longer be indemnified for clinical tasks undertaken on behalf of the practice.

MDDUS would like to reassure members that we provide all GP and GDP partners in membership access to indemnity for any act or omission arising from the proper and authorised duties of all members of staff, including practice managers, practice nurses and any other ancillary staff not eligible for full or associate MDDUS membership. This vicarious liability will continue to apply as it has in the past.

The RCN changes should also have no effect on subscription rates.

Please phone our Membership Department on 0845 270 1208 if you have any concerns regarding staff indemnity.

Practices still swamped with paper

GP SURGERIES still process vast amounts of hard copy documentation despite nearly 95 per cent expressing a preference for electronic communication.

A survey of 673 practices conducted on behalf of Healthcare Gateway Ltd has found that 84 per cent of clinical communications is still sent on paper. An average of 373 clinical documents were delivered per week to each practice and 31 per cent of practices reported receiving more than 500 a week.

An estimated 200 million clinical documents are sent in the post to UK practices each year at a cost of £1 per letter.

The research has revealed that practice administration staff spend the equivalent of two working days each week scanning and inputting paper documents. Forty-four per cent of practices also reported having documents lost in the post, and 16 per cent said documents failed to arrive every week.

Healthcare Gateway Ltd is a joint venture by GP software providers INPS and EMIS which has developed a technology known as the Medical Interoperability Gateway (MIG) to facilitate data sharing between healthcare professionals (with patient consent).

Peter Anderson of Healthcare Gateway said: "This survey shows that there is an overwhelming demand for electronic communication delivered directly into the GP system that is not being met. Yet the technology already exists to quickly and securely share vital clinical information between secondary care clinicians and GPs using different IT systems."

Keynote speaker takes PM conference into orbit

➔ WHAT DOES your average medical or dental practice share with NASA? Quite a bit when it comes to being a "safety critical organisation". This is the theme of the keynote address to be given by Stephen Carver of the Cranfield School of Management at the 2012 MDDUS Practice Managers' Conference being held on 1-2 March 2012 at the Fairmont St Andrews.

The full conference programme is now available and includes workshops on understanding your team and yourself using the DISC behavioral awareness tool, assertiveness skills, risk management at the primary-secondary care interface, dealing with bullying and harassment, changing employment contracts, handling media inquires and much more.

Bookings are now rolling in so to register your interest or to find out more go to our website or contact Karen Walsh at **kwalsh@mddus.com** or on **0845 270 2034**.

Employees to pay fee for tribunals

➔ EMPLOYEES making claims in employment tribunals will be charged a fee from April 2013 according to plans announced by the Chancellor George Osborne.

Workers will face a £150 to £250 charge to make any employment tribunal application and a further £1,000 for starting a hearing. There will be a refund for any individual who wins their case and the upfront fee may be waived or reduced for low-paid claimants or those out of work.

The measures are intended to reduce the number of vexatious claims and supporters of the change say it will save businesses £6m a year in payouts and legal fees.

The chancellor also confirmed that from April next year the qualifying period for an employee to bring a claim of unfair dismissal will rise from one to two years. At present employees only need to have been working in an organisation for one year.

Last year, 236,000 employment tribunal claims were made and the average award to successful claimants was £8,900, while organisations spent an average of £4,000 defending cases.

"We are ending the one way bet against small businesses," Mr Osborne told the Conservative conference in Manchester.

Dental practices warned over discount deals

➔ DENTAL practices offering discounted treatment deals must not forget their responsibilities to patients, the General Dental Council has said.

The GDC issued the reminder in the wake of the increasing number of cut-price offers made available via email and online by companies such as Groupon and Living Social.

The regulator highlighted its guidance that warns dental professionals not to make claims that could mislead patients and requires practitioners to be trustworthy and honest, ensuring financial interests are not prioritised ahead of patients' interests.

Dental professionals who breach guidance could face action to restrict or stop them practising, the GDC added.

The regulator said: "If a GDC registered dental professional offers a treatment deal he or she must assess the patient, obtain valid consent, obtain a medical history and explain all the options before carrying out any work. Registrants must put patients' interests before their own or those of any colleague, organisation or business."

The GDC is currently drawing up draft guidance on ethical advertising as part of its review of *Standards for dental professionals*.

Patient guide to primary care

➔ A STEP-BY-STEP guide to help patients get the most from their GP practice has been launched by the Royal College of General Practitioners.

It's Your Practice: A patient guide to GP services is a free resource that contains information on topics including choosing and registering with a surgery, making appointments, accessing health records and how patients can get involved in the running of a local surgery.

It highlights the differences in GP services across the four nations and has links to organisations such as the Citizens Advice Bureau and the Princess Royal Trust for Carers who can also provide support for patients.

Professor Sir Bruce Keogh, NHS Medical Director, said: "Primary care is the backbone of our NHS, but no two GP practices are the same. This guide will help people understand how primary care works so they can engage with and get the most from a practice of their choice."

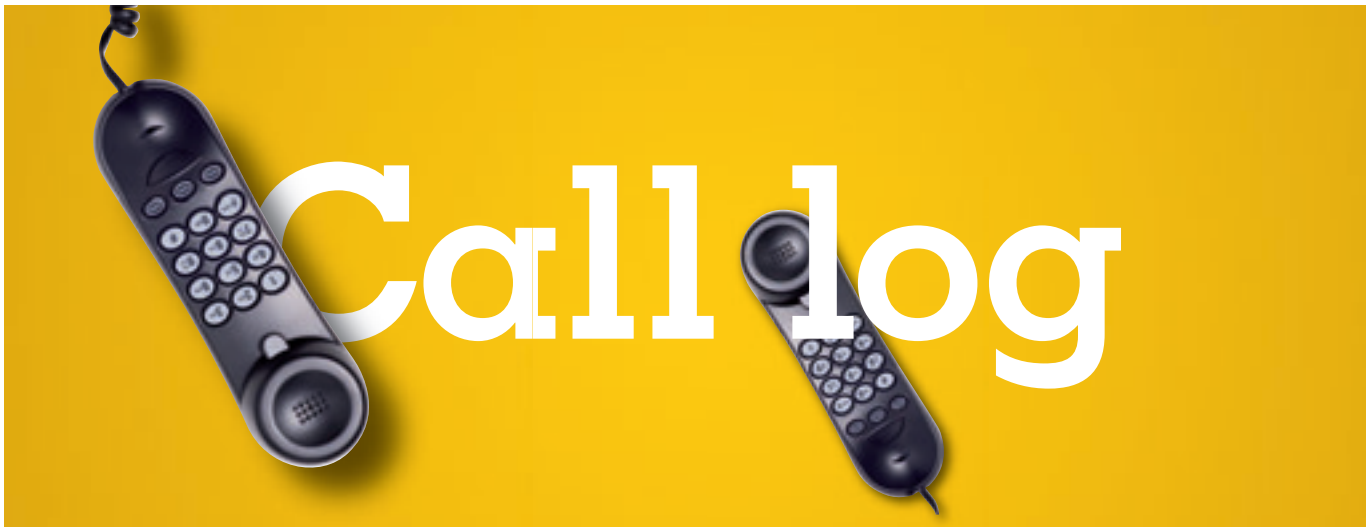
Access the guide at **www.tinyurl.com/3e3zf2s**

Dental PMs – sign up for training news

➔ CALLING all dental practice managers – would you like to find out about the latest MDDUS training courses that can be tailored to suit your practice's needs?

