The Primary Care Foundation is committed to developing and spreading best practice in unscheduled, emergency and primary care in the UK

PCT: Example
Service provider: Example

Benchmark comparison of Out of Hours services

March 2009

Contents

Purpose

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 an 'honest 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.

Summary

This report is prepared as an example to illustrate the information that is made available to those services that have contributed data. In these cases the report would identify the PCT/Provider and provide some commentary within the text. Within the summary we would also typically comment on

- **Case volume:** Measured in cases per hour
- **Cost**: Measured as cost per case and cost per head of registered population
- **Productivity:** Measured in cases per clinician hour at the busy time at a weekend
- **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 n Appendix 2 to review what processes are appropriate locally.
- **Outcomes**: looking at the levels of advice, base attendance and home visits as well as at referrals or self-referral to hospital.
- **Performance**: Against the standards for time to definitive clinical assessment and time to the face to face consultation
- **Patient experience**: measured annually – to be included in the next benchmark.

No individual comments are included within this version nor does it identify any individual PCT or provider. The data used in the summary sheet is test data only.

Introduction

The benchmark is supported by the Department of Health, the NHS Alliance, and Primary Care Contracting and the comparison will be made twice each year based on the six months to the end of March and September. Great care is taken to present comparable information as far as is practicable.

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 through the six month period. The analysis of the data extract 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 every six months these gaps can be filled, any errors corrected and the analysis refined over time.

This report compares the performance across five main performance areas (cost, efficiency, process and governance, performance and outcomes). The benchmark will retain some core measures but will look in more detail at different aspects from time to time. In the feedback sessions planned for the second half of March 2009 we will be explaining some of the findings in greater detail with some examples of good practice in governance and performance measurement. Contact rick.stern@primarycarefoundation.co.uk if you would like to attend.

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, and will be seeking suggestions as to how the benchmark can be made more valuable for users and simpler for those supplying information. We would also welcome any feedback about the style and format of this report so we can refine our approach for future benchmarks.

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 and with the advice of a national reference group 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.

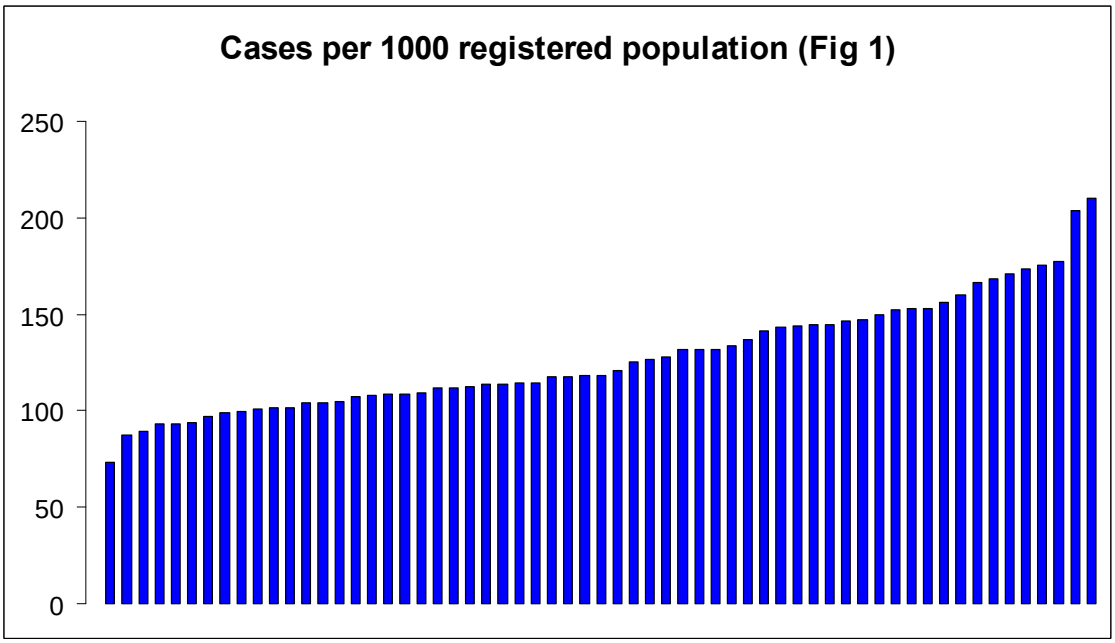
Case volume

In this section we contrast the volume of cases per 1,000 of registered patient population. There are striking variations, even after ensuring that we are counting a similar case mix and

(as case volume is a clear cost driver) it is important to recognise this variability between services.

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). Sometimes these are the subject of a separate contract and sometimes they form part of the out of hours contract. To ensure comparability we have had to exclude these cases and, where necessary, to adjust the contract price accordingly. This cannot be a precise science, but we have put in considerable effort to try to reconcile apparent differences between the reported case volumes and that found in the data extract and, no doubt, we will refine the estimate of the normal out of hours case-load in future benchmarks.

