Evaluation of Right Care, Right Place

09/10/2007

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August 2007

Acknowledgements

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1 Introduction

The Right Care Right Place pilot project commenced in January 2007. The essential feature of this scheme is that a senior nurse screens adult ED ambulatory attenders for conditions that are considered to be primary care conditions and redirects them to primary care. The project steering group agreed a list of qualifying conditions so screening and redirection to a GP, pharmacist or self-care is by protocol. The pilot was to be supported by a GP registration officer located in the ED who could both register patients and arrange appointments with General Practitioners. The triage nurse position and the GP registration officer were both funded by Islington Primary Care Trust. The pilot was intended to run for 6 months and then be formally evaluated reviewed. This evaluation was planned to inform the next stage of service development.

2 Background

The Whittington is category 2 Emergency Department seeing approximately 85,000 patients a year. Nationally, the number of people accessing emergency care has increased. In recent years, the Whittington hospital has experienced an 8% growth in annual attendances, a significant proportion of which present with primary care problems (Right Care: Right Place Draft Operational Policy 2006).

The funding of Emergency Departments like other hospital services switched to a tariff-based mechanism (PbR) in 2005. However, unlike other services these costs are currently born entirely by the hosting or commissioning Primary Care Trust. So, for example, Islington PCT funds the cost of all ED attendances despite almost half of attendances being registered in other PCTs. The usual ED tariff cost for minor attendances is currently £55 per attendance.

There are perceived benefits for both the PCT and the Whittington of introducing Right Care Right Place. For Islington PCT Right Care Right Place aims to divert appropriate patients with primary care conditions to primary care. This is fundamentally because there is a belief that primary care is the appropriate place for primary care patients to be seen and primary care is where Islington invests in the treatment of patients for primary care conditions. It would also be less costly if patients were seen in primary care. For the Whittington the main gain is reducing operational strain on the emergency department. There is some evidence to support the idea that overcrowding is associated with not only greater inconvenience from longer waits but poorer health outcomes (Cook, et al 2004). So there are potentially important operational and health-related reasons for concentrating resources on patients who need ED care. The Whittington also needs to meet strict four-hour ED wait targets.

2.1 Brief literature survey

Attending Emergency Departments with minor or primary care conditions is common and is seen in many countries and health care systems. For example, Dale (Dale, et al 1995) reports that 41% of presentations to King's College Hospital in London could be classified as having a primary care condition. This high load of primary care conditions is partly because of perception of illness severity. Beecham (1999) found that more than one in three patients who attended the ED with minor ailments believed that they should be seen in hospital rather than visiting their GP, pharmacist, or treating themselves at home. Over half the patients had not attempted to contact their surgery. Hilditch (1980) showed that an increase in family physician's availability led to decreased use of hospital ED. While Murphy (1998) suggested that the most important factors that influence ED attendance were the perceived appropriateness of the condition for ED, ED accessibility and GP availability.

Various interventions have been tried to reduce utilization of ED by patients with primary care conditions. These have included

- Educational initiatives [Small and Seime (1986)]
- Providing primary care in the accident and emergency department [Robertson (1998)]
- Employing general practitioners in accident and emergency departments [Cooke (1996) and Dale, et al (1996)]
- Triaging patients out of emergency departments to other clinics or to primary care [Derlet et al (1992), Hansagi et al (1989), Hansagi (1990), McGugan and Morrison (2000)]

Cooke et al (2004) in their systematic review of innovations to reduce attendance and waits in accident and emergency departments classify schemes such as Right Care Right Place as "triage-out" systems. They identify a reasonable literature to support the feasibility of such schemes to divert substantial numbers of patients. In one of the largest natural experiments approximately 15% of patients were triaged out by protocol from a busy (60,000 p.a.) emergency department in the United States over a three-year period. This was a specific response to a problem of overcrowding.

However, such triage-out schemes raise several natural questions, specifically: whether triaging away from the emergency department is safe, whether it is appropriate and whether it is acceptable to patients and professionals. In the above natural experiment example the authors followed up3740 individuals triaged away by telephone and found that 42% received care the same day, 37% within 2 days and 22% decided not to seek medical care. A minority – 1.6% - sought care at another emergency department. Letters and calls to other emergency departments and the coroner's office did not find any patient that they considered had been grossly mis-triaged. This view that many of these schemes are essentially safe is supported by a small RCT that randomised half of patients to next day primary care clinic: self-reported health status was no different. There are several other studies that support the safety of such schemes. However, the evidence is not entirely uniform. In another small study in the UK 1.1% of triage out patients were subsequently admitted.

Triage-out may be feasible, safe and even appropriate but it does not necessarily mean this is what patients or even practitioners want. According to Cooke's review only a third may be willing to go elsewhere if asked. Additionally some professional bodies do not consider that it fits within the general ethos of emergency department care to direct patients away.

So in summary the literature suggests that triage-out schemes can be feasible and safe, appropriate and acceptable. However, much of this evidence is from the United States. Whether any particular scheme is feasible, safe and acceptable is probably to an extent dependent on the case-mix of usual attenders, the surrounding health system that must receive and care for these patients, the triage systems and protocols used and systems that govern these and other contextual features.

2.2 Project Objectives

The stated RCRP service aims were to:

- Identify adult patients suitable for management in Primary Care
- Proactively redirect adult patients to appropriate Primary Care services
- Inform and educate patients about appropriate use of services

- Ensure unregistered patients are registered with local practices

Following an audit and feasibility study the PCT had an expectation that 15-25 patients per day would be redirected.

2.3 Right Care, Right Place – processes and procedures

2.3.1 Operating hours

The RCRP redirection service operates from 10 a.m. to 8 p.m. seven days a week.

2.3.2 Basic processes

All ED attendees give their basic details to the ED receptionist. One of the Band 7/8a senior nurses is allocated to RCRP on a shift-by-shift basis. All nurses working at this level are highly competent in first contact triage. The ED nurse and the RCRP nurse identify patients in need of ED care and those potentially suitable for primary care from the initial details provided when they register.

The RCRP nurse assesses these potential primary care patients using the Manchester Triage system and follows the operational/redirection policy, which includes a detailed list of agreed conditions that can be redirected.

Patients suitable for redirection are educated about primary care services suitable to manage their current health problem and given various options depending upon their clinical presentation. Possible redirection routes include the patients own GP, CAMIDOC (GP out of hours service located onsite near the ED with operational hours after 6 p.m.), minor ailment scheme/pharmacies, family planning clinics, dental services, NHS direct or self-care. Patients who choose not to be redirected to a primary care service are seen in the ED. Information leaflets on primary care services are given to patients.

If a patient accepts redirection, an appointment is arranged for them either by the GP registration officer or the RCRP nurse. All redirected patients are recorded on a database with the Manchester triage code, redirection location and rationale for redirection.

2.3.3 Exclusions and qualifying conditions

Absolute exclusions agreed by the project steering group included children under the age of 18, patients not haemodynamically stable, patients with an assessed triage category of 1, 2, or 3 and any patient previously seen for the same problem in any clinical setting.

A list of qualifying conditions is listed in the appendix.

