UCLPartners

Example Standard Operating Procedure

Example Standard Operating Procedure (SOP)

Purpose

The purpose of this Standard Operating Procedure (SOP) is to:

- Describe the operational process to run a non face-to-face (NF2F) COPD clinic pilot between the partner organisations
- Outline the Information Governance, accountability and responsibility considerations of the pilot

Background

Local primary and secondary care data reveal that care co-ordination in the management of patients with COPD could be improved. Working towards an integrated approach for these patients could have beneficial impacts on patient outcomes, patient experience, clinician engagement and secondary care use. The partner organisations have agreed to pilot a non face-to-face (NF2F) clinic model to manage a cohort of respiratory patients.

Objectives

- To test the non face-to-face (NF2F) COPD model within the locality
- To evaluate the impact of non face-to-face (NF2F) models on patient experience and outcomes, clinician experience, primary and secondary care measures (e.g. impact on prescribing budgets; secondary care attendance; emergency admissions)
- To evaluate the effectiveness of the non face-to-face (NF2F) model

Definitions

Non-face-to-face clinics: clinical interactions in health care that do not involve the patient and clinician being in the same room at the same time. These can either be synchronous (patient / clinician interact in real time) or asynchronous (interactions occur at different times).

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Procedure

This pilot will test non face-to-face (NF2F) models in three groups of patients with COPD:

1. Stable patients currently being seen by the secondary care respiratory team.
2. New patients who are frequent attenders to primary care and A&E/Urgent Care Centres due to repeated exacerbations of their COPD.
3. New patients due to be referred to the secondary care respiratory team

   (*patients in group 2 and 3 would be unknown to the secondary care respiratory team prior to referral).
4. These patients will be selected and agreed upon by both the local acute NHS trust and GP practice.

- Both verbal information and a patient information leaflet will be provided to the patient outlining the change in their management, or referral as a new patient, to a non face-to-face (NF2F) model.
- Patient consent sought and documented through SystmOne.
- Patients managed through non face-to-face (NF2F) clinic. Patients are first and foremost managed with this integrated model in primary care. The GP has access to the respiratory physician through an agreed communication channel for any specific queries regarding the patient's COPD management.
- Respiratory physicians have access to SystmOne and can access patient GP records including investigations, management and treatment. There must be an agreed process for communication between the GP and respiratory physician when investigations require review by the respiratory physician.
- Communication channels with the patients managed through the non face-to-face (NF2F) clinics should be considered. Patients with stable, well managed COPD, can be communicated with via digital channels (SMS / emails) or letter. This should highlight that both GP and respiratory physician are happy with their condition. Patients with less well managed COPD that require more input, may require an urgent non face-to-face (NF2F) review, phone call, face-to-face visit with the GP or face-to-face visit with the respiratory physician. These communication and management methods can be escalated as required.

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- The first prescription is issued by secondary care and repeats requested via primary care. There will need to be an agreement devised for counselling on patient's started on new medications. Testing of this process and the development of an SOP will be considered to ensure there is clarity regarding the responsibility of primary and secondary care.
- Prescriptions budgets to be agreed.
- Agree outcomes to be captured to support evaluation of the pilot through PDSA (Plan, do, study, act) cycle.

During the pilot phase a total of twelve patients will be managed in the non face-to-face (NF2F) clinic:

- Patient group 1: 3 patients
- Patient group 2: 3 patients
- Patient group 3: 3 patients

Accountability

To be agreed and formally documented

Option one: The acute trust will be solely accountable and responsible for the management of patients through the non face-to-face (NF2F) model. This includes patient management or treatment, ordering investigations, following up on investigation results and communicating with patients.

Option two: The accountability for patient management will be shared between the acute trust and GP practice.

Secondary care will be responsible and accountable where primary care requires the advice and input of respiratory physicians. This includes where secondary care is advising on patient management or treatment, advising on ordering investigations or following up on investigation results. Primary care will then be responsible for communicating this to their patients.

Accountability and responsibility should be clearly agreed and formally documented between both the acute trust and GP practice.

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IT

SystmOne is fully accessible (read and write functions) in both primary and secondary care. This enables the non face-to-face (NF2F) pilot to use a system that both the acute trust and GP practice can communicate through to facilitate patient management. Respiratory physicians delivering the non face-to-face (NF2F) clinics will require a smart card and the correct access rights to be able to access SystmOne.

Interoperability between SystmOne and EPR requires further consideration to ensure SystmOne non face-to-face (NF2F) clinic entries are shared with EPR

Information Governance

Much of the IG work and considerations have been undertaken in the locality for the shared care records. Consequently, for the purpose of the non face-to-face (NF2F) pilot, the main consideration is patient consent. Patients will be required to consent to sharing their records with the acute trust. This consent can be documented in SystmOne. Once consent has been provided and documented, under GDPR rules, patient records will be available for Respiratory physicians running the non face-to-face (NF2F) clinics to access the patient records.

The following will require local agreement

- Prescribing budgets and funding from primary care or secondary care
- Accountability model to be agreed and formally documented