MDDUS training and consultancy services are designed to help dentists, doctors, practice managers and their wider healthcare teams manage and mitigate business and clinical risk. We have developed a range of training courses, masterclasses and workshops tailored to suit different groups, many of which are free or of minimal cost to members.

If you don't already receive email updates about the range of training courses available to members and non-members, then contact Ann Fitzpatrick at **afitzpatrick@mddus.com**.



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

NAME CHANGE

Q A mother phones up her GP practice and asks for her five-year-old daughter's surname to be changed to her own on the child's medical records. She tells the practice manager she'd rather not involve the girl's father. The manager is concerned about proceeding without first speaking to both parents.

A An MDDUS adviser explains that if the child's father has parental responsibilities, then his consent would be required before the child's name is changed on the records. A father holds parental responsibility if he is married to the child's mother (either when the child is born or at a later date), or if he is registered on the birth certificate as the father (in England and Wales since December 2003, in Northern Ireland since April 2002 and in Scotland since May 2006). An unmarried father can also acquire parental responsibility by court order or having a Parental Responsibility Agreement with the mother (for which there is a formal procedure). If the mother can't provide evidence of the father's consent then the child's name should not be changed.

PATIENT SATISFACTION

Q A practice manager notices that a number of patients have been leaving the practice in recent months and is concerned by the trend. She would like to contact some of them to ask their reason for leaving but is worried about breaching the Data Protection Act (DPA) and calls MDDUS for advice.

A The manager is advised to proceed carefully in this case as confidential patient details should only be accessed for sound clinical reasons. In addition, accessing the records of patients who are no longer with the practice risks breaching the DPA. Rather than contacting the individual patients who have left, the MDDUS adviser tells the manager to consider inviting current patients to complete a questionnaire asking for their views on the services provided. This may offer a more effective means of finding out if patients are satisfied with the services provided by the practice. A questionnaire would also be less intrusive than making direct contact with former patients.

EQUAL ACCESS

Q A deaf patient has sent a bill to his dental practice requesting payment for the sign language interpreter who accompanies him during his consultations. The interpreter was previously free but recently decided to charge the patient. The patient did not consult the practice before arranging this particular interpreter. The practice manager believes the hourly rate charged is too high and objects to the request. The manager tells an MDDUS adviser that she has tried to come to an agreement with the patient over the costs, but the patient insists that if the practice does not pay for the interpreter then that amounts to discrimination under the Disability Discrimination Act (DDA).

A The DDA requires practitioners to make "reasonable adjustments" for disabled patients, such as providing clearer signage and induction loops. The Act explains that, although they are not required to anticipate the needs of every individual, they are required to take reasonable steps to overcome any features that may impede disabled people. The manager is advised to look for a suitable alternative to the expensive interpreter, such as approaching charities to enquire about the availability of free, or more reasonably priced, interpreting services. If a suitable alternative is found that meets the needs of the disabled patient then the patient would be unable to refuse under the terms of the Act.

IMMIGRATION ISSUE

Q A refused asylum seeker from Somalia tries to register at a GP practice and is seeking treatment for a skin infection. After making checks, the practice manager discovers she is in the country illegally and has no right to NHS funding. He calls MDDUS and asks whether he should register the woman considering he may not be able to secure NHS funding for her. He also wants to know whether he should alert the authorities about the woman because of her residency status.

A The manager is advised that the Somali woman should be given any immediate necessary care and that GPs in England, Wales and Scotland have the discretion to register any patient irrespective of residency status. Once registered with a GP, asylum seekers and refused asylum seekers are entitled to free primary care services, although some statutory charges, such as those for prescriptions, may still apply. Practices are not required to check the identity or immigration status of prospective patients and patients are not obliged to provide evidence in this regard. Refused asylum seekers have the same right to confidentiality as other patients and the manager must not disclose confidential information to a third party without patient consent. More information is available in the BMA guidance document *Access to health care for asylum seekers and refused asylum seekers*.

EMAIL PRIVACY

Q A practice manager wants to cut down on the amount of hard copy letters sent out and is considering making contact with some patients via their private email addresses. She feels this would be a more efficient way of keeping in touch with patients but is concerned about data security.

A Practices should not send confidential information to patients' private email addresses without their prior consent to avoid the risk of a third party accessing the message. Disclosing sensitive information in this way could breach the Data Protection Act and practices could face stiff penalties. Where possible, use more secure NHS email accounts, double-check you are sending to the correct recipient and only include the minimum amount of information necessary for the purpose of the disclosure. If you are concerned that email may not be suitably secure, use another means of communication. ❋

Online or off limits?

TODAY it seems hard to imagine life without access to a computer and use of the internet. From routine tasks such as grocery shopping to buying music to ordering repeat prescriptions – how we use the web is changing day by day.

This presents a unique challenge to employers. You want to be able to place trust in your staff and fully restricting access to the internet for non-work related reasons is perhaps not the best way to foster such trust. So what guidelines should you put in place to avoid abuse and other potential issues that may arise?

A clear internet policy is a must in any practice and all employees should receive a copy of that policy on commencing employment. Current staff also need to be reminded on a regular basis of internet policy and managers should revisit those policies on occasion at team meetings to raise awareness of the content.

One might hope it would be obvious to employees that accessing pornography, gambling or other such web sites in a work setting is clearly inappropriate. But it always makes the process of potential disciplinary action easier if there is an explicit policy stating what is unacceptable and also what the repercussions will be if that policy is ignored (i.e. possibility of immediate dismissal). Apart from appropriate content you should also be clear when and how often non-work-related access to the internet is acceptable. Some offices will restrict use of non-work-related sites to the lunch period or may block access to certain sites.

Appropriate use of social media should also be spelled out in practice IT policy. Facebook, Twitter, blogs or personal websites can blur the boundaries between personal and professional life and it should be made clear to employees that all communications related to the practice must be respectful and not a forum to disparage the organisation or anyone working in it. The use of the practice logo or pictures of any activities within work time should not be used without express prior permission. You may wish to have as part of your internet policy that mangers are not social network "friends" with other employees to avoid the potential conflicts of interest that can come with this.

