LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

# Planning for Quality Improvement in Primary Care:

## WORKLOAD

### TOOLKIT

**Need project help or advice?**
**Contact: QINetwork@nhslothian.scot.nhs.uk**

# Introduction

There is an urgent need for cultural change within general practice from one of acceptance of 'quantity overload' amid shrinking resources, to one of efficient demand and workload management. Seeing your practice as a system of processes and knowing what value your work adds to patient care, and eliminating steps or tasks that do not meet the needs of your patients (known as workload 'wastes'), can help you transform your current practice into one that's more efficient & productive.

But general practice workload is both high in volume and complex in its nature, so it may be difficult to know where to start to try and address it. This toolkit is designed to help you identify where you have opportunities for change, and signposts you to other resources which will help you test and implement changes to help reduce the workload issues that are within your influence. Practices are not expected to address all workload issues; indeed it would be far more sensible to choose just one priority area for focus. However, it is suggested that you follow the basic steps of planning, then testing new ideas, and then measuring to ensure they are effective (see the outline plan on page 3).

A word from Lothian Medical Committee –

Dear Colleagues,

Now more than ever, General Practice needs to be able to demonstrate the enormous pressure we are under. For too long we have talked about being busy without having robust evidence to support our claims. This lack of objective measures has meant that acute services have received all the attention and investment over the past two decades. As we hopefully exit the pandemic, we have an opportunity to shape services in new ways and get more resources into the Community. Sharing workload data with the LMC will mean we can move away from presenting anecdotes and small-scale pressures to undeniable need for better support. By sharing with the LMC we will be looking to present the pressure across all practices, not criticise the individual, as has been the fear of data sharing in the past.

I hope you will consider signing up to the SESP to aid your own practice recovery and share the results with the LMC so we can get General Practice the recognition and support it deserves.

You can opt-in to sharing any workload data you collect with the LMC here.

Dr Iain Morrison
Chair, GP Sub-Committee & Lothian LMC

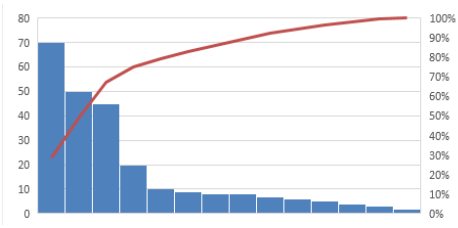
LOTHIAN LMC

## Contents

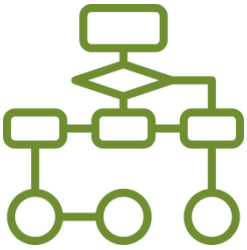
# Toolkit outline

Are you ready?
What matters to you & your team?

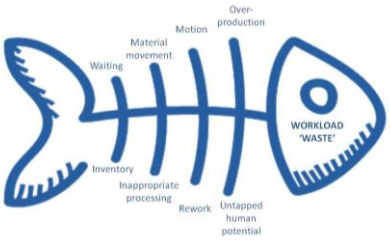

Collect your baseline data




Use a Pareto chart to identify **what** your top workload issue is



Use a process map to look at this issue more closely and identify **how** you can make changes




Consider **why** this issue is happening and what you can influence
see pages 7-8

Decide what you would like to change and state your aim


Look for ideas or use a change package –
see pages 11-13

Test and see if it's working –
make further changes if it's not

Measure your workload reductions to ensure they are sustainable

Real practice examples: Acute Prescribing, Hypothyroid Recall and Workflow Optimisation

# 1. What are we trying to accomplish?

## Theory of knowledge – what does the literature tell us? And why is this important?

How can you transform your practice into one that's more efficient & productive, as well as satisfying to you and your patients?

Quality Improvement encourages you to simplify your processes by understanding what adds value and how to eliminate unnecessary workload ('waste'). This is an approach reflected in several of the QI planning tools you may be familiar with, for example process mapping, which can help to identify duplication, gaps, waits and unnecessary steps in a process. Seeing your practice as a system of processes, knowing what value your work adds to patient care and eliminating steps or tasks that do not meet the needs of your patients will help to control workload.

The BMA Strategy (2018) for controlling workload in general practice builds on these principles by aiming to publicise reasonable safe workload limits, and provides practices with a range of practical tools to help control workload, including the use of HSCP pools for triage, diagnostics and mixed workforce (which may be particularly helpful in times of acute workload stress e.g. during COVID pandemic waves).

## Variation – Identify & quantify all the work you currently do

Do you know how much work you actually do?

