BSW Cinapsis System Design Summary v2.3

The Cinapsis system is highly configurable and can be set up in a number of ways. This paper seeks to ensure that its initial setup reflects clinical practice and facilitates its progressive development over time with a view to maximising the benefits in terms of admission avoidance and outpatient attendance avoidance.

Principles:

1. Cinapsis operates on a hierarchical principal with the following levels (from top down):

   Trust > Service > Clinical Pathway > Triage Hub > Comms modality > Outcome

   a. The referrer navigates down the hierarchy with a single click at each point.
   b. Services are not synonymous with specialities. An individual speciality may support more then one Service (see below).
   c. Clinical Pathways are groups of related clinical presentations relevant to the Service concerned which are amenable to common messaging and audit data collection.
   d. Key messages & Signposting are Clinical Pathway-specific and are displayed after the specific pathway has been selected and before the referrer can progress to the next step. These can be developed and added later.
   e. Triage Hub is *optional*. It allows for additional options to be offered after the Pathway level. It can be added later.
   f. Communications Modality refers to Direct Call, Call Back, eOpinion, and other options such as joint appointments, video, etc which are not being used at present. These can be set per Service, per Clinical Presentation or per Triage Hub selection.

   For a number of reasons, Services are best build around the types of cases they are likely offer A&G support for, the teams who will staff them, the speed of response required and the objectives of the service – in general this means that most specialities subdivide into some form of urgent Service and a non-urgent Service (see below).

2. Specialities
   a. A speciality may support one or more Services – e.g. 'ENT acute' and 'ENT non-acute' (see below).
   b. Most specialities would be expected to support two services once they are fully up and running and these services should be either 'acute' and 'non-urgent', or 'urgent' and 'non-urgent'
   c. The number of services a speciality supports should be limited to two to avoid complexity.
   d. If a speciality offers only one service it should either be for eOpinion, or for Direct Calls, *but not for both*. Exceptions to this should be discussed with the Trust A&G Clinical Lead.
   e. NOTE: **during the Sept-Oct 2021 transition period** when direct calls using 'Consultant Connect' are being transferred over to the Cinapsis system, services that are struggling to meet their relevant GoLive deadline may initially offer a single 'Direct Call only' service. However, if they move to provide an eOpinion service as well they will need to split the services into two (see above).

3. Specialists
   a. A specialist may be associated with one or more specialities or services when registered with the service, and when they select to be 'on duty'.

4. Services
    a. A ‘Service’ is the key top level within any given Trust in the decision tree for referrers.
    b. Specialities offering A&G are best split into urgent and non-urgent Services. This split service provision methodology best serves the needs of referrers, the objectives of the Services, the design of the clinical pathways/key messages/signposting, and the design of the associated KPI’s.
    c. Urgent Services can be divided into being an ‘acute’ Service if they take acute admissions and an ‘urgent’ Service if they do not, *and should be named as such*. This split best supports the function of any given Service with ‘acute’ services being critical to the local urgent care landscape and ‘urgent’ service being important but not critical to it.
    d. An ‘acute’ Service will offer synchronous direct Calls, together with a Call Back option if they wish. It will need to be staffed so that it can consistently respond to these calls, preferably to a 90%+ level, and thereby maintain the confidence of referrers. Data from Cinapsis can later be used to identify period of high and low call volumes to help with staff planning. An ‘Admission agreed to unit x’ output from an admitting service can be set up to route an ‘expected admission notice’ to the receiving unit by email or other means.
    e. An ‘urgent’ service will operate like an ‘acute service (above), but does not admit patients directly and may not need to achieve such high response rate standards as an ‘acute’ service.
    f. A ‘non-urgent’ Services may offer eOpinion and also offer synchronous Call or Call Back options for more urgent or for more complex issues, if they wish.

Specialty	**Listed service - only 2 allowed**		
	Acute (admitting)	**Urgent (non-admitting)**	**Non-urgent**
Paeds	**Yes**	No	**Yes** (eOpinion + Calls)
Neuro	No	Yes	**Yes** (eOpinion + Calls)
Haematology	No	Yes	**Yes** (Calls only)
Acute medicine	Yes	No	No
Renal	No	Yes	Yes (eOpinion + Calls)
Acute Surgery	Yes	No	No
Vascular	No	Yes	Yes (eOpinion + Calls)

Fig 1: Example speciality/services splits

5. Service opening times
    a. ‘Acute’ (admitting) services will be offering synchronous access 24/7 and will be displayed to the referrer as ‘always open’.
    b. ‘Urgent’ (non-admitting) service will be open within specified times, such as 0800-1800 and displayed to the referrer as being ‘closed’ when no one is registered as being ‘on duty’.
    c. eOpinion (non-urgent) is by definition ‘always open’.
    d. Duty rotas can be set up manually or uploaded from an Excel spread sheet in advance. They can also be adjusted on the fly by duty clinicians for on-duty, rest and ‘time out’ periods, as needed. All functions are accessible from both desktop and mobile devices.

