Herts Urgent Care

GP Trainee Induction
2017

Putting the patient at the start and heart of our care

Aims of Session

- GP OOH Training requirements and competencies
- Progression of training
- Trainee responsibilities
- History of HUC
- NHS 111 / OOH overview
- OOH roles
- Booking shifts
- Overview of clinical system – Adastra
- The patient journey through OOH.

GP OOH Training

- Time Requirement
  - minimum **one 6 hour session per month** in GP posts.
  - Complete **e-portfolio entry** for each session and attach "record of OOH session" to demonstrate evidence.
  - **Plan** and book shifts early. Make sure they are evenly spread. Bear in mind new junior doctors contract requirements.

OOH Competencies

Care of acutely ill people:

1. Ability to manage common medical, surgical and psychiatric emergencies in the out of hours setting.

2. Understanding of the organisational aspects of NHS out of hours care.

3. Ability to make appropriate referrals to hospitals and other professionals in the out of hours setting.

4. Demonstration of communication skills required for out of hours care.

5. Individual personal time and stress management

6. Maintenance of personal security and awareness and management of the security risks to others.

OOH Competencies – Useful links

- OOH GP Training: Guidance for GP Trainees

https://heeoe.hee.nhs.uk/sites/default/files/heeoe_ooh_training_guidance_for_trainees.pdf

- Mapping of Out of Hours competencies to the GP curriculum and WPBA

RCGP - Mapping-of-Out-of-Hours-competencies.

- Bradford VTS resources

Progression of Training

Traffic Light System:

- **Red Session – Direct Supervision** - first 1-2 months in GP post. Usually observing or jointly consulting

- **Amber Session – Close Supervision** months 3-5 of GP post

- **Green Session – Remote Supervision** 6-18 months into GP post

Trainee Responsibilities

- Booking and organising own OOH Shifts
- To attend and work full shift. Non-attendance is a **probity issue.**
- Minimum 2 weeks notice to cancel a shift.
- Up to date BLS and safeguarding competence
- Have nhs.net e-mail account
- Bring smartcards and own equipment to shifts.

Who are HUC?

- Not for profit organisation
- HUC provides NHS 111 and Out of Hours services to the residents of Hertfordshire, Luton & Bedfordshire, Cambridge and Peterborough.
- Call-handlers, clinicians and pharmacists within the 111 call centre
- GP in call centre for refused ED dispositions and re-triage of green ambulances
- Headquaters at Welwyn Garden City
- Numerous primary care centres and visiting cars
- Other services provided include:
  - Urgent Care Centres
  - GP-Led Health Centre
  - GP Practices
  - District Nurse call-handling

History of HUC

- 2007 – Herts Urgent Care founded, creating an urgent care social enterprise
- 2008 – Provided Out of Hours unscheduled care throughout Hertfordshire
- 2012 - Extended to include NHS 111 for Hertfordshire
- 2012 – Commenced providing an in-hours home visiting service for East and North Herts CCG
- 2013 – Provided NHS 111 service for Cambridgeshire and Peterborough
- 2016 – Commenced providing Integrated Urgent Care service for Cambridgeshire & Peterborough
- 2017 – Commenced providing Integrated Urgent Care service for Bedfordshire & Luton
- 2017- Commenced providing the Luton Town Centre Practice and Walk-in Centre
- 2017 – Commissioned to provide the new Integrated Urgent Care Service across Hertfordshire

Clinical Team

Clinical Leads for GP Trainees

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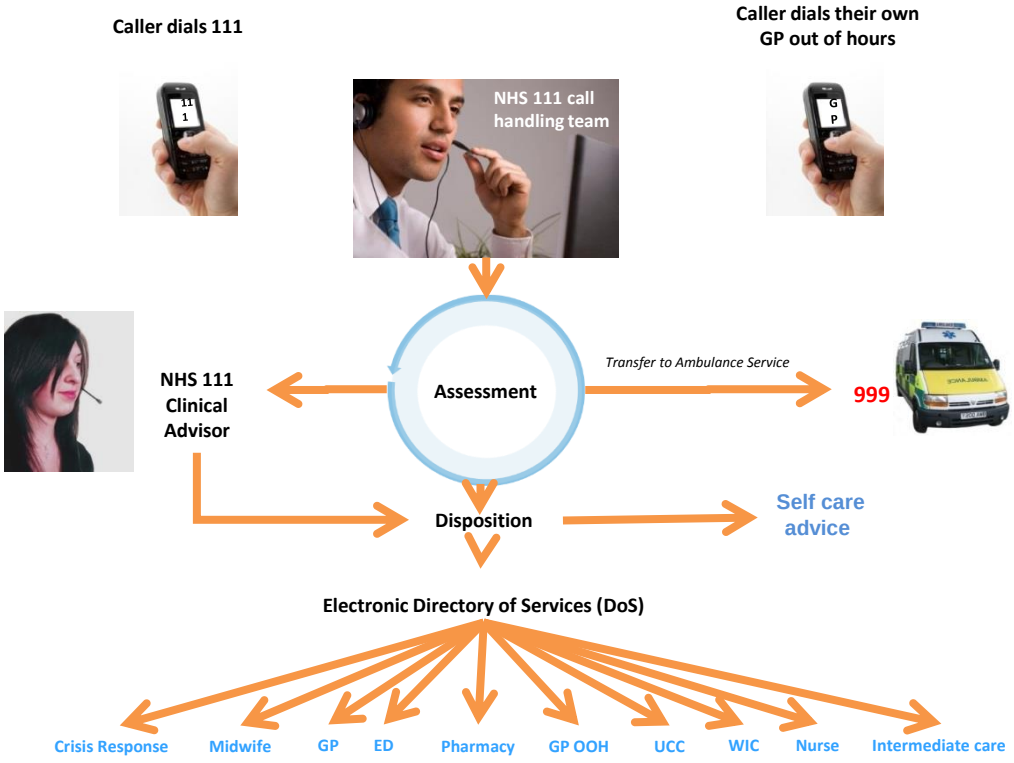
Overview of NHS 111



Targets

- Patient calls NHS 111 -> NHS Pathways assessment
- Disposition reached (DX code)
- Various timeframes from 20 minutes to several working days
- Directory of Services then interrogated by NHS Pathways to highlight available services
- Speak To and Face to Face dispositions

Following targets apply (Adastra supports monitoring)

- Telephone triage
  20/30/60 minutes
- OOH base consultation
  2 or 6 hours
- Home visit
  2 or 6 hours

- Comfort Calling
  Call to check no deterioration just before breach occurs
- Courtesy Calling
  Call to advise that doctor is en route to home visit and opportunity to check that no deterioration

Shift Roles

- Telephone Triage/GP 111/MCAS
- Base
- Visiting
- Redeye GP (overnight shifts)

Which shifts can be booked?

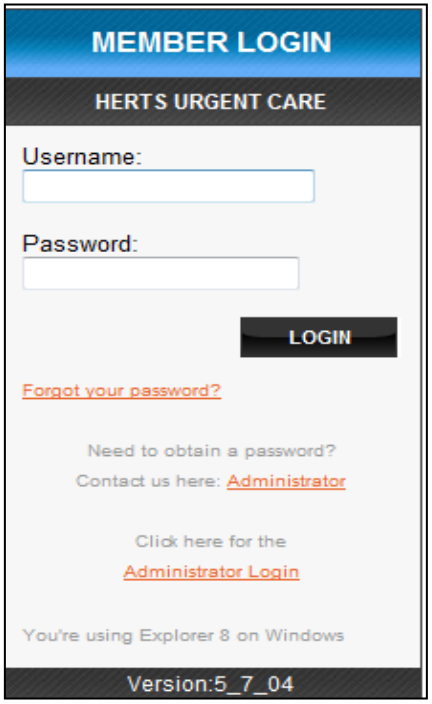
- **ST1** Trainees can book shifts on Monday – Friday evenings only.
- **ST2** Trainees can book shifts Monday-Friday evenings, Saturday, Sunday and Bank holidays PM only.
- **ST3** Trainees can book shifts anytime.

