EXAMPLE REPORT

PCT: Borsetshire
Service provider: AMDOC

Benchmark comparison of Out of Hours services

November 2009

Contents

Summary

The service in Borsetshire is delivered by AMDOC. The bullet points summarise some of the comparisons with others in the benchmark. In total the benchmark covers over half of the PCTs in the country, some of which have more than one provider. There are 90 different services that are included in the comparison, though where data is not available or is not comparable with others, the data points are omitted. In cases where two different providers operate together to deliver a service to one group of patients (for example if one organisation does the call-handling and another the clinical assessment and face to face consultations) the overall service is analysed as one.

- **Case volume:** the service receives an average level of demand when measured as cases per 1,000 of registered population which may reflect the nature of the area served.
- **Cost**: the service is a below the average for the cost per head and offers a lower cost per head than the majority of others in the rural grouping (with low population density).
- **Productivity:** The service is among the more productive ones measured as cases per clinician hour at the busy weekend morning period. This is particularly difficult to achieve in a rural area such as Borsetshire where travelling distance for the home visiting doctor and the need to open a number of centres makes it more difficult to be productive.
- **Clinical governance:** Because of doubts about the comparability of the answers using the self-assessment process we recommend providers and PCTs to use the questions in Appendix 2 to review what processes are appropriate locally. The below average scores on many of these aspects suggests that there may be work to do following such a review.
- **Outcomes**: levels of advice are exceptionally high compared with other services and home visits are among the lowest.
- **Performance**: The service has a very low level of cases that are identified as urgent. However the percentage of urgent cases definitively assessed in 20 minutes falls short of the standard as does the percentage of urgent cases seen face to face in two hours exceeds the standard for compliance.
- **Patient experience**: Responses to the survey of patient experience show a slightly lower than average number score the service as very good or excellent on but they rate the help received from health professionals slightly above average as measured in the composite score of understanding, listening, explanation, advice, treatment and reassurance .

Purpose and background

This report provides a view of the performance of out of hours services. It is prepared for the PCT – although the information is also made available to providers.

The benchmark has been developed to support world class commissioning and to help providers in driving up the quality of care by highlighting variations and opportunities for improvement. Our aim is to inform local discussions between commissioners and providers about how to improve patient care and ensure that the service delivers best value to the local health economy. Whilst we have suggested some of the common factors that may impact on performance we have avoided interpreting the results without an understanding of the local issues and context.

The benchmark is supported by feedback and learning sessions which we see as a vital part of improving performance and we recommend them to key staff from the PCT and providers. We are also happy to provide further support, including participating in a session to discuss the findings locally, or acting as a 'marriage broker' to match up your services with others who are currently performing better on a specific aspect of service delivery. Contact details are provided towards the end of the report.

Data comes from questionnaires completed by PCTs (mainly the scope and cost of the contract) and providers (about the operational model, governance processes, staffing and telephony) and from a data extract for four sample weeks spread over a period. The analysis of the information is validated by the PCT and providers before this report is prepared as part of our process. Considerable effort has been made to check information and some data has been omitted for some PCT/providers when it did not seem possible to reconcile different figures within the timescale. With the benchmark being repeated approximately twice a year these gaps can be filled, any errors corrected and the analysis refined over time.

One additional source of information is a survey of patient experience carried out for us by CFEP. The findings from this work are included as a separate report and we have compared some aspects of measured performance to see if patients perceive a difference.

We are very grateful for the support and help from PCT and provider staff in compiling the information and would like to thank everyone who has helped to make this possible. We recognise that there will be areas that we can improve to make the benchmark more valuable for users and simpler for those supplying information. The user group has already contributed in a detailed discussion and some of the points will be tested at the feedback events. In addition we will be developing the benchmark further in a small number of areas to ensure that we collect and compare information about those areas identified as being important for PCTs to examine in the recent Care Quality Commission interim findings.

We have been party to considerable detail from individual PCTs and providers and it is this detail that has allowed us to provide what we believe to be genuinely comparable

information. Because of this we have agreed to protect the confidentiality of different PCTs and providers. For this reason we have identified only the specific PCT/provider combination to which this report is presented. One of the aspects that we propose to discuss at the feedback events is a recommendation from the user group that, now that confidence is growing in the validity and usefulness of the comparisons, we should be open about which service is which and to publish the results.

Cost

In comparing cost we have made considerable effort to try to ensure that the costs are genuinely comparable. Our questions were targeted particularly at PCTs to make sure that an 'arms-length' contract cost is compared. We asked a senior financial officer to provide adjustments where, for example, the PCT provides support with financial and management expertise and resource, HR support, IT support or by paying IT licence costs, rent, rates, cleaning, hygiene etc. We have also adjusted the cost to reflect the different range of services that are covered under the contract in different areas. Since informed estimates were required for this, you should be cautious about reading too much into small cost differences.

In this section we have looked at the cost per head of population and have compared the cost taking into account two possible explanatory factors – the volume of cases and the rurality (population density). In each case we have plotted the cost per head against this other axis so that you can see where the service stands compared with others. At the end of the report we return to cost and compare this against the patient's satisfaction with the experience.

Note that in the scatter graphs the label is immediately to the right of the spot for your service. We recommend that you look particularly to compare your service with others that are close to you on the X axis (across the bottom) on the basis that they will be similar to you in that aspect.

