Partners in Practice

Management and administration

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This is the fifth of a series of articles focusing on the current tasks and functions of the primary health care team

Throughout its short history the primary health team has moved through various phases of development. In the sixties the emphasis was on attaching health visitors and district nurses from health authorities. In the seventies and eighties practice nurses came into their own. The nineties will be the decade of the practice manager.¹

In 1949, 80% of general practitioners worked in single-handed practices, with no help other than perhaps their wives. In 1989, just before the inception of the general practitioners' contract, 80% of general practitioners worked in group practices,¹ and the current trend seems to be towards bigger practices. In many practices 15-20 years ago the senior receptionist was responsible for the reception area, filing and medical records, and the appointment system, and the doctors took on the management of the other aspects of the practice. Increases in medical knowledge and technology, greater patient expectation, and the demands of successive reorganisations in the NHS have led to an increasing number and variety of staff being employed in general practice. The increased complexity of the organisational structure, along with the more stringent availability requirements of current legislation, means that general practitioners must either manage the staff, resources, and finances of the business in their shrinking spare time or employ someone else to manage the practice with them.

Emergence of the practice manager

During the years leading up to the white papers *Promoting Better Health*,² *Working for Patients*,³ and *Caring for People*,⁴ "practice managers" and "practice administrators" began to appear, but in most practices their true function was administrative. It was recognised that training was needed for these members of staff, and the Association of Health Centre and Practice Administrators (AHCPA) and the Association of Medical Secretaries, Practice Administrators and Receptionists (AMSPAR) both offered training courses covering practice administration and also, though to a lesser extent, management issues.

The real pressure for enhancing the role of the practice manager came from the legislation which followed the white papers. It became imperative to have someone in the practice who could manage the process of implementing the changes required in staffing and working procedures, the financial implications, and so on, and then continue to run the practice effectively, efficiently, and economically. It has to be said that there was some resistance from general practitioners to the change in the practice manager's role—this may have stemmed more from resentment of the imposition of the 1990 contract than

Management responsibilities of the practice manager

- Patient services
- Quality assurance and audit
- Staffing and motivation
- Internal communication
- Financial management
- Public relations
- Liaison with outside bodies
- Information management
- Legislation
- Systems (design, implementation, and monitoring)
- Premises
- Change

from any rational analysis of the situation with which general practice was faced.

Increasing professionalism

The administrative role within a practice involves implementing and overseeing policy set by the partners, dealing mainly with rules and procedures, and it is essentially a reactive role. In an environment where change is minimal and flexibility and responsiveness to new demands are not required an administrator is a valuable asset, but general practice is in a phase of rapid development which is likely to continue for some time.

There are many definitions of a manager's role: "getting things done through people," "deploying people, resources and money," "planning, organising, monitoring and reviewing," and many more. There is no doubt that any organisation will function more effectively if someone is setting organisational objectives, planning how to achieve them, and monitoring progress towards their achievement, and general practice is no exception. A management role is essentially proactive and requires someone with the ability to respond positively to a changing environment and who can define and agree objectives, analyse problems, establish priorities, negotiate between conflicting demands, devise a strategy, implement the plan, monitor its progress, and review its effectiveness.

A further issue is that managers in small organisations like general practices have a much wider range of responsibilities than managers in large organisations, who usually have only one area to deal with—for example, a personnel manager or a sales manager. In contrast, a practice manager would expect to deal with all of the areas shown in the box.

There has been some development in training available to practice managers to enable them to cope

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with this expansion of their role: the AHCPA and AMSPAR courses now have a larger management component, and the Open University now offers a distance learning course, "managing health services," which gives practice managers a broader perspective on their role within the rest of the NHS as well as exploring concepts of management in depth.

Some general practitioners still take the view that they do not want to "be managed": this is inevitable, given that one of the reasons why doctors choose to become general practitioners in the first place is that they place a high value on independence and personal autonomy (incidentally, this may also go a long way towards explaining the initial powerful reaction against the imposed changes of the 1990 contract). However, assuming that a practice has employed someone capable of carrying out all the tasks and roles outlined above, what sort of relationship should the partners expect to have with their practice manager?

