Accident and Emergency

Performance update

AUDITOR GENERAL

Prepared by Audit Scotland
May 2014

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website:
www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

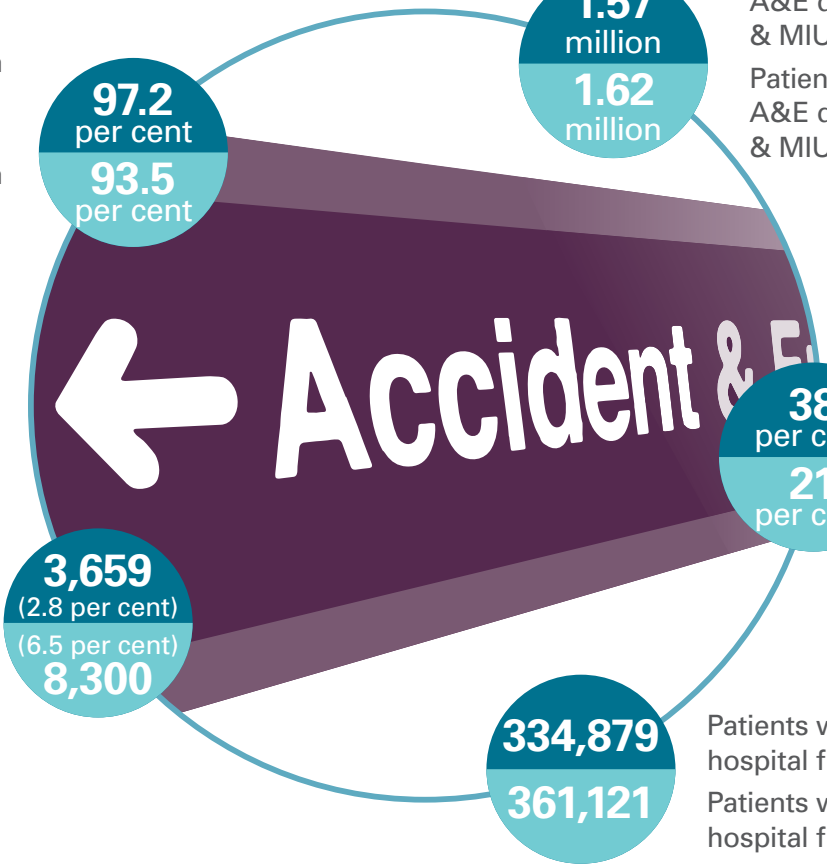
Contents

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Summary

Key facts



1.57 million
1.62 million

Patients attended A&E departments & MIU in 2008/09

Patients attended A&E departments & MIU in 2012/13

97.2 per cent
93.5 per cent

Patients were seen within four hours in December 2009

Patients were seen within four hours in December 2013

38 per cent
21 per cent

Patient delays in A&E were reported as 'wait for a bed' in 2012/13

Patient delays in A&E were reported as 'wait for first full clinical assessment' in 2012/13

3,659 (2.8 per cent)
8,300 (6.5 per cent)

Patients waited longer than four hours in December 2009

Patients waited longer than four hours in December 2013

334,879
361,121

Patients were admitted to hospital from A&E in 2008/09

Patients were admitted to hospital from A&E in 2012/13

Background

1. Typically, Accident and Emergency (A&E) departments assess and treat patients with serious or life-threatening injuries or illnesses. There are 31 A&E departments in Scotland. Around 1.35 million patients attended these departments in 2012/13, at a cost of around £163 million.[1] To ensure patients are being treated quickly, NHS boards have a standard to treat and discharge or admit 98 per cent of patients within four hours of arriving at A&E.[2] The four-hour standard also applies to minor injury units (MIUs) where patients are treated for less serious, but urgent, injuries. There are 64 MIUs in Scotland that provide treatment to over 260,000 patients a year, at a cost of around £25 million. In April 2014, the Scottish Government announced plans to set up four new trauma units in Scotland.[3] The units, which will be open from 2016, will provide life-saving treatment for patients who suffer a major trauma such as a serious head injury.

2. We published a report, *Emergency departments* (PDF) (August 2010), which also included an analysis of data from the Scottish Ambulance Service and NHS 24.[4] We looked at:

- how these emergency care services met the needs of patients
- if they were making the best use of available resources, such as money and staffing
- how effectively services were working together to manage demand and deliver coordinated patient care.

3. We reported that NHS boards had improved the way they tackled longer A&E waiting times, but faced challenges in maintaining the four-hour standard. We made a number of recommendations for the Scottish Government. These included setting out a clearer strategic direction for emergency care services in Scotland and improving information to ensure best use is made of existing resources for emergency care. Since then, A&E departments' performance against the standard deteriorated and during winter 2012/13 performance fell to the lowest it has been since the standard came into effect. Winter 2012/13 was particularly challenging for A&E departments across the UK. Patients in England, Wales and Northern Ireland also experienced delays in A&E.

4. In April 2013, the Scottish Government introduced a new interim target of 95 per cent of patients being treated within four hours by the year ending September 2014. Maintaining good performance on the four-hour A&E wait was one of the Scottish Government's 25 key objectives for 2013/14.[5]

5. As highlighted in our recent report, *NHS financial performance 2012/13* (PDF) (October 2013), NHS boards are facing a changing and challenging time. As well as increasing financial pressure, with limited funding increases and difficult savings targets, they face growing pressures from Scotland's ageing population and the challenges of having more people with long-term health conditions needing healthcare. NHS boards face staffing challenges from Modernising Medical Careers and the European Working Time Directive, for example difficulties in recruiting suitably qualified staff and maintaining a flexible medical staffing rota. They also have challenging waiting times targets for planned inpatient and outpatient care, and targets for emergency and urgent care.[6] Whilst facing all of these pressures, NHS boards are striving to continually improve the quality and safety of patient care.

About the audit

6. We focused on reviewing A&E departments' performance against the four-hour waiting time standard since our previous audit. We used information that NHS boards routinely submit to Information Statistics Division (ISD) Scotland.[7] The four-hour standard also applies to MIUs so they are included in our analysis of performance against the standard. Most of these units do not report detailed activity to ISD Scotland because they do not have the same data systems in place as A&E departments and therefore they are not included in the more detailed analysis in this report. We compare 2012/13 performance data with data going back to 2008/09, as this is the base year we used in our previous A&E report.

7. Our objectives were to provide an update on:

- how NHS boards are performing against the A&E waiting times standard and the main reasons for delays in A&E treatment
- what the Scottish Government has done to help improve the way A&E departments perform.

Key messages

1 The NHS in Scotland's performance against the four-hour A&E waiting time standard has deteriorated since our last report. The percentage of patients seen within four hours fell from 97.2 per cent in December 2009 to 93.5 per cent in December 2013, although there was improvement during 2013. Performance varies considerably between A&E departments, and many face challenges in meeting the interim target of 95 per cent by the year ending September 2014.

2 A&E departments are part of a complex health and social care system. Problems across the whole system can delay the flow of patients out of A&E. Around a third of patients who are delayed in A&E are waiting because hospital beds are not available at the time they need them. This can be for a variety of reasons, including the time of day that patients are discharged from hospital. Since our last report, more patients are being admitted to hospital from A&E. Challenges around staffing can also affect how long patients wait in A&E. Although A&E consultant numbers have increased, there are still pressures around medical staffing.

3 The Scottish Government launched the National Unscheduled Care Action Plan in February 2013 in response to the deterioration in performance against the four-hour standard. Supported by planned funding of £50 million over three years, the Action Plan aims to address the challenges that NHS boards are facing in delivering emergency and urgent care, including reducing A&E waiting times. It is too early to comment on the impact of the Action Plan as significant changes to services will take time to deliver, but the Scottish Government and NHS boards are taking steps to address some of the causes of delays.

Recommendations

The Scottish Government should share good practice on:

- GPs referring appropriate patients directly to hospital without first attending the A&E department
- protocols that allow senior A&E staff to admit patients directly to hospital themselves
- effective models of A&E services and use of assessment units
- effective hospital discharge processes which support early planning of patient discharge.

The Scottish Government should:

- ensure that NHS boards have access to benchmarking information on staffing levels and skill-mix in A&E departments.

Part 1

A&E waiting times

Longer A&E waiting times are often a sign of pressure across the whole system

8. A&E departments are part of a complex healthcare system. Delays are not always the result of inefficiencies within the A&E department, but can be a sign of pressures across the wider health and social care system. Our last audit highlighted that patient satisfaction with A&E services was linked to how long they had to wait. Longer waits can also compromise patient safety and clinical effectiveness.

9. To provide quick and effective care, A&E departments rely on having:

- enough staff
- access to diagnostic tests
- access to advice from other hospital departments, for example orthopaedics
- access to hospital beds when required.

10. To achieve the four-hour target, A&E departments depend on all parts of the health and social care system working together. Although most patients attending A&E are discharged home, around 27 per cent of patients are admitted to hospital for further care. Patients who need to be admitted to hospital are more likely to wait longer in A&E, often because beds are not available at the time patients need them. This in turn can be linked to the time of day that patients are discharged from hospital and delays while patients wait for appropriate care outside the hospital.[8] Delays in moving patients through the healthcare system are sometimes referred to as problems with patient flow (Exhibit 1, page 10).

the number of patients waiting longer than four hours is higher than in 2008/09 but this has improved recently

