The Royal College of Emergency Medicine Scotland (RCEM Scotland) is the single authoritative body for Emergency Medicine in Scotland. The College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Are services safe, effective, and evidence-based?

1. NHS Scotland’s medical workforce faces a significant challenge to meet the health needs of a growing and ageing population. Scotland’s population is projected to rise by 7% in the next 22 years and the number of people aged 75 and over is predicted to grow by 85% by 2039.¹

2. Accompanying this growth is an increasing propensity to access the health and social care services, including Emergency Departments (EDs), which can place more pressure on the system and compromise patient safety.

3. Partly due to this increase in demand, it is noticeable that we have seen a gradual deterioration in 4-hour performance when compared to five years ago. Whilst this might not seem very significant on the face of it, when we look at the 8-hour and 12-hour performance data, we can see that there are still a substantial number of patients left waiting in busy and crowded EDs for eight hours, or more.²

¹ National Records of Scotland, Projected Population of Scotland (2014-based), Published in 2015
² ISD Scotland, Emergency Department Activity
4. Longer waits in Emergency Departments are associated with higher mortality rates, whilst they also highlight the deeper issues of patient flow through the hospital and congestion in hospital wards.  

5. Nevertheless, over the last couple of years, performance in Scottish Emergency Departments has improved and Scotland continues to have the best Emergency Department 4-hour performance among the UK Nations.

6. This enviable performance is due to a number of reasons including support from colleagues in other hospital departments to ensure patient flow and an evidenced based approach to workforce planning. Indeed, the emergency medicine workforce has risen to keep up with demand: in the space of six years, the number of whole time equivalent emergency medicine consultant staff has increased by 68%, from 131.2 WTE in March 2011 to 220.6 WTE in March 2017.

7. This increase in senior staff has been translated directly into providing more cover to the out of hours period, when EDs are busiest. Emergency Medicine is the only specialty which has achieved this. There is a Consultant present on the ‘Shop Floor’ deep into the night in most EDs now. This has improved patient safety, especially when compared to the past. Consultant cover has also been extended during weekends and public holidays which, due to a reduction in staffing elsewhere in the NHS, still pose a significant safety issue, including creating a backlog of work impacting on the ‘normal’ week.

8. The RCEM Scotland believes that this improved performance points to the beginnings of a safety culture in NHS Scotland. However, limits to resources within both the social care and health care communities mean that Exit Block and ED crowding can still be an issue, causing harm and motility to patients and poor patient experience. Whilst emergency care services are safer and more effective than ever before, we still have a substantial way to go to ensure that the 4-hour standard is constantly met.

Are patient and service users’ perspectives taken into account in the planning and delivery of services?

9. A commitment to deliver high quality, patient centred care should be at the heart of every health care team. However, currently there is insufficient data to understand patient journeys, meaning that the planning and delivery of services are sometimes not well informed.

10. Patient experiences are not robustly collected in Emergency Departments for a variety of reasons. For example, due to the nature of emergency care, patient experience data is hard to collect: the ED is a dynamic place and both patients and staff are in constant motion, making experience data collection difficult and sometimes inappropriate.

11. It is arguable that this lack of research hinders the improvement of patient journeys. When dedicated staff have been involved in shadowing exercises very high-quality feedback is revealed. These exercises are most valuable following the whole patient journey, not just within the walls of the ED.

12. Furthermore, the lack of accessibility to patient care records and variability means that the patient journey is sometimes compromised. If patient records were standardised, health care

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3 C. Sullivan, The National Emergency Access Target (NEAT) and the 4-hour rule (2016) and Nuffield Trust, Understanding patient flow in hospitals (2016)
4 ISD Scotland, NHS Scotland Workforce Information, Consultant staff in post
plans would be formulated earlier, making the transition from hospital based care to community services more timely and efficient, improving patient outcomes overall.5

**Do services treat people with dignity and respect?**

13. Health and social care staff constantly aim to treat patients with care, dignity and respect. However, due to resource constraints and poor patient flow within the health and social care system, this is sometimes difficult to achieve.

