PRACTICE OBSERVED

GPs and Their Staff

Looking after your new employee

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If you have expended effort on recruiting good staff it would be pointless to dissipate this by failing to help them to become accustomed to your practice and to do their jobs satisfactorily. It may seem self-evident that any new employee should be properly trained and introduced to the practice, but it is surprising how often employers neglect or forget this essential task. Your staff are a vital asset to your practice, and you owe it to them and to yourself to ensure that they are able to contribute to the best of their abilities. If you fail to provide adequate induction and training you may leave yourself seriously at risk if you ever need to take disciplinary action. The term "induction" may be unfamiliar to you and you may reasonably assume that it is yet another example of technical jargon intruding into the English language, but its use may be justified because it encapsulates the specific task that any employer should undertake.

Why "induction" matters

You need to help your new employee to settle into the practice as quickly as possible. This means that she should be helped to get to know her colleagues and the partners, to become familiar with the surgery premises, and to know the wider contacts that will be an important part of her job (these may be other practices, the local health authority, local hospitals, local health services department, and the family practitioner committee). Above all, she will need to be helped in getting to grips with the job. Of course, a lot of this knowledge may be "picked up" gradually without any formal induction programme. But there are good reasons for ensuring that this wide range of information is acquired in a planned and systematic way.

When someone starts a new job there is usually some anxiety about certain aspects of the job. She is faced with new colleagues, a new boss, new tasks, and a new environment. Helping your new employee to settle in is not just a matter of courtesy and consideration, it also contributes to the smooth running of your practice. Induction may be just as important in a small organisation as it is for those large organisations which run formal training courses, and properly done it need not be costly in time or resources. But if you neglect or forget it, it may be very expensive indeed.

Until your new employee has settled down she is unlikely to be fully responsive to the demands of her job. There is always an initial (and often steep) learning curve to be surmounted and it may be just as important to respond quickly and effectively to the demands of the new job. The time lag that occurs before a satisfactory performance is achieved is likely

to be increased if there is no induction programme. Your instructions (or more likely those coming from your practice manager) may be misunderstood or forgotten, and important procedures may be neglected. Your new employee's initial enthusiasm for the job may simply wane before she begins to feel settled, and she may soon become disenchanted and even resign. If discontented your new employee is unlikely to be effective and may even cause friction in the practice. A new and inexperienced colleague may even have an unsettling influence (albeit unintended) on your existing staff, so there is a strong case for speeding up her integration into the practice. If you get your induction programme right you can avoid these problems. You will have positively helped your new recruit to settle in and to develop a loyalty and commitment to your practice. Of course, if the employee becomes disenchanted and leaves all the time and effort that you have spent on recruitment has been wasted.

When should induction start?

In fact "induction" actually begins when you are recruiting the new employee. Any applicant for your vacancy should learn something about general practice and how your surgery runs. She is likely to form some first impressions of prospective colleagues. After she has been selected for the post it may be helpful to invite her to meet her new colleagues informally before accepting the job. In a small, tight knit unit it is crucial that the practice manager and staff get to know each other so that staff are compatible and that conflicts of personality should not occur.

The next stage is to ensure that there is a welcome on the first day. Although your practice manager may be busy and preoccupied with the normal daily pressures of the surgery, she should make a special effort to give the newcomer her full attention. Many employers ask the recruit to come later on the first day—for example, after morning surgery has ended—so that the practice manager may then give her undivided attention. Induction may be spread over several days, or even weeks.

In a small organisation it should not take long. However short the induction programme, it should be comprehensive. Any newcomer can absorb only a limited amount of information at a time, but, on the other hand, the more established the becomes the more difficult it is to set aside time for induction. It is important to allow time for your new employee to gain confidence in her new job. There is likely to be a high and continuous pressure of work from the moment she arrives until the end of the day. It is unlikely that this pressure of work was experienced in a previous job. It may even lead to an early resignation from the job. Thus it is important to ensure that she is gradually eased into the new working pattern.

