PPI and Scoping Review for GP at Door of Accident and Emergency services

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Background

HEALTH | IN CHARTS

One in four UK adults can't see a GP and 12-hour A&E waits are soaring

Eleanor Hayward, Health Correspondent | Max Kendix | Kat Lay, Health Editor

Monday January 30 2023, 10.00pm, The Times

Author: Louis Morris
Job Title: Lead Journalist
Company: National Health Executive
Published: February 28th 2023

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Long A&E waits associated with 23,000 excess deaths, royal college estimates

Norfolk ambulance waits among worst in the country

12th April

HEALTH

Ambulances queues outside the Norfolk and Norwich University Hospital. Picture: Mike Page

By David Hannant
DHannant87
Specialist reporter: health and education

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Comments

Ambulance crews spent the equivalent of three-and-a-half years stranded outside Norfolk's hospitals over the winter, staggering new figures have shown.

Local response strategy:
part of NHSE triage expectations since 2017…
site GPs/primary care next to A&E: GPFD or GDAE

Service Objectives:
* Turn unscheduled into planned care
* Ease pressure in nearby A&E
* Appropriate level of investigation and treatment
-> Can we understand low acuity attenders better, *why* is A&E their best option? And how can they be put on a non-A&E pathway?

Blame Game

Why I feel for that doctor who ranted about A&E time-wasters

By DR MAX PEMBERTON FOR THE DAILY MAIL
UPDATED: 08:32, 5 March 2016

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Suppose you're a doctor in A&E. You are eight hours into your shift when the door to the ambulance bay swings open and a young boy is rushed in on a trolley.

He's been hit by a car. He has multiple fractures and is bleeding profusely.

As the senior doctor in the department, you're ready to fight to save him, but he has a cardiac arrest and dies before you

EXCLUSIVE

News > Health News

TIME IS MONEY One in 10 Brits who turned up to A&E last year turned away for wasting time

Two million 'time wasters' presented themselves to hospital emergency units despite not having 'genuine life-threatening emergencies'

Ryan Sabey
Published: 2:17, 4 Feb 2018 | **Updated:** 2:52, 4 Feb 2018

Nursing Times

ACCIDENT AND EMERGENCY

READERS' BLOGS

Time-wasters in A&E: time to shake the label

05 MARCH, 2015

There is one of those memes doing the rounds on social media; you know, a picture with words to give a message.

2 activity strands for our research:

1) PPI: How can we interview GDAE attenders quickly and without stigma to get honest answers about their health-care seeking decisions?

2) Mixed Methods systematic Review of previous GPFD (GP at door of A&E, GDAE) programmes as described in peer-review literature, what benefits/harms they tried to measure or found

PPI: Pilot questions, approach method, duration, privacy or confidentiality aspects and context of sitting at A&E with a relatively ‘minor’ health problem

1) How to remove/prevent stigma, starting with approach manner

2) How to phrase questions, simple, *quick*, honest

3) Own insights about using A&E for more minor health problems

3 x 1-1.5 hour sessions with 4-5 people in city (Norwich, retired age group), town (North Walsham, young-middle age parents + one teenager), rural area (near Pullham Market, low income parents of young children), especially young / lower income / not Uni-educated public advisors.

- Some Key PPI suggestions:

-- Being told at triage point that a survey was taking place in clinic would be useful, info leaflet at this point
-- Dress down, be approachable and low key. Have an ID (not a random weirdo/fellow pt), but *do not* seem like a clinical person (can't help their medical problem, care not dependent on participation)
-- Ask questions as simply as possible, not age bands but just age & sex, whatever ethnicity they say (e.g., "Saucepan")
-- Be mindful that people feel ill, they are present because they feel unwell, don't make high demands on them
-- Low literacy materials likely to be best, that state key information simply not exhaustively
-- Do not ask them to sign to given consent, how could giving their name mean confidentiality/ too official
-- Do not ask them to look at a lot of paperwork, instead just enough paperwork
-- Collect demographic information at interview start, to demonstrate & state that this is the only personal information collected (age and sex, maybe travel distance)
-- Expect that some people would need to vent, like turning on a tap to have someone listen to their problems, expect to make time for this
-- "*Do any of these reasons apply …*" phrasing

-- People only hear the start and beginning, filler info inbetween won't get absorbed
-- Parents of small children have very small time/attention to give
-- Little expectation of confidentiality in a public place (necessary interview location), unreasonable expectation

From PPI comments: Factors in seeking ad hoc urgent care for non-urgent conditions:

* Coping skills / resilience undermined by poor mental health
* Lack of follow-up care after initial consultations with other HCPs
* Seemingly conflicting/incompatible health advice from different health professionals
* Needing more confidence in advice already given

Reasons…

* People go to A&E for reassurance
* A&E is somewhere you can get a full assessment
* Especially if you have a problem GP tried but can't figure out
* Feels like you'll make definite progress with chronic problems

Above and more, is good background to help us do literature search and frame expectations in application for funding to actual approach patients and ask them questions.

