Practice Manager
AN MDDUS PUBLICATION
ISSUE 20

CALLING MDDUS
Our professional advisers deal with a range of queries as reflected in our regular Call log

ZERO TOLERANCE
Is a 'zero tolerance' approach always the answer with aggressive patients?

STAFF CONFIDENTIAL
How should you deal with staff who breach patient confidentiality?

PARKRUN APOSTLE

HOW AN ABERDEEN PRACTICE IS PROMOTING REGULAR EXERCISE FOR PATIENTS

TRANSFORMING NURSING ROLES
NEW HEALTHCARE SUPPORT WORKERS

Practice Manager

DNAs (did not attends) account for over 15 million general practice appointments each year in England. Out of 307 million sessions scheduled with GPs, nurses, therapists and other practice staff every year, five per cent are missed without sufficient notice according to NHS England. Around 7.2 million of these are with GPs, which adds up to more than 1.2 million GP hours wasted each year – or the equivalent of over 600 GPs working full time for a year.

DNAs are an enduring source of frustration to PMs across the UK and on page 8 of this issue MDDUS risk adviser Kay Louise Grant looks at risks associated with missed appointments and how practices can ensure no vulnerable patients slip through the net.

Parkrun is a worldwide initiative encouraging people to get out and get active, with organised 5km runs held every Saturday morning at over 800 locations across the UK. GP practices are now being encouraged to develop links with their local parkrun and become certified 'parkrun practices'. One of the first was Danestone Medical Practice in Aberdeen. On page 10 PM Tracey Thom tells how it all got started – and also how parkrun has transformed her own life.

Scotland has been looking at ways to refocus nursing roles in primary care with the introduction non-clinical healthcare support workers (HCSW) to allow nurses in future to focus less on monitoring of care and more on prevention and management. On page 12 Liz Price looks at the plans and potential lessons for primary care across the UK.

Our regular employment law column on page 7 offers advice on dealing with confidentiality breaches by practice staff – intentional or not – and on page 6 we consider a new 'zero tolerance' strategy aimed at preventing violence against healthcare workers.

You can also check out our regular Call log (page 4), Case study (page 14) and Diary (page 15).

Helen Ormiston
Editor

COVER PHOTOGRAPH: NEWSLINE MEDIA

MDDUS
UK INDEMNITY, ADVICE & SUPPORT

EDITORS:
Scott Obrzud
Helen Ormiston

MANAGING EDITOR:
Jim Killgore

ASSOCIATE EDITOR:
Joanne Curran

DESIGN:
Connect Communications
www.connectmedia.cc

PRINT:
21 Colour
www.21colour.co.uk

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

t: 0333 043 4444
e: PM@mddus.com
w: www.mddus.com

CONNECT
ENGAGEMENT IS EVERYTHING

recycle
When you have finished with this magazine please recycle it.

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 Articles of Association.
The opinions, beliefs and viewpoints expressed by the various authors in *Practice Manager* are those of the authors alone and do not necessarily reflect the opinions or policies of the Medical and Dental Defence Union of Scotland.

PM CONFERENCE – BOOK NOW

THE MDDUS Practice Managers' Conference 2019 will be held at the Fairmont Hotel, St Andrews in Scotland on 28 and 29 November.

This year's theme is *New Horizons: Navigating safety through change*, which addresses emerging areas of risk as practices welcome an increasingly diverse mix of health professionals, with more tasks being delegated to non-clinical teams.

New for 2019, delegates will be able to choose for themselves which masterclass topics are most relevant to their professional needs. The masterclasses will explore a range of medico-legal topics, including investigating patient safety incidents, dealing with challenging patient contacts and raising concerns about safety, health, behaviours and performance – and much more.

To find out more and book a place go to Training & CPD > Events at **www.mddus.com**

NEW STANDARDS FOR END OF LIFE CARE

A NEW set of standards in providing end of life care has been agreed for GP practices.

The Royal College of GPs has joined forces with charity Marie Curie to create the Daffodil Standards, designed to support primary care teams in caring for patients (and their loved ones) living with an advanced serious illness, or at the end of their lives.

Practices who adopt the eight standards commit to making improvements in at least three per year, with the aim of having reviewed all of them within three years. Those practices will also be able to display a "daffodil mark" to show their commitment.

The Daffodil Standards are:

- Professional and competent staff
- Early identification of patients and carers
- Carer support - before and after death
- Seamless, planned, co-ordinated care
- Assessment of unique needs of the patient
- Quality care during the last days of life
- Care after death
- practices being hubs within compassionate communities.

A survey carried out to coincide with the launch found that 85 per cent of GPs felt they did not have as much time as they would like to care for patients at the end of life because of workload.

Dr Catherine Millington-Sanders, end of life care lead, said: "Our colleagues are already working hard to provide this level of care, but pressures on our system and a lack of resources in the community can sometimes make going the extra mile that bit harder, which can be incredibly frustrating for us and our teams.

"That's why the RCGP and Marie Curie have developed these standards. Most importantly, they are there to ensure that when patients see the 'daffodil mark' in our window or on the wall in our waiting rooms, they know we are committed to providing the care and support they need and deserve."

HALF A MILLION EXTRA HOURS FOR PATIENTS

A PROGRAMME which NHS England claims has freed up more than half a million hours for primary care patients in the last year has been extended for three more years.

The Time for Care programme will now be rolled out across the country after success in pilot sites, with the aim of being extended to three quarters of GP practices by 2022. It involves surgeries adopting new ways of working, such as letting patients book appointments sooner, cutting paperwork and offering faster access to different specialist health professionals.

The decision comes after the programme posted its latest results, showing pilot practices around the country have freed up 205,157 clinical hours and 330,096 administration hours in the past year, which is the equivalent of 1.23 million GP appointments of 10 minutes each.

NHS England says the initiative comes on top of a new five-year contract for general practice across England, which will see extra investment for improved access. An extra 20,000 staff – including clinical pharmacists, physiotherapists, community paramedics, associate physicians and social prescribing link workers – will be employed to help GP practices work together to provide a wider range of care for patients, closer to their homes.

MDDUS RECRUITING PRACTICE ADVISER

MDDUS has an exciting opportunity for a Practice Adviser based within either our Glasgow or London office. The role is ideally suited to an experienced practice manager and involves assisting MDDUS members with a range of medico-legal matters. You will be working as part of a team providing advice via the telephone helpline and handling written cases. The job also involves supporting MDDUS risk, educational, marketing and membership programmes.