Cases per 1,000 patients, by service



We will look further in future benchmarks at the more than two-fold variation shown in Figure 1 (which would be wider still if we included cases from Scotland, Wales and Northern Ireland). There is no obvious simple relationship but it does appear that those in holiday areas tend to have a higher demand per head of registered patient population (perhaps because of the influx of visitors that use the service) and that in towns and cities (where

there are a number of alternative healthcare services) demand tends to be lower. No doubt there will be many other factors that also influence the demand.

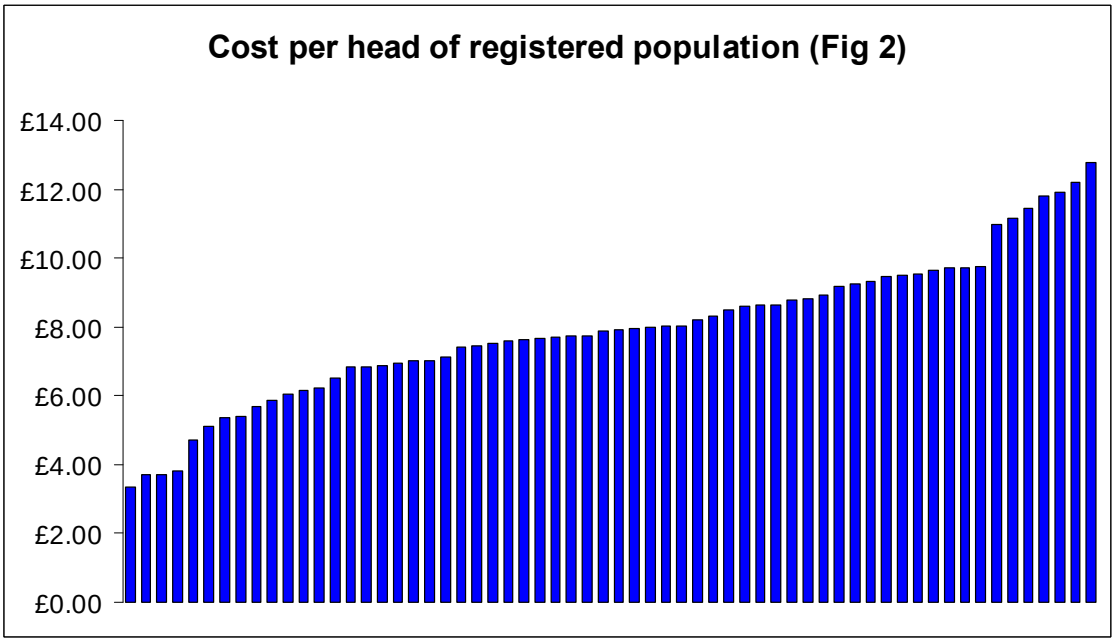
Cost

Two main measures of performance are used in this section; cost per head and cost per case. Again, we have made considerable effort to try to ensure that the costs are 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.

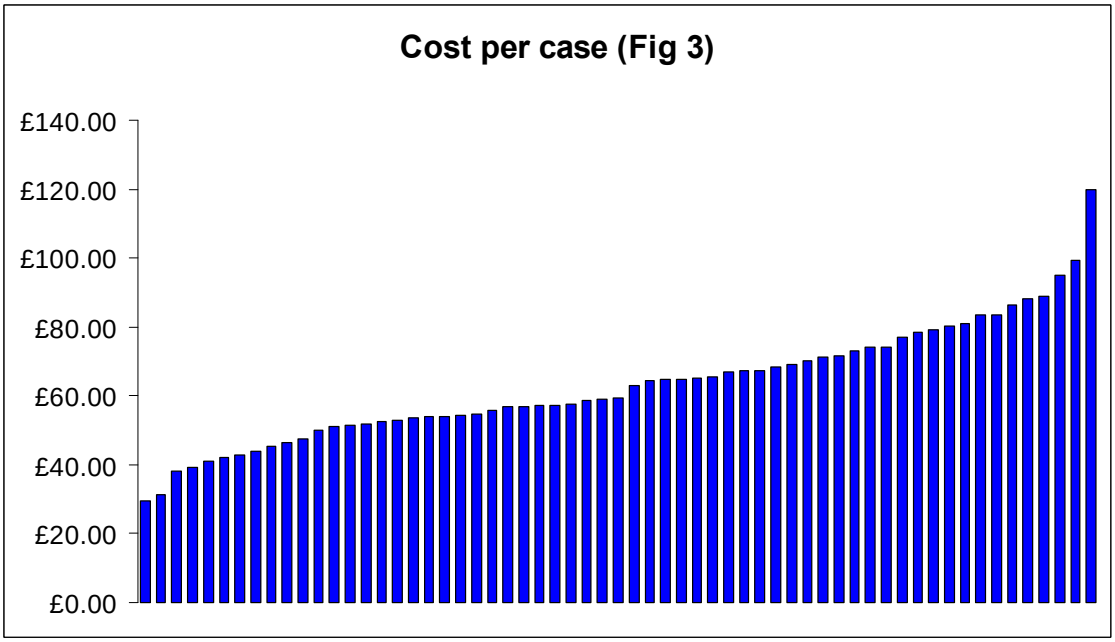
Figure 2 is a simple comparison of the cost per head of registered population covered by the service. Figure 3 shows the cost per case and Figure 4 looks at this cost compared with the annual number of calls per 1,000 patients. Comparison of the position of an individual service on this graph with others with a similar case volume per head perhaps gives a better measure of value for money.

