

primary
care
FOUNDATION



Quality, Productivity and Urgent Care
Lessons from the Out of Hours Benchmark
Christmas & New Year 2009/10

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Henry Clay: 07775 696360

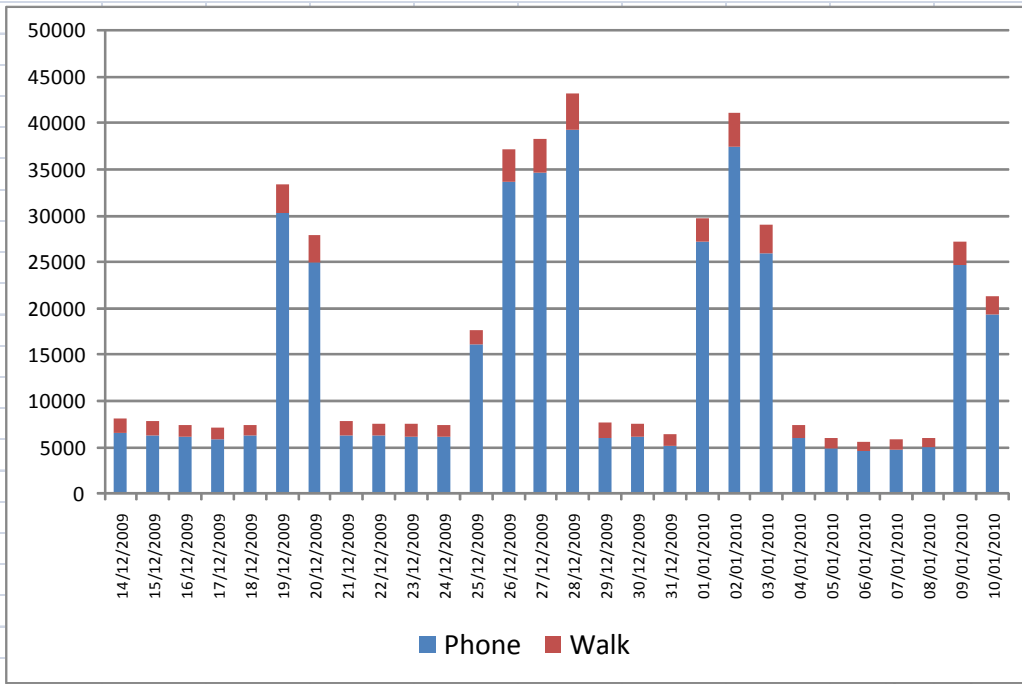
henry.clay@primarycarefoundation.co.uk

The points I want to make

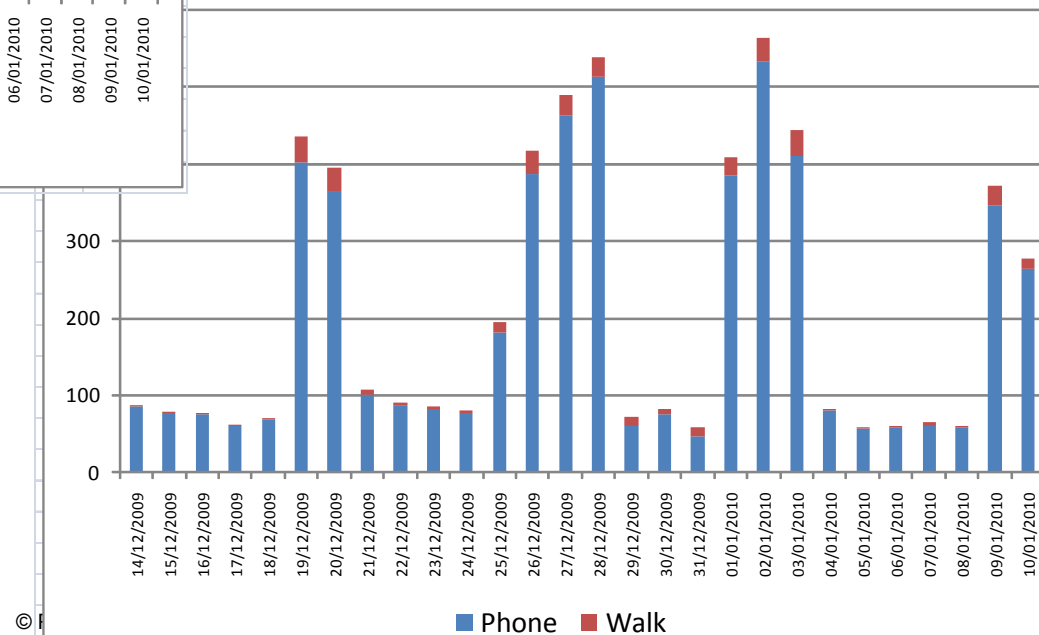
- Demand is predictable
- Although performance is improving it falls short of the quality requirements
- There are two reasons
- Services can do something about both