Knowing what your baseline data looks like will provide you with some useful insights, and perhaps some surprises.

- **TO DO**: Consider collecting a workload snapshot by undertaking a day or week of care survey / time motion study - this data collection template may be helpful. It includes all possible measures to ensure every source of workload is captured, but this may be too big a task, so just decide which measures feel most relevant to your practice team and prioritise collection of those.
- Consider sharing any workload data you collect with the LMC by opting-in here. You do not need to have collected all the suggested measures, but any data that you are willing to share may be useful to them.
- **TO DO:** It is strongly recommended that you follow NHS Lothian's 'Vision Recording Encounters Protocol' (see Appendix 1) to accurately record Consultation/Encounter types before you start. This will significantly increase the reliability of your data.

If you need help with setting up searches contact the QI team or contact Lothian Analytical Services who may be able to assist with this analysis.

*Suggested* possible workload baseline measures (remove or add other measures as relevant to your area of focus):

| Measure per day/week/month | Source |
|---|---|
| **DIRECT PATIENT CARE:** | |
| Number of pre-booked routine appointments<br>(phone, F2F)<br>(GP, PN, phleb, physio, MHN, etc) | Vision / EMIS / SPIRE |
| Number of on-the-day acute consults<br>(phone, econsult, walk-ins) | Vision / EMIS / Econsult |
| Multi-morbidity and Frailty | SPIRE |
| Number of blood tests taken<br>(primary care request, shared care monitoring, secondary care request) | ICE or labs analyst |
| Number of/Time spent on Enhanced Services patient contacts<br>(minor surgery, LARC, substance misuse, Care Homes etc) | Vision / EMIS |
| Number of vaccines given<br>(Flu, Covid, childhood imms) | Vision / EMIS |
| **INDIRECT PATIENT CARE:** | |
| Total number of patient contacts to reception/admin<br>(phone, econsult, walk-ins) | Reception count /<br>telephone system record |
| Number of prescription requests<br>(acute, repeat) | STU |
| Number of prescription reauthorisations | Vision / Emis |
| Number of results received<br>(haem, biochem, micro, imaging, etc) | DOCMAN |
| Number of documents received<br>(discharge letters, clinic letters, info, requests for action) | DOCMAN |
| Time spent/ number of Enhanced Services admin<br>(Anticipatory Care Planning) | Individual time & motion |
| **OTHER WORK:** | |
| Number of report requests<br>(insurance, employment, DVLA, gun licence, child protection) | Practice count / DOCMAN |
| Time spent in meetings<br>(huddle, clinical, whole team, Partnership, Cluster, other) | Individual time & motion |
| Time spent on small business management & finance | Individual time & motion |
| Time spent on staff management, recruitment, wellbeing | Individual time & motion |
| Time spent teaching | Individual time & motion |
| Time spent on Quality Improvement initiatives<br>(SESP, Cluster projects, other practice projects) | Individual time & motion |
| **POSSIBLE PROXY MEASURES:** | |
| Log-out time | Vision reporting manager |
| Validated perceived stress score | Individual record |

**Are you ready?**


Doing a piece of data collection like this is a big undertaking. Consider whether this is the right time for your team. Ask them 'What matters to you?' Buying their engagement to collect all the data will be important. You can help to do this by talking about:

**WHAT** you are planning to do.

**HOW** you are planning to do it, and what that means for individuals.

And most importantly, **WHY** you are doing it.

There is no point collecting data if you are not going to do anything with it to identify areas where workload can be reduced, and then not take the appropriate actions to improve or reduce it! Try to give your team a vision of what might change as a result of this work.

Focus on what you can influence or control, and not what you can't.

Do you have capacity to do the subsequent improvement work needed?

It may also be useful to know how you benchmark to expected or peer workload.

- **TO DO:** Consider doing this work as a Cluster to be able to compare workload between practices, if you express data as rates per practice population size.

