Practice Manager
AN MDDUS PUBLICATION
ISSUE 11

FLAMING ANNOYANCE

How should practices deal with negative or abusive comments online?

TRUST, CHALLENGE AND RISK

Conflict is natural in teams but for it to be healthy you must have trust.

WHO WOULD BE A PARTNER?

A growing number of PMs are becoming practice partners. What are the pros and cons?

CAMPUS CARE

PROFILE : BARCLAY MEDICAL PRACTICE AT UNIVERSITY OF GLASGOW

MDDUS

PHOTOGRAPH: DANIELE CAROTENUTO

Practice Manager

I AM pleased to take my first turn as editor in this issue of *Practice Manager*. First I would like to welcome Jill Thomson to the advisory team as a practice adviser. Jill is currently undergoing training and is looking forward to speaking to our members on the advice line in the very near future.

Many practices and individuals are finding themselves at the sharp end of comments on social media and the article on **page 7** offers some advice on dealing with unwelcome postings.

A few years ago it was almost unheard of but today more PMs are becoming partners in their surgeries. On **page 12** solicitor Michael Royden looks at the pros and cons for those considering an offer.

Most of us don't like challenging others but can a team function effectively without it? Trust and respect are essential in enabling challenge and healthy conflict to ensure patient safety and on **page 8** risk adviser Cherryl Adams explores how these can be fostered.

It's not all hangovers and STDs but university students do pose some unique challenges as patients. Barclay Medical Practice operates a surgery on the campus of Glasgow University dealing with over 15,000 students. On **page 10** Jim Killgore meets practice manger Kim McWilliams and senior GP partner Dr Des Spence.

Next April, fathers who want to take a greater role in the day-to-day care of their newborn children will be afforded that right by the new Shared Parental Leave (SPL) scheme. On **page 6** Liz Symon looks at what this will mean for employers.

And on **page 4**, tannoy gaffs, mistranslations, DNAs, overcritical parents, grimy carpets and a consent form past its sell-by are among the topics addressed in our Call Log.

Helen Ormiston
Editor

Bleak Practice – the sequel

A SEQUEL to our video eLearning module *Bleak Practice* – featuring a fictional GP surgery in crisis mode – is now available to MDDUS members.

It follows on from the events and characters introduced in the first module – this time focusing on additional risks common in general medical practice such as record keeping, results handling to avoid delayed or missed diagnosis, supporting colleagues with health problems and team communication. As with the first module, a downloadable discussion guide is available to help PMs and GPs take their teams through the risk areas and apply lessons learned to their own practices.

MDDUS doctors and dentists can access the video eLearning module in the Risk Management section of mddus.com using their surname and membership number. Practice managers should contact **risk@mddus.com** to receive a unique access code.

MHRA warning on bogus dental equipment

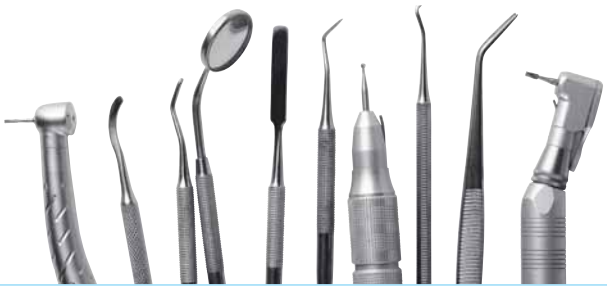
OVER 12,000 different pieces of poor quality dental equipment imported into the UK from China and Pakistan and sold on auction websites have been seized by the Medicines and Healthcare products Regulatory Agency (MHRA) in the past six months.

The regulatory agency is warning dentists and practice managers about the potential danger of buying and using counterfeit and unapproved dental equipment. It has six ongoing investigations involving the purchase of dental equipment from auction websites by UK dental practices.

The seized items include dental X-ray machines that emit high levels of radiation, hand-piece drills that could malfunction and disintegrate inside patients' mouths and poor quality root canal files that could break on use. About 40 per cent of the equipment is counterfeit and 60 per cent non-compliant with European medical device regulations.

Alastair Jeffrey, the MHRA's Head of Enforcement, said: "Dentists must source their dental equipment from reputable suppliers. Purchasing from auction websites and being unable to verify the integrity of the seller has the potential to increase risks to patients and cause reputational damage to the dental profession."

The MHRA is asking dental staff to report non-compliant devices to the MHRA Adverse Incident Centre at **aic@mhra.gsi.gov.uk** or on **020 3080 7080.**



MDDUS

EDITORS:
Scott Obrzud
Helen Ormiston

ASSOCIATE EDITORS:
Jim Killgore
Joanne Curran

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

PRINT:
J.Thomson Colour Printers
www.jtcp.co.uk

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

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

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

Video modules on assertiveness and data security

MDDUS members can now access new video modules on the importance of assertiveness skills in effective risk management, and also tips on enhancing data security in your practice.

Assertiveness is a key skill in communication and a lack of assertiveness can contribute to adverse incidents. The video – *Human factor risks: assertiveness* – explores what it means to be assertive and provides some practical examples and familiar scenarios to illustrate the theory.

Data security breaches in general practice are not as uncommon as you might think and can lead to unwelcome scrutiny by the Information Commissioner. Our new *Data Security* video module explores some common issues, along with possible measures that can be put in place to keep patient information secure and ensure that it is processed in a safe manner.

MDDUS doctors and dentists can access the video eLearning module in the Risk Management section of mddus.com using their surname and membership number. Practice managers should contact **risk@mddus.com** to receive a unique access code.

Flexible working requests now for all

EMPLOYEES who have worked in an organisation for more than 26 weeks now have the right to request flexible working following the introduction of the Children and Families Act.

This aspect of the bill came into effect on June 30 and was a right that was previously only made available to those with childcare or caring responsibilities. It is now being extended to all employees as an option to enhance good work-life balance. Surveys suggest that having flexibility in the workplace is regarded by many employees as a greater benefit than pay and can be a useful retention tool.

Rather than set specific timescales, the new code states that an employer has an obligation to consider requests in a reasonable manner and meetings should take place as soon as possible. Of course, not all applications will be successful and practices may not be in a position to grant all requests.

MDDUS employment law advisers have provided guidance on the new scheme which can be found in HR and Employment Law section of **mddus.com.**

GPs still prescribing unnecessary antibiotics

A SURVEY of over 1,000 GPs has found that 70 per cent have prescribed antibiotics when unsure if an infection is bacterial or viral.

It also found that 90 per cent of GPs feel pressured by patients to prescribe antibiotics and 45 per cent say that they have prescribed them for a suspected viral infection even when they knew it would not treat the condition.

