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Primary care streaming: Roll out to September 2017

Introduction

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Attendances to Emergency Departments continue to increase, and a proportion of these patients have pathology that could have been dealt with by services other than Emergency Medicine. Streaming these patients away from or out of highly pressured EDs, to co-located GP led primary care services, ensures that:
- Patients receive the care that they need,
- Performance against the four hour standard improves, whilst also making sure that those patients who need a GP can go straight there.

Various options for primary care streaming models are used by trusts across England. As part of the wider transformation of urgent and emergency care services, all systems now need to ensure they have a robust streaming service in place, following the best practice principles, examples, and minimum standards set out in this document.

It is recognised that there are already a range of streaming and other services co-located with many emergency departments, and therefore there are multiple implementation routes available:
a) Where there is already and Urgent Treatment Centre (UTC) on site, the existing protocols need to be adapted to comply with best practice set out in this document
b) Where there is some kind of streaming in place (but not involving a co-located UTC), the service needs to be re-designed to comply with best practice(or the elements of it not currently in place, which will achieve the necessary positive impact on the ED)
c) Where there is no service in place, the best practice in this document needs to be implemented to the greatest extent possible locally, based on a robust cost-benefit analysis

Where successful alternative arrangements are already in place that can thoroughly demonstrate that they are achieving desired positive impact on their ED, adopting this best practice will not be mandated.

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Overview

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The Luton & Dunstable (L&D) model is based upon several years of collaboration between providers and commissioners. The end result of which is that now, during the hours of opening, the Urgent GP service sees around 40% of patients who walk into the department. In order to establish a similar model elsewhere, the principles in set out in the following pages need to be considered.

The Luton and Dunstable Emergency Department recognised the risks of increased attendance and overcrowding and invested in the expansion of the department to include an onsite Urgent Care GP centre. The centre is designed to see an agreed cohort of patients attending A&E and is open from 8:00am to 11.00pm seven days a week. The centre only takes referrals from the emergency department.

When the centre is open, between 40-60% of all WALK-IN attendances go through streaming

THE URGENT CARE GP CENTRE STREAMING PROCESS:

Patients greeted by experienced nurse in A&E → Assessed against checklist (see below) → Algorithm supports decision making → Patient directed to ED, minors, majors, resus or GP centre

- Visual check
- Speech test
- Chest pain?
- Can they walk?
- Unscheduled revisit within 72hrs with the same condition
- Injury or illness?

Streaming allows staff to quickly assess the patient and make a quick decision to stream to primary or secondary care.

Traumatic and head injuries are never referred to the UCGP.

Ongoing care following streaming is a two way process and patients can be quickly transferred if subsequent triage identifies additional or different diagnostics or treatment.

GPs can refer to admitting specialties without coming through ED.

Streaming protocols constantly reviewed and audited annually.

A monthly joint Clinical Governance meeting ensures any suspected inappropriate referrals are addressed and learning is shared.

The below should be considered when doing a baseline/gap analysis to support implementation of a streaming service:

Minimum service requirements

- Service operational from 8am to 11pm (365 days per year)
- ED streaming – 1x band 7 nurse
- GP clinic
- 2 GPs available (for quiet periods this can be 1 GP, and flexed up if required)
- 1 clinical nurse
- 1 HCS

Space requirements

- 2 consulting rooms
- A clinic room (which can also be used as a 3rd consulting room)
- Small waiting area
- No diagnostics

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Commissioner specification

- An on-site GP service needs to be developed in order to provide this capacity. The commissioners should identify a practice / consortium of GP's who are able to provide a clinical service appropriate for the level of activity that is predicted.

- The service needs to have a reliable staffing capacity which is able to provide consistent levels of clinical expertise, and is completely self contained. GP's should be experienced at providing unscheduled care, as the expectant level of pathology in an Emergency Department attender is significantly higher than in everyday general practice.

- The service should be a self-contained service, which ideally does not have a patient list of its own, and services only the ED (i.e. It does not have its own front door facility for patients to choose to walk-in there).