Booking shifts with HUC online Rotamaster

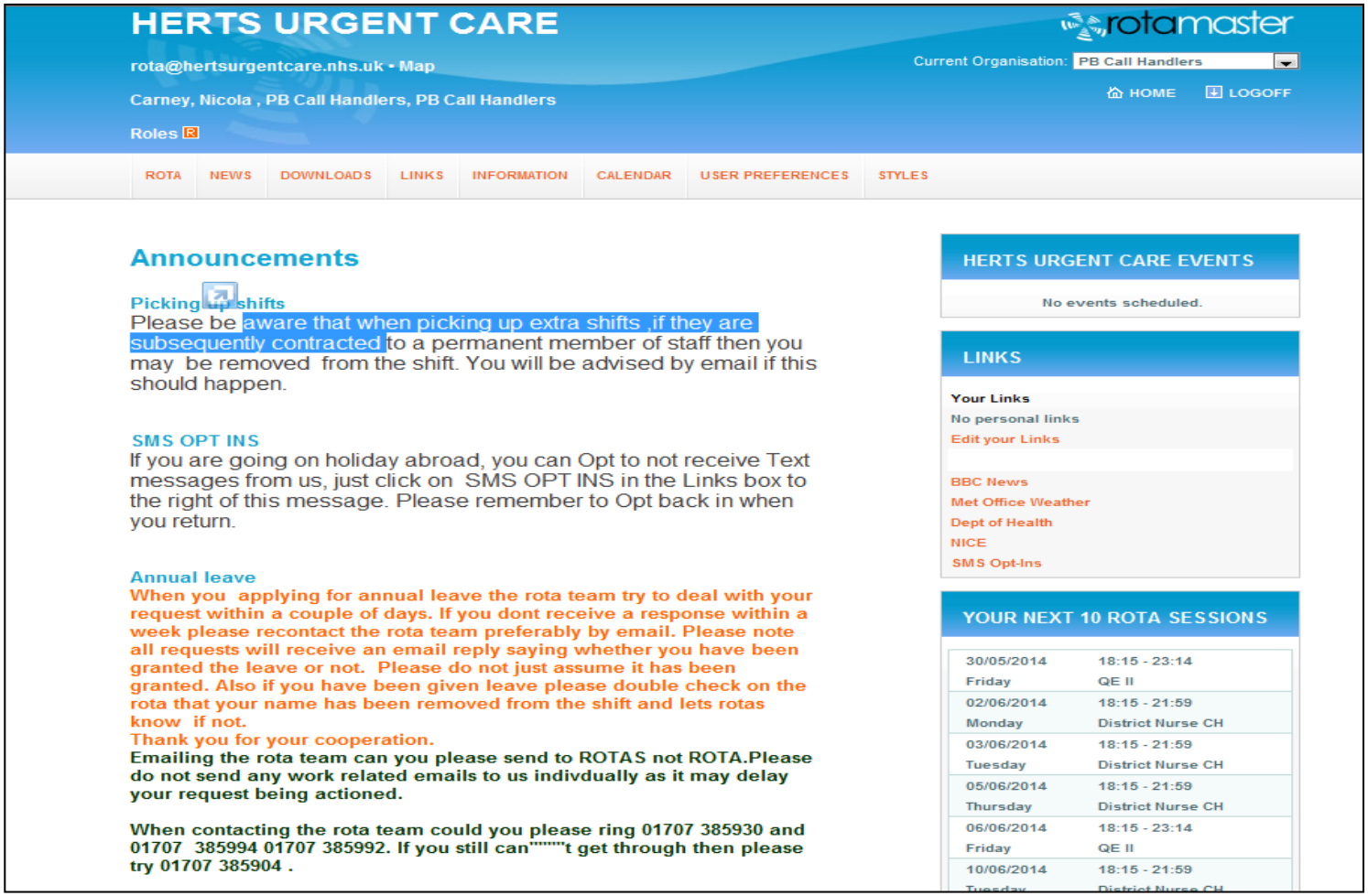
- The website address is:

