Urgent and Unscheduled Care

Best Practice Guidance for Professional to Professional Decision Support

Supporting shared decision making

April 2022

Scottish Government
Riaghaltas na h-Alba
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Acknowledgements:

The national Redesign Urgent Care team would like to extend its grateful thanks to all stakeholders who supported the development of this document and to NHS Grampian for testing the approach provided. All have helped inform the development of this guidance.

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Introduction

The national Redesign of Urgent Care (RUC) programme was launched on the 1st of December 2020 focusing on delivery of the right care, in the right place, at the right time. The RUC programme aims to deliver urgent care as close to home as possible and making most effective use of appropriate access to senior clinical decision makers, where it is clinically safe and appropriate to do so. This can be supported by rapid and efficient communication between clinicians working across different settings, supporting shared decision making and access to the most beneficial local care pathways for patients.

Professional to professional clinical advice supports decision making in interactions between healthcare professionals. This could apply across multiple care providers including primary and community care, ambulance service and secondary care. Advice can support the provision of self-care, immediate treatment and provide guidance for the most appropriate location and timing for further assessment and ongoing care, maximising benefits to the patient.

Whilst being immediately relevant to the RUC programme, effective professional to professional decision support can contribute to all patient care, including urgent and unscheduled care, to enrich patient care and develop professional relationships to ensure patients have a direct route to the most appropriate service for their needs.

This professional to professional best practice guidance will facilitate effective clinical communication and support shared decision making, with the aim of accessing alternatives to hospital attendance or admission where appropriate and safe to do so.

This document has been developed in partnership with key stakeholders in NHS Scotland (Appendix A) and describes the overall principles to be adopted when implementing professional to professional decision support.

Purpose

This document aims to:

- Support the design and implementation of a professional to professional clinical decision support approach
- Describe the benefits of effective professional to professional communication in the delivery of patient care
- Provide examples of successful models of professional to professional service implementation
- Underpin the RUC Programme to support right care in the right place at the right time as well as the Scottish Government's vision to deliver care closer to home; whilst allowing local flexibility in a way that best fits local challenges and available care provision

This document is designed to open dialogue, encourage collaboration and support improved integration between the following key stakeholders:

- Primary Care Services e.g. General Practice, Out of Hours and Community Pharmacy
- Secondary Care e.g. Emergency Departments, Ambulatory Assessment areas and Acute Admission Units
- Health and Social Care Partnerships
- Scottish Ambulance Service
- Mental Health Services
- Third Sector Organisations

Benefits

Professional to professional decision support can facilitate direct referral from primary care and community services, NHS 24 and the ambulance service to the most appropriate pathway of care without the need for additional clinical touch points for further triage. Successful implementation of professional to professional decision support can bring whole system benefits and improved visibility of pathways of care which previously may not have been accessible.

Benefits for the patient include the avoidance of non-value added steps in the patient journey. This aims to improve patient experience, has the potential to create system wide capacity by minimising duplication and repeated handoffs, improving flow and reducing harm from multiple transitions of care.

Professional to professional decision support can inform decision making to ensure the patient receives the right care in the right place which can be by immediate urgent care treatment, scheduled appointment or virtual consultation.

Anticipated benefits of professional to professional decision support:

- Direct access to specialist clinical advice
- Facilitation of shared decision making
- Signposting or referral to the right place of care
- Mechanism for appropriate clinical information sharing to inform diagnosis and destination decisions
- Enabling care closer to home where possible and safe to do so
- Providing an alternative to hospital attendance or a scheduled appointment, thereby improving patient experience and reducing exposure to avoidable harm associated with hospital admission
- Avoiding unnecessary attendances at care venues
- Increased flexibility and efficiency of service delivery
- Reducing demand on ambulance service resources by reducing inter-hospital patient transfers, reducing ambulance turnaround times at sites and reducing some patient conveyance journeys where a suitable alternative pathway can be accessed
- Two-way professional to professional conversations across multiple care providers

Design

Effective professional to professional decision support should be designed taking into account local structures and existing referral and communication pathways. Communication between clinicians should advocate best practice, be supportive in nature and be captured in the patient record.

