Practice Manager
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ISSUE 10

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MIRIAM PRIMARY CARE GROUP

MDDUS

Practice Manager

I AM very pleased to join the team at *Practice Manager* in a new role as co-editor with my colleague, Helen Ormiston. Helen and I joined the MDDUS in May 2013 as practice advisers to add to the expanding Medical Division. As former practice managers we are able to provide doctors and PMs with telephone and written advice on medico-legal matters and are pleased to expand our roles to include editorial duties. The plan is to alternate issues - starting with me on this current one.

Over 24 million UK users log on to Facebook each day, while one in four people (15 million) have Twitter accounts, so it's hardly surprising there are implications regarding staff use of social media. On **page 6** MDDUS employment law adviser Janice Sibbald offers advice on establishing a practice policy.

Back in the old days of NHS England (a few years ago) PCTs were effectively the landlords for GP premises but in April 2013 all of that changed. Solicitor Sam Hopkins offers a short guide to the current players on **page 7**.

On **page 8** MDDUS risk adviser Liz Price asks what emotions do you and your team experience at work. Promoting positive emotions could help reduce patient complaints.

On **page 10** Jim Killgore meets an innovative practice team on the Wirral. In 2009 the Miriam Primary Care Group piloted a nurse-led minor injury and illness service which is now treating 50 to 60 patients a day.

On **page 12** I look at factors to consider in removing an abusive patient from the practice list, and the case study on **page 14** offers an example of how one practice dealt with the problem.

Among the topics addressed in our Call Log on **page 4** are stolen patient records, same-sex chaperones, parents refusing vaccines for children and managing holiday closures.

Scott Obrzud
Editor

NHS complaints process "too complex"

CONCERNS about poor NHS care often go unreported because of the complexity of the complaints system, according to a new survey.

Patients and relatives find complaints procedures relating to GP practices, hospitals and care homes "utterly bewildering", leaving many unsure of how to proceed.

The concerns have been raised by Healthwatch England which identified 75 types of organisations south of the border with a role in complaints handling and support, from councils and CCGs at a local level to national regulators.

The patients' group commissioned a YouGov poll of 2,076 UK adults which found less than half of those who experienced poor care between 2010 and 2013 reported it. Just over two-fifths (43 per cent) said this was because they didn't know how to complain or provide feedback while half (49 per cent) said it was because they lacked confidence that their complaint would be dealt with effectively or thought that it wouldn't make any real difference.

Of those who did pursue their complaint, 13 per cent entered a formal complaints process. Healthwatch said this means the system is "failing to take any formal learning from almost nine out of 10 experiences of poor care." They are calling for the complaints system to be simplified and for it to offer a more "joined-up" approach.

Healthwatch England chair Anna Bradley said: "It's no wonder the public are left confused and frustrated. With so many organisations involved it's difficult to know where to start, let alone having the strength and persistence to navigate the system on your own.

"A key improvement would be a straightforward and independent advocacy service to provide the support people need to make their voices heard."

New editors for *Practice Manager*

WE are pleased to welcome our two new co-editors at MDDUS *Practice Manager*. Scott Obrzud and Helen Ormiston are practice advisers at MDDUS and both former practice managers. They will be sharing duties as editor on alternate issues – with Scott leading off on this current one. Their joint expertise in medico-legal matters and risk will be very welcome.

MDDUS would like to thank our previous editor Aileen Wilson for the time she devoted to *PM* in addition to managing a very busy practice group. We have benefited greatly from her experience "on the ground" and hope to continue to do so with articles in future issues.

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Agree levels of disclosure before emailing

PRACTICES should have consent and agree levels of disclosure before emailing or texting patients.

The use of email may now be part of everyday work, but MDDUS Joint Head of Medical Division Dr Anthea Martin believes practices should not become complacent and must consider consent and confidentiality issues when sending patient data electronically.

"Not all patients wish to receive emails or texts from their medical or dental practice," says Dr Martin. "It is therefore important that only those patients who agree to communicate electronically receive information via email or text."

MDDUS has dealt with calls from members concerned over what information is appropriate to share with patients via email. "To avoid any potential breach of confidentiality, it is beneficial to agree levels of disclosure," says Dr Martin.

"Does a patient want to be contacted via email or text for vaccinations, appointments reminders or repeat prescriptions, or for more personal matters such as test results?"

Dr Martin points out that there are still risks of confidentiality breaches even with something as straightforward as rescheduling a patient's appointment. It is important to consider who might have access to an email account or mobile phone other than the patient. "Personal circumstances and relationships within families are all different and you should not presume to know what people might want to keep private."

Healthcare professionals should familiarise themselves with policies and procedures issued by their employer or contracting body in regard to protecting patients' privacy. They must also be mindful of the Data Protection Act 1998 which requires information to be fairly and lawfully processed.

"Doctors who fail to protect patient information risk incurring a fine from the Information Commissioner's Office," says Dr Martin. "Furthermore, failure to adequately secure electronic medical records could result in a GMC hearing or even criminal charges."

MDDUS launches online video modules to mitigate risk

FIVE new online video modules have been launched by the Risk Management Team at MDDUS, offering advice and guidance on some common medico-legal risk areas in general practice.

These resources are among the first to go live as part of a new online risk management service at MDDUS being developed to help doctors, dentists and their wider healthcare teams manage and mitigate business and clinical risk. The new service is exclusive to MDDUS members and builds upon our long history of helping doctors, dentists, practice managers and their teams improve the quality of processes, people and patient service.

Each video is led by one of our experienced MDDUS risk advisers and is accompanied by a relevant risk checklist to help teams work towards building a safer practice. Topics include maintaining the integrity of your prescribing record, managing confidentiality in a practice setting, managing test results and process mapping.

MDDUS Risk Management can provide members with CPD verification for all of our risk video modules. More modules will be available soon along with podcasts and other resources on a variety of risk management topics.

To access the videos go to the Risk Management section of mddus.com. You can also check out our new Risk Management blog page at **http://riskblog.mddus.com**

Two-thirds of PMs have considered quitting

A RECENT survey by Medeconomics has found that 67 per cent of practice managers have contemplated leaving their job due to stress brought on by increased workloads.

In the survey of 216 UK practice managers, 95.7 per cent reported increased workload complexity and rising intensity (94.8 per cent), with greater stress (90 per cent) and hours worked (79 per cent). The survey also found that 64 per cent had considered moving out of general practice and 42 per cent leaving the NHS altogether. Another 35.3 per cent contemplated either retiring or reducing their hours.

