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# **Streaming and Redirection: The London Model**

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## Overview

This document details recommendations for streaming and redirection in London's Accident and Emergency Departments (A&Es) and Urgent Treatment Centres (UTCs). It outlines the rationale behind having a separate model for London and the process and methodology used to develop this model.

This document has been produced to ensure London has a clear and consistent streaming and redirection model by October 2017.

It should be noted that as the purpose of redirection is to ensure patients receive the most appropriate care in the most appropriate setting, there is no expectation of redirection as a target.



## Introduction

The *Five Year Forward View (FYFV) next steps* commits to providing an effective, comprehensive front-door clinical streaming service in every hospital by October 2017. In spring 2017 there was a national recommendation that all A&Es should follow the Luton and Dunstable (L&D) model [Primary care streaming: Roll out to September 2017](#).

London's Urgent and Emergency Care (UEC) Clinical Leadership Group (CLG) considered this model and recognised that London has its own specific set of challenges that may require a different model. This was also considered in light of the fact that a clinically agreed specification for Urgent Treatment Centres (UTCs) existed in London, based on the London Quality Standards and published in November 2015. The UEC CLG also recognised that London would greatly benefit from redirection as a key feature of streaming to maximise use of alternatives that have been developed across London, such as GP access hubs, and assist with longer term behavioural change across London where a greater percentage of patients choose A&E to access primary care (7% compared to a 4% national average). [Engagement](#) in 2015 showed that three in five Londoners find urgent care services confusing and 68% of Londoners don't know the difference between 'Urgent Treatment Centres', 'Walk in Centres', 'Minor Injury Units' and GP led health centres. Londoners have asked for services that are easier to navigate and less confusing. A single streaming and redirection model will help provide that desired consistency which will allow Londoners to gain a shared understanding of the best place to access urgent and emergency care, most suitable to their needs within the UEC system.

Recent [Correspondence](#) from Pauline Philip, National Director of Urgent and Emergency Care on 7 July 2017 outlined [national guidance](#) prepared by NHS England and NHS Improvement to support clinical streaming in the A&E department, including streaming to co-located primary care services which allowed greater flexibility than the L&D model and is more closely aligned to the London model.

London's UEC CLG led the development of the streaming and redirection model for London. Over the course of an eight week period in spring 2017 engagement took place with key stakeholders across London's 27 A&E departments and their co-located UTCs in London. This included meetings with A&E Clinical Directors, A&E Consultants, A&E Matrons, Lead Nurses within the A&Es, and providers of urgent care to develop a comprehensive understanding of the range of streaming and redirection models already in place across London. From this research and based on good practice, expert clinical advice, patient feedback and academic research into the practices of streaming and redirection a set of recommendations were drafted.

These draft recommendations were considered by London's UEC Transformation and Delivery Board which is jointly chaired by NHS England (London), NHS Improvement (London) and London's CCGs and has representation from clinicians, the five UEC Sustainability and Transformation Partnerships (STPs) across London, the London Ambulance Service, Health Education England, Directors of Commissioning and Nursing, ADASS, and service users. The draft recommendations were also considered by the GP Five Year Forward View Access Delivery Group, commissioners across London's Urgent and Emergency Care Networks, and the pan-London UEC Patient and Public Network. The proposed model was then further tested with frontline clinical staff across London's A&Es.

The UEC Clinical Leadership Group approved the model on 6 July 2017, endorsement for the model was received from London's UEC Transformation and Delivery Board on 1 August 2017 and the model was signed off nationally on 13 September 2017.

This model is expected to be implemented in line with the national expectation that every hospital must have comprehensive front-door clinical streaming by October 2017.