Another serious risk involved in staff discussing work-related issues on social media sites is the potential for breaches in patient confidentiality. Even just the mention of a patient, named or not, could be deemed a breach and lead to a complaint or legal action.

A practice internet policy should make it clear that employees must not use any internet site to harass bully or intimidate other employees, for example any comments in relation to their race, religion, gender, sexual orientation colour or disability. Sexually suggestive comments and threats to stalk or intimidate other members of staff should also be spelled out as unacceptable.

> "A CLEAR INTERNET POLICY IS A MUST IN ANY PRACTICE AND ALL STAFF SHOULD RECEIVE A COPY OF THAT POLICY ON COMMENCING EMPLOYMENT"

Policies should extend beyond computers to the use of mobile and smart phones. Not only is the constant use of mobile phones distracting and disruptive to an employee who should be busy at work, it also does not give a professional impression to patients and other staff.

Another common question we hear on the employment law helpline at MDDUS is whether practices are entitled to act on information about employees posted on social media sites. The short answer is "yes".

Deciding whether what goes on out-with the office has an impact on the working environment can be a fine line but clearly any remarks that directly affect the practice and those who work in it may be in a position to be acted upon. Evidence of dishonesty or other activities may come to light via social media. For example, you might spot a photograph posted on Facebook of an employee signed off work for a sore back dancing in a nightclub over the same period. It may not be a black-and-white situation but you can certainly use this as a basis for discussion and/or investigation with the employee.

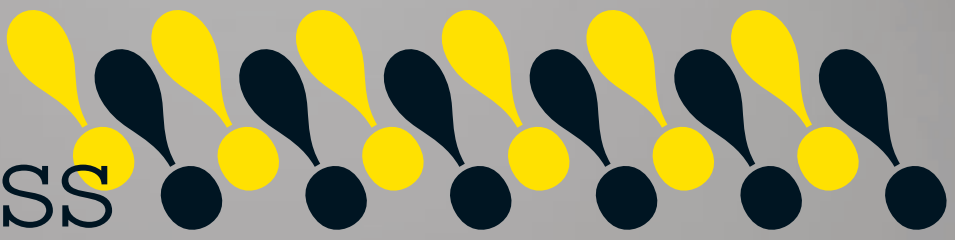
Recent case law has also highlighted the dangers of employees sending or forwarding information from their home PCs into the workplace – again this can be deemed unacceptable if the material contained in the email is offensive in any way. So it's best to warn employees to think twice before forwarding that "funny joke". Whilst some people may find it amusing, there is a chance that other colleagues may find it offensive. Remember the law looks not at how you intended the email to be taken but how the recipient perceived it. ✱

Janice Sibbald is an employment law adviser at MDDUS

MDDUS offers free in-house employment law and HR advice to practice managers within MDDUS group schemes or members with employment responsibilities.

Call: 0845 270 2034
email: employmentlaw@mddus.com
web: www.mddus.com

Risky business



HEALTH and safety rarely reaches the top of the pecking order in a typical medical or dental practice, but failing to manage risks properly can lead to serious consequences. A trailing cable can cause a trip and result in broken bones. A faulty door closer can lead to injured fingers. And a failure to ensure sharps are disposed of safely can result in nasty cuts and infections.

The ultimate responsibility for ensuring the health and safety of staff and the public in primary healthcare normally rests with the practice partners, but day-to-day responsibility is usually delegated to practice managers. And the task of handling yet another area requiring legal compliance can sometimes leave the average practice manager feeling overwhelmed.

High-profile media coverage of instances where children have been banned from playing conkers at school, or firemen's poles have been outlawed, or knitting allegedly prohibited in hospital has given health and safety a poor public image. But just like healthcare, the great majority of day-to-day health and safety activity is of high quality, undertaken by competent and dedicated people and geared towards ensuring that people do not suffer where suffering can be avoided.

Despite the legal requirements, compliance can be achieved without clocking-up excessive time, money, effort and inconvenience. The first step is to recognise that risk management can and should be sensibly apportioned. The HSE says that risk management should:

- Ensure that workers and the public are properly protected
- Provide overall benefit to society by balancing benefits and risks, with a focus on reducing real risks, in particular high frequency and severity risks
- Enable innovation and learning
- Ensure those who create risks manage them responsibly and understand that a failure to manage real risks responsibly is likely to lead to robust action
- Enable individuals to understand that, as well as the right to protection, they also have to exercise responsibility.

Sensible risk management is NOT about:

- Creating a totally risk-free society
- Generating useless paperwork mountains
- Scaring people by exaggerating or publicising trivial risks
- Stopping important recreational and learning activities for individuals
- Reducing protection of people from risks that cause real harm and suffering.

There are a number of basic parameters for risk management in primary healthcare that managers can use as a guide to assessing risk in their own practice.

RISK ASSESSMENTS

The law requires risk assessments to be "suitable and sufficient". A step-by-step process is the best way to ensure compliance. These steps are:

- Identifying the work tasks/processes
- Identifying the hazards
- Deciding who might be harmed and how
- Estimating and evaluating the risks involved
- Recording the findings and implementing any required controls or procedures
- Reviewing the findings regularly.

Risk assessments must be conducted by a competent person. This means someone with the necessary training, skills, experience and knowledge.

NOT JUST ACCIDENTS

The hazards people face in the workplace also include stress, physical and mental health issues and the risk of workplace violence. Options for managing stress and mental health might include setting realistic consultation times, crisis management plans for coping with emergencies and arranging external support from occupational health or counselling services. There are many strategies to manage the potential for workplace violence. These range from ensuring cash and medications are not kept on the premises (and providing clear signage to that effect) to training personnel most at risk to be able to recognise aggressive/ threatening behaviours and to defuse potentially volatile situations. Dealing with staff health factors might include offering manual handling strategies or access to an occupational physician.

SPECIFIC HAZARDS

Clinical procedures and equipment bring specific hazards into the workplace and in some cases the severity and likelihood of risk is deemed high in the absence of proper controls. Robust rules are required for such cases and there is a shared responsibility between the practice manager and the clinicians. This requires excellent communication and trust if risks are to be reduced to acceptable levels. Issues to consider include medications, hazardous substances and clinical waste.

The work environment features a wide variety of hazards and risks including fire, slips and trips, lighting, electricity, asbestos and display screen equipment. Again, suitable and sufficient risk assessments are required for these, and the findings will flag up where control measures and procedures are needed.

Despite the urban myths about absurd health and safety requirements, a sensible approach to risk management will ensure risk control and reduction without unreasonable demands for time, money and other resources.