3 Evaluation Objectives

This evaluation aims to assess the effectiveness and appropriateness of RCRP in reducing the number of adult patients who attend Whittington emergency department with conditions that could be managed in primary care.

The specific objectives are:

- To estimate the effect of the project on attendance at the ED and other health services
- To investigate reasons why patients with minor illness attend Whittington ED.

- To assess the appropriateness and safety of RCRP
- To assess the acceptability of RCRP to both patients and professionals

4 Evaluation Methods

The basic components of the evaluation were:

- Review of routine attendance data through the Emergency Department Information System
- A patient questionnaire
- A GP/Health professional questionnaire
- Semi-structured interviews with key informants

4.1 Routine attendance data

We obtained basic attendance information extracted from the EDIS system from 1 January 2006 until the end date of the evaluation on 8 July 2007. For a shorter study period (21 May to 8 July) we extracted additional anonymised patient information from EDIS for patients consenting to follow-up, patients refusing redirection and remaining patients in triage categories 4, 5, and 6.

4.2 Patient questionnaire

This was intended as a telephone questionnaire with 18 questions designed to establish patient characteristics, reasons for attendance, satisfaction and outcome of redirection. The RCRP nurse recruited patients sequentially with the assistance of the evaluator. Information sheets were given to each patient and they were asked to consent to be contacted a few days later (after they had seen the health professional they are redirected to). We estimated we would be able to recruit 350 patients over a period of 6/7 weeks. Patients were not recruited on weekends.

4.3 GP/Health professional questionnaire

This consisted of 6 questions designed to assess health professional satisfaction and their assessment of the appropriateness and safety for each patient directed to them. The questionnaire was given to patients to give to the health professional they were redirected to with a return addressed envelope.

4.4 Qualitative study

A series of semi-structured interviews were conducted with various professionals and stakeholders. These consisted of 5 open-ended questions designed to highlight their views on the original aims of the project, implementation difficulties, impact of project on patient's A&E attendance behaviour, the future of the project and it's sustainability. Interviewees included a Whittington representative, an ED manager, a CAMIDOC GP, the RCRP triage nurse and a PCT representative. A focus group using the same basic outline was conducted with a group of Whittington ED nurses.

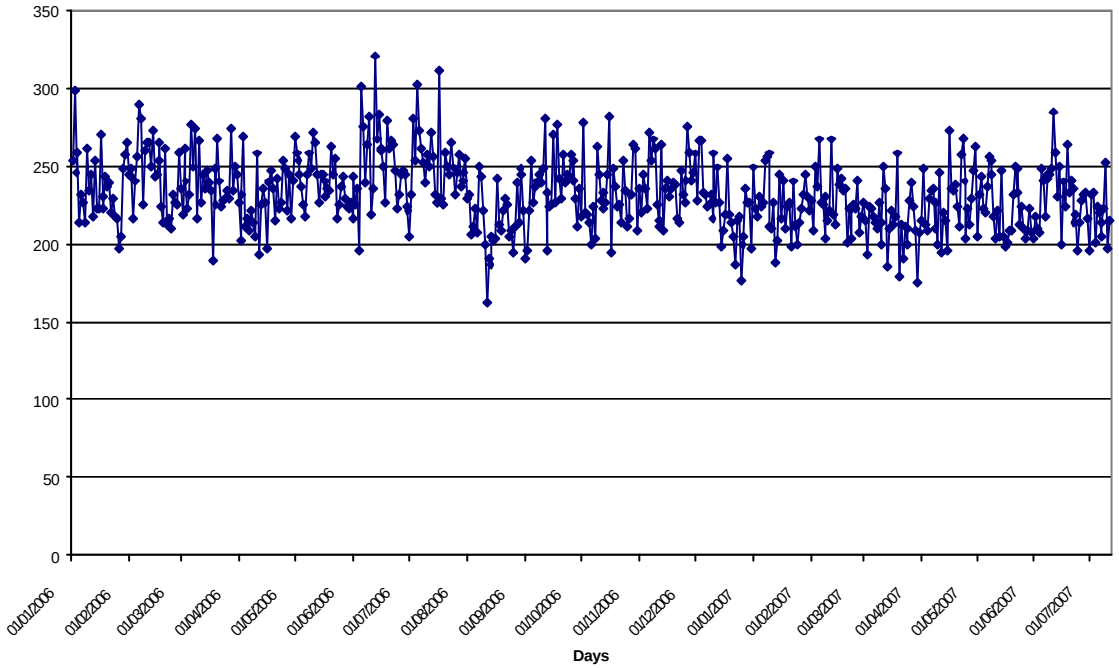
5 Evaluation Results

5.1 Overall impact of Right Care Place on routine activity

5.1.1 Trends in overall activity

We examined a relatively short time frame covering the full year from before the start of RCRP until the end of the last week of our evaluation period (11 July 2007). There were a total of 129,271 attendances over this approximate 18-month period with 86,245 in 2006. The maximum daily attendance during this period was 321 and the minimum 162. Average daily attendance over the whole period was 232. Figure 1 clearly shows that there has been a small and fairly steady decline in ED attendances over this period.

Figure 1: Trend in daily attendances Whittington Emergency Department January 2006 to 11 July 07



Dividing the period into quarters the average daily attendance was 240 in the first calendar quarter 2007 (January to March) declining to 222 in the first calendar quarter 2007 and rising a little in the latest quarter. This represents a modest decline in overall activity (comparing equivalent quarters) of either 7.5% (Q1 2006 cf Q1 2007) or 5.4% (Q2 2006 cf Q2 2007).

Table 1: Average daily attendances and quarterly total attendances January 2006 to end June 2007

Quarter	Average daily	Quarterly total

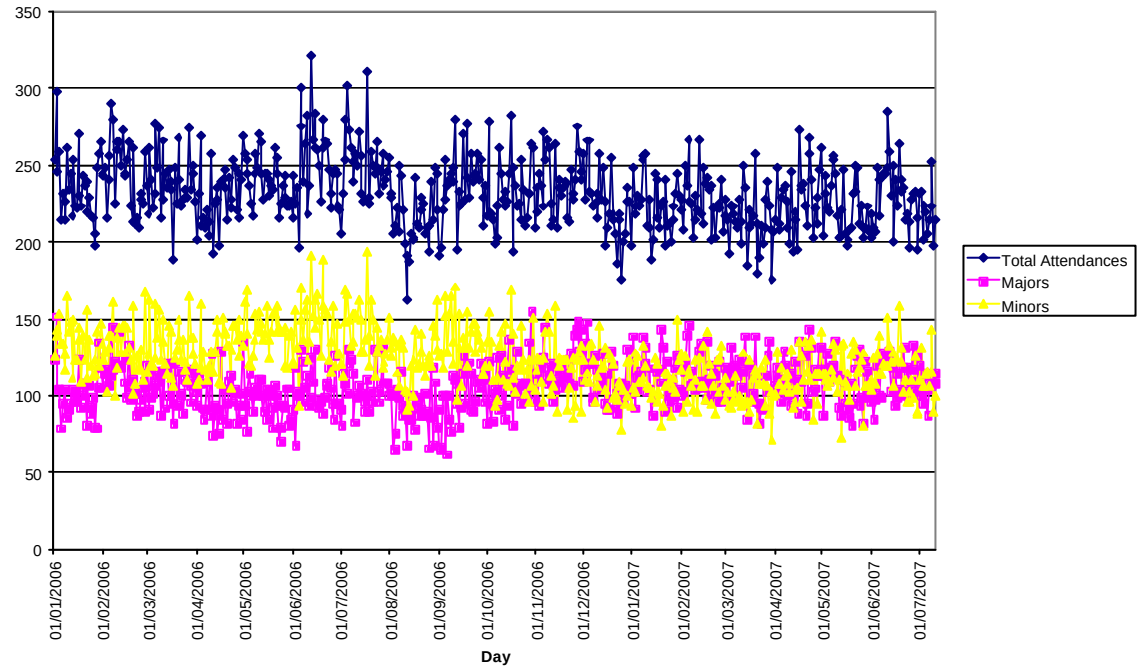
Jan-Mar 2006	240	21593
Apr-Jun 2006	240	21826
Jul-Sep 2006	234	21546
Oct-Dec 2006	231	21262
Jan-Mar 2007	222	19960
Apr-Jun 2007	227	20650