What kind of training is needed?

Although induction training is usually informal, particularly in a small organisation, it should nevertheless follow a defined plan. Ideally this "plan" should be written down (perhaps in a

Practice Research

Age-sex registers as a screening tool for general practice: size of the wrong address problem

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Abstract

Age-sex registers were compiled and updated for the east London general practices participating in a screening study for hypertension. Of 1435 addresses in the registers of two practices that were checked, 228 (16%) were incorrect, according to the return by the post office of the screening invitations and checking the addresses of the non-responders using telephone directories and the medical records. The non-responders to the screening invitation for whom a new address was not found, were visited at the address as recorded on the age-sex register. This showed that the true address error rate from the original age-sex registers was 25%, and thus substantially greater than that calculated from returned letters.

It is concluded that the non-acceptance rate of screening in general practice might be exaggerated as a result of the lack of a correct address for a substantial proportion of the patients on a general practice list.

Introduction

A major use of an age-sex register in general practice is to identify a target population for a screening procedure.¹ This often requires sending out written invitations to attend a special clinic, and thus any inaccuracy in the recorded addresses would limit the effectiveness of such a screening strategy while underestimating the acceptability of the procedure.² Error rates in address

based on letters returned either by the post office or the current occupant have been between 13 and 17%.³⁻⁵ These rates, however, may underestimate the true wrong address rate, which can be ascertained only by visiting the non-attenders at home for whom no such returned letter has been received.

As part of a screening study for hypertension in inner east London, the extent of the address error in apparently updated age-sex registers was obtained by visiting non-responders at home. In addition, the general practice records of these patients were examined to determine the proportion who, despite the absence of a correct address, were still attending the same practice.

Methods

Patients aged 50 to 64 at 1 January 1980 in two general practices that were participating in a hypertension screening programme were studied. Practice A was a single handed general practitioner with 457 patients in the age range, whereas practice B was a group practice based in a health centre with 978 such patients. Age-sex registers were constructed for the former and updated for the latter practice using the general practitioner records. These were cross checked with the relevant family practitioner committee lists to check for deaths and those who had moved to another practitioner. An invitation for screening was sent during 1980 or 1981 to all the target population thus identified and a second invitation, followed by a third when necessary, sent to non-attenders. All patients for whom letters were returned were noted. For both these patients and those of the remainder who did not attend for screening the information in their general practice records was checked. This, together with an examination of local telephone directories, provided some addresses more recent than those on the register. The non-attenders for screening for whom no new address was available were visited at the address recorded on the age-sex register during the early evening. In most instances these visits, which included interviews with the occupant or neighbours, were necessary, showed whether the patient was or was not living at that address. Finally the general practice records of all the patients with a wrong address were examined at the end of 1982. Patients were

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divided arbitrarily into two groups: those (i) who had attended the surgery since 1 January 1980 and (ii) those who had not. The former were designated as attenders at the study practice during the period of screening, despite the absence of a correct address.

Results

The figure shows the number of incorrect addresses before home visits were made. Overall, 20% (14.3%) of letters were returned by the post office, for which subsequent checking showed the correct address in 20. A further 23 (1.6%) addresses were shown to be incorrect by further inquiry of the non-attenders. Thus the original registers had an error rate of nearly 16%, though this included 43 (3.0%) for whom

Flow chart of invitations for screening generated by age-sex register.

correct addresses were subsequently found by further examining the general practice records and local telephone directories. The difference between the two practices in this rate (18.7% v 9.8%) was significant ($p < 0.0025$), with practice A having the lower rate. Of 299 home visits made to non-responders, 85 (28.4%) failed to discover whether the address was correct. A further 147 (49.8%) equivalent to 10.2% of the original population addresses were found to be incorrect after interviewing the current occupant or neighbour, with no difference in this rate between the two practices. Thus in total the 43 mentioned above for whom new addresses were found, the records of the remaining 332 were sought (table). This showed that nearly one third were untraceable, probably representing patients who had left the practice between 1980 and 1982. Most of the remainder had not visited their general practitioner within those three years, and in many instances their last visit was over 10 years previously. Sixty seven (20.1%), however, were still attenders despite no correct address being available.

