Practice Manager
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ISSUE 9

STUCK IN THE MIDDLE
Survival tips for PMs thrust in the middle of difficult partnership disputes

OFFICE PARTY PITFALLS
Jingle bells could turn to alarm bells when office festivities get out of hand

EXPANDED CALL LOG
Two pages of short case studies based on calls to MDDUS advisers

FUTURE VISION

WHAT WILL GENERAL PRACTICE LOOK LIKE IN THE YEAR 2022?

PROFILE
BLACKHILLS SPECIALIST DENTAL CLINIC

MDDUS

Practice Manager

COVER INSET: RICHARD LEE

CONFRONTATION is not something practice managers are unused to – be it among staff or with unhappy patients. But dealing with disputes between partners can be especially trying. Whether a minor spat or a major conflict threatening the ongoing survival of a partnership, PMs often find themselves stuck in the middle. On page 12 of this issue Michael Royden offers some survival tips for any manager thrust in the role of "peacekeeper".

Christmas should hopefully be a time free from disputes, when staff enjoy themselves at the office party, but PMs should be aware that employment law still applies during the festivities. MDDUS employment law adviser Janice Sibbald offers advice on page 6.

With so many changes taking place in UK healthcare – what lies ahead for managers? On page 8, Joanne Curran looks to the future and the potential for ambitious PMs to become general practice leaders.

Protecting patient data is an important responsibility for managers. MDDUS risk adviser Alan Frame offers an overview of new rules on subject access requests on page 7. Staying with this topic, our case study on page 14 looks at a breach of confidentiality following a subject access request.

A team of specialist dentists offers a unique mix of skill and knowledge to patients at the private Blackhills Dental Clinic in central Scotland. Jim Killgore goes behind the scenes to find out more in our practice profile on page 10.

And emailing patient records, dental inspections and outsourcing practice mail runs are just some of the topics tackled in an extended edition of our call log Q&As on page 4.

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Telephone triage common in primary care

A SIGNIFICANT percentage of patients accessing primary care services are being triaged by healthcare staff and some without medical backgrounds according to a survey by Campden Health.

The survey of 1,195 GPs, nurses and practice managers found that 28 per cent of practices triaged up to 10 per cent of patients and 9 per cent of practices triaged all their patients. Many practices consider it a convenient and efficient way of providing healthcare with 95 per cent of users rating it as either "moderately" or "extremely" successful.

But the results call into question the general quality of practice triaging with nearly half of providers (48 per cent) having received no training in telephone triage and 13 per cent of respondents reporting that receptionists without a medical background were involved and sometimes without support from a nurse or doctor.

A median of 90 per cent of triaged patients were given face-to-face appointments within five days if needed – "showing that access to clinical care does not seem to have been significantly comprised amidst increasing demands on GPs".

Fiona Dalziel, co-lead of the General Practice Foundation at the RCGP said: "Anecdotally, receptionists are quite good at differentiating urgent from non-urgent situations.

"However, they have had no medical training and are frequently not working to a decision-making protocol and so that leads to increased patient risk."

The authors of the Campden Health report – *On the line: Patient access in UK primary care* – conclude: "As telephone triaging becomes increasingly integrated in healthcare access, reflecting our era of mobile technology, given the number of factors that can influence effectiveness, it is important that every effort is made to ensure its standardisation and the management of risk."

Survey reveals practice managers "demotivated"

A SURVEY of 471 practice managers has found that 68 per cent felt demotivated in their jobs, with 65 per cent saying they would consider leaving the profession.

The top factor contributing to this demotivation was excessive workload, but the respondents also cited too much change, lack of support and bureaucracy.

The survey was conducted by First Practice Management which has also recorded a 12 per cent rise in practice manager vacancies advertised on its website since January.

The announcement echoes reports last year when Somerset LMC said that it has been "shocked by the number of calls it has received from PMs and the numbers taking sick leave or even resigning" and that CQC registration had been the "last straw" for some retiring PMs.

Chair of Norfolk and Waveney LMC Dr Tim Morton also wrote recently in a newsletter: "The LMC is aware of an increasing number of practice managers feeling the strain of the exponentially increasing workload they face. Practice managers are an integral part of running a practice and the sudden loss of one would most likely destabilize any practice."

RCGP opposed to "policing" visitor healthcare

GP PRACTICES should not be tasked with being a "new border agency", says RCGP chair Dr Clare Gerada.

The statement comes in response to a study commissioned by the Government that concludes the NHS could recover up to £500m by charging overseas visitors and migrants to use the health service.

The study estimates that £388m is spent each year on patients who find themselves in need of healthcare while in England and who should already be paying for their care. In addition, there is a cost of between £70 million and £300 million from people who deliberately travel to England to get free NHS treatment – so-called 'health tourists' – which could be significantly reduced through a better cost recovery system and deterring abuse.

Health Secretary Jeremy Hunt says: "Having a universal health service free at the point of use rightly makes us the envy of the world, but we must make sure the system is fair to the hardworking British taxpayers who fund it."

In the RCGP response Dr Gerada says: "GPs have a duty of care to all people seeking healthcare, and should not be expected to police access to healthcare and turn people away when they are at their most vulnerable.

"GPs are already facing ballooning workloads and a recent RCGP poll has shown that GPs are routinely carrying out up to 60 patient consultations a day, with nearly half saying they can no longer guarantee safe patient care.

"We also strongly oppose the extra administrative responsibilities for GPs and practice staff that would be created as a result of these proposals, which will further impact on all patients."

Patient complaints in Scotland higher than reported

COMPLAINTS against NHS doctors and dentists in Scotland increased by over a third last year, according to revised government figures.

The original report from information unit ISD Scotland in September indicated complaints had dropped by 15 per cent between 2011/12 and 2012/13.

However, these figures were later found to be inaccurate and the result of a "formula error".

The updated report reveals complaints against GPs and dentists actually went up by 36 per cent in 2012/13. The first report said there had been 2,992 complaints in 2012/13 but the true figure stands at 4,804. That compares to the previous year's total of 3,538.

The revised report found complaints against medical practitioners had risen by 39 per cent while dental complaints went up by 20 per cent.

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.

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Key changes to compromise agreement

PRACTICES should be aware of a number of employment law changes brought into force on July 29 of this year, including the compromise agreement being renamed the settlement agreement.

Compromise agreements have been an option for employers looking to part ways with an unsatisfactory employee, but they have always been advised to be used with caution as, if handled the wrong way, employers could face a constructive dismissal claim.

Under a settlement agreement, employers and employees will be able to enter into such discussions which will now be inadmissible in an ordinary unfair dismissal claim (pending certain conditions). It is similar to the "without prejudice" rule but with some differences.

The government has recognised that there may be times when either the employer or the employee wants to enter into a pre-termination discussion, even where there is no current dispute. The concept of such "confidential" discussions has been introduced with the intention of encouraging both employers and employees to enter into a settlement agreement.

However, employers are advised to hold pre-termination discussions with employees only when there is the prospect of a straightforward unfair dismissal claim (as employers cannot fully rely on the use of settlement agreement in other claims, such as whistleblowing or potential discrimination issues).