Average demand by day is predictable

Total of all services

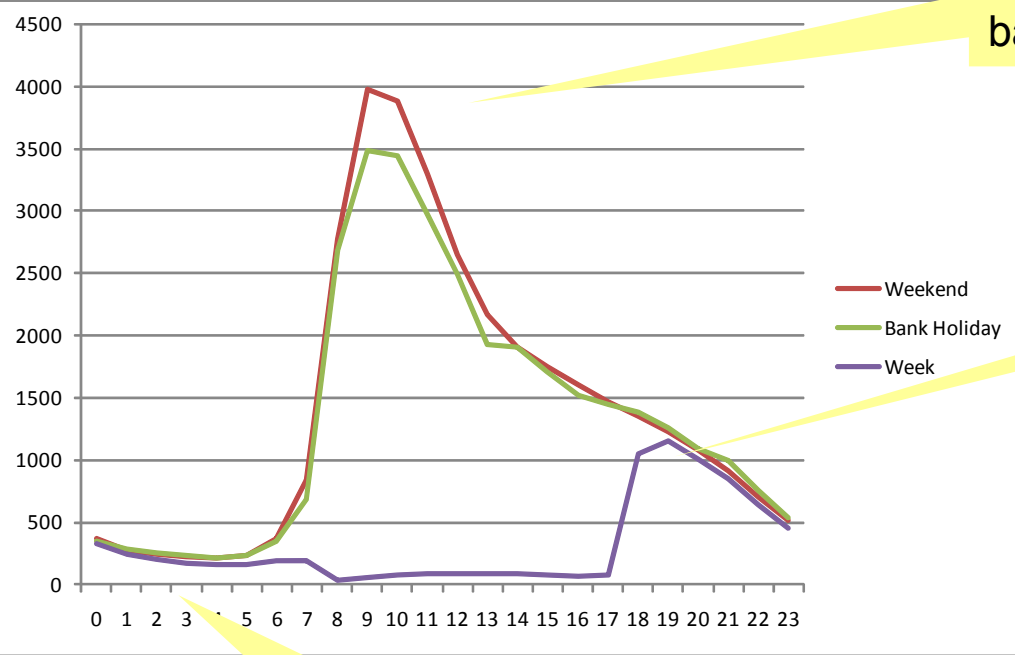


Example provider



Average demand by hour is predictable

Total of all services

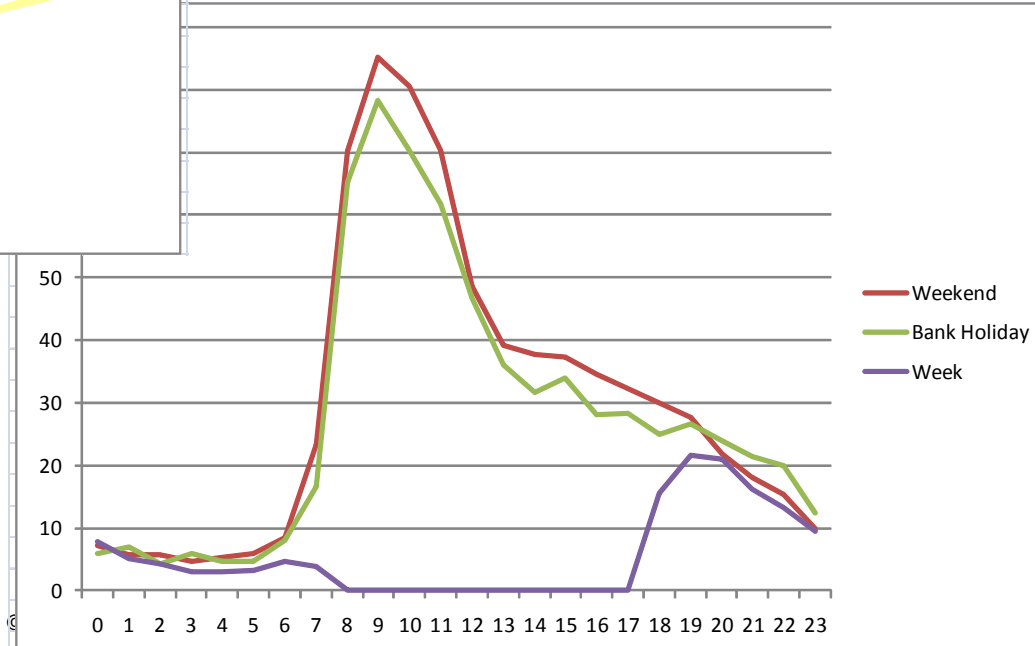


Peak from 8 to 12 at weekends and bank holidays

Demand, tails off during the evening, but is similar for all types of day

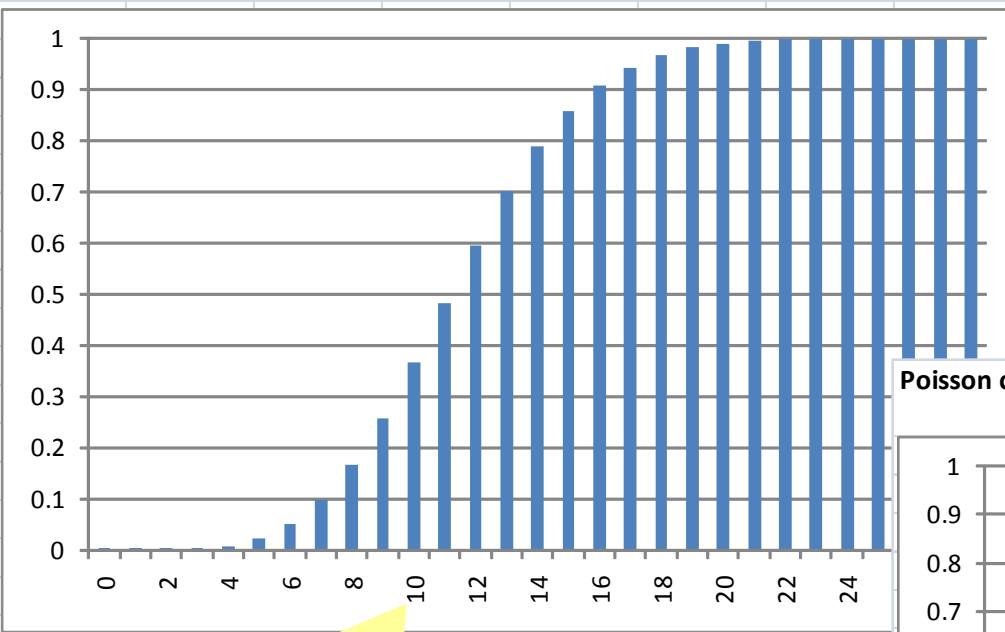
Low levels of demand in the 'red-eye' shift

