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Practice Administrative Staff Collaborative (PASC)

Evaluation Report

June 2019

Acknowledgements

This document was commissioned by Healthcare Improvement Scotland Primary Care Improvement Portfolio. The author of this document is Sheila Inglis (SMCI Associates).

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The Practice Administrative Staff Collaborative

The Practice Administrative Staff Collaborative (PASC) focused on the development of roles and skills of practice administrative teams in GP Practice settings. The Collaborative ran from February 2018 to May 2019.

The aim of the Collaborative was to support the development of practice administrative teams, and improve GP practice processes with regards to the amount of time spent on correspondence management (workflow optimisation). It also supported improvement in care navigation to direct patients to the most appropriate source of help or advice, thus improving the overall outcomes and care experience for people, families and staff.

Following a competitive recruitment process, four teams from six Health and Social Care Partnerships (HSCPs) were selected by Healthcare Improvement Scotland (HIS) to join the Collaborative:

- Argyll and Bute HSCP
- Clackmannanshire & Stirling and Falkirk HSCPs
- East Lothian HSCP
- South Lanarkshire and North Lanarkshire HSCPs.

The teams involved a selection of 13 GP clusters (9% GP Clusters in Scotland) and 9% (81) of GP Practices in Scotland. Almost one fifth (18%: 36) of GP Practices engaged in the PASC team were rural – notably in Argyll and Bute, where 58% (19) of GP Practices engaged in PASC teams were rural and almost one half (24%: 8) were dispensing GP Practices.

Each local team was supported by an Associate Improvement Advisor and a relevant senior manager from each of the HSCPs.

PASC was overseen by a Steering Group chaired by a Professional Advisor who was a Practice Manager.

PASC reach and engagement

PASC successfully reached Practice Managers (48%: 180 participants) and Practice Administrative staff (20%: 81 participants), with 14% (56) participants being GPs. In total 198 GP Practices were engaged in PASC activities (21% GP Practices in Scotland) – of which 140 (71%) were Collaborative team members.

HIS invited wider stakeholders in primary care in Scotland to participate in Learning Sessions and WebExes in order to share the learning from the Collaborative. Staff from more than three-quarters of all HSCPs in Scotland attended PASC events, with almost half (49%) of the participants working in HSCPs that were not PASC demonstrators.

The ‘right people’ were involved in PASC activities. Stakeholders welcomed their involvement in PASC activities because they:

- Provided support for ongoing development within the context of the implementation of the GMS Contract.
- Enabled them to learn about practice elsewhere.
- Provided support for individual development.

Stakeholders considered that engagement at the local level, notably GP communication and collaboration – including with other care providers – had improved over the duration of the Collaborative. This is particularly relevant in relation to care navigation, which relies on there being other care providers to which patients can be appropriately directed.

Workflow optimisation

Workflow optimisation work was welcomed by stakeholders, in particular GPs who were keen receive less and more relevant clinical correspondence. It appears to be less relevant in rural GP Practices – in particular single-handed GP Practices.

Practice Managers carefully selected Practice Administrative staff to work on workflow optimisation, striving to ensure that they wanted to extend their job role, were experienced and/or confident in their competence, and that they could act as champions for this new role.

The provision of support for Practice Administrative staff undertaking this new extended role was essential: firstly to ensure their competence; and second to assure the quality and safety of this work.

The formal certified training that the funding from HIS provided was important – but it was challenging for GP Practices to provide protected learning time for Practice Administrative staff. Formal certified training also supported Practice Administrative staff confidence, and will also support and perhaps facilitate their career development.

Perhaps even more important than formal training was work that Practice Administrative staff, Practice Managers and GPs did together to develop the new process/protocol for devolved management of clinical correspondence. A key challenge was to achieve consensus across GPs on this, in particular on how best to ensure clinical governance and management of risk, and maintain GP overall responsibility.

By the end of the Collaborative (May 2019), the volume of documentation sent to GPs within the 17 GP Practices that reported data had reduced by 44% on average. All these GP Practices saw a reduction which ranged from 13% to 81%. GPs were seeing more relevant documentation, and had more time to focus on patients. GPs were happier, and Practice Administrative staff were enjoying their extended role.

Care navigation

The development of care navigation processes was welcomed by stakeholders, in particular within the context of the new GMS Contract, as a means of directing patients to new Multi-Disciplinary Teams (MDT) within GP Practices, and to health and care providers in the community.

Some demonstrator GP Practices were clear that – at this early stage in the development of care navigation – they only navigated patients to the in-house MDT. As the development MDTs at Practice level is also in the early stages, relatively few demonstrator GP Practices were able to do this.

Whether the GP Practice had a MDT or not, Practice Administrative staff were asked to extend their role to include asking patients why they want to see a GP, and make an initial assessment using an agreed protocol to decide whether it was appropriate for them to see a GP, or if navigation away from a GP to another health or care provider is more appropriate. This can be very challenging and stressful work.

By freeing up some GP time through care navigation to other members of the MDT – and indeed through the workflow optimisation stream of the PASC work – some GP Practices developed navigation to extended GP appointments i.e. 20 minutes instead of the routine 10-minute appointment. Practice Administrative staff involved in navigating patients to extended GP appointment were experienced, trained in care navigation, and had the confidence to have an empathetic conversation with the patient and make the judgement as to whether to offer an extended GP appointment. It was also important to have agreed Practice protocols for care navigation in place; and it helped if the Practice Administrative staff member had some knowledge of the patient.

Formal certified training – in particular on having confident conversations with patients – for Practice Administrative staff to empower them and support their care navigation work was important. It was challenging for GP Practices to provide protected learning time for Practice Administrative staff. Peer support, and the development of tools such as ‘prompts’ to have appropriate conversations with patients around navigating them were also very important in supporting Practice Administrative staff in this extended role.

Advanced Nurse Practitioners play a particularly significant role in care navigation within GP Practices, with these staff undertaking clinical triage (often through phone consultations), after Practice Administrative staff have navigated the patient to them.

In order to develop effective care navigation to other local health and care providers it is important first to know who they are; and second to develop effective communication and working relationships with them. GP Practices generally have good relationships with local pharmacies – PASC supported the development of these relationships to appropriately navigate patients away from GP towards pharmacists.

Face-to-face meetings with local health and care providers, whether statutory (e.g. opticians, dentists), third sector or private providers, is an important way of developing relationships that facilitate a shared understanding of care navigation, and consequently successful care navigation. By the end of the Collaborative, this relationship building work was very much in the early stages.

There is an urgent need for the development and implementation of concerted and consistent national and local public awareness campaigns which stress that seeing a GP might not be the most appropriate professional to help with some healthcare concerns. This should include engagement with patients.

Stakeholders interviewed to inform the evaluation of PASC considered that both the development of care navigation process **and** the involvement of patients in the development of GP Practice processes were in the very early stages. Nevertheless, in some PASC areas patients were engaged/consulted about the introduction of care navigation – in particular, about whether they would be comfortable with reception staff asking them to explain why they wanted an appointment with a GP; and how they would feel/had felt when referred by reception staff to a Nurse Practitioner rather than a GP. Patients were generally comfortable with both process – their main concern being that they get the right care at the right time.

Although it can be relatively easy to engage patients if consultation was brought to them (e.g. whilst they are in Practice waiting rooms waiting for their appointment, at routine flu clinics) the key challenge was finding time with the whole Practice team – and perhaps especially GPs – to consider and reflect upon patients reviews.

By the end of the Collaborative (May 2019), Practice Administrative staff were more comfortable with the extension of their roles to include care navigation; patients in demonstrator GP Practices were getting used to being asked why they wanted to see a GP; and GPs were beginning to see more appropriate patients. At this early stage in the development of care navigation the collation of quantitative data was not possible; however, as this work progresses it will be important to collate and analyse data, including on the impacts of care navigation away from GP Practices and to other care providers – perhaps in the first instance, the impacts on Advanced Nurse Practitioners.

Capacity and capability

PASC raised awareness of the actual and potential capacity and capability of Practice Administrative staff. In particular it emphasised the role of GPs as employers[1], and the importance of valuing and investing in their Practice Administrative staff – including supporting their career development.

PASC also raised awareness of the (potential) helpfulness of Quality Improvement (QI) approaches and methods, in particular amongst GPs. These approaches, focusing on 'starting small' and 'testing' whether the new process or tool actually achieved the desired improvement were important in reassuring Practice Administrative staff, who were anxious about having more responsibility in handling clinical documentation and in care navigation; and GPs who were worried about the potential clinical risk in devolving these responsibilities to administrative staff.

Key achievements

- Reduced and more relevant documentation going to GPs.
- A set of principles and a designed mechanism for care navigation.
- Practice Administrative staff development.
- Improved GP Cluster working.

Key lessons

- Involve people and win hearts and minds.
- Have a whole Practice approach, with Practice Administrative staff, Practice Managers and GPs working together to improve Practice processes. Achieving consensus on risk management across all GPs within the Practice is a key to workflow optimisation.
- Value and invest in Practice Administrative staff, including supporting their career development. This clearly has cost/financial implications.
- Use and develop existing networks, in particular Practice Managers networks and GP Cluster meetings.
- Use QI methodology to test potential improvements.

[1] This may not be so relevant in GP Practices which are salaried and managed by the NHS Board.

1 The Practice Administrative Staff Collaborative

The Practice Administrative Staff Collaborative (PASC) focused on the development of roles and skills of practice administrative teams in GP Practice settings. The collaborative ran from February 2018 to May 2019.

The aim[2] of the Collaborative was to support the development of practice administrative teams, and improve GP practice processes. The focus of the work was to reduce the amount of time spent on correspondence management and improve care navigation to direct patients to the most appropriate source of help or advice, thus improving the overall outcomes and care experience for people, families and staff.

The objectives[3] of the Collaborative were for the Healthcare Improvement Scotland (HIS) Primary Care Improvement Portfolio to work with Health and Social Care Partnerships (HSCPs) and GP Clusters to apply quality improvement (QI) tools and methods designed to ensure patient involvement to:

- Improve care navigation and direct patients to the most appropriate source of help or advice and be able to demonstrate their patients receive the right care at the right time.
- Improve processes and develop protocols for seamless documentation management and be able to demonstrate reduced GP involvement in correspondence management.
- Promote collaboration and communication across practice teams and with other care providers.
- Build capacity and capability in QI methodology and develop leadership, facilitation and influencing skills.
- Develop and test protocols and related resources to support testing of interventions and measure improvement in care navigation and document management.

[2] PASC Webpage https://ihub.scot/improvement-programmes/primary-care/practice-administrative-staff-collaborative/ accessed 16/5/2019.

[3] Practice Administrative Staff Collaborative 2017-19 specification, 2.2.

1.1 The PASC approach and expected benefits

The PASC approach was based on the Institute for Healthcare Improvement's Breakthrough Series (BTS) Collaborative model developed by Langley and Nolan[4]. The vision of this model is that there is reliable evidence about how the costs and outcomes of current health care practices can be greatly improved, but much of this knowledge is generally unused in daily work. There is a gap between what we know and what we do. The Breakthrough Series approach is designed to help organisations to close that gap by creating a structure in which interested organisations can easily learn from each other and from recognized experts in topic areas where they want to make improvements.
A Breakthrough Series Collaborative is a short-term (6- to 15-month) learning system that brings together a large number of healthcare staff to seek improvement in a focused topic area – in this case the development of roles and skills of practice administrative teams in GP Practice settings **in order to** improving the overall outcomes and care experience for people, families and staff.

PASC was designed to engage and support HSCPs to work together on three key areas:

- QI methodology and Leadership Skills – to support development of capacity and capability, and leadership, facilitation and influencing skills.
- Document management – to improve practice processes and document management.
- Care navigation – to guide service users to appropriate resources and services, both inside and outside the practice.

A key principle of the Collaborative process is to engage stakeholders to work together to prototype processes and tools rather than providing the process and tools.

All HSCPs in Scotland were invited to apply to join the PASC, and it was originally intended to select three. The application process was clear that each selected Partnership would be expected to recruit approximately four GP Cluster[5] teams to take part in PASC, and an Associate Improvement Advisor to support the work.