  www.huc-online.com

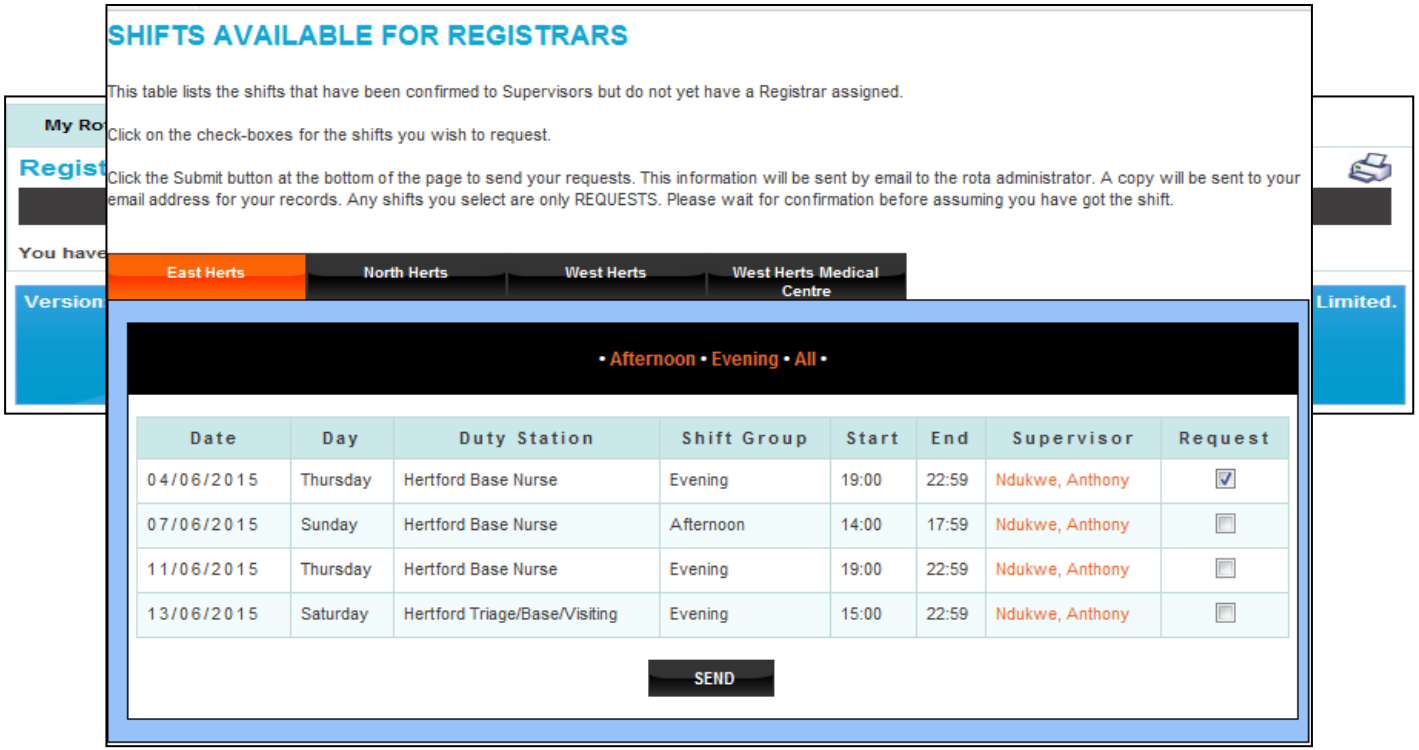
- Enter username and password to login



HUC online Homepage



Booking shifts with a Trainer



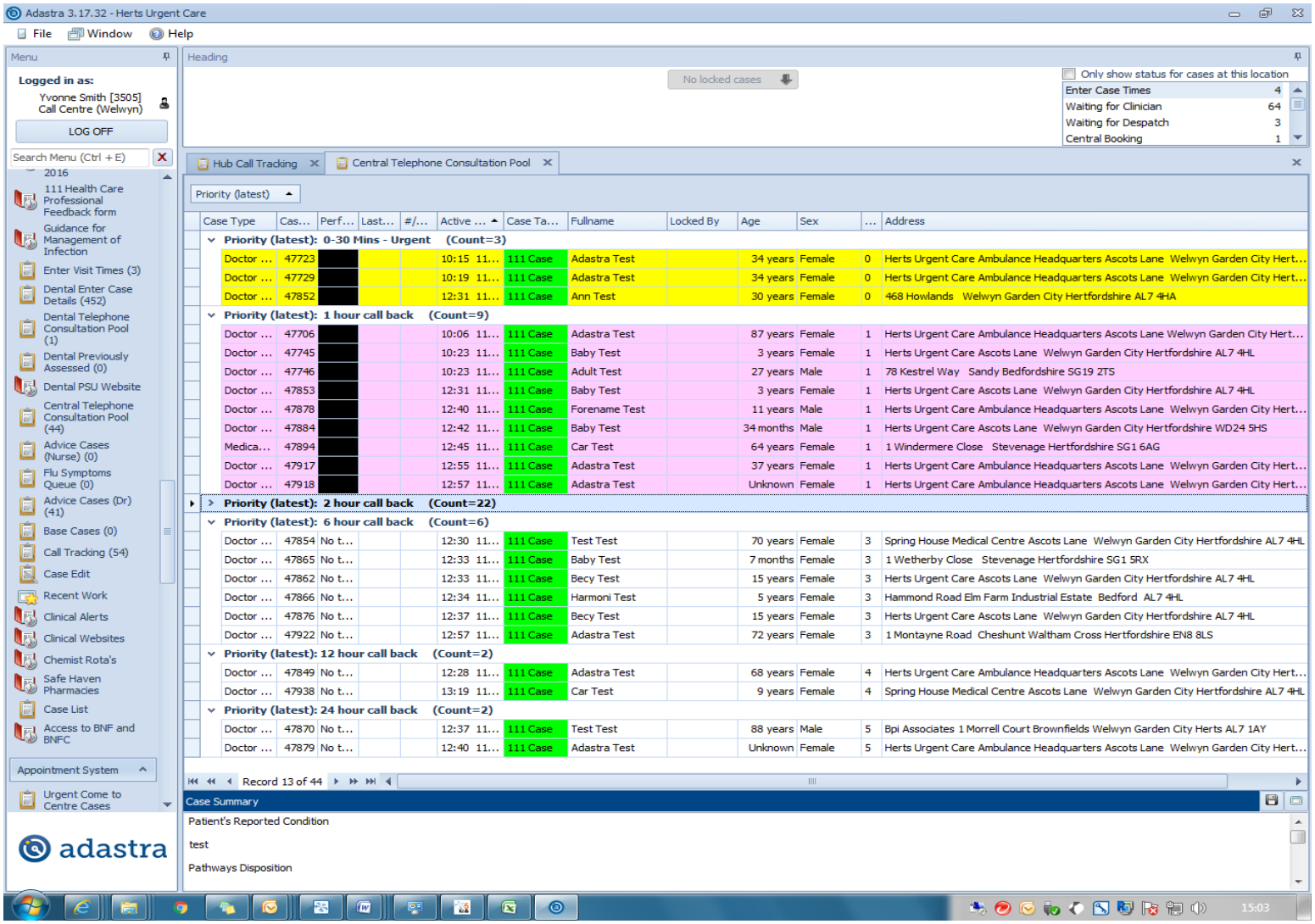
Things you will need for shifts

- NHS Smartcard
- Own equipment - Stethoscopes, auriscopes, opthalmoscopes, tendon hammers, sphygmomanometers, thermometers.
- Login details for Adastra

Overview of Adastra

OOH consultation skills and practical advice

THE PATIENT OOH JOURNEY



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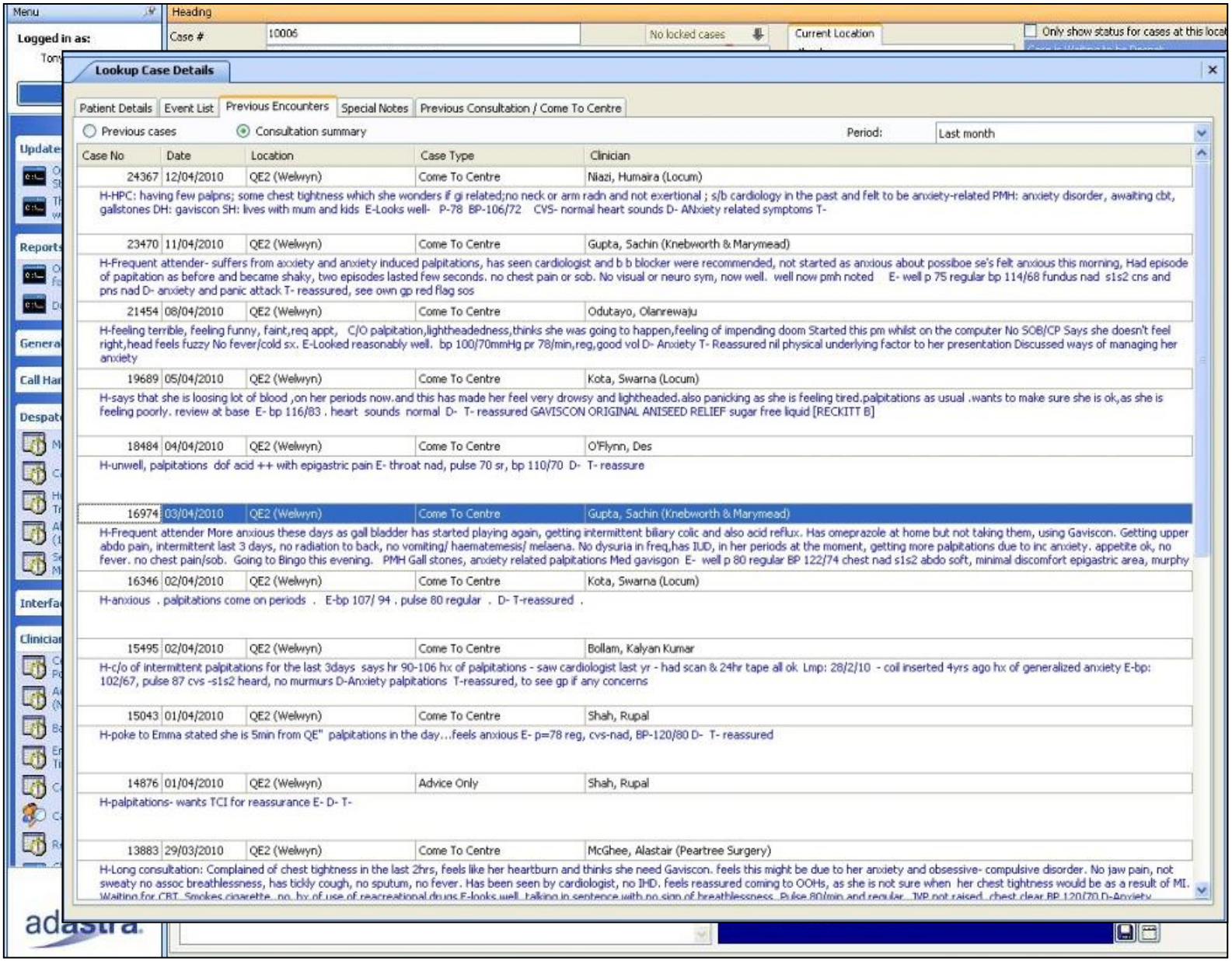
Before the Consultation

