

DRAGON AT THE GATE

Can the myth of the "surly" and unhelpful receptionist finally be slayed?

A VISIT FROM THE CQC

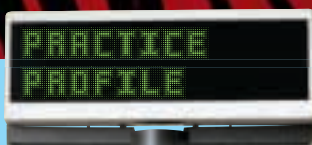
What to expect when you're inspected by the Care Quality Commission

HANDLE WITH CARE

Is your results handling system fail-safe or a disaster waiting to happen?

PATIENT PARTICIPATION GROUPS
NOT JUST ANOTHER TICK-BOX EXERCISE

PATIENT POWER!



BRANCH GP SURGERY AT HEATON PARK SAINSBURY'S





IN the increasingly complex world of general practice it is vital to keep reviewing the bread and butter of our core services. The handling of mail and results continues to be an area of significant risk and, when reviewing the handling of results, including the whole team in this is vital. Potentially everyone working in the practice may influence this system, and there is opportunity for things to go wrong. Frequent review of your system and maintaining staff awareness is key. Liz Price offers advice in her article on **page 12**.

An example of how results handling failures can have worrying consequences is highlighted in our case study on **page 14** where an abnormal result is missed.

Care Quality Commission inspections can be a source of concern for practices and PMs, and on **page 7** the CQC's James Hedges describes what to expect when your practice is inspected.

Positive patient relations are key to providing good care and a growing number of practices are setting up patient participation groups (PPGs) to gather feedback and suggestions. PPGs need not be just another box-ticking exercise and on **page 8** Joanne Curran looks at what is involved in setting up a successful group.

Is a supermarket the right place to establish a branch GP surgery? The King's Fund think tank recently endorsed the idea and more in-store surgeries are sprouting up around the UK. In our profile on **page 10** Jim Killgore visits a practice with a consulting room in a Sainsbury's superstore at Heaton Park near Manchester.

They are often the first point of contact for patients but receptionists have a reputation for sometimes being unhelpful and "surly". On **page 6** Jim Killgore looks at new research which debunks this myth. Strong personalities can upset any practice team and on **page 5** employment law adviser Liz Symon offers some useful advice for managers on dealing with personality clashes among staff.

Meanwhile, our Call log on **page 4** covers covert recording, disclosure of records, dental treatment planning and the security of voicemail messages.

✦ **Aileen Wilson**
Editor



Vaccinations pose workload challenges

GENERAL practice surgeries in the UK face increased workload challenges with new government initiatives on vaccinations kicking in over the next year.

In April the Department of Health in England announced a national catch-up programme to increase MMR vaccination with cases of measles hitting a record high. Public Health England (PHE) and NHS England will be working with GPs and local authorities in targeting a million children for vaccination by September.

PHE estimated there are a "third of a million" unvaccinated 10- to 16-year-olds and the programme will focus on rapidly identifying these individuals on GP registers and promoting immediate vaccination in time for the next school year.

In Scotland, Chief Medical Officer Dr Harry Burns announced in April that NHS Boards will be writing to parents of all unvaccinated or partially vaccinated children aged 10-17 with an invitation to attend for vaccination.

Said Dr Burns: "While measles will continue to circulate throughout the UK, risks in Scotland are much lower due to our higher uptake rates and the work already undertaken over the last 18 months."

The Department of Health in England has also announced a series of changes to the current vaccination schedule to include three new programmes to protect against flu, shingles and rotavirus.

The rotavirus vaccination programme will start on 1 July 2013 when children under four months will be routinely vaccinated against this highly infectious illness. In addition, children aged two years (around 650,000 in total) will be offered a nasal flu vaccine from September as part of a number of pilot programmes to vaccinate primary and pre-school aged children against seasonal flu.



EDITOR:
Aileen Wilson FIHM

ASSOCIATE EDITORS:
Jim Killgore
Joanne Curran

DESIGN:
CMYK Design
www.cmyk-design.co.uk



When you have finished with this magazine please recycle it.

PRINT:
Creative Print London
www.creativeprintgroup.co.uk

CORRESPONDENCE:
PM Editor
MDDUS
Mackintosh House
120 Blythwood Street
Glasgow G2 4EA

t: 0845 270 2034
e: PM@mddus.com
w: www.mddus.com

Practice Manager is published by The Medical and Dental Defence Union of Scotland, Registered in Scotland No 5093 at Mackintosh House, 120 Blythwood Street, Glasgow G2 4EA. The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Memorandum and Articles of Association.

Ombudsman investigations to rise

COMPLAINTS against medical and dental practices in England are more likely to be investigated by the Parliamentary and Health Service Ombudsman under new procedures enacted in April.

The plans were outlined in a recent statement from the Ombudsman service which said: "The starting point will be that once a complaint meets some basic tests, it will usually be investigated. This means the Ombudsman service will be investigating and sharing the learning from thousands more complaints each year."

The Ombudsman has also pledged to share more information on complaints with government organisations and the NHS in order to identify service failures and deliver service improvement, especially in light of the recent findings by the Mid Staffordshire Public Inquiry.

Julie Mellor, the Parliamentary and Health Service Ombudsman said: "We want complaints to make a difference and help improve public services for

everyone. There will be more opportunities for service providers to learn from complaints which can be used to improve public services. We still want complaints to be resolved locally wherever possible. By sharing more of the learning from complaints that do come to us, we will help organisations get better at resolving the complaints themselves."



Patient guide to doctors' key duties

A GUIDE for patients on what they should expect from their doctor has been published by the General Medical Council.

What to expect from your doctor: a guide for patients explains that doctors must act quickly if they think a patient's "safety, dignity or comfort is being compromised" and advises patients to inform a doctor, nurse or other health professional if they become aware of any safety risks. It also advises patients to ask for clarification if they are struggling to understand what the doctor is telling them, including technical words or jargon.

The guide is based on the GMC's core guidance *Good Medical Practice* and explains how patients can "help create a partnership with your doctor." It covers key topics such as patient safety, dignity and respect in the patient-doctor relationship and the standard of conduct, knowledge and skills doctors should achieve.

The guide is available on the GMC website (www.gmc-uk.org).



GDC gives green light to direct access

DENTAL hygienists and therapists will now be able to offer treatment without a prescription or patients having to see a dentist first under new GDC rules.

The decision to remove the barrier to direct access for some dental care professionals was made following a GDC consultation and the changes came into effect on 1 May 2013.

