Centre for Sustainable Delivery

NHS SCOTLAND

Urgent & Unscheduled Care

Emergency Department Guidance Signposting/ Redirection

Best Practice Guidance (Update)

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Healthier Scotland
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Contents

1. Background

The 6 Essential Actions for Improving Unscheduled Care National Programme first published guidance setting out best practice around 'signposting and redirection' from Emergency settings in 2014, sponsored by the Royal College of Emergency Medicine. The documentation was the outcome of collaboration between an expert group spanning multiple professions, determining best practice guidance in order to 'reduce variation across NHS Scotland and to ensure a consistent, cohesive, safe practice that can be established nationwide'.

This collaborative approach of amalgamating good practice remains at the centre of the Scottish Government's approach to delivering Urgent and Unscheduled Care in Scotland, supported by the National Centre for Sustainable Delivery (CfSD).

Building on significant progress and developments that have already been made through redesign and transformation, the CfSD will support the rapid rollout of new techniques, innovation, and safe, fast and efficient care pathways for Scotland's patients.

By working in collaboration with NHS Boards, health and social care partners, third sector, patients, academia and industry, CfSD aims to implement best practice through a 'Once for Scotland' approach, aligned with the priorities of the Scottish Government.

2. Introduction

The 6 Essential Actions to Unscheduled Care support the delivery of safe, person centred, effective care delivered to every patient, every time without unnecessary waits, delays and duplication.

A key part of this approach is the Redesign of Urgent Care Programme which heralds a significant change in how we provide safe and effective urgent care on a 24/7 basis. This work includes modernising wider Unscheduled Care pathways to ensure the public have access to the best clinical advice and care, from the right professionals, every time. **Right Care, Right Place, Right Time.**

The level of people self-referring to hospital Emergency Departments is returning to pre- Covid levels. It is recognised that some of these patients do not require emergency care and care could be provided closer to home by a more appropriate care provider e.g. pharmacy, GP practice or indeed, managed with self-care guidance.

In order to ensure that citizens are supported to access the right care in the right place, this document builds on the extant guidance, provides a refreshed framework and proposes a number of high impact changes which will enable NHS Boards and Health and Social CarePartnerships to maximise the impact of the signposting approach.

3. Approach

A national Unscheduled Care Short Life Working Group, established in February 2021, was led and sponsored by the Scottish Government (SG). The over-arching group was co-chaired by Craig Cunningham, Head of Commissioning and Performance, South Lanarkshire Health and Social Care Partnership and Eddie Fraser, Director, EastAyrshire, Health and Social Care Partnership.

This group engaged clinical and operational leaders across the system to revisit and build on the extant Unscheduled Care National Redirection Guidance. Membership of the Short Life Working Group is located in Appendix A.

General feedback from Emergency Departments in Scotland suggested they undertake some form of redirection but these are often informal arrangements and there are inconsistencies in application. This variation in approach presents a significant opportunity for improvement to provide consistent signposting and redirection to most appropriate care.

This updated guidance supports a 'Once for Scotland' approach. NHS Boards, Health and Social Care Partnerships, (H&SCPs), Primary Care (PC) and the Royal College of Emergency Medicine (RCEM) have worked collaboratively with the Scottish Government to review and amalgamate best practice examples from across the country and translate them into implementable guidance.

4. Who is this document for?

This guidance offers a framework for NHS Boards and H&SCP's to undertake a critical review of the effectiveness of current signposting approaches. This review should engage key stakeholders and take a whole system approach to developing a consistent and effective process, ensuring the framework laid out in this document are implemented consistently.

5. Purpose of this Guidance

The purpose of this guidance is to:

- provide a framework to enable NHS Boards and H&SCPs to develop a consistentapproach to signposting
- ensure NHS Boards and H&SCPs support citizens to access the right care in theright place

The guidance outlines a set of underlying principles and defines the key component parts of best practice Emergency Department signposting/redirection. This approach is supported and endorsed by the Royal College of Emergency Medicine (Scotland).

6. Signposting/redirection

Signposting and Redirection aims to direct patients to areas/services appropriate to their needs where their healthcare requirements can be better addressed.

