Joining up Urgent Care - the link between Primary and Secondary Care

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Bona fides

- Started GP training 30 years ago and have always worked in Out of Hours
- Years of working my own on-call, then various GP OOH cooperative arrangements
- Started Vizdoc in 2004 when the GP Contract changed
- Partnered with Harmoni and GWAS to win OOH contract in North Somerset (based with AA in Almondsbury)
- North Somerset Single Point of Access (SPA) project for all admissions
- Equitable Access Centre in Weston
- SW NHS 111 with Care UK
- BrisDoc for last two years as a Clinical Lead
    - Part of the team setting up GP Support Team in NBT this year
    - Initiated the extension of Professional Line to AWP

Urgent & Emergency Care - my current role

- Daytime Salaried GP in Broadmead Medical Centre (APMS practice)
- Clinical Coordinator - Professional Line (Approx 2,500 Professional Line calls per annum)
- Mental health lead
- Crisis Concordat (Street Triage)
- One Care Consortium – PMCF programme
- Connecting Care
- Rio Access
- Section 12 Mental Health Assessments
- NEWS enthusiast
- Working with Centre for Academic Primary Care in Lab Result Project

BrisDoc Professional Line

- SW NHS 111
- SWAST Clinical Desk
- Paramedics
- Laboratory Results
- Community Nurses, Rapid Response teams
- Hospice
- GP Support Unit, GP Support Team
- Southmead Operation Centre and Site Manager UHB
- Doctors - GPs and Hospital doctors
- Crisis Team
- Callington Road Hospital
- Pharmacists
- Police
- Emergency Duty Team (Social Services)
- Patient advice (complex cases referred by other GPs)

Data streams

- Adastra
- Connecting Care (MIG data and many other data streams)
- Primary Care Record (MIG data)
- Summary Care Record
- One Care EMIS Web integration
- VPLS, RIS
- AWP RIO
- Clinical Document Service from NBT and UHB

One Care - Prime Minister's Challenge Fund

- EMIS Web integration project – data sharing
- Seven-day access
- Case streaming eg physiotherapy
- One Care EMIS integration management plan not care plan (which tech for EOL output)
- Access to GP specialisms
- Access to medications

Urgent & Emergency Care - current challenges

- Lack of **interoperability** eg NHS 111 to SWAST to BrisDoc to ED to Practice - 5 different platforms
- Lack of **Clinician to Clinician communication**, particularly NHS 111 CAs, SWAST Clinical Desk and Hospital doctors
- **Multiple clinical triage** - NHS 111 PEM largely ignored
- Patient journeys cross **too many boundaries** to achieve simple outcomes
- **GP recruitment** problems - number one risk
- Problems of **GP capacity**. Finite, limited resource
- Lack of acuity - too many **unnecessary ambulance and ED journeys**
- Balancing **demand against capacity**. At the moment locally based Clinical Coordinators take responsibility for this

Urgent & Emergency Care - possible improvements

- **EMIS Web (and other GP system) integration** - Quantum / Seismic Leap forward. Seeing free-text of GP management plans (not to be confused with EOL Care Plans)
- EMIS integration and Professional Line the key to an effective clinical hub
- **Single platform** for NHS 111, 999, OOH, ED and Acute Trusts – Adastra or other. Continuing the assessment rather than starting again
- Increasing the number of **clinician to clinician conversations** (voice, the shared platform, PEMs, nhs.net email)
- Access into new **Seven-day Access Surgeries** and **access into Secondary Care** clinics

Urgent & Emergency Care - possible improvements

- Effective **case streaming**
- Greater flexibility with **NHS pathways** for early clinical assessment
- Creating a greatly improved **learning environment** through feedback eg referring doctor gets discharge summary via nhs.net
- Regular **clinical meetings** for key clinicians across the Urgent & Emergency Care Network
- Using Datix for all **incident reporting** to promote improvement and learning across the network

Urgent & Emergency Care - possible improvements

- Extending Callington Rd use of Professional Line to **other AWP sites**
- **Laboratory / Professional line interface** on the web (ICE or VPLS) or via email
- Greater use of **Nhs.net email**
- **All** referring clinicians to receive a **discharge summary** not just registered GP (promoting learning and feedback)
- Greater use of **telemedicine** eg fastECG, facetime or skype etc.
- One Master Copy of a patient's medications (kept on SCR or Connecting Care)
- **24 / 7 pharmacies** with delivery to patient's home address
- Universal adoption of **National Early Warning Scores**

Clinical Hub - does size matter?

- In BrisDoc, Clinical Coordinators are part of the OOH team taking professional line calls but also seeing the more complex patients face to face, and going on complex visits. This provides valuable expertise to the OOH service and makes the role more interesting
- Balancing demand against capacity - requires GPs who feel part of the local OOH organisation
- If this role is restricted to working solely in a Clinical Hub then it will not be as attractive to local GPs
- Local GPs working for BrisDoc take full responsibility for implementation
- Recruiting and retaining GPs in OOH is the services number one risk, and is getting progressively more difficult
- Circle of trust amongst GP practices allowing One Care to negotiate EMIS integration
- Implementing organisation must be a "responsible local community provider”

In conclusion…..

- All the **pieces of the jig-saw** are on the table
- **One fully interoperable platform** using current data streams
- Full access to the **GP patient record**
- Bridge building between **primary and secondary care** through
    - adoption of BrisDoc's Professional Line model
    - more conversations at key handover points (vocal and digital)
    - better case by case feedback (after referral and at discharge)
    - shared incident reporting
    - clinical meetings