5.1.2 Trends by triage category

There are 6 triage categories used at the Whittington from one being most severe and six being least severe. The triage nurse at initial assessment gives all patients a triage category. This includes RCRP redirected patients. Categories one, two and three traditionally describe major attendances and categories four, five and six traditionally describe minor attendances. Numerically attendances are dominated by triage categories 3 and 4, which in 2006 contributed some 72,940 out of the total of 86,245.

We can simplify trend by triage category by looking at trends in minors and majors. This is shown in the figure below. This shows that there has been a small fall in minors and a small increase in majors.

Figure 2: Trends in daily attendance for majors and minors January 2006 to 11 July 2007



If we look more closely at trends by triage category by quarter this shows this pattern quite clearly.

Table 2: Quarterly trends by triage category Whittington Emergency January 2006 to Jun 2007

	1	2	3	Majors	4	5	6	Minors	Not recorded
Q1 06	142	1404	8024	9570	10095	759	972	11826	197
Q2	119	1223	7693	9035	10724	919	940	12583	208
Q3	126	1270	7699	9035	10718	851	683	12252	217
Q4	187	1482	8634	10303	9353	844	584	10781	178
Q1 07	144	1464	8485	10093	8588	672	444	9704	163
Q2	155	1519	8397	10071	9190	725	516	10431	148
Average daily change	+0.0	+1.1	+3.1	+4.3	-11.2	0.4	-5.0	-16.8	-0.2
% change	+2%	+7%	+3%	+4%	-11%	-5%	-86%	-15%	

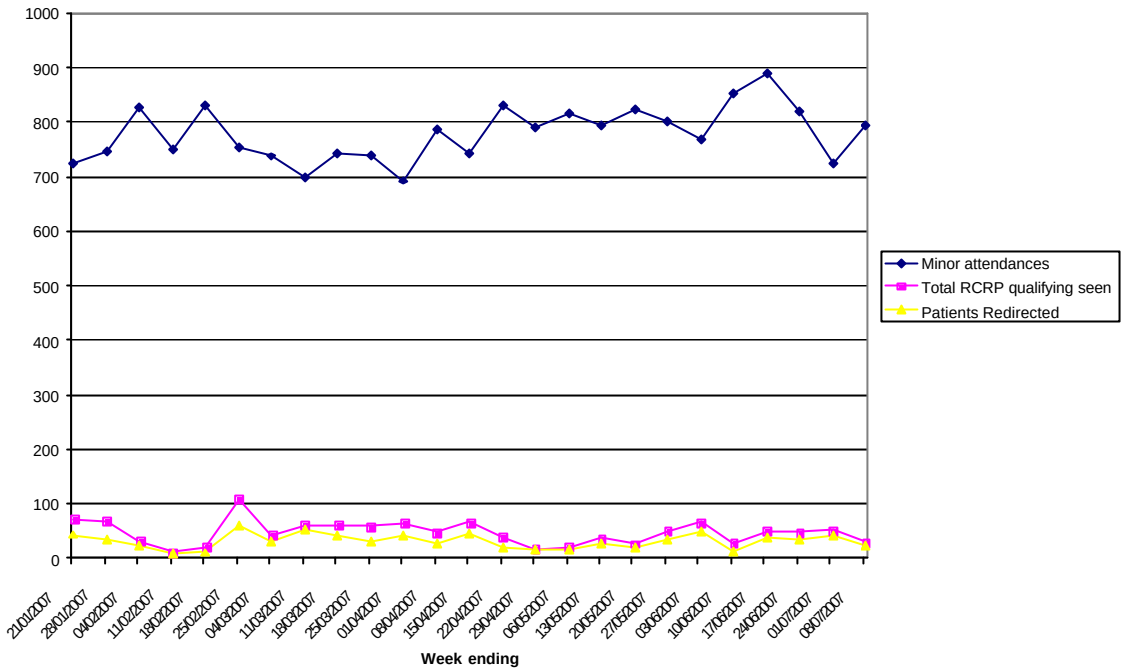
Note quarters are not exactly comparable because of small variation in numbers of days in each. Variations in daily averages are comparable.

The average daily change comparing Q1 2006 to Q2 2007 is approximately 13 fewer daily attendances. This consists of an average increase of around 4 attendances in triage categories one to three and almost 17 fewer daily attendances in triage categories four to six. The biggest proportional decrease was in triage category six, which has seen a fall of almost 90%. However, this triage category is almost redundant and most triage classifications (e.g. Manchester) now offer only five categories. So this could be a change in coding practice. The most important numerical shift was in triage category four in which there were on average 11 fewer attendances each day.

5.1.3 Right care right place redirections

Right care right place redirection began in the third week in January 2007. Over the 25-week period until week ending 8 July there were a total of 761 redirections recorded or an average of 30.4 redirections per week. There was a high week-to-week variation with a minimum of minimum of 7 redirections and a maximum of 59. The RCRP redirections are a small fraction of the 19,478 minor attendances during this period – 4%. The total of RCRP-qualifying attendances as recorded in the EDIS system was 1163, which is itself only 10% of minor attendances. This is shown graphically in figure 3.