It is important to get in to the habit of making the following checks using a standardised approach before you telephone a patient, call them into the consultation room or go out onto the home visit

- Patient demographics – 3 point check
  Confirm patient identity
- Number of contacts
  In past few days, week, month
- Medical History tab
  Check this and complete it if not populated – helped with future consultations
  Works with prescribing module and will flag interactions, allergies etc
- Previous encounters
  Valuable information regarding consulting behaviour, past medical history etc
- Special Patient Notes (SPNs)
  Reading these is mandatory, important info regarding end of life plans, safeguarding, violent patients, those seeking drugs of misuse etc



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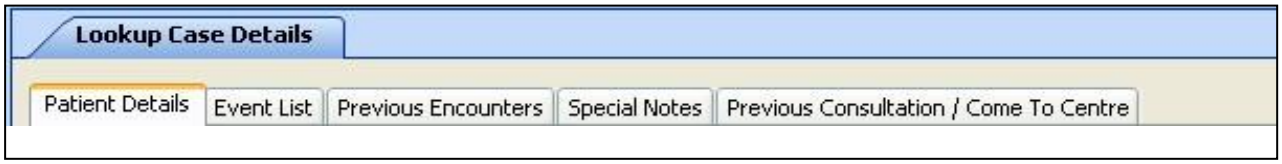
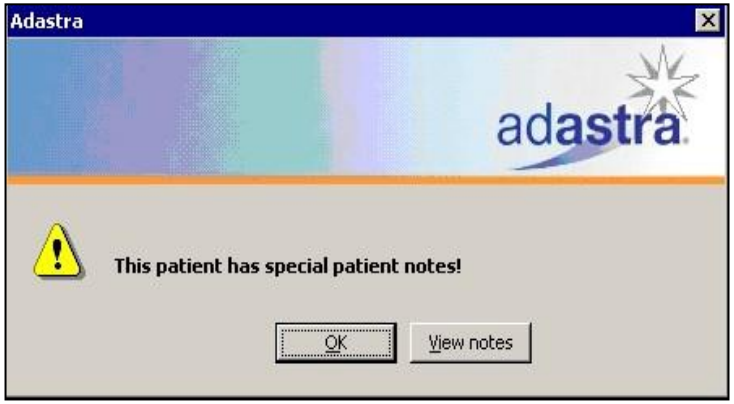
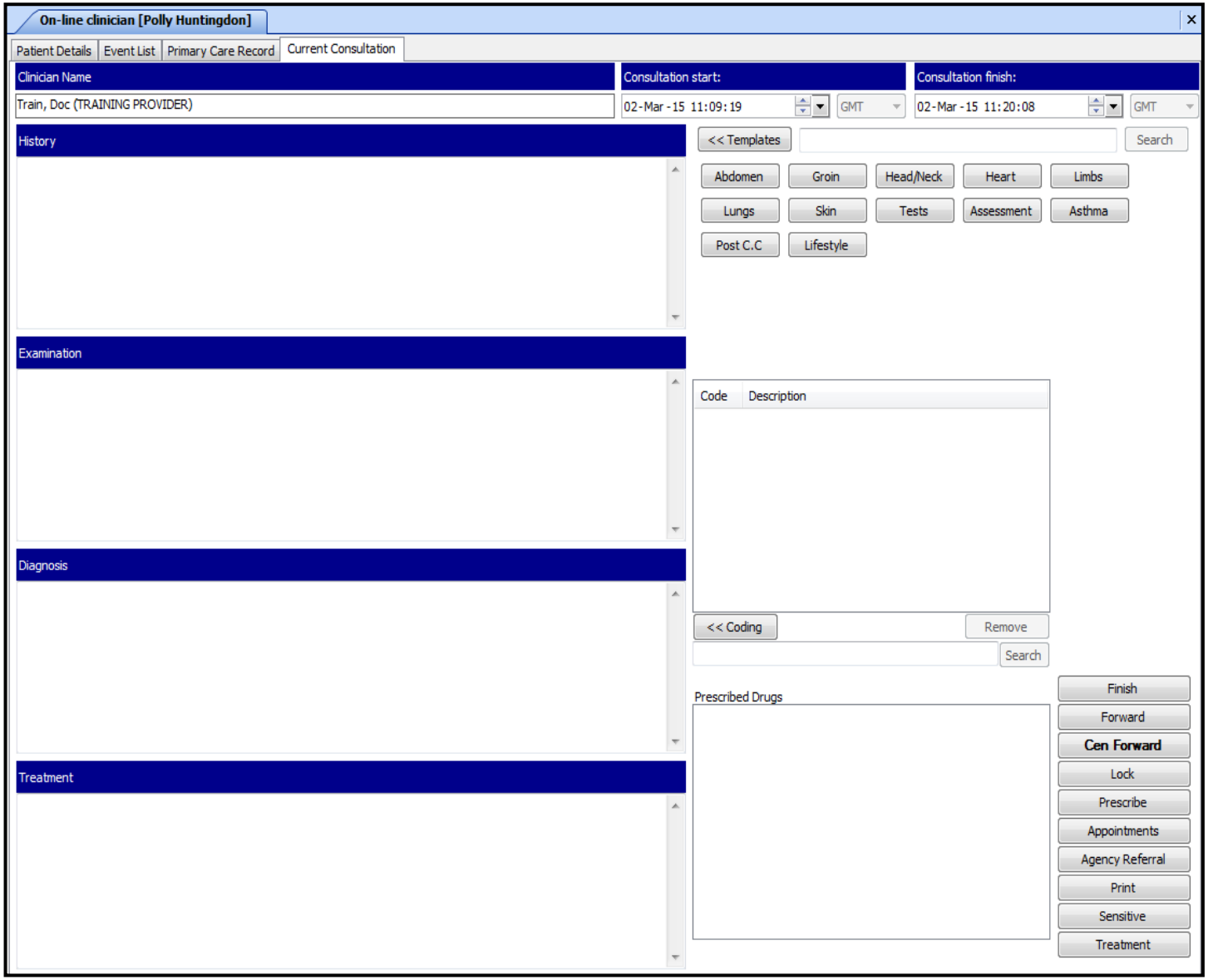
Special patient notes





Telephone Triage Process

- All cases are received via NHS 111
- Pathways assessment is visible in Adastra record
- Ensure that you review medical history, previous encounters and SPNs
- All calls are recorded
- State your name and role and check patient's details (ensure check name, date of birth and first line of address)
- Summarise the reason the patient called 111 to check understanding
- Use silence and allow the patient to talk
- Open questions then close down and **EXCLUDE RED FLAGS**
- Ask about PMH/medications/allergies
- Decide IF needs to be seen and if so WHEN (routine vs urgent)
- OOH base appointment or home visit
- If closing with advice then check patient's understanding and agreement and record clear specific safety netting