Below are the key considerations when designing and implementing a professional to professional decision support approach:

Workforce

- Access to an appropriate Senior Clinical Decision Maker during evidenced key hours. This clinician should have the experience, knowledge and skills to provide remote clinical decision support and access to the required patient records and information
- Ideally the Senior Clinical Decision Maker should not be undertaking other direct clinical duties whilst providing professional to professional decision support, particularly during evidenced key hours and for high call volume specialties such as acute medicine, acute surgery and emergency medicine. However professional to professional decision support could be provided in association with other remote / virtual consultation work, for example within Flow Navigation Centre operations. Individual health boards should develop the workforce model that works best for them

Systems, Processes and Data

- The Senior Clinical Decision Maker should be easily accessible. The service should be well publicised with clear guidance on hours of operation and scope of practice
- The necessary supporting infrastructure is in place to enable effective clinical communication
- Ability to record and subsequently access calls to support good clinical governance
- Ability to electronically capture data in relation to calls received, missed calls and outcomes
- Ability to respond to calls in real time, within an agreed timeframe (local standard / key performance indicator [KPI]) and fall back processes for unanswered calls should this not be met, as part of local board processes
- Agreed structured handover and conversation tool e.g. SBAR (Appendix B) and the use of ‘read back’ (it is important that the receiver of the information reads back a summary of the information and any shared decisions, also using the agreed structured handover and conversation tool format)
- Patient consent, the handover and agreed shared decisions / patient plan should be recorded within the patient management systems (patient record) using a structured format
- All records should be stored in line with current records management policies for the organisations

Health Boards may consider procurement of products which support professional to professional communication approaches by providing an infrastructure to deliver the service in line with governance and data requirements. Health Boards who use such products report advantages such as:

- Ease of set up, ease of scale up, single number multi-specialty and minimal training required
- Immediate post call access to the call recording
- Ability to securely store recorded calls over a period of time
- Ability to easily access and interrogate call data including:
    - Call volumes and timing
    - Source of calls
    - Call duration
    - Call outcomes
- This data can be utilised to inform management of workforce and service gaps, and identify pathway opportunities
- Specialist platform support

Clinical Governance

Individual health board clinical and corporate governance arrangements would apply to activity undertaken as part of the professional to professional decision support approach. This does not impact on the pre-existing governance arrangements in health boards regarding split of responsibility for a patient between clinicians. It is important that patients are kept informed and updated about the decisions related to their care, what they can expect to happen next and any safety-netting that is required.

Clinical Governance measures should include:

- Review of clinical records, ideally including transcription or recording of the professional to professional conversation
- Regular audit of outcome data
- Feedback to clinicians, including improvements and shared learning after audit or review

Complaints management and adverse event reviews should be undertaken jointly between organisations. Learning should be shared by both parties and joint improvement, education and training developed.

High frequency monitoring, evaluation and rapid reporting should be undertaken during an implementation period to ensure safety and to respond to any unintended consequences.

Information Governance

Strict adherence to the Caldicott principles and issues of patient confidentiality must be observed. The sharing of information between Health Boards is to be in accordance with the Intra NHS Scotland Information Sharing Agreement (NHS Scotland 2020). A data protection impact assessment (DPIA) should be in place for any new data flows to meet the governance requirements, if required.

Clinical Engagement

There should be a shared understanding of roles and scope of practice, along with shared understanding of professional to professional decision support expectations. Systems should be co-designed, with clearly defined processes and hours of operation.