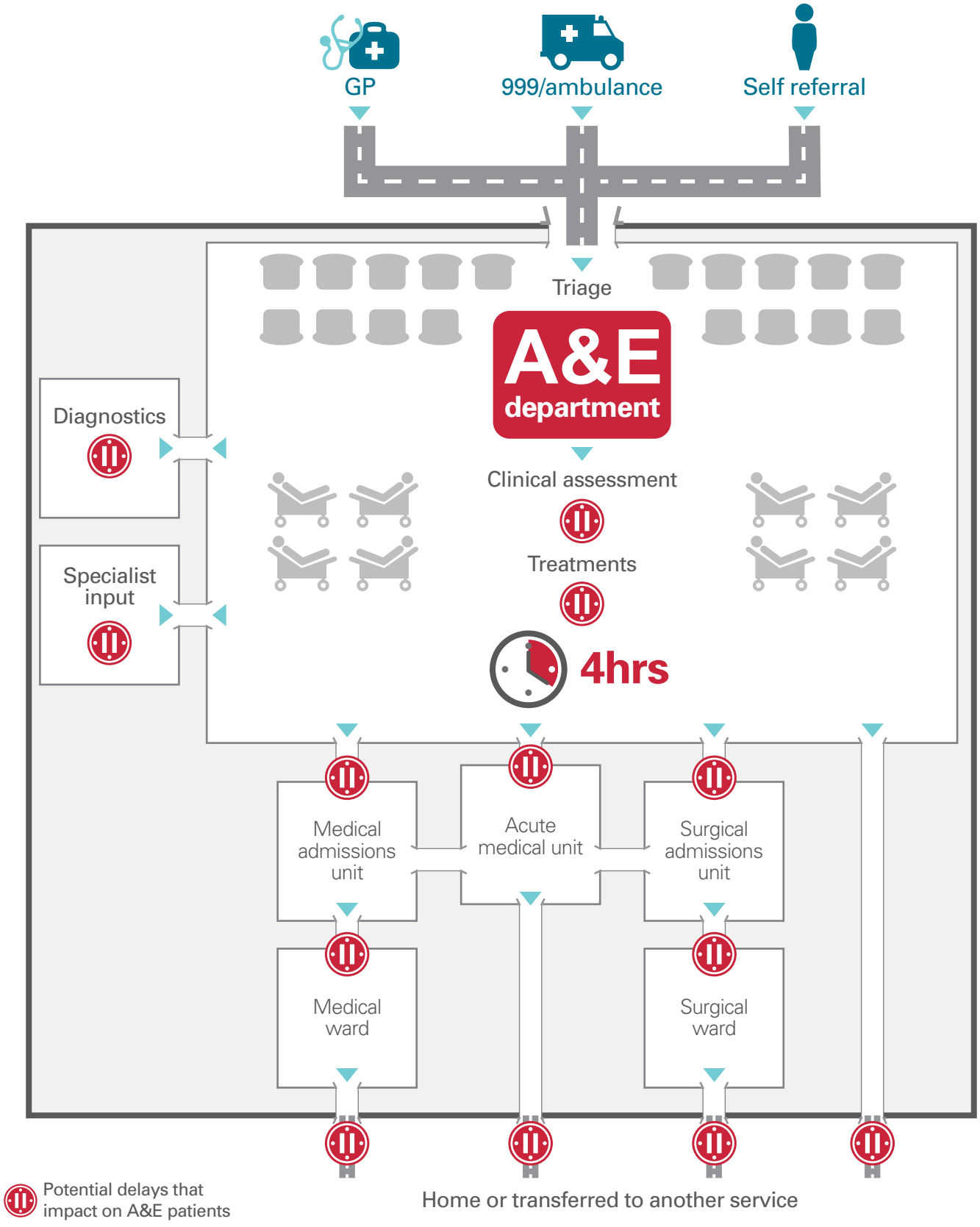
More A&E departments now have more people attending

11. Across Scotland, overall demand for A&E and MIU combined has risen by 3.1 per cent over the past five years, from 1.57 million attendances in 2008/09 to 1.62 million in 2012/13. This is due to increasing attendances at MIUs which have grown by 34 per cent, from 198,991 attendances in 2008/09 to 266,439 in 2012/13 (Exhibit 2, page 11).

Exhibit 1

A&E departments within the wider healthcare system

There are many factors that can delay the flow of patients around an A&E department.

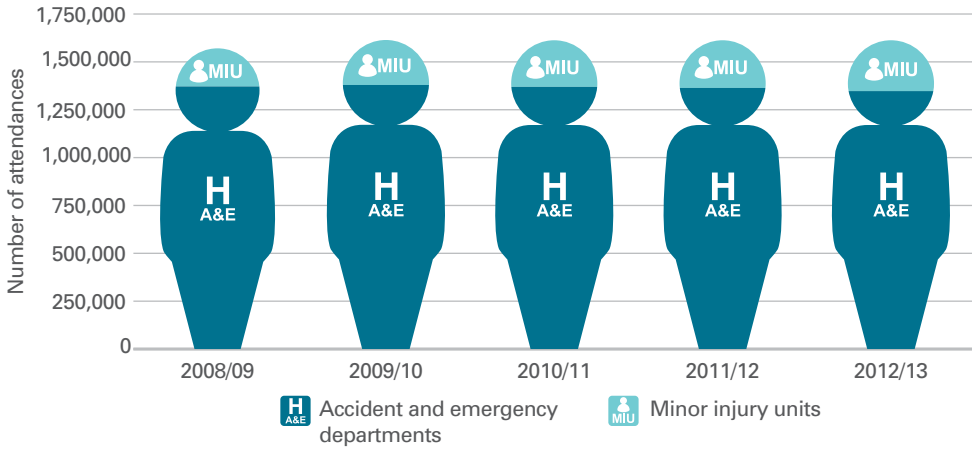


Source: Audit Scotland

Exhibit 2

Attendances at A&E departments and MIUs, 2008/09 to 2012/13

Overall attendances at A&E departments have fallen slightly while attendances at MIUs have risen.



Note: Appendix 1 lists ISD Scotland's classification of A&E departments and MIUs within each NHS board.

Source: ISD Scotland, A&E datamart

12. Attendances at A&E departments overall reduced by 1.4 per cent over the same period, from 1.37 million to 1.35 million. But some A&E departments have seen a significant increase in attendances, while attendances at others have decreased (Exhibit 3, page 12).

13. Attendance rates vary significantly across Scotland. In 2012/13, there were 305 attendances per 1,000 population at A&E departments and MIUs combined. This is a slight increase since we last reported (302 per 1,000 in 2008/09). Attendance rates are around 38 per cent higher for NHS Greater Glasgow and Clyde (375 per 1,000 population) compared with NHS Borders (231 per 1,000 population).[9] As we highlighted in our last report, deprivation and the distance that people live from an A&E department help explain some of the variation in attendance rates.

Attendances vary by type of service

14. Attendances vary across NHS boards by the type of service. For example, NHS Highland treats around 45 per cent of all attendances at MIUs and 55 per cent at its four A&E departments. In NHS Lanarkshire, nearly all patients (99 per cent) are seen at the three A&E departments and one per cent at the two MIUs (Exhibit 4, page 13).

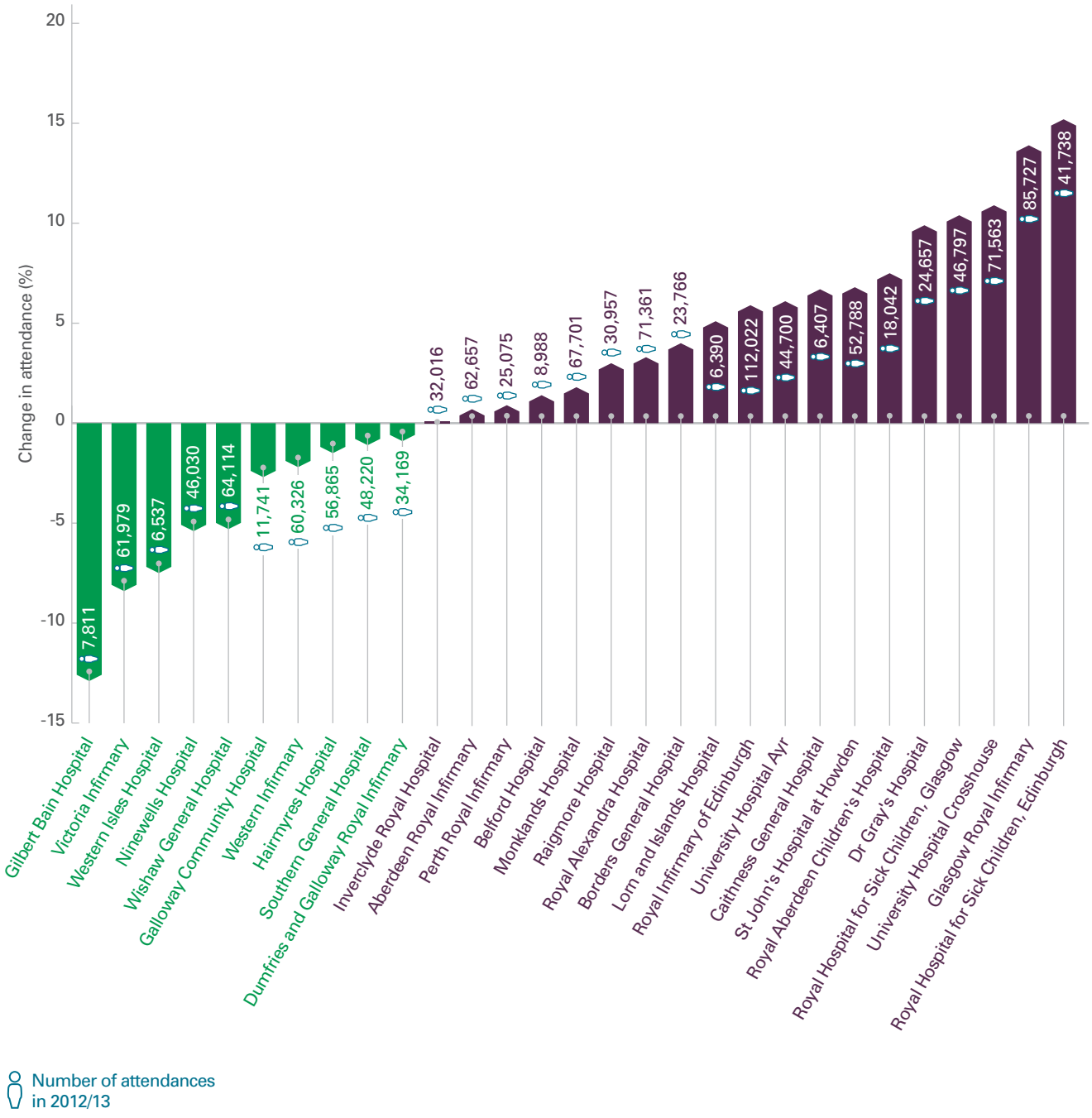
Most patients refer themselves to A&E departments

15. The overall pattern of referrals to A&E departments is the same as when we last reported. Most people who attend (66 per cent) refer themselves. GP referrals make up around ten per cent of attendances and NHS 24 referrals make up around four per cent.[10] This varies across A&E departments (Exhibit 5, page 14).

Exhibit 3

Change in attendances at A&E departments, 2008/09 to 2012/13

Overall attendances at A&E departments have decreased slightly. But attendance varies across Scotland, with significant increases in some A&E departments.