Law At Work provides a combination of sensible, practical and bespoke solutions to risk management. This article only provides a brief overview and we welcome any queries you may have about health and safety. ❋

Ian McKinnon is head of Health and Safety Services at Law At Work

Q&A

Jill Taylor, President, Association of Dental Administrators and Managers

JILL Taylor became president of the Association of Dental Administrators and Managers (ADAM, formerly the BDPMA) in May 2011. She started in dentistry as a dental nurse before making the move into practice management three years ago. She works full-time as practice manager at Botanics Dental Care in Glasgow but her role as ADAM president takes her to meetings and seminars across the UK.

How did you get into dental practice management?
I started working as a dental nurse in 1994. Dentistry captured my interest immediately and I craved to learn more so in 1999 I completed a pilot course that was an 'HND in healthcare supervisory development'. It gave me a great insight into health and safety, risk assessment and employment. I continued to work as a dental nurse, dabbling a bit in management, until 2008 when the practice I was working in was sold and the new practice owner, Colin Gardner, invited me to be his practice manager (PM). We knew that I would need some more training for that role and that was when I joined the BDPMA [British Dental Practice Managers' Association].

What do you like most about the job?
The team. Without the support of the team and Colin, I would not be able to work properly as a PM. I have their full support and they know how much I appreciate them.

What is your biggest headache?
When I speak to PMs and they tell me that their dentist undermines them. This should never happen. When a PM makes a decision and the staff member is unhappy with that decision it should never be the case that they get their own way by complaining to the dentist. I admit I am lucky, but it also comes down to mutual respect. A PM can only do his/her role if he/she has the support of the team and most especially the principal. No staff member should ever play one off against the other.

Describe a typical working week?
I work full-time in the practice, as do all ADAM executive and regional team members. That's why most of our communication is primarily via email. Our head office is in Gloucester and if we need a conference call we book it for an evening. The location of any team meetings varies - last time it was Glasgow, before that East Midlands. I pick up emails before work, lunchtimes and after work. I have alternate Fridays off and do a lot of ADAM duties on these days.

How can joining ADAM help make PMs better at their jobs?
ADAM is run by PMs for PMs. We fully understand what the role involves and can empathise with difficult decisions. We provide support and have our members-only area of the website, which is packed full of advice sheets and information to help PMs with the daily running of their practices/clinics. We have seminars, the topics of which come from members' feedback. We have our Facebook page too where we often address questions from managers who may have no one else to ask.

You recently changed the name from BDPMA to ADAM. Why?
The name enables us to broaden our membership to include all practice administrative team members. It is more inclusive. Many prospective members were put off joining the BDPMA as they felt that although they did the role of PM they were not recognised as a PM. This allows us to incorporate and support them.

What future plans are there for the organisation?
The aim of the association remains unchanged: to provide advice and guidance through coaching, mentoring and support for members that encourages their self-development through education and training.

We have a conference booked for May 18-19, 2012 at the Majestic Hotel, Harrogate and we are delighted to be running that event in conjunction with MDDUS. It is an excellent programme and we are all very excited about it. We have our ADAM Awards: Practice Manager of the Year, Administrator of the Year and Treatment Co-ordinator of the Year. I will be on the judging panel alongside Hew Mathewson (MDDUS Special Adviser) and Roger Mathews (Chief Dental Officer, Denplan). The winner from each category will receive a cheque for £500.

How has dental practice management changed over the last 10 years?
It has changed hugely as more and more dentists are realising the benefit of having a fully functional practice manager. PM is not just a title, it is a role that has a huge impact on the business. Dentists are highly skilled individuals and so are practice managers. Dentists are valued by their patients and that is how it should be - dentists in surgery with patients, leaving the spreadsheets and staff issues to their trusted managers.

What challenges do you see in the next 10 years?
The current economic climate is the single biggest challenge for any business. With the most recent evidence from the Scottish Government suggesting that it could take a further 16 years to see Scotland back to the level it was at in 2008, we are all set for tough times. ❋

Interview by Jim Killgore, associate editor of Practice Manager

Looking to the future

MOST people will readily agree that organisations benefit from strong leadership. But when it comes to deciding which leadership approach is the most effective, opinions tend to vary. Much of the theory revolves around two conflicting models.

The much-praised 'transformational' model focuses on being visionary, charismatic and influential, while the much-maligned 'transactional' approach is defined as procedural, mechanistic and process-focused. So when it comes to practice management, which one is best?

The answer is that practice managers need to incorporate elements of both models in order to be truly effective within their roles. In a smaller organisation such as a general practice, the most effective managers are those who can be both a strong leader and a good planner/organiser.

One of the most important elements linked to strong, effective leadership is the presence of a clearly defined vision of where the practice is going. This 'visionary' side of leadership can be a uniting and guiding force and is a true combination of both leadership models. While visualising the future falls under the 'transformational' approach, a failure to map the practical steps to get there (the transactional side) can leave great purpose and vision without any substance or direction.

So how exactly do you go about visualising the practice's future? The first practical step is to recognise where the practice is now, and the people best placed to consider this are those who work in it every day. A useful activity that will help form a holistic picture – and give people the opportunity to simply get together – is to protect some time and undertake a SWOT analysis. This process will look at the strengths, weaknesses, opportunities and threats that might impact on your practice.

It's important to involve as many staff members as you can and then split your team into multi-disciplinary groups. Ask each group to consider what might impact upon the practice – the people, processes, facilities, patient group and overall healthcare environment. Thinking around this, identify any strengths that the practice can build upon and any weaknesses that you may need to address (often the internal aspects of the practice). Consider external aspects of the organisation (are there opportunities that you can take advantage of) and think about any threats that you might need to be aware of or mitigate.

Next, pick out the elements of the analysis that you will need to prioritise and focus on. Which opportunities are a good fit to the practice's strengths? It might be that the skill set within your team provides an opportunity to introduce a new service. Which threats or weaknesses need addressed within the planning timeframe to allow the practice to continue to operate effectively and safely? With finite resources available, effective prioritising is essential.

When priorities are identified, allocation of tasks and responsibilities to achieve these is the natural next step. Being the practice manager does not mean that you are responsible for everything – no matter how much others may think this is the case!

Effective delegation and recognition of how tasks should be allocated is the aim here and understanding your team and their skills, knowledge and preferences is key. This can allow you to identify any gaps within your team and any skills or tendencies that people may have that you are not utilising – all of this should have formed part of the practice analysis. Ensuring that tasks are assigned to the correct team members will help achieve the vision. For example, a staff member who thrives on dealing with people is probably not the best person to allocate a back office, number-crunching project. You are aiming for a good match in relation to tasks and skills and this involves 'knowing' your team. Ask yourself:

- Do you understand their capabilities, individually and as a whole?
- Do you understand team members' preferences (and your own) with regard to communication and learning styles?
- Do you understand what motivates them?
- Are you aware of your team's strengths and weaknesses (and yours)?