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[4] Institute for Healthcare Improvement (2003) The Breakthrough Series – IHI's Collaborative Model for Achieving Breakthrough Improvement. Innovation Series 2003. http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

[5] GP Clusters are typically groups of between five to eight GP practices in a close geographical location. As described in the Scottish Government's 2017 publication, Improving Together, the purpose of the clusters is to encourage GPs to take part in quality improvement activity with their peers; and to contribute to the oversight and development of their local healthcare system. Improving Together offers an alternative route to quality through facilitating collaborative relationships and learning in order to develop and improve together for the benefit of local communities

HIS envisaged that the benefits[6] of participating in the Collaborative would be that:

- Patients
  - Will be signposted to the appropriate source for advice and guidance.
  - Will find it shortens the wait to get the appropriate help and advice.
  - Will support self-help and self-management.
  - Will find it easier to get an appointment with the GP if they need to see a GP.
  - Will have overall improved outcomes and care experience for people, families and staff.
- The Practice Team
  - Will have improved communication and collaboration across the practice team.
  - Will be recognised as leaders in improving the processes within their practice to ensure their patients receive the right care at the right time.
  - Will be able to build on their pool of knowledge about improvement methods and apply this to future improvement work.
  - Will have improved practice processes resulting in reduced GP involvement in documentation management.
  - Will develop practice staff roles and provide opportunities for increased job satisfaction for practice team members.
  - Will be improving the overall care experience and reducing delays for their patients.
- HSCPs and GP Clusters
  - More collaborative working across the cluster.
  - Development of the role of practice managers in the cluster.
  - Recognition as leaders in improving skills of non-clinical practice staff.
  - Improved collaboration and communications across teams leading to overall improved outcomes and care experience for people, families and staff.

1.2 The PASC 'team'

Following a competitive recruitment process, four teams from six Health and Social Care Partnerships (HSCPs) were selected to join the Collaborative:

- Argyll and Bute HSCP
- Clackmannanshire & Stirling and Falkirk HSCPs (joint application)
- East Lothian HSCP
- South Lanarkshire and North Lanarkshire HSCPs (joint application).

[6] Practice Administrative Staff Collaborative 2017-19 specification, 2.4

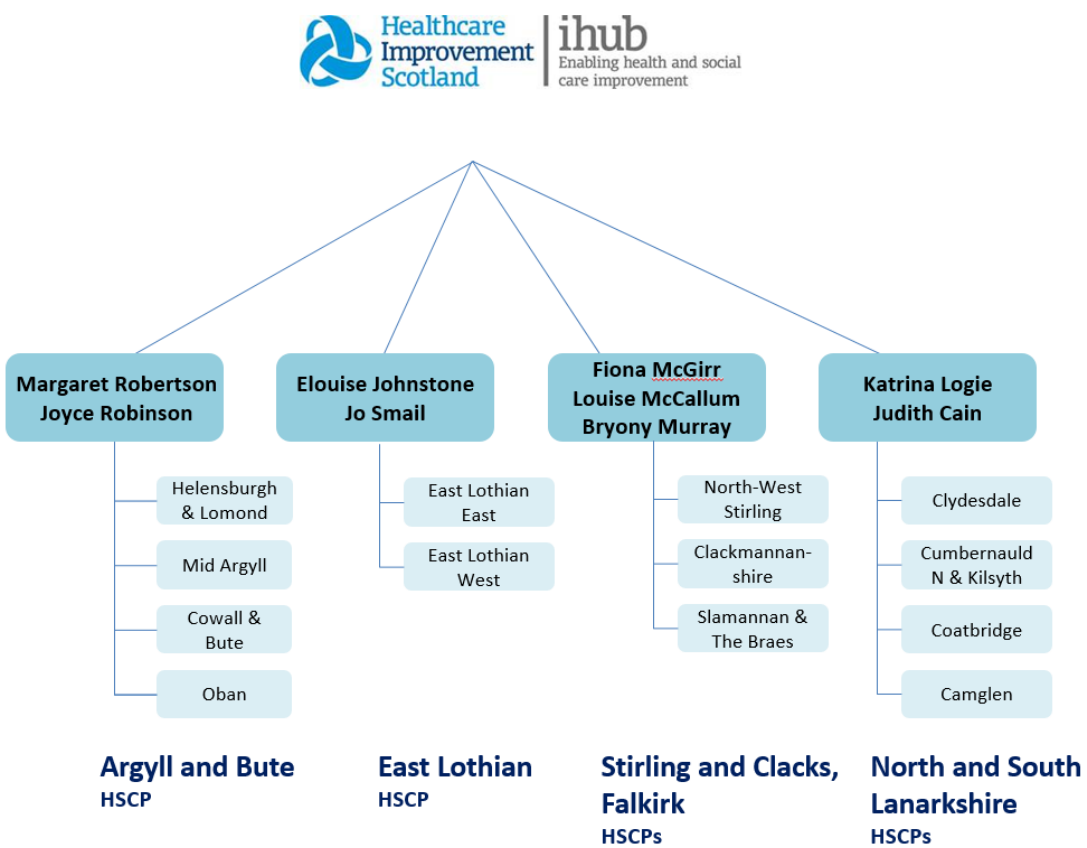
The teams involved a selection of 13 GP clusters, participating in a range of quality improvement activities. GP Clusters are typically groups of between five to eight GP practices in a close geographical location. The purpose of GP Clusters was set out in the Scottish Government's 2017 publication, Improving Together[7], to:

- Encourage GPs to take part in quality improvement activity with their peers.
- Contribute to the oversight and development of their local healthcare system.

The development of GP Clusters is designed to provide an alternative route to quality through facilitating collaborative relationships and learning in order to develop and improve together for the benefit of local communities. As such, Clusters are absolutely complementary to the Breakthrough Series Collaborative approach taken by the PASC.

Each local team was supported by an Associate Improvement Advisor and a relevant senior manager from each of the HSCPs. See Figure 1.

Figure 1: The PASC team



[7] https://www2.gov.scot/Resource/0051/00512739.pdf

HSCPs selected to join the PASC were provided with £107,350 to support their work to develop practice administrative staff teams. HIS did not provide any direction on now the funding should be used, but it did provide clear guidance that use of the funding should include the appointment of a part-time (0.5 WTE) Associate Improvement Advisor (AIA) for 12 months.

Table 1: The PASC Core Team

Local team	HSCP leadership	Associate Improvement Advisor (0.5 WTE)
Argyll and Bute	Primary Care Manager Argyll and Bute HSCP	Recruited specifically for PASC
East Lothian	GP Partner, and Cluster Quality Lead	Absorbed into work of Quality & Safety Improvement Officer, NHS Lothian
Stirling & Clackmannanshire and Falkirk	Improvement & Innovation Advisor, NHS Forth Valley	2 x Practice Managers supported into the AIA role
North and South Lanarkshire	Senior Improvement Manager Primary Care, NHS Lanarkshire	Recruited specifically for PASC

1.3 Governance

The ihub Quality Committee was responsible for the governance of PASC; and is responsible to the Board of HIS. For the duration of the Collaborative, an operational Steering Group was convened comprising key representatives of participating HSCPs, NHS Education for Scotland and HIS. The Steering Group was chaired by a Professional Advisory who was a Practice Manager. See Table 2 for membership.

Additionally, a 'Network Group' for the PASC area AIA was established to provide support and facilitate collaboration across the four different PASC areas. Over the life of the Collaborative the Steering/Networking Group met approximately every six weeks.

Table 2: PASC Steering Group membership

Name	Organisation	Job title/role
Gordon Black	HIS	GP Clinical Lead
Linda Brown	HIS	Public Partner
Margaret Hogg	HIS	Public Partner
Claire Mavin	HIS	Improvement Advisor
Jill Gillies	HIS	Portfolio Lead, Primary Care Improvement Portfolio
Anne Ribet	HIS	Practice Manager (PASC Professional Advisor) **(Chair)**
Tracey Crickett	NES	Business and Development Manager
Carol McCambley	NHS 24	Stakeholder Engagement Manager
Louise McCallum	NHS Forth Valley	Practice Manager/PASC AIA
Fiona McGirr	NHS Forth Valley	Practice Manager/PASC AIA
Bryony Murray	NHS Forth Valley	Improvement & Innovation Advisor
Brian McLachlan	NHS Highland	Medical Director
Margaret Robertson	NHS Highland	PASC AIA
Joyce Robinson	NHS Highland	Primary Care Manager
Judith Cain	NHS Lanarkshire	Senior Improvement Manager
Katrina Logie	NHS Lanarkshire	PASC AIA
Elouise Johnstone	NHS Lothian	Community Engagement and Improvement Support Manager/PASC AIA
Joanna Smail	NHS Lothian	GP (CQL)
Christine Johnstone	Scottish Health Council	Community Engagement and Improvement Support Manager

2 The evaluation of the Practice Administrative Staff Collaborative

The purposes of the evaluation of PASC were to:

1. Assess the achievement of PASC aims and objectives.
2. Identify enablers for and challenges to the achieving the change needed.
3. Identify lessons learned.

An outcomes chain approach was used (see Figure 2, and the technical appendix for the evaluation framework[8]) which:

- Draws the relationship between programme activities and outcomes.
- Tests the PASC theory of change i.e. that programme activities will contribute to improved overall outcomes and care experience for people, families and staff by
  - Developing practice administrative teams.
  - Improving GP practice processes and appropriate care navigation.

The evaluation framework was strategic rather than detailed, allowing for analysis across the programme as a whole whilst drawing out the similarities and differences etc. across the different areas.

Figure 2: Summary outcomes chain and evaluation framework

	Summary outcomes chain
Impacts: Have you achieved the impacts that you need to?	**Improved care experiences**: reduced wait for appropriate help; support for self-management • Effective signposting • Reduced GP involvement in documents
Intermediate outcomes: Do you have the building blocks in place to enable you to achieve the impacts that you need?	• **Behaviour change**: role development; communication; collaboration • Learning: from testing; re QI, leadership/facilitation/influencing skills • Testing
Immediate outcomes	• Stakeholder **reactions**/engagement • Stakeholder **reach** • Establishment of **relationships**: HIS/HSCP/GP

[8]The evaluation framework was clearly based on the Specification for the Practice Administrative Staff Collaborative 2017 – 2019; and agreed with the PASC Steering Group. This can be found www.ihub.scot/pasc.

2.1 Evaluation activities and tools

The evaluation methods were designed in relation to the evaluation framework, and included:

- Analysis of programme reach and engagement.
- Interviews and focus groups
  - seven focus groups were conducted, engaging 37 stakeholders, plus a focused reflective discussion with the PASC Core Team, see evaluation tool document
  - 14 interviews were conducted face-to-face or by phone, see evaluation tool document
- Reflective workshops at PASC Learning Session 2 (28th November 2018), engaging 82 stakeholders.
- Stakeholder survey: the web-based survey was disseminated by the HIS PASC team and the AIAs for each demonstrator area from 27th March 2019; it was closed on 28th April 2019. There were 189 respondents to the survey.
- Almost three quarters (72%: 101) of survey respondents came from PASC demonstrator areas, indicating their engagement in PASC as well as showing that the survey response was a reliable indicator of stakeholder perspectives from those areas. See Table 6 (Section 3.1: Engagement in PASC).

For more information about the tools used in the evaluation please visit www.ihub/pasc

3 PASC reach and engagement

For a collaborative to work effectively it needs to reach and positively engage the relevant stakeholders. For PASC, it was important that the key stakeholders to engage included:

- Practice Administrative staff
- Practice Managers
- GPs
- GPs who were Cluster Quality Leads
- Health and social care professionals to whom patients could be directed, as appropriate
- Supportive strategic stakeholders.

Whilst it was especially important for PASC to engage these stakeholders in the selected areas, HIS also wanted to draw upon the vast expertise of the wider primary care workforce in Scotland.

3.1 Engagement in PASC

3.1.1 PASC teams

HIS selected four teams from six HSCPs to join the Collaborative. This covered 13 GP Clusters (9% GP Clusters in Scotland) and 81 GP Practices (9% GP Practices in Scotland[9]). See Table 3.

Table 3: National engagement in PASC

	Scotland[10]	Engaged in PASC teams[11]		Engaged in PASC events[12]	
GPs	5,103			56	1%
GP Practices	940	81	9%	198	21%
GP Clusters	147	13	9%		

Almost one fifth (18%: 36) of GP Practices engaged in the PASC team were rural – notably in Argyll and Bute, where 58% (19) of GP Practices engaged in PASC teams were rural and almost one half (24%: 8) were dispensing GP Practices. See Table 4. Remoteness and rurality are key factors for consideration in care navigation away from GPs.

[9] Data from https://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/ Accessed 21 May 2019

[10] Source: https://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/ Accessed 21 May 2019

[11] Source: local PASC AIAs

[12] Source: SMCIA analysis of data provided by HIS

PASC was designed to support the development of processes and tools to optimise workflow ('Workflow Optimisation' [WO]) i.e. documentation away from GPs; and to appropriately navigate patients to health and /or social care professionals and resources instead of to GPs ('Care Navigation' [CN]).

The establishment of Multi-Disciplinary Teams (MDT) varied widely across the PASC teams, with them being relatively more being established in Forth Valley. The development and establishment of MDTs in GP Practices is significantly important for the development of care navigation within the Practice for example, from GPs to Advanced Nurse Practitioners (ANPs) or Physiotherapists (see Section 5).