GDC guidance on the changes states that dental hygienists and therapists must be confident that they have the skills and competences required to treat patients direct and suggests that a "period of practice working to a dentist's prescription is a good way for registrants to assess this".

Also under the new rules, dental nurses will be allowed to participate in preventative programmes. Dental professionals and practice managers are encouraged to get in touch with the GDC if they have any questions.

Employment Law



MDDUS publishes a twice-yearly online Employment Law Update that brings you up-to-date news and features covering the latest employment law hot topics.

Subscribe now by emailing PM@mddus.com

Government challenges change on criminal records checks



SOME prospective employees in England and Wales may not have to disclose their criminal records following a landmark court ruling.

The Court of Appeal decided that a require-

ment to disclose criminal convictions when applying for certain jobs is a breach of a person's human rights. The scheme in Scotland, known as Protecting Vulnerable Groups (PVG), is not under review.

The government, however, is set to challenge the ruling. At the heart of the Court of Appeal ruling is the issue of declaring 'spent' criminal convictions - crimes, often minor, which were committed a long time ago.

The disclosure of old convictions and cautions was designed to protect children and vulnerable adults. Those applying to work with those groups must be subject to an enhanced check under which spent convictions are disclosed.

The government is taking its case to the Supreme Court. But if the Supreme Court backs the Court of Appeal's decision then the current criminal records check system will have to be reformed to introduce a 'proportionate system'.

In the meantime, while it is under review, it is business as usual for those undertaking such checks.

Did you know?

THE Employment Law team at MDDUS have a range of useful documentation available, including a template contract of employment, template handbook including social media policy and fact sheets addressing such topics as disciplinary, short-term absence, changing contracts and redundancy.

If you are interested in receiving any of these documents, please email employmentlaw@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.

FULL DISCLOSURE?

Q A practice has received a request from the UK Border Agency for the address and phone number of a patient who they intend to arrest. The practice manager is unsure about whether or not to release this information and calls MDDUS for advice.

A Under certain circumstances, the disclosure of patient information is required by law and the patient's consent is not necessary. This applies here. As with any disclosure made without consent, the minimum necessary information should be provided. In this instance, the practice is only required to provide the address of the patient and not the phone number. There is no need to inform the patient concerned as this would defeat the purpose of the disclosure. Make sure the reason for any decision made is fully documented in the patient record. In general, disclosure without consent may be justified in certain circumstances where the public interest in disclosing the information outweighs the patient's interests in keeping it confidential. Normally, the patient should be made aware of any disclosure unless it is not practicable to do so (i.e. they can't be contacted quickly enough) or if informing them would defeat the purpose of the disclosure (as in this case).

SECRET RECORDING

Q A patient has secretly recorded a conversation with her dentist, provided him with a transcript and demanded her dental record be changed to reflect the verbatim account. The practice manager is not happy about the recording and is unsure about changing the record.

A Patients are within their rights to covertly record consultations with their

dentist (or doctor). It doesn't breach the Data Protection Act because it is their own personal data being processed and it doesn't breach the dentist's rights because the discussion is about the patient's own care. The dentist could only object if a discussion of his private life had been recorded. When changing the record, the old notes should not be obliterated. Simply score through with a single line and add a note confirming that a recording was taken and the new note reflects what was said.

EMERGENCY HELP

Q A practice manager calls MDDUS and explains an elderly woman recently collapsed outside the practice. A passer-by came in and asked for help but the receptionist advised him that the doctors could not assist as the woman was not a patient. He told the passer-by to call 999. The manager has only just learned of this incident and is concerned it may lead to a complaint.

A Doctors are required by the General Medical Council to provide assistance in emergencies – wherever they arise and regardless of whether the person is a patient – provided they take account of their own safety, competence and the availability of other options for care. Practice staff should be made aware of this and a procedure for responding to emergencies should be drawn up. The adviser tells the manager to call back for further guidance if a complaint is made.

TREATMENT PLANNING

Q A dental practice manager has received a complaint from a patient over a disputed bill for orthodontic treatment that has been carried out. The dentist says a price of £3,000 was agreed but the patient says she believes the figure was £2,000. There is no record in the patient's notes about the treatment cost. The manager asks MDDUS which party is in the right.

A The General Dental Council requires dentists to provide clear, written guidance to patients regarding the

recommended treatment, the basis on which it is being provided and the likely costs. In the absence of such a treatment plan, the dentist might struggle to insist on the £3,000 bill being paid. The manager is advised to encourage the dentist to reach agreement with the patient on the matter.

TOO MUCH INFORMATION


Q A practice has called a number of patients to inform them of test results, but one is not answering. The receptionist is considering leaving a voicemail message but the manager is unsure if this is appropriate.

A Practices who wish to contact patients by email, text or phone should always have prior consent before doing so to ensure messages can be sent in a way that won't compromise confidentiality. Voicemail messages pose a particular risk as these could easily be intercepted by other members of the household. Without the patient's express consent, it may be advisable to find an alternative way of communicating the test results.

MISSING PRESCRIPTION FORM

Q A new batch of prescription forms have been delivered to a practice and the manager is concerned about securing them following a theft last year. She asks MDDUS for advice.

A When a new delivery arrives, medical and dental practice managers should ensure a process is in place to record how many pads are in stock and the relevant serial numbers. In using the forms, the prescriber should be recorded along with the date of issue, the number of prescriptions issued and to whom. This means missing forms can easily be accounted for, at which point the matter should be reported to the relevant person at the health board/CCG. Retain serial number records for at least three years along with an audit trail for prescription forms, including forms completed and subsequently not used together with forms not issued due to an error filling them out. Staff should also be encouraged to report any incidents of theft.



Don't treat employees like children – even if they may be acting like them!

Dealing with personality clashes

WOULDn'T it be nice if we lived in an ideal world where all staff got on well together and there were no issues between individuals? Unfortunately human behaviour is far too fickle for ideal worlds. In reality, personality clashes between staff can cause major upset and disruption in any practice environment.

Reasons for flare-ups and fall-outs amongst employees may often seem petty but their impact can have major consequences in the workplace. Personality clashes can distract others from their work, cause friction between team members (who can be made to feel they need to take sides), dampen morale, affect professionalism and customer service standards and threaten productivity.

It has been reported that supervisory staff spend an average of 18 per cent of their time dealing with personality clash issues between employees. We cannot expect all employees to be the best of friends but we can at least expect professional behaviour whilst at work. Employees should act with respect to both colleagues and patients at all times.