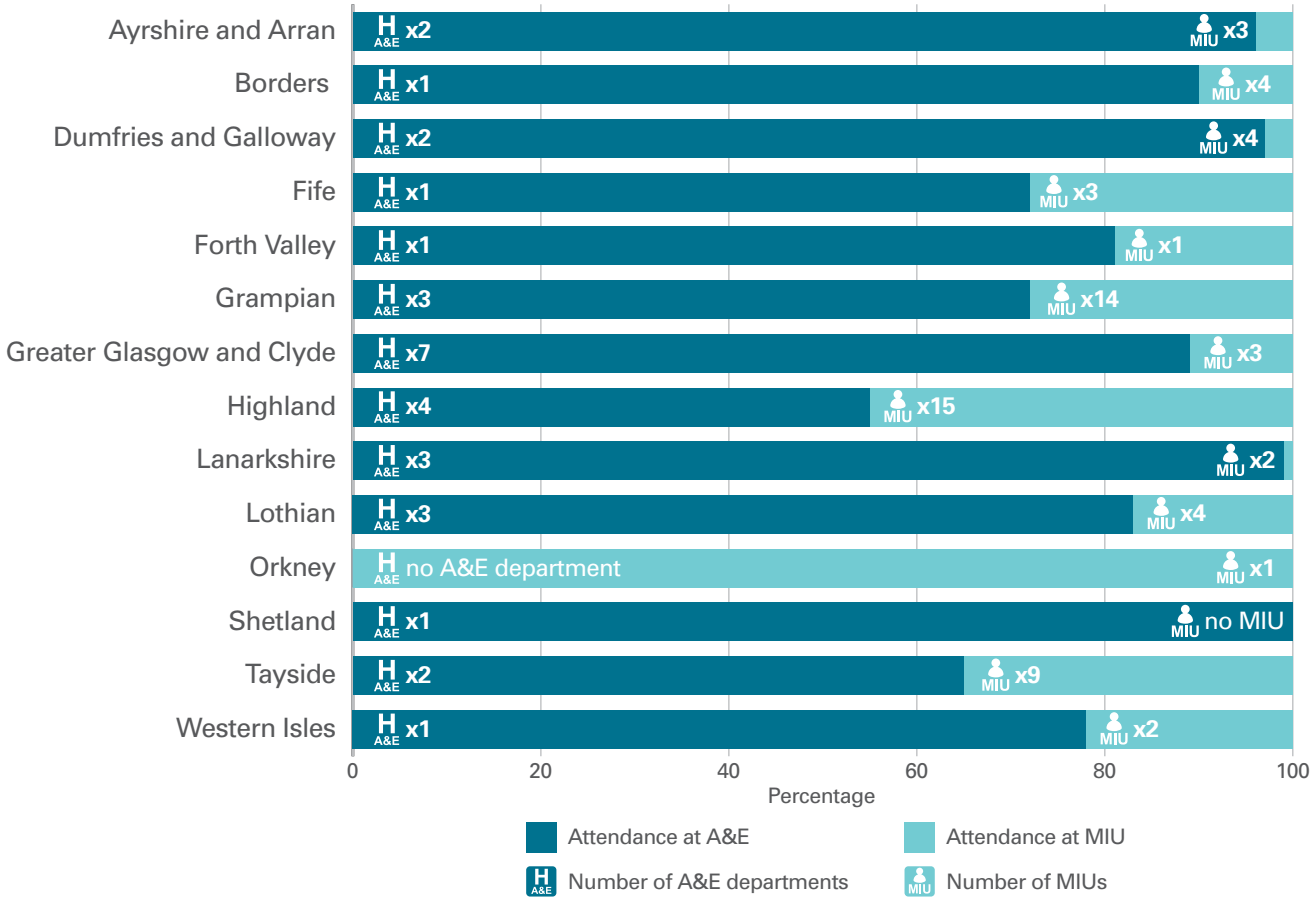
Notes:
1. A&E departments in NHS Fife and NHS Forth Valley are not included in this exhibit because of changes to services over this time period. It is therefore not possible to compare demand at these A&E departments. Appendix 1 lists all the changes to services.
2. Stobhill Hospital changed to a minor injury unit in 2011 and this is likely to have affected the number of attendances at the nearby Glasgow Royal Infirmary. From September 2009, Victoria Infirmary started recording A&E and MIU attendances separately.
3. Balfour Hospital in NHS Orkney is not included in this exhibit as ISD Scotland records the service provided as a minor injury unit.

Source: ISD Scotland, A&E datamart

Exhibit 4

Distribution of activity at A&E departments and MIUs, 2012/13

Across Scotland, most patients are seen in A&E departments. The number of MIUs and the percentage of attendances at MIUs vary across boards.



Note: The Acute Receiving Unit at the Western General in NHS Lothian is included as one of its four MIUs.

Source: ISD Scotland, A&E datamart

Performance has deteriorated over the last five years, although it has recently improved

16. NHS boards' performance against the four-hour A&E waiting time standard has varied over the last five years and the NHS in Scotland has rarely achieved the 98 per cent standard in that time. The percentage of patients seen in A&E departments and MIUs within four hours fell from 97.2 per cent in December 2009 to 89.7 per cent in January 2013, the lowest it has been since the standard came into effect (Exhibit 6, page 15). Overall, the number of patients who waited longer than four hours almost trebled from around 36,000 in 2008/09 to around 104,000 in 2012/13.[11] Performance has improved over the last 12 months, and the latest figures show that 93.5 per cent of patients were seen within four hours in December 2013. However, the number of patients who waited more than four hours (8,300) in December 2013 is considerably higher than when we last reported (3,659 patients waited longer than four hours in December 2009).

Exhibit 5

Attendances at A&E departments by source of referral, 2012/13

Most patients decide to go to an A&E department themselves. The percentage of referrals from other sources, such as GPs, varies across A&E departments.

A&E department	Referral source (percentage)							
	Self referral	999 services	GP[1]	GP referral for admission[2]	Out of hours[3]	NHS 24	MIU	Other[4]
Belford Hospital	82.5	0.0	7.7	0.0	0.7	1.5	0.0	7.5
Hairmyres Hospital	80.0	2.2	1.7	8.4	1.5	2.6	0.0	3.7
Southern General Hospital	79.8	3.0	13.7	0.0	0.5	0.7	0.0	2.3
Glasgow Royal Infirmary	79.4	7.6	5.2	0.0	1.2	2.8	0.0	3.7
Dr Gray's Hospital	79.3	1.4	10.4	0.0	2.2	2.7	0.0	4.0
Inverclyde Royal Hospital	78.5	1.0	8.1	0.0	0.4	1.9	0.0	10.1
Lorn and Islands Hospital	75.7	0.0	11.2	0.0	1.0	1.9	0.0	10.1
Victoria Infirmary	74.9	2.3	12.2	0.0	1.4	1.6	1.3	6.4
Aberdeen Royal Infirmary	74.7	7.2	6.1	0.0	0.4	5.4	0.0	6.2
Royal Alexandra Hospital	73.0	3.9	10.4	0.0	2.2	3.0	0.2	7.2
Royal Hospital for Sick Children, Glasgow	72.9	0.0	11.5	0.0	6.2	5.2	0.0	4.2
Galloway Community Hospital	70.7	12.1	8.7	0.2	0.9	2.1	0.1	5.1
St John's Hospital at Howden	70.5	2.9	0.0	10.0	1.7	8.6	0.0	6.3
Perth Royal Infirmary	70.5	17.9	2.4	0.0	0.1	4.6	1.0	3.5
Western Isles Hospital	70.0	13.1	7.9	0.6	0.3	4.1	0.0	4.0
Western Infirmary	70.0	8.7	9.1	0.0	1.4	3.9	0.1	6.9
Raigmore Hospital	68.4	0.0	7.3	0.0	1.4	5.6	0.0	17.3
Wishaw General Hospital	65.6	6.8	2.1	5.6	0.6	3.8	0.0	15.5
Royal Aberdeen Children's Hospital	64.5	3.3	12.5	0.0	4.7	7.1	0.0	7.8
Monklands Hospital	63.8	8.5	2.5	8.0	3.0	3.3	0.0	10.9
Royal Hospital for Sick Children, Edinburgh	63.3	4.8	0.0	11.2	2.6	5.3	0.7	12.1
Gilbert Bain Hospital	63.1	8.0	14.3	0.0	1.0	8.1	0.0	5.5
Caithness General Hospital	61.6	0.0	16.4	0.0	1.4	4.1	0.0	16.5
Forth Valley Royal Hospital	58.4	29.3	1.5	0.0	0.3	6.2	0.3	3.8
Victoria Hospital	57.2	31.8	2.2	0.0	0.2	4.8	0.0	3.9
University Hospital Crosshouse	57.0	15.4	8.8	7.4	2.1	4.4	0.0	4.8
University Hospital Ayr	56.3	18.4	2.1	16.3	0.7	2.5	0.1	3.6
Dumfries and Galloway Royal Infirmary	51.4	20.4	5.2	13.1	1.3	4.8	0.3	3.5
Ninewells Hospital	49.8	27.4	2.3	0.0	0.4	6.3	1.4	12.4
Borders General Hospital	48.6	21.2	4.6	6.2	2.7	4.1	0.4	12.2
Royal Infirmary of Edinburgh	46.1	28.1	2.8	8.9	2.9	6.1	0.6	4.4
SCOTLAND	**65.9**	**11.7**	**5.7**	**3.9**	**1.6**	**4.2**	**0.2**	**6.7**

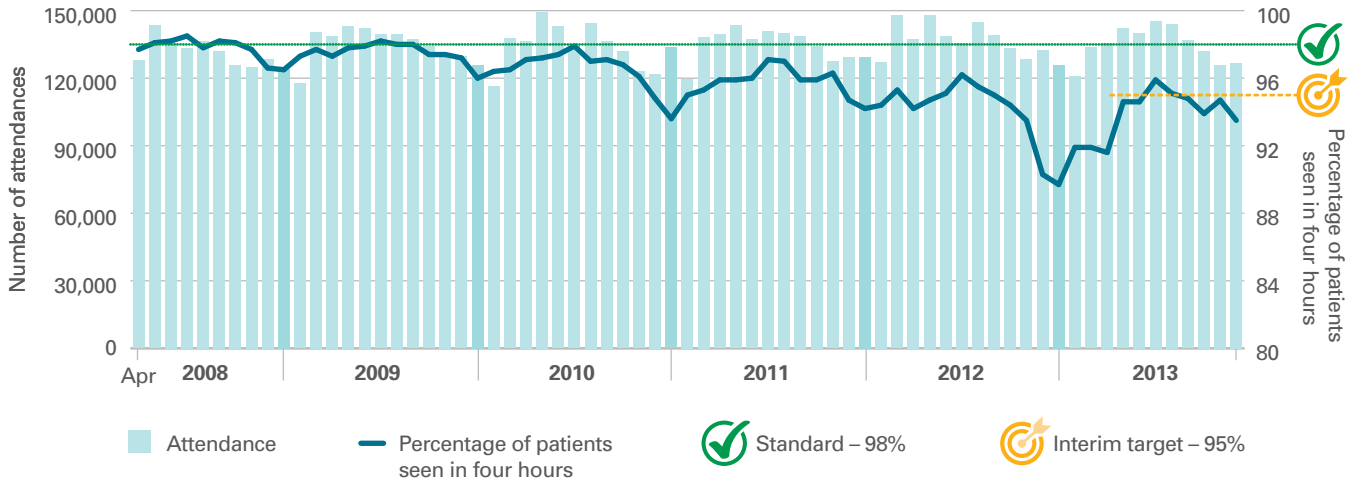
Notes:
1. GP: referral to A&E for assessment and treatment.
2. GP referral for admission: GP refers patient to an inpatient bed but local policy means the patient goes through A&E before being admitted.
3. Out of hours: this is a referral from GP out-of-hours services that provide care after 6pm when GP practices are closed.
4. Other: referrals from same hospital; other hospital; community-based healthcare professional such as a pharmacist; social services; a private organisation such as a nursing home.

Source: ISD Scotland, A&E datamart

Exhibit 6

Monthly attendances at A&E departments and MIUs, and the NHS in Scotland's performance against the standard and the interim target from April 2008 to December 2013

Compliance with the four-hour standard has been poor but there has been improvement since the lowest performance in January 2013.