The new settlement agreement guidance is slightly convoluted but ACAS has published a booklet detailing the new arrangements and includes template letters and agreements. The ACAS guide can be found at **www. tinyurl.com/nen7tb5**

This remains a contentious area in employment law so it is advisable to seek legal guidance before commencing such discussions.

Did you know?

THE Employment Law team at MDDUS has 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**

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.

EMAILING RECORDS

Q An insurance company has asked a practice to email the dental records of one of their patients. The patient has already given her consent for the disclosure but the manager is unsure how safe it is sending confidential information electronically.

A Principle four of the General Dental Council's new standards guidance relates to maintaining and protecting patient information. It makes it clear that practices must keep patients' information secure at all times, whether they are held on paper or electronically. If you are sending confidential information, such as records, you should use a secure method. If confidential information is sent (or stored) electronically, the GDC advises that it should be encrypted. It may be worth seeking professional IT advice to ensure your computer system is up-to-date and secure.

HIDDEN DIAGNOSIS

Q A patient has recently been diagnosed with an aggressive form of skin cancer and has just a few months to live. She is also HIV positive but does not want her family to know. The practice is unclear as to whether her HIV status could be omitted from her death certificate, which the family would have access to. There are also concerns the family may request access to the patient's medical records after her death, which would also reveal her status.

A The patient is within her rights to request her HIV status is not disclosed to family after her death. In this case, there would not appear to be any connection between the HIV and the cancer's rapid progression which means there would be no need to include it on the death certificate. (This fact could be confirmed by consulting an infectious disease specialist.) In terms of relatives accessing the records, the practice must respect the patient's wishes and be sure not to disclose anything that makes reference to her HIV status. Also, it would be useful if there was a note somewhere in the record to confirm that the issue has been discussed and the patient has specifically requested her family not be told about her HIV status.

RETAINING RECORDS

Q The widower of a gynaecologist/obstetrician has discovered a pile of private patient records in the loft. He is concerned they should be kept somewhere more appropriate but is not sure what to do with them.

A Ideally, private practitioners would explain in their will what should be done with records in the event of their death. If not, then the next of kin/executor becomes the data controller and must ensure they are stored/disposed of securely. Private practitioners are advised to adhere to the retention periods set out in local NHS guidelines. Remember also that the Data Protection Act prohibits the retention of personal data for longer than necessary.

Obstetric records in England should be kept for 25 years after the birth of the last child while gynaecological records, and hospital records generally, should be kept for eight years after conclusion of treatment/patient death. Time limits vary for GP records. Those relating to mentally disordered people should be kept for 20 years after treatment completion/10 years after the patient's death. Other adult personal health records should be kept 10 years after treatment completion/the patient's death/ the patient has permanently left the EU. In this case, it would be advisable to seek a secure storage solution, for example from an information management company. If in doubt, seek further advice from MDDUS.

DENTAL INSPECTIONS

Q A dental practice manager in Scotland has been notified of a forthcoming practice inspection. She knows the system has recently changed and asks how best to prepare for the visit.

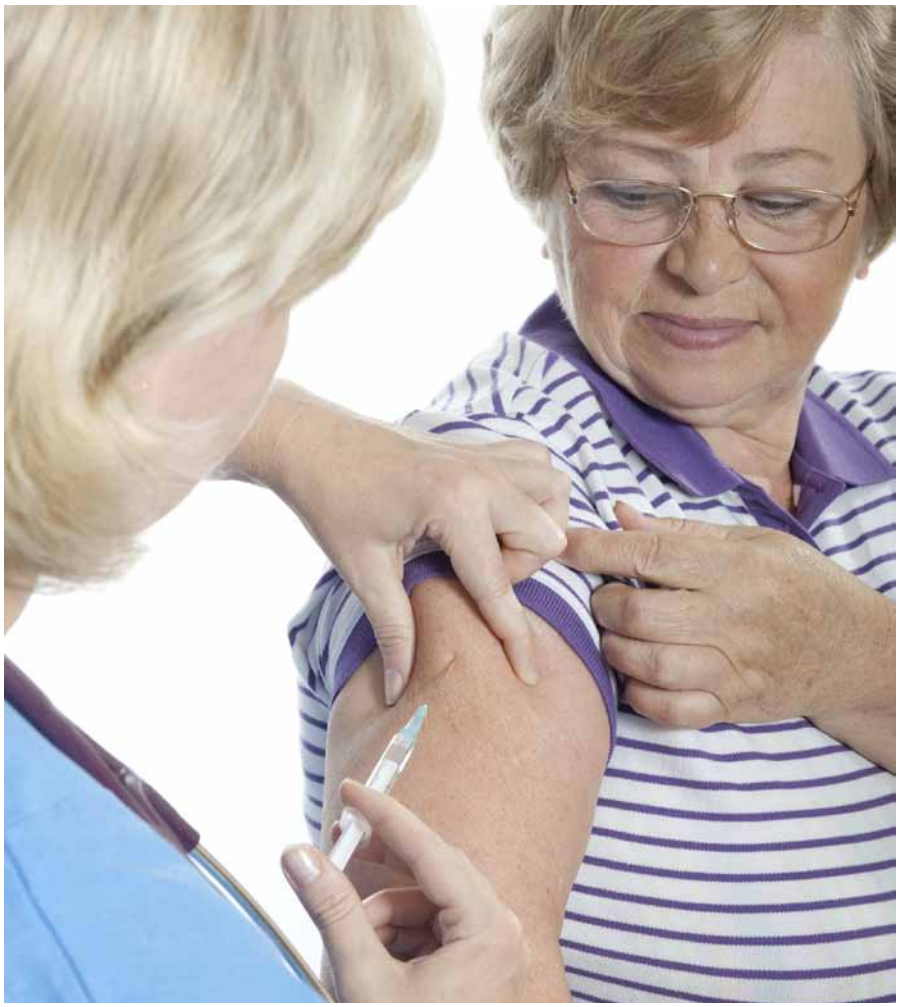
A A single combined practice inspection (CPI) process was implemented in Scotland at the beginning of 2013, replacing those previously carried out separately by NHS boards and NES. It is a three-year rolling programme and practices should start to prepare now as the process can be time-consuming. Familiarise yourself with the CPI checklist (or the sedation practice inspection checklist where relevant) and ensure your practice meets all essential criteria. There is a list of documentation that you should have ready to produce on the day and forms that should be completed in advance of an inspection. Failure to comply with the checklist standards could affect a practice's access to NHS grants and allowances. Find out more at www.scottishdental.org

OUTSOURCING OPTION

Q A private company has been in touch recently offering to take over large practice mailings inviting patients to use services such as flu vaccinations and disease clinics. The practice manager knows this would save his team a lot of time but is worried about breaching confidentiality.

A Practices are allowed to outsource the printing and mailing of such patient invites to a third party, but only under certain conditions. It's important to bear in mind that the practice's data controller (often the PM) remains responsible for ensuring the third party organisation complies with the Data Protection Act. As such, you should only use a company that you consider can carry out the work in a secure manner.

