EQUIP Total Triage Manual Version 2

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Key updates in this version -

- Frequently Asked Questions added after each section
- Dedicated section for Frequently Asked Questions added

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ABSTRACT

This Total Triage manual has been designed to help general practice staff implement the triage process and make ongoing improvements. The manual is aimed to cover the essential building blocks of triage: the purpose of triage, the theory that underpins it, the systems needed to get started and processes involved to make it work. Tips and tricks and key metrics have been included to get triage working really well for the practice as well as patients.

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1. INTRODUCTION

1.1. Introduction to EQUIP

EQUIP (Enabling Quality Improvement in Practice) is a programme created to enable sustainable positive change in the way services are delivered and experienced by both patients and staff in general practice.

EQUIP's approach is to embed a Quality Improvement methodology and culture within general practice, empowering all staff to be skilled stewards of context-specific changes which improve services for patients. EQUIP also works to facilitate general practice teams to develop consistent systems that free up time and resources to devote to improving care for patients.

VISION	A world in which empowered citizens experience great primary care
MISSION	To empower all teams involved in primary care to make improvements on an ongoing basis
GLOBAL AIM	Empower all practice staff to make operational improvements on an ongoing basis which have a tangible impact on the satisfaction of staff and patients
VALUES	• Practice ownership • Data driven • Capability building of the whole team • All voices are equal • Continuous curiosity • Develop the team to deliver the task

EQUIP – The programme vision and aim

EQUIP's Approach

There are many Quality Improvement approaches used in healthcare. In the National Health Service (NHS) in England the most widely adopted Quality Improvement approach is based on the Institute for Healthcare Improvement (IHI).

The Quality Improvement methodology provides a systematic way to define and measure impacts of improvement projects. It allows for the creation of compelling business cases for successful projects and a clearly articulated process for repeating similar projects across multiple locations. It consistently identifies and reduces duplication, inefficient use of assets, bottlenecks in administrative and/or clinical processes.

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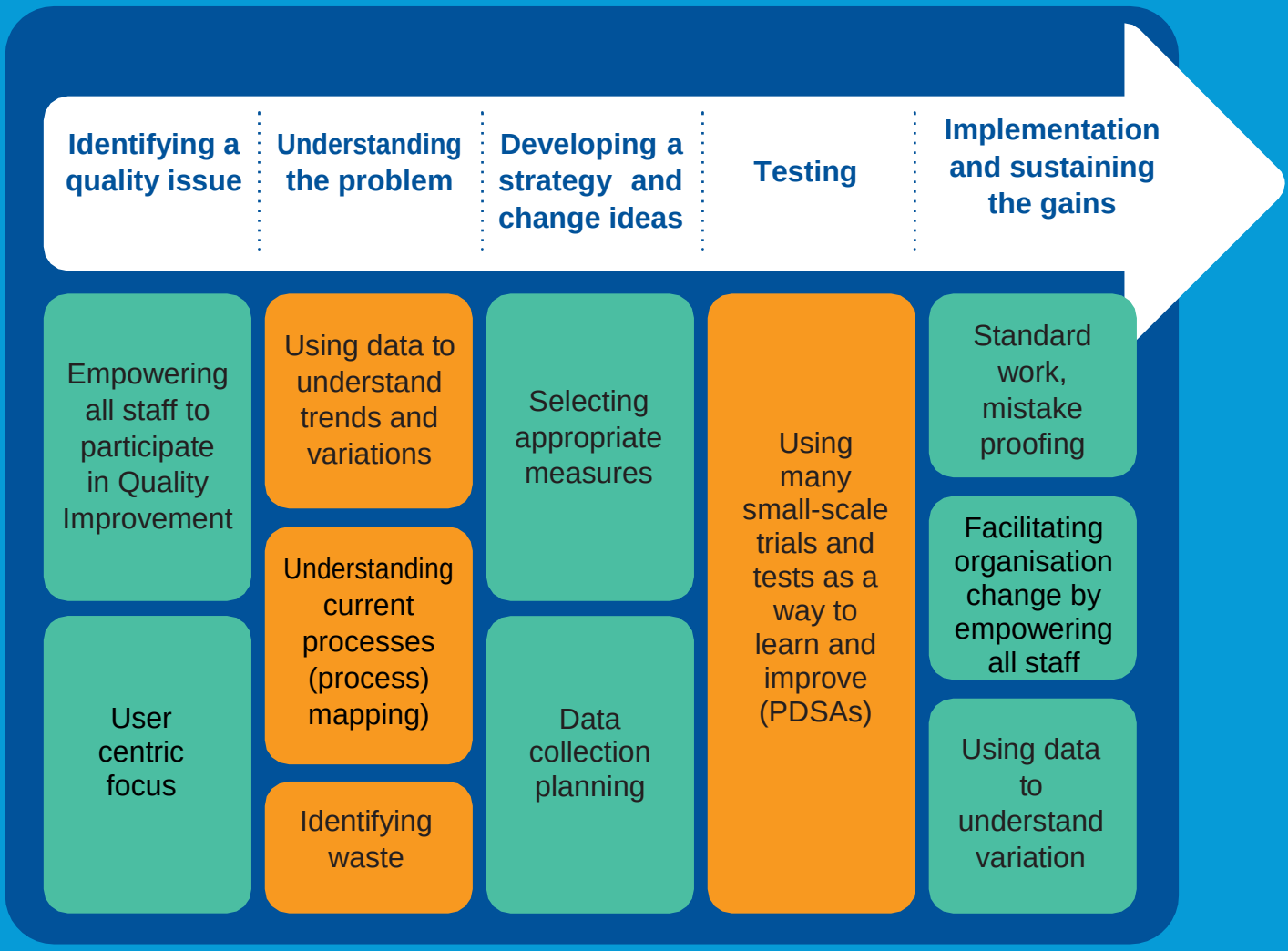

EQUIP is currently working with 35 general practice surgeries in WEL CCGs (Newham, Tower Hamlets and Waltham Forest) covering a population of 286,000 and has recruited and trained 32 improvement coaches who support practice teams on their improvement projects.

EQUIP's model includes:

- Quality Improvement training
- Quality Improvement coaching
- Supporting improved team culture and development
- Data analytics

Coaching

- To support in-practice improvement work
- Principal relationship between practice teams and EQUIP programme
- 1 hour per week with practice QI microteam
- Coaching support can be used flexibly

Team Culture and Development

Organisational Consultants
- Work with team and practices
- 3 hour sessions (max 12 sessions)

Strengths Deployment Inventory (SDI)
- Look at motivations, strengths and behaviour when things are going well and when in conflict
- Full teams (up to 30)
- Format: online questionnaire followed by 3 hour session

1:1 Practice Staff Mentoring and Targeted Practice Support
- Ad-hoc with trained organisational consultants

Data and Project Management

Edenbridge
- Data visualisation and business analysis
- Extracts data daily from EMIS to store on secure cloud server for secondary analysis of clinical and activity data
- Accessed via web interface
- Installed and configured in individual practice

In Practice Data Wall Sessions

SnapComms

LifeQI
- Online QI project management platform
- Share ideas and learning
- Invite to join individual projects

Training

EQUIP Basics
- Introduction to the fundamentals of QI
- All welcome
- Half day

EQUIP in Action
- Deeper dive into QI
- Based on running live projects
- Teams or individuals
- Ideally 2-3 per practice
- 3 days over 4 months with calls between workshops

Data Masterclass

Improvement Coaching
- ELFT/IHI QI accredited coach training programme
- 7 days over 5 months

Capacity and Demand
- Open to practice staff (ideally PM / Nurse / Clinician / Network)
- Half day

Systems Learning

Re-learning at Scale
- Stakeholder engagement for standardisation of processes

Overview of the EQUIP Programme

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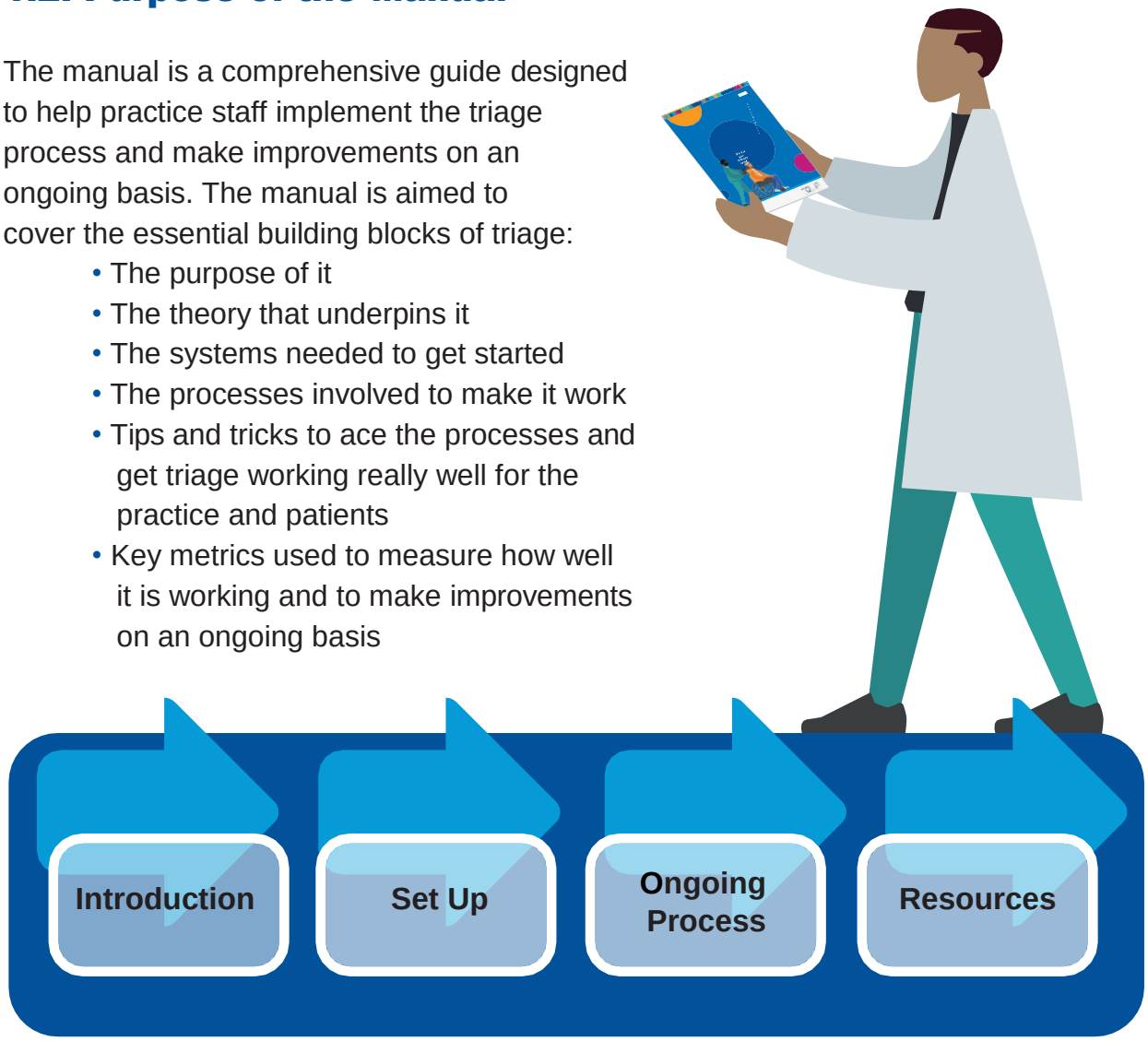
1.2. Purpose of the Manual

The manual is a comprehensive guide designed to help practice staff implement the triage process and make improvements on an ongoing basis. The manual is aimed to cover the essential building blocks of triage:

- The purpose of it
- The theory that underpins it
- The systems needed to get started
- The processes involved to make it work
- Tips and tricks to ace the processes and get triage working really well for the practice and patients
- Key metrics used to measure how well it is working and to make improvements on an ongoing basis



Overview of the manual

This manual was informed sourcing clinical as well as administrative perspectives. In most sections, practical examples are used to describe best practice, however, practices will have to adapt processes to best fit their local context depending on multiple factors like skill mix, capacity, previous experience etc.

To achieve best results, it is recommended that this Triage Manual is referred to alongside Quality Improvement coaching support from EQUIP's coaches.

EQUIP will not be held responsible for the actions or the impact of the actions taken by practices based on their interpretation of this document. This is a manual on based on best practice and on what has worked for some practices, and should be used on discretion of each individual GP surgery.

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1.3. Introduction to Triage

What is Total Triage?

- Total triage means that every patient contacting the practice for an appointment, first provides some information on the reason(s) for the contact.
- The purpose of total triage is to get patient need met by the most appropriate person or service with the minimum amount of handoff.
- The total triage model aims to help practices better meet patient demand within their existing capacity by using the skill-mix of the wider team, utilising online services, telephone and video consultations as well as face-to-face consultations when needed.
- It explicitly acknowledges that a large proportion of the need that presents to general practice does not need a general practitioner to deal with it, and in fact is likely to be better managed by another person, service or by the patient themselves if they have access to the right information.
- The three critical steps in a triage model of general practice are: asking patients what they need, signposting by administrative teams and clinical triage.
- There are two main routes into triage systems:
    - online consultations/eConsult
    - telephone
- It offers a way of managing patient demand and improving efficiency.
- It mainly focuses on reactive care to expressed patient need, rather than proactive care such as immunisation or antenatal care.

Benefits of Triage

Any change to a major organisational process will cause some uncertainty for teams trying to change to a new process and also for the people trying to use the new process. This is normal and to be expected, even if the previous system was the cause of dissatisfaction for both patients and staff. Most practices that move to a total triage system will see a rise in patient complaints at first as the new system ‘beds in’, but satisfaction with access usually increases quickly and complaints reduce significantly. Our observation through the COVID-19 crisis is that there has been little resistance from patients in the move to triage as the case for change was so clear cut. It is still important to emphasise on the benefits for patients and staff in order to build the continued case for sustaining the change. This will also help in gaining a clearer understanding of those people who have the potential to be disadvantaged by a total triage system.

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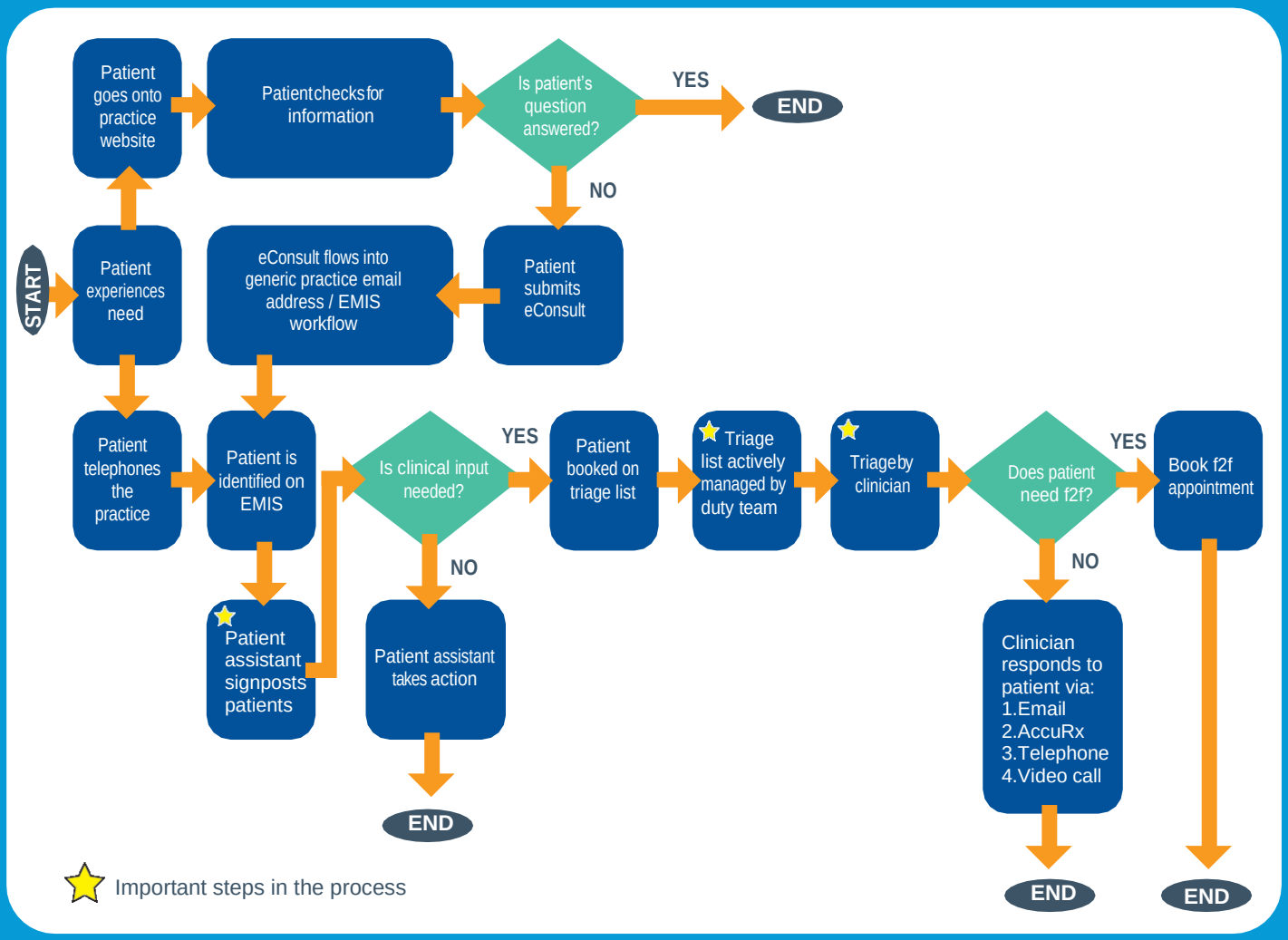
Benefits to Patients

- Higher user satisfaction – patients access a clinician in real time, and more appropriately
- Elimination of travelling, saving travel costs and reducing the carbon footprint
- Elimination of waiting room time
- Reduced need for face to face consultations
- Less of an 'appointment lottery'
- By asking the patients about their reason for contacting the practice, patients are more likely to get their need met by the right person, service or information
- Triage offers the opportunity for continuity with a specific clinician if it is needed

Benefits to Practice

- Improved ability to offer contacts (increased throughput)
- Reduction in clinical variation (quantitative and qualitative)
- Increased throughput (better access, at comparatively lower cost)
- Improved use of skill mix (including highly trained admin staff)
- Reduction in DNAs to 2% or less
- Reduced acute spend
- Flexible use of capacity, moving away from the '10-minute model' of care
- 'Getting today's work done today', and the work of the consultation done in real-time
- Increased possibility of giving continuity to patients that need it
- Decreased sense of professional isolation by working in shared rooms
- Remote working for team members enabled
- Allows team members to develop their skills and give real career progression as they work at the 'top of their licence'.
- Upskill staff especially when admin feel less confident about different tasks
- Gives opportunities for real team working around the needs of patients
- Helps solidify relationships within the team
- Utilises resources effectively
- Helps embed a positive culture

1.4. Overview of the Triage Process



Patient Process Flow

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1.5. Background Theory, Myths and Truths

To understand triage, it's important to be clear on the basic theory behind capacity, demand and flow.