Source: ISD Scotland, A&E datamart

17. MIUs generally perform well against the standard. Only six of the 64 MIUs have performed below 95 per cent since the Scottish Government introduced the interim target in 2013. If MIUs are removed from the overall figure, the NHS in Scotland's performance against the four-hour standard drops slightly, from 93.5 to 92.7 per cent in December 2013.

Fourteen A&E departments met the four-hour interim target in December 2013

18. In December 2013, 14 of the 31 A&E departments reached the interim target of 95 per cent. Performance ranged from 99.2 per cent at the Perth Royal Infirmary to 81.5 per cent at the Western Infirmary in Glasgow. Some A&E departments have performed consistently well against the 98 per cent standard over the last five years (Royal Aberdeen Children's Hospital; Gilbert Bain Hospital; Ninewells Hospital; Royal Hospital for Sick Children Edinburgh; and Perth Royal Infirmary). However, other hospitals have continued to perform poorly, even against the interim target (the Royal Infirmary of Edinburgh; Wishaw General Hospital; the Western Infirmary; Royal Alexandra Hospital; and Glasgow Royal Infirmary) (Exhibit 7, page 16). The Scottish Government has indicated it will review the 95 per cent interim target after September 2014.

Exhibit 7

A&E department performance against the four-hour waiting time standard and interim target, April 2012 to December 2013

Performance against the standard and the interim target varies considerably across A&E departments.

Hospital	2012/13 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E and MIU	94.2	94.7	95.1	96.2	95.5	95.0	94.4	93.5	90.3	89.7	91.9	91.9
A&E sites only	93.5	93.8	94.5	95.6	94.7	94.2	93.5	92.6	89.0	88.3	90.7	90.7
University Hospital Ayr	90.8	89.1	90.9	96.1	92.2	91.5	90.0	93.1	85.7	80.5	79.2	83.1
University Hospital Crosshouse	95.1	90.7	94.3	96.3	94.9	95.2	93.4	94.4	88.4	87.3	93.1	92.9
Borders General Hospital	92.5	97.0	98.8	97.1	97.8	97.0	98.4	95.3	94.4	95.2	96.5	96.7
Dumfries and Galloway Royal Infirmary	91.1	91.7	94.4	91.2	93.0	91.3	93.1	95.0	94.5	91.9	93.4	93.0
Galloway Community Hospital	96.8	98.2	97.5	97.2	95.7	97.1	95.8	98.6	97.3	97.0	97.1	96.8
Victoria Hospital	89.4	94.8	93.9	97.7	98.4	98.5	95.9	91.3	88.0	90.2	89.4	95.8
Forth Valley Royal Hospital	91.7	90.5	95.1	94.3	93.2	89.8	87.9	92.7	83.1	84.7	89.2	84.6
Aberdeen Royal Infirmary	92.5	94.4	95.1	95.5	94.0	95.7	95.0	92.6	91.0	92.2	94.4	92.8
Dr Gray's Hospital	96.8	96.3	96.8	96.7	96.9	97.2	93.5	93.1	92.3	91.8	93.1	91.7
Royal Aberdeen Children's Hospital	99.1	98.8	99.2	99.2	98.0	98.5	99.0	99.1	99.0	98.5	98.3	98.6
Glasgow Royal Infirmary	96.0	96.3	97.2	97.3	95.9	97.1	96.3	97.5	92.9	88.2	89.5	87.1
Inverclyde Royal Hospital	96.5	95.4	97.4	96.9	98.1	97.5	96.0	96.4	92.5	89.8	91.2	90.7
Royal Alexandra Hospital	94.1	92.7	88.4	90.9	92.1	91.8	92.9	95.5	91.5	86.2	85.3	82.0
Royal Hospital for Sick Children, Glasgow	95.7	94.7	97.2	97.0	96.5	97.1	95.9	92.2	92.9	97.4	97.8	97.2
Southern General Hospital	92.9	94.0	94.3	93.9	96.3	93.4	94.7	95.3	90.7	88.5	88.9	90.9
Victoria Infirmary	89.5	91.3	92.9	95.2	94.1	91.5	93.3	92.1	82.6	80.8	83.1	88.9
Western Infirmary	89.4	91.0	91.8	96.7	95.3	94.6	92.1	89.4	83.3	79.2	82.6	86.8
Belford Hospital	97.1	98.2	98.9	98.1	96.3	95.8	96.5	96.3	95.8	93.7	98.0	94.3
Caithness General Hospital	98.1	98.4	98.8	98.1	98.8	98.0	97.5	97.2	97.4	97.0	98.1	97.5
Lorn and Islands Hospital	98.3	98.2	98.6	98.0	96.8	98.4	95.3	95.1	97.9	97.3	97.5	97.0
Raigmore Hospital	96.7	95.1	96.6	96.7	97.4	96.7	95.3	97.8	96.9	96.9	95.8	97.4
Hairmyres Hospital	94.4	93.3	94.5	94.2	91.8	89.6	89.4	92.6	85.1	77.7	90.1	89.8
Monklands Hospital	96.3	95.4	95.2	96.0	95.2	95.1	93.6	92.9	84.5	88.4	93.6	92.9
Wishaw General Hospital	93.9	95.9	94.3	95.5	91.0	88.4	88.9	83.0	83.4	82.8	87.8	92.0
Royal Hospital for Sick Children, Edinburgh	98.1	99.2	99.0	99.2	99.0	98.3	98.5	96.7	97.0	98.0	98.1	97.7
Royal Infirmary of Edinburgh	87.5	89.3	88.8	93.0	90.0	89.3	88.6	79.7	81.9	83.6	86.1	80.2
St John's Hospital at Howden	92.9	93.9	94.5	94.9	93.7	94.1	94.6	92.4	85.5	94.5	94.9	94.4
Gilbert BainHospital	99.5	99.3	99.4	99.4	100	98.7	99.2	99.0	98.8	98.7	99.6	99.5
NinewellsHospital	98.4	97.8	98.4	98.7	98.1	98.7	99.2	98.8	97.2	98.6	97.8	98.8
Perth RoyalInfirmary	98.5	96.7	98.8	98.5	98.3	99.0	98.4	98.8	98.4	98.3	97.7	96.8
Western Isles Hospital	97.1	98.5	97.4	98.4	98.4	98.2	97.6	97.3	97.8	97.3	98.3	98.6

0 Performance below 98 per cent standard

0 Performance at or above 98 per cent standard

Exhibit 7 (continued)

Hospital	2013/14 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
A&E and MIU	91.6	94.6	94.6	95.9	95.1	94.8	93.9	94.7	93.5
A&E sites only	90.4	93.6	93.7	95.1	94.3	94.0	93.1	94.1	92.7
University Hospital Ayr	86.9	89.4	88.1	94.0	95.2	90.9	90.6	93.7	92.6
University Hospital Crosshouse	89.3	93.4	95.2	94.6	93.4	94.3	95.9	93.0	93.1
Borders General Hospital	95.9	99.1	99.2	99.0	97.5	98.0	97.9	97.7	97.7
Dumfries and Galloway Royal Infirmary	93.2	93.9	95.5	94.2	93.4	92.8	94.4	95.0	94.9
Galloway Community Hospital	97.8	96.8	98.4	97.9	98.0	96.3	98.7	97.5	97.5
Victoria Hospital	91.0	95.2	95.6	96.7	96.4	94.5	93.5	99.1	97.9
Forth Valley Royal Hospital	83.8	95.2	93.3	95.4	91.3	91.7	91.6	94.0	92.2
Aberdeen Royal Infirmary	91.9	95.7	97.5	97.6	95.3	95.1	95.5	94.9	89.7
Dr Gray's Hospital	90.9	95.2	97.2	98.2	94.4	91.8	93.8	97.3	96.7
Royal Aberdeen Children's Hospital	98.5	98.5	99.3	99.5	98.4	99.0	99.2	98.3	99.0
Glasgow Royal Infirmary	88.6	90.3	84.4	91.3	92.0	93.5	90.1	91.3	88.0
Inverclyde Royal Hospital	91.1	93.4	92.8	95.1	94.7	94.6	95.5	92.3	93.7
Royal Alexandra Hospital	88.3	91.2	92.4	92.8	93.0	94.2	90.9	89.6	88.3
Royal Hospital for Sick Children, Glasgow	95.9	97.1	97.7	98.8	98.6	98.6	98.1	98.1	98.1
Southern General Hospital	91.6	90.1	93.2	94.0	94.2	95.0	93.2	93.5	93.3
Victoria Infirmary	89.3	92.6	95.0	95.4	93.1	93.4	90.6	96.0	89.4
Western Infirmary	89.1	87.8	83.9	89.0	87.5	87.1	84.1	84.7	81.5
Belford Hospital	95.7	93.2	96.3	95.8	98.3	96.0	96.4	94.4	95.2
Caithness General Hospital	97.8	96.1	95.8	96.5	95.4	94.8	97.1	95.7	92.1
Lorn and Islands Hospital	96.5	97.0	98.6	96.0	97.2	98.8	97.4	98.1	98.4
Raigmore Hospital	96.2	96.5	96.6	97.9	96.2	96.4	95.8	97.2	95.2
Hairmyres Hospital	84.1	92.7	94.7	95.2	95.8	93.7	91.5	91.9	92.5
Monklands Hospital	90.2	93.4	93.7	95.7	90.5	89.4	89.3	92.3	90.9
Wishaw General Hospital	88.5	88.4	89.2	92.4	93.0	93.5	89.3	92.4	92.6
Royal Hospital for Sick Children, Edinburgh	98.3	98.3	99.3	99.0	99.0	99.1	98.8	98.9	98.2
Royal Infirmary of Edinburgh	82.5	92.3	91.2	91.6	93.3	91.2	91.3	91.7	90.6
St John's Hospital at Howden	93.2	97.2	98.0	98.1	97.6	97.3	96.8	97.5	94.5
Gilbert BainHospital	99.5	97.7	99.1	99.7	99.2	98.4	99.1	99.3	98.4
NinewellsHospital	98.7	99.1	98.5	99.1	98.3	98.3	98.9	99.1	98.5
Perth RoyalInfirmary	97.2	99.0	99.3	98.8	98.6	98.8	98.6	99.3	99.2
Western Isles Hospital	97.6	99.3	97.4	98.8	96.6	97.4	98.8	98.5	97.9

0 Performance below 95 per cent interim target (in place from April 2013)

0 Performance at or above 98 per cent standard

0 Performance at or above 95 per cent interm target

Source: ISD Scotland, A&E datamart

A&E departments have made progress over the last year in tackling the longest waits

19. The number of patients who waited longer than 12 hours in A&E departments has increased since we last reported, from 398 patients in 2008/09 to 1,435 patients in 2012/13. But there has been significant improvement over the last 12 months. In December 2013, 42 patients waited longer than 12 hours compared with 297 patients in December 2012. Overall, 25 A&E departments had no patients waiting longer than 12 hours in December 2013. Small numbers of patients waited 12 hours or more in the following A&E departments:

- Royal Infirmary of Edinburgh (17 patients)
- Hairmyres Hospital (11 patients)
- Victoria Infirmary (7 patients)
- Wishaw General Hospital (5 patients)
- Aberdeen Royal Infirmary (1 patient)
- Caithness General Hospital (1 patient).[12]

The median wait for A&E patients has increased

20. The four-hour standard focuses on reducing delays longer than four hours. This can mean that less attention is given to the overall time patients are in the A&E department. There is an underlying trend of patients generally waiting longer in A&E. The median wait across A&E departments has increased from 99 minutes in 2008/09 to 126 minutes in 2012/13.[13] In 2012/13, fewer patients were treated within two hours of arriving at A&E than in 2008/09.[14] Around 60 per cent (814,528) of patients were treated within 120 minutes of arriving in 2008/09, compared with 48 per cent (645,253) in 2012/13.[15]

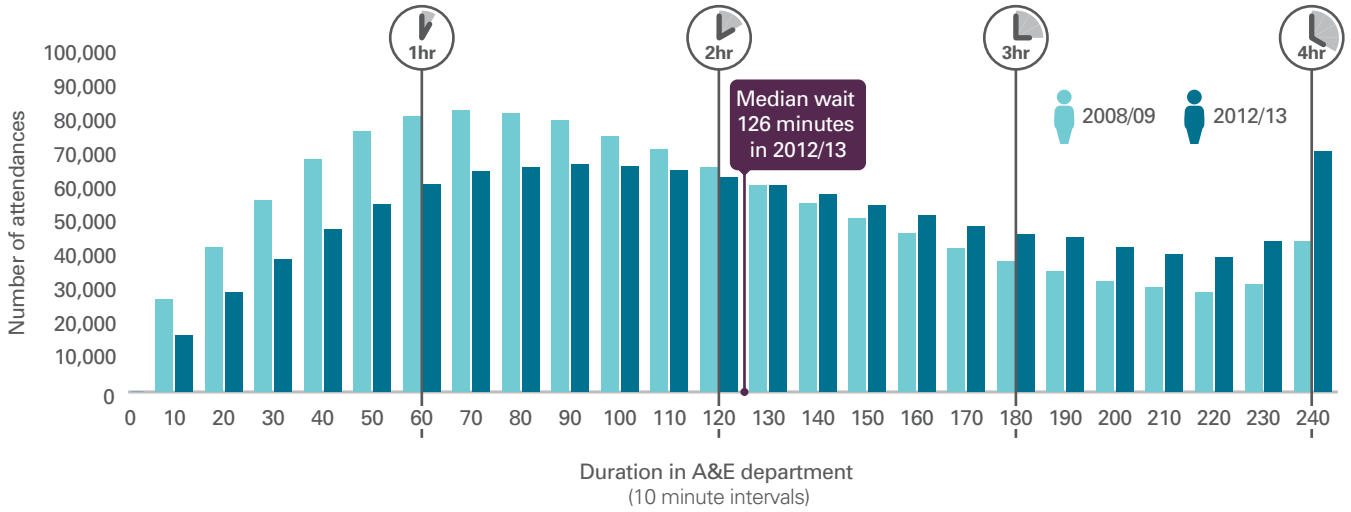
More patients are seen just before the end of the four-hour target period

21. There is a peak across A&E departments in the number of patients who are discharged or admitted just before the four-hour target. In 2012/13, around 70,000 patients (5.3 per cent of all attendances) were dealt with during the last ten minutes of the four-hour period (Exhibit 8, page 19). This figure is up from 45,000 (3.3 per cent) in 2008/09. Of these patients, 38 per cent (27,000) were discharged home and 58 per cent (41,000) were admitted to hospital in 2012/13.

Exhibit 8

Distribution of A&E attendances treated and discharged or admitted within four hours, 2008/09 and 2012/13

The number of patients in A&E departments who are discharged or admitted just before the end of the four-hour period has increased since 2008/09.



Source: ISD Scotland, A&E datamart

Part 2

Reasons for delays in A&E

Many interrelated factors affect how A&E departments perform against the four-hour waiting time standard

22. As highlighted in our last A&E report, it is difficult to draw clear conclusions about the relative performance of A&E departments because the services provided vary across the country. No single factor explains the deterioration in waiting time performance since 2008/09. Each local unscheduled care system is complex. The following factors can affect how A&E departments perform against the four-hour standard:

- pressure on the availability of hospital beds from an increasing number of patients being admitted as emergencies and delays in patients being discharged from hospital
- increasing complexity of care
- local policies on emergency admissions
- local policies on informing A&E patients about alternative services
- the time of day that patients are discharged from wards
- staffing pressures.

many factors affect how long patients wait in A&E

23. We analysed the national data to look for any features shared by the A&E departments that perform better against the four-hour standard, and identified some factors that may be linked to performance.[16] Where we refer to factors than can affect performance against the four-hour standard, this also applies to performance against the interim target. A&E departments that perform better against the 98 per cent standard generally have fewer attendances, but this alone does not explain the variation in performance (Exhibit 9, page 21).

Seasonal variation in demand can affect performance

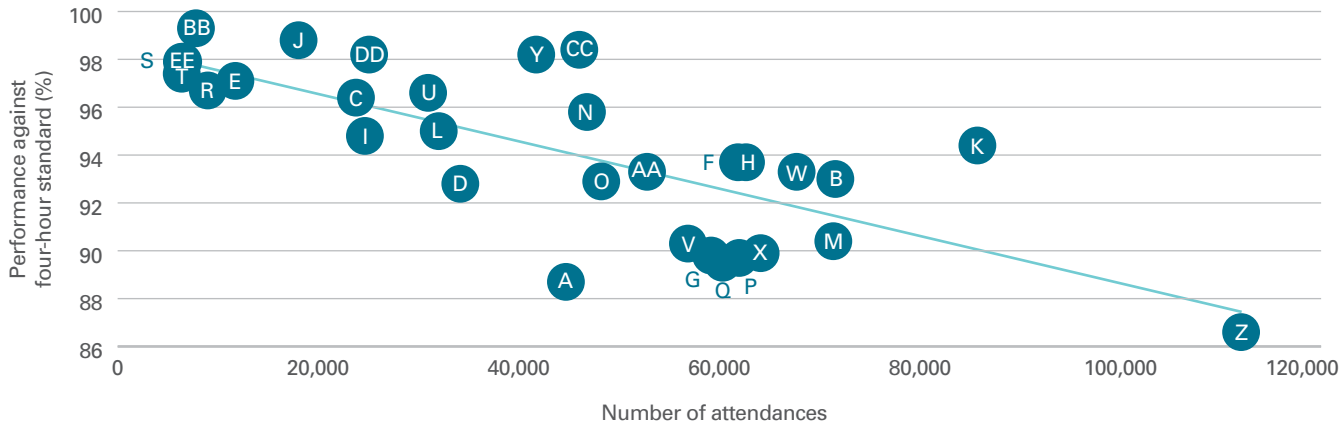
24. Performance against the four-hour standard shows strong seasonal variation. Performance against the standard is poorer in winter months, even though attendances are lower than average. Admissions to hospital from A&E also peak in winter when performance is lowest (Exhibit 10, page 22). During winter 2012/13, performance against the standard dipped to 89.7 per cent. This is likely to be as a result of increased pressure on the healthcare system caused by patients being more ill during winter, and seasonal illness which can lead to more unplanned hospital admissions overall. For example, from 1 November 2012 to 31 January 2013, NHS Greater Glasgow and Clyde had to close 80 wards due

to Norovirus, compared with 23 wards closed in 2011/12. Ward closures result in greater pressure across the whole system as fewer available beds can cause delays for patients in A&E departments who need to be admitted.

Exhibit 9

Attendances at A&E departments and performance against the four-hour waiting time standard, 2012/13

A&E departments with fewer attendances generally perform better against the standard.



A University Hospital Ayr
B University Hospital Crosshouse
C Borders General Hospital
D Dumfries and Galloway Royal Infirmary
E Galloway Community Hospital
F Victoria Hospital
G Forth Valley Royal Hospital
H Aberdeen Royal Infirmary
I Dr Gray's Hospital
J Royal Aberdeen Children's Hospital
K Glasgow Royal Infirmary
L Inverclyde Royal Hospital
M Royal Alexandra Hospital
N Royal Hospital for Sick Children, Glasgow
O Southern General Hospital
P Victoria Infirmary
Q Western Infirmary
R Belford Hospital
S Caithness General Hospital
T Lorn and Islands Hospital
U Raigmore Hospital
V Hairmyres Hospital
W Monklands Hospital
X Wishaw General Hospital
Y Royal Hospital for Sick Children, Edinburgh
Z Royal Infirmary of Edinburgh
AA St John's Hospital at Howden
BB Gilbert Bain Hospital
CC Ninewells Hospital
DD Perth Royal Infirmary
EE Western Isles Hospital

Source: ISD Scotland, A&E datamart

There is some evidence that A&E patients have more serious conditions than in previous years, and more older people are attending

25. A&E departments attribute a flow category to each patient attending. This indicates the complexity of the case and length of attendance.[17] The percentage of patients classed within each category varies across A&E departments (Exhibit 11, page 23). We highlighted in our previous report that the methodology A&E departments use to define patient flows differs, and that there are limitations around this data. NHS boards may hold better local information than is available at a national level, on the types of medical conditions that A&E patients have. Using the available national data, fewer patients were classed as minor injury or illness, with 50 per cent of patients being classed this way in 2012/13 compared with 55 per cent in 2008/09.[18] There is evidence that A&E departments with more patients classed as minor injury or illness perform better against the four-hour standard.