Example service



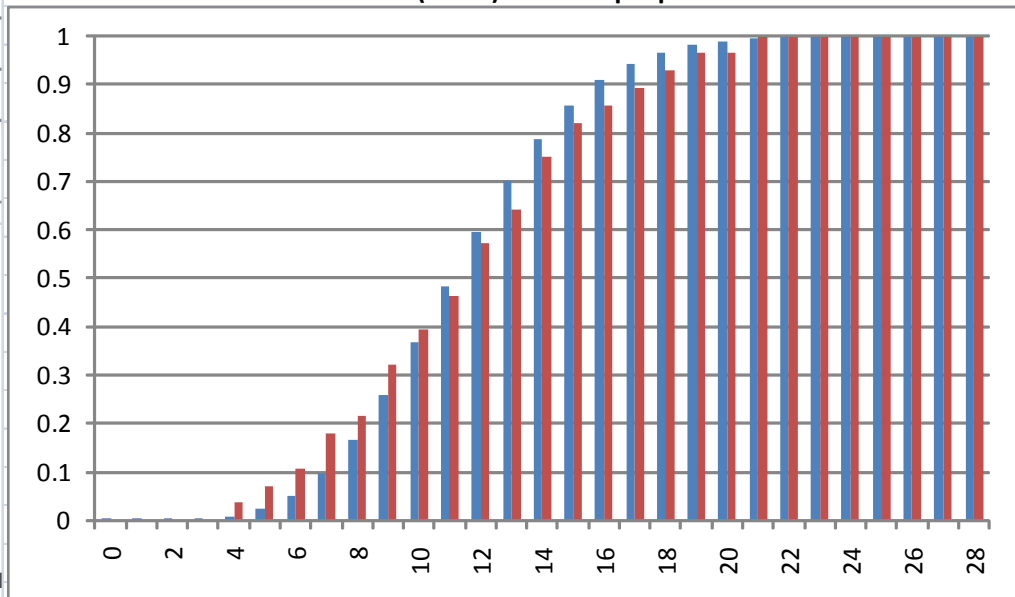
The day to day fluctuation for one hour is predictable

Poisson curve for an average demand of 11.82 showing the cumulative chance of demand in any particular hour equalling the value shown at the bottom



This is the same graph with the red showing the actual distribution for your service based on the 28 days in the sample

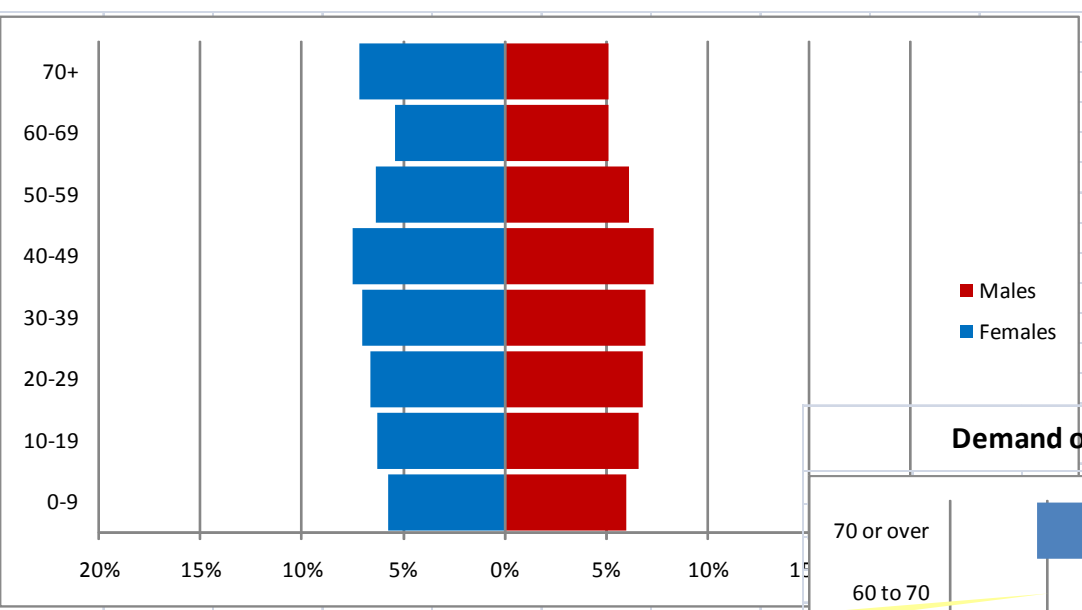
Poisson curve compared with the actual spread of demand over the 28 days looking at one hour (20.00) for Example provider



This shows the expected cumulative probability distribution around your average for 20.00 to 21.00 in the evening

