NHS
Bolton Clinical Commissioning Group

NHS BOLTON CLINICAL COMMISSIONING GROUP
Public Board Meeting

AGENDA ITEM NO: ………6…………….

Date of Meeting: ……………25th May 2018……………

TITLE OF REPORT:	Patient Story	
AUTHOR:	Simon Irving, Consultant, Bolton FT	
PRESENTED BY:	Jane Bradford, Clinical Director Governance and Safety	
PURPOSE OF PAPER: **(Linking to Strategic Objectives)**	This month's patient story details case studies relating to the use of the Bolton Care Record and the positive effects this is having on patient care.	
LINKS TO CORPORATE OBJECTIVES (tick relevant boxes):	**Delivery of Year 1 Locality Plan.**	
	Joint collaborative working with Bolton FT and the Council.	
	Supporting people in their home and community.	
	Shared health care records across Bolton.	
	Regulatory Requirement	
	Standing Item	√
RECOMMENDATION TO THE BOARD: **(Please be clear if decision required, or for noting)**	For noting.	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED:	N/A	
REVIEW OF CONFLICTS OF INTEREST:	Review of conflicts of interest not required for this report.	
VIEW OF THE PATIENTS, CARERS OR THE PUBLIC, AND THE EXTENT OF THEIR INVOLVEMENT:	These stories originate from issues raised with the CCG or providers through complaints and incidents.	
OUTCOME OF EQUALITY IMPACT ASSESSMENT (EIA) AND ANY ASSOCIATED RISKS:	This standard report has been considered against the criteria of EIA and an assessment is not considered necessary for this report.	

Case Study One

The Bolton Care Record is an important addition to the health and social care economy in Bolton. It has the potential help all people from all backgrounds if they are signed up.

This fact was highlighted recently when a 25-year-old former asylum seeker, who had been in the UK for five years, who was admitted to A&E with chest pain – which did not seem to be the result of a cardiac issue.

The young man did state, however, that both of his parents had died at a young age from unspecified cardiac disorders and that he previously had received cardiology investigations at hospital.

Due to the availability of the Bolton Care Record, staff at in the A&E department of Bolton NHS Foundation Trust we are able to confirm that he had previously been discharged from cardiology and that he had no ongoing cardiac concerns – leading to a safe discharge from A&E.

Case Study Two

One of the most important elements of dealing with patients is time; the time it takes to diagnose and the time it takes to treat.

The following real-life scenario is an example of how the historical system does not provide information about a patient in a sufficient timescale and how the Bolton Care Record is a direct remedy for that.

A patient attended A&E at Bolton NHS Foundation Trust suffering from confusion and was unable to provide a medical history.

The Consultant at the hospital called Tonge Fold Health Centre, the patient's local GP Practice, and reception staff offer to fax over the patient's details.

The Consultant has to then go away to find the appropriate fax number whilst the receptionist at Tonge Fold waits on the phone.

The ward clerks on D1 then confirm that they are unable to receive the incoming fax, this information is passed back, by the Consultant to Tonge Fold, and an email is requested as an alternative.

When the email was sent over to the hospital by Tonge Fold there was no attachment with the email, the Consultant then has to reply to Tonge Fold stating that no attachment has been received, Tonge Fold state that there was an attachment and they resend.

The Consultant still receives no information which eventually has to be sent over as a JPG image, at which point the Consultant finally has the information required.

If the Bolton Care Record was available in this case the Consultant would simply have to employ the 'Break Glass' function and the information would be available immediately.
There are also concerns with this process in regards to information governance. Is the Consultant required to get consent from the patient prior to calling the GP Practice? Is sending a fax a secure way of sharing information? What is the audit process for GP Practices for sending out faxes?

All of the above concerns are easily allayed by the adoption of the Bolton Care Record.

Care4Bolton
A new approach to better, quality care.

Case Study Three

The Bolton Care Record is an incredibly useful tool when it comes to helping patients who are in need of immediate medical attention but are not well enough to provide information about their medical background due to their condition.

Dr Simon Irving was on duty in the A&E department when he noticed a patient who was in a very serious condition.

The patient had been looking for somewhere to sleep and had fallen between a fence and a garage.

When the patient was found he was hypotensive, hypothermic, ketotic, acidotic and had many pressure sores.

He was unable to give any information apart from his name, from which his NHS number was retrieved from PAS.

Dr Irving logged onto the Bolton Care Record and found what medication the patient was currently on, his full medical history, allergy status and baseline BP.

It was discovered that the patient had suffered from Hepatitis C, was a Type 2 Diabetic and suffered from Hypothyroidism.

The information which the Bolton Care Record offered was incredibly value to the treatment of the patient and ensured that his treatment was appropriately tailored to his specific needs in a much faster timeframe than would otherwise have been available to medical staff at A&E.