However, PCTs should be aware that, although the volume of cases is an obvious cost driver, the geography of the area and the breadth of the service specification may also drive cost higher. As an example, it is very difficult to keep productivity high if the specification requires the service to keep a number of centres open at less busy times. Some of the impact of this on productivity may be highlighted in the graphs of productivity included later in this report.

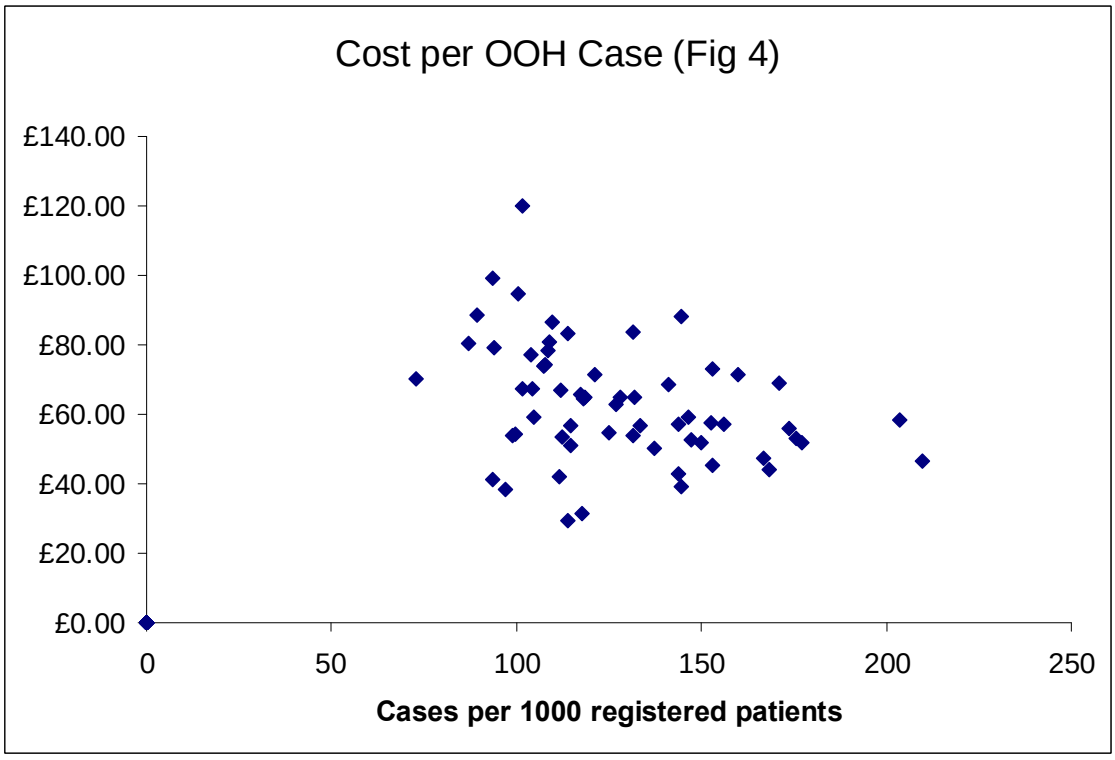
Cost per head, by service



Cost per case by service



Cost per case compared to cases per head of population



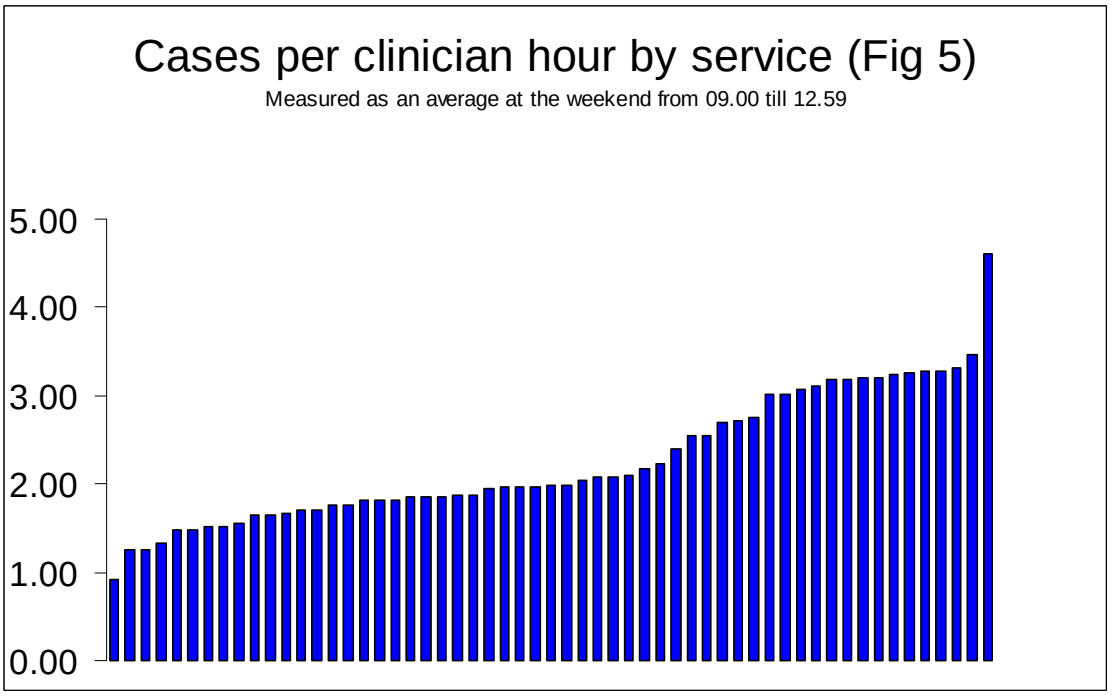
Productivity

In any out of hours service the largest cost, by far, is the cost of the clinicians (typically this cost is over 60% of the cost of the service). Within this benchmark we are looking at the average number of cases in each hour of the day compared to the number of clinicians on duty. The level varies within all services and it is no surprise that productivity is low overnight when very few cases are received. All services are, however, at their busiest on the weekend mornings and we have chosen to compare them in Figure 5 by looking at this measure of productivity for the time from 09.00 to 13.00 based on the demand during the four sample weeks. Information on how these figures are derived is included within the end note (see note 1).

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 others. Some of these factors may be influenced by the specification, the way the service operates and the clinical decisions made – but they are not controlled exclusively by

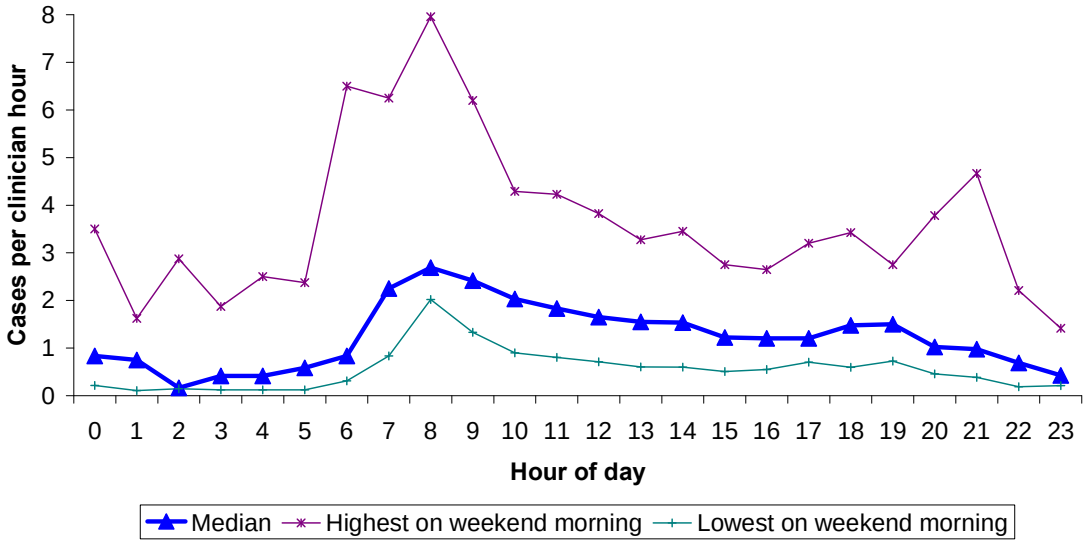