6.1 Definitions

Term	Reference	Definition
Signposting	NHS Networks	"Provide patients with a first point of contact which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional. Receptionists acting as care navigators can ensure the patient is booked with the right person first time."
	NHS Greater Glasgow and Clyde	"Signposting is an Emergency Nurse Practitioner delivered process of streaming or directing attendees to specific services within the emergency care system, out with the Emergency Department"
Redirection	Royal College of Emergency Medicine (RCEM)	"The referral of patients who are assessed as not requiring emergency care away from the Emergency Department. This may be to another service or with self-care advice"
Emergency Medicine	Royal College of Emergency Medicine (RCEM)	"Emergency Medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders."[1]

The underpinning principle remains:

'Any guidance that is put in place will have to fulfil basic requirements of Safety, Simplicity, Efficacy and Reliability. The decision to redirect individuals will be based on assessment by an experienced member of clinical staff to ensure that patients receive the right care at the right time, in the right place from the right person'.

Consistent and effective signposting practice offers a number of benefits to the citizen and the system. These include:

- care appropriate to the patient's need in the right place and at the right time for their condition

[1] RCEM CARES during the Coronavirus Pandemic.pdf

- enables and releases capacity for Emergency Medicine clinicians to deliver emergency care to those in need of the skills of an Emergency Department team
- reduces delay in assessment and treatment for clinically urgent cases
- reduces the risk of overcrowding in Emergency Departments and supports the application of safe distancing where required
- provides an opportunity to increase public awareness of alternative routes to access care appropriate to their needs

7. Key Principles and Definitions

The following four key principles reflect best practice and are the basis from which to develop a signposting approach. They are written acknowledging that local interpretation and variation is likely however it is recommended a consistent approach is agreed and implemented.

The principles recognise Emergency Medicine as a specialty and that Emergency Consultants are trained specifically to provide emergency care in accordance with RCEM's definition of Emergency Medicine.

7.1 Principles

Principle 1 - Patients receive the right care, at the right place, at the right time

- Patients self-presenting at Emergency Departments (ED), with a condition not requiring emergency care will be clinically assessed by an appropriate clinician for potential signposting/redirection.
- Where a formal referral from a non-healthcare professional has been made, patients will be registered and, following a timely initial assessment, a senior clinical decision maker will discuss the reason for attendance with the patient and may provide self-care or signposting/redirection advice if considered to be appropriate. If a patient has been formally referred by NHS 24 111, the source of the referral should be taken into consideration in the signposting/redirection process.
- Availability and effective use of Professional to Professional communication prior to presentation will avoid further need for patient signposting/redirection and local pathways should reflect the importance of making this easily available.
- Geographical location to be considered when signposting/redirecting a patient to the right place for ongoing care.

Principle 2 - Ensuring patient and staff safety

- Clinical decisions should involve patient interaction and be underpinned by good practice and care governance processes while being mindful of reducing health inequalities and meeting the needs of the wider population
- It is important that all staff within EDs apply a consistent approach to the application of the signposting/redirection guidance
- Appropriate and robust clinical governance should be in place which includes the ability to share learning from events and provide feedback with

the aim of improving patient and staff experiences. This includes the ability to review and discuss cases, outcomes and share learning.

Principle 3 - Providing effective staff and patient education and communication

- Ensure communication is appropriate to the individual's understanding. Use positive language when undertaking a signposting/redirection consultation and providing subsequent care advice.
- Ensure resources are in place to support signposting/ redirection using leaflets, web-links or telephone numbers
- In the Out of Hours (OOH) period, if it is assessed the patient is not in need of emergency or urgent support, it is appropriate to advise them that they should access services via their own GP practice/other non-emergency services in-hours.
- Where there is considered to be an urgent need which would be more appropriately managed by the OOH General Medical Service (GMS), this should be facilitated via a professional to professional call with the respective OOH service and the patient redirected accordingly. (In many areas, local pharmacies can provide minor ailment/other support in the out of hours period – including weekends - and these should form part of the list of alternative services available to refer to.)
- Safeguarding and redirection to social services should be considered. Provision of good local knowledge to support effective signposting/redirection is essential.
- NHS Boards, Medical Directors, Senior Executives and local teams should provide explicit support for all staff in local board EDs to signpost and redirect confidently. This should also be publicised via signage in the Emergency Department.
- Each Health Board or H&SCP should provide a basic directory of approved local services to include appropriate contact details to facilitate signposting/redirection.

Principle 4 - Sustaining and maintaining services and patient flow

- Resources including the provision of appropriately skilled ED staff (Medical, Nursing, AHP's and non-clinical etc.) are required to sustain new models of working and ensure staff are available and have time to appropriately signpost/redirect patients.
- EDs will be required to review current staffing patterns and redesign accordingly to support the delivery of signposting and redirection.