Cost per head compared with volume of cases per 1000 population

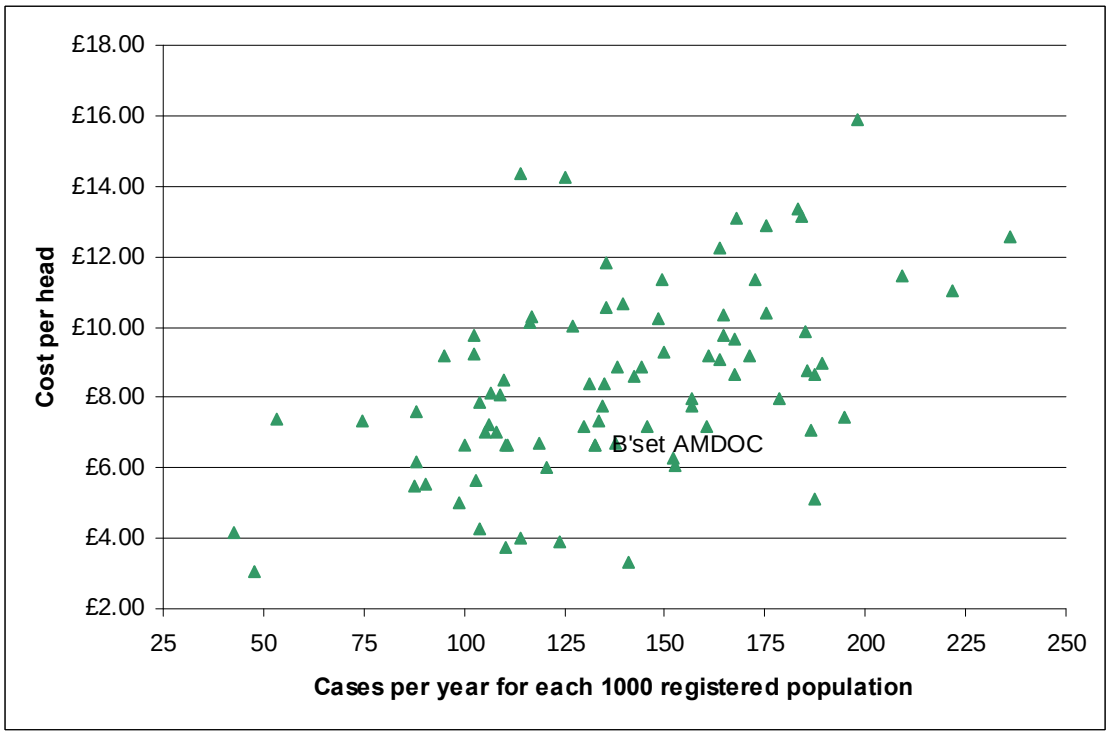
All out of hours services are different. Virtually all services take responsibility for cases received by them from around 18.00 on a weekday evening, will deal with NHS Direct cases passed over to them and will refer patients to and receive cases from other professionals or services (e.g. walk-in centres, A&E, district nursing, rapid response and mental health crisis teams). We have assumed that a modest level of this sort of activity is all part and parcel of the normal out of hours case-load that we want to compare. However, some services have very considerable volumes of cases of this type (for example if they run the walk-in centre or are co-located with A&E and have set up protocols so that substantial patient numbers are passed to the out of hours service). To ensure comparability we have excluded these cases

and, where necessary, adjusted the contract price accordingly. This cannot be a precise science and, despite our best efforts the reader should assume that some of the services that appear to have a very high demand may have included a number of other cases in the count that cannot be reliably separated (often because of inconsistent coding or poor coding structures left as accidents of history).

Generally, demand for out of hours services comes from the elderly (and, to a lesser extent, from children) so it is often those places with a preponderance of retirement home that have a high demand measured in cases per 1000 of population, an effect that can be exaggerated if there is an influx of holiday visitors or students.

Figure 1 is a comparison of the annual cost per head of registered population covered by the service compared with the annual case volume per 1000 registered population.

Figure 1 – A comparison of cost per head with annual case volume



Unsurprisingly, services that have higher case volumes tend to cost more per head – but there is a wide variation in the cost within any given range of case volumes or, put differently, some services deal with many more cases for the same cost per head as other services.

The AMDOC service in Borsetshire is a below the average cost per head and has a demand that is in the middle range – perhaps to be expected for the largely farming community with some choosing the county for their retirement.

Cost per head compared with rurality (population density)

There is an enormous difference between out of hours services operating in a city or urban area where typically there is a need for only one centre, where driving distances are short and where there are a range of alternative services available to patients compared with the service that has to cover a large shire county that is sparsely populated.

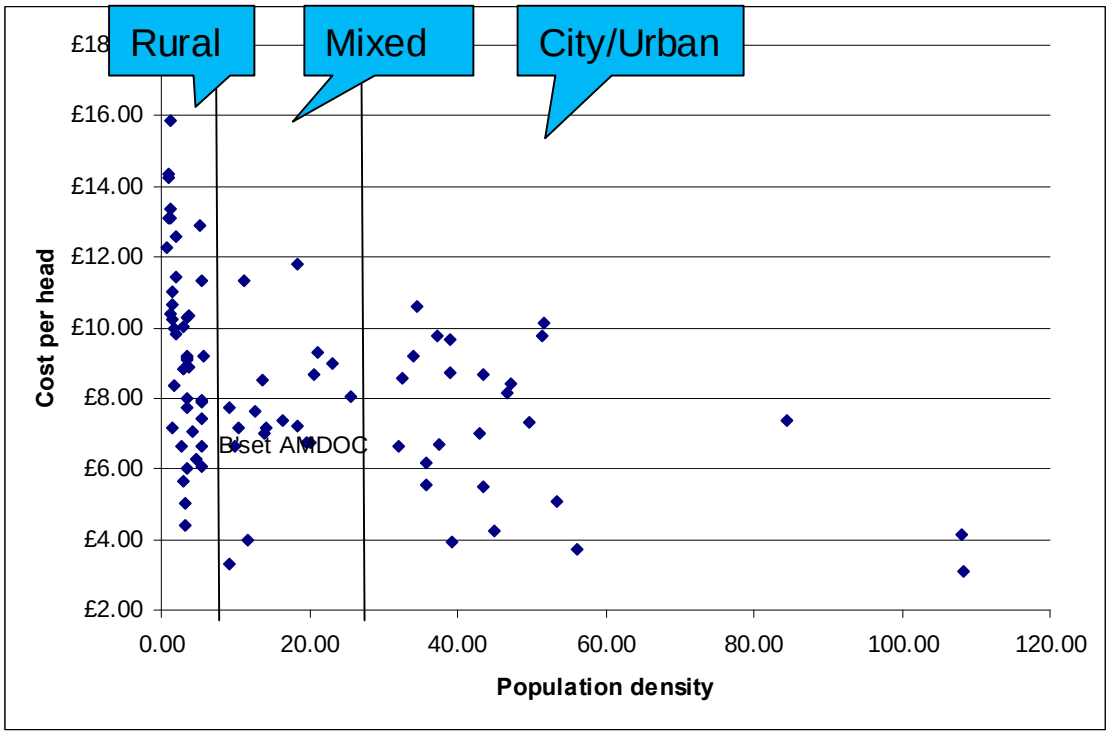
Figure 3 plots the cost per head again – but in this case against the population density based on the population numbers provided by the PCT (sense checked against the recently published estimates of the registered population by PCT) per hectare. There is a clear relationship (as expected) indicating that on average it is more costly to provide an out of hours service in a rural area than in a densely populated PCT.

We have chosen some groupings where we think it is reasonable to compare similar services of:

- Very rural (less than 7 people per hectare and including for example such PCTs as Norfolk, Leicestershire County and Rutland, Devon and E&NE Hertfordshire). Typically a considerable number of centres is open at busy times.
- Mixed urban and rural (7 to 27 people per hectare and including for example Knowsley, Sheffield, Torbay and West Hertfordshire). Here some services will operate with only one base whilst others will have several.
- City and Urban (27 or more people per hectare and including for example Liverpool, Leicester City, Dudley and Greenwich). Usually there is only one base open, even at busy times.

As with the other diagrams we recommend that you compare your cost per head with other services that are similar to you - in this case in respect of their population density.

Figure 3 – Cost per head compared with rurality



The AMDOC service in Borsetshire is among the lower group of those that we have classified as largely rural.