The Information Commissioner's Office states that you must have a written contract in place with the company that requires them to take appropriate security measures and ensures they only use and disclose the personal data in line with your instructions. It also recommends that you audit the organisation regularly to ensure they are maintaining standards and that you ask them to report any security breaches or problems. Make sure you have procedures in place that allow you to act appropriately should you receive one of these reports.



WHO CAN VACCINATE?

Q During a busy flu season, a practice is considering delegating the provision of some flu vaccinations to two of its healthcare assistants in order to ease the burden on the nursing team. The manager wants to know if the HCAs can administer vaccinations under a patient group direction (PGD).

A The short answer is "no", HCAs cannot administer vaccinations under a PGD. But there are circumstances under which they can administer vaccinations. To explain, the majority of NHS flu vaccinations are administered via PGDs which are written instructions for the supply and/or administration of a named licensed medicine for a defined clinical condition. PGDs allow certain healthcare professionals to administer a medicine directly to patients under a specified criteria without the need to see a doctor or other qualified prescriber. However, the healthcare professional must be professionally regulated (i.e. nurse, pharmacist, health visitor etc) and HCAs are not.

An HCA would however be able to administer a flu jab via a patient specific direction (PSD), or if prescribed by a doctor/qualified prescriber. A PSD is a written instruction from a doctor (or dentist or other independent prescriber) for a medicine to be supplied or administered to a named patient. It could be a prescription or simple written or electronic instruction in the patient's notes. A PSD must state the name of the patient, the name and dose of the prescription-only medicine to be administered and "show evidence to confirm that the patient has been considered as an individual".

PSDs do not limit who can supply or administer the medicine and thus a suitably trained HCA can be tasked to give a flu vaccination to a named patient. The practice should ensure their HCAs are competent to provide any relevant care and treatment and that they are adequately supervised.

PATIENTS AS FRIENDS

Q A teenage patient has attended a practice numerous times in recent months for ongoing treatment, becoming well known and liked by the staff. He recently sent one of the GPs a "friend" request on Facebook, but she is unsure about accepting.

A Most people now have a presence on some form of social networking site, be it Facebook, Twitter, blogs and the like. For healthcare professionals, this poses risks in maintaining patient confidentiality and professional boundaries. It is advisable NOT to accept "friend" requests from present or former patients, to ensure the relationship remains a professional one. When faced with such a request, offer a polite refusal and a brief explanation as to why accepting would be inappropriate. Where a patient displays inappropriate or sexualised behaviour, either through actions or words, the doctor/dentist should, where possible, treat them politely and considerately and try to re-establish a professional boundary.

DANGEROUS DRIVER

Q A patient who is taking methadone to treat a heroin addiction has started a new job. He says the position requires a clean driving licence and has asked his GP not to inform the DVLA of his medical issues. He also claims not to have been driving recently. However, the GP has just discovered the patient has been using heroin in addition to methadone and that he has driven to his latest practice appointment. The GP is unsure how to proceed.

A Where a patient suffers from a medical condition that affects their fitness to drive, they are legally responsible for informing the DVLA. However, if a patient refuses and continues to drive, the GMC advises doctors to make every reasonable effort to persuade them to stop. First, consider raising your concerns with the patient in writing and advise him that he must stop driving or you will inform the DVLA. Should the patient continue to drive, inform the DVLA promptly and tell the patient you have done so. Doctors can breach confidentiality without patient consent if it is in the public interest, i.e. if a patient poses a risk to other road users. In this case, it might be useful to seek the advice of an experienced colleague or speak in confidence to the DVLA's medical adviser.

DISCLOSURE OF HOSPITAL LETTERS

Q A practice has received a DWP request for a report on a patient who has made a claim for benefit. A paragraph in the request states: "Please include in your report any relevant information contained in letters or reports from hospitals or consultants. If you think that it is essential to send us originals or copies of any letters from consultants, please obtain the author's consent beforehand. You should also confirm in a covering note that they have agreed to the correspondence being used in connection with this claim". The practice is unfamiliar with such a request and is concerned about data protection.

A There is no requirement to treat hospital doctors as third parties when responding to subject access requests under the Data Protection Act and therefore no need for consent of the author of a letter for disclosure as it forms part of the patient records. But this is not strictly speaking a subject access request from a patient or representative. The practice may wish to simply summarise the contents of any letters that are relevant to avoid the need to contact the authors, or perhaps name the authors as the source of the information so that the DWP can approach them directly. But if a decision is made to include a copy letter or report from the hospital then it would be advisable to comply with the direction from the DWP on the author's consent.

Party pitfalls

Jingle bells could be replaced by alarm bells for practices who fail to consider some of the potential problems of the Christmas party season

ALL I want for Christmas is... no disciplinaries or grievances please! Most people enjoy a good office Christmas night out. They can be a great way to boost morale and reward the hard work and effort made by employees throughout the year. However, what may not be apparent to some managers is that employment law still applies whether a practice's party takes place in or outside the workplace, during or after working hours. The right for an employee to be protected by the practice's bullying and harassment policy continues even at a social gathering.

So let's start with some practicalities and some tips on how the risk to staff can be minimised.

It might be tradition to run a Secret Santa gift swap in the workplace. Most people use common sense here as to what's appropriate but it won't do any harm to let employees know that gifts cannot be obscene or offensive – remember the recipient may not find the joke as funny as everyone else.

Practices considering festive decorations might be concerned about the potential to offend faith groups who do not celebrate Christmas. It is useful to know that the Equality Act does not forbid any traditional customs and, as most festive decorations are not inherently religious, it would be hard to see how these could cause any offence to anyone on the grounds of their religion.

It may seem like overkill but, before the party takes place, consider advising staff about acceptable behaviour and boundaries and warn them of the potential consequences of inappropriate behaviour. Remind them that, even though they are at a party, it is still work and every employee has the right to be in an environment free from bullying and harassment. It would be useful to highlight to staff the practice's bullying and harassment policy and the disciplinary sanctions that could be invoked if rules are breached. Some examples of inappropriate behaviour include excessive alcohol consumption, fighting, making discriminatory or inappropriate sexual comments and taking illegal substances.

While employers are not responsible for their staff's alcohol consumption, the risk of excess can be minimised by not providing a free "all you can drink" bar. Consider providing a limited supply – perhaps half a bottle of wine for each employee? It would be wise to ensure there are plenty of non-alcoholic options available for non-drinkers and drivers. Bear in mind too that employees of certain religious beliefs may not drink and may also be vegetarian or unable to eat certain types of food.

