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NHS

SevernSide IUC Clinical Coordinator Handbook

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Contents

The Clinical Coordinator Role

Clinical Coordinator (CC) shifts are diverse and rewarding. You will work closely with clinical and operational colleagues and encounter a wide range of clinical presentations and problems.

CC shifts involve:

- Proactive approach to engaging with the clinical team on shift, to ensure that all colleagues feel able to approach the CC when support is needed
- Supporting out of hours, System CAS and Weekday Professional Line clinical colleagues' clinical decision-making, holding uncertainty and clinical risk when required, or when advice and support is sought
- Close working with the operational team, particularly the Shift Manager, to enable joined up operational and clinical leadership on shift
- Supporting the flow of patients through the IUC service, including reviewing face to face appointment and visits put through by triaging clinicians
- Clinical oversight and management of cases in the Follow Up queue, which includes cases requiring follow up/ review after an earlier assessment in IUC
- When capacity allows, the CC will also telephone consult with patients and / or Healthcare Professionals on the IUC Advice queue. This may include CAS, System CAS and medical admission/ admission avoidance cases on weekdays, and CAS and Professional Line cases at the weekends.
- Clinical Coordinators who are also approved Clinical Supervisors can supervise/ train GP trainees during times of lower service pressure (e.g. weekday evenings).
- Using the local health economy in the most efficient way at the same time as making the right choices for patients (right time, right place, right clinician, right treatment), usually in the lowest acuity setting which can safely manage the patient's need(s).
  This clearly depends on understanding how it should work and how it actually works, and making the right pragmatic decisions. Where there is doubt, always discuss with other clinicians or with the relevant service(s) concerned.

Clinical Coordinator Shifts

CC hours	**Elements of the IUC service operating during the time period and supported by the Clinical Coordinator**
Mon-Fri 8am-2pm	Medical admissions/ admission avoidance (via the Weekday Professional Line, WDPL) ED/999 cases from NHS111, including mental health cases arising from NHS111 (System CAS) Subset of CAS cases arising from NHS111 across 24/7 Frailty Assessment and Co-ordination of Emergency and urgent care (ACE) Paediatric ACE
Mon-Fri 7-11pm	OOH primary care dispositions arising from NHS111 OOH SevernSide Healthcare Professional Line cases ED/999 cases from NHS111 (System CAS)
Mon-Fri 7-11pm	OOH primary care dispositions arising from NHS111 OOH SevernSide Healthcare Professional Line cases ED/999 cases from NHS111 (System CAS)

Weekends and bank holidays 8am-11pm	OOH primary care dispositions arising from NHS111 OOH Healthcare Professional Line cases

Wherever possible, the Clinical Coordinator works on site to enable direct conversations and support with both operational and clinical colleagues. 8am-11pm the CC role is based at Osprey Court, and 7-11pm on weekdays the CC is located at Marksbury Road.

Skills and Experience required to be a Clinical Coordinator

Clinical Coordinators are General Practitioners with

- Excellent verbal and written communication skills to support clinical and operational colleagues
- A positive approach to person-centred decision making, holding clinical risk and managing uncertainty to support effective and safe community management wherever possible
- The ability to balance and appropriately prioritise workload, including balancing the needs of all patients in the service as well as individual patient consultations
- No ongoing clinical governance concerns relating to their clinical work in IUC, with standard (green) auditing in place on Clinical Guardian
- Recent clinical work in Severnside (in the last three months)
- Knowledge of the local health economy, and how to access current information about referral pathways using, for example, the Clinical Toolkit, speciality advice lines and BNSSG Remedy
- An interest in urgent primary care and/ or hospital experience
- Familiarity with local urgent care pathways in and out of hours, and insight into the importance of preserving hospital capacity for people whose health needs can only be met in this setting

The Clinical Coordinator role is diverse, so CCs need to be confident to support clinical care and colleagues' decision making across all types of presentations and age groups. The most important skills are being a strong team player and communicator, with the ability to support pragmatic decision making and manage uncertainty in the lowest acuity setting possible.

