LETTER FROM DEREK FEELEY, ACTING DIRECTOR GENERAL HEALTH AND CHIEF EXECUTIVE OF NHS SCOTLAND TO THE CONVENER OF THE PUBLIC AUDIT COMMITTEE, 26 NOVEMBER 2010

Thank you for your letter of 10 November to Dr Kevin Woods, which is further to the oral evidence we gave to the Committee at its meeting on 27 October about the Auditor General's report *Emergency Departments*. Following that session, the Committee has asked for some additional information. I am pleased to respond as follows:

**Increasing demand on emergency services and inappropriate attendances**

The Committee asks how we are working with NHS boards to manage down emergency department attendances, and encourage people to use other services where appropriate, such as GP surgeries or minor injury units.

The Scottish Government has a national Emergency Access Delivery Team (EADT) to oversee the work carried out by NHS Boards and their partners to reduce the number of patients attending A&E with non urgent or minor conditions that could be better treated outside acute hospitals. Through the EADT we have been working with NHS Board leads in unscheduled care and a wide range of partners to implement a range of initiatives designed to support people in accessing appropriate care quickly. We have also established a learning network that meets regularly to share information and experience and NHS Boards provide quarterly reports of progress against a set of milestones. There is also a HEAT target for A&E attendances, which forms part of the Local Delivery Planning process.

The Committee asks for information on whether any of the pilots or initiatives identified during oral evidence to manage down inappropriate attendances will be rolled out across Scotland; and when and how we will measure their effectiveness. Patient education is one of the key elements of our strategy to reducing the number of unnecessary attendances to A&E departments; and I am grateful to be given this further opportunity to tell the Committee more about the approach we are taking in this area.

The key pilot referred to during our oral evidence session is the “Know Who to Turn to” awareness campaign, which took place in the NHS Grampian area between May and August 2009. The effectiveness of the pilot was fully evaluated and led to us rolling out the Know
Who to turn to marketing toolkit and associated material in March 2010 to all NHS Boards, along with funding to help them run similar social marketing campaigns in their areas. Scottish Government officials and Health board representatives will be meeting shortly with NHS 24 colleagues to discuss how the NHS Board materials could feature on the recently launched NHS Inform website so the public can access all the NHS Boards’ marketing material from one source.

Following the national Unscheduled Care conference held in Dundee on 25 June 2010, we published the ‘Building on Success: Examples of Progress in Unscheduled Care’ guide. This important guide sets out the detail of the various areas of good unscheduled care practice that were showcased or mentioned by NHS Boards at the Conference. The guide was published on 14 August and sent to all NHS Chief Executives to let them see what various innovative approaches have been taken across the country; and to consider whether any of these practices could be adopted in their Board area.

The guide can be viewed at:


There are a range of other initiatives being piloted in different Board areas which will be rolled out as appropriate during 2011/12. These include:

- the use of clinical protocols for patient redirection from A&E to other more appropriate sources of care and treatment;
- targeted social marketing specifically for young people and for parents with young children who are high users of A&E for minor conditions; and linking information on frequent attendees to ensure patients get the right support in the most appropriate place; and
- improving access to primary care in-hours for both planned and urgent care.

From April 2011, improvements in the rates of attendance at A&E will be monitored via the HEAT target mentioned earlier in this letter.

Monitoring and information on activity, cost and quality

We advised the Committee during our evidence session that ISD Scotland and the College of Emergency Medicine were developing a range of indicators on quality to compliment the four-hour waiting target. The Committee asked for further information on these indicators, including what these indicators will measure, how they have been selected, when they will be implemented and how they will improve and complement the measurement of activity, cost and quality.

A prototype medical profile with a suite of clinical indicators on medical specialties (including emergency medicine) is in development. This work is being led by NHS QIS and ISD with input from the Scottish Branch of the College of Emergency Medicine. ISD provides routinely available data, and information obtained from national clinical audits for inclusion in the pack. The pack is being piloted with 2 NHS Boards and currently provides rates and comparisons for unplanned returns and information around the 4 hour wait standard.
We anticipate that following this pilot stage, and any subsequent changes, that information will be published, although timescales have yet to be confirmed. The profile is linked to a governance framework designed to ensure there is accountability for reviewing and acting upon the data locally in order to stimulate reflection on clinical practice and service provision.