The 'seven don'ts' for dealing with such issues are:

1. Don't avoid the situation – any personality clash issue needs to be tackled, as such issues will not get better by themselves.
2. Don't delay and act promptly – the earlier a situation is tackled the less likely to cause major impact in the practice.
3. Don't take sides.
4. Don't spend time trying to allocate blame – focus on moving the situation forward.
5. Don't force any party to apologise – this

may worsen the situation and cause more friction between the two parties.

6. Don't treat the employees like children – although they may be acting like them!
7. Don't deal with the matter in public – always arrange private meetings to discuss the issues.

In some situations it may be enough to speak to both parties involved on an informal basis and resolve the issues. If this approach does not work and there continues to be problems, it may be that formal disciplinary procedures need to be invoked. As with any potential disciplinary hearing, it is essential that you carry out a full investigation so that you have your facts in place before deciding whether any further action needs to be taken against the employee or employees, and if it merits disciplinary action being invoked.

Remember, there are always two sides to a story. You need to get the facts and details from all the employees involved as individual accounts of events are likely to vary. Any other witnesses should also be spoken to, although it may not be appropriate to ask patients for their account of the situation. If, after a thorough investigation, you feel that formal disciplinary action should be taken, the employee should be invited in writing to attend a disciplinary hearing with sufficient notice and informed of their right to be accompanied.

The employee will need to be advised of what standards of performance will be expected in the future and it may be beneficial to get all the parties into a meeting to discuss the dispute and how things can be improved in future to avoid further conflicts.

Strategies to consider helping move a situation forward include:

- Urge the parties to think about their actions and behaviours and how these may be perceived by the other party and their colleagues.
- Consider providing conflict resolution training to all employees.
- Ask the parties involved to write out the issues they have and their side of the dispute as it may help them see that they are not so far apart in reality.
- Refer the parties for mediation, counselling or arbitration.
- Appeal to the employee's sense of professionalism and team working.

It is important that when dealing with personality clashes you focus on the behaviours of the employees and not personalities. Remember that dealing with such conflicts can be hard but to allow them to fester is even worse.

Liz Symon is an employment law adviser at MDDUS

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

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

Dragon at the gate

Can the 'dragon behind the desk myth' be slayed?

LAST August the *Daily Mail* ran an article with the headline 'Grumpy receptionists and problems making an appointment fuel surge in patients' complaints about GPs'. It reported on statistics released by the NHS Information Centre that complaints against GP surgeries had increased by almost 10 per cent in a year – "not least because of a surge in grievances over 'surly' receptionists".

Just how significant a "surge" was not addressed but then facts rarely stand in the way of a good headline.

Medical and dental receptionists make easy targets. They do not have the professional mantle of doctors or dentists or practice nurses; there is no Royal College of Receptionists. Yet their role in health-care provision is both important and at times fraught with complexity according to research published recently in the *British Journal of General Practice*.

In an article entitled 'Slaying the dragon myth: an ethnographic study of receptionists in UK general practice' researchers from the University of Manchester and the University of Liverpool reported on the results of a qualitative study that explored the wider practice context in which GP receptionists work.

"The historical perception of the receptionist as a 'dragon behind the desk' has been getting in the way of understanding the role of receptionists and thus improving patient care," write the authors, among them lead researcher Jonathan Hammond of the Institute of Population Health at Manchester. He adds that their research addressed the perception "that receptionists are imposing rules on their own whim and with disregard to the amount of power they have over patients."

"What we were really trying to unpack was this idea of the receptionist as lacking empathy or being undertrained or just being difficult for the sake of it. From our observations this represented only a very surface level of engagement. To get underneath that you have to look at the systems and policies and dynamics of a practice in order to understand why receptionists behave the way they do in particular situations."

In the study the researchers observed 45 GP receptionists at seven different practices in over 200 hours of interaction with patients and practice staff. The researchers spent

most of this time in the reception desk area making handwritten notes.

"We tried not to get in the way first and foremost," says Hammond. "But we also took the opportunity to talk to receptionists as they were doing their work; asking when we were unsure about things."

Their observations confirmed the important role receptionists play in general practice, acting as a primary contact point for patients and "shaping patient access to health professionals" in the allocation of appointments and other tasks. This frequently involves making decisions about patient need and determining the level of urgency in order to prioritise care – a role in which they often have "minimal time, information, or training".

One area involving keen negotiation skills and a certain forthrightness was in dealing with patients who were regarded as trying to 'play' the system. A receptionist interviewed in the study spoke of her frustration in dealing with chronic DNAs.

"They know how the system works so they miss one [appointment] and then phone in the morning and book one for that day/next day. The ones that don't know how the system works are the ones that need to."

This was often coupled with a desire to protect less demanding but sometimes more vulnerable patients – to act as "advocates". Some receptionists would go to great lengths to help certain patients navigate the system, ensuring they obtained urgent appointments even if they had not been requested directly.

This concern often extended to a sense of clinical responsibility. One receptionist commented: "At the end of the day, I don't want someone leaving the practice without diabetic medication and have that be on my head. Or if it's an asthma attack or something ...".

One common response among practices to any perceived problems with reception

staff is to provide additional training. But the authors of the study suggest this may only be preparing receptionists "for what is supposed to happen, rather than what actually happens in an unpredictable and potentially chaotic series of encounters".

Hammond explains: "Training is important but it's not the be all and end all. You should also look at the practice more broadly and reflect on what opportunities there might be to make everybody's work flow a bit more smoothly."

He suggests that practices should foster an environment in which receptionists feel able to provide input into policies and procedures that affect them and to contribute to improved practice systems. The study found that the most harmonious surgeries were those with plenty of interaction between receptionists and GPs or other staff with a free exchange of opinion.

"Time and again we saw practice policies that were very straightforward on paper but never worked in specific situations," says Hammond. "They didn't make sense a lot of the time and receptionists were well aware of this but there wasn't an avenue for feeding that back and making changes."

He adds: "I think practice managers are in a very good position to link the experiences of reception staff to broader practice systems."

And this may help to slay the dragon myth once and for all.

Jim Killgore is an associate editor of MDDUS Practice Manager

ON 1 April 2013, all primary medical service providers in England registered for the first time with the Care Quality Commission (CQC). The Commission's focus is to look at the impact of care on patients and to ensure that all patients receive safe and good quality care, wherever it is provided.

Inspections by the CQC focus on the experiences people have when they receive care and the impact that care has on their health and wellbeing. Inspectors check their findings in a number of ways - including speaking with staff - before reaching their judgements. Our judgements against the regulations are informed by people's experience. This is why inspectors spend a lot of their time on an inspection talking to patients.