Familiarity with urgent care and local urgent care pathways is of course useful, but this can and will be learned on the job, as well as learning the IT systems and specifics of how the service operates. The Clinical Toolkit, Remedy and this handbook are all resources designed to support Clinical Coordinators, alongside the supportive team that works alongside the role.

Becoming a Clinical Coordinator

Support for becoming a Clinical Coordinator will include

- Exposure to the breadth of the Clinical Coordinator role, including managing the Oversight queue, Follow Up cases and providing advice and support to other clinicians in the service
- Discussion about supporting the management of risk and uncertainty, including balancing the needs of all patients in the service as well as at an individual level

- Familiarity, and confidence in the use of CLEO, EMIS, ICE, Connecting Care and the Clinical Toolkit.
- Familiarity with the most frequently used policies e.g. Home Visit Policy, Failed contacts SOP

Prospective employed Clinical Coordinators

are welcome to apply for these roles when advertised on the BrisDoc website. Successful candidates will be supported with a full induction including a *shadow shift* then a *supported shift*. During the shadow shift the new CC will work alongside an experienced CC (usually a Lead GP or DMD) to observe and discuss the work. Both clinicians can pick up CC workload during the shift. In the subsequent supported shift, the new CC will be the named CC on shift but be working with easy access to an experienced CC for advice if needed. The new CC is paid for both the shadow and supported shifts. Debrief and support from your line manager is important, and may include case discussion. The CC handbook supports the role.

GPs who are already employed by BrisDoc and working clinically in IUC

are encouraged to speak with their line manager about training to be a Clinical Coordinator and/ or picking up CC shifts. Again, training and line manager support is provided for this with a *shadow and supported shift*, as outlined for new employed Clinical Coordinators. The CC handbook supports the role.

Self-employed GPs

should contact the rota team to express interest in offering their services as a Clinical Coordinator. The rota team will link you with one of the Lead GPs or Deputy Medical Director who will check your experience and background to approve you starting CC shifts. Severnside will then seek to coordinate a *paired shift* with you, in which the new CC will be booked into the CC shift alongside an experienced colleague. The self-employed CC will work as the CC, with access to support from an experienced CC who can provide advice and contribute to the management of the CC workload if required. The CC handbook supports preparation for that first shift, and subsequent CC shifts. Both clinicians are paid for the paired shift. If a self-employed new CC wishes to undertake a shadow shift prior to this, the self-employed GP is not paid for this.

New CCs are encouraged to book their next CC shift(s) soon after to build on the initial shift(s).

The wider team around the Clinical Coordinator

In addition to the clinical team, who may be working at the Treatment Centres, in the visiting cars, at Osprey or from home, other key roles that interface with the CC role include:

Shift Manager (24/7)

The shift manager provides vital operational leadership and is the usual first port of call for queries from both clinical and operational colleagues. This is a busy role, providing leadership

and oversight for the whole service. The shift manager is able to escalate concerns to an on call (operational) manager who in turn can escalate to a senior on call manager with access to the lead clinician on call. This is a key axis between the CC and shift manager in providing joined up operational and clinical leadership on shift. The shift managers are enormously experienced and have a huge amount of knowledge about the service, so do ask them for advice if you are unsure about any given situation.

Call handlers and WaCCS (Workflow and Capacity Coordinators)

The call handlers receive Professional Line calls across the 24 hour period, and contribute to safety calling at times of peak demand where patients may experience delays in call backs. The WaCCS work out of hours only and their main role is arranging and booking home visits and appointments, but they will also answer professional line calls and safety call when required.

On call and leadership team support

The Shift Manager is able to access advice and support from the on-call manager, senior on-call manager and the Head of IUC. The Head of IUC can seek advice and support from a Director on-call. The senior leadership team, therefore supports escalation or rare/ unusual events causing concern in the service. Extreme escalation and exceptional pressures on the service are examples of when the Head of IUC and Medical Director/ Deputy Medical Director may be contacted. Although unusual, if the CC identifies a significant and immediate clinical concern, they should liaise with the Shift Manager to discuss support and consideration of involvement of the on-call teams if required.

Clinical Coordinator work during the 'OOH' period

Handover from outgoing Clinical Coordinator

When you arrive for your CC shift, you may be taking over from another CC. It is helpful to take a moment to have a chat with the outgoing CC to enable handover of any complex cases they have been involved in but remain live on the system, or which will require action from you later in your shift.

