Improving the Management of Clinical Calls into a Specialist Palliative Care Service

Dr Natalie Davies, December 2020

Rowans Hospice

NHS Health Education England

Background: Rowans Hospice is a charitable organisation which provides Specialist Palliative Care for the population of Portsmouth City and South East Hampshire. Hospice services include:

19 bed
In-Patient Unit

Hospice at Home
(End of life care for patients in their own homes)

Bereavement Support

Multidisciplinary Team Working

Living Well Centre
(Out-Patient Services)

Support for Community and Hospital Palliative Care Teams

With ever expanding clinical services, the number of telephone calls into the hospice is increasing. It is not always obvious to the volunteers answering the calls which service a caller requires. Can we improve the management of these calls?

Aim: To improve the response to clinical calls into Rowans Hospice, resulting in improved caller, volunteer *and* staff satisfaction.

Current status…..It's complicated! Establishing a baseline:

- Quantitative analysis of the number of clinical calls into the hospice each day (answered by untrained volunteers): On average 80 calls a day, half of which are clinical.
- Quantitative analysis of the time taken for administrators to redirect calls/find a clinician for support: An average of 15 minutes each day - less than expected from anecdotes, but all cause interruptions to an ongoing task.
- Process mapping and a focus group: Volunteers answering calls need to be able to elicit the service the caller requires. If the caller is unclear, it can be difficult for the volunteers to know how to manage the call, particularly as documenting patient identifiable information is felt inappropriate.

This results in inconsistency and dissatisfaction for all, including anxiety for the volunteer telephonists, lengthy hold times, frustration for the clinical administrators and distracting interruptions for clinicians.

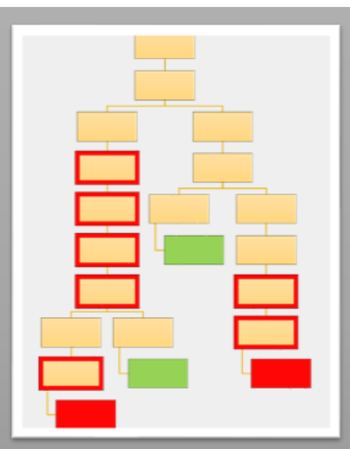

***Fig 1.** Process map demonstrating the complexity involved in taking a call, with the red boxes indicating where the process is failing.*

TEAM INVOLVED:

Medical Director
Director of Clinical Services
Clinical Lead
Clinical Managers
Clinical Administrators
Chief Executive
Hospice Executive Group
Board of trustees
Senior Clinicians
Volunteers
Housekeeping staff
IT Team

Project Development:

- Identified the need for trained staff, skilled at managing anxious callers and eliciting information, thus facilitating the appropriate transfer of calls.
- Designed a pilot rota of current clinical administrative staff to manage calls into the Hospice. However, staff had valid concerns that this extra workload would impact the service in other areas. Their concerns were accepted by the Hospice Executive Group and Board of Trustees who have since agreed to the recruitment of additional staff.
- Agreed the need for a named senior clinician to be available at all times, thus giving the caller prompt, expert clinical advice. Devised an acceptable rota for this.
- Worked with housekeeping and IT staff to procure suitable office space and equipment.
- Worked with IT staff and telephone engineers to implement an improved telephone system with an automated messaging service.

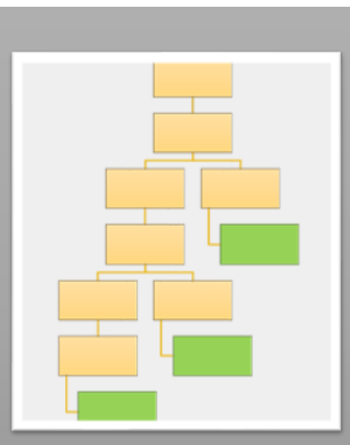

***Fig 2.** Process map with the new, simplified process, with less room for error.*

And then, there was Covid-19….

Which caused delays and halted the recruitment of new staff BUT made the need for rapid access to Specialist Palliative Care advice even more of a priority.

The Clinical Coordination Hub (CCH) was established on 29 April 2020:

- All clinical queries are managed in the CCH.
- Administrative staff were able to remain un-furloughed during Covid-19 to support the CCH.
- An automated telephone system (*"press 1 for clinical advice"*) has been in place since 22 June 2020.
- Callers are receiving immediate advice with a thorough and specialist response.
- Qualitative surveys demonstrate that non-CCH administrative staff are less burdened by calls and CCH clinicians and administrative staff feel time spent in the CCH is useful and satisfying.
- We plan to quantitatively analyse In-Patient, community and Hospice at Home referrals.
- Development of pathways/ guidelines for common queries are in progress to allow more remote/junior clinician staffing.

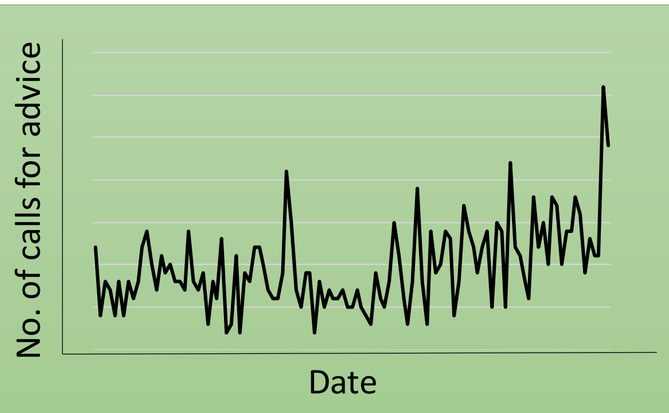

***Fig 3.** Graph demonstrating an overall increase in calls for advice, with significant day to day fluctuations and unpredictability.*

Lessons Learnt:

- I thought I realised the importance of **good communication** in change management and felt this was one of my skills. However, with so many staff involved it has proved difficult to keep everyone up to date at all times and this has indeed caused difficulties along the way.
- Everyone was enthusiastic for change at the start. As people start to feel burdened by an increasing workload, the need for change suddenly becomes less important and **enthusiasm wanes.**
- Achieving small goals along the way builds momentum. I failed to set small timelines/ **short term goals** – this is definitely something I will do for my next quality improvement project.
- No large scale change can be made alone, being part of an enthusiastic **team** is vital.