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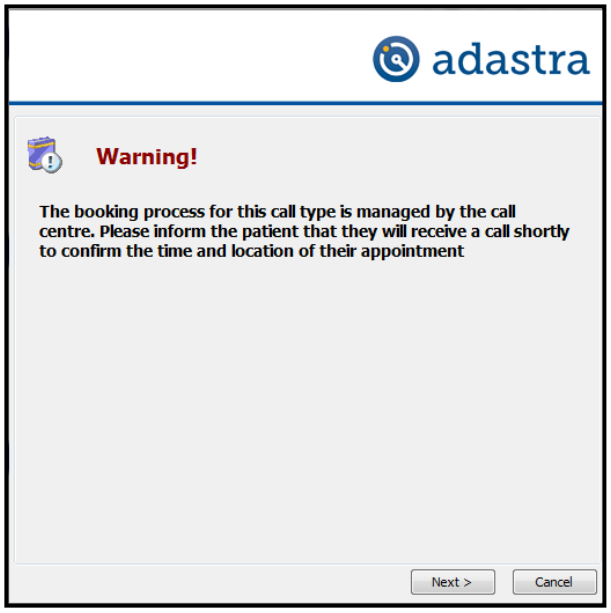
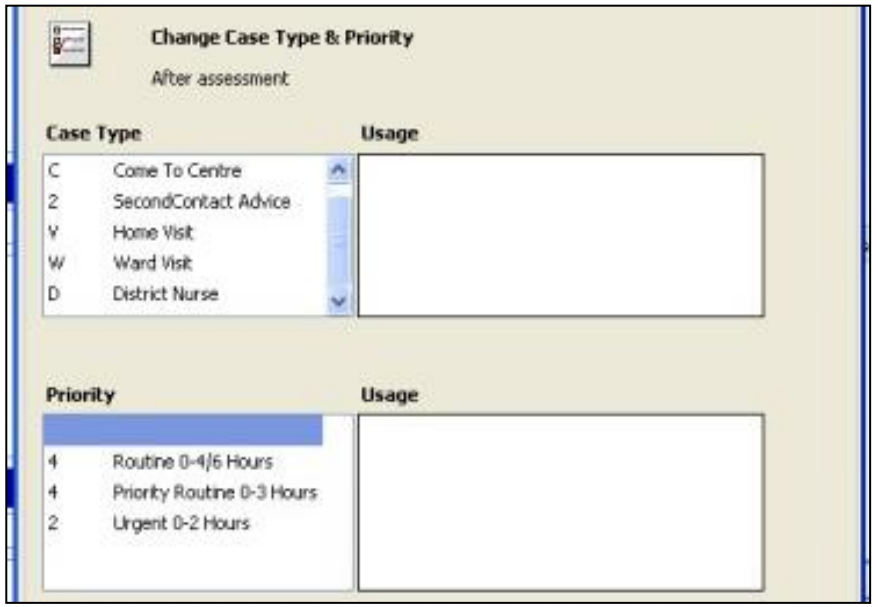
Telephone Triage Tips

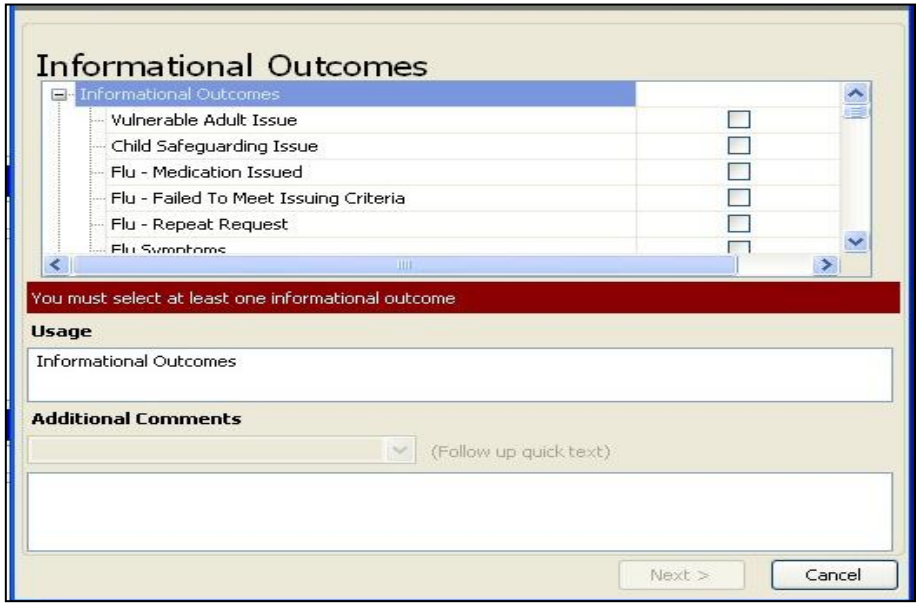
- ALWAYS speak to the patient if possible – be very careful with histories from relatives, paramedics etc
- Be aware of patient's ideas, concerns and expectations
- Beware febrile chidren, rashes and abdominal pain
- Do not jump to conclusions / diagnose too early
- Make detailed notes
- Always try and persuade patients who need a F2F consultation to come to base
- BUT if they need to be seen and they refuse to come to the base they MUST be visited!
- Resist telephone prescribing for new conditions – it is risky

Booking a face to face appt/home visit





Finishing a case



Face to Face appointments at urgent care centres

- Traditional face to face consultations at base
- Booked appointments and also walk in illness patients
- Don't be too relaxed in approach – there are still risks:
  - No access to medical records
  - No knowledge of the patient
  - Reliant upon the history obtained from the patient
  - A need to take the patient at face value
- Keep detailed records
  - Significant negatives
  - Red flags
  - PMH/medications/allergies
  - Differential diagnoses
  - Management plan
  - Safety netting – timely and specific

Home visits

- Reserved for patients who require a face to face assessment and who are:
  Too unwell to come to the OOH (e.g. nursing home patient with SOB)
  Immobile or bedbound (e.g. MS patient with UTI, housebound elderly patient with vomiting)
  Palliative care
  Unable to attend the OOH due to circumstances e.g. single mother with younger children etc
  High risk mental health patient

- Routine 6 hours
- Urgent 2 hours

- You will regularly be faced with patients who insist on a home visit
- Negotiation and a rational discussion will be required including other methods of transport (public transport, friends and relatives etc)

BUT……..ultimately the clinical needs of a patient who requires a face to face consultation during the OOH period must come before any disagreement about their ability to come to base.

The OOH Visiting Service
Car and driver
ARemote
Medications
Equipment

Home visiting tips

Guidance on patient refusal/inability to attend base

- Before offering a face to face consultation, clinicians should establish whether it necessary during the out of hours period.

- If this is the case, then we would recommend that the patient is always seen, and that there is no retraction of this decision if transport is unavailable. As clinical responsibility for this patient rests with the assessing clinician, it is safer to undertake an occasional 'unnecessary' home visit than to deviate from safe clinical practice. This is particularly true when dealing with children and other vulnerable groups (those with complex needs, the elderly).

If you encounter a situation where you feel unhappy with a request to visit, or if you find yourself dealing repeatedly with a specific patient, then please contact the Urgent Care Clinical Lead to discuss further.

