Practice Manager
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ISSUE 6

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SOMETHING'S GOT TO GIVE

HOW ONE PRACTICE IS TACKLING A RISE IN PATIENT DEMAND

PROFILE:
PAT STEVENSON, SEATON PARK MEDICAL GROUP

MDDUS

Practice Manager

IN THE ever demanding world of general practice we as managers are always looking for ways of becoming more financially streamlined whilst trying to balance this against maximising services to our patients. It is enabling patients to access services as it suits them, and this can involve ordering scripts, booking appointments and making enquiries all online. Surgery pods and patient check-in systems are also ways in which patients can be actively involved in their own healthcare. This allows practices to reduce costs and deliver high-quality, patient-centred care.

On page 8 Joanne Curran looks at some of the technologies already being employed by practices across the UK and in one surgery in particular near Edinburgh.

Much of the push behind telehealth is to help deal with increasing patient demand in general practice and this theme also emerges in our practice profile by Jim Killgore on page 10. Seaton Park Medical Group is the largest primary care team in Northumberland, and managing partner Pat Stevenson provides an interesting perspective on how the practice has embraced the concept of "demand management".

On page 12 we look at the issue of how non-clinical information – in this case rude and aggressive behaviour in a patient – is recorded and stored, and the importance of fully understanding how practice IT systems operate in order to ensure compliance with principles of data protection.

There is an important difference between being aggressive and being assertive and on page 8 MDDUS trainer Cherryl Adams offers some hints on how to "respond" rather than "react" to a situation. In a similar vein, employment law expert Ian Watson (page 5) provides some tips on handling "difficult" conversations with employees.

Our Call Log on page 4 highlights some recent advice calls made to MDDUS, with topics including dental practice websites, disclosure of medical records after death and using Twitter to communicate with patients. The case study on page 14 concerns a prescribing error that ended up as the subject of a report by the Health Service Ombudsman.

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Dentistry Scotland Awards

THE call is out for entries to the 2012 Dentistry Scotland awards which again are being sponsored in part by MDDUS.

Categories include most attractive practice, best employer, best patient care, best dental team and culminating in practice of the year, both north and south. Last year's inaugural awards ceremony was held at the Gleneagles Hotel in Perthshire and was so successful that the organisers have decided to return there for the 2012 ceremony.

For more information and details on how to enter the awards go to **www.dentistryscotland.co.uk/awards**

Draft guidance on social media

DOCTORS should avoid using social media such as Facebook and Twitter to discuss individual patient care, according to new draft guidance from the General Medical Council.

Interacting with patients through personal social media profiles should also be avoided. *Social Media for Doctors* says doctors should instead direct patients to their professional social media accounts and ensure privacy settings limit the availability of personal information.

The use of social media, the draft guidance says, has "blurred the boundaries between 'public' and 'private' and changed the way in which online aspects of private lives are accessible."

The draft guidance, which will be out to consultation until June 13, makes recommendations about privacy online, interacting with patients through social media, behaving respectfully towards colleagues online, anonymity, raising concerns, confidentiality and conflicts of interest.

It recognises that the use of social media by doctors has the "potential to bring benefits to patient care by engaging with the public and colleagues" but it also has risks. It advises: "If a patient contacts you through a private profile, you should explain that it is not appropriate to mix social and professional relationships and, where appropriate, direct them to your professional profile."

To take part in the GMC consultation on *Social Media for Doctors*, visit **www.tinyurl.com/gmcec1** by June 13.

Does your website meet new criteria?

DENTAL practice managers are being urged to review their practice websites to ensure compliance with strict new GDC guidance.

MDDUS is advising every practice to check that their website includes all relevant and up-to-date information as detailed in the GDC's *Principles of Ethical Advertising*. Under the new rules, practice websites must include a range of information including the dentist's professional qualification and GDC number, the GDC's address and contact details, details of the practice's complaints procedure and the date the website was last updated.

MDDUS dental adviser Rachael Bell said: "Websites can be a great marketing tool, but exactly what is being offered and to whom needs to be clear and accurate if dentists are to keep themselves in line with the GDC's guidance. Most practices that have websites will already have most of the information that the GDC are asking them to display but it would be beneficial for practices to re-check their websites in light of the new guidance.

"If dental practices are exploring setting up their own website they will now know from the GDC what information must be included."

Other information that must be displayed includes the practice name, address and contact details. Websites must be kept up-to-date and accurate and cannot display information comparing one dental professional's skills with another.

Unfair dismissal rule change

EMPLOYEES will have to wait longer to bring a claim for unfair dismissal under major new laws that came into effect in April.

The required qualifying period enabling employees to raise a claim has increased from one year to two years for new employees only. The government says the move is designed to "provide more time for employers and employees to resolve difficulties, give employers greater confidence in taking on people and ease the burden on the employment tribunal processes".

The predicted drop in unfair dismissal claims as a result of the change will save British businesses an estimated £6 million a year. However, the changes may see an increase in the number of discrimination claims made, as this does not involve any service requirement and may be a way for an employee to get their claim into a tribunal.

The maximum compensatory award for unfair dismissal has increased from £68,400 to £72,300.

Other new measures affecting employment tribunal procedures include a requirement for costs to be paid up-front in order to lodge a tribunal claim, the right for employment judges to hear some unfair dismissal cases alone and witness statements being 'taken as read' unless the tribunal directs otherwise.

One in 20 GP prescriptions contains error

GPs in England make mistakes in one in 20 prescriptions, a major new study has revealed.

And while most errors were classed as mild or moderate, one in every 550 prescriptions contained "serious errors". The research commissioned by the General Medical Council found one in eight patients had mistakes in their prescriptions, with the elderly and the young the worst affected.

The study looked at 15 general practices from three areas of England and analysed the records of 1,777 patients. Among the mistakes noted the most common were incomplete information on the prescription (30 per cent), dosage errors (18 per cent) and incorrect timing of doses (11 per cent). The most common monitoring error was a failure to request monitoring (69 per cent).

Researchers identified a number of contributing factors in prescribing errors including deficiencies in GP prescribing training, pressure and distractions at work, lack of robust systems for ensuring patients receive necessary blood tests and problems relating to GPs using computer systems, i.e. overriding important drug interaction alerts.

GMC chairman Professor Sir Peter Rubin said effective computer systems and careful patient monitoring were key to reducing errors. He also suggested doctors and patients could benefit from greater involvement from pharmacists in supporting prescribing and monitoring.

He added: "We will be leading discussions with relevant organisations, including the RCGP and the CQC, and the the Department of Health, to ensure that our findings are translated into actions that help protect patients."

PM conference 'amazing and informative'

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

The two-day event at the Fairmont St Andrews Hotel got off to a fantastic start with keynote speaker Stephen Carver from the Cranfield School of Management. His opening presentation looked at the similarities between medical and dental practices and NASA as 'safety critical organisations'.

The keynote address was hailed as "excellent" by many delegates, with one practice manager commenting: "Stephen Carver's presentation was the best I've ever attended", while a fellow practice manager added: "As per previous conferences, the key speaker was amazing and informative."

Around 180 delegates attended a varied range of workshops during the conference, learning about topics including understanding your team and yourself using the DISC behavioural awareness tool, assertiveness skills, the anatomy of a claim, dealing with bullying and harassment, new GMC guidance, changing employment contracts, handling media enquiries and much more.

