

Primary Care in Emergency Departments

A guide to good practice

**The Emergency Care Intensive Support Team
in association with**



February 2015

Primary Care in Emergency Departments – a guide to good practice

Introduction

This brief paper describes the factors that should be considered when planning how best to use primary care clinicians in emergency departments and how the arrangements should be monitored to refine and improve their effective use. While financial issues are not covered in detail in this guidance, local health communities should satisfy themselves that new services are economically evaluated after a reasonable running-in period to ensure cost effectiveness.

Background

As with many aspects of urgent and emergency care, the evidence base is not sufficient to point to a definitive model for primary care involvement in emergency departments. A well-argued overview was published in 2010, commissioned by the Department of Health (*Primary Care and Emergency Departments*, Primary Care Foundation 2010). This helpfully considered best practice principles, the potential pitfalls, and observed examples of good practice. This guide draws on that paper and from the experience of managers and clinicians who have set up or worked with primary care services in emergency departments.

Purpose of the service

It is important from the outset that local health communities explicitly agree the purpose and objectives of using general practitioners and other primary care practitioners in emergency departments. Examples of objectives from existing services include:

- To provide a 'streaming' system to redirect people to the 'right' care.
- To provide expert care for patients presenting to emergency departments with primary care presentations or minor illnesses.
- To develop a more integrated, whole system approach to urgent and emergency care.
- To provide expertise about the availability and capability of local health and social care services.
- To support early diagnosis to expedite the early discharge of patients, particularly for older frail patients and those with long term conditions of the type that general practice sees regularly.
- To reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
- To improve the effectiveness of the system as a whole

We do not recommend that primary care clinicians are used to redirect patients away from emergency departments. This is not an efficient use of resources, leads to duplicate assessments and may in some cases be clinically inappropriate.

Patient involvement

Many local health communities have patient groups that can describe what they want from a primary care service in emergency departments. It is important to capture this information and use tools such as experience-based design in service development. Such partnership working with patients can yield great results.

Managing Change

For some local health communities, the implementation of a primary care stream in an emergency department will be a major project that will require significant management support and expertise in service improvement. It is unrealistic to expect managers and clinicians to do this as part of their 'day job'. It is important that experienced primary care managers are also involved to maximise the quality and appropriateness of the service.

Leadership

A primary care lead should be appointed to work alongside the emergency department clinical director. They should share joint responsibility for developing and running of the service. The purpose and objectives of the service should be agreed and written into an operating model. The primary care service should be considered a fully integrated element of the emergency department, not a separate 'add on'. It should participate in clinical audit, service improvement and governance (including clinical governance) meetings and processes. Examples of integration can be found in many hospitals, including the Heartlands Hospital, Harefield Hospital NHS Foundation Trust, the Homerton University Hospital NHS Trust, and the Charing Cross Hospital, Imperial College Healthcare NHS Trust.

Capacity and demand

The reported rate of primary care presentations to emergency departments varies considerably across the country (the literature suggests between 10 and 30%). In general, urban centres will have a higher demand for a primary care service than rural centres.

Local intelligence and concrete evidence should be used to calculate demand. The opening and closing times of the service and staffing levels should be based on demand profiles. A primary care 'stream' may consist of a combination of medical, nursing, allied health professional and community pharmacy staff.

Information

Primary care clinicians should have access to patient data to support clinical decision making. This could include recent visits to primary care, prescription information etc. Data held on pathology and radiology systems should also be readily available.

Diagnostics

The service should be able to access diagnostic investigations to support patient care and be able to directly refer patients. The results of the tests should be available within similar timescales to those in the main emergency department.

Ongoing care

Some patients will benefit from review by their own GP. There should be agreements in place that describe how such patients will be offered an appointment at an appropriate time. Best practice is for the service to make patients an appointment before they leave.

Systems

It is important to ensure that:

- Information is fed back to a patient's general practitioner promptly.
- Cases are managed within A&E quality indicators and waiting time standards
- The totality of the patient journey should be reviewed regularly. Care received as part of the pathway should be audited against performance standards and improvement metrics.