The survey was conducted on behalf of the Longitude Prize, run by the innovation charity Nesta. In June the public voted for antibiotics to be the focus of the £10 million prize, the remit being "to create a cost-effective, accurate, rapid and easy-to-use test for bacterial infections that will help health professionals worldwide to administer the right antibiotics at the right time".

Last year over 50 million antibacterial items were dispensed in the community in the UK and antimicrobial resistance poses a "catastrophic threat" to health in the coming decades. Read more in our Risk blog at **http://tinyurl.com/l483pch**

Practices urged to link up

MEDICAL practices need to evolve into "super GP practices" or networks that can pool resources and draw in specialist expertise from other professionals like pharmacists, geriatricians and psychiatrists.

This is one of the findings of a report by the Nuffield Trust entitled *Is General Practice in Crisis?* which draws on analysis of the latest data on GP services and the results of a separate survey of over 100 influential health and social care leaders.

The report points out that the number of one-doctor GP practices has halved in seven years, from 1,717 in 2006 to 891 in 2013, whilst the number of practices with 10 or more doctors has grown by over 75 per cent. Over three quarters (77 per cent) of the health and social care leaders surveyed believe that small GP practices are no longer fit for purpose. The briefing also shows that reported funding for general practice has fallen by almost £300m in a single year to 2013/14 and its authors argue that general practices will need extra resources and support to link up and find new ways of meeting the different needs of their patients.

Mark Dayan, lead author and Nuffield Trust Policy Officer said: "Many GPs are already joining up to build successful networks with other healthcare professionals in their area. This doesn't mean that the familiarity of local practices will be lost or that GPs will vanish from rural areas. Working in bigger, better-organised groups can carry the important neighbourhood presence that many GP surgeries have through tough times. But it will need politicians to give GPs time and support as they make the switch to scaled-up general practice fit for the future."

Access the report at **http://tinyurl.com/m445698**

MDDUS recruits new practice adviser as membership grows

MDDUS has recruited a new practice adviser in our Glasgow office, as membership continues to grow throughout the UK.

Jill Thomson – former practice manager at the Tranent Medical Practice – joins the medico-legal team, bringing the number of new MDDUS staff recruited since the beginning of last year to 27. MDDUS has enjoyed more than a decade of undiminished growth with a 75 per cent increase in active membership since the year 2000.

Figures from the company's 2013 annual report reveal that 58 per cent of MDDUS members are now based outside of Scotland, while our GP market share in the rest of the UK has increased from seven per cent in 2000 to 22 per cent in 2014.

Membership also increased among private physicians, hospital doctors and general dental practitioners. As of July 1 2014, total membership stood at 38,634, a rise of 9.8 per cent over the previous year, with this number estimated to exceed 40,000 by the end of 2014.

MDDUS Chief Executive Professor Gordon Dickson said: "Increased membership brings with it an inevitable increase in cases and we have expanded our team of advisers to ensure we continue to offer members the very best service."

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.

BROADCAST BLUNDER

Q A patient recently attended our practice to consult with a GP who called him to the consultation room using the tannoy function installed in the new telephone system. However, the doctor failed to switch off the tannoy and the first few minutes of the consultation were broadcast for the whole waiting room to hear. The doctor reassured the patient at the time that he should not worry because no particularly sensitive matters had been discussed. The patient has since made a complaint and, as practice manager, I am unsure how best to proceed.

A As with all complaint responses, it is important to acknowledge that a mistake was made, to apologise for the distress caused and to offer a full explanation of how things went wrong. You should also take steps to ensure a breach of confidentiality like this does not happen again, and to reassure the patient of this. You should certainly not seek to dismiss their concerns: in this case, it seems unwise to simply tell the patient "not to worry". Be sure to discover what went wrong with the phone system in this instance and make sure that in future all staff are aware of how to operate it, particularly when a tannoy function is available. MDDUS can assist with the drafting of written responses tailored to each individual complaint and provide further advice and support should the case escalate.

HOLIDAY CHANGES

Q A couple of our practice employees regularly work overtime and I have heard them mention that they will soon be entitled to more holiday pay because of a recent employment tribunal ruling. Will the practice have to start paying them more?

A Yes. The long awaited judgement on the *Bear Scotland & ors v Fulton & ors* (and related cases) has held that holiday pay calculations should include regular overtime, even non-guaranteed overtime. The judgment only applies however to four weeks under the Working Time Directive and not the additional 1.6 weeks granted in the UK and may be subject to appeal. Any members who have questions on this please contact the MDDUS employment law advice team.

LOST IN TRANSLATION

Q A patient from Poland recently came into the practice for dental treatment but did not speak very good English. One of our nurses is Polish and speaks very good English and it was agreed he would translate what the dentist was saying. The patient has since complained about his finished treatment, claiming he did not expect his teeth to look the way they do. The dentist also did not note any details of the process of translation or consent. How should we proceed in future?

A When treating patients with limited English, ideally a professionally qualified interpreter should be used. They should be told beforehand that the dentist must hear all information offered by the patient and that everything the dentist says should be translated for the patient. Check the patient is comfortable before proceeding and clearly record in the notes that an interpreter is present, including their name and contact details. It should also be noted that the patient has consented to the arrangement and a clear account given of the information shared during the consultation. Extra care should be taken when using a non-professional interpreter – relatives/friends are often not appropriate as there is no way of knowing their grasp of the language and they could undermine confidentiality. They may also lack objectivity and be unfamiliar with clinical terminology. Take care also when using a practice staff member to translate as they may not be sufficiently skilled for the task. For valid, informed consent, it is vital to confirm the patient has understood the information given and is happy with the proposed course of treatment.

TACKLING DNAs

Q A number of our patients frequently do not attend for reviews or monitoring of their medication. To what extent are we expected to keep contacting these patients to encourage them to come in?

A It is important to explain to patients the benefits of attending for review and the risks of not doing so, ensuring they have sufficient capacity to understand and make their own decisions on the matter. Be sure to clearly document all attempts to contact the patient and the advice given to them about non-attendance. Practices should have a clear policy on dealing with DNAs, with a system in place to identify patients who fail to attend and a means of dealing with those who cause concern. There should be a prompt investigation of why a patient has not attended as some vulnerable patients may need extra support/advice. It would be for the GP to exercise their clinical judgement as to whether repeat prescriptions should be ended for repeat non-attenders, taking into account the GMC guidance on this issue: www.gmc-uk.org/guidance/ethical_guidance/14325.asp

REASONABLE REMOVAL

Q One of our patients has made a large number of complaints over the past two years about various aspects of his clinical care as well as criticising the practice appointments system and the behaviour of some of our staff members. He has just submitted yet another complaint and I feel it may be better if he was removed from the practice list and encouraged to find another GP.