Applicants will be expected to have knowledge and wide experience of practice management, NHS complaints procedures, and medico-legal matters including GMC guidance – as well as excellent written and oral communication skills, objective analysis and problem solving, and an ability to make decisions and manage expectations/demands for assistance. Good call-handling skills are essential with an ability to handle sensitive and sometimes challenging issues. Request a full role profile and apply at **hr@mddus.com**

PATIENT SAFETY MASTERCLASSES

PRACTICE managers and GPs can learn how to create a practice culture where patient safety thrives by taking part in an interactive day with MDDUS risk advisers.

Workshop sessions will focus on increasing awareness of why, where and how the most common medicolegal actions arise and how to review key strategies to maximise both 'proactive' and 'reactive' management of risk.

The training day is open to both MDDUS members (£135) and non-members (£195) and can be attended in either our London office (29 June) or our Glasgow office (29 August). Go to Training & CPD > Events at **www.mddus.com** to book your place.

DENTAL MEMBERSHIP RISES BY A THIRD

MDDUS dental membership in England, Wales and Northern Ireland rose by almost a third during 2018, as more dentists put their faith in our "gold standard" indemnity.

Total dental membership in England, Wales and Northern Ireland has doubled since 2015, while in England alone there was a 41.5 per cent increase in 2018 compared to the previous year. Market share in Scotland stands at approximately 70 per cent and is now above 20 per cent elsewhere in the UK and growing fast.

MDDUS Head of Dental Division Aubrey Craig believes the sustained growth is built on a firm commitment to quality and an indemnity model that provides comprehensive protection. He said:

"MDDUS provides more than indemnity cover for claims in negligence. We believe what we offer is the gold standard, with personal service from a team of experienced dental and legal advisers providing dentists with lifetime peace of mind.

"Alternative commercial insurance products are becoming more widely available and it is increasingly difficult for dentists to access accurate information about the pros and cons of each product type... MDDUS is a mutual membership organisation. Unlike insurers, we're not in it for the profit, we have no small print to hide behind."

FRESH PUSH TO BRING BACK GPs

A NEW campaign designed to persuade hundreds of doctors to return to general practice has been launched by NHS England and HEE.

It is hoped that the campaign will encourage more doctors to take part in the Induction and Refresher scheme (I&R), which has so far attracted almost 800 applicants since its launch in March 2015. Of these, 279 have fully completed the programme and re-joined the GP workforce in England.

The scheme targets doctors who have taken a break from general practice, whether to retire, raise a family or work abroad or in a different profession. It promises to provide "a safe, supported and direct route for qualified GPs to join or return to NHS general practice in England", offering financial and practical support.

Dr Nikita Kanani, NHS England's acting medical director for primary care and a south-east London GP, said: "We're delighted to see how many GPs have returned via the scheme, with more than 50 per cent of the recruitment target already achieved".

The campaign is one of several plans NHS England has in place to boost GP numbers, including increasing trainee numbers.

These cases are based on actual calls made to MDDUS advisers and are published here to highlight common challenges within practice management. Details have been changed to maintain confidentiality.

ANTENATAL CARE AS SICK LEAVE

Q A part-time member of our practice staff is pregnant and all of her antenatal appointments are on a day that she is at work. We are setting up our regular rota to cover the busy Christmas period and would prefer her to work on regular "in" days. Is it a reasonable request to ask that she rearrange her antenatal appointment for another day? We always give such appointments for staff as paid leave. Is this standard practice or should it be classed as sick leave?

A In general terms an antenatal appointment should be paid and would not be classed as sick leave. You can ask for evidence of the appointment and whether it can be rescheduled but you should make it clear that if rescheduling is not possible then the original time and date will be honoured and she will have the right to take the time off when it suits

GAP IN GDC REGISTRATION

Q Our dental practice recently hired a dental nurse who has only just completed her training. She has applied to the GDC register. Is it possible for her to work in the practice before her registration is in place?

A The GDC has confirmed that a dental nurse in this situation can continue to work, provided the same supervision is in place as that which existed during training. GDC guidance states: "A named GDC supervising registrant must take full responsibility for providing direct supervision of the individual trainee. However, according to the ability and progress of the trainee, supervision may be delegated (if appropriate) to other GDC registrants. The named supervising registrant will continue to be accountable overall for the trainee. The employer must ensure that the individual trainee keeps a log book of training they receive (including induction), which is regularly signed off by the designated supervisor."

RETAIN RECORD REQUESTS?

Q Is our medical practice required to keep/scan requests from solicitors for copies of patient records and from insurance companies for reports?

A A patient's medical records should contain only relevant information for the ongoing care of that patient. Administrative requests can be stored separately, with reference to such documentation in the medical records in the unlikely event they may be required in future.

NON-MEDICAL MEDICINES MANAGER

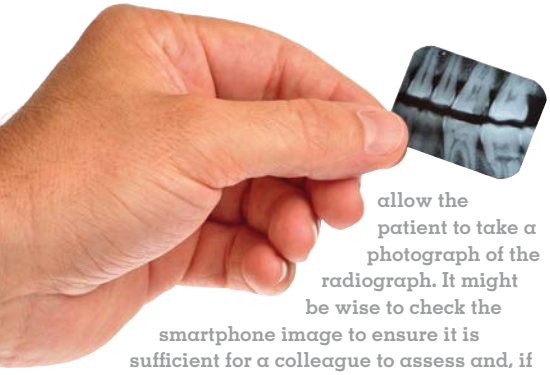
Q Our practice has a non-medical member of staff who processes all repeat prescriptions. Would she be allowed to add or make changes to medication following recommendations received from hospital letters, if done under adequate supervision from a practice GP?

A In approaching such a decision you should be mindful of GMC guidance on delegation (*Good Medical Practice*), which reminds doctors that when delegating the care of patients to a colleague they must be satisfied that this person has the appropriate qualifications, skills and experience to provide safe ongoing care for that patient. It is therefore important that clinicians are satisfied that the medicines manager is competent to undertake this role. The GMC also states that doctors must prescribe medicines, including repeat prescriptions, only when they have adequate knowledge of the patient's health and are satisfied that the medications serve the patient's needs. They must also undertake a careful review to ensure that any amendments to a patient's treatment are appropriate. It is understandable that the practice would wish to review how it actions correspondence from secondary care in order to improve both efficiency and ongoing patient care, but the focus must remain on patient safety. A medicines manager simply undertaking the administrative task of uploading information that has been actioned by a clinical member of staff would be fine, as long as it does not involve any clinical decisions. The practice should regularly review the approach and ensure that systems are in place to monitor the changes. You might also consider asking your local medical committee (LMC) how other practices in the area have approached the same issue.