- The service needs to be provided on site at the acute trust, but separate & discrete from the main ED. It is important that the service looks and feels like a GP service, and that the GP's are not "embedded" within the ED.

- For clinical governance reasons, the streaming process should not be able to send patients "away" or to services off-site.

- The payment for the service is the GP tariff, and the hospital only gets reimbursed for the cost of the streaming nurses

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Clinical criteria

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- Patients need to be sent to the GP service according to explicit criteria based upon presenting complaint and basic physiology. Importantly, the criteria should **not** be based upon pathology, as this is only evident after clinical consultation.

- Examples of well established protocols are available for consideration (see annexes), and these have worked successfully in practice at L&D. The basic premise is that if a patient is clinically stable enough to present on foot, and can continue to walk and talk unaided without deterioration, then they are suitable for initial clinical consultation with a GP. However each hospital needs to agree their own criteria.

- The example protocols have been developed over a period of time following the service starting in 2011. The protocols are represented in a flow chart for the staff to follow, and are available at all times at the streaming desk.

- There are certain groups of patients who should be excluded as being suitable for streaming to the GP service, because the risk contained in these patient cohorts is considered to too great. These patients include all repeat attendances within 72 hours, all head injuries in children under 16 years, all traumatic injuries, all foreign bodies, and all patients obviously requiring intervention or investigation in an ED.

- In addition, there are specific sub-protocols for the direction of babies under 6 months of age, feverish children under 5 years and all non-traumatic chest pains. These sub-protocols have a lower threshold for retaining patients in the ED.

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Robust governance structures

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- Clinical liaison and governance between the two organisations should be regular and robust. There should be at least monthly governance meetings between the two organisations which examine cases, including all risk reports, incidents and cases where clarification is required.

- The group needs to consist of senior representatives of each organisation, at least the clinical directors and matrons. These meetings should also make recommendations to the commissioners if any changes in specification need to be made to the process, which the commissioners should take seriously.

- Further to this there should also be an explicit agreement that the GP service have the right to send back to ED any patient that they are concerned about or require further assessment.

- There should also be robust Medical Emergency cover (2222 calls) provided by the acute trust to the on site GP service.

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The front door process

- The process of registration of walk-in patients should be modified. The first person a patient should have contact with is a nurse, who applies the criteria referred to earlier. It is important that a suitably qualified experienced nurse (likely in most places to be ED nurse).

- The nurse should be of appropriate seniority, who has experience in Emergency Medicine and is familiar with triage of patients in their role in ED.

- The nurse should be an ED nurse under the employment of the acute trust, as they are making clinical decisions on behalf of that trust and require indemnity by that employer. The streaming nurse applies only the streaming criteria, which importantly is not a triage process and should not be confused with this.

- There should be no "hands on" contact with the patient and no observations are taken. Streaming is simply to ascertain if this is an Injury (which automatically is then streamed to ED), or an Illness (which is possibly suitable for the GP).

- The criteria are then further followed to clarify suitability for GP. The patient should then be booked in by reception staff to either the ED system, or the GP system. The four hour clock starts then at this point for both streams.

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The referral process

- The GP service should be set up to deliver General Practice consultations to patients who would otherwise have been seen in ED.

- In light of this, there will inevitably be a group of patients in whom the attending GP would like to refer to an inpatient team, or for diagnostics.

- These patients should be referred into the hospital teams via the same route as any other GP in that locality, which should follow local protocol.

- Traditionally, this has usually involved a phone call to the specialty SHO of registrar for a discussion of the case and to allow the team to add the patient to the take list.

- As referred to earlier, there should be an agreement for the GP to immediately return to ED any patient in whom they are clinically concerned and requires immediate attention.

- The clock starts when the patient is registered in ED and stops when the patient has completed their consultation with the GP.

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Overall management

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- While the GP service should be provided by an independent organisation, this is done in collaboration with the acute trust. In the L&D model, patients are streamed to the GP, but the service is expected to and does return patients if necessary.