Primary care is not unique in being a customer-facing service with limited resources in terms of people, space and kit/product, that needs to try to match capacity with demand to prevent a growing queue. It has differed in the past where patients were registered with a practice and didn't have much choice in terms of where they could register. This was, more or less, determined by which practice catchment area patients lived in. This meant that Primary Care capacity was largely static on the 'supply' side i.e. the GP practice set fixed capacity (plus some on-the-day flexibility in terms of 'urgent' or 'on-call/duty' capacity) and experienced fluctuations in patient demand which were expressed in:

- The length of time before a 'routine' appointment was available
- The pressure on the on-call/duty GP

Will we be overwhelmed with demand?

One of the most common anxieties around triage models is that it would open the practice to high levels of demand that practices would not be able to manage or sustain. An understanding of the basics of capacity and demand is essential for planning and helps overcome this anxiety. This section also addresses some of the myths and the truths that exist.

What is capacity? What is demand?

Let's start with the terminology:

Demand in general practice = the number of people expressing a need to primary care with a question or concern about their health or care

Demand = what we should be doing

Capacity = what we could be doing

Activity = what we are actually doing

Backlog/Queue = what we should have done

Utilisation = $\frac{\textbf{Actual activity} \text{ (what you really do)}}{\textbf{Capacity} \text{ (what you can potentially do - theoretical maximum activity)}}$

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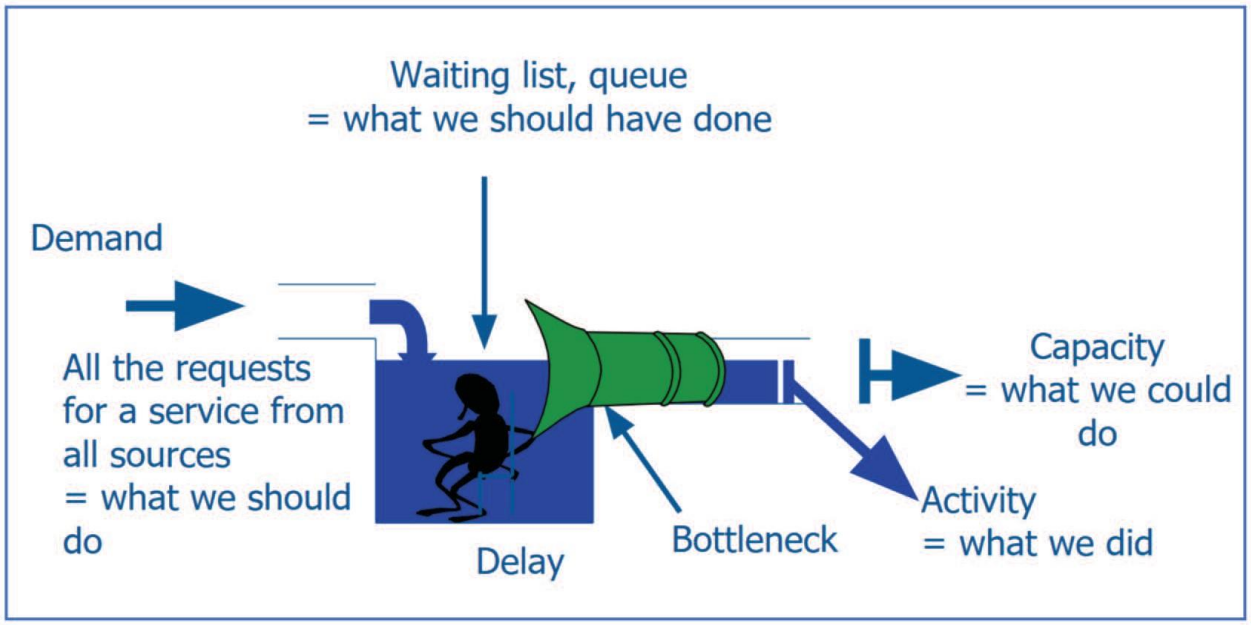
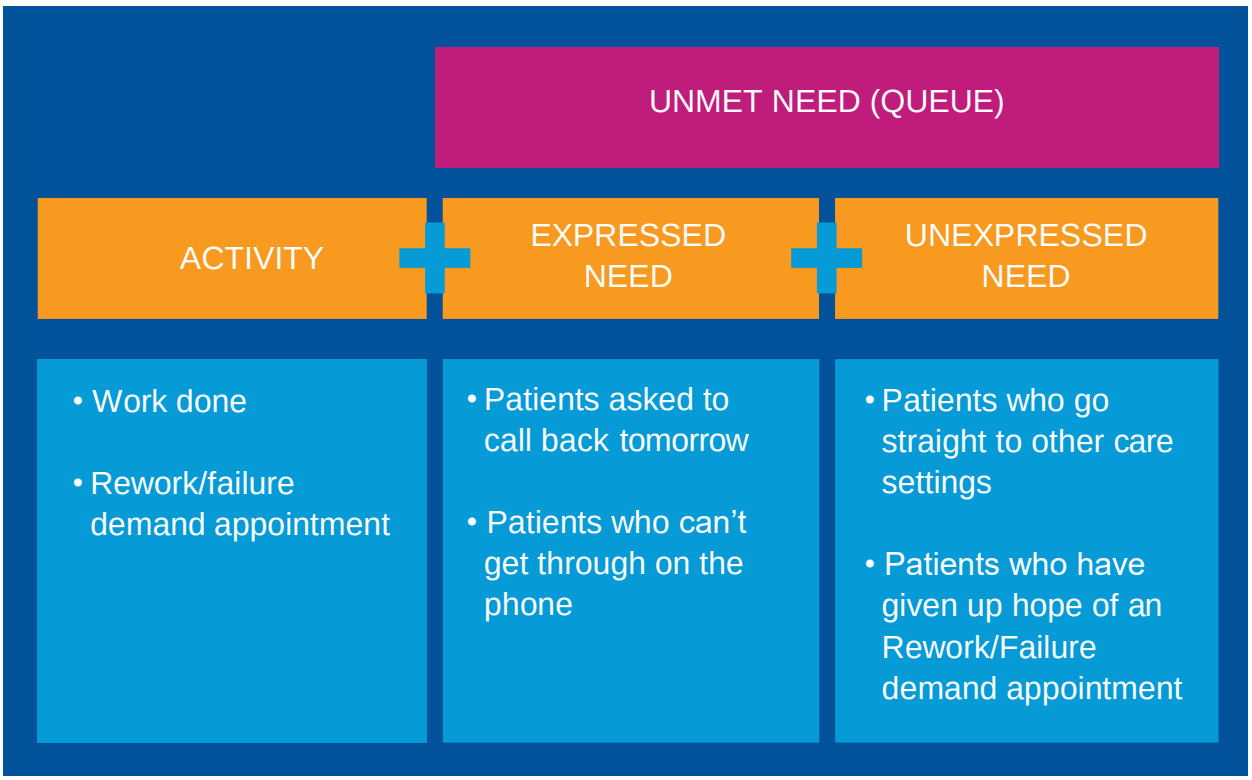


Understanding capacity and demand

We strive for 100% utilisation, though this is rarely possible in the real world, but if capacity and demand are not constant, and matched, then queues will form.

In primary care (as in other systems) it is true that – whilst some (but not all) demand carries over from day-to-day, capacity cannot be carried over. Once capacity is gone on the day, it's gone, whether it was used or not.



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Myths and Truths

Many GPs and practice managers bear deep scars from attempts to 'fix' problems with access, planning rotas and trying to match their clinical capacity to the demand from patients. There are some well-established mantras which may be holding back the practice rather than helping.

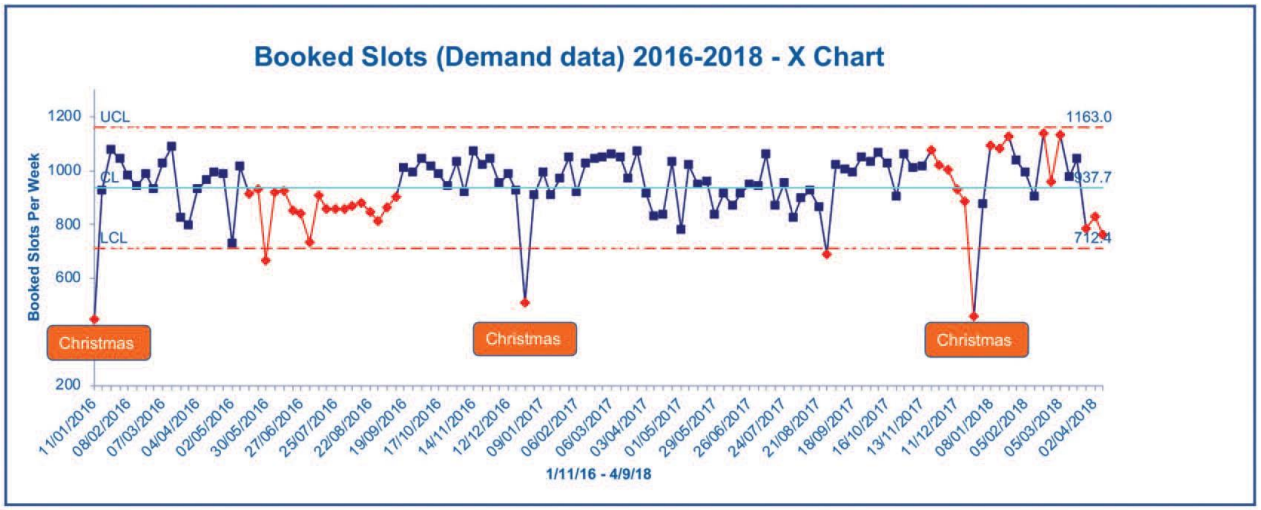
MYTHS	TRUTHS
"Demand is infinite"	Demand is large, but finite
"Demand is unpredictable"	Demand is predictable and varies far less than capacity
"We have two types of demand: urgent/'on-the-day' and routine"	It is all just work that needs doing

Myth 1 - "Demand is infinite"

TRUTH - DEMAND IS LARGE, BUT FINITE

If demand for Primary Care were infinite, then the wait (queue) for an appointment would increase every day. In reality, most practices operate in a stable system with a pretty constant waiting time to get an available appointment. If practices have a queue, this suggests that demand exceeds the practices' current capacity, but most practices are relatively close to meeting the average demand. The critical thing is around when and how capacity is used.

The example below is demand data for GP appointment from a practice with around 12,500 registered patients. The average number of GP contacts is equal to 85 per 1000 patients per week, though seasonal variation is noticed where demand rises and falls.



Example: Seasonal variation shows patterns which help us to predict demand and plan capacity

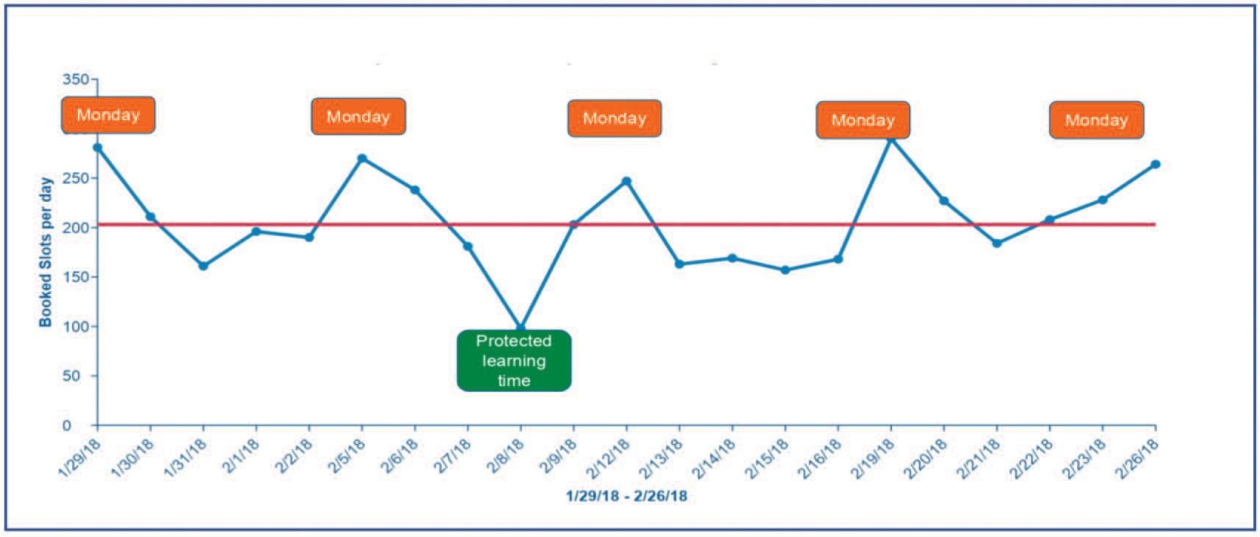
Myth 2 - "Demand is unpredictable"

TRUTH - DEMAND IS PREDICTABLE AND VARIES FAR LESS THAN CAPACITY

Demand in general practice is predictable by:

- Time of day
- Day of the week
- Month of the year
- Special events

Taking into account changes in registered list size, practices can get a very good sense of a particular day's demand by comparing it with the same day in previous years. Most practices see a predictable pattern in the number of patient contacts through the week as outlined below.



Most of the things that cause demand to vary in general practice are fairly predictable:

- Seasonal (hay-fever, flu-season, bank holidays, half-term)
- Event-based (closures to attend training)
- Demographic profile (variation across geographical area)
- Media campaigns (cough, bowel screening)

Occasionally, there are events that make demand far less predictable, for example Coronavirus/COVID-19, but such events are the exception rather than the rule.

In practice, variations in capacity, and how we use it, have a much bigger impact on activity and the wait for an appointment than normal variations in demand.

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Capacity varies due to:

- Annual leave
- Sickness
- Training/supervision
- Meetings
- Blocking off appointments for specific activities
- The mode (or type) of appointment offered e.g. telephone versus face- to-face, or on the day vs pre-booked

Even if:
Average demand = Average capacity
Variation in demand + Variation in capacity = QUEUE!
The trick of an effective triage system is trying to match capacity with expected demand.

Myth 3 - "We have two types of demand: urgent and routine"

TRUTH - IT IS ALL JUST WORK THAT NEEDS DOING

There is demand in primary care that is clinically urgent and needs to be dealt with as such, but to use urgent and routine as a way of deciding about 'on-the-day' or 'routine' appointments, is a false distinction. It's just work that needs to be dealt with. The choice practices have is in who does the work, where and how it is done.

One of the areas where it is useful to make a distinction is between reactive activity (i.e. most GP activity) and planned activity (e.g. antenatal, minor surgery, long-term conditions), as these systems behave differently and are driven by different needs.

Practical things that can be done to balance supply and demand

Working with capacity and demand is its own entire area of work! The main thing to highlight is that to work with total triage effectively we have to look critically at how we use our existing capacity. There are some relatively straightforward, high impact changes that can be made on the capacity side that free up time and resource to manage patients differently. If you would like explicit support on capacity and demand analysis, please contact the EQUIP team.

Capacity side

HIGHER IMPACT

- Change session times/days
- Mode of contact (phone/video/ face-to-face/eConsult)
- Avoid blocking capacity for specific bits of activity (i.e. doing planned care during periods of high predicted demand)
- Look for bottlenecks/constraints
- Remove pre-booked appointment systems
- Utilise skill-mix
- Look critically at avoidable contacts (which varies between 25%-45% depending on sources)

LESSER IMPACT

- Avoid over processing patient work
- Watch for 'spillage' between planned and reactive care
- Clinical Personal Assistants to take on clinical administration

Demand side

- System-generated demand
- Group consults
- Self-service e.g. eConsult, NHS App
- Social prescribing
- Co-production
- Look at episodic continuity (how many different professionals are involved with treating the patient during a specific episode of care)
- Segmentation according to (customer) need
- Frequent attendance analysis

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1.6. Frequently Asked Questions

Does total triage involve EMIS?

Triage has some essential building blocks, one of which is EMIS set-up. Getting EMIS set up properly helps with processing work safely and effectively, and also with capturing data that enables teams to understand how well their system is working.

How much variation is there in total triage models, and what are some examples of best practice?

The manual aims to cover the essential building blocks of triage. It was developed by sourcing clinical as well as administrative perspectives to give a picture of best practice. Practices will have to adapt processes to best fit their local context, depending on multiple factors like skill mix and team capacity.

What is the most challenging part about triage?

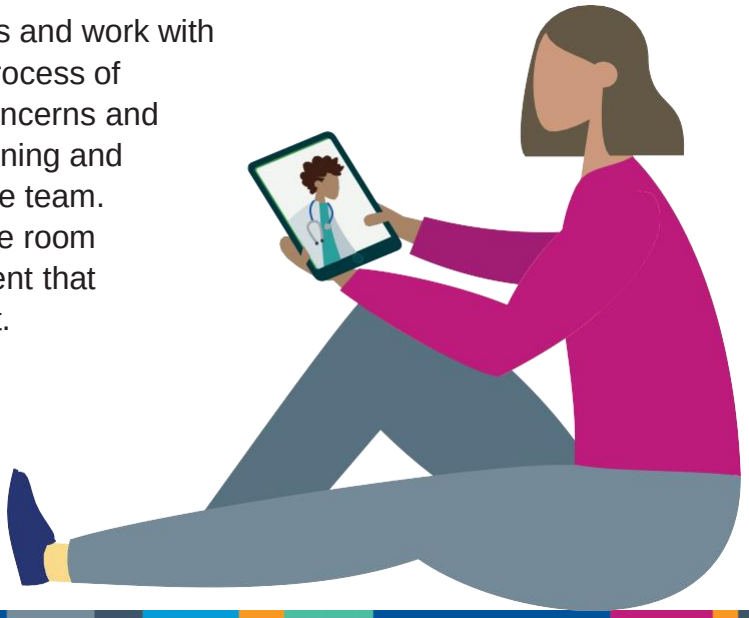
Most practices have moved to total triage at a time when demand is low compared to normal. So, the system has to be set up to be able to manage when demand increases.

People often have a fear that demand is infinite and therefore is unsustainable to manage, which is where using data to inform planning can really help. Any significant changes in ways of working can be challenging. Open discussion about concerns, challenges, success and benefits of the new systems will enable teams to refine and improve their system in a way that appreciates and develops the skills of the wider team.

How do we manage anxieties about remote (non face-to-face) consultations from clinical teams?

Some anxiety when moving to a new way of working is understandable, though increasingly the ability to undertake remote consultations is increasingly an essential skill for primary care clinicians.

It is helpful to identify specific concerns and work with these. The practice is undertaking a process of change, so an open dialogue about concerns and how to mitigate them is part of the learning and adapting that needs to take place in the team. When team members work in the same room as each other, it creates an environment that encourages learning and development.



How do we manage risk?

Triage is a means of managing risk in the system and the duty roles are critical to this. Work on the triage list needs to be managed through the day in order to prioritise according to clinical need, available skill mix and the capacity on the day.

No system of access is risk-free and it can be argued that a total triage system is more likely to identify and manage patient need than a traditional pre-bookable system, where patient need is not identified early on and the system operates usually with fixed capacity and tries to squeeze in 'on the day' demand.

A mindset shift for teams moving to total triage is that, the role of triage is simply to get patient need met with the minimum handoff - this might be a face-to-face appointment or an AccuRx message. This is different to the 'on-call' doctor in a pre-bookable system where the role is more about firefighting and trying to limit overbooking in a system that is already working at capacity.

What is the ability of a new system to absorb surge in demand?

Demand is largely predictable (within 5% tolerance) and the art of running a total triage system is planning capacity according to predicted demand. Refer to capacity and demand section for more information. If a team requires more support with capacity and demand modelling, then please contact the EQUIP team.

Where are the main potential bottlenecks in a total triage system?