Guidance Note: Geography and availability of other services should be considered when signposting and redirecting patients, particularly in remote and rural locations. The range of facilities available to Emergency Departments will differ in and out of hours; it is acknowledged that this will impact on the implementation of signposting/redirection at different sites. However, this will provide an opportunity to highlight areas where extended or additional operational hours, or availability of alternative services will help to expand the range of signposting/redirection options.

In line with the requirements of the general equality duty as set out in the Equality Act 2010 you should consult and evaluate the impact of your local policy on your community to ensure this does not cause any disadvantage to others, and in particular those with protected characteristics. Thereby ensuring that the policy does not discriminate unlawfully; consider how the policy might better advance equality of opportunity; and consider whether the policy will affect good relations between different groups. The national team will extend the published iterative Redesign Urgent Care Equality Impact Assessment (EQIA) to consider the national impact.

8. National Redirection Guidance Framework

The following steps are considered high impact changes. **Evidence suggests these are the 4component process steps that will have the greatest impact.** Following the steps set out in each of these key component parts will ensure a safe and effective, consistent approach to signposting/redirection is in place. These should form the basis of local approaches.

Key approach considerations:

1) Trigger
2) Process
3) Clinical decision
4) Clinical guidelines

1) Trigger

Signposting/redirection is not appropriate for every patient presenting to the Emergency Department. A defined group of patients can be identified and considered for signposting/redirection, using a criteria based trigger. Suggested trigger criteria used to initiate a signposting/redirection assessment include, for example:

a) Illness or health problem normally seen and dealt with by the primary care team
b) Conditions with which citizens have already been seen by their own primary careteam or have an ongoing treatment plan in place
c) Condition that has been present for more than 3 days

These criteria should be adapted and applied consistently in the context of local service requirements.

An example of assessment guidance for patients who present to the Emergency Department can be found in Appendix C.

2) Process

A standard system should be put in place so that those identified as ‘potential for signposting/ redirection’ have consistently applied the same process and messaging. The key to the success of the approach is consistency. The process must involve information, education and a review by an experienced Emergency

Department clinician. Suggested process, scripting and patient information leaflet can be found in Appendix D and Appendix E.

3) Clinical decision

A clinical decision around appropriate signposting has to be made by an Emergency Department senior decision maker (with sufficient department experience).

Signposting/redirection will require the senior clinical decision maker to consider safeguarding and will require a working knowledge of available social care and community support services.

It should be acknowledged and accepted that the senior clinical decision maker is sufficiently experienced and therefore able to distinguish between those conditions requiring immediate attention and those which should be referred out with the Emergency Department. See Appendix F for an example signposting/redirection process.

4) Clinical guidelines

Best practice suggests there is a requirement for a number of underpinning protocols for frequent ‘non-emergency’ presentations or ‘primary care type’ presentations. These should be easily accessible and form part of training and development processes to ensure they are fully understood and utilised.

Peer review is recommended and protocols can be shared with other Boards which will ensure variation is minimised and does not undermine the key principles outlined in this guidance.

Clear documentation and guidance for staff applying the principles and written information for patients is essential.

Summary of 4 Key Components and Associated Requirements

1. **Trigger**
   - Criteria based triggers identified at triage
   - 'Flow chart' type protocols for agreed pathways for operational use

2. **Process**
   - Standardised processes/standard operating procedures
   - Monitoring of adoption/compliance
   - Built into existing training and development
   - Scripts to guide conversations for clinical staff
   - Patient information leaflets detailing the approach

3. **Clinical Decision**
   - Clinical decision peer support structure
   - Information on safeguarding/contacts
   - Knowledge of available health and social care services, directory of services in and out of hours
   - Guidance on requirements to be considered a senior clinical decision maker
   - Development opportunities to support learning

4. **Clinical Guidelines**
   - Definitions for 'non-emergency' presentations or 'primary care type' presentations
   - Regular peer review
   - Review of clinical outcomes and information for improvement
   - Overall guidance for staff to refer to detailing the rationale for signposting
   - General information on appropriate use of services

9. Measuring impact of Signposting/Redirection

There are a number of recommendations to ensure that reflection and learning is used to refine pathways and processes. In order to measure the impact of signposting/redirection it is important to:

- regularly review patient outcomes, including where patients were signposted or redirected to e.g. back to GP practice, self-care and community pharmacy
- analyse outcome data to allow for identification of high frequency presentations, ensure consistency in the patient journey and ensure there is continual learning and refinement of pathways
- record total numbers of patients signposted/redirected per site. This will allow an understanding of how effective the signposting/redirection approach is. Examples of how this may be achieved include:

1. regular random sampling of a small group of signposted/redirected patients (10 orso) to ensure signposting/ redirection process was appropriate
2. monitoring non-attendance rates of patients referred to Emergency Department
3. monitoring re-attendance rates to Emergency Department or Acute Care
4. linked data to show subsequent touch points and mortality if CHI is recorded atredirection
5. use surveys or patient feedback forms as measurement tools of patient satisfaction
6. engage with staff involved in redirection to establish areas of concern or highlightopportunity for improvement
7. conduct equality impact assessments to identify any unintended consequences

10. Recommendations

This guidance provides a framework to enable NHS Boards and Health and Social Care Partnerships to develop a consistent approach to signposting/redirection which supports patients to access the **right care, in the right place.**

- this process should be adapted to complement local services and regional requirements
- signposting/redirection practice should be accompanied by patient education and community information campaigns which highlight how to access care for different conditions
- access to Flow Navigation Centres via NHS 24 111 for urgent care not requiring immediate Emergency Department attendance should be promoted to support early signposting or remote assessment, avoiding attendance

It is recommended this guidance is adopted nationally by NHS Boards and Health and Social Care Partnerships across Scotland, to ensure consistency of approach. This is supported by local and national campaigns helping citizens to access the **right care, in the right place.**

11. Next Steps

Additional Support

National Improvement Advisors are available to provide additional support in assessing existing approaches and implementing the high impact changes laid out in this signposting/redirection guidance.

Each NHS Board has access to improvement support and this should already be known and in place. However if you are not sure who your Advisor is, and need to access this support, please email unscheduledcareteam@gov.scot

Guidance feedback and further questions

If you have further questions or would like to provide feedback please contact unscheduledcareteam@gov.scot

Guidance Review

This document will be reviewed on an annual basis by an expert group of clinicians as part of the wider Unscheduled Care programme. The work of this programme is governed by the Integrated Unscheduled Care Steering Group, chaired by John Burns, Chief Operating Officer, and NHS Scotland.

Appendix A – Emergency Department Signposting/Redirection Short Life Working Group Members

This Short Life Working Group was commissioned by the Alternatives to admission workstream, chaired by Craig Cunningham, Head of Commissioning and Performance, South Lanarkshire Health and Social Care Partnership and Eddie Fraser, Director, East Ayrshire, Health and Social Care Partnership.