RADIOGRAPHIC SELFIE

Q A dental patient has requested to be allowed to use his iPhone to take a photograph of his own radiograph in order to show the image to another practice for an opinion on the potential viability of an implant. Would this be okay or should he be allowed to take the original radiograph?

A The patient is entitled to a copy of his dental records under the Data Protection Act and you are obliged to provide it on request. Original records and radiographs should always be retained. On this basis it would be entirely reasonable to



allow the patient to take a photograph of the radiograph. It might be wise to check the smartphone image to ensure it is sufficient for a colleague to assess and, if not, to offer to make arrangements for copies of the records and radiographs to be provided either directly to the patient or to the other dentist. Be aware that any patient-sensitive data sent in electronic form should be encrypted and it might be simpler to print off the records, including X-ray images, and give them to the patient to take to the treating dentist.

TREATING A FAMILY MEMBER

Q We have recently discovered that a healthcare assistant (HCA) at our medical practice has been involved in the treatment of her own 18-year-old son. Can we remove the son from our patient list and institute a policy that immediate family members of practice staff cannot be patients?

A The fact that a patient is related to a staff member would not normally be grounds for removal from the practice list. The HCA's son is an adult and has the right to be registered with the surgery if he lives within practice boundaries. You should speak to the HCA about ethical guidance on avoiding the treatment of family members and consider referring to such guidance in your practice policy. It would also be advisable to remind the HCA not to access her son's records uness there is clinical justification. The practice could also implement a policy discouraging family members from registereing, and any current patients this applies to could be asked to consider registering with another practice.

DISPUTED RECORD ENTRY

Q A patient who recently registered at our medical surgery is requesting that notes from the last consultation at her previous practice be removed as they are inaccurate, making reference to potential domestic abuse. Can you please advise how we should respond?

A There is extensive legal and professional guidance in relation to amending patient records. The General Data Protection Regulation (GDPR) permits patients to request amendments to their records. These may relate to the correction of factual errors or redacting sensitive information from notes. In cases where both the doctor and patient agree that the recorded information is factually inaccurate, the record can be amended, but the original information should remain legible and the amendment should be accompanied by an explanation of why there has been an alteration to the records. If there is disagreement over the accuracy of an entry, the patient is entitled to include a statement in the record to that effect. In these circumstances you may wish to offer to include an addendum within the records setting out the patient's concerns over the entry. It would ultimately fall to the discretion of the patient to contact the previous practice in regard to the disputed entry, but it would be considered good practice for you to ensure the accuracy of the notes and to assist the patient in resolving the matter.

NEWSPAPER GIFT

Q An elderly lady who has been a patient at our medical practice for many years has offered to pay for two subscriptions to a local daily print newspaper for the waiting room. Would it be ethical/legal to accept her offer?

A The decision as to whether this gift should be accepted would ultimately lie with the practice and depend on how the gift is perceived by both the patient and healthcare staff. The GMC states in its guidance *Good Medical Practice*: "You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect the way you prescribe for, treat or refer patients or commission services for patients." The practice is also advised to consult GMC guidance on *Financial and commercial arrangements and conflicts* (paragraphs 6 to 13) which offers advice in relation to gifts and conflicts of interest. The only other matter to consider is registering the gift in line with performers list regulations. Gifts with a value of over £50 should be entered on a practice gift register, along with the approximate value and name of the patient and relevant staff.

CHILD TEST RESULTS

Q Our practice team have been discussing child patient test results and whether these should be sent directly to the parent, to the child or a combination of both. We are based in Scotland – at what age are children considered to have competence and therefore potentially to have their own test results sent directly?

A When considering whether to give young patients (rather than their parents) information about their healthcare, it is important to remember that it is not simply a matter of chronological age. The key is to first assess the child's capacity to understand the information at hand. The age of consent in the UK is 16, above that age a young person is presumed to have capacity and can consent to treatment in their own right. Below this age a young person might be able to consent to treatment, depending on their maturity and understanding. In Scotland, anyone over 12 years of age is legally presumed to have such capacity. However, the extent of that capacity does of course depend on the individual child. It is not really possible to make a blanket decision that any child over a certain age should receive their own results (results for children under that age should be provided to the parents). It will always depend on the individual situation and the specific child's capacity. The GMC *0-18 years: guidance for all doctors* is a useful resource and includes a section dealing with access to records.

Zero tolerance – can it work?

Violence against NHS staff is on the increase – but can a new 'zero tolerance' Government strategy solve the problem?

VIOLENCE against healthcare staff has been an increasing problem in the NHS. In October of last year, Matt Hancock, Secretary of State for Health and Social Care, announced a new strategy to tackle the issue in England, including specific measures to better protect staff and prosecute offenders.

Key action points included:

- better collaborative working between the NHS and the Crown Prosecution Service to seek prosecutions and assist victims in giving evidence
- improved training in dealing with work-place violence
- improved psychological support for staff who are victims of work-related violence
- Care Quality Commission (CQC) to include scrutiny of violent incidents as part of its inspection regime.

Results from a 'staff survey' in England found that more than 15 per cent of NHS workers had experienced actual physical violence during the previous 12 months, which is the highest estimated figure for five years. The new strategy will allow staff to more easily record assaults and other incidents of abuse or harassment in order to help understand the reasons behind this rise in reported violence.

Trusts will be expected to investigate each incident and ensure that the lessons learned are used to protect staff from future incidents. Plans are also being drawn up for violence and abuse data from across the NHS to be reported nationally in order to determine which staff are most vulnerable to violence and what action can be taken to protect them.

The new plans follow on from the Assaults on Emergency Workers (Offences) Act, which has been brought into law and will see the maximum prison sentence for assaulting an emergency worker double from six months to a year.

Matt Hancock said: "We will not shy away from the issue – we want to empower staff and give them greater confidence to report violence, knowing that they will see meaningful action from trusts and a consistent prosecution approach from the judicial system."

Part of the announcement also included a relaunch of the so-called 'zero tolerance' approach, which aims to protect the NHS workforce from deliberate violence and aggression from patients, their families and the public at large.