1. Telephone answering - this can be mitigated by:

1. Rota planning for predicted busy periods - look at the telephone call volume in 30 minute chunks and plan accordingly. Hint - the busiest times of the day on the phones are from 08:30-09:00 and 13:30-14:00
2. Using standard scripts for answering the telephone
3. Directing people to use eConsults and online bookable triage slots

2. Clinical triage - this can be mitigated by:

1. Rota planning for predicted busy days
2. Optimising the workflow of the day by using the duty team
3. Planning session times around times of peak demand
4. Avoiding undertaking planned care on days and times where demand is high

Is demand more in the morning than afternoon?

In an ideal world demand would be the same through the day, but practices usually tend to experience more demand in the morning than in the afternoon. This is partly driven by historical need for patients to call early in order to access limited GP appointments on offer on a specific day.

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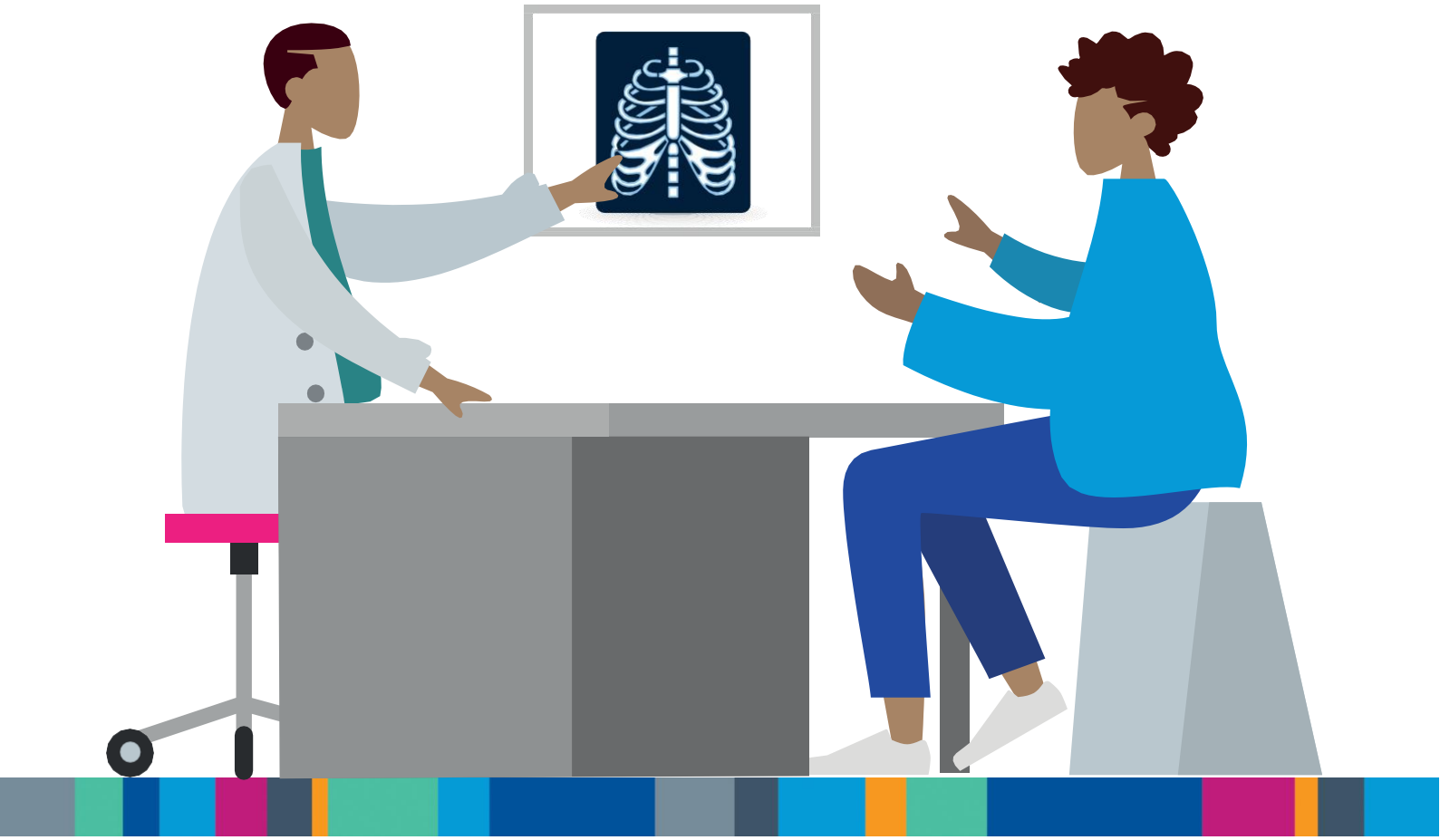
What is same day and next day work?

This is a myth. The concept of ‘same day’ or routine work is a false distinction based on supply side factors i.e. availability of appointments. In reality, actual clinically urgent demand is only a small proportion of daily activity and everything else is just work that needs to be dealt with. The choice practices have is in who does the work, where and how it is done.

One of the areas where it is useful to make a distinction between types of work is between reactive activity (i.e. most GP activity) and planned activity (e.g. antenatal, minor surgery, long-term conditions), as these systems behave differently and are driven by different needs.

Do we know what the best examples of triage are?

The manual is based on available ‘best practice’ from a lot of sources. There isn’t a huge amount in the peer-reviewed literature on the setup of triage systems, but we have sourced from grey literature. We should consider ourselves a large learning system – the manual is a way, but not the only way to do things and we are keen to learn from cases. We are capturing similar data on processes and outcomes so that we can compare and learn.



2. SETUP

2.1. IT Requirements

2.1.1. Introduction

To enable triaging a strong IT system is recommended. The IT system can either make the journey through triage simple and smooth or complicated and time-consuming.

2.1.2. Minimum Requirements

Type	Item Required	Comments
Hardware	Computer	Ideally should meet the minimum spec requirements, which are: • 8GB RAM • Windows 10 minimum • Minimum 10 GB hard drive • MS Office/Office 365 • For laptops, built-in: - voice capability (microphone) - speakers - camera - smartcard reader - headset compatibility
	Web camera	Not essential as AccuRx video consultations can be done through any smartphone EQUIP recommended webcam: Logitech C270 HD Webcam
	Headset	EQUIP recommended headset: Communicator Liberty Binaural headset
	Double screen	This facilitates processing of eConsults
	Stable internet connection	
Patient Messaging Services: (one of these)	AccuRx	Single SMS messaging direct from EMIS, Video consultations and document sending
	iPlato	Batch messaging campaign using EMIS/ NHS numbers

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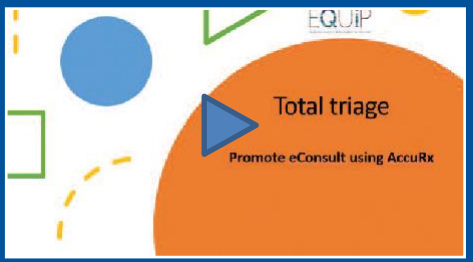
Type	Item Required	Comments
Remote working: (one of these)	Away From My Desk	Remote access from home to a specific computer in the practice
	Hard VPN	Using a laptop / PC from home with a secure connection via a physical token access. This enables access to EMIS with smart card functionalities
	Soft VPN	Using a laptop / PC from home with a secure connection via a software token access. This enables access to EMIS with smart card functionalities
Online patient services:	eConsult:	Patients can submit consultations from the safety of their homes either on laptop/desktop, smartphone or via NHS App
	NHS App	Patients can access their health "system" including repeat prescriptions, medical records, allergies, immunisations and external documents from say hospitals
Video meetings	Microsoft Teams	MDT meetings, practice team meetings when people working from home – preferred for NHS
Total patient triage systems:	Telephone triage	- Triage/consult patients primarily over the telephone - Video consult
	eConsult	Consult patients primarily via messaging and email

Video: Promote eConsult using AccuRx



2.2. Setting up Triage System in the Appointment Book on EMIS

2.2.1. Introduction

The appointment book is the place where the work of triage is captured. When used well it is a workspace where the team can manage the work of the day. If set up badly, it can be confusing to operate by team members and patient contacts can get missed.

Getting things set up properly will make the day-to-day work of triage more straightforward and will enable you to get good quality data on your practice's demand and resource utilisation, which can be viewed on Edenbridge Apex.

2.2.2. Checklist of activities

- [ ] Set up session holder
- [ ] Set up triage session on EMIS
- [ ] Set up slot types
- [ ] Edenbridge configuration

2.2.3. Roles and responsibilities

Practice administrator:

- Initial appointment book setup
- Set up category user for the purposes of having a session holder for triage
- Set up triage slots

Whole team:

Book appointment to slot types and change slot types using slot properties when booking an appointment or assigning work as part of a duty role

2.2.4. Tools, techniques and resources

A. Setting up a triage session on EMIS

Step by step:

Principles of session setup – remember this is a place to put the work to be done, times and session holders are only indicative.

1. Set up 'Dummy Dr' category user – high level: General Medical Practitioner. This will be visible to patient facing services (i.e. Apps), so should be called something that clearly identifies what the person is booking into e.g. *THIS IS A TELEPHONE CALLBACK REQUEST.* Please do not come to the surgery. We aim to call you back within 6 hours of the time of the booking.

Video 1: Setting up session holder on EMIS Web

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2. Create Session

- Session name – this is what is seen by patients using NHS App / Patient Access to book appointment
- Select timed list – this allows online booking (Patient Facing Services)
- Slot duration – suggest one minute: this is indicative only
- Set from-to time – indicative only
- Location – this is equivalent to Service setting on NHS National Standards
- Click on: Save as template
- Click on: Create

Video 2: Setting up triage session tutorial

TIPS

- Create one long list (much longer than your predicted demand) of a single slot type for triage per session. The whole team works off the same triage list, changing slot types as necessary, as patients get booked into them. This makes the day's work visible to the whole team and avoids things being missed.
- Set up session with timed slots as this facilitates online booking using NHS App and other patient facing online services.
- Enable online booking of some slots (enable 'patient facing services' in slot properties). Make it clear in the session holder name that this is an online booked appointment with an indicative call back time. The reason to offer online bookable appointment slots is to make booking a triage appointment more convenient for patients, and eases the pressure on reception teams by reducing the volume of incoming phone calls.
- When setting up sessions decide whether you use one session/two sessions or three sessions in a day based on your workforce availability through the day. AM/PM sessions can be an artificial distinction – think about what works best for your team and your patients.
- The number of booked slots will help you understand your patient demand over time.
- Individual clinicians should have their own sessions set up but left unbooked. This allows patients to be booked in for face-to-face appointments with a specific clinician through the day as necessary.
- It is good practice to agree in advance the broad time-ranges when each clinician will try to book in face-to-face patients. If face-to-face bookings are staggered through the day this means that there will always be clinicians working through the triage list and the queue will not build up excessively. It also limits footfall into the surgery at any one time which is better for social distancing and reducing number of people in the waiting room.

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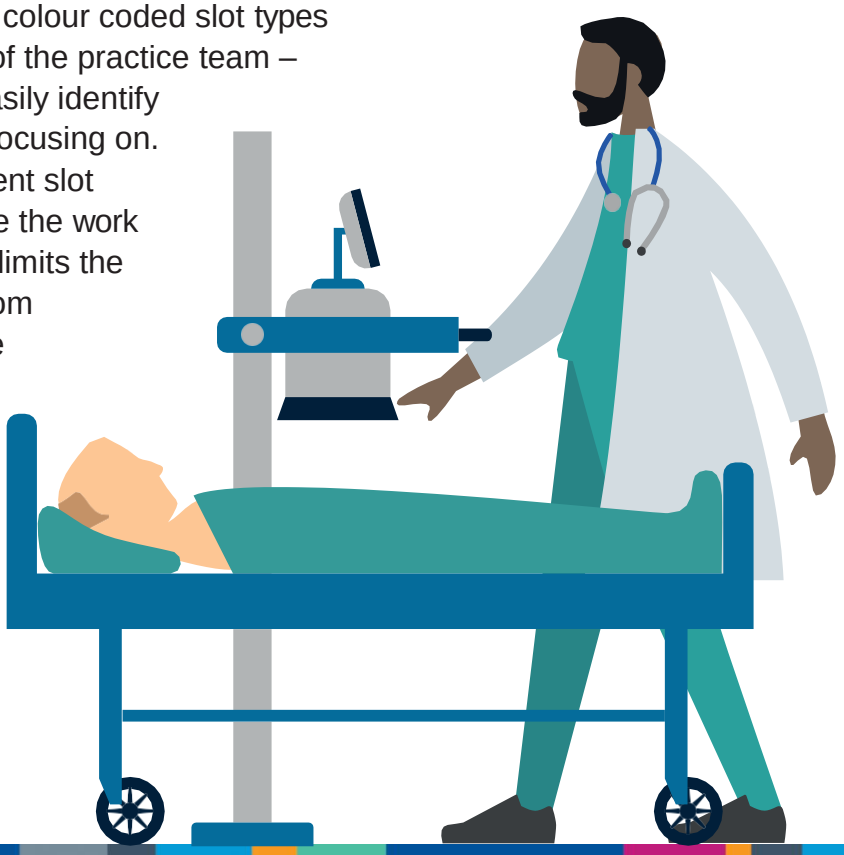
EXAMPLE SLOT TYPES FOR TRIAGE
Telephone triage
Nurse triage
Pharmacist triage
eConsult CLINICAL
eConsult ADMIN
URGENT
Needs advocate triage
Administration triage
Online bookable triage
Special – e.g. COVID follow-up, COVID Response Service direct booking, 111 Direct Booking

B. Setting up slot types

- The slots you use to book patients into for triage need to be clearly different to your other practice activity such as planned care e.g. antenatal clinics.
- Using a clearly defined set of colour coded slot types helps the different members of the practice team – administrative or clinical to easily identify the patients they need to be focusing on.
- If practices use too few different slot types, it is hard to differentiate the work on the triage session list and limits the useful data that can be got from Edenbridge to understand the practices' activity and plan more effectively. If practices use too many different slot types, the triage list becomes confusing to manage and things may get missed. Think three bears – not too few, not too many, *just right!*



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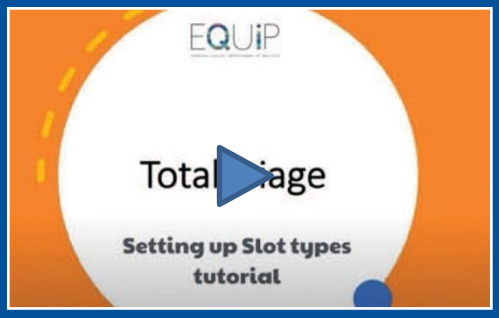
Set up slot types:

Video 3: Setting up slot type on EMIS Web



Video 4: Adding patients and changing slot properties

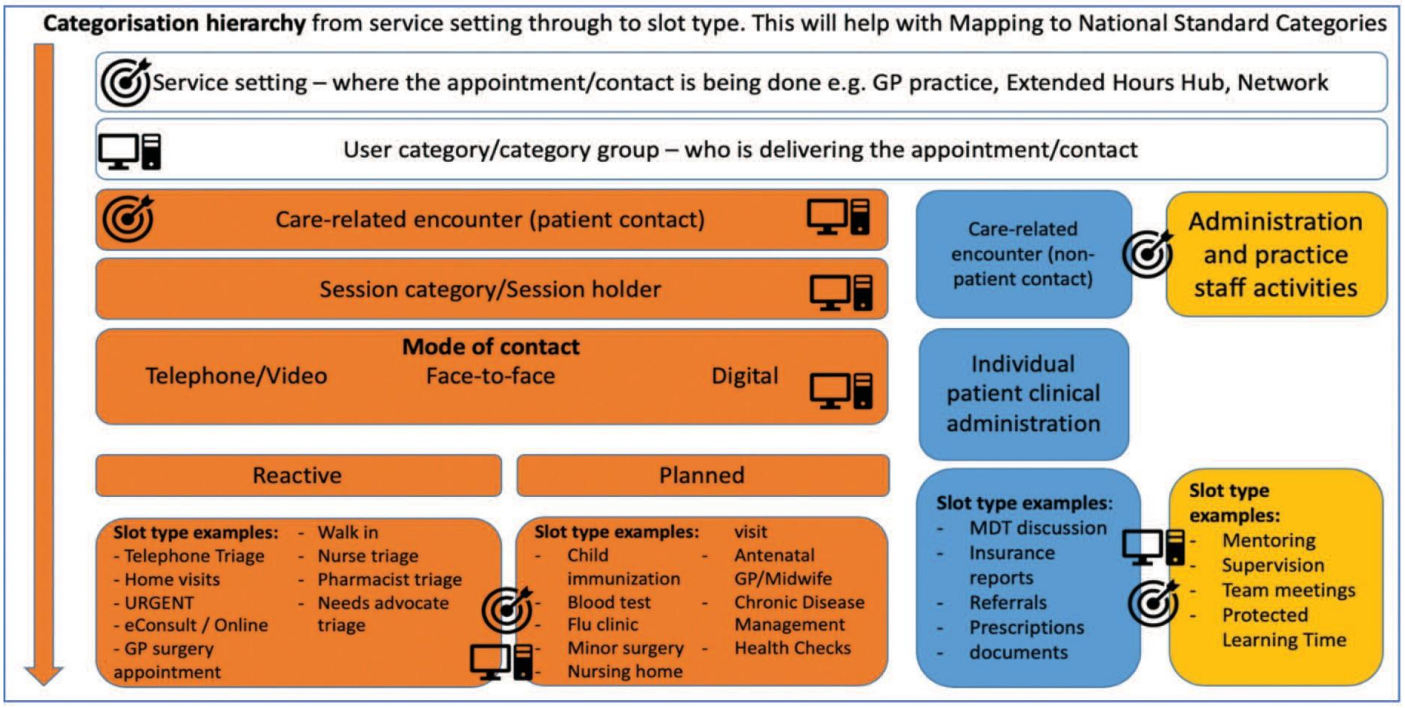
C. National Standardisation of Categories

Setting up the practice appointment book will help the practice with triage, but there is a wider context to consider. There is a national drive to understand GP practice capacity, unlike in secondary care, there has not been any national view of capacity and utilisation or patient experience in terms of waiting times in general practice. The Department of Health and Social Care (DHSC) has commissioned NHS England to collect information on general practice capacity and utilisation across all practices. The GP contract Five-Year Framework published in January 2019, which was agreed with the BMA's General Practitioners Committee – commits to the publication of activity and waiting times data at practice and network level from April 2021.

There are over 400,000 different appointment types throughout the practices in England (and over 3,000 slot types used in Tower Hamlets alone!), which are in most cases unique to the individual practices that configured the appointment book. The result is that data available from general practice does not reflect the full Primary Care workload because of:

- A lack of standardisation and consistency across appointment systems
- A wide variation between practices in terms of the way appointment systems are set up and the activity is recorded

Over the course of the next year it will be a contractual obligation to map GP appointments to a set of national standard categories. This will allow practices, Clinical Commissioning Groups (CCGs) and Primary Care Networks (PCNs) to measure activity in the same consistent way. The aim is that all General Practices, CCGs and PCNs will be able to use their information to help plan their capacity and workforce to make health and care better for their patients.