Productivity, governance and clinical decisions

Without governance processes, measurement and feedback, primary care clinicians can and do operate in very different ways and at very different paces. In the feedback events last time we demonstrated how, although there is variation between services, there is even more variation between individual clinicians. The example that we used (based on six months of data) showed that some doctors carrying out assessment tended to end the call with telephone advice with only 35% of patients being invited to a face to face consultation whilst other doctors were much less comfortable giving advice over the phone and invited 70% of patients to a face to face consultation. There were also very significant variations in the length of consultations.

If the service does not manage these issues it will be impossible to offer the consistently reliable response that patient safety demands. In practice those regularly employed in the service know which clinicians are slow, which refer more patients to hospital and which tend to invite patients to a face to face consultation. In many cases, however, this is one of those 'cultural silences' that is not openly discussed.

The recent CQC interim report emphasised the importance of PCTs digging deeper into many of these areas including the quality of clinical decisions made when they said: *"It's not just about monitoring numbers of people treated, or how much this costs. It's about examining the finer detail of the actual care patients receive, to ensure the service is safe and meeting people's needs".*

We urge the PCT to discuss the detailed answers to the questions that we asked about governance with their provider as part of this process of understanding how clinical decisions are monitored by the service.

Productivity

Productivity should never be looked at in isolation – a rapid consultation is not necessarily a thorough one. The productivity of the service will also be significantly affected by such factors as the case mix and availability of alternative services, the mix of skills employed, the proportion of home visits, the geographic area covered, the numbers of PCCs that are open and many other factors. Some of these may be influenced by the specification, the way the service operates and the clinical decisions made – but they are not controlled exclusively by either the provider or the PCT. It is comparatively easy for a service operating within a small city area, with good alternative services and only one centre, to be more productive. Nevertheless, some services of this type have low productivity and others who appear to start with few of these advantages are among the more productive.

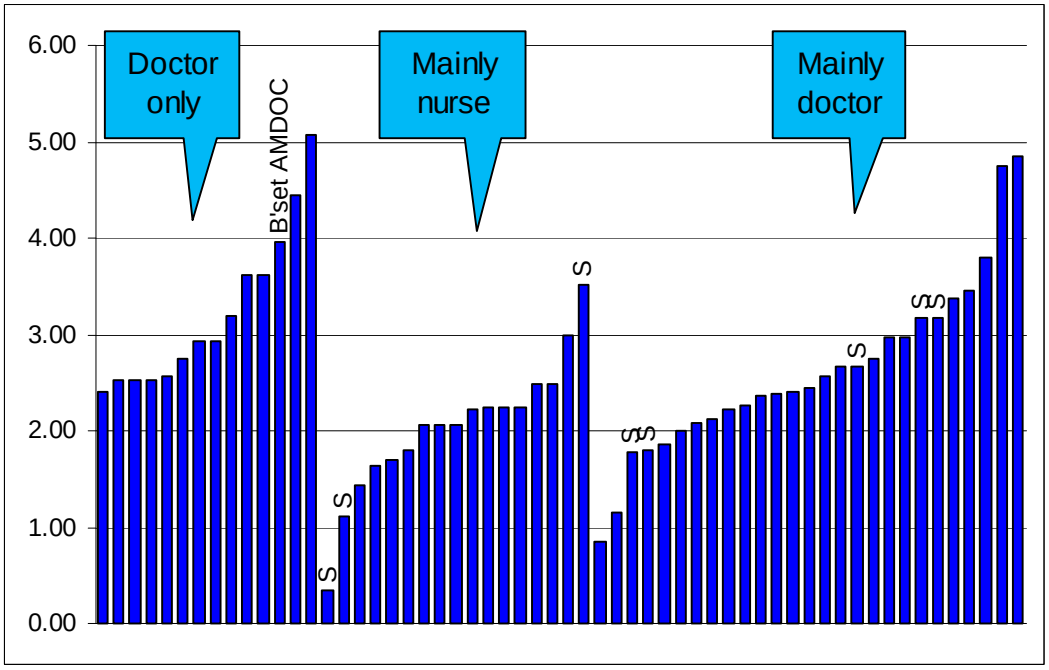
Our observation is that those services that manage and measure how clinicians spend their time and what decisions they make avoid being among the least productive group and ensure a consistent response to demand from patients.
Figure 4 looks at the productivity measured as cases per clinical hour for the weekend morning. It compares services according to the skill mix used for the telephone assessment. Services are defined according to whether their telephone assessment was defined as

- doctor only;
- mainly doctor, but some nurse/other skills or
- mainly nurse/other skills but with doctor support

In addition, using an "S" the chart identifies those services that have protocols to allow the streaming of some patients directly to the centre. Despite the theoretical saving by avoiding the need for both a telephone and face to face consultation these services are not conspicuously more productive than those that adopt the more conventional model of ringing back virtually all patients.

The AMDOC service is more productive than the majority of other services when measured as cases per clinician hour for the weekend morning period – something that is more difficult to achieve in a rural area where the travelling distances and need to open a larger number of services will often lower productivity when measured in this way.

Figure 4 – Productivity compared across services



In looking at the graph above the reader should not forget that nurses are typically considerably cheaper than doctors. In services that have sufficient demand for there to be plenty of work for both sorts of skills it is undoubtedly possible to establish cost-effective and patient friendly services that make good use of nurses.

Process and governance

The individual decisions made by clinicians matter. They matter to patients receiving care and they matter because they drive the performance, reliability and cost of the service. Their importance has been highlighted in the recent interim findings from the CQC who particularly emphasised that PCTs should look at the clinical decisions made in out of hours services. We recommend a careful review of the questions included in appendix 2. Whilst there are many different ways by which an organisations may choose to review and manage clinicians at the heart of the process must be a mechanism to allow clinical staff to see how they stand compared with their peers if the service is to provide a consistent service. Appendix 2 should provide a good topic guide to review this area.

We asked providers to self assess themselves by answering 'Yes' or 'No' to the questions in the appendix. In some instances we strongly suspect that the intent behind the question was not fully understood so, although we have compared scores against the average, PCTs and provider services should not place undue emphasis on the comparisons. What the questions will undoubtedly provide is a robust topic guide that will allow understanding of how the service is "*continually improving the quality of their services and safeguarding high*

standards of care by creating an environment in which excellence in clinical care will flourish" (from Scally and Donaldson's definition of clinical governance 1998)

Figure 5 – self assessment scores based on answers to the questions in Appendix 2

QR3 Exchange of information			
Score exchange of information	Average	6.862	7
QR4 Audit, Governance and feedback			
Score - Initial Priority	Average	5.448	1
Score - Disposition and Clinician priority	Average	7.54	3
Score - Coding and Prescribing	Average	5.092	1
Score - Referrals	Average	7.678	0
Score - Productivity	Average	5.885	2

The numbers in gold are an above average score, those in pink below. The average is across all services

Outcomes

Within this section we focus on two measures. The first is the end dispositions - percentage receiving advice, being seen at a centre, or being visited at home. PCTs should be wary of reading too much into these figures – two examples perhaps illustrate why:

- Whilst the cost of servicing a home visit is high and the cost of a simple advice call is low it is not necessarily the case that increasing the percentage of advice will support a reduction in cost. On occasions, we have seen a clinician assessing calls over the phone who spends more time trying to convince a patient that they do not need to attend the PCC than it would take to complete the initial assessment more quickly and then to see the patient a little later at base.
- Increasing the numbers of home visits during the 'red eye' period when demand is low may help to reduce cost by saving the need for a number of centres to be open, each with their reception staff.

