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HEALTH SCRUTINY
Overview & Scrutiny Committee
Agenda - supplementary

Date Tuesday 1 September 2020

Time 6.00 pm

Item No	
6	Urgent Care Review (Pages 1 - 12)
	Appendix to the report

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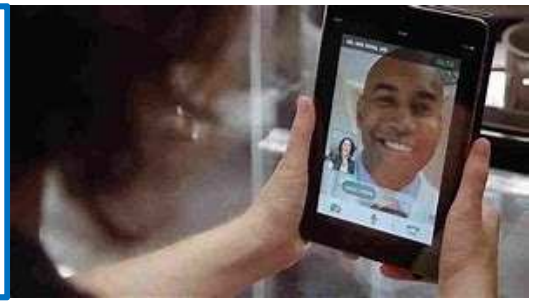
Joan's Primary Care Digital Hub Journey…….

Joan lives in a care home, she was not feeling well during the evening and her carers were concerned about her.

Her carers felt Joan need a clinical review, they rang the Oldham Digital Clinical Hub to speak to a clinician.

The carer was able to use simple equipment to provide some clinical observations to the clinician.

A virtual video consultation was arranged with a clinician who had full access to Joan's medical records.



This allowed the clinician to clinically assess Joan's health and formulate a treatment plan that allowed Joan to stay at home.

The treatment plan was forwarded to the care home via text messaging along with safety net advice and her Primary Care records were updated ensuring her own GP was fully informed

Joan remained in her own environment, where she received the appropriate care she needed. Keeping her safe and out of hospital and her carers supported.

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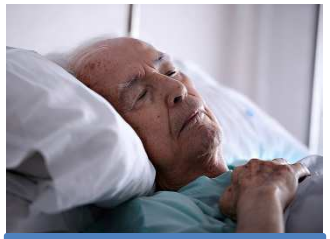
John's Current Journey……



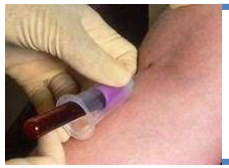
John lives in a care home, he had been feeling unwell through the afternoon and by evening time his carers were concerned. His own GP practice was now closed

His carers felt John need a clinical review, they rang NHS111 for advice

A clinician spoke to the carers, but had no access to Johns medical records and no access to video consultation to assess John.

The clinician was concerned about possible urosepsis & dehydration. As he was unable to assess John & was not connected to local community offers, the clinician advised the carers to send John to A&E to be assessed.

Due to capacity pressures, John had an extended wait in A&E to see a clinician.



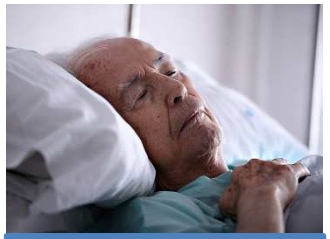
He underwent multiple clinical tests

It was now very late at night, John was given the IV fluids he needed and admitted to a ward.

John spent time on a hospital ward with no further treatment following his IV fluids awaiting discharge.

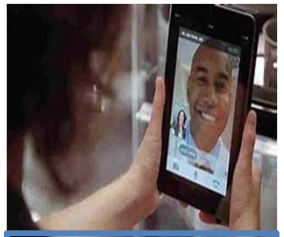
John was discharged back to his care home, his carers noted his mobility was worse and he was less orientated to his surroundings than prior to his admission.

John's Digital Hub Journey with Community Care input ……



John lives in a care home, he had been feeling unwell through the afternoon and by evening time his carers were concerned. His own GP practice was now closed

His carers felt John need a clinical review, they rang the Oldham Digital Clinical Hub to speak to a clinician



A virtual video consultation was arranged with a clinician who had full access to John's medical records.

The carer was able to use simple equipment to provide clinical observations to the clinician.

The clinician was able to speak with the Integrated Crisis Enablement (ICE) Team.

A plan was agreed to care for John at his home.

The ICE Team visited John at home and administered S/C or IV Fluids for dehydration.

