Emergency departments

Report supplement: A survey of emergency department staff

AUDIT SCOTLAND

August 2010

Auditor General for Scotland

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Contents

Introduction

1. Audit Scotland published its national report, *Emergency Departments,* on 12 August 2010. The main report is available at www.audit-scotland.gov.uk. As part of our review of emergency departments a postal survey was issued to emergency department clinical staff in Scotland in November 2009. Of the 690 questionnaires issued, 180 were completed and returned within the deadline, giving a return rate of 26 per cent. A copy of the questionnaire is included at **Appendix 1**.

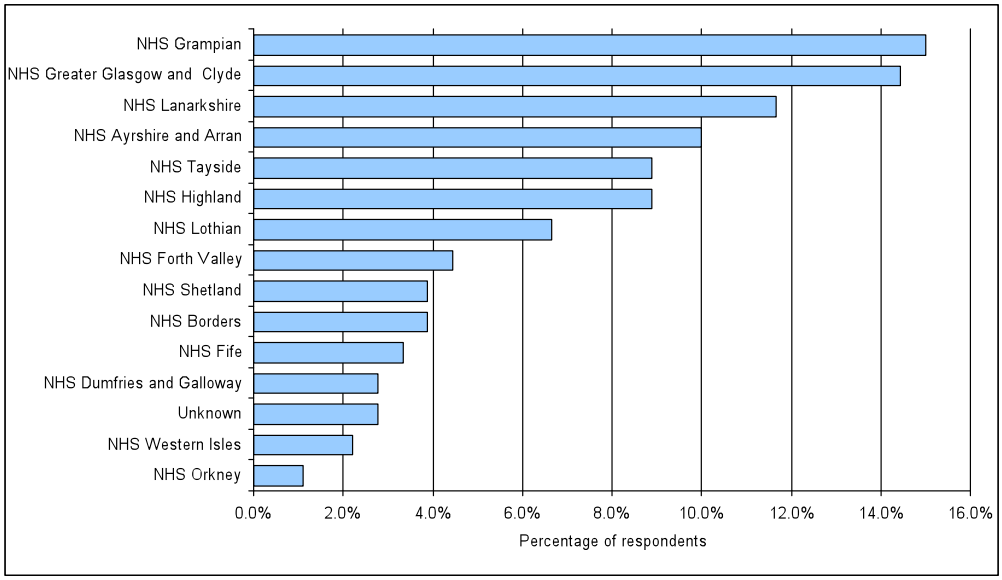
2. The survey explored issues such as reasons for increased demand for emergency care services, the waiting times standard, the effect of the European Working Time Directive (EWTD) and Modernising Medical Careers (MMC) and referrals to the emergency department from other services.

Part 1. About the respondents

3. The survey was sent to emergency department staff in Scotland and staff from each board area responded. **(Exhibit 1)**

Exhibit 1.

Respondents by NHS board area

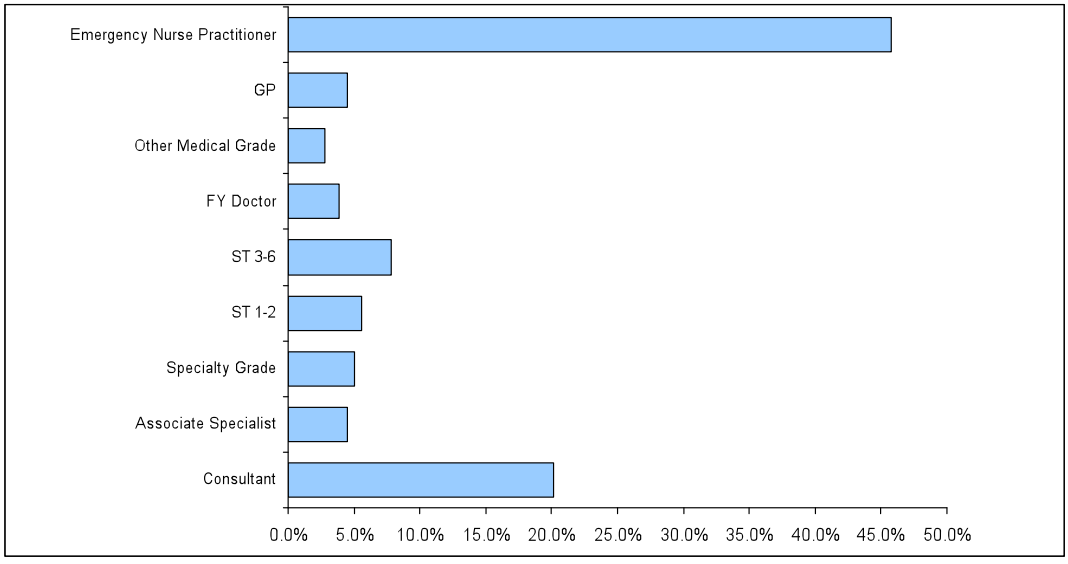


Source: Audit Scotland, 2009

4. Just under half of respondents (46 per cent) are employed as emergency nurse practitioners (ENPs) and one-fifth are consultants. **(Exhibit 2)**

Exhibit 2.