Home visiting – Other Strategies

- Assure patients that a face to face will occur

- Consider prefacing your suggestion of a face to face consultation (especially with parents of children) with the phrase "as you seem concerned we should see your child…"

- Tell patients that although as clinicians we are always happy to visit patients in their homes, that this reduces the opportunities for other patients to be seen and it would be helpful (especially the housebound elderly and patients dying of cancer) if they could please come to base

- Ask them to ring round their friends / relatives and see if they can find someone to drive them to base, but assure them that you will ring back within 30 minutes to see how they are getting on with this.
  The call back must then be made

More tips for home visiting

- Be careful about changing a colleague's home visit decision or the priority (unless as part of a need to manage demand and prioritise cases)

- Security – the triaging clinician should alert visiting GP to potential concerns, driver may be used as chaperone – if cannot assure GP safety then consider joint visit with police
- NB mental health cases

- Failed home visits – if a GP cannot make contact with a patient at a home visit and patient cannot otherwise be traced, must consider gaining entry by police

Failed Patient Contact

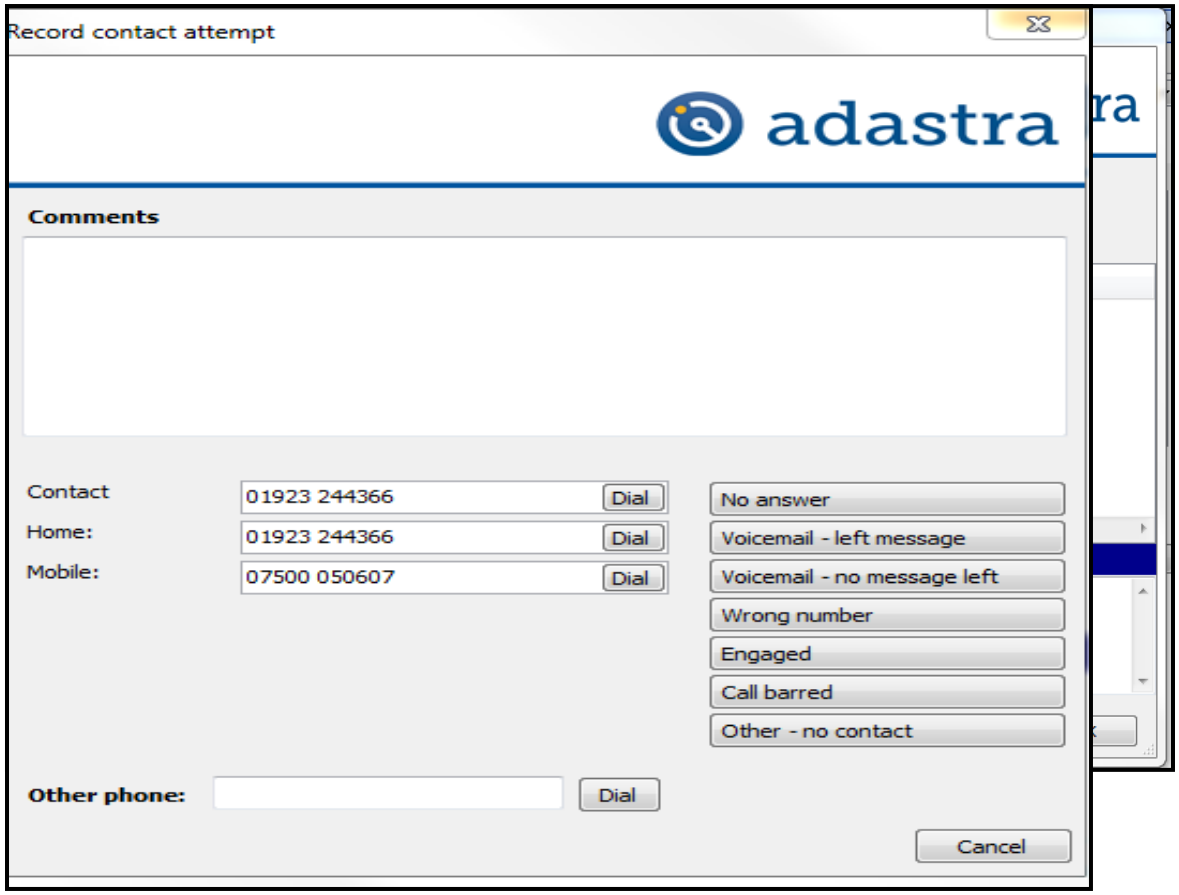
Policy used where unable to contact a patient by telephone and/or at a visit.

Clinicians should assess the information at hand to determine whether routine or urgent case.

General points for ALL cases if no answer on telephone:

- Review previous encounters/calls to check whether any other numbers available
- Contact 111 to check details correct
- Contact LAS and local EDs to check whether patient has been transferred
- Consider contacting next of kin/relatives

Logging a failed contact



Failed contact – Routine/Low risk cases

- Make 2 attempts 20 minutes apart over one hour
- Log each call on Adastra by pressing the telephone icon on patient demographics screen
- If no contact risk assess case and either close case (e.g. leaving answerphone message with call back advice and document information to be passed to own GP) or pass for OOH visit

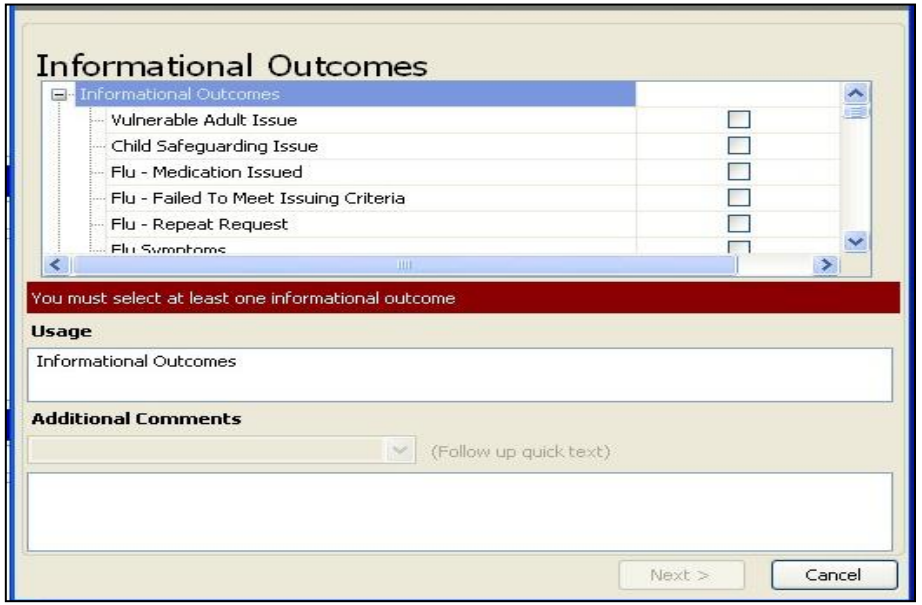
Failed contact – high risk cases

- Make 3 attempts every 10 minutes for 30 minutes
- Check telephone number by looking up previous calls, asking 111 to check number – note that you have done this
- Check whether patient has contacted LAS and contact local hospitals
- If still unable to contact patient pass for urgent visit
- If not able to contact patient at the address contact police to gain entry in light of urgent priority
- GP to remain at address until police arrive

Did not attend

- Where patients are > 60 minutes late for their booked appointment the case will return to the GP callback list to be contacted to check on well-being
- GP telephones patients and assesses
- If patient declines appointment (e.g. states that they are better) GP to document this and close case
- Otherwise if patient wishes appt or GP advises that it is clinically necessary appropriate appt is booked

Finishing a case



3 Strike rule

This policy is aimed at reducing the risk to patients associated with repeated contacts with healthcare services and ensuring that deteriorating clinical conditions are detected and acted upon appropriately

The Principle

- Any patient who has made 3 or more contacts with a Healthcare Professional (not only OOH GP) during an acute episode of illness by telephone OR face to face **must** be seen face to face in OOH
- This can be at the base or by home visit
- There should be a low threshold for onward referral / admission

Exceptions

- Patient refusal (must document clearly)
- Where contact is part of a pre-agreed management plan or follow-up
- Extenuating circumstances e.g. hoax caller

Out of Hours

SPECIAL SCENARIOS

Confirmation of death

Police Doctor: *101*
First a reminder:
Certify complete a death certificate (OOH has no role)
Confirm confirm that life is extinct but not the issuing ofa death certificate (OOH has a role)

Was death expected?
An expected death may be defined as death which follows a period of illness which had been identified as terminal and where no active life prolonging treatments are in place or planned

Expected deaths at home
Unless a community nurse or other appropriate healthcare professional is available then the OOH GP should visit the patient to confirm death. This should be done on a routine basis but as soon as practically possible. This situation should be handled very sensitively.