Discussion

There are several conclusions from this study. Firstly, an age-sex register, even when updated as far as is feasible during its compilation, is no guarantee of providing accurate addresses for screening. Further, as others have suggested, it should not be used as a research tool without further checking.⁶ Secondly, the true error rate in the recorded addresses might be approximately double that reported by others.³⁻⁵ Most of this increase is probably a manifestation of an underestimate of wrong address

Attendance by patients with no correct address at two general practices

Practice	No. of patients	Attended since January 1980		Records not traced (%)
		No (%)	No (%)	
A	76	21 (27.6)	55 (72.4)	77 (100.0)
B	256	42 (16.4)	214 (83.6)	77 (30.1)
Both practices	332	63 (19.0)	269 (81.0)	105 (31.4)

rate when relying on returned letters alone, though the population in this inner city area is likely to be more highly mobile than studies in more stable areas. Thirdly, it is likely that one in five of those patients with an incorrect address might still attend at a registered practice. This was highlighted by the results of a recent study in which 11% of a random sample of patients from the age-sex registers of 10 participating practices, who could be contacted, reported that their registered address was incorrect.⁷ In addition, there may be some patients with an unknown current address and no recent attendance who still consider themselves part of that general practice, but they are likely to be few as it has been reported that only 2% of patients had not attended their general practitioner in a five year period.⁸ Fourthly, the acceptance or response rate from screening needs to be calculated from a denominator of invitations received rather than those sent. A high wrong address rate, if not corrected for, would result in an underestimate of screening acceptance. These 67 in the current study (table) who still attended the study practices and had a wrong address represent 5% of a practice population who would not be covered in any screening study. They would, however, be covered by a case finding approach to disease detection.⁹

The population for this study was an inner city population, which was highly mobile and thus not typical of other areas. Nevertheless, it is perhaps in such areas where screening is most important. As there is no incentive for a patient to inform either the general practitioner or the family practitioner committee of a change in address, screening can reach only 75% of its target population. The effectiveness of an age-sex register, therefore, to generate screening invitations is limited by this phenomenon.

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checklist) to ensure that you neither forget nor neglect anything. If your new recruit is a receptionist your practice manager will need to be closely concerned in preparing this plan and implementing it. Indeed, most (if not all) of the induction process may need to be undertaken by your practice manager, or another member of your staff. Not all practices have a practice manager, however. Thus one of the partners should be responsible for administration and he would normally ensure that induction is properly completed. Even where there is a practice manager, it is often most helpful for one of the partners to take a personal interest in the new member of staff. This allows working relationships with the doctors to be developed, it ensures that the methods and objectives of the practice are not diluted or misinterpreted, and it may even give the doctor greater insight into the daily running of the practice.

Normally, induction requires your new recruit to listen to other members of your staff talk about their work and how the practice runs. Your employee will also be watching the pattern of work activities and the should, of course, be encouraged to ask questions, however basic or simple. In addition, you may wish to use your written statement of terms and conditions of employment and the job description to help explain how the practice is organised.¹⁻³

Who needs induction?

Anyone who is new to your practice (or even someone who is transferred from another job) needs some induction. But there are particular groups of people who may need special help and advice. It is not surprising to find that no induction is provided for an employee who is transferred from another job or promoted. Often it may not be necessary. But it is never advisable to assume that a highly competent receptionist will automatically become an effective practice manager immediately after promotion. Indeed, internal promotions in a small organisation may create special difficulties; you should not expect someone to easily assume managerial authority and responsibility over colleagues who were formerly her "equals". If the promotion is to be successful for all concerned one of the partners may need to put aside time regularly to advise and assist the newly promoted practice manager. You should not assume that someone who was recruited from a similar position in another practice will easily slot into your practice. New staff from other practices may have firmly developed preconceptions about how their job should be done, which do not fit in with your own arrangements. These preconceptions may be helpful in understanding and applying the methods and philosophy of your practice.