3.1.2 PASC events

HIS engaged 450 individuals from 25 (81%) HSCPs in the Collaborative: almost half (49%: 168) of the people attending PASC events etc were from HSCPs that were not PASC demonstrators. See tables 5 and 6.

More than three quarters (24: 77%) of the HSCPs in Scotland sent staff to PASC events. Out of 191 GP Practices, 415 people participated in at least one PASC learning session/celebratory event (not including WebExes). Out of the 415 people, 7% (29) attended both learning events and the celebratory event – most of these people (76%: 22) were from GP Practices engaged in PASC. See Table 8.

Almost one third (32%: 143) people engaged in PASC participated in at least one WebEx, see Table 9. Almost half of the people participating in WebExes were Practice Managers (45%: 64), with 22 (15%) participants being Practice Administrative staff, and 21 (15%) being GPs. The majority (65%) of individuals participating in WebExes were not from PASC demonstrator GP Practices.

Almost half of the people reached by PASC were Practice Managers (48%: 190); with 81 (20%) Practice Administrative staff being engaged in PASC events. Of the people engaged by PASC, 14% (56) were GPs– 1% of all GPs in Scotland. See Table 10. More than one fifth (21%: 198) of GP Practices participated in PASC events, of which 140 (71%) were Collaborative members. Almost one third (58: 29%) of GP Practices engaged in PASC were not Collaborative members.

Practice Administrative staff have a variety of job titles, see Table 11. One third (33%: 27) of these staff engaged in PASC were 'Administrators' and one quarter (25%: 20) were 'Receptionists'. Notably some staff were 'Healthcare/Patient Advisors', perhaps indicating the development of job roles relating to care navigation; and some were 'Workflow Administrators', perhaps indicating the development of job roles relating to workflow optimisation.

Table 4: The PASC areas

	PASC area				
	Argyll and Bute	East Lothian	Forth Valley	Lanarkshire	Total
Total GP Clusters[13]	6	2	9	16	33
GP Clusters engaged in PASC[14]	4 (67%)	2 (100%)	3 (33%)	4 (25%)	13 (39%)
Total GP Practices[15]	33	15	55	102	205
GP Practices engaged in PASC[16]	22 (67%)	15 (100%)	19 (35%)	25 (25%)	81 (40%)
Rural Practices[17] engaged in PASC[18]	19 (58%)	4 (27%)	3 (5%)	10 (10%)	36 (18%)
Dispensing Practice engaged in PASC[19]	8 (24%)	0	0	2 (2%)	10 (5%)
Practices with MDTs engaged in PASC[20]	8 (24%)	N/A	17 (31%)	16 (16%)	

[13] Source: https://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/ Accessed 21 May 2019

[14] Source: local PASC AIAs

[15] Source: https://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/ Accessed 21 May 2019

[16] Source: local PASC AIAs

[17] As defined in the General Medical Services Statement of Financial Entitlements

[18] Source: local PASC AIAs

[19] Source: local PASC AIAs

[20] Source: local PASC AIAs

Table 5: Individuals engaged in PASC and survey respondents

HSCP	Engaged		Survey respondents	
Angus	4	1%	1	1%
Argyll and Bute	**21**	**6%**	**13**	**9%**
City of Edinburgh	27	8%	2	1%
Clackmannanshire & Stirling	**28**	**8%**	**20**	**14%**
Dumfries & Galloway	6	2%	1	1%
Dundee City	3	1%		
East Dunbartonshire	6	2%	1	1%
East Lothian	**63**	**18%**	**36**	**26%**
East Renfrewshire	1	0%		
Falkirk	**8**	**2%**	**3**	**2%**
Fife	28	8%	5	4%
Glasgow	29	8%	6	4%
Highland	9	3%	8	6%
Inverclyde	9	3%	1	1%
Moray			2	1%
North Ayrshire			1	1%
North Lanarkshire	**26**	**8%**	**8**	**6%**
Perth and Kinross	4	1%	2	1%
Renfrewshire	16	5%		
Scottish Borders	5	1%	2	1%
Shetland	1	0%		
South Lanarkshire	**28**	**8%**	**24**	**17%**
West Dunbartonshire	11	3%	2	1%
West Lothian	4	1%	3	2%
Western Isles	5	1%		
Total	**342**	**=76% engaged individuals**	**141**	**=75% survey respondents**

Source: SMCIA analysis of data provided by HIS and SMCIA Survey of PASC Stakeholders

Table 6: Individuals from PASC areas engaged in PASC

PASC areas	Engaged		Survey respondents	
Argyll and Bute	21	6%	13	9%
East Lothian	63	18%	36	26%
Forth Valley	36	11%	23	16%
Lanarkshire	54	16%	32	23%
Total	**174**	**51%**	**104**	**74%**

Source: SMCIA analysis of data provided by HIS and SMCIA Survey of PASC Stakeholders

Table 7: Participation in PASC Learning and Celebratory events

	Overall		3 Events	
Total participants	**415**		**29**	
Individuals from GP Practices engaged in PASC	136	33%	22	76%
Engagement Staff	1	0%		0%
GPs (including CQLs)	53	13%	9	31%
IT/Information/Data staff	9	2%		
Managers (not in GP Practices)	19	5%		
Nurse	3	1%		
Other	11	3%		
Practice Administrative Staff	75	18%	2	7%
Practice Business Manager	10	2%		
Practice Manager/Assistant/Deputy	182	44%	15	52%
QI staff	12	3%	2	7%
n/a	39	9%	1	3%

Table 8: Participation in PASC WebExes

WebExes		
Total participants	**143**	**=32% people engaged in PASC**
Individuals from GP Practices engaged in PASC	50	35%
Engagement staff	1	1%
GPs (including CQLs)	21	15%
IT/Information/Data staff	1	1%
Managers (not in GP Practices)	4	3%
Practice Administrative Staff	22	15%
Practice Business Manager	1	1%
Practice Manager/Assistant/Deputy	64	45%
QI staff	7	5%
Other	6	4%
n/a	16	11%

Source: SMCIA analysis of data provided by HIS

Table 9: Job titles of people engaged in PASC

Job title		Engaged		Survey respondents
Practice Manager/Assistant/Deputy	190	48%	36	49%
Practice Administrative Staff	81	20%	21	28%
GPs (including CQLs)	56	14%	10	14%
Managers (not in GP Practices)	20	5%		
QI staff	12	3%		
Practice Business Manager	11	3%	1	1%
IT/Information/Data staff	9	2%		
Engagement Staff	3	1%		
Nurse	3	1%	3	4%
Other	13	3%	3	4%
Total	**385**	**=86% total engaged**	**74**	**=39% total survey respondents**

Source: SMCIA analysis of data provided by HIS and SMCIA Survey of PASC Stakeholders

Table 10: Practice Administrative Staff job titles

Practice Administrative Staff job titles	Engaged		Survey respondents	
Administrator	27	33%	6	29%
Clinical Coder	1	1%	1	5%
Contract Administrator	1	1%	1	5%
Communications and Engagement Officer			1	5%
Lead Clerical Officer	1	1%	1	5%
Medical Administrator	1	1%		
Medical Receptionist	5	6%	2	10%
Medical Secretary	1	1%	1	5%
Office Manager/Supervisor	15	19%		
PA	1	1%		
Reception Manager/Supervisor	6	7%	1	5%
Receptionist	20	25%	3	14%
Healthcare/Patient Advisor	1	1%	3	14%
Workflow Administrator	1	1%	1	5%

Source: SMCIA analysis of data provided by HIS and SMCIA Survey of PASC Stakeholders

3.2 Stakeholder perceptions of reach and engagement of PASC

Stakeholders generally considered that 'the right people' were involved in PASC activities, see Figure 3. They also generally welcomed their involvement with PASC, with 76% (125) survey respondents saying that they welcomed their involvement with PASC – 73 (41%) of whom welcomed their involvement 'very much'. See Table 12. Survey respondents' comments about their involvement in PASC related to:

- Support for ongoing development within the context of the implementation of the GMS Contract
  - *This is a significant programme which serves to support the capacity and capability building within GP practices as one of the commitments within the GMS Contract.*
  - *Recognise it is essential the provision and organisation of care provided from health centres needs to be more efficient and effective. Making best use of the skills of each member of the multidisciplinary team.*
  - *I hope to use the workflow optimisation work to create a similar system to implement in my own practices as part of my Work Based project for the PM VTS.*
- Support for individual development
  - *I really enjoyed the process as did our practice team. I am studying towards my PgCert QI in Healthcare with UHI and this has aided my understanding of the theory and methodology.*
- Hearing about practice elsewhere
  - *The training sessions were very good, and it was interesting hearing how other Practices were doing.*

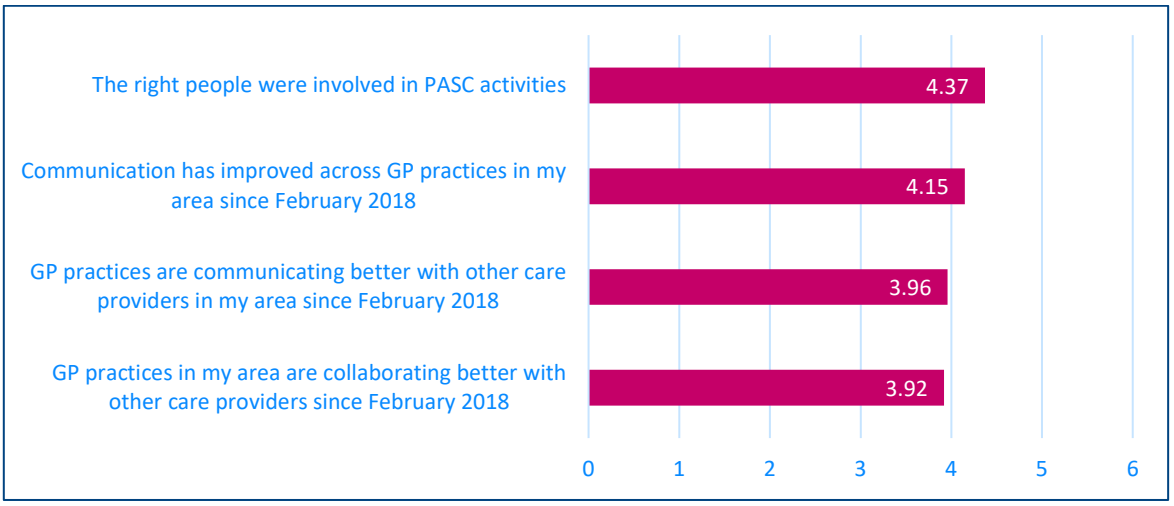
- Time to participate in PASC put staff under pressure
  - *General Practice is so busy any time away creates a backlog and puts staff under pressure.*
- Unwelcome involvement because 'imposed'
  - *Imposed on us from on high with precious little evidence base and no choice in the matter.*

Table 11: Did survey respondents' welcome involvement with PASC?

	Respondents involved in PASC activities	
I welcomed my involvement with PASC very much	73	41%
I welcomed my involvement with PASC	62	35%
I didn't really welcome my involvement with PASC	4	2%
I didn't welcome my involvement with PASC at all	0	0%
Total	**139**	**79%**

Stakeholders also considered that engagement at the local level, notably GP communication and collaboration – including with other care providers – had improved over the duration of the Collaborative. See Figure 3. This is particularly relevant in relation to care navigation, which relies on there being other care providers to which patients can be appropriately directed. See Section 5 (Care Navigation).

Figure 3: Stakeholder perceptions of engagement



Source: SMCIA Survey of PASC stakeholders
N=141 (75% of all respondents)
0 = strongly disagree; 6 = strongly agree

3.3 Summary

Four demonstrator teams from six HSCPs were selected by HIS to form the Collaborative. This covered 9% (13) GP Clusters in Scotland) and 9% (81) GP Practices.

HIS invited wider stakeholders in primary care in Scotland to participate in Learning Sessions and WebExes in order to share the learning from the Collaborative. Staff from more than three-quarters (81%: 25) of all HSCPs in Scotland attended PASC events, with almost half (49%) of the participants working in HSCPs that were not PASC demonstrators.

More than one fifth (21%: 198) of all GP Practices in Scotland were engaged in PASC activities – of which 140 (71%) were Collaborative team members. One percent of all GPs in Scotland (56) were engaged in PASC activities.

PASC successfully reached Practice Managers (48%: 180 participants) and Practice Administrative Staff (20%: 81 participants).