Expected deaths at Nursing & Residential Homes
Residential Homes - required to call in a community nurse or the Out of Hours service to verify death. Where a call is made to OOH via 111 then a GP visit should be undertaken.
Nursing Homes - may have staff on duty who have been appropriately trained and who are deemed competent to verify death and can do so. In the event that there is no appropriately trained staff on duty the OOH GP should visit to confirm death

Prescribing for OOH patients

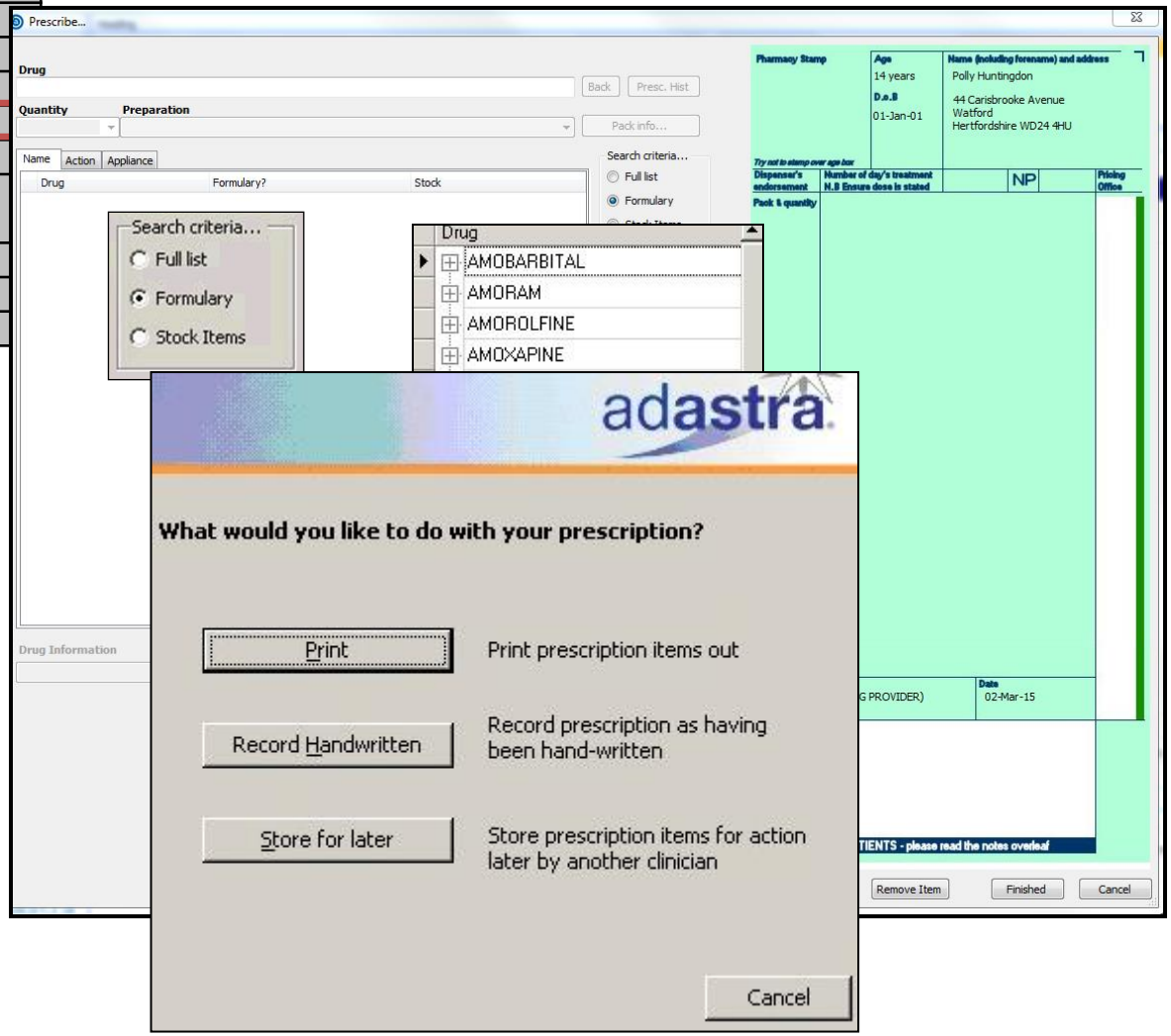
Basic principles

- For patients with a booked appointment at the OOH following GP triage all prescribing is to be completed on an **FP10**
- Medications from stock will be permitted only when pharmacies are closed
- Please pay attention to National and Local prescribing guidance e.g. local anti-microbial guidance
- Do not lower your threshold for prescribing – prescribe only if a clear indication to do so
- Medications should be prescribed generically
- Patients should be encouraged to obtain over the counter products from the pharmacy

Record keeping of Prescriptions

- Past medical history, medications and allergies must be recorded (preferably on the Medical History tab)
- Prescriptions must contain correct dosage instructions and quantity
- Handwritten prescriptions to be used only when IT fails
- Prescribing module in Adastra must ALWAYS be used – never free text

- Finish
- Forward
- **Cen Forward**
- Lock
- Prescribe
- Appointments
- Agency Refferral
- Print
- Sensitive
- Treatment