The new strategy acknowledges that a zero tolerance approach is indicated in cases where "deliberate violence" is used against NHS workers. This appears to be a subtle change from the original NHS zero tolerance campaign, introduced throughout the UK in the 1990s, to reject all aggression and violence against NHS workers. The reality is that the triggers for violence are complex and multi-faceted and it quickly became clear that such a basic approach to its management was in some cases unhelpful and unworkable.

It is fairly easy to justify taking substantive action, such as removal from the practice list, against an individual who has behaved in an unacceptable manner through the use of personal abuse, threats and aggression or violent assault. But this becomes more problematic where there is an underlying illness or condition present, or circumstances where someone's behaviour is out of character, or they lack insight into their actions.

The original NHS zero tolerance strategy gradually made way for the development of more flexible and circumstance-driven 'unacceptable behaviour policies', which attempt to mitigate where appropriate but also allow for decisive action to be taken in circumstances where aggression and violence is premeditated and deliberate.

At MDDUS we regularly receive calls from members seeking advice on the removal of patients from practice lists, and the use of aggressive and violent behaviour against workers is certainly a compelling reason for doing so. However, we would encourage members to carefully consider each case on its own merits, rather than simply relying on a blanket 'zero tolerance' policy. Be sure to follow the GMC's guidance on *Ending your professional relationship with a patient*, which highlights the importance of steps such as warning the patient of your intentions in writing. Members should also contact our advice line for specific help.

ACTION POINTS

- Adopt a risk assessment approach to the management of workplace violence and aggression that fully considers both the prevailing circumstances and any mitigating factors.
- Ensure that all incidents of work-related violence are recorded and reported through appropriate health and safety systems and, if appropriate, to the police.
- Have a clear and comprehensive policy in place for dealing with aggressive or violent patients, including the steps to be taken when considering removing such patients from a practice list.

Alan Frame is a risk adviser at MDDUS

Dealing with employee breaches

Janice Sibbald offers advice on dealing with confidentiality breaches by practice staff – intentional or not

THE HR and Employment Law team at MDDUS often gets calls passed to us from our medical and dental legal adviser colleagues relating to breaches in patient confidentiality. We don't need to tell you that confidentiality breaches can have a major effect on the reputation of a medical or dental practice and have to be taken extremely seriously.

In many cases, these can be dealt with under routine SEA (significant events analysis) procedures and learning can be applied to individuals or to the whole practice. This may include additional training or revised internal processes and procedures being put in place. Individual training plans may be devised for those employees whose performance or conduct has been substandard. In any profession, human error can play a part in confidentiality breaches but you should ensure that internal processes are adequate and reviewed regularly and that employees have had appropriate training.

In some cases an employee's conduct may warrant a disciplinary hearing. The decision as to whether the error or mistake warrants a formal disciplinary action can only be taken once a full investigation of the situation has been carried out.

You should conduct an investigation to establish all the facts in order to determine whether a disciplinary hearing is required. Any witness statements should be obtained and signed, and written notes should be taken as these may be used as part of disciplinary proceedings. It is usual practice for an employee to remain at work during the investigation phase. Suspension should only be used in exceptional circumstances and is normally paid.

The investigation should be carried out where possible by someone who is not involved in the disciplinary hearing to ensure objectivity. Many IT systems are able to provide you with an audit trail if you believe that medical records have been accessed inappropriately. Internal calls are usually recorded and can be reviewed to obtain evidence of any potential confidentiality breach over the phone.

You may also wish to check that the practice has a confidentiality policy that the employee has signed and was trained on.

Should you decide that the matter warrants a formal hearing, invite the employee in writing to the meeting, giving at least 48 hours' notice. If dismissal is a possibility then reference should be made to this in the letter. Ensure that the employee is aware of the right to be accompanied by a colleague or a trade union representative (not a family member or legal representative) and be clear that their role in these meetings is to ask for points of clarity and to take notes, but the majority of the speaking should be done by the employee.

Any relevant documents, such as audit logs or transcripts, should be provided to the employee in advance of the hearing. Make sure that you have thoroughly prepared prior to the meeting with the facts and a list of questions you want to ask the employee, and ensure that there is sufficient opportunity for the employee to have their say during the meeting and raise any mitigating circumstances.

At the hearing you should focus on the behaviours or actions that you are concerned about, providing the employee with clear facts and examples. Create a further opportunity for the employee to inform you if they feel that further support or training is necessary or if there are any obstacles to avoid repeating mistakes – or the reasons for their unacceptable behaviour.

After the hearing has taken place, you should then adjourn the meeting in order to give yourself sufficient time to make a decision. In some cases, you may need to adjourn until the next day and this would certainly be the recommendation if considering a dismissal.

You should refer to your internal disciplinary policy, but possible outcomes would include no action, a verbal warning, first written warning, final written warning or dismissal. You can jump to any stage depending on the severity of the conduct or performance. A sanction can stay "live" or on the employee's file for around 6-24 months. It is useful also to consider the reaction of the employee and if they understand why there was a breach and show remorse for the situation.

After every formal stage, the employee should be given the right to appeal the outcome of the hearing. Employees should state the basis of their appeal in writing, and appeal meetings should be convened within a reasonable timescale. The employee has the same rights to be accompanied at an appeal, and someone impartial, where possible, should conduct the hearing. The result of the appeal should be confirmed to the employee in writing.

Where possible, different managers/partners should conduct different levels of disciplinary hearings to ensure the process is fair and impartial. A confidentiality breach is normally detailed in disciplinary procedures as a significant event.

Confidentiality is the backbone of every medical and dental practice and any breaches should be taken seriously and under relevant UK employment legislation. If you require any further assistance, including our disciplinary factsheet and template letters, please do not hesitate to contact one of the employment law advisers on 0333 043 4444 or at **advice@mddus.com**.

Janice Sibbald is an employment law adviser at MDDUS

DNA DILEMMA

Risk adviser **Kay Louise Grant** looks at risks associated with missed GP appointments and possible mitigation

MISSED general practice appointments are an enduring source of frustration to practice managers and indeed all primary care staff in the UK. Over 15 million appointments (around one in 20) are missed each year in England alone, with an estimated annual cost to the NHS of around £216 million.

Dr Richard Vautrey, BMA GP committee chair, recently commented: "Every appointment at a GP practice is precious, especially at a time when GP services are struggling to cope with rising patient demand, staff shortages and inadequate budgets."