Speak with the Shift Manager

The shift manager is co-located with the CC when working from Osprey Court, to enable direct liaison and discussion throughout your shift. At the start of the shift, it is particularly helpful to seek to understand the lie of the land for the shift. This might, for example, include awareness of short notice sickness which means that one of the Treatment centres has to close earlier than usual, or that visiting capacity is limited. You do not need to act or manage this information, except that awareness of the wider service may influence your CC approach during the shift.

Supporting clinicians, including sending a Screen Message to all Colleagues at the start of your shift

Ensuring that all clinicians feel able to access support and advice is the single most important part of the CC role. It is vital in supporting both good, safe patient care, as well as colleague's wellbeing, sense of being part of a team and enjoyment of their clinical shifts. Please value and

prioritise this part of the role.

Please proactively reach out to clinicians on shift by sending a screen message. This is key in ensuring that clinicians know who is CC, and helps them to feel that you are approachable if they need advice and support. Please include how you would prefer that they contact you. Options include either direct screen messaging, or they can phone through to the shift manager who can pass the call through to you when you are available. You may want to share relevant service updates or clinical updates you think would be helpful in your message. Motivational comments to encourage few in the queue have proved to be effective.

The shift manager will also send messages to the whole team during the shift about operational issues such as escalation/ failed contacts, treatment centre closures, and encouraging people to look at Message of the Day for relevant service information.

Clinical shifts start at different times throughout the out of hours period, so do message clinicians through your CC shift. That may simply be to thank them for their hard work, with reminders/ asks if required or simply to ensure that everyone working knows you are accessible if they need you.

Management of face-to- face requests in the Oversight queue

The Oversight queue contains cases that have been put through for home visits and face to face appointments following remote assessment/ triage by a SevernSide clinician. It is important to remember that patients who do need face to face assessment to determine the next steps in their care can and should be seen in IUC. This queue is managed by the CC on weekdays from 18.30 until 23.00 and weekends and bank holidays from 08:00 until 23:00.

Clinical Coordinator Review of Oversight cases

It is important to keep on top of this element of the role throughout the shift, as prompt review/ approval of cases enables flow through the service without backlogs. We encourage Clinical Coordinators to check the Oversight queue between each other element of the role.

Enter the case record in the Oversight queue by double clicking on it. You can use the panels within the record to review the detail of the triaging clinician's consultation, and any NHS111 Pathways assessments.

Appointments and Home Visits land in the Oversight queue with the following information as requested by the triaging clinician:

- As the sub service the triaging clinician is requesting i.e. Face to Face or Home Visit
- Priority set as the triaging clinician intended and the breach time already counting down to show the time left before we need to see the patient
- The sub classification set as per the triaging clinician's assessment i.e. No PPE Required, PPE/Isolation Room Required or High Consequence Infectious Disease

Please work from the top of the queue down to ensure we are working on the case with the shortest timeframe to the breach first. Right click on the case in the Oversight queue and select

Oversight validation to review the request,, including whether the patient has infectious symptoms, whether the request is for a visit or appointment and the requested timeframe (2 hours or 6 hours).

When reviewing cases put through for face to face

- Explore the information available to you. Are the notes clear about how unwell the patient is and/ or the reason(s) why face to face may be needed?
- What differentials are being considered? Are they reasonable? Could further information obtained remotely be helpful in guiding management?
- Does face to face aid confirmation of a diagnosis and therefore treatment plan (eg differentiating LRTI and heart failure)?
- Or will the face to face help to clarify the severity of the presenting problem? We actively encourage face to face within IUC for patients where admission is also being considered, to ensure that all other options have been considered. The notable exception to this would be time critical conditions (eg MI, stroke, sepsis) or immediate emergency presentation warranting 999.
- Does the triaging clinician need support to 'be courageous' in holding the management remotely?
- Some patients will be anxious and have a clear expectation/ wish for a face-to-face assessment. For children, this alone can be the main reason for arranging to see a child, even if the clinician's level of concern is much less than that of the parent/ carer. Please approve the face to face in this situation, although this may not be required for adults, particularly high intensity users or people with care plans to support their management in the OOH setting.
- Could other options for further assessment be helpful? For example, would a video consult add to the clinical information available? Could a planned follow up in, say, 2 hours be helpful or reassuring, and avoid the need for F2F? This can be useful if, for example, a patient is febrile and optimising treatment for the fever and/ or increasing fluid intake may improve the clinical picture and provide reassurance to both the patient/ carer and clinician.