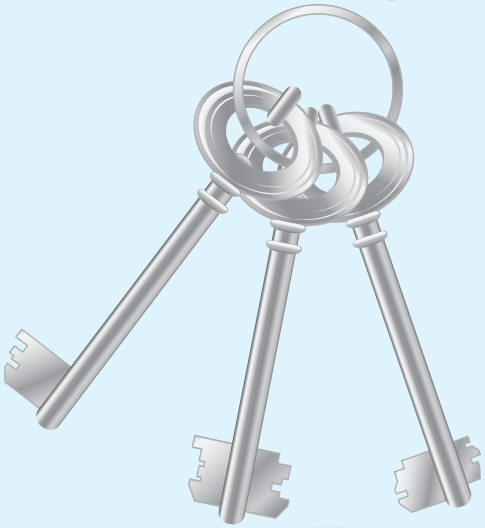
Despite your best efforts to encourage moderate behaviour, where parties are held mid-week some employees will always be tempted to phone in sick the following day. It is important to make clear that attendance at work the next day is expected from everyone, including practice managers, doctors and dentists. Where an employee does phone in sick the next day, proceed carefully. The reason for their absence may appear obvious to you but it can be hard to prove it is due to excess alcohol consumption, so we suggest seeking further advice on this. One way to avoid this would of course be to hold the party on a night where no work is planned the next day.

If you are responsible for arranging any sort of entertainment or corporate speakers then plan this accordingly to avoid embarrassing any member of staff with rude or inappropriate jokes or comments. Keep a common sense attitude. Similarly, at the end of the night, consider how staff will get home safely. If there are plenty of transport links employees can access then this may not be a problem. It is worth having taxi numbers to hand for those who need them and, if the party venue is remote, consider arranging a minibus. And if you know a staff member is taking the car home, don't let them drink and drive.

Social media presents another risk area during party season. A recent decision from a tribunal in Northern Ireland held that an employee was fairly dismissed because comments he posted on his Facebook page amounted to harassment of a female colleague and he was therefore in breach of the employer's Dignity at Work Policy. He posted obscene, derogatory and sexual comments about the woman after a work night out. The comment mentioned his employer's name and was read by a number of other work colleagues. The woman heard about the comments and asked if he would remove them. Following this intervention the man posted further lewd comments, eventually leading to his dismissal.

Clearly this article covers many worst-case scenarios but most Christmas parties go off with little or no hitches. Common sense prevails (usually), so have a great (and careful) time. ✱

Janice Sibbald is an employment law adviser at MDDUS



Opening access

New guidance has been published to help practices respond to subject access requests for personal data. Alan Frame offers an overview

HANDLING requests to access sensitive patient information can be a minefield for practices. No manager wants to get it wrong and find themselves facing the consequences of breaching the Data Protection Act (DPA).

Under the 1998 DPA, anyone has the right to find out what information an organisation holds about them by making a subject access request. In a bid to help data controllers navigate this tricky area, the Information Commissioner's Office (ICO) has published its new *Subject access code of practice*. It provides useful step-by-step guidance for responding to such requests efficiently and in accordance with the law and good practice.

Some highlights include the following.

THE PURPOSE OF THE CODE

The guidance explains that subject access is one of the rights afforded to individuals under the sixth principle of the DPA. Subject access requests (SARs) are then made under section 7 of the DPA. As well as clarifying individual rights, it also provides guidance on the limited circumstances in which personal data is exempt from subject access.

WHAT IS SUBJECT ACCESS?

This enables an individual to find out what personal data an organisation holds about them, why they hold it and who they disclose it to, and is fundamental to good information governance.

Subject access provides a right for the requester to see their own personal data, but not an absolute right to view or obtain copies of actual documents containing that data. Some documents may, for example, contain sensitive third party information that it is not practical to redact and the relevant data may have to be disclosed in another format.

WHAT IS PERSONAL DATA?

It must relate to a living individual and allow that individual to be identified from it (either on its own or along with other information likely to come into the organisation's possession).

In relation to patients, this will include information about their physical or psychological health made by a health professional. It may also relate to information supplied by a third party, such as a close relative, which the health professional considers to be relevant. If such information is contained in a medical or dental record, it is classified as "personal sensitive data" under the Act.

DOES A SAR HAVE TO BE IN A PARTICULAR FORMAT?

In short, no. However, a SAR needs to be in writing and the responsibility to confirm the identity of the individual making the request rests with the data controller.

Some organisations provide forms for patients to complete when making a SAR. You cannot insist on this, but a specific form may assist the requester to provide the information you need to deal with their request.

CAN I CHARGE A FEE?

The maximum fee a data controller can charge for processing a SAR is usually £10, but different fee limits apply where the request concerns health records. If the original record is held in written format only, or in a combination of written and electronic formats, then a maximum charge of £50 can be made to process the SAR. Otherwise the £10 fee would apply.

It is important for healthcare providers to be consistent in how any charges are applied to patient requests. A written policy or protocol can be helpful, and may minimise the risk of any allegations of discriminatory practice.

IS THERE A TIME LIMIT FOR RESPONDING?

In most cases you must respond to a subject access request promptly (the Department of Health suggests 21 days) and at least within 40 calendar days of receiving the SAR in writing, along with any applicable fee.

IS ANY INFORMATION EXEMPT FROM SUBJECT ACCESS REQUESTS?

Yes. Some types of personal data are exempt from the right of subject access and so cannot be obtained by making a SAR.

Information may be exempt because of its nature or because of the effect its disclosure is likely to have. In health terms, this could relate to sensitive information contained in the record that the patient is unaware of, and that would be likely to cause serious psychological or physical harm if they found out. This can be a difficult judgement call and it is important that any such decisions are made by health professionals and not, as in some instances we have encountered, by an administrator.

The General Medical Council also provides guidance to doctors in this area and this states that potentially harmful information does not equate to something that would make the patient upset or angry if they find out about it.

There are also some restrictions on disclosing information, including where it relates to another individual or third party, and where information has been provided by a relative about a patient in confidence.

The consent of the third party is generally required before they can be identified, unless it is impracticable to do so, or reasonable to dispense with this requirement. Third party considerations do not apply to the identity of other health professionals and this must remain as part of any copy record supplied.

The code also addresses important areas such as locating and retrieving relevant information and dealing with requests which involve other people's information.

If in doubt members are encouraged to contact MDDUS for advice before proceeding.

The *Subject access code of practice* is available on the ICO website at **tinyurl.com/k6z6fy6** ❋

Alan Frame is a risk adviser with MDDUS

Future

The RCGP recently published its ambitious vision for general practice in 2022. Will this mean greater opportunities and responsibilities for managers?

VIRTUAL clinics, Skype consultations, federated organisations and the need to achieve more with less resources. The future of general practice presents managers across the UK with a dizzying array of challenges.

The recent NHS reforms have already dramatically changed the general practice landscape in England, with PCTs gone and practice based commissioning replaced by clinical commissioning groups.

Now the RCGP has added to this a number of ambitious goals, outlined in its report *The 2022 GP – A Vision for General Practice in the Future NHS*. A decade from now it envisions a prominent role for technology and an expanded, skilled general practice workforce with a greater emphasis on multidisciplinary "micro-teams". It also foresees a greater need for clusters of practices to work together to get the best results from limited resources.

Some may not be ready to embrace such a bold future, but these goals and the changes brought by NHS reform create real potential for managers keen to expand their roles and become leaders in general practice.