However, it should be acknowledged that there are many compounding factors that may also influence workload which need to be considered when making any comparisons between practices, including:

- Deprivation
- Demographics
- Multi-morbidity & frailty
- Rurality & time to travel
- Ethnicity & time to translate
- Additional services e.g. Care Homes

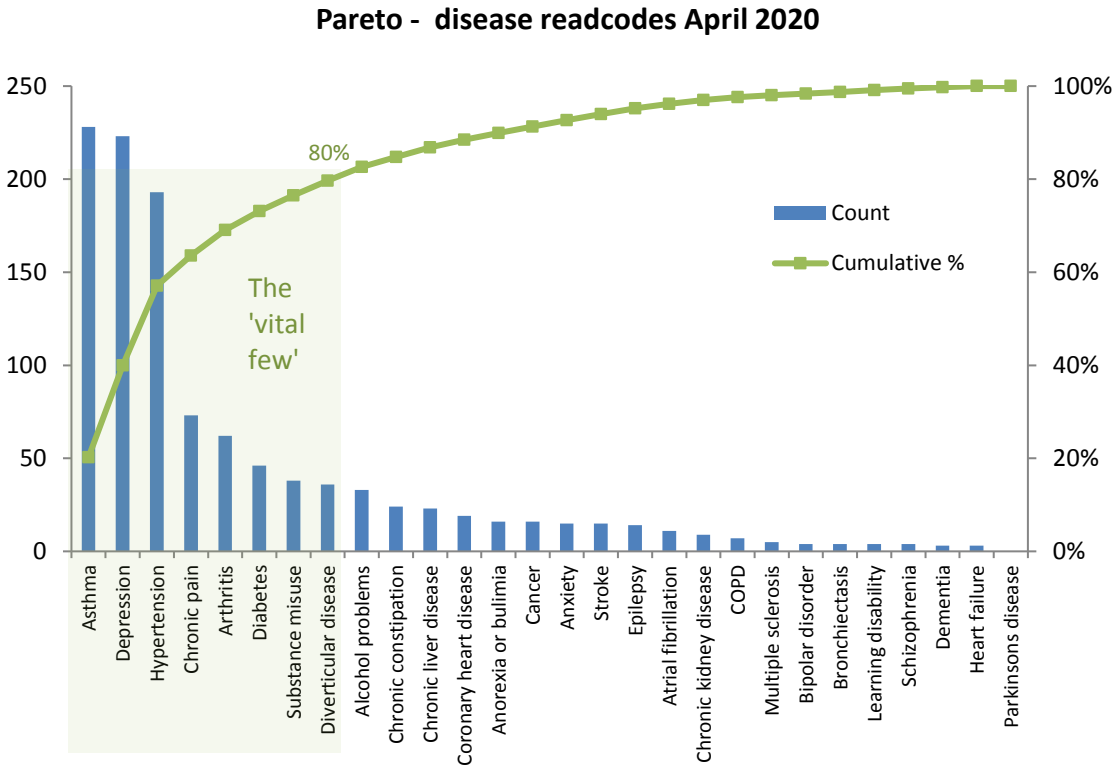
## Appreciation of your system – how does your system currently work?

Now look at your data; what it is telling you?

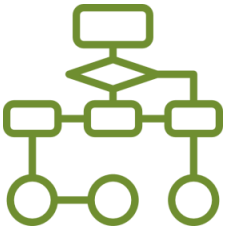
**TO DO:** Use a Pareto chart to help you focus on where your greatest workload is. Remember that 80% of workload identified comes from 20% of the causes (the "vital few") – **what** are these?

Add either count OR time data groups to your Pareto chart, as it won't work to mix them. But you could produce a chart for each and look at them side-by-side.

Looking at your Pareto chart, now work with your team to understand your biggest workload area(s) better. For example, this Pareto produced by a local GP practice shows their most frequent disease readcodes and the 'vital few' where 80% of their clinical workload effort was. Focussing on processes and pathways that support the signposting and multidisciplinary care of these patients, e.g. Mental Health Nurse triage, online pain management resources, or reviewing frequency or need for low-risk single chronic disease monitoring, might therefore be a good place to start.



Next, you can use a process map to determine the start and end points of that workload process, and then map all the main steps in between. To get an accurate 'picture' like this you may actually need to walk the process, considering **how**, when and where people move during the process, how information is recorded and exchanged, how technology is applied, how steps in the process are sequenced, what triggers the work, and how much time is spent at each step and for the entire process, including waiting time. Stay focused on high-level steps and focus on the usual process, not on the exceptions.