BEFORE THE INSPECTION

CQC receives information from a number of different sources, including members of the public, commissioners, professional and other regulators, as well as notifications, complaints and safeguarding

How long an inspection takes will depend on the size of your practice or the range of the services you provide. In most cases it is unlikely to be more than one working day.

DURING THE INSPECTION

During the inspection, inspectors will talk to patients and to staff, and they will cross-check what they see and hear against other evidence such as records. They are looking to see evidence that the regulations are not being met; however, where they see or find good, excellent or innovative practice, this will also be included in the report.

Inspectors will speak with managers and members of staff at all levels. They won't expect all staff to have the same knowledge but they will expect them to understand their role in providing good outcomes for patients and also what to do if they have concerns. Inspectors may also speak with members of your patient participation group (see page 8 of this issue).

One of the tools that an inspector will use is 'pathway tracking'. This

What to expect when you're inspected

Inspections by the Care Quality Commission – either announced or unannounced – are now a fact of life for general practices in England. Here **James Hedges** of the CQC provides some details on what to expect

alerts, contract monitoring reports and, where applicable, the last inspection report. CQC inspectors and analysts continually monitor and assess this information.

If a decision has been made that an inspection is warranted then an inspector will call you at least 48 hours before a scheduled inspection to let you know they will be visiting. Responsive inspections, where there are concerns about a service or the care of patients, are likely to be unannounced.

As inspections are carried out at short notice, inspectors won't ask you to send any information before an inspection, but they may ask you for some details during or after a visit.

THE INSPECTOR ARRIVES

When an inspector arrives, they will introduce themselves and show their identification. CQC identification badges include a photograph of the inspector on the front and a copy of their warrant on the reverse, signed by the chief executive. If you are unsure about the identity of an inspector please contact the CQC enquiries team on 03000 616161, who can verify details for you before allowing access.

The inspector will want initially to speak to the registered person or the nominated individual. If they are not available, they will ask to speak to a partner and/or a practice manager. They will inform them which of the regulations they will be focusing on during the inspection. They may also request a suitable room or place to use for the duration of the visit which will be used as an interview room to talk to staff and patients.

Inspectors will give you time to organise yourselves after they arrive. However, sometimes they may need to start the inspection before a senior person is contacted, for example if they are carrying out a responsive inspection.



looks at a person's route through your service and tracks their views of that journey. It is an important part of an inspection as it captures information about a sample of people receiving care or treatment from you and their views about it.

Inspectors may ask to look at specific areas of your service (e.g. how you involve people in their care) and may also ask you to show information such as training records. They will not normally spend a great deal of time reading policy or procedure documents, unless they need to look at them to substantiate other evidence. For example, staff may be asked what training they have completed and how they use it in their role. Inspectors may then want to verify this by checking the training records.

There may be times when it is not appropriate or possible for our inspectors to speak to patients or staff. Where this is the case, you may be asked for information about how you gather feedback, such as patient surveys, and inspectors may ask to see this feedback. You might also be asked for your help to arrange to contact patients after inspectors have left.

THE END OF THE INSPECTION

CQC inspectors may ask for additional information to confirm evidence that has been gathered during the inspection. They may be able to tell you what they require at the end of the visit or they may request it later. If they do ask, it must be provided within 48 hours.

Before an inspector leaves they will meet with you to give you feedback and update you about the inspection. This is also an opportunity for you to give us feedback and ask any questions.

James Hedges is a media officer at the CQC



PATIENT POWER

They may form part of CQC compliance, but well-run patient participation groups can be more than just another box-ticking exercise

PATIENT choice has become something of a buzzphrase recently as the NHS undergoes major changes.

"Respecting and involving patients" is one of the requirements of registration with the Care Quality Commission in England and, with that in mind, the BMA's General Practitioners Committee has advised medical practices to have a "patient participation scheme" in place.

Many practices may already feel overwhelmed by paperwork and the thought of setting up a patient participation group (PPG) may seem like just another box-ticking exercise.

But, done well, PPGs can be an excellent way of involving people in local healthcare decision-making and can provide valuable feedback. By choosing the right people they can help practices better respond to patients' wants and needs and improve practice-patient relations.

PPGs can be found across the UK in both medical and dental practices, with more than half of English medical practices operating one. PPGs do operate in Scotland although they are not a contractual or statutory requirement. The Scottish Health Council promotes the benefits of PPGs as a means of public involvement and recently published practical guidance regarding the scheme. A 2010 NHS circular containing recommendations on engaging with patients states that general practices "should be able to demonstrate that patient or other lay involvement is welcomed and enabled in all aspects of the delivery and planning of services."

GETTING STARTED

The National Association for Patient Participation (NAPP) is an umbrella organisation for patient-led groups within UK general practices. They define a PPG as a group of people who "work with their practices to provide practical support, to help patients to take more responsibility for their own health and to provide strategic input and advice. They are based on cooperation between the practice staff and patients. They help to improve communication."

Guidance on setting up a PPG makes clear that a key element of success is that the group is representative of the patient population in terms of age, gender, race, physical abilities and so on. Look for motivated people with useful skill sets who are willing to share decision-making in the running of the practice and not those simply interested in attending for coffee and a chat.

A structure must also be in place for regular engagement and the group should have a strategic and overarching focus. Every PPG is different and can choose which direction it wishes to take, whether to focus purely on strategic input or to include wider issues such as improving communication and promoting good health.

A PPG scheme tends to involve regular face-to-face meetings which should ideally be attended at times by a GP and/or practice manager (particularly for the first few meetings). They can also be virtual, where contact is made with a patient group via email. Whatever the format, make clear from the start that the group is not a forum for pursuing individual personal complaints or single issue

ENTER!

campaigns. Areas of priority should be agreed with short, medium and long-term objectives – a few worthwhile short-term objectives can provide 'quick wins' and help boost confidence. Patient views can be collected through surveys on various topics and the results should be published alongside any achievements and actions taken.

GIVING PURPOSE

PPGs can be used for various purposes: offering suggestions on improving disabled access to the surgery, appointment systems, consultation times, buying new toys for the waiting room or maintaining plants. They can help obtain patient views, for example where two practices are merging, and can also highlight the need for patient support in terms of bereavement counselling, a carers group, hospital visiting or befriending of housebound patients.