1. Gender: 3 options: M, F, neither / other *Survey Tool Now*

2. May I ask for age of patient ? (in whole years, don't suggest age bands, that makes people have to concentrate harder)

3. Something about travel time or point of origin; *this would need development*.

// START OF DECISION TREE //

4. The health problems that brought you here today, Did you try to see a Pharmacist, GP or visit a walk-in centre about those health problems before you came here today? Yes/No

5a. (only if no to 4.) Do any of these reasons apply for why didn't you try to see someone else?
-> go to Question 7 next. Options = (multiple possible)
-- Not a problem Pharmacist, GPs or walk-in centre can treat
-- Too difficult to see them
-- Needed treatment right away-- Not registered with a GP or don't know how to access those options
-- Other: (state)

5b. (yes to 4) Were you able to get treatment from a GP, pharmacist or at walk-in centre for your health problem before you came here today? Y/N

6a. (no to 5b.) Do any of these reasons apply? Options = (multiple possible) **-> go to Question 7 next**
-- Couldn't get appointment soon enough, or problem was getting worse too quickly to keep trying to get to see someone else
-- Pharmacist, walk-in centre or GP said that I should go to A&E instead
-- Other: (state)

6b. (yes to 5b) Why did you come here after they treated you? Options (multiple possible)
-- Problem got worse or changed
-- Treatment that was given didn't work
-- GP/walk-in centre/pharmacist said to come here
-- Other: (state) ……**-> go to Question 7 next**

// end OF DECISION TREE //

7. Is the health problem that brought you here today something new that only started within the last 2 weeks or a problem that you've had in some kind of way for at least a year? Options =
- Less than 1 week
- More than a month
- Had problem inbetween 1 week and one month, or not sure

8. How long did you think you might have to wait here today?
Code in hours & minutes options (2 boxes)

Literature review:

Primary care clinicians *providing treatment* in or near hospital emergency departments in the UK: A mixed methods systematic review

Objectives: To synthesise evidence about primary care clinicians treating patients in or adjacent to hospital emergency departments in the UK.

Eligible studies were in English and described general practitioners or nurse practitioners that treat patients within or adjacent to hospital Emergency Departments (ED). Searches were conducted in October 2022 on Medline, EMBASE, Cochrane Library and CINAHL databases. 2+ reviewers screened articles, extracted data, resolved via discussion.

Results: From 4189 studies screened-> 20 included studies. Four studies assessed typology and streaming of services. Seven studies reported PPI. Ten studies reported differences in clinical outcomes between primary care and emergency services, but not definitive benefit for either. Likewise, results were equivocal for economic evaluations. Diverse delivery formats complicate evaluation and may explain why clinicians had mixed opinions about the utility of such services. Patients were generally satisfied with the service they received, in either primary care or emergency services.

Conclusion: Diversity of implementation complicate conclusions that can be drawn. Existing evaluations provide little evidence that primary care services in or near emergency departments offers any system advantages for clinical outcomes, or cost savings. Process evaluation in future evaluations is essential to understand what aspects of primary care at emergency departments are likely to improve system and patient care.

Research in context and next steps

Existing related projects

- We used our own PPI in writing up the MM syst. review
- Feasibility of GDAE services: one published service evaluation study (pilot at NNUH) and another study in revision (QEH and JPUH)
- Profiling deprivation of GDAE service users: are high deprivation communities genuinely over-represented or not (and why…. ->)
- Can innovative service pathway (e.g. RAIS) prevent escalation of health care needs, replacing old 'step up' beds system

Future projects (potentially)

- Getting patient perspectives on care quality and access (qualitative)
- Getting real data about patient experiences/decision-making/barriers that lead to A&E attendance for 'minor' problems
- Understanding if reattendances are similar/better/worse for GDAE patients (safety issue; compared to GP-attended patients)
- Can local format GDAE services do better job of repatriating attenders back to regular GP service?

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