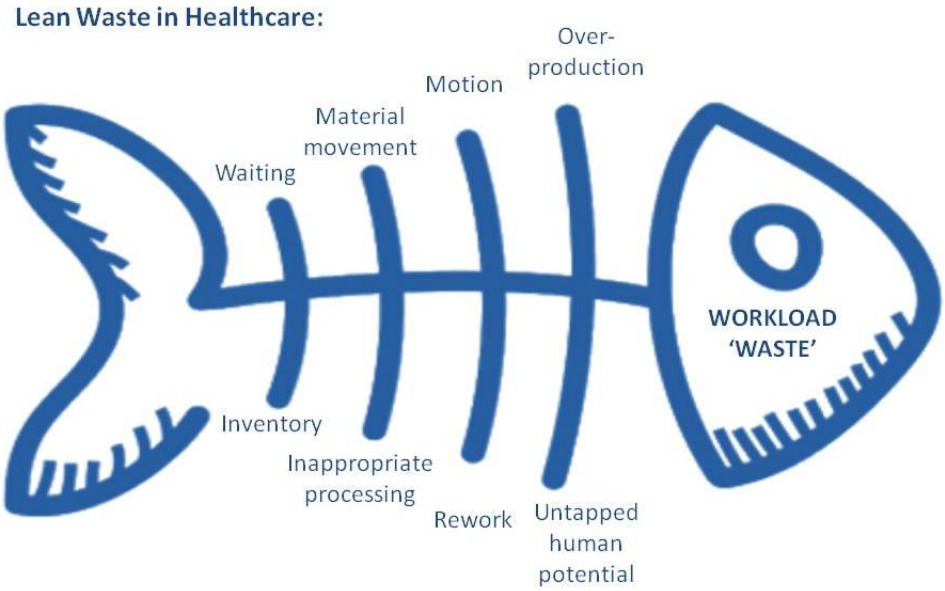
- **TO DO**: Create your own Process map.
- **Or try** RCGP Quick guide: Process and Value Stream Mapping

Looking at the map of your current workload process, can you now identify **why** you have the flow problems that create workload or steps that don't bring value to patients? These cause the workload 'waste' in your process.

There are eight categories of workload 'waste' which can be identified:

- **Overproduction** involves completing any work that isn't indicated. Examples include issuing medical certificates for first 7 days illness or housing or benefits appeal letters. Are others (patients or third sector services) asking for unnecessary or non-GMS work? What can you do to control this? Consider raising the issue with the LMC GP-subcommittee.
- **Motion** refers to any unnecessary movement of patients, staff or clinicians. Could your patient demand be managed safely in fewer appointments or remotely?
- **Material movement** refers to any unnecessary transfers of materials or information, such as the hand-off of messages from the reception to clinician. How many steps are there in your prescription processes?
- **Waiting** refers to any delays or idle time involving the patient, clinician or staff, such as patients waiting for their appointment or prescriptions, or GPs waiting for that day's acute prescription requests to be allocated.
- **Inventory** involves any information or materials waiting to be used, such as results & correspondence arriving by EDT, or allocated to clinicians.
- **Inappropriate processing** refers to handling work in a way that is excessive, such as handling correspondence in duplicate or triplicate e.g. discharge letters, or multiple single disease recalls for chronic diseases, or acute phone/econsult triage followed by F2F consultation when the problem could have been dealt with remotely. Are clinicians being sent Docman tasks that are purely administrative and could be done by someone else? This may be one of the areas where you could make the biggest gains in unnecessary workload reduction.
- **Rework** involves any unnecessary work required because of an error, such as sending the patient back for another blood test because a required test was not ordered, or worker-issuing lost prescriptions. How could you prevent or control this?

- **Untapped human potential** involves ensuring that all workers (both clinical & non-clinical) are working to the top of their abilities and professional licence. Are tasks being undertaken by GPs that could be safely & effectively carried out by other MDT practitioners, or by admin staff? What are your local arrangements for the provision of New Contract Primary Care Improvement Plan? Do you have level 1 or 2 pharmacotherapy, MSK physio or Mental Health Nurses in your practice yet? Can you do anything to influence this by speaking to your HSCP Clinical Director or Strategic Lead?




Using these 'waste' concepts can you now identify the specific reasons for the workload issues that you have identified in your baseline data or process map? Do they give you clues about opportunities for improvement?

**TO DO**: Create your own Fishbone/cause & effect diagram, add the detail of specific issues as the little bones on each of the bigger waste bones illustrated above.

If you identify new or significant workload issues during this process which you think need addressed via the larger system or organisation consider discussing this as a Cluster / with your CQL, with your local Clinical Lead or HSCP Clinical Director, or consider raising the issue with the LMC GP-subcommittee to see how they can help.

### Psychology of people involved – what are their values?

Every step within every process within your practice should add value. Of course, some steps or processes may not be directly valuable to patients but may be essential to operating your business. The point is simply to make the experience as value-added as possible for both you and your patients.

