Grove House Surgery, Shepton Mallet

Document Workflow

We are a practice with a population of 6500 patients, now with four GPs, but for two or three years we had only three. We are a training practice and have a registrar, often two working with us. We also have medical students at times.

We had made a start on this some time ago when the GPs gave the admin team a list of documents they did not need to see. This only resulted in a very small reduction in the number of documents sent.

About two years ago we decided to extend the scanning duties and went about dealing with it as a project. We followed some processes put in place by another practice (Wincanton). Our aim was to reduce the number of documents sent to the GPs by 25% within a year.

We decided to restrict the scanning duties to three or four specially trained individuals rather than continue with all the admin staff scanning. The reason for this was we wanted some uniformity in the process and also the potential to train a smaller number of people with allocated time to be able to extend their duties. Conversely we did not want to employ one person to scan exclusively, as this would cause us difficulty with cover. We chose to keep 4 people well trained which keeps up their skill and provides flexibility for cover.

We recruited four existing administrative staff. We selected a GP partner to lead the project from the clinical perspective. They have all been on the workflow training.

We also used an external trainer from Insight Solutions to carry out some additional training.

We rearranged our admin/reception rota to ensure there was allotted time for the scanners to scan. Having calculated the number of hours we would require each week, we engaged another person to backfill some of those hours.

We purchased a second scanner machine.

We set up regular meetings with the lead GP so that the scanners could further their knowledge and also advise the GP of any issues they had experienced.

We set up audits with the GPs to check how many documents they were being sent and how many they need not have seen, or could have been dealt with elsewhere or by someone else in the practice. We also asked them to record how long they spent on documents – reading and actioning. It was, for the first week, 18.25 hours in total.

We set up a process for the secretary to be able to do some referrals herself without GP intervention, such as ophthalmology, audiology and podiatry.

We have a protocol for the scanners which we continually update as they learn. We also have a list of commonly used codes.

We have reached a point now where the scanners can carry out many of the actions required in a document, before it is sent to the GP. This saves time as the GP does not then have to send a task for the action to be carried out, and it reduces delays for the patient.

We did an audit recently, and we found that we have now reached a point where only 13.6% of documents received are being sent to the GPs – the others have all been scanned, coded, and tasks completed by the scanners. Now, for the week, based on time the GPs say on average they spend reading and actioning, they are down to 2.5 hours for the week.

Pitfalls

We definitely underestimated the amount of admin time it would take.

Consequently a backlog built up – this continues to occur at times when there are absences in the scanning team. However we do have a process to prioritise, and act on anything urgent, and everything is on the patient’s record without delay. Less urgent documents are coded etc later.

It was very difficult to arrange meetings with lead GP due to part time hours for all staff, but we have now fixed monthly meetings in advance for remainder of year.

Some judgement continues to be needed re documents not sent – ie GPs still want to know of DNA letters relating to mental health, psychiatry, and oncology. Also if patient the document relates to is vulnerable or a child.

Doctors were not good at completing audits so the figures and times we worked on were not terribly accurate.

We did have to employ more admin hours but this has proven to be much more efficient than GPs spending so much time on documents.

We experienced a number of EMIS bugs – some of which are still unresolved.

Stage 1

May 2016

Consulted staff (admin and clinicians)

Counted incoming documents, and time taken to process/act by both admin and clinical staff

We developed a list of document types and associated actions.

Created a list of documents the clinicians advised they did not need to see or act upon

Produced a flow chart/list for admin staff to work to when scanning

Examined the documents still being sent to clinicians for actions required.

Sept 2016

Selected admin staff to scan. Admin staff allocated more time to read documents, and to start to arrange tests, referrals and follow ups as required. Also read coding.

Already realising significant reduction in number of documents sent to clinicians, and reduced double handling. Increase in admin time spent scanning and following up actions

Realised time needed for admin staff was greater than we had estimated, but significant saving in clinicians time.

June 2017

Arranged external training and created a list of commonly used codes and a protocol. Set up mailbox specifically for training and queries.

Sept 2017

We focused on improving knowledge and efficiency through training, working towards increasing the actions admin staff could complete including coding.

Plans in place to ensure all documents scanned within 48 hours of receipt. Actions taken on all urgent documents. Meetings with lead GP set up.

Rachel Witcombe

Practice Manager

September 2018

Document Flow Quality improvement Project – GP comment

Objective: to significantly reduce the time GPs where spending at the end of long clinical days sifting through and auctioning letters.

This process had started a couple of years before, removing cohorts of letter that the GPs felt it was unnecessary for them to see at all, such as physio outcomes and MIU attendances.

GPs were still overwhelmed by the increasing number of documents coming their way.

We started to think about ways that we could get a lot of the admin nature of the letters done by the admin team and we were lucky enough to get an offer to attend a training day run by a GP who had initiated a document work flow system within her own practice at this time.

This helped us clarify the system we would want to use and how the coding etc might be achievable.

The plan was for all documents to go to the scanners who would code any significant diagnoses and organise admin tasks such as follow up appt/ blood tests, do ongoing referral eg from opticians to ophthalmology etc before sending just the relevant letters on for the GPs to view - the ones which the GPs had indicated that they wanted to see.

We organised a feedback system from the GPs, so that if the GP felt that a letter could have been dealt with in a different way these letters were actioned again then kept to one side to discuss in regular meetings so everyone could learn from them.

Glitches along the way:

Staffing : needed more admin staff than initially thought to complete the scanning. Recruiting and training of new scanning staff.

Because of the learning involved it was felt a dedicated team of a few was better than all the admin team doing infrequently, however this created some difficulties in ensuring enough scanners when staff on holidays etc

Computer problems - an issue with Emis that meant processing e-mailed letters were very difficult and caused a huge back log.

Difficulty finding time to get all the relevant staff together for feedback meetings, which didn’t happen as frequently as they should have in the first few months.

Coding : Understanding the abbreviations such as STEMI, TURP and why they were so important , but other diagnostic procedures not always necessary to code especially if normal. The difference between coding adenocarcinoma / as opposed to rectal cancer etc

Current position:

GPs currently see significantly less letters than previously.

 Many of the actions required are actioned before the GP sees the letters

Letters can be sent back to scanning team to re-action

Aspirations moving forward:

Currently the biggest task remaining from the clinical letters for the GPs is reconciliation of medication changes.

My inspiration is to see this transferred to the admin team so that GP can check and authorise the changes rather than having to do them. (Not sure the scanning team are ready to embrace this just yet)

Dr Philippa Girling

GP partner and clinical lead for this project

Sept 2018.