While the RCGP's future vision contains few specifics about the practice manager's role, in the report *Liberating Practice Management*, NHS Alliance chairman Mike Dixon says practice managers "hold the keys to the future NHS". He believes that "as commissioning and increasing provision passes to GP practices and frontline clinicians, practice managers will be required to hold things together."

General practice is evolving and changing differently in each of the UK's four health systems, with the most profound changes likely to take place in England over the next few years. However, managers in Scotland and the rest of the UK will not be immune from changing work practices.

THE FUTURE PM

So, how to define the role of practice manager? It is a job title that covers a broad spectrum of skills and responsibilities. In some practices the PM's main function is as office administrator dealing with basic day-to-day tasks. But in others the PM assumes greater responsibility and plays a more strategic role in managing the direction of the business, often across multiple practice sites.

> "WHILE SUCH ADDITIONAL TRAINING OPPORTUNITIES WOULD NO DOUBT BE WELCOMED BY PMs, IT IS NOT YET CLEAR HOW THESE WOULD BE PROVIDED/FUNDED"

It is this pro-active, leadership role that looks set to be a more prominent feature of future PMs.

Fiona Dalziel has been a practice manager in Aberdeenshire for 23 years and runs DL Practice Management Consultancy. She is also the RCGP's Quality Programmes Assessment Lead. She believes practices whose managers work at a basic administrative level will soon need input from an individual working at a higher level, whether full time or part time.

She says: "Practices, especially in England but throughout the UK, are not going to be able to cope with the amount of change that is taking place if they do not have a manager who is looking outside for ideas and bringing innovation. They will need someone to act as a leader in the practice, and someone who is regarded as such by the partners."

Fiona believes the basic administrative functions of running a practice will clearly still need to be done, but says: "Practices will need someone working at a higher level, whether that is someone employed in the practice every day or shared across a group of practices working in a co-operative. That is inevitable."

While this may present smaller practices with even greater budgetary pressures, Fiona

sees it as an opportunity for career progression that has not been present before. "This will be a great opportunity for ambitious, forward-thinking, skilled managers who can work as leaders and develop their careers," she adds.

Such changes could also pave the way for a rise in self-employed managers who may choose to swap a fixed, salaried position to instead work on a self-employed sessional basis for a number of practices.

These steps forward will rely in no small part on the establishment of a more structured training pathway for managers.

This is echoed by objectives detailed in the RCGP's vision report which identify a need to "enhance the skills and flexibility of the general practice workforce to provide complex care" and "to put in place additional training and development opportunities for practice managers, with the potential to include specific vocational training."

While such additional training opportunities would no doubt be welcomed by PMs, it is not yet clear how these would be provided/funded.

RESOURCE-SHARING

The RCGP report goes on to predict that practices will "work in federated organisations, with interconnected clusters of practices and other care providers, spanning traditional primary, secondary and social care boundaries." This would allow practices to "combine 'back-office' functions, share organisational learning and co-develop clinical services."

Such resource-sharing could help make limited budgets go further, with practices joining forces to generate greater "buying power". Sharing could extend to functions such as HR services, accounting or even indemnity provision. But these arrangements would not be entirely trouble-free as employees asked to work in new or unfamiliar settings could present their own challenges for managers.

The RCGP also foresees practices working in multidisciplinary micro-teams to care for patients with a range of complex needs, especially those with long-term conditions, the elderly, and mothers and young children. This would, the RCGP says, improve continuity of care through a focus on team-based continuity. It would also have implications for PMs.

Fiona says: "I've noticed during meetings and conferences recently, particularly in Scotland, there has been a lot of talk of micro-team working where we will be grouping service delivery by patient group. This may indeed be an improved way of working but it's clear that co-ordinating micro-team working and resource-sharing with other practices, in addition to all the other new responsibilities, will have a huge impact on practice managers."

HI-TECH RISKS

"Greater use of information and technology to improve health and care" is a prominent theme in the RCGP's future vision of general practice. So-called "telehealth" and "telecare", where patients monitor issues such as blood pressure via machines in the practice or at home, is already a government priority. Virtual clinics and patient consultations conducted via Skype or similar online media, as well as communicating with patients by text or social media, are also expected to play a greater role.

This raises a number of issues for PMs who will be the main gatekeepers of this technology.

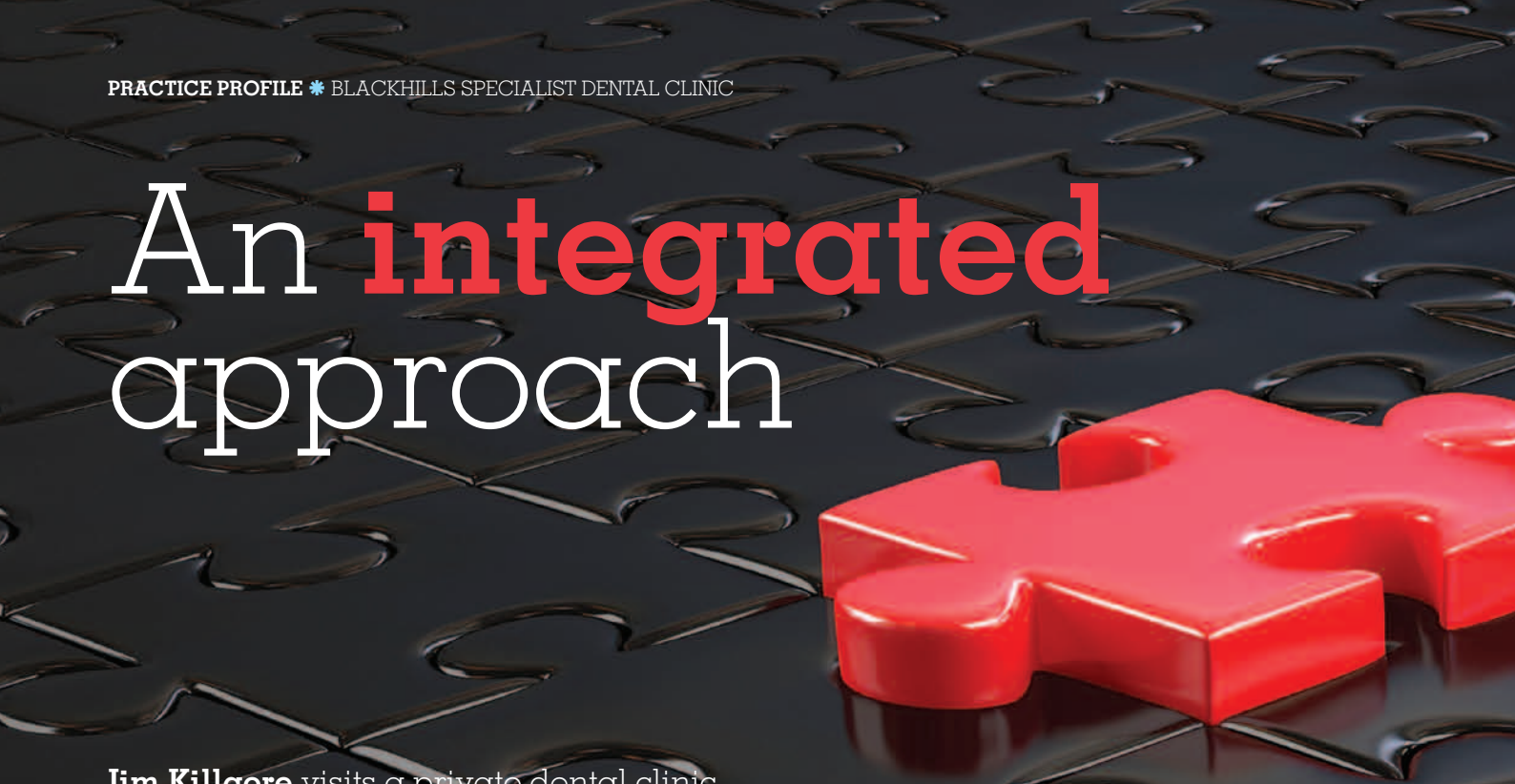
MDDUS senior risk adviser Liz Price says: "Practice managers will assume greater troubleshooting responsibilities in the future as they will be responsible for risk-assessing the local implementation and use of all the new technology.