Last year Wilsden Medical Practice in Bradford won the NAPP's PPG of the year award. Formed in 2010, the 10-strong group are aged between 40 and 80 and include wheelchair users, minority ethnic groups and parents with young children. They meet monthly and have provided feedback on issues such as telephone appointments and extended opening hours as well as offering an insight into the general 'patient experience' at both Wilsden and the practice's other site, Cullingworth Medical Practice.

Practice manager Susan Crowther says the PPG has made it easier for patients to share comments and concerns and has even lightened the practice workload.

She says: "The group attended an open flu clinic recently and helped recruit 50 patients who were willing to be seen by our trainee doctors. On another occasion, we used the group to carry out a survey on our telephone service which helped us discover if there were key times where staffing levels affected service delivery.

"It's often the case that the group will do work that would normally be done by me or the other practice staff, so it's saving us time."

Susan says the key to success is communication. She and a GP partner meet with the PPG to set objectives for the following 12 months. The practice is now setting up a virtual PPG where more than 100 patients have agreed to offer comments and suggestions by email.

Susan adds: "The virtual PPG is a great way for the practice to communicate with patients, especially those who are not often in the practice. With 10,000 patients you need different ways of promoting what you do, other than just posters and flyers."

PATIENT VOICE

Amblecote Dental Care in the West Midlands set up its group in 2011 which meets every two to three months. PPG liaison and receptionist Jayne Vallance says the

group plays an important role. "We keep them informed with changes like staffing and new equipment, and they give us valuable feedback," she says. "Recently, there were concerns one of the patient letters was unclear so we asked the PPG to review it and then re-worded it based on their suggestions."

Following another of the group's suggestions, an Amblecote dentist gave a talk about oral health at local schools. The PPG has also helped the practice carry out customer satisfaction surveys.

Jayne adds: "We like to think they are the patient voice and they are asking questions for the wider benefit, not just for themselves."

Nairn Healthcare Group in the Scottish Highlands set up Nairn Patients Group in April 2012 following a practice merger, with updates publicised on their new web (www.nairnpatientsgroup.org.uk) and Facebook pages (www.facebook.com/NairnPatientsGroup).

Practice manager Barbara Graham says the process has been a learning curve. "It has been very stressful setting up the PPG and with hindsight I would've done some things differently," she says. "I firmly believe it's an invaluable resource but I failed to make clear from the start exactly what the practice expected from the group and also that it's not a forum for personal grievances.

"Things are improving and now the PPG operates the Facebook and web pages which are a phenomenally useful way to communicate with patients, particularly when, for example, our phone lines went down recently. There are so many great resources out there, like the NAPP and RCGP websites, and it's vital to seek advice before starting a PPG."

KEY POINTS

Remember: keep communication lines between the practice and PPG open, set ground rules and stick to them, ensure the group maintains focus and direction (plan ahead if possible), and source a varied group of active and interested volunteers. Get support from the doctors/dentists and practice staff and consider enlisting help from key members of the community (local councillors, school headteachers) who can help raise the group's profile and widen its focus.

LINKS

- National Association for Patient Participation www.napp.org.uk
- Scottish Health Council www.scottishhealthcouncil.org

Joanne Curran is associate editor of publications at MDDUS



SUPER [STORE] SURGERY

Jim Killgore visits Sainsbury's first ever in-store GP surgery

Dr Mohammed Jiva at Heaton Park (Photograph: Getty Images)

IT all started with parking – or more a lack of parking. Peterloo Medical Centre is located on a busy main road in Midsley, North Manchester. Back in 2008 a senior partner in the practice, Dr Mohammed Jiva, was hearing an increasing number of patient complaints about the lack of parking in the area, especially at busy times of the day.

It seemed apparent to Dr Jiva that the practice would need to find an additional location but he knew funding from a cash-strapped NHS was not going to be easily had. So he sat in his office and pondered the question in general: how can we make life more convenient for patients and the public at a reasonable cost?

"The common sense approach to me was superstores," he says. "They have long opening hours. It's a place where people go out anyway – they have to shop and the vast majority shop in a superstore."

Dr Jiva decided to run with the idea. He phoned three large supermarket chains. Only one took him seriously and that was Sainsbury's.

"This is the bit that I'm still gobsmacked about," he says. "Essentially I'm this GP ringing a big chain store at their home office in London. And I thought, I'll possibly get invited down to present my case. They'll then discuss it and give me feedback in a month or two months. It'll be a waiting game."

Dr Jiva got through to the professional services manager at Sainsbury's, David Gilder. "This was Monday and he said, okay, I'll be up there on Wednesday. I did a short PowerPoint presentation – about six or seven slides – to show what the model would be. How we could work with the PCT providing NHS services within the store. He liked it. I think within a two or three week turnaround period the Sainsbury's Board had approved the model."

EVERYTHING COVERED

I speak to Dr Jiva in the small, single consulting room of his branch surgery in the pharmacy section of a vast Sainsbury's superstore at Heaton Park in Manchester. Five years on now Sainsbury's has 35 branch GP surgeries across the UK operating either inside a superstore or on the premises. The company recently announced its intention to open more in-store surgeries in the coming year.

The announcement follows on from a report published last year by The Kings Fund which asserted that "the current cottage industry model of general practice is not fit for purpose". It called for radical changes in the delivery of healthcare and among a number of recommendations suggested that primary care services could be offered in more convenient settings such as supermarkets.

The deal Sainsbury's is offering GPs is hard to fault from a business point of view. Dr Jiva and his partners are allowed the use of the in-store consulting room rent-free. They also pay no business rates and nothing for clinical waste or water and other amenities.

"Everything is covered – so really what is there to lose?" says Dr Jiva.

In addition the pharmacy staff at Sainsbury's act as receptionists in the three clinical sessions conducted at Heaton Park – two on weekday evenings and one on a Friday morning. The five GPs at Peterloo Medical Centre work at Heaton Park on a rota – and sometimes combine this with doing their own shopping.

"It virtually runs itself," says Kath Oldham, practice manager at Peterloo. "Most patients are happy to go there because the parking is extremely good. It's also quite safe for out-of-hours sessions. We can secure the building here at half-past six when we close and don't need extra staff working late. We use the Sainsbury's staff there. It's a great benefit."

In addition to the parking there are other benefits to patients. The in-store pharmacy means that patients can have prescriptions filled immediately. This is especially helpful after hours as the pharmacy is open until 11 pm on weeknights.