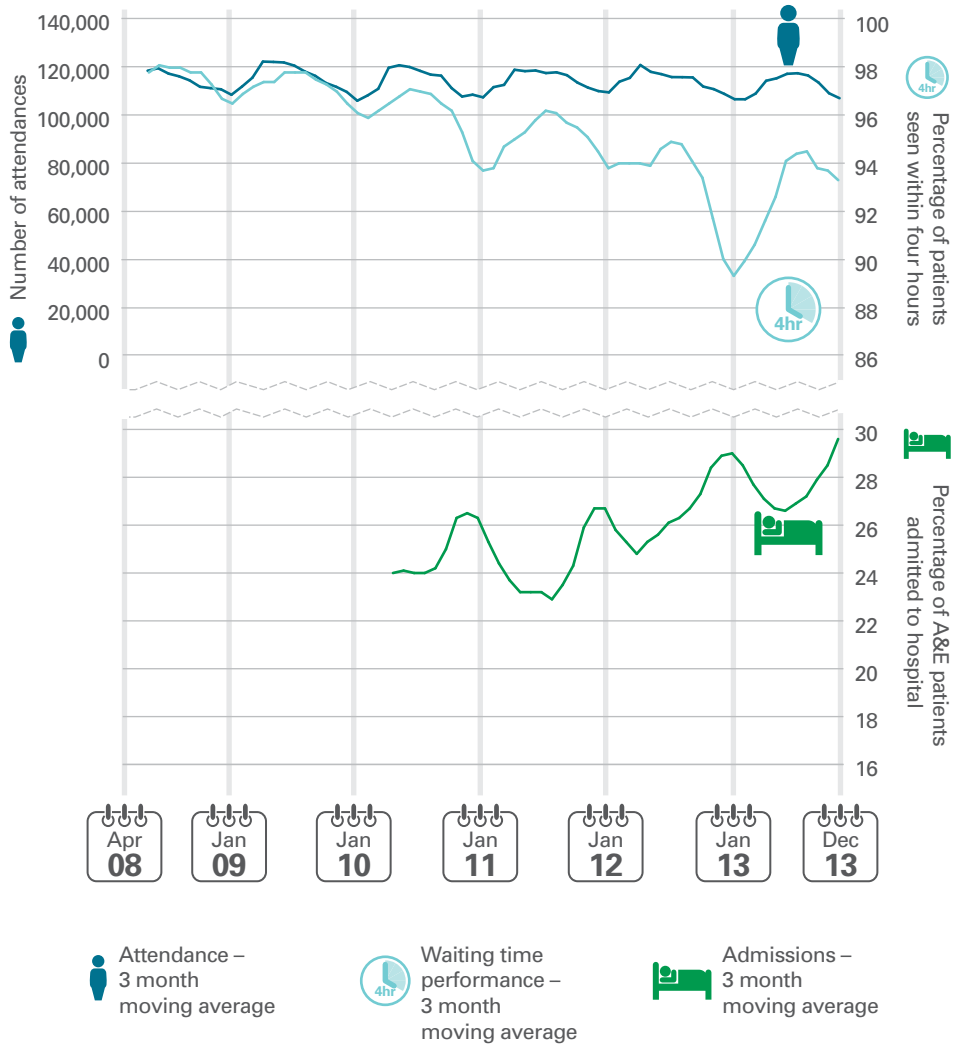
26. Our report on *Reshaping care for older people* (PDF) (February 2014) highlighted that people in Scotland are living longer.[19] By 2035, a quarter of Scotland's population are expected to be aged 65 or over, up from 17 per cent in

2010. Older people are more likely than younger people to have long-term health problems that may need emergency care. This is a significant cause of growing pressure on all healthcare services. The number of older people attending A&E has risen, from 242,677 patients aged over 65 in 2008/09 to 273,192 patients aged over 65 in 2012/13.[20]

Exhibit 10

Attendances at A&E departments, percentage of patients admitted to hospital from A&E and waiting times performance, April 2008 to December 2013

Waiting times performance is poorer in winter and dipped most significantly in January 2013. Admissions to hospital from A&E peak in winter.



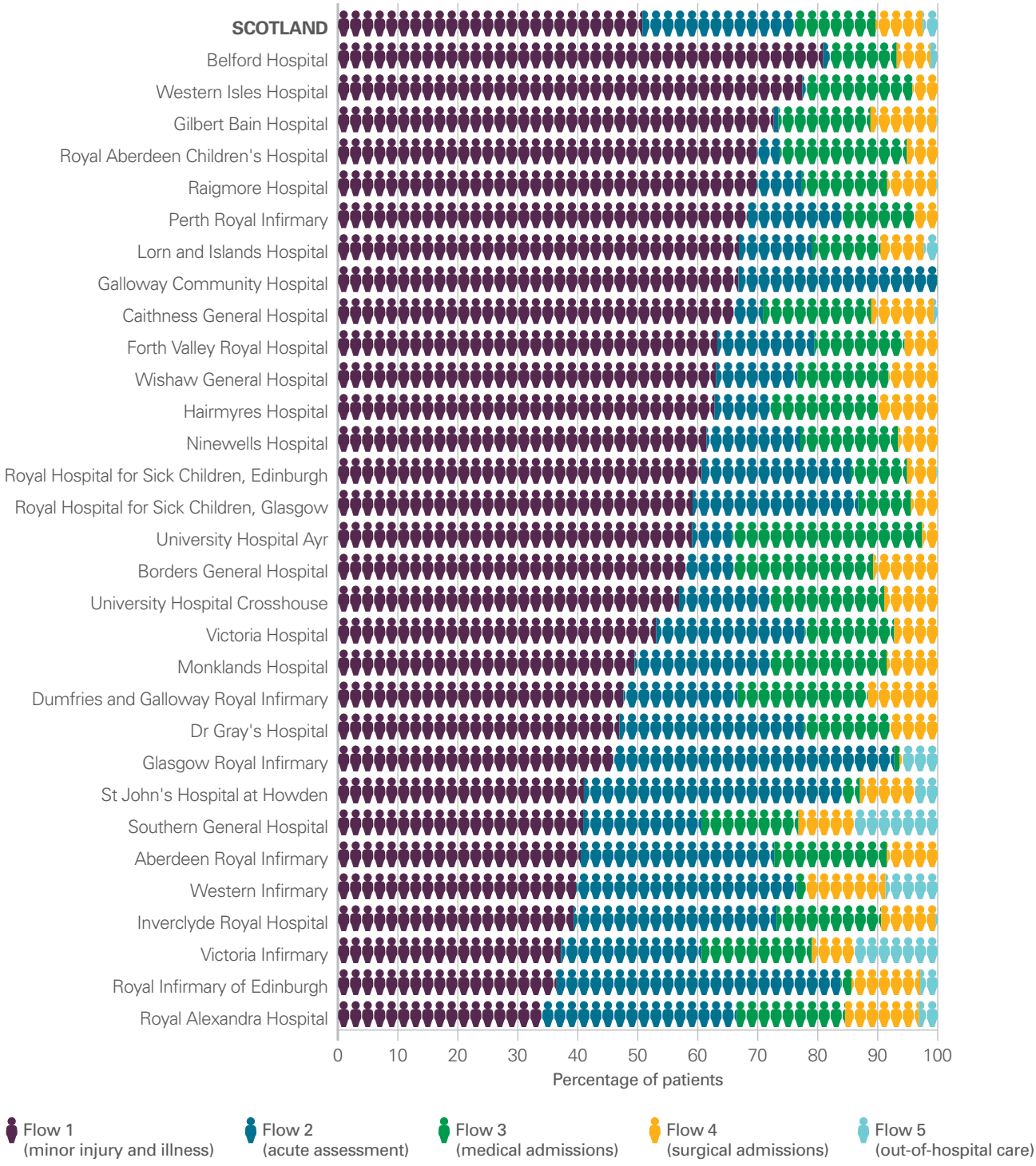
Notes:
1. Admissions data covers patients admitted from A&E to the same hospital only. This figure does not include patients transferred from other A&E departments.
2. The three-month moving average smooths out spikes in the data to allow the seasonal trend to be seen more clearly. Each mark on the chart is the average of the previous two months and the current month. For example, the dark blue attendance line at December 2013 is the average attendance across October, November and December 2013.
3. Data on the percentage of patients admitted to hospital from A&E is not available before April 2010.

Source: ISD Scotland, A&E datamart

Exhibit 11

Flow category by A&E department, 2012/13

Half of A&E patients are classed as flow 1 (minor injury and illness).



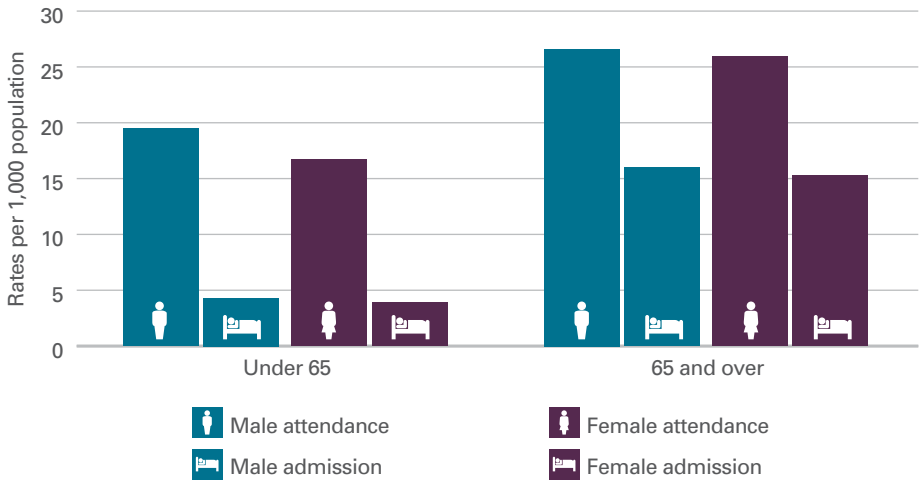
Source: ISD Scotland, A&E datamart

27. Patients aged 65 and over have higher rates of attendance at A&E. Patients in this age group are also more likely to be admitted to hospital from A&E (Exhibit 12). In December 2013, 60 per cent of A&E attendances for people aged over 65 resulted in admission to hospital, compared with 23 per cent of patients aged under 65.

Exhibit 12

Rates of A&E attendances and admissions per 1,000 population by age and gender, December 2013

Patients aged over 65 are more likely to attend A&E and be admitted to hospital for further care.



Note: This excludes patients where a valid Community Health Index (CHI) number was not recorded.

Source: ISD Scotland, A&E datamart

28. Our report on care for older people highlighted that effective primary care may be able to prevent emergency admissions to hospital for a series of conditions. These are sometimes referred to as potentially preventable hospital admissions, and include influenza and pneumonia. The rate of potentially preventable hospital admissions has remained relatively stable, from 4,552 per 100,000 population aged 65 or over in 2002/03 to 4,550 in 2012/13.

The number of patients admitted to hospital from A&E has increased over the last five years

29. The number of patients admitted to hospital from A&E has risen from 334,879 in 2008/09 to 361,121 in 2012/13, an eight per cent increase.[21] Admission to hospital from A&E varies considerably, from 40 per cent of attendances at University Hospital Crosshouse to 13.9 per cent at the Royal Hospital for Sick Children, Glasgow (Exhibit 13, page 25).[22]

Exhibit 13

Where patients go from A&E departments, 2012/13

Most patients attending A&E departments are discharged home but around 27 per cent are admitted to hospital.