Appointment book Configuration against National Standard Categories

KEY:

Used for Edenbridge Apex configuration

Used for Appointment Configuration to National Standard Categories

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TIPS

The National Standardisation Categories for GP appointments data run in a hierarchy from:

- Service setting e.g. GP practice, Extended Hours Hub, Primary Care Network
- The user category e.g. General Medical Practitioner, Nurse, Midwife
- Context type - care-related encounter, administrative
- Session Category
- Mode of contact e.g. telephone, face-to-face, digital
- Slot type - e.g. Telephone Triage

Article - National Standardisation of Categories for GP appointments Data
Article - Appointment Categorisation Standards

2.2.5. Frequently asked questions

How do we label vulnerable patients so that reception can spot them easily?

This is done by using major alerts.

Could practices split the list equally if they wanted to or is it necessary to work off one list?

It's good practice to have one list to work from, with a separate session for each clinician to book face-to-face patients into. If patients are put on different lists, patients can get missed or lost, which is risky. And even though the number of contacts may be equal that may not accurately mean the complexity of the work distributed is equal.

Concerns around parity of workload are very live in teams moving to triage and having open conversations early as part of planning will help. These conversations are valuable in the context of a discussion around shared purpose – connecting to *"why we do the work we do?"* and how that purpose serves the communities where we work. Triage is a process that helps with access but it must connect with the purpose and values of the practice team or it will be very difficult to sustain.

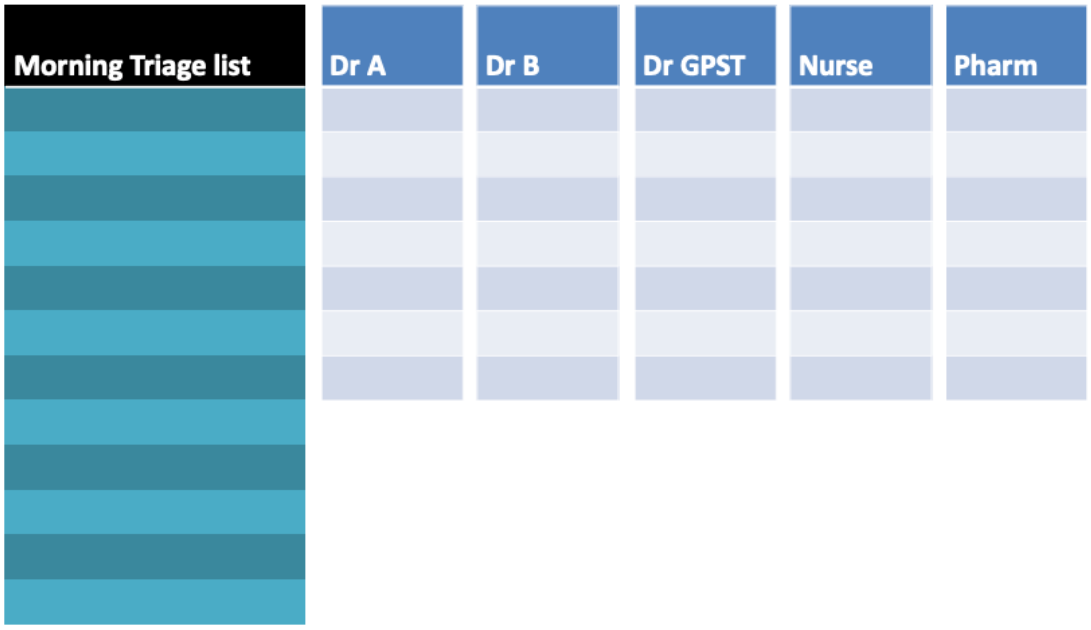
Total triage is a shared endeavour. Moving to this way of working is a situation where it is essential as a team to have an open discussion about expectations, transparency and trust. There will be differences in work-rate between clinicians and this is an opportunity to learn from each other and build in opportunities for personal and professional development. Data can be helpful, looking at re-attendance rates, use of diagnostics, conversion to face-to-face and case-mix are all useful markers to balance simple data on number of patient contacts.

Number of clinical contacts/consultations undertaken by each clinician (as well as re-attendance, conversion rates, case-mix and use of diagnostics) is available on

Edenbridge and can be used to guide discussions around working rates and working styles. Having real transparency on the work done by team members is essential for professional development, setting expectations and understanding how individual clinician and team performance changes over time.
Undertaking triage work in a shared room with administrators and clinicians, rather than individual clinical rooms is a great opportunity to share and learn as a team.

With one list how do you sort out who does what?

Admin or Duty team put the appropriate name against appointments in slot properties, (have a look at the schematic below). The team works off the list, then books into their own session (or someone else's) as they need to. The trick here is to avoid bringing in all the face to face citizens/patients at the same time as this means the triage list builds up.
Use slot types to capture different modes of appointment, then the conversion data can be picked up easily through Edenbridge.



Do you put all the follow up cases, like the ones that need a COVID review or have a mental health issue into the total triage list rather than having a separate list?

There is more than one 'right' way on this, but we recommend putting all proactive follow-ups on the triage list for a call/SMS/email (or ask patients to message the practice on a day their usual GP is in). This is a good way to build in continuity for those patients who need it. Having all the contacts on one list helps with capturing actual activity/work.

Should GPs keep slots in their clinics for their own phone calls and video calls?

The main thing is not to pre-book lots of fixed slots in individual clinician's session unless there is a good reason in terms of equipment/room/skill. This is carve out and affects triage workflow unless it's planned in properly at a good time. We reccommend that these patients should be booked onto main triage list to make the work visible,

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it helps to plan doing it at the right time during the day. It also means that work won't get missed if it's booked onto someone's list who ends up being off sick or something.

How do you actually manage fitting in the extended Hours DES into the total triage model? Do you use them for long term conditions work? Do you extend your triage sessions into the 6:30 pm - 8 pm slots?

- Practices fulfil DES by setting up some slots on the triage list to be bookable via 'patient facing services' i.e. apps though this requires a workaround on EMIS by setting up a 'dummy' session holder for triage.
- It would depend, as a general rule planned care should be done outside of peak demand times i.e. not Monday or Tuesday, and in the afternoons.
- Practically speaking, practices are speaking to patients later on in the day so they get 'booked' into the later slots. The DES may not be continuing in it's current form as it doesn't really incentivise the triage model.

Where do you put sports medicine slots since they are longer sessions?

As a general rule planned care should be done outside of peak demand times i.e. not Monday or Tuesday, and in the afternoons

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2.3. Practice Website Requirements

2.3.1. Introduction

The practice website is an essential shop window on the practice. It can help direct patients quickly to the information or advice that they need. This section will help optimise the practice website for triage.

2.3.2. Checklist of activities

Add COVID -19 screening questions, updates and other relevant information	☐
Promote eConsult triage pathway	☐
Add all important and relevant information about the digital pathway to inform patients how to use it	☐
Make patients aware of other routes to get in touch with the practice	☐

2.3.3. Roles and responsibility

It is good practice to have a named individual responsible for each of the above outlined activities. They can either carry it out directly, or delegate the activity whilst remaining accountable for making sure it's completed and updated as and when required.

2.3.4. Tools, techniques and resources

Adaptations to the practice website to support the triage model:

- Make updates in light of current climate of Covid-19.
  - Add latest information on Covid-19 and routes for patients to take including self-care.
  - Add screening questions: ask patients upfront before contacting the practice e.g. - is your query related to a cough or high temperature, and signpost according to national guidelines. Adapt as and when the guidance changes.

- Identify the triage pathway that the practice wants to give priority to – e.g. eConsult, telephone. The most effective is eConsult: reduce the visibility of the practice phone number on your website, and move towards switching this off completely in time, other than a dedicated line for vulnerable patients.
- Promote eConsult by making it the most prominent part on the website followed by clear outlined steps the patients need to follow.
- Add all important information about the eConsult/video consultations app that you plan to use.

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- Tell patients that there is no need to ring in advance to make a booking. They should call the practice only on the day when they need to be seen.
- Make it clear that the patient will be speaking to a clinician if there is a need, even if a patient assistant/administrator answers the call.
- Clarify that they would be speaking to a clinician on the same day and seeing one too if necessary.
- Do not forget to inform patients that they will still be able to book appointments through the 'traditional route' with healthcare assistants and midwives via reception depending on the environmental situations.
- There is additional contractual functionality through GP Connect to offer bookable slots for telephone consultations for 111 to book into (recently adjusted from 1 per 3000 to 1 per 500 patients per day till 30th June 2020). BUT locally in Tower Hamlets this is going through the GP hubs so practices DO NOT have to set this feature up currently.
- Information and stats on practice website hits can be accessed on the GP care group website: https://www.gpcg.info/v/Web-stats-1920

Have you heard the news? As of DATE, we change booking system to TOTAL TRIAGE...

- All bookings to be made on the day, for the day.
- No need to ring in advance to make a booking! Call us only on the day when you can/need to be seen.
- Patient assistants will take your call and ask you for the reason for contacting the practice. A team member will ring you back to make an appointment.
- If you want to speak to a specific doctor, just ask.
- This will make the system fairer to everyone – no more "appointment lottery", everyone who needs to be seen will be seen– on the day.
- This system shows higher patient satisfaction rates in practices where it already works…
- But please make sure we have your up to date contact details!
- If you don't speak English, please have someone at home to help translate.
- You will still be able to book appointments with healthcare assistants and midwives.

In a nutshell: Need a clinician? Speak to one directly, and you will be seen on the day if you need to!

Sample script for website update

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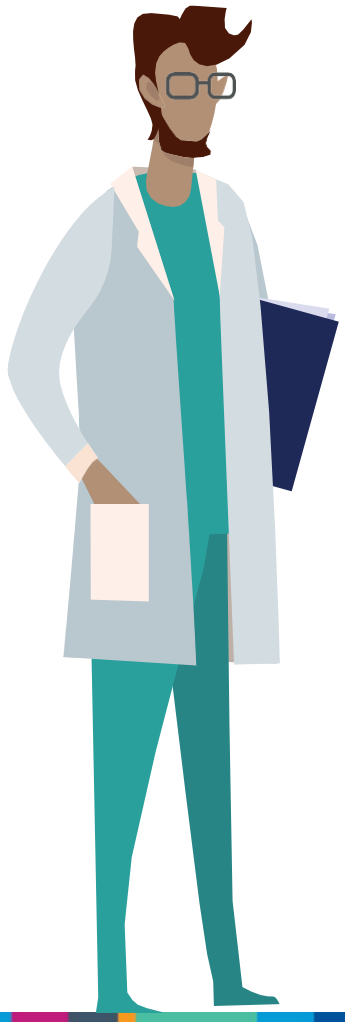
2.4. Initial Demand and Capacity Assessment

2.4.1. Introduction

To plan how the practice will use the team's clinical capacity it is necessary to look at how it currently manages skill mix to meet demand.

2.4.2. Checklist of activities

Configure EMIS	☐
Configure Edenbridge Apex	☐
Look at practice telephone data for unique 'dropped calls'	☐
Consider sampling number of patients who reception 'say no' to each day for a week	☐
Get data on hub activity, urgent care activity and Accident and Emergency VB11Z activity (a code for 'no treatment, no investigation' – a proxy for A&E activity that would be better dealt with in primary care) – EQUIP can provide this	☐



2.4.3. Roles and Responsibilities

- Senior non clinician/data person:
  - Collates telephone data
  - Configures Edenbridge and EMIS
- Reception team tallies demand manually for a finite period of time (two weeks ideally)

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2.4.4. Tools, techniques and resources

To work out demand you need to know the following things:

Existing capacity is a sum of:	Unmet need can be estimated as a sum of:
• Number of booked appointments per week • Number of appointments on 'oncall/ duty/urgent' list or overbookings per week	• Number of unique dropped calls per week • Number of hub appointments booked per week • Number of VB11Z A&E attendances per week • Number of patients that are turned away from the practice e.g. asked to call back tomorrow or the next day – this requires sampling by reception team. Usually one week of data is sufficient for this

In summary

Demand = existing capacity (actual) + unmet need (estimate)

This can be expressed as contacts per 1000 patients per week.

In a triage system GP capacity can usually be estimated around 25-30 contacts per session.

Actual GP, nurse and other clinician activity can be found easily on Edenbridge. Using Edenbridge Apex will allow you to quickly access activity data on a daily basis and allows for week on week and year on year comparison. It shows activity data in terms of appointments, but more usefully in minutes and hours. This is particularly helpful when working out capacity when using different modes of contact such as telephone, video, eConsult and face-to-face.

For a more in-depth exploration of demand and capacity contact the EQUIP team:
thccg.equiptowerhamlets@nhs.net or Vyoma.shah@nhs.net.

For Edenbrige support and configuration contact Edenbridge:
enquiries@edenbridgehealthcare.com or Tel. (0)1924 900177

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2.5. Key Decisions

2.5.1. Introduction

To improve the chances for success of triage, a number of decisions need to be made by the team and supported at the most senior sponsorship level. Potentially contentious decision points and operational definitions are best agreed in advance, with the commitment to stick to these for a minimum agreed time period (to avoid the pull of reverting to comfort and allowing change a real chance of success).

2.5.2. Checklist of activities

Agree on how to use the 'usual doctor' role	
Decide the duty administration's role	
Agree as a practice what problems are clinically URGENT	
Discuss and create own practice conditions/skill mix list	
Decide on capacity limits	
Agree on response time	
Agree on cut-off times	

2.5.3. Roles and responsibilities

- **Patient assistants:**
  Assign calls to the registered or most appropriate doctor by adding a comment under the slot or put in slot notes. It may be that the patient is being cared for by someone different from their usual doctor, in which case he/she will express that preference
  Assign presentations to the correct member of staff to manage these
  Communicate expected response times to the patient
- **The Duty team:**
  Reviews the triage list to confirm appropriate clinical allocation
  Monitors how calls are going and makes a judgement around whether it is necessary to move to urgent calls only
- **Clinicians:**
  Book any face to face appointments for the following day after the agreed cut off time.

Note that there is no cut off time for calls to be returned on the day. All calls received on the day are returned on the day.

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2.5.4. Key Decisions

- **Usual doctor:** Agree how to use this role. This will depend on how the practice manages their registered lists, but in all practices there will be a cohort of patients who benefit from continuity, even if this is only through an episode of care i.e. a period of time where there are regular contacts with practice, perhaps because of an acute illness or exacerbation of a mental health problem. This is called episodic continuity.

$$\text{Episodic continuity} = \frac{\text{number of different clinicians in contact with the patient}}{\text{total number of contacts during an episode of care}}$$

It is a function of the total number of contacts during an episode of care divided by the number of different clinicians who have been dealing with the contacts. As a general rule – the lower the number of different clinicians through an episode of care, the better. We know that patients will make a trade-off between speed of access and continuity, depending on the nature of their problems. Trying to improve continuity for patients who access the practice frequently is one approach to shaping demand.

As an example:

- If the patient's usual or preferred GP is not in, advise the patient that their query will be addressed the next time the doctor is in (unless the doctor is away). This is particularly important for results, investigations, sick notes, medications, or any letter requests. Only add the request to the triage list if the patient doesn't need any of these things and is happy to speak to any doctor or doesn't want to wait till the usual GP is in.
- If the patient asks for a particular doctor, put the name as a comment underneath the booked slot, or enter in slot notes.

Actively promoting the usual doctor role will shape demand through the week. Inform patients when their usual doctor is in and consider giving out business cards (or AccuRx template) as a reminder.

- **Duty admin:** Decide the duty administration role and the types of patient requests that would be dealt with by the duty admin team on the day.

- **Clinically urgent:** Agree as a practice what problems constitute clinically URGENT e.g. chest pain/new onset short of breath/suicidal.

- **Skill mix:** Agree the practice's appetite for working at the top of each individual's clinical license. Confirm this, in detail, and stick to it!

- **Capacity limits:** Agree what your clinical (in this case - GP) capacity is for the day and at which point to cap the number of calls or contacts for the day.

An estimate for this is approximately 26 contacts per session per GP, though this can be discussed and agreed as a team, also data on actual clinician activity can be found on Edenbridge Apex.

For example, 5 GPs doing 2 sessions in a day = 5 x 2 x 26 = 260 contacts as a maximum. Things that need to be factored into the calculation as deduction are:

- the impact of supervision of trainees
- undertaking duty roles
- clearing lab results for colleagues on leave
- the number of pre-booked appointments (though these should be minimal) etc.

In practice it can be helpful to start to cap booked contacts when 80% of the day's maximum capacity has been reached as there is likely to be some overspill even once the 80% capacity is reached. Suggested way of communicating this to patients:

"We have reached our safe number of appointments for the day. Unless your problem is very urgent and cannot wait, please submit an eConsult or call us back tomorrow and we will deal with it then".

- **Response times:** Agree these, in coproduction with your registered citizens. This is critical for developing trust in the triage system – that people know they will be contacted back in a timely manner.

- **Cut off times:** Know at which point in the day the patient might be seen the next day, i.e. contacts received after 17:00 on the day.

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2.5.5. Frequently Asked Questions

How do you put a cap on daily capacity?
In the morning huddle the duty team works out each morning what the capacity is of the team that day, in terms of number of contacts on the triage list. This calculation is based on approximately 25-28 contacts per session per GP and takes into account any prebooked appointments or absent team members. The capacity calculation can also take into account the capacity of other clinical team members e.g. GP specialist trainees, pharmacists, nurse/advanced nurse practitioners, physician assistants etc.

Once booked slots reach 85% of daily capacity total, it is time to try to limit contacts for the day. Tell the patients 'We have reached our safe capacity for the day. Please can you call back tomorrow or submit an eConsult'. You can also manage flow by telling patients to call on the day that their regular GP is there, as it helps influence demand.

How does starting to limit the triage bookings at 80% of the day's capacity work?
Ideally you have clinical capacity to match predicted demand. Triage systems need sufficient capacity to work properly then you can influence demand from there. Setting a cap on capacity and beginning to apply the brakes when 80% of capacity is reached is a pragmatic approach when there are capacity constraints. It does start to limit the number of contacts and helps to reassure staff that they can apply a brake to demand when necessary.

2.6. Cleaning Books

2.6.1 Introduction

Total triage can only work effectively within coherent appointment systems, where different types of demand are not in competition.

A key part of the 'Cleaning Books' process is to ensure that the appointment system holds no advance bookings at all so that 100% capacity is available for on-the-day demand. This usually takes up to seven weeks to be done effectively and is relatively expensive. But due to the current COVID-19 situation where demand has fallen naturally, this step does not have to be conducted. Under other circumstances, it is best practice to conduct this step.

2.6.2 Checklist of activities

- [ ] Establish operational definitions within the practice. Practices would need to define the small minority of patients allowed to pre-book.
- [ ] Ensure appointment book has no pre-booked appointments, other than for a small minority of clearly identified vulnerable patients (based on agreed principles and conditions).

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2.7. Stakeholder Engagement/Communications

2.7.1. Introduction

Stakeholder engagement and communication are important steps that determine the success of implementation of the process. Stakeholder engagement and communication on 'ways to access system' are crucial. Early involvement of citizens/patients will benefit the quality of the new system as well as change management. This helps build commitment from the citizens when change is not done to them, but when they have helped developed the change, and have partially become responsible for it.

2.7.2. Checklist of Activities

Consult and engage the practice's registered citizens about the practice adopting the triage process	
Agree and train admin to the asset based script	
Create a patient leaflet on triage and share it	
Send text messages to all practice patients regarding practice adopting triage process	
Update voice mail message with adaptations for the triage process	
Include information about the triage process in welcome pack	
Advertise the practice adopting triage wherever possible	

2.7.3. Roles and Responsibilities

- The Patient Participant Group (PPG) lead is responsible for consulting registered citizens about the practice adopting the triage process and explaining to patients how the system works.
- Admin staff is responsible for sending text messages to all patients regarding total triage, creating patient leaflets, advertising total triage and including it in the patients' welcome pack with inputs from the practice team.
- The practice manager could be responsible for initiating discussions around the practice adopting an asset based script (never say "you can't book an appointment anymore"!!) and training staff if agreed. It's important to identify a senior sponsor for the practice's substantial culture shift around communication.
- A senior administrator ensures the voice mail message is changed.