Practice Administrative staff have a variety of job titles. One third (33%: 27) of these staff engaged in PASC were 'Administrators' and one quarter (25%: 20) were 'Receptionists'. Notably some staff were 'Healthcare/Patient Advisors', perhaps indicating the development of job roles relating to care navigation; and some were 'Workflow Administrators', perhaps indicating the development of job roles relating to workflow optimisation.

The ‘right people’ were involved in PASC activities. Stakeholders welcomed their involvement in PASC activities because they:

- Provided support for ongoing development within the context of the implementation of the GMS Contract.
- Enabled them to learn about practice elsewhere.
- Provided support for individual development.

Stakeholders considered that engagement at the local level, notably GP communication and collaboration – including with other care providers – had improved over the duration of the Collaborative. This is particularly relevant in relation to care navigation, which relies on there being other care providers to which patients can be appropriately directed.

4 Workflow optimisation

4.1 The need for change/improvement

Survey respondents who were involved in workflow optimisation work through PASC (89: 51% survey respondents) generally considered that there was a need to improve their workflow/ document management. See Figure 4. GPs noted that GP Practices were receiving more documentation, with significant duplication:

- The issue in document management is that there's a lot of duplication – we need to cross-check and filter things out.
- The volume of documentation is increasing significantly.

However, GPs in rural practices – in particular single-handed GP Practices – considered they there was less need – and less capacity – to change how they handled documentation:

- We're a small Practice, and we don't have separate 'receptionist', 'administrator' and 'coder' roles – so we haven't prioritised this work.
- I only have one admin staff, so I can't have a dedicated workflow person.
- Systems to reduce documents going to GPs are less relevant because we don't have the quantity of documents as larger practices do; and we have fewer staff – we only have two GPs and less than 1.5WTE admin staff. We can't have someone doing just document scanning – the admin staff are both multi-tasking on reception, doing pharmacy etc.
- I'm not sure how relevant PASC is to rural practices, but I wanted to ensure that rural practices were represented in PASC – to stress that we can't do much on workflow optimisation because of the number and capacity/skills of staff: it's important that the toolkit reflects this. We need other kinds of investment in staff training etc.

Nevertheless, GPs who were engaged in PASC consider that they have learnt from their involvement, and have made some changes to how they handle documentation:

- We've taken the ideas of PASC, and are doing coding – literally for only one or two things e.g. some lab results – before they go to the GP.

One Practice Manager interviews stressed the importance of explicating the need the change workflow in order to win the buy-in of Practice Administrative staff:

- We gave the admin staff the why – the reasons behind what we wanted to do i.e. so that GPs could have quality time to spend with patients, and so that GPs and other staff could go home on time. Then we invited people to volunteer to be involved in the workflow work.

4.2 Intermediate outcomes: learning and behaviour change

Interviewees and participants in focus groups stressed the need to have the support of both Practice Administrative staff and GPs before attempting to change workflow:

- We needed GP buy-in.
- It's all about attitude – we're lucky. We offered the work to people [Practice Administrative staff] who wanted to develop their role. The key thing is that they wanted to do it.

Practice Managers stressed the importance of "starting small", to 'test' the change (see Section 6.2: Capacity and Capability in QI Methods) and prove to the team that "it's worth it".

- We were already using Docman[21]. We started small, and built up what we didn't send to the GP.
- We started small.
- I'm keen to start the more junior staff doing simpler documents – we have a lot of younger staff who are eager to learn. We'll start small, for example, with A&E letter, Opting-in letters; and then – when we've proved that it works – we'll increase to include them working with hospital discharge letters, medication change, coding; and then we'll get to the stage where they can flag things to the GPs.

Practice Administrative staff expressed their anxieties about having more responsibility in handling clinical documentation:

- We had Docman before [PASC], but everything went to the GPs – it's a big change to manage it all ourselves [Practice Administrative staff].
- It's more responsibility – it's scary.
- At the start we [Practice Administrative staff] were nervous because it was a lot of responsibility. But now we're OK because we have the protocols.

Practice Managers described how carefully they selected Practice Administrative staff to work on workflow optimisation. Not only did they need to **want to do** this new work, with this new responsibility, but they also needed to be **experienced** and/or confident, and act a 'champions' for this new extended Practice Administrative staff role:

- We identified a fairly new staff member to work with the GPs on workflow optimisation. She was interested in developing her role further, and we asked her if she wanted to do it. We'll train two other staff on workflow so that we can support further role diversification.
- We chose three very experienced admin staff to be 'workflow managers'.
- We chose two experienced admin staff to do workflow. They'd used Docman before, but with this project they started doing other workflow to absorb the documents that would have gone to GPs. This was brand new.

[21] A cloud based software platform that manages inbound clinical correspondence https://www.docman.com/

Practice Managers were also mindful of team capacity and the resourcing of this additional work for Practice Administrative staff:

- We wanted to have more than one person managing the workflow so that we had cover, and so that they wouldn't be alone in the new role.
- We started with workflow optimisation because we were keen to build on the success of other Practices, but we needed the resource: we invested 10 extra hours to develop the business case so we could do test runs. The GPs were happy, so now we've invested in an additional colleague for 20 hours a week to provide cover. She started a few weeks ago, and is doing backfill for the two admin staff who cover the workflow for the week. They don't do workflow for all of their time, each does two or three days a week, but the new post covers their time so that they can do this. It's beginning to become business as usual, so that we have someone on workflow five days a week.

Practice Administrative staff who were working in this new extended role described that:

- They enjoyed their new responsibilities
  - We've begun to talk about blood results being managed by the admin team – I'd like that, I like being more involved, I like the responsibility.
  - I like new challenges, and having something else to learn.
- Some previous experience of clinical coding helped
  - I already did a lot of coding, which makes it much easier – it would be difficult if you hadn't done coding before.
- They simply had to absorb the new responsibility into their other work
  - It is extra responsibility, but we just fit it in around other things.

Practice Managers noted that the provision of formal certified training for Practice Administrative staff on workflow optimisation was important:

- It really helped boost their confidence that they did formal training that was certificated.

However, a key issue for GPPractices was finding time for Practice Administrative staff to do the training, with a real need for protected learning time for these staff:

- The training hasn't happened yet – the admin staff don't have time to do it.
- The big issue is having time for the admin staff to do it.
- We really need protected time for the admin staff.

More important, perhaps, than formal training, was for Practice Administrative staff, Practice Managers and GPs to take time to develop the process – or protocols – for Practice Administrative staff to have a greater responsibility for document management. The key aspect of this is for GPs to work with and support Practice Administrative staff:

- We [Practice Manager] extended the GP 'buddy' system to buddy each administrator with 1 or 2 GPs, so the training happened 'naturally' as on-the-job training.

- We supported [the Practice Administrative staff] – I [Practice Manager] sat with her for the first month or so to work out the plan, and we had a GP with her for the first hour every day for 2 weeks to develop the system and quality check the work.
- It was important to stress that the GPs would support the admin staff. A lot of them have been here for a while, and were worried about any change. So the GPs sat with them for the first week, and we stressed that if they weren't sure about anything that they should send it to us. Now it's become business as usual to use the protocol. And it's given them confidence.

A key challenge is to achieve consensus within the Practice on how to deal with different types of documentation. Practice Managers and GPs noted that this took time, and patience – and that the development of consensus was generally facilitated by the Practice Manager:

- The Practice Managers and GPs developed a list of the different kinds of documentation to tell us [Practice Administrative staff] where everything goes. It's working really well.
- Every GP wants something different – each of them wants to see different documents, so getting agreement across 10 GPs is difficult!
- All GPs are different – some are interested in seeing somethings, and some other things. But we need a consistent procedure.
- Getting agreed protocols takes time to develop – a year isn't long enough!
- We [Practice Administrative staff] asked the GPs for feedback on whether we were doing the right things with the documents, and to clarify what they need to see and what they don't need to see. We spent a lot of time discussing it with GPs and developed a spreadsheet to identify what doesn't need to go to GPs, what GPs just need to read, and what GPs need to read and action. It took us months to develop it! [The Practice Manager] facilitated the meetings.

The key issue in developing protocols for Practice Administrative staff taking on more responsibility for workflow is clinical governance. All stakeholders stressed the importance of GPs having overall responsibility for clinical correspondence:

- We developed a process for GPs to have oversight.
- The GPs do a monthly audit and review it against our protocol. This is really helpful in reassuring us [Practice Administrative staff] that we're doing it right.
- I [Practice Administrative staff] like the feedback from the doctors – we have a monthly audit where the GPs check, and give us written feedback.
- Mail is scanned into Docman, and everything is sent to the workflow administrator. She decides what to do and put it into a 'trial' mailbox, and the GPs check it – they spent an hour every day doing this. Now we're still continuing the trial mailbox, but only for approximately 1 in 10 documents. As a rule of thumb, we say that if you need to think too much about it, put it into the trail mailbox so that the GPs can check it, or send it straight to the GP.
- The GP needs to quality assure the process – we've done a lot of work on this.
- A GP meets regularly with the Coders to manage the risk.

One Practice Manager interviewed suggested that the extension of the Practice Administrative staff to manage clinical correspondence raised issues of the professionalisation of this role:

- The problem with a protocol is that it can become very black and white – and General Practice isn't black and white. There needs to be professional autonomy for the administrator, and assurance of safety through GP checking. The GPs need to take time to work with the administrator to work out the process. There definitely needs to be a quality check, and feedback to the admin staff on whether it's working. Everyone needs to be aware of the risk, but not scared half to death and too risk averse.
- Some GPs interviewed expressed their continuing worries about the risk in "handing over" management of clinical correspondence to Practice Administrative staff.
- We [GPs] don't want not to send things to the doctors – it's a small Practice thing: we're reluctant to let that risk be present. It's about giving responsibility to staff who are not trained and not paid to take the risk.
- A big issue is the medico-legal risk, the clinical governance of it.

Some GPs expressed their concerns about not being able to provide holistic care if they don't see all documentation relating to each patient:

- We've [GP] had some issues with not being informed about everything. The letters are interesting and important to our relationship with the patient. It's about having a holistic view.

Other GPs recognised the challenges that they have in "letting go" of some responsibilities:

- It's difficult to get used to things happening that I don't know about – it's about letting go.

A Practice Manager clearly expressed the developmental stage of workflow optimisation:

- We're all still learning what should and shouldn't go to the GPs – it's all part of the process, it's about learning what's appropriate.

Overall stakeholders were optimistic about the development of the Practice Administrative staff role to handle clinical correspondence:

- The admin staff are increasing their confidence and skill in workflow optimisation. It has made their role more interesting.

4.3 Perceived impacts: improved experience

Practice Administrative staff have experienced that the extension of their role to optimise workflow was "easier than they thought":

- It's easier than we thought.
- It's getting easier – we thought that we couldn't do it at the start.

They have seen the impact that it's having on GPs time:

- It's freeing up GPs so that they can do more housecalls.
- This is freeing up GP time.
- We've reduced the workflow to doctors by 48%!
- Now we've reduced the documents going to GPs by 60%.
- I didn't usually get home on time, but now I do!

Practice Managers interviewed commented on the impacts of the extension of the Practice Administrative staff role in reducing GP workload:

- I know it's better because since we started the Workflow Optimisation the GPs have waxed lyrical about it. They're not here until 8pm any longer. GPs from elsewhere have come to see what we're doing.
- We've seen a 45% reduction in the documentation that goes to GPs. They're all comfortable with it at the moment, but I don't think that we can reduce what they see any further.
- We've seen a 85% - 90% reduction in the documents going to GPs. They still get clinical results.

