GP Study Day Communication! Communication! Communication!

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Hospital communication to GP practices

- Emergency Department letters
- ICE discharge summaries
- OP letters
- CDS/emails/telephone
- ED GP advice line
- Other specialities?
- Choose and book (grrrrrr)
- Specific child protection issues?

Your feedback required

What can/should we do better?

 How do we make the patient journey and our ability to 'follow' it both efficient and seamless

Reminder to self: communication involves more than one person (usually)

Certain frustrations

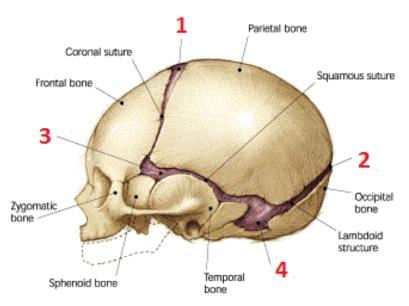
- Penicillin V prescribing
- Difficulty to talk to you (lunchtimes!)
- Duplication of information
- Streamlining and standardising the advice
- Allowing ourselves not to lose the ability to be doctors

GPSI patient

- Seen in Yate, oddly shaped head, organised CT head, referred to neurosurgery. All happened within a month. No hospital attendance other than for CT until the OP with neurosurgeon
- All important and needing sorting, family gave hospital secretary a really hard time!

PS – do you all use the GPSI service – promote development?

Baby with lump







• Tell the story

Dermoid info

Head and neck

- Cutaneous cysts most commonly occur on the head (forehead), mainly around the eyes. Occasionally, they occur on the neck or in a midline region. When on the head, dermoid cysts are often adherent to the periosteum. The usual diameter of the lesions is 1-4 cm.
- In one study, 25 benign tumors on the forehead and brow of children and adolescents were successfully removed by means of endoscopic excision. Of these, 6 were classified as dermoid cysts. Dermoid cysts on the forehead and brow are known to cause pressure-related erosion of the underlying bony tissue, and surgical intervention may be helpful.

Cancer two week 'wait'

NHS B&NES & Wiltshire Two Week Wait Referral Process

August 2010 (revised Mar 11)

Guidance for children with suspected cancer in accordance with NICE 2005

Please DO NOT refer children with suspected cancer by the twoweek wait process. Please ring the RUH switchboard on 01225-428331and ask to speak to the on-call paediatric registrar or on-call paediatric consultant for same day assessment.

applicable entries in preparation for your discussion with the children's team at the RUH.	
SUSPECTED DIAGNOSIS:	CLINICAL EXAMINATION:
[] Leukaemia	[] Lymphadenopathy
[] Brain tumour	[] Soft tissue mass
[] Lymphoma	[] Fever
[] Neuroblastoma	[] Abdominal mass
[] Wilms' tumour	[] Hepatomegaly

CLINICAL INFORMATION: You might find it beneficial to look at the following and tick all

Reg's local info

Update from Dr Bragonier:

Local analysis of 5 years to end of 2013 completed. National figure have dropped from 1% detection to 0.5% detection. Local figures – 200 seen in 2013 and none diagnosed with cancer.

See handout

What we need to do

Act upon this

Validate a better system

Suggest National Implementation

next: did not attend OP

APPENDIX A: Management of Outpatient DNA flowchart

Note: This flowchart should be printed separately, laminated and displayed in all clinical areas where children and young people attend outpatient clinics.

Pending List 3 appts offered and not accepted

CHILD DNA appointment Including ward or investigation non-attendance Cancelled appointment

Significant health risk or child protection concern/child in need issue identified

Contact CP advice

Ensure Child's
Health needs are
met. Follow Trust
CP policy/South
West Child
Protection
Procedures. (Refer
to Children's and
Young People's
Services, CYPS, for
Assessment)

OPD Admin staff check patient details to confirm that the contact details are correct; highlight any electronic Safeguarding Information Alerts, print Medway information detailing other professionals involved with child, other DNA's and pass info for clinician to review

Amber 1: Child should be seen by a specialist or requires specialist followup, e.g. cardiac, fractures, diabetic. i.e. hospital input required

Moderate Health risk (should be seen in secondary/tertiary care): Letter sent by Clinical lead/ Consultant/AHP to patient/ family and Primary Healthcare Team (PHT) emphasising importance of attending. Include date/time of next appt. Ask PHT to check contact details agree with SCR/Medway. Ensure child attends and/or health needs are met by liaison with family and PHT and involve CYPS if necessary.

Continued DNAs or on-going concern Amber 2: Child should be seen by a clinical person to establish on-going health needs and ensure overall well-being

Minor health risk: Clinical Lead/ Consultant/AHP writes letter to patient/family with a copy to Primary Healthcare Team stating:

'We are concerned about the health of your child because ---Our records show that you have been unable to attend ----- (give details). Please make an appointment with your GP to have your child reviewed.......'

Copy of letter to GP and Health Visitor or School Nurse asking again to check contact details. Indicate that GP should contact the family to discuss future Appears to be non-concerning, may have settled, can be discharged

Clinical lead/
Consultant to
write to family /
Primary
Healthcare Team
informing them of
DNA, and that No
further hospital
appointment will
be sent unless
specific request
from Healthcare
Professional

If there are additional concerns in the primary care setting, the PHT can involve CYPS re concern of failure to meet child's health needs – liaison between hospital and primary care, school and CYPS may be needed

Did Not Attend (ED: DNW)

- Why is it important?
- Pattern recognised in serious case reviews following child death – not just in the CP arena!

- Importance of communication
- How is it for you?

Child Death (unexpected)

- Awareness
- Age?
- What is GP role?

Can you give examples?

What is unexpected death in a life-limiting illness?

Child Death

Bereavement issues SUDI

Society and Expectation Overlying

Multinational society Co-sleeping

False reassurance
 Sepsis

Raised ICP

Trauma

Congen/Met

Confusion in multiple processes

Child death process

Mary Gainsborough

Vicky Sleap

Rapid response to all

- Local CDR all professionals involved
- RCA/SCR hospital based
- Coroner Inquest adversarial
- CDOP Child Death Overview Panel

Child Death Bereavement

Lullaby Trust, largely for babies
child death review guide
Bereavement support leaflet
Child death helpline
email address and website
discussion forum

Process information from UHBristol

Bereavement for families - Need to be proactive? PTSD and trauma/ resuscitation events

Families present at resuscitation?



We are Winston's Wish

Support

Families

- Understanding grief

 - * How men and women grieve
 - Supporting bereaved friends and family
- Helping children and young people deal with death
 - * When your partner dies
 - After a death
 - When someone is not expected to live
 - School
 - Children and funerals
- Death of a child
 - >> Post mortem examination

Helping children and young people deal with death





Questions?

Importance of allowing ourselves to be doctors

Decisions do not always have to be immediate

- History and Examination and discussion
- Advice is available (and will not always be right!)

Educated research – we have a yardstick to gauge medical conditions by – our experience fills in the scale.

Communication! Communication! Communication!

The exchange of thoughts, messages, or information, as by speech, signals, writing, or behaviour.

Biology: The transfer of information from one molecule, cell, or organism to another, as by chemical or electrical signals or by behaviours.

Anatomy: An opening or connecting passage between two structures.

courtesy of 'the free dictionary', with English spelling