Healthcare Improvement Scotland | ihub

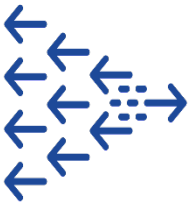
Case study

Primary Care Improvement Support Team

Workflow Optimisation in Coldstream General Practice

Context

Coldstream General Practice (NHS Borders) is a rural practice only 1 mile from England. Their list size is 4000 and a third of the list is registered in England which makes the administrative process more complex. They have the highest elderly population in Scotland.



Why a change was needed

- Struggling with workload - greater administrative burden on already overworked GPs
- Three partners and a Senior Practice Nurse leaving due to retirement or to changing role.
- Needed new ways to work with the resources they have

Impact

- Reduction of documentation going to GPs
- More accurate documentation management –> Safer care and GPs have more time to look at complex cases
- Greater job satisfaction for GPs and workflow team
- Better guidance for patients

Top tips

- You need someone that is passionate about workflow to drive the work within the practice, to make things happen.
- It is important to discuss the changes with the practice team to ensure their understanding and buy-in to the change. You may also need other staff to change their hours to enable the new way of working.
- All practice GPs should support workflow optimisation. If they are not on board they will not let go of their correspondence.
- Workflow team and GPs have to work closely to optimise workflow.
- Implement workflow gradually as you learn and your confidence grows.
- Make sure your workflow staff are trained and supported throughout implementation- schedule dedicated support time.
- Set up Docman folders to make correspondence management and the audit process more efficient and safer.
- Explain the rationale behind the quiet workflow station to all members of the admin team to prevent any misconceptions.

Workflow Optimisation in Coldstream General Practice

Where can I learn more?

- View the appendixes for template ideas for measurements and protocols.
- View the ihub's Workflow Optimisation toolkit from the Practice Administrative Staff Collaborative which includes further guidance, examples and templates.
- View our motion graphic (4 mins) which gives you an overview of workflow optimisation and what you can find in the Workflow Optimisation toolkit.

Tell us your thoughts

We need your feedback to help us improve. Let us know your thoughts on this case study by completing our online form.

Context

List size: 4,000

Population: highest elderly population in Scotland. Area often described as 'God's waiting room'. Very complex patients.

Geography: rural, only a mile from England. A third of their patients are registered in England, which makes their administrative processes more complex, as they have different policies and processes regarding e.g. registration of patients, screening protocols, etc.

NHS board: NHS Borders

Practice Manager: Yvonne Archibald

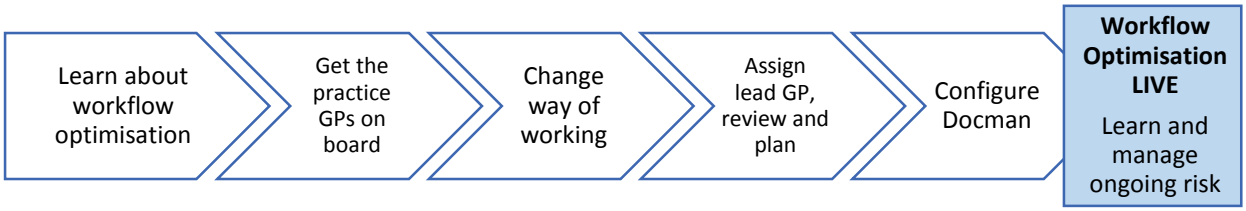
The work carried out within Coldstream practice has helped to inform the work of the Practice Administrative Staff Collaborative which launched in February 2018, to support the development of practice administrative teams and improve GP practice processes.

Why a change was needed

- Struggling with workload - greater administrative burden on already overworked GPs
- Three partners and a Senior Practice Nurse leaving due to retirement or to changing role.

They needed to look at new ways of working which would build resilience and reduce the admin workload **BUT** with the resources they already have.

What they did



Learn about Workflow Optimisation

Due to their location they were very aware of what was happening in England regarding workflow optimisation as they were subscribed to newsletters and had good links with the nearby practices. The Practice Manager, Yvonne Archibald, decided to visit a practice in Berwick Upon Tweed (Northumberland) with one of their admin staff, Moira Patterson, to learn more about how they had implemented workflow optimisation. They spent 2-3 hours with them watching how they workflow correspondence. Although this was a bigger practice and they follow the English system for coding, it was really helpful in understanding how to optimise workflow.

