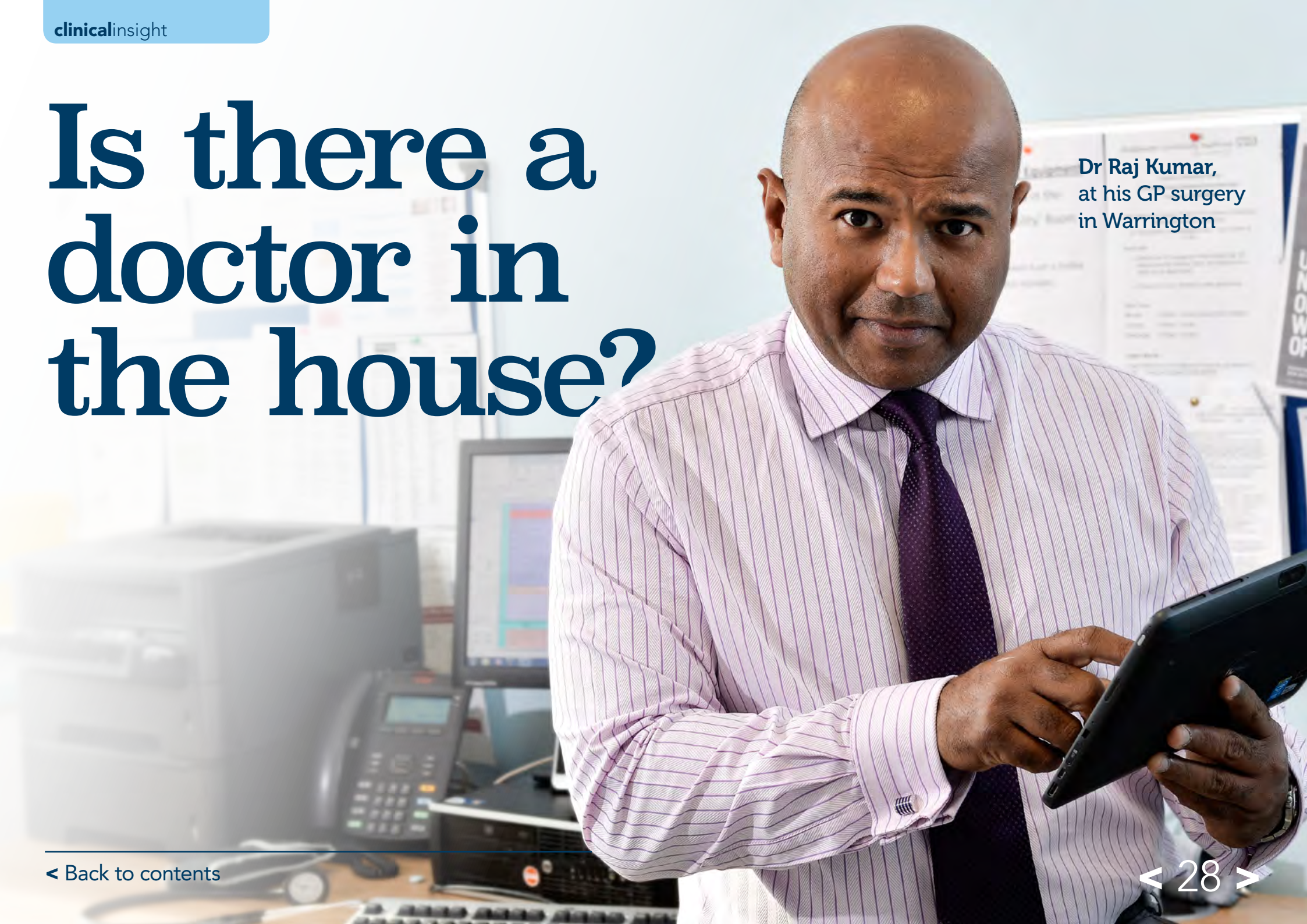
Is there a doctor in the house?