Figure 3: Weekly minor attendances, potential RCRP qualifying and redirections

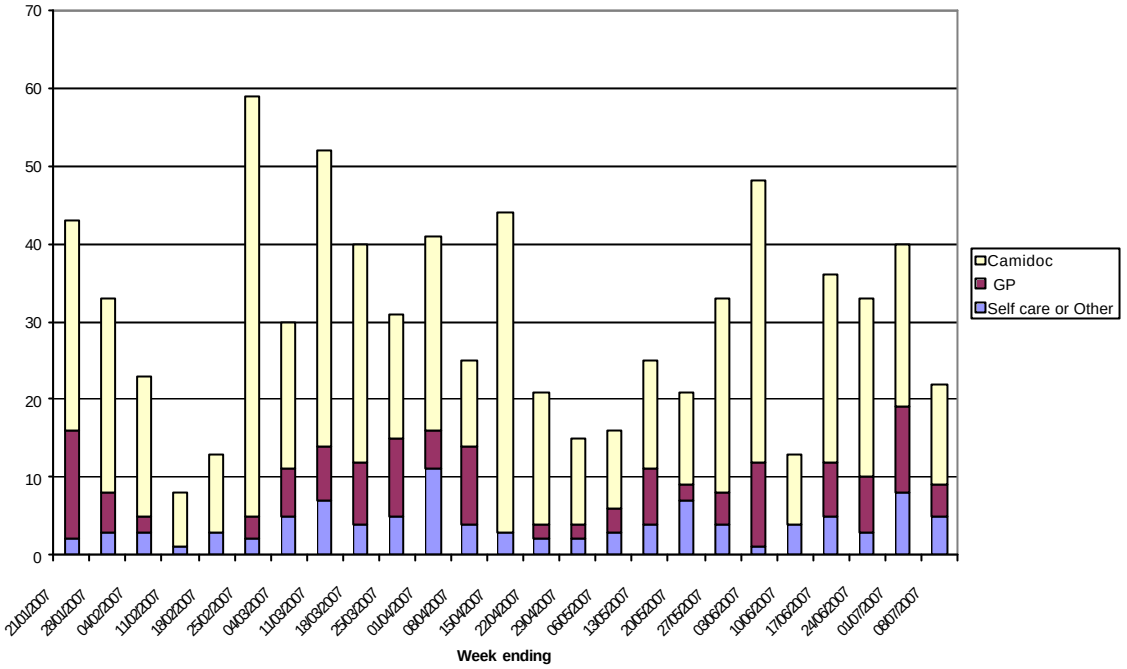


We can also express the impact of Right Care Right Place in terms of daily redirections. Using a denominator of 7 days, which allows us to compare directly with the overall shift in activity, there were, during the 25 weeks of operation examined, an average of 4.3 redirections daily. This is 4% of the 111 average daily minor attendances during this period.

5.1.4 Destination of RCRP redirections

The majority of RCRP redirections were to CAMIDOC the after-hours GP service. On average 70% of redirections were to CAMIDOC, 16% to GPs and 14% to self-care or another provider (pharmacist, etc). This appears to have been a relatively constant pattern throughout the 25-week period.

Figure 4: Weekly redirections by destination of redirection



5.2 Characteristics of patients redirected - equity impact

For the detailed evaluation period which ran from the 21 May until 8 July we were able to divide patients into three groups: (1) patients who consented to be redirected and then consented to be contacted for the patient questionnaire, (2) patients who refused redirection, and (3) remaining patients in the minor triage categories 4, 5 and 6. This enabled us to compare a group RCRP-qualifying patients with those who did not qualify. Our concern here is that the group qualifying for redirection may be substantially different and may represent a disadvantaged group that could be further disadvantaged by redirection. It should be noted this is an imperfect comparison because the group of redirected patients is larger than group (1) - there were additional patients who did not consent to be contacted and there were patients redirected at weekends for which we were not able to organise consent and questionnaires. However, because the minor triage categories constitute such a large group, the inclusion of a small number of RCRP redirected is likely to have little impact on the results. To improve the comparison we restricted the minor attenders group to those who were 18 years and over and minors seen between the hours of 10 am to 8 pm – i.e. the operating hours of RCRP.

5.2.1 Patients qualifying for redirection compared with other minors

During the detailed evaluation period there were 251 RCRP qualifying patients (including 50 refusers) and 5565 other minors were seen. By restriction to adults and RCRP operating hours the comparison group of minors is reduced by almost half to 3031.

The main findings are listed in the table below:

Table 3: Characteristics of RCRP-qualifying patients compared with other patients in triage category 4, 5, and 6

Characteristic	RCRP-qualifying patients	Other minors in triage categories 4, 5, and 6
Females	46%	49%
Mean age	34 years*	40 years
Non-White British ethnicity	73.3%*	62.7%
GP Registered	66.9%*	78.5%
Islington residents	47.4%	43.8%
Employed	44.6%	46.8%
Route of attendance - self	77.3%	66.0%

* Statistically significant difference at conventional levels ($p<0.05$)

The important differences were that the group attending with the range of primary care conditions that indicated that they qualified for RCRP redirection were younger on average (although this comparison was skewed by the inclusion of some children <18 in the RCRP sample), they were less likely to be registered and less likely to identify as White British. Looking across the different ethnic categorisations there was particular over-representation in RCRP amongst those identifying as being from any other white background. This group as a whole makes up 20% of minor ED attendances and typically includes eastern and western Europeans and Turkish.

5.2.2 Differences between patients who qualified for redirection and agreed to be redirected and patients refusing redirection

The group of refusers during this period was small – 50 persons. However, there were still differences we were able to detect. They were much more likely to be registered - only 18% of this group were not registered with a GP. They more likely to be employed - 60% vs. 47% and they were a little older compared with RCRP-qualifying (average 39 years). In other respects - sex, ethnicity, and Islington residence there was no apparent difference.

5.3 Views of redirected patients

We were able to obtain detailed questionnaire information either by telephone or completion of a written questionnaire from 81 patients who were redirected between the 21st of May and the 8th of July.

5.3.1 Characteristics of redirected patients by survey

These finding largely replicate those extracted from the EDIS database except that additional information was obtained about first language and educational status.

- **Sex:** There were more males (57%) being redirected than females (43%)
- **Age:** The majority of all the patients redirected were between 20-29 years age range.
- **First Language:** 56% of the patients said English was their first language. The remaining 44% included Arabic, Polish, Iranian, Turkish, and French.
- **Ethnicity:** The White British ethnic group had the highest number of presentation at 31% (25). Followed by White other 25% (20) and then the Black African 12% (10). Others include the Turkish (2), Greek (2), Latin America (1), and Czech (1).