Grade and profession of respondents



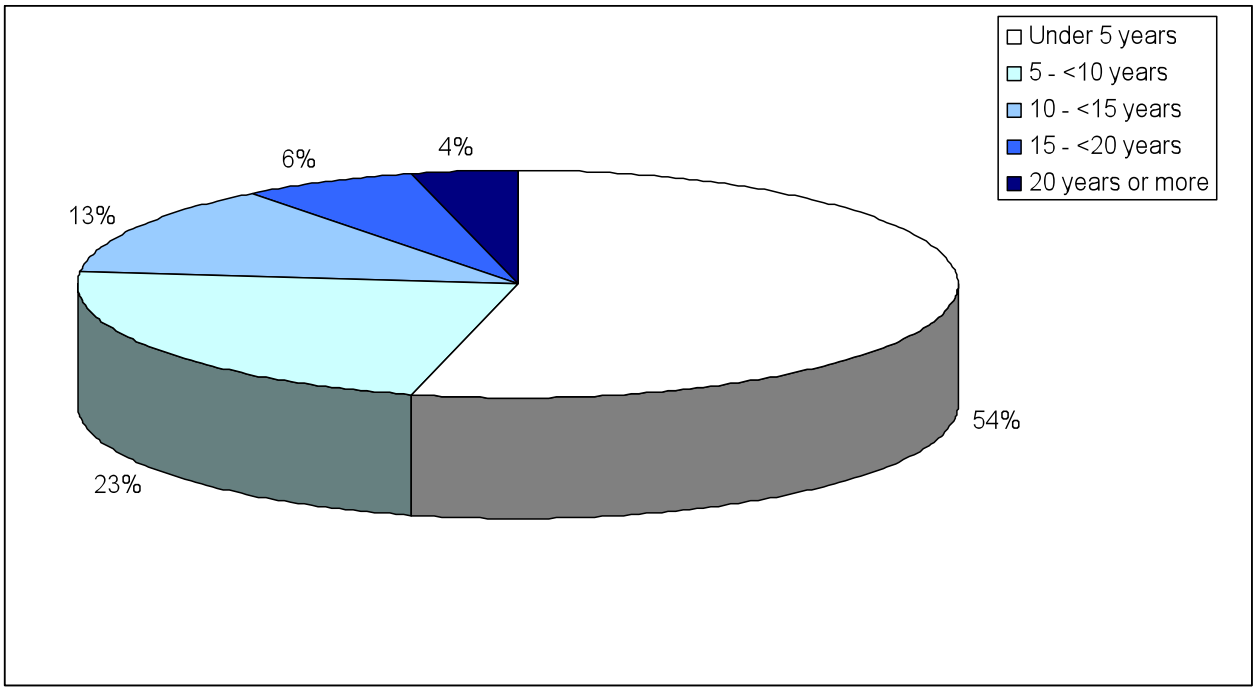
Note: FY Doctors refers to doctors on the foundation programme which is a two-year programme of training in order to gain practical experience as a doctor as well as the general competencies required of a doctor. These doctors undertake supervised training in hospitals and sometimes in general practice. ST refers to specialist training which doctors carry out once they have completed the foundation programme and have chosen which particular area they want to specialise in.

Source: Audit Scotland, 2009

5. On average, staff have been in their current post in the emergency department for just under six years but most respondents have been in post for less than five years. (**Exhibit 3)**

Exhibit 3.