Dr Kailash Chand, deputy chairman of the BMA, said: "Practice managers are working harder than ever before to meet the needs of the practice. We are seeing a morale dip to a level that I cannot remember in my 35 years as a GP.

"This could lead to a serious workforce crisis. The cause is that practice managers along with GPs are facing an unprecedented combination of rising patient demand, unnecessary targets and duplication of paper work for various quangos like the CQC."

Source: *GP Online*

GPs fear workload risks patient safety

MORE than 80 per cent of GPs worry about missing a serious condition in a patient because of their heavy workload, a new survey has revealed.

The vast majority of GP respondents – 91 per cent – also believe general practice does not have sufficient resources to deliver high quality patient care.

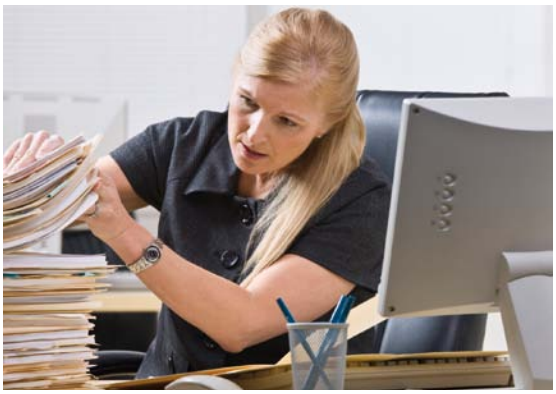
The views emerged in a poll by ComRes commissioned by the Royal College of General Practitioners (RCGP).

When asked to what extent they were concerned about missing a serious illness because of workload, 29 per cent of GPs said they worried a great deal, and more than half (55 per cent) worried a fair amount.

Nearly all of the 251 GPs surveyed (96 per cent) said they found their job stressful with the same amount saying that morale has decreased in the past five years.

Most predicted big changes to come with 70 per cent believing that the provision of general practice as we know it today will not exist in 10 years' time.

The RCGP has raised concerns about GP funding, highlighting figures showing 90 per cent of NHS patient contacts take place within general practice, yet it only receives 8.39 per cent of the NHS budget.



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.

CHAPERONE POLICY

Q A PM is reviewing the practice's chaperone policy and has found that, for intimate examinations involving a doctor and patient of the same gender, a chaperone is not routinely offered. The practice is often short-staffed and the manager asks MDDUS if the offer of a chaperone is essential for these same-sex consultations.

A MDDUS has handled a number of cases where a patient undergoing an intimate examination with a doctor of the same gender has complained about not being offered a chaperone. Finding a suitable chaperone for intimate examinations can put practice resources under pressure, but GMC guidance clearly states: "When you carry out an intimate examination, you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the patient." Chaperones should stay for the whole examination and, where practicable, be able to see what the doctor is doing. The chaperone does not have to be medically qualified but should have received appropriate training to understand what constitutes a normal examination and must be respectful of the patient's dignity and confidentiality.

MISSING RECORDS

Q A dentist suspects his receptionist may have stolen a number of patient records from the practice. Relations between the pair have been strained for several weeks after the receptionist was disciplined, and he has recently made comments about "getting even". The dentist is unsure of what to do if the records have indeed been stolen.

A The first step is to check if the records have been misfiled, rather than stolen from the practice. If you are sure they have been deliberately and inappropriately removed then ideally the practice would have in place a policy on dealing with a data security breach. This will include informing the patients concerned in writing and alerting the Information Commissioner's Office. The ICO identifies four key steps in a breach management plan: containment and recovery; assessment of ongoing risk; notification of breach; and evaluation and response. More detailed advice is available from MDDUS and from ico.org.uk.

RIGHTS OF ACCESS

Q The father of a six-year-old patient wants to access his son's medical records to check a prescription for a minor infection as the boy is staying for the weekend. The practice manager is aware the man is estranged from the boy's mother and that she doesn't want him to access their son's notes. She asks MDDUS how to proceed.

A A key element to consider before allowing access to records is whether the child's father has parental responsibility. While all mothers are automatically deemed to have parental responsibility, not all fathers do. A father acquires parental responsibility if married to the mother at the time of birth (or conception in Scotland). An unmarried father only has parental responsibility if it is recorded on the birth certificate at registration (since 1 December 2003 in England or Wales, 15 April 2002 in Northern Ireland and 4 May 2006 in Scotland). An unmarried father can acquire parental responsibility by legal agreement with the mother or by applying for a court order. The same laws apply to step-parents and civil partners. If the father's name is not on the birth certificate and he has not been granted parental rights by agreement or by court, then he is not entitled to access the records. If he is entitled, be sure that allowing access is not against the child's best interests. Any third party information should also be redacted from the notes.

NO VACCINES

Q The mother of a young girl is refusing consent for her daughter to be given the MMR vaccine, preferring instead a homeopathic treatment. The GP is concerned that this would not be in the child's best interests and also fears being held to account should the girl subsequently fall ill.

A Parents have the right to refuse vaccinations for their child and GPs should respect their decision. However, with such an important decision, consider involving both parents in the discussion. Be sure to clearly explain the risks and benefits of immunisation – leaflets or other learning materials may be a useful aid. If the parent(s) cannot be persuaded then make a detailed note of the discussion in the child's medical record.

PATIENT CONTACTS

Q A dental nurse volunteers for a local support group for people who suffer from dental phobias and anxiety. She occasionally talks to patients in the practice about it and wants to access the practice database to find their contact details and send out information about the group's work.

A Despite the nurse's good intentions, accessing the practice's systems to find patient contact details for this purpose would breach confidentiality. It would also be a breach of the Data Protection Act as personal information should only be used to provide patients with dental care or to inform them of services your practice provides. It should not be used to inform them of non-dental products, meetings or services. Make sure all staff are clear about who can access data and for what purposes.

HOLIDAY CLOSURE

Q The practice will be closed for an upcoming bank holiday weekend and the manager is concerned about the disruption that could be caused to patients, particularly as there were issues with the management of test results during the last holiday closure. She asks MDDUS for advice.

