**Use Case Template Document**

**Use Case Name:**

Health Visitor appointments during a child’s early years

**Brief Description:**

A health visitor will have four mandatory visits with each child and mother over the first few years of the child’s life. These take place at 10 days, 6-8 weeks, 9-12 weeks and 2-2.5 years.

Before each appointment, the health visitor needs to collect all information about the child to provide the best possible care to the child during development.

The Health Visitor seeing the child will have full access to the child’s record. They may also request access to the mother’s and father’s GP record.

**Use Case Justification:**

Clinical and Administration:

* Access to accurate information at the point of care reducing the opportunity for errors to occur.
* Reduction in clinical time wasted, away from the patient, collecting and collating information.
* Reduction in clinical time wasted, away from the patient, manually updating IT systems.
* Reducing the paper flow through departments/organisations by utilising the systems workflow to manage tasks using staff time efficiently.

Patient Focused:

* Security of patient information is maintained and improved through the reduction of paper-based “Patient Identifiable Documents” in use within departments.
* Increased patient / clinician time due to reduction in clinician time spent collecting and transcribing information away from the patient.
* Increased patient safety due to the reduction in manual transcription errors.
* Better patient experience as the parents are not being asked for information which should already be available to the clinician.

**Primary Actors:**

Health Visitor

Community System

GP Connect

GP Clinical System.

**Secondary Actors:**

Patient

**Triggers:**

The Community Health Visitor will visit the child at:

* 10 days
* 6-8 weeks
* 9-12 weeks
* 2-2 half years

**Pre-Conditions:**

* The patient’s details have been verified and entered on the community system.
* Health Visitors have the correct / appropriate system access rights.
* The patient’s GP has agreed to share patient information via GP Connect.
* The patient allows this shared information to be viewed / used by GP staff.
* Electronic Interactions between Community system / GP Connect / GP Clinical System have been correctly configured.

**Post Conditions:**

* **On Success:**
* **Guaranteed:**
  + All the relevant available information on the patient’s medical history has been viewable on the community system used by health visitors.

**Basic Flow with Alternative and Exception Flows:**

*{The basic flow is the best case scenario (i.e. the happy path) of what should happen in the use case if all the conditions are met. Describe other allowed variations of the basic flow. Are the any alternate routes that can be taken? Describe Error Conditions or what happens when a failure occurs in the flow}*

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| Step 1 | Child is seen by health visitor at:  10 days  6-8 weeks  9-12 weeks  2-2 half years |
| Step 2 | The health visitor logs into their usual community system |
| Step 3 | Health Visitor searches for patient via NHS number (child and mother) |
| Step 4 | The community system will request the patient’s relevant sections of the patient’s record that are held in the patients registered GP Practice system via the GP Connect Service |
| Step 5 | GP Connect and the GP Practice system will check that the community organisation is allowed access to the data and that the patient has not objected to their data being shared. |
| Step 6 | GP Clinical System provides all relevant requested sections including:   * Medications * Allergies * GP Encounters (whether mother or child have had any GP appointments and what happened in these) * Future appointments * Non-attendance of GP appointments (including cancelations)   + These can indicate safeguarding issues. Particularly if appointment is part of child protection plan. * Conditions * Referrals including reason for referrals * Diagnosis * Immunisations * Alerts (warnings) – certain conditions, safeguarding, domestic abuse * Any concerns raised by the GP   **Out of scope** (some of the below may be considered for a future stage)   * Letters from GP – referrals that are made * Letters received back to practice   + E.g. outpatient letters from hospital * Mental health assessment information – developmental mental information |
| Step 7 | The community system imports the all information supplied from the GP practice. This data is now available for clinicians to review and maintain. |
| Step 8 | The medical data retrieved by the health visitors from other sources is manually added to the community system. |
| **Alternative Path** | |
| Step 5a | Where there are not the appropriate permissions to share the data, GP connect returns an error message saying the information cannot be returned.  The Health visitor will retrieve the information using the SCR, Local Care Record and direct requests to the GP practice. They will then manually enter the data. |