"Many practices are already using a variety of new technologies day-to-day. This looks set to increase further and managers need to be aware of the implications in terms of data protection, patient consent and confidentiality."

Many changes lie ahead for UK general practice and it seems practice managers – with the right investment and training – could indeed hold the keys to future success.

Joanne Curran is an associate editor of Practice Manager

An integrated approach



Jim Killgore visits a private dental clinic that is building success on referrals

TRUDIE Imrie was working as a manager within NHS Scotland when she had a phone call from former colleague Paul Stone. They had worked together in the department of oral surgery and orthodontics at Perth Royal Infirmary – he as a specialist oral surgeon and she as a departmental administrator.

Paul had often discussed with Trudie his plans to someday open a private specialist dental clinic – one that would bring together a varied team of specialists offering integrated care all under one roof but outside of the hospital. Now that vision was set to become a reality and he was asking Trudie if she would come and run the business.

Trudie had by then taken on a role in NHS Scotland setting up managed clinical networks – the first being for cleft lip and palate and then another for phototherapy services. What Paul was proposing was a totally new challenge – managing an office with staff and specialists, having to deal with finance, marketing, procurement, IT, health and safety regulations, HR issues and recruitment, premises management and much more. But after some deliberation she decided to accept Paul's offer and in 2007 became clinical manager of the Blackhills Specialist Dental Clinic.

> "MAINTAINING GOOD RELATIONSHIPS WITH REFERRING DENTISTS IS ESSENTIAL BECAUSE IN REALITY THEY ARE ALSO OUR CLIENTS"

"It was a risk but a risk worth taking," says Trudie as we chat in her office overlooking the Ochil Hills in rural Perthshire.

Blackhills operates in a purpose-built clinic located in a business park in the village of Aberuthven just off the A9 between Perth and Stirling. It started out with only two specialists – Paul and the other founding partner Ken Watkins.

"There was quite a learning curve coming here," says Trudie. "It was only me and one dental nurse. I was doing everything – reception, typing, IT support, everything."

But in the intervening years the practice has grown to eight specialists with five dental nurses, three administrative assistants and one general assistant. Trudie has helped oversee that growth with a zero staff turnover and a thick "testimonial book" of appreciative patient letters displayed in the practice waiting room.

Paul Stone happily acknowledges that Trudie's skills have in no small way contributed to the success of the clinic as testified by Blackhills being named Best Specialist Referral Clinic at the Scottish Dental Show Awards 2013. At the same ceremony Trudie brought home the award for Dental Business Manager of the Year. Not bad for someone with only six years experience as a practice manager.

COMPLEX CASES

Blackhills Clinic provides treatment for all aspects of adult dentistry (apart from orthodontics). "Almost all our business is through referrals from other dentists," says Trudie. She estimates that the clinic has about 600 referring dentists and treats 750 to 800 patients per year. They come from as far as the Shetland Islands and the Scottish borders but most are from the central belt of Scotland.

Each of the clinicians at Blackhills is a GDC-registered specialist, providing the clinic with a wide range of expertise in oral surgery, prosthodontics, restorative dentistry, endodontics, periodontology and dental and maxillofacial radiology. All of the specialists work at the clinic part-time having other academic and NHS commitments.

"Many of our patients come to receive dental implant and restorative treatment as well as periodontal treatment for gum disease," says Trudie. "Some of our patients need full mouth rehabilitation; they may have a difficult occlusion and failing extensive crown and bridge work that needs to be dismantled and reconstructed, often utilising dental implants. So we do see and treat some really complex cases."

Blackhills has three surgeries with a central sterilisation room and its own cone beam CT scanner – one of the first to be installed in an independent dental referral clinic in the UK. This allows the specialists to image patients in three dimensions and is used on a daily basis for the precise planning of implants and other complex dental treatments.

Perhaps the most unique aspect of the Blackhills Clinic is

Trudie Imrie and (above) the reception area at the Blackhills clinic.

its emphasis on integrated treatment. Paul Stone explains: "We work together as teams. So a patient might see three or four specialists during their consultation appointment. We find that this is an amazingly effective way of arriving at the most appropriate diagnosis and treatment plan. It also saves the patient having to make multiple visits by enabling them to see several specialists at one go."

Blackhills also has a policy of only treating patients for the problem for which they have been referred unless other significant issues become apparent during treatment. Patients completing their treatment are always sent back to their regular dentist for continuing dental care.

"Maintaining good relationships with referring dentists is essential because in reality they are also our clients," says Trudie. "We don't ever want them to feel we're taking their business."

MARKETING TO DENTISTS

Indeed, keeping referring dentists onside has become a big part of Trudie's role at Blackhills. The clinic runs regular educational meetings to support referring practices and last year inaugurated a half-day symposium. It was held at the Perth Racecourse conference facilities and had 170 delegates and 20 trade stands. The theme was "team working" and Blackhills specialists lead a range of sessions. All the organising was down to Trudie. This year they expect an even bigger turn out and have invited business and marketing gurus Ashley Latter and Les Jones to give the keynote presentations.

Says Paul Stone: "It's a major event for us and a significant cost. But it's good service to provide really excellent education to our referrers because without them we don't have a practice. They rely on patients coming through their doors and we rely on them sending us patients for the more complex or specialist treatments."

HERDING CHICKENS

Working in a business with overheads and profit margins was also a departure for Trudie, coming from the NHS. Private patients offer a different challenge. "Their expectations are a lot higher," she says. "They expect really good service and assume they will be seen quickly."

Given the number and overwhelmingly positive comments from patients treated at Blackhills it's clear that they are doing something right.

"It's been that way from the beginning," says Trudie. "We like to give our customers the feeling that they're always welcome and that they are going to be really well looked after. We want them to see that we are completely professional and ethical and won't provide dentistry that's not appropriate to the patient's needs. It's purely patient focused."