A With any holiday closure, planning ahead is key. On the day or two before the practice closes staff should be vigilant in relation to any abnormal result handling. Complaints can often arise in this area, particularly regarding issues like warfarin results or electrolyte abnormalities that may require more urgent attention. Clear, accurate and contemporaneous record keeping is essential, as always. Let your patients know about the closure – via the noticeboard, face-to-face or on the practice's website/social media pages. Patients on repeat prescriptions should be given a reminder to allow them to pick up any repeats before the long weekend. Prescription counter slips can also carry a special notice so that patients can make sure they have adequate supplies of repeat medication.

GAMES TIME OFF

Q A number of practice staff have tickets for the Commonwealth Games and have requested time off to attend. The manager cannot accommodate all the requests and asks MDDUS how to proceed.

A Check how many staff want time off and then compare that to the practice's staffing needs. There is no legal obligation for you to grant all requests, but be sure to follow practice policy and be consistent, fair and transparent. Options for staff include taking annual leave, making up time at a later date, allowing flexible working during the event or granting special paid/unpaid leave. A lottery system of picking names out of a hat could help when you cannot accommodate all requests. When refusing requests, give at least one day's advance notice for every day of leave requested, i.e. two days' notice if refusing a request for two days' holiday. You should also make it clear that unauthorised absence will constitute misconduct and could lead to disciplinary proceedings.

ACCIDENT QUERY

Q A patient explains his car has been hit by a taxi while it was in the practice car park. He is looking for potential witnesses to support his insurance claim and has requested a list of all patients who attended the practice that day around the time of the accident. The manager wants to help but is conscious of data protection rules. She adds that a disclaimer sign is displayed in the car park, stating that vehicles are left there at their own risk.

A Under the Data Protection Act you cannot reveal the contact details of patients for this purpose. The General Medical Council allows disclosure only where a serious crime has been committed. As with any minor road traffic accident, it would be the driver's responsibility to obtain the details of witnesses at the time. If a patient contacts you to say they witnessed the incident then you could invite them to contact the driver directly. You may sympathise with your patient but you are not required to help him with this issue.

ENTITLED TO CARE

Q A patient has been undergoing cancer treatment for several weeks and her GP has referred her for hospital treatment. However it has since come to light that she is a failed asylum seeker and, as such, is not entitled to free NHS care. The hospital has contacted the practice manager to confirm that, given the patient's illegal status, the practice will fund her care.

A An MDDUS adviser agrees that it would be unreasonable to expect the practice to fund the patient's secondary care. The practice should continue providing any immediate necessary treatment and the PM should contact the local clinical commissioning group (CCG) to clarify what this level of treatment would involve. The CCG should also be able to explain who is responsible for the cost of providing the patient's care. Until this decision is made, the practice should continue to keep the woman on their list and to meet her clinical needs as far as possible under the circumstances. The adviser also cautions the PM that MDDUS has defended cases on behalf of members where refusing or delaying treatment on the basis of eligibility has led to claims of negligence.

ABUSIVE PATIENT

Q A patient has been repeatedly rude and aggressive towards staff in the past few months, on one occasion insisting he only wanted to see a "male white doctor". He also shouted at reception staff and has been refusing to take his prescribed medication. The PM wants to remove him from the practice list and asks MDDUS for advice.

A GMC guidance advises that deregistration should be a rare event prompted, for example, by a patient being threatening, abusive or violent, persistently acting inconsiderately or unreasonably, stealing from the premises or making sexual advances towards a doctor/staff member. Before ending your relationship you should warn the patient in writing, highlighting his unacceptable behaviour – citing incident dates and details where appropriate – and advising that he may be deregistered if there are any further incidents. Include only relevant incidents – a failure to comply with treatment is not a valid reason for considering removal. Do what you can to restore the relationship with him and explore alternatives before deciding whether to remove him from your list. MDDUS is happy to review a draft letter before you send it to the patient.

The right time to **tweet**

In this age of social media, a clear practice policy is a must

SOCIAL media has become a firm fixture in recent years for both individuals and businesses alike, but such fast technological advancement is not without risk for medical and dental practices.

A huge number of people are active on social media now as part of their everyday lives, with recent figures revealing a staggering 24 million UK users logging on to Facebook each day, while one in four people (15 million) have Twitter accounts.

It is therefore hardly surprising that there are implications for practices regarding staff and their use of social media. At MDDUS, we often deal with calls from practices asking for advice on issues relating to social media- from how to deal with staff using smartphones or handheld devices during work time to Facebook posts containing derogatory comments about the practice, staff or patients.

Employees can be dismissed or disciplined for their online activities if their actions bring the practice into disrepute. Risks include a lack of productivity during working time and possible confidentiality and data protection breaches.

So what can a practice do to protect itself and ensure employees are fully aware of the risks and expectations when using social media?

Practices should have a social media policy within their IT policy which clearly states when and how often employees can access certain sites – if at all. This will make the process of taking disciplinary action easier if the need arises.

All new employees should receive a copy of the practice's social media policy while, for current staff, team meetings should be used to revisit policies on occasion as this can help raise awareness and educate staff on the pitfalls of social media misuse.

As part of your social media and IT policy, it should be made clear what is and what is not acceptable in and outside the workplace. For example, staff must not use blogs or personal websites to disparage the practice or anyone working there and an employee should not post anything critical or negative about the practice or anyone associated with it.

If an employee has had a bad day or a run-in with their manager, they should think twice about posting this on any social media website. A well-reported example of this came a few years ago when a group of dental nurses caught the attention of the General Dental Council for creating a Facebook group called "I'm a dental nurse and I hate patients" filled with insulting comments. Likewise, consider the possible implications before posting photos from a work night out and don't tag colleagues in pictures without their permission.

It might also be an idea to have a policy where practice managers and dentists/doctors are not "friends" with employees on Facebook.

A social media policy should cover both business and personal use as, even from the comfort of their own home, employees should be mindful of what they post online. Even with the proper privacy settings in place, anything posted online may end up being distributed further than intended, with the risk of messages or photos being shared by friends of friends. And remember that even deleted posts are often still visible via internet searches long after they have been removed from your social media pages.

Many people these days have a smartphone or tablet, so even where access to social media sites is restricted on work computers, you should ensure the policy covers internet use on employees' personal devices. It is one thing to be able to monitor and restrict access to the internet and social media sites on work computers, but more difficult to control when accessed via an employee's phone.