Relationship with partners

It may be useful to consider the partners as company directors and the practice manager as a managing director: thus the overall aims for the practice are set by the partners, then translated into objectives by the partners and practice manager together, then planned and implemented by the practice manager, and, finally, reviewed by the partners and practice manager together. In this way, the partners are not in danger of feeling that they are losing control of the practice, but at the same time the practice manager is fulfilling a management role, not an administrative one. Working in this way is true delegation: giving a clear task objective with the resources necessary to carry it out and the support to ensure its completion rather than dumping unpopular tasks with no backup. This sort of teamwork is also valuable in that it is visible to the rest of the staff and will thus reinforce the practice manager's authority with them.

The practice manager is a key member of the practice team, and his or her skills are complementary to those of the partners. The practice manager would not expect to be consulted on clinical matters (unless perhaps they had legal or public relations implications), but would likewise expect the partners not to intrude in management matters where they have been delegated. It is important to ensure that the boundaries of the practice manager's authority are carefully drawn and recorded: in many practices these issues are commonly not made explicit, so the practice manager is unsure of

the true extent of his or her remit. This lack of clarity is a common cause of unnecessary friction between the partners and the practice manager. At the same time sufficient opportunities for communication and liaison between the partners and the practice manager must be built into the practice schedule; otherwise the trust so necessary to good working relationships will not develop. It is also important for practice managers to ensure that they are not partial towards any of the partners: the practice manager's job is to ensure the quality of the service offered to the patients and the wellbeing of the practice as a whole.

Staff appraisal

Another factor which complicates the relationships of practice managers within practices is that although not partners, they are responsible for the rest of the staff. This is an isolated, and sometimes rather vulnerable and unsupported position, which can lead to difficulties for practice managers, and hence their practice, if the partners are not aware of problems faced by the practice manager. Management when well done should be "transparent," but it (and the person doing it) thus faces the danger of being taken for granted and overlooked unless something goes wrong.

In many practices one of the tasks of the practice manager is that of staff evaluation, or staff appraisal. This productive technique relies on a positive approach to draw out the skills of the staff and to encourage them to perform better. But who is to appraise the practice managers and motivate them to improve their performance? It is perhaps fortunate that most practice managers are self motivated to a large extent, and the intrinsic challenge of the job itself is enough to keep them working towards their objectives, but staff appraisal is not something which general practitioners can expect to do with no training. The commitment of practice managers who know that they are appreciated and that their talents are recognised will be a dividend which more than offsets the time and cost of learning the skills of appraisal.

Another way of recognising the value of a good practice manager is performance related pay. This can be handled in several different ways: a formula could be agreed by which the practice manager received a set proportion of any increase in profit on top of his or her normal salary, or alternatively a set sum of "bonus" pay could be paid when a particular objective had been achieved (this could be extended to other members of staff also). Some practices have made their practice managers into profit sharing partners after an initial cash investment into the practice by the practice manager, and others have an arrangement where all practice workers, doctors included, divide practice profits equally. Any of these arrangements would secure great commitment from the staff and underline the partners' appreciation of their role in the running of the practice.

Financial management

An area of practice management which has changed and expanded considerably over the past five years or so is financial management. The "market" model and the laws of supply and demand do not sit very comfortably with general practice: the complex structure of remuneration in general practice means that there is often little direct relation between actual hours of doctor-patient contact time and the resulting income, particularly now that government policy places an increasing emphasis on the capitation element. The practice manager must maximise income while at the same time minimising expenditure, as in any other small business, but all the while ensuring

Teamwork among partners and the practice manager enables true delegation of tasks

Necessary skills for a practice manager

- Ability to respond positively to change
- Ability to define objectives, devise strategies, implement plans, and review progress
- Ability to deal with diverse issues
- Communication and liaison skills
- Staff appraisal skills
- Financial management skills

that standards of patient care are not compromised.

Financial management is a skill that is often absent in small businesses, but the current economic climate forces close attention to be paid to it. The emphasis at the moment is very much on value for money and efficiency. General practice is expected to deliver services of increasingly high quality to patients (or consumers) who are becoming more knowledgeable and articulate, in purpose built premises of a high standard, with specialist staff using up to date medical equipment and computers. At the same time cash limits have been imposed on reimbursement for practice staff and the cost-rent scheme, and the indicative drug amount is a tool designed at the least to increase doctors' awareness of the cost of the drugs they prescribe, though active case finding through health promotion initiatives is likely to lead to increased spending on prescribing. Similarly, bids for resources are now often required by the family health services authority in order to obtain extra funds for developing a practice's services. Preparing a plan of action, collating evidence to support the bid, and preparing the bid itself will usually fall to the lot of the practice manager. Practice managers who do not have experience in financial management need training to enable them to cope with these extra demands.