The conference was brought to a close with a two-hour live scenario showing the Journey of a Complaint featuring a presentation from the Scottish Public Services Ombudsman. SPSO and MDDUS staff acted out the scenario that involved the removal of a family from a practice list.

More than 70 per cent of the delegates who gave feedback said they found the conference "extremely useful". One manager praised the "relevant and informative" topics while others praised the impressive venue and great networking opportunities. In summing up the event, another manager concluded: "Once again you pulled out all the stops and provided a fabulous conference."

Call log

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.

WEB RULES

Q A dental practice manager is tasked with updating the practice website. She wants to highlight the dentists' considerable experience in treating older patients and plans to include details on the site that they "specialise in denture work". She calls MDDUS to check if this is allowed.

A An MDDUS adviser tells the PM that the General Dental Council have introduced strict new rules on what can be published on websites. Only dentists who are on one of the GDC's 13 specialist lists can use the title 'specialist' or describe themselves as a 'specialist in…' Under these rules, the practice website cannot use the phrase 'specialise in denture work' as the GDC says this may mislead patients by implying specialist status. Various other information, including the dentists' GDC numbers, professional qualifications, GDC contact details and the practice complaints procedure, must now also be included on practice websites. See *Principles of Ethical Advertising* for more details.

PRIVILEGED INFORMATION

Q A practice has been asked for a copy of all complaints correspondence by the health service ombudsman relating to the case of a delayed diagnosis of renal cancer in a 74-year-old patient. The PM prepares his response and gathers together all relevant emails and letters, including those between the practice and MDDUS. He calls an adviser before sending the bundle.

A Although the ombudsman has asked for all correspondence relating to the complaint, MDDUS correspondence with members should NOT be included. All letters and emails sent between MDDUS and our members are privileged and do not require to be disclosed. There is no requirement to disclose to anyone the advice MDDUS has given to members to assist them in responding to a complaint appropriately.

RECORDS AFTER DEATH

Q The daughter of an elderly patient who died two years ago has requested access to her late mother's medical records to find out more about the treatment she received before her death. The deceased patient's husband, who is the executor of her estate, has not given consent for the disclosure. The PM asks MDDUS if she is obliged to provide the daughter with access.

A In the case of a deceased patient, the patient's personal representative (the executor/administrator of their estate) and any person who may have a claim arising out of the patient's death has a right to access their medical records. If the daughter is merely seeking information about her mother then the practice requires consent from the patient's personal representative – in this case the patient's husband – in order to grant access to the records. However, if the daughter intends to make a claim on her mother's estate, the Access to Health Records Act (1990) allows for the information to be divulged without the consent of the patient's personal representative. All requests should be considered on a case-by-case basis.

POWER OF ATTORNEY

Q A GP is approached by the brother of a patient who has lost capacity and can no longer make decisions about her treatment. The brother says he has power of attorney and wants to discuss his sister's care and future treatment. The GP is unsure if he is allowed to discuss the patient's case with her brother.

A If you have confirmed the patient has lost capacity then the next step is to clarify which type of attorney power the brother holds. These can be for financial or welfare decisions or both. If the brother has powers covering welfare then this would permit you to have discussions regarding medical treatment decisions. Legislation varies in Scotland and England but common themes state that any decisions must be made on the basis of most benefit to/best interests of the patient, the least restrictive option should be preferred, account should be taken of the patient's previous expressed wishes if known, and the views of relatives and carers should be taken into consideration.

PRACTICE TWEETS

Q A practice manager wants to open a practice account on the social networking site Twitter to keep patients informed about holiday closures, flu jabs/vaccination schedules and other relevant information. She does not want the Twitter account to be used to contact patients or as a means for patients to contact the practice. She asks MDDUS for advice.

A There are no specific rules barring practices from using social media to communicate with patients, provided patient confidentiality is always respected. You must never 'tweet' (make public via your Twitter account) confidential patient information and patients should not be contacted individually through Twitter. Be mindful of patient confidentiality when seeking to advertise the Twitter feed to patients. It is also worth clearly stating on the Twitter page that this is not a means for patients to book appointments or contact practice staff with clinical queries, and alternative practice contact details should be clearly posted. Refer to Twitter user guides to ensure your account does not allow 'followers' of your feed to send you direct messages.

AGENCY WORKERS

Q A practice has employed an agency worker for the past four months to fill in for a receptionist on maternity leave. The practice has recently agreed to increase employees' annual leave allowance by one day but does not intend to include the receptionist as she is only an agency worker. The manager asks MDDUS if this is allowed.

A New legislation came into force in October 2011 that granted agency workers the right to equal treatment after 12 weeks on assignment. Because your receptionist started after this date and has worked for more than 12 continuous calendar weeks, you must include her when awarding an extra day's annual leave.

Difficult conversations

IN the course of developing and presenting some new training courses for managers I have become increasingly aware that the gap between the theory and practice of resolving staff problems can centre on the confidence some managers feel about having "difficult" conversations.

Many people I speak to who are seeking advice or guidance about employment law and HR management issues understand that early intervention, through discussion of a concern regarding a staff member's performance, conduct or attendance, can be crucial in resolving the problem. However, the perception that the discussion is going to be heated, stressful or challenging often leads managers to delay such interventions.

Ironically, many managers I advise admit that procrastination frequently results in the eventual meeting with the employee being even more challenging than they initially feared. In many cases, they recognise that if they had acted sooner, the conversation may not have been so fraught.

Similarly, informal concerns raised by an employee may not be properly discussed if a manager fears the process will raise "difficult" issues. The issue is then glossed over and the matter remains unresolved. The result is likely to be an escalation of the matter to a formal grievance – with potential attendant stress for both employee and manager.

So how do I reassure managers that they should bite the bullet and start these difficult conversations as soon as they suspect a problem exists? The answer lies in preliminary investigation and analysis, planning and the deployment of some simple interpersonal skills techniques.

While it won't guarantee that the conversation will be plain sailing, following these basic steps could potentially allow the manager to remain in control, which would clearly improve the chances of achieving a successful resolution.

As a first step in resolving staff problems, it is useful to take time to analyse the background to the matter. Often this reveals that the source of the problem lies in the organisation's own policies, bureaucracy, management practice or external factors. With this information in mind, the manager can speak to the employee and acknowledge the role played by the relevant organisational factors and provide reassurance that little or no blame lies with the staff member. This method allows the heat in the conversation to be moderated and the discussion can concentrate on how the two parties can proceed together in the future. This is certainly preferable to the manager ignorantly assuming the employee is a troublemaker or serial complainer and setting up an inevitable clash at a disciplinary or grievance meeting.

Similarly, if the manager has, through preliminary investigation, gathered some background about the employee's personal circumstances or work history they may avoid jumping to conclusions about where blame lies in a particular situation.

Advance planning of the meeting is another important part of the process that can help the manager feel more confident about the prospect of handling conflict when the parties get together. Such simple things as deciding in advance the outcome desired by the manager can help to avoid pussy-footing around at the meeting. Producing concrete evidence, documents, facts and figures will ensure that, if the manager meets fierce vocal resistance to their attempts to raise their concerns with the staff member, they can defuse the situation by placing their evidence on the table so that a calmer, more rational discussion can take place.