But missed appointments are not simply a matter of cost or inconvenience – a recent study published in *BMC Medicine* linked DNAs (did not attend) with a higher risk of death in patients, particularly those with mental health problems. Data from 136 GP practices in 11 different health boards within Scotland revealed that "around five per cent of patients who missed more than two appointments a year over a three year period had died within a year of follow-up". The cause of death was commonly "non-natural" and often suicide. This research suggests that even something as simple as a five-minute medication review could have significant implications if missed.

CAUSATIVE FACTORS

Practices bear an obvious responsibility in ensuring patients do not miss appointments. MDDUS has seen an increase in claims being made against GPs where a missed appointment has played a factor in patient harm and sometimes in early/unexpected death.

It is important you can demonstrate that you have given your patient all relevant information relating to their treatment, including the risks associated with not engaging. GMC guidance on *Consent* states: "You should not make assumptions about: (a) the information a patient might want or need; (b) the clinical or other factors a patient might consider significant, or (c) a patient's level of knowledge or understanding of what is proposed."

Patients with alcohol and drug misuse problems, or those with cognitive impairment such as dementia, may lack motivation or capacity to cancel or rearrange their appointment. There may be other mental health issues, such as anxiety or phobias, that prevent patients from engaging. It is important doctors realise that their duty of care extends to ensuring that patients fully understand the reason for appointments and the consequences of not attending.

Certainly, competent adults have a responsibility to ensure they attend scheduled appointments – though there may be genuine reasons for non-attendance, such as being unaware of the cancellation process or simply forgetting. However, with vulnerable patients or those undergoing ongoing care for a chronic condition, practices are expected to be more proactive in understanding and mitigating any factors behind non-attendance.

PREVENTING DNAs

Existing primary healthcare appointment systems may not be effective for everyone, and practices are being urged to develop interventions to reduce non-attendance. Obvious suggestions include ensuring you have up-to-date contact details for each patient and that they are aware of the importance of cancelling appointments they cannot attend.

Practices and clinics should also review their policies and protocols for missed appointments and ensure that all staff are trained and clear on these. This should include a system which checks contact information and flags patients failing to turn up for review appointments, allowing clinicians to follow-up those that habitually do not attend or those at higher risk. Once the practice has taken measures to make contact with the patient and rearrange an appointment, it is important to keep accurate records of these steps and follow a set protocol of further

engagement, which would include letting the GP know if the process has ended without reaching the expected outcome.

Patient reminder text messages that include the cost of missed appointments have proven to be successful in reducing DNAs. This method is also popular within the NHS, being low cost, easy and efficient. Patients should be told that the practice is sending out text reminders for appointments and this should be clearly stated in your privacy notice (with patients reminded at all appropriate opportunities). The messages must relate only to medical care (i.e. not for marketing purposes) and a generic note of the cost of missed appointments could be added to the texts.

Practices could also use e-communications to reinforce reminders for review (as long as patients are aware of the process in advance and it is displayed in your privacy notice). These could include alerts to patients regarding test results and action required, for example: "Please contact the practice within the next seven days as your results have been received and the GP wishes to consult with you".

When a GP or other healthcare professional has initiated a request for a patient to book an appointment for review or further treatment, there should be a system to check these appointments have been made and also that the patient has indeed attended. Including information in the appointment slot when the patient is booked-in can allow the receptionist to take action when a patient calls to cancel that appointment – this might be as simple as a prompt to re-appoint during the call or a simple message to alert the requesting GP of the cancellation. The clinician is then prompted to assess whether the patient requires further follow-up or any other action.

For practice-initiated follow-up appointments, it is advised that clinicians and other healthcare support workers check the appointment slot for information to assess what the reason for the follow-up was and therefore whether further is required.

It could also be useful to consider how accessible the practice is for all patients. Could there be alternative ways of reviewing patients, particularly those with long-term conditions? Options might include telephone appointments, video consultations, extended-hours clinics or even the choice of on-the-day appointments for the purpose of review if there is a risk of non-attendance with pre-booked appointments. Care Navigation* could be considered as an option for some patients but this should not be offered as a substitute for GP appointments for the sake of time saving.

The BMA has recognised the need for patients also to take responsibility in tackling missed appointments. Dr Richard Vautrey said: "Practices will try many ways to address this problem, but ultimately patients do need to play their part. With the NHS finances under historic strain, it's vital that we don't waste the resources we currently have."

ACTION POINTS

- Recognise that regular DNA patients may be vulnerable.
- Make the effort to understand the patient's needs and be flexible with appointment types when requesting review.
- Review policies and protocols for missed appointments.
- Practice-initiated appointments should have prompts for further action if a patient calls to cancel or does not attend.
- Keep clear and accurate records of all communications with patients.

Kay Louise Grant is a risk adviser at MDDUS

* Care Navigation refers to assistance offered to patients and carers in identifying and accessing the systems and support that are available to them within health and social care and beyond.

PARKRUN APOSTLE

Jim Killgore meets a PM whose life was transformed by running and now wants the same for her patients

PHOTOGRAPHS: NEWSLINE MEDIA

TRACEY Thom had decided to take stock of her life.

This was 2013 and she loved her job as a senior receptionist at Danestone Medical Practice in Aberdeen. Over the years, though, her weight had crept up to 20 stone and she felt now was the time to start thinking about how to change her unhealthy lifestyle.

"I started with diets and that worked well to begin with. Then my sister said to me: 'Look, Tracey, I think you need to do some exercise. Come and join me at parkrun on Saturday morning'."

Parkrun is an initiative that organises free, weekly 5km timed runs at over 850 locations in the UK and around the world, mainly in public parks, attracting over 140,000 runners each week. The events are coordinated entirely by local volunteers and are open to people of all ages and abilities. Participants can run, jog or walk the set course.

"I had done some netball at school as most girls do but had never done anything in the way of running," says Tracey. "To be honest when I first went I was petrified. The thought of turning up somewhere new, everyone in lycra. I was the least likely person to be running."

But she did turn up at the Aberdeen seafront that Saturday morning in January 2014. "I walked and jogged the whole thing, out of breath most of the time. But the encouragement I got from everyone there was amazing. I could tell even from just the first day that it was for all abilities: from the fast runners at the front doing the 5km in 16 minutes to those walking at the back taking 50 minutes or sometimes over an hour to finish."

"From that day onwards it has been the one constant thing I do every Saturday in my week – and the friendships I have developed over the years have just been amazing.

"That was the catalyst for me to get into running. It was a few weeks before I could run the whole 5km. But eventually I was able to improve, get a bit faster, run a bit longer. That created an appetite to go further, so I started signing up for 10kms and then half-marathons."