This understanding can let you tap into the informal leaders within your organisation who can be hugely beneficial to you as practice manager. These are the go-to people – the receptionists who have influence, the nurses who can relate and relay well. Identifying these people, matching the skills and tasks then actively involving them in projects that require leadership from within can strengthen any efforts on your part.

A practice analysis provides an overall picture of the practice – a situational analysis of where you are now and where you should be focusing your efforts – that is followed by the development planning to determine how you might get there. Bringing everyone together to understand the practice and the direction it will be taking is a transformational approach – forming the vision. The practical progression from that stage to then prioritising and mapping out the actual steps involved uses the transactional elements. It is an effective combination of both approaches, or a leader-manager approach if you will.

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

A visit from the police

A POLICEMAN is asking for you at reception" – words no practice manger is likely to relish hearing.

But neither should it be cause for undue panic. A police constable might turn up at your reception desk for any number of reasons and these could include seeking verbal information relating to a particular patient or making a demand for surrender of a specific medical record.

In such scenarios it is important to remember that under the Data Protection Act 1998 (DPA) the practice is considered a "data controller" and has a legal obligation to ensure that any such requests are lawful before disclosure is made. Importantly, all such requests must comply with Section 29 of the DPA, which specifically relates to matters of crime and taxation and gives the 'data controller' statutory authority to process personal information held by the practice in relation to these matters.

> "REQUESTS MAY BE ASSOCIATED WITH AN INVESTIGATION INTO AN ALLEGED CRIME, WHERE DISCLOSURE IS NECESSARY FOR THE PREVENTION OR DETECTION OF AN UNLAWFUL ACT"

Such requests may be associated with an investigation into an alleged crime, where disclosure is necessary in the public interest for the prevention or detection of an unlawful act. The arrangements created by Section 29 do not cover the disclosure of all personal information in any circumstance but only for the stated purpose and only if not releasing it would be likely to prejudice any attempt by the police to prevent crime or apprehend a suspect.

Whereas the Data Protection Act is fairly straightforward and prescriptive in the area of disclosure of patient information, healthcare professionals must also be aware of the guidance on confidentiality and consent issued by the various regulatory bodies.

For example, the General Medical Council (GMC), *Guidance for Doctors – Confidentiality* – provides additional food for thought. Paragraph 53 states: "Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons for refusal".

So far, so good. However, the guidance goes on to state that such a situation might arise, for example, where disclosure would be likely to assist in the prevention, detection or prosecution of "serious crime", especially crimes against the person.

It might be considered helpful to understand what the GMC considers to constitute a serious crime, but alas there is no agreed definition. This leaves the final decision whether to disclose or not up to the healthcare practitioner and potentially leaves a doctor open to further investigation and possible criticism or censure.

Reference is made by the GMC to a previously published NHS code of practice from the Department of Health in 2003. This provides some examples of what may constitute a serious crime and also gives some suggestion of crimes that are not usually serious enough to warrant disclosure without consent.

However, the message here is one of "buyer beware", and MDDUS members are encouraged to speak to one of our medical or dental advisers where any specific doubt exists.

Alternatively, the police may have a court order or warrant in their possession which requires the practice to surrender specific identified personal information. The existence of a lawful warrant or court order allows the practice to disclose the specified information without fear of breaching the DPA. Before complying, the practice should always carefully check the content of any order or warrant and supply only the information requested, and in all such cases confirm the identity of the requesting police officer.

It is likely that the police will also ask for the originals of any paper records that are held. This relates to the rules of "best evidence", whereby a court expects original documentation to be presented, rather than a facsimile. Such a request can and often does present real difficulties, as the practice could be deprived of the original record for an extended period of time. Under these circumstances, it would be reasonable to ask the police if they will accept an authenticated copy.

Indeed, in Scotland an agreement has been reached with the Crown Office that the NHS will no longer routinely provide the Crown with the original medical records of patients who are still alive for use in criminal proceedings. Instead, suitably authenticated copy medical records will be provided in the first instance. However, the Crown reserves the right to request the original records in certain circumstances. The full details and application of these arrangements were set out in The Scottish Government, Primary and Community Care Directorate CEL 11 (2007) letter. Scottish-based practices should make themselves fully aware of the new arrangements, as the police officer who turns up at your practice may not be aware of them either.

See the case study on page 14 for more on disclosure of patient records.

Releasing information to prevent or detect crime is a handy guidance notice on the practical applications of Section 29 produced by the office of the Information Commissioner for the UK. It can be found at **www.ico.gov.uk**

Alan Frame is risk adviser with MDDUS Training and Consultancy

Top to bottom

PHOTOGRAPH: MARTIN HUNTER WWW.MARTINHUNTER.CO.UK

Janette McMillan (left) and Kathleen Diamond of The Ker Practice

Jim Killgore visits a Glasgow practice where deprivation and ill health are all too closely linked

NOWHERE in Britain is health inequality more obviously a matter of geography than in the city of Glasgow. Travel from the leafy affluent suburb of Bearsden north of the city to the housing estates of the Gorbals four miles south and average life expectancy for males drops nearly eight years from 79.4 to 71.6.

Scotland has long held the reputation as the "sick man" of Europe with life expectancy at birth less than any EU country apart from Portugal. And central Glasgow lies at the bottom of the table in Scotland. The public health challenges faced by healthcare and social care professionals here are immense.

Staff at The Ker Practice know well the effects of poverty and chronic deprivation on a patient population. The practice operates at two sites serving the Gorbals and the nearby districts of Croftfoot and Castlemilk. Croftfoot Road Surgery is only a short taxi ride across the River Clyde from the offices of MDDUS in central Glasgow. It is here I have been invited to meet the practice's two managers.

Croftfoot Road is the "hub" surgery of The Ker Practice and lies on a quiet residential street of semi-detached houses. The practice has seven GP partners and over 15 staff with a patient list of around 10,300 both here and at the Gorbals Health Centre.

"We may only be three miles apart but the patients here are completely different from the patients at the Gorbals," says practice manager Kathleen Diamond as we chat in her office along with co-manager Janette McMillan. "There is a huge difference and much of it to do with deprivation."