- These cases should be identified and discussed in depth at the monthly governance meetings, and education of staff or modifications to the streaming protocol should occur as a result if necessary.

- There should be a robust clinical governance model, and both organisations should maintain a "watching brief" on the service by monitoring capacity, performance and safety etc.

- Services should operate between 8am and 11pm.

- When assessing a streaming service, the denominator should be the number of patients attending whilst the service is running, rather than over the whole 24 hour period.

- Within the GP clinic, there should also be information provided to patients about registration with their normal GP, and additional patient education to ensure patients don't default to the clinic, and revert back to using their registered GP.

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Phased implementation

To ensure services are well embedded to achieve maximum impact and reduce pressures on EDs as far as possible, all local systems are expected to have a streaming model compliant with best practice in place according to the following time scales:

- Where there is a co-located UTC, a primary care streaming service compliant with best practice should be in place by Easter 2017

- Where there is no co-located UTC, no streaming service in place, or a different model in place (which is not achieving the desired impact), a primary care streaming service compliant with best practice should be in place by September 2017

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Annex – L&D protocols (1)

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The following flow charts and protocol diagrams are the latest draft of the protocols used in Luton & Dunstable (accurate as of February 2017, but are under constant review). When implementing primary care streaming, the following should be considered.

Ambulatory patients

Feverish Children Under 5 years

NICE CG160 Compliant
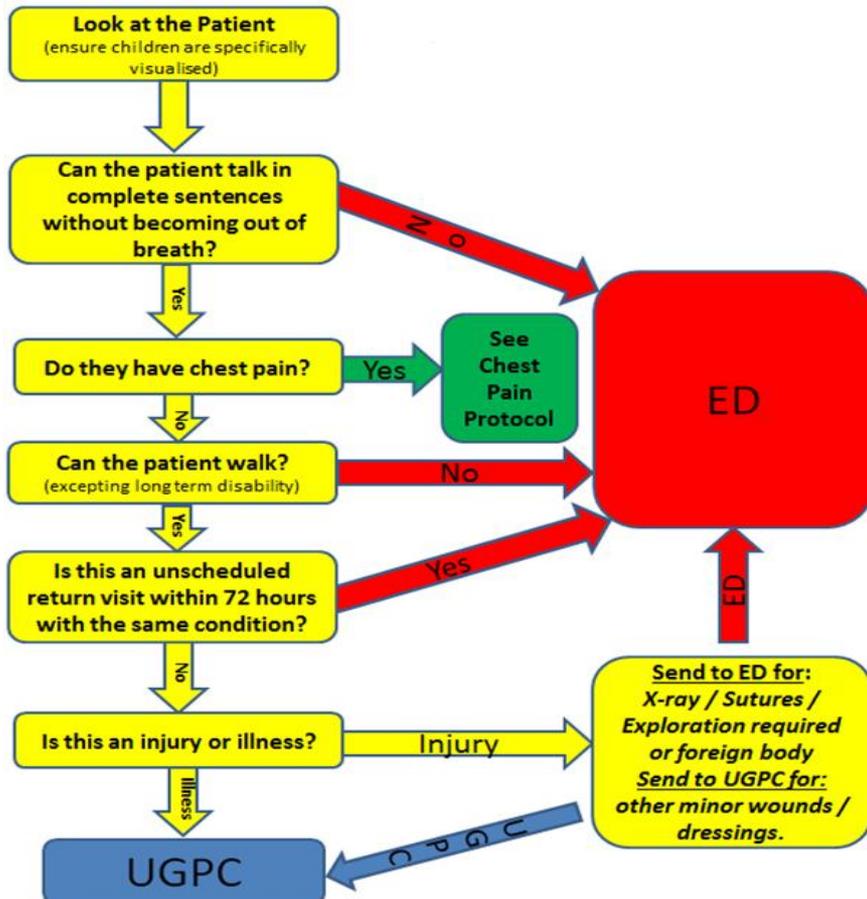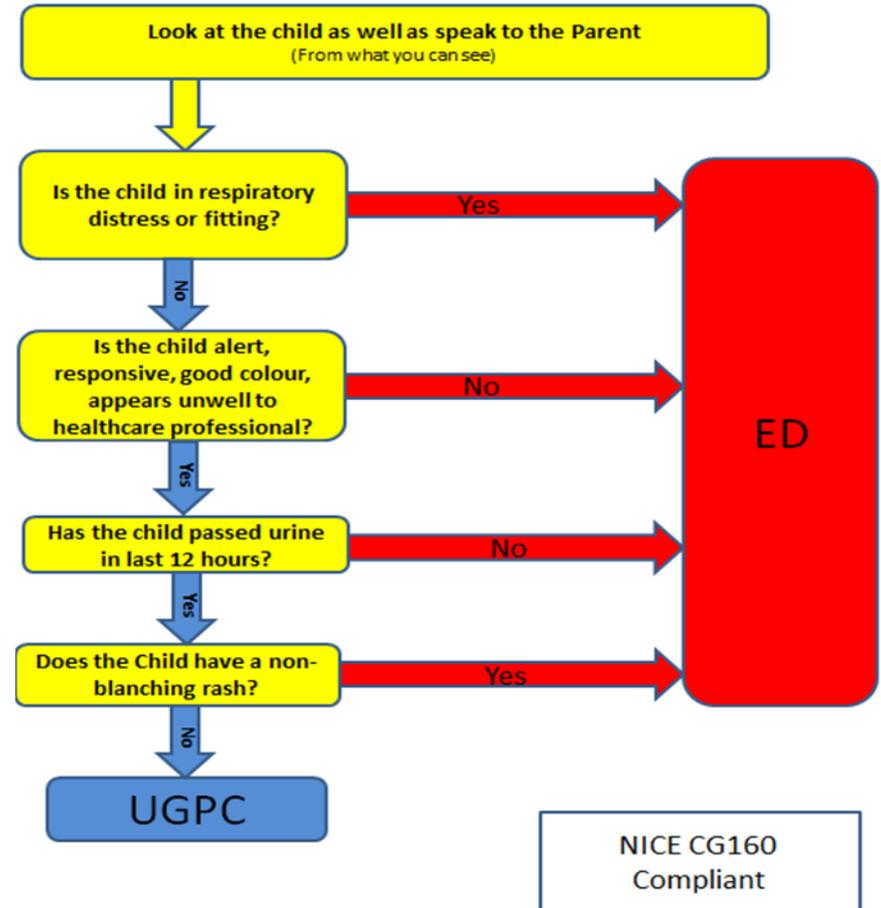
Annex – L&D protocols (2)

