Academy of PHYSICAL MEDICINE

Transcript

Electronic Notes and Diaries
With Jeremy Allen

APM: Our speaker this evening is Jeremy Allen. He's an osteopath himself, which is; of course, very useful because it means he knows what practitioners need when it comes to running their clinics. He qualified in 2007, prior to which he was in finance which means he's got a good ear and eye for business and he's been working full time with TM3, as it now is, running their clinic diary software and clinic note software for the last five years I think. Jeremy, welcome to our studio.

JA: Good evening.

APM: It's a delight to have you here.

JA: Thank you.

APM: Tell us a little bit about this whole data business. I mean it's a bit of a revolution at the moment, isn't it? There's a big boom in the number of people providing online systems for us and, you know, we've heard all about big data from Tony Blair and everybody else. I mean how much of this applies to you and to us as osteopaths these days?

JA: Absolutely. There's a whole myriad of different sort of solutions out there and big data is all in the press. It's all over the newspapers and actually getting to the bottom of it, really, and understanding what it is, it's probably a really good place for us to start. Just a —

APM: Just to summarize, what the hell is this big data?

JA: Well, as you can imagine, it's really big.

APM: And it's data, I'll bet.

JA: Yes but basically, it's a combination of our interactions with the internet and storage of that. Now the big question is how big is big data? Now in 2003, a scientist in Berkeley in California actually asked that question. So they looked and researched and they looked back to the very beginning of humanity up to 2003 to find out how much data there was actually generated and it was a figure called 5 exobytes and I apologize to everybody listening. I won't make any more technical references but in reality, what that is is five billion CDs and what that really means is it fits into a football ground. So that's not bad from 0 to 2003. What they then found was by 2011, that exact same amount of information was being produced every 10 minutes and by now, they reckon that exact same amount of information is being produced every couple of seconds. So that's what they call a big data.

APM: Why that relevant to us though? I mean you and I had a brief discussion about it before we went on air but to me, I'm only interested in maintaining my clinic diary, my clinic notes and so on.

JA: Of course. Well, the most important thing, of course, is that's a great dinner party stat to share with your colleagues but when we sort of hone that down into the level of a clinic, we need to look at why you want to use systems. What's the point behind it all? What's the benefit of actually having data for yourself? And that's what we'll get to tonight.

APM: Well, you've traveled the length and breadth of this country looking at one-man bands and big clinics as well as big data, haven't you and how this fits into the clinics. And I presume that included osteopaths and chiropractors and other practitioners as well. Just out of curiosity, what sort of percentage would you say of therapists are using electronic systems? And I don't mean just computers to do their emails and stuff. I mean recording patient notes or using electronic diaries as opposed to those who are still…I won't say stuck in the world of paper diary because they can be really, really useful especially when the electricity goes off but, you know, what's the —

JA: Well, at TM3, we have a very broad church So as you quite right say, osteopaths, chiropractors, physiotherapists, podiatrists, sports therapists, talk therapies, there's a very, very broad selection of practitioners. Majority of folks around physiotherapy, they seem to be much more keen on the uptake. They also have larger numbers, which always helps. Chiropractors —

APM: So you think there's more as a percentage of physiotherapists or just more in simple numbers?

JA: More as a percentage of physiotherapists —

APM: As are presumably because they grow up in the NHS in most cases and therefore, they're used to using electronic notes and diaries.

JA: Indeed.

APM: Harder to break that mold.

JA: So I think the numbers are…certainly over the last 5 to 10 years, the uptake has been enormous but there's still room for improvement, of course. There's still a lot of paper out there.

APM: What's the resistance, do you think, to switching from paper to electronics?

JA: In very broadened, simple terms, it's the fear of change or the fear of what people perceive to be the unknown and my job in Blue Zinc and TM3 is to help translate from receptionist, practitioners, business owners into the technology and also through that, into sort of the world of the development to make sure that the software's actually fit for its purpose and actually works in the real world.

APM: And I should've done this at the start, really. I normally say to our viewers that, you know, you clearly have an agenda in coming to speak with us because TM3 has a product to sell and it's clearly one of the market leaders from what I've seen about it but what we'll try to do with this evening's broadcast is to allow people to make up their own minds about the pros and cons about electronics.

JA: Absolutely.

APM: And then decide which system suits them better. Obviously, they'll have an insight into what your system does but, you know, there are other brands available, clearly. So the main fear is simply that's a change or is it fear that the electronics will fail or the Internet will fail or the electricity will go off?

JA: I think that the second one is sort of further down the road. The first fear is literally shifting from a paper diary or paper notes. I've had lots of experience of walking into fantastic clinics, great atmospheres and then you get to the front desk and there's these sort of seas of filing cabinets and paper diaries for each practitioner that's sort of folded over and dog eared and falling apart and the processes themselves are actually very sound. It's actually where it's stored and the manner in which it's stored which is usually slowing down the growth of a clinic or actually slowing down the progress or actually maybe leading to more serious consequences around data storage and things like that.

APM: Well, that's an interesting point because my clinic, we had a contract with the NHS for several years, which was brought to a close across the whole county for everybody last year. I have to say, that's in case people think that we did something wrong and their concern about security of information was

absolutely intense, I mean completely out of proportion to the size of our clinic because of course, they're used to dealing with hospitals where they've got thousands of patients changing on a daily basis.

JA: Of course.

APM: But the hoops we had to jump through to satisfy them that our paper notes were secure were, you know, quite bizarre really. What are the safeguards in terms of keeping records online, whether it's a diary or whether it's notes because we have to keep them both secure, obviously? If we're using something like your system, how we'd protect that from —

JA: Well, there can be sort of two routes. One is slightly older school than the other one but we'll start with the older school one which is whereby people, say, begin with buy a laptop or have a computer in the office and storing the information there which, if it was stolen or if there was a fire or if there was a leak, those kind of events that hopefully don't happen but occasionally do then that data is lost and that's probably where the concerns for the larger organizations come from. What they're looking for is a solution whereby the information is not actually stored on the premises and is hosted by a third party and that third party will have the necessary protections and codes because within those data centers…another technical word but big room with fans, they all store it in the correct way or fashion.

APM: And backed up presumably somewhere—

JA: Absolutely.

APM: --so if there is a fire, it won't get destroyed. I mean I've often thought that that's a big risk, isn't it, when you have a fire but actually if you have a fire, you lose all your paper notes and diaries as well. So it's not as though you're more safe that way. You're more vulnerable to theft if you're keeping stuff on a movable computer, aren't you? And the data on that computer is possibly more vulnerable than paper notes because first of all, no one's going to pinch my filing cabinets, I wouldn't have thought but it's actually relatively easy to get into a computer in many cases because a lot of people don't use good sound passwords or other security and then you've got access to everything, not just one set of notes.

JA: There was one story that I'd heard of where somebody had generally left their work computer in their bag, securely in the boot of their car but the car got stolen and despite all the passwords and security…nobody will ever be able to get into that computer but that data was lost or alternatively, I think it was a spine doctor, he left a laptop or a memory stick similar sort of bad practice, really. So the cost these days are becoming so much cheaper and it's part of what we would consider to be a service. The reasons to have data on premises are running out.

APM: What are the reasons to keep your data on the premises? I don't mean necessarily on paper form but, you know, in any form, whether it's in a computer or otherwise.

JA: Well, in terms of the notes, having on the premises, it means they are on paper, which is the worst outcome possible. Although some notes of clinics I worked with are stored off site. Sort of mid-sized clinic, they were spending… we worked out it was around £20 per journey for the clinical files and that's assuming that the correct information was picked up and distributed in a correct fashion to the correct locations and so on and so forth.

APM: Well, I have to say then, I mean one of the big considerations for me in my clinic is that first of all, a third of our waiting room is taken up with ruddy filing cabinets and there are more elsewhere with sort of historically archived data and awful lot of our receptionist's time is taken up in getting notes out and putting those notes back and finding them when they've been misfiled and so on.

JA: Exactly.

APM: And I suspect, particularly the misfiling, is far more difficult with electronic notes.

JA: Exactly.

APM: I'd like to think that. I mean clearly if I spelled someone's name incorrectly, it will be possibly difficult to find them but you can probably search for near misses and pick them up, can you not?