And what do Sainsbury's get from the arrangement? "There is the extra footfall and increased prescription sales," says Dr Jiva, "but for the kind of retail site we're talking about it's a drop in the ocean. From my experience over the last four years, they've valued the relationship a lot higher than any monetary gain."

David Gilder of Sainsbury's agrees. "We want our stores to play a

positive role in the local community and feedback from our customers told us that this is a service they would really like. Patients can access both medical and pharmaceutical services under one roof, something that is really convenient for them."

SUPERMARKET OFFERS

The notion of in-store GP surgeries is, of course, not without critics. In 2010 the chair of the RCGP Dr Clare Gerada was quoted as saying: "Supermarkets should stick to selling fruit and vegetables. General practitioners would be sanctioned for selling tobacco products, alcohol and high calorie foods or advertising and selling products of limited medical value within their surgeries. Yet, supermarkets can do all of these alongside providing pharmacy and now, general practice care."

"Access to services is of course important and it is right that GPs think imaginatively about the settings they work in so they are able to serve the public. However, we would urge any GPs tempted by supermarket offers of 'no rent' and 'no overheads' to take a step back and consider how they are able to provide excellent generalist care in such environments."

Dr Jiva finds that the notion of in-store GP surgeries often gets wrapped up with the perceived commodification of healthcare and creeping privatisation in the NHS in England. He has himself been subject to some criticism.

"I've had comments from GPs about working with the private sector. Questions like – are you defecting to the other side? This is nothing about defecting. This is about collaborative working."

Operating a GP surgery in a retail environment does come with

“PATIENTS CAN ACCESS BOTH MEDICAL AND PHARMACEUTICAL SERVICES UNDER ONE ROOF. SOMETHING THAT IS REALLY CONVENIENT FOR THEM.”

some practical difficulties. In 2011 NHS North Lincolnshire rejected an application by local GPs to practise in an in-store surgery in Scunthorpe. An audit of the facilities cited concerns about patient confidentiality and the possibility that a consultation could be overheard by customers in the pharmacy, as well as worries about infection/decontamination and the fact that there were no toilets separate from those used by shoppers.

EXPANSION PLANS

Dr Jiva admits that his branch surgery at Heaton Park is very much a limited adjunct to his main surgery at Peterloo and that there are certain things he would not do in the in-store consulting room, such as any invasive procedures or "cutting" and certain intimate examinations such as taking vaginal or cervical swabs. It would also not be an appropriate setting for breaking bad news or other more serious discussions.

More often than not patients book into the Heaton Park surgery for things like repeat prescriptions or acute health problems like coughs, colds or rashes or to discuss test results. The consultation room has a computer with a secure link to the server at the main practice that allows the GPs to call up patient records.

"We log on here exactly the same way as we do at the main surgery," says Dr Jiva. "So we are not walking away with any information."

The practice is currently developing plans to extend the services at the branch surgery including an expanded rota to accommodate other days or evenings. Dr Jiva has also considered starting a travel clinic there. Even more ambitious are his plans to link Heaton Park to the main surgery at Peterloo using secure teleconferencing technology.

He believes that to keep up with the fast pace of change in society and increasing patient expectations general practice needs vision and a willingness to innovate.

"It doesn't matter who you are or where you are," says Dr Jiva. "If you think there is mileage in a vision – pick up the phone and ask the question. What's the worst that can happen?"

Profile by Jim Killgore, associate editor on Practice Manager

H
A
N
D
L
E

with

C
A
R
E

Is your practice system for results handling fail-safe?

Liz Price highlights three common areas of risk

As a practice manager it is likely that you will be responsible for overseeing the effectiveness and safety of clinical systems. In the absence of standardised results management systems within primary care, practices often develop their own processes for managing tests and results. This has commonly resulted in systems that lack clarity on clinical and non-clinical boundaries and responsibilities, and can create conditions within which a number of errors may occur.

Here I highlight three of the most common risks associated with results handling systems. Mismanagement of results can have serious implications on patient safety and lead to adverse events, complaints and claims, but there are strategies to reduce risk.

RISK 1: MULTIPLE OR MISSING RESULTS

Consider the case of a patient who attends a practice with symptoms which a GP decides warrant further investigation. The patient is referred to a treatment room nurse for blood tests to be undertaken. Once the bloods are taken, the patient is asked to contact the practice later that week to receive his results.

The patient phones the practice as requested and a receptionist checks that the results are back and tells the patient that the GP has marked his results as satisfactory. The patient ends the call feeling reassured that there doesn't seem to be anything wrong and that his symptoms will eventually resolve.

However, the symptoms worsen and the patient returns in four month's time. When the GP checks the previous consultations, she realises that one of the requested results is not available within the record and sends the patient for re-testing. It is unclear why the result was not returned to the practice; however this failure could result in a delayed diagnosis for the patient which could result in a poorer prognosis and additional unnecessary suffering.

This scenario is not unusual. Other common errors relating to multiple results (see also page 14 of this issue) include clinicians filing the result without required action, or results for the same patient being seen by different clinicians leading to fragmented views of the patient's overall condition.

To minimise risk consider:

- Undertaking regular audits to assess the number of tests which are not returned – this can vary significantly by practice. This will allow you to make a judgement about the frequency of the problem and allocate resources to mitigate the risk.
- Implementing a system where all specimens taken are matched with the corresponding result received at the practice. These matching systems can allow receptionists to see clearly when there are any outstanding results – information which is useful to pass on to the patient and for prompting investigation into the reason for the delay or non-return of the result.
- Building continuity within clinical systems to reduce risk – and also increase efficiency. For example, when the clinician who requests the test also reviews the results, this can lead to better situational awareness and prevention of harm.

RISK 2: ACTIONING OF SIGNIFICANT RESULTS

The majority of results in general practice are work-flowed and viewed electronically. When a clinician is concerned about a result, they may direct a non-clinical member of staff to take action. Required actions can include contacting the patient to make an urgent or non-urgent follow-up appointment, asking the patient to collect a prescription for treatment, or informing a patient of the results and advising that they be rechecked after a period of time. There are multiple opportunities for error here.

Has the level of urgency been effectively communicated between clinician and non-clinical staff and is the message to be passed to the patient clearly understood? If not, this could result in the patient receiving inaccurate information or a receptionist being placed in the difficult position of feeling pressurised to interpret a result.