NOT JUST PHYSICAL

Parkrun has similarly transformed the lives of many people across the UK and last year this prompted The Royal College of General Practitioners and parkrun UK to launch a groundbreaking initiative that could see thousands of patients being "prescribed" outdoor physical activity.

GP practices are now being encouraged to develop links with their local parkrun and become certified 'parkrun practices' – signposting patients and carers to parkrun, particularly those who are the least active and have long-term health conditions.

Research published recently in the *Journal of Epidemiology & Community Health* found that sedentary lifestyles are linked to more than 50,000 deaths per year in the UK and a total cost to the NHS of around £0.8 billion in 2016-2017. Adults are recommended to get at least 150 minutes of moderate exercise or 75 minutes of high intensity activity per week to reduce the risk of chronic health conditions. An estimated one third of men and half of women do not achieve this target, and one fifth of men and a quarter of women are physically inactive – achieving less than 30 minutes of moderate activity per week.

Parkrun is seen as one potential means of encouraging patients to achieve more healthy active lifestyles. Professor Helen Stokes-Lampard, RCGP Chair, said: "Small, often simple, lifestyle changes can have a really positive impact on our health and wellbeing, so anything that encourages patients to live better, and move more is a good thing. Parkrun is a diverse, fun and free way of getting our patients up and moving about, and empowering them to make basic lifestyle changes in the best interests of their long-term health and wellbeing."

And the benefits extend beyond physical fitness, with parkrun offering isolated and lonely patients the opportunity to socialise, make friends and become part of a welcoming, supportive community. A recent report stated that loneliness could be as harmful to health

Opposite page and left: Danestone practice manager Tracey Thom with Ashton McCombie. **Below:** Tracey with practice partners Dr Damian McGrory and Dr Kevin Cormack

as smoking 15 cigarettes a day and is linked to a range of damaging conditions such as Alzheimer's disease, heart attack and stroke.

SLOWER THE BETTER

Tracey Thom recalls the impact of first taking up parkrun, not just personally but on others around her – patients and colleagues at work. "I didn't really speak about it to begin with, but then people began to ask: 'What are you up to Tracey because it's quite noticeable that you're losing weight'. In a year and a half I was able to lose over eight stone – which was life-changing to be honest. I started telling my story, sharing my enthusiasm for parkrun with friends and colleagues and really anyone who would listen."

> "IT'S BEEN THE ONE CONSTANT THING I DO EVERY SATURDAY – AND THE FRIENDSHIPS I HAVE DEVELOPED OVER THE YEARS HAVE JUST BEEN AMAZING"

In the meantime she had taken up the job as practice manager at Danestone upon the early retirement of a devoted colleague. The practice has a list of around 5,000 patients in a suburb of Aberdeen – with five GP partners, mostly part-time. An email arrived one day from the RCGP announcing the launch of the parkrun practice initiative.

Says Tracey: "I replied to it right away and we applied to be a parkrun practice. A number of the partners were already runners. So they were happy for me to drive this forward.

"I was so proud. It's a little thing but we were first in Grampian, third in Scotland, and twenty-fifth in the UK to sign up to be a parkrun practice and now there are over 700 in the UK. It really has taken off."

The RCGP provided a "toolkit" including details on how to become a parkrun practice and ideas to promote the initiative to patients, including posters and flyers, display information on waiting room video screens and online via practice websites and on social media, with links to "inspirational stories" on the parkrun YouTube channel.

Tracey contacted the run director at Aberdeen parkrun to discuss the logistics. "It was as much to alleviate any fears over what kind of patients were going to be referred. Is it going to be patients with triple heart bypasses or at risk of stroke? We reassured him that the people we would be signposting to parkrun would be medically classed as fit to do so – patients who could benefit by increasing their physical activity.

"I think one of the selling points is that it's free. We are not suggesting that patients sign up for expensive gym membership. And also it's a group activity. You've got other people there you can chat to and develop friendships with if you want to."

The initiative is still very much a work in progress and Danestone and other parkrun practices, along with the RCGP, will be monitoring its effectiveness in improving health over the coming years. Parkrun ambassador for health and wellbeing, Dr Simon Tobin, recently noted that the average finish times for different parkrun locations are getting slower and he sees this as a positive thing. It means that parkrun is bringing in new participants that are less active and less fit, which is exactly what it is aiming to do.

Certainly Tracey Thom is in no doubt of the personal impact of parkrun.

"I think it has improved my confidence; certainly it's improved my health. It's made a huge difference to my life."

Jim Killgore is associate editor of Practice Manager magazine

● Find out more and get your RCGP parkrun practice toolkit at **tinyurl.com/y5nt4e24**

Liz Price looks at changes taking place in practice staffing roles in Scotland – with lessons for across the UK

TRANSFORMING

GIVEN the continuing growth in chronic disease in the community – driven mainly by an ageing population – the Scottish Government has been busy looking at ways to refocus nursing roles within primary care. A paper published in 2018 featured a new framework* introducing the role of non-clinical healthcare support workers (HCSW) to allow nurses in future to focus less on monitoring of care and more on prevention and management, including self-management and anticipatory care.

These changes sit within a wider agenda designed to support a move in care from hospital to community and primary care settings, with the aims of improving population health, access to services and best value from health and social care services. This is also driven by a refocused Scottish GP contract which looks to support practices to better understand and meet the differential needs of local patient populations. A total of £3 million has been committed over three years to fund training provision to support changing roles.

MDDUS has been involved in a series of workshops led by Greater Glasgow and Clyde health board, who are working with the West of Scotland Advanced Practice Academy to support practices through this transition. Our role was to highlight the medicolegal issues and regulatory responsibilities in relation to the changes for GPs, PMs and practice nurses, as nursing and HCSW roles in future will require to be more closely aligned with the national framework.

Whilst this is a change particular to Scottish general practice, many of the points below will be of interest to practice managers across the UK in relation to service development.

OBLIGATIONS UNDER THE FRAMEWORK

Practice managers will now have a duty, along with the partners, to ensure that they have a clear understanding of the types of services their patient population will require and how this can be supported by practice nurses and HCSW roles.

It may be that roles, along with job descriptions, will require adjustment to reflect local priorities and necessary core competencies, and PMs should be making themselves aware of what options are available to their teams.

From this position, PMs should be planning how the practice can support competency development to close any performance gaps, and this may mean allowing time for training which can be challenging, particularly in small practices. There will also be a need to risk manage the process by ensuring that supervision and support mechanisms are in place.