Dr Raj Kumar, at his GP surgery in Warrington

< Back to contents

Dr Raj Kumar is one of HSCIC's Clinical Leads working within the Professional Leadership Group. Since 2003, Raj has consistently maintained a part-time national role as a senior clinical advisor, through the NHS Modernisation Agency, NHS Connecting for Health, the Department of Health and now the HSCIC.

Nevertheless, Raj's main passion in his professional career remains that of his role as a hands-on frontline GP at his own practice in Warrington, Cheshire. He has a 32-strong team of family doctors, nurse clinicians, practice nurses and A&C staff across two sites.

The practice has won several national awards and has been acknowledged for pioneering frontline innovation in clinical informatics and clinical care-related transformational change.

The work undertaken at the practice has supported many a model of alternative care delivery locally, regionally and nationally.

Understanding the front line and how programmes support the front line is crucial for colleagues across HSCIC. In his opinion, there is no clearer description of the front line in health and social care than the interface he comes across in General Practice.

The front line accounts for 11% of the overall NHS budget, and yet provides over 90% of patient contacts, proving to be one of the most cost-effective models of healthcare delivery for the public purse besides being the envy of the world.

There is an evolving crisis with multiple resourcing, recruitment and increasing workload challenges. However, despite this, Raj explains that there is no other fulfilling role or place he would rather be.

The front line accounts for 11% of the overall NHS budget, and yet provides over 90% of patient contacts, proving to be one of the most cost-effective models of healthcare delivery

The practice team at Dr Kumar's surgery

Continues >

A day on the frontline

Raj takes colleagues on a snapshot journey of the General Practice frontline, and also touches on commissioning and provider developments. To place the informatics agenda into context he has highlighted the HSCIC enabling tools that he uses.

06:00

Alarm kick starts the day/ coffee / 20 mins on treadmill

07:00

In home office, working on an email on **NHSmail** as a response to the Practice Manager. Manage to kiss the girls (3 & 7) goodbye, who are leaving for school.

07:30

Set off to Surgery

08:00

Catch up with Assistant Manager and senior team on a possible patient complaint. Also discuss appointment schedule and availability for the rest of the week. We offer assured routine appointments within two working days and urgent appointments on the same day, opening 8am to 8pm on weekdays and Saturday mornings.

08:25

Log onto **TPP SystmOne GP system using my NHS smartcard.** There is a **GPSoC** meeting due soon to review the provider where we have the choice of renewing or changing provider. Begin to review blood results which arrive directly from the local hospital through Anglia **ICE** which links the pathology/radiology requesting and reporting interfaces.

08:30

Receive call from Coroner's office about a patient's death. Reviewed notes on **TPP** system then telephoned family to offer condolences and explore circumstances of death. Contacted Coroner thereafter and I declined to issue a Certificate as death unex-pected and requested a Coroner's post mortem.

A busy day in the surgery for Raj

09:00

Patients begin logging in on **Self Check-in Screens.** Screen colours change in a psychedelic manner as patients arrive and register at reception for their appointments. I prefer walking down the corridor to call my patients - makes it more personal and welcoming, and provides an excuse to clock up extra steps walked. Besides it helps me touch base with the two other GPs and nurse clinician and practice nurses who were seeing patients that morning. There is a flatscreen TV in the patients' waiting area to support patient education.

09:00 to 12:30

The morning consists of 16 pre-booked patients, two urgent/emergency

Continues >

patients and three telephone consultations. Multiple prescriptions were issued using the **Electronic Prescriptions Service (EPS),** three sick (or 'fit') notes were issued using the new eMed3 electronic forms, two patients were referred to secondary care using the **Electronic Referrals Service (eRS).** This process is now commissioned and undertaken indirectly through a new call centre, called a local referral gateway system.