Is it clear that a SevernSide appointment or home visit is needed?

What will it add to the patient's management or decisions about next steps? Might there be alternatives to support safe patient care and remote management? Is the patient more acutely/ seriously unwell warranting consideration of direct referral to 999 or hospital? Could the patient be managed remotely?

When approving face to face assessments, please ensure that you

- Follow the guidance in **the CLEO Clinical Coordinator User Guide on the Development Hub. about how to approve the face-to-face assessment**. Once the CC has approved a face-to-face request, the Workflow and Capacity Coordinators (WaCCS) will go on to phone the patient back to arrange either the appointment, or allocate the visit to the car.
- Double check the notes to know **whether the patient does or does not have symptoms which may be infectious.** For example, gastroenteritis, rashes associated with a potentially infectious cause (eg measles, slapped cheek, chicken pox), or fever where the source is not clear. Please ensure that you select the correct option in terms of which room a patient should be seen in at their appointment (isolation room, or usual consulting room).

- **Sense-check the requested timeframe** for the face to face assessment. Further information about this can be found in the time frame for appointments section on page 10. One of the most common interventions made by the CC is to downgrade timeframes from 2 to 6 hours, which materially benefits efficiency in the service and ensures that 2 hour ('urgent') capacity is preserved for people who truly need it (eg acutely distressed palliative patients).

If you think that there may be alternative or better management options

- Remember that SevernSide covers a wider geographical area so patients will often need to travel further to be seen at an appointment, particularly overnight when we have three treatment centres open. It means that patients are often very grateful to receive the right care at home. However, we can and should see patients where the face to face assessment will make a difference to the management plan and/ or the patient wants this.

- See Appendix 1 for some specific examples when there are established alternative options

- Liaise with the triaging clinician who has put the case through for the face to face, usually initially via a screen message including the offer of a conversation. See the tips provided below for more information.
    - When speaking/ liaising with the triaging clinician about a case in this situation, please be supportive in your approach and open minded to new information and the triaging clinicians' concerns. You are seeking to achieve and support a mutually agreeable plan, which may result in either the triaging clinician calling the patient back, or the face to face being approved. Another possibility is that the CC undertakes a further consultation with the patient instead.
    - It will not be possible to speak with the triaging clinician if they have finished their shift. In this situation, the CC has two options. One will be to approve the face to face as requested, or to undertake a further telephone consultation themselves. This is a judgment call, informed by many factors including the clinical scenario, overall pressure on the service, and CC workload at the time.

- If either you or the original clinician are going to call the patient back, you will need to choose the correct action from the Oversight Validation. The WaCCs can then forward the case to the clinician, Use the free text ' box to add brief free text comments to capture the agreed plan/ your clinical reasoning. Alternatively you can pick up the consultation directly from the Oversight queue.
- If the **patient appears to be more seriously unwell, and you are concerned that hospital/ ED or 999 may be required**
    - What are you concerned about? If it is unclear or would more information would be helpful? Seek to discuss the case with the triaging clinician as soon as possible to be clear about how unwell the patient is.
    - If you consider that there may be an immediate, life-threatening, time critical emergency, it is probably most time-efficient to speak directly to the patient/ carer to ascertain whether they need an ambulance or hospital care. This scenario, although relatively rare, highlights the importance of reviewing cases in the Follow Up queue promptly. If sending to hospital, please always refer to the relevant speciality rather than advising people to present to ED.

Tips for feeding back to clinicians when there may be alternatives to F2F
You will find your own style for doing this, but the emphasis is on support to triaging clinicians. It is vital that they do not feel undermined in their clinical decision making, or that they cannot book/ access face to face assessment when it is required.