JA: Exactly that and usually, well, within software, you will have unique identifiers. So that's a reference number for a particular patient that is sequential and generated by the system and that cannot be doubled up on. So therefore, it's easier to sort of reduce those types of mistakes.

APM: So in the case of TM3, for example, who is it that vets your systems to say these meet the requirements of, I don't know, the Department of Health or the General Osteopathic Council?

JA: Understood. Well, we don't work with the Department of Health but we do have partnerships with Physio First, The College of Chiropractors and we have worked with the Institute of Osteopathy on certain projects. So many of the organizations are reluctant to rubber stamp sort of commercial products, which is understandable. So we tend to go down the route of partnerships and that's around trying to collate the data.

APM: But the data…what's the data controller called for the UK? People we have to have —

JA: Spot quiz… I have no idea.

APM: No, we have to sign up with them in order to keep data records and things like that. I mean it's gone completely out of my mind but presumably, they must be happy that records are kept this way because if they weren't, there will be a huge outcry.

JA: There's many, many technical and in depth questions around storage of data which you experienced with the NHS and depending upon its contract, there could be different requirements and those requirements can shift. So I sort of go back to my point previously whereby if the data is stored in a good data center which we use and we have more than one, for backup purposes, the data is in the same position, for instance, as…we work with Nufield and Axa and larger organizations and whether somebody is a single practitioner or a larger organization, they effectively have the same level of security.

APM: Without naming any names because that wouldn't be reasonable, what's your rough size of your biggest customer then in terms of patient records rather than —

JA: I don't know about numbers of patient records but an example I can give you is we have an educational solution around booking patients in for the British School of Osteopathy and they see approximately around 600 appointments and patients a week across their fantastic selection of different clinics. So that's —

APM: You speak as a BSO graduate.

JA: I do.

APM: So you're a prejudice and…

JA: Just slightly, sorry.

APM: So it's easy to manage that number of patients, which will probably satisfy a huge number of clinics.

JA: Absolutely. The reality of the space that is taken up to store a single record is so small these days, there's no need to ever delete files. So if there's a mistake for instance, there's no need to delete it because you could just keep it and mark it as an error which is good practice as opposed to just ripping, shredding, off it goes, it never appears again, didn't happen, you know. So it gives a lot of safety.

APM: So could you show us how your diary system works?

JA: I certainly can. I can take you for a little walk.

APM: Take us for a little walk around the computer screen then. Show us what we would expect and you might have to aim this at those people who are not already using computers for their notes and their diaries. So where shall we start?

JA: Well, in front of us here, we have sort of a simple looking diary screen and that's actually the beauty of it. Any type of software that you look at should appeal to you. You'd be working with it on a daily basis. So it needs to be friendly and approachable and that includes sort of the color tones and buttons and things like that.

APM: So this is a single clinic, a single practitioner is showing who happen to be you.

JA: Yes, so if we look to the top left-hand corner there, what I can point out is that one of the common fears about moving from paper to electronic notes is that there's this huge change when the reality is that if you click on this, you have the months. It's no different to flipping a page, scrolling backwards and forwards, you know, skipping a few pages in a diary. We have buttons that can take you back to particular dates which is very easy to use as well. We have different locations. So whereby previously, perhaps there was 4 or 5 different diaries, knocking around for different locations and practitioners, it's really just a click of a button. So simplicity is the beauty of it, really. Say with practitioners, there's just me there for the moment but if we had multi-sites, multi-practitioners, again, it's very easy to put them into the system and it's also easy to expand. So over the years, we've been lucky enough to have many clinics who we've worked with and then expanded rapidly and it's meant that adding extra locations or practitioners has actually been very easy and light in terms of sort of the economics of it and also the practicality of, "We need another license," or, "We need another location." So there's a lot of flexibility in that system, especially if maybe somebody out there wants to build a network, things like that, it's very achievable. A couple things I'll point out also, within electronic diary, one of the benefits is we can actually set up reminders. So frequently, receptionists would be, as you say, moving files around, maybe calling patients to chase them for appointments, things like that which is sort of still valid but it's perhaps not the best use of their time and what we can do here is actually set reminders so that they're automated. So they can be sent out either via an email or an SMS text message to the individual patients —

APM: So you can send those text messages from within this system, can you?

JA: Yes and it can all be automated.

APM: And is that a bolt on so you have to buy certain minutes to —

JA: Yes, it works like that. There's a fee per text message that you send.

APM: Any idea what that is?

JA: It's around 10 pence at the moment.

APM: So OK, if someone were doing that manually from their own phone, using their own paper diary, it would probably save them at least 10 pence worth of time even if they've got three emails I would have thought.

JA: Very true. So what many clinics use this for is to help reduce the number of cancellations and DNAs and actually even manage that situation. So although 10 pence may sound expensive when you're thinking you get a free text message on your phone, the purpose of this text is to prevent a £30 or £40 cancellation of an appointment.

APM: But actually, if you can send emails, since everyone these days, apart from my father, has a smartphone, emails will pop up on their phone anyway and those will be free, won't they?

JA: That's true. It's true but there are some interesting stats out there around the difference between SNS messages and emails. Now, most people keep their mobile phone number much longer than an email address and they tend to have several email addresses, whether it's one for work, one for personal life, one for another thing and so on and so forth whereas a mobile number tends to stay more static. And also, the open rates on text message is around 90…about 90%. I'd have to check that but it's around 90%. So it has a really powerful capability. I was working with a clinic in Central London which has a very perhaps different demographic to some others whereby the professional people around them were cancelling appointments at very short notice, lawyers, barristers that type of situation but it was a real problem because the cancellations were amounting up to say 100 a week. So the solution was to start sending SMS reminders but as a way of backing up their cancellation and DNA policy.

APM: Much easier if you send one a day before and —

JA: Exactly and you can schedule it that way. So it has two sides. Ideally, it's preventative because nobody wins with a cancellation. Practitioners don't practice. A patient doesn't get better and tell everybody how fabulous your clinic is. So it's better to reduce —

APM: And if you put on a slightly cynical marketing head, could one send reminders at certain intervals to say to people, "How you're doing? I noticed you

haven't been in for a while. Are you still OK?" and sort of jog their memory? Everyone else thinks that's horrible and sharp practice but actually, quite often, people do benefit from repeat appointments rather than waiting for themselves to get injured, don't they? So is that possible within the system?

JA: In this scenario here, this is appointment based but there is a capability to create emails and letter templates and send them out as and when you choose although there's no automation on that at that sort of level.

APM: Let's assume for a moment that we've got a fairly busy practice with half a dozen different practitioners in at any one time. The person on the reception desk is going to need to see all of those appointments so that she can book people in, do whatever else she needs to do or he, of course. Ideally, one associate shouldn't be looking at the other associate's diary. Is that controllable within the system? So I could give you access only to your own diary whereas my receptionist has access to all of those?

JA: Exactly that. So depending on the user level, it'll control the access to the actual functionality but also, from a practitioner level when you create it control the view that somebody has of a particular location, for instance. So if I didn't want you to see my diary in Dartmouth, I would just not set you up to do that.

APM: And that's easy to do, is it? Because again, we're dealing here with people who may not want to be experts in big data, small data or computer, they just want a diary that work.

JA: Absolutely and this is an essential part in choosing the right software and it's something called an implementation process which I work with the guys in Belfast and that implementation process —

APM: Who are these guys in Belfast?

JA: The client focused team —

APM: Client focused team.

JA: Yes because we are very focused on getting the right software to the right clinics in the right way. So there is an implementation process whereby the setup of the system is walked and talked through so that everything goes as smooth as possible.

APM: Can we incorporate accounts in this as well? Because I know we can in my own clinic but I don't use TM3 software. And what we do at the end of each appointment is we mark down how the patients paid, how much they paid and so on so we can immediately generate invoices, receipts, account

summaries for patients and of course, generate our own cashbooks for the end of the week or the end of the period. Easy to do?

JA: Indeed. I'll show you a little patient journey but just before I do that, I just want to continue on the top line here because there's a couple of little things to show. We can show some overview figures here about what's happening in a diary at the click of a button and there's a really nice feature whereby we have a little eye here and what that would do, if your viewers look at the screen there, you can see your name is booked as an appointment and if I press that, it should take you out. So it only says appointment and that means that when you're in the room with a patient, in closed quarters, they don't see the rest of the diary. So that's —

APM: So this is for the practitioner who has the diary in the treatment room —

JA: Exactly.