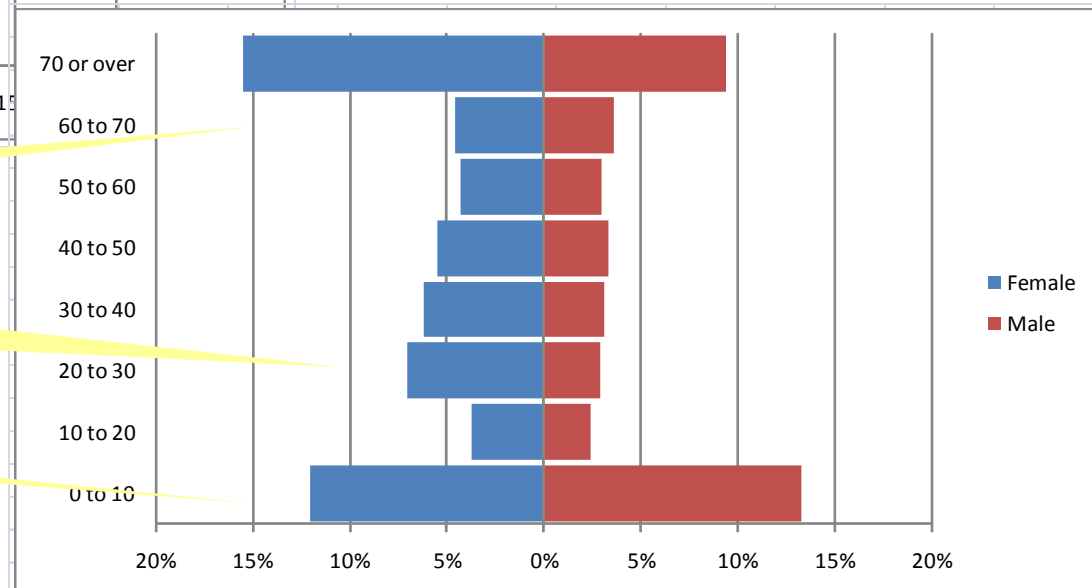
The split by age and gender is as expected

Population by age for All PCTs in the benchmark



Note: On this slide (and the next) population by gender and age band is shown as a percentage of the whole and the demand by gender and age band is shown as a percentage of the calls coming in by phone. Male children are less than 7% of the population but represent 13% of demand whilst women over 70 are just over 7% of the population but make up over 15% of demand.