Some tips from our experience:

- Make initial contact via screen message to the triaging clinician on CLEO. This is made easier if you have let clinicians know you may do this in your message to the team at the start of the shift. Include that you have reviewed the case and the case number. You may opt to include some information about the alternatives you were wondering about. It is not always clear why they think F2F is needed, so simply asking about that can be helpful.
- Always offer to have a conversation at this first contact. You can provide a direct telephone number, or ask them to ring the shift manager. In general, it is difficult to sort out plans via screen messaging, and there is scope for misunderstanding/ miscommunication. For the same reason, take care with your wording too. If the clinician is in the same building as you, do feel free to speak in person. However, if they are working elsewhere in the service do use a recorded line.
- Offer support and advice to the triaging clinician, seeking that they will take the case back if there are reasonable, and mutually agreed, alternatives to face to face. We would not anticipate that the CC would undertake the next step of the patient journey in most cases. If the triaging clinician has finished their shift or the clinical need (eg EOL prescribing) is not something that the triaging clinician is trained to do, you can manage the case yourself or consider discussing the case with another clinician and asking the ops team to reallocate the case to them.

The main part of being a CC is being supportive to colleagues if they need advice. Mostly that is a listening ear, offering a different perspective and sense-check based on 'two heads are better than one' if it is complicated/ difficult. Most CC shifts simply require a sensible, pragmatic GP head rather than additional clinical experience/ knowledge or detailed knowledge of pathways and referral options. The shift managers are brilliant with expert knowledge and experience so do link in with them if you are unsure, and use the Toolkit, Remedy and national guidance for more specific clinical information.

Time frames for appointments

Please see the full guidance about prioritisation of 2 hour and 6 hour face to face assessments (at visits and appointments). This includes the clinical criteria for face to face assessment within 2 hours/ 6 hours, guidance about your triage documentation and how to arrange the appointment/ home visit.

Principles:

- **6 hours is the default timeframe** for all appointments and home visits triaged by IUC clinicians. It is clinically appropriate for the vast majority of patients requiring face to face assessment following triage in IUC to be seen within 6 hours. Please ensure that the case prioritisation is set to 6 hours when forwarding cases.
- This guidance complements the home visit policy, which defines patients who are eligible for home visits and those who are not.
- A home visit or appointment within 2 hours (urgent), is *only* appropriate if the patient is:
    - **Either** rapidly deteriorating
    - **And/ or** acutely/ significantly distressed

  - **Or** there is other pressing, urgent clinical need
  - **And** an emergency/ 999 response is not required (IUC is not an emergency service, so emergency appointments or visits are never appropriate)
- This will ensure that 2-hour appointment and visiting capacity is reserved for patients who truly require this, and therefore improves patient care and safety in the service.
- You can see the urgency the clinician has suggested for the face-to-face review in the case questions tab. If they have selected 2 hours and you feel 6 hours is appropriate, you may (but not always needed) wish to discuss this with the clinician. You may want to signal to the operational team you are looking for a "sooner end of routine" appointment as opposed to an urgent appointment.

Face to face appointments and the isolation room

The triaging clinician will specify whether the patient needs to be seen in the isolation room or a usual consulting room when forwarding a case for an appointment. You can find this information in the Classification column of the Oversight queue. Anyone with symptoms which may be infectious to others should be seen in the Isolation room. Examples include diarrhoea, vomiting, fever where the source is not known, rashes which may be infectious in origin (eg Parvo virus, Strep, chicken pox, possible measles). Occasionally triaging colleagues select the wrong room; you can override this by signalling what room you want them to be seen in. If this happens, please feed this back to colleagues via a screen message. If you think the patient might have a High Consequence Infectious Disease (HCID) please flag this to the operational team.

Clinician Scope of Practice

Please consider whether any of the following may be required during a face-to-face consultation and flag to the operational team. They can then make sure the patient is seen by a clinician with the appropriate skill set:

- Catheters
- Intimate examination
- Babies less than 12 weeks

Managing the Follow Up Queue

The other work you will do as a CC is picking up cases from the CAS queue with a Follow Up sub service. Cases in this queue will often be labelled to say when action is required. If this is not the case, you can enter the case to review what is required and then exit the record to add a 'Comfort call' note. To do this, right click on the case on the queue and select 'Add comfort call' from the drop-down menu. Any text you add to the first line in the box will be visible on the queue. Adding, for example "***SAT PM call back to review blood results***" makes it much easier to know which cases need picking up when.