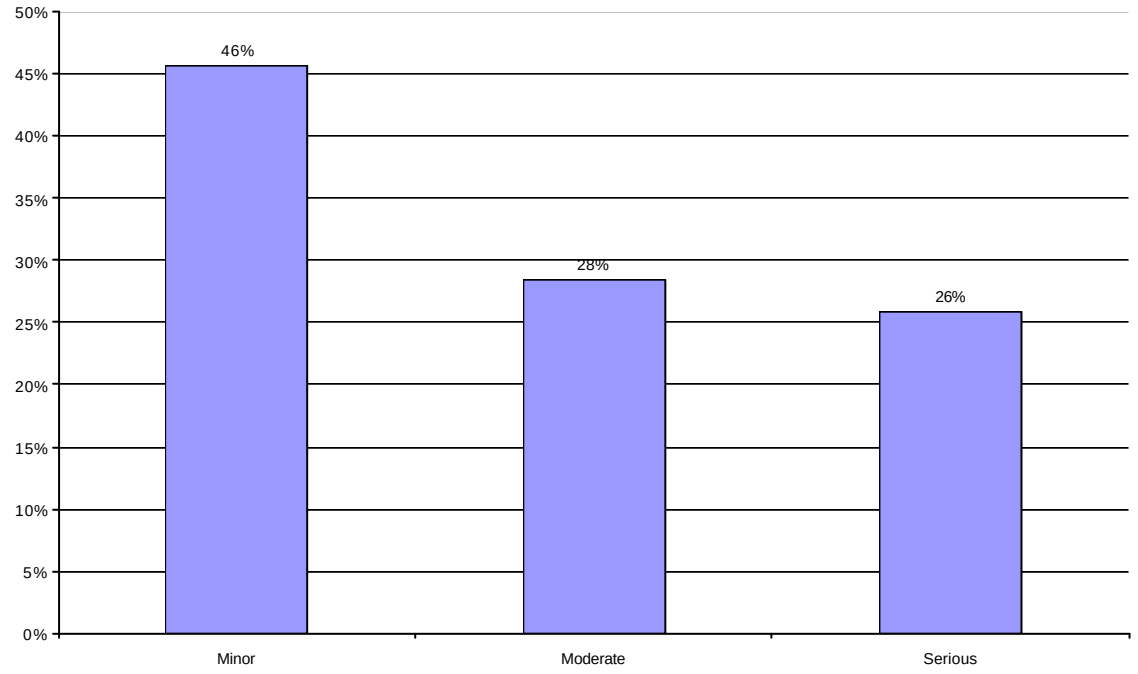
- **Educational Status:** Most of the patients were University graduates 47% (38), followed by Secondary School attainers 30.9% (25). Other levels were Diploma, Primary School level and those with no formal education.
- **Employment Status:** Over half of these patients were working 57% (46) while16% (13) were either unemployed or job seekers. 17% were students while 7% (6) were retired.
- **GP Registered:** Majority of the patients had a GP 68% (55), 28% (23) had no GP while 4% (3) said they had a GP but had not registered with a GP at their new residence.

5.3.2 Attending health problem

Self reported health problems were various and a line listing is given in Appendix 2. Common conditions included sore throats and chest infections, a variety of ear and eye problems, some musculoskeletal conditions and requests for the morning after pill.

46% (37) of the patients rated their health problem as minor, 28% as moderate and 26% (21) as serious.

Figure 5: Patient self-rating of health problem amongst surveyed RCRP redirected

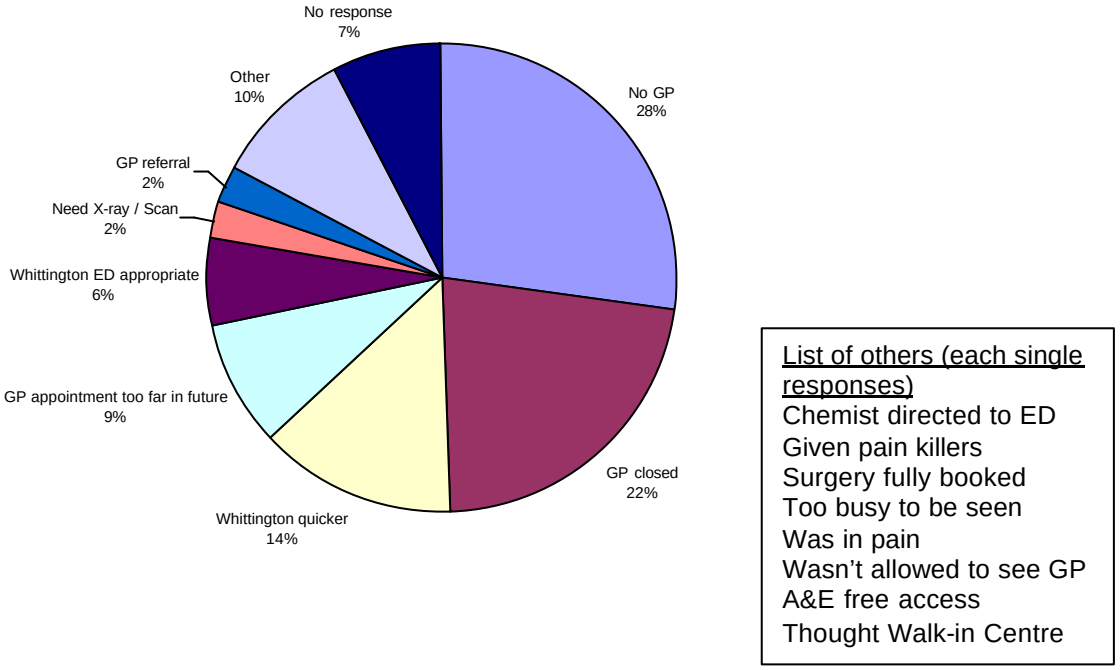


5.3.3 Reasons for redirected patients attending

Around a quarter (27%) had seen a health professional for the same health problem in the past. Of these, half had seen their GP and the rest nominated specialist doctors or pharmacists. Around a quarter (25%) had seen or called a GP or other health provider before coming to the Whittington ED, and of these, three quarters (or 20% of the total) had seen or called their GP. Only 10 respondents gave further information about the outcome of seeing or calling their GP or health professional; 7 indicated that they had been given an appointment too far in the future. For the three quarters of patients who made no attempt to contact a GP or other health professional before attending the most common reason given for attending

was that they had no GP, followed by that their GP was closed, followed by it was felt the Whittington would be quicker. The combined reasons (for those who did and did not contact a health care provider before attending the Whittington ED) are summarised in the figure below.

Figure 6: Reasons for attending the Whittington Emergency Department for surveyed Right Care Right Place redirected patients



5.3.4 Outcome for redirected patients

Amongst the 81 surveyed patients 66 (81%) were directed to CAMIDOC, 3 (4%) to their GP, 1 (1%) to pharmacy and 5 (6%) to self-care. When asked whether they attended the health professional (or self care) as advised or redirected the responses were as below. Many of those who indicated they had attended went to CAMIDOC.

Table 4: Whether attended the health professional when redirected

Yes	63 (78%)
No	3 (4%)*
No response	15 (18%)
Total	81

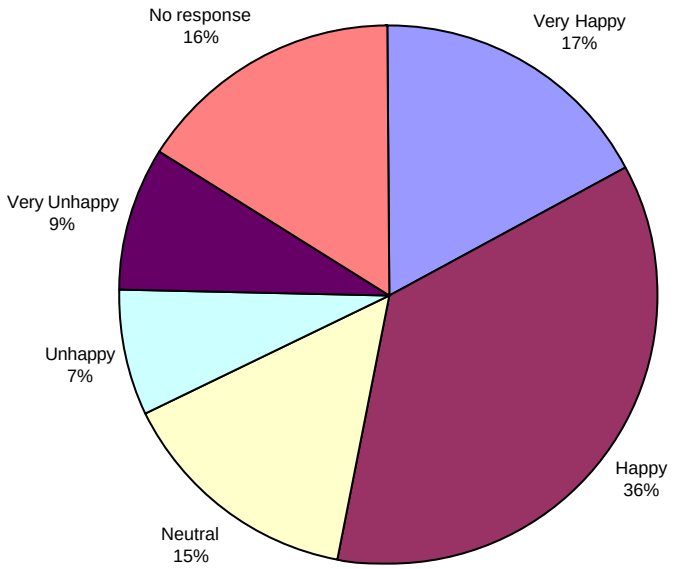
*Reasons: Didn't think was serious, eye got better, time wasting

5.3.5 Overall views of redirected patients about the process of redirection

Patients were asked whether they were happy or unhappy with being redirected and the majority (53%) indicated that they were happy or very happy (see figure). When asked about what aspects they were happy with 35/54 (43%) said that the process was quick. When asked what they were less happy about there were a variety of responses the most common being

asked to come back at a later time (this is a reference to care at CAMIDOC), but also included a few responses such as “rude service” or “felt pushed from pillar to post” (see vignette case reports).