APM: Or at any desk that might be overlooked.

JA: Exactly that. Back to your journey, so in terms of what happens financially, a receptionist would select the appointment and will go to mark it as complete and it'll be as simple as recording a payment method. So it could be cash, check, card and maybe there's other scenarios that exist for instance, whereby maybe they want to invoice them but they pay them later, maybe there's a free treatment involved —

APM: Insurance companies?

JA: Yes, we specialize in that in particular and I can show you that in a second but from this functionality here, we can choose to print receipts or email receipts and invoices directly from the record and we can choose to add other items. So if a clinic is selling some ice packs, sprays, Thera-Bands, those types of things, we can do it. So all they would do is hit card and we'll now see what happens. We get an option to say what we'd like to do next. So we could book in your appointment, we could create a task, maybe it's to send a letter, things like that, so on and so forth. I will say nothing for now, OK because we can see that your appointment now has a nice little tick next to it and all is well but for many people, that's enough in terms of finances, perhaps a receptionist who doesn't want to get involved in the deeper finances on a daily basis. That's a simple repetitive step they do to handle patients. Now in the background, what's happening is all the finance work, so there's a charge being put on to an invoice and a payment accepted against that and reconciled. That's where you get the tick and that is sitting in the database to be looked at whenever you choose whether it's immediately or in a month's time and so on and so forth. So you mentioned about insurance patients. We have someone here who belongs to AXA. Frequently, one of the challenges around insurance are authorization codes and collecting the correct

authorization code with the correct number of treatments. So we have a nice solution here whereby we actually have a tab and a ticket that says how many treatments are left. So that should prevent any overtreatment.

APM: Why does mine say two?

JA: Because I just put it on there earlier just to demonstrate. If I go to this patient here and hit complete, there's no physical transaction of cash in this scenario. AXA's going to pay for the patient, so you hit pay later ad hoc and that sits in an AXA account to be invoiced at a later date. So —

APM: And more generally, a clinic might produce all those at the end of the month regardless of whether the treatment—

JA: Very interesting question.

APM: --sequence is finished or is that dependent on the insurance company?

JA: It depends on all of those factors. Traditionally, a bit like the fishmonger and the baker and butcher, people like to invoice perhaps at the end of the month but realistically, these days, unless you get your invoice out as soon as possible, payments are delayed. So the trend now would be that people want invoices out as soon as possible. Depending on how and if people want to work with insurance companies then there's different sort of contractual levels of what they can do but we make it as easy as possible to perform invoice runs at a touch of a button.

APM: Might be a silly question, is it possible to interface this equipment with the card machine so that it sends the amount to be charged to the card machine and so on or is that a step further on —

JA: It's not there yet but technology moves forward and it's —

APM: I'm not sure it's important because generally, in a clinic, our charges are not vastly different, are they? So it's not as though you need to ring up some strange figure.

JA: Some clients have raised questions around sort of till performance, if you like because they have a bit more of a retail base. The reality is that's not the world that many of our clients and your viewers probably live in. There's fixed charges that happen regularly and maybe there's a few bits and bobs but there's no real stuff there but there is…there's things on the table but I can't say what that is.

APM: At the end of the day, when I want to check that we've got the right amount of money still in our till and the right amount of card receipts and the right amount of check, God forbid, how do we do that? Can the system can

generate a report to show me how we should've received all that day's money?

JA: Absolutely. Let me just —

APM: I remember, this is a real pain in the ass when we had paper diaries, trying to work out exactly how people had paid and where it should be and whether we had the right amount at the end.

JA: Exactly.

APM: Maybe it's good thing audit trail for the Inland Revenue.

JA: We have —

APM: I didn't say that.

JA: We have finances here where we can look for invoices, we can look at payments. We can get summaries from that but if we look actually into the reporting area itself, we have some very simple income reports and we can actually run that if we wanted to by date ranges, locations, practitioners and the beauty of that is that once you have run the report, you can export it or print it, whatever you choose to do and the information is available in this grid format, as a timeline if you choose to view it that way or as a pie chart and this particular one is 100% so it's one blue colour.

APM: So I guess my point was at the end of the day, can I have three lines that says this is how much you got in checks, this is how much you got in cash, this is how much you got in card receipts?

JA: Yes.

APM: I can or I could break it down by individual patients so I can work out who didn't pay or —

JA: Exactly that. Just going back to the diary for a second, there's some other functionality around here within the appointment itself. And when people start out with us, in addition to the implementation process and the handholding, if you like, this is a new feature where we have some tips and pointers. So when you go to do something for the first time, it holds your hand. It gives you a little sort of commentary about what's about to happen. So again, try to break down these barriers of fear of change.

APM: And you're absolutely right. I mean we set up our electronic diary I can't remember how many years ago now and every time we wanted to change something, I really don't want to get into the software to work out how we do this. It was complicated. I'm guessing that things have moved on, although

now my receptionist do the messing around with the diary and I do less of it but this is obviously something which helpful.

JA: It's helpful but also, support exists in different ways at TM3. There's a phone line where people can call and speak.

APM: Does it go through an office in Bangladesh or…?

JA: No, it's our office in Belfast with our really experienced support team and also, what we have —

APM: So we still won't be able to understand the accent though.

JA: They're actually very softly spoken which is great. The other way people can actually get help, should they wish, is via live chat, which is becoming even more popular. In fact, it's the most popular and quickest way to get some support.

APM: And actually, it's proving very popular in all walks of life I think. I mean as our members will know, I mean we use our live chat a lot and Hollie is the star who answers all the questions most of the time and will be fielding a lot of the questions this evening along with Claire. It's a really useful and usually very responsive way to get answers, isn't it?

JA: Absolutely.

APM: And it's cheap.

JA: So there's a lot of support there in terms of contacting people but there's also this area we called 2gether, which is a combination of a knowledge-base community and training. So we can look at all sorts of different media there. We have video clips on how to. We have written documents with pictures and screen grabs. So there's a real variety.

APM: If somebody who's never used one of these before comes to you and says, "I'm a solo practitioner. I just want a diary I can use in my clinic which is taking up a lot less space than the filing cabinet and all these old paper diaries that I've got stuck in a cupboard," I suppose I could ask how much are they likely to have to spend, assuming they've got a computer but how much are they going to need to change once your team have implemented this? I mean is there much that they're likely to want to do?

JA: To actually change the system itself or change the way they work?

APM: Well, it won't change the way they work, yes, so that's a different question that you should answer but I don't know. Typically, what do they need to do?

You set it up for them. What would they find they need to change within a week, 2 weeks, 3 weeks?

JA: Very little.

APM: If they suddenly decide to open in Thursday evenings, is it easy to change the appointments or —

JA: Yes, they just add extra time in the diary. So if I just click in a random spot here, you can see, we can choose appointments, events or working times. So it's easy to set and we can even schedule them to be daily or weekly. So there's no multiple pressing of buttons that takes up too much time.

APM: And what about the big busy clinic that I mentioned earlier on? If I want to book in myself for an appointment where I'm not normally scheduled, can I do that and how does the system stop me overbooking someone who's already in that particular room?

JA: So I think we're sort of getting towards the topic of online bookings or —

APM: No, I was thinking if a friend calls me up and says, "Can I have an appointment?" and I say, "Yeah, I'll book you in for Wednesday," and there are six treatment rooms and a number of practitioners.

JA: Of course.

APM: I don't want to be able to overbook someone else or have them overbook someone else. If it's not a time when I'm normally in clinic, I'd like to be able to do that just so I can get my mate in for treatment. Is that —

JA: You can always override the system but it will remind you that this is outside of your working hours. So you can always drop that in but on the topic of managing the rooms, we do actually have a room view and a room sort of manager function. So if you have multiple practitioners and not quite enough rooms, you can manage those —

APM: What if you're booked into a room but I see you've got an empty space and I want to take it up to treat my colleague, my friend, can I do that or does the system get grumpy?