Examples of Follow up cases include

- Following up results of bloods taken during previous face to face assessment in the service. These are easiest to review on Connecting Care, selecting 'Laboratory results' in the left hand menu. It can take a while to load. Sometimes you may need to ask

operational colleagues to phone the lab to obtain the results you need. If so, be specific about what you need eg Potassium, egfr rather than 'UE'
- Patient review after a period of watchful waiting and/ or trial of treatment
- Tricky situations. Examples might include failed contacts where the previous clinician has concerns about the patient being vulnerable or there are patient safety concerns. Usually, clinicians will call to speak with about cases like this before passing them across to the Follow Up queue.
- EPS. Make sure you agree with the decision that has been made, including sense checking eGFR, drug allergies, interactions and whether the patient is pregnant. The triage notes should include details of where to send the EPS. If there has been a delay between the case being passed through for the EPS and the script being issued, check that the pharmacy is still open, particularly if the script is needed on the same day. Once the EPS is sent, it is good practice to text the patient to confirm this and send the EPS code so they can use this to collect from another pharmacy if required.

If a case in this queue looks particularly complex or is likely to be very time consuming you might like to discuss with the shift manager delegating this to an experienced colleague on shift in order to be available to manage to Oversight queue and support colleagues that contact you.

Links with the clinical navigator role

When the advice queue is long, the Shift Manager may ask the CC to support 'navigation' of cases in the Advice queue. This involves reviewing cases to alert the shift manager about patients who need to be prioritised for a clinician to call them back (eg worrying or worsening symptoms, red flag symptoms, symptomatic palliative patients). The shift manager will put priority call tags on these cases.

Consulting patients on the IUC CAS queue

If the Oversight and Follow Up queues are relatively calm you may have capacity to take a case from the main advice queue. We recommend going for more straightforward cases. It is really tricky if you get bogged down in a long complex case as CC (recognising that some of the Follow Up cases may fall into this category). If the Follow Up queue is particularly busy, the shift manager may be able to identify another clinician to support/ work on it alongside the CC.

Supervising GP trainees

It is not a requirement for CCs to be approved Clinical Supervisors, but the supportive nature of trainee supervision is a very overlapping skill set with the wider CC role. We therefore encourage CCs to complete the supervisor training, not least because working alongside GP trainees can be very rewarding. It is unusual for GP trainees to book into CC shifts and if they do, we ask they are familiar with the IT and have a reasonable amount of clinical experience. This means they can potentially contribute to the CC workload or work on the Advice queue as they would on any other OOH shift. The CC may supervise an experienced trainee remotely if they are deemed competent for this, or provide near supervision if they are co-located.

Supporting new clinician induction/ first shifts

Clinical coordinators provide invaluable support for new clinicians starting their first shifts in the service. The SevernSide Training and Support Coordinators provide an overview of the service including logins, IT familiarisation and information about processes. After this, new clinicians do clinical work and proactive contact from the CC is very important in helping new starters to feel welcome and supported. Please reach out to new starters to say hello and welcome to the service, and invite them to reach out to you if they need anything. Prospective SevernSide clinicians may also join the CC to see what happens in the service.

Service changes and improvements

These are part and parcel of always striving to optimise the patient care provided by SevernSide and colleagues' experience when working in the service. The Clinical Coordinators are key in providing clinical leadership on shift, which includes supporting change and improvement. The CCs will, in turn, be supported by the Lead GPs and Deputy Medical Director to enable this.