Figure 7: Proportion of patients happy or unhappy with redirection



Patients were also asked overall if they felt satisfied with the care / treatment they received. This question was intended to refer to patients’ treatment after they had eventually seen a health care professional or had self-cared. The distribution of responses was very similar to the above either indicating that overall satisfaction with care was similar to their feelings about being redirected, or that it was difficult to distinguish between the process of redirection and satisfaction with care.

5.4 Clinical acceptability, safety and appropriateness

5.4.1 Information from patient responses

There was limited material that could be gathered from patient responses that would cast real light on the questions of clinical safety. Indirectly if patients are not seen or assessed according to protocol there is a potential for lack of safety. There were a number of persons redirected who were less than 18 years of age – strictly outside protocol.

There was a single self-report for “angina” which assuming it was an accurate self-report should not have been redirected. However, on review of this patients record they presented with probable gout and probably recorded an intercurrent health problem. There was a young 20 year-old female with fever and abdominal pain (see vignettes) who was admitted when representing at Whittington the next day.

5.4.2 Information from health professionals patients were directed to

As described in methods a short written questionnaire was distributed to health professionals via the redirected patient. Each questionnaire referred to the single patient redirected to them. We received 33 completed responses. All of these were from CAMIDOC GPs; none were from other health professionals or a patients regular GP. We asked three different questions of the health professional: whether they whether they thought it was appropriate to see the redirected patient, whether it was safe to have seen the redirected patients, and whether they were happy to see the redirected patient. 100% of health professionals thought it was safe, 85% thought it was appropriate and 79% were happy or felt neutral about seeing the patient (they were not unhappy). The reasons for not being happy to see the patient are given below.

Table 5: Reasons why health professional (CAMIDOC GPs) were not happy to see redirected patients

Patient bypassed normal queue	1
Inappropriate CAMIDOC out of hours attendance – patient should have seen own GP	4
Waste of CAMIDOC time searching for nearby STI clinic	2

5.5 Contextual and operational issues

We did not feel able to describe in detail all constraints that may have hampered the operation of Right Car, Right Place and other people with day to day responsibility for the service are better placed to do this .For example, there were occasional staffing problems that led to no nurse taking on RCRP triage duty, and for the entire period of the evaluation there was no GP registration officer in place. However, some insight can be gained from the views of staff and managers to understand whether the process of redirection was working efficiently, and whether there were any cultural, contextual or attitudinal barriers.

5.5.1 Views of ED nursing staff

The dominant theme to emerge from the focus group with nurses could be described as 'role conflict'. They regard themselves as professionals with the ability to diagnose and recommend treatment but feel obliged because of the RCRP policy to redirect some with primary care conditions. This is often combined with a sense of frustration and a feeling that this is inefficient.

> "There is also a fine line here between somebody saying that they have a viral throat infection that needs no treatment, now are you going to redirect them to their GP to get that diagnosed or are you going to look in their throat and say you just need to go to the pharmacy and get some paracetamol. Now once you have done that, have you treated them or redirected them. You have diagnosed them as an ENP (extended nurse practitioner) yet we treat that as redirected and you still got to write your notes to cover yourself that you have made the right diagnosis. It is quite difficult. And again what's the point sending them to their GP, when you know they don't need any treatment, except going to the chemist."

Offering treatment is the natural role of the ED and ED staff and it felt difficult to send some away. However, a view was also offered that RCRP was a useful alternative that was frequently appreciated by the patient especially when the ED was busy.

Most nurses felt it was an important part of their role to educate patients about their condition, the role of the ED, and that primary care conditions were best seen elsewhere. In this sense they were supportive of RCRP.

Offering redirection as an option was important. Most of those who refused were unhappy to wait to go to CAMIDOC (which is clearly the redirection option which is either most attractive or presented as the most attractive by the nurses).

Not all patients are treated equally and nurses use their discretion when deciding the appropriateness of redirection. For example those without a passport and asylum seekers are not redirected.

Nurses suggested various ways in which RCRP could be improved including using Band 6 nurses, and extending the hours of CAMIDOC.

5.5.2 Views of managers and other stakeholders

There was frankness amongst stakeholders about the potentially conflicting agendas and incentives of Islington Primary Care Trust and The Whittington. In part this is reflected in some of the comments about the culture of the ED (see below). Nevertheless there was recognition from all of the legitimacy of the intention to reduce ED attendance by those that needed primary care attention - either because primary care practitioners were better placed to offer appropriate care, or because this is what they are paid to do.

Reflections on the performance and challenges of Right Care Right Place generally dwelt on operational difficulties ranging from simple staffing issues to cultural. For example the lack of a GP registration officer (due to sickness) was seen as a major impediment as were their hours of work, which only cover 10 a.m.-3 p.m. whereas project hours were 10 a.m. to 8 p.m.

There were several comments along the lines of a change in culture that was needed for successful implementation and this was most concretely expressed as the challenge to "embed the behaviour of redirection in nurses".

> "Because they are trained to treat patients, they do find it difficult to redirect patients especially when it's something they can treat. Some are better at this than others."

> "...the ethos of the trust is treating people and we are turning them away. As a trust when people come to us we want to meet their needs"

Safety was not raised as a major concern by stakeholders except to observe that the protocol, which was designed to minimize risk and enhance governance over the project, reduces the number of patients who can be redirected. The implication here is that there are patients who fall outside the protocol who could be redirected safely but nurses are prevented from doing so.

Reflections on the sustainability and future of Right Care Right Place were mixed. Some felt that RCRP would be taken over by other initiatives such as urgent care. However, there was no shortage of improvements suggested including having an RCRP nurse on duty all the time,

integrating RCRP as part of generic triage, making the protocol less restrictive, ensuring that a GP registration officer was present at all times, and expanding primary care to have options other than CAMIDOC after hours and on weekends.

5.6 Financial savings

We did not evaluate the financial aspects of RCRP in detail. In simple terms redirection of 761 minor attendances over 25 weeks at a cost of £56 each results in a saving to the PCT of £42,616. This is equivalent to annual savings of £88,641. This must be balanced against investment in staff to run the project.

6 Main findings

The main findings of the evaluation of the Whittington Right Care Right Place initiative are summarised below.