In figure 6 the proportion of cases that receive telephone advice (including referral to other services) is indicated in blue whilst in figure 7 the proportion of cases with a home visit case type is in pale red.

Figure 6 – Cases given advice compared across services

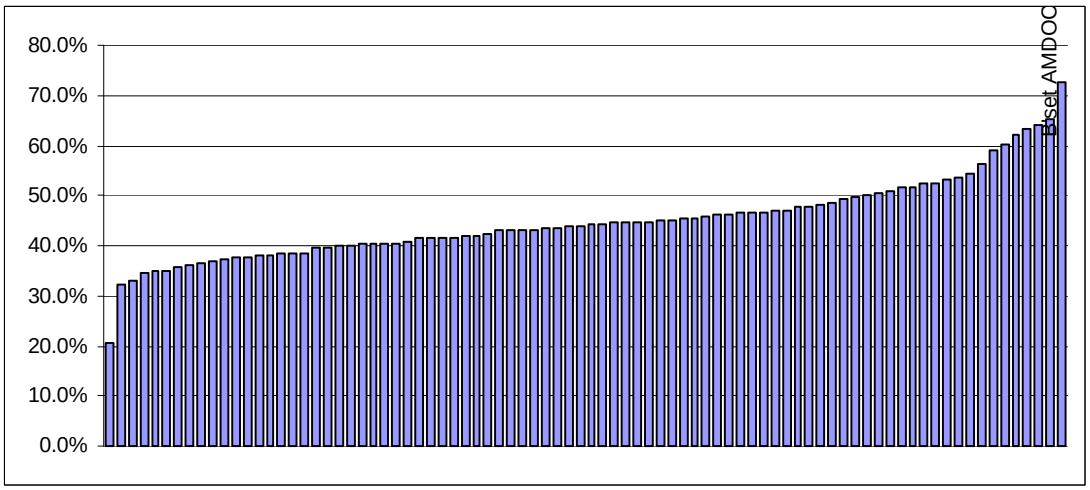
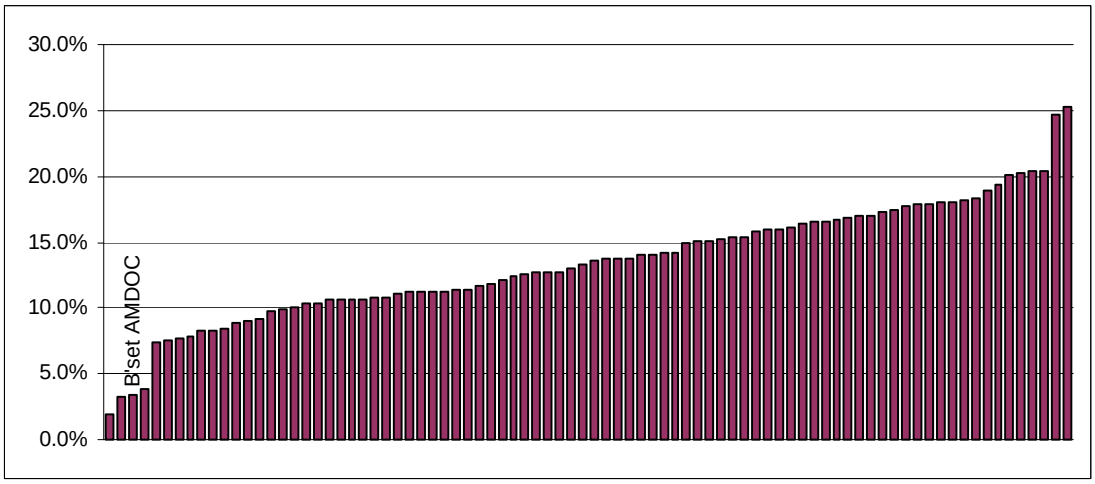


Figure 7 - Cases receiving home visits compared across services



The AMDOC service has an exceptionally high level of telephone advice and a level of home visits that is well below the vast majority of other services.

In the first benchmark we included a graph comparing the proportion of patients going towards hospital. We made it as clear as we were able that many providers coded cases inadequately for it to be a fair like for like comparison. Although some have improved considerably it is still the case that many are failing to identify these cases. In the last benchmark we made clear that the typical proportion of patients that go on from an out of hours service towards the ambulance service or hospital is 12 to 16%. We have revised this estimate to 12 to 17.5% and have tried to highlight the concerns about comparability on the graph.

Importantly, though this figure seems to be higher than many expect, most of the patients should be going towards hospital because, for example

- They have symptoms indicative of a potentially life-threatening condition
- They have injuries or suspected fractures that need to be seen at an emergency department
- They are referred for admission after they have been seen at the centre or in their home
- The service and PCT has made arrangements that certain paediatric cases should be seen in the hospital