Above all, managers can benefit from training which provides them with some effective interview techniques. These include:

- reading the signs of frustration and conflict in meetings and defusing emotional reactions wherever possible
- getting the thorny issue on the table as early as possible (preferably in as few words as possible!)
- steering the interviewee on to problem-solving ground at the critical moment when the exploration of the issue is completed.

All this cannot guarantee a conflict-free conversation but experience tells us that deploying these techniques can narrow the scope for heated interchanges and give the manager enormous confidence – both for tackling the matter early and for steering the process towards a constructive conclusion.

For more information about Law At Work's training programme for managers visit: **www.lawatwork.co.uk/in-house-training** ❋

Ian Watson is training services manager at Law At Work

Under the COSHH

MEDICAL and dental practices are often regarded as safe places where health considerations are of paramount importance. But most practice managers would agree that the work performed by clinical, administrative and support staff presents a number of potential risks to the health of both employees and the public.

This article looks at the risks associated with the storage and use of hazardous substances on practice premises and, in particular, considers practices' duties under the *Control of Substances Hazardous to Health Regulations (COSHH) 2005*. In general terms, the risks are much the same for medical and dental premises, although there are likely to be more hazardous substances stored at GP surgeries.

One of the more significant risks in practices relates to cleaning operations which often take place outside normal opening hours. Depending on the size of the premises, practices may use a single cleaner or a team of workers who will make use of a variety of cleaning agents.

Due to the requirement to maintain a high standard of cleanliness in premises, some of the substances used by cleaning staff will be more powerful – and potentially more dangerous – than those found in the typical home. Some of the most powerful cleaning agents, such as sulphuric acid and bleach products, are highly acidic or alkaline and can inflict serious injury if accidentally spilled on skin or splashed in eyes.

It is important to bear in mind that, whether the cleaner is self-employed or supplied by an agency, the practice will share the legal responsibility for any injury resulting from a spillage. In the event of such an injury, the practice can only demonstrate legal compliance by proving that a suitable COSHH risk assessment had been carried out, that the risk of injury from the cleaning fluid had been identified, and that suitable and sufficient control measures had been taken to ensure the cleaner's safety. This can be done through various means including ensuring you have followed the steps explained in the 'hierarchy of control' (Elimination, Substitution, Control the risk at source, Education and Training, and Personal Protective Equipment) as well as providing training in the use of the substance.

The same principles apply to every hazardous substance routinely stored and used at the practice's premises.

A second key COSHH consideration is drug supplies stored on practice premises. The practice should maintain a comprehensive inventory of all drugs, and staff should be required to maintain permanent records of the arrival of drugs at the practice as well as when and to whom they are issued. This requirement applies even more rigidly to controlled drugs and stems indirectly from the Harold Shipman case which centred on the alleged murder of more than 200 patients by Dr Shipman. Shipman ran a single-handed practice and routinely obtained supplies of diamorphine which he then used to deliver fatal doses to elderly patients.

Full guidance on the receipt, storage and issuing of controlled drugs is available from a variety of NHS sources, while the Misuse of Drugs Act and the Misuse of Drugs Regulations clearly set out the legal requirements. Guidance is also given on the recommended security arrangements for controlled drugs kept on practice premises.

Another relevant COSHH consideration centres on the procedures required for the taking, receipt, storage and despatch of blood, urine and stool samples. Patients will rarely turn up at the surgery with their own blood samples, but GPs and nursing staff will take blood samples on a daily basis. In addition to the obvious dangers associated with the use of sharps, it needs to be borne in mind that blood is a major infection hazard and COSHH obliges the practice to have assessed the hazards associated with taking blood samples, identified who is at risk, put suitable control measures in place and provided appropriate training to those involved. These steps need to be recorded in writing and reviewed at least once a year.

Similar considerations apply to urine and stool samples and to vomit. Patients may supply urine samples while at the surgery, bring stool samples in for analysis and will sometimes vomit unexpectedly while on the premises.

COSHH requires practices to have gone through the same process as that described above for blood. Each set of risks is subtly different so different hazards and control measures will apply.

Finally, it is worth noting that COSHH also applies to the range of so-called superbugs, including MRSA and *C. difficile*. While many outbreaks of infection take place in hospital, these infections can easily be acquired in the community, and this means that practices should have appropriate risk assessments and control measures in place in respect of these. Although compensation claims stemming from superbug infection are relatively rare, no medical or dental practice wants to find itself on the receiving end of a claim based on a negligent failure to take the required control steps. ❋

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

> "ASSERTIVENESS IS ABOUT ALLOWING TIME AND SPACE TO RESPOND TO A SITUATION RATHER THAN REACT TO IT"

Fight, *flight* or...

IN EVOLUTIONARY terms we humans are no different from our hunter-gatherer ancestors of ten thousand years ago who struggled to survive in a sometimes harsh wilderness. When faced with a perceived threat, we tend to respond in one of two ways – either we meet that threat head-on and aim to control it, or we retreat, withdraw and avoid it. This fight-or-flight instinct is hard-wired into our brains and has served us well in past millennia when threats were often physical and life-threatening.

Today most of us have exchanged the wilderness for a (some might say even wilder) office-based environment but that hard-wiring can still dictate our responses to stressful situations – whether it's handling a conflict, saying "no" to colleagues, or giving someone constructive feedback. We tend to fall back on our natural passive or aggressive responses and this can make interactions more difficult. Passive behaviour might mean being unable to say "no" and thus becoming swamped with work. Aggressive behaviour can lead to fraught relationships within a team and hinder effective communication.

Assertiveness is often referred to as the middle-ground behaviour. It involves confidently identifying your wants, needs and rights in a situation while considering the wants, needs and rights of others. Assertiveness is about allowing time and space to respond to a situation rather than react to it. This might involve centering yourself, breathing and counting to 10, reflecting on an interaction and responding in an appropriate manner. It could mean a 10-second pause, or it might mean asking someone to come back to you tomorrow/next week/next month.

Another way of characterising assertiveness is – saying the right thing, in the right way, to the right person, at the right time. So what does this mean in practice?

THE RIGHT THING

Be clear about what message you are trying to convey in an interaction. For example, are you saying "no" to someone or "not right now"? Sitting down with pen and paper (or laptop) and scripting out the conversation can be beneficial. Start with what your desired outcome is and then what your opening sentence will be. Try and anticipate the other person's responses – put yourself in their shoes. This will help you be prepared for any questions or objections they might raise. Also try and note key phrases that you want to include – not a tight script but a loose guide to help steer you through the interaction.

THE RIGHT WAY

Think about how you sound to the other person – your pace and tone of voice. Assertive individuals use an even, low tone and a steady pace, not too fast or slow. Catch yourself in the moment – what is your body language saying? Are your gestures fast and furious or are you standing with arms folded? Eye contact is also important. Maintain direct eye contact for around 60 per cent of the time. Any more than that and you may appear aggressive, any less can be perceived as passive or disinterested. Practice in front of a mirror or role play difficult conversations with a neutral party.

THE RIGHT PERSON

Ask yourself two questions. First: am I the right person to be dealing with the situation? If not, pass it on to whoever is responsible. Just because a task has landed on your desk does not mean that you need to own it. Second: are you speaking to the appropriate person to deal with a situation? There is no gain in complaining and moaning to others in the hope that they will champion your cause. What is high on your priority list may not be on somebody else's.