A The decision to remove a patient from the practice list must be made very carefully. Guidance from the RCGP and GMC is clear that you should not end a professional relationship with a patient solely because of a complaint the patient has made about you or your team, or

because of the resource implications of the patient's care or treatment. There is a clear process to be followed, one which must be fair and reasonable and does not discriminate against the patient. Usually removals are made where the relationship between the practice and the patient has broken down, often as a result of aggressive or violent behaviour. GMC guidance also provides for removal in situations where a patient has "persistently acted inconsiderately or unreasonably," leading to a breakdown of trust between doctor and patient. Before removal, you should warn the patient of your intentions and do what you can to restore the relationship. If the decision to remove is taken, inform the patient in writing (explaining the reasons why) and note this in their record. Be sure to give the patient information on finding another GP.

INFECTION CONTROL

Q I have recently started work managing a medical practice and have been checking compliance with infection prevention and control requirements. I notice one of the waiting rooms still has carpeting on the floor. Is this a problem?

A Each clinical commissioning group (CCG) or health board area will have its own infection prevention and control policies and you should consult the relevant policy for your area. Generally, carpeting is not recommended in any clinical areas (particularly not treatment rooms) or patient waiting areas due to the risk of body fluid spills. Any other carpeted areas should be well vacuumed and cleaned regularly in line with local policies. This should be set out clearly within the practice's written cleaning schedule. Practices in England and Wales will have to comply with requirements of their registration with the Care Quality Commission (CQC) while those north of the border are inspected by Healthcare Improvement Scotland.

DRINK PROBLEM

Q One of our practice staff members has turned up to work recently smelling strongly of alcohol and her appearance is sometimes dishevelled. She has made an increasing number of errors lately and I am concerned she has a drink problem which could impact on patient safety.

A If you believe a staff member is under the influence of alcohol then it must be addressed immediately. Ask her about it in a confidential setting, focusing on the workplace performance issues and giving clear examples of where errors have been made. If she denies it, then give clear timescales for improvement and offer extra support and training. If she admits to a problem, offer to refer her to a counselling or AA group, as well as focusing on the errors. It should be made clear that being drunk at work will not be tolerated and can be a dismissible offence. Where an employee is clearly drunk at work, consider sending them home on paid leave while the matter is investigated. A clear, up-to-date practice policy on alcohol use is essential. It may also be worth involving occupational health services.

OLD CONSENT

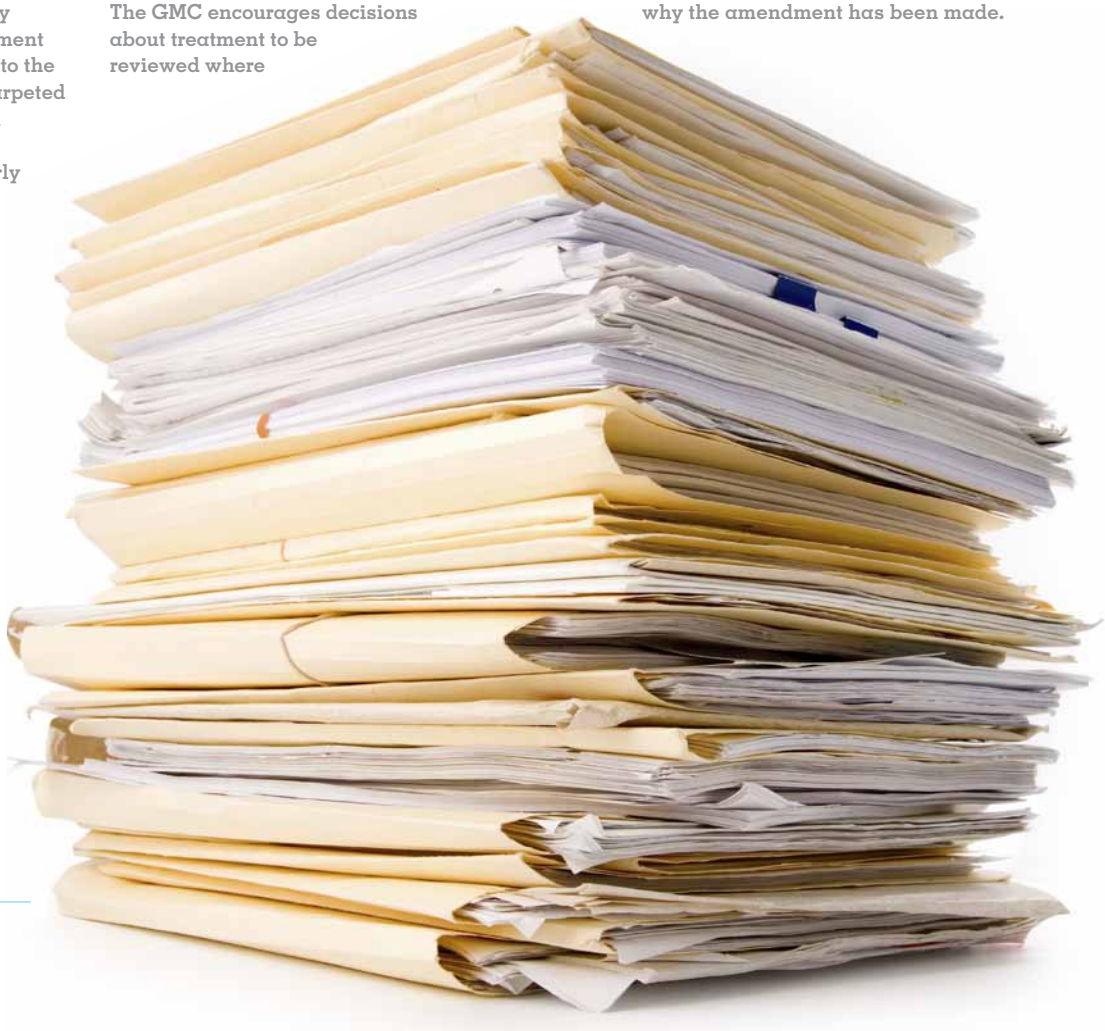
Q The social worker of a 15-year-old patient, who suffers mental health problems, has contacted the practice seeking access to his medical records in order to update his file. The GP asked for evidence of written consent from the patient and the social worker has sent back a consent form dated almost two years ago. Is this still valid?

A It would be reasonable to conclude that a consent form signed so long ago is now so old as to be no longer valid. While there is no official time limit on consent taken in advance of treatment or for other purposes, such as third party disclosure of confidential information, it would be advisable to review it in this case. The GMC encourages decisions about treatment to be reviewed where "significant time has passed since the initial decision was made" as patients have the right to change their mind at any time. Ask the social worker for an up-to-date consent form before releasing the patient records.

MAKING AMENDS

Q A patient has asked to amend their record because they believe the information to be incorrect. Are they allowed to do this?