Demand on OOH (phone cases) by age for Total of all services



Greater usage by the elderly

Women of child-bearing ages usage higher than men

Greater usage by children

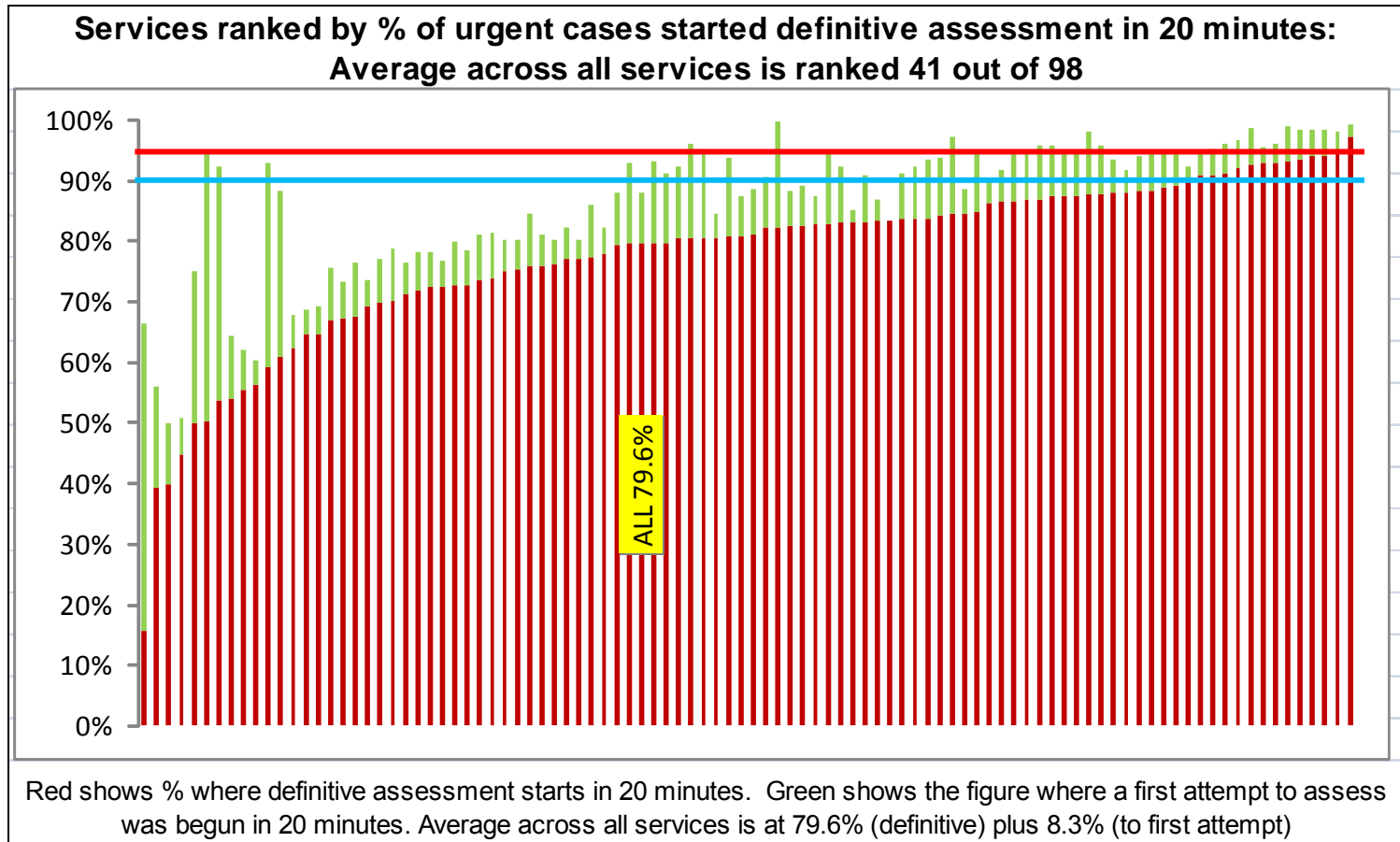


Performance falls short of the quality requirements for timeliness

The requirements are for reasons of patient safety

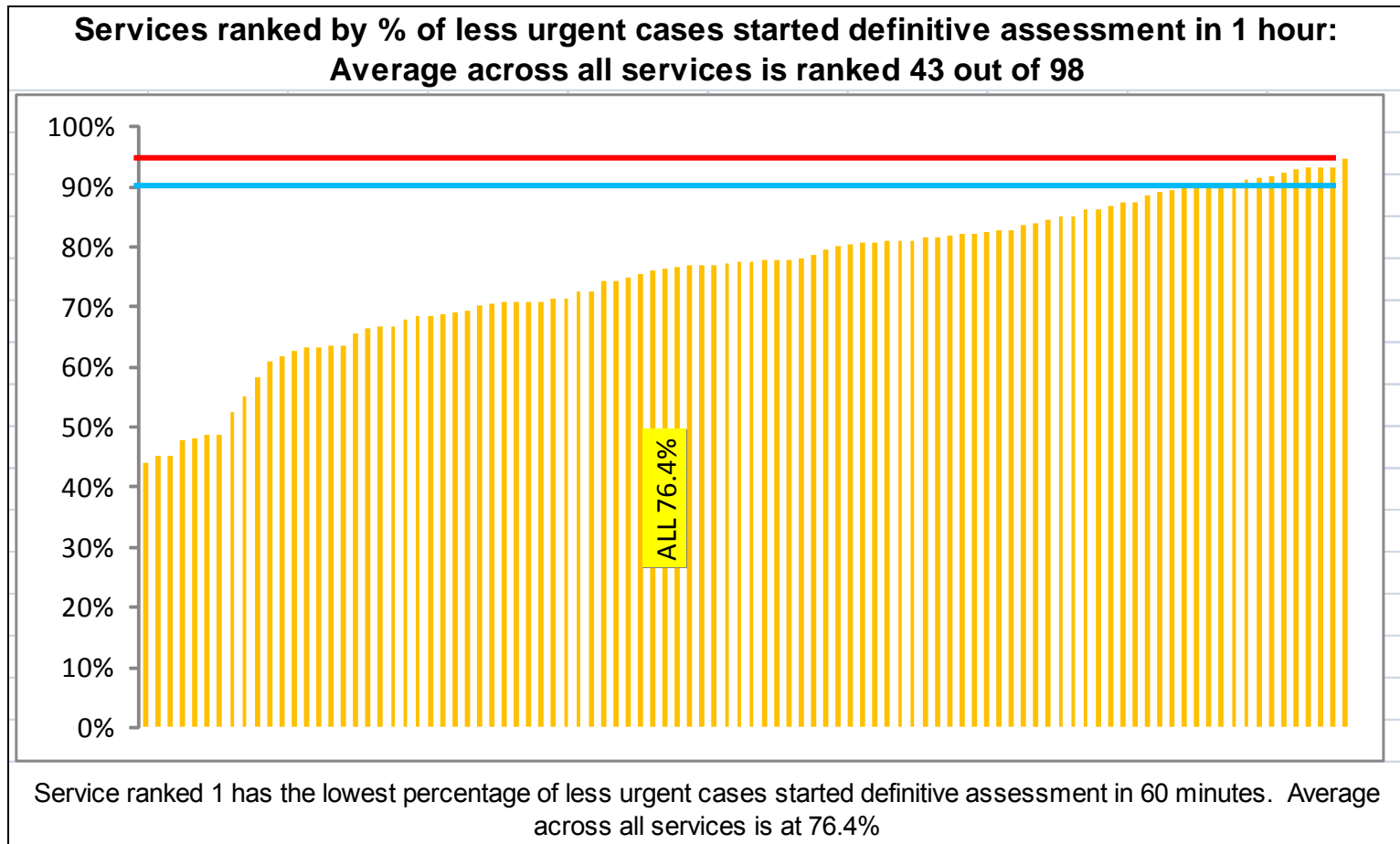
Services fall short of the quality requirements

Definitive assessment of urgent cases in 20 minutes....