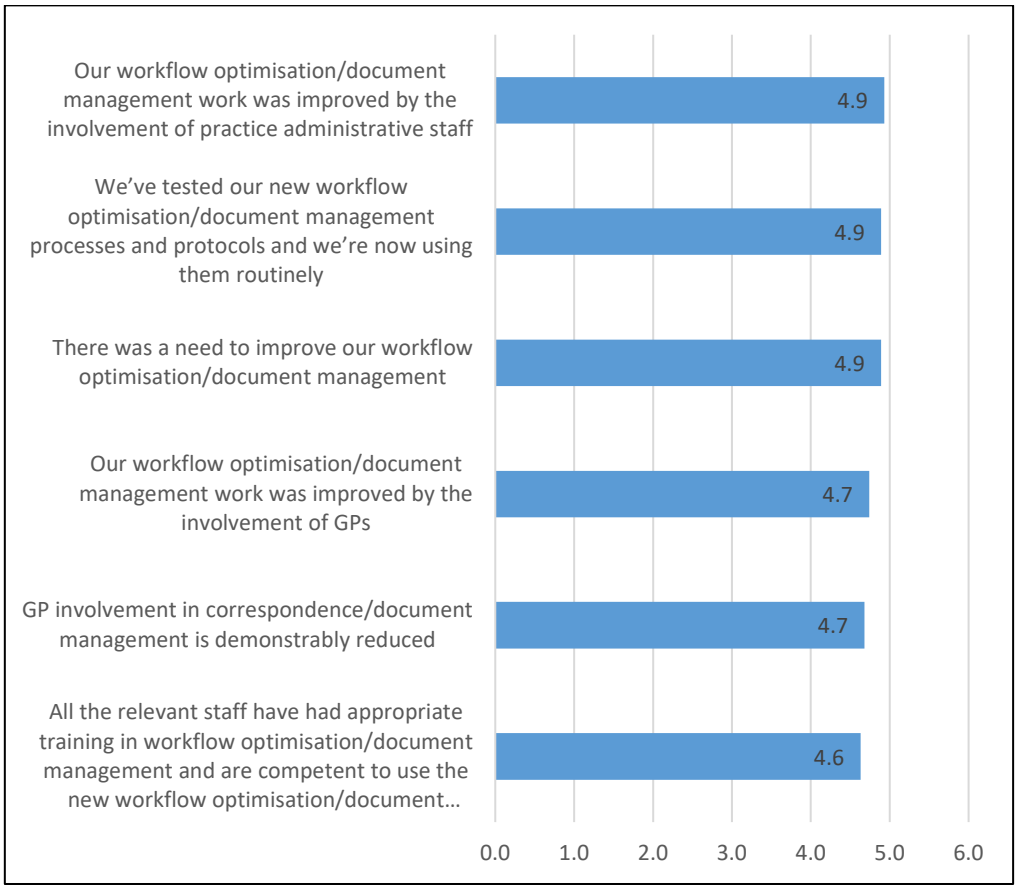
GPs interviewed also welcome the development of workflow optimisation by extending the Practice Administrative staff role:

- It has reduced the documents seen by GPs by 90%. Now we only see the key items.
- It's brilliant – it's reduced the volume.
- It's reduced our workload enormously.
- It's been amazing – the workflow work has reduced GP workload considerably.
- I welcomed the changes in improved workflow. The data showed the improvement that we experienced and knew. We [GPs] are getting less documentation, so it's easier to tackle.
- The admin staff coded documents that I'd [GP] struggle to code – that makes it much quicker to read letters.
- It's making us [GPs] much happier.

4.4 Stakeholder survey

Survey respondents who were involved in workflow optimisation work through PASC (89: 51% survey respondents) considered that this work was improved by the involvement of Practice Administrative staff and GPs – emphasising that the development of protocols and GP practices required effective teamworking and collaboration. They also generally considered that (in April 2019) relevant staff had had appropriate training and were competent in their newly extended roles; and they were confident that their new processes and protocols had been effectively tested and were being used routinely. Survey respondents were also confident that GP involvement in document management had been demonstrably reduced. See Figure 4.

Figure 4: Perceptions of the need for and usefulness of WO work



N=88 (99% respondents involved in WO)

0 = strongly disagree; 6 = strongly agree

4.5 Quantitative impacts

By the end of the Collaborative (May 2019), the volume of documentation sent to GPs within the 17 GP Practices that reported data had reduced by 44% on average. All these GP Practices saw a reduction which ranged from 13% to 81%.

4.6 Summary

Workflow optimisation work was welcomed by stakeholders, in particular GPs who were keen to receive less and more relevant clinical correspondence. It appears to be less relevant in rural GP Practices – in particular single-handed GP Practices.

It is important to have the support of both Practice Administrative staff and GPs for the development of workflow optimisation; and to 'start small', to 'test' whether the new process or tool actually achieved the desired improvement. Starting small and testing was also important in reassuring Practice Administrative staff, who were anxious about having more responsibility in handling clinical documentation; and GPs who were worried about the potential clinical risk in devolving this responsibility to administrative staff. Testing – and the collation of data on – the new approach to workflow also enabled some Practices to develop successful business cases for additional Practice Administrative staff.

Practice Managers carefully selected Practice Administrative staff to work on workflow optimisation, striving to ensure that they wanted to extend their job role, were experienced and/or confident in their competence, and that they could act as champions for this new role. The provision of support for Practice Administrative staff undertaking this new extended role was essential: firstly to ensure their competence; and second to assure the quality and safety of this work.

The formal certified training that the funding from HIS provided was important – but it was challenging for GP Practices to provide protected learning time for Practice Administrative staff. Formal certified training also supported Practice Administrative staff confidence, and will also support and perhaps facilitate their career development.

Perhaps even more important than formal training was work that Practice Administrative staff, Practice Managers and GPs did together to develop the new process/protocol for devolved management of clinical correspondence. A key challenge was to achieve consensus across GPs on this, in particular on how best to ensure clinical governance and management of risk, and maintain GP overall responsibility.

By the end of the Collaborative (May 2019), the volume of documentation sent to GPs within the 17 GP Practices that reported data had reduced by 44% on average. All these GP Practices saw a reduction which ranged from 13% to 81%. GPs were seeing more relevant documentation, and had more time to focus on patients. GPs were happier, and Practice Administrative staff were enjoying their extended role.

5 Care navigation

5.1 The need for change/improvement

Survey respondents who were involved in care navigation work through PASC (87: 49% survey respondents) generally considered that there was a need to improve their care navigation. See Figure 5. However, interviewees and focus group participants noted that there can be particular challenges:

- In remote and rural areas
  - There's no capacity for us to do care navigation – in rural GP practices we're it: there's nothing else. So we can't care navigate. But PASC provided an opportunity to look at it, and see if we could learn.
  - Care navigation is more tricky in rural areas. People think that there's nothing there to navigate patients to, but what if you had a locum – how would they know what's there to support patients?
- If the Practice doesn't have a multi-disciplinary team
  - We're getting better at internal signposting - it's much easier if there's a functioning MDT in the Practice.
- If Practices rely on internet appointment booking
  - We use internet booking, and you can't use care navigation in that unless the admin staff phone them.

5.2 Intermediate outcomes: learning and behaviour change

5.2.1 Relationships with other local care providers

Interviewees and focus group participants stressed the need for GP Practices to develop effective working relationships with other local care providers:

- You really need to work on your connections with local partners – it's different in each locality.
- Care Navigation has been fantastic – the admin staff default was to send the patient to the GP. PASC has broadened our view that there are other people out there who can help. You have to feel confident about signposting.

Existing links between GP Practices and Pharmacies have been strengthened through the PASC work:

- We have good links with the pharmacies anyway – they were initially worried that they'd have a huge increase in patients coming to them – but they were very supportive and put up flyers.
- Things are working better with the pharmacists in our areas.
- We've developed links with partners in the community, and are now having meetings every two to three months [with the local pharmacy].

One-off meetings with other care providers have helped develop relationships:

- We're having one-off meeting with partners in the community.
- We've had one-off meetings with opticians and dentists – they're happy to meet with us.
- In my Practice we invited pharmacists and independent opticians to meet with us. That helped.
- People don't know much about LENS22 [local optometric practices], and there are limited appointments available, but the PQLs went out and met with them.

Interviewees reflected that that the PASC work on care navigation had enabled them to better understand the capacity of other local care providers:

- This work has highlighted where our expectations can't be met – for example, the optician isn't there every day.

Some interviewees noted that care navigation away from GPs was putting other providers – notably opticians – under pressure:

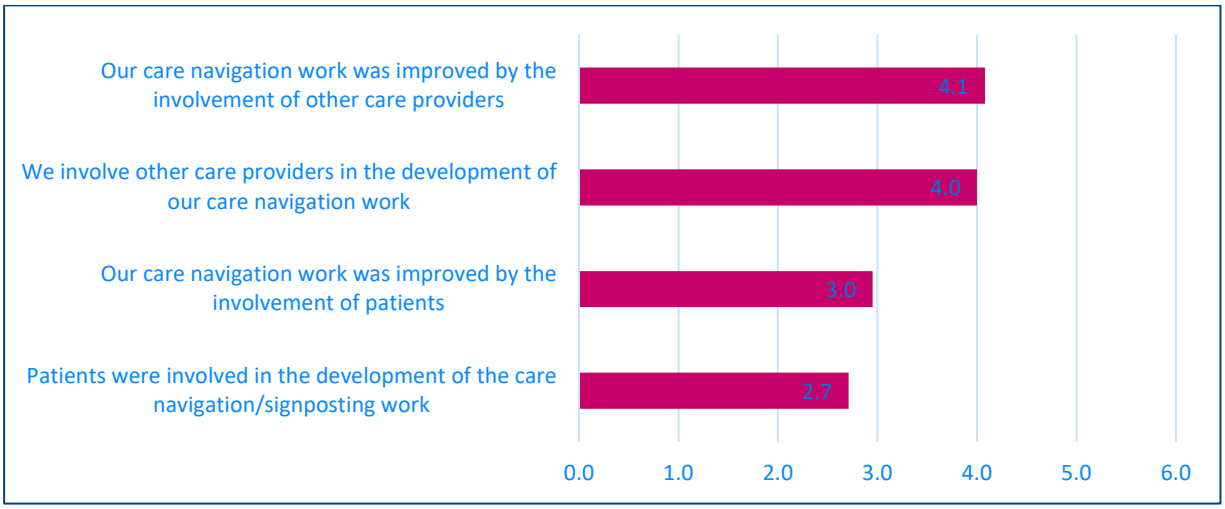
- The optician is getting lots more patients, and is now complaining.
- The feedback from opticians is that they're getting annoyed about patients being sent to them by the Practice.
- An independent optician complained to my Practice – the GPs assumed that it was in their contract to see patients referred from GP Practices.

Survey respondents who were involved in care navigation work (87: 49% survey respondents) generally considered that they had involved other care providers in this work – and that this involvement had improved the development of care navigation.

It is important to note, however, that survey respondents who were involved in care navigation work generally disagreed that patients had been involved in care navigation work. See Figure 5. This provides a particular challenge as patient involvement and empowerment in self-care is a key aspect of care navigation.

[22] https://www.nhslanarkshire.scot.nhs.uk/download/lens-optometric-practices-lanarkshire/

Figure 5: Stakeholder perceptions of engagement in care navigation work



Source: SMCIA Survey of PASC stakeholders
N=86 (99% respondents involved in Care Navigation work)
0 = strongly disagree; 6 = strongly agree

5.2.2 General Practice Multi-Disciplinary Teams

The establishment of Multi-Disciplinary Teams (MDT) varied widely across the PASC areas (see Section 3.1.1. The PASC areas), and is a key factor in the nature and development of care navigation. Some Interviewees were clear that the only care navigation that they did was to the in-house MDT:

- We don't do non-in-house signposting.

Advanced Nurse Practitioners (ANPs) were identified as playing a particularly important role in both clinical triage, and as an appropriate source of care instead of GPs:

- Now all patients are triaged in a phone conversation with the ANP. Sometimes they don't want to speak to her, but we just need to stick to our guns.
- Some of my colleagues are still not comfortable about sending someone away for a phone call with the ANP – but we all need to do it with all patients for consistency.
- The ANP's job has changed – it's moved away from diabetes, asthma, COPD etc, and now she just has slots for phones with patients – she had 82 the other day! She can give a prescription over the phone, give an ANP appointment or a GP appointment.
- We have an ANP in around three days a week – that really helps with on-the-day appointments.
- Having ANPs, mental health nurses, physiotherapists in the Practice really helps.

Practice Administrative staff who were interviewed stressed their need to understand the roles of the different professionals within the MDT so as to more effectively navigate patients to them:

- At one of the Create sessions we had a 'meet the experts' day, where we met mental health nurses, physiotherapists, pharmacists, ANPs to find out what they all do.

- The GPs get information about new professionals joining the MDT – but reception needs that information.
- We need to know who we can signpost to – how do we develop effective relationships with, for example, opticians.
- We had a community pharmacist come to one of our meetings, and she went through minor ailments.

5.2.3 Development of extended appointments with GPs

By freeing up some GP time through care navigation to other members of the MDT – and indeed through the workflow optimisation stream of the PASC work – some GP Practices developed navigation to extended GP appointments i.e. 20 minutes instead of the routine 10-minute appointment. Practice Administrative staff involved in navigation patients to extended GP appointment were experienced, trained in care navigation, and had the confidence to have an empathetic conversation with the patient and make the judgement as to whether to offer an extended GP appointment. It was also important to have agreed Practice protocols for care navigation in place; and it helped if the Practice Administrative staff member had some knowledge of the patient.

