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ADASTRA

Please contact the service desk if you have any ideas about how we can improve adastra as we are keen to get your feedback to ensure we can as user friendly as possible.

If you have any ideas, please contact servicedesk@gmupca.co.uk

CAS SERVICE UPDATE:

CAS SERVICE UPDATES

ED ALTERNATIVES

Please consider alternatives to ED.

GP CONNECT

For in hours, please consider using GP connect wherever possible to directly book remote consultation slots with the person's registered GP practice.

If you have any issues accessing GP Connect e.g., identify a GP practice that never has slots available please let the CAS shift lead know at the time.

OUT OF HOURS

For Out of Hours please utilise the Out of hours for cases that can be managed within primary care and that do not require any investigations.

Wherever possible, please prescribe using EPS i.e., symptoms of a UTI, tonsillitis using Fever pain score. skin conditions.

Minor eye conditions service
https://primaryeyecare.co.uk/services/minor-eye-conditions-service/

Greater Manchester Minor Ailments Scheme (MAS)

https://greater-manchester.communitypharmacy.org.uk/greater-manchester-minor-ailments-scheme/

Sexual Health Clinics

https://thenorthernsexualhealth.co.uk/

Think: Urgent Care Response Services which can provide 2hr responses

They provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews etc.

We have pre-bookable slots in:

Urgent Treatment and Care Centres: Stockport, Trafford, Leigh, MRI, Rochdale

MENTAL HEALTH

Consider referring to GM and Pennine 24hr MH helplines rather than advising ED. Referrals can be made electronically but if you have any questions or want to disucss a referral please call them on the numbers below:

GM Mental Direct Number
07435927273
Pennine Mental Health helpline
0800 014 9995.

NHS SERVICE FINDER
This is a great Directory of Service for accessing up to date information about services.

With the ever-increasing complexity of services on offer for patients within different localities we have located an easy-to-use website which will help our clinicians access contact details for various services. Some of you may use this but if you

don't, it would be worth having a look.
Clinicians will need to register with the site which is quick and easy. Please find the link below: https://finder.directoryofservices.nhs.uk/login

DX333

Please be aware that the DX333 cases that come from NHS111 online have now got a reduced call back priority of **30 mins**. This was previously 10 mins.

We hope this change will help manage the cases more effectively.

FORWARDING FOR ADVICE

If you feel the case can be closed in CAS with Dr advice, then you can forward the case with a clear rationale. However, please be mindful if CAS is busy or if you think the case will need a f2f review then please forward to the OOHs, where appropriate.

ASSESSMENT OF BACK PAIN

Following recent missed diagnoses of both Cauda Equina Syndrome (CES) and a lumbar vertebrae fracture, please can we be vigilant in the assessment of lower back pain.

As we know back pain is a common presentation and we need to ensure we have taken an appropriate history and if a face-to-face consultation is required that the person receives an appropriate examination.

Please review the N.I.C.E. guidance for assessment of back pain with an emphasis on excluding the red flags:

https://www.nice.org.uk/guidance/ng59

Caudia Equina Syndrome (CES).

Sudden onset bilateral radicular leg pain or unilateral radicular pain

progressing to bilateral pain; severe or progressive neurological deficit such as major motor weakness of knee extension, ankle eversion, or foot dorsiflexion.

Recent onset difficulty initiating micturition or impaired sensation of urinary flow; urinary retention and/or overflow urinary incontinence (late signs).

Recent onset loss of sensation of rectal fullness; faecal incontinence (late sign).

Recent onset erectile dysfunction or sexual dysfunction.

Perianal or perineal sensory loss (saddle anaesthesia or paraesthesia).

Unexpected laxity of the anal sphincter (Assessing anal sphincter laxity is difficult but could be offered if the diagnosis is suspected and you are considering referral to orthopaedics.

Spinal fracture.

Older age.

Major trauma at any age (such as a road traffic collision or fall from a height), mild trauma in people aged over 70 years, prolonged corticosteroid use, history of osteoporosis.

Structural deformity of the spine (such as a step from one vertebra to an adjacent vertebra) may be present.

Contusion or abrasion.
There may be point tenderness over a vertebral body.

Cancer.
Age over 50 years or under 18 years.

Gradual onset of symptoms.

Severe unremitting pain that remains when the person is supine or at rest, aching night pain that prevents or disturbs sleep, pain aggravated by straining (for example, at stool, or when coughing or sneezing), and thoracic pain.

Localised spinal tenderness.

No symptomatic improvement with therapy.

Unexplained weight loss.

Past history of cancer — breast, lung, gastrointestinal, prostate, renal, and thyroid cancers are more likely to metastasize to the spine.

Infection (such as discitis, vertebral osteomyelitis, or spinal epidural abscess).

Fever.

Tuberculosis, or recent urinary tract infection.

Diabetes mellitus.

History of intravenous drug use.

HIV infection, use of immunosuppressants, or the person is otherwise immunocompromised.

Pain at rest.

Raised inflammatory markers

Please see the flowchart from the GMC that can help to weigh up if a remote consultation is appropriate.

[Remote consultations flowchart - GMC (gmc-uk.org)]

Clinicians have often regarded musculoskeletal problems as requiring a physical, hands-on approach. We have developed examination routines that focus on the palpation and movement of joints. How do we assess a patient if we can't do this?

However, remote consultations can be effective if a logical and structured approach is taken – beginning with a careful history, thinking about the information needed to narrow a differential diagnosis, and early awareness of potential pitfalls and red flags.

Please read the Pulse today article below, that describes two clinical scenarios.
[CPD: Remote consulting for musculoskeletal problems - Pulse Today]

CLINICAL CODING

Adastra has been updated to ensure that clinical coding is now a mandatory field for Adastra cases prior to closing/finishing a patient case.

Please can we remind all clinicians to accurately code clinical presentations/ diagnosis on completion.

COGNITIVE BIAS AND MEDICAL ERROR

In the last few decades, we have recognised the importance of patient and clinic led factors associated with medical errors. Standardised approaches to acute management including ABCs for cardiopulmonary resuscitation which have led to better outcomes by decreasing medical errors.

However, we should also consider how cognitive bias can lead to diagnostic error and negative impacts on patient outcomes. As clinicians, we frequently start consultations, which have been assessed by an external third party including 111, NWAS prior to our consultation.

Does the third-party involvement in cases increase the risk of medical misdiagnosis and error due to cognitive bias……?

One of the most commonly reported cognitive bias is 'anchoring'. As we have been 'handed over' a request or diagnosis by a third party there is an increased tendency to anchoring bias whereby we prematurely anchor a diagnosis or request based on a few important features of the initial presentation and fail to adjust or consider new information which becomes available.

Our clinical reasoning can become impaired, and this can lead to error, complaints and poorer patient outcomes.

For example, if we have a request from a paramedic for laxatives or antiemetics in an elderly patient we should consider all differentials involved and complete a full assessment of the symptoms before prescribing any treatment. If we have prematurely anchored a diagnosis of constipation or gastroenteritis without considering a full history and red flag symptoms there is an increased risk of error.

If we can acknowledge the cognitive bias involved in our clinical reasoning, when a third party makes requests or a medical diagnosis, we can minimise the risk impaired by anchoring a premature diagnosis.

CAS TRAINING EVENTS

16th May 6.30pm-8pm

Case Studies and Safeguarding Procedures when working across the alliance.

Please contact rachaelingram@nhs.net if you would like to be involved in the next event and have any cases you wish to share or have any suggestions for future topics.

If you want to book a place, please contact your training department.