

**1.16.11 Case Study 1: Clinician call backs below 80%**

The proportion of call backs by a clinician within the agreed timescales is below 80% for a second consecutive month. What will you do to address and prevent a third successive month of failure?

(Maximum Word Count 1000 words)

Words used = 999

**1.16.11.1-Data integrity**

**Data collected:** Routinely collected data on clinician activity will help identify:

- When individual and collective clinical performance is near/below required standards.
- Where variation is within expected levels versus true outliers.
- The root cause of unwarranted variation.

Data will include:

- Cases versus outcomes for a view on case acuity and complexity that may impact on productivity e.g. longer consultations for more complex presentations.
- Call flow, to see if times calls present is changing e.g. increased call volumes at shift changes.
- Workforce review to check impact of new personnel, changes in skill mix and absences.

**Analysis:** Data will be analysed by contract leads (Operations Manager, Medical Lead and Clinical Services Manager) and reviewed with the Area Operations Director (single point of contract accountability) in monthly contract meetings. The contract leads will have ready sight of daily, weekly and monthly data and data will be used in Area Daily Risk Meetings and Area/Regional boards.

**1.16.11.2-Action after the first month's failure**

Through the above analysis, we would have been aware of the first month where call backs within agreed timescales were <80%. At that point, the contract leads would have reviewed data integrity, staffing (including skill mix and demand patterns to make and monitor suitable adjustments using a PDSA cycle if appropriate and then re-base our forecasting and rota.

**1.16.11.3-Discussion with the clinician on root cause**

The first step following a second month below 80 is establishing the root cause of the performance with the clinician. We will analyse the data from the second month, comparing it to the first month and previous months when performance was above 80%. We will also compare it to other clinicians on the same shifts and review patient/HPF/staff feedback.

Roles we may involve in determining root cause include front-line staff on this contract, management and governance teams and managers from other GP-OOH contracts and potentially wider health-economy partners.

We will also consider why changes made following the first month's failure have not solved the issue.

Activity to establish the root cause will be captured in an investigation report from the Medical Lead or Clinical Services Manager, depending on the type of clinician involved. It may also be discussed and minuted in forums such as weekly operations meetings (monitoring the third month's data), service improvement forums, Contract Review Meetings and Clinical Quality Reporting Meetings.

Where this process identifies risks, we will log them on Datix system, which will track our activity to control or mitigate the risks at contract level or higher.

*A GP's recent poor productivity/outcomes were flagged by team leaders & fellow clinicians. A deep dive into their previous 6 weeks' performance against that of colleagues identified productivity of <2 cases per hour irrespective of complexity, which directly impacted on patient delays & KPI achievement. The contract's Medical Lead & Area Medical Director meet with the GP, presented the information & requested their reflection. During the reflection, we significantly reduced their working hours to facilitate their review and performance improvement while mitigating impact with additional resource. Following a further meeting, their hours were increased incrementally to ensure they could sustain improvements with increased hours. This GP has not only sustained these levels but is now one of our highest performing GPs for productivity & safe/effective patient outcomes.*

#### **1.16.11.4-Action plan**

Content of action plans to restore performance will depend on whether the cause solely affects this clinician or the whole service element or has potential to also affect other clinicians. In addition, causes may be linked to other system partners e.g. WMAS' NHS-111/CAS.

Where causes relate just to this clinician, their line manager will work directly with them to develop and agree an action plan to restore performance. Causes could be personal (e.g. recent bereavement) or professional and plans will include activity to specifically address the issue e.g. remedial training, referral for counselling, temporary reduction in working hours/days/shifts, real-time support and monitoring via Team Leaders/Shift Clinical Leads and review of performance and feedback. All will be reviewed with consideration of previous audits and performance against Vocare's 'REFLECT' audit tool. Targets will include productivity rates or adaptation to new/amended patient flows. The timescales will depend on e.g. the extent performance improvement and actions to be taken. However, we will expect no third month of failure.

Where causes involve others, the most suitable contract lead will develop and own the action plan, involving the clinician and others as required. Potential action could include changing staffing levels at certain times or skill mix to better meet the cause of the performance issue. We may need to make changes to how we work with NHS-111 on patients coming into the service streams and referral pathways (e.g. mental-health crisis teams) and with clinicians on e.g. when to escalate patients to face-to-face appointments. Action plans for such wider-ranging issues will be produced within our service-improvement approach and managed through service-improvement meetings.

Action plans will include improvement timescales and target deliverables that we will monitor over the timeframe.

#### **1.16.11.5-Progress review**

The contract-level lead will monitor progress and report to the Area Operations Director in the contract's monthly governance/performance meetings and service-improvement meetings. We will also monitor progress/performance in daily risk meetings and contract-level weekly operations meetings. We will use real-time reviews where possible using dashboard data.

#### **1.16.11.6-Further action**

Assuming performance is >80% in the third month, we will maintain close performance oversight for an agreed timeframe with the clinician that tapers off to standard oversight as performance improvement continues.

Should performance be <80% for a third month, we will assess if there was any improvement over the preceding two months, e.g. the action plan is effective but needs more time or if the action plan needs to change.

Where appropriate, we will review performance with system partners and at Area, Regional or Divisional levels within Vocare. We will liaise with the CCGs to advise and monitor any quality impacts.

If the action plan does not deliver sufficient improvement, we will re-evaluate and identify other potential causes to generate a revised action plan.