14. As already stated, there are still a substantial number of 8-hour and 12-hour breaches in Scottish Emergency Departments.6 The difficulty of meeting the four-hour standard of 95% has been shown comprehensively to be due to “Exit Block”.7

15. Exit Block is symptomatic of other issues. It is directly connected to timely flow into, as well as the timely availability of, appropriate beds in a hospital or social care in the community.8 Exit Block is particularly pernicious as a reduction in operational capacity leads to crowding. ED crowding is linked categorically to poor patient outcomes, poor patient experience and poor staff morale. Indeed, the issues of Exit Block, ED crowding, and under capacity across the acute care journey as a whole, causes harm and mortality.

16. In cases such as these, patients can be left on a hospital trolley on a corridor or ward waiting for an appropriate bed to become free for a substantial length of time, without regular or appropriate care. In these extreme examples, patients are not treated with dignity, respect or high-quality care. We must ensure that clinical governance activities help to reduce these prevailing issues.

**Do quality of care, effectiveness and efficiency drive decision making in the NHS?**

17. Both the Organisation for Economic Co-operation and Development (OECD) and the Nuffield Trust recently concluded that “Scotland is home to a unique culture and set of institutions that seek to improve the quality of health care”.9

18. To some extent, the reports are correct: NHS Scotland uses clear methods of testing quality improvements which are overseen by a single organisation, unlike the rest of the UK Nations. This means that initiatives are more likely to be implemented and that many decisions are based on quality of care and efficiency.10

19. Furthermore, the Scottish Patient Safety Programme’s (SPSP) objective is to “improve the safety and reliability of healthcare and reduce harm, whenever care is delivered” through in-depth data collection and focused programmes.11

20. Nevertheless, the College believes that more time and resources injected into clinical governance is required so that Health Boards can deliver a more robust patient safety programme. At present, some Scottish EDs do not have a clear and organised clinical governance framework which is necessary to drive quality of care decision making.

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5 RCEM Scotland’s written evidence to the Health and Sport Committee’s Technology and Innovation in the NHS – Call for Views (2017)
6 ISD Scotland, Emergency Department Activity
7 The Royal College of Emergency Medicine, Exit Block
8 Ibid.
9 OECD Reviews of Health Care Quality (2016) and Nuffield Trust, Learning from Scotland’s NHS (2017)
10 Nuffield Trust, Learning from Scotland’s NHS (2017)
11 Scottish Patient Safety Programme
21. There are several benefits of Positive Reporting, and learning systems such as ‘Learning for Excellence’ in England drive quality improvement and sharing best practice. There is an opportunity for Scotland to initiate this on a national scale.

Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

22. Clinical governance has been described as “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”. However, the College does not believe that NHS Scotland has optimised these aims.

23. Some of our Members and Fellows working in Scottish EDs have reported that due to funding constraints, organised approaches to clinical governance have been significantly diminished or abandoned altogether. In some cases, clinical governance departments have been closed and the work distributed among other hospital teams. This has resulted in the delivery of much smaller and fewer patient safety programmes. We are also aware of some CG software support contracts not being renewed, with the c.£7000 a year cost being cited as prohibitive when queried by the suppliers.

24. One of our Scottish Fellows commented: “there is little coordinated, recognisable work in this area across our Health Board. We have become reactive and respond only to serious incidents - the feel is that ‘firefighting’ has become the new norm”.

25. It is arguable that a ‘Closed Loop’ system remains in NHS Scotland. The ‘Blame Culture’ is still prevalent and prevents learning from a truly open system. Furthermore, the terms of reference of new systems such as ‘Root Cause Analysis’ are limited. Systemic problems such as staffing or reduction in capacity are placed out of their scope meaning that important data can be missed.

26. The DATIX reporting system (a patient safety system that provides web-based incident reporting and risk management software) has, in some cases, hindered rather than helped. It is not easy to use the system of incident reporting required to drive learning and to help shift the culture further to one which seeks out errors to learn ways to prevent them from re-occurring.

27. Although the College recognises that the safety and quality of Emergency Departments has greatly improved, we should not become complacent, nor should we only concentrate on extreme incidents.

28. The Scottish Government and NHS Scotland should ensure that we constantly strive for improvement, clinical governance teams should be established, or re-established, in every Health Board and patient safety and the quality of services should not be compromised.

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12 BMJ, Clinical governance and the drive for quality improvement in the NHS