# Definitions

For the purpose of clarity this document will use the following definitions when referring to the terms 'streaming', 'triage', 'redirection', and 'assessment':

## Streaming

*Streaming is the process of allocation of patients to the most appropriate physical areas of a hospital, and the most appropriate clinical pathways. The purpose of streaming is to quickly determine the most appropriate place for a patient who walks through the front door of an A&E/co-located Urgent Treatment Centre (UTC) to be assessed or treated. This includes sending the patient to the right department within the hospital or redirecting them off-site to a more appropriate setting (see 'redirection' definition below).*

## Assessment

*The process undertaken by a clinician, in whichever area the patient has been streamed to and determines the clinical plan and treatment.*

## Triage

*The prioritisation of cases so that when there is a queue/delay to see a clinician those with time dependent conditions are prioritised over those with other conditions.*

## Redirection

*Redirection is the act of sending patients away (off-site) from a hospital to other parts of the health and care system including other parts of the urgent and emergency care system, specialist services and community and primary care services.*



# 1. Clinical governance recommendations

These recommendations apply to all A&Es and Urgent Treatment Centres in London

Recommendation	Additional guidance
<b>1a. Every A&amp;E/UTC must have a robust clinical governance protocol in place which should include streaming and redirection</b>	<ul style="list-style-type: none"><li>i. Individual organisations should have clinical governance in place aligned with integrated urgent care and in accordance with this document</li><li>ii. A&amp;E Delivery Boards should provide oversight to ensure adequate capacity capability and system-wide overview of the effectiveness of the model</li><li>iii. There should be consistent application of London-wide processes in order to gain access</li><li>iv. Governance should include adverse incident and significant event reporting and investigation procedures led by and reporting to the A&amp;E delivery board with a named contact</li></ul>



## 2. Streaming recommendations

These recommendations apply to all A&Es and Urgent Treatment Centres in London

Recommendation	Additional guidance
<p><b>2a. Streaming should be performed by a suitably experienced clinician with the relevant and appropriate training and competencies</b></p>	<ul style="list-style-type: none"> <li>i. It is recommended (but not limited to) that streaming is performed by the equivalent of a band 6 nurse or above</li> <li>ii. It is recommended that the streamer have detailed knowledge of locally available services</li> <li>iii. It is recommended that the streamer has relevant experience appropriate to that care setting</li> <li>iv. The suggested level of experience is a minimum of 2 years in order to recognise 'red flag' signs and symptoms in ambulatory patients</li> <li>v. It is recommended that the streamer have a solid understanding of primary and community care including time spent in primary and community care</li> </ul>
<p><b>2b. Streaming should be operational 24 hours a day (365 days per year)</b></p>	<ul style="list-style-type: none"> <li>i. None</li> </ul>
<p><b>2c. Streaming should be performed as soon as possible and no longer than 15 minutes after the patient's arrival to the hospital</b></p>	<ul style="list-style-type: none"> <li>i. None</li> </ul>
<p><b>2d. The four-hour A&amp;E target will begin upon arrival at the A&amp;E/UTC in line with national guidance</b></p>	<ul style="list-style-type: none"> <li>i. In line with NHS England guidance 'the clock starts from the time that the patient arrives in A&amp;E and stops when the patient leaves the department on admission, transfer from the hospital or discharge' (<i>A&amp;E Attendances and Emergency Admissions Monthly Return Definitions, 2015</i>)</li> </ul>
<p><b>2e. Where appropriate, observations should be performed and an early warning score calculated</b></p>	<ul style="list-style-type: none"> <li>i. Where appropriate, streaming should include performing observations and calculation of an early warning score e.g. the national early warning score (NEWS) for adults or paediatric equivalent</li> </ul>
<p><b>2f. It is recommended that there are clear protocols and software in place to assist with systematic streaming</b></p>	<ul style="list-style-type: none"> <li>i. Appropriate protocols and software should be in place to assist the streamer in identifying the most appropriate disposition</li> </ul>
<p><b>2g. There should be joint governance of the streaming and redirection service by the Acute Trust and the UTC provider. This must include a written agreement outlining which elements of the patient pathway each organisation is accountable for. The streaming and redirection service should fall within the clinical risk and quality improvement systems of both organisations</b></p>	<ul style="list-style-type: none"> <li>i. When the provider of the UTC is not the Acute Trust, a formal service level agreement or equivalent must be in place and include (but is not limited to) clear lines of clinical and non-clinical responsibility and accountability both within and between provider organisations in regards to streaming and redirection, and be agreed by commissioners</li> <li>ii. In London, when front door streaming is provided by an organisation different to the A&amp;E, existing governance arrangements will remain in place but there should be joint oversight of that governance to ensure a seamless process of the patient journey</li> <li>iii. There is an expectation that London will converge on a model in which the Acute Trust has control of the 'front door' and this should be built into next contract arrangements</li> </ul>
<p><b>2h. A clear list of streams should be made available to the streamer</b></p>	<ul style="list-style-type: none"> <li>i. Streams can include and are not limited to:            Urgent Treatment    Ambulatory care    Majors    Resus    Redirected off site    Paediatric stream(s)</li> <li>ii. No child should be put into a queue to wait without review from a suitably trained clinician</li> </ul>