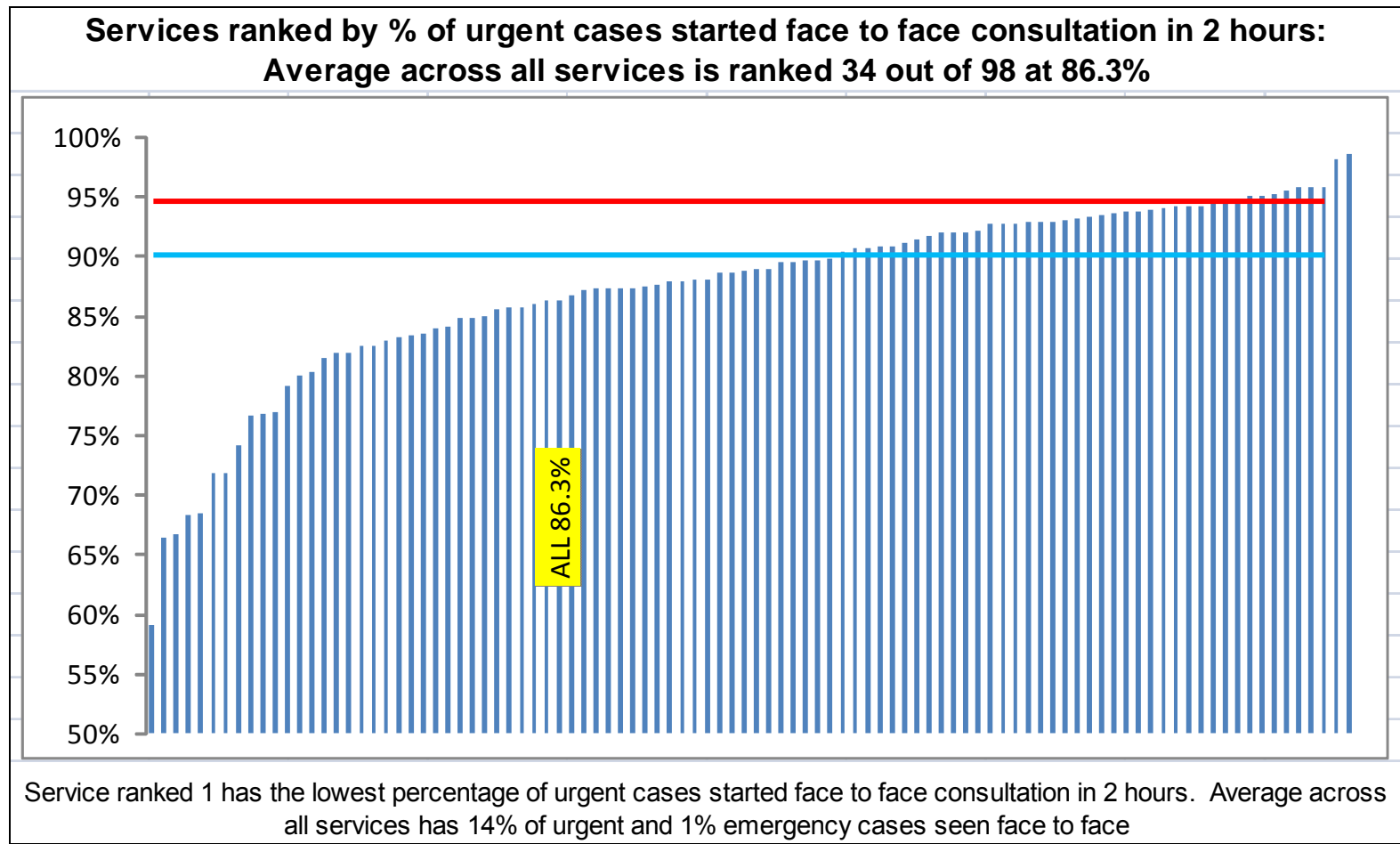
Services fall short of the quality requirements

Definitive assessment of less urgent cases in an hour...



Services fall short of the quality requirements

Face to face for urgent cases in two hours...



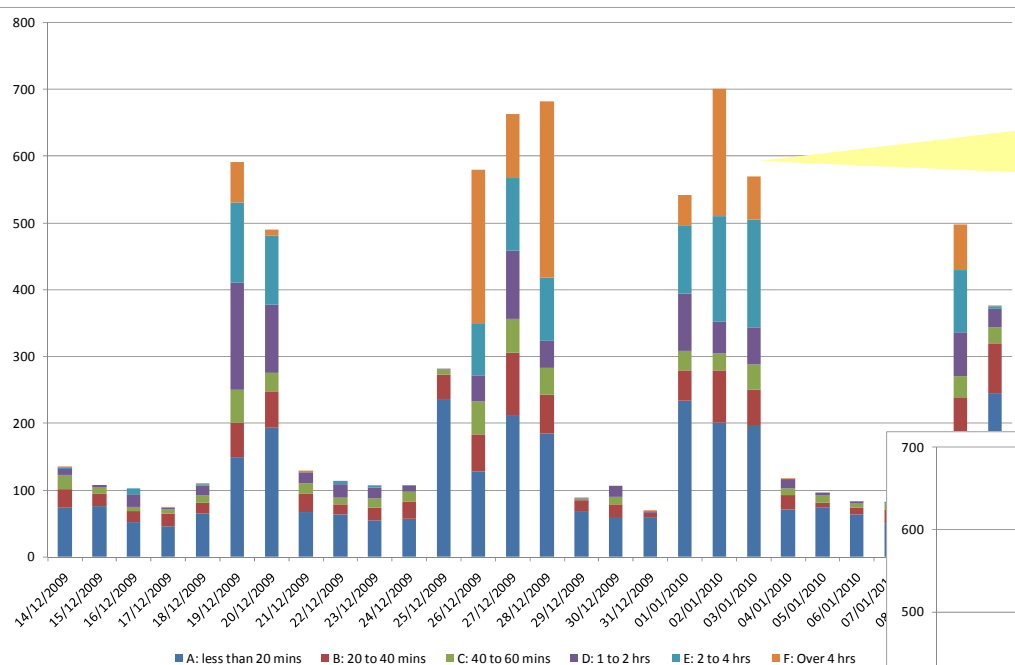


Since demand is predictable, why is performance below par?

Two reasons:

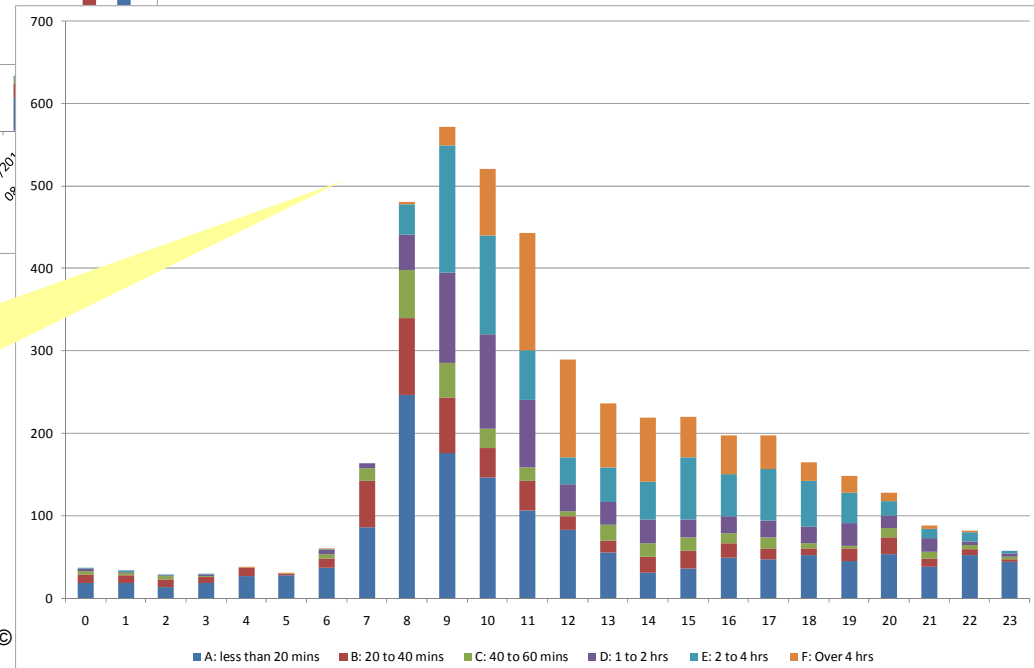
- Not enough people on the busy days
- Not addressing the variation between individuals