The treatment plan was forwarded to the care home via text messaging along with safety net advice and John's Primary Care records were updated ensuring his own GP was fully informed

John remained in his own environment, where he received the appropriate care he needed. Keeping him safe and out of hospital and his carers supported.

Hilda's Current Journey……

Hilda lives in a care home, she had been complaining of a sore leg. It was weekend and her leg looked red and swollen and her mobility was poor. Her carers were concerned about her.

Her carers felt Hilda need a clinical review, they rang NHS111 for advice.

A clinician spoke to the carers, but had no access to Hilda's medical records and no access to video consultation to assess Hilda

As the clinician was unable to assess Hilda he was concerned about a possible DVT the clinician advised the carers to send Hilda to A&E

Due to capacity pressures, Hilda had an extended wait in A&E to see a clinician. A DVT was suspected.

Hilda was referred to the Ambulatory Care Unit and underwent multiple tests.

Whilst awaiting test and results Hilda was admitted to the ward.

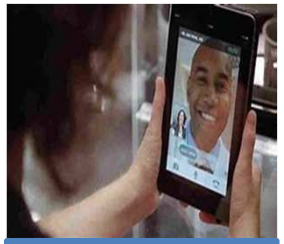
Hilda spent time on a hospital ward with no further treatment following her results, which showed no DVT, awaiting discharge.

Hilda was discharged back to her care home, her carers noted her mobility was worse and she was less orientated to her surroundings than prior to her admission.

Hilda's Potential Digital Hub Journey with Secondary Care input……

Hilda lives in a care home, she had been complaining of a sore leg. It was weekend and her leg looked red and swollen and her mobility was poor. Her carers were concerned about her.

Her carers felt Hilda needed a clinical review, they rang the Oldham Digital Clinical Hub to speak to a clinician



A virtual video consultation was arranged with a clinician who had full access to Hilda's medical records.

The carer was able to use simple equipment to provide clinical observations to the clinician.

The clinician was able to speak with a secondary care consultant in the virtual hospital on a 3 way virtual consultation with the carers & Hilda

A plan was agreed to care for Hilda to be treated in the community.

Hilda was referred to the Community SDEC pathways to be assessed for a DVT.

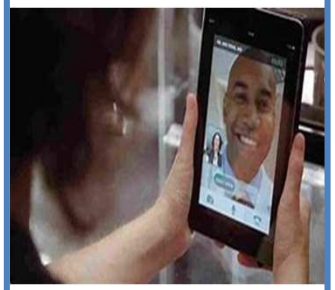
It was found that Hilda did not have a DVT, she & her carers were advised of her results and were provided with safety net advice. Her medical records were updated fully informing her GP. Follow up was arranged with the community therapy team.

Hilda remained in her own environment, where she received the appropriate care she needed. Keeping her safe and out of hospital and her carers supported.

Case Study – Current Digital Offer for Care Homes.

John is a 73 year old man who lives in a care home. His carers were worried about increased signs of lethargy, a raised temperature and possible UTI symptoms.
His own GP practice was now closed so the carers rang through to the Hub.

A virtual video consultation was arranged with a clinician who had full access to John's medical records which showed John had a PMH of Ca Lung, advanced dementia and diabetes. It was established that he was doubly incontinent and had a 3 month history of weight loss.



Through the consultation it was also established that John had an avoidance of hospital admission care plan in place from his GP and a DNAR but no SOI.

John had no symptoms of Covid-19 and the care home was free from any Covid-19 infections.

The carer was able to provide clinical observations to the clinician.
These showed John had a low grade temperature of 37.3 and a raised heart rate of 107bpm

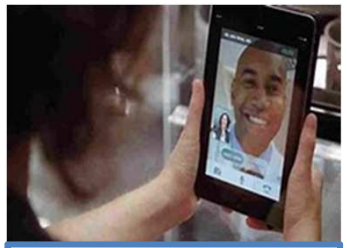
A plan was agreed to treat John with antibiotics, a prescription was provided electronically and John remained in his home.