JA: No, absolutely. You could block it out if you wanted to and put a note in, saying that you were doing that and then —

APM: That's actually more…I can't say it's more flexible than the system I'm using at the moment. So that's very useful. OK, sorry, I interrupted you. You were going to talk about how to interchange the working practices and…

JA: Yes and online as well. So one of the changes that people often have to make is the interaction with the patients, whether it's staring at the screen, trying to make an appointment for the first time or whether it's taking clinical notes and practice is really the answer and nobody fills out a diary or writes clinical notes without actually looking at a page, that I've met yet. So it's really about not sitting behind a desk like a bank manager and I don't think many practitioners do that now but it's about getting comfortable using the software and our software is accessible enough so the practitioner can concentrate on the patient, the most important person in the room and then what I used to do, certainly, was sort of to turn to it, enter some information as we —

APM: I think where the diary's concerned, nobody's going to be bothered about that, are they?

JA: True.

APM: Because if you're using a diary, you're going to have to look at something in order to check spaces are available and so on. How easy is it to search for an available space in…not at a specific time but if you say, "Well, I want an appointment with somebody in such and such period of time," can you look up all the free appointments?

JA: You can certainly look at their diary in terms of a week view. So you get a larger panoramic there and you can choose to sort of scroll through that if you wanted to. That's probably the best way that I can see.

APM: And now, let's talk about online bookings because that was mentioned by the machine earlier on and you talked about it a second ago.

JA: It was.

APM: We use online bookings and it's proved very useful. There are lots of members in the public who don't want to have a telephone conversation just because they're busy people. They're just used to do it that way.

JA: Indeed.

APM: How easy is it to build that into the system?

JA: It's a very good question. Online booking is usually, for many practitioners, a real stumbling block because the challenge is understanding that the patient does not see your entire diary. Often people think they link straight in to see everything. The reality is that with the system, they only see the appointments that you choose to offer and also they have to register and then they only have a provisional appointment. So you control it as a…you have a lot of control on an online booking —

APM: Could you insist on the machine taking a fee in advance if they're booking online or not?

JA: It depends.

APM: We don't do it. It's just that I believe some people do and it's possibly a useful thing to do if you're on that risk that someone booking for the first time might just stand you up.

JA: It has happened but there's lots of changes around online payments and refunds and things.

APM: If I were booking an appointment with you online, what controls have you got? If I say I want an appointment on Wednesday morning and then I suddenly see, well, your diary's completely empty on Wednesday morning, I might think, "Well, he can't be any good if he hasn't got any patients."

JA: Understood and that's another common fear. So if we —

APM: Not that it would be empty obviously.

JA: If we look back at the diary here and the working times, we can actually set them to include online bookings. So I could make a half hour slot available and what many of our clients do is use the online function to help shepherd patients into perhaps the quieter slots. So after the rush, you know, slightly before lunch, slightly after lunch and before the kids get picked up, those kind of things and the uptake is interesting. The other thing is that you effectively turn your clinic into a 24-hour clinic because people, when in their moments of need, have the opportunity to reach out to you and ask for your help.

APM: Again, I mean I know that some people will get cross if they think I'm talking about marketing here but it's really useful. When someone wants an appointment, they want to do it now, don't they? And if they can't get through to you, if they get an answering machine message, I suspect they are more likely to move on to the next clinic in the list until they get an answer that satisfies them and if it's the middle of the night and all they get from your clinic is, well call at 8:00 in the morning, they might move to the next one where it might say, "Well, go to this website and you can book an appointment now," and that would make me a lot happier than thinking —

JA: Absolutely. There's also another solution to that, Steven which is we have a 24/7 reception service which we offer our clients and that is 365 days a year, 24 hours a day and they can, under your control, have access to a diary. The interaction is scripted and it effectively turns your clinic into a full 24-hour clinic. You can turn service on and off. So when we used it, we used to find

that we thought we were answering the phone well. We'll get a few answering machine messages but not until we use that service and people started speaking to a real human being did we start picking up another 5 or 6 new patients a week. So it was interesting and the other interesting stat was that some of the calls were coming in Sunday nights around, say, 2:00 AM where I guess if you injured your back gardening on a Saturday, you've been uncomfortable, it's probably getting pretty peak-ish around then and again, a good marketing ploy to be a truly accessible clinic.

APM: And I don't know if I'm in a small minority. When that happens to me, I…you automatically know this is an answering service. It's not the clinic but I suspect that doesn't matter to people who do know it but I am constantly astonished by the number of people who have spoken to our virtual receptionists because the phone lines are busy or because we're closed and they genuinely feel they've spoken to the clinic because the scripting is good and the receptionists are good and they've got enough information to be able to answer questions properly. Yours presumably only deal with medical practitioners of one persuasion or another

JA: They're actually geographically very close to us which means we can train and sort of help with their —

APM: Once again, it's not Bangladesh.

JA: No, it's Belfast.

APM: I'm not being rude about Bangladeshis but of course, when you have an accent, you can't understand then it doesn't make the experience that good for the caller. I have no idea you did that. That's quite, I would've thought, a very attractive proposition for people.

JA: Yes, we certainly —

APM: It does depend on the quality of the people answering the phone, of course. That's…

JA: Yes, we do look for sort of the total solution, if you like, of…basically breaking down the barriers for patients to get to the practitioner because everything else in between, most practitioners know 99% of the time, you can get your patient well and if you can't, you can get them on the right road to recovery. It's getting them on that plinth in the first place.

APM: Well, it is, isn't it? Right, we're done with diaries and I thought we'd spend about 10 minutes on diaries because they're dead easy and I think it's simple for everyone to understand. I think the big worry for practitioners who haven't switched to them already is electronic notes because let's face it, they're horrible because I can't talk to you and write on my pad like I could in

the paper days and if I'm typing on my screen while you're looking me then that's bad patient interaction. I can't draw on the screen anymore. It's basically crap, isn't it?

JA: No.

APM: I kind of knew you were going to say that. There's —

JA: Well, again, let's go back, way back in time I suppose. I guess 80's still maybe didn't even take any notes, who knows?

APM: Well they certainly didn't use a computer did they/

JA: Progressing into paper which is great and there's different styles, different styles of practitioners. We are all taught in a very similar fashion whether it's SOAP notes or whether it's vindicator or thread notes or…all these different things but at the heart of them, they all flow in the same way to try and capture the information. So the challenge is to get that flow into an electronic environment that doesn't break the patient interaction and to make it as smooth as possible. So we've got experience of having electronic clinical notes back over sort of 10 years and touch notes, touch screen notes, innovators at that time, lots of flexibility in the way that practitioners can create their own templates so that it reflects their practice. Many people will buy software and a bit like a camera at Christmas or a nice present, you get it out of the box, you just start taking pictures. You don't actually read the bits. So you need it to start off…you need the starting point to be —

APM: So familiarity in this is going to be quite important, isn't it? Because if I've been trained to take my notes in a particular way, no matter what it is, I kind of want my electronic notes to reflect that. Otherwise, I am going to have to read the instructions and that's not going to happen. We know that.

JA: I think that is the reality that we face with or that I'm faced with and —

APM: But your team help people through this, I take it and —

JA: We can do it, absolutely. There's all sorts of different types of training available. Of course, we start off with some standard flexible notes. Very often, they're sufficient and people are very happy with them. Then people start to want to tweak things and if we start looking at outcome measures and clinical reporting…and then at the moment, that's generally contractually driven such as the NHS or the larger —

APM: More and more it's not, is it? More and more people are being…we're being told to do clinic audits. It's actually one of the possible requirements of the new osteopathic CPD theme. I say possible because it's one of the options you have under the 3 yearly requirement is to do clinic audit. Well, actually, if

you've got software that helps you do that, that makes life a whole lot easier, doesn't it?

JA: Absolutely. Dare I say Bupa they put lots of people under lots of different pressures including sort of clinical audits and these files and I have literally spent two weeks with a client, trying to get to the bottom of what was their paper notes, not the electronic, or they were doing 50/50 and we came up with a solution and we basically like a Bupa report and what that does is as you're interacting with the software and clicking the buttons, if you're clicking the right buttons, it's entering information to that port. So if you wanted to know, need a 10% audit to match whatever criteria it is, it would tell you that you've got 10% or it'd tell you you've got 6% so therefore, you know you need to do some more.

APM: What do you mean in terms of 6%? Six percent meaning? What's it measuring?

JA: Six percent of the total footfall of their patients through your door, so 6 cases out of a 100.