A&E department	Where patients go (percentage)			
	Admission to same NHS provider	Private residence	Transfer to other NHS provider	Other
University Hospital Crosshouse	40.0	53.7	1.9	4.4
University Hospital Ayr	36.5	56.7	3.3	3.6
Borders General Hospital	34.8	47.8	14.8	2.6
Dumfries and Galloway Royal Infirmary	34.1	62.5	2.9	0.6
Royal Alexandra Hospital	31.6	48.7	1.8	17.9
Western Infirmary	31.5	60.2	1.9	6.4
Royal Infirmary of Edinburgh	29.9	66.6	3.3	0.2
Victoria Infirmary	29.6	64.0	3.9	2.5
Monklands Hospital	29.2	59.7	3.6	7.5
Caithness General Hospital	28.8	70.1	0.1	1.0
Southern General Hospital	28.3	66.7	2.7	2.3
Hairmyres Hospital	27.9	65.4	3.0	3.7
Inverclyde Royal Hospital	27.3	65.1	1.0	6.5
Aberdeen Royal Infirmary	26.9	68.0	1.2	3.9
Gilbert Bain Hospital	26.6	68.2	0.5	4.6
Royal Aberdeen Children's Hospital	26.5	73.2	0.2	0.2
Forth Valley Royal Hospital	25.0	64.8	1.1	9.1
Victoria Hospital	24.8	63.9	4.3	7.0
Glasgow Royal Infirmary	24.7	59.3	2.1	13.9
St John's Hospital at Howden	23.6	73.3	3.0	0.1
Wishaw General Hospital	23.5	66.1	5.0	5.4
Ninewells Hospital	22.7	71.3	4.7	1.3
Western Isles Hospital	22.5	69.1	3.1	5.2
Raigmore Hospital	22.5	75.8	0.1	1.7
Dr Gray's Hospital	22.3	75.3	1.4	1.0
Lorn and Islands Hospital	18.6	78.5	1.9	1.1
Belford Hospital	17.5	79.0	0.4	3.1
Perth Royal Infirmary	16.7	63.4	15.5	4.3
Royal Hospital for Sick Children, Edinburgh	14.2	85.7	0.0	0.0
Royal Hospital for Sick Children, Glasgow	13.9	85.9	0.0	0.1
Galloway Community Hospital	11.2	85.3	3.2	0.3
SCOTLAND	**27.0**	**65.2**	**2.9**	**4.9**

Note: Admission to same NHS provider includes admission to ward and, if available, assessment unit. Others includes deceased; private healthcare provider; residential institution; temporary residence; not known.

Source: ISD Scotland, A&E datamart

30. Performance against the waiting time standard tends to be better in A&E departments that have lower admissions from A&E to hospital. Patients who need to be admitted wait longer in A&E than those who are treated and discharged home. In 2012/13, the median wait across A&E departments for admitted patients was 188.5 minutes, compared with 109 minutes for patients who were discharged home.[23] The number of patients admitted to a hospital includes those admitted to a hospital ward, an A&E short-stay ward, or an assessment unit.

It is difficult to identify the impact that assessment units have on A&E waiting times performance

31. Some hospitals have an assessment unit to accommodate patients who need further treatment or observation before they are transferred to a hospital ward or discharged.[24] These units can reduce admissions to hospital wards and limit the waiting time for patients in A&E departments.[25] Our previous audit highlighted that opening hours and levels of staffing vary across the country. Up-to-date national information about how hospitals use these units and how they operate is limited. Across Scotland, admissions from A&E to these units are not recorded consistently. Of the 27 per cent of patients who are admitted to hospital from A&E, we do not have a complete picture of how many were admitted to a ward or to an assessment unit. Only eight A&E departments submit data to ISD Scotland on the number of patients admitted to an assessment unit. This ranged from one patient to 10,750 patients in 2012/13. This makes it difficult to identify the impact these units have on emergency admissions or waiting times in A&E.

Eleven per cent of all admissions to hospital from A&E departments took place within the last ten minutes of the four-hour period

32. In 2012/13, around 11 per cent of all admissions to hospital from A&E departments happened within the last ten minutes of the four-hour period. There is significant variation across A&E departments, ranging from 18 per cent at the Royal Infirmary of Edinburgh to 1.1 per cent at Royal Aberdeen Children's Hospital (Exhibit 14, page 27).

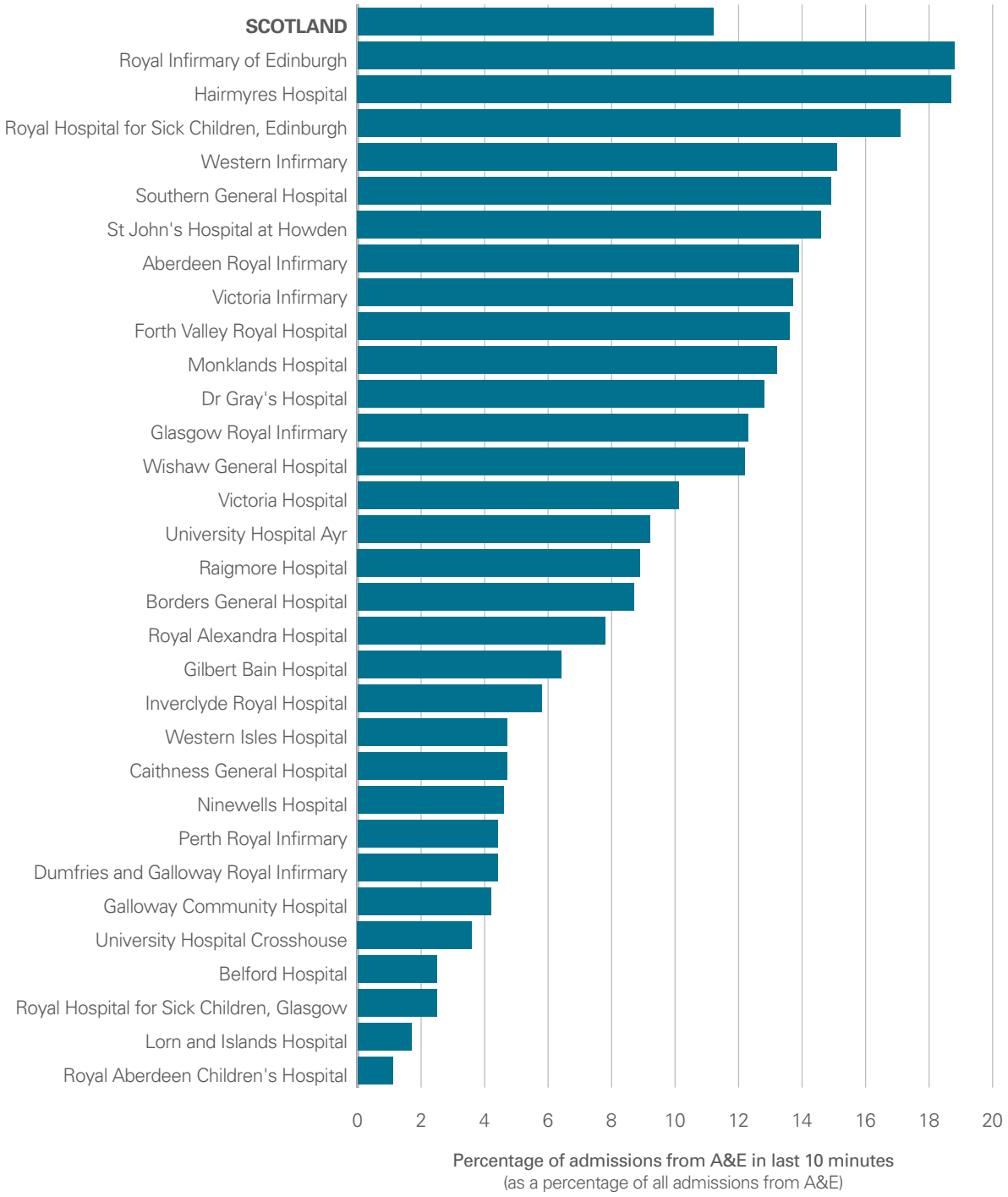
Patients admitted during the last ten minutes are more likely to stay in hospital longer

33. We cannot tell from national data whether patients are admitted to hospital inappropriately to meet the waiting time standard. If patients were systematically being admitted to avoid the A&E department failing to meet the standard, then those admitted just before the four-hour period ends would be more likely to spend only a short time in hospital. National data shows that patients who are admitted just before the end of the four-hour period are likely to spend longer in hospital. The data shows that 51 per cent of patients admitted in the last ten minutes stay three days or more, compared with 14 per cent of patients admitted in the last ten minutes who stay less than one day (Exhibit 15, page 28). While it may be clinically appropriate for the patients to remain in A&E until this time, higher than average admissions during the last ten minutes could suggest issues in managing the patient flow through the hospital. There is no evidence that A&E departments with higher admissions in the last ten minutes perform better against the standard.

Exhibit 14

Admissions from A&E departments to hospital in the last ten minutes of the four-hour period, 2012/13

The percentage of admissions made during the last ten minutes varies across A&E departments.

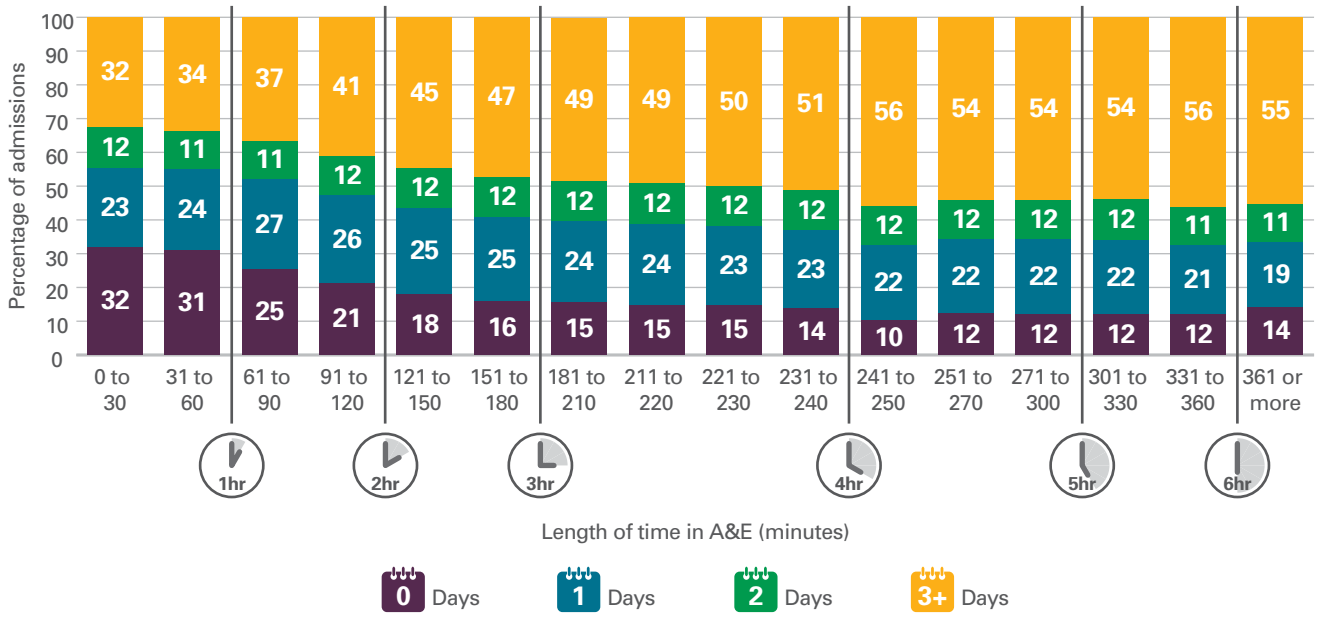


Source: ISD Scotland, A&E datamart

Exhibit 15

Emergency admissions by length of stay for patients admitted from A&E departments, by the time they spend in A&E, 2012/13

Patients who are admitted in the last ten minutes of the four-hour period in A&E departments, or after the four-hour period, are more likely to stay longer in hospital.