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Children under 6 months

UGPC (*Low Risk Features*)

- Feeding normally or >50% of normal
- No fever / Fever if over 3 months old
- Wet nappy or passed urine in past 12 hours
- Active
- Crying loudly

ED for Stabilisation then PAU (*High Risk Features*)

- Respiratory distress – breathing fast with increased effort tracheal tug/recessions
- Non-responsive
- Floppy Child
- Fitting Child
- < 3 months old with temperature

Ambulatory non-traumatic chest pain

UGPC (*Low Risk Features*)

- Good Colour
- Complete sentences
- Walking Unaided (except chronic disability)
- Associated viral/fever symptoms, cough
- Aggravated by movement
- Indigestion
- >72 hours pain duration

ED (*High Risk Features*)

- Sent by another health professional
- Poor colour
- Unable to complete sentences
- Needs help to walk
- Feels like previous heart attack, pneumo-thorax, PE
- Associated dizziness, tingling, palpitation, difficulty breathing
- High risk CHD-diabetic, smoker, >65 years, obese

Nosebleeds

ED

Patients presenting with any of these below to remain in Emergency Department

- Active severe bleeding
- Bleeding not stopped in 20-30 minutes
- Trauma to nose/face
- On anticoagulant therapy
- Has cancer of head, neck, ear, nose or throat
- Has bleeding or blood disorders
- Has advanced liver disease