TIP: You need **someone** that is passionate about workflow **to drive** the work within the practice, to make things happen.

Get the practice GPs on board

The Practice Manager presented the idea of implementing workflow optimisation and its benefits to the practice GPs, such as reducing workload. Initially there were some reservations about letting admin staff action clinical correspondence but there was a unanimous approval by the practice GPs to try it. This stage was very important to the success of the change.

If your GPs are not on board, you will not go anywhere
Practice Manager

Change practice administrative staff's way of working

The practice agreed to have a minimum of 2 staff dedicated to correspondence management (15 hours/week each), not only to support each other but also to provide continuity 5 days a week and cover for annual leave or sickness. There was an overlap between their daily 'workflow' shifts to allow them to discuss complex letters together.

I had to give up the diabetes recalls which I loved to do but it has been really good!
Workflow Administrator

The Practice Manager explained the plan to her admin team and the opportunity to become Workflow Administrators was offered to all members of the admin team and two people volunteered.

This required having to rearrange existing roles, responsibilities and rotas to enable the new way of working. It also required up skilling the rest of the admin team.

The lead GP, Dr Nicola Henderson, was initially the main point of contact for the other GPs and the workflow team.

TIP: It is important to **discuss the changes with the practice team** to ensure their understanding and buy-in to the change. You may also need other staff to change their hours to enable the new way of

Assign lead GP and plan process

The workflow team worked closely with the lead GP. They reviewed the volume and type of correspondence to be able to establish what needed to go to a GP and what did not. They started with a brief list of documentation types initially (Appendix A contains the initial list they agreed on). They decided not to procrastinate and go live in July 2017. This step also provided them with baseline data to monitor their progress against as shown on Figure 1. Refer to Appendix B for a printable version of the workflow tally sheet.