APM: That's useful. One of the things that I've…I think I've come to an answer in my own mind about this but you've probably been asked this question by many, many people. In terms of patient consent, there are a lot of practitioners who will physically get a patient to sign a piece of paper to say they've agreed to treatment, let alone if it's an invasive treatment, you know, the PRs or anything like that. How do we cope with electronic notes if we're not going to keep a separate bit of paper for those consent forms?

JA: That's a very good question. I think it depends on your professional body and I'd always tell practitioners to revert to their professional bodies to check these things. You can scan paper notes into electronic system or you should be able to. Whether an electronic note overrides the requirement for a paper perhaps is a little question mark and I think it's probably dealt within a case by case —

APM: Well, I'm using this iPad. I can sign things on my iPad or draw on my iPad but I'm very well aware that when the delivery man sends me my Amazon orders and things, the signature which goes out on his little pad is nothing like my own signature. It never is, so I suspect that might not stand up in court. I don't know if there's any easier way around but then I suppose keeping consent forms, if that's all you have to do, is going to take a very small amount of space.

JA: Exactly that. Maybe that's a topic for another chat, the medico legal side of things because it's a very —

APM: We might put that to Lawrence Butler. You remember Lawrence, I'm sure. We had him in talking about medico legal issue sometime back and yeah, he was very hot on consent, as you can imagine. You talked about scanning documents in. If a third of my waiting room is taking up with filing cabinets at the moment, how am I going to get all those notes into the system?

JA: Very interesting and it's a big challenge and there's a variety of options and they have varying degrees of severity, if you like. You could say that from now on, any new patients is just going to be electronic and over time, you whittle down your existing patient list and you deep file or actually destroy it, depending on what your governing body says.

APM: Is it seven years of medical notes then.

JA: It depends. If you're treating pediatrics, for instance, it's much longer than that. So lost my thread there, sorry.

APM: We were talking about —

JA: Yes, getting notes in. So you can literally do new patients only and gently whittle down. That's a very soft approach. Some clinics choose to do a summary document, depending on how thick the patient file is and scan that in, that's sufficient. Some choose to just move entirely to electronic and say, "You need to book in for a review case." Which again is quite extreme in my mind.

APM: To what extent do you and your team help us in that process? If I say, "Right, I've got all these clinic notes and they're all an inch thick and I want them all recorded on the system…"

JA: That is not a service that we offer.

APM: But you'll advise us what to do, will you?

JA: I would suggest employing family members for —

APM: I see this as being one of the biggest obstacles you must have to overcome though. I mean people thinking, "Well, God, I've got all these notes and I don't know who's going to book in next week and, you know, I don't want to move all these files to a warehouse down the road," or whatever it is, "But I need to have the note in."

JA: I just wonder how many people out there actually check and deep file their notes or even in fact keep them in any reasonable order. So there's probably a large section that could go, in my opinion and that's the first step and then from that, you may feel enlightened and want to move forward.

APM: In my own case, and I won't speak for anybody else, I know that I read back a couple of case histories or a couple of appointment histories in a case file. I don't go back through an inch of stuff. There's the basic data on the front cover and so on but most of the treatments for the first however long, I don't look at. I look at the ones that happened in the last six weeks. So there's a limited amount of information one needs to keep. I suppose one of the biggest advantages of having notes like this…you met my sports therapist from my clinic earlier on. Now, I'm convinced that he employs a dyslexic monkey with broken fingers to write his notes because he can't read his own notes. They're impossible to read. That's, of course, not something that's going to happen with electronic notes, is it? They're going to be legible.

JA: Exactly, they're legible and they do not decay or bend or shred or get coffee stains on. The transport issue is gone because they should be hosted and the security issue is gone as well.

APM: Can you show us an example?

JA: I can show you some clinical notes, certainly —

APM: Let's look at how it might work and see if we can generate some questions about how you might use them in your own clinic.

JA: Actually, I'm going to show you a prototype. So we're working on a new version of notes and I want to give your viewers the best that we can see. So we're going to have a look at a new environment but they'll understand the flow and the simplicity behind it but it's a work in progress. So I'm going to take your good self, let me just close that out and what we talk about in terms of clinical notes and keeping it together is a case and a case is simply an episode of care and from a case, you normally select the body site to begin with. Of course, as osteopaths, we think about the whole body but this is about to say really, what's the crux of it? Is it a neck injury? Is it a shoulder injury? Yes, there's lots of other factors but it helps set the scene and they can be adjusted and customized if you want to have scapulothoracic or all those kind of things. So let's go into —

APM: Now I'm a patient you've not seen before. So you're starting from scratch with me, are you?

JA: Exactly. I'm not going to press every single button because it would take another hour.

APM: So these are supposed to make life easier —

JA: For new consultation in its entirety but what we have simply in…we're going to start and talk about your name, date of birth, key information and as we move along, that bar along to the middle, we have admission dates, what the

body site was, the first person to see the patient, so effectively the owner of the case and then these little numbers over here reflect authorization codes. So the control of an authorization is not just the front of house reception admin, there's a responsibility on the practitioner as well if you want that and I'm sure, as a practice only, you know how often practitioners generally over treat —

APM: Very interesting. See, we had to resort with our NHS contracts of writing notes…the receptionist would write in the notes how many appointments were left because the NHS would get cross when we went over it and of course, people didn't get paid.

JA: Of course. That's the solution to exactly that problem. We also have, over in the right here, some new features and this is a different sort of status of a case. So there are times whereby a patient could be on hold, so perhaps they're being referred back to a surgeon or their GP and so the reporting sees the case in a different light. Being on hold takes it out of the equation, if you like, put in its own separate area so it doesn't affect your stats. That's a new feature. We then have, over on the left hand side again here, some flags. Now we've gone for a full suite of flags, all the colors, almost of the rainbow, no quite because this reflects the broad nature of our client base and some of our clients work in the sort of settings of occupational health where by return to work. So things about perceptions about relationship between work and health are important and key and need to be flagged.

APM: And where does that flag appear when you add it? Because it's always visible. Is it on the notes when I'm —?

JA: It is and if I just put something here like belief that work is unsupported and save that, it's added to the top there and I can always click on it to go back to it but the benefit is that these flags track a patient. They stay with a patient. So if they were to come in for a separate issue, separate locations, those flags are there to be verified at the initial assessment.

APM: Also, and I didn't look at those question in detail but they look to me like standard depression questions that were coming up there. So that means that you can have those questions on your script for you to make…as a memory jogger rather than —

JA: Exactly and this is fully customizable. Let me show red flags, which we all probably know but they can be quite sort of a long list and these are the ones that do move around. They move around in as much as when you go through the assessments, they can pre-populate. So you can pick them up as we go through. I'm just going to put a few up here. So maybe there's some…maybe there's a chaperone and maybe there is a fracture. We'll just save that as well. So you can see we get these nice sort of flagging system that's very, very clear.

APM: Can I just take you off piste for a minute?

JA: Of course.

APM: Because I need to do with some of the questions that come in. We have one about patient notes from a lady called Sarah in Glasgow. It's always nice when people give us their names because it makes it a little bit more, I don't know, human when we're interacting with real names. She wants to know if you're using electronic notes, can you stop practitioners from accessing those when they're off-site so that there's less of a risk of confidentiality breaches. So they can access their diary but they can't go into the case histories.

JA: Very good question. It depends again on the access that they have. That's how it sort of basically boils down to.

APM: And that can be set by the practice manager or whoever?

JA: Yes.

APM: And how's the access managed then? Is it managed by your name or by the computer you're using? Because obviously, if you're in the clinic, you want to be able to see those notes.

JA: Yes, very tricky question. I don't have a full answer on that I'm afraid.

APM: I mean I'm intrigued. That's a really good question and not so…yeah, and I'm not sure it's as much of a problem as we might imagine but of course, there is that possibility, isn't there? The NHS would be really grumpy if they thought you could have patient notes on your home computers and things like that because they're very umpty about where you keep the records.

JA: True. I shall investigate and —

APM: We'll come back on that one because it is an interesting question. OK, sorry, I interrupted you when you were talking about —

JA: No, absolutely fine.

APM: This disgraceful patient in front of you.