THE RIGHT TIME

Timing is often key in being assertive. Is the person you are approaching already overloaded with a task or in a state of anger and frustration? Also you should allow yourself time to reflect on what you want to say, and to get into the proper state of mind. Don't be afraid of asking for time to digest and reflect on a request. Remember the aim is to respond rather than react. Location is another consideration here. Neutral ground is often best for conversations where one party may feel disadvantaged – perhaps in the coffee room or an empty surgery.

Remember that assertiveness isn't about "winning" every interaction. There are times when it won't work and you have to accept that outcome, reflect and learn from it and move on. What assertiveness is about is dealing with others fairly, allowing them the same rights and considerations you expect. Sometimes that might mean being able to say "no" to a request or to ask for more time – or simply an understanding that everyone occasionally gets things wrong. ❋

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

Step into **the future**

How can technology help practice managers save resources and improve patient care?

THERE have been some big promises made about the benefits of increasing the use of technology in delivering healthcare, with supporters arguing that doing so will cut costs, save resources and improve patient care.

Finding ways to provide better care in a more efficient way has long been the dream of many an NHS manager and is proving particularly pertinent in these economically straitened times. Motivated by the hope that advanced IT systems are key to realising this dream, the Department of Health in England has launched a campaign to dramatically ramp up the use of telehealth in the NHS over the next five years, while the Scottish Government has also signalled its support to increase uptake.

When talking about technology in healthcare, there are various terms in use, but the most common are telehealth and telecare. The former is generally defined as the use of electronic equipment to monitor patients at a distance (through mobile phones, internet services or self-monitoring equipment). It also includes practice-based technology such as patient self check-in and 'surgery pods' to monitor patients' blood pressure, weight, alcohol consumption and more.

The term telecare, meanwhile, tends to refer to the use of technology to help patients live independently in their homes (i.e. falls monitors and motion sensors) and may be less relevant to general practice management.

The main aims of using technology in healthcare are to prevent unnecessary hospital admissions, deliver cost savings, improve quality of life by giving patients greater control over their care and to reduce pressure on NHS resources.

TECHNOLOGY IN PRACTICE

For practice managers, some relevant telehealth systems include texting patients with blood results (which can reduce use of staff resources), texting appointment reminders (reduces Did Not Attends), emailing prescriptions (increases accuracy and is easy for staff to fit around other duties), self-testing at home (reduces need for practice appointments and home visits) and patient self-testing pods in the surgery (reduces consultation times, increases 'patient ownership' and results can be uploaded direct to patient records).

Each week seems to bring new reports of the latest projects making use of technology in healthcare, but there are still many practices who have yet to get on board. Any new idea has its supporters and critics but if practice managers carefully consider which hi-tech systems suit their practices' needs, then technology can provide an effective means of delivering more efficient patient care.

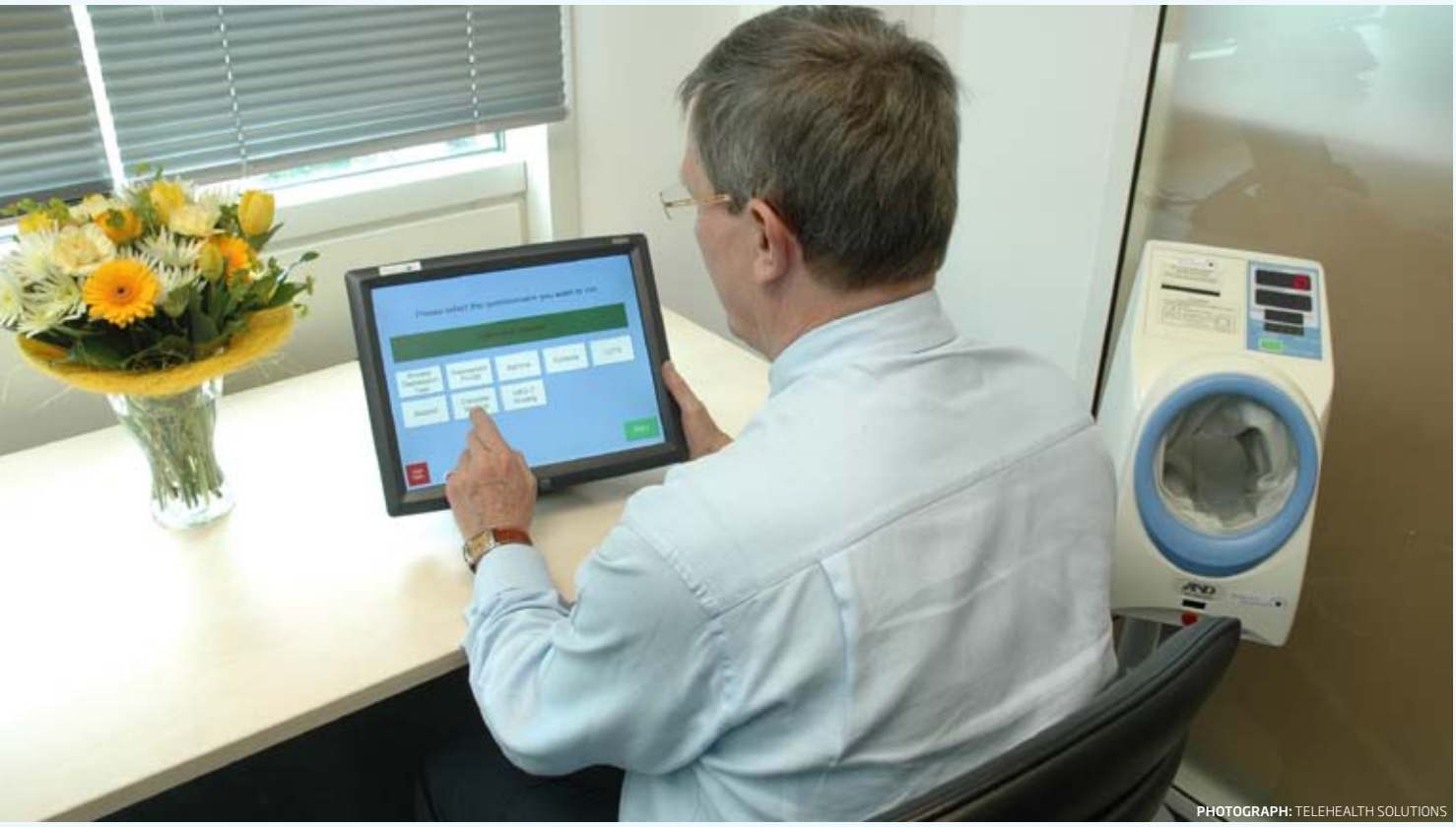
HI-TECH SOLUTIONS

One practice that has embraced telehealth is Tranent Medical Practice in East Lothian, near Edinburgh, which has a patient list of 13,000. In the last few years, they have launched a new website (**www.tranentmedicalpractice.co.uk)** which allows patients to order repeat prescriptions, complete a patient survey, update contact details and even update their clinical record online. The site also links to the practice's Twitter feed, offers various information sheets and forms to download and plans are also in place to introduce online appointment bookings once the software becomes available.

A patient newsletter was launched late last year and mailed out to all patients in the catchment area, informing them of all the new developments.