You should have a relevant policy that states when the internet can be accessed for personal use and when mobile phones can be used – whether that is not at all, during breaks or only in case of emergencies. You may wish to state that phones should be set to 'silent' to minimise disruption to the practice.

Social media can also have a business use within the practice and can be a helpful resource for sending out messages or information notices to patients. Practices who operate a Twitter/Facebook account should consider delegating a suitably trained member of staff to post relevant news and updates for patients. This can be useful in many ways, such as publicising health information, highlighting practice holiday closures or for situations where, for example, the practice phone lines are down.

Detailed policies usually only have to be enforced where employees cease to use common sense in their approach to what is and isn't acceptable. However, there are risks to consider with the use of social media and a clear policy can help protect the practice and ensure employees understand what is expected of them.

Janice Sibbald is an employment law adviser at MDDUS

GP premises – a new landscape

Sam Hopkins of Capsticks LLP offers a short guide to the role of new NHS organisations in practice premises in England

THE reforms introduced by the Health and Social Care Act 2012 were particularly relevant to GP premises in England.

Before the act came into effect, things were (relatively) straightforward. PCTs were responsible for commissioning GP services and for the reimbursement of GP premises costs. They owned thousands of GP surgeries and health centres occupied by GPs and were head tenant at all LIFT (Local Improvement Financial Trust) buildings.

In other words PCTs were landlords, commissioners and funders of GP premises costs. So GPs in occupation of PCT buildings only ever had to deal with their local PCTs in respect of surgery premises issues.

On 1 April 2013, all of that changed.

Ownership of the old PCT estate was transferred in several different directions. Some of the properties were transferred to local trusts. All of the old PCT head tenancies in LIFT properties were transferred to Community Health Partnerships Limited. The remainder of the PCT estate was transferred to a new company, NHS Property Services Limited.

Responsibility for the commissioning of GP services was transferred to NHS England. NHS England also assumed responsibility for the funding of GP premises costs.

If all of those changes have left you wondering who you should be speaking to in connection with premises issues today, you may find this short guide to the current role of NHS organisations in GP premises helpful.

CLINICAL COMMISSIONING GROUPS

CCGs took responsibility for the commissioning of elective and emergency hospital care, mental health and other services on 1 April 2013. They do not own GP surgeries but are a key stakeholder in the establishment of primary care premises strategies by NHS England.

COMMUNITY HEALTH PARTNERSHIPS LIMITED

CHP is a limited company but the Secretary of State is the only shareholder. CHP has existed in this form since 2007 but prior to that date it was known as Partnerships for Health Limited. On 1 April 2013, CHP acquired all of the former PCT head tenancies in NHS LIFT premises. Overnight CHP became the landlord to all GPs in occupation of NHS LIFT buildings. CHP does not commission healthcare services and does not provide reimbursement of GP premises costs.

CARE QUALITY COMMISSION

CQC was established in 2009 and, since 1 April 2013, has been responsible for inspecting GP surgeries to ensure that they provide 'safe, effective, compassionate and high quality' care. CQC publishes the results of its inspections on its website.

NHS ENGLAND (THE NHS COMMISSIONING BOARD)

NHS England assumed responsibility for premises costs funding on 1 April 2013. As a result, all new applications for reimbursement of premises costs by GPs should now be made via NHS England. NHS England must follow the new Premises Costs Directions 2013 when considering such applications. The 2013 Directions are closely based on the 2004 Directions, but there are some important changes.

NHS PROPERTY SERVICES LIMITED

NHS PS is a new limited company and, as with CHP, the Secretary of State for Health is the only shareholder. It was established to own and manage most of the remainder of the ex-PCT estate and is now the landlord to most GPs in occupation of old PCT buildings. NHS PS does not provide reimbursement of GP premises costs, but many PCT employees with previous experience of working with the GP premises costs regime transferred to NHS PS on 1 April 2013, rather than to NHS England. As a result, NHS PS does now provide advice to NHS England on GP premises costs issues. NHS PS does not have any commissioning responsibilities, although part of its remit is to provide "estates solutions" for commissioners. Most GPs in occupation of properties owned by NHS PS do not have formal leases in place. NHS PS will ultimately wish to grant formal leases to every GP, but this will be a considerable task, and GPs will wish to protect their own legal position.

In summary, there are a large number of new organisations in place today. If you are seeking advice or support in relation to GP premises issues, it will be important to develop relationships with the correct organisations at a local level. If you still have contacts with ex-PCT employees who worked on GP premises issues, then it would be worth keeping in touch with them so that they can introduce you to the right people.

Sam Hopkins is a partner in the Real Estate Department at Capsticks LLP. For further information he can be contacted at Sam.hopkins@capsticks.com

Accentuate

Influencing emotions amongst practice staff can help reduce patient complaints. MDDUS senior risk adviser Liz Price explains how

WHAT emotions do you experience at work? Whatever your own experience, you can be sure that your practice team experience the same variety – and probably others too.

All of us differ in how we feel about the expression of emotion in the workplace. Emotional displays can sometimes be difficult for managers and other team members to handle and they absolutely have an impact on others.

Although these impacts can be negative, evidence is building in support of the view that managers attending to, trying to understand and influencing emotions can be a useful risk management tool.

As a practice manager, you could try to ignore emotion but this can have negative consequences for yourself, other team members, the practice and your patients.

Emotions can have an impact on all areas of work within a practice, but I will highlight some of the ways emotions can impact on patient-service-related complaints. Following from these, there are some strategies managers can experiment with to help support the delivery of good patient service, and so reduce the likelihood of patient complaints.

POSITIVE EMOTIONS

There is strong evidence that the incidence of complaints in general practice can be reduced if patients have a positive emotional experience associated with encounters across the practice team.

Many complaints practice managers deal with are prompted by behaviour exhibited by clinical and non-clinical staff, and the resultant feelings experienced by the patient. The degree to which patients like your practice and your team is a function of the emotional value you add to the relationship. Therefore, to deliver patient service which promotes a positive experience in the patient, members of the practice team must add emotional value during each interaction. This applies to telephone and face-to-face contacts, and also in writing.

Many practices have tried to improve customer service by ensuring receptionists answer the telephone or greet patients at reception with a smile. Some have tried to script patient encounters positively to improve the patient's experience, and often this includes making contact with the patient at the end of each encounter.