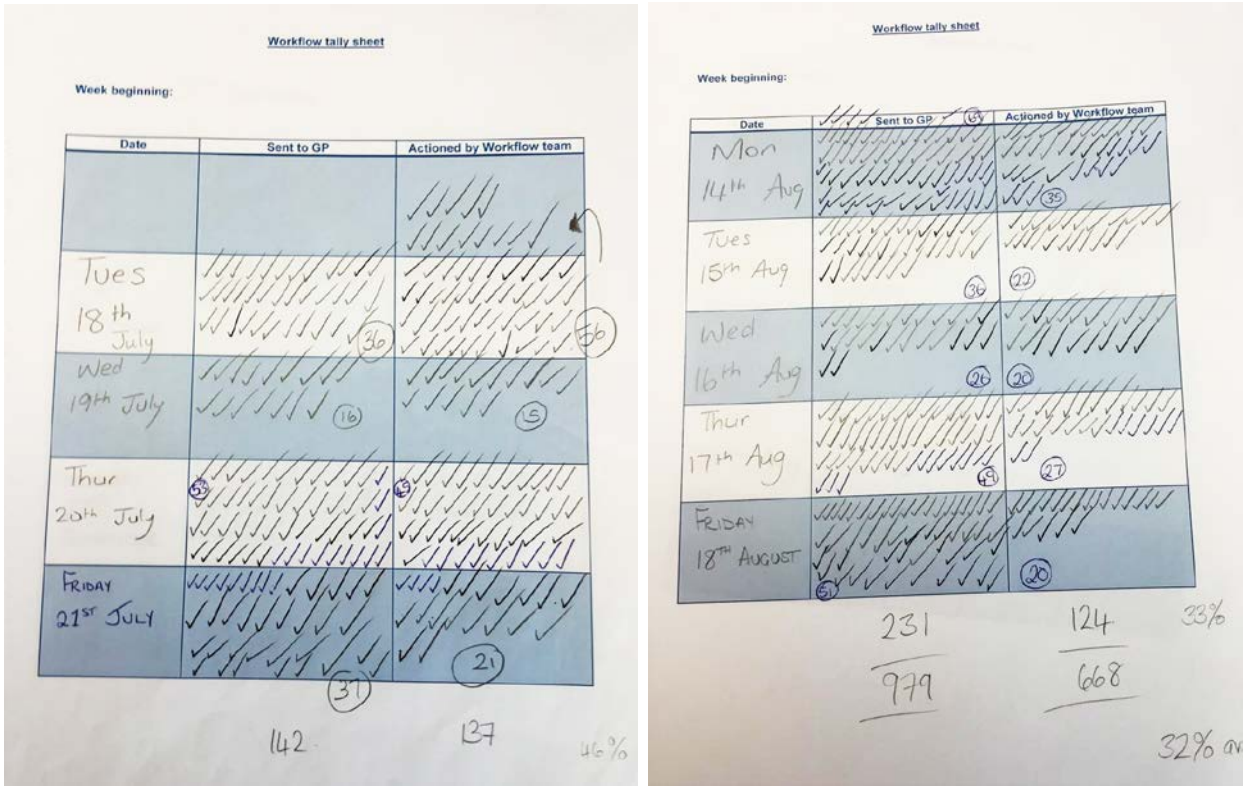


Figure 1. Tally charts used for gathering data

Baseline data also allowed them to understand changes in the demand. For example, if the practice nurse had been on leave, there was a decrease in blood test results and after ophthalmologist clinics, there was an increase in ophthalmology letters.

Coding training was not required as staff was trained internally by the practice nurse, when and as required.

TIP: Workflow team and GPs have to **work closely** to optimise workflow. It can help to assign lead GP.

Configure Docman

The Practice Manager configured Docman so that all documents were sent to a separate inbox for the workflow team only. She also set up folders for each member of the team so that the workflow team could easily see what documents everybody had. This allowed them to reallocate documents to other GPs if, for example, a GP was off sick. Also, having a 'Completed' folder allowed them to review that tasks had not been completed by GPs by mistake.

TIP: Set up **Docman folders** to make correspondence management and audit process more efficient and safer. Find more information Docman templates and ways to measure in our Workflow Optimisation toolkit.

Going live and ongoing learning

The Lead GP had time blocked at the end of the surgery for three days on the first week to be alongside the admin team as they processed the workflow documents and provide ad-hoc advice. This helped to increase the workflow team's confidence rapidly. The Practice Manager was always at hand to provide support. Any diagnosis letter was checked with the Practice Nurse.

One of the Workflow Administrators commented that initially they were apprehensive looking at people's consultations but this was necessary, for example, to see who requested bloods and to workflow the results to the right clinician. After a while they became used to it.

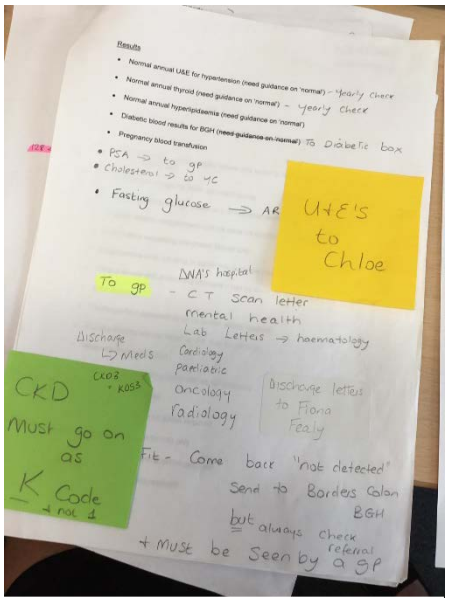


Figure 2. Recording of learning - annotations made to the protocol

TIP: Implement workflow **gradually** as you learn and your confidence grows

The list of documents to be actioned by the two administrators increased gradually as they grew in confidence. The protocol they used changed to incorporate the learning and new document types. Refer to appendices B and C to see the updated protocols they started using in January 2018 and in May 2018 or view some example protocols developed by other teams across Scotland in the ihub's Workflow Optimisation toolkit.

The lead GP and the workflow team continue to meet on a bimonthly basis to review the protocols and discuss any learning points (figure 2).

TIP: Make sure your workflow staff are trained and supported throughout implementation. **Schedule in support time.**

Risk management

The lead GP carries out regular, random audits of correspondence actioned by the team to ensure risk is kept to a minimum and feeds back any learning points.

Initially the audits were carried out on a monthly basis and it entailed looking at a selection of 20 random letters. As the confidence in the new system of working increased, the frequency of audits was reduced to 3 monthly and now to 6 months. Also the volume of documents reviewed was reduced to 10 random letters. The workflow system is fully embedded in the way the practice works and the risk level is low.

There has only been a mistake since the workflow team started. It was a three page letter and there was a request for bloods at the bottom of the last page. GPs said that they would have also missed it.