either the provider or the PCT. It is comparatively easy for a service operating within a small city area, with good alternative services and only one centre, to be more productive. Nevertheless, some services of this type have low productivity and others who appear to start with few of these advantages 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. In each of the feedback events we intend to provide some illustrations of the variations within a service and to invite a provider to talk about the lessons that they have learned in addressing this issue.

Comparison of productivity - cases per clinician hour (weekend morning)



The next graph (Figure 6) shows productivity by hour of the weekend based on average demand from the Saturdays and Sundays sampled. We have compared your service against the service that appeared most productive and that which appeared least productive in the graph above.

Cases per clinician hour over an average weekend day (Fig. 6)



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. In this round of the benchmark we have focused particularly on the processes and clinical governance aspects (see note 2) through which services can manage and measure clinical decision-making.

We asked providers to self assess themselves by answering 'Yes' or 'No' to a number of questions. 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 we will do within the feedback sessions is to describe some of the variability that is often found within a typical out of hours service and ask a provider to describe their own lessons from measuring and managing this aspect of the service. With the benefit of this understanding PCTs and providers might like to revisit the questions that we asked of the services in the questionnaire (in a separate appendix). It is certainly not necessary to be able to answer 'Yes' to all of the questions but consideration of each may help in identifying ways in which services can be made more consistently able to provide good care to patients.