AUTHENTICITY

It is not that these "improving customer care" initiatives are not useful. In fact the evidence is clear that they are. What causes them to fail is that these behaviours are not always displayed authentically. I am sure you will all have experienced the fake smile and "have a nice day" moments as a patient or customer yourself.

These inauthentic behaviours are very often related to the morale levels of the team members, the way they feel about their role and the way they feel about the practice. Research suggests that poor morale when delivering patient service predicts declining patient satisfaction.

Think about a receptionist. From their perspective, if they feel unhappy or under-valued in their role then any positive emotion they are asked to display is unlikely to be authentic. Their negative emotions may start to leak out and they may feel stressed by the conflict between what they feel and what their role requires them to display.

For a GP, eye contact during consultations can strongly influence how a patient feels about them. People who feel bad or stressed often struggle to maintain positive levels of eye contact, which can create a poor rapport with patients and perhaps provide them with a negative emotional experience.

From the patient's perspective, when a receptionist offers up a fake smile, rattles out positive words in a negative tone, or doesn't seem to be listening properly on the telephone, the overwhelming emotional impact of the encounter is negative. The patient may leave feeling that perhaps the receptionist doesn't really like them, or is disinterested. Certainly no rapport is felt and so if something subsequently goes wrong, the patient is likely to be less tolerant and more likely to raise a complaint.

Worse than this though, research shows that if a patient is dissatisfied, only four per cent will complain. The other 96 per cent who have had a negative experience will tell others, perhaps tainting the practice's reputation

the positive

in the community. There is also potential for these unhappy patients to become difficult to deal with as they remain frustrated but feel they cannot do anything about it.

EFFECTIVE TEAMS

If a manager can influence the mood of the practice team and promote activities which result in positive emotional experiences at work, then this can improve the effectiveness of individuals and the team as a whole.

Experiencing more positive emotions at work appears to have a direct link to increased cooperation and helpfulness within the team, feelings of satisfaction and motivation and importantly the urge to go the extra mile to please patients. Because when people feel happier they are much more likely to seem happier, which means displaying naturally positive emotions and associated customer care behaviours.

It is evident that positive emotions support improved practice performance and promote better team-working and individual feelings of wellbeing. So what can practice managers do to increase morale and ensure team members naturally feel more positive emotions at work?

PROMOTING POSITIVE EMOTIONS IN INDIVIDUALS

Practice managers can take opportunities during performance reviews to try to increase each individual's identification with their work role. Where individuals understand the positive impact of their role on patient care (and how it supports other team members), they often feel more positively about the work – even when it becomes more difficult.

Managers could include evidence about emotional competencies within frontline recruitment and selection decisions. For example, competencies such as agreeableness and extraversion (as opposed to introversion) are associated with more easily generating positive emotions.

Also, helping each staff member to script positive responses to common negative messages should reduce negative patient responses. It can also make difficult encounters feel less uncomfortable and help the patient feel less frustrated.

Practice managers must do as much as they can to create the conditions which support positive emotions in individuals, but sometimes negative emotional experiences are inevitable. And if these emotions are not recognised and handled promptly they can escalate and infect other team members as well as patients. Being 'present' and 'available' to recognise negative emotions can be difficult to manage if your location is isolated from frontline services or where you are under pressure yourself.

PROMOTING POSITIVE EMOTIONS IN TEAMS

Identifying opportunities to promote a strong social identity within the team is important. Many practices encourage group activities to promote positive social engagement and cross-team comfort. Effective examples I have come across include: a running club, which aimed to have a group of willing team members complete a charity relay race in aid of a local hospice, and a practice social club that arranged opportunities both in and outside of work for folk to have a bit of fun together (e.g. monthly informal team get-togethers over home-baked buns where team/practice achievements are highlighted).

To avoid feelings of unfairness or resentment building up that will impact negatively on the rest of the team, their morale and patient service, it is important that practice managers have the ability to identify team conflict at an early stage and put in place effective conflict resolution.

Many managers find this a difficult area to deal with and it can be hard work – especially if you yourself don't feel positive at times (we're all human).

It can help to keep in mind that creating and supporting conditions in which individuals and teams feel a high proportion of positive emotions can promote naturally occurring positive behaviours and communication. This will then reduce patient dissatisfaction, the potential for ongoing difficult behaviours and ultimately reduce the likelihood of patient complaints.

Liz Price is a senior risk adviser at MDDUS

Wirral innovation

Jim Killgore visits a Birkenhead practice group with a reputation for forward thinking in healthcare

IT'S a complaint heard increasingly often in NHS hospitals – an inordinate number of people turning up at accident and emergency with minor problems such as chest infections or cuts and sprains or stitches needing removal. Indeed it has recently sparked talk of a national crisis in emergency care. No one benefits as patients can end up spending hours waiting to be seen while overstretched A&E staff are distracted from dealing with more complex cases.

Such was the dilemma faced by Arrowe Park Hospital on the Wirral Peninsula. In 2008 the local PCT (through the local PBC Group) decided to set up a pilot scheme for dealing with minor injuries and illness within a primary care setting. This would extend access in addition to three local walk-in centres. It would be a nurse-led service with GP support. Patients could "drop-in" without an appointment and be treated on the spot or referred to a doctor if necessary.

Among local practices tendering for the service was one with a reputation for innovation. The Miriam Primary Care Group is headquartered in a purpose-built medical centre based in Birkenhead and run by an ebullient GP named Dr Abhi Mantgani. Spearheading the bid was his practice partner and senior nurse practitioner Philomena Potts.

The Miriam bid was successful and the pilot kicked-off in January 2009 at two locations. It was promoted among the 58 practices across the Wirral. Five years on the drop-in clinics are now open seven days a week at one site and five days at the other. Following this success the local commissioning consortia have piloted the service at three other sites. Conditions treated include bites, stings, burns, cuts, ear and throat infections, UTIs, minor eye or head injuries. The clinics also offer emergency contraception, dressings and removals of stitches and staples.

"We started off seeing about 10 or 15 patients on a week day and now we see between 50 and 60 in this one practice alone," says Philomena.

Wirral CCG estimates that the service is averaging around 23,000 to 24,000 patient encounters per year. The average cost is around £20 per patient episode. This is about half the per-patient cost of a walk-in centre and a third of the cost of an A&E visit. The Miriam team is immensely proud of what has been achieved.

"A&E attendances in the Wirral have remained static over the past three years whereas nationally you hear about 10 to 12 per cent more people attending A&E annually," says Dr Mantgani. "I think the minor injury and illness service has helped reverse the trend here."