One of the biggest changes seen by Tranent's patients is the addition of the computerised 'surgery pod', installed in a discrete area next to reception, that allows patients to perform their own tests. The touch-screen pod is programmed with practice-specific settings and measures blood pressure and weight and can record alcohol consumption. Patients can use it before consultations or at their convenience during practice opening hours. The results are then automatically uploaded to their clinical record and any abnormal results are immediately flagged up and acted on by practice staff.

Patients attending for appointments are given the option to use the self check-in system, while the new Patient



PHOTOGRAPH: TELEHEALTH SOLUTIONS

Call system tells patients, through an audio and TV screen, when/where to see their GP.

A driving force behind many of the big changes at Tranent is practice manager Jill Thomson.

She says: "We brought in the surgery pod because the practice has 1,800 people on its hypertension register and it was a huge task trying to recall them to be tested every nine months. We weren't able to give them the service we should have given them – but this way we can.

"We don't enforce the use of the pod, and staff are always on hand to help, but the response has been fantastic with 1,110 patients using it in the first six months. It is also safer than more traditional machines because the results go straight into their record and abnormal results are flagged up.

"In terms of cost, it has paid for itself already as it saves the time of practice nurses and healthcare assistants and frees them up for more appointments. We also now meet every QOF target relating to hypertension."

Jill admits the self check-in has not been such a big success but believes this is because it was situated next to reception, meaning it wasn't very visible to patients. She is now looking at moving it to a better location in a bid to drive up usage.

Jill says: "It's important to carefully consider any new technology and to make sure it meets the needs of your patients. Everything we do is about delivering a better service to patients and this technology has been a huge benefit to the practice. The patients are happy and feel more in control of their care so I wouldn't hesitate to recommend it to other practice managers."

CHECKS AND BALANCES

As with any system that holds/transmits patient data, it is vital to always respect patient confidentiality and to comply with the Data Protection Act. PMs who want to text patients with results or reminders should be sure to first ask patients for their consent – a mobile phone may be accessed by people other than the patient and may not be a reliable means of communication.

Equally, when considering emailing patients, gain consent first, ensure you are sending to the correct address and aim to use more secure NHS email systems rather than personal, web-based accounts. Messages should contain the minimum amount of detail necessary and data should be encrypted where practical. It is advisable to allow patients to opt-in to any new service, rather than automatically including them.

PMs should ensure GPs/GDPs know they must clearly indicate if test results are urgent so that this can be included in any text/email communication. In urgent cases, it may be advisable to communicate with patients by more traditional means to ensure they have received the message and understand the urgency of any action required.

Many practices now allow patients to book appointments online, order repeat prescribing online or even amend their clinical records via the practice website. It's vital that systems are put in place to ensure data is secure and that a staff member closely monitors emails/alerts indicating that a patient has booked online or communicated in any way with the practice. If one dedicated staff member is charged with this, ensure monitoring continues in their absence.

Any telehealth system is only effective if the equipment is functioning properly and is used in the correct way. You must ensure equipment is maintained and checked regularly to ensure readings are accurate and that both staff and patients are trained in its use. Where relevant, you should provide a discrete space for patients to use equipment that requires inputting personal information.

Joanne Curran is an associate editor of Practice Manager

DEM MANAG

How do you manage increasing patient demand in an era of funding cuts? **Jim Killgore** finds out how one practice in Northern England is coping with the challenge

HARD times are nothing new in the town of Ashington, located 15 miles up the Northumberland coast from Newcastle-upon-Tyne. At one time it was said to be the world's largest coal-mining village, employing thousands of men in local collieries. But the decline of the industry in the 1980s and 1990s brought high unemployment and social deprivation – a legacy the town still suffers with today.

Sweeping government budget cuts in this age of austerity bite hard in such areas and healthcare provision is no exception. One local provider struggling with these challenges is the Seaton Park Medical Group. On a chilly April afternoon I travel the short distance by taxi from Morpeth Station on the main east coast rail line to meet Pat Stevenson – managing partner at Seaton Park.

With over 19,000 patients and 10 GP partners, three salaried GPs and a total staff of about 50, Seaton Park is the largest medical practice in Northumberland. In three branch surgeries in both Ashington and nearby Newbiggin-by-the-Sea, the practice deals with high levels of morbidity among a mainly white, low-income population.

"I know from the GPs that it's not unusual for someone to come to the surgery with as many as six genuine health issues to sort out in a 10-minute consultation," says Pat. "And our statistics show that every quarter the demand is getting higher – the same number of patients but higher demand."

Like many practices across the UK, Seaton Park is seeing no increased funding to cover this rising demand in services.

"Our PMS contract was forcibly renegotiated in 2007," says Pat. "Nearly £2 million was taken out of the area, out of primary care. We suffered the loss of an equivalent of £125,000 per year. That was a big blow. And we've seen a static or falling income for the last four or five years. How do you cope with that?"

HAVING VISION

For Pat the answer is mainly through hard work and a clear vision of what the practice is trying to achieve. She comes from a business background, having worked for many years with a software company supplying IT systems to hospitals across the UK. In addition, before joining Seaton Park in 1997, she held a senior management role at an NHS Trust.

Five years after taking on the job of practice manager she was invited to become a partner. "It was quite a radical move," says Pat. "Not that it's made much difference really. I've always worked with the approach that there's a job rather than a clock." Notionally, Pat works four days a week which means "only about 60 or 70 hours". Most important to her is the personal stake or "ownership" being a partner offers and the challenge of setting the future course for the practice – providing vision.

"Having a vision is as important as oxygen is to breathing," she says. "Knowing where you want to be and what you want to achieve is the thing that stops you being mediocre or worse, and determines how likely you are to survive in a changing and threatening world. Certainly I think general practice in its current model is under attack politically in the UK."

Pat believes that to make it in the current climate, a general practice must be run like any other commercial venture. It requires a broad outlook, looking months, years ahead, and also an ability to learn from other industries. But she admits that the model doesn't quite stack up from a business point of view.

"If you are a Tesco – greater footfall and greater sales mean more profit," she says. "But for us the more appointments we offer, the more it costs us. It turns the business model completely on its head. Contacts cost."

So how does a large practice like Seaton Park deal with rising demand and diminishing resources? One possible option is to strive for greater efficiency. Compared to most hospitals, says Pat, the amount of waste in Seaton Park is miniscule. "I have been working on reducing it for the last 15 years and that makes a difference but it can only go so far."

CHANNELLING DEMAND

In recent years Pat has embarked on a different tack and become a fervent believer in the concept of demand management. Looking at it in the context of general practice, Stephen Gillam

AND GEMENT

> "WE ARE VERY MUCH DRIVEN IN HOW WE DELIVER OUR SERVICE BY WHAT IS AVAILABLE TO SPEND. BUT OUR PRACTICE VALUES ARE ALSO HUGELY IMPORTANT"

PHOTOGRAPH: RICHARD LEE

wrote in the *BMJ*: "The objectives of demand management are essentially utilitarian: the maximisation of total met need for the greatest number within available resources. The process is not simply about curtailing demand for ineffective services but may involve creating demand for underused services known to be cost effective."

In explaining the concept to me, Pat likens it to building roads. "They put a motorway around Newcastle, two lanes in each direction. Fantastic – it took traffic from the toll tunnel underneath the Tyne. It was wonderful. Within a year or two the road was full. So you build more lanes and what do you get – more cars. At some point you have to do something to stop people from wanting to drive. You need to offer alternatives."