Implications of fundholding

For practices which are contemplating becoming fundholders in the near future either the existing practice manager will become the fund manager, with

extra training if needed, or a fund manager will be appointed while the existing practice manager (if there is one) continues to manage the rest of the practice. The appointment of a fund manager could lead to some conflicts over responsibilities and job boundaries unless these issues are carefully considered beforehand. Fundholding may also have an effect on non-fundholding practices in that patients might transfer to nearby fundholding practices in search of preferential hospital referral unless the service they are offered by the practice is otherwise first class.

The future of the practice manager

Finally, looking briefly towards the future of the practice manager, it is noticeable that the "new breed" of super managers who entered general practice two or three years ago from industry and the services are now beginning to leave general practice. It seems that they saw practice management as a stepping stone to other management positions, and this exposes a fundamental problem for all practice managers and their employers. It is undeniable that there is no real career structure to practice management, other than moving on to a larger practice. This is echoed in the structure of general practice itself: because of the financial repercussions it is very difficult for partners to move once they are established within a practice. This may lead to stagnation and conservatism within a practice unless positive efforts are made to maintain interest. If practices wish to employ managers of high ability who can cope with the many demands and stresses that go with the job they will have to accept that these people, who are likely to be ambitious, will wish to move on after a few years. Alternatively, the practice must find some way of keeping their commitment and interest.

This series has been edited by Dr Mike Pringle.

- 1 Drury M, ed. *The new practice manager*. Oxford: Radcliffe, 1989.
- 2 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Promoting better health*. London: HMSO, 1987. (Cmnd 249.)
- 3 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmnd 555.)
- 4 Secretaries of State for Health, Social Security, Wales, and Scotland. *Caring for people, community care in the next decade and beyond*. London: HMSO, 1989. (Cmnd 849.)

Update box for Oxford Handbook of Clinical Specialties (3rd ed), p 311

Intraosseous infusion

Immediate vascular access is required in paediatric practice in cardiopulmonary arrest, severe burns, prolonged status epilepticus, and hypovolaemic and septic shock. In many cases rapid intravenous access is not easily obtainable; intraosseous infusion is comparatively safe, easy, and effective in obtaining vascular access and is recommended for *life threatening emergencies* in young children in whom *other methods of access have failed*.

Fluids, blood products, and a wide variety of pharmacological agents can be administered intraosseously.

Contraindications: Osteoporosis, osteogenesis imperfecta, and fracture or infection at the site of insertion.

Preparation

- Set trolley with dressing pack, povidone-iodine 10% (Betadine), needles, 10 ml syringe, lignocaine 1% (5 ml), scalpel, intraosseous needle, paediatric infusion set, 10 ml normal saline, elastic adhesive plaster.
- Choose insertion site: the proximal tibia is best, then the distal tibia and distal femur. Choose a point in the midline on the flat anteromedial surface of the tibia two finger breadths below the tibial tuberosity. The patient's

leg should be restrained, with a small support placed behind the knee. Sterilise the skin with antiseptic and infiltrate with lignocaine as necessary. Puncture skin with scalpel.

Procedure

- Insert the intraosseous needle at an angle of 60-90° away from the growth plate and advance with a boring or screwing motion into the marrow cavity.
- Correct location of the needle is signified by a decrease in resistance on entering the marrow cavity. Stabilise the needle in the cortex and verify position by aspirating bone marrow or obtaining easy flushing, or both, without infiltration of 5-10 ml normal saline. The needle should stand upright without support but should be secured by tape. Flushing with heparin in saline may prevent clotting.

Complications: Uncommon but local extravasation of fluid and cellulitis, fractures, osteomyelitis, pain, and fat and bone microemboli have been reported. These are more common with prolonged use, and intraosseous infusion should be discontinued as soon as conventional access is attained. — R J EVANS

Principal source

Fisher DH. Intraosseous infusion. *N Engl J Med* 1990;322:1579-81.

Anybody may submit an update box; all boxes are peer reviewed.