Metrics

Metrics to assess service effectiveness should be reported at joint governance meetings and used to support service improvement. Examples of metrics used around the country include:

| | |
|-------------------|---|
| Process metrics | Total number of patients seen per clinician per hour Median time from arrival to treatment Median time from arrival to discharge from department (or admission) Four-hour performance of service ¹ Number and type of tests requested and trends |
| Clinical codes | Arrival method (how many arrived by ambulance) Case mix |
| Balancing metrics | Percentage of patients admitted Percentage of patients re-presenting within 7 days Percentage of patients seen referred to the main emergency department (ED) Serious untoward incidents |
| Outcome metrics | Percentage of patients discharged home Key points highlighted in complaints and compliments Fully absorbed costs per case (using the A&E tariff to measure 'savings' is poor practice and may only reflect cost shifting). |

The aim in collecting this data is to enable the local health community to evaluate the safety, clinical and cost effectiveness of the service.

¹ It should be noted that type 1 emergency department 4-hour performance may be affected where a new primary care service is designated as a type 3 department. This is due to a change in the denominator. Overall campus performance should not be affected.

Cautions and factors to consider

The service should be designed to ensure that:

- It only operates when demand is sufficient to justify it and does not induce new demand.
- It is staffed by a group of local primary care practitioners (GPs, nurses, allied health professionals (AHPs), pharmacists etc depending on the agreed model) who have committed to regular sessions. This will promote good working relationships with the main emergency department, thus enhancing clinical safety and better collaboration between primary and secondary care practitioners.
- There is a consistent service offer that is not dependent on the skills of specific individuals. The required competencies of practitioners working in the service should therefore be clearly specified and agreed.
- Effective processes exist to present the right patients to the right clinicians.
- Processes exist to manage the total clinical team working in the emergency department to make efficient and effective use of their complementary skill sets. This should include an agreement to provide mutual support during periods of pressure.
- Triage and navigation is established to get patients into the primary care service promptly and not to direct them away from the ED.
- The service is cost effective and staff remuneration is transparent and fair.
- The service does not deplete or compete with main stream primary care provision in the locality.

Examples of primary care involvement in emergency departments

Effective services are invariably context specific and have been set up to address specific local needs. 'Off the shelf' solutions rarely work. Some examples include:

- At Kettering General Hospital NHS Trust integrated urgent and emergency care centre, primary care clinicians manage the majority of paediatric attendances and most patients arriving from care homes.
- Several emergency departments have GPs as part of the team seeing 'majors' patients. Their local knowledge enables some patients to be managed without an overnight hospital stay and creates learning opportunities for junior doctors. Examples of this are at Nuffield Health Hospitals Chichester and Exeter.
- Whipps Cross University Hospital, Barts Health NHS Trust has a long established pathway where appropriate patients are streamed to the primary care out of hours service 24-hours a day.
- In Sunderland Royal Hospital, a nurse navigator directs appropriate patients to the on-site urgent care centre for treatment led by emergency care practitioners.
- In Blackpool Teaching Hospitals NHS Foundation Trust, NHS Pathways has been used to support the navigation of walk-up patients to the right emergency care stream, including the on-site urgent care centre.