Some important points for consideration to encourage clinical engagement include:

- Review and map current pathways, identify gaps and opportunities, widen access and develop ambulatory assessment services
- Resource the professional to professional decision support service appropriately
- Consideration should be given to the benefits of incorporating this within the operations of a health board's Flow Navigation Centre as part of the RUC pathway. This guidance can also be used for other settings within primary, community and secondary care services
- Identify a clinical champion within the organisation to support with engagement and the ongoing delivery and development of the service
- Establish key stakeholders, engage early and co-design the service
- Ensure the necessary technical infrastructure is in place to deliver the requirements
- Ensure the necessary clinical governance arrangements are in place
- Ensure regular communication at the implementation phase and during the introduction of any new specialties, as well as regular communication with service users e.g. GP localities, ambulance service, etc
- Establish a clear and structured education and training plan, with ongoing team support
- Identify, capture and share best practice and support the spread of innovation

Examples

A number of Health Boards have already applied a professional to professional decision support approach. Appendix C details the framework applied within NHS Tayside and Appendix D provides case study examples within NHS Greater Glasgow and Clyde and NHS Lanarkshire.

Additional Support

The Scottish Government Urgent and Unscheduled Care Team can provide additional support in implementing professional to professional decision support where required. To access this support, please email **RedesignUrgentCare@gov.scot**.

Feedback and Further Questions

If you have further questions or would like to provide feedback on this guidance document, please contact the above email address.

Guidance Review

This document is also based on a Rapid Response from Healthcare Improvement Scotland (2021). The guidance will be reviewed on an annual basis by a range of clinical experts as part of the Scottish Government's national Urgent and Unscheduled Care programme.

Appendix A – Stakeholder List

Name	Designation	Health Board
Danielle Brooks	Unscheduled Care Policy Officer	Scottish Government
Dr Ronald Cook	Consultant Emergency Medicine	NHS Tayside
Dr Amanda Cotton	Consultant Psychiatrist	NHS Borders
Carol Goodman	Redesign of Urgent Care Programme Director	Scottish Government
Janice Houston	Associate Director of Operations and Nursing	NHS 24
Heather MacKay	Unscheduled Care Senior Policy Officer	Scottish Government
Dr Gordon McNeish	Consultant Emergency Medicine	NHS Lanarkshire
Gerry Mooney	Unscheduled Care National Improvement Advisor	Scottish Government
Dr Gillian Mulholland	Consultant Gastroenterologist	NHS Lanarkshire
Kerri Neylon	Deputy Medical Director / National Primary Care Leads Group Chair	NHS Greater Glasgow and Clyde
Marese O'Reilly	Unscheduled Care Project Manager	Scottish Government
Susan Paterson	Clinical Care Group Manager	NHS Tayside
Dahrlene Tough	Consultant Paramedic / Unscheduled Care National Improvement Advisor	Scottish Ambulance Service / Scottish Government
Amanda Trolland	Unscheduled Care Programme Manager	Scottish Government
Merrell Veitch	Unscheduled Care Project Support Officer	Scottish Government
Jonathon Will	Clinical Effectiveness Lead	Scottish Ambulance Service

Appendix B – SBAR Template

It is recommended that organisations educate their professionals / clinicians in SBAR methodology to support decision making. This will support earlier detection of patients who are suitable to be referred directly to the right services and not conveyed to Emergency Departments.

S	**Situation** **I am (name) on scene calling about** <Patient Name> **I would like to consider this patient for** <e.g. SDEC> **Chief complaint is** <xxx> **I am calling from** <the patient's home / care home>
B	**Background** **Patient:** has / has not sought medical advice / treatment in last 7 days **Long term conditions are** <xxx> **Known care plans / Resuscitation status** <xxx> **Medication is** <known / unknown> **Patient is** COVID <positive / negative / unknown>
A	**Assessment** **NEWS-2 score** <xxx> GCS, Resp Rate, HR, Sats, BP, Blood Glucose **I think the problem is** <xxx> Or **I am not sure what the problem is, I think the patient requires** <e.g. further diagnostics> **I have given** <e.g. oxygen / fluids / analgesia>
R	**Recommendation** **I think the patient requires** <secondary care and would be suitable for an alternative pathway to ED> Or <**I feel the patient is** clinically safe and happy to make their own way to an alternative pathway (specific time to be agreed)> **Is there anything I need to do in the meantime?**

Appendix C – Local Framework Example

NHS Tayside professional to professional services support an innovative multi-front door model which enables direct access to services such as Acute Medicine, COVID Assessment, Cardiology and Stroke; supporting delivery of providing early definitive care for patients and supporting the aim of care from the right person, in the right place, first time. This also allows their Emergency Departments to provide timely patient care, which is reflected in sustained performance against unscheduled care targets, and no identified issues with ambulance "stacking".