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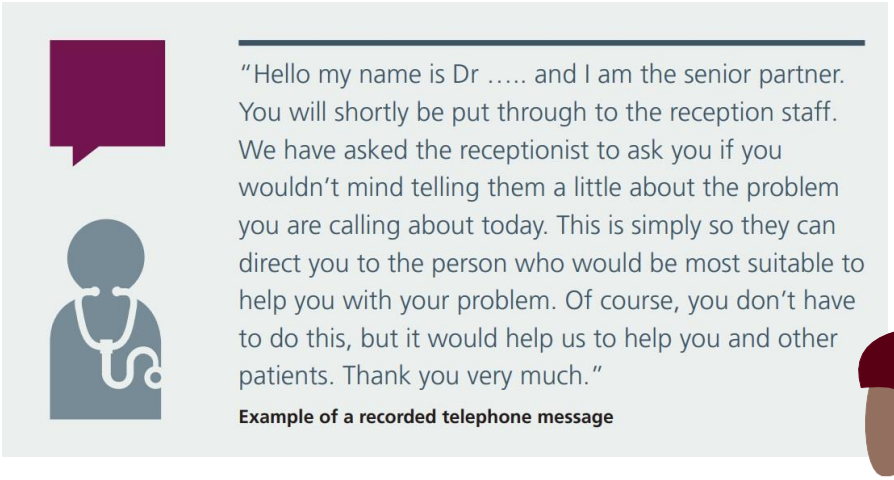
2.7.4. Activities in more detail

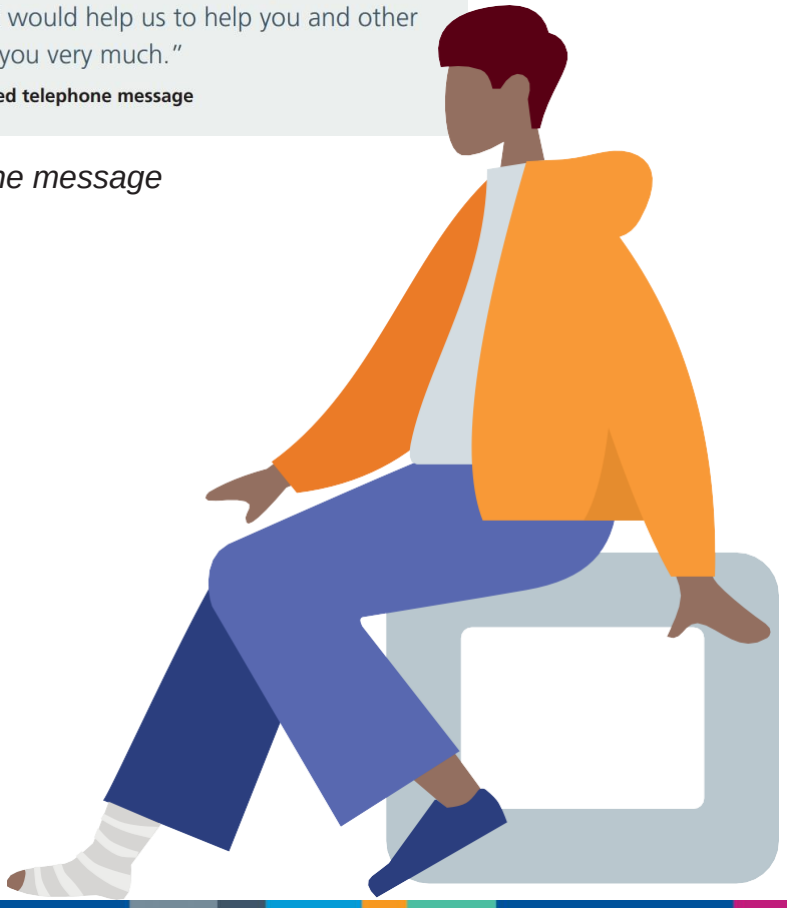
- Consult your registered citizens – and listen with curiosity. Take their feedback into consideration and use it to shape the triage process.
- Improve transparency: explain to patients how the booking system works and meaningfully engage with different groups of patients, including working people.
- Agree and train admin to the asset based script the practice is going to use: never say “you can’t book an appointment anymore”!
- Create a patient leaflet: include online prescriptions and letters/reports.
- Send a text message to all the practice patients.
- Change practice voice mail message – in the voice of the most senior person.
- Include in practice welcome pack for new patients.
- Advertise: in practice newsletter, on practice website, social media, NHS Choices.
- On day one, clinician by the door and the phones.



“Hello my name is Dr ….. and I am the senior partner. You will shortly be put through to the reception staff. We have asked the receptionist to ask you if you wouldn’t mind telling them a little about the problem you are calling about today. This is simply so they can direct you to the person who would be most suitable to help you with your problem. Of course, you don’t have to do this, but it would help us to help you and other patients. Thank you very much.”

Example of a recorded telephone message

Example of recorded telephone message



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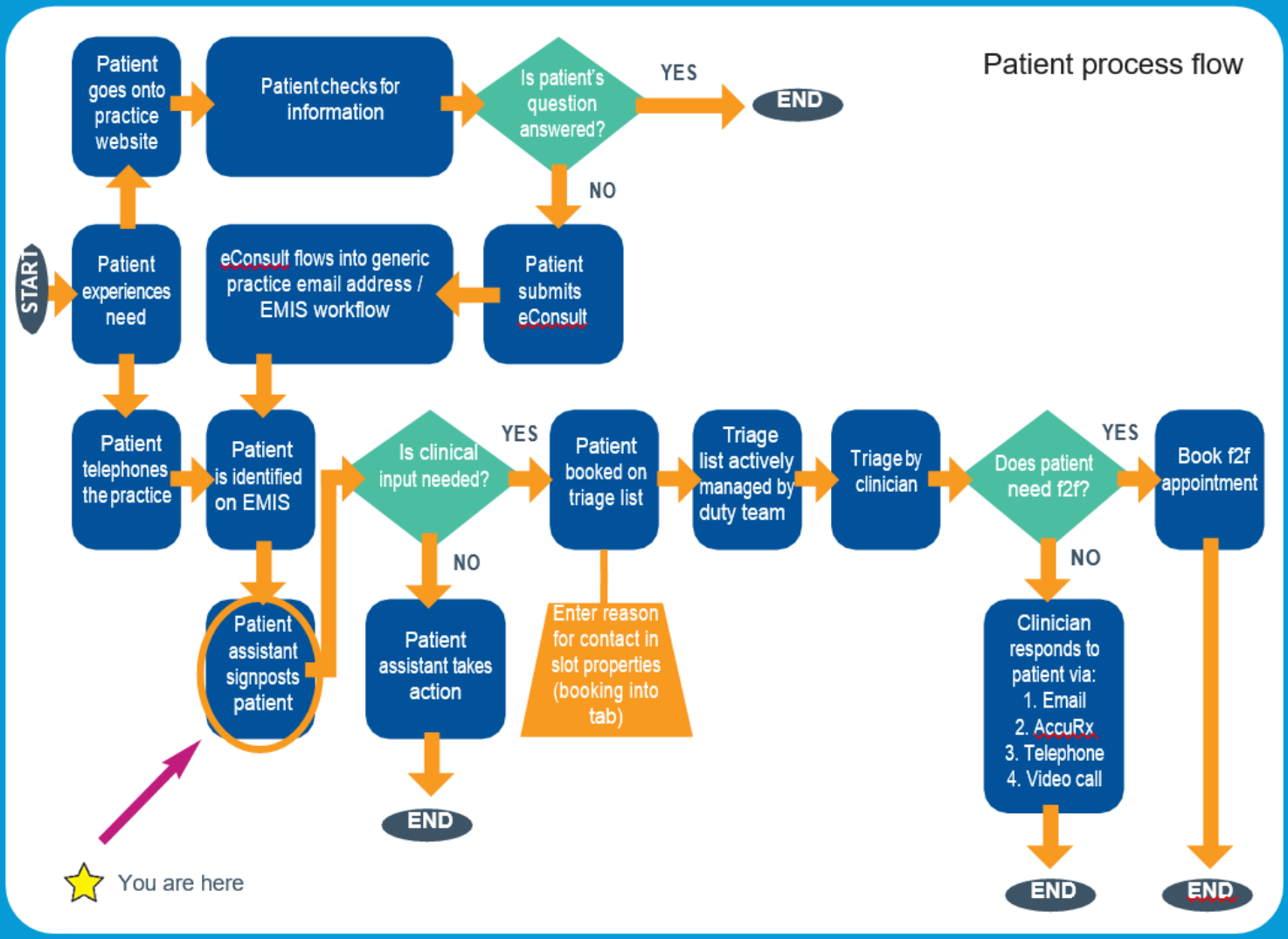
Sample poster

3. ONGOING PROCESS

3.1. Signposting



3.1.1. Introduction

After the patient is identified on EMIS, the next step is for the patient assistant/admin to signpost the patient.

- Active signposting is the act of connecting patients/carers with the most appropriate source of help or advice. It aims to change the patients' assumption that GPs are the first point of care for patients. This is important as GP capacity can be a bottleneck and this helps use their capacity more efficiently.
- Signposting can be done towards services or individuals with responsibility for specific areas of work.

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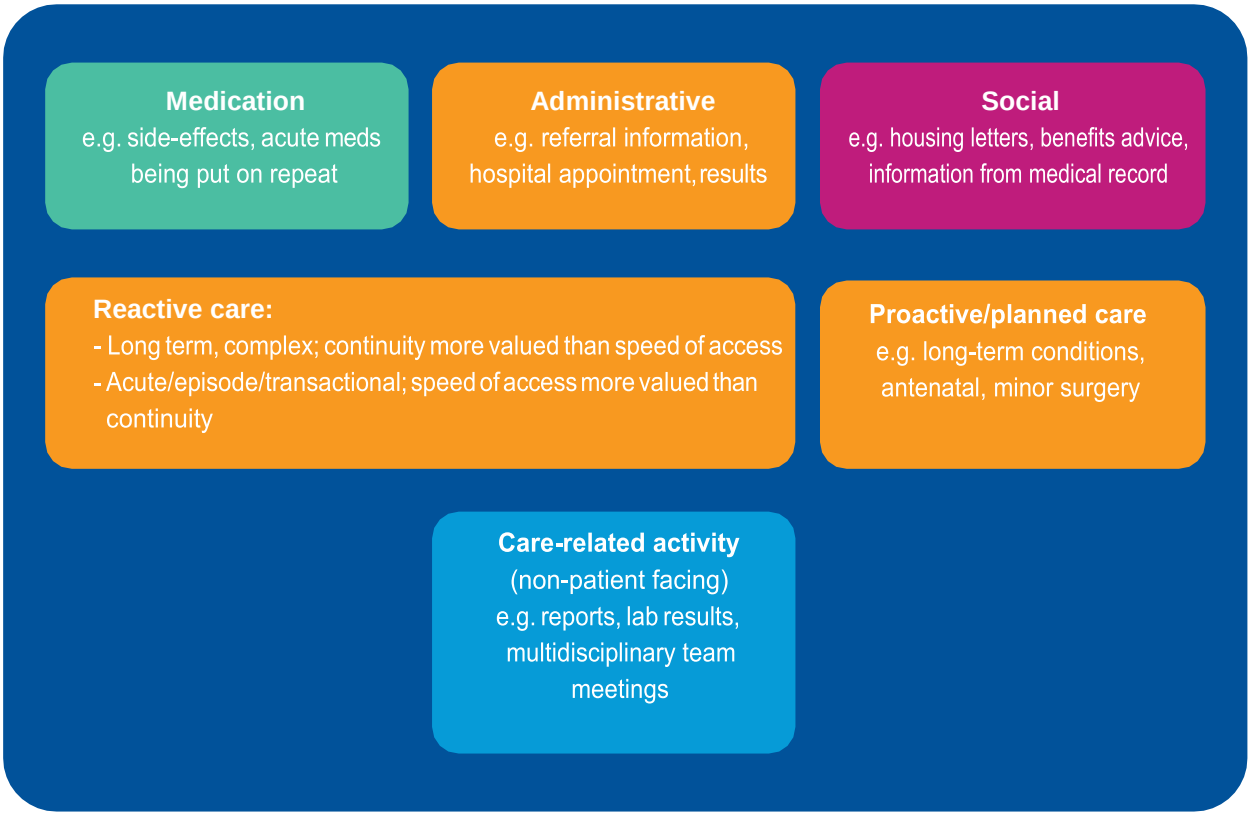
- Signposting is fundamentally about empowering patient choice and using the wider skill-mix of the practice team and information that is available for patients to help themselves.
- It is not about clinical decision-making.
- Signposting begins by establishing what the reason for a person contacting the practice is via phone, eConsult or email.
- Signposting does depend on the skill-mix available in the team and on the day.
- One of the possible outcomes of the step of signposting is a patient being added to the triage list for further clinical input. It is essential that the person is added to the triage list with sufficient information for the clinician.
- Think safeguarding, think child, think adult, think family. Link to article- Remote consulting: domestic abuse and violence.

Broad categories of activity or need

It can help to think of the kind of work that flows through a GP practice and the type of person or service that can manage it.

There are six broad categories of patient-related activity or expressed need that come through general practice. Using these categories enables thinking about who might be the best person or service to deal with each of them. It provides a useful frame to consider how best to use the skill-mix in individual practice teams.



Broad categories of activity/need

3.1.2. Checklist of activities

Make sure recorded telephone message is updated*	
Ensure posters on triage are put up around the practice*	
Make sure videos/slides on waiting room screens are updated*	
Make sure website is updated*	
Create clear script for admin/reception to follow and share	
Decide on which conditions are signposted to who depending on skill mix	
Prepare a list of relevant services and roles (i.e. care navigators)	
Ensure clear understanding of the use of different slot types for booking patients onto the triage list	

*These steps have been covered in the stakeholder engagement/communication and practice website requirements

3.1.3. Roles and responsibilities

- Duty administration
  Deals with agreed patient requests on the day (based on how the practice has agreed to use its skill mix)

- Patient Assistant
  Identifies what problems constitute clinically URGENT e.g. chest pain/new onset short of breath/suicidal

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3.1.4. Tools, techniques and resources

Step by step signposting process:

1. Answer the telephone.

2. Greet, introduce yourself and ask how you can help.

3. Identify the patient / caller. Check identity against DOB / address / telephone number.

4. Caller/patient will help you identify him/ her.

5. Ask what the patient wants today? Find out details of what the problem is? Explain that this will enable the correct person to deal with the call in a timely manner. Inform them that if they say 'personal', it will be low priority and may be called back later.

6. Patient gives detail of the problem. If it is an administrative or other problem that can be dealt with by the admin team member then the appropriate action can be taken. Write down as much as possible.

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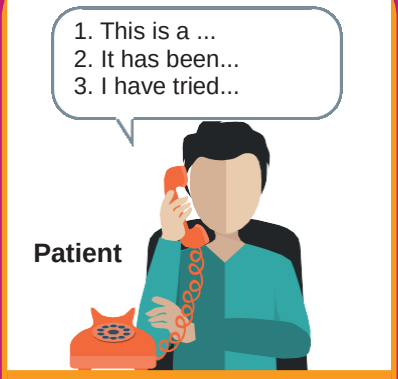
7. Ask the 3 questions in the order to add more information.



8. Take down notes while the patient/caller is answering, in as much detail as possible. It is **important** to note the reason for the contact should be clearly added as free text in 'reason' box and any other information in 'slot notes' found in slot properties (Right click on slot - see video). This helps the triaging team make decisions more easily whilst reviewing the triage list.

- Inform them to have their phone available.
- Check if the EMIS system has the right telephone number.
- Check if there are certain times when the patient won't be available.
- Check if the patient needs an advocate and take action accordingly. Book into triage sessions 'Needs advocate triage' slot. Be aware of the times the advocate is available and if not - ask the patient to call back later with an English speaker.
- Advise that they will be contacted 'today' (on the same day) by one of the team. Ideally give a timescale for this, but this is dependent on the ability to turn around the request within a defined timescale.
- Say that the call will be attempted twice so they do not need to call back if they get a missed call.

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Signposting

Actions to take depending on what the patient says:

Presenting issue	Action
Urgent clinical problem	• Confirm if the patient is complaining of clinically urgent problem e.g. new onset or worsening chest pain, difficulty breathing, severe pain, parent very concerned about unwell child, patient is expressing suicidal or self-harm intentions. • At the discretion of the patient assistant – if one is concerned about a specific patient - the patient is booked onto the triage session into an URGENT slot type and an urgent screen message is sent to the clinical team.
Minor problem or one appropriate for pharmacy* **according to recommended list of conditions – see skill mix*	• Advise them to try the pharmacy first. • Encourage patient to get self-help advice and use eConsult accessed via the practice website.
Benefits or housing or care needs	Consider referring the patient to the Social Prescribing team.
Patient wants results	Check if the results are back and have been filed. • If results are back, filed, normal/satisfactory tell the patient that. • If results not back advise them to call another day - inform them which days their usual clinician is in. • If a result has been seen and needs acting on as is it abnormal this gets booked onto the triage list when the patient's usual doctor is in, but in any case within 2 working days of a result having arrived.
Administration type problem – e.g. chasing up results which are not back yet, CT or MRI results or checking about letters or hospital appointments	Dealt with by the duty administration team or the regular administration team (as agreed by practice admin team).

EQUIP TOTAL TRIAGE MANUAL

Presenting issue	Action
Duty admin problem	Book the contact on the triage session into Administration triage slot - which would mean the Duty Admin will deal with it. This is usually because an administrative task is required to prepare the patient request for clinical triage e.g. accessing patient information on Cerner (hospital record).
Nurse problem* **according to recommended list of conditions – see skill mix*	Book onto the triage session in a Nurse triage slot.
Nurse problem that needs an appointment	Book it directly
Medications	Do not do repeat medications over the phone, encourage patients to sign up to electronically ordering medication via the NHS App.
Rash or other skin problem (not in an intimate area)	Ask them whether they would be happy to take a photo of it and send it to the practice using AccuRx or email it in so that when the clinician calls them back they will be able to see it (BUT no photos of breasts/genitalia).
Request is for a home visit	Highlight in comments under the appointment slot.
Call is from a hospital/ social worker or other professional colleague	Add in the comments underneath and inform the Duty GP so they can call back before they finish work.
If patient's own clinician is not there	Let the patient know this and advise them to call back the next time the clinician is in (unless they are away) - this is particularly important for results, investigations, sick notes and medications, or any letter requests. Only put them on the triage list if they don't need any of these things and don't want to wait till their usual GP is in.
If patient is asking for a particular clinician	Put their name as a comment underneath.
If patient comes as a walk-in	Change slot type to 'walk-in' and send screen message to Duty doctor.

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EQUIP TOTAL TRIAGE MANUAL

Examples included below:

1. Signposting telephone answering script (can be altered according to practice team preference)
2. COVID-19 template: practices would need to review and update according to national guidelines
3. Conditions/skill chart mix: to be altered depending on available practice skill mix

Desktop Prompt Script:

"Good morning/afternoon, NAME OF practice, YOUR NAME speaking. How can I help?"