It is important to note that in the GP Practices where extended GP appointments are being tested this is not yet routine. However, patients who have experienced extended GP appointments consider that they have benefited from them:

- The thing I found most valuable was the fact that I was in with the doctor longer than 10 minutes. And in that 10 minutes I felt I wasn't being rushed, I was being asked the appropriate questions. She took her time, listened to me, formed her opinion and then arranged for the blood test to be taken. (Patient interviewed by a PASC AIA)

5.2.4 Training and support for Practice Administrative staff

Practice Managers noted the challenging nature of the front-door (reception) aspect of many Practice Administrative staff roles:

- It's very challenging being the first port of all for patients.
- Our reception team found it really very difficult to ask people why they wanted an appointment. Training reception staff is very important. It's changed their job.
- It's very stressful for reception staff, so they need the phrases, the questions to ask.

The training provided through PASC to support the development of care navigation was welcome. That the training was certificated was especially valued; and also the opportunity to meet staff from other GP Practices. Practice Managers and GPs stressed the importance of valuing and investing in Practice Administrative staff:

- Our admin staff were initially concerned about redirecting patients. Then they got training in assertiveness and communication – that really helped: they felt more positive and empowered...and they got certificates. They were very proud. Now the more they do care navigation, the more like second nature it is: we've given them the tools so that they know that this symptom goes there, that symptom goes there etc.

- The Receptionists are feeling more empowered to signpost patients.
- They did the training as a Cluster – not just the Practice. So the admin staff met staff from other Practices, and some went to PASC meetings.
- The training for admin staff has been successful – they've all enjoyed it: the trainer was great, they got to meet people from other Practices. They felt valued, and invested in.

Practice Administrative staff interviewed reflected how challenging their role as 'care navigators' can be:

- This is trickier than [workflow] because patients don't want to speak to us.
- It can be tricky if someone says 'no I don't want a nurse to call me'
- It's difficult to ask patients why they want and appointment, even though we now have the Dr [Popular] recording warning patients when they call that they will be asked why they want an appointment.
- We live in the area...I don't want to have to ask my neighbour why they want and appointment.
- It's more difficult if you've been in the job longer because it's been instilled into you that it's all confidential, especially routine appointments.

Peer support, and the development of tools such as 'prompts' to have appropriate conversations with patients around navigating them were also very important in supporting Practice Administrative staff in this extended role:

- We have prompts for us all to use – the Practice Manager and me [Reception Supervisor] developed it.
- We were all new to care navigation, and we all find it difficult. But we have a lot of team support – we're all together in the main office.

Some GP Practices reviewed and changed the job title of some Practice Administrative staff to better reflect their extended role in care navigation:

- In this Practice we changed the job title of 'Receptionist' to 'Patient Advisor' – they chose the title. A neighbouring Practice changed the job title to 'Patient Care Advisors', but we didn't want this because of possibly mixing messages about caring and the Carers role. The staff here welcomed the change, and now we have eight Patient Advisors.

5.2.5 Patient/public information

All stakeholders engaged through the evaluation stressed the need for consistent national and local patient/public education about care navigation – essentially stressing that a GP might not be the most appropriate professional to help with healthcare concerns:

- We need to work with the unrealistic expectations of patients.
- It's crucial to educate patients that they don't need to see the GP all the time. Language is important – perhaps say 'another clinician'.

GP Practices have developed their local information about care navigation, notably posters and telephone messages:

- We've changed our phone message so that 'Dr Popular' provides the message about signposting.
- We now have a GP recording for the phone, directing patients to other places.
- We have posters up in the waiting room. We share the posters across the Cluster, and have tweaked them for local information.
- We have posters in the waiting room, film on the TV in the waiting room, leaflets.
- We've developed posters and flyers…we just need to make patients more aware of other services.

However, stakeholders consider that there needs to be a concerned national awareness-raising strategy:

- A lot of people just don't know that they can go to see, for example, an optician instead of a GP.
- Patients need more education about it – there needs to be adverts on TV, like the ones about flu jags.
- The issues are to do with patient's perceptions of a Health Centre and seeing GPs – it's a national thing: we need a consistent national message.
- It would really help if there was a national comms approach.
- There's a big media issue – I've seen a GP on TV being very negative about patients being asked about why they want to see a doctor by a receptionist. There needs to be a Scotland-wide campaign.
- There needs to be a consistent message.

5.2.6 Involving patients

Although survey respondents who were involved in care navigation work (87: 49% survey respondents) did not consider that patients had been involved in care navigation work. See Figure 5. Some PASC Associate Improvement Advisors (AIAs) worked with GP Practices to involve and consult patients to inform the development of care navigation processes. This involved, for example, spending a day in a Practice waiting room and interviewing patients waiting for their appointment. The AIAs noted that some GP Practices are routinely asking patients for feedback to inform the development of their service.

In one PASC area, patients at routine flu clinics in the winter of 2018/19 were asked to complete a short questionnaire, which included a question asking "Reception staff may ask you some brief questions to make sure you get the most appropriate appointment. Would you be happy to provide brief information to your receptionists?" Of the 997 responses from Clackmannanshire and NW Stirling Practices just over 89.5 % of those that completed the survey stated that they would not mind being asked for a reason by a receptionist.

Although the development of care navigation is in the early stages, patients interviewed by AIAs about care navigation seem to be generally comfortable with being asked by Practice

Administrative staff about why they want to see a GP, and also being referred to a Nurse Practitioner instead of a GP. See the following quotes from patient interviews with PASC AIAs:

- The receptionist told me that I had to see the Nurse Practitioner instead of the GP. I thought it was really good as the Nurse Practitioner could sort it, so I wouldn't have to book another appointment later which is just a waste of everyone's time.
- Sometimes I've specifically said it doesn't have to be a doctor it can be the nurse practitioner. It's not an emergency and I don't need a doctor. I've tried it all at home first.
- You will see the nurse practitioner quicker than waiting for a doctor's appointment. The nurse is fine. I realise they're struggling with getting doctors and I appreciate that and I try everything I can at home before actually coming down.
- There's plenty notices around to say what to do if you don't need to see a doctor, the pharmacist is there, you can go to the chemist and they could probably help. There's lots of information posted for you, I really don't know what else they could do as no amount of antibiotics is going to get rid of your cold.
- [When the receptionist asks] sometimes it's a wee bit uncomfortable to say what it is but you can kinda narrow it down to help them out with it. I never had anything to hide and I know it's confidential.
- They've [reception staff] offered the nurse practitioner once they've asked what it is and I've seen her. It was alright, if she can deal with my problem, I'm happy with that.

Stakeholders interviewed to inform the evaluation of PASC considered that both the development of care navigation process **and** the involvement of patients in the development of GP Practice processes were in the very early stages. One interviewee said that they had worked with a Patients Group to develop care navigation, and one interviewee was considering engaging patients in care navigation:

- We worked with the Patients' Group to inform them about starting care navigation, and got their willingness. The Patients' Group helped to spread the word to other patients through their newsletter and word of mouth, and now we're getting good feedback from patients.
- We're developing a new website and posters so that there's a long lead up for patients. The next step will be consult patients – we might have a patients' forum.

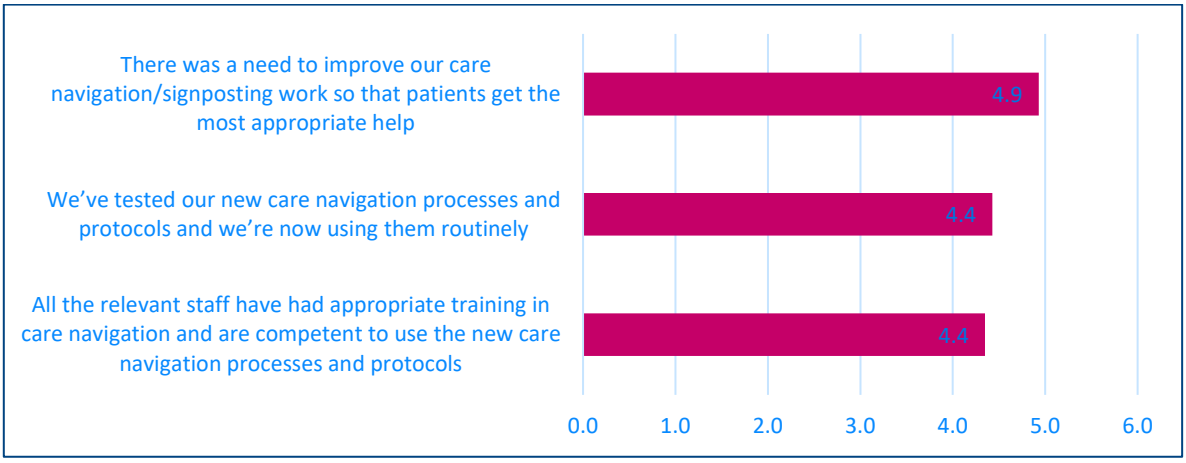
PASC Associate Improvement Advisors noted that although patients were relatively easy to engage and forthcoming if consultation was brought to them (e.g. whilst they are in Practice waiting rooms waiting for their appointment, at routine flu clinics) the key challenge was finding time with the whole Practice team – and perhaps especially GPs – to consider and reflect upon patients reviews.

5.2.7 Stakeholder survey

Survey respondents who were involved in care navigation work through PASC (87: 49% survey respondents) generally considered that all relevant staff had had appropriate training and were competent in their newly extended roles; and they were confident that the new processes and

protocols for care navigation had been effectively tested and were being used routinely. See Figure 6.

Figure 6: Stakeholder perceptions of the need for and development of care navigation



Source: SMCIA Survey of PASC stakeholders
N=86 (99% respondents involved in Care Navigation work)
0 = strongly disagree; 6 = strongly agree

5.3 Perceived impacts: improved experience

Practice Administrative staff who were interviewed generally welcomed the extension of their role into care navigation – despite the challenges:

- It's beginning to work better now, now that we're getting more experience in asking questions.
- Sometimes we slip, and a patient isn't asked why they want to see a GP, but it's becoming more and more routine.
- We've learned a lot, it makes us better at our jobs.
- Now everyone is happy, and we're all used to it.

Patients in GP Practices which have implemented care navigation appear to be beginning to embrace it:

- They are getting used to explain to Practice Administrative staff why they want to see a GP:
  - Our patients are increasingly explaining why they need an appointment with the GP – the recorded phone message from 'Dr Popular' helps.
  - We want everyone [i.e. all admin staff] to feel comfortable with asking patients for the reason they wanted to see a GP. The patients are getting used to it, and the GPs have that conversation with the patient – why did you want to see me?
- They are getting appropriate help more quickly:
  - Now they get a phone from the ANP quicker than an appointment with the GP, and we're beginning to get patients phoning in and asking for a phone consultation.
  - If a patient phones and we signpost them to an optician, they can be seen that day.

One GP who was interviewed noted that:

- Now we're hearing patients reflecting and saying that they're wasting the doctors time.

GPs were beginning to see more appropriate patients:

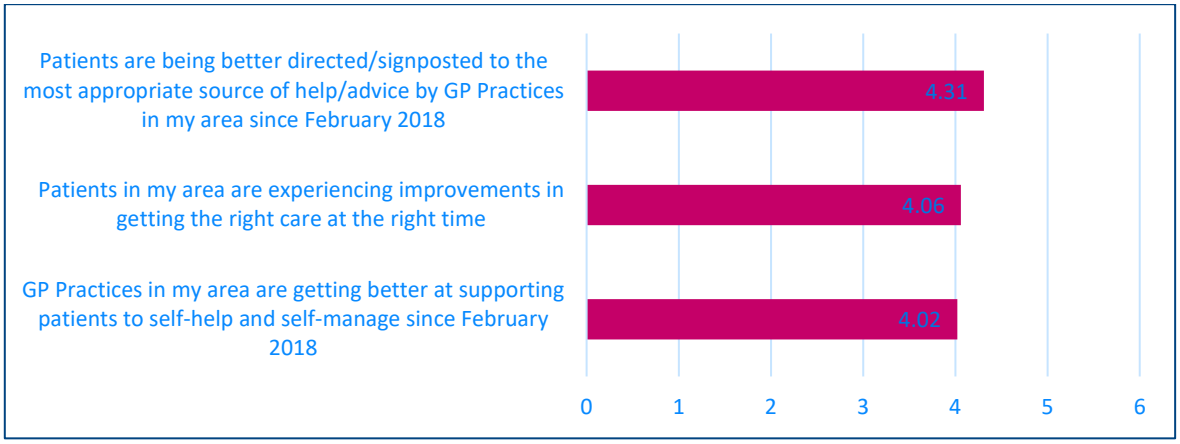
- My Practice has got used to reception staff asking patients why they want an appointment, and triage is usually working, and GPs aren't seeing patients who are navigated away, and are seeing more appropriate patients.

All stakeholders noted that it is difficult to measure the impact of care navigation:

- It's difficult to get data on care navigation.
- We can't develop quantitative data on care navigation because everything is different in different areas.
- For care navigation there could be data on where patients are directed to – but we don't even know how many people who phone a Practice can't get through.
- It's difficult to get data on care navigation. It's too time consuming for the admin team to go into the patient record to record care navigation. So we've used little balls in a jar to count the number of patients who have been redirected – [the AIA] suggested it.