➔NO MEAN CITY

Certainly the Gorbals has long been synonymous with urban poverty. The writer Alexander McArthur in his sensationalist novel *No Mean City* recounted stories of its razor gangs, poverty and overcrowding. In the 1960s many of the older slums were razed and replaced with high-rise towers but the damp and soulless housing seemed only to

make problems worse. In the 1980s the Gorbals was often referred to as the most dangerous place in the UK with its street gangs and drug violence. In recent years many of the decaying high-rise blocks have either been demolished or refurbished and much of the area has now been redeveloped with an innovative mix of private and social housing. But even with urban redevelopment the health and social problems are deeply ingrained and generational.

Kathleen knows first-hand the challenges of dealing with the health consequences of deprivation. Prior to taking on the role of manager at The Ker Practice she worked for 21 years as practice nurse both in the Gorbals and Croftfoot surgeries. Janette also has experience in the frontline having started at the practice as receptionist in 2003 and prior to that working in a local pharmacy.

"Because I grew up in Ayrshire I didn't know the Gorbals when it was mainly tenements," says Kathleen. "I came up to Glasgow and moved to the Southside in 1980 and by then they had knocked down the original sandstones and had built the tower blocks which were an absolute disaster.

"GPs here would tell you stories of going into the bedrooms in some of those flats and standing in puddles on the carpet because the condensation just ran down the walls. Everything was black-moulded."

But both Kathleen and Janette are quick to point out that conditions have improved in the Gorbals and surrounding areas with the redevelopment and investment in housing. Now the area is even beginning to attract more affluent residents.

"We've got neurosurgeons, accountants, a couple of dentists on the list," says Janette. "But they live in the penthouses at the top. You're going from top to bottom in the one G5 postcode."

HEALTH CHALLENGES

Public health researchers often refer to a so-called "Glasgow effect" meaning that while certain aspects of health are no different than elsewhere in Scotland, a number of health indicators, such as obesity, diabetes, poor diet, high alcohol consumption and smoking rates are particularly elevated in the city. The long-term consequences of such health behaviours are all to obvious with standardised mortality rates for stomach cancer, lung cancer and heart disease in Glasgow almost twice as high as in other areas.

Tackling these health issues is a major objective for the National Health Service in Scotland and local primary care services such as The Ker Practice, with health screening and preventative care being key elements. Local diabetes rates are just one example.

"Type 2 diabetes rates have exploded," says Kathleen. "And you're seeing it in younger and younger people. We are now picking it up earlier with health checks and this is adds to the burden on the practice. But on the other hand we are probably increasing the life expectancy of these patients by hopefully preventing some of the complications that can occur later."

Smoking cessation and encouraging exercise are other important initiatives. Kathleen is herself a smoking cessation facilitator and does evening sessions as part of the local Community Health Partnership.

"In Glasgow we are very fortunate as smoking cessation was brought in quite early and has now been running for around 10 years," she says. "We can also now offer referrals to the Live Active scheme where chronic disease patients are encouraged to take up a gym membership. They get one-to-one contact with a lifestyle councillor who can work out an exercise programme and monitor them over a year. And the people who go actually do enjoy it."

Kathleen believes such initiatives are having an impact on the high rates of chronic disease but she feels there is only so much you can do for patients.

"Some people just want a magic pill to solve all their ills," she says. "So they don't have to think about smoking or their diet or being healthy. They are just not going to change."

On the other hand she sees the continuity of care provided by services such as The Ker Practice as vital. "You can look at families and identify those, say, with a very high risk of cardiac illness and target the kids to try and make sure they don't follow the same pathway as their parents. Put things in place to help improve their chances."

Another challenge the practice must cope with is the large number of asylum seekers and undocumented migrants seeking healthcare (see page 12 of this issue).

TWO HEADS BETTER THAN ONE

Heaping these pressures onto the everyday challenge of running a practice would make a difficult job for any one practice manager. So Kathleen and Janette feel lucky that the practice has taken the unique approach of having co-managers.

"Historically there had always been a manager and deputy at the practice," says Janette. "But the GPs looked at it and felt that we both had unique skills to bring together into the role."

Kathleen with her experience as a practice nurse tends to deal more with clinical issues, such as QOF and also rotas. Janette takes on the majority of the staffing issues and tasks such as the Medicines Management Enhanced Services given her pharmacy background. Both agree the split roles play to their individual strengths.

> "GPS WOULD TELL YOU STORIES OF STANDING IN PUDDLES ON THE CARPET BECAUSE THE CONDENSATION JUST RAN DOWN THE WALLS"

"It wouldn't work in every practice and it wouldn't work with every person," says Kathleen. "Some people are born to be a manager in their own right. But I must admit when Janette is on holiday I just go round in circles."

In dealing with practice staff they are both keen on a "democratic" approach. Kathleen says: "The staff don't need to know the fine detail, down to the last penny coming into the practice. But they should know how the practice gets its income. It's like dealing with a family. Working with budgets the way you would work with a budget in your own house."

"It's not always this lovely picture we're painting," adds Janette. "Some days can be fraught. But we discuss it. We don't let anything fester. We deal with it."

Jim Killgore is an associate editor of Practice Manager

Bridging the divide

Society is growing increasingly diverse and it's changing the face of UK general practice. But what does this mean for practice managers?

COMMUNITIES across the country are becoming increasingly multicultural. More than 300 languages are said to be spoken in London schools alone and over 7.5 per cent of the total UK population were born abroad.

The trend has had an inevitable impact on UK healthcare provision. Indeed, the significance of language and cultural differences between doctor and patient is such that the BMA has identified them as "the most important barriers to healthcare in Britain". So how does this affect the role of the practice manager?

At Woodside Health Centre in the north of Glasgow, the patient list is diverse and a growing number of patients speak little or no English. During their GP consultations they require a translator and a double slot is allocated to allow extra time for communication. The most common languages requiring translation are Cantonese, Mandarin, Farsi, Arabic, Punjabi, Urdu and Portuguese.

Manager Cari Blackwood says the main challenges facing the practice arise when patients fail to attend appointments and also in booking interpreters.

She says: "These patients are booked in for a double consultation so when they do not attend that wastes a lot of valuable time. Another problem can occur if the reception staff are busy and forget to book an interpreter or when the interpreter or GP is running late.

"Things are fine when everything runs to schedule but that doesn't always happen in general practice so a patient might be left waiting for an interpreter or the interpreter has to leave mid-way through a consultation to attend another appointment."

FLEXIBLE AND FAIR

Despite the occasional problem, Cari says running a multicultural practice does not require much more work than any other practice. "Flexibility and fairness are crucial," she says.

"We had one instance where a female patient wearing a full veil objected to being asked to briefly remove it to allow staff to verify her identity when registering her. In the end she agreed to remove her veil briefly during her consultation with the GP. You have to be prepared to work around these issues."