Certain other groups may need special help. School leavers or young people without any experience of employment may be excited yet nervous about their first job. Indeed, they may need to be helped in a sympathetic but firm way to understand the discipline of working life, in particular punctuality, reliability, courtesy to patients, and the need to have a positive attitude to work. Women returning to work after a long absence may also find difficulty when readjusting to working life. Special help may also be needed if you employ a disabled person or a member of a minority racial group.

Who does the induction?

Although several people may be concerned in the induction programme, it is advisable to identify one person who has overall responsibility for this task. In most practices the practice administrator will have the main responsibility (and the greatest interest) in ensuring that your new employee settles in and quickly becomes an effective member of your staff. If the new recruit is a receptionist or secretary then your practice administrator will have the main responsibility for their induction. They will be equipped to provide much of the initial training. They will also be familiar with the newcomer's job and close at hand to

advise and assist. Above all, someone must be given specific responsibility for this task; your new employee should know who to turn to when seeking guidance or reassurance.

Important task often neglected

How you approach the induction of your new employees will clearly depend on the circumstances of your practice and the resources that you can devote to it. Induction need not be an elaborate business, but it should be well thought out, planned ahead, and then undertaken with care.

The effort and care that you and your staff commit to the induction of a newcomer should result in a more effective and motivated employee. Although it may be self-evident that any employer would want to ensure that a new employee is quickly trained to do the job and encouraged to feel at home in the practice, this task is often neglected. It is too easy to assume that the newcomer will automatically acquire the necessary skills and knowledge for the job and there is no need to make any special arrangements for this learning process.

When induction is completed this does not mean that training has ended. You may wish to encourage your staff to attend training and continuing education courses. The Association of Medical Secretaries, Practice Administrators and Receptionists, the qualifying body in this field, is also the principal organisation responsible for running courses for practice staff. You may wish to ascertain when your interview prospective candidates whether they have an interest in training.

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This article can provide only a general guide to the provisions of existing legislation. It does not offer a definitive statement of law.

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ONE HUNDRED YEARS AGO Having been acquitted of the charge of indecent cremation of the body of his dead infant, Mr. Price accomplished his object on March 14th. He faced three hurdles on his way, then piled half a ton of coal within the triangle thus formed, and upon a pair of large iron gales he placed a box containing the body of the child, wrapped in napkins. Petroleum was poured over the coals, and this served to make the pile a mass of fire as soon as ignited on the place. Mr. Price was present during the process, and chanted an ancient song in the presence of a number of spectators. After the material used in the cremation of his son were half a ton of coals, a gallon of paraffin oil, and stipensworth worth of the coal, the total cost being only 8s. 2d. Every vestige of the infant's body was burnt, and the breeze carried away the ashes. The fire was so fierce that it melted the iron of the grate on which the body was deposited. He now announces his intention of erecting a crematorium at Llantrisant, Glamorgan, where he desires that he himself and all his family shall be cremated. Persons who intend that their corpses should be consumed on the funeral pyre, or whose executors wish the remains to be so disposed of, may find a large number of letters of approval from London, the continent of Europe, and India. Although many will disagree with the Welsh surgeon in matters of detail, he deserves a considerable amount of sympathy for having carried out what he believed to be the right way of disposing of his child's remains in the face of strong social pressures. The advocates of cremation will do well to bear in mind that all the judges on the English bench may not agree with Mr. Justice Stephen's decision in favour of the practice; and further legal opinion on the subject will be available if many persons desire to carry out cremation as an established practice, and therefore on a large scale. (*British Medical Journal* 1884; **i**: 624.)