Length of time working in the emergency department



Source: Audit Scotland, 2009

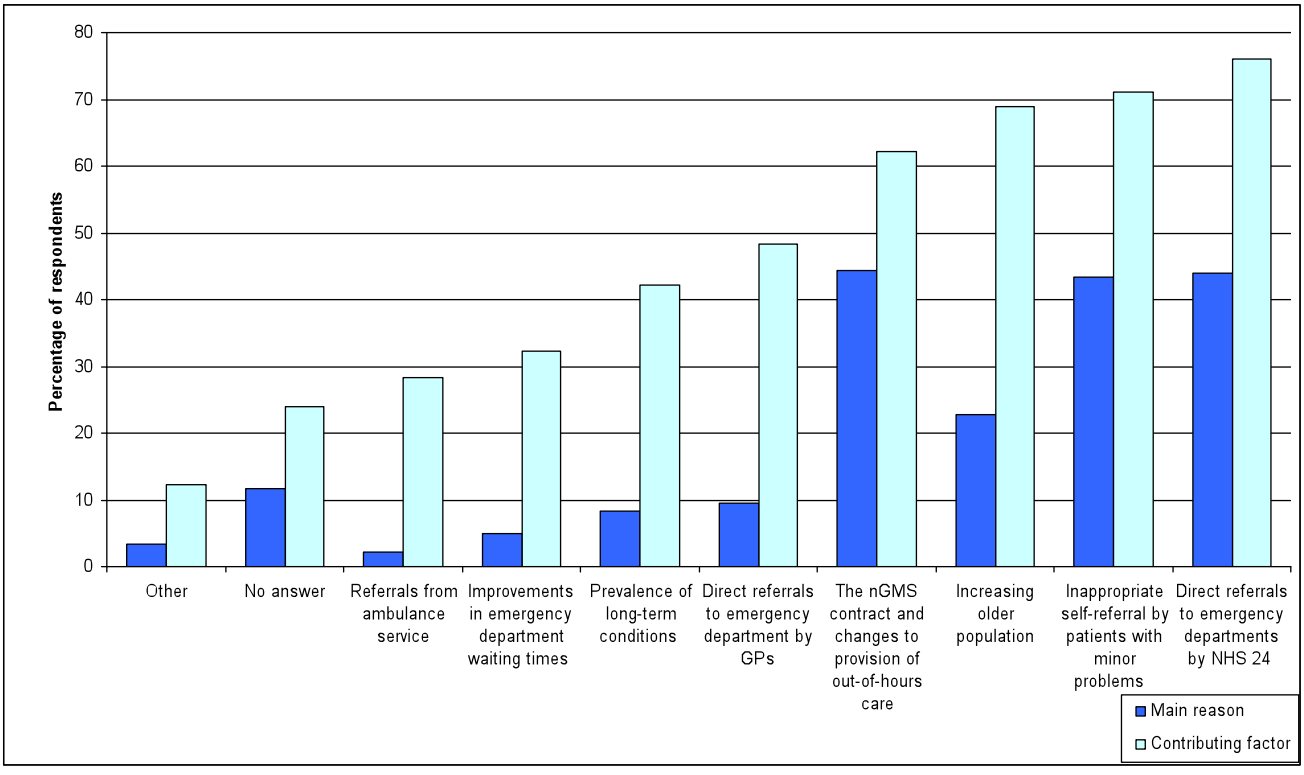
Part 2. Emergency department activity

Demand for emergency department services

6. We asked staff a series of questions about activity. Eighty-seven per cent of respondents said that demand had increased over the last three to four years and of these, 83 per cent said that this had not been matched by an appropriate increase in staff resources. We asked staff to indicate what factors they felt had contributed to an increase in demand for emergency department services. The main reasons given were the introduction of the new General Medical Services contract and changes to the provision of out-of-hours care, direct referrals to the emergency department by NHS 24 and patients with minor problems attending emergency departments inappropriately. [1] Although less than a quarter of respondents felt that the increasing older population was the main reason behind increasing demand for emergency services, over two-thirds cited this as a contributing factor. **(Exhibit 4)**

Exhibit 4.

Reasons for increase in demand for emergency department services[2]



Source: Audit Scotland, 2009

[1] The nGMS contract is a UK-wide general medical services contract, implemented on 1 April 2004, which has made fundamental changes to the way in which general practice is funded and services are delivered. The nGMS contract allowed GP practices to opt out of providing some services, including out-of-hours services.

[2] 'Other' reasons include access to GP services, patient expectation and lack of education.

7. We asked staff to indicate whether they felt that a range of key issues had an impact on the work of their emergency department. Staff felt that the availability of inpatient beds was the issue that had the most impact, with 70 per cent of staff reporting that this had a major effect. Nearly two-thirds of staff felt that a lack of nurses and delayed discharges from wards also had a major effect on their department. **(Exhibit 5)**

Exhibit 5.