So to what does Trudie attribute her success at Blackhills?

"I am a very calm person," she says. "When there's a problem my attitude is 'we'll just sort it'. You have to think logically. Stop, think."

Paul Stone is a little more expansive. He says: "Running our practice is a bit like trying to herd chickens because there are so many different people –specialists in different hospitals and universities, part-time and full-time staff, and then all the different referring dentists and their patients coming from all parts of the country. Trudie really is the glue that holds everything together – and it's on all levels.

"Some practice managers can be strong-willed and quite dogmatic but Trudie is different. She also has a good perspective of what's important and what isn't – and she's taught me as much as anybody to take a step back sometimes." ❋

Jim Killgore is an associate editor of MDDUS Practice Manager

SCALP

Trudie Imrie is also the administrator for the charity SCALP (Scottish Association for Cleft Lip and Palate) and spends many hours co-ordinating fund raising activities and working with the various groups involved to distribute funding and organise educational events, as well as helps maintain the profile of this important organisation which is so relevant to dentistry. Blackhills Clinic supports this role, giving time to Trudie as well as financial support to the charity. To learn more go to **www.scalp4kids.org**

Stuck in the

Practice managers can often find themselves thrust into the role of peacekeeper in partnership disputes. Michael Royden of Thorntons Law offers some survival tips

WE would all like to live in a perfect world where people don't fall out, where differences are a rare occurrence and confrontational situations don't arise. Unfortunately the world is not perfect and fallouts among business partners are all too common.

Disputes within a practice can range from very minor differences to major conflicts threatening the on-going existence of a partnership. What is most important to remember is that when a disagreement does arise every effort should be made to resolve the situation in a constructive manner.

As specialist dental and medical lawyers, we at Thorntons have seen many forms of partnership dispute over the years, and it is often the case that the practice manager becomes involved in trying to resolve the conflict. This might involve simply acting as a middleman to ensure that the partners reach an agreement – although it may seem more like acting as a UN peacekeeper at times. The key is to act in a way which will bring a resolution for the benefit of the practice as a whole.

AVOIDING PROBLEMS

It goes without saying that it would be far better if disputes didn't happen in the first place. Regular discussions between the partners can help, and we often find that the occurrence of disputes is greatly reduced if there are monthly or quarterly meetings.

I would also stress the importance of having in place a carefully worded partnership agreement which sets out the relationship between the partners and their rights and responsibilities. An agreement itself will not absolutely prevent disputes arising but by working through the details of a partnership agreement, often issues which wouldn't otherwise have been considered will be discussed and mapped out at an early stage of the partnership. This will mean that the partners are more likely to have considered a number of eventualities within the life of the partnership, some of which may otherwise be a source of potential dispute.

COMMON FLASH POINTS

It is impossible to envisage all the various forms of dispute which might arise in a practice, or the impact a dispute will have. However, it is possible to categorise the types of dispute which we have seen over the years.

Disputes which relate to administrative matters. This could include questions regarding responsibility for locum cover in the event of the absence of a partner.

Differences which arise at key points in the life of a partnership, such as retiral. This is a common source of disagreement within a partnership and can involve differences of opinion regarding, for example, property valuations, which are often controversial, with a number of different views being expressed within the partnership.

A breach of certain obligations, either to fellow partners or professionally. We have seen extreme situations like fraudulent activity on the part of one partner, such as submitting fraudulent claims to the NHS, and situations where one partner had shown inappropriate behaviour towards a member of staff.

Armageddon. This is the worst-case scenario where the relationship between the partners breaks down completely, resulting in a total separation of the partners and, potentially, the dissolution of the practice as a whole.

The nature of any dispute will have a significant impact on how best to resolve it, however there are key pieces of advice which I would give to a practice manager in order to assist with its resolution.

If there is a partnership agreement in place, it will govern the relationship between the parties, and a good agreement should hopefully give an answer to the majority of disputes.

Appropriate professional advice should also be sought where necessary. Thorntons is often consulted by practice managers who ask us to assist with differences of opinion between the partners, and on occasion there is also a need for accountancy advice. In many disputes, it may also be necessary for individual partners to seek independent advice

middle

of their own, rather than advice being given to the partnership as a whole.

TAKING SIDES

It can be difficult not to take sides in a dispute, but the practice manager should act as impartially as possible. Having said that, if it appears that one partner is clearly at fault, you may find that you need to represent the majority position, in which case it may be appropriate for the individual partner to seek independent advice. This may appear counterintuitive, in that it may feel like you are drawing lines within the partnership, but the benefit of independent professional advice can help the partners to appreciate both perspectives.

> "IT CAN BE DIFFICULT NOT TO TAKE SIDES IN A DISPUTE, BUT THE PRACTICE MANAGER SHOULD ACT AS IMPARTIALLY AS POSSIBLE"

Wherever possible, the potential for staff to be drawn into the dispute and/or take sides should be avoided. The more people involved in the dispute, the more likely there will be an impact on the day-to-day working of the practice. Where it is impossible to avoid an individual staff member becoming involved, ideally they should be asked to maintain the details of the discussions as confidential in order to avoid a ripple effect within the practice.

It is important to keep dialogue going, and all-party meetings can be very helpful in that they can allow the partners to express their opinions in what is hopefully a less formal setting. Where that doesn't happen, we tend to find that the partners resort to exchanging emails, and often these are typed at the end of a long day. Even when the intention is to try to seek a resolution, exchanging views in this way can often be counterproductive, leading to the situation escalating rather than improving.

Even if the individual partners are represented separately, a constructive approach to finding a resolution should still be pursued. Stressing the need to reach a resolution which is for the benefit of the practice as a whole and will allow a high level of continuing care to the patients is a very good way of trying to avoid an entrenched position developing.

ARBITRATION AND MEDIATION

A partnership agreement may also set out ways in which disputes should be resolved. For example, it may refer to arbitration, with an independent expert being appointed to resolve the dispute. However, I feel that arbitration is often not a particularly helpful method of resolution, in that it can be time consuming and costly without the guarantee of an outcome which will suit all of the partners.

An alternative is mediation and there are situations in which this can be very useful. In particular, this form of discussion can allow disputes to be handled in a way that is much more conducive to agreement being reached. It tends to be conducted in a setting that is far removed from a formal court process and it also allows the partners to express their opinion and to debate the issues without undue confrontation.

In the midst of any partnership dispute, ultimately there is still a practice to run and the impact on the business as a whole should be kept to a minimum. Essentially, patient care should never be prejudiced by a practice dispute, and whilst this isn't always possible, it is important that the partners do not lose sight of any impact on the delivery of that service.

Hopefully in the majority of cases, by following a constructive approach, you can assist the partners to reach a resolution without needing to draw battle lines.

Michael Royden is a partner with the Scottish legal firm, Thorntons

Shared name

Day one

A GP surgery receives a subject access request from a patient – Mr Jason D – wanting a copy of his full medical records in regard to a complaint he made to the practice two months previous. The surgery complies fully under the requirements of the Data Protection Act and a week later sends the copy records.