JA: So here, we have an admission part and this can be fully customized. So it doesn't necessarily reflect everybody's flow and this is, as I said, a test database. We have a read mode and an edit mode and if we hit edit, we can see there's a nice sort of clear choice of buttons and from here, we can, for instance, set a body site. If I do that, along with the practitioner, eventually, that'll populate up there when I work my way through. I can have referral

dates and who they're referred by and admission into care. So that creates something called case waiting times which is used in other key performance indicator for the contracts we're talking about or anybody else. So there's lots of other buttons we can sort of select through there but once we've gone through, we can save as a draft. This system automatically saves every 30 seconds, OK? So when I've done that, what I then go to is my first consultation, OK? And we have —

APM: Who's entered that data? Has that been entered by the receptionist when the appointment is made or is that you at the start of a consultation?

JA: It could be either/or.

APM: And another one of the questions that come in actually is how much data can a patient enter online or could we ask them to enter online. Could we send them a form, saying, you know, "Populate your date of birth," and various others in advance?

JA: Yes, for online bookings at the moment, to keep the registration process as smooth and as quick as possible. What comes through is patient contact details effectively. We are somewhere on the horizon, somewhere down the road looking at patient registration. Now, of course, that is a huge topic and there's lots of different varieties and variability's around that.

APM: You mean in terms of the information that someone might require?

JA: Absolutely. Is it actually going to be valid? Is it actually going to be, you know, coherent? Is it going to be of a standard that's actually of any use? Will they actually do it? Because patient compliance is remarkably tricky to predict.

APM: I suppose the things that people might be interested in, is a existing pathologies, any medications, simple stuff like date of birth, who their current GP is or practice they go to, that's fairly straightforward, isn't it? You're thinking beyond that where people start to describe what their problem is and —

JA: Absolutely and that's, I say, a full…describes a full registration process and what would be potentially encompassed in that would be PROMS scores for instance which opens up a whole other world of when you record them, which one do you use and so on and so forth but that's another chat all together.

APM: And I know just on your notes here, somewhere, you had something, you had a VAS score being indicated. It always tickles me because it's not VAS if it's digital but if someone's writing it is grade 5 out of 10, it's not a visual indicator anymore. It's digital.

JA: True but we do have a piece of paper dare I say stuck to the clinic wall with a smiley face. They convert it easily. So these areas can be jumped or customized but I'm going to show you a quick…scroll through a quick assessment just to give you an idea of some of the things that are in the system, some of the things to look forward to in the future. So if I go to a detailed initial assessment, how detailed an assessment is, in my experience, varies enormously on the practice, on the practitioner, length of time of being a practitioner as well but what we are doing in this beta test zone is just having a starting point to sort of demonstrate some of the information that we can capture. So we can pre-populate the templates, picking up from the previous journeys. We have the usual presenting complaints, history of presenting complaints, the text, if you like. So people have freedom. Frequently quick picks and choices can be seen to limit or restrict a practitioner. So we like to use text to help free them up, if you like but then as we get down here, there's certain quick picks that can actually help direct or prompt as you…I think that's the word you used earlier, practitioners. The other thing we've got here is if we log this as a radiation or altered sensation or weakness, we have the option to add text but it also adds it into the flags automatically. So what we're working at is we can set certain flags to respond to certain answers to questions which is great stuff, really, really —

APM: Very helpful. You said this is in beta testing.

JA: This is, yes.

APM: Which I think most of us has a vague idea what beta testing means. It means it's not quite ready yet. It's out with real users testing it —

JA: It is. If it was a pot, it's simmering nicely, just needs a little longer.

APM: And how much longer does it need before this stuff hits the streets and people…are we talking late next year, next Christmas or…?

JA: No, not that far. I'll say early in the New Year.

APM: Early in the New Year. So now is the time to start thinking about moving to clinic notes if you, you know, are at all interested.

JA: Absolutely.

APM: I have to keep dragging you away from what you're trying to tell us here. One of the questions is how long do you reckon it takes someone to get used to using electronic notes if they've only ever used paper notes in the past?

JA: Very good question. If somebody came along and looked at, say, my template, just as they would for a, if they went to a different clinic with paper notes then you have this period of adjustment and change. I think that if you

can recreate, as a starting point, your paper notes in an electronic system, I reckon the uptake is 100% quicker because as practitioners, we're very visual and really, the notes and all the computing stuff is the end result of everything that we learn and all the other talks and chats, this is the end bit in a way. So if we make it approachable and friendly and familiar, that's the key to me.

APM: One of the things which I imagine every practitioner is thinking is that when we run through your list of things on your computer form here, I have got to type this in. Now normally, if I'm dealing with a patient, I'm going to have my notes on my table next to me and with my right hand, I will be scribbling one handed, not to look at the notes but I only have to do that briefly and I can look back at you. If I actually got to turn around and concentrate and start typing, that's a real…it's a block between me and the patient and myself, isn't it? You know, this is patient communication. It's not good. Do they feel unhappy about this, do you think —?

JA: Exactly.

APM: I know they're used to it in the GPs but we're not GPs. We're much better than them in our patient handling.

JA: Exactly. Well, I can only give you my experience, direct experience and my happy medium was that as we're facing each other and talking like now, a computer wouldn't be quite as low as out one but the opening conversation is, "How can I help you today?" Really, for most practitioners. So letting a patient talk and have that contact…well, any interference of any notes at all is, to me, the key. That's the first step and they go, "Uh-huh, yeah, OK," and you start forming your sort of thoughts and your pathways and you probably maybe get to the history presenting complaints. You say, "OK, thank you very much. I'm just going to make some notes now, just one second," and they'd be absolutely fine. No different from you looking down to your paper to write and I think that softens the blow, if it is a blow.

APM: It might not be the appropriate point in the communication with your patient to do this but can we dictate into the system?

JA: Dictation is an interesting factor because it generally…usually, it depends upon the hardware more than the software, although there are software options out there like Dragon, etcetera, etcetera. So I think the new MacBook has some dictation in as a byproduct of the Siri world.

APM: They've had it for ages at MAC

JA: Yes but does it —

APM: Does anyone still use PCs out there?

JA: But it doesn't kind of…it depends on the setting. If I'm asking a silly question, it sounds fine. Dictation is a very different thing and the…well, with the Dragon software, you have to train your Dragon and even then, it takes time.

APM: Just so that people can understand what we're talking about here, Dragon is a dictation software package. We're not talking about dragon's den or something like that but in the old world, I think it would only work for one person because you had to train it to recognize your voice. It took quite awhile to do that but it was the most accurate of the dictation packages I think by some independent message.

JA: Yes. I would say for now, keep your eye on what's out there. You may see some sort of showy bits that may seem to work but I'm not entirely convinced yet. We do have clients who will record dictation electronically and that's simply a file and store that and then somebody types up a letter, for instance. That's usually the way I see dictation. I think people would like to see dictation as —

APM: That's not lessening the workload, is it? That's actually injecting another step in the process.

JA: Yes.

APM: But if you did dictate, you would have to pay close attention to making sure that it was accurate but then it'll probably still be a lot more legible than my handwriting, let alone the sports therapist I was talking about earlier on. So OK, we're going through this form. It doesn't look anything like a case history that I would use in my clinic at the moment.

JA: No, it's —

APM: Some of the words are the same.

JA: Exactly and if the words are the same, it flows in the same kind of way and it works in a page fashion. It scrolls down. I'll just point out a couple of features. So we have previous medical history. Now this area can be, again, depending on practice, quite in depth and has a lot of key information and just like the flags, what we now have within that software is the ability for that to follow and track the patient so that when they come in to see another practitioner or another case, it's with them and they can…it can be verified. So rather than copying the whole thing out again, it sort of speeds things up and smooth that through. So we have MSK problems and then we start getting into out of text and into some of the quick picks which do save time and help with a practitioner. So if I was to say, for instance, test some imaging, I select that. I've got some pre-selected options there. These can all

be customized to reflect your practice and I can select multiple options there and I can also add some free text if I wanted to.

APM: And what would be interesting there. MRI means nothing on it's own does it? Where is the MRI? What date did they MRI?

JA: Exactly. Yes, so we type in MRI and you can put the data if you wanted to. With the flexibility of the template we have here, if you wanted MRI followed by date and text—

APM: So you could set that up.