A Under the Data Protection Act 1998, patients have the right to request amendments to their records. This includes correcting simple errors, but can also extend to redacting sensitive details or more complex disagreements over clinical content. In this case, if the doctor agrees with the proposed amendment (that there is, in fact, a mistake/inaccuracy in the patient's record) then the amendment can be made. A contemporaneous entry should also be made to indicate what has been altered and why. If the doctor does not agree that the record should be amended, an offer can still be made for an additional entry to be made in the records noting the patient's view/disagreement with the contents. When amending paper records, be sure not to obliterate the piece of information that is being amended. Cross it out with a single line and add the amendment, including an explanation of why the amendment has been made.



Shared parental leave

Liz Symon looks at what this will mean for employers

THE fifth of April of next year is an important date for some fathers wanting to take a greater role in the day-to-day care of their newborn children – and also for their partners. Parents with babies due on or after that date will be able to take advantage of the new Shared Parental Leave (SPL) scheme.

The new arrangement will allow parents to be more flexible with their childcare arrangements. Each parent will be able to request up to three separate blocks of leave to be taken between the birth of the baby and the child's first birthday, or within one year of the adoption of a child. Intended parents in surrogacy who meet certain criteria will also be eligible. For any babies born on or after 5 April, additional paternity leave will stop although the right to take one or two weeks' paternity leave within 56 days of the birth will continue.

In order to be able to take shared parental leave, the mother must give eight weeks' notice that she is ending her maternity leave and that the remainder will be taken as shared parental leave. To qualify, the mother must share the care of the child with a husband, wife, civil partner or joint adopter. The scheme is not available for grandparents, uncles or aunts.

For example, if a mother and her partner are both eligible for SPL and the mother ends her maternity leave after 12 weeks, leaving 40 weeks of the total 52 week entitlement, she can take 30 weeks and her partner can take the other 10 weeks.

There will be a two-part process to establish eligibility for the new scheme. First, to qualify the parent seeking the leave has to be employed continuously for at least 26 weeks by the end of the 15th week before the due date and must be employed by the same employer during SPL. The partner must be working at least 26 of the 66 weeks before the baby is due – employed, self-employed or as an agency worker – and earn at least £30 a week on average in 13 of the 66 weeks.

Second, to qualify for shared parental pay, the parent must have passed the test above and have earned an average salary above the lower earnings threshold for the eight weeks prior to the 15th week before the baby is due. Shared parental pay will be at the lower rate of statutory maternity pay (SMP), which is currently £138.18 a week (or 90 per cent of average weekly earnings, whichever is lower). Unlike SMP, shared parental pay is not paid at the 90 per cent enhanced rate.

In notifying a practice of the intention to take shared leave, the employee should include details of:

- How much shared leave is available
- How much shared leave they are entitled to take
- How much they are intending to take
- How they expect to take it.

As advised before, three separate blocks of leave can be requested by giving the eight weeks' notice and this can be requested as a continuous period of leave, which the employer cannot refuse, or a discontinuous period which can be refused. The mother and her partner can decide to take blocks of leave at the same or at different times. Once a request for leave has been received, the practice should consider:

- Is the request for one block of leave or for split blocks?
- What cover is going to be required?
- Will a discussion with the parent be beneficial at this time?
- Does there need to be any modification to a request for discontinuous leave?

If you decide you can accommodate split blocks of leave this can be agreed but the employee should take blocks of at least a week at a time, and not odd days.

An employee may be able to change their decision to end maternity leave early in certain circumstances if the planned leave end date hasn't passed or they haven't already returned to work.

The old regime of the mother being allowed to return to work for up to 10 KIT (keeping in touch) days will still stand, along with a new additional right for both parents on shared parental leave to work up to 20 SPLIT (shared parental leave in touch) days. Both KIT and SPLIT days remain optional and need to be agreed by both the employee and the employer.

Pregnant employees are allowed reasonable time off with pay for antenatal care. Under new regulations which came into effect in October partners of pregnant women are also entitled to unpaid time off to attend two ante-natal appointments for up to 6.5 hours.

ACAS has prepared detailed guidance on this new system which can be found at http://tinyurl.com/ns2nvfw ❋

Liz Symon is an employment law adviser at MDDUS

Flaming annoyance

How best to deal with negative or abusive comments online? PM editor **Helen Ormiston** offers some advice to practices

GOOD medical practices are very protective of their reputations – and understandably so as this can affect the trust patients place in the care being offered.

MDDUS has in recent years been increasingly contacted by members looking for advice on handling comments or complaints posted on social media sites such as Facebook and Twitter. Many of these posts express unhappiness with the service provided by a practice or an individual clinician or member of the staff team. Some can be personal and malicious and very distressing, as well as frustrating if the comments made are inaccurate or untrue. The situation can be made even worse when other individuals comment or add to the original post.

> "ALTHOUGH THIS CAN BE FRUSTRATING OR DISTRESSING, IT DOES NOT RELIEVE YOU OF YOUR DUTY TO RESPECT YOUR PATIENT'S CONFIDENTIALITY"

Posts that are malicious or derogatory in nature, using racist or discriminatory language, may violate the law and it would be reasonable for you to contact the social media site directly and request that the comments be removed. Most social media platforms have a checklist of questions that will be asked before they decide if it is appropriate to remove a comment or part of a post.

You may then wish to contact the patient and let them know that you have become aware that they are unhappy about some aspect of their care and invite them to a meeting to discuss their concerns. Guiding the patient towards the local complaints procedures may allow them the opportunity to voice their concerns directly and provide an opportunity to respond accordingly. It is also always possible that the comments were written by somebody other than the patient.

Be aware that any written communication should be worded carefully and perhaps restricted to an invitation to discuss their concerns. It has been known for patients to post copies of such correspondence on their media site just to back up their claims! Avoid sending warning letters or deregistering patients from the practice list as a result of their comments. GMC guidance is clear that patients should not be deregistered because they have made a complaint or a claim and a full investigation should be made in line with the complaints procedure before any other action is taken.

The GMC issues guidance regarding clinicians and staff and the use of social media sites for learning and teaching. They offer advice on using social media and networking sites responsibly but they do not provide specific guidance on how to respond to comments that are made on networking sites. We also advise that members follow the GMC explanatory guidance regarding confidentiality. Perhaps most applicable in this context is the advice given to doctors who have been criticised by patients in the press.

GMC guidance states: "Although this can be frustrating or distressing, it does not relieve you of your duty to respect your patient's confidentiality. Disclosures of patient information without consent can undermine the public's trust in the profession as well as your patient's trust in you. You must not put information you have learned in confidence about a patient in the public domain without that patient's express consent.

"Disputes between patients and doctors conducted in the media often serve no practical purpose; they can prolong or intensify conflict and may undermine public confidence in the profession, even if they do not involve the disclosure of personal information without consent."