Day nine

Mr D phones the surgery and angrily demands to speak with one of the partners. The practice manager takes the call. Mr D states that in looking through the records he has come across a letter written two months ago by one of the GPs – Dr K – to an insurance company. It relates to an insurance claim for a back injury at work and subsequent treatment for depression. The letter also refers to appended medical records for the previous two years. Though Mr D's name appears at the top of the letter none of the details apply to him. He is now upset and worried that his own personal medical records may have been sent to the insurance company. The practice manager says she will investigate.

Later on day nine

The practice manager pulls Mr D's medical files and finds the letter in question. Checking the reference number on the letter she discovers it refers to a different patient – Mr Jason O – who had suffered an injury at work. The report was requested in order to process the resulting insurance claim. The practice manager phones the insurance agent dealing with the case who confirms that the appended medical notes do indeed appear to be those of Jason D not Jason O. The practice manager phones Mr D back and admits that there does appear to have been an inappropriate disclosure of his medical records.

Day twelve

The practice receives an official letter of complaint from Mr D alleging breach of the Data Protection Act 1998. He demands an explanation of how this happened and exact details of the records sent. He also wants proof that the copy records held by the insurance company have been either returned or securely destroyed/removed from their computer system.

FURTHER investigation is conducted by the practice manager and this results in an adverse incident report detailing the events that led to the breach. The case began with a request for information by the insurance company on the medical status of Jason O in relation to his back injury at work. The request included a permission form from Mr O consenting to the disclosure.

Dr K dictated a reply which was typed out by a medical secretary. The correct reference number relating to the insurance query was included in the letter but there was some obvious confusion with both patients having the same first name. This may have been related to an interruption either during the dictation or transcription of the letter.

The letter was returned to Dr K who signed it without recognising the error. Seeing Mr D's name at the top of the letter the secretary appended the wrong medical records and posted the material to the insurance company. A third error occurred at the insurance company when the processor failed to notice that the medical records did not refer to the subject of the claim – Mr O. Fortunately the claim was still pending when the error was discovered.

In rectifying the error the practice contacted Mr O and informed him of the mistake and made an unreserved apology to both patients – admitting breach of the Data Protection Act. In the adverse incident report it pledged to review working practices at the surgery to minimise unplanned interruptions to doctors and secretaries undertaking administrative tasks. It developed a new protocol for document management – including steps to ensure that file attachments are appended and stapled to letters before signature.

The incident was also subject to review and discussion among staff at a practice meeting with the internal report concluding: "This is a stark reminder to us all, to thoroughly check our own work and that of our colleagues".

KEY POINTS

- Minor administrative errors can lead to major adverse incidents.
- Carefully check all subject access requests against guidelines set out by the ICO (Information Commissioner's Office; see page 7 in this issue).
- Develop document protocols that guard against disclosure errors.

Diary

➔ GET THEE TO A DENTIST Diary always feels a keen sense of injustice when dental visits are used as a barometer of unpleasantness. Take for example a recent survey carried out by Coppenrath & Wiese ("Europe's largest producer of frozen desserts!") which found that 75 per cent of Brits would rather go to the dentist than host a dinner party. A quick review of Google also uncovers that 43 per cent of women would rather visit a dentist than see their mother in law and 44 per cent would prefer the dental chair over shopping for a swim suit. Filling out a tax form is worse than going to the dentist for 40 per cent of Americans and one in eight managers would happily see the dentist to avoid completing a performance appraisal. One respondent on Mumsnet said she would prefer childbirth over having another wisdom tooth extracted. Diary finds this most unfair as our dentist is always delightful and attentive, as is the staff. I would not demean them by comparing a visit there to, say, public speaking (give me root canal any day).

➔ MANAGERS NEVER LIE Well, nearly two thirds don't according to a survey conducted by the Chartered Management Institute (CMI). Only 35 per cent of managers admitted to telling a lie at least once a day in the workplace – though more so than among workers where the figure was 25 per cent. Curious when you consider other studies suggesting people on average lie no less than three times a day – and one study claiming most people can't go 10 minutes in conversation without telling a lie. One can only assume a tendency to lie about lying. Who was it that said the truth is overrated?

➔ WEIGHT WATCHING Are you putting on a few pounds? It might just be your job. Receptionists are most likely to be overweight while scientists are least at risk of piling on the pounds, according to a survey of almost 3,700 workers by the company CareerBuilder. Administrative assistant tops the list of jobs that make you put on the most weight; 69 per cent of admin assistants gained weight as a result of their job compared to just 39 per cent of scientists. More than half of those surveyed blamed sitting at a desk most of the day while a third blamed stress-eating. Another prime candidate was the office sweet jar (17 per cent), while nine per cent blamed pressure to eat food colleagues bring in.

➔ ENEMIES AND QUESTIONABLE STRANGERS TEST It was recently reported in *Pulse* that trials have begun of the much touted 'friends and families' test in 36 GP practices across England. Patients are to be asked how likely they are to recommend a practice to people they presumably like (quite a presumption in some families) with a choice of six options ranging from 'extremely likely' to 'extremely unlikely'. The test has been operating in selected hospital wards and A&E departments since April 2013. Diary would be keen to see the results of these trials – though NHS England has said there will be no formal reporting and that the results of the unofficial trials would 'not be published'. Should the test prove less than illuminating might we suggest a somewhat inverted approach as in the title of this item? Diary offers it gratis in the spirit of public service.

➔ WHAT A FEELING Diary believes that all practice managers should be encouraged to browse the "Reviews and ratings" section of the NHS Choices website. Perhaps not so much for those five-star ratings praising excellent clinical skills or courteous staff or waiting room musak that could inspire a flashmob. More bitter truth can be found in opinions offered at the lower end of the scale. Say for example: "On my last visit the doctor I saw was more interested in their own personal call on their mobile from their friend, did not seem interested in me and looked bored, was miserable and you could not fill the back of a postcard the amount of time they talked to me. I have never heard anything good said about this place and will look for somewhere else." Even worse: "The doctors were rude, when I said there were a couple of things, was interrupted before I could go on and told to make another appointment. Bizarre! Do not bother registering here as you will regret it."

➔ CLASSIC CALLS Does your practice favour a catchy pop tune or something a little more upmarket to entertain callers while they wait? A survey has revealed Mozart is the top choice for local councils' "on hold" music. *Eine Kleine Nachtmusik* and *Symphony No 40* were the Mozart pieces deemed most suitable by local authority bosses, according to the Press Association. Selections from Debussy, Handel and Strauss were also popular, no doubt thanks to the fact these classics are out of copyright and can be played free of charge. Elsewhere, Lincolnshire County Council has reported that middle-of-the road pop songs by Simply Red and the Lighthouse Family are the most effective in keeping people on the line. The authority says the number of people hanging up while on hold has more than halved since it replaced traditional hold music with commercial tracks. However, the council did admit fault in its use of the Lighthouse Family's *Ocean Drive*, describing the move as "a deplorable lapse in judgement."