Impact

Reduction of documentation going to GPs

They kept a note of volume of correspondence for a 9-week period and it quickly became apparent that the **number of documents sent to GPs had reduced by an average of 65%.**

This was fairly cost neutral to the practice as **it only required an increase of 5 hours by one member of the admin team** from 22 hours to 27 hours per week.

More accurate documentation management –> Safer care and GPs have more time to look at complex cases

Before GPs often looked at correspondence at the end of the day, after 5pm before going home. After a tiring day which could have run over due to delays, it was more likely to miss details. Now GPs can spend more time looking at correspondence and results for complex patients.

Also the number of documents that had to be redirected has reduced, as correspondence is directed to the right person in the first instance.

Greater job satisfaction for GPs and workflow team

The workflow team really enjoy the new role and their increased knowledge has meant that the GPs are more confident in their abilities and have expanded the list of things the team can action.

The rest of the admin team had to be up skilled which increased their job satisfaction.

Workflow optimisation has also had an impact on GPs' work life balance. No GPs work beyond 6pm while this was happening before implementing it.

The confidence of the workflow team has grown unbelievably
Practice Manager

I was so scared at the beginning but now I just love doing it!
Workflow Administrator

The difference to our workload in a short space of time was even better than we had anticipated and there is no longer a feeling of dread opening Docman in the morning
GP

Now that Moira and Lauren are doing workflow it has meant that our roles in reception have expanded and we have taken on new tasks
Receptionist

Better guidance for patients

The workflow team has developed a very good knowledge of the practice patients and get the full picture of their situation. As a result they are better able to advise patients for example, on what clinician could help them with their needs.

Final remarks

Give it a go!

It is not as scary as I thought it would be!
Galashiels Practice GP – visiting Coldstream Practice to find out more about workflow

And remember:

Top Tips

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2. It is important to discuss the changes with the practice team to ensure their understanding and buy-in to the change. You may also need other staff to change their hours to enable the new way of working.
3. All practice GPs should support workflow optimisation. If they are not on board they will not let go of their correspondence.
4. Workflow team and GPs have to work closely to optimise workflow (e.g. assign lead GP).
5. Implement workflow gradually as you learn and your confidence grows
6. Make sure your workflow staff are trained and supported throughout implementation. Schedule dedicated support time
7. Set up Docman folders to make correspondence management and the audit process more efficient and safer.
8. Explain the rationale behind the quiet workflow station to all members of the admin team to prevent any misconceptions.

Where can I learn more

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APPENDIX A - WORKFLOW (JULY 2017)

Letters/correspondence

- DESMOND (thank you for referral)
- Ophthalmology – where action is no change/review 1 year
- Cataract / eye injection / lucentis discharge letters (need coded)
- Aortic aneurysm screening
- Post op letters for simple surgery where only action is removal of sutures or wound check (need coded)
- Berwick A&E sheets for minor ailments/injuries
- Any 'For your information' letters (e.g. invitation to counselling)
- Dietician letters – supplements can be done via special requests
- WGH letters requesting pre-chemo bloods only
- Osteoporosis clinic advising of zoledronic acid / denosumab infusions
- Clinical emails with prescribing changes – can be done via special requests
- DNA letters
- Discharge from caseload when no further action required
- Routine hospital clinical follow up (i.e. 6 or 12 monthly)
- Maternity discharge letters
- Letters to patient advising result with no GP follow up
- Pregnancy booking forms
- Audiology letters where no action required
- DWP/SBC letters where for info only
- A&E letters where no further action required

- OOH where no GP action required

Results

- *Normal annual U&E for hypertension
- *Normal annual thyroid
- *Normal annual hyperlipidaemia

All to practice nurse

- Diabetic blood results for BGH
- Pregnancy blood transfusion

* Normal means with grey parameters on result (i.e. cholesterol 3.5 – 5.18)

APPENDIX B – WORKFLOW TALLY SHEET

Week beginning:

Date	Number of documents sent to GP	Actioned by Workforce team
Insert day and date	*Tick when sent to GP then circle the total.*	*Tick when actioned by workforce team and then circle the total.*

Weekly totals:		

APPENDIX C - WORKFLOW (JANUARY 2018)