QR3 Exchange of information	The self-assessment scoring approach is described in the notes		
Score exchange of information	Average score	5.3 (across all services)	5
QR4 Audit, Governance and feedback	The self-assessment scoring approach is described in the notes		
Score - Initial Priority	Average score	5.3 (across all services)	5
Score - Disposition and Clinician priority	Average score	7.1 (across all services)	7
Score - Coding and Prescribing	Average score	4.8 (across all services)	5
Score - Referrals	Average score	6.8 (across all services)	7
Score - Productivity	Average score	5.5 (across all services)	5

The numbers in green are an above average score, those in blue below. The gold colour allows comparison with the average

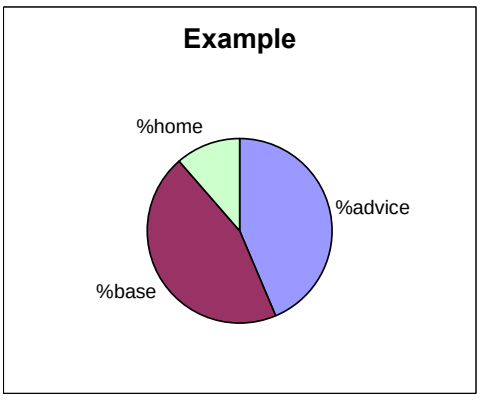
Outcomes

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 safe to assume 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.

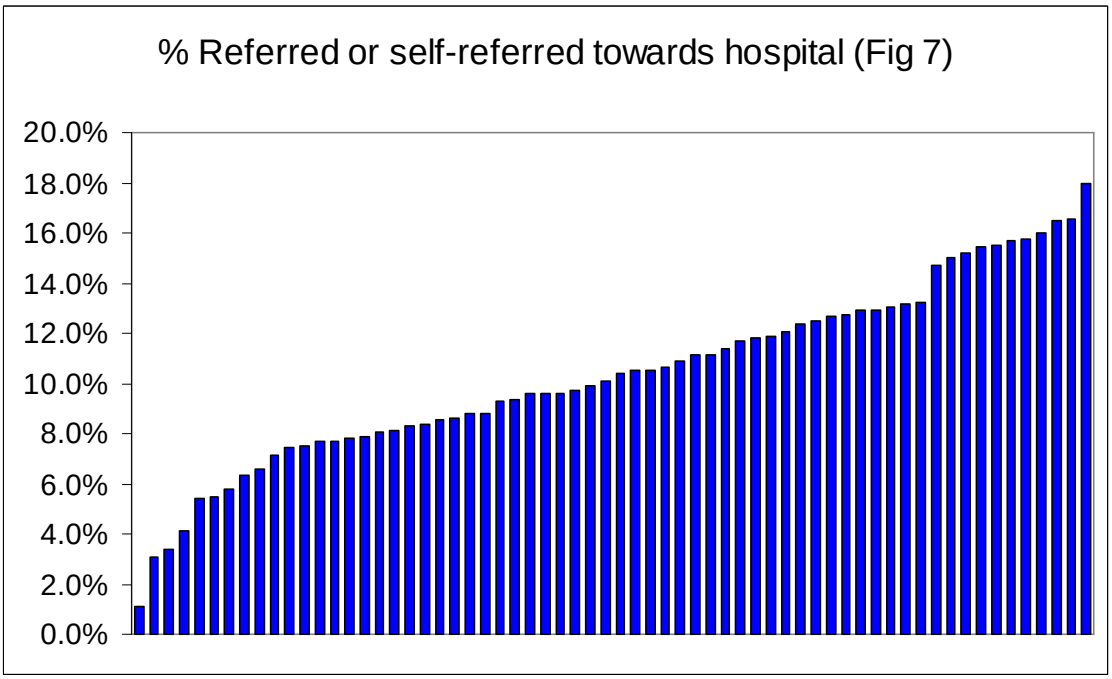
Outcome of Patient Contacts (Dispositions)

	%advice	%base	%home
Minimum	21.2%	19.0%	3.3%
First quartile	36.8%	34.8%	10.9%
Second Quartile	43.5%	42.9%	12.6%
Third Quartile	49.3%	48.9%	15.7%
Maximum	67.4%	69.2%	23.6%
Example	43.5%	45.2%	11.3%
Rank (1 is lowest, 63 highest)	32	38	19



Referral towards hospital

Figure 7 is included because we understand that it is a measure that many PCTs will be interested in comparing. At the moment, the consistency with which different services ensure that 'informational outcomes' are completed by clinicians varies, so in many cases the apparent percentage referred or self-referred to hospital will be lower than the actual number. Because the count is based on the message given to the patient's GP it is unlikely to understate the level of referral. In the feedback events we will suggest that providers need to look at a simple yet comprehensive list of informational outcomes and make completion of the field mandatory if they want to ensure that they can reliably report on this measure.



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.