Their existing framework means that it was possible to rapidly establish a dedicated professional to professional advice line for the COVID Assessment Unit, which was launched on the 13th March 2020. This dedicated unit directly accepts patients with known or suspected COVID-19 and provides rapid assessment, alternatives to admission or admission to the specialist 'hospital within a hospital'. This ensures that the 'assess to admit' principle successfully applied in other unscheduled care areas is equally embedded in the Tayside COVID model.

Since September 2018, professional to professional services have been supported by Consultant Connect enabling call recording and effective activity analysis. Over 50,000 calls have been handled through the system in Tayside.

Professional to professional advice is available to Primary Care in and Out of Hours, Scottish Ambulance Service, NHS 24 and regional services such as Minor Injury Units and prison health services via a dedicated telephone line. This ensures senior clinical decision maker advice early in the patient journey.

Data analysis of these services over the last 10 years consistently shows the efficacy of this approach. Even more so since the introduction of the COVID Assessment Unit in March 2020 and the establishment of a local Flow Navigation Centre as part of the RUC programme in December 2020 including:

- Consistent 30% alternative to hosptial attendance in calls from the Scottish Ambulance Service
- 30% reduction in acute inter hospital transfers
- 35-40% of NHS 24 Direct Referrals to Flow Navigation Centre result in "non ED attendance"
- Only 20% of patients receiving a 4 hour call back from the Flow Navigation Centre require an unscheduled attendance at the Emergency Department
- During "wave 2" 30% of patients discussed with the COVID Assessment Unit did not attend hospital

Through promoting availability of professional to professional services, uptake and use of the service has significantly increased during the COVID pandemic. During this time outcomes of calls including accessing care outside the hospital environment in 30% of cases were maintained, significantly increasing the number of patients accessing early community care and avoiding unnecessary hospital attendance. These pre-hospital remote consultations have also resulted in a significant decrease in inter hospital transfer between their two acute sites.

Appendix D – Patient Case Study Examples

Example 1: NHS Greater Glasgow and Clyde (Primary Care)

Patient: Female / Aged 55 years

History: Patient had experienced 6 weeks of persistent vomiting and feeling unwell. Patient taking methotrexate for Rheumatoid Arthritis. Recurrent contacts with GP (phone and face to face). Bloods had persistently shown raised white cells and lymphocytosis, low albumin and raised Alkaline Phosphatase

Situation: Deterioration in condition and consideration of admission

Response: Use of Consultant Connect to link with the Acute Consultant on call. Discussion held regarding case and agreement made to see the patient the following day to have imaging undertaken

Results: Patient diagnosed with Crohns disease with hospital admission avoided by prioritising the Professional to Professional discussion and also having the facility to see the patient ("hot clinic") the next day, alongside easy access to CT scan

Example 2: NHS Lanarkshire (Cardiology)

Patient: Female / Aged 62 years

History: Patient presented to their GP with intermittent palpitations in the context of known Atrial Fibrillation. This had been occurring for a long period of time despite various attempts to reduce symptoms with different medications

Situation: Patient was becoming increasingly frustrated about the symptoms and was starting to develop associated symptoms of shortness of breath when exerting herself

Response: The patient's GP would have previously considered an unscheduled care referral to an acute site due to tachycardia and failed attempts to control with medications. However GP utilised Consultant Connect to obtain professional to professional advice from a Consultant Cardiologist at University Hospital Hairmyres

Results: The Consultant Cardiologist was able to look at previous telemetry, out-patient echocardiogram images and recent community blood results, providing advice with regards to change in medications. Both decided that the patient would be suitable for catheter ablation and the patient was added to the ablation waiting list at the point of discussion

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80435-235-9 (web only)

Published by The Scottish Government, April 2022

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1051370 (04/22)