Issues which impact on emergency departments

	Major effect	Minor effect	No effect	Not relevant	Not answered
Not enough available inpatient beds	70.0	20.6	3.3	1.7	4.4
Lack of nurses	62.8	22.8	4.4	5.0	5.0
Delayed discharges from wards	62.8	24.4	3.9	2.8	6.1
Impact of Modernising Medical Careers	53.9	23.9	8.9	6.7	6.6
Lack of middle grade doctors (ST 3-6)	51.1	23.3	5.0	12.8	7.8
Delays in admitting patients	50.6	33.9	6.1	2.2	7.2
Lack of staff during antisocial hours (after 6pm and at weekends)	45.0	31.1	8.9	7.8	7.2
Lack of specialty doctors	36.1	33.3	8.3	15.0	7.3
Impact of the European Working Time Directive	36.1	37.2	13.3	6.1	7.3
Delays in accessing specialist opinion	35.0	46.7	8.9	4.4	5.0
Emergency Department too small	31.7	30.0	16.7	14.4	7.2
Lack of junior doctors (ST 1-2)	30.6	32.2	11.1	15.6	10.5
Lack of emergency nurse practitioners	30.6	33.9	19.4	7.8	8.3
Delays in accessing diagnostic services	27.2	44.4	15.6	6.1	6.7
Lack of consultants	26.7	27.8	13.3	28.3	3.9
Lack of admin staff	22.2	36.7	21.7	13.9	5.5
Lack of staff training	21.1	41.7	18.3	10.6	8.3
Lack of associate specialists	16.7	26.7	15.6	28.9	12.1
Lack of communication between providers of emergency care	13.9	49.4	16.1	12.2	8.4
Lack of patient information sharing between health services	13.3	48.3	18.9	11.7	7.8
Inaccurate recording of information (patient data, arrival times)	7.8	30.6	31.1	20.6	9.9
Other[3]	6.7	-	0.6	3.3	89.4

Source: Audit Scotland, 2009

[3] Other issues cited by respondents include poor patient record systems, ambulance arrivals in quick succession and poor layout of emergency department.

Staffing

8. Over half of all respondents felt that Modernising Medical Careers (MMC) had a major impact on the emergency department and over one-third felt that the European Working Time Directive (EWTD) had also had a major impact.[4] [5] Respondents were asked to provide further comments on any effects on the department from either the EWTD or MMC. Staff who provided additional comments felt that current rotas are unsustainable and that some emergency departments have noticed increased use of locum staff, particularly in the out-of-hours period, in order to maintain rotas. Staff noted gaps due to staff shortages which increases the pressure on existing staff and can result in less flexibility for study leave and less time available for consultants to train or supervise junior doctors.

9. Before the introduction of MMC, junior doctors worked in a specialty for six months before moving to their next speciality area, but under the MMC scheme junior doctors spend only four months in a specialty and respondents raised concerns about the impact that this has had on emergency departments.