JA: --you could create that. So there's a lot there. If we go down to blood tests, again, similar area where we can list things and if I just go down to some sort of special questions…and again, these are yes, no's and this is where it becomes quicker. They can raise flags accordingly into the case automatically without having to do another step. I will just show you my favorite at the moment, which is prescription medicines, despite being an osteopath because I was always spelling them wrong and it took ages. So we now have…if somebody is currently taking a prescription medicine, if I select yes here, what I get here is details of medications and we've got some commonly prescribed drugs and I can just select them that way and it gives me a nice little journey and it's a couple of seconds.

APM: And if I enter the first few letters of a drug, will it pop up with a prompt and say what you really meant was amitriptyline?

JA: That's a different type of search, which we don't have in Beta yet but yes, you could, in theory, look at doing something like that.

APM: So that sounds interesting, you don't have it in Beta. I don't have it in my paper notes either, you know. I start to write amitriptyline, it doesn't pop up.

JA: It's a great idea though. It's a great idea. That's almost…it's not a spellchecker it's a prompt, isn't it? I'll raise that with the developers. That could be something to think about but what it can do is…we do have a spell check which is great.

APM: Absolutely, yeah.

JA: So there's lots of different things we can add in here and the flow goes all the way through to our systems, questions if we choose to ask them and this is a detailed yes, no. You can fly through this, save yourself lots of time and we can choose to add in goals and scores. So I'm just going to need to pick up the keyboard just for a second and just add in a goal there.

APM: While you're doing that, I mean if this were a touch screen, could we do all this on the screen itself? Presumably, you know, like any other software.

JA: Absolutely, yeah. So I'm going to put in a goal for 10,000 steps and I say, you're going to it today in my notes.

APM: Can we customize the goals and, say, we can add in whatever we want as goals?

JA: Absolutely. So —

APM: Because one of the questions we've got here, from Pierre in London is could we change what we want under red flags if we want to customize those ourselves?

JA: Totally flexible and customization which is very different to our current note system. There's a bit more structure and it's a bit more fixed but we realize that we need to respond to the, you know, varying requirements of all the different types of practitioners out there and even within the same professions, there's a vast variety of approaches out there.

APM: And I've got to make an apology while we're doing this. One of the questions that's come in isn't a question, it's a complaint and it's that I haven't asked of you a viewers question yet. I will. I promise. I'm just trying to make sure I do it at the right juncture.

JA: So just before we get to there, we put in a goal and we can record as a line graph or as a doughnut which is much more tasty and that can be added to the record.

APM: Does this interact with any exercise sheets as well? Can we sort of put in the exercises we might want to prescribe to a patient and print them off for a patient from the system?

JA: Yes. We have partnerships with certain exercise prescription software. There's a few of them out there, Salaso, Physiotec, Physiotools, Exercise Prescriber and what you effectively have is a light link that takes the patient's contact details into their world and you record the information —

APM: What's a light link? That means…?

JA: It means —

APM: Not much goes

JA: Yes. So the systems do not talk at the moment directly as such. It's the light link that takes, you know, date of birth, patient name and identifies them. So

it means the information stays with the patient. So there's some goals and scores. I'm just going to quickly jump into some images, just…because this is some —

APM: Well, I'm glad you've done that because one of the questions I haven't yet asked is from Tracy in North Scotland who…apparently it is very cold right now. He wants to know if we can draw on the case history sheets. So let's have a look at some pictures.

JA: Absolutely. Let me just pop that down for a second and go into a sheet. Now, this is old school pictures but very popular. I'll show you some funky stuff in a short while.

APM: Going to extreme lengths to make sure we have better pictures in our paper case histories than that one but you're right, that's the one we'd always —

JA: It looks like a four-year-old has drawn it but it's —

APM: With a very thick crayon.

JA: Yes but we have something called SVG. So we can actually vector and change these images and now, what we can actually do is turn it into more…almost like a sketchbook. So we can add multiple images and we've got a little pencil. So we can mark areas there. I'm using a mouse but if you do…touch screen, you can use your finger or a stylus. We've got some nice lines here. So if you're looking at, say, making a comparison…across there, let's make that a bit wider and maybe different color and we will say the hips are out. yeah, you can sort of make stick diagrams should we wish. We can add some pointers. So if I were to do that, OK and we have the ability to add annotations. So if I wanted to add text into this area, I could do so very easily. So there is an enormous amount of flexibility in there now. The one thing I did want to show was if it's possible to look at the picture of the body charts, the modern picture.

APM: I don't know how because it's your software.

JA: It was on the Powerpoint. So —

APM: Excuse me, leaning forward to deal with this.

JA: There we go. So we're testing these things out at the moment. So these images, compared to those, as you could see, are much crisper. The interaction is the same now but much more flexible and on the right-hand side, we've got almost like a new sort of experimental type of diagram that we're looking at which can be used I think…it could be easier for a practitioner to see exactly what's going on but also to show a patient, I think.

APM: What about those standard diagrams that appear in so many case histories which show…I mean there are various styles of them that show forward, bending side, bending…rotation of the spine and neck and so on. Those can be incorporated in this? Could we add one of your funky little red arrows and show degrees of motion on that?

JA: We could do that right now if we get to the right screen. So if I just close that and go to image and this is a standard sort of movement diagram. OK, let's get that out of the way. If I wanted to, I could put in a very simple mark like that, OK? This actually works as a sort of…the way an engineer would draw. So you start at the end point and work back.

APM: Where they go.

JA: So there you go, that's really simple.

APM: Which kind of…that's a bit odd, isn't it? Because really, they're all going to start on the origin of this diagram. So they should go the other way around.

JA: It's one on the developer's list. Alternatively, you can use your crayon to sort of mark, you know…if that's a bit more your style, a bit more freedom.

APM: A chap has sent in a question, Mike in Swansea, doesn't say whether it's cold in Swansea. How do we write all the shorthand that's not on the keyboard? The sort of stuff that saves us a lot of time in our hand written notes. Presumably, just use the same keys but…from the keyboard. So if we want hx for history, we write hx and…are there shortcuts available to us?

JA: There are shortcuts available but they are, at the moment, Maitland's symbols, which stem around physiotherapy. So that's usually about directional movement and grade of manipulations and things like that but it's a good thing to mention. My sort of rule of thumb, if the developers where watching they would have a fit, is that if we can do it for one, we should be able to do it for another but again, it's around the standardization because I remember when I graduated, my tutors were using dorsal and we're using thoracic.

APM: Thoracic, yes.

JA: Who knows? It could be something different by now entirely. So there is this sort of…there are these changes but it…maybe it's nice to have. Thanks for the question.

APM: Well, I mean that's…I don't know we'll overcome that sort of difference in language between people but, you know, as long as it's clearly written, we can all understand it whether it's dorsal or thoracic or whatever can't we. What's this say? Can this case history section be modified, e.g. they only have

aggravating and relieving symptoms but I'd record non-affecting symptoms as well. So again, is that another —

JA: Totally, absolutely.

APM: I want to know about this as well. I mean this is a lovely screen that's up on this computer now but where would I see this…when you come back to me for your second appointment, how would I see this? Does it flash up as part of the screen as I scroll down?

JA: Well, that's a very good question because if I just close out of this, we have a summary section. Now bear with me on this. So it is a little as I say Beta but in summary, what we can have is images and their goals. So if you wanted to go straight and see a certain amount of information, it will be there. There's another function, which is called a highlight. So if you wanted to highlight, for instance, diagnosis code plus your diagnosis notes and put that in the summary, that's effectively your top page at a glance.

APM: That would reassure me because I suppose there are ailments on the front page of all my case histories which I generally want to look at and where I've got a box which says cautions, those are things I always want to have visible which they're not in a standard paper case history because once it gets beyond a few pages, you know. It's easy to overlook those and of course, you can't tell how…you could but very often, you can't tell how recently those cautions were added because—

JA: True.

APM: --you write something but that was true when the patient came in and it's still true. So all very useful because I imagine that a lot of this will be auditable. So if somebody, God forbid, ones hauled in front of some tribunal but they'll be able to say when was this note added, when was it amended?