Postings on social media tend to be transitory in nature – topics are quickly dropped and forgotten by the patient or individual concerned as they move onto to the next topic of conversation. But they can leave a very bitter taste for those who were the target of the criticism or abuse.

In the past these complaints would have been voiced aloud to anyone who might listen and then usually forgotten. But the advance of technology has meant that they are now available for all who wish to have their say on a subject. Time will show whether new cyber troll laws will make patients think twice before posting comments. ❋

Helen Ormiston is an MDDUS practice adviser and co-editor of Practice Manager

challenge & RISK

Most of us don't like conflict but can a team function effectively without it? Not likely – but you must also have trust. MDDUS risk adviser **Cherryl Adams** explores why

NO practice system can be 100 per cent risk-free – be it one for following-up test results or for triaging patients. Even the most carefully designed systems can have 'holes' in them.

Most people familiar with concepts of risk will have come across the Swiss cheese model, first proposed by James Reason of the University of Manchester. Holes or gaps in a system can create windows of opportunity for errors to occur. In practice they are often picked up as near misses or recurring low-level failures. But when the holes align within a particular system and under particular circumstances there is the potential for catastrophic harm to occur.

To promote safe practice it is important to have mechanisms in place to control known risks and these must also extend to "softer" areas of practice such as team communication and interaction. Risks here might include difficulties around access to an appropriate clinician where multidisciplinary interactions are necessary (for example a receptionist facilitating access to the right clinician at the right time) or communication between healthcare professionals. This is particularly relevant where there is shared care and treatment by multiple clinicians over time.

Actions to mitigate such risks include building trust, facilitating challenge and ensuring that there is a level of comfort within the team's interactions.

TRUST AND CHALLENGE

A strong factor influencing the way individuals communicate and work together is the level of trust present. Trust impacts on the willingness of individuals to challenge each other during team interactions. Healthy conflict and interpersonal challenge amongst individuals and groups is dependent on the level of trust they share and this can have real impact on day-to-day interactions and outcomes and, significantly, can create potential for increased risk.

Effective team interaction is essential in supporting risk reduction in systems of working, particularly where failures in service delivery are discussed, new processes are agreed and where the risks within clinical systems are reviewed. Problems can arise when key issues are not explored fully and honestly.

The connection between trust and risk – in particular how it can lead to poor team outcomes – has been widely demonstrated in other sectors. In his 2005 work on team functioning, management consultant and author Patrick Lencioni outlined five dysfunctions in teams which prevent them from achieving their goals. The main goal in the case of healthcare is to deliver a service through systems and working practices that support patient safety.

WHAT MAKES A FUNCTIONAL TEAM?

Absence of trust and fear of conflict are the first two of Lencioni's dysfunctions which, if unresolved, lead to poorer team working and outcomes. Lencioni argues that the foundation for a functional team is the ability to "trust each other on a fundamental, emotional level". Team members must be comfortable exposing their weaknesses, mistakes, fears and behaviours to each other and to get to a point at which they can be completely open with one another without filters.

Lencioni believes this is essential because teams who trust each other are much more able to engage in healthy conflict, i.e. disagreeing with, challenging and questioning one another. These teams will achieve a better resolution to problems and more effective, safer and robust systems of working.

Where healthy conflict is present, the added benefit is that individuals are often more committed to decisions and feel (and

can hold each other) accountable for them. This type of development within teams makes achieving their goals much more realistic. To attain this it is important to have a foundation of trust.

Within team meetings when difficult decisions have to be made around patient care, systems and use of resources, it is important that all critical points and views are up for discussion. Team members must trust that their points – particularly where they are different from those of the majority – will be listened to and respected and not ignored or ridiculed. Healthy conflict can then result in effective problem-solving and agreements that all individuals can own and buy into. Where this happens, individuals are less likely to violate agreed patient safety procedures or undermine decisions.

SYMPTOMS AND IMPACTS

In team interactions where there is an absence of trust, it is likely that people will avoid conflict or challenging others. Telling symptoms of a lack of trust include:

- Critical and challenging points are not raised or incorporated into discussions.
- Individuals are more likely to conceal mistakes from one another.
- Individuals will hesitate to ask for help when they are struggling.
- Individuals are likely to dread approaching others for help for fear of rejection, ridicule or lack of support.

Such behaviours have a direct impact on risk. Commonly a lack of trust will mean that:

- Teams and individuals won't have full situational awareness when making decisions about patient safety.
- Incident reports won't be submitted and learning from mistakes will not occur.
- Individuals will choose (or feel forced) to work outside their boundaries or expertise because it is too hard to challenge others if they do not immediately offer support.
- Patients will not receive safe levels of care because support is not being asked for or provided.

Trust makes the difference in achieving healthy conflict and challenge which can really improve the way teams work and support risk reduction. Trust can also reduce the likelihood of negative conflict which can increase risk and threaten patient safety.

BUILDING TRUST

One of the simplest ways to build trust is to create opportunities for individuals to get to know each other better. If people can understand their own and other people's strengths and weaknesses – particularly in relation to communication and working preferences – they are more likely to be tolerant and understanding of their colleagues. Some organisations use formal behavioural profiling to do this – for example options such as DISC analysis or Myers-Briggs. These tools give team members an objective and reliable means for describing and understanding each other. In practical terms, this might mean a receptionist understands better how to approach a GP and present information in a way that is helpful to that individual's preferences. This type of change in approach makes the communication process easier and more effective for all.

Other organisations arrange team building activities, create functional project groups across areas of work or support opportunities for social activities. In these activities, individuals can be encouraged to be more natural and equal with each other.

Developing clarity around roles, responsibilities and boundaries can also help build trust. This can be facilitated through teams examining shared systems through the different lenses associated with different roles. Highlighting the importance of each role serves to identify gaps or misinterpretations in a more objective way, this in itself working towards risk reduction.

So to reduce the potential for unacceptable clinical risk, it is important for teams to openly explore the link between trust, healthy conflict and risk reduction – so they can agree comfortable ways of ensuring healthy conflict happens. This includes acceptance that conflict is natural and that building trust is beneficial to risk reduction.

Cherryl Adams is a risk adviser at MDDUS

For more on this topic MDDUS members can access our new video module on Trust and challenge which can be found in the Risk Management section of **mddus.com**

CAMPUS CARE

Jim Killgore visits an NHS medical centre with some unique challenges

PHOTOGRAPH: DANIELE CAROTENUTO

Dr Des Spence and practice manager Kim McWilliams of the Barclay Medical Practice

A BRIGHT afternoon in mid-September – cars line both sides of Caithness Street in the Maryhill district of Glasgow. Traffic is down to one lane. A mob of student helpers in pink t-shirts unload suitcases and trunks from tightly packed boots and backseats. Parents clutch registration papers and argue with teenage daughters and sons – no one exactly sure where to go among the rows of three-story brick housing blocks. This is Murano Street Student Village and it's the start of freshers week at the University of Glasgow.