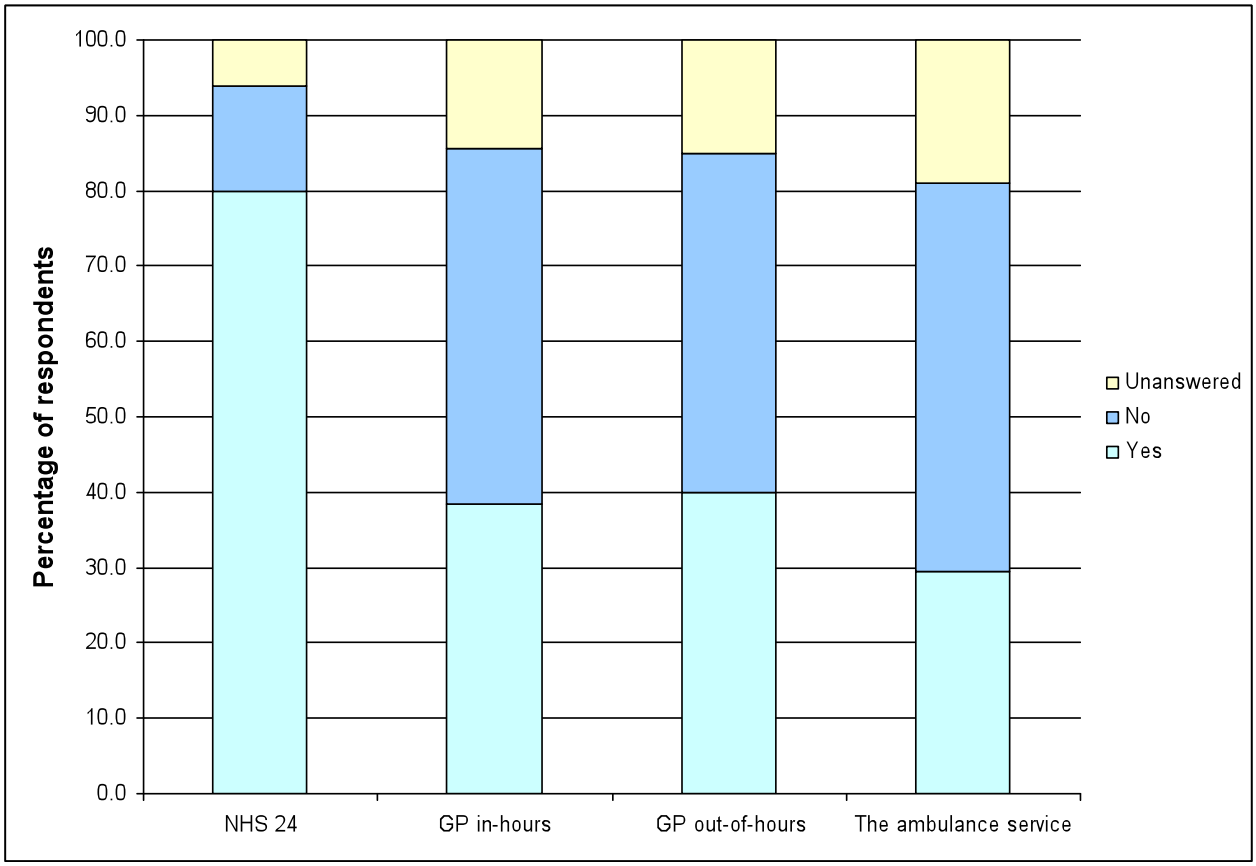
Referrals

10. We asked staff whether they had any concerns regarding referrals from other emergency care providers. The majority of respondents (80 per cent) had concerns about referrals received from NHS 24, compared to 40 per cent who had concerns about GP out-of-hours referrals, 38 per cent who had concerns about GP in-hours referrals and 29 per cent who had concerns about referrals from the ambulance service. **(Exhibit 6)** Staff who provided further comments felt that all emergency care partners were becoming increasingly risk averse which leads to patients being referred to an emergency department when they could have been seen and treated in an alternative setting.

[4] The European Working Time Directive introduced Working Time Regulations in 1998. This introduced a number of entitlements for public sector workers such as a limit on the numbers of hours that can be worked in a week to 48 hours. The introduction of the 48-hour week in the NHS was done in stages with final implementation in August 2009.
[5] The Modernising Medical Careers scheme (now known as Scottish Medical Training in Scotland) was introduced across the UK in 2007. It established a new system of recruitment and training in postgraduate medical education.

Exhibit 6.

Concerns with referrals to the emergency department



Source: Audit Scotland, 2009

11. Concerns about NHS 24 referrals were common across each staff grade ranging from 63 per cent of GPs working in emergency departments to 84 per cent of trained doctors who said they were concerned.[6] Staff recognised the difficulties with assessments by telephone but felt that the NHS 24 directs patients to the emergency department when they could be treated elsewhere. Some respondents mentioned that NHS 24 could improve their awareness of local knowledge and local service provision.

[6] Trained doctors include consultants, associate specialists and specialty grade staff.

Key issues

12. We presented a series of statements to staff about emergency department processes and asked them to indicate their level of agreement with each. (**Exhibit 7)**

Exhibit 7.