The treatment plan was forwarded to the care home via text messaging along with safety net advice and John's Primary Care records were updated. Arrangements were made for John's own GP to follow up on his wellbeing the next day.

John remained in his own environment, his GP reviewed him the next day and found he had deteriorated further. His GP initiated a SOI and prescribed anticipatory drugs to ensure John could remain in his home whilst being kept comfortable and John and the carers received the support they needed ensuring any admission to secondary care was avoided.

Case Studies – Current Primary Care Streaming from ED

7 year old with a rash to her scalp.



Previously had 2 remote consultations with her own GP in the last 2 weeks

GP prescribed two topical treatments and a shampoo

As the treatment had had little effect and despite being able to share a photo with the GP her father was worried and led to him attending ED.

She was streamed by ED to the Hub as she had a primary care need and went home to await her consultation

Received a telephone consultation that evening and was brought in for a face to face appointment.

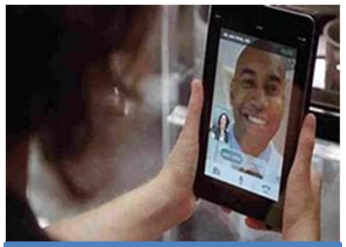
She was seen by the hub's paediatric trained ANP, had a full clinical examination and was diagnosed with an infection.

She was prescribed antibiotics and a follow up plan was made with her own GP.

Streaming this patient out of ED to primary care ensured she received the appropriate care and treatment closest to home with the least acuity. It reduced her waiting time and supported the ED to maintain social distancing.

Case Studies – Current Primary Care Streaming from ED

57 year with abdominal pain. 1 month history, worse in the past week with food being a trigger.



Previously had 4 remote consultations with her own GP in the last 5 weeks

Her GP treated her for indigestion and referred her to gastroenterology.

As the treatment had had little effect and despite her referral she wanted an second opinion and attended ED in the evening.

She was streamed by ED to the Hub as she had a primary care need and went home to await her consultation

She received a telephone consultation that evening and was brought in for a face to face appointment.

She had a full clinical examination, an acute abdomen was ruled out and she was diagnosed with constipation.

She was reassured and advised to follow up with her own GP.

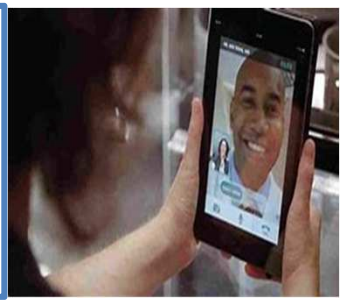
Streaming this patient out of ED to primary care ensured she received the appropriate care and treatment closest to home with the least acuity. It reduced her waiting time and supported the ED to maintain social distancing.

A Patient Journey….

James is a 73 year old man who lives in a care home. His carers were worried about increased signs of lethargy, a raised temperature and possible UTI symptoms. His carers felt James was deteriorating throughout the day, his own GP practice was now closed so the NHS111 and were advised to ring 999 due to his presentation.

A crew was dispatched and arrived on scene. James was unwell but following their assessment the crew did not feel conveying him to A&E was the best outcome for him.

The crew contacted the Oldham Clinical Hub and a virtual video consultation was arranged with a clinician who had full access to James's medical records which showed James had a PMH of Ca Lung, advanced dementia and diabetes.



Through the video consultation with the crew, patient and carers present, clinical observations could be shared, the patient could be visibly assessed and it was established that James could be kept at home with a treatment plan.

It was agreed to treat James with antibiotics, a prescription was provided electronically which the carers could obtain and James remained in his home.

The treatment plan was forwarded to the care home via text messaging along with safety net advice and James's Primary Care records were updated. Arrangements were made for James's own GP to follow up on his wellbeing the next day.