Cari ensures practice leaflets on topics such as contraceptives, smear tests, bowel screening and child vaccinations are available in some of the most commonly spoken languages. The practice also included patients who speak English as a second language in a recent questionnaire exercise to find out their opinion of the services provided, which gave useful feedback.

She adds: "It's important not to treat patients from other countries differently. Everyone at our practice is treated the same. When registering, for example, all patients have to show their passport and have their ID checked. Managers should make sure practice staff are familiar with the protocols and procedures and that they are applied universally."

Gorbals Health Centre in Glasgow serves a large multicultural community, with a migrant population including patients from Somalia and other African states. Kathleen Diamond and Janette McMillan share managerial duties at the centre as well as at the practice in nearby Croftfoot Road.

They find the task of communicating with non-English speaking patients and arranging interpreters to be a time-consuming one.

Kathleen says: "We looked at the work of receptionists at both sites and found the staff at the Gorbals centre took around three times as long to do simple tasks such as booking appointments. They are having to constantly repeat themselves and ask if the patient needs an interpreter and then they have to book the interpreter."

The managers have found many of these patients come from countries affected by war and require treatment for complex health problems including mental health issues.

Janette says: "They present with everything and anything. It's very varied. There's a lot of abuse and mental health issues. Some come from war torn areas where they may have watched their family members suffer."

And there is the additional consideration of patients' immigration status. BMA guidance *Access to health care for asylum seekers and refused asylum seekers – guidance for doctors* states that practices are not required to check the identity or immigration status of people registering to join their lists and prospective patients are not obliged to provide evidence in this regard. While practices are not forbidden from doing so, the BMA advises they proceed with caution to avoid discriminating against particular groups of patients.

CULTURAL COMPETENCE

Communication is key within any multicultural practice and it is important that staff are "culturally competent", which means they know how to effectively interact with patients from different cultural backgrounds.

Many NHS trusts or health boards have practical information available for staff, such as the Cultural Competency Toolkit (**www.tinyurl.com/6knxtlk**) from West London Mental Health Trust. The booklet aims to fill the gaps in knowledge regarding the culture, customs and practices of ethnic minority patients and highlights the importance of being aware of cultural differences. It urges staff to find out as much as they can about the needs of ethnic minority patients and to try to understand the differences in their values and lifestyles.

> "IT'S IMPORTANT NOT TO TREAT PATIENTS FROM OTHER COUNTRIES DIFFERENTLY. EVERYONE AT OUR PRACTICE IS TREATED THE SAME"

One simple example highlights how people of south Asian origins are generally not accustomed to routinely saying 'please' and 'thank you' – a custom that could be misinterpreted in the UK for rudeness or ingratitude.

The toolkit offers tips to healthcare staff when speaking to patients with little or no English. It recommends speaking slowly and clearly without using jargon or acronyms and without raising your voice. It underlines the importance of regularly checking the patient is following what you are saying but advises against asking "Do you understand" or "Is that all right?" as the answer will almost always be yes. The guidance explains: "Yes is often the first word someone learns in a foreign language, but does not necessarily indicate that they understand."

Staff are also advised to be aware that people who speak English as a second language may be less able to remember large chunks of information. The guidance recommends providing a simple note for the patient to refer to once they have left.

PATIENT EXPECTATIONS

Recent research suggests there is still room for improvement in the provision of primary care services to patients born abroad. One study suggests a number of practices in England are not meeting the expectations of some of these patients. The latest English General Practice Patient Survey published in September 2011 in *BMJ Quality & Safety* has found that some patients from minority ethnic groups are not satisfied with NHS primary care services.

Despite efforts to provide a healthcare system that offers universal coverage, the research shows satisfaction is particularly low among people from south Asian and Chinese backgrounds, as well as younger patients and those in poorer health.

Bangladeshi, Pakistani, Indian and Chinese patients gave their practices significantly lower scores for professional communication than either white British or black patients. Researchers say the fact that patients from these ethnic backgrounds tended to be clustered in generally low performing practices accounted for half of this difference for south Asian patients and for 14 per cent of that for Chinese patients.

The authors argue: "Substantial ethnic differences in patient experience exist in a national healthcare system providing universal coverage. If the overall performance of low-performing practices were improved (as is the goal of a series of major UK Government policy initiatives), this would also help improve the patient experiences of south Asian and Chinese patients."

The research serves as a timely reminder to managers to ensure all the necessary practice systems are in place and that staff are equipped with the right skills to care for the growing multicultural community.

Joanne Curran is associate editor of publications at MDDUS

An abandoned car

Background

The police arrive at a GP surgery and ask to speak to the practice manager – Ms R. They inform her that an abandoned car has been found in a local woods. They have obtained the registered keeper's name and an address but have been unable to trace that individual. A search of the vehicle has also found a diary in the car, which seems to indicate that someone has a doctor's appointment at 2pm today. They tell Ms R that officers are visiting all local hospitals and surgeries asking for the names of all patients with 2pm appointments. The officers say that they require this information under the powers conferred to them by Section 29 of the Data Protection Act 1998.

Scenario 1

The practice manager and senior partner take the officers into one of the consulting rooms for a quiet chat. One of the officers explains that they believe some harm may have come to the owner of the vehicle and it is important that they contact the individual if possible.

Scenario 2

The practice manager and senior partner take the officers into one of the consulting rooms for a quiet chat. The lead officer says it's a "routine" investigation into a possibly stolen car and they need to speak to the owner.

FIRST to consider is that the request in the initial scenario is very broad in nature and it would be entirely inappropriate for the practice to simply disclose the names of all patients with 2pm appointments that day. The police themselves may be wary about providing specific information, which could identify an individual at this stage, but the practice manager in this case really does require more information to proceed with here.

As well as breaching the duty of confidentiality owed to the patients concerned, disclosure of these names could amount to a breach of the Data Protection Act 1998. There is an exemption in the Act under Section 29 – Crime and Taxation – which allows a 'data controller' to give out personal information for these purposes, but there are limits on what can be released (see page 9 in this issue). The Information Commissioner's Office advises that if you do decide to release personal information to the police, you should consider what is the minimum necessary for them to be able to do their job.

Importantly, Section 29 does not confer any particular police powers in this respect, but allows the 'data controller' to consider release of personal information for the stated purposes and only if not releasing it would be likely to prejudice any attempt by police to prevent crime or catch a suspect.

The second consideration in any such request is: "Am I sure that the person making the request is who they say they are?" Confirmation of identity is essential before proceeding any further. In relation to this particular request, the manager could then ask what specific concerns the police have about the circumstances in which the car has been discovered.

In the case of Scenario 1, it would be more helpful if the police could ask a direct question about whether the registered keeper is a patient at the practice, if they had an appointment at 2pm today, and if they turned up for it. This would allow Ms R to respond by disclosing only the minimum amount of information necessary to answer the police request while at the same time acting in the best interests of the patient.