Does the patient attend for a follow-up appointment? If not, are DNA patients reviewed to check whether the practice has initiated contact? The fact that a patient has not attended for an appointment can be a 'positive' within a busy morning surgery – however if the record is not checked by a clinician, required actions may be missed. What happens to prescriptions connected

to abnormal results which have been left for patient collection? If the patient decides not to attend and collect the prescription, can it be destroyed after a period of time without a cross-check for clinical need?

Such actions could constitute missed 'flags', alerting a clinician to non-compliant behaviours. Although patients have the right to refuse treatment, such decisions should be informed by a full discussion of the associated risks and consequences – and it is unlikely that this will have taken place at the initial consultation when tests were ordered or later when results and necessary actions were passed on by a non-clinical team member.

Another consideration is how the practice deals with hospital requests for follow-up in general practice? Depending on the nature of the patient's condition and the clinical risk, it may be that the practice should diarise these actions for appropriate follow-up.

To minimise risk in the actioning of significant results consider:

- Reviewing the clarity of instructions given by the clinical teams to receptionists or other non-clinical staff – particularly those who are communicating directly with patients about results.
- Encouraging clinicians to take the time to review patients who DNA for consultations.
- Empowering non-clinical team members to check with clinicians when unsure of messages – or passing the patient back to a clinician when the patient requires further advice.
- Encouraging team members to document all contacts and attempts to contact patients, including messages or instructions that have been passed. This ensures that there is an audit trail in place and that information is available to whomever next deals with that patient record.
- Incorporating the responsibility for recalls for repeat testing within existing call/recall roles.
- Returning uncollected prescriptions to the responsible GP for review before they are destroyed.

RISK 3: GIVING OUT RESULTS

Practices will feedback results to patients in a variety of ways. Many will task receptionists to provide results via telephone

whilst some retain that responsibility within the clinical team. A few will still write to all patients with results.

There are benefits and risks associated with all these approaches. For example, a clinician providing results directly to patients over the phone will be able to have a comprehensive view of the results in the context of the consultation. In addition, they will be able to engage in discussion with the patient if they have questions about the results. But using clinical time in this way could reduce the availability of appointments within the practice, resulting in delays and complaints.

When a receptionist has been delegated responsibility to pass on results to patients, an important consideration concerns protected time. Multi-tasking, distractions and interruptions are a direct cause of human error. Does the receptionist know how to deal with questions of a clinical nature? Are they able to review whether any results are outstanding? What identity checks are carried out before giving out the result? Could a spouse or parent access results inappropriately – for example when a minor has been seen by a GP on their own?

To minimise risks consider:

- Whether the individuals tasked with providing results to patients, if non-clinical, are trained and competent to do so – and that they understand the risks.
- Asking clinicians to note any urgent flags about the confidentiality of the result as part of their actioning – e.g. 'result to be given to patient only' where the patient is a minor.

REVIEWING PROCESSES

To support patient safety, practice managers should review each step in their results handling systems and ensure that the practice has a written, shared protocol for managing results. In particular, this should underline the responsibilities of all individuals within the system, and include agreed minimum timescales and mechanisms for viewing and actioning results.

By working together to develop a results management system, clinicians and non-clinical staff can understand the risks within their system and their own important role in mitigating these risks.

Liz Price is the training and consultancy services manager at MDDUS

Good news

bad news

→ Day one

A young mother attends a busy general practice in Sheffield worried about her sexual health after learning that her husband has been unfaithful. One of the GPs – Dr Y – examines the patient in the presence of a chaperone and takes two swabs (HSV and ECS) and a third ECS to test for chlamydia. The patient is asked to phone in for the results.

→ Day six

The patient phones into the surgery for her results and is put through to a practice nurse. The patient is informed that the tests revealed “no abnormalities” and there is “nothing to worry about”. She rings off feeling immensely relieved.

→ Day 118

The patient comes into the surgery complaining of an ingrown toenail. She sees Dr Y who asks how she got on with the antibiotic treatment for her chlamydia. The patient is shocked and upset, claiming that the practice had not informed her of any such diagnosis. Dr Y offers his sincere apologies and starts the patient immediately on oral antibiotics. Two days later an angry letter arrives at the practice from the patient expressing worries over her ongoing health and fertility and also threatening legal action if an adequate explanation is not forthcoming.



THE practice undertakes an investigation to find out how the positive test result was missed and this reveals a flaw in the practice results handling system. It is routine policy at the practice to record test results against the date on which samples are taken and not the date on which results are received. On the day the patient phoned the results from only two of the swabs were available to the nurse so she communicated these results unaware of the pending chlamydia swab.

Two days later a positive result for chlamydia was received by the practice and highlighted to Dr Y. He gave specific instructions for the patient to be contacted with the result and to come into the practice to pick up a prescription for antibiotics. The nurse responsible for contacting the patient looked up her file on the computer system and saw that the patient had already been informed of the test results. The nurse assumed this was for all three swabs.

The uncollected prescription for antibiotics offered another opportunity to catch the error but it is practice policy for all prescriptions not collected after three months to be

routinely destroyed without review.

The practice conducts a significant event analysis (SEA) in which the factors leading to the system failure are examined and recommendations are made to ensure the error is not repeated. Among the weaknesses identified is a lack of specificity in the electronic record system to clearly demonstrate the number of tests performed in a single patient interaction and a clear procedure for individual “patient informed” annotations for each test. It is decided that new guidelines must be drawn up for the IT system to ensure that individual abnormal results are flagged with an alert until reported as “informed test result”.

The SEA also highlights a need for better communication when tests are undertaken so that patients are informed of what tests are being undertaken and how long to wait before requesting results.

The analysis also prompts a re-evaluation of practice policy on uncollected patient prescriptions. It is decided that before destroying any uncollected prescriptions these will be returned to the prescribing GP for evaluation and possible patient follow-up or recall.

The practice contacts MDDUS to liaise over an appropriate written response to the patient’s letter of complaint. In the response the practice manager admits to the failings that lead to the missed test result and offers a sincere apology. She also states that the practice has learned from the incident and that steps have been taken to help prevent such errors in future. The practice also assures the patient that Dr Y is available to discuss any worries she might have over her long-term health and the need for referral to a gynaecologist.

KEY POINTS

- Ensure the practice has a fail-safe system for patient call-backs in abnormal results.
- Consider a policy of reviewing all uncollected prescriptions before destruction.
- Ensure patients are aware of what tests are being undertaken so they can ask for specific results.

Alan Frame is risk adviser with MDDUS Training and Consultancy

Diary



DIARY assumes if you are reading this you must be awake – at least for now. Please stay with us as below you'll find some important news from...

