RTC 'Sharing Practice' Day – 9th February 2011

Notes from Shared Care Document Break Out Session

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A very brief history and overview was done at the group introduction. The group in the breakout session discussed the achievements, problems and barriers of the shared care form. The group then went on to brainstorm how to move on in the London Region. Points of the discussion are as below, followed by a recommendation for London RTC to take forward.

Existing Shared Care Form

This is working in some hospitals and settings. This should be maintained and continually supported to avoid any good working being repeated or discarded.

Lab issues with the form

They are not informed from the clinical area
Difficulty in finding fax numbers for referral hospitals (would need doc control database perhaps on the RTC website?)
A confirmation fax not received (where does the line of responsibility lie?)
Maintaining the audit trail of communication

Clinical Barriers

Form is duplicated in some settings (risks of transcriptional errors also discussed)
People are tired of hearing about it, but many are still not aware of it and the barriers have not been removed.
The form is not high on the clinical risk agenda

Policies

Need exists for a robust mechanism for referral, a policy on patient referral
The procedure when a GP refers to a specialist centre
Raising awareness for patients not on Haematology and Oncology wards but who need special requirements. Generally not picked up in these areas.

Use of electronic system

Have the shared care on an electronic system which can be e-mailed, (would need to be via nhs.net network so email accounts may need to be set up)
Having a section for special blood requirements on summary Care Records, Can it be covered on the NHS National Spine Programme.

Patient Empowerment

Share the responsibility with patient for shared care
Amount of time and resources that will need to be given, and from whom, to the patient.
Results of a patient empowerment pilot at Guys Hospital were discussed – issue of treating hospital identify cards. Possibility of information storage was also discussed: Database information systems would need to be set up with passwords for the users, but where and who would manage it.

Recommendations for RTC feedback to group

It was highlighted that the purpose of the shared care communication is of vital importance and some areas of discussion were resource heavy to implement. Below are recommendations that are suggested to be started in the London Region and reviewed to see if communication is improved.

1. Review Documentation

- Keep existing shared care document in use if it is successfully implemented
- Use of Trust Special Requirements form (Trust can then approved as a control document), *avoiding the problems of duplication and transcriptional errors*. As this is completed by hospitals in clinical area on admission (shared care done on discharge)
    - Include Box for Ref/Shared Care hospital for communication back.
    - Use this to send to hospitals to communicate need for shared care

Action: Need to know how many Special Requirements forms exist ask all hospitals who have them to send them to Aman Dhesi, TLP for reference.
Action: Create a RTC generic template for a Special Request form to use in addition to the Shared Care form if preferred by clinical areas and if hospital does not currently have one.

2. Implementation

Clinical Team
Need a Campaign to motivate, communicate and educate the need of shared care and its importance.

Patient
Agree a way to empower them via card, letter, information leaflets, bracelets and patient representatives.
Get the patient (if possible) to take ownership of their needs with minimal understanding of the requirements but greater understanding of not have it.

Laboratory Team
Have all shared care hospital secure fax numbers on a password protected area on the RTC website.
Follow up mechanism needs to be established?

3. Further Consideration -

    a. BCSH guidelines
    b. Survey
    c. Electronic Forms
    d. Use of National Spine