Advantages and disadvantages of different models

| Model | Advantages | Disadvantages |
|--|---|--|
| <p><i>Within the emergency department.</i> Patients attend the ED and are triaged into separate streams (urgent or non-urgent/primary care). The primary care stream is staffed by primary care clinicians.</p> | <ul style="list-style-type: none"> *Allows main ED to focus on higher acuity patients. *Provides patients with the most appropriate level of service. *May reduce waiting times for all streams and increase patient satisfaction. *Supplements shortages of hospital staff. | <ul style="list-style-type: none"> *May induce demand and duplicate existing local primary care services. *May not be cost effective *May create local competition for staff |
| <p><i>Alongside the emergency department.</i> Primary care is distinctly available next/close to the ED with patients choosing themselves or being redirected from the ED towards the primary care service.</p> | <ul style="list-style-type: none"> *As above and.... *Where flow is compromised by exit block, may help reduce crowding in main emergency department. *By clearly delineating services, is less likely to positively reinforce public belief that A&E is for all comers | <ul style="list-style-type: none"> *As above and.... *Less likely to promote seamless team working than more integrated models. *May lead to more 4-hour breaches if handovers between services is not efficient *May use part of the hospital estate that could be used for higher priority activities. *May reduce exposure of trainee doctors to minor injuries and illnesses. |
| <p><i>Primary care front-end screening/filtering emergency department patients.</i> Primary care practitioners are involved in the triage or filtering of non-emergency patients at the front of the emergency department, thus preventing them from accessing the ED.</p> | <ul style="list-style-type: none"> *Allows main ED to focus on higher acuity patients. *Where flow is compromised by exit block, may help reduce crowding in main emergency department | <ul style="list-style-type: none"> *May create local competition for staff. *Wastes overall NHS resources due to duplicate assessments. *Poor use of primary care practitioners who are trained to assess and treat, not triage. *May deprive vulnerable and those with a chaotic lifestyle of required care. *Not cost effective. |
| <p><i>Fully integrated.</i> Care provided jointly with ED staff to all groups of patients who choose to attend the hospital for their care, including higher acuity and primary care patients.</p> | <ul style="list-style-type: none"> *Makes full use of the skills of the primary care clinicians. *Enhances team working and cross-skilling *Helpful for managing children, people with mental health problems and frail people with long term conditions *Supplements shortages of hospital staff *Enhances training and learning for junior doctors and nurse practitioners | <ul style="list-style-type: none"> *May create local competition for staff. *May induce demand and duplicate existing local primary care services. |

Conclusion

The requirements for primary care services in emergency departments will vary widely across the country. It is important that there is a clear local agreement describing how the service will operate. Traditional boundaries of primary and secondary care should be broken down to create an integrated and simplified service for patients. It is particularly important that an integrated governance structure is put in place.

Primary care services in emergency departments do not necessarily need to be provided by general practitioners. Indeed, local staff shortages may militate against this. Local services may include allied health professionals, social workers and advanced trained paramedics. Examples of where professionals other than GPs are used include:

- Brighton and Sussex University Hospitals NHS Trust, where allied health professionals and social workers work in the emergency department using a shared health and social care database to assess and manage patients.
- Southend University Hospitals NHS Foundation Trust, where the 'Home from Hospital' allied professional team work with a dedicated social worker to assess and redirect patients to more appropriate care and then follow up the patients in the community.
- West Midlands Ambulance Service where emergency care practitioners avoid conveyance using their advanced training.

Useful Reading and References

Primary Care Foundation (2010), *Primary Care and Emergency Departments*.

<http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading Reports/Reports and Articles/Primary Care and Emergency Departments/Primary Care and Emergency Departments RELEASE.pdf>

Primary Care Foundation/NHS Alliance (2011), *Breaking the Mould without breaking the system*.

<http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading Reports/Reports and Articles/Urgent Care Commissioning/Breaking the Mould RELEASE.pdf>

Cooke et al (2005), *Reducing attendances and waits in UK emergency departments- a systematic review of present innovations*. Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO).

http://www.nets.nihr.ac.uk/data/assets/pdf_file/0003/64344/FR-08-1204-029.pdf

Purdy, Sarah, (2010) *Avoiding hospital admissions, what does the research evidence say?* Kings Fund. <http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf>

Purdy et al (2012) *Interventions to reduce unplanned hospital admissions- a series of systematic reviews*. P.60-61. Bristol University et al.
<http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/unplannedadmissions.pdf>

Primary Care Foundation, *A Review of Urgent Care Centres* (2010)
<http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading Reports/Reports and Articles/Urgent Care Centres/Urgent Care Centres.pdf>

The College of Emergency Medicine (2013), *The drive for quality - How to achieve safe, sustainable care in our Emergency Departments*,
<http://secure.collemergencymed.ac.uk/code/document.asp?ID=7030>

Thanks

With thanks to the many colleagues who contributed to this paper, especially Claire Old, Vincent Connolly, Stephen Duncan, Henry Clay, Taj Hassan, Ian Higginson and Cliff Mann.

This document was produced by the NHS Emergency Care Intensive Support Team (ECIST), which is part of NHS IMAS. The views expressed are those of ECIST. The content is copyright, but may be used freely within the NHS for non-commercial purposes. For further information about ECIST or to comment on this paper, email Russell Emeny, Director of ECIST, at nhs.imas@nhs.net We welcome feedback and will include suggestions in future revisions.

February 2015