"Please can I take your DETAILS." (DOB, name, confirm phone number always)

"Can I take a reason for the call to understand how we can best help?
Patient gives detail of the problem.

Ask the 3 questions below in the particular order to add more information:
"Is this a new or ongoing problem?"
"How long have you had this for?"
"Have you tried anything for it?"

If input from a clinician is required, tell the patient:
"Please have your phone available and a team will call you back within... (2 hours)."

Points to remember:
- If urgent, change slot type to 'urgent' and message GPs to alert them. Take as much information of their symptoms and correct contact number.
- Can the patient wait until own GP in clinic?
  Yes - **Tell the patient when the GP is in next**
  No - **Add the patient to the triage list**
  eConsult - **Give patient details of how to use**

- Check if patient needs advocate and *write the advocates availability here*

Important note: The reason for the contact should be clearly added as free text in the 'reason' box and any other information in 'slot notes' in slot properties.

Sample telephone answering script for patient assistant

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Covid Triage Template

Question 1: Do you have a high temperature (fever)?
(You don't need a thermometer to know the precise temperature. If you feel hot to touch on your chest or back answer 'yes')

Question 2: Do you have a new continuous cough?
(New means a cough that you've not had before, or if you usually have a cough, it's got worse. Continuous means a lot more than an hour, or 3 or more coughing episodes in 24 hours).

If yes to question 1 or 2 code as suspected 2019-nCOV (Wuhan) infection

Question 3: Are you having any chest pain?

Question 4: Are you breathing harder or faster than usual or breathless?

Question 5: Are you so ill that you've stopped doing all of your usual daily activities?

Question 6: Have you suddenly become confused, or much more confused than normal? (For example, you're not making sense, aren't sure where you are or you're behaving strangely?)

Question 7: Has a doctor told you that getting an infection might be very serious? (This means you have a condition that weakens your immune system. For example having chemotherapy, had an organ transplant, have HIV/AIDS or had your spleen removed).

Question 8: Have you had a letter from the NHS advising you to shield (isolate) for the next 12 weeks? (People with very serious health conditions have been identified by the NHS, and sent a letter. The letter says you should stay at home for up to 12 weeks and avoid any face-to-face contact with people, unless they're your carers or health professionals = shielding).

If yes to question 1 and/or 2 but no to all the other questions - advise patient to self-isolate, do not put on triage list.

If yes to 1 and/or 2 and yes to any other question - put call on triage list.

COVID triage template

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Administrators
Referral queries
Missed hospital appointments - needing re-referral
Help with eRS
Private medical report requests
Access to online medical record
Giving normal test results

Healthcare Assistant
BP
ECG
Ear syringe
Flu jab
NHS health checks &
Annual health checks
Spirometry
Earache/ear pain

Nurse Practitioner/Physician Associate
Dermatological symptoms
Explaining test results
Ear problem
Abdominal pain
Back pain
Urinary symptoms
MSK pain
Gynaecology problems

Pharmacist
Cold sores
Colds
Conjunctivitis
Hay fever
Head lice/scabies
Medication queries/side effects
Constipation
Heartburn
Mouth ulcers
Nappy rash
Worms
Warts/verrucas

GP
Any baby < 4 weeks unless skin rash/constipation
Any new breast lump in a woman > 20 yrs
Asthmatic with some shortness in breath/wheeze/difficulty in breathing
Any child who is wheezy/short of breath
Anyone with bleeding or lots of discharge from ear
Child < 5 years with new ear pain/discharge
Child < 5 years with new onset lump and no injury
Anyone with chesty cough > 4 weeks not seen before with this
Fit note

Nurse
Abscess
Asthma
BP medication
Burns
Contraception
Cuts/wounds
Diarrhoea/vomiting
Eye infection
Ingrown toe nail
Insect bite
New pregnancy
Smear test
Smoking cessation
Sore throat
STI
Screening
Thrush
Travel advice
UTI in women
Vaginal infections
Travel vaccination query

Social Prescribers
Low level anxiety/depression
Weight loss advice
Benefit/debt advice

Condition/skill mix chart

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3.1.5. Frequently Asked Questions

What's the difference between signposting and triage?

Signposting is fundamentally about empowering patient choice and using the wider skill-mix of the practice team and information that is available for patients to help themselves.

Clinical triage is a way of prioritizing and planning work according to clinical need, available skill mix, and capacity on the day. It differs from signposting in that it is a clinically led process i.e. signposting is done prior to this stage, filtering out work that does not require clinical input and would be best dealt with by another person or service.

Should we give people times when we will call them back?

Indicative time slots are problematic unless you can reliably stick to them. If a patient has real constraints on when they can be called back during the day e.g. work breaks, then this information should be added as free text in 'slot notes' in slot properties. The duty team can then prioritise this contact as necessary.

How best to manage people who don’t answer the phone?

Set a policy of two attempts to contact a person, then send an email (via eConsult), AccuRx message (set up a template for this) or leave answerphone message.
This should be coded, in history, NOT as a problem title in the consultation as 'failed encounter’ as this allows a practice to capture failed encounters, a useful indicator of how effective the triage process is.

Clearly there will be times when clinicians use their discretion and try more times to contact someone, but if this policy is clearly articulated to the team and also to people accessing the service it really helps.

The golden rule here is: the longer it takes to call a patient back, the more likely you are to get a failed encounter. So, turnaround time is very important, as well as not booking in patients for call-backs on another (later) day.

What is the importance of turnaround time?

No matter what the route in is (telephone, eConsult), you have to inform patients how long it will take to respond for them to develop trust in the triage system. It would depend from practice to practice on what they decide collectively. For example, some practices decide that eConsult will be actioned on the same day if submitted before 17:30 and all phone calls will be actioned on the same day.

The idea is for practices to aim to ‘do the work of the day on the same day’ and for clinicians to complete the work arising from the consultation e.g. referral, advice and guidance, letter or test request, at the same time rather than building up tasks that require action.

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Is there a way to train members for signposting?

There are answering scripts for admin staff and skill mix conditions list that are in this manual. There is no substitute for learning by doing. Undertaking signposting and triage work in a shared room, rather than individual clinical/admin rooms is a great opportunity to share and learn as a team. Daily huddles are an opportunity to refine the approach.

Starting the session by asking:

- What did we test yesterday?
- What did we learn?
- What are we testing today?

Capture the outcomes of the huddles in brief, each day, build a narrative on how the practice has improved the total triage process over time, it also helps with handover of information to team members working part-time.

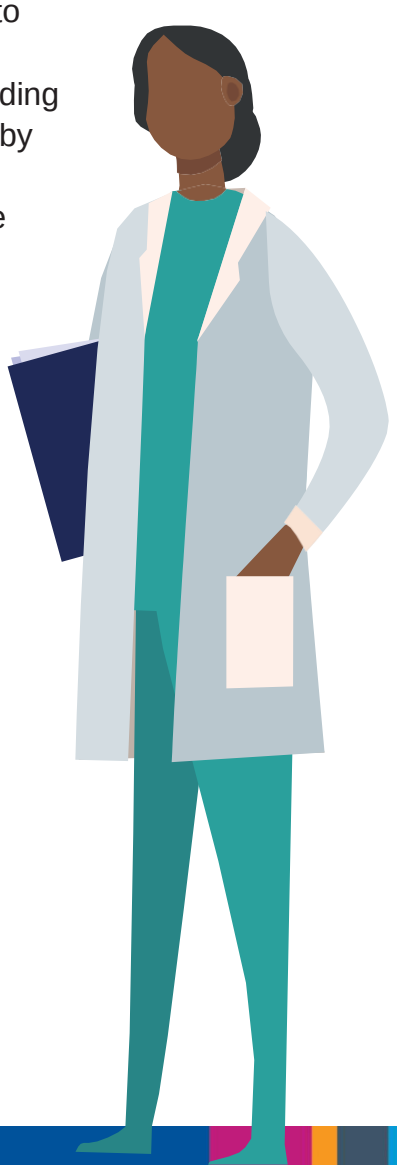
What happens to patients that can't do eConsult? Would the patient assistant do it for them? Is there any way to get everything to flow onto the triage list in a uniform way?

The core principal of total triage is to meet demand with the right person at the right time with the minimum amount of handoff. eConsult is one route into a triage system, and the time taken to by frontline patient assistants to transcribe eConsults may mean that this is not a viable option for practices. We have not specified this approach as an essential building block of total triage. That said, it is an approach that can be tested by practice teams to see if it works for them.

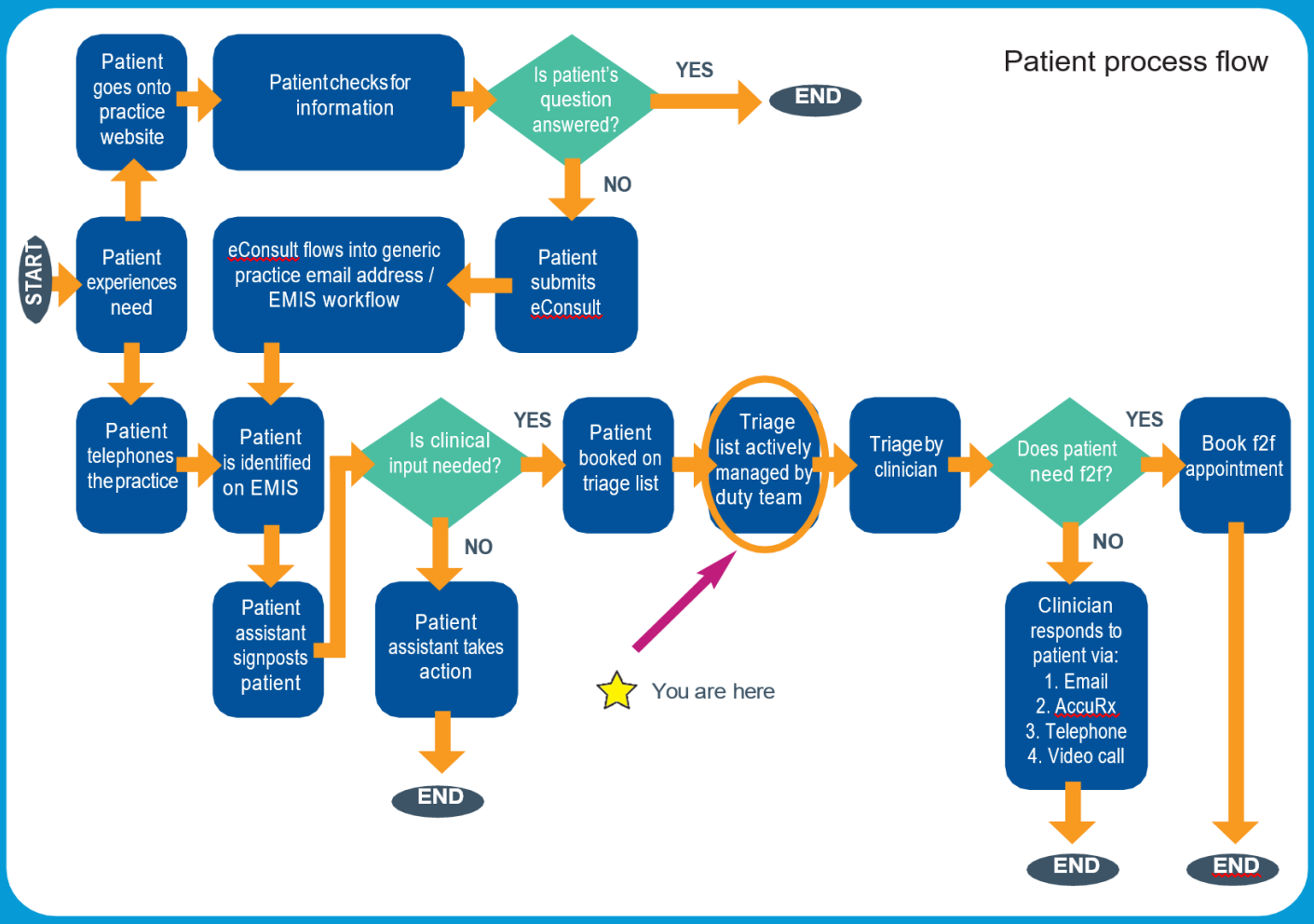
In order for work, from telephone or eConsult, to flow into the triage list in a uniform way three things are needed:

1. Use of correct slot types for booking
2. Reason for contact clearly entered in slot properties
3. Use of slot notes with more detail, if needed, in slot properties

This makes the work of triage much more straightforward for the duty team and clinicians.



3.2. Duty Roles



3.2.1. Introduction

An important step between signposting and triage is undertaken by the duty team. It is their responsibility to continuously review the triage list and make sure that the day's work is being done as effectively as possible at the right time, by the right person with the right information.

Duty roles gives the opportunity for the team to learn about each others' skills and therefore get most out of working together.

3.2.2. Checklist of activities

- [ ] Put down names of duty admin, duty GP and Duty nurse on an organisational notepad
- [ ] Organise huddles at the beginning of each session

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3.2.3. Roles and responsibilities

Each session should have a named people in Duty Roles.

Duty Admin

- They are protected from reception duties in order to work specifically on triage duties and will not answer calls or deal with patients in reception in this time.
- Monitor triage session screen and check calls are being dealt with according to the reception protocol, check comments and reasons for call etc.
- Take action if needed e.g. mark call for nurse if appropriate and not been done.
- Action all 'Administration triage' slots on triage list and deal with as appropriate. This may involve calling a patient, chasing up results, speaking to the pharmacy, speaking to secretaries regarding hospital appointments etc.
- Check the Practice email account for eConsults and other patient-related emails.
- Upload photographs to EMIS patient record that have been taken by patients and submitted via email or AccuRx.
- Liaise with the advocate ensuring they are aware of telephone calls as well as booked patients who need them.

Duty GP

- Ensures all calls are closed off at the end of a session.
- Is responsible for working out, with the duty team, what the capacity is of the team that day in terms of number of calls. This calculation is based on approximately 25 contacts per session per GP.
- Ensures all home visits and walk-in patients are allocated to the clinical team.
- Is the initial contact person for nurses, district nurses, health visitors, community drug team etc. Although he/she may allocate action to another clinician if this is more appropriate.
- Helps to prioritise calls based on clinical urgency.
- Ensures 'Administration triage' slots are used appropriately and liaise with Duty Admin.
- Supervises trainees and physician assistants during the session.
- Looks through calls and allocate each call to a specific person, based on continuity and equity of number of calls per triaging doctor/clinician (pro rata for part sessions).

Duty Nurse

- Monitors triage session and picks up contacts suitable for nurse triage.
- Acts as point of contact for activities related to triaging e.g. urgent ECG or nebulisers needed. These tasks can be delegated to another nurse/Healthcare Assistant as appropriate, but the duty nurse is the person to contact.

3.2.4. Activities in more detail

- The name of the Duty Admin, Duty GP and Duty Nurse should be posted on the organisational notepad each morning. If working remotely, make sure all team members are notified through huddles or other creative ways…
- It is good practice to start each session with a brief huddle, ideally with the full team, but as a minimum with the duty team. This huddle should be used for important handovers, to update on clinical and admin capacity and give a heads-up on any issues that are arising that day. When teams are working remotely, similar huddle can be organised on video call (MSTeams)

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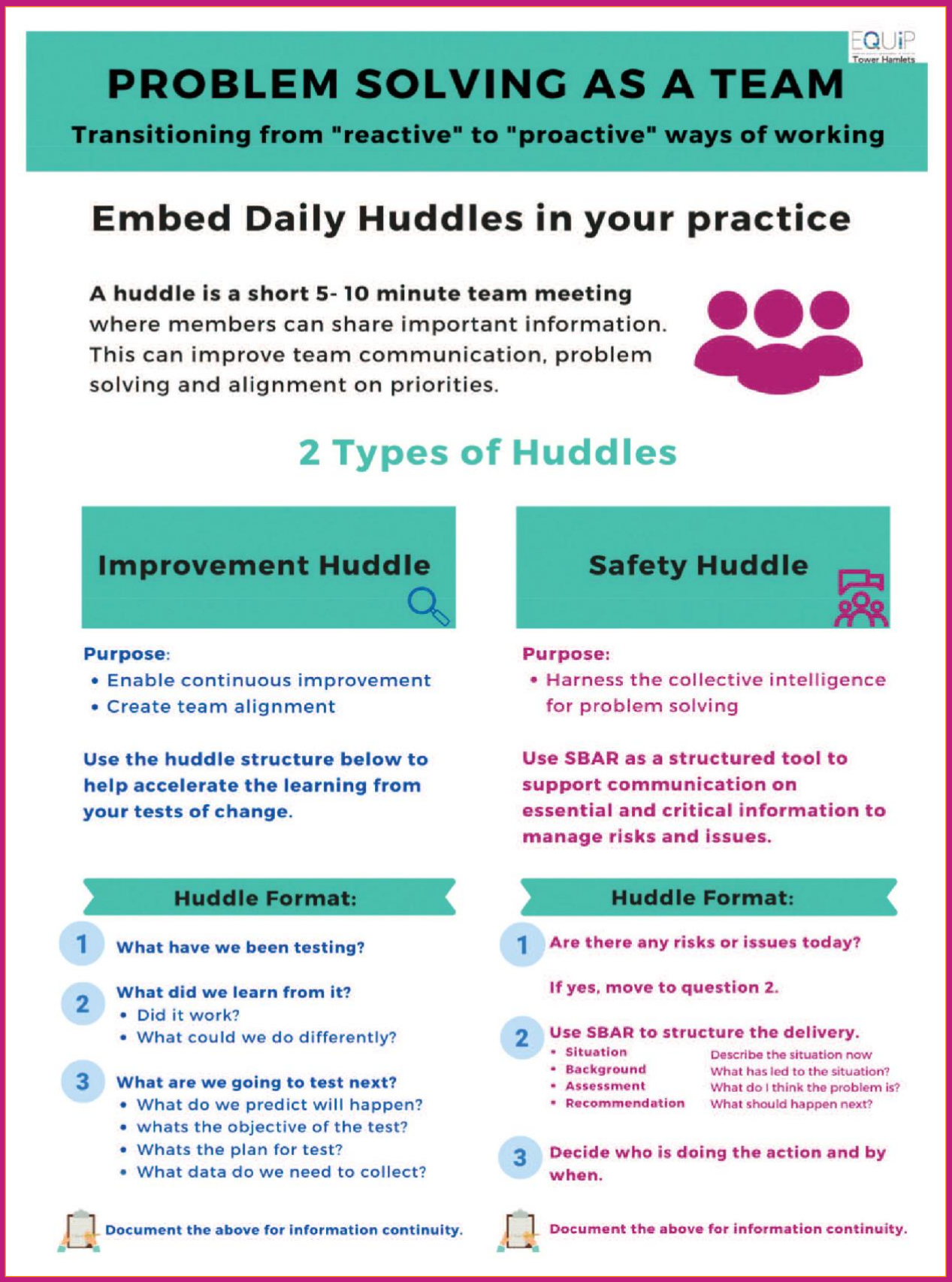
EQUiP
Tower Hamlets
PROBLEM SOLVING AS A TEAM
Transitioning from "reactive" to "proactive" ways of working
Embed Daily Huddles in your practice
A huddle is a short 5- 10 minute team meeting where members can share important information. This can improve team communication, problem solving and alignment on priorities.
2 Types of Huddles
Improvement Huddle
Purpose:
• Enable continuous improvement
• Create team alignment
Use the huddle structure below to help accelerate the learning from your tests of change.
Huddle Format:
1 What have we been testing?
2 What did we learn from it?
• Did it work?
• What could we do differently?
3 What are we going to test next?
• What do we predict will happen?
• whats the objective of the test?
• Whats the plan for test?
• What data do we need to collect?
Document the above for information continuity.
Safety Huddle
Purpose:
• Harness the collective intelligence for problem solving
Use SBAR as a structured tool to support communication on essential and critical information to manage risks and issues.
Huddle Format:
1 Are there any risks or issues today?
If yes, move to question 2.
2 Use SBAR to structure the delivery.
• Situation — Describe the situation now
• Background — What has led to the situation?
• Assessment — What do I think the problem is?
• Recommendation — What should happen next?
3 Decide who is doing the action and by when.
Document the above for information continuity.