Acute prescriptions

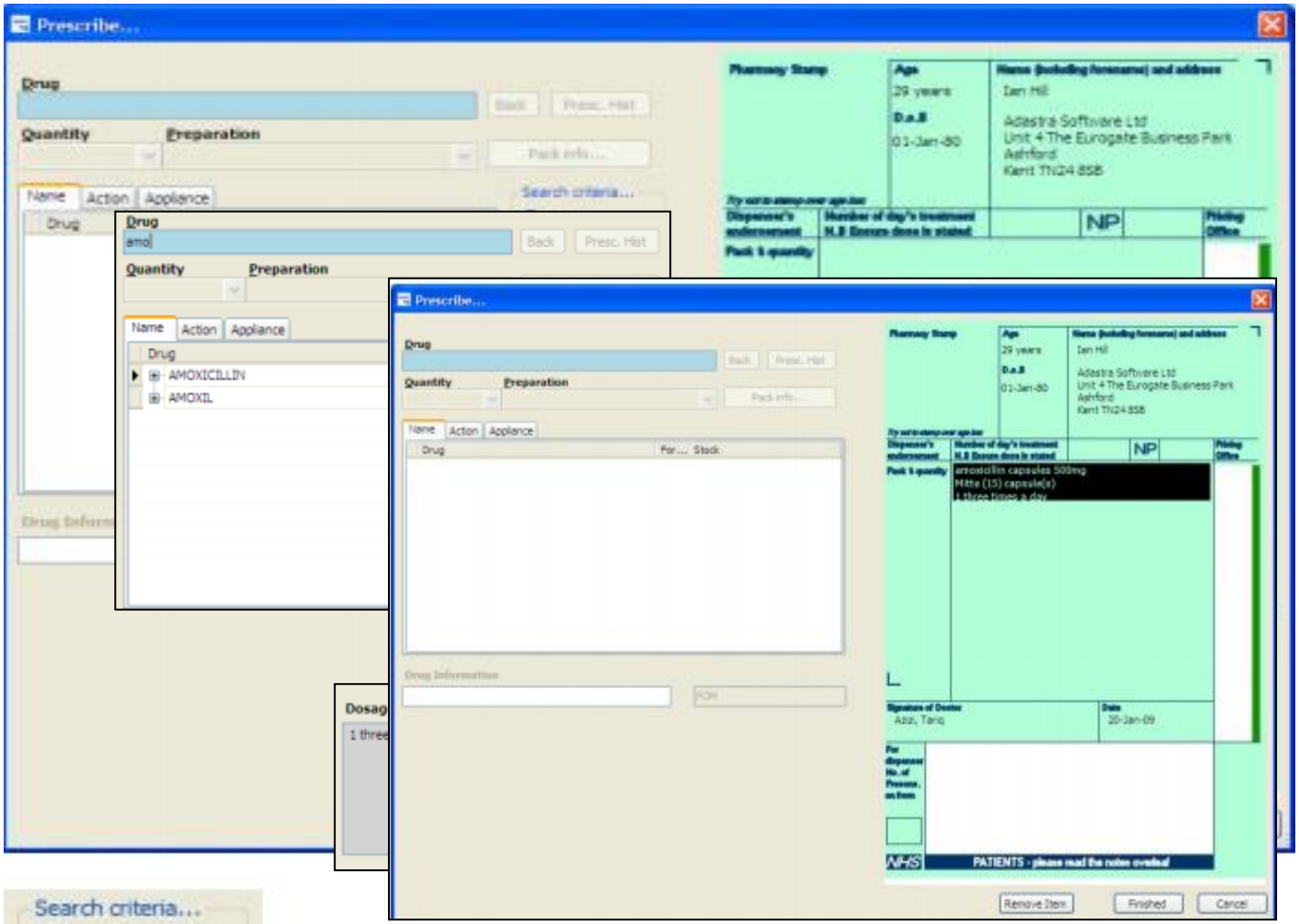
- Complete courses to be prescribed
- Analgesia – pay attention to analgesic ladder and be wary of opioids in opioid naïve patients
- Maximum 7 day supply unless otherwise indicated (e.g. penicillin in scarlet fever)
- No methadone or Subutex to be prescribed under any circumstances
- Maximum 3 days supply low dose diazepam e.g. 2mg qds for 3 days

Personally administered drugs

- Patients may occasionally need PA drugs

- The drug name, dose, batch number, expiry date, route of admin, site of admin and time and date of admin must all be recorded

- FP10REC must be completed



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Repeat prescriptions

- Frequent occurrence; many requests are genuine e.g. lost or forgotten meds or delayed scripts; others are for convenience or even fraudulent
- Going forward most repeat prescribing will be handled by the Pharmacist in 111
- In the first instance, clinicians are advised to suggest to patients that it may be possible to contact their usual pharmacy for an emergency supply

<u>If patient unable / unwilling to comply:</u>

•Assess the ***immediate clinical need*** for a prescription to be issued

Establish the patient's current medical condition, current medications, previous history, and allergies.

- Check SCR

•Ensure that you are happy that request is consistent with the history

•Prescribe the minimum amount necessary for the patient, to cover until they can contact their own GP/original prescriber

•Resist faxing prescriptions unless absolutely necessary –If a prescription is faxed, the prescriber must write the name and branch of the pharmacy in the top left of the prescription and FP10 must be posted and received by pharmacy within 72 hours ***CD prescriptions are not to be faxed***

•Faxed prescriptions should be preceded by a telephone call to the pharmacy to ascertain that they will be open when the patient arrives, that the fax is working and that they have the appropriate stock to deal with the request.

Telephone Prescribing and faxing scripts

Telephone Prescribing – Acute

•This must be avoided

•High risk – serious incidents have resulted

•Only exception is a simple uncomplicated lower UTI

•Rules regarding faxing still apply

Telephone Prescribing – Repeat

•The prescribing clinician must be satisfied that the history given by the patient is consistent with the repeat prescription request (e.g. check previous encounters, look for previous prescriptions etc)

•If satisfied then may be prescribed for collection

•If not satisfied or not happy to prescribe on telephone (e.g. opioid analgesia, CD etc) then to book for F2F appointment in OOH and patient to bring repeat slip, empty box, other evidence

•Maximum 7 days

Faxing of Prescriptions

•Ideally patients or their friends / relatives should be encouraged to collect their prescriptions

•A repeat medication slip, empty box or other evidence should be brought when collecting prescriptions

•If clinician is satisfied about indication, is happy to prescribe and script cannot be collected then they may decide to fax – *see next page*

Faxing Prescriptions

Faxing is a last resort

Prescribing clinician is responsible

- Indications for script to be clearly documented in notes
- FP10 to be printed
- FP10 is then faxed to one of the safe haven pharmacies only
- Pre-programmed fax numbers **ONLY** to be used – no manual keying in of fax numbers
- Nominated pharmacy is telephoned in order to confirm receipt of prescription
- FP10 is put in envelope with pharmacy's postal address – to be posted next day

Controlled drugs/Drugs liable to misuse

•Methadone and Subutex are NOT to be prescribed

•Exercise caution when assessing requests for controlled drugs, or those liable to misuse (such benzodiazepines, dihydrocodeine, methylphenidate, tramadol, mirtazapine and olanzapine).

•Given the difficulty in confirming the prescription details out-of-hours, and the higher likelihood of deception, we advise that such prescriptions are *not* given.

•Exceptions must be clearly documented, or where clear clinical need can be demonstrated through the patient notes e.g. palliative care patients.

•Prescriptions for medicines that are liable to misuse SHOULD NOT be faxed unless there are documented exceptional circumstances.

•Patients or carer should be asked to collect such prescriptions from their local base with some proof of their identity and address corresponding to the details taken by the call handler. Where it is necessary to fax a prescription the pharmacy should be advised to confirm the collector's identity as well.

•Lost/Stolen prescriptions must be replaced only in exceptional circumstances – max 3 days supply

Abnormal Lab results

Occasionally abnormal lab results will be called through to the Out of Hours via NHS 111 as per their protocol. Note that NHS 111 will not take the actual result but instead the call will be passed to the OOH for a GP to call back

When calling back the lab it is important to obtain:

- Latest result
- Any previous results
  - E.g. creatinine 320 now but 300 six months ago
- Clinical details / past medical history
  - E.g. raised blood glucose called through but patient known Type 2 diabetic
- Confirm patient contact details

Contact made with patient

- Introduce yourself and explain why calling as patient usually not expecting the call
- Complete a normal telephone consultation based on the result from the lab and decide upon closure with advice and follow-up, consultation at OOH base, home visit or hospital admission (e.g. little to be added by visiting a patient with a potassium of 7.5 – admit)

No contact made with patient

- Follow failed contact guidance

Questions?

Thank you for listening

Our Values


Quality Services
We have high standards
Efficiency
We are cost effective
Patient Care
We give our best
Respect
We are committed to working together
HUC