Members

Gerry Mooney	Unscheduled Care National Improvement Advisor, Scottish Government – Chair of the Short Life Working Group
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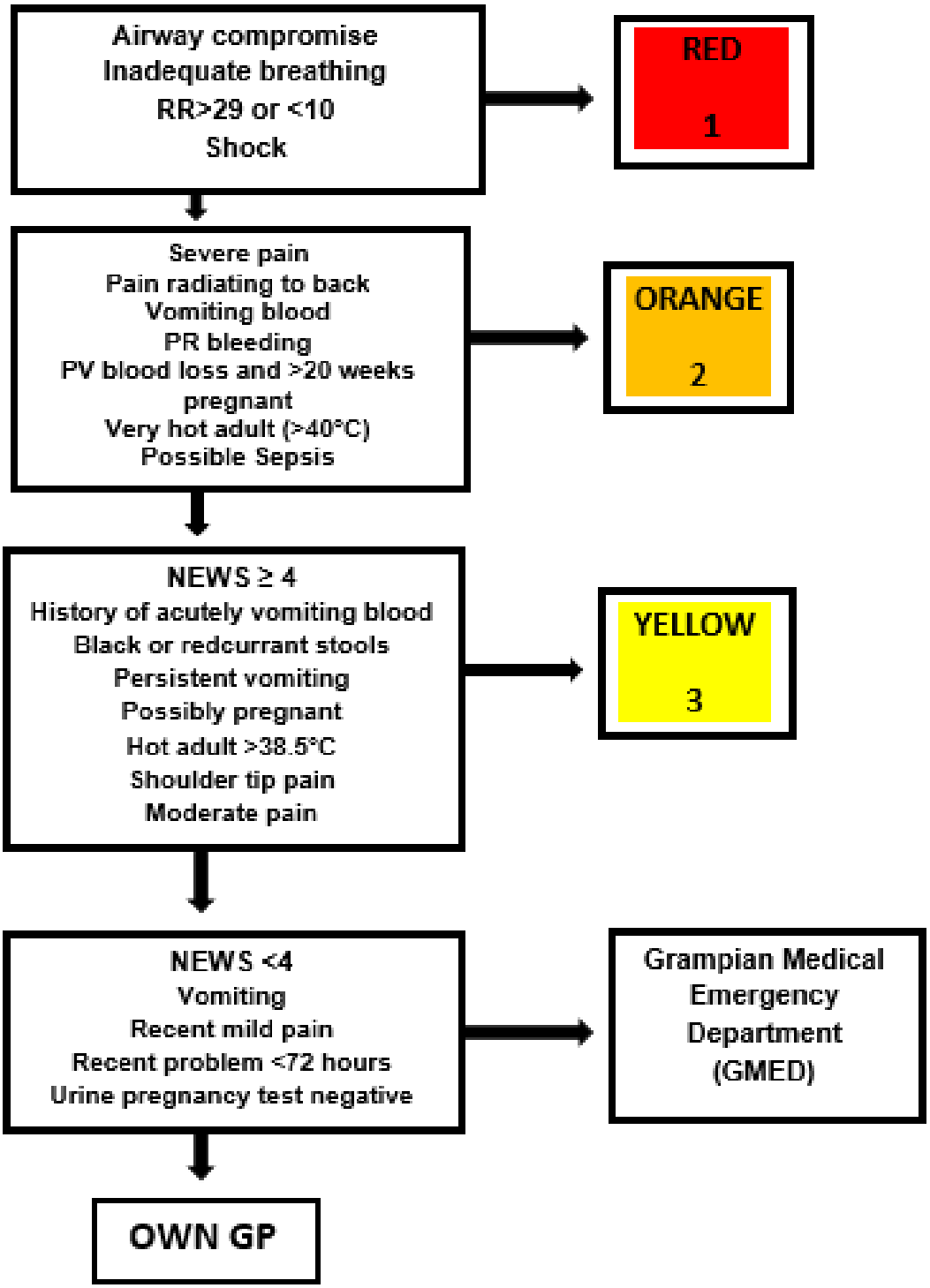
Amanda Trolland	Programme Manager, Unscheduled Care
Merrell Veitch	Project Support Officer, Unscheduled Care

Appendix B: NHS Grampian, Aberdeen Royal Infirmary - Emergency Department Triage Matrix

(Extract example for Abdominal Pain)



Appendix C: Suggested script for post 3-day injury/primary care presentation Signposting/Redirection.

Please note that practices differ by location.

“Hi, I am XXX, one of the Senior Nurses/ Doctors, I just need to have a brief conversationwith you. What seems to be the problem?”

If a patient gives a history of an injury that is over 3 days or presents with a primary care presentation, then they may be suitable to be advised of the signposting/ redirection process

As your injury is more than 3 days old **OR** as your problem is something that would normallybe seen at a GP practice or another of our health services, e.g. MSK physio, we have a **GOOD, SAFE** system where the Senior Doctor/ Nurse will come and speak with you

This is the best system for you as you will be seen by someone senior who will make a decision if you require **EMERGENCY** treatment then we will take you through and provide this or if you can be **SAFELY** signposted/ redirected to another health care professional thatwould be more suited to deal with your problem. This would prevent an unnecessary wait in the Emergency Department without any benefit to you.

This card goes over what I have said and this card lets you know of services available withinNHS XXXX

The Senior Doctor/ Nurse will be with you when they are free.

Appendix D: Example Patient Information Leaflet

NHS XXX Emergency Department

Signposting / Redirection Information

Due to the symptoms you have been experiencing, we think your case:

- May be better dealt with by another health care service locally
- and / or
- May not require immediate treatment in the Emergency Department at this time