Huddles

Consider developing the role of clinical buddies, who are Patient Assistants working closely with GPs:

- Clinical 'buddies', AT Medics practices: https://www.england.nhs.uk/wp-content/uploads/2016/03/releas-capcty-case-study-4-137.pdf
- Enhanced staff roles to release GP time: https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/enhanced-staff-roles-to-release-gp-time-at-medics

3.2.5. Frequently Asked Questions

Do pharmacists and nurses have a different number of pre booked slots? How does it work?

This depends on overall capacity, individual skill-levels and training. There isn't good data on proportions that EQUIP can share. The first step is to clearly identify pharmacy and nurse triage from GP triage using specific slot types. Then data on actual activity will quickly become available that can inform planning. Avoid blocking out sessions for particular types of activity unless there is a specific reason to do it e.g. bits of equipment or a particular room is needed. If a nurse or pharmacist is doing a mixed triage/planned session then there will need to be some flexibility in planning to allow for higher/lower demand on the day. Basically there should always be work to do – if triage activity is lower, then more planned activity/audits/reviews can be done and vice-versa. It is important to keep in mind that reactive care (the main work coming through triage) is different from planned care. It is a whole other piece of work to look into planned care, it usually has much higher rates of DNA/no-shows and the time allocated often does not match with time needed.

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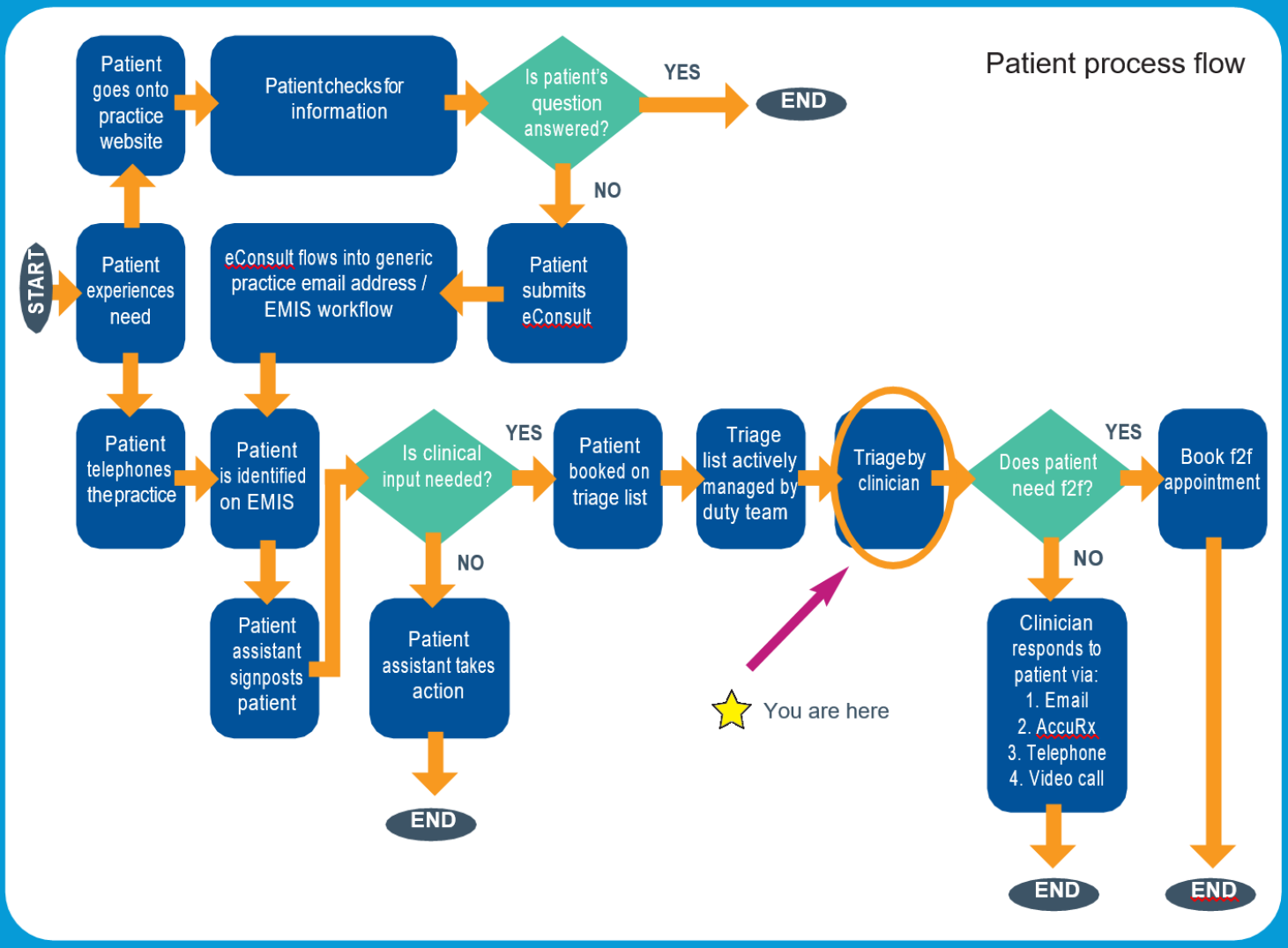
3.3. Clinical Triage



3.3.1. Introduction

Clinical triage is a way of prioritizing and planning work according to clinical need, available skills mix, and capacity on the day. It differs from signposting in that it is clinically led process – i.e. signposting is done prior to this stage, filtering out work that does not require clinical input and would be best dealt with by another person or service.

3.3.2. Tools, techniques and resources

Making triage work

- Signposting is critical to whole process flow.
- Duty roles – duty should be fun! Duty admin/GP/nurse are there to make the triage list work get done smoothly.
- Start each session with short huddle: Who is here? Any live problems? What are we testing this session?
- Physical location of the team is important to help with supervision and efficient use of people resource – ideally use rooming: admin and clinical in one room.
- Really use skill-mix and get everyone involved working at the 'top of their license' (to their fullest potential).
- Minimize handoffs and over-processing.
- Agree number of callback attempts – ideally two, then send an AccuRx/email asking patient to call back if still needed.
- Agree what problems constitute clinically URGENT e.g. chest pain/new onset short of breath/suicidal repeat.
- All doctors to aim for a standard level of activity per triage session around 25-30 patient contacts (telephone/video calls; face-to-face; eConsult), pro rata for part session. This is a level of activity to aim for, it is not expected or necessarily desirable that all doctors will achieve this level immediately or consistently.
- Usually (in non-COVID times) there should be no more than three face to face appointments booked in advance on each triage doctor session – this includes booked by that doctor as well as booked by others. Any more than this and the triage system grinds to a halt.
- Try not to pre-book call-backs in advance, ask the patient to call back or submit an eConsult on the day that they need it.
- For vulnerable or discretionary patients needing a proactive call or review, book this on triage session on the appropriate date with doctor's name clearly in slot properties.
- If you fail to contact a patient, document 'failed encounter' in the clinical history (not problem title) of the consultation. Attempt to contact each patient twice (or more at the discretion of the clinician e.g. if a vulnerable patient).
- If a patient has been spoken to previously about the same problem, then strongly consider if they should be seen face-to-face.
- Encourage continuity of care. Patients will make a trade-off themselves between speed of access and continuity. Inform patients when their usual doctor is in and consider giving out business cards (or AccuRx template) as a reminder.
- Think safeguarding, think child, think adult, think family. Link to article- Remote consulting: domestic abuse and violence.

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3.3.3. Frequently Asked Questions

Could practices split the list equally if they wanted to or is it necessary to work off one list?

It's good practice to have one list to work from, with a separate session for each clinician to book face-to-face patients into. If patients are put on different lists, patients can get missed or lost, which is risky. Even though the number of contacts may be equal that may not accurately mean the complexity of the work distributed is equal. Concerns around parity of workload are very live in teams moving to triage and having open conversations early as part of planning will help. These conversations are valuable in the context of a discussion around shared purpose – connecting to "why we do the work we do?" and how that purpose serves the communities where we work. Triage is a process that helps with access, but it must connect with the purpose and values of the practice team or it will be very difficult to sustain.

Total triage is a shared endeavour. Moving to this way of working is a situation where it is essential as a team to have an open discussion about expectations, transparency and trust. There will be differences in work-rate between clinicians and this is an opportunity to learn from each other and build in opportunities for personal and professional development. Data can be helpful here, looking at re-attendance rates, use of diagnostics, conversion to face-to-face and case-mix are all useful markers to balance simple data on number of patient contacts.

Number of clinical contacts/consultations undertaken by each clinician (as well as re-attendance, conversion rates, case-mix and use of diagnostics) is available on Edenbridge and can be used to guide discussions around working rates and working styles. Having real transparency on the work done by team members is essential for professional development, setting expectations and understanding how individual clinician and team performance changes over time.

Undertaking triage work in a shared room with administrators and clinicians, rather than individual clinical rooms is a great opportunity to share and learn as a team.

Can demand be covered in 25-28 contacts per GP per session?

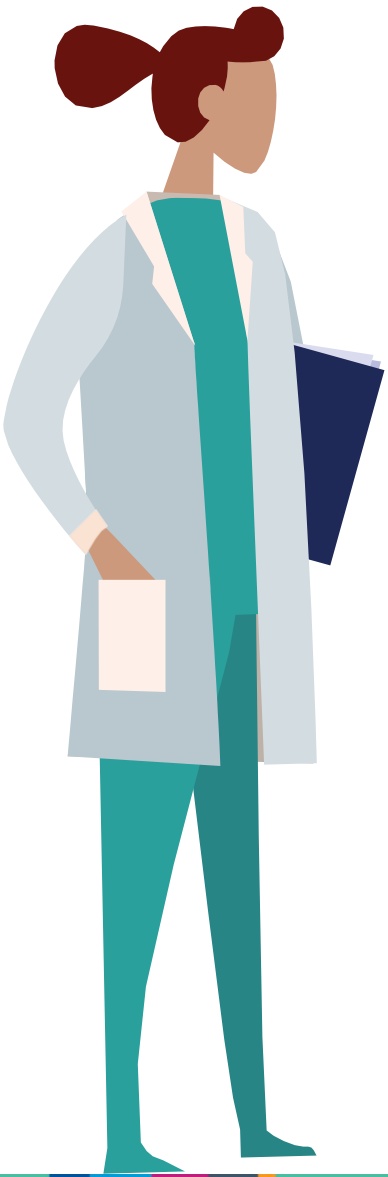
The 25-28 contacts figure is an estimate of clinical activity that is broadly sustainable based on lived experience and the use of different modes of consultation. Whether demand can be covered by this activity depends on how well practices plan and use their clinical capacity against predicted demand, and also, whether signposting away of non-clinical work is happening.

What if doctors start sessions at staggered times?

Staggered start times can be really beneficial. This means that people with fresh energy are coming in through the day to work on the triage list. Setting expectations about number of contacts that should be dealt with by each clinician per session and checking back through data on Edenbridge on actual activity, can help with discussion around parity of workload.

How do locums fit into clinical triage?

This is where the duty team come in. They should be picking out the acute/transactional/simple work from the triage list and either booking that in for the locum face to face or for calls – if complex work is streamed to locums then the net effect is increased workflow (referrals, diagnostics) and reattendance. This is a real advantage of a triage system–patients are different and clinicians are different. Triaging helps to match demand with the right capacity. Increasingly locums are going to need to be skilled at telephone triage. Setting clear expectations about conversion rates and work rate (in terms of numbers of contacts) is critical in this. This also highlights an advantage of working in shared rooms so new team members can learn the nuances of a practice system in real time. It is also good practice to give performance data (easily obtained from Edenbridge) back to team members, including locums, so they know about the number of contacts, conversion rates to face-to-face and reattendance.



How do trainees fit in and get adequate face to face consultations?

Use the duty team to identify suitable work for trainees. They can even flag specific patient groups e.g. mental health or paediatrics from the triage list that will be prioritised for them to deal with. Question the need for booked ‘just in case follow-ups’ with patients.Trainees and regular doctors should consider using telephone/eConsult for follow-ups to avoid blocking up capacity with reattendance.

With one list how do you sort out who does what?

Admin or Duty team put the appropriate name against it in slot properties.

Have a look at the schematic below,the team works off the list then books into their own session (or someone else’s) as they need to. The trick here is to avoid bringing in all the F2F citizens/patients at the same time as this means the triage list builds up.

Use slot types to capture different modes of appointment then the conversion data can be picked up easily through Edenbridge.

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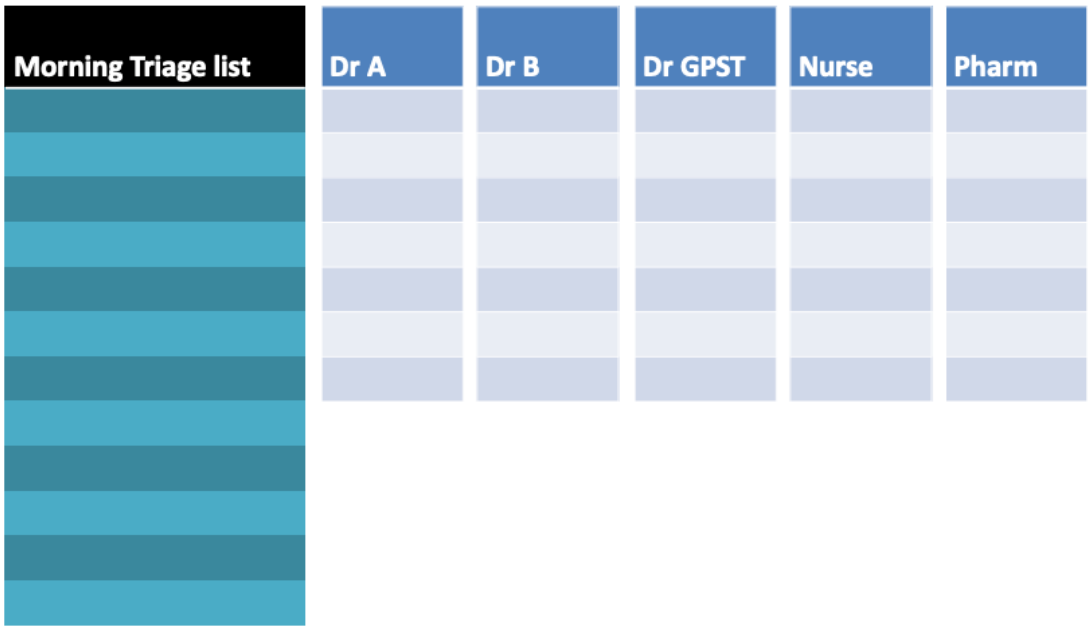

Should GPs keep slots in their clinics for their own phone calls and video calls?

The main thing is not to pre-book lots of fixed slots in individual clinician sessions unless there is a good reason in terms of equipment/room/skill. This is carve out and affects triage workflow unless it's planned in properly at a good time. We recommend that these patients should be booked onto the main triage list to make the work visible, and it helps to plan doing the work at the right time for the person on the day. It also means that work won't get missed if it's booked onto someone's list who ends up being off sick or something.

How do you actually manage fitting in the extended hours DES into the total triage model? Are you using them for long term conditions work? Do you extend your triage sessions into the 6:30 -8 pm slots?

- Practices can fulfil DES by setting up some slots on the triage list to be bookable via 'patient facing services' i.e. apps though this requires a workaround on EMIS by setting up a 'dummy' session holder for triage.
- It would depend, as a general rule planned care should be done outside of peak demand times i.e. not Monday or Tuesday, and in the afternoons.
- Practically speaking, the practice is speaking to patients later on in the day so they get 'booked' into the later slots. The DES may not be continuing in it's current form as it doesn't really incentivise the triage model.

Where do you put sports medicine slots since they are longer sessions?

As a general rule planned care should be done outside of peak demand times i.e. not Monday or Tuesday, and in the afternoons.

How long is an average call list e.g. on a Monday?

Depends on the Monday, you need to look at your historical activity on that Monday over previous years (plus correct for unmet need – this takes a bit of counting/looking back) to really get a clear view on this. 85 contacts/1000 patients a week is about usual in EQUIP's experience. In order of business: Monday, Tuesday, Friday, Wednesday, Thursday.

How do ensure that work is shared fairly amongst GPs?

- Set expectations as a team.
- Radical transparency: share data on actual number of contacts as a team. Make it visible and discuss it in a developmental way, this is on Edenbridge.
- Triangulate contact data with reattendance, use of diagnostics, and complexity of caseload.

What don't we code 'failed encounter'?

Failed encounter codes are important to use. It's okay to use as long as it is not under 'problem', use 'history' so it doesn't clog up the problem list. Don't use DNA as this will be terrible for appointment reporting.

What happens if we only have a patient's landline number and there is no reply and we cannot send AccuRx?

The reception should to try to get email addresses as well. The reception should try contacting the patients/citizen depending on the risk assessment of the caller. There's only so much you can do. Leave an alert on EMIS to get alternative contact details.

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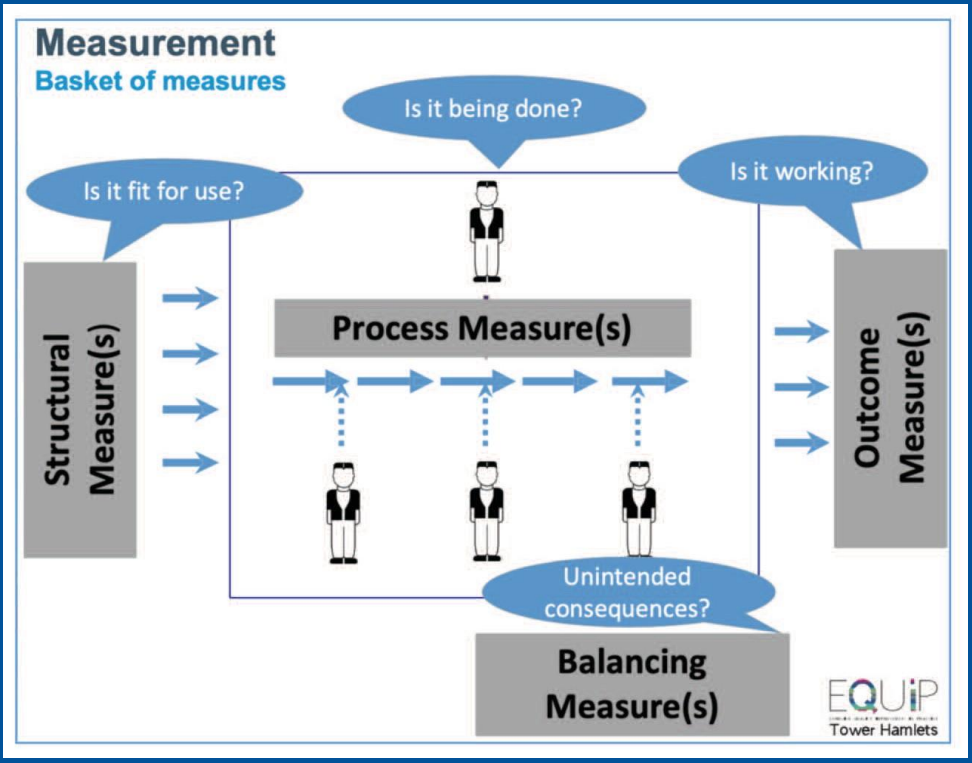
3.4. Analysing data and improvement

3.4.1. Introduction?

Measurements are important as they help to demonstrate current performance (or baselines), set goals for future performance, and monitor the effects of changes as they are made.