Of the two 'urgent' appointments, the first patient required emergency admission to hospital and the second was reviewed for further investigations after being in A&E late last night. A&E teams would have accessed the Summary Care Record (SCR) of this patient during their assessment. I arranged a Spirometry, repeat ECG and a 24-hour BP assessment for the patient all of which is undertaken by our practice healthcare assistants. We are fortunate that we have a skill-mixed team that delivers most investigations in-house including a consultant-led community ultrasound scan service that can offer same day urgent appointments and a two-week assured scan service. The ability to perform all of these investigations in-house allows us to assess and manage our patients better in the community and although it increases our workloads significantly and requires us to maintain enhanced clinical skills, it does keep more patients away from hospitals.

12:30

Set off on a home visit to a housebound patient who has recently moved to our practice. He has a two-week urgent cancer referral to the respiratory team. Following x-rays and a bronchoscopy, a suspected malignancy discovered. This lesion has been bi-opsied and the histopathology report unfortunately confirmed cancer.

Before his referral, I had sight of the patient's previous surgery's notes received through **GP2GP.** In the past, we might have waited 16 weeks for his paper notes, after which they would need to be summarized and coded. I accessed further details on the patient during the home visit when the family queried the consultant's diagnosis letter using my **mobile tablet.**

13:15

GP practice mortality meeting. A list of patients who passed away in the second quarter of this year were discussed in detail using their TPP notes. Access to each patient's notes immediately flags up a privacy alert to our practice's **Caldicott Guardian** as they are notes on deceased patients.

These meetings are a weekly opportunity to catch up formally with the entire clinical and senior administration team. Team working and effective team communication is absolute-ly crucial to delivering a joined up seamless service across the practice together with partner agencies. Other weekly meetings include reviews around medicines management, referrals, clinical governance, complaints and risks. Effective communication is electronic and face-to-face is key to delivering a successful service. Though the practice is spread across two sites a mile apart, we use instant screen messaging, TPP task lists and NHSmail in addition to

Continues >

face-to-face meetings to ensure we are joined up as a single team.

14:30

I have an opportunity to catch up with the Practice Business Manager and Lead Nurse to prepare for our local areas **GP Provider Federation/ cluster** meeting at 15:00. Our Nurse Lead heads up a team of three nurse clinicians, two practice nurses and HCAs. In our practice we have evolved into delivering a skill-mixed service, well-balanced between GP and nursing teams, both groups supporting each other in a seamless integrated way. She is due to submit a report on a very successful enhanced care home services that she leads for our cluster.

15:00

Our GP provider meeting. As I am due to take over as next Chair later this year, I felt that it was important to get a grip of the current developments. The main areas of discussion related to updates from the programme leads on current change projects. Current blockers to progress appear to be **IT access from remote sites and consent issues,** the general dearth of GPs, **data sharing** issues and **conflicts of interest** issues. Our practice's lead nurse presented on the nursing home integrated care service.

> Our Nurse Lead heads up a team of three nurse clinicians, two practice nurses and HCAs. In our practice we have evolved into delivering a skill-mixed service, well-balanced between GP and nursing teams, both groups supporting each other in a seamless integrated way

17:30

Return back to Surgery to catch up on the rest of my 'duty doctor' responsibilities including my patient-related NHSmail messages and tasks on TPP, scanned on paper-work (outpatient/ secondary care letters) through the **electronic document management tool** on **TPP,** remnant duty doctor queries - 112 repeat prescription on TPP/ EPS, remnant blood results through **ICE** on **TPP**. Just when I thought I was done, I noticed a telephone appointment was still on my list.

19:30

Phoned the patient. He was difficult to understand since he had a speech impediment from a mild stroke. I left the Surgery to visit him and found that he had an evolving chest infection. I used my **TPP mobile** device to access his notes and left an urgent script through **EPS** to his local chemist to be delivered in the morning and also **TPP messaged** the district nurses to visit to take bloods. I requested blood tests and a Chest X Ray on the hospital system through **ICE**.

20:40

Arrive home. Girls already asleep - remind myself to get home earlier for the rest of the week or risk not being recognized at all by my offspring!

21:00

Late dinner with my wife, who has had a busy day herself (she is a consultant Dermatologist at Salford). We make a point of NOT discussing work and instead catch up on the weekend and upcoming family half term holidays.