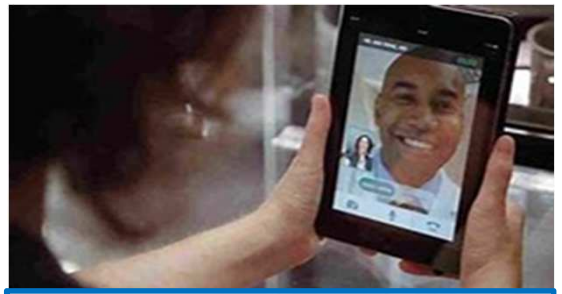
The crew were able to clear the call quickly and safely. With confidence that James and his carers were fully supported, a plan for follow up was in place and safety netting advice was provided in a text message that the carers could revisit.

James remained in his own environment, his GP reviewed him the next day and found he had responded to the treatment provided. His GP initiated a Oldham One Support Plan and agreed with James and his carers an admissions avoidance plan to ensure James could remain in his home with the support he and his carers needed. Ensuring any future admission to secondary care was avoided.

Patient Journey from ToC….

Jack is a 52 year old man who had a witnessed fall on the stairs at the GP practice, injuring his leg. The Practice Nurse (PN) contacted 999 and a Cat 4 response was allocated.

The information with NWAS should the patient was unable to weight bear, and alcohol intoxication. Crew awaited for transfer to A&E ROH. Through the ToC the team intercepted this call.



The ToC team rang the PN, she had undertaken clinical observations which were reported as stable, no GP was in the practice due to home visits. History given; leg gave way on the stairs, no other injuries other than lower leg twist injury. Jack had been assisted into a wheelchair, given fluid and food and his GC was 15/15.

It was established through the call and access to his full medical record that Jack's PMH included alcohol misuse, mildly deranged LFT's. He reported recurrent falls but not disclosed, known to community services (DN, SW & MH involved) but no MDT care coordination.

Following discussion of option to support Jack it was agreed that his PN would refer him to the community falls team, alcohol worker and focus care worker at the practice to coordinate his care.

Jack however still had a immediate need – he needed an injury assessment. His injury was minor, he did not need A&E but he required an X-ray so a NWAS taxi was utilised and he was transferred to Rochdale UCC ensuring he received care in the least acute and most appropriate service to meet his need .

By intercepting this call the team prevented the dispatch of NWAS crew and supported the PN to ensure Jack received the most appropriate care for his needs, with a timely response and ensured there was a plan of care to manage his ongoing needs in the community.

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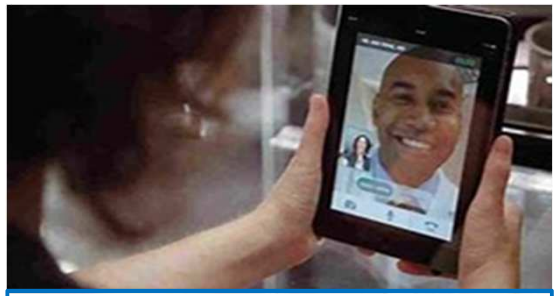
Case Study - Pharmacy Integration

Lesley is a 33 year old woman who attended her local pharmacy on a Saturday for advice and treatment for her ears. She had pain and discharge from both ears and wanted ear drops to treat them.

The pharmacist discussed her needs and felt that due to the presence of bilateral discharge she needed to see a clinician who could examine her and prescribe treatment. Given the patients GP was closed they referred the patient to the Oldham Clinical Hub instead of directing her to ED. Lesley was sent home with an appointment for a virtual consultation.



The clinician at the hub conducted a consultation via video with access to her full patient records. It was determined she needed to be examined and Lesley was given an appointment to attend the Hub for a face to face examination that day.

Following her examination Lesley was prescribed antibiotics for an infection in both ears.

Due to the findings from her examination the hub clinician felt Lesley required a further review by a specialist ENT doctor and arranged an out-patients appointment for 2 days later.

By referring Lesley to the Hub she was seen and treated the same day in the community without delay and had follow on care arranged with specialist services. Her Primary Care records were updated ensuring her own GP was fully informed.

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