The success of the service has also earned the Miriam Primary Care Group numerous plaudits, including nominations for HSJ and GP Awards and most recently a shortlist place in the Primary Care Team category of the 2014 BMJ Awards.

> "THERE IS A LARGE WORKFORCE OF NURSES WHO WANT TO BE EMPOWERED AND UP-SKILLED"
>
> *Philomena Potts*

SERVICES ON THE DOORSTEP

Recently I visited Dr Mantgani and his team at the Birkenhead Medical Building. Walking from Park Station the large three-story centre appears almost incongruous rising among the small terraced houses. Here Miriam shares facilities with the Cavendish Medical Practice along with a range of secondary care services run by Peninsula Health. The new building was opened in 2010. Passing through the front doors you enter an open and spacious ground floor reception and waiting area with almost the feel of a small hospital.

The centre is a far cry from Miriam's previous premises, says Practice Manager Jackie Ireland. "It looked a bit like Colditz," she says – a one-story building with barbed wire along the roof edge. "It was a bit of a shock when I first drove up for an interview." But she has now worked at Miriam for 23 years – first as receptionist and then a secretary and practice administrator before becoming a practice manager 10 years ago.

Dr Mantgani came to Birkenhead in 1986, employed as a young GP at a local practice, but within a year he had founded his own practice in a small neighbourhood health clinic. It was a brave move.

"Most practices would not have even set foot in this area back then because the reputation was pretty dire to say the least," says Paul McGovern, a commissioning support manager at Wirral CCG. The area suffered chronic long-term unemployment and was number one for child poverty in the whole of the UK. Among the older male community there was a legacy of industrial disease with a high incidence of respiratory illnesses. Drug and alcohol misuse was common among the youth, fed by the lack of work and low self-esteem. But Dr Mantgani embraced the challenge and within a few years the practice had grown from just under a 1,000 patients to 5,000. Many of the problems remain but things have improved locally.

In subsequent years Dr Mantgani and the staff at Miriam pioneered new ways of improving healthcare services in the area. It was one

Practice manager Jackie Ireland (centre) and the team at the Miriam Medical Centre in Birkenhead

PHOTOGRAPHS: COLIN MCPHERSON

Philomena Potts and other nurse practitioners based at the Birkenhead Medical Building (right)

of the first practices in the Wirral to introduce chronic disease clinics for conditions like hypertension and diabetes with patients able to see consultants and other specialists on the doorstep rather than having to go to hospital. The practice also invested in IT early on and became "paperless".

"That little building was like a Tardis inside," says Jackie. "We had so many extensions and add-ons because he brought so many new services into the practice."

EMPOWERING STAFF

Miriam occupied its old premises for 23 years before making the welcome move to the Birkenhead Medical Building. Here practice patients share the waiting area with those attending for the minor injury and illness clinic.

"At the moment I have about 12 or 13 nurses who primarily do minor injuries and around 11 have achieved their nurse prescribing status," says Philomena. "The practice has supported this and the nurses have benefitted from training budgets at the CCG and through bursaries. This attracts good nurses."

Making use of skilled practice nurses in this way has met with some resistance, admits Dr Mantgani. "A few of our colleagues challenge the ethos of what we are doing because their view is that care should all be centred around the GP in terms of triage and delegation. If we had enough GPs in the NHS to do that it would be fine. But what we have demonstrated here is that if you empower nurses and provide support to take things forward you can deliver a high-quality service which is economical and scalable. This may be one model that can help to meet the unrelenting demand for access in primary care."

> "IF YOU EMPOWER NURSES AND PROVIDE SUPPORT TO TAKE THINGS FORWARD YOU CAN DELIVER A HIGH-QUALITY SERVICE."
>
> *Dr Abhi Mantgani*

In addition to the minor injury and illness service Miriam also provides Wirral CCG with other nurse-led services, including one for hospital admissions avoidance. The Kings Fund has reported that over 80 per cent of emergency admissions staying for more than two weeks are patients aged over 65, and other studies have shown that older people admitted to an acute hospital setting are more likely to stay and suffer life-threatening infections, falls and delirium. The Admissions Prevention and Facilitated Discharge (APFD) service in the Wirral (along with a second similar scheme) aims to reduce hospital admissions and also facilitate a discharge process for those who may already be languishing in hospital.

Patients are referred to the service by their GP or a district nurse or social worker. A senior nurse clinician then works closely with health and social care multi-disciplinary teams to support home care or other solutions such as long-term care placements within nursing homes.

"The admission prevention nurses are a separate team from minor injuries," says Philomena. "But I try and get them trained so they can step into any role if ever there is a shortage in one area. They like the variety and it enhances their knowledge and their skills."

Philomena joined the practice 13 years ago with a varied background in nursing and also a stint working as a pharmaceutical rep. Four years ago, having been instrumental in developing the expanded services at Miriam, she was invited by Dr Mantgani to become a partner in the practice, which is unusual for a practice nurse. Last year she also won the Nurse of the Year at the 2013 General Practice Awards for her efforts on the Wirral.

Philomena says she would like to see more practice nurses taking on a greater role in developing and delivering enhanced services to make the NHS more efficient.

"There is a large workforce of nurses out there and they do want to be empowered and up-skilled."

Jim Killgore is an associate editor at Practice Manager

Removing a troublesome patient from the practice list is rarely an easy option. PM editor **Scott Obrzud** urges caution

Last resort

MOST practice managers will have at some time faced the prospect of removing a patient from the practice list. In many cases the rationale is obvious and clear cut, for example when a patient no longer lives within the boundaries of the practice. Sometimes it may be for more fraught reasons such as when a patient has become violent towards a doctor or member of staff. But what about those patients who are continually rude to staff or who seem to complain perpetually about one issue after another?

MDDUS advisers frequently get calls from practice managers in regard to deregistering patients. Often the request has come from a doctor at the end of their tether with a patient's unrelenting demands, or the practice staff is no longer willing to tolerate an individual's bad behaviour at the reception desk.

Practices must act with care when considering removing a patient from the practice list. MDDUS has dealt with many cases where practices have faced censure for deregistering a patient without adequate warning. Complaints over removal not resolved at practice level can escalate to the ombudsman or a professional regulator who may levy criticism on practices or individuals for failing to follow contractual or professional requirements.