Partners within practices have an obligation to "ensure anyone you are delegating to has the qualifications, skills and experience to provide safe care" and to "ensure that all staff you manage have appropriate supervision" (GMC – *Good Medical Practice*).

In future, all advanced nurse practitioners (ANPs) in Scotland will need to hold a master's level qualification in advanced practice and meet all the required competencies for the primary care role. Existing ANPs will need to evidence that they meet the requirements before they can be recorded as an ANP on a list held by their Board, giving them additional authority. It is likely that GPs will be required to undertake workplace, clinical sign-off on these competencies, and should bear in mind their regulatory responsibility in relation to honesty and objectivity when appraising or assessing the performance of colleagues.

If a nurse currently working as an ANP does not meet the requirements within the new framework, it is perhaps worth knowing that

NURSING ROLES

both the NMC and the RCN oppose the use of the ANP title without recognised training or competence. Set against the new framework, this could pose a problem if only until gaps are plugged.

If the practice is looking to recruit an ANP from outside primary care, they will be required to assess any gaps in that individual's knowledge and competencies relevant to the primary care role and plan to plug these. Also, if an ANP is recruited from an out-of-hours setting, their competencies are more likely to be closely aligned to primary care than if they trained as an ANP in oncology, for example.

ESTABLISHING COMPETENCIES

Once future service needs have been established, the nurse should work with the PM and partners to consider where training and development is required.

Any gaps in competencies in relation to the new framework or defined requirements (for example the nurse may fulfil all the competencies required to be classed as a senior practice nurse (Band 6) but may not be a non-medical prescriber) should be addressed with appropriate support and access to training.

It is very important that the nurse, or a HCSW, is not expected to work outside the scope of their current competencies and, indeed, nurses have a regulatory duty to raise concerns with their employer and to ensure they ask for help.

The nurse's aspirations should be considered alongside the requirements, and (for example) if an ANP role is to be introduced, it could be that the practice can plan the change over a period of time in order to support the current practice nurse to progress their career to meet this need.

Practice nurses are most likely going to have the lead role in developing HCSWs to learn new skills within the framework – and nurses have similar regulatory duties to doctors in relation to delegation and supervision. By supporting the development of other non-clinical staff in expanded HCSW roles, it is likely that practice nurse time can be released for other activities that require clinical expertise.

It is equally important that both nurses and HCSWs expanding their skills are supported to ask for help at the interface of care or boundary of competence between themselves and other team members. For example, the nurse should feel confident to ask a GP to review a patient for them, and the HCSW should feel they can stop and ask a nurse for advice or support.

TAKE A CONSIDERED APPROACH

Although there are no set timescales for the framework changes to be implemented, there is now a clear direction of travel for GP practice development of nursing and HCSW roles.

I would urge practice managers to take a slow and steady approach to managing the required changes. Ensure you access employment law advice as and when appropriate to risk manage changing roles as, in my experience, some HCSWs and practice nurses will be worried about what the changes mean for them and what the practice will expect. They will also perhaps be nervous about new roles or undertaking training, and will need support through the process.

Our experience is that team members are much more likely to embrace the challenges – and opportunities – ahead if a collaborative approach is taken to understand patient population needs and to identify how service development will best meet these needs and benefit patients.

Liz Price is senior risk adviser at MDDUS

* *Developing the general practice nursing role in integrated community nursing teams.* Scottish Government, December 2018

Visual loss

Day one

Mr T is a 68-year-old retired lawyer who attends his GP practice complaining of headaches over the past week. Dr A takes a history and examines the patient, noting tenderness around both jaws. He records: "? tension headaches. No temporal tenderness or visual upset; TA [temporal arteritis] unlikely". Given the slight risk of TA he does order blood tests including a FBC and plasma viscosity (PV). Mr T is advised to take paracetamol and to contact the surgery if the pain does not ease or he experiences any new symptoms.

Day eight

Mr T is driven to the surgery for an emergency appointment. He reports a loss of visual acuity in his left eye over the last 24 hours. He is seen by the duty GP – Dr W – as Dr A has been on annual leave for the past week. Mr T says he is still suffering from headache and feels pain in his jaw on chewing. Dr W also notes tenderness in the left temporal artery and diagnoses temporal arteritis. An urgent referral is made to the local hospital eye clinic and the patient is prescribed prednisolone stat.

Day nine

A consultant at the eye clinic examines Mr T and finds visual loss in the left eye and impaired pupil light reaction, indicating significant damage to the optic nerve. She diagnoses giant cell arteritis with ischaemic optic neuropathy. Mr T is prescribed high-dose intravenous methyl prednisolone, followed by a tapering course of oral prednisolone. The consultant also notes that plasma viscosity was significantly elevated in the blood test undertaken by Dr A (on Day 1). A C-reactive protein (CRP) test was also markedly elevated.

Day 16

Mr T attends an out-patient clinic and visual acuity in the right eye is measured at 6/9 but there is no perception of light in the left eye. The prognosis is considered poor.

A CLAIM for clinical negligence is received by the practice from solicitors acting on behalf of Mr T. It alleges that the practice failed to act on the results of an abnormal blood test and this resulted in delayed diagnosis and treatment of the patient's temporal arteritis, with complete and permanent visual loss in the left eye. It is further alleged that Dr A failed to examine the patient's fundi and check his BP.

MDDUS instructs a primary care expert to review the patient records and other documents, including a significant event analysis (SEA) conducted by the practice. The expert concludes that there was a systems error in processing the abnormal blood test, which amounted to a breach of duty of care.

The expert notes that Dr A ordered the blood tests but then went immediately on annual leave. Practice protocol would normally call for the results to be sent to the duty doctor, but instead admin staff sent these to the practice nurse. The FBC was forwarded to the duty doctor with a note to say the PV was abnormal (but not the actual result). The duty doctor checked the FBC resulted but failed to notice the comment relating to the PV. She then sent the FBC report on to Dr A, not realising he was on leave. It was not until the patient attended the eye clinic that the elevated PV was noted and acted upon – a delay of over seven days.

In regard to Dr A's failure to examine the patient's fundi, the expert points out that the crucial elements in making a diagnosis of TA are the history and examination of the temporal arteries, along with blood tests. Examination of the back of the eyes would not normally be indicated.