Pat and her team began exploring more innovative ways of dealing with the rising demand among patients at Seaton Park. Among the initiatives they introduced was an Xpress Clinic run by specialist trained nurses, offering treatment for minor illnesses such as acute cough and chest infections, earache and urinary infections. The service has helped free up more GP consulting time. The practice also offers a telephone consultation service in which a patient can speak to a GP about minor illnesses and other issues such as medication reviews or fit notes. Again this reduces the need for more lengthy face-to-face consultations.

But providing alternative services is of no use unless patients are actively directed to use them. So the practice introduced a computer-based tool called Navigator which the medical receptionists use to guide patients to the most appropriate service. This might mean offering an appointment at the Xpress Clinic or with a practice nurse or healthcare assistant – or if necessary a GP either by phone or face-to-face. Patients may also be directed to the primary care access centre at the local hospital or Pharmacy First. The system was developed by GPs and includes safety features to manage emergencies and urgent needs.

"It's not about denying access to doctors," says Pat. "If the patient says 'I want to see the doctor' then they have that right to do so. And it's also not about receptionists being clinicians."

She admits to some resistance among patients. "There will always be people who think a receptionist has no right to ask them anything. But the majority of our patients think Navigator is a good thing."

PRACTICE VALUES

Such innovations tend to be driven by budget considerations and it's easy for practice managers to get overly focused on the balance sheet. Says Pat: "We are very much driven in how we deliver our service by the money – what is available to spend. But our practice values are also hugely important."

On the Seaton Park website these values are clearly articulated: a commitment to patient-centred care which looks at the whole family, equality of treatment, listening to and respecting patients, and respecting and caring for colleagues. They serve as the litmus paper for the decisions made by Pat and the other partners. No initiative can avoid the question: "Is this something good for our patients?"

Or as Pat puts it: "We have to preserve what's precious, because that's what gets us up in the morning, that's what makes us all work ridiculous hours – because we believe in what we do."

Jim Killgore is an associate editor of MDDUS Practice Manager

Keep it **clinical**

A scenario involving a potentially violent patient raises the issue of how non-clinical data is recorded and stored

MEDICAL staff often see people at their worst – feeling ill or worried either for themselves or a family member. Some rude or aggressive behaviour at the reception desk or in a consulting room is hardly surprising, unacceptable though it may be.

Deciding just when such behaviour goes beyond what is tolerable or even safe in terms of the personal security of practice staff can sometimes be difficult. MDDUS has, however, become aware that this type of behaviour is increasingly being logged within patients' medical records.

A discussion of this topic at the recent MDDUS Practice Managers Conference sparked some debate. The specific scenario concerned use of messaging facilities within practice IT systems.

Consider a patient – Mr A –who arrives at reception late and agitated for an appointment and snaps at the receptionist, calling her a "stupid cow". In the time before he is called for his appointment the receptionist transmits a message via the practice IT system informing the GP that Mr A has been "threatening and abusive". The expectation is that the GP – with justification – will confront Mr A on his inappropriate behaviour. But also at issue is what happens to that message. Depending on how it has been transmitted, the receptionist's comment could be stored as part of Mr A's permanent clinical record.

This scenario touches on a number of areas of concern including how practices manage patient information using clinical IT systems and other means of storing non-clinical data. It also concerns the duty of care to practice staff in regard to harassment or aggressive behaviour from patients.

CLINICAL RECORDS IN PRINCIPLE

GP practices across the UK use a variety of IT systems to manage patient records, such as EMIS, SystemOne, Vision and Synergy. It is beyond the scope of this article to go into the fine details of how data is captured, stored and transmitted in each system. However, it is essential that practices understand how their IT systems operate in order to ensure compliance with the Data Protection Act 1998 and basic legal and regulatory requirements to ensure confidentiality.

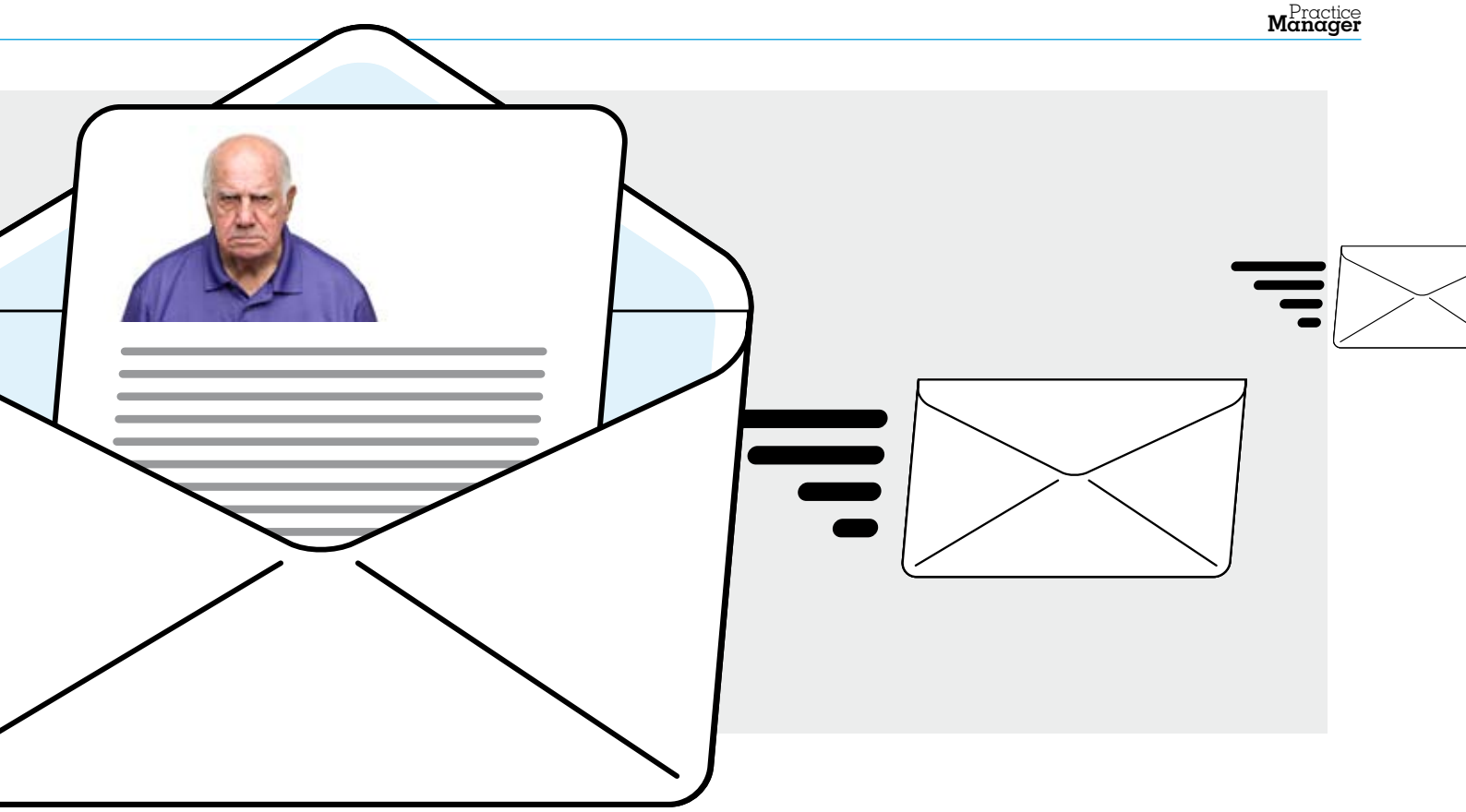
In this scenario the message string used to inform the GP of the patient's rudeness was automatically appended to the patient clinical records. It is doubtful that a record of this exchange entered by a receptionist would be considered of clinical relevance. A GP in some circumstances may wish to record a patient's behaviour in the clinical notes – for example in cases of mental illness – but the choice of what is recorded and the format in which that information is logged is a clinical decision and one for the GP to make.