- There has been a fall in volume of minor patient attendances at the Whittington A&E of about 5-8% over the course of the last year, from around 240 daily attendances to around 222. This fall was entirely attributable to falls in minor attendances of around 17 daily. 25% of this fall could be attributed directly to RCRP.
- The volume of RCRP redirections was small. On average it amounted to only 4.3 attendances redirected daily. It was small as a total proportion of all minor attendances (4%), small compared with initial predictions and expectations about what could be achieved and very small compared with reports in the literature (from the United States) about the proportion of attendances that could be redirected or "triaged out".
- There was high week-to-week variation in the number of variations and the maximum redirected in any one week was 59 - equivalent to approximately 7.6% of minor attendances This perhaps indicates what can be achieved.
- The main reason for the low number of redirections were most probably a combination of a relatively conservative or restrictive protocol which limited the proportion of patients that could be redirected, nurse staffing and operational problems (this is supported by the high week to week variation in patients redirected), the absence of a GP registration officer which increased the administrative burden on nurses and made redirection to a non-CAMIDOC GP difficult, and 'role conflict' amongst nurses in A&E who found it difficult to turn some patients away.
- The patients who qualified for RCRP redirection were younger, less likely to be registered with a GP (67% cf. 78%) and less likely to identify as being of White British ethnicity (27% cf. 37%) compared with other patients attending for minor conditions (triage categories 4, 5 and 6). However, these differences were not marked and in general RCRP patients were not substantially different from other persons attending with minor conditions. This evaluation does not support the idea that this group attending with primary care conditions was especially vulnerable, although many clearly may need assistance with accessing the NHS including registering with a GP.
- Only one quarter of RCRP patients had contacted another health professional before attending. Most of these had contacted their GP and the most common reason for attending A&E was that they were given an appointment too far in the future.
- Most patients were redirected not to their own GP but to CAMIDOC. This was understandable given that there was no GP registration officer available and it offered a guaranteed appointment to the patient with a GP on site (albeit later in the evening). However, this can be viewed as an operational failing because it continues to provide a substitute service for primary care. CAMIDOC GPs felt they should not have seen some patients for these reasons.

- The majority of patients were generally happy to be redirected and the clearest reason for this is that they were dealt with relatively quickly by A&E staff and did not have to wait. However, a minority were not happy. It is clear that redirecting someone to see a health professional at a later time or date is going to be highly inconvenient to some and this can be seen in some of the case reports included in the appendix
- We found no evidence to suggest that triage was unsafe, however, our methods of determining safety were limited to patient self-reports about outcomes of care and a small sample of responses from CAMIDOC GPs who received some of these patients. There was one self-report that suggested they had been admitted to a hospital at a later date. This is consistent with reports from the literature suggesting a rate of subsequent admission of 1.6% and is plausibly (this needs to be investigated) consistent with the rate of readmission of other minors who are treated and discharged. There were a number of examples of patients redirected who probably fell outside protocol guidance (less than 18 years).

7 Conclusions and recommendations

Right Care, Right Place is at best a modestly successful "triaging out" scheme that currently presents limited return on the investment of time, money and energy by both Trusts. On the positive side it has been carefully conceived, works to a written protocol, is safe and enjoys a reasonable amount of mutual support at a managerial level in both Trusts. It should be acknowledged that operational staffing issues and lack of GP registration officer have impacted on results.

However, RCRP has scope for improvement. There are clearly simple measures that can be taken to improve the scheme and increase the volume of redirections and these are well appreciated by those involved on the project steering group. These include improving way in which the RCRP triage nurse position is staffed, integrating it with the ordinary triage process, and getting a GP registration officer to be there most of the time. We can also anticipate that a liberalisation of the protocol will allow more patients to be redirected. However, the cultural or professional and practical concerns expressed by nurses, who feel reluctant to redirect some patients who they could either easily treat or feel reluctant to turn away, may place a limit on the capacity of such a scheme to deliver two, three or four-fold increases in the number of redirections.

The experience of this pilot raises the question of whether "triaging out" is the best approach to the problem of primary care presentations in emergency. Given that access to a general practice is still a commonly stated reason for attendance there could be still more specific measures that could be done to improve this. There are other schemes with some evidence base - such as incorporating general practitioners into the emergency department - to manage this primary care workload. However, evidence from the United States suggests this is associated with an increase in primary care attendances in the long run.

Next Steps

- Review and expansion of redirection protocol for band 7 & 8 staff
- Use of current protocol by band 6 staff over a 24 hour period
- Development of facilitated workshop for ED and Primary Care staff to shape future model

Bibliography

Beecham L. Accident departments are not used properly. BMJ. 1999 May 8; 318(7193): 1293.

Cooke M, Fisher J, Dale J, McLeod E, Szczepura A, Walley P, and Wilson S. Reducing attendances and waits in Emergency Departments: a systematic review of present innovations. Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO), January 2004.

Cooke M. BMJ 1996; 313:628. Employing general practitioners in accident and emergency departments better to increase number of consultants in accident and emergency medicine.

Cunningham PJ, Clancy CM, Cohen JW, Wilets M. The Use of Hospital Emergency Departments for Nonurgent Health Problems: A National Perspective. Medical Care Research and Review 1995; Vol. 52, No. 4, 453-474

Dale J, Lang H, Roberts JA, Green J, Glucksman E. Cost effectiveness of treating primary care patients in accident and emergency: a comparison between general practitioners, senior house officers, and registrars. BMJ 1996; 312:1340-4. (25 May.)

Dale J, Green J, Reid F, Glucksman E. Primary care in the accident and emergency department: I. Prospective identification of patients. BMJ 1995; 311:423-426

Dale J, Lang H, Roberts JA, Green J, Glucksman E. Cost effectiveness of treating primary care patients in accident and emergency: a comparison between general practitioners, senior house officers, and registrars. BMJ 1996;312:1340-1344 (25 May)

Derlet RW, Nishio D, Cole LM, Silva J Jr. Triage of patients out of the emergency department: three-year experience. American Journal of Emergency Medicine, 1992 May; 10(3): 195-9

Hansagi H. Referral of non-urgent cases from an emergency department: patient compliance, satisfaction and attitudes. Scandinavian Journal of Social Medicine. 1990 Dec; 18(4): 249-55.

Hansagi H, Carlsson B, Olsson M, Edhag O. Trial of a method of reducing inappropriate demands on a hospital emergency department. Public Health. 1987 Mar; 101(2): 99-105

Hangasi H, Allebeck P, Edhag O. Health care utilization after referral from a hospital emergency department. Scandinavian Journal of Social Medicine. 1989;17(4):291-9.

Hilditch JR. Changes in hospital emergency department use associated with increased family physician availability. Journal of Family Practice, 1980 Jul;11(1):91-6.

McGugan EA, Morrison W. Primary care or A&E? A study of patients redirected from an accident and emergency department. Scottish Medical journal, Oct 2000, vol. 45, no. 5, p. 144-7, ISSN: 0036-9330.

McLauchlan CAJ, Harris A. Providing primary care in accident and emergency departments. Referral back to primary care is cheaper. British Medical Journal. 1998 July 18; 317(7152): 207.