22:00

News at 10 – usually my only link on weekdays with the wider world.

22:40

Start working on some of my HSCIC emails through **NHSmail** that I left "un-read" and caught up on documentation in relation to the GMC and revalidation.

00:00

My day closes and I look forward to travelling to Leeds at 8 am tomorrow for my HSCIC role. Tomorrow is a different day and brings forth other experiences and challenges. I look forward to it as it breaks up the practice week in a refreshing manner. A healthy dose of optimism and a positive outlook and agreed balance between work and family is key.

Continues >

HSCIC programmes and their positive contribution to my working day

As detailed in bold on the previous pages, almost all activities that I have encountered during the day have been supported or facilitated through current programmes that are supported through HSCIC and partner organisations - including GPSoC enabled TPP systems, GP2GP, errs, Anglia ICE enabled TPP access to hospital pathology/PACS systems, EPS-enabled prescribing, SCR, mobile devices supported working, and secure NHSmail-enabled access and communication on patient issues.

It is reassuring to know that despite the negative publicity about the past IT programme, it has certainly enabled my working life in an incredibly positive manner. Unfortunately, the frontline NHS has a very poor understanding of the HSCIC in its new expanded data re-pository and provider role. Targeted and appropriate communications in this area will be incredibly useful.

Continues >

Clinical Commissioning Groups - origins and my perspective

Clinically led commissioning was mooted in the early days of World Class Commissioning under Mark Britnell (I worked as Associate Medical Director to him) over 9 years ago. The thinking behind this was that GPs and clinicians are better placed to determine the needs of the local population.

As part of this process, there was a stage where there was significant acceleration of the rollout process that saw hundreds of senior chief executives/ directors and very experienced managers being made redundant and brought out a new cohort of evolving GP leaders supported in many areas by junior and middle level remnant managers, often taking responsibility for a devolved local budget of hundreds of millions of pounds for local areas.

In my area, the Clinical Commissioning Group has successfully managed this transition and we have representation through our locality commissioning federation, of which I am a member and Chair from November. We have a representative who sits on the main CCG governing body and represents our federated Locality Commissioning Groups on commissioning services.

The future of CCGs and their responsibilities is set to change yet again, amidst an evolving appetite for integrated care vanguards who may receive total commissioning budgets and devolved integrated health and social care bodies taking over from CCGs from 2020. With continually shrinking NHS England central commissioning power, understanding and engaging CCGs directly in a robust and meaningful manner would further support and shape the direction for organisational change and the future sustainability of the HSCIC.

GP Clusters/ Federated Provider Models - the new "Vanguards"?

In my area, all of the GPs have joined together to create a community interest provider company - called Warrington Health Plus. This organisation was fuelled through the Prime Minister's recent Challenge Fund and is attempting to deal with restructuring pa-tient care around the GP practice once again as it used to be in the past.

Our GP Provider Federation is now supporting the rollout of seven days a week access to GP care along with other innovations such as nursing home medical care projects, community cardiology clinics, seven-day GP access and paediatric nurse specialists

As CCGs, by statute, only commission services and do not offer service provision, this provider model is being promoted to deal with the inadequacies of the existing, often fragmented, system in terms of offering cost-effective, joined-up care models with alternative pathways of care,

Our GP Provider Federation is now supporting the rollout of seven days a week access to GP care along with other innovations such as nursing home medical care projects, community cardiology clinics, seven-day GP access and paediatric nurse specialists - again all based around GP practice clusters.

Representing my practice at the cluster provider group, I can see how this group and the model being promoted will take forward projects that include integrated care delivery through 'Vanguard' type schemes.

As these are the 'doing and sharing information' teams, these federated groups and vanguards should equally be targeted at local and regional levels by HSCIC for current programmes, and as commissioners of future projects.

Dr Raj Kumar can be contacted through his NHS PA on **catherine.whyte@nhs.net** and through the HSCIC through the Clinical Directorate PA: **deborah.hainsworth@hscic.gov.uk**