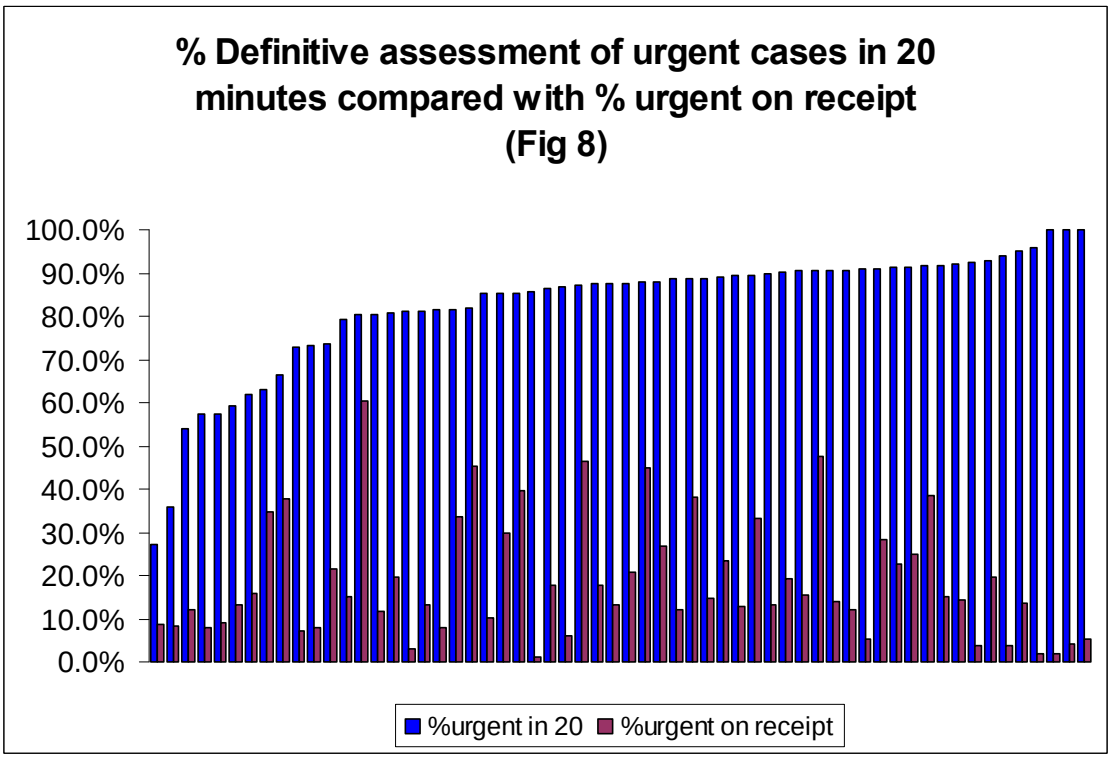
Time to definitive assessment

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 has previously been reported. We are measuring to the start of the definitive (final) advice consultation in line with the standard and 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).

PCTs and providers are, of course, free to agree their own targets and methods of measuring any aspect of performance – but precisely because of these differences our results will not match if we are to provide comparable information across services.

In Figure 8 below, the first bar in each pair (blue) is the time to definitive assessment of urgent cases, while the second bar (red) is the level of calls identified as urgent on receipt. There is a striking variability in the level of cases that non-clinical call-handlers identify as urgent from less than 2% to close to 60%. Unless there is very early clinical review of all cases we would be concerned about any provider that has a very low a level of urgent or emergency calls identified by non-clinical call-handlers and equally concerned about whether clinicians will be able to identify the really important calls if the level of urgent or emergency calls is too high.

Because of the variability in the level of urgent cases we have included a measure of the percentage of all cases (regardless of priority) assessed in 20 and 60 minutes that is shown in Figure 9. Those services that have adequate clinical staff and that ensure clinicians keep pace with the work as it comes in assess over 60% of cases in 20 minutes and 95% in 60 minutes.


% Definitive assessment of urgent cases in 20 minutes compared with % urgent on receipt (Fig 8)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
%urgent in 20
%urgent on receipt