Survey respondents who were involved in care navigation work through PASC (87: 49% survey respondents) generally considered that patients were being better directed/signposted to the most appropriate source of help/advice by GP Practices. They also considered – although slightly less confidently – that GP Practices were getting better at supporting patients to self-help and self-manage. See Figure 7.

Figure 7: Stakeholder perceptions of impacts of care navigation work



Source: SMCIA Survey of PASC stakeholders
N=141 (75% of all respondents)
0 = strongly disagree; 6 = strongly agree

5.4 Summary

The development of care navigation processes was welcomed by stakeholders, in particular within the context of the new GMS Contract, as a means of directing patients to new Multi-Disciplinary Teams within GP Practices, and to health and care providers in the community.

Survey respondents who were involved in care navigation work (87: 49% survey respondents) generally considered that they had involved other care providers in this work – and that this involvement had improved the development of care navigation.
Some demonstrator GP Practices were clear that – at this early stage in the development of care navigation – they only navigated patients to the in-house MDT. As the development MDTs at Practice level is also in the early stages, relatively few demonstrator Practice were able to do this.

Whether the Practice has a MDT or not, Practice Administrative staff are being asked to extend their role to include asking patients why they want to see a GP, and make an initial assessment using an agreed protocol to decide whether it is appropriate for them to see a GP, or if navigation away from a GP to another health or care provider is more appropriate. This can be very challenging and stressful work.

By freeing up some GP time through care navigation to other members of the MDT – and indeed through the workflow optimisation stream of the PASC work – some GP Practices developed navigation to extended GP appointments i.e. 20 minutes instead of the routine 10-minute appointment. Practice Administrative staff involved in navigation patients to extended GP appointment were experienced, trained in care navigation, and had the confidence to have an empathetic conversation with the patient and make the judgement as to whether to offer an extended GP appointment. It was also important to have agreed Practice protocols for care navigation in place; and it helped if the Practice Administrative staff member had some knowledge of the patient.

Formal certified training – in particular on having confident conversations with patients – for Practice Administrative staff to empower them and support their care navigation work was important. It was challenging for GP Practices to provide protected learning time for Practice Administrative staff. Peer support, and the development of tools such as ‘prompts’ to have appropriate conversations with patients around navigating them were also very important in supporting Practice Administrative staff in this extended role.

Advanced Nurse Practitioners play a particularly significant role in care navigation within GP Practices, with these staff undertaking clinical triage (often through phone consultations), after being directed to the ANP by Practice Administrative staff.

In order to develop effective care navigation to other local health and care providers it is important first to know who they are; and second to develop effective communication and working relationships with them.

GP Practices generally have good relationships with local pharmacies – PASC has supported the development of these relationships to appropriately navigate patients away from GP towards pharmacists. Face-to-face meetings with local health and care providers, whether statutory (e.g. opticians, dentists), third sector or private providers, is an important way of developing relationships that facilitate a shared understanding of care navigation, and consequently successful care navigation. By the end of the Collaborative, this relationship building work was very much in the early stages.

There is an urgent need for the development and implementation of concerted and consistent national and local public awareness campaigns which stress that seeing a GP might not be the most appropriate professional to help with some healthcare concerns.

Stakeholders interviewed to inform the evaluation of PASC considered that both the development of care navigation process **and** the involvement of patients in the development of GP Practice processes were in the very early stages. Nevertheless, in some PASC areas patients were engaged/consulted about the introduction of care navigation – in particular, about whether they would be comfortable with reception staff asking them to explain why they wanted an appointment with a GP; and how they would feel/had felt when referred by reception staff to a Nurse Practitioner rather than a GP. Patients are generally comfortable with both process – their main concern being that they get the right care at the right time.

Although it can be relatively easy to engage patients if consultation was brought to them (e.g. whilst they are in Practice waiting rooms waiting for their appointment, at routine flu clinics) the key challenge was finding time with the whole Practice team – and perhaps especially GPs – to consider and reflect upon patients reviews.

By the end of the Collaborative (May 2019) Practice Administrative staff were more comfortable with the extension of their roles to include care navigation; patients in demonstrator GP Practices were getting used to being asked why they wanted to see a GP; and GPs were beginning to see more appropriate patients. At this early stage in the development of care navigation the collation of quantitative data is not possible; however, as this work progresses it will be important to collate and analyse data, including on the impacts of care navigation away from GP and to other care providers – perhaps in the first instance, the impacts on Advanced Nurse Practitioners.

6 Capacity and Capability

6.1 Generally

Stakeholders that were interviewed and who participated in focus groups stressed the significance of PASC in raising awareness of the actual and potential capacity of Practice Administrative staff:

- Improved GP awareness of Practice Administrative staff capabilities
  - It hasn't gone as smoothly as all that – some GPs didn't want change, they made assumptions that the admin staff didn't have the knowledge and skills.
  - PASC has given us [GPs] confidence that we can go onto the next stage – we can begin to involve admin staff in routine bloods for chronic disease.
- Improved confidence and competency of Practice Administrative staff
  - The admin staff feel better – their confidence has been boosted, and they feel valued.
  - The really positive thing is that they [Practice Administrative staff] are really keen to do more training, and have become more confident in making improvements.
  - The admin staff loved the training on workflow, and they're keen to do more training, so we [GP Partners] are beginning to organise more training for them. They are identifying the training that they want, so they have ownership of it.

GPs who were interviewed considered that PASC had highlighted the need to value and invest in Practice Administrative staff:

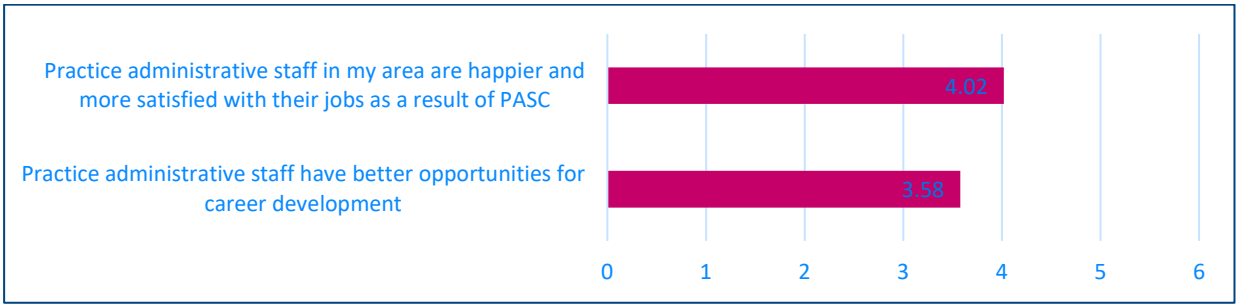
- I think that we [the GP Partners] will support and invest in more training for admin staff.
- We'll fund Practice admin staff to do relevant things like training because PASC has focused the need for us to invest in admin staff.
- PASC has been a springboard for us – about investing in admin staff and developing the confidence of admin staff.

One strategic stakeholder reflected on the need to support career development for Practice Administrative staff:

- We need role descriptors for Practice admin staff, and the development of professionalisation and career progression opportunities. We need coherence across Practices.

Survey respondents generally agreed that Practice Administrative staff were happier and more satisfied with their jobs as a result of PASC; they were less convinced that Practice Administrative staff had better opportunities for career development. See Figure 8.

Figure 8: Stakeholder perspectives on impacts on Practice Administrative staff



Source: SMCIA Survey of PASC stakeholders
N=121 (69% respondents involved in PASC activities)
0 = strongly disagree; 6 = strongly agree

6.2 Quality Improvement approaches methods

PASC has raised awareness of the (potential) helpfulness of Quality Improvement (QI) approaches and methods – in particular amongst GPs:

- It's been useful for us [GPs] to look at QI tools – process mapping, data.
- PASC has given us more skill in developing driver diagrams and measurement – tests of change, PDSAs. A GP said to me that 'I thought that doing all these driver diagrams and other QI things was a waste of time until now.'
- I've [GP] got a better understanding of QI and the strategic context.

Stakeholders valued the testing and reflective aspects of QI methodology in particular:

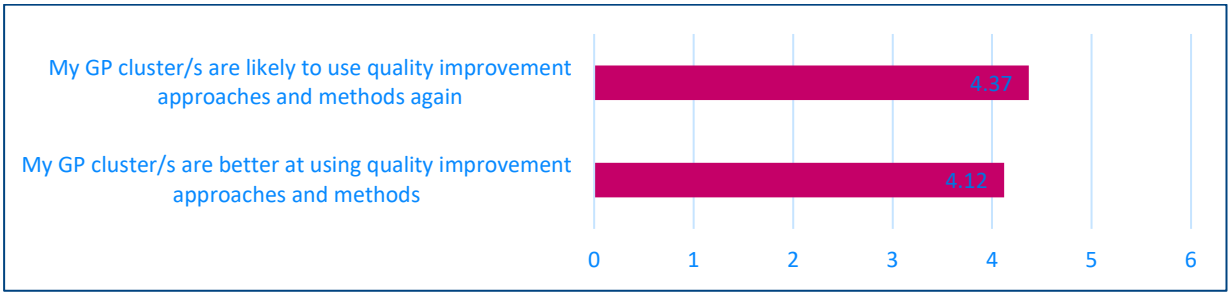
- General Practice is quite fast moving, and there's not a lot of bureaucracy to slow us down, so doing PDSAs was good to get us to stop and take time to reflect.
- It's important to take time to have meaningful conversations about change.
- There's an understanding that improvement needs to start with people's confidence, firstly in QI methodology, and second in implementing change. Through training and small tests of change they can try it out in a safe environment.
- People need permission to test.

Some stakeholders had already started other Quality Improvement work – or were actively considering it:

- We're also moving onto other QI projects because PASC has helped to develop staff confidence in using QI. For example, improving uptake of cervical screening – Receptionists/Patient Advisors are now confident in asking patients why they haven't had their smear test and whether they'd like an appointment for one.
- Now I'd like to do more QI projects – we have the tools. I'd like to focus on bowel screening and cervical screening.

Survey respondents generally considered that they would use QI approaches and methods again, and were better at using these methods and approaches. See Figure 9.

Figure 9: Stakeholder perspectives on using QI approaches and methods

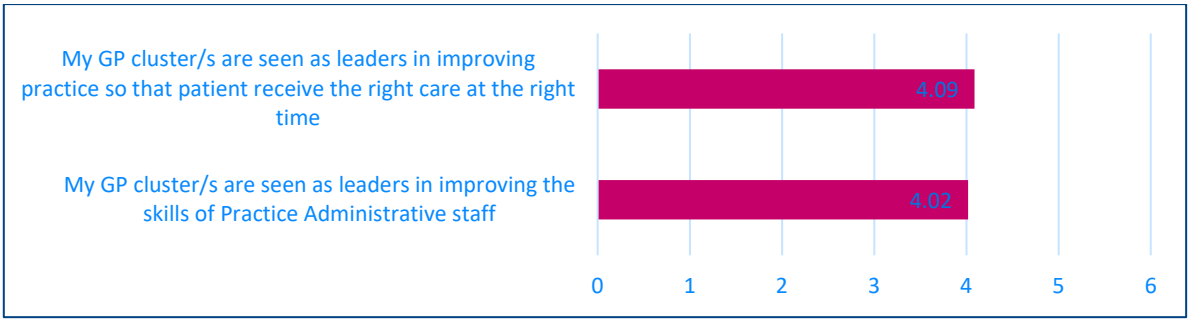


Source: SMCIA Survey of PASC stakeholders
N=121 (69% respondents involved in PASC activities)
0 = strongly disagree; 6 = strongly agree

6.3 Leadership

Survey respondents generally – but not strongly – agreed that the GP Clusters involved in PASC were seen as leaders in improving practice so that patients receive the right care at the right time; and in improving the skills of Practice Administrative staff. See Figure 10.