Weekday daytime Clinical Coordinator work

During these hours, the clinical team manages a different but overlapping cohort of patients compared to the OOH period. The daytime case mix includes:

- The System Clinical Assessment Service (CAS) team manages cases which would otherwise be referred to a category 3/ 4 ambulance or to ED without further clinical input. The System CAS team includes ED, paediatric, General Practice, SevernSide colleagues.
- The Integrated Access Partnership (IAP) mental health team work alongside the System CAS team and the CC has a particular role in supporting and managing any physical health concerns and/ or prescribing needs in partnership with mental health colleagues.
- The SevernSide Weekday Professional Line (WDPL) supports community healthcare professionals seeking adult medical admission for patients. The WDPL team enable the most appropriate hospital pathway when hospital attendance/ admission is required, and support alternatives to admission wherever possible.
- '24 hour' CAS cases which flow through from NHS111 to the BrisDoc end of SevernSide 24/7. These cases currently include 'toxic ingestions', indeterminate outcomes from Pathways for people aged 85 and over or 2 and under, plus Health Information cases.
- Frailty ACE (F-ACE) takes calls from paramedics who are on scene with frail patients and would otherwise convey them to hospital. The team supports management in the community where safe and appropriate to do so. The F-ACE team includes GPs, nurses, social care, Sirona and a geriatrician of the day.
- Paediatric ACE (P-ACE) is an acute advice line for community healthcare professionals staffed by senior paediatricians which aims to provide care to children who are aged 15 years and under, giving the right care at the right place and the right time.

All of the same principles apply to those covered for OOH clinical coordinator work, in terms of key priorities relating to supporting colleagues in the above teams, clinical decision making and risk holding. However, there is no face-to-face service during the weekdays, so face-to-face

requests will not be part of the daytime CC workload. Similarly, there will likely be only a small number of cases requiring a consult and hold approach during these hours. Key elements of the weekday CC role will therefore be:

- **Supporting clinician decision making, risk holding and community management** wherever possible. This may include encouraging and enabling consult and hold approaches to management, prescribing for non-prescriber colleagues and potentially facilitating alternatives to admission if more time/ further phone calls are required to achieve this.
- To **ensure that our mental health colleagues have timely access to physical health expertise, advice and support**. This may involve assessing a patient who the mental health team have received from NHS111, but where they have concerns about physical health symptoms. Similarly, the mental health team may seek prescribing support for mental health patients. Generally, this will be a short-term supply of anxiolytic or sleep medications as an interim until the patient can access their own GP or face-to-face mental health follow up is undertaken. Examples may include a short course of diazepam, zopiclone or antihistamine or potentially restarting a usual medication if the patient has run out. All usual SevernSide guidance applies in terms of quantities issued. The CC should ensure the current level of risk has been considered when determining what drugs and the quantities to be prescribed. Mental health colleagues have full access to all mental health records and care plans for patients known to them and this can be invaluable in supporting the care of patients being managed by other clinicians in the System CAS or WDPL. Cases can also be passed from these teams to our Mental Health colleagues.
- **Supporting decision making, together with the Shift manager, about flow of ED/ 999 cases into the System CAS, and consulting ED/ 999 cases**. We ask that the CC is proactive in their approach to turning on ED/ 999 flow from NHS111 to ensure that all System CAS clinicians are fully occupied. It is likely that the CC themselves will likely spend a large proportion of their shift consulting with System CAS (ED/ 999) patients, to ensure that they are fully occupied throughout. The CC's capacity should therefore be factored into decision making about flow of cases into the service. The CC role is in large part funded by the System CAS so System CAS work should be prioritised ahead of WDPL cases (see below).
- A key priority for the WDPL team is to achieve 'warm transfer' of cases from the call hander to the WDPL clinician, in order to maximise the opportunities admission avoidance. If there are flurries of activity in the WDPL such that some cases would otherwise need a call back, the **CC can pick up WDPL cases** to support medical admission and alternatives to admission.

Key SOPs and Policies relevant to the Clinical Coordinator role

All clinically relevant IUC SOPs and policies are visible on Radar. The home visit policy, the failed contact SOP and guidance about the timeframes for face to face assessments are particularly relevant to CC shifts.

IT systems and Access

All IUC clinicians have read-only functions on EMIS (providing full visibility of patients' practice records, Sirona's community records and St Peters Hospice records). In addition to this, Clinical

Coordinators will likely use the following systems more frequently

BrisDoc Weblinks

BrisDoc Weblinks provides quick links to most online resources you may need to access during your shifts. This includes the Clinical Toolkit, Remedy, nhs.net mail, and ICE, as well as the Learning events and IT support form portals.