In 2011 former Parliamentary and Health Service Ombudsman Ann Abraham expressed concerns that "far too often" GPs don't seem to be aware that their contracts require them to give a warning before a patient is removed "unless the circumstances are exceptional." She said that in "far too many cases [what we see] is a knee-jerk response to a single incident where an individual – sometimes a whole family – is removed."

IS REMOVAL JUSTIFIED?

A good starting point for any practice contemplating patient removal is a careful consideration of GMS contractual requirements. These stipulate that the patient should have had a warning in the previous 12 months about the situation or behaviour that the practice finds unacceptable, pointing out that the patient may be deregistered if this continues. The warning should offer the patient an opportunity to reflect on their actions and modify their behaviour. The GMS contract allows discretion to remove a patient without warning if a practice has a genuine belief that the issuing of such a warning would be harmful to the physical or mental health of the patient, or might put at risk the safety of the doctor or practice staff.

In the circumstance of aggressive or other unacceptable behaviour it would be reasonable to provide the patient with a formal warning in the form of a letter. The letter should advise the patient of the issues that have led to an erosion of the patient-practice relationship and should draw attention to the particular behaviour in question and in a manner that offers an opportunity to change that behaviour. The warning letter should detail what is expected from the patient, as well as any boundaries the practice might wish to implement in order to improve the situation.

Except in extreme cases (such as those involving violence), removal should only be considered where the patient has persistently displayed unacceptable behaviour and should not be based on a single incident. Patients should not be removed from a practice list simply because they have made a complaint against the practice, for failing to comply with health advice or because they have a highly dependent condition or disability.

The GMS contract has separate provisions for the immediate removal of violent patients, but in these circumstances it is expected that the police would have been informed of the incident. As well as their contractual requirements, practice managers should also be mindful of professional guidance offered to doctors by the General Medical Council. In the document, *Ending your professional relationship with a patient*, the GMC stipulates that:

- Deregistration should be a rare event

prompted for example by the patient being threatening, abusive or violent, persistently acting inconsiderately or unreasonably, stealing from the premises or making sexual advances towards a member of staff. Patients should not be deregistered simply because they have made a complaint or a claim, or because their medical needs are burdensome.

- Every attempt should be made to restore the relationship or consider alternatives.
- A warning should be given that you are considering ending the relationship.
- When the decision has been made, the reasons should be explained to the patient in writing.
- When documenting the circumstances into the patient's records, the entries should be factual and not written in a way that may unfairly prejudice future care.

The GMC also states that you must make prompt arrangements to ensure the continuing care of the patient and pass on the patient's records to a new practice without delay.

MEDIATION FIRST

One key element in all the guidance dealing with the breakdown in the practice-patient relationship is the need for a genuine attempt to resolve any issue that may have led to the impasse – to avoid that "knee jerk" reaction to "difficult" patients. The NHS Choices website informs patients: "you have the right to complain, have your complaint investigated, and be given a full and prompt reply." Not only this but patients have the right to expect that making a complaint will not prejudice their ongoing care.

Our advice to practices in dealing with "difficult" patients is first to open a dialogue. Invite the patient to attend the practice for a discussion and try to get at the root of the problem. Sometimes there may be some underlying issue, such as a previous grievance. It may not even have to do with the patient themselves but with a family member. Some patients may also have unreal expectations of the service you are providing – for example that care should always be offered by a doctor rather than a practice nurse.

You should also consider the patient's personal circumstances, bearing in mind any known physical or mental health conditions that may explain the reason for the difficult behaviour. Have they suffered a recent bereavement or job loss or marital breakdown?

To avoid charges of prejudicial treatment it is important to demonstrate you tried to mediate and resolve the breakdown in the relationship with the patient. There should be some discussion of possible ways of moving forward constructively and these discussions should be documented before making any decision to deregister.

Other alternatives to removal should be considered such as transferring the patient's care to another partner (with the consent of both parties) or persuading the patient that it would be better for all concerned for he or she to attend another practice. In any case, it would be wise to get some advice before considering the deregistration of any patient and remember that MDDUS advisers are on hand to discuss such matters.

Scott Obrzud is an MDDUS practice adviser and co-editor of Practice Manager

FURTHER RESOURCES

- *British Medical Association – General Practitioners Committee (GPC) Removal of patients from GP lists*
- *Department of Health - Health service circular 2000/001 Tackling violence towards GPs and their staff*
- *General Medical Council - Ending your professional relationship with a patient (2013)*

tolerance

Day one

Mr P is 53-year-old arts administrator. He has been a patient at the surgery for five years and is a frequent attender with a reputation for being demanding and sometimes rude and abusive to staff when he does not get his way. He phones the surgery first thing in the morning and demands an emergency appointment.

Later that day

Mr P is seen by a young GP locum – Dr L – and enters the consulting room with a plastic folder bulging with printouts from the internet. Even before the doctor can ask what the problem is he says: "I need for you to arrange some blood tests to check my vitamin levels – in particular A, D, E and K." He informs the GP that he has inflammatory bowel disease (IBD) which affects the absorption of fat soluble vitamins. Dr L checks the records and notes that Mr P has been investigated previously and diagnosed with irritable bowel syndrome. She explains that the two conditions are different – IBD being much more serious. Mr P replies "I'm not stupid" and stands up from his chair, thrusting a print-out into Dr L's face. "Look at the symptoms. I've been misdiagnosed. The blood tests will confirm that!"
Dr L calmly asks the patient to sit down. She explains that such tests are not routine and first she must take a history of the complaint and then do an examination. Only then can she order relevant tests.
Mr P grows angry and accuses Dr L of being ignorant along with the rest of the staff – especially the female ones. He stands up and shakes a finger in her face ranting about how it's just the NHS trying to save money. He then kicks over his chair and storms out the room.

Day three

The practice manager – Ms K – writes to Mr P to say Dr L has informed her of his aggressive conduct during the consultation. In the letter Ms K also refers to a number of previous incidents in which Mr P had been verbally abusive toward staff, including an incident when she had tried to arrange a referral for him to a local homeopathic clinic. Mr P had shouted and accused her of incompetence over the phone before hanging up. On that occasion she had written to Mr P stating: "Please note that this practice operates a zero tolerance approach. No form of aggression against staff, verbal or physical in nature, will be tolerated and this letter is to inform you that any repeat of such behaviour may result in you being removed from the practice's list of registered patients." Given the further incident of abusive behaviour Ms K now informs Mr P that he will be removed from the practice list and that the local CCG has been informed of the reasons behind his removal. The removal will take effect in approximately 10 days and she suggests Mr P register with another practice.