Emergency department processes

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly disagree	Strongly disagree	No answer
	(percentage of respondents)					
Emergency Departments should see everyone who presents regardless of clinical need.	8.3	13.9	3.9	31.1	41.1	1.7
There are opportunities for greater co-ordination of care between the ED and other services, e.g. social work, to manage frequent attendees.	52.2	33.3	7.2	1.1	4.4	1.8
High numbers of patients presenting at this ED could be dealt with in primary care.	40.6	31.7	9.4	9.4	7.2	1.7
Patients should be deterred from presenting at EDs with minor injuries and encouraged to attend a Minor Injury Unit where available.	32.2	28.3	21.1	10	6.1	2.3
This board is likely to achieve a reduction in ED attendances by 2010/11.	6.1	7.2	18.9	20.6	42.2	5
The ambulance service and NHS 24 should refer more patients to minor injury services.	23.9	28.3	27.2	8.9	7.2	4.5
Direct transfer of patients to GPs and the Out of Hours service will help reduce demand for ED services.	37.8	38.3	13.9	3.9	2.2	3.9
Ambulance service initiatives such as treat at scene make a positive contribution to avoiding unnecessary attendances at ED.	18.9	15	17.2	9.4	8.3	31.2
More GPs with a special interest in emergency medicine working in the ED would improve emergency care for patients.	20.6	29.4	9.4	8.3	1.7	30.6
Increasing the number of urgent care slots at GP practices will help to divert work from the ED.	54.4	31.7	5.6	3.9	1.1	3.3
Clinical decision units improve care for patients.	26.1	25	37.2	4.4	3.9	3.4
Better sharing of information across health and social care services will improve emergency care for patients.	41.1	38.3	13.9	2.8		3.9
ED staff training in detecting patients at high risk of suicide is crucial.	38.9	34.4	15.6	5.6	2.8	2.7
Carrying out alcohol brief interventions can ultimately cut down on the workload of EDs.	12.2	25	25	18.9	16.1	2.8
A policy of redirecting patients who do not require an ED service is an effective way of reducing attendances.	44.4	27.8	13.3	9.4	2.2	2.9

Source: Audit Scotland, 2009

13. Fifty respondents provided further general comments at the end of the survey and these views mainly focussed on how emergency care could be improved. Of those who commented, the majority of staff felt that emergency departments should expect increases in attendances and that the emphasis should be on improving staffing so that the department is sufficiently resourced to deal with demand. These respondents highlighted concerns about patients receiving their emergency care from GPs or from a minor injury unit, where they feel staff may not be appropriately qualified. However, when all respondents were asked whether a policy of redirecting patients who do not require and emergency department service is an effective way of reducing attendances, 73 per cent agreed that it is an effective method.

Part 3. Waiting times

14. We asked staff to indicate what measures were taken within their emergency department or hospital to help achieve the four hour waiting time target and to sustain the four hour standard.[7] The mostly commonly selected measures to achieve and sustain the four hour standard are: redesign of emergency department processes; improved working between the emergency department and other parts of the hospital; and hospital wide improvement of processes. Less than one-third of staff suggested that capacity and demand data analysis is still carried out. **(Exhibit 8)**

Exhibit 8.

Measures taken to achieve and sustain the emergency department waiting time standard[8]

	Measures taken to achieve target	**Measures taken to sustain standard**
	(percentage of respondents)	
Redesign of emergency department processes e.g. see and treat	68.3	53.3
Improved working between emergency department and other parts of the hospital	63.9	45.0
Hospital-wide improvements in processes and working practices	55.6	38.3
Capacity & demand data analysis	41.7	30.0
Change in shift patterns	36.7	25.6
Use of trolleys in a corridor area	28.9	20.6
Increase in the number of patients admitted to hospital	25.0	16.1
Use of agency/ locum staff	20.6	13.3
Use of a short stay ward	19.4	15.6
Use of emergency department observation ward	18.3	15.6
Extending staff shifts	13.3	9.4
Improved working with the ambulance service and NHS 24	13.3	7.8
Other	5.0	5.0
None	2.2	1.7
Patients waiting in ambulances	1.7	0.0

Source: Audit Scotland, 2009

[7] The four hour waiting time target states that 98 per cent of patients should spend no longer than four hours in an emergency department from arrival to admission, discharge or transfer. The target became a standard in January 2009.

[8] Other measures noted by respondents include increased consultant presence in the emergency department, using data more effectively and reviewing patients who could have been treated in an alternative setting.

15. We asked staff about the four hour waiting time standard and the processes in place locally to meet the standard. (**Exhibit 9)**

Exhibit 9.

Waiting times

	Strongly Agree	Slightly Agree	Neither Agree nor disagree	Slightly Disagree	Strongly Disagree	Unanswered
	(percentage of respondents)					
Clinical care for patients has improved since the introduction of the 98% four hour waiting time standard.	7.2	28.3	28.3	16.7	17.8	1.7
There is always enough time for patients to be adequately assessed or stabilised before being discharged or moved.	8.9	13.9	6.1	35	35	1.1
Patients are moved to inappropriate areas in order to meet the 98% four hour waiting time standard.	20	35.6	8.3	15.6	18.3	2.2
There are no 'trolley waits' in the ED.	8.3	5	9.4	26.1	45.6	5.6
Staff always get the necessary breaks during their shift.	6.7	12.8	7.8	35	36.1	1.6
Performance data on the 98% four hour waiting time standard is always accurate.	13.9	16.1	13.3	31.7	22.2	2.8
Patients are admitted unnecessarily to hospital to avoid breaching the 98% four hour waiting time standard.	13.3	29.4	11.1	25	20	1.2
Patients discharged from the ED are often delayed because of reasons out with control of the ED, e.g. patient transport.	64.4	27.2	1.7	1.7	3.9	1.1
The 98% four hour waiting time standard is sustainable.	11.7	24.4	17.8	25.6	18.9	1.6
Since the introduction of the 98% four hour waiting time standard, patients are sometimes treated depending on how long they have been waiting rather than on the seriousness of their medical condition.	28.3	32.2	10	12.2	16.1	1.2