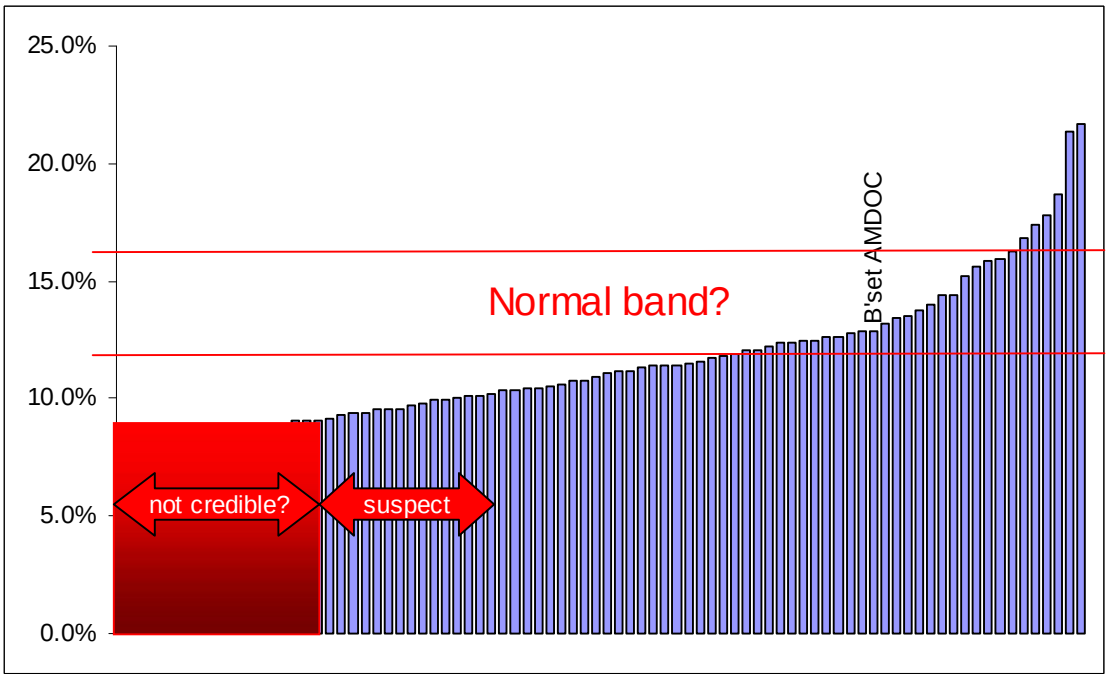
In addition the mix of cases that the out of hours service takes on can affect the proportion that do go on towards hospital – for example those services that field a large number of cases where the ambulance is already on site face a different mix from those that do not work with the local ambulance trust in this way. This does not mean that measuring the proportion of cases going towards hospital is not important just that, like every other figure in this report, it needs to be interpreted in the light of the local specification and with an understanding of the local circumstances.

There are a some things however that an out of hours service can do to reduce the numbers of patients that go on to hospital by:

- Minimizing the time delay before definitive clinical assessment. All services that utilize a ring-back model find that some worried patients have decided themselves to go to the emergency department. Usually this becomes clear when contact is eventually made with the patient either at A&E or on their return. Presumably the shorter the time before ring-back the greater the chance of speaking to the patient or carer and suggesting an alternative course of action.
- Establishing processes by which the border-line cases can be warm-transferred to a clinician. Whilst speed is of such importance in some, there are other cases where it is possible for a clinician to assess whether the ambulance is required by warm-transfer of the call. Because of their training and experience the clinician can not only reduce the frequency with which the ambulance service is called on but can usually inspire greater confidence over the phone than the non-clinical call-handler.

We have said that this measure is important. Although some services have improved their recording, there are still far too many instances when informational outcomes are so poorly completed that the service cannot possibly report this measure accurately. In general we have yet to be convinced that any service has fewer than 10% of their patients that go towards hospital. We expect providers to rationalize their codes if necessary and to reinforce with clinicians the importance of ensuring that this measure is reliably counted by proper use of the informational outcome codes. Once the measure is reliably counted PCTs and services can measure the trends and we can better compare the different services. We plan to circulate some comments and suggestions to providers that we hope will be helpful and they will cover this aspect among others.

Figure 8 – Cases going "towards hospital" compared across services



We identified from the extract that 13.3% of the AMDOC cases were going towards hospital. We also identified a number of others (using a key word-search) that were not included in this percentage because they were not coded with appropriate informational outcomes indicating that the underlying percentage is at least a little higher than this.

Performance

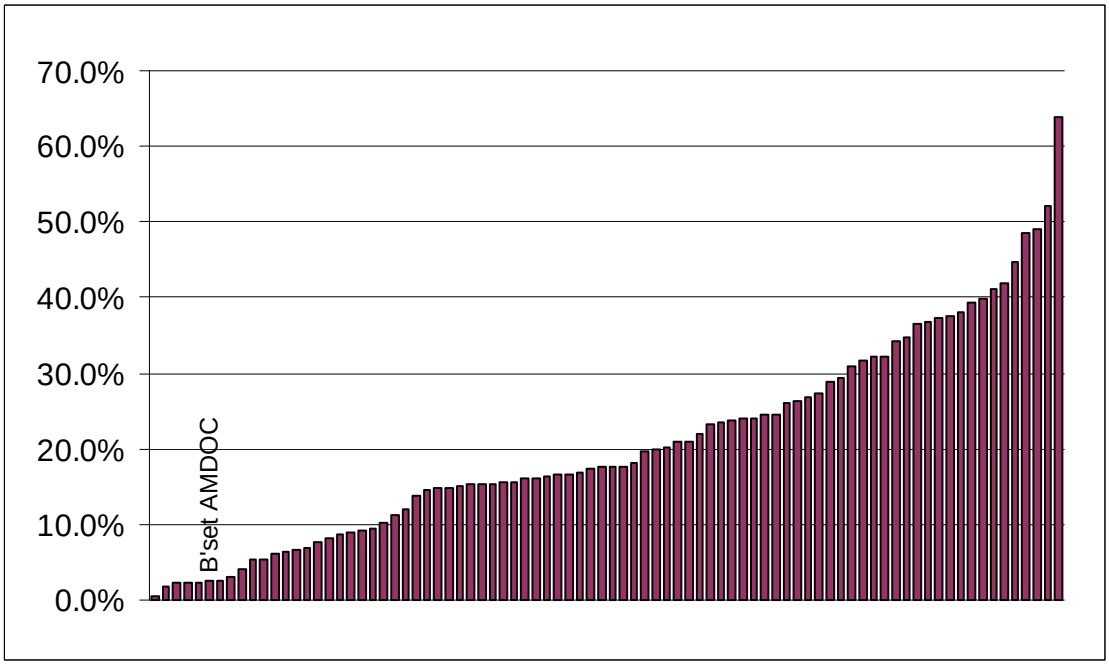
Through the questionnaire and the benchmark we collect information on all of the National Quality requirements. Within this report we have consciously focused on some of the more difficult to achieve standards. There seems little point in looking in detail, for example, at the performance on reporting to practices by 8.00 am on the next working day when the system automatically sends the report. We have included a table in Appendix 1 that provides information across the wider range of the national quality requirements. In this section we focus on two measures of timeliness.

Time to definitive assessment

The standard for time to definitive assessment recognises a difference between urgent cases (20 minutes) and less urgent cases (60 minutes). Services have very different definitions of

urgency with the range of cases identified as urgent on receipt varying from less than 2% to over 60% (Figure 7).

Figure 9 – Cases identified as urgent on receipt across services



We strongly recommend that PCTs that find themselves towards either end of this graph review carefully the processes used by call-handlers in identifying life threatening conditions and setting priorities. Unless the provider can demonstrate that their process for prioritisation is safe and effective the PCT should insist that the standard used is the harsher one that requires all calls to be assessed in 20 minutes.

Figure 10 may throw some light on the way that those with few urgent cases on receipt find that priorities are escalated through the process. It compares the percentage of cases that are urgent on receipt with the percentage of cases to be seen face to face that are identified as urgent or emergency after assessment. Although the comparison is not exactly of like for like most services have a lower percentage after clinical assessment than was identified by the non-clinical call-handlers – but in a few cases the priorities escalate. For more detail on this graph see Note 4. Importantly those below the line (where there is escalation of priority) should consider whether this indicates that urgent cases are waiting longer for clinical assessment than they ought, bearing in mind that the clinician defined them as urgent enough that they should be seen face to face in one or two hours.