6. Communications modalities
    a. Asynchronous (eOpinion)
        i. Will be offered by most specialities in due course, but not necessarily all.
        ii. Is for non-urgent cases with a 72 hour or quicker turnaround.
        iii. Will generally need to be routed to senior staff within any given speciality.
    b. Synchronous (Direct Calls and Call Backs)
        i. Due to the burden they place on the receiving clinicians, for most specialities Direct Calls should over time become limited to 'acute' or 'urgent' cases and to more complex cases. However, because established practice across BSW for local referrers has been a "phone for advice if you want to" service, the shift to calling only for urgent or complex problems needs to be gradual and cannot be forced too quickly. Appropriate messaging can be added to the system to encourage this.
        ii. Specialities which take acute admissions will offer an 'acute' service. This will include 'urgent' advice in order to limit the number of Services to the maximum of two per speciality.
        iii. Specialities which do not take acute admissions may wish to offer an 'urgent' (Direct Call) Service as well as an eOpinion Service. If so, one of the listed outcomes for the urgent Service should be 'Admit to xyz unit' to allow for urgent patients who do need admission, albeit under a different service (e.g. neuro -> acute medicine).
        iv. Calls can be routed to different recipients (to individual phone numbers or to those staffing a specified Service), based on settings made at Service, Pathway or Triage Hub level. For example, a caller to Neurology who select an MS Pathway could be offered 'Call Consultant' or 'Call MS service nurse' at the Triage Hub level, together with instructions as to when to select which option. In either case the call would go through to the selected service, be recorded and a PEM sent to the referrer in the usual way.
        v. Specialists can be registered with more than one Service and can be set up to and can self-select to receive calls from more that one of these Services when on duty (e.g. 'Acute medicine' plus 'renal - urgent').
        vi. Some specialities may wish to route acute preadmission calls to more junior staff while routing calls about less urgent but complex patients to more senior staff. This can be done.
        vii. Non-acute specialities (e.g. biochemistry) wishing to provide only synchronous calls and not eOpinion should still be separated into: 'Acute' and 'Non-acute' where possible, for ease of design and monitoring purposes.

7. Clinical Pathways (or clinical presentations groupings)
    a. Need to be agreed and uploaded before go-live. Two lists are required, one for urgent ('acute' or 'urgent') and for 'non-urgent' Services.
    b. 'Acute' Clinical Pathways are more limited in scope than non-urgent and can be used to target the referrer with key messages and signposting.
    c. 'Non-urgent' Clinical Pathways will usually cover a wider range of clinical groupings. As such, these presentations need to be fairly broad and designed to be suitable for key messages, signposting and audit.
    d. Non-specific clinical groupings such as 'Complex patient' or 'Other' if offered as a Clinical Pathway should mandate the referrer to enter a free-text description. This will enable a service to gain insight as to what patients are being referred and whether there are themes to be found amongst these cases which can be developed.

8. Key messages and signposting
    a. Can all be developed later and implemented progressively.
    b. Should be limited to those issues seen as being important to the receiving service.
    c. For 'acute' and 'urgent' Services these should be designed to reduce unnecessary admissions.
    d. For 'non-urgent' Services these should be designed to reduce unnecessary referrals.

9. Outcomes
    a. After advice has been given to a referrer, the specialist must and select an 'Outcome'. These are the key measures against which the service can be monitored and evaluated against its objectives. This can be done either via the Cinapsis app on their mobile device or on a desktop PC.
    b. Outcomes can be used to direct communications to specific recipients by email or other method – e.g. to notify the designated unit of an accepted/expected patient. For example, an output from an 'acute' Service could be set up to default to sending an 'expected admission notice' to the designated receiving unit containing associated notes and/or instructions.
    c. Outcomes will differ between services, but there will be consistent elements should be named consistently:

        <u>Terms to be used</u>:

        "Send to" Should be used instead of 'admit' or 'attend' as it is a instruction to convey which is independent of the length of stay.
        "Refer to" Should be used for referrals to outpatient clinics.

        <u>Terms not to be used</u>:

Admit	Should not be used as it implies an overnight stay which may not happen.
Attend	Should not be used as it implies a time limited stay which may be overnight.

    d. The following are standard outcomes which should be included as options in most pathways:
        i. Continue to manage in Primary Care
        ii. Send to ED (can be used to route a PEM to ED)
        iii. Refer to routine outpatient clinic
        iv. Refer to urgent outpatient clinic
        v. Refer to 2WW clinic
        vi. Other

    e. The option 'Other' is used to capture unexpected or uncommon outcomes and also to allow clinicians to express views such as 'call should have gone to paeds', etc. This outcome should then forces the user to enter a free text description of the outcome into a mandatory entry textbox. This text can be used to help monitor and develop the service.

    f. Example speciality Outcomes list from the 'RUH Older People Acute Service':
        Continue to manage in Primary Care
        Send to Frailty Unit
        Send to Medical Ambulatory Care Unit
        Send to ED
        Refer to routine outpatient clinic
        Refer to urgent outpatient clinic
        Refer to community services [comment: with a mandatory free text box]
        Call failed
        Other [comment: with a mandatory free text box]

END