Source: Audit Scotland, 2009

Appendix 1. Survey questionnaire

Audit Scotland is conducting a survey as part of a review looking at Emergency Departments and how they work with the ambulance service and NHS 24. This survey forms part of a wider data collection exercise on activity, cost and workforce information which we have issued to Emergency Departments across Scotland.

The NHS in Scotland has made significant improvements in the time patients wait for treatment in Emergency Departments. We are keen to capture the views of medical staff and emergency nurse practitioners working in Emergency Departments to inform our national report which is due to be published summer 2010.

We would appreciate you taking the time to complete this short questionnaire. All questionnaires returned will be treated as confidential. Please return your questionnaire to Audit Scotland in the reply paid envelope by *December 18th 2009.* **Thank you for your help.**

Q1. Please indicate the NHS board in which you work _____

Q2. Please indicate your grade within the Emergency Department

Consultant	☐
Associate specialist	☐
Speciality grade	☐
ST 1-2	☐
ST 3-6	☐
FY doctor	
Other medical grade	☐
GP	☐
Emergency Nurse Practitioner	☐

Q3. Please indicate how long you have been in your current post

Q4. Has demand within your Emergency Department increased in the last 3-4 years?

Yes	☐
No	☐
Don't know	☐

Q5. If you think demand has increased, has this been matched with an appropriate increase in staff resources?

Yes	☐
No	☐
Don't know	☐
Not Applicable	☐

Q6. Do you feel any of the following contributed to an increase in demand for the Emergency Department services? (Tick all that apply) And which would you consider the top two contributing factors?

	Contributing factors	Top two factors
The nGMS contract and changes to provision of out-of-hours care	☐	☐
Direct referrals to ED by NHS 24	☐	☐
Increasing older population	☐	☐
Referrals from ambulance service	☐	☐
Inappropriate self-referral by patients with minor problems	☐	☐
Prevalence of long-term conditions	☐	☐
Improvements in ED waiting times	☐	☐
Direct referrals to ED by GPs	☐	☐
Other, please specify	☐	☐

Q7. In column A please indicate which, if any, of the following measures were taken within your Emergency Department or hospital to help achieve the four hour waiting time standard (98% of patients should spend no longer than four hours in an ED from arrival to admission, discharge or transfer). In column B please indicate which, if any, your ED continues to use to sustain the standard?

	A	B
Redesign of ED processes e.g. see and treat	☐	☐
Hospital-wide improvements in processes and working practices	☐	☐
Improved working between ED and other parts of the hospital	☐	☐
Use of agency/locum staff	☐	☐
Extending staff shifts	☐	☐
Improved working with the ambulance service and NHS 24	☐	☐
Change in shift patterns	☐	☐
Capacity & demand data analysis	☐	☐
Use of trolleys in a corridor area	☐	☐
Use of ED observation ward	☐	☐
Use of a short stay ward	☐	☐
Patients waiting in ambulances	☐	☐
Increase in the number of patients admitted to hospital	☐	☐
None	☐	☐
Other, please specify	☐	☐

Q8. Please indicate your level of agreement or disagreement with the following statements by ticking the appropriate box.

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly Disagree	Strongly Disagree
Clinical care for patients has improved since the introduction of the 98% four hour waiting time standard.	☐	☐	☐	☐	☐
There is always enough time for patients to be adequately assessed or stabilised before being discharged or moved.	☐	☐	☐	☐	☐
Patients are moved to inappropriate areas in order to meet the 98% four hour waiting time standard.	☐	☐	☐	☐	☐
There are no 'trolley waits' in the ED.	☐	☐	☐	☐	☐
Staff always get the necessary breaks during	☐	☐	☐	☐	☐

their shift.					
Performance data on the 98% four hour waiting time standard is always accurate.	☐	☐	☐	☐	☐
Patients are admitted unnecessarily to hospital to avoid breaching the 98% four hour waiting time standard.	☐	☐	☐	☐	☐
Patients discharged from the ED are often delayed because of reasons out with control of the ED, e.g patient transport.	☐	☐	☐	☐	☐
The 98% four hour waiting time standard is sustainable.	☐	☐	☐	☐	☐
Since the introduction of the 98% four hour waiting time standard, patients are sometimes treated depending on how long they have been waiting rather than on the seriousness of their medical condition.	☐	☐	☐	☐	☐

Q9. Do you have any further comments on the 98% four hour waiting time standard?