In short there are patient safety concerns about those with very low levels of cases identified as urgent on receipt and these are reinforced if the service is below and to the right of the diagonal line in figure10.

AMDOC has a very low level of cases identified as urgent on receipt and an almost identical proportion of those that are to be seen face to face are also identifired as urgent. . Whilst the priority of an individual case will change through the process, we recommend the service to look at the way that priorities are identified at each stage to understand which sorts of cases have their priority escalated and whether this is because some urgent cases are missed.

Figure 10 – highlighting the escalation of priority in some services

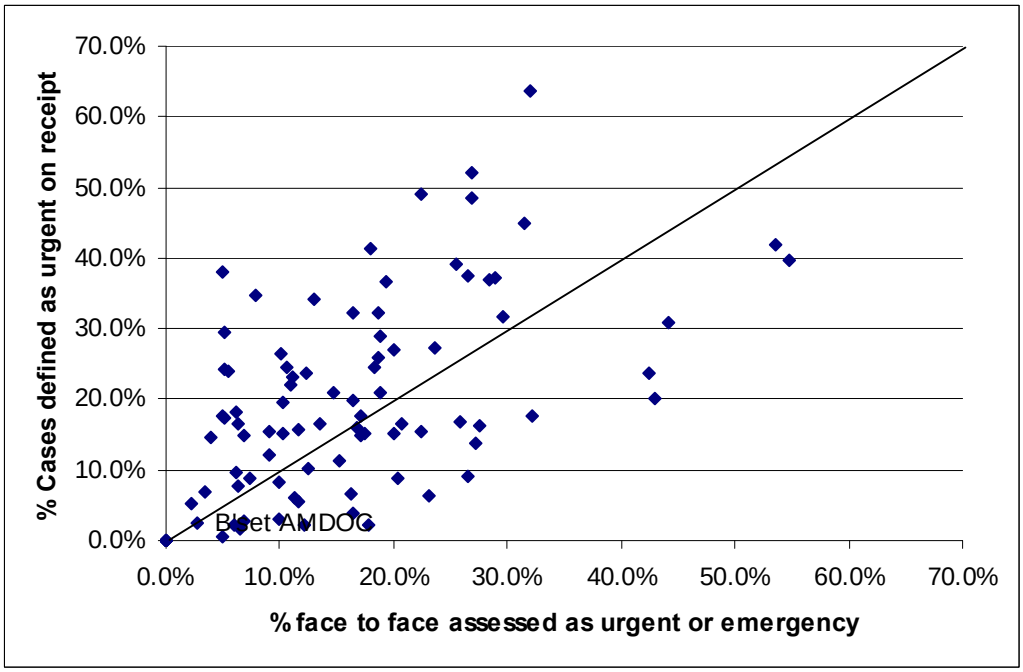
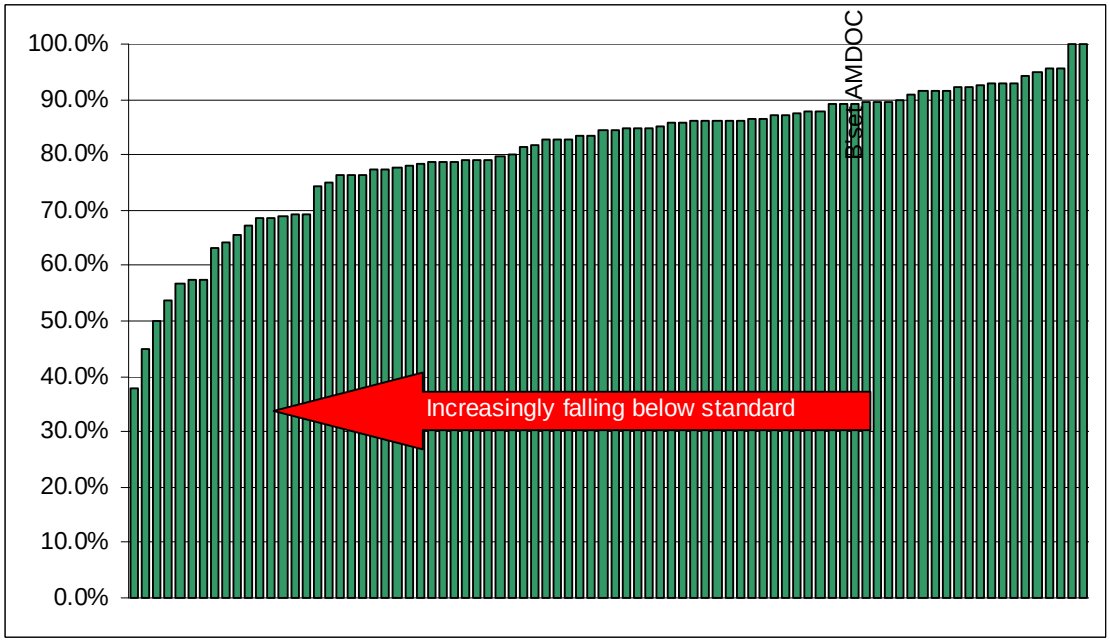


Figure 11 shows the percentage of urgent cases that are definitively assessed in 20 minutes. We have had a number of discussions with providers about how we are measuring performance against this standard (see note 3). There are two main reasons why our measure may appear worse than is sometimes reported:

- We measure to the start of the definitive (final) advice consultation in line with the standard
- To ensure comparability across services, we are NOT excluding those cases where, through no fault of the provider, they could not start the assessment (for example because the phone was engaged

Particularly in places where the responsibility for telephone assessment rests with one organisation and responsibility for face to face consultation rests with another, but also in services that use nurses or ECPs to carry out the telephone assessment a significant number of second assessments often takes place. This will make it much more difficult to achieve the standard for definitive assessment.

Figure 11 – Urgent cases definitively assessed in 20 minutes



AMDOC is (just) partially compliant with the standard for definitive assessment of urgent cases in 20 minutes at 90%.

In the final section we have compared performance in time to definitive assessment against the patient's view of timeliness as measured through the survey.