Connecting Care (via EMIS)

Connecting Care can provide invaluable additional/ complementary information, including

- Lab reports (including previous hospital investigations and those which are not yet visible on EMIS)
- Recent discharge letters which may not be visible on EMIS
- Real time information about whether the patient has presented to/ been admitted at any of the three hospitals

To access Connecting Care, enter the patient's EMIS record, and then select the Connecting Link which is about half way down the screen in the left menu bar. If this link does not work for you, please complete an IT Support Form to request that your access is (re)activated. Please note that accounts are inactivated if they are not used regularly.

ICE (accessed via Weblinks, must use Edge as the browser)

ICE provides web-based access to pathology results. Results are usually visible here before they are available on EMIS. Clinicians have to submit a request for ICE access to NBT, by emailing from your nhs.net email account to servicedeskplus@nbt.nhs.uk. NBT will send the Clinician a form to be filled out and returned back to them.

Ongoing support and development for CCs

The CC role is unique and interesting and provides variety compared to purely patient facing clinical sessions. It's a great opportunity to interact with colleagues both operational and clinical, on shift.

Being a CC means you will have a much broader sense of the service. We are wholly committed to learning and improvement, so please proactively log any learning events you come across via the learning event portal on weblinks. As always, employed GPs should contact their line managers if they would like to debrief about a complex or challenging case.

IUC Clinical Forums are a valuable opportunity for professional development, reflection and informal peer support. Interesting and tricky cases are discussed between clinicians in a supportive environment. Each year we run CC-specific Clinical Forums and all colleagues are welcome to join these sessions, both as part of CPD but also contributing ideas to shape future improvements.

And finally

Please contact Becky Cooke, Deputy Medical Director or any of the Lead GPs with any queries, or feedback about CC shifts.

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Thank you for all your hard work for SevernSide.

Appendix 1

Specific IUC OOH scenarios where patients can be managed remotely without face to face

1. **Expected deaths**

Verification can be completed by any qualified person who is competent and with the patient under new legislation

Are community nursing teams already involved and likely to be attending to eg remove the syringe driver? If so, consider asking them to undertake the verification at the same visit.

2. **Could the case be managed with a video consultation?**
   This is useful for building rapport with the patient/ family/ carer, but has a particular value in providing additional visual information, for example assessing work of breathing in a child. Video consulting information is on the toolkit (search "video").

3. **Could photos aid the clinical management?**
   Photos can provide invaluable additional clinical information to aid diagnosis and/ or reassurance. This can be particularly helpful for visible symptoms such as rashes. Again, information is available on the toolkit.

4. **End of life drug charts, and community authorisation charts**
   End of life discussions can be undertaken remotely, with the patient, carers and/ or family. EOL drug charts can also be completed electronically and emailed, as can community authorisation charts (eg for enemas). Again, full information is available on the toolkit.

5. **Appointments for medications to be dispensed at base.**
   Stock medications should be issued only if the patient's clinical need means they cannot wait until pharmacies reopen. If the patient can wait, the script should be sent via EPS. Requests for medications to be dispensed need to be managed as an appointment. Full information about what drugs are stocked at the Treatment Centres (and in the visiting cars) is available on the Toolkit.

6. **Requests for a visit to deliver (eg a chart or medications)**
   Clarify that there are no other options for the patient or their carer/ family to attend to collect from base. If not, you can liaise with the shift manager to see if a driver may attend without the clinician to make the delivery. A driver can deliver non-controlled medications which have been dispensed and labelled by the Treatment Centre clinician. All controlled drugs must be dispensed and delivered by a clinician so cannot be delivered by a driver alone.

7. **Cases passed to the Oversight queue for EPS to be sent**
   This can happen in error, when the clinician had intended to pass it to the Follow Up

queue You can pick the case up yourself to issue the script, or alert the shift manager/ pharmacist to ensure it is actioned. Do screen message the triaging clinician, so they are aware of the correct queue for next time.

Version Control

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2017	1.0	M Taylor	Document created
Jan 2023	1.2	A Whitehouse/ L Whyte	
March 2025		L Whyte/ J Edwards	
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