Extreme rudeness or aggression in a patient may be worth recording in other contexts, say if relevant to an ongoing behaviour issue or in connection with a potential complaint against the practice. But such records should be kept separate from clinical notes.

MDDUS has had many calls over the years from practices who have either inadvertently breached patient confidentiality by storing non-clinically relevant information in patient records, or have received complaints from patients who after a subject access request have objected to the recording of such information within the medical records. Among documents often misfiled with the clinical records are:

- Medical reports for insurance companies or DVLA, e.g. heavy goods vehicle (HGV) applications
- Case conference meeting minutes regarding issues of child protection or a vulnerable adult
- Correspondence with solicitors including reports for court purposes
- Reports and correspondence regarding employment issues
- Reports for the DWP or benefit agencies
- Correspondence in regard to medico-legal claims or complaints from the GMC or GDC
- Correspondence, notes and reports to do with the investigation and resolution of patient complaints.

Such information should be held in a separate file. The risk of inappropriate disclosure has been further increased by the computerisation of patient records. Many practices now routinely scan and store all patient-related correspondence in electronic folders. To copy and send a folder takes only a matter of seconds. But just as with paper records it is essential such records are thoroughly checked to prevent inappropriate disclosure of non-clinically relevant details or third-party information.



Some issues, such as a child protection order, can be noted on the medical file along with any relevant medical information but detailed files should not be kept in the clinical records. Remember that clinical records will follow a patient throughout their life.

DATA PROTECTION RISKS

Another risk in recording non-clinical patient details comes under the Data Protection Act 1998. This Act applies UK-wide to all data about identifiable, living individuals. In the context of medical and dental practice it covers patient records held on computer or in paper files, and extends to handwritten notes and imaging. Under the Act a patient has a right of access to see personal information and to have it corrected if it is wrong. The Act introduces eight data protection principles that set out the standards for handling information. Data must be:

- fairly and lawfully processed
- processed for limited purposes
- adequate, relevant and not excessive
- accurate
- not kept for longer than is necessary
- processed in line with the data subject's rights
- secure
- not transferred to countries outside the EU without adequate protection.

Anything recorded, no matter where it is stored, is potentially recoverable under the Data Protection Act so it should be made very clear to practice staff that relevant emails, text messages or other notes may someday be seen by a subject patient or carer and possibly challenged. Notes on patient behaviour should be neutral and non-judgemental – a simple statement of the facts: For example: "The patient clenched his fist and called me a ..."

> "IT IS ESSENTIAL THAT PRACTICES UNDERSTAND HOW THEIR IT SYSTEMS OPERATE"

Not every heated confrontation need be recorded. The RCGP offers guidance on what is considered unacceptable behaviour, such as discriminatory abuse, sexual or racial harassment, physical or verbal abuse including threats and gestures, and violence.

HEALTH AND SAFETY CONSIDERATIONS

In the context of aggression and violence all practices have a legal duty of care not only to staff and other patients but all healthcare professionals who may come in contact with an abusive patient. Most practices will operate a zero tolerance policy towards violence against staff with all incidents followed by a formal warning and possible removal from the practice list. The RCGP provide clear guidance on removal of patients from a practice list and it is advised that wherever possible this guidance should be followed.

A formal system for placing violence markers on the electronic or paper records of potentially violent individuals is in place in some NHS service providers. Markers can be applied regardless of whether the act was intentional or not so as to "reduce possible risks to NHS staff by enabling them to consider and implement measures for their protection."

Practices should be aware how their own local commissioning bodies or health authorities identify violent patients but should also be aware that any such schemes must be compliant with the Data Protection Act on issues of fairness. This will mean informing the patient that they have been identified as being potentially violent.

There are also obligations to staff under health and safety regulations. No less than five pieces of legislation are relevant to protecting employees from violence at work, including The Health and Safety at Work Act 1974.

It is important that serious incidents of patient aggression are logged and dealt with but the trick is to ensure that doing so brings no additional medico-legal risks for practices.

Jim Killgore, associate editor, Practice Manager, in discussion with Liz Price, training and consultancy manager, Alan Frame, risk adviser, and Dr Anthea Martin, senior medical adviser at MDDUS

Prescribing without reviewing

Scenario

Mrs G, who was 84 years old, had looked after her granddaughter as a child and had lived with her for almost her entire life. Her granddaughter described her grandmother as "an amazing lady" who was "perfectly healthy" before she suffered a fall and underwent hip surgery.

Following surgery, Mrs G was discharged to a nursing home with a prescription which included diclofenac (a non-steroidal anti-inflammatory drug – NSAID), and given a two-week supply of the discharge medications. Mrs G was described by her granddaughter as being at this time "very mobile ... and had most of her faculties with her". She said Mrs G was looking forward to moving out of the home to live with her.

In the meantime, following receipt of the hospital's discharge summary, administrative staff at Mrs G's GP practice added the medications, including diclofenac, to her list of repeat medications.

Eleven months later

The practice continuously prescribed diclofenac to Mrs G for the next 11 months, without review and without an accompanying proton-pump inhibitor (which may help protect against NSAID-associated duodenal ulcers).

Mrs G went to live with her granddaughter as arranged. Her granddaughter soon noticed that Mrs G was having difficulty with food and that her health was deteriorating. Things came to a head on Christmas Day, when Mrs G was "violently sick, was as white as a ghost, could not move and was in pain". She was taken to hospital and underwent emergency surgery for a perforated duodenal ulcer. Sadly, she died two months later from septicaemia, acute renal failure and urinary tract infection. Mrs G's death caused her granddaughter "immense grief due to the fact that I only recently lost my mother".

Realising that Mrs G had taken diclofenac continuously for 11 months, her granddaughter complained to the practice. The practice accepted their failure to check and review Mrs G's medication, and they also conducted a significant event review. The main learning point from that review was that doctors (not administrative staff) should add medication to repeat medication lists so that they can consider appropriate co-prescribing, and that they should prescribe NSAIDs in accordance with the practice's protocols.

Mrs G's granddaughter then brought her complaint to the Parliamentary and Health Service Ombudsman. She said that although the practice had admitted errors, they had not said why they had occurred. She wanted to know why it had taken her grandmother's death to highlight the mistakes, and whether her death had been preventable.

THE INVESTIGATION

The Ombudsman found that the errors in Mrs G's case occurred partly because the practice's administrative staff were inappropriately involved in the processing of her medication. However, the major cause was the failure by doctors at the practice to follow their protocols, or the professional standards relating to prescribing and reviewing medication. They issued repeat prescriptions for the entire 11 months that Mrs G received diclofenac. As a result, no consideration was given to whether Mrs G still needed diclofenac, or whether a proton-pump inhibitor should be prescribed.