Over the next month these young students must quickly adjust to life away from home – making new friends, cooking, doing laundry, balancing academic work with the temptation of countless parties and two-for-one club nights. Among all this activity many will also register for medical care.

Kim McWilliams is practice manager at the Barclay Medical Practice which runs the University medical centre located in the Fraser Building – a bright and airy office block in the heart of the main campus. Glasgow is one of the oldest universities in Britain, being founded in 1451, and it boasts an enrolment of around 25,000 undergraduate and postgraduate students from over 120 different countries. The practice staff at the medical centre look after the primary care needs of 15,000 to 16,000 of these students.

"It's hard to say how many patients we have registered here at any one time," says Kim, as we chat in her office among five busy consulting rooms at the centre. "We have an admin team who register new patients on a daily basis but there's also a deductions team removing patients who have moved on. Each year the practice adds and deducts around two thousand patients."

> "OFTEN IT'S ALMOST A PARENTAL ROLE YOU FILL - GIVING DIRECTION AND ADVICE OR SIMPLE REASSURANCE"
>
> *Dr Des Spence*

Keeping the practice list tidy is just one of the challenges in dealing with a student population which by nature is fairly transient. Another one is funding. Dr Des Spence is a senior partner at the practice and works closely with Kim at the medical centre.

"Our main income here is drawn from capitation but that's weighted capitation," says Des. "The capitation for a student is something like a third of what it might be for an inner city patient. So you work with a relatively higher list but as they're younger and fitter the demands are less – at least in theory. In practical terms it's hard to say."

The Barclay Medical Practice runs another branch surgery at the nearby Maryhill Health Centre with an additional 15,000 patients more typical of an inner city population. Being in a largely working class district of Glasgow the Maryhill branch deals with a familiar set of health issues – high rates of cardiovascular disease, diabetes, smoking, obesity and alcohol and drug abuse. This offsets some of the funding gap associated with providing primary healthcare to students at the University site, for instance in achieving QOF points and payments.

HOMESICKNESS AND OTHER ANGST

That's not to say students don't come with their own unique health issues, including higher rates of mental ill health, risky sexual behaviour and problems associated with drug and alcohol overuse. Just being young and experiencing life away from home can be difficult for students.

"They may be very bright but most are also relatively inexperienced," says Des Spence. "Often it's almost a parental role you fill – giving them direction and advice or just simple reassurance, because obviously people go online and they Google things. And all things in Google lead to cancer, so there can be a lot of angst."

Homesickness is another common problem. "Fortunately the University provides additional counselling services," says Des. "But we try as much as possible to de-medicalise some of the adjustments to being at University. We limit the use of antidepressants. Often it's about giving it time, telling them 'speak to your friends, to your family and we'll see how you are next week'. Things often work out on their own."

An increasing number of students at Glasgow come from overseas and this also creates challenges. All students enrolling in the University require a certain proficiency in English but there can still be language difficulties.

"Recently we purchased two iPads to take out from behind reception to help with communication," say Kim. "Google Translate is a big help for single words and phrases. Sometimes we have to call an interpreter and there is an interpretation helpline as well."

Cultural differences also come into play. "People's experiences of healthcare can vary greatly across the world," says Des. "If you are from the States, for example, you will probably be used to being billed for your healthcare, and students from China or India come from a private medical system where people pay. In these systems there's almost an incentive to intervene. Here in the UK we tend to do a bit less – use less antibiotics, fewer blood tests – and that takes some adjusting."

A certain amount of flexibility with practice systems is also essential in dealing with a student population. The Barclay Medical Practice has done away with the standard appointment system at its University branch and now runs drop-in clinics every weekday morning from 8:30am, along with a booked surgery in the afternoon.

"Students tend to have a different agenda to other patients – a greater sense of immediacy," says Des. "So we found our old appointment system didn't work terribly well. Now virtually all of our appointments are available on the day so if a student is concerned and they arrive at 9am they are guaranteed to be seen that morning. It may not work in other places but it suits our needs."

'GREETING' MEETING

The practice's relationship with the University goes back over 25 years. Seven years ago the University embarked on a refurbishment of the Fraser Building and saw this as an opportunity to rationalise student healthcare and open an NHS practice on site. The building also houses the University accommodation office, student services and catering, as well as a John Smiths shop and a pharmacy.

Inside the building it's bright and busy with students milling about and this makes for a pleasant work environment, also helped by an easy informality among the practice staff.

"There is never a sense of them and us," says Des. "No Dr this or Dr that – it's all first-name terms and we are very open to staff coming to us with ideas. Approachability is important."

Kim is also keen to foster openness as a means of improving not just the quality of patient care but also job satisfaction. She says: "We have regular 'greeting' meetings [as in crying, not saying hello] where the admin staff can let off a wee bit of steam but also discuss ideas. And we do listen because they know best; they're doing the job."

One idea that emerged from these meetings was the introduction of a four-day working week with admin staff putting in longer hours in rotas in order to have a fifth day off. "Not one member of staff said no to the idea," says Kim. "Now people are in at half-eight to answer the phones and there is always enough staff around at six. So it works well and the staff also feel they are getting a good deal."

Having a total practice list of over 30,000 patients, the Barclay Medical Practice is already large but there are plans to expand further either by merging or opening other surgeries in Glasgow. "One of the things about being bigger is that you get significant economies of scale," says Des. "You can share a lot of back-office functions like telephone call-backs and prescriptions, that sort of thing. You can merge a lot of your other responsibilities and you can specialise with your admin staff doing different roles."

Such forward thinking is just part of what keeps Des and Kim engaged in their work and the enthusiasm is clearly apparent. "Everyday it's something different," says Kim. "I absolutely love my job. I really am quite passionate about it; passionate about the practice."

Jim Killgore is an associate editor of MDDUS Practice Manager

Who would b

A few years ago it was almost unheard of but today more practice managers are becoming partners in their surgeries. Solicitor **Michael Royden** looks at the pros and cons when considering an offer

e a partner?

REGULATIONS relating to the management of GP practices do allow non-clinical individuals (in other words non-GPs) to become partners in the practice, subject to certain rules and restrictions. It is currently much less common in Scotland than in England but it is a topic about which our firm is increasingly receiving queries.

Sometimes advice is sought by the practice and in other cases it is the practice manager seeking guidance having been approached regarding the prospect of becoming a partner. In either case there will be pros and cons in any proposed arrangement and this article considers the perspective of the practice manager.

RECOGNISING A KEY ROLE

A report published in 2013 found that just over four per cent of UK practice managers were partners in their practices (based on a survey of 600 managers) and it is a growing trend.