To understand what is truly important to your patients, consider several ways of collecting their views. The most obvious way to gain knowledge about what your patients want or need from your practice is simply to ask them. You can do this informally at the end of a consultation, via a phone call, or you could even use questionnaires to elicit their opinions. Patient journey mapping can also be enlightening. Follow the patient process through their eyes and experiences, right from initial contact through to exit, and record your observations, surprises and frustrations.

Once you understand what you and your patients need, and where you can best add value to them in keeping with Realistic Medicine principles, you can begin to select one aspect of care delivery (e.g. chronic disease management, prescriptions, correspondence or results handling) that you might focus on first.

Start with the basics to decide if an area is a priority or not:

- **TO DO**: BRAN analysis (Benefits, Risks, Alternatives, do Nothing)

## Deciding on your aim

Using some QI tools should have helped you identify areas where you could make improvements to reduce your workload. We suggest that you choose ONE area to work on to start with. Consider which will have the biggest impact first.

### PROJECT AIM – (examples below)

*Example 1:* By March 2022 we will have developed a safe, efficient and effective process to reduce the time spent by clinicians dealing with documentation by 30%.

*Example 2:* By March 2022 50% patients contacting the surgery with straightforward minor conditions will be signposted to self-management resources or another more appropriate service.

- **TO DO**: Specify your own practice's aim. Try and keep it 'SMART' – think about tacking one priority issue first by certain amount within a planned time frame (rather than a vague plan to fix everything!) – as this will help ensure that you are more successful.

Support from the QI team is available to generate a practice specific project aim.

# 2. What changes can we make that will result in an improvement?

A driver diagram can be used to help show which parts of the system need changing by providing some order and themes to the ideas that you want to test. It helps to understand the current system and to develop the aim and change ideas.

- **TO DO:** Consider creating your own Driver Diagram that supports the aim within your own practice context and takes into account what you have learned from your process mapping and other QI planning tools.

This is now your opportunity to re-map your processes, building in the changes that you believe will eliminate any waste problems and maximize value, **and crucially help to control your workload**.

The RCGP spotlight report on the 10 High Impact Actions is the result of their research on the effectiveness of NHS England's *Time for Care Programme*, specifically its 10 High Impact Actions: a range of initiatives that were introduced two years ago with the aim of increasing capacity in general practice and reducing GP workload.

The Kings Fund: Innovative Models of General Practice report makes some helpful generic suggestions for new models of care which might help manage some workload issues where there is appropriate support or resources.

Some basic design features may also be useful to consider in redesigning the process, including:

**Eliminate needless work**. Manage your demand.

- ihub Care Navigation

  Various examples of local care navigation projects are here.

- Digital Access toolkit

**Make your processes more productive.** Consider new innovate ways to manage daily tasks that are time-consuming and high volume.

- S&S acute prescribing process review

  Other examples of local prescribing projects are here.

**Increase clinician support**. Delegate admin tasks where possible.

- ihub Workflow Optimisation

Various examples of local workflow projects are here.

**Don't move the patient.** Work remotely when appropriate and safe to do so.

- NearMe video consulting toolkit

**Consider using technology** to play a role in reducing spent contacting patients or for signposting before access.

- Digital Access toolkit

**Make use of your multidisciplinary team**. Create broad work roles so your staff are all working at their appropriate skill level, working autonomously & efficiently to reduce the number of handoffs to other professionals that are required, and so no staff are 'over-qualified' for tasks done.

- Is an AHP/Practice Mental Health Nurse right for your practice?
- ihub Community Link Workers

**Add value to patient care** using Realistic Medicine principles.

- Planning for Chronic Disease Management re-design

  Various examples of local chronic disease projects are here.

Further ideas for workload reduction projects from other Lothian practices can be found here.

Whatever you try, it's important to follow a stepwise PSDA approach for every new change idea you try, alongside regularly looking at data to best understand whether change ideas are resulting in an improvement.

- **TO DO**: Use a PDSA plan for testing in your own context


Critical success factors to think about when testing:

- Is your new process sustainable?
- Will it keep happening?
- Will other patients in the future benefit from the improved process?

Start small, with a single patient or workload item, and test first to make sure it works, then reflect and make necessary adjustments. Apply to another patient/item or small group of patients/items. Test one new idea at a time.

Stop and reflect. Are your changes making a difference? (see measures below)

It is imperative that you stop and reflect after each test, and consider what you need to adapt or refine before you test again.