Figure 10: Stakeholder perspectives on leadership



Source: SMCIA Survey of PASC stakeholders
N=121 (69% respondents involved in PASC activities)
0 = strongly disagree; 6 = strongly agree

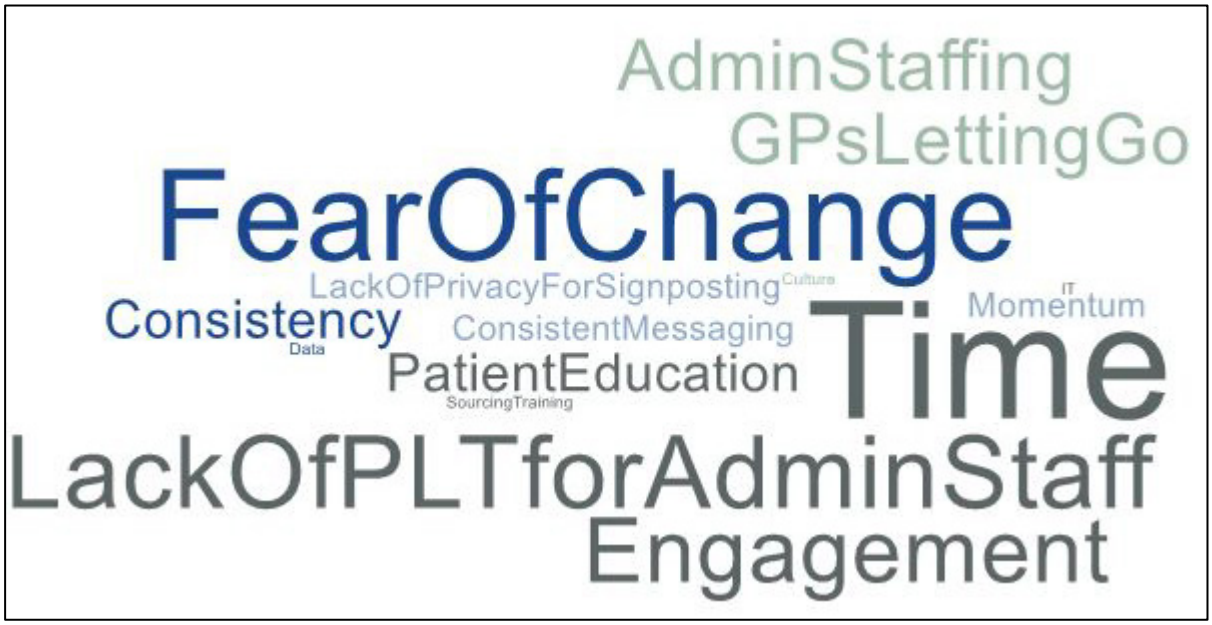
7 Key challenges

Interviewees and focus group participants considered that fear of change and time to engage in PASC activities were the biggest challenges:

- Motivation and countering cynicism
    - It's a challenge to keep everyone motivated, but when you see that things make a difference it helps.
    - Practices, GPs and Practice Managers saying 'we've seen it all before, and we're doing it anyway'. They were a tiny, but significant minority.
- Identification and capacity of other local health and care providers to navigate patients to
    - We need to know more about what's available locally.
    - The optician has complained that too many patients have been sent to them.
    - Practices need staff to have conversations with patients, and have ANPs, Physios, HCSWs etc at the Practice to support self-care – this can't happen in single-handed Practices.
- GPs awareness of
    - They need to recognise their role as employers and responsibilities to support and develop their Practice Administrative staff.
    - Quality Improvement approaches and methods
        - We [GPs] are not of a QI mind set, so we need to take a step back.
        - We [GPs] can decide to make changes instantly, and we say that we 'just know when it works'. Most GPs don't consider QI data to be relevant at all.
- Engaging and empowering patients in for self-care
    - Patients need to understand why it might not be appropriate for them to always see the GP.
    - It's all about care navigation to self-care.
    - The Press is significant. It's the culture – the patient, the staff, and the spin.
    - The biggest challenge is finding time for the whole Practice – perhaps especially GPs – to find time to consider and reflect on the patient feedback.

Participants at the workshops at Learning Session 2 echoes these challenges. See Figure 11.

Figure 11: Key challenges in working to the PASC aims



Source: SMCIA Evaluation activities: workshops at Learning Session 2 (28th November 2018) N=82

8 Key facilitators/enablers

Interviewees and focus group participants identified existing infrastructure/networks, CQL/GP support and HIS support and resourcing as the key facilitators of the change/improvements made through PASC:

- Existing networks
  - We have a Primary Care Network, and CQL meetings – so we have a mechanism to spread the learning.
  - Our infrastructure includes CQL meetings, Practice Managers network.
  - It's helped that I'm part of the Scottish Practice Managers Network.
  - We discuss workflow optimisation at Cluster meetings – that helps.
- CQL and GP support
  - As a CQL we've all shared examples of what we're doing as we go – that's really helped.
  - The GP leading this is also the CQL. That's really helped to encourage other GPs to buy-in and stop worrying about the what if.
  - You need to have a willingness to change, and that's not easy in General Practice – but we got it! Maybe that was because of the pressures that General Practices are under just now, and the general recognition that things needed to change – GPs can't continue to be the first port of call.
  - It helps to have GP advocates of PASC – this helps to get the buy in of other GPs.
  - We needed a strong GP lead for PASC in each practice, especially to deal with worries about the indemnity issues
- Permission to try
  - PASC gave us permission to develop a new way of working – we knew it was needed – and GPs needed encouragement to 'let go'.
- Support and resourcing from HIS
  - That PASC paid for some time for people to get involved really helped.
  - The support from [the AIA] has been outstanding.
  - The AIA was the key thing that made it work.
  - The Collaborative has really helped to reflect data back, and enable admin staff and GPs to meet other Practices nationally, and in their areas.
  - The national events have been springboards for development – they've provided energy.
- Practice Managers as AIAs
  - Having Practice Managers as AIAs really helped. You need someone on the ground to go around the Practices to get buy-in and keep up momentum. Having the Practice Managers as AIAs enabled them to model behaviours, including making time for PASC work, including collating data.

Participants at the workshops at Learning Session 2 also identified these facilitative factors, additionally emphasising the importance of training for Practice Administrative staff. See Figure 12.

Figure 12: Key supports in working with PASC

Source: SMCIA Evaluation activities: workshops at Learning Session 2 (28th November 2018) N=82

9 Key achievements

Interviewees and focus group participants identified the outputs of the Collaborative as the key achievements:

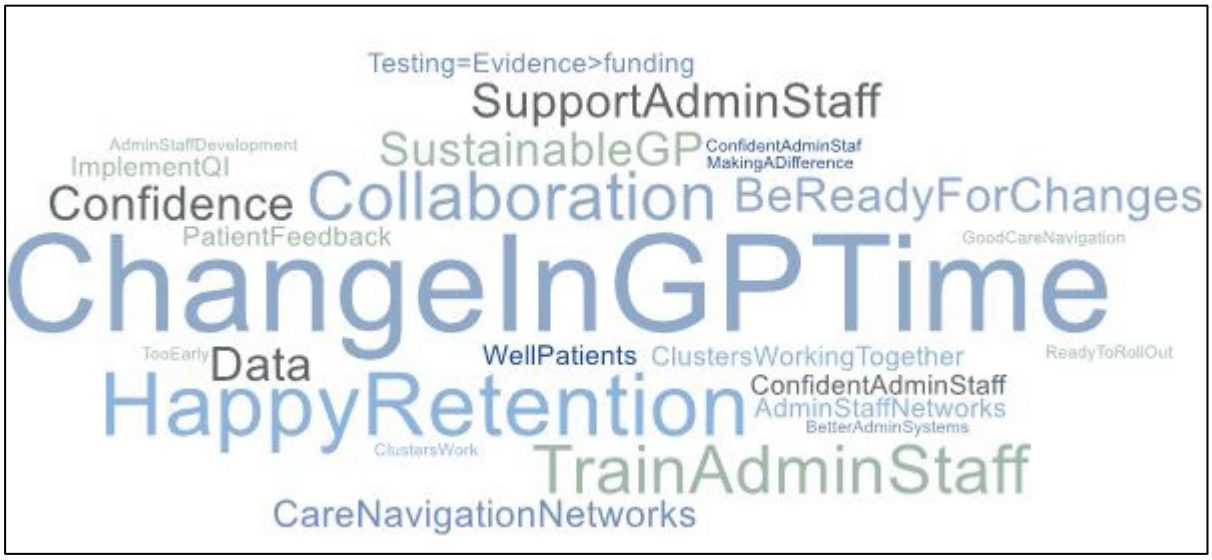
- Reduced and more relevant documentation going to GPs
  - We've seen a tremendous difference: the GPs had in excess of 50-70 items each day to deal with, and we've seen a drop of around 84%. The GPs are delighted!
  - We [GPs] were seeing so much on the day, so it's freed up our role to do more complicated things.
- A set of principles and a designed mechanism for care navigation
  - My Practice has got used to reception staff asking patients why they want an appointment, and triage is usually working, and GPs aren't seeing patients who are navigated away, and are seeing more appropriate patients

Additionally, the following were identified as key achievements:

- Practice Administrative staff development
  - Admin staff have had good training
  - The admin team is more collaborative – they know each other across the Practices, and are perhaps more confident and proactive about change
  - Admin staff meeting each other from different Practices
- Improved GP Cluster working
  - Here the Cluster meetings were going nowhere, but now Practice Managers are involved in Cluster meetings
  - Clusters actually working together, including for training
- Testament that QI actually works!
  - It potentially switches off people – we need not to start with driver diagrams, but to start with developing the aim and working backwards
  - We've built capacity – even if they don't know it, people are doing PDSA, using driver diagrams. They know now to set an aim, describe the problem and potentially have some data/experience to evidence it

Participants at the workshops at Learning Session 2 also saw these as key achievements, additionally emphasising that staff involved in PASC seemed to be happier, with a likely improvement in staff retention. See Figure 13.

Figure 13: Hopes for March 2019



Source: SMCIA Evaluation activities: workshops at Learning Session 2 (28th November 2018) N=84

10 Key lessons

Interviewees and focus group participants identified the following key lessons learned from the experience of PASC:

- Involve people and win hearts and minds
  - Let your admin team speak: we did a SWOT analysis with the whole team in my Practice. And then we had a quiet time when people could write their views on post-its, so it wasn't just the people who are happy speaking out who were heard.
  - Practice Managers need to be at Cluster meetings – they're the movers and shakers. CQLs can say 'yes' on others' behalf, but the Practice Managers need to do it on their own behalf.
  - We discuss workflow regularly at GP meetings, and we remind the GPs to regularly check.
  - We've had total buy-in from the GPs – they really wanted to do this.
  - You really need the buy-in of all (or most!) GPs.
- Have a whole Practice approach, with Practice Administrative staff, Practice Managers and GPs working together to improve Practice processes. Achieving consensus on risk management across all GPs within the Practice is a key to workflow optimisation.
- Value and invest in Practice Administrative staff, including supporting their career development. This clearly has cost/financial implications.
- Use and develop existing networks, in particular Practice Managers networks and GP Cluster meetings (see key facilitators/enablers).
- Use QI methodology to test potential improvements
  - At the beginning we didn't have a QI person to help [AIA]. We were going to launch everything at once and then [the AIA] started and said No! Do small tests of change. She explained everything, and it was very helpful.
  - You need to have experienced and skilled improvers on the ground – don't underestimate the skills set.

Figure 14: Key lessons

Source: SMCIA workshop at PASC event November 2018: N=82

10.1 Lessons for Healthcare Improvement Scotland

Interviewees and focus group participants considered that HIS could have improved PASC by:

- Providing clearer guidance
  - When we applied to join PASC there wasn't a lot of understanding about what is was – about what a Collaborative was. But we were enthusiastic about the opportunity, and the funding to do some improvement work.
  - We were surprised that the focus wasn't on GPs – it was on admin staff. We thought that it would give GPs something to do on improvement. The Clusters were (and still are, a bit) very doctor focused. We didn't know what we signed up to: it would have been important to have a Practice Manager involved in developing the bid.
  - HIS could have made their expectations more clear from the start: we have had to write and re-write reports for them. It would have been helpful to have had a time providing expectations of pace and reporting.
  - At the beginning the guidelines weren't clear: it wasn't clear what data HIS wanted from us.
- Having AIAs in post from the outset
  - It would have been helpful if we'd had [the AIA] in post from the beginning.
- Better focusing the events
  - It might have been better to keep the open events to the end of the programme so that the earlier events could have focused on shared learning across the selected Practices.

    - I wonder about the value of the 2 day HIS events – they could have been condensed into 1 day.
- Taking better account of rural issues
    - PASC has highlighted the need to do things differently in rural areas. Rural Practices have always provided more services than urban Practices; and economies of scale don't work and are less safe in rural areas.
    - It would have been helpful if PASC had recognised that there was a difference between rural and urban Practices. It needed to be aware and demonstrate understanding that the problems are different for rural and urban Practices, so the solutions must be different.

Stakeholders particularly valued having a Practice Manager involved in leading the work for HIS:

- It was important to have Practice Manager rather than a GP on the national leadership team.

Overall stakeholders considered that PASC was a great success, with the following comment being typical:

- I can't praise this collaborative enough – I've been involved in several, and this has been the best organised, the most helpful.

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