I can also advise that ISD recently closed their consultation about the publication of routine A&E data that are submitted to ISD. The consultation, which took the form of a survey, presented a number of charts and asked respondents to score their usefulness either as published data in the public domain or as management information for improving services, planning, efficiencies and benchmarking.

Responses to the consultation were received from 62 individuals who represent a variety of backgrounds e.g. Emergency Medicine Consultants, General Managers, Public Health Specialists, Local Authorities and Scottish Government. The survey presented 16 different charts for comment; examples include death rates in emergency departments, admission rates following an attendance, discharge and costs associated with Attendances. Work is underway to analyse the responses, some high level findings are:

- respondents indicated that the majority of the charts would be useful to them in their role;
- suggestions were provided on how the charts/tables could be enhanced to make them more useful/relevant to their needs;
- respondents indicated that quarterly publication of some of the charts would be advantageous, others suggested that annual would be more appropriate;
- management information is required more frequently; and
- the data should be fully described to highlight the differences in working and recording practices across Emergency Departments

A final report on the consultation will be published mid/end December 2010 indicating frequency and content of both publication and management information.

Four hour wait standard

Your letter refers to the concerns that were expressed by Dr Woods at our oral evidence session about figures in the AGS Report on moving patients to meet the four hour wait standard when he advised that the figures may not be accurate. The Committee seeks our further views on the accuracy of that information.

Dr Woods confirmed at our oral evidence session that any decision by a doctor to admit a patient must be based first and foremost on the clinical assessment of the patient’s needs at that time; any definitive assessment as to whether that admission was necessary or not can only be made later. Whilst we accept that an unnecessary admission will occur from time to time, the four hour wait time standard should have no influence on clinical decision making and I am aware of no evidence that it has had such an impact – a point re-inforced by Dr Bill Morrison during our dicussions with the Committee.

By way of further clarification on the points we made at our Committee session, I would advise that our particular concerns are around paragraph 59 of the Auditor General’s report where it states that “Over 55 per cent of staff feel that patients are sometimes inappropriately admitted to hospital to avoid breaching the standard.” Having examined the detail of the postal survey used by Audit Scotland for their report, we note that only 180 of the 690
questionnaires distributed were returned and that 46% of the responses were from Emergency Nurse Practitioners who represent just 17% of the emergency medicine workforce – staff who, as the Audit Scotland report confirms have admitting rights in only 2 of the 30 emergency departments surveyed.

We would also ask the Committee to note that the quoted figure in the Audit Scotland report of “Over 55 per cent of staff” correlates to the responses to a statement which said that “patients are moved to inappropriate areas”, not that they are “inappropriately admitted”. A patient may be moved to what is perceived as an inappropriate area, but this is very different in meaning to an inappropriate admission.

Treating access: a toolkit for GP practices to improve their patients’ access to primary care

The Committee has asked for a copy of the guidance which Dr Woods referred to at our oral session on access to primary care. The toolkit guidance enclosed with this letter was published on 15 November 2010; and has been developed by RCGP Scotland, the Scottish Government and other partners to help practices improve access to appointments, treatments and information.

The toolkit makes a range of innovative suggestions about how GP practices can improve access, including setting up patient groups, increasing use of Healthcare Assistants and Nurse Practitioners and increasing use of the internet for ordering prescriptions and booking appointments. It also recommends increasing capacity at busy times, moving clinics away from periods of peak demand and using telephone consultation where appropriate.