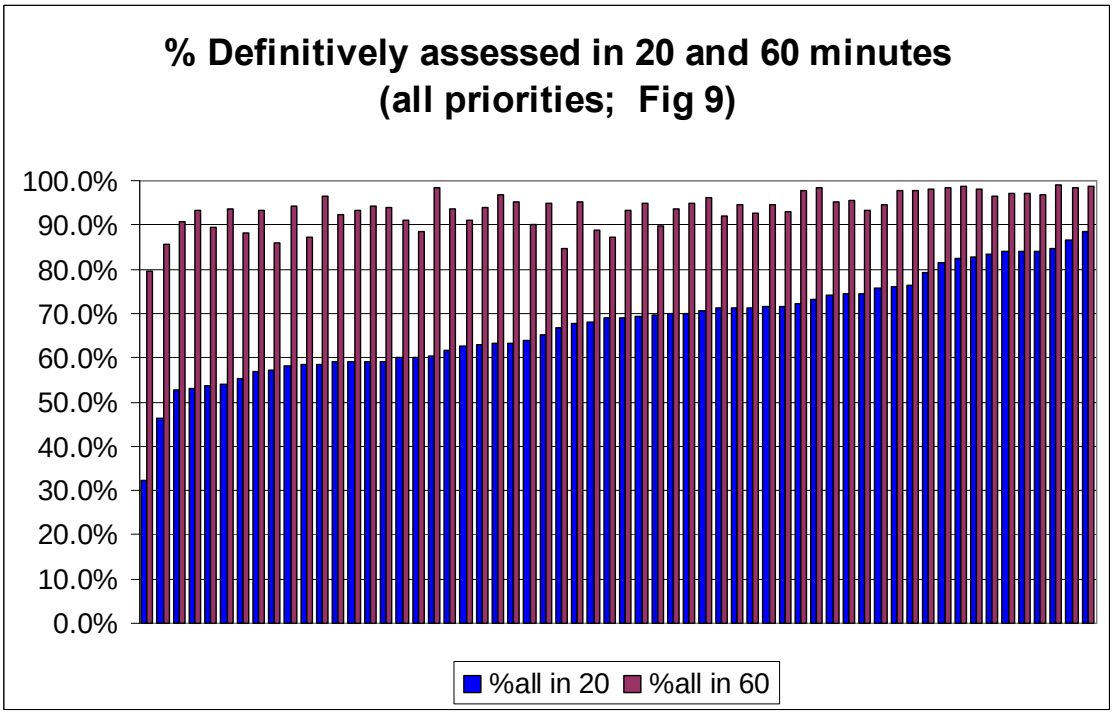
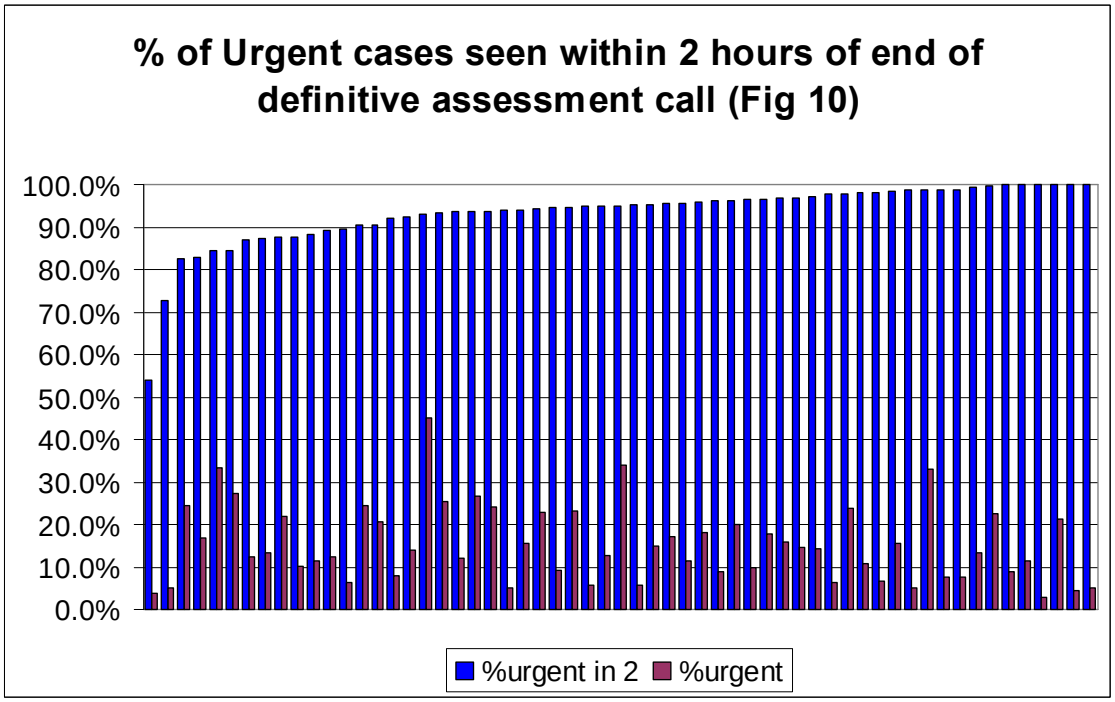

% Definitively assessed in 20 and 60 minutes (all priorities; Fig 9)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
%all in 20
%all in 60

Figure 10 shows the percentage of cases that were urgent after assessment and that were seen face to face within two hours (blue). It also shows the percentage of urgent cases after the assessment stage.

The graph includes both home visits and attendance at a primary care centre (as does the national standard). A number of providers focus attention on getting to home visits within the prescribed period but allow individuals to choose their own appointment time for attendance at the base. However, bearing in mind that the clinician assessed the case as urgent enough for the patient to be seen within two hours, services perhaps have a duty of care to the patient to make sure that the importance of prompt attendance is understood.



Patient experience

As part of the benchmark we plan to measure the patients' view of their experience of out of hours services through a survey of users, working in partnership with CFEP. This will involve patients answering a consistent set of questions so that providers and PCTs can be compared and trends measured over time. This information will be collected annually and this initial survey is seen as setting a baseline as it is the first time that a significant sample of patient opinion about their experience of out of hours services has been collected against the same set of questions. The results later this year will form a key area of focus for the next round of the benchmark.