Obviously the thinking behind practice managers becoming partners is that most already play key roles in the day-to-day running and ongoing development of their practices. They may have assisted the practice to grow over the years, showing a great deal of commitment and loyalty along with having valuable experience. Often the practice manager is one of the few constants in a practice over a significant period of time.

The main distinction between being a salaried practice manager and acting as a partner is that all partners are self-employed. It is important to note that there is no distinction in legal terms between categories of partners – so if a practice manager becomes a partner they act in that role in just the same way as a GP partner. There is also no distinction so far as the outside world is concerned.

ADVANTAGES OF PARTNERSHIP

There are a number of potential advantages to being a partner in the practice as opposed to being an employee. First, there is the potential to benefit from growth in the profits of the practice. This depends on the profit arrangements but if the practice as a whole generates more profits than budgeted in any given financial year, a practice manager partner would normally benefit from an increased profit share. Having said that, the converse also applies. A worse than expected year will result in a reduced profit share for a non-clinical partner. The practice manager partner therefore sacrifices the certainty of a salary in exchange for the potential of a larger windfall by way of profit share.

Second, a partnership is often seen as a recognition of status within any type of business, including a GP practice, and the appointment of someone as a partner recognises their position within the practice. This of course assumes that the other partners within the practice (the GPs) actually recognise a practice manager partner as being on an equal level. This is not a guarantee in some practices.

A practice manager partner, being self-employed, would also be taxed accordingly. There are certain benefits to being subject to self-employed taxes rather than being taxed as an employee. The flip side of that benefit, of course, is that being self-employed a PM partner will lose employment rights and other related benefits that go with being an employee. This is something that should be carefully weighed-up when considering an offer of partnership.

DOWNSIDES

Alongside the benefits of partnership there are unfortunately some downsides. First and perhaps most importantly, each partner in a practice is jointly and severally liable along with all other partners for the obligations of the practice. A third party who is owed any form of obligation by the partnership can look to any one or more of the partners to satisfy all or any part of the liabilities owed to them by the partnership. An example might be a bank where there are borrowings. This is a very important distinction between partnership status and employment, and is probably one of the key areas of concern for any practice manager who is considering becoming a partner.

On that front, it would be appropriate for a practice manager partner to seek an indemnity from the other partners so that if they end up with any liability arising from their partnership, the other partners would make good the loss suffered by the non-clinical partner. This may be something that the GP partners would have a difficulty with granting.

Of course, the benefit of having an indemnity only exists if the other partners can actually pay up under that indemnity. A practice manager partner would therefore be relying upon the GP partners to have sufficient assets to meet any liabilities which they owe under that indemnity.

It may be appropriate for the partners as a whole to agree a division of responsibilities between clinical and non-clinical partners so that it is clear between them who has responsibility. This doesn't change things so far as the outside world is concerned, but it would mean that within the partners as a group there would be a clear division of responsibility.

PARTNERSHIP AGREEMENT

It may be appropriate to record how decision-making will be undertaken within the practice. There may be certain matters that the non-clinical partners should have a role in and others which should be left solely to the clinical partners, and that should be recorded for future reference.

In regard to all of these matters, it would be essential that a partnership agreement is put in place which records the agreement between the parties and this should be tailored to reflect the presence of non-clinical partners within the practice.

IN SUMMARY...

Taking all of the above into account, practice managers may have some genuine concerns in considering whether to become a partner in their practice. Having said that, with appropriate advice and entering any arrangement with eyes open, individual practice managers can work comfortably in partnerships, enjoying the potential for a higher return from the practice in the longer term. A practice manager not comfortable with such risks might find other alternative arrangements more appropriate to "incentivise" remaining with the practice and contributing to growth. One alternative might be some form of bonus arrangement linked to profit levels within the practice.

In considering an offer of partnership, it is advisable for practice managers to seek specialist legal and accountancy advice. This will ensure you have all of the necessary guidance needed to make a decision.

Michael Royden is a partner with the medical team within the Scottish legal firm Thorntons and a member of the National Association of Specialist Solicitors advising Doctors

Obvious mistake honest apology

Day one

Mr G is a self-employed builder and attends his local practice for an emergency appointment complaining of a very sore ear. He is seen by the triage nurse who examines the patient and notes a purulent discharge from the ear. She diagnoses otitis media and writes a prescription for amoxicillin.

Day two

Mr G's wife phones the surgery and informs the receptionist that she would like to speak to a doctor in order to make a complaint. The receptionist forwards the call to the practice manager. Mrs G states that her husband had just come home from work early feeling unwell and suffering from an itchy skin rash and swelling. Mrs G checked the label on the tablets her husband had been given from the pharmacy and looked it up on the internet – only then realising that amoxicillin is a "type of penicillin". She says the practice should be aware that her husband is allergic to penicillin. The PM asks to ring Mrs G straight back. She calls up Mr G's file and confirms there is indeed an alert for penicillin allergy. After speaking to the senior GP partner, she phones Mrs G and advises that her husband should stop taking the amoxicillin. She tells her to pick up some antihistamine tablets for her husband at the pharmacy and apologises for the mistake. She also offers to send Mrs G a copy of the practice's complaints procedures.

Day five

Mr G attends the surgery still complaining of allergic symptoms and a painful ear. He is angry because he missed three days of work, and being self-employed this resulted in lost earnings. The senior GP partner sees Mr G and apologises again for the error.

Day nine

The practice receives a formal letter of complaint from Mr G in which he recounts the consultation for his earache and states that when given the amoxicillin script he had reminded the triage nurse that he was allergic to penicillin. The PM acknowledges the letter and undertakes a formal investigation of the incident. She speaks (again) to the triage nurse who states that she had consulted the minor illnesses book used regularly by the practice nurses and it stated that many antibiotics were contraindicated in penicillin allergy but for amoxicillin it stated only "avoid using for patients with allergies". The nurse felt it was okay to prescribe the amoxicillin as the word "avoid" did not suggest an explicit instruction not to do so in patients with penicillin allergy. The PM writes a formal reply to the complaint, again apologising for the error and also setting out steps the practice will take to ensure it is not repeated in future.

Day thirteen

Mrs G phones the practice to say her husband has received the letter but is surprised there is no offer in respect of his loss of earnings. The PM replies that it is not practice policy to offer compensation in patient complaints. Mrs G then says that she and her husband have taken advice from a solicitor and without such an offer they will be forced to sue. The PM contacts MDDUS who advises the practice to reply in writing restating practice policy on the matter.

THE PM contacts MDDUS again and forwards all relevant medical records and correspondence. The case is assessed and given the clear breach in duty of care acknowledged by the practice it is decided that the best course is to settle on behalf of the practice based on an accurate accounting of Mr G's loss of earnings.