JA: So if I just pop up to settings here, there's a full audit function in TM3 and that shows you the user and the action. So if I just click over here, you can see on the screen there, I've done some treatment and there's been an update. Now I haven't been following a full sort of flow, if you like but you can see I've added…I've created an alert here and it's got be logged as a user. So there's a lot of information in there. So maybe the answer to the question about accessing notes…because the system is so fully auditable. It's unlikely people would…the other thing, of course, about the notes is you can set timers to actually close off the notes. So the CSP for the physiotherapist, guidelines for 24 hours within seeing the patient and you can actually automate that with the system here, should you wish to follow it. You don't have to. Some people choose to have a bit longer perhaps but there's a lot of control around that and you can close off consultations as you go along.

APM: I think there's some people who will think that they don't want this sort of stuff in their notes but actually, it strikes me, and I haven't even considered this until just…when you said that but this takes an awful lot of responsibility off the practitioner, doesn't it? It just means it's so much easier to do what is regarded as being ethically sound practice without having to think about what have I done with the notes? Where do I keep them? It's just done for you and I'm not trying to force anybody into taking up electronic notes nor am I trying to sell TM3 to anybody but it does strike me that this is probably the way ahead and all those people who I've spoken to who've moved to electronic notes say they would never go back. It hasn't affected their patient interaction. It has made their consultations more readable, more…and in some ways, more accurate I think. There's a question here saying, possibly quite predictable that it all sounds very good for a big clinic but what about the solo practitioner who doesn't have a receptionist and so on?

JA: True.

APM: I mean is this a cost effective system for them? How much does it cost? I was going to wait until the end because I was going force you into giving us all discounts but what is the outline cost for, say, a solo practitioner who wants to take up an online diary and clinic notes?

JA: Currently, there's an offer on. I did check with our sales team before coming today. For solo practitioners. I think it finishes around Christmas time, £50 straight in.

APM: Always with the deadline.

JA: £50 straight in. My contact details and the website to check things out will be on the slide I believe at the end.

APM: We'll put that up on the screen, it could be up there now for all I know.

JA: Excellent and I think the usual cost is about £79. So when you factor in all the functionalities —

APM: That's per…?

JA: Per month.

APM: £79 per month. Does that depend on the number of practitioners or patients or entries or access to the diary?

JA: The way it's priced, although I don't work in sales at the moment, is on practitioners licensing and using. So really, it only grows when you grow.

APM: That's useful. I mean I suspect that people aren't going to remember that and in any case, the details will vary by clinic. So we will put your contact details up and again, you know, there are other systems available feel free to look.

JA: Of course.

APM: But they'll have your email so they can contact you if they have questions.

JA: Please do.

APM: And they'll have your website address which gives them a breakdown of what, PPS, what TM3 are offering at the moment, sorry about that. Another question here is that if you're going from paper notes, actually, suddenly, particularly who got a big clinic, you need to buy a dozen computers as well.

JA: True.

APM: So what sort of computers are people using in their clinics to make this effective?

JA: It's a really good question because of course, everybody starts out with the sort of Christmas list present and we'll all have MacBook Pros or iPads and —

APM: Now is a great time —

JA: Yes, all those kind of and other but in my mind and in my experience, realistically, they should be workhorses. Maybe for a solo practitioner, you need something that does a bit of everything and because you can log in and out, that's fine but when you start scaling up, computers have a different role and there's different responsibilities. So laptops may go walkies if you like. They can be moved. I'm quite a fan of desktops in a clinic environment although since testing a new software, I'm starting to shift slightly towards like a Microsoft Surface. They've got enough power now these days to sort of…to have some really nice functionality.

APM: So you mean an iPad.

JA: It could well be, yes. It could well be but the other thing is —

APM: But very expensive, surely. I mean how much does a Microsoft Surface cost?

JA: I have no idea actually.

APM: Actually —

JA: About 300 quid for 3 I think.

APM: I came across somebody recently, a chap called Chris who…this is me doing marketing now for a chap in Birmingham. He runs a computer business but he's recently set up a business called Computers 4 Life and his website is computers4life.co.uk. And he does computers, brand new computers on a monthly fee. So we've looked into this because we'll need to buy a lot of new computers for our own clinic in order to put one in each of the treatment room so that people can take notes

JA: Sure.

APM: And he's starting…the basic computer I think is £30 a month and top end is something like 50 quid a month and that's for a very big state of the art thing. Touch screens, they do Surfaces and tablets and stuff like that and these computers are replaced after three years. It's a bit like leasing a car. So you're not paying much over the value of a brand new computer. So you could do this quite cheaply for a whole clinic, really and his other guarantee is not only does he do all the servicing and everything else, if ever a computer goes down, it's replaced instantly with a new one.

JA: That was supposed to be my question because it…the accessibility sounds fantastic.

APM: As you can imagine, I've been looking into this, trying to find faults in the program but it just seems to me like a really, really good way of getting state of the art, brand new computers for a clinic without shelling out a huge amount of money all in one go. Anyway, that's enough. Computers 4 Life. We'll make sure we've got the reference right and I'll put that up on the screen towards the end of the broadcast.

JA: Interesting.

APM: I have a question here and I don't understand the question so I'm going to have to read this one out. Is there an app? I also take calls, which are diverted, from my advertising contact number so often I'm booking appointments…I see what they mean. Apps, that you can put it on your mobile phones that you could do this. So could you operate the system from a mobile phone by some devious method?

JA: In theory, you could but mobile…depends what sort of mobile phone you're talking about. I've tested these things on my iPhone 6, you know, the large one. It's OK but practically…there's a limitation I think on where and how you take notes. I would say anything smaller than an iPad or a surface is getting out of the realms of being functional. That's my personal experience. You can have a look at things like —

APM: I suppose actually…you no worse of now if you're in a supermarket now and you're not doing electronic notes and you have to write something down as

opposed to having an iPhone 6 which is a reasonable size thing and having to type something. And I reckon I could book appointments on my iPhone 5. I've never gone for a 6 myself. So the answer is yes, it could be done. It does work on a smartphone at least.

JA: It does but I wouldn't be a fan of it. No, so it —

APM: Well I hope that answers the question anyway and next one here is…a lady here has written in, saying that she's using…I think it's a lady, written in, saying she's using off site answering service, not yours obviously. Could they be incorporated into using your online diaries and so on?

JA: I'd have to check —

APM: Presumably, they can just have a license to have access to the diary can't they?

JA: They could well do that. It depends on the interaction. I guess the sales team would know more about that. Obviously we would champion our service whether we would extend it to anybody else.

APM: A lot of people are very loyal to their answering services, aren't they? Because you get to know them and you build a relationship and you trust them and so on. I certainly would, you know…I think long and hard about giving up the one that we use because we know them so well and we've been using them for many years now but with them, they just have a license to access our diary which we purchase —

JA: It could easily be done. The best thing to do is ask, really.

APM: One of the last questions we've got here. Ella who's on a holiday in Cyprus and apparently warmer than Scotland, I'm not surprised, she wants to know if there are treatment abbreviations built into the system. I think we dealt with that question earlier on, didn't we? So they're not built in but you can use your own abbreviations.

JA: So if you wanted to…let's say you had Steven Bruce abbreviations as an assessment. You could create them in terms of a look up, you know, a list of cervical descriptions, thoracics, lumbars, etcetera, etcetera. So as long as you have it written down, in theory it can be created for you and it may well be that you look at what's in the system, say, "I don't want that. I don't want that," and simplify which is sort of where I was heading earlier, really.

APM: So Maria in Rome asked about touch screens on an iPad and touch sensitive computer screens. We've dealt with those and I presume on a touch screen, we could do drawing on the case history with a finger or a stylus —

JA: Yes, you hit the pencil but it's your finger.

APM: And we have dealt with that one. So I thought we would struggle to fill all this time talking through—

JA: Me too.

APM: Give us 30 seconds or a minute on what have you not covered that we need to know about? Why should we be contacting you to find out more about clinic notes? Is there something exciting in here that you haven't covered?

JA: There is so many things around the software. There's a pronto network which we haven't covered, which sort of gets into the world of referrals from third parties, matches and lines with online but also the reception services. I think one of the unique things is that I've spent a lot of time with Blue Zinc. There was six of us when we started and we're up to about 40 now and the big difference is the representation of our clients all the way through the company, myself and through the products so that we ensure that they get the best stuff.

APM: Jeremy, it's been fantastic. Thank you very much.

JA: Absolute pleasure.

APM: It's been very interesting. I hope it's been very —