Reason number 1 – Not enough people on the busy days to keep up with demand



At weekends and bank holidays significant numbers of cases are above the green and are taking more than an hour to definitive assessment

This is the picture by hour for the weekends – the service gets behind in the busy morning period and takes a long time to catch up

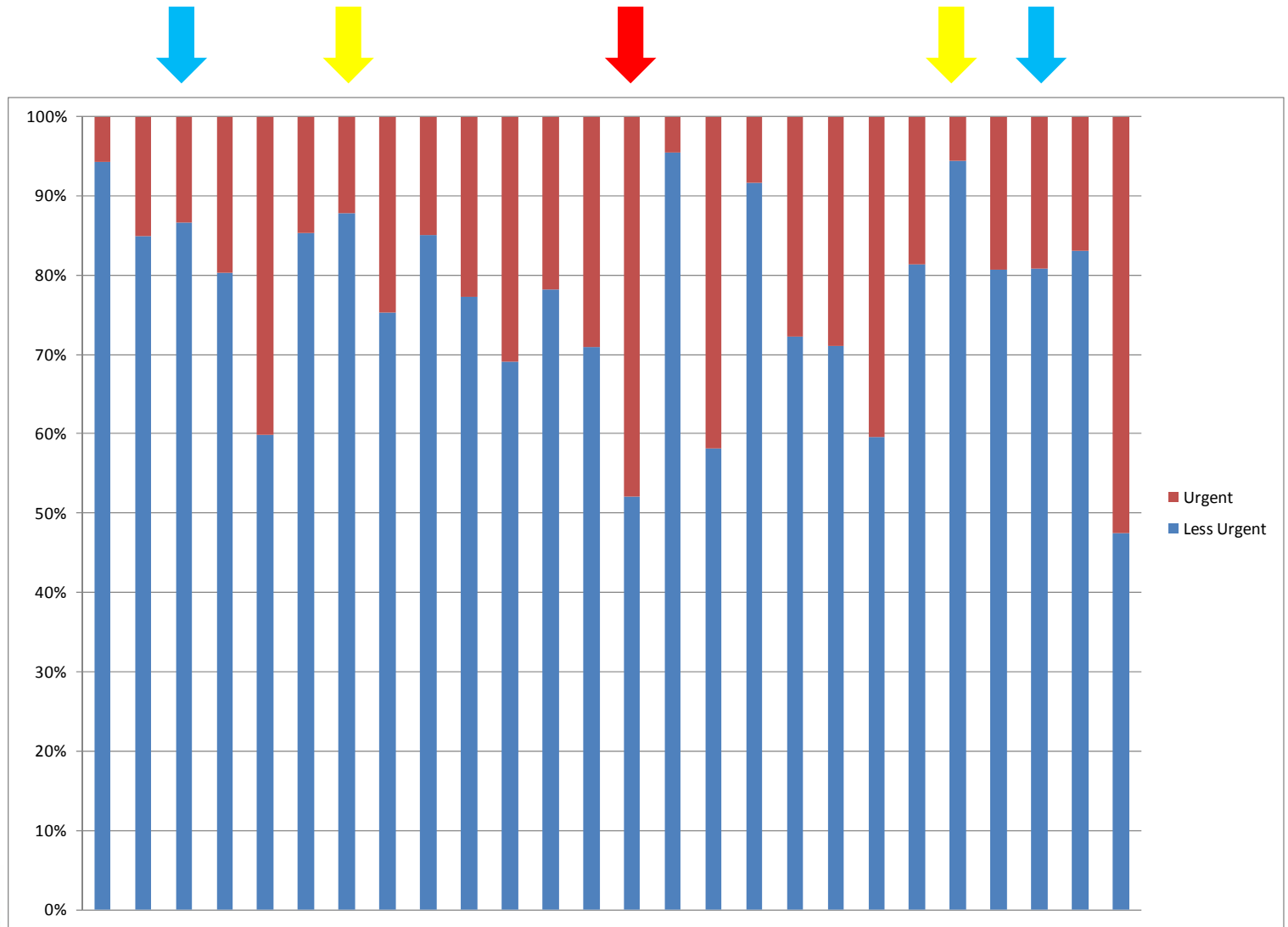


In the example above the colours are to highlight variation in performance as measured by standard minute values earned:

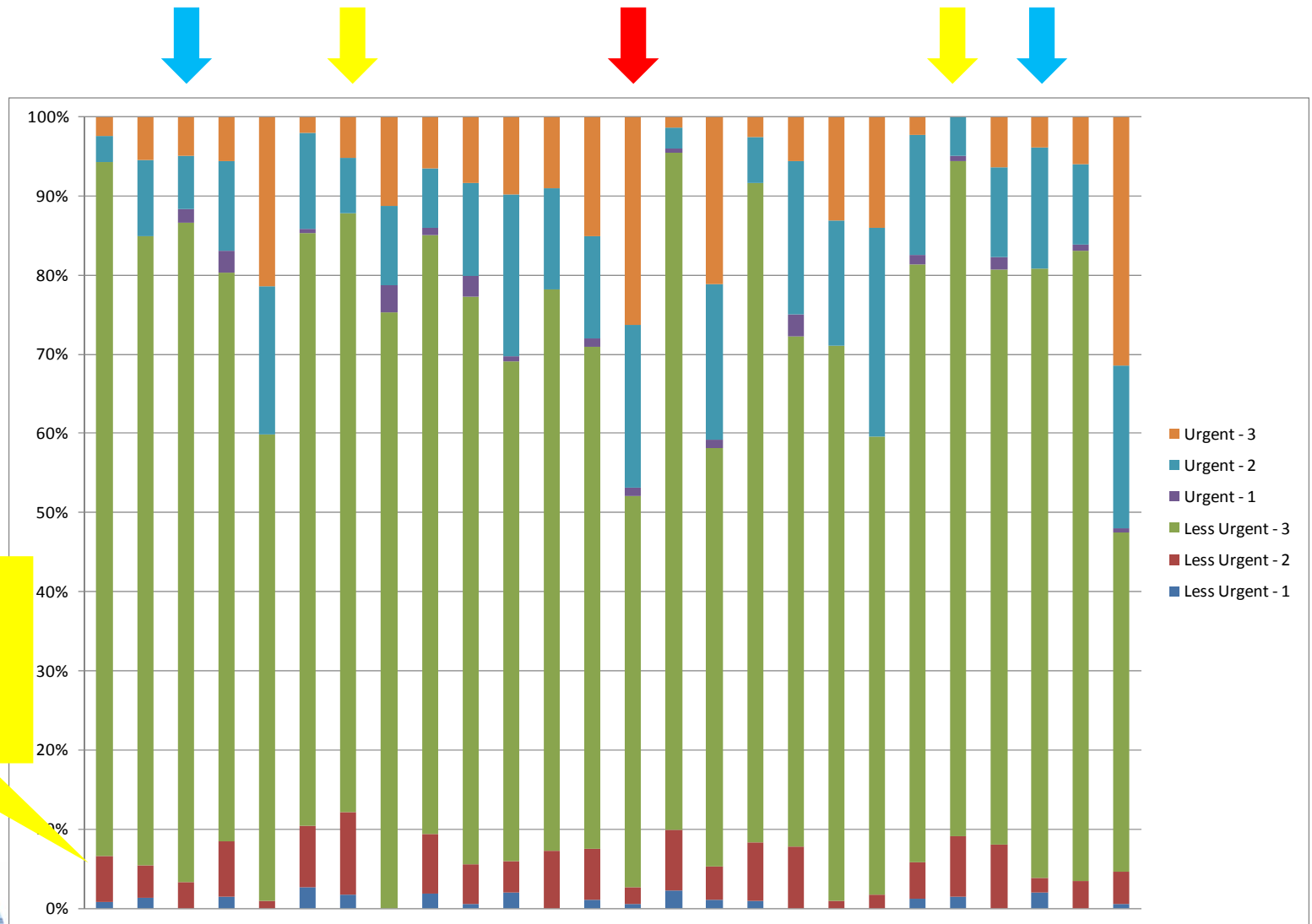
- Both of the orange clinicians only carry out phone consultations/advice. They average 2.5/2.6 case an hour and earn 15 minutes per hour on average
- The red clinician also only carries out phone consultation/advice but averages 13.4 cases an hour and earns 80 minutes per hour on average
- Particularly if this variation persisted over time - would you be happy with it? Would you be worried about whether the red clinician was devoting enough time to ensure understanding of any advice given? Would the service have kept up with demand if the red clinician had not shouldered the bulk of the advice workload?
- The yellow clinician is seeing patients only in the base at 3 cases an hour earns 36 minutes per hour whilst the blue clinician sees 3.3 cases an hour in the base, but also manages to carry out some telephone assessment and earns 47 minutes per hour on average

A formal process for comparison and feedback to individuals addresses these sorts of issues – hence our highlighting the new tools available to support this in slide 26 above.

For one provider showing percentage urgent and less urgent by call handlers (over 50 cases)



Same service, same call-handlers but showing the proportion that had priority changed by clinicians



Less urgent on receipt changed to emergency or urgent is at the bottom

The new Adastra support for audit makes it easy to feed back information to clinicians and call-handlers

Sample Quarterly Call Handler Audit Report

Call Handler Name :

Period :

Productivity : (Mean = Average for organisation)

Cases Received		Average Duration	
Call Handler	Mean	Call Handler	Mean
122	48	00:02:52	00:02:34

Outcomes :

Primary prioritisation							
ILTC		ILTC (within 3 min)		Cases < 20 Mins		Cases < 60 Mins	
Call Handler	Mean	Call Handler	Mean	Call Handler	Mean	Call Handler	Mean
4.10%	2.60%	3.28%	2.08%	5.74%	6.77%	80.33%	81.25%

Streaming :

999 / Ambulance		A&E		Other		Other	
Call Handler	Mean	Call Handler	Mean	Call Handler	Mean	Call Handler	Mean
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Productivity: Average length of call for this individual compared to overall average

Disposition: Percentage of calls going to 999, urgent and less urgent for this individual compared to overall average

Conclusion

- Demand is predictable
- You can plan for the peaks
- You can reduce the amount of variation by giving information to staff
- And thereby achieve much greater consistency, provide better care for patients and meet the quality standards