Day five

Mr P writes a letter in reply to the practice manager refuting that he acted abusively or with aggression. The letter states he is aware that the doctors have been keen to be "rid of him" as he does not "conform to their ideal of the submissive, unquestioning patient".
Mr P then states that Ms K's criteria for "abusive" seems subjective at best and that he would describe his behaviour as "forthright". He concludes the letter by saying he will be taking the matter up with the Ombudsman.

THE practice manager contacts MDDUS for advice on the complaint. Ms K drafts a reply and forwards it to an MDDUS medical adviser to review. Among other advice it is suggested that all staff members abused by Mr P provide an account of the experience including administrative and clinical details. Dr L should also provide a full account of the consultation on Day one.

Ms K is sent a copy of GMC explanatory guidance on *Ending your professional relationship with a patient*. She is also provided with a link to guidance by the Royal College of General Practitioners on the removal of patients from the practice list.

A week later Ms K posts a reply to Mr P's letter stating that the practice has considered his comments. She restates the reasons behind the decision for removal, adding that there has been a breakdown in the doctor-patient relationship and it is clear that Mr P no longer has confidence in the GPs in the practice. She again advises the patient to register with another practice so that a transfer of records can be quickly facilitated.

KEY POINTS

- Ensure practice leaflets include policies on removing patients and "zero tolerance" to violence/abuse.
- A patient being removed from the practice list should have been given a written warning within the last 12 months.
- Consult GMC, RCGP or BMA guidance on patient removal.

Diary

DEMATERIALISING GPs, sadistic dentists, sickeningly cheerful managers, put-upon family doctors and accident-prone health visitors - it's Diary time again.

➔ BAD MOVES Diary rarely makes mistakes but has great sympathy for all those who do. Maybe you've wondered why you seem to keep making bad decisions or repeating past mistakes. Perhaps your lateral frontal pole prefrontal cortex is to blame. Scientists at Oxford University have discovered this part of the brain plays a vital role in pondering life's "what ifs". They compared brain scans of 25 men and women with monkey brain scans and found our simian relatives lacked a lateral frontal pole. This uniquely human area of the brain – which is also linked to multi-tasking – helps us learn from watching others' mistakes, speeding up the acquisition of new skills. It varies in size from that of a Brussels sprout to as big as a tangerine. Source: *Daily Mail*

➔ RISK ON THE ROAD Healthcare workers are apparently among the most accident-prone motorists on the road. Research from gocompare.com has found that GPs made proportionately more car insurance claims than many other professions last year. Figures show 28.6 per cent of GPs had at least one claim in 2013. Professor Andrew Smith from Cardiff University's school of psychology believes the stress of the job could be making them absent-minded and distracted, adding: "You might even find that [stress makes you] become especially clumsy at times." Health visitors and community nurses were also in the top 10 list of claims. Gocompare.com recommends stressed-out drivers are encouraged to take time to calm down before getting behind the wheel. Sage advice, although there doesn't seem to be any data on the relationship between GP car insurance claims and the number of home visits doctors make to those less salubrious areas.

➔ GET YOURSELF LIKED If you've ever wondered how to get more out of your practice employees then (yet another) survey appears to have the answer. Job website TipTopJob found that 86 per cent of employees believe they are more productive if they like their boss. A good working relationship with managers and bosses was shown to be more important than with fellow employees. Just over a third of respondents (37 per cent) said a good working relationship with colleagues made them more productive. Happiness was also listed as a motivator for 22 per cent of workers. Diary is now off to spread some good cheer.

➔ JERKS (AND WORSE) Poor dentists never seem to catch a break when it comes to Hollywood. There's been a string of films portraying them as psychopaths and predators, from the Nazi in *Marathon Man* to the sadistic nitrous oxide sniffer in *Little Shop of Horrors* and the sexual harasser in *Horrible Bosses*. Now Woody Allen has thrown in his tuppence worth. His latest Oscar winning flick *Blue Jasmine* stars Cate Blanchett as a down-on-her-luck ex-socialite who takes a job working for a San Francisco dentist. And it's not long before her lecherous boss makes a move on her, proving that dentists continue to rank among Hollywood's favourite respectable bad guys. No doubt revenge by filmmakers for all those traumatic childhood memories of giant syringes and painful extractions. Source: *The New York Daily News*

➔ WHAT'S IN A NAME? Ten years' worth of frustration to one angry doctor. An Essex GP recently applied to change his name by deed poll to Dr John Cormack-the-Family-Doctor-who-works-for-the-NHS-for-free. This was done in protest at serious underfunding from his local CCG. The GP who runs a practice of 4,000 patients has been reduced to paying his staff – four nurses and a part-time locum – from his own pension fund and claims that in 2011/12 the cleaner earned more than he did from the practice. Ten years of unfruitful negotiation with representatives of his LMC and former PCT drove him to this final desperate act. Dr Cormack-the-Family-Doctor-who-works-for-the-NHS-for-free is now in the process of registering his change of name with the GMC and Mid Essex CCG.

➔ NOW YOU SEE HIM... Most retiring GPs slip quietly away with a few buns at coffee time or maybe staff drinks at the local pub. Patients are often none the wiser. Not so with Dr Richard Hughes who retired in April at age 60 from Hanway Medical Practice in Portsmouth. Patients queued for four hours to thank the GP in person for his 32 years' of service. Practice manager Denise Fenton said that Dr Hughes was so dedicated that he would sometimes call worried patients at 10pm to give them test results. "He knew most patients by name, made them feel valued and treated them as individuals." A much splashier exit was planned by Dr Ajay Vora for his retirement from Barnetby Medical Centre after 25 years. Dr Vora put on a show at Grimsby Auditorium for over 1,000 of his patients with magic, music and dance. The doctor, who is member of the Magic Circle, performed along with his wife and practice nurse Angela. Dr Vora said: "We wanted to let everyone have an invitation to thank them personally and wave goodbye from the stage." Diary would prefer buns.

CALL FOR DIARY ITEMS Do you have any tidbits, anecdotes or absurdities in a similar vein to the items above? Please write in or email them to **PM@mddus.com**

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