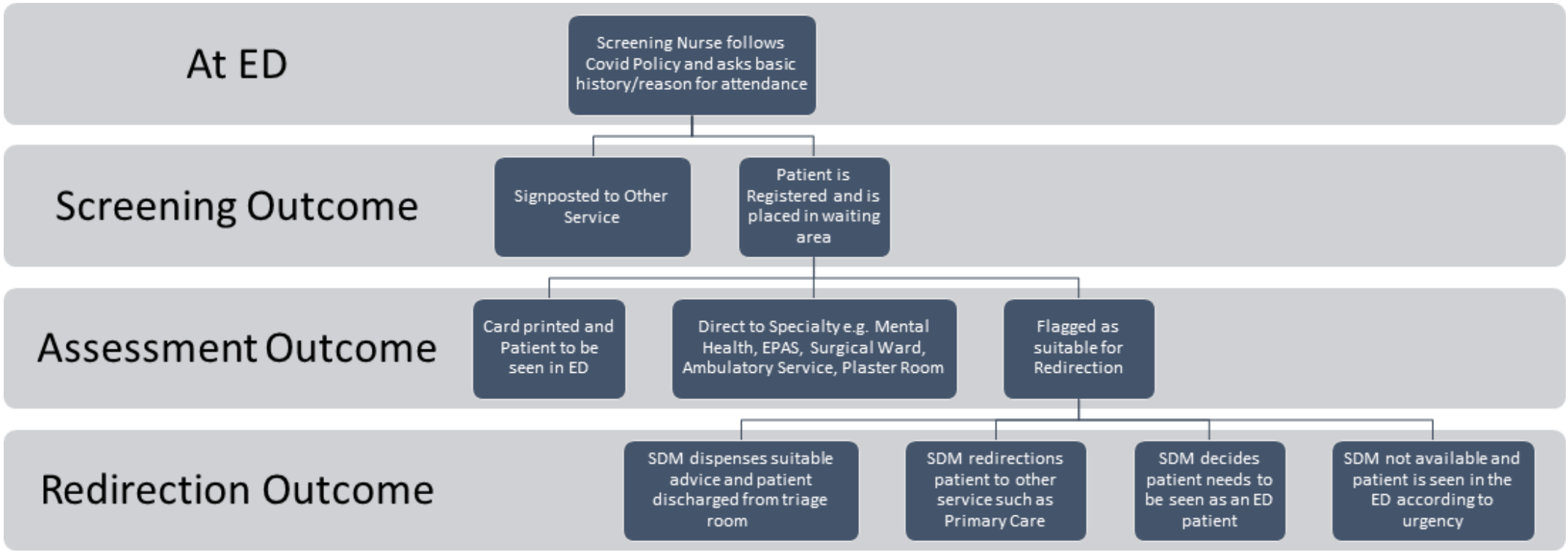
A Senior Doctor/Nurse will speak to you about this when they become available. You may be signposted or redirected to another healthcare service better suited to your care needs.

If you would prefer not to wait, please inform a nurse or member of reception staff. Information on alternative healthcare services can be found at NHS Inform – www.nhsinform.scot. You may also wish to call your GP or call 111 (NHS 24), to be signposted to the most appropriate healthcare service.

If you have any questions, please don't hesitate to ask a member of staff. Remember, if you think you need A&E, but it's not life-threatening, you can now call NHS 24 on 111, dayor night. For additional information or advice, please follow the QR code (example only) orlink below.

https://www.nhsinform.scot

Appendix E: Sample Signposting/Redirection Process at Emergency Department



Appendix F - Signposting/Redirection – Quick reference guide

Trigger - identified at Triage

- Patients attending with an illness or a health problem that would normally beseen and dealt with by a General Practitioner;
- Patients attending with a condition with which they have already attended theirown General Practitioner, and
- Patients attending with a condition that has been present for more than 3 days.

Process

- The patient should be advised that their attendance is unlikely to be appropriatefor the Emergency Department and that a senior member of the Emergency Department clinical staff will decide if they will be seen.
- While waiting they should be given a copy of the guidance which should give apositive message about the advantages of seeking care from alternative care providers and the need for Emergency Departments to concentrate on dealingwith emergencies.

Clinical Decision

- The next step will involve an experienced member of nursing or medical staff.Local circumstances will dictate.
- The patient should be seen by the senior member of the Emergency Department team as early as convenient and advised to seek care from the identified alternative care provider (GP practice/ NHS 24 111/ self-care etc.) unless there isa clear and pressing need for immediate intervention. The following definition is suggested as a guideline in reaching this conclusion:
  - ‘the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected toresult in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part’
- If this is done by a senior member of nursing staff, there must be clear guidelinefor involving, and ready access to, a senior medical staff in cases of uncertaintyor dispute.

Clinical Guidelines

- Each locality should develop a limited number of clinical guidelines to support asignposting/ redirection policy but these should not replace, undermine or be regarded as a substitute for the experience and judgement of the senior clinicaldecision maker.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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