The access toolkit was developed by a working group made up of representatives from RCGP Scotland, the Scottish Government, Practice Nurse and Practice Managers Networks, NHS boards and patients after wide consultation. It follows a medical model which will be very familiar to practices. It describes the symptoms that exist when access is a problem, such as how easy it is to get through on the phone and how long a patient has to wait to see a GP. After the problem has been diagnosed, the toolkit provides advice on how to treat the problems where they exist.

Officials are negotiating with RCGP Scotland how the work from the toolkit can be taken forward and RCGP have put forward a training proposal for discussion.

I hope this additional information is helpful.

Yours sincerely

DEREK FEELEY
I am writing to thank you and your colleagues for the oral evidence you gave to the Committee at its meeting on 27 October 2010, as part of the Committee’s consideration of the Auditor General's report *Emergency Departments*. A copy of the Official Report of that meeting is available at the following link:

http://www.scottish.parliament.uk/s3/committees/publicAudit/meetings.htm

Following that evidence session, the Committee agreed to write to you on a number of issues raised during discussion and would appreciate further information on the following.

**Increasing demand on emergency services and inappropriate attendances**

The Auditor General for Scotland reported that attendances to emergency departments are on the increase, despite the Scottish Government setting a HEAT target to reduce attendances between 2007/08 to 2010/11. (*Emergency Departments*, Page 34) The Committee also had concerns about the increasing numbers inappropriate attendances at emergency departments and therefore questioned witnesses on how the Scottish Government would ensure that there is a focus on services that are more appropriate to people’s needs (Public Audit Committee Official Report, 27 October, Col 2068).

- How is the Scottish Government working with NHS boards to manage down emergency department attendances, and encourage people to use other services where appropriate, such as GP surgeries or minor injury units?
- The Committee would appreciate information on whether any of the pilots or initiatives identified in oral evidence to manage down inappropriate attendances will be rolled out across Scotland, when, and how you will measure their effectiveness.

In oral evidence to the Committee, Dr Bill Morrison informed the Committee that work needs to be done to equalise and improve access to primary care, out of hours and within hours. (Public Audit Committee Official Report, 27 October, Col 2071).

- You offered to provide the Committee with a copy of the Scottish Government’s forthcoming guidance on the issue of access to primary care and the Committee would be grateful if you could provide this with your response.

**Monitoring and information on activity, cost and quality**

The Auditor General for Scotland’s report highlights a number of areas where there is inadequate information to demonstrate that the best use is made of existing emergency care resources (*Emergency departments*, page 3). For example, the AGS reports that data on the four-hour waiting standard are incomplete (page 21), information on why people attend emergency departments is limited with unhelpful data on triage and flow categories (page 15 and 16), there is confusion over the different status of short-stay wards, observation units, clinical decision units and assessment units (page 18) and until accurate data are in place, it will be difficult for NHS boards to actively manage demand for emergency departments. (page12)

You confirmed in oral evidence to the Committee that ISD Scotland and the College of Emergency Medicine are developing a range of indicators on quality to compliment the four-hour waiting target. (Public Audit Committee Official Report, 27 October, Col 2076).
The Committee would appreciate further information on these indicators, including what these indicators will measure, how they have been selected, when they will be implemented and how they will improve and complement the measurement of activity, cost and quality.

Four hour waiting target
You also expressed that you had concerns regarding figures within the AGS Report on moving patients to meet the four hour waiting target. (Public Audit Committee Official Report, 27 October, Col 2089) The Auditor General for Scotland’s report states—

“It is not possible to tell from existing information whether patients are moved inappropriately to meet the waiting time standard, but 70 per cent of doctors and nurses surveyed disagree that there is always time for patients to be adequately assessed or stabilised before being discharged or moved (Emergency Departments, Page 27).

You stated that the figures may not necessarily be accurate and you would happy to provide the Committee with a note with your views on this topic. The Committee would also be grateful for this information.

I would be grateful for a response to this letter by 1 December 2010 Should you require any further information please do not hesitate to contact the Assistant Clerk, Jason Nairn on 0131 348 5236 or by email at pa.committee@scottish.parliament.uk.

Yours sincerely

Hugh Henry MSP, Convener