An opinion on causation is also solicited from a consultant ophthalmic surgeon. He concludes that had Mr T's elevated PV been acted upon in a timely manner it would have led to a diagnosis of giant cell arteritis and prompt treatment with steroid medications such that the patient would not have lost vision in his left eye. He also concludes there is no reasonable prospect of any visual improvement.

MDDUS agrees to settle the case with approval from the GP partners but no admission of liability on the part of Dr A. The practice acts on the SEA and makes changes in the results-handling process to prevent any repeat of the systems error.

KEY POINTS

- Ensure holiday or other staff absences are sufficiently highlighted in the practice and in regular meetings.
- Ensure all test results ordered by staff taking leave are flagged and acted upon.
- Conduct an SEA when errors are reported to ensure lessons are learned.

Diary

MORE random items of questionable relevance from the PM team...

➔ KEEP YOUR GERMS TO YOURSELF The idea came to GP Dr Robin Kerr of Teviot Medical Practice when he was lying in bed wondering which of his patients had given him the flu. "I was thinking how could I have stopped this. By the time the patient comes in for an appointment with a cold or flu the time has passed – it's no good saying 'next time you have a cold, consider self-care'." His idea was a carefully-worded telephone recording – before talking to a receptionist – signposting appropriate patients with cold symptoms in the direction of a community pharmacy to basically tough it out. Research conducted by Dr Kerr and colleagues found that the approach led to a 5.5 per cent reduction in calls continuing through to reception in a period when the incidence of the common cold was at its highest, and a 21 per cent reduction in the mean waiting time to the third available routine appointment. Voltaire did say: "The art of medicine consists in amusing the patient while nature affects the cure." *Source: GPonline*

➔ POO-POO TO STOOLS It's out with the stool and in with the poo at the nhs.uk website. After much analysis of research and feedback, a team of content designers have revealed the words and phrases that they believe are easiest for users to understand. Among the most hotly contested areas is that concerning toilet habits. Diary can officially confirm that peeing and pooing is preferable to urinating and bowel movements. Diuretics are no longer "water tablets", but "tablets that make you pee more" and stools are something you sit on. They decided against "wee" as this can be too easily confused with "we" or "wee", meaning small. In a blog introducing the new A to Z list, content designer Sara Wilcox admits: "We get some complaints when we use words like 'pee' and 'poo'. People tell us they see it as 'dumbing down', 'simplistic' and 'patronising language'." But she defends the word choices and says most people describe the language as "clear, direct and pitched at the right level." So now you know. Get your vocab up-to-date at **tinyurl.com/yyx9pzxs**

➔ AN ANGLO-SAXON DENTAL CONSPIRACY British dentists planning a holiday in the Veneto region of Italy are best advised to keep a low profile. Italian farmers are said to be fizzing over UK warnings that acidity and sugar levels in prosecco are damaging teeth. Professor Damien Walmsley, scientific adviser for the British Dental Association, said: "Prosecco offers a triple whammy of carbonation, sweetness and alcohol, which can put your teeth at risk, leading to sensitivity and enamel erosion." Imports of prosecco to the UK fell by 7 per cent this year after a decade of growth and the farmers are said to be blaming dentists, along with a Brexit-enfeebled pound. Veneto region governor Luca Zaia called the health warnings "the umpteenth Anglo-Saxon crusade against Italian products". Prosecco sales are also being hurt by the rising quality and popularity of English sparkling wines. We might be doomed by trade tariffs and climate change but at least we can enjoy some quality British plonk.

➔ JAM IN A JAM Sticking with the theme of sugar shaming, it seems Public Health England (PHE) bears some blame for the drop in popularity of jam. Sales of the fruity spread in Britain fell by 2.9 per cent in 2017, down to £106 million. This follows PHE's drive to reduce children's sugar consumption by 20 per cent by 2020. Jam has fallen out of favour as it contains a whopping 10g of sugar per tablespoon. But jam's loss is peanut butter's gain, with sales of the nut spread up by nearly a fifth in 2017 thanks to the introduction of new "healthy" and less-sugary upmarket versions. Ironically, marmalade (which contains 12g of sugar per tablespoon) has seen its fanbase increase thanks to the popularity of the film *Paddington 2* which is credited with driving a three per cent surge in sales. Who said life is fair?

➔ PRESCRIBING HAPPINESS Considering the current buzz around social prescribing, *Diary* couldn't help but cast a sceptical eye over a recent report in the *Times* highlighting a new US import to London – cannabis yoga. It seems a popular gym chain in the city is among the first to offer "cannabliss" yoga classes, which promise to help customers recover from their "static nine to five". Participants are given a patch infused with cannabidiol, known as CBD, before doing a series of stretches and yoga poses. The article is quick to emphasise that CBD is derived from the cannabis plant but does not make you high because it contains only tiny levels of tetrahydrocannabinol (THC), the psychoactive element of the plant. CBD, which comes in the form of an oil, has apparently become increasingly popular in Britain over the past year, with capsules for sale in Holland & Barrett. Those in favour of the practice say CBD and yoga "amplify each other's restorative gifts", but one yoga instructor admitted that some people felt no effect from the patches and that those who did might have been benefiting from a placebo effect. No word yet on whether cannabliss will make it onto the government's list of approved social prescribing activities...

NAVIGATING CHANGE

MDDUS Practice Managers' Conference 2019

Book before 28 June and enjoy our early bird rates

MDDUS invites you to join us for the 2019 Practice Managers' Conference at the Fairmont, St Andrews on 28 and 29 November 2019.

NEW HORIZONS: NAVIGATING SAFETY THROUGH CHANGE

The general practice landscape is changing rapidly. Managers are facing new challenges as practices welcome an increasingly diverse mix of health professionals, with more tasks delegated to non-clinical teams. We know that risk increases at the interface of healthcare providers and between clinical professions and this year we are focusing on safely navigating this change.

Delegates will be able to choose from a range of masterclass topics including:

- Investigating patient safety incidents – including human factors and duty of candour
- Dealing with challenging patient contacts
- Raising concerns – about safety, health, behaviours and performance
- Managing online presence – your own, clinicians, practice and patients.

Other topics include creating safe workflow optimisation strategies, care navigation, safe change management, building personal resilience, business continuity exercises, and practice nurse and HCSW workforce development strategies.

MDDUS

UK INDEMNITY, ADVICE & SUPPORT

Keynote speaker: **Mark Rhodes**

International motivational speaker and author of *Think your way to success* and *How to talk to Absolutely Anyone.*

"A BRILLIANT STORY TELLER WITH PRACTICAL AND REAL EXAMPLES..."