Murphy AW. Inappropriate attenders at A&E department I: Definition, incidence and reasons for attendance. Family practice, 1998, Vol. 15, No. 1: 23-32

Robertson-Steel IRS. Providing primary care in the accident and emergency department. BMJ 1998; 316:409-410.

Appendix 1: Case reports

CASE REPORTS – Patients' stories[1]

Case One

Patient A is a 50-year-old working class man, who presented at the ED with vague ear symptoms. He had a GP's appointment for ear syringing, which was too far in the future. Due to the long wait, he decided to attend the ED. The RCRP triage nurse redirected him to the CAMIDOC GP (GP Out Of Hours). He was unhappy with being sent to CAMIDOC, but went anyway. He felt even worse when the CAMIDOC GP referred him back to his GP. He went back to his GP but the relevant nurse to syringe his ear was not available.

"I think everyone is pleasant and professional but I didn't find any solution to my problem and felt rather pushed from pillar to post. I have been to A&E twice, a Walk in centre once and a GP once (relevant nurse not there) all about the same problem. Finally I went to Yorkshire and had my ears syringed"

Case Two

Patient B is a 19-year-old female Diploma student who presented to the ED with chesty cough, sore throat and voice hoarseness. She thought it was a minor illness and contacted her GP. She was given an appointment too far in the future so she decided to attend the ED. She was very happy to be redirected to CAMIDOC because she did not have to wait in the ED, got a doctor's appointment the same day and felt treated nicely by the health staffs. She was however not happy to be asked to come back at a later time that same day. She was satisfied with the treatment she received from the CAMIDOC GP. She is not sure if she will go to her GP first if she had similar health problem in the future.

"CAMIDOC was more helpful than my GP"

Case Three

Patient C is a 28-year-old unemployed female graduate who presented with rashes on her neck. She thought coming to Whittington was quicker than getting a GP appointment. She was happy to be sent to CAMIDOC because she was seen straight away and was very satisfied with the care/treatment she received from the CAMIDOC GP. She will not go to her GP first if she had similar health problem in the future. She will go back to Whittington instead.

"It takes about 2 weeks to get an appointment to see my GP"

Case Four

Patient D is a 21-year-old female who presented at the ED with severe stomach pains, fever, nausea and diarrhoea. She felt her health problem was serious and thought the Whittington Hospital was the appropriate place to manage her health problem. Her GP surgery was also closed. She was indifferent about being sent to CAMIDOC but was dissatisfied with the treatment she received from the CAMIDOC GP. She will not go to her GP first if she had similar health problem in the future. She will go to UCH instead.

[1] These are not intended to be representative but to illustrate a range of different responses

“I was sent home from CAMIDOC feeling really unwell. I was back next day and admitted”

Case Five

Patient E is a 58-year-old woman who attended the ED on a weekend requesting a tetanus injection following an injury to her right foot (stepped on a garden fork). She was very happy to be sent to CAMIDOC and satisfied with the doctor’s treatment because he was able to identify that the wound was infected and gave her antibiotics. But however dissatisfied because she did not get the tetanus injection. She was advised to go back to her own GP.

“I would not have minded paying £20 to see a doctor to get the tetanus injection”

Case Six

Patient F is a 19-year-old university student who developed a painful rash around her neck. She contacted her surgery and was given some tablets by the practice nurse. The painful rash did not resolve so she contacted her surgery again, but was not allowed to see her GP. She was told she had to plan ahead to book an appointment. She was very happy to be redirected to CAMIDOC when she attended A&E and satisfied with the treatment she received. She will not go to her GP first if she had similar health problem in the future. She will go back to Whittington Hospital.

“I was not given urgent attention when I went to my GP surgery. I was not allowed to see my GP and I was in serious pain. They wanted me to plan ahead to book an appointment but illness is not something you plan because you don’t know when or the nature it’s gonna come”

Case Seven

Patient G is a 20-year-old female student who attended the ED requesting the morning after pill. She had been to the chemist because her GP surgery was closed. She was advised to go to the hospital because MAP was not free in the chemist. Though happy to be redirected to CAMIDOC, did not go back to CAMIDOC.

“I have exams and it is time wasting walking back to the hospital again. I had to borrow 25 quid from my friend to buy from the chemist”

When asked what she was less happy with, she said, “The triage room was not private, drunken people falling on me. People heard me say out my personal details at the reception”.

In the future if she had similar health need and her GP surgery is open, she will go to her GP first.

Appendix 2: Line listing of health problems as stated by patients*

Ear problem
Needed morning after pill
Needed morning after pill
Needed morning after pill
Chest infection
Ear pain
Eye growth
Eye infection
Sore eye
Ear infection
Penile itch
Headache
Thought had broken foot
Ear infection
Shoulder pain
Bladder infection
Dizziness, tiredness, high cholesterol
Headache
Skin infection
Eye irritation
Glandular problem
Eye infection
Neck lump
Eye inflammation
Infected bunion
Felt unwell, back pain, painful red spots on back
Sore throat
Muscular spasm and pain after cat scratch
Wrist injury
Hand injury
Sore throat
In growing toenail
Sinus allergies
Ear pain
Severe abdominal pain
Ear problem
Disfigured finger
Elbow lump
Blisters on toes
Angina
Difficulty with breathing
Thought was pregnant and needed emergency pill
Ear infection
Ear problem
Chesty cough, sore throat, loss of voice
Rash on neck
Ear pain and hearing loss
Trigger finger on right hand
Painful neck rash
Ear pain
Throat problem and difficulty with breathing

Foot injury
Needed a new epi pen - allergic to nuts
Ran out of diabetic medications
Foot pain
Swollen hand
Knee tightness
Sore throat
Tendonitis - frozen shoulder
Severe stomach pains, temperature, sickness
Asthma, arthritis, pain in joint, backache
Foot injury - needed tetanus injection
Ear pain
Wort
Hay fever
Back pain
Neck pain
Ear pain and infection
Pleurisy
Strong cough
Arthritis - difficulty walking
Shoulder pain
Hay fever
Swollen painful toe
Cut to finger - thought needed stitching
Ear problem
Spots on face
Sore throat

Note 3 non-responses

Appendix 3: Conditions appropriate for referral to primary care

Typical Walk in Centre conditions

Sore throat (able to swallow fluids)
Colds and flu
Hay fever
Earache, ear discharge
Sunburn (with no evidence of blistering)
Emergency contraception
Opportunistic tetanus vaccination
Suture removal
Dressings
Prescription requests including regular injections
Sickness certificate request
Very minor cuts and bruises
Health advice

General
General health advice and health promotion

ENT
Ear syringing / wax in ear
Colds

Hay fever/allergic rhinitis
Toothache

Sexual health
Pregnancy tests
General contraception advice

Respiratory
Coughs

Skin
Rashes, simple skin disorders eg eczema
Insect bites / stings
Head lice/infestations
Verrucae (for advice, no cryotherapy)
Musculo-skeletal
Minor Sprains, strains
Ingrown Toenails and other podiatry problems.

Notes

On dressings, ROS etc, practice nurses hours of availability and session times and emergency appointments for us to refer to them should also be made available. The patient will otherwise bounce directly back to ED.