3.4.2. Metrics

Structural measures checklist

- EMIS appointment book setup
- Staff training in standard process
- Setup physical location for triaging activity (‘back of house’)
- Equipment/IT

Other metrics are outlined below. This is a long list; essential performance metrics are marked with *.

Type of measure? (Outcome, Process, Balancing, Structural)	**Measure Name** (Indicate if it is a count, percentage, rate, days between, etc.)	**Operational Definition** (Define the measure in very specific terms. Provide the numerator and the denominator if a percentage or rate)	**Data Collection Plan** (How will the data be collected? Who will do it? Frequency? Duration? What is to be excluded?)
Process*	Total number of daily contacts on triage list	Total number of booked slots on triage list. This data represents raw demand	Daily data can be obtained using Edenbridge as long as slot types are configured to clearly identify triage activity
Process*	Number of telephone calls	Number of telephone calls through the course of each day	Daily and hourly (to help plan and manage peak demand times). Obtain data from telephone system
Process*	Signposting process	Expressed as a percentage. Numerator: number of booked slots on triage list per day. Denominator: Number of telephone calls per day	Can be collected daily and collated weekly or monthly. This data is indicative as not all calls into the surgery will lead to signposting or triage, but over time gives a useful guide on the effectiveness of the signposting step
Process	Number of submitted eConsults	Number of eConsults that are submitted to the practice for action	Daily data can be obtained using Edenbridge as long as slot types are configured to clearly identify eConsult activity. Monthly eConsult data sent to practices from eConsult
Process	Number of patients processed and disposed completely by admin team	Can be expressed a percentage or rate – denominator is total number of patient contacts on triage screen, numerator is the number of contacts managed by admin team	Daily data can be obtained using Edenbridge as long as slot types are configured to clearly identify activity from triage list that is undertaken by admin team. Suggested slot names: - Administration Triage, - eConsult ADMIN

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Type of measure? (Outcome, Process, Balancing, Structural)	**Measure Name** (Indicate if it is a count, percentage, rate, days between, etc.)	**Operational Definition** (Define the measure in very specific terms. Provide the numerator and the denominator if a percentage or rate)	**Data Collection Plan** (How will the data be collected? Who will do it? Frequency? Duration? What is to be excluded?)
Process*	Number of patient contacts disposed by clinician	Can be expressed a percentage or rate – denominator is total number of patient contacts on triage screen, numerator is the number of contacts managed by clinical team This data can be obtained at team or individual clinician level depending on focus of analysis	Daily data can be obtained using Edenbridge as long as slot types are configured to clearly identify triage activity as distinct from other activity. Daily data can also be obtained for number of consultations undertaken by each clinician or clinician group (nurse, GP, pharmacist) on Edenbridge
Outcome	Conversion from clinician triage to face-to-face appointment	Numerator is number of face-to-face appointments Denominator is number of patient contacts on triage list	Daily data can be obtained using Edenbridge as long as slot types are configured to clearly identify triage activity from face-to-face
Outcome	Turnaround time from contact to disposal (admin or clinical)	Sampling required from main areas of activity – telephone and eConsult	Weekly sampling from triage list based on analysis of slot history
Outcome	Team satisfaction	Team sentiment captured via response to yes/no questions and free-text comments	Snapcomms 'pop-up' questions administered daily on enabled PC screen Weekly analysis and practice report provided by EQUIP team. Snapcomms will need to be enabled at PCN level

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Type of measure? (Outcome, Process, Balancing, Structural)	**Measure Name** (Indicate if it is a count, percentage, rate, days between, etc.)	**Operational Definition** (Define the measure in very specific terms. Provide the numerator and the denominator if a percentage or rate)	**Data Collection Plan** (How will the data be collected? Who will do it? Frequency? Duration? What is to be excluded?)
Outcome*	Patient satisfaction	Proportion of people who 'would recommend' their practice to friends and family members. Denominator: total F&FT submissions Numerator: number of people who 'would recommend' their practice Star ratings and free-text responses on NHS choices	Friends and family test (F&FT), results can be viewed on Edenbridge. Confidence in the statistical value of results is improved by increasing number of submissions - NHS choices stars and comments - Monthly data
Balancing	Reattendance	Within 14 days and 28 days	Daily data available, by service and clinician, on Edenbridge
Balancing	Failed encounters	Expressed as a proportion of overall contacts. Denominator: total consultations Numerator: number of 'failed encounters' Requires consistent recording of 'failed encounter' codes on EMIS	Daily total consultations data available on Edenbridge EMIS searches will be required for 'failed encounter' codes. Monthly
Balancing	Unique dropped calls	Marker of unmet need and effectiveness of telephone answering process. Expressed as a percentage Denominator: total calls Numerator: unique dropped calls	Data available from practice telephone systems Measured daily
Balancing	Hub or VB11Z A&E activity (no investigation with no significant treatment)	Expressed as activity per 1000 patients per week	Data available from CCG, monthly

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3.4.3. Frequently Asked Questions

Do practices have an EMIS template to help them gather data on conversion rates etc?

EMIS is not set up well to capture conversion rates, though the way in which the EMIS appointment book is configured will make a big difference on the quality of any data that can be used. Edenbridge gives the best view on this and can be seen from a practice and clinician level. Please contact Edenbridge team for support on configuration.

4. RESOURCES

4.1. Frequently Asked Questions Pool

How do we manage anxieties about remote (non face-to-face) consultations from clinical teams?
Some anxiety when moving to a new way of working is understandable, though increasingly the ability to undertake remote consultations is increasingly an essential skill for primary care clinicians.

It is helpful to identify specific concerns and work with these. The practice is undertaking a process of change, so an open dialogue about concerns and how to mitigate them is part of the learning and adapting that needs to take place in the team. Team members working in the same room as each other creates an environment that helps with learning and development.

How do we manage risk?
Triage is a means of managing risk in the system and the duty roles are critical to this. Work on the triage list needs to be managed through the day in order to prioritise according to clinical need, available skill mix and the capacity on the day.

No system of access is risk-free and it can be argued that a total triage system is more likely to identify and manage patient need than a traditional pre-bookable system, where patient need is not identified early on and the system operates usually with fixed capacity and tries to squeeze in ‘on the day’ demand.

A mindset shift for teams moving to total triage is that the role of triage is simply to get patient need met with the minimum of handoff, this might be a face-to-face appointment or an AccuRx message. This is different to the ‘on-call’ doctor in a pre-bookable system where the role is more about firefighting and trying to limit overbooking in a system that is already working at capacity.

What is the ability of a new system to absorb surge in demand?
Demand is largely predictable (within 5% tolerance) and the art of running a total triage system is planning capacity according to predicted demand. Refer to capacity and demand section for more information. If a team requires more support with capacity and demand modelling, please contact the EQUIP team.

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Where are the main potential bottlenecks in a total triage system?

- **Telephone answering** – this can be mitigated by:
  - Rota planning for predicted busy periods by looking at the telephone call volume in 30 minute chunks and planing accordingly. Hint – the busiest times of the day on the phones are from 08:30-09:00 and 13:30-14:00
  - Using standard scripts for answering the telephone
  - Directing people to use eConsults and online bookable triage slots
- **Clinical triage – this can be mitigated by:**
  - Rota planning for predicted busy days
  - Optimising the workflow of the day by using the duty team
  - Planning session times around times of peak demand
  - Avoiding undertaking planned care on days and times where demand is high

How much variation is there in total triage models, and what are some examples of best practice?

The manual aims to cover the essential building blocks of triage. It was developed by sourcing clinical as well as administrative perspectives to give a picture of best practice. Practices will have to adapt processes to best fit their local context, depending on multiple factors like skill mix and team capacity.

What's the difference between signposting and triage?

Signposting is fundamentally about empowering patient choice and using the wider skill-mix of the practice team and information that is available for patients to help themselves.

Clinical triage is a way of prioritizing and planning work according to clinical need, available skills mix, and capacity on the day. It differs from signposting in that it is a clinically led process – i.e. signposting is done prior to this stage, filtering out work that does not require clinical input and would be best dealt with by another person or service.

What happens to patients that can’t do eConsult? Would the patient assistant do it for them? Is there any way to get everything to flow onto the triage list in a uniform way?

The core principal of total triage is to meet demand with the right person at the right time with the minimum amount of handoff. eConsult is one route into a triage system, and the time taken to by frontline patient assistants to transcribe eConsults may mean that this is not a viable option for practices. We have not specified this approach as an essential building block of total triage. That said, it is an approach that can be tested by practice teams to see if it works for them.

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In order for work, from telephone or eConsult to flow into the triage list in a uniform way three things are needed:

1. Use of correct slot types
2. Reason for contact clearly entered in slot properties
3. Use of slot notes with more detail, if needed, in slot properties

This makes the work of triage much more straightforward for the duty team and clinicians

Same day or next day work?

This is a myth. The concept of ‘same day’ or routine work is a false distinction based on supply side factors i.e. availability of appointments. In reality, actual clinically urgent demand is only a small proportion of daily activity and everything else is just work that needs to be dealt with. The choice practices have is in who does the work, where and how it is done.

One of the areas where it is useful to make a distinction between types of work is between reactive activity (i.e. most GP activity) and planned activity (e.g. antenatal, minor surgery, long-term conditions), as these systems behave differently and are driven by different needs.

Could practices split the list equally if they wanted to or is it necessary to work off one list?

It’s good practice to have one list to work from, with a separate session for each clinician to book face-to-face patients into. If patients are put on different lists, patients can get missed or lost, which is risky. And even though the number of contacts may be equal that may not accurately mean the complexity of the work distributed is equal.

Concerns around parity of workload are very live in teams moving to triage and having open conversations early as part of planning will help. These conversations are valuable in the context of a discussion around shared purpose, connecting to “why we do the work we do?” and how that purpose serves the communities where work. Triage is a process that helps with access, but it must connect with the purpose and values of the practice team or it will be very difficult to sustain.

Total triage is a shared endeavour. Moving to this way of working is a situation where it is essential as a team to have an open discussion about expectations, transparency and trust. There will be differences in work-rate between clinicians and this is an opportunity to learn from each other and build in opportunities for personal and professional development. Data can be helpful here, looking at re-attendance rates, use of diagnostics, conversion to face-to-face and case-mix are all useful markers to balance simple data on number of patient contacts.

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Number of clinical contacts/consultations undertaken by each clinician (as well as re-attendance, conversion rates, case-mix and use of diagnostics) is available on Edenbridge and can be used to guide discussions around working rates and working styles. Having real transparency on the work done by team members is essential for professional development setting expectations and understanding how individual clinician and team performance changes over time. Undertaking triage work in a shared room with administrator and clinicians, rather than individual clinical rooms is a great opportunity to share and learn as a team.

Can demand be covered in 25-28 contacts per GP per session?

The 25-28 contacts figure is an estimate of clinical activity that is broadly sustainable based on lived experience and the use of different modes of consultation. Whether demand can be covered by this activity depends on how well practices plan and use their clinical capacity against predicted demand, and also, whether signposting away of non-clinical work is happening.

How do you put a cap on daily capacity?

In the morning huddle the duty team works out each morning what the capacity is of the team that day in terms of number of contacts on the triage list. This calculation is based on approximately 25-28 contacts per session per GP and takes into account any pre-booked appointments or absent team members. The capacity calculation can also take into account the capacity of other clinical team members e.g. GP specialist trainees, pharmacists, nurse/advanced nurse practitioners, physician assistants etc.

Once booked slots reach 85% of daily capacity total, it is time to try to limit contacts for the day. Tell the patients ‘We have reached our safe capacity for the day. Please can you call back tomorrow or submit an eConsult’. You can also manage flow by telling patients to call on the day that their regular GP is there, as it helps influence demand.

What is the most challenging part about triage?

Most practices have moved to total triage at a time when demand is low compared to normal. So, the system has to be set up to be able to manage when demand increases.

People often have a fear that demand is infinite and therefore unsustainable to manage, which is where using data to inform planning can really help. Any significant changes in ways of working can be challenging. Open discussion about concerns, challenges, success and benefits of the new systems will enable teams to refine and improve their system in a way that appreciates and develops the skills of the wider team.

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Does total triage involve EMIS?

Triage has some essential building blocks, one of which is EMIS set-up. Getting EMIS set up properly helps with processing work safely and effectively, and also with capturing data that enables teams to understand how well their system is working.

Is there a way to train members for signposting?

There are answering scripts for admin staff and skill mix conditions list that are in this manual. There is no substitute for learning by doing. Undertaking signposting and triage work in a shared room, rather than individual clinical/admin rooms is a great opportunity to share and learn as a team. Daily huddles are an opportunity to refine the approach. Starting the session by asking:

- *What did we test yesterday?*
- *What did we learn?*
- *What are we testing today?*

Capturing the outcomes of the huddles in brief each day will help to build a narrative on how the practice has improved the total triage process over time and helps with handover of information to team members working part-time.

What is the importance of turnaround time?

No matter what the route in is (telephone, eConsult), you have to inform patients how long it will take to respond for them to develop trust in the triage system. It would depend from practice to practice on what they decide collectively. For example, some practices decide that eConsult will be actioned on the same day if submitted before 17:30 and all phone calls will be actioned on the same day.

The idea is for practices to aim to ‘do the work of the day on the same day’ and for clinicians to complete the work arising from the consultation e.g. referral, advice and guidance, letter or test request, at the same time rather than building up tasks that require action at a later stage.

How best to manage people who don’t answer the phone?

Set a policy of two attempts to contact a person, then send an email (via eConsult), AccuRx message (set up a template for this) or leave answer phone message.
This should be coded, in history, NOT as a problem title in the consultation as 'failed encounter’ as this allows a practice to capture failed encounters, a useful indicator of how effective the triage process is.

Clearly there will be times when clinicians use their discretion and try more times to contact someone, but if this policy is clearly articulated to the team and also to patients/citizens accessing the service it really helps.

The golden rule here is: the longer it takes to call a patient back, the more likely you are to get a failed encounter. So, turnaround time is very important, as well as not booking in patients for call-backs on another later day.

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Should we give people times when we will call them back?

Indicative time slots are a problematic unless practices can reliably stick to them. If a patient has real constraints on when they can be called back during the day e.g. work breaks, then this information should be added as free text in 'slot notes' in slot properties. The duty team can then prioritise this contact as necessary.

How do locums fit in to this?

This is where the duty team come in. They should be picking out the acute/transactional/simple work from the triage list and either booking that in for the locum face to face or for calls. If complex work is streamed to locums then the net effect is increased workflow (referrals, diagnostics) and reattendance. This is a real advantage of a triage system, patients are different and clinicians are different. Triaging helps to match demand with the right capacity. Increasingly locums are going to need to be skilled at telephone triage. Setting clear expectations about conversion rates and work rate (in terms of numbers of contacts) is critical in this. This also highlights an advantage of working in shared rooms so new team members can learn the nuances of a practice system in real time. It is also good practice to give performance data (easily obtained from Edenbridge) back to team members, including locums, so they know about number of contacts, conversion rates to face-to-face and reattendance.

Do pharmacists and nurses have a different number of pre booked slots? How does it work?

This depends on overall capacity, individual skill-levels and training. There isn't good data at this stage on proportions that EQUIP can share.

The first step is to clearly identify pharmacy and nurse triage from GP triage using specific slot types. Then data on actual activity will quickly become available that can inform planning. Avoid blocking out sessions for particular types of activity unless there is a specific reason to do this e.g. bits of equipment or a particular room is needed. If a nurse or pharmacist is doing a mixed triage/planned session then there will need to be some flexibility in planning to allow for higher/lower demand on the day. Basically there should always be work to do. If triage activity is lower, then more planned activity/audits/reviews can be done and vice-versa. It is important to keep in mind that reactive care (the main work coming through triage) is different from planned care. It is a whole other piece of work to look into planned care, it usually has much higher rates of DNA/no-shows and the time allocated often does not match up with time needed.

How do trainees fit in and get adequate face to face consultations?

It's similar as in the case of locums. Use the duty team to identify suitable work for trainees. They can even flag specific patient groups e.g. mental health or paediatrics from the triage list that will be prioritised for them to deal with. Question the need for booked 'just in case follow-ups' with patients. Trainees and regular doctors should consider using telephone/eConsult for follow-ups to avoid blocking up capacity with reattendance.

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What if doctors start sessions at staggered times?

Staggered start times can be really beneficial. This means that people with fresh energy are coming in through the day to work on the triage list. Setting expectations about number of contacts that should be dealt with by each clinician per session and checking back through data on Edenbridge on actual activity, can help with discussion around parity of workload.

Starting to limit the triage bookings at 80% of the day's capacity? Does that work well?

Ideally you have clinical capacity to match predicted demand. Triage systems need sufficient capacity to work properly, then practices can influence demand from there. Setting a cap on capacity and beginning to apply the brakes when 80% of capacity is reached is a pragmatic approach when there are capacity constraints. It does start to limit the number of contacts and helps to reassure staff that they can apply a brake to demand when necessary.

How do we label vulnerable patients so that reception can spot them easily?

This is done by using major alerts.

Do practices have an EMIS template to help them gather data on conversion rates etc.?

EMIS is not set up well to capture conversion rates, though the way EMIS appointment book is configured will make a big difference on the quality of any data that can be used. Edenbridge gives the best view on this and can be seen from a practice and clinician level. Please contact the Edenbridge team for support on configuration.

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4.2. Contact for further help

EQUIP team:
Email: thccg.equiptowerhamlets@nhs.net
Vyoma.shah@nhs.net

Edenbridge:
Email: enquiries@edenbridgehealthcare.com
Call: +44 (0)1924 900177

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4.3. Abbreviations

List of abbreviations

A & E	Accident and Emergency
BP	Blood Pressure
BMA	British Medical Association
CT	Computerised Tomography
DOB	Date of Birth
DD	Duty Doctor
ECG	Electrocardiogram
eRS	Electronic Referrals
F2F	Face to Face
GP	General Practitioner
HCA	Healthcare Assistant
HV	Health Visitor
HX	History
IT	Information Technology
MRI	Magnetic Resonance Imaging
MDT	Multidisciplinary Team
MSK	Musculoskeletal
NHS	National Health Service
PCN	Primary Care Network
STI	Sexually Transmitted Infections
UTI	Urinary Tract Infection

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4.4. Bibliography and references

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  https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/appointments-in-general-practice-supporting-information

- **Appointment Categorisation Standards:**

  https://www.emisnow.com/csm?id=kb_article_view&sys_kb_id=acd8b4301b7b0050acae2f06bd4bcb49&spa=1

- **Information and stats on practice website hits on GP care group website:**

  https://www.gpcg.info/v/Web-stats-1920

- **Clinical 'buddies', AT Medics practices:**

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- **Enhanced staff roles to release GP time:**

  https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/enhanced-staff-roles-to-release-gp-time-at-medics

- **Healthwatch GP report:**

  https://www.healthwatchtowerhamlets.co.uk/wp-content/uploads/2019/04/the-GP-Report_-FINAL.pdf

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