Q10. Please indicate by ticking the appropriate box what effect the following issues have within your Emergency Department. If you feel the issue is not relevant for your department, please indicate this.

	Major effect	**Minor effect**	**No effect**	**Not relevant**
Lack of consultants	☐	☐	☐	☐
Lack of associate specialists	☐	☐	☐	☐
Lack of specialty doctors	☐	☐	☐	☐
Lack of junior doctors (ST 1-2)	☐	☐	☐	☐
Lack of middle grade doctors (ST 3-6)	☐	☐	☐	☐
Lack of nurses	☐	☐	☐	☐
Lack of emergency nurse practitioners	☐	☐	☐	☐
Lack of admin staff	☐	☐	☐	☐
Lack of staff during antisocial hours (i.e. after 6pm and at weekends)	☐	☐	☐	☐
Inaccurate recording of information (i.e patient data, arrival times)	☐	☐	☐	☐
Lack of patient information sharing between health services	☐	☐	☐	☐
Lack of communication between providers of emergency care	☐	☐	☐	☐
Impact of the European Working Time Directive	☐	☐	☐	☐
Impact of Modernising Medical Careers	☐	☐	☐	☐
Delays in accessing specialist opinion	☐	☐	☐	☐
Delays in accessing diagnostic services	☐	☐	☐	☐
Not enough available inpatient beds	☐	☐	☐	☐
Delayed discharges from wards	☐	☐	☐	☐
Delays in admitting patients	☐	☐	☐	☐
Emergency Department too small	☐	☐	☐	☐
Lack of staff training	☐	☐	☐	☐
Other, please specify	☐	☐	☐	☐

Q11. If the European Working Time Directive has had an effect on your Emergency Department, please provide further comment.

Q12. If Modernising Medical Careers has had an effect, on your Emergency Department, please provide further comment.

Q13. Do you have any concerns about referrals received from the following services?

	Yes	No
NHS 24	☐	☐
The ambulance service	☐	☐
GP in hours	☐	☐
GP out of hours	☐	☐

Q14. If yes, please explain

Q15. Please indicate your level of agreement or disagreement with the following statements.

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly Disagree	Strongly Disagree
Emergency Departments should see everyone who presents regardless of clinical need.	☐	☐	☐	☐	☐
There are opportunities for greater co-ordination of care between the ED and other services, e.g. social work, to manage frequent attendees.	☐	☐	☐	☐	☐
High numbers of patients presenting at this ED could be dealt with in primary care.	☐	☐	☐	☐	☐
Patients should be deterred from presenting at EDs with minor injuries and encouraged to attend a Minor Injury Unit where available.	☐	☐	☐	☐	☐
This board is likely to achieve a reduction in ED attendances by 2010/11.	☐	☐	☐	☐	☐
The ambulance service and NHS 24 should refer more patients to minor injury services.	☐	☐	☐	☐	☐
Direct transfer of patients to GPs and the Out of Hours service will help reduce demand for ED services.	☐	☐	☐	☐	☐
Ambulance service initiatives such as treat at scene make a positive contribution to avoiding unnecessary attendances at ED.	☐	☐	☐	☐	☐
More GPs with a special interest in emergency medicine working in the ED would improve emergency care for patients.	☐	☐	☐	☐	☐
Increasing the number of urgent care slots at GP practices will help to divert work from the ED.	☐	☐	☐	☐	☐

Clinical decision units improve care for patients.	☐	☐	☐	☐	☐
Better sharing of information across health and social care services will improve emergency care for patients.	☐	☐	☐	☐	☐
ED staff training in detecting patients at high risk of suicide is crucial.	☐	☐	☐	☐	☐
Carrying out alcohol brief interventions can ultimately cut down on the workload of EDs.	☐	☐	☐	☐	☐
A policy of redirecting patients who do not require an ED service is an effective way of reducing attendances.	☐	☐	☐	☐	☐

Q16. Please use this box for any further comments you wish to make.

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