Further information and future benchmarks

This first report provides a thorough comparative view of performance across the different participating PCTs. More information can be extracted from the data that is collected and will be included within future rounds of the benchmark. We will also focus on different aspects of the service in different rounds of the benchmark and will try to respond to suggestions and requests from participating PCTs and provider services.

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. We are particularly interested in measures and comparisons that will support commissioners and providers in improving their service.

We are conscious that some of the performance measures may appear a little different to those that have been shared between providers and PCTs in the past. Should it be helpful to understand this, or to understand some more 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

Appendix 1 – Performance against national standards

Summary of Performance

PCT	**Example**
provider	**Example**
Short description	**Illustrative example only**

Key:

Comments and summary information about other services are in gold

Compliance with standard (Yes)	Yes
Non-compliance (No)	No
Full compliance with numeric standard	97.4%
Partial compliance with numeric standard	92.3%
Non-compliance with numeric standard	88.7%
Self-assessment score, below average	4
Self-assessment score, above average	8

Your Service

	% frequency across all PCT/Provider Services					
QR1 Reporting to PCTs	Weekly	Monthly	Quarterly	6 or 12 monthly	Other	
Quality requirement 4 - audit of patient contacts by clinician	1%	36%	36%	22%	4%	Quarterly
Quality requirement 5 - audit of patient experience	0%	40%	40%	17%	3%	Half Yearly
Quality requirement 6 - review of complaints	8%	69%	17%	5%	1%	Monthly
Quality requirement 8 - telephony response times	3%	74%	12%	0%	12%	Monthly
Quality requirement 9 & 10 - time to clinical assessment	3%	83%	12%	0%	3%	Monthly
Quality requirement 12 - time to face to face consultation	4%	79%	12%	0%	5%	Monthly
Contract Review - frequency of formal review with the PCO	3%	21%	29%	33%	13%	Annually

QR2 Sending details to practices		
Have you set up your system so as to reliably send details of all consultations to practices by 08.00 on the next working day?		Yes
For what percentage of cases is information sent by 08.00?	97% of services are better than 95%	100.0%
QR3 Exchange of information	The self-assessment scoring approach is described in the notes	
Score exchange of information	Average score 5.3 (across all services)	5
QR4 Audit, Governance and feedback	The self-assessment scoring approach is described in the notes	
Score - Initial Priority	Average score 5.3 (across all services)	5
Score - Disposition and Clinician priority	Average score 7.1 (across all services)	7
Score - Coding and Prescribing	Average score 4.8 (across all services)	5
Score - Referrals	Average score 6.8 (across all services)	7
Score - Productivity	Average score 5.5 (across all services)	5
QR5 Audit of patient experience		
Do you regularly audit a random sample of patient experiences and take appropriate action on the results?		Yes
How often do you compile the results of the audit?		Monthly
What percentage are typically returned?		30
QR6 Managing Complaints		
Do you have a complaints procedure?		Yes
Do you analyse them and provide a summary for the PCO including information about lessons learned/changes implemented?		Yes
Do you provide detail on each complaint to the commissioner PCO as a matter of routine?		Yes
Is every complaint audited in relation to individual staff so that, if necessary, lessons can be fed back to the individual?		Yes
QR7 Matching capcaity to demand		
We did not ask a question about this, preferring to look at the whether the service kept up with predictable peaks in demand - see slides		
QR8 Telephone response	There has been considerable confusion about the questions that we were asking....	
% engaged	No comparison is made across services this round	0.00%
% abandoned	No comparison is made across services this round	2.33%
Do you have an introductory message for callers?	No comparison is made across services this round	Yes
If yes, calls answered within 60 seconds	No comparison is made across services this round	92.44%
If no, calls answered within 30 seconds	No comparison is made across services this round	
QR 9 &10 Definitive assessment	These figures are discussed further within the report	
%Urgent in 20 minutes		91.6%
%Urgent		38.3%
Additional % if asssessment had been completed at first attempt		2.4%
%Urgent in 20 minutes if had been completed at first attempt		94.0%
%Less Urgent in 60 minutes		79.6%
% of cases that appear to be walk-in		1.1%
% of cases that appear to be streamed		2.7%
QR11 Seeing a Doctor		
Where it is clinically appropriate will patients have a face to face consultation with a GP		Yes
Where it is clinically appropriate will patients receive a home visit from a GP		Yes
QR12 Time to face to face	These figures are discussed further within the report	
%Emergency in 1 hour		100.0%
% of face to face that are emergency		0.1%
%Urgent in 2 hours		86.8%
% of face to face that are urgent		12.5%
%Less urgent in 6 hours		99.2%
% of face to face that are less urgent		12.5%
QR13 Interpretation		
		Type Talk
Please describe what arrangements you have in place for patients with impaired sight		
		Type Talk
Please describe what arrangements you have in place for patients with impaired hearing		
		Language line
Please describe what arrangements you have in place for patients who have limited or no English		
		Yes
Can these arrangements for patients who have limited or no English be put in place within 15 minutes		

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 was reported.

- **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.**
- **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.**

In addition to these points there are sometimes smaller differences that come from the way that we have treated 'locked cases' and because we count, in line with the standard, from the start of the initial call.

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.