## Summary:

| What are we trying to accomplish? | What changes can we make?<br>Further ideas for workload reduction projects from Lothian practices can be found here | How will we know a change is an improvement?<br>(example process measures) |
|---|---|---|
| ↓ **Over-production**<br>*Completing any work that isn't indicated* | Eliminate needless work<br>BMA Strategy<br>Encourage self-management<br>ihub Care Navigation | No. Med3 requests<br>No. housing / benefit appeal letters<br>No. of contacts for uncomplicated UTIs, impetigo<br>No. of secondary care requests |
| ↓ **Motion**<br>*Unnecessary movement of patients, staff or clinicians* | Take work to the patient<br>NearMe video consulting toolkit<br>Consider technology<br>Digital Access toolkit | No. F2F appointments where examination, investigation or procedure not needed<br>No. of econsult enquiries resolved with first reply |
| ↓ **Material movement**<br>*Unnecessary transfers of materials or information* | Make your processes more productive<br>FV Medicines Care & Review service (serial prescribing) | No. of repeat Rx issued & signed |
| ↓ **Waiting**<br>*Delays or idle time involving the patient, clinician or staff* | Process productivity<br>S&S acute prescribing process review | No. of acute Rx processed<br>Time to Rx issue |
| ↓ **Inventory**<br>*Any information or materials waiting to be used* | Increase clinician support<br>ihub Workflow Optimisation | Time until results seen & checked<br>Time until Docman actions completed |
| ↓ **Inappropriate processing**<br>*Handling work in a way that is excessive* | Eliminate needless work<br>ihub Workflow Optimisation | No. of items spent to a clinician<br>Time spent doing Docman |
| ↓ **Re-work**<br>*Unnecessary work required because of an error* | | No. of repeat blood test appointments<br>No. of Rx duplicates issued |
| ↓ **Untapped human potential**<br>*Workers are not working to the top of their abilities or poor team skill mix* | Increase clinician support / Make use of your MDT<br>ihub Care Navigation<br>ihub Community Link Workers<br>Is an AHP/Practice Mental Health Nurse right for your practice? | No. of MSK presentations direct to physio<br>No. of mental distress contacts direct to Mental Health Nurse or CLW |
| ↑ **Value-added actions for patients**<br>*Actions are evidence-based or person-centred* | Realistic Medicine<br>Planning for Chronic Disease Management re-design<br>Evidence-based locally agreed care pathways<br>RefHelp | No. of vitamin D requests<br>No. of B12 injections<br>No. on annual thyroid recall<br>No. birthday multi-morbidity recalls |

# 3. How will we know a change is an improvement?

**TO DO**: Write a Measurement plan for your project to show improvement over time. This will help you stay focussed and ensure that the changes you make are making a difference, and not causing any unintended effects elsewhere in your system.

The measurement plan will be dependent on your aim. Please contact the QI team if you would like support writing your measurement plan.

## Example measures:

### Outcome

This is the reduction in workload 'waste' that you expect to see as a result of your changes. This should match your Aim.

*Example 1:* % time spent by clinicians dealing with documentation

*Example 2:* % patients contacting the surgery with straightforward minor conditions who are signposted to self-management resources or another more appropriate service

### Process

These are measures of your new changes.

Usually are counts of something done.

*Example 1:* Number of clinic letters filed directly by admin staff

*Example 2:* Number of patients with UTI symptoms signposted to Community Pharmacy

### Balancing

It will be really important to pay attention to what or who else might be affected by your new changes, to ensure you are not just off-loading work elsewhere.

*Example 1:* Time spent by admin staff doing Docman, cost of extra staff, time spent to train them, number of patient queries needing further action after filing

*Example 2:* Number (or %) of patients sign-posted to Community Pharmacy who call back because do not meet criteria for Pharmacy First, optician or dentist etc

### Patient & staff experience

Collect verbal or written feedback from patients.

Talk to your team regularly about their wellbeing and how they are coping. Note themes and emerging issues.

You could also consider using a validated **stress score**.

The QI team can also produce data charting tools, if required. These have not been included in the current toolkit as these are varied depending on your practice's chosen aim and measures. Please contact us with any data requests or measurement support that you need.

# And finally…

A piece of improvement work like this, which involves your whole team and needs some dedicated time to work through the various steps, would be ideally suited for the Lothian Quality Improvement Enhanced Service (QI SESP). You will receive QI support & coaching for your project via a structured 'workbook' over the course of a whole year, in return for a payment intended to fund protected time within your practice to do the work. Our next QI SESP year begins in April 2021. Watch out for our regular newsletters with updates.

We'd love to hear how you get on, and also how useful you found this toolkit – comments & feedback are welcome. Thank you.



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