The practice later conducts a significant event analysis to ensure that all such contraindications are accounted for. Further training is provided for practice nurses involved in prescribing, with particular emphasis on contraindications.

KEY POINTS

- Double check records and confirm any potential medication allergies.
- Ensure practice staff are fully trained and competent to carry out delegated clinical tasks.
- Consider guidance used to support clinical decisions/prescribing.
- Candour along with a sincere apology can often (though not always) forestall further legal action in patient complaints.

Day twenty

A letter arrives from solicitors representing Mr G claiming negligence on the part of the triage nurse for which the practice partners are vicariously liable. The letter states that as a result of Mr G being off work he had lost a contract worth over £3,000 and he is seeking compensation for that amount.

Diary

MORE useless observations from the Diary team on cash for candy, tired and larcenous managers, put-upon prescribers, cyber-self-diagnosticians, flush young GPs and a hero for PMs nationwide.

➔ REMEMBRANCE OF COFFEE TIMES PAST Diary might not know a pièce montée from a pencil sharpener but we were none-the-less delighted to claim *Great British Bake Off* winner Nancy Birtwhistle as one of our own. Over 12 million viewers watched as the former practice manager from Central Surgery in Barton Upon Humber triumphed in the finale with her show-stopping Moulin Rouge-inspired centrepiece of sponge, caramel, choux pastry and petit fours. The 60-year-old grandmother-of-eight is married to GP Dr Tim Birtwhistle and no doubt coffee time at Central Surgery has been a desolate experience ever since her retirement.

➔ SHAPE UP, YOU LOT Maybe it's just as well GBBO is now behind us as overweight healthcare staff are being told to slim down by NHS England chief executive Simon Stevens. He said NHS staff should "get our act together" before offering healthy living advice to patients. Suggestions for achieving the goal include encouraging healthcare professionals to take part in weight loss competitions and building more gyms. A newspaper report suggests as many as 700,000 of the 1.3 million health service staff are either overweight or obese. Mr Stevens apparently overcame his own weight problem, shedding three stones gained while working for a private health company in the US. None more abstemious than the reformed...

➔ GOLDEN HELLOS Mr Stevens has also been endearing himself to GPs. In a speech to the RCGP conference he suggested GPs stop complaining so much as they are putting off potential trainees. "There's a balancing act to be struck here - a conundrum. Quite rightly you are telling it as it is in general practice at the moment... but the danger is that wake-up call sounds like a proposition to young doctors, that you want to steer clear of general practice." Perhaps local health authorities should just be more proactive in dealing with the current recruitment crisis. Leicester City Council's health and wellbeing board has recently been offering £20,000 golden hellos to attract new GPs to the city. Similar schemes in Essex are using funding from Health Education England to offer golden hellos worth £10,000 and one practice in Doncaster is putting up £20,000 of its own budget to fill a long-vacant partner post. Sadly Diary is more familiar with the golden goodbye.

➔ GOOGLE SAVED MY LIFE Who needs GPs when you have the world's favourite internet search engine to rely on? A recent report in (where else but) the *Daily Mail* told the story of two women who claimed the web had saved their lives in the face of alleged indifference from their doctors. One patient's symptoms research helped her reach a breast cancer diagnosis while the other discovered she had oral cancer after trawling the web. The report went on to quote a UK survey from earlier this year suggesting 21 per cent of patients trusted Google above their GP while 27 per cent said they relied "entirely on Google for a diagnosis". Nothing though about YouTube for minor surgery...

➔ SLUMP-TIME PRESCRIBING A recent survey of over 1,000 GPs found that 90 per cent feel pressured by patients to prescribe antibiotics and 45 per cent say that they have prescribed them for viral infections even when they knew it wouldn't do any good. Now a US study has found that afternoon is the worst time for over-prescribing antibiotics (or best for those patients convinced GPs delight in hoarding ciprofloxacin). Researchers reporting in *JAMA Internal Medicine* found that primary care physicians become worn down by the "cumulative demand" of making dozens of decisions throughout the day and by late afternoon are more likely to prescribe antibiotics for respiratory infections. Maybe a nap would help.

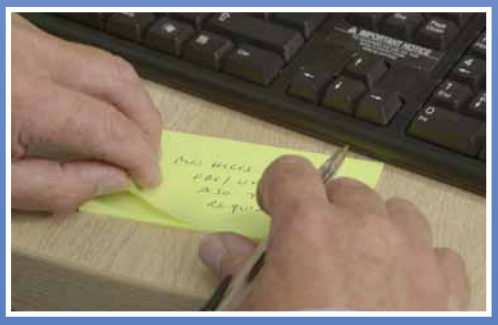
➔ BREAKING GOOD Do you consider yourself a decent, fair-minded manager? If so - Diary feels your pain. Researchers reporting in the *Journal of Applied Psychology* conclude that tough bosses might be more effective (and happier) than those who try to be equitable to workers. Professor Russell Johnson said: "The act of carefully monitoring the fairness of workplace decisions wears down supervisors mentally and emotionally... Managers who are mentally fatigued are more prone to making mistakes and it is more difficult for them to control deviant or counterproductive impulses." He cites several studies which have found that mentally fatigued employees are more likely to steal and cheat. "Managers who are fair cannot realistically avoid some burnout." Virtue has other rewards...we hope.

➔ CANDY AMNESTY Halloween presents a particular challenge to dental practices keen to tackle tooth decay among young patients by encouraging healthy eating. Diary's solution - sitting in a darkened house pretending not to hear the doorbell - is hardly sociable. Nor is handing out sour apples and monkey nuts to potentially vandalous teens. One practice in Canada may have hit upon the perfect solution - cash for candy. Spearmint Dental in Edmonton offered $1 for every pound of candy returned to the office on 1st November. "We believe in rewarding children for their efforts by giving them something in return," says Dr Sean Bhasin. No word on what is to become of all that waste sugar but Diary suggests an ongoing campaign: Christmas is coming - convert those candy canes to hard currency!

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**

Bleak Practice

Some days are better than others at the Wellnot Surgery...
Watch this dramatisation of a day in the life of a GP surgery which starts off badly for practice manager Alison and can only get worse.



BLEAK PRACTICE

This video eLearning Module has been developed to help PMs and GPs consider risk in partnership with their teams. Members can watch the film along with our discussion guide and consider ways in which the practice can assess and take action in risk areas such as confidentiality, record-keeping, dealing with difficult behaviours and disclosures in the public interest…..

BLEAK PRACTICE 2

And for another PLT session, watch this sequel to Bleak Practice dramatising another incident at the Wellnot Surgery which has led to a claim for medical negligence – as seen through the eyes of our GP expert.

This second eLearning module is designed to help practices reflect on their risks in relation to record-keeping, team and patient communication, and dealing with results.

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