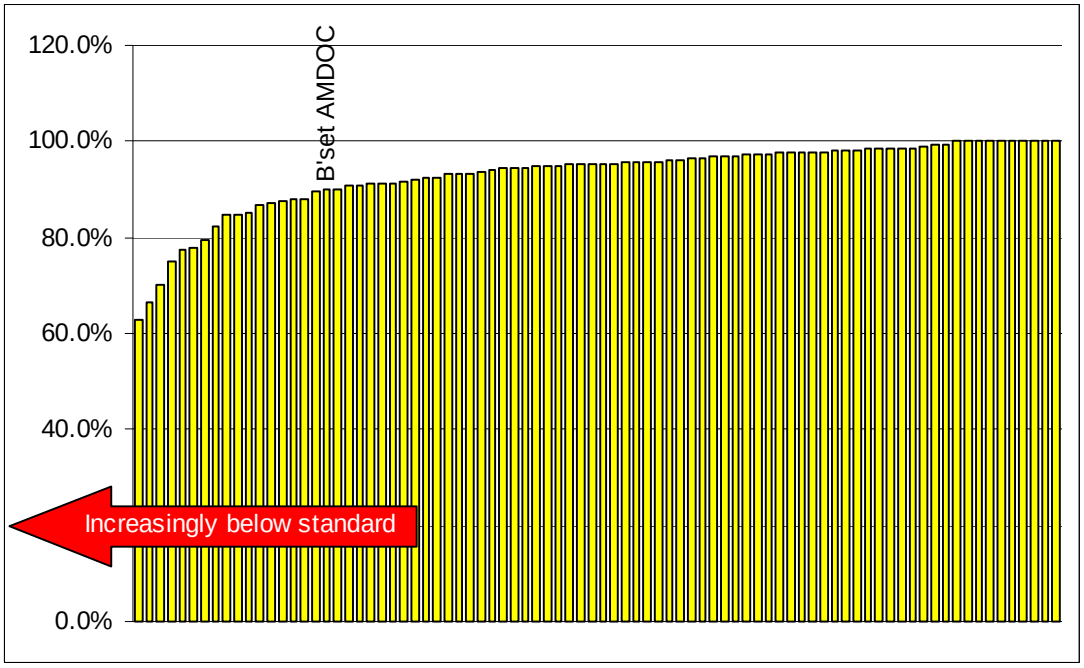
Time to face to face consultation

The standard requires services to see emergency cases face to face within one hour of the end of the definitive assessment and urgent cases within two hours. In practice, most services will see the vast majority of patients within the two hour period – but for urgent and emergency cases it is important that the service makes clear to patients coming to the base that they should not delay.

Figure 12 looks at timeliness of seeing those patients defined as urgent after assessment within the two hour period. The majority of services perform well against this standard exceeding the 95% required to be classified as fully compliant.

AMDOC sees 86% of urgent cases within the target two hour period, falling short of the standard.

Figure 12 – Urgent cases seen face to face in 2 hours



Patient experience

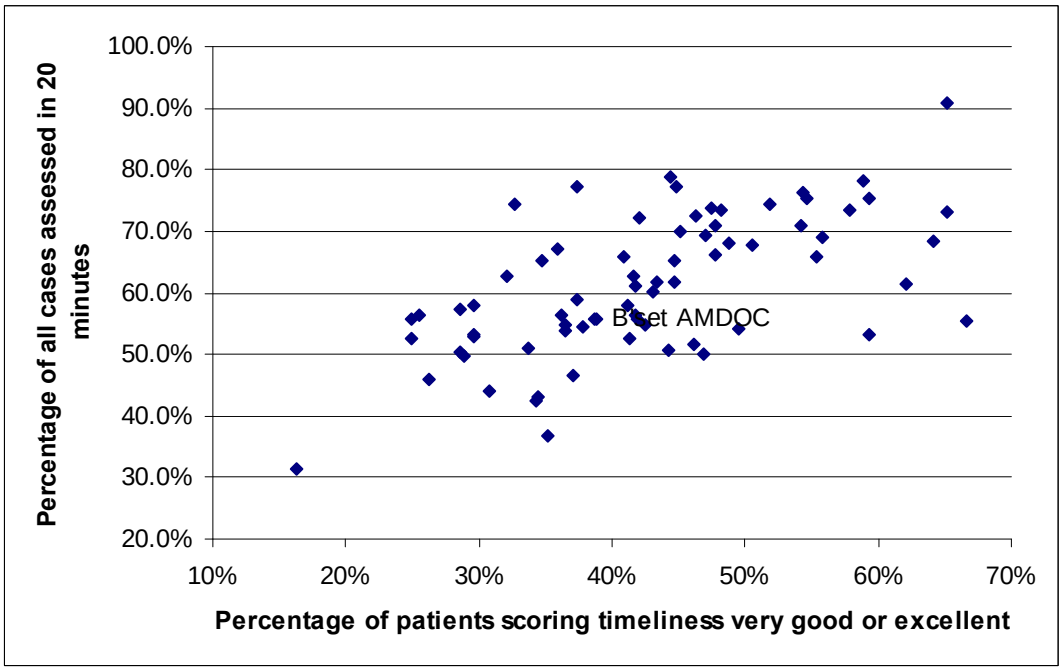
As part of some of the benchmarks we measure the patients' view of their experience of out of hours services through a survey of users, working in partnership with CFEP. You will find a report from CFEP enclosed with this report that includes a copy of the questions asked of patients. Within this section we have chosen to make some comparison of the measured performance of the service with the view of the patient. In a small number of cases the response rate (which was typically above 40%) was numerically low (we suspect because of difficulties and delays in providers getting the questionnaires distributed) so caution should be exercised in these cases.

We will share more of these comparisons in the feedback sessions (and make available the slides via our web site www.primarycarefundation.co.uk following these events). It is interesting, for example, that there is no obvious correlation between high levels of telephone advice and any dissatisfaction with the disposition.

It does seem that patients recognise a service that responds rapidly. In general the services that assess a higher proportion of all patients within 20 minutes are more likely to have patients that score them very good or excellent on the question about timeliness.

The Borsetshire AMDOC service definitively less than 60% of all calls within 20 minutes and is scored very good or excellent by a lower proportion of patients than many others.