## 3. Redirection recommendations

These recommendations apply to all A&Es and Urgent Treatment Centres in London

Recommendation	Additional guidance							
<b>3a. The decision to redirect should be made by the streaming clinician</b>	<ul style="list-style-type: none"> <li>i. Although non-clinical navigators may assist in effecting redirection (see recommendation 3f), the streaming clinician should make the decision to redirect</li> </ul>							
<b>3b. Redirection should be to an alternative care setting which can be accessed at the time the patient needs the service</b>	<ul style="list-style-type: none"> <li>i. If appropriate stream is one that needs an appointment, the appointment should be booked - either by the streamer or non-clinical navigator (see recommendation 3f). If that appointment cannot be made, the patient will be seen in the UTC</li> <li>ii. The streamer should have access to the IUC "Directory of Services" (DoS). The CCG will be responsible for the DoS.</li> <li>iii. The redirection system should be able to book appointment where an appointment is required (e.g. general practice or dental)</li> <li>iv. As expected, appropriate safety netting advice should be given to all patients redirected away off site</li> </ul>							
<b>3c. Commissioners should ensure that direct access to alternative services is in place to support redirection</b>	<ul style="list-style-type: none"> <li>i. It is recommended that arrangements are made within the local UEC system and primary care, community services, and GP Hubs to allow for direct access to booking appointments such as: A set number of slots per day within practices; Locally agreed protocols on what services will accept patients when and how</li> <li>ii. National targets for direct booking of integrated urgent care systems should be taken into account</li> <li>iii. A clear escalation protocol should be in place for when systems/alternatives are full</li> </ul>							
<b>3d. There should be a documented record kept of who has been redirected and by whom, where they have been redirected to and what the recommended disposition was</b>	<ul style="list-style-type: none"> <li>i. As a minimum, sufficient information including name, date of birth, complaint, and discharge status (i.e. where they've been redirected to) should be recorded on all patients redirected to allow for an audit trail</li> </ul>							
<b>3e. It is recommended that where appropriate, patients who have been sent to the hospital via another healthcare provider are not redirected away from the site</b>	<ul style="list-style-type: none"> <li>i. If a patient has already sought appropriate direction (i.e. they have gone to their GP first, have been sent to the hospital via 111 or were brought to the hospital via an ambulance) an appreciation of that should take place and care should be taken to avoid patients bouncing around the system</li> </ul>							
<b>3f. Redirection should be supported by a non-clinical navigator subject to levels of demand</b>	<ul style="list-style-type: none"> <li>i. It is recommended that a non-clinical navigator is included in the model when necessary to effect redirection once a patient has been deemed appropriate to be seen elsewhere. The navigator's role can include but is not limited to:               <ul style="list-style-type: none"> <li>- Having local knowledge of services in the area;</li> <li>- Assisting with GP registration and directing patients – i.e. booking transport, giving direction;</li> <li>- Providing a 'patient education' function for long term behavioural change – i.e. provide adequate information on appropriate local services; and</li> <li>- Booking direct appointments for patients.</li> </ul> </li> </ul>							
<b>3g. It is recommended a clear list of local services is available to the streamer and/or non-clinical navigator</b>	<ul style="list-style-type: none"> <li>i. Destinations for redirection can include but are not limited to:               <table border="0" style="width: 100%; text-align: center;"> <tr> <td>Home/Self-care</td> <td>Pharmacy</td> <td>Own GP</td> <td>GP Hubs</td> <td>IUC (111)</td> <td>Community services</td> <td>Specialist services</td> </tr> </table> </li> <li>ii. Paediatric cases should only be redirected by someone suitably qualified and non paediatric-trained streamers should not redirect children</li> </ul>	Home/Self-care	Pharmacy	Own GP	GP Hubs	IUC (111)	Community services	Specialist services
Home/Self-care	Pharmacy	Own GP	GP Hubs	IUC (111)	Community services	Specialist services		



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