In the case of Scenario 2 – the stolen car – the situation is less clear. While the police request would appear to comply with Section 29 DPA requirements, allowing appropriate disclosure for the purposes of investigating a crime, the corresponding GMC guidance for doctors on confidentiality and consent is less helpful, and boils down to whether the alleged offence constitutes a 'serious crime' or not. The GMC do not state what constitutes a 'serious crime', and the practice would have to consider the relevant facts and circumstances available before coming to a decision. In order to do this, sufficient information from the police will be required if they are seeking compliance.

In these circumstances it would also be prudent and possibly extremely helpful, to attempt to seek the patient's consent before agreeing to provide the police with the information. If this is not possible or the patient refuses, then the practice would have to make a judgement call based on the 'public interest' criteria – having first of course, discussed the matter with an MDDUS adviser, who will be able to help in considering the various factors relevant to the request before coming to a decision.

Also, remember, that in a decision not to disclose the information requested, the police can apply for and obtain a lawful warrant or court order requiring disclosure.

KEY POINTS

- Give careful consideration to any police requests for patient information – even confirmation that someone is a patient.
- Consider all relevant GMC guidance on disclosure in the public interest, weighing it up against the patient's right to confidentiality.
- Obtain consent for disclosure if possible, practical and/or reasonable.
- If disclosing, provide only the minimum information necessary to fulfil the purpose.
- Ask for confirmation of identity of any officer making a disclosure request.
- Call MDDUS for advice in specific cases.

Alan Frame is risk adviser with MDDUS Training and Consultancy

Diary

FEW THINGS are more gratifying than having a cherished preconception confirmed by hard (well, hard-ish) evidence. Diary can now officially report that young professionals today are basically "soft". In a survey of more than 3,000 UK workers, 55 per cent of those over the age of 55 revealed they had not taken a sick day in the last year compared to less than a third of under-30s. These are the findings of research commissioned by a well-known brand of probiotic multivitamin. The survey also found that employees under 30 were "far more likely" to take time off because of stress, tiredness or feeling run-down than the over 55s, who said they would not call in sick unless "bedridden". Younger workers were also more likely to suffer from flu, allergies and food intolerances. Acceptable reasons cited for curling up on the couch under a blanket with the TV remote included constipation and car sickness. Under 30s also drink more, sleep less, eat a more unhealthy diet than people twice their age – and no doubt have much more fun.

➔ SOME PARACETAMOL AND BOX SET OF *FRIENDS* Curling up with the remote might not be such a bad idea if you are genuinely suffering. Research recently published in the *Proceedings of the Royal Society* found that our pain threshold is higher after watching funny videos. In a study at Oxford University, volunteers were split into two groups with one shown 15 minutes of comedy and the other more "boring" material such as golfing programmes. They found the subjects watching the comedy videos were able to withstand 10 per cent more pain whereas the group stuck with the boring stuff was less able to bear pain. Slapstick comedy such as *Mr Bean* worked best though situation comedies such as *Friends* were also effective. Lead researcher Professor Robin Dunbar of Oxford University believes that uncontrollable laughter releases endorphins which generate mild euphoria but also dull pain.

➔ AND CHOCOLATE TOO Research published in the *BMJ* suggests that eating chocolate might actually do you good. A few longitudinal studies looking into chocolate consumption suggest that it is associated with a "substantial reduction in the risk of cardiometabolic disorders". Academics think this might be due to the high level of polyphenols in cocoa which could increase the bioavailability of nitric oxide and improve endothelial function. Sadly the study does not go as far as recommending a chocolate free-for-all as it concludes that "further experimental studies are required to confirm a potentially beneficial effect of chocolate consumption."

➔ BREAST IS BEST From heart-healthy chocolate to the less appetising human breast milk ice cream. It seems that plans by London shop The Icecreamists to sell the unorthodox frozen delicacy – which costs £14 a scoop – may have hit a health and safety snag. Just weeks after it was launched, officials have moved to ban the sale of the snack following customer complaints. Fears were raised that a foodstuff made from another person's bodily fluid might pass on viruses, although owner Matt O'Connor said the ice cream was perfectly safe and had proved popular with customers.

➔ OH THE IRONY Straight from the file marked "misguided good intentions" comes this fundraising campaign by a fast food restaurant. A KFC franchise in Utah is asking customers to support the fight against diabetes by purchasing an 800-calorie Mega Jug of sugary soft drinks, according to website **theweek.com**. For every $2.99 half-gallon drink it sells, the restaurant is promising to give $1 to the Juvenile Diabetes Research Foundation. The move has met with some criticism from anti-obesity activists but a JDRF spokesman pointed out that type 1 diabetes is not caused by diet or obesity. A fair point, but as any doctor knows, regularly downing a drink containing 56 spoonfuls of sugar may well set customers on the road to type 2 diabetes.

➔ EXTREME MEASURES A GP practice recently had to call in the police to warn a patient that he had a life-threatening condition. Michael Spence, 64, from Essex hadn't left a contact number with the practice but tests sent to the hospital showed he was at risk of a fatal stroke due to a suspected blood clot in his neck. Two officers duly chapped on his door and told him to phone the hospital immediately. They only left once he'd arranged to go to A&E for treatment. Mr Spence told the *Daily Mail:* "I'm sure I wouldn't be here now if it hadn't been for the GP, the wonderful team on Benfleet Ward and the policewomen." Diary assumes dialling 999 to contact patients would not normally be the recommended approach.

➔ PRESCRIPTION PUFFING Doctors in Iceland could be thrust onto the frontline of the country's anti-smoking campaign under a proposed new initiative. The parliament in Reykjavik is considering a proposal to ban the sale of cigarettes and make them a prescription-only product. Under the plan, cigs would be distributed by pharmacies only to people with a valid medical certificate. Only around 15 per cent of Icelanders smoke regularly, giving it the lowest smoking rates in Europe. But the plans are not expected to be accepted into law. Spare a thought for any poor doctor expected to stand between a smoker and their cigarette.

➔ YAWN NOW Have you ever wondered if tortoises also suffer from contagious yawning? Well cease wondering – the answer is no! Dr Anna Wilkinson of the University of Lincoln has won the 2011 Ig Nobel in physiology after spending six months training a red-footed tortoise called Alexandra to yawn on command – this in order to test if other tortoises would yawn in response. The Ig Nobel awards given at Harvard University are a spoof on the Nobel awards and honour achievements that "first make people laugh, and then make them think". And then laugh again louder. Apparently yawning has to do with empathy or understanding the emotional state of another individual which seems to be a product of higher-level consciousness..... Sorry just off now for a short kip.

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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