Figure 13 – Speed of assessment compared with patients view of timeliness



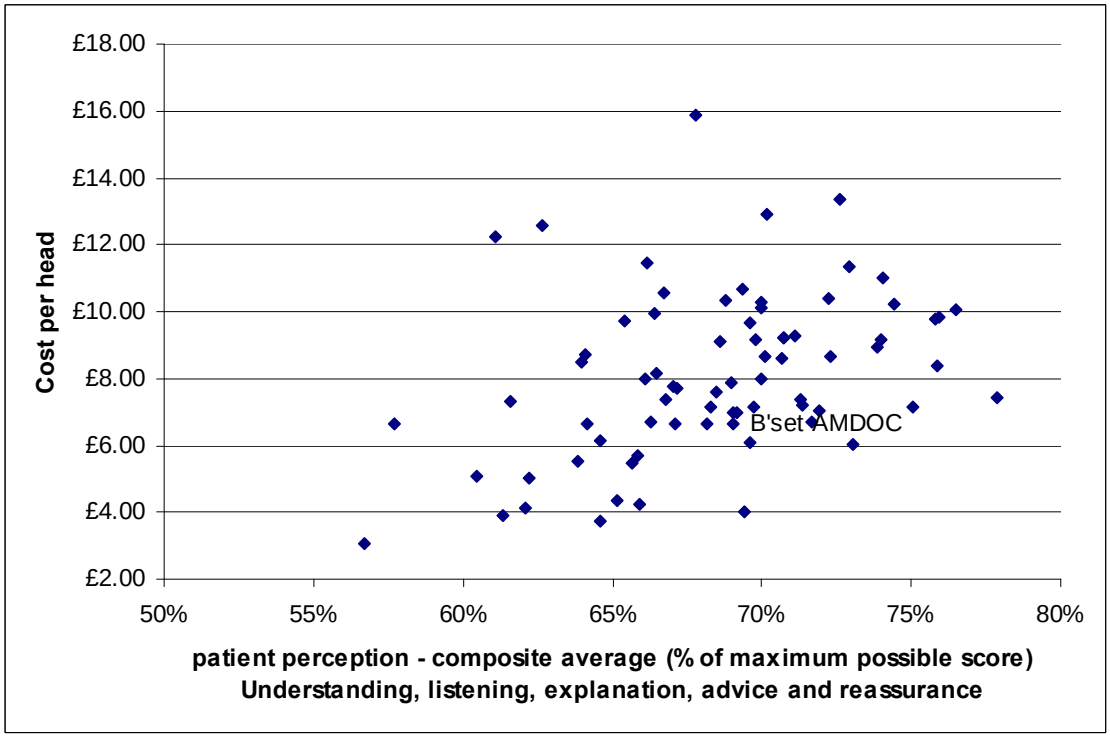
The survey carried out be CFEP provides a valuable additional perspective on the view of the patient about the quality of care that they receive. There are a number of questions about the overall help received in the clinical consultation (whether by phone or face to face) covering understanding, listening, explanation, advice, treatment and reassurance (questions 4a, b, c, d e and f). We have devised a composite score based on the average of the answers given to these questions (see note 5)

We have chosen to compare this composite score against cost to test whether the services that are more expensive are perceived as being better in the patient's eyes. Whilst it does appear that some of the less costly services score much lower than others the better scoring services are very much in the middle cost range – see figure 14.

AMDOC appears to fall in the middle on this composite view from patients.

Within the feedback sessions we aim to explore some more of these relationships. Later, when the information is available at provider level, we may also be able to look at the information about out of hours services as collected through the very large IPSOS Mori survey.

Figure 14 – Cost per head compared with composite score of the overall help received



Further information and future benchmarks

This report on the second round of the benchmark provides a thorough comparative view of performance across the different participating PCTs. We would encourage attendance at the feedback events so that you can understand more about aspects of the data and comparison and so that you can contribute towards the future shape and format of the benchmark. Should it be helpful to understand more of the detail we would be happy to join a conference call at suitable time. Should you wish to discuss the benchmark, to make suggestions or to know more please contact Henry Clay on 07775 696360 or by email henry.clay@primarycarefoundation.co.uk

Notes and definitions

1 The measure of clinician hours per call

This information is derived by comparing the number of 'normal out of hours calls' during the sample four week periods (excluding other calls not related to the out of hours doctor service, for example if the provider takes calls for the district nursing service or if the system is also used to record patients seen in an A&E department or a MIU) against the reported number of clinicians that were planned to be on duty (so assuming that the rota was fully staffed) in a normal week in February. Where larger providers share clinicians across a wider area (for example if all calls are assessed centrally) then the figure for calls per clinician hour is arrived at by adding the different figures for the different elements of the service. For a small number of providers we have not been able to calculate a reliable measure and these providers do not show in the results.

2 Clinical Governance

Clinical governance has been defined as corporate accountability for clinical performance or as a framework through which NHS Organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

To compare providers we asked them to answer a number of specific questions about five main areas of governance – initial prioritisation usually by call-handlers, prioritisation by clinicians and clinical outcomes, clinical coding and prescribing, referrals to other services (particularly to A&E, ambulance and hospital) and productivity. To judge whether providers had an adequate framework and were using it to drive up performance we asked providers whether they recorded and reported on the measures (some of which are not directly linked to the out of hours standards but are still important measures of the service), whether they analysed the differences in outcomes on these measures between staff (clinical and non-clinical as appropriate), whether this information was fed back to them and whether they reported on them to the PCT.

3 Time to clinical assessment

Time to clinical assessment is important to patient safety in that the risk to the small number of patients who may have a condition that needs urgent attention is not managed until a clinician has assessed the case and decided what action is appropriate (which may include telephone advice, attendance at a patient care centre or a home visit as well as referring the case to other services such as Ambulance or A&E).

The standard defines two requirements – that 95% of urgent cases should be assessed within 20 minutes and 95% of less urgent within 1 hour. There are two main reasons that the measure may look worse than has been reported by the service.

- **We are measuring to the start of the definitive (final) advice consultation in line with the standard. If the service has significant numbers of cases that receive more than one advice consultation (which may happen more frequently if nurses and other health professionals carry out clinical assessment compared with a 'doctor-only' model), this will produce a lower level of compliance than is indicated by measuring to the start of the first assessment. Guidance to the standard makes clear that the definitive assessment is, in practice, the one which results either in reassurance and advice or in a face to face consultation.**
- **We are NOT excluding those cases where it is no fault of the provider that they could not start the assessment (for example because the phone was engaged). This is important to ensure comparability across providers.**

Because of these differences within appendix 1 we have shown the additional percentage of cases that would have met the standard if clinical assessment had been completed during the first attempted call to the patient.

4 Identification of priority

A typical service identifies around 20% of cases as urgent on receipt. After the clinical assessment the percentage of patients that are identified as urgent or emergency and are to be seen face to face usually drops – on average to near to 15%. Although the cases being seen face to face are likely to be of greater acuity this is because of the expertise of the clinician (compared with the non-clinical call-handler) in identifying those cases that are less urgent. In figure 10 those services in the upper left hand part above the diagonal line demonstrate this pattern of an overall reduction in urgency. Those below and to the right are services in which the level of urgency has escalated. Virtually all services with less than 5% urgent on receipt demonstrate this escalation.

Bearing in mind that the cases defined as urgent or emergency at assessment have been identified as needing to be seen face to face in 2 hours or 1 hour respectively there is a question over whether some patients have already been at risk of delay because the urgency was not recognised by the call-handler. Because of the safety implications of this we recommend that any service below the line review its definitions and application of priority.

5 Composite score of the help received from health professionals

CFEP have adopted a standard approach to scoring responses to questionnaires. We have adopted the same approach of attributing a score as follows:

0%	**Poor**
25%	**Fair**
50%	**Good**
75%	**Very Good**
100%	**Excellent**

We have averaged this percentage in calculating the average score. In doing this we included the response only when the individual answered all of the questions about understanding, listening, explanation, advice and reassurance. In addition we counted the score for treatment in calculating the average when this question was answered.