→ **THE SLEEP COUNCIL** Nothing is more embarrassing than nodding off in a practice meeting – especially if you're chairing. Perhaps you are among the 40 per cent of Britons not getting the recommended six to nine hours of sleep per night. In March The Sleep Council released its first ever *Great British Bedtime Report*. Some 5,000 people were surveyed in January 2013 offering an overview of British sleeping habits. The report found that the average Briton goes to bed at 11.15pm and gets just six hours and 35 minutes sleep per night. Almost half of Britons say that stress or worry keeps them awake at night and – not surprisingly these days – high earners (£65 – £75,000) get the best sleep of all. "Sleeping well is as crucial to our health and wellbeing as eating a healthy diet or exercising regularly," says Jessica Alexander of The Sleep Council. "We want to see sleep moved up the political agenda". She has obviously never watched live debate in the House of Lords. Just the concept of a Sleep Council conjures an image of peaceful relaxation. Diary imagines an office of profound quiet. You approach a receptionist dozing at her work station. Gentle snores are heard coming from down the corridor... well, you get the picture.

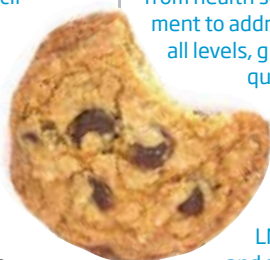
→ **PET PROTECTION...FROM** It's a far more dangerous world out there than you might imagine for GPs dispatched on home visits. Recent figures show that there were almost 60,000 assaults against NHS staff in England in 2011/12 – not by patients but their dogs. New proposals put forward by NHS Protect's Legal Protection Unit would see laws relating to dog attacks in public places extended to cover private premises. This means owners would be held responsible for the behaviour of their pets during home visits by medical staff. Speaking to the BBC,

Liverpool GP and chair of Sefton LMC Dr Andrew Mimmagh was just a bit sceptical: "Fingers crossed it might improve things but at the end of the day it's not going to stop you getting bitten if there's a sick patient who needs attention and they cannot control a dog due to their ill health.... Dogs are quite territorial and as usual it's not the dog barking loudly at you at the door you need to worry about but the ones that are waiting quietly inside for you." Maybe



the NHS could encourage GPs to adopt an approach familiar to the US gun lobby. Bring a bigger dog!

→ **HIDE THE BISCUIT TIN** NHS staff have long been tasked by NICE and various other bodies to address the growing problem of obesity among UK patients. But recent discussion in The House of Lords adds a new dimension to the debate. Former president of the Royal Society of Medicine, Baroness Finlay of Llandaff raised the question: "Are the Government considering including in commissioning from health service employers a requirement to address obesity in their staff at all levels, given that the staff are often quite severely obese and act as a very poor role model for those patients whose obesity should be addressed?" Dr George Rae, chief executive of North Tyneside LMC, did not take kindly to this and subsequent remarks calling them "absolutely insulting" and not to be taken seriously. Source: *Pulse*



→ **FAME MAY BECKON** Role models for patients may be one thing but do you happen to know a GP with a "relaxed style who definitely enjoys having a drink or perhaps the odd cigarette"? Someone with "everyman appeal who does not necessarily believe you need to live like a saint to be happy and healthy". If so they could be destined for TV fame. The producers of Channel Four's *Embarrass-*

ing Bodies are looking for GPs or hospital doctors based in the north of England who could be a "counterpoint to many of the groomed, conventional, super toned medical professionals already on television". Or so says assistant producer of Maverick TV Sue Ng. Sadly the deadline might have already passed but CVs – suitably tailored to impress – may still be welcome

→ **LET THEM EAT NUTS AND BERRIES** Still on the topic of healthy eating, Diary recently paid a visit to the Edinburgh Royal Infirmary and was much impressed by the large pick 'n' mix stand given pride of place in the central lobby newsagent. One can only imagine Professor Terence Stephenson of The Academy of Medical Royal Colleges bursting in like Jesus in the temple, brandishing *Measuring up: the medical profession's prescription for the nation's obesity crisis*. "You are just consuming neat sugar. Your body didn't evolve to handle this kind of thing," he might shout, as quoted recently in *The Guardian*. No doubt on our next visit it will be a selection of dried figs and blanched almonds.

→ **PULL THE PLUG** On paper the Summary Care Record sounds like a no-brainer – a system by which a doctor or other medical staff can access NHS records, anywhere, anytime, no matter how famous the patient (though with an audit trail). To date some 23 million SCRs have been created for patients in England. Impressive numbers, possibly justifying the astronomical investment until you consider a recent statement by Dr Paul Cundy, chair of the GPC's information technology subcommittee. Dr Cundy calculates that given the current low utilisation rate, each viewing to date has effectively cost an estimated £1,200. He commented: "The system is an absolute disgrace and the plug should be pulled out on it as soon as possible". Diary is unqualified to comment.

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

THURSDAY
6th March

PRACTICE MANAGERS' CONFERENCE 2014

FRIDAY
7th March

WATCH AS YOUR

WORST NIGHTMARE

PLAYS OUT IN MARCH 2014

Fairmont St Andrews,
Thursday 6th & Friday 7th March 2014

Imagine your worst day in practice ... staff down, system failures, serious incidents, GPs behaving badly.

Attend the 2014 MDDUS Practice Managers' Conference and learn from the experience of one unlucky practice manager faced with a series of unfortunate events. Delegates will watch the drama unfold together then explore the key issues through attending a series of four risk masterclasses.



www.mddus.com

Day 1 A series of unfortunate events

Four risk masterclasses covering areas including the management of clinical systems, medico-legal risk management of critical incidents and managing difficult situations with staff and doctors.

Day 2 Interactive workshops

Select from a range of interactive workshops and engage in discussion on risk topics relevant to your own practice. Each session explores a current risk area within general practice and will allow delegates to share best practice in order to mitigate these risks.

BOOK NOW

and take advantage of our Early bird rates available until the end of September 2013

Conference fees

Residential single room	Early bird - DPS*	£275
	Early bird - non DPS	£300
	Standard fee - DPS	£300
	Standard fee - non DPS	£325
Residential double room	Early bird - DPS*	£225
	Early bird - non DPS	£255
	Standard fee - DPS	£255
	Standard fee - non DPS	£285
Day delegate (Thursday only)	Early bird - DPS*	£125
	Early bird - non DPS	£145
	Standard fee - DPS	£145
	Standard fee - non DPS	£165

*DPS: Discount Practice Scheme