The advice at that time from the British National Formulary was that NSAIDs should be used with caution in elderly patients and that a proton-pump inhibitor may be considered for protection against NSAID-associated gastric and duodenal ulcers.

Mrs G's granddaughter specifically asked whether her grandmother's death had been avoidable. The Ombudsman could not say that the ulcer and the chain of events which led to her death were the consequence of the diclofenac prescription. However, the prolonged prescription, especially without a proton-pump inhibitor, put Mrs G at increased risk of developing the duodenal ulcer.

The Ombudsman upheld this complaint.

WHAT HAPPENED NEXT

The practice apologised to Mrs G's granddaughter for their failings. The Ombudsman's report was discussed at a significant events meeting, attended by all their doctors, nurses, receptionists and clerical staff. Robust procedures were put in place for prescribing and reviewing medication, and the practice increased awareness of the need to follow their review processes strictly and to monitor the prescription of NSAIDs. The practice nurse is now qualified in prescribing and conducts the medication reviews.

KEY POINTS

- Prescribe responsibly, according to good practice guidelines.
- Ensure any prescribing system provides thorough checks for repeat prescriptions.
- Monitor the issue of repeat prescriptions and prescribe dosages that are appropriate for the patient and their condition.

Diary

KEEPING with the technology theme in this issue of PM – not long ago Diary came across a cartoon by Stephen Collins in the *Guardian* newspaper. A couple are lying on a hillside and a passenger jet flies high over head. The woman says: "You know Brad, sometimes I like to come up here and just watch the planes. I like to wonder where they're going…New York…Paris…Cairo… maybe even Ulaanbaatar… And I like to think of the people on them, and how their lives might be changed by this journey, and how maybe, just maybe, one day it'll be me, flying away from this dreary little town, with its dreary little dreams…Y' know?" The man holds his smartphone up toward the plane – "Blip, blip" – and says: "It is going to Luton." The final panel in the cartoon reads: "APPS: SPOILING THINGS SINCE 2008."

➔ I HAVE AN APP FOR THAT News that the Department of Health could soon be directing GPs to "prescribe" patient apps had Diary struggling not to swallow its own scepticism much like a bottle-fed baby does air. At a recent event held to showcase the best ideas for new and existing health smartphone apps, Health Secretary Andrew Lansley said: "So many people use apps every day to keep up with their friends, with the news, find out when the next bus will turn up or which train to catch. I want to make using apps to track blood pressure, to find the nearest source of support when you need it and to get practical help in staying healthy the norm." Perhaps he could benefit from an app to pinpoint and avoid the baying mobs opposed to his NHS reforms.

➔ EYE ROBOT Just when you learn to savour the few precious places free from the daily bombardment of emails (shower, swimming pool, MRI scanner), scientists come along with a new technology to shatter those rare quiet moments. A new generation of bionic contact lenses has been developed that will allow users to read emails via projected images floating before their eyes. Like a scene straight out of *Terminator*, the flexible lens and its complex microcircuitry can beam computer-generated images straight out of your eyeballs. A crude prototype has been tested on rabbits at the University of Washington, according to the *Journal of Micromechanics and Microengineering*, and is said to be safe and feasible but currently only works within centimetres of a wireless battery. Other uses include lenses that can monitor the wearer's health through sensors in their body.

➔ SOUND OF SILENCE If the increasing demands of practice management all get a bit much for you, then there may be just the place for you in a remote part of Minneapolis, USA. The 'anechoic chamber' at Orfield Laboratories, Minnesota, with its 3-foot thick walls, holds the Guinness World Record for the quietest place on earth. But before you rush to book your flights, staying there for too long tends to cause hallucinations. The longest anyone has managed to stay in the chamber is 45 minutes as the total silence amplifies your body's own noises which quickly become disorientating. Source: *Daily Mail*

➔ DIGESTIVE DRAMA Next time you reach for that Hob Nob in the practice biscuit tin, spare a thought for staff at the Department of Health. The *Independent* reports that an "urgent review" has been ordered after it was revealed the DoH had spent £109,017 in three months buying "tea and biscuits" for meetings with staff and visitors. Responding to the mild outrage, a DoH spokesman said the bill was actually a "marked improvement" compared to the first three months of last year when officials notched up £137,000 on light refreshments, and in 2010 when they spent £194,000. One suspects more biscuit down-sizing to come.

➔ CROSSING GENDERS Shock new figures reveal that, between 2009 and 2010, over 17,000 men attended NHS obstetric services, more than 8,000 to gynaecology and nearly 20,000 to midwifery. What's more, during that time more than 3,000 people aged 0-19 attended geriatric services while 20,000 people aged over 30 attended outpatient paediatric services. The phenomenon isn't a new innovation designed to increase social inclusion, but a symptom of erroneous capturing and coding of patient episodes. Authors from Imperial College London NHS Healthcare Trust have highlighted the issue in a letter published on bmj.com. They are calling on clinicians to take extra care when recording this data as it will eventually inform the decision-making regarding how NHS services are commissioned.

➔ KEEP CALM AND CARRY ON Arguing at work is more damaging health-wise than taking part in competitive sports, new research suggests. Workplace bust-ups can result in raised pro-inflammatory cytokines which might trigger or exacerbate disorders such as hypertension, diabetes and even some types of cancer. Food for thought next time you're tempted to shout at one of your practice employees. It'd be far safer to try your hand at a spot of Olympic wrestling… Source: *Proceedings of the National Academy of Sciences 2012*

➔ NO PREVIOUS HISTORY OF SUICIDES In a random surf of medical-related guff, Diary came across a collection of notes allegedly entered on hospital medical charts. Here are but a few:

"The patient is tearful and crying constantly. She also appears to be depressed."

"Rectal examination revealed a normal size thyroid."

"She is numb from her toes down."

"Occasional, constant infrequent headaches."

"The lab test indicated abnormal lover function."

"Skin: somewhat pale, but present."

"The patient has been depressed since she began seeing me in 1993."

"When she fainted her eyes rolled around the room."

"The patient was in his usual state of good health until his airplane ran out of fuel and crashed."

"The patient had no previous history of suicides."

Top ten tips on avoiding trouble

for dental professionals

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Session dates and venues

- Thursday 7 June 2012
  Liverpool Crowne Plaza, Liverpool
- Tuesday 12 June 2012
  Drumossie Hotel, Inverness
- Wednesday 13 June 2012
  The Marcliffe Hotel, Aberdeen
- Tuesday 19 June 2012
  MDDUS Offices, Glasgow
- Wednesday 20 June 2012
  RCP of Edinburgh, Edinburgh
- Thursday 21 June 2012
  Wright Cottrell offices, Dundee

Contact **Karen Walsh** at **kwalsh@mddus.com** or call **0845 270 2034** for further details and an application form

How to avoid complaints, claims and the GDC

Presented by Aubrey Craig, dento-legal adviser, MDDUS

Being on the receiving end of a claim, complaint or referral to the GDC is an expensive, time-consuming and stressful experience. Every year we assist members who find themselves in these situations and this session will draw upon our considerable experience to provide you with practical advice on how to avoid professional difficulties.

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A light buffet will be available from 6pm and the programme will commence at 6.30pm

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