Letters/correspondence

- DESMOND (thank you for referral)
- Ophthalmology – where action is no change/review 1 year
- Cataract / eye injection / lucentis discharge letters (need coded)
- Aortic aneurysm screening
- Post op letters for simple surgery where only action is removal of sutures or wound check (need coded)
- Berwick A&E sheets for minor ailments/injuries
- Any 'For your information' letters (e.g. invitation to counselling)
- Dietician letters – supplements can be done via special requests
- WGH letters requesting pre-chemo bloods only
- Osteoporosis clinic advising of zoledronic acid / denosumab infusions
- Clinical emails with prescribing changes – can be done via special requests
- DNA letters
- Discharge from caseload when no further action required
- Routine hospital clinical follow up (i.e. 6 or 12 monthly)
- Maternity discharge letters
- Letters to patient advising result with no GP follow up
- Pregnancy booking forms
- Audiology letters where no action required
- DWP/SBC letters where for info only
- A&E letters where no further action required

- OOH where no GP action required

Results

- *Normal annual U&E for hypertension
- *Normal annual thyroid
- *Normal annual hyperlipidaemia
- All cholesterol
- All fasting glucose

All to practice nursing team

- Diabetic blood results for BGH
- Pregnancy blood transfusion
- Normal bowel/breast screening

* Normal means with grey parameters on result (i.e. U&E's >60)

APPENDIX D - WORKFLOW (MAY 2018)

Letters/correspondence

- DESMOND (thank you for referral)
- Ophthalmology – where action is no change/review 1 year
- Cataract / eye injection / lucentis discharge letters (need coded)
- Aortic aneurysm screening
- Post op letters for simple surgery where only action is removal of sutures or wound check (need coded)
- Berwick A&E sheets for minor ailments/injuries
- Any 'For your information' letters (e.g. invitation to counselling)
- Dietician letters – supplements can be done via special requests
- WGH letters requesting pre-chemo bloods only
- Osteoporosis clinic advising of zoledronic acid / denosumab infusions
- Clinical emails with prescribing changes – can be done via special requests
- DNA letters
- Discharge from caseload when no further action required
- Routine hospital clinical follow up (i.e. 6 or 12 monthly)
- Maternity discharge letters
- Letters to patient advising result with no GP follow up
- Pregnancy booking forms
- Audiology letters where no action required
- DWP/SBC letters where for info only
- A&E letters where no further action required
- OOH where no GP action required

All routine correspondence goes to referring GP, even if they are on annual leave

Results

- *Normal annual U&E for hypertension
- *Normal annual thyroid
- *Normal annual hyperlipidaemia
- All cholesterol
- All fasting glucose

} All to practice nursing team

* *Normal means with grey parameters on result (i.e. U&E's >60)*

- Diabetic blood results for BGH
- Pregnancy blood transfusion
- Normal bowel/breast screening
- PSA from recall – unchanged repeat (<.1) – send to June, if from a hospital consultation then goes to a GP
- Blood results out with normal parameters go to requesting GP (if not here then D/D):-
  - Hb (115 – 165) - if less than 115
  - WBC (4.0 – 11.0) – if less than 3.5 or more than 11.0
  - PLT (150 – 400) – if less than 100 or more than 600
  - MCV (80 – 100)
  - Neut (2.0 – 7.5)
  - Lymp (1.0 – 4.0) – if more than 4.0
  - EOS (0 – 0.4) – if more than 0.5
  - ESR (0 – 19) – if more than 30
  - Albumin (35 – 50) – if less than 25
  - Bili (3 -21) – if more than 30
  - ALT (0 – 55) – if more than 150
  - ALP (40 -150) – if more than 250
  - TSH (0.3 – 4.9) – if more than 10
  - Vit B 12 (187 – 883) if less than 100
  - Serum folate (3 – 20) if less than 2
  - Ferritin (12- 150) - if less than 12
  - Sodium (137 -144) - if less than 128 or more than 145
  - Potassium (3.5 – 5.0) – if less than 3.2 or more than 5.5
  - Glucose fasting (3.9 -6.1) if diabetic and less than 20 goes to GP, if not diabetic and more than 10 it goes to D/D
- All QFIT results go to a GP (even if states 'not detected)

NOTE: ***Huge thanks to Yvonne, Moira and the rest of the team at Coldstream Practice*** *for receiving the members of the Primary Care Improvement Team and telling us their workflow optimisation story*