Note: This excludes patients where a valid Community Health Index (CHI) number was not recorded.

Source: ISD Scotland, Unscheduled Care datamart

The way that patients are admitted to hospital may affect performance against the four-hour standard

34. There is wide variation among NHS boards in the percentage of emergency admissions that go through the A&E department. Overall, around 98 per cent of NHS Ayrshire and Arran's emergency admissions go through an A&E department compared with 34 per cent in NHS Tayside. Admission rates from A&E to hospital also vary considerably by NHS board. Rates are highest in NHS Ayrshire and Arran (120 per 1,000 population) and lowest in NHS Tayside and NHS Highland (both 36 per 1,000 population).[26] Higher admissions from A&E departments are linked to weaker performance against the standard.

35. NHS boards take different approaches to admitting patients who are referred to hospital by their GPs. Some patients are admitted directly to wards or to special admitting units without first attending the A&E department. In some areas or specialties, patients go through A&E before being admitted to a hospital ward.

36. GP referrals to A&E departments fall into two categories: GP referrals for A&E treatment; and GP referrals for admission. In 2012/13, GP referrals for A&E treatment made up almost six per cent (76,869) of A&E attendances and GP referrals for admission made up almost four per cent (52,413). GP referrals for admission vary from around 16.3 per cent (7,305) of attendances at University Hospital Ayr, to 5.6 per cent (3,581) at Wishaw General Hospital (Exhibit 5, page 14).[27] There are some limitations with this data as A&E departments

record these referrals inconsistently.[28] However, there is some evidence that A&E departments with higher GP referrals for admission perform less well against the four-hour standard. This may be because these patients have more serious health conditions.

Three reasons account for nearly 70 per cent of delays in A&E

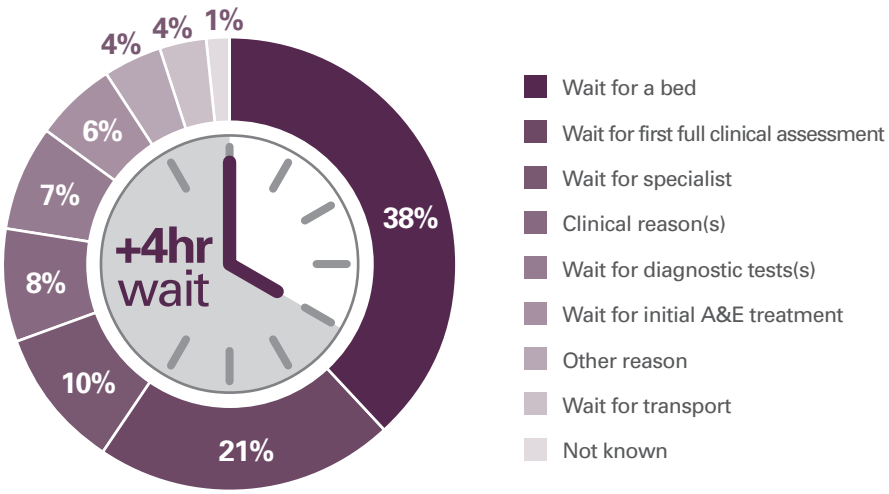
37. The most common reasons that NHS boards report for failing to achieve the A&E four-hour standard are largely the same as those reported in our previous A&E audit:

- waiting for a bed
- waiting for first full clinical assessment[29]
- waiting for a specialist (Exhibit 16).

Exhibit 16

Reasons for waiting over four hours in A&E, 2012/13

Waiting for a hospital bed is the most common reason for patients waiting longer than four hours in A&E. About one in five patients who are delayed are waiting for their first full clinical assessment.



Source: ISD Scotland, A&E datamart

38. Once a decision to admit has been made, the A&E department relies on the efficiency of the rest of the hospital to be able to move patients out of the A&E department and into a more appropriate setting. Some of the bottlenecks are beyond the control of the A&E department itself.

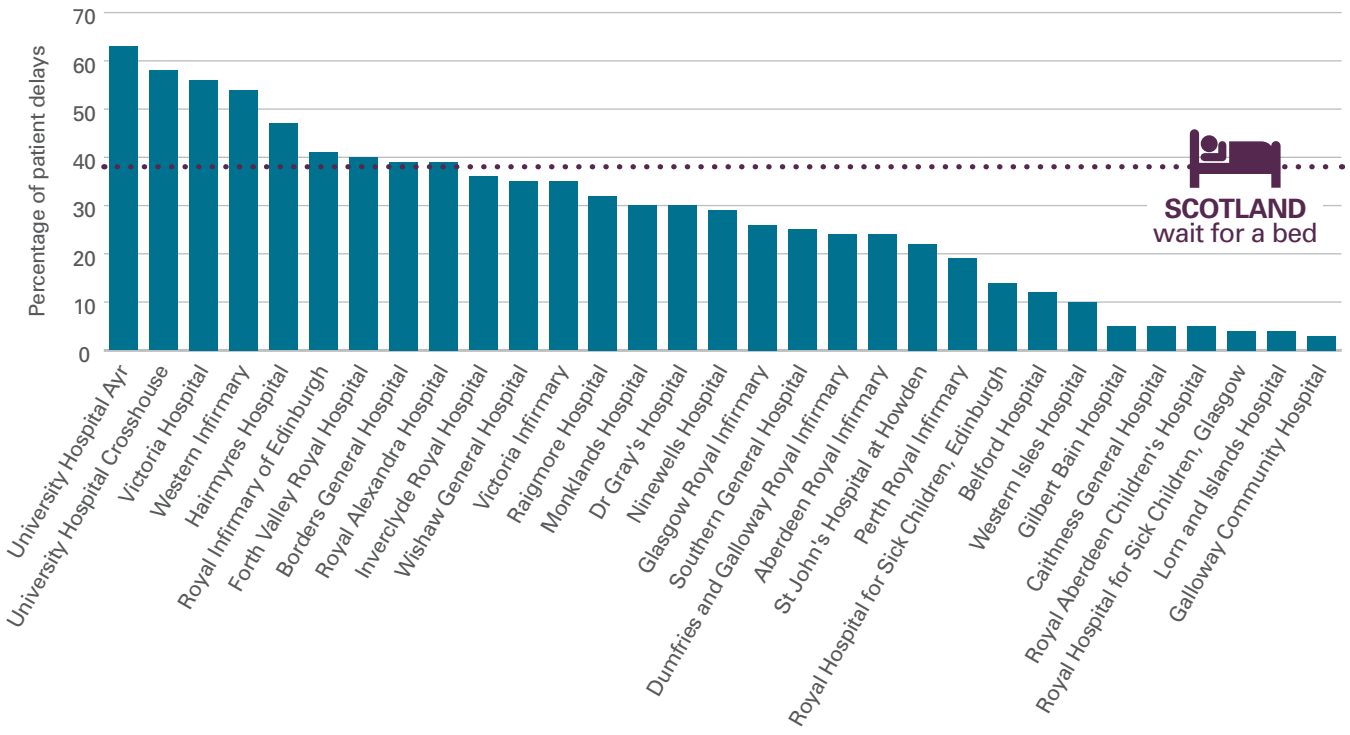
Difficulties in getting access to hospital beds at the right time affect waiting times in A&E

39. In 2012/13, around 38 per cent of delays were reported as 'wait for a bed', up from 25 per cent in 2008/09. This is four times the number of 'wait for a bed' delays we reported in our previous audit (37,946 patients in 2012/13 compared with 8,505 in 2008/09).[30] Some A&E departments are under particular pressure because of these delays (Exhibit 17). Across Scotland, 54 per cent of those delayed due to 'wait for a bed' were waiting for a bed to become available in the medical admissions ward. Patients waiting for an acute assessment bed made up 26 per cent of 'wait for a bed' delays, and those waiting for a surgical admissions bed accounted for 17 per cent.[31]

Exhibit 17

Delays due to 'wait for a bed' by A&E department, 2012/13

The most common reason for patients being delayed longer than four hours in A&E is 'wait for a bed'. This varies considerably by A&E department.



Source: ISD Scotland, A&E datamart

40. The average number of available beds across Scotland for all acute specialties, for example cardiology and respiratory medicine, decreased by around seven per cent, from 17,374 in 2008/09 to 16,230 in 2012/13.[32] The reduction in beds is mostly from a decrease in the number of surgical beds as hospitals are carrying out more day case procedures. The average occupancy rate of acute hospital beds has increased from 82.1 to 83.5 per cent over the same period, although this varies by different specialties and at different times.[33] For example, in 2012/13, the average occupancy rate for acute surgery was 77 per cent and the rate for acute medicine was 85 per cent. Average occupancy rates

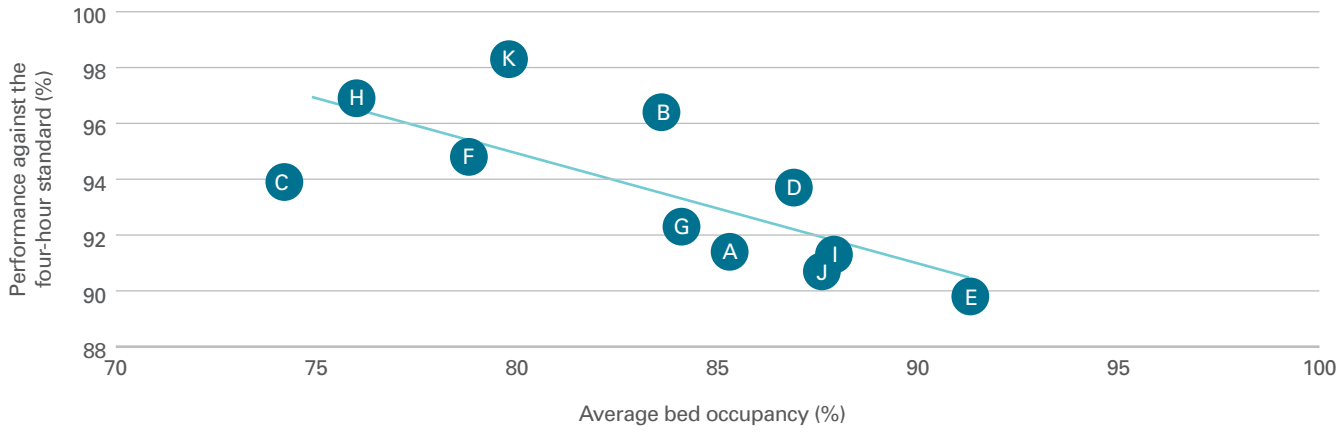
can also conceal times of extremely high occupancy. Research indicates that occupancy rates higher than 85 per cent can carry risks. For example, hospitals could experience bed shortages at these times and this can have an effect on the quality and safety of patient care.[34]

41. In 2012/13, six NHS boards had average occupancy rates over 85 per cent.[35] Our analysis suggests that NHS boards with lower average bed occupancy rates are more likely to perform better against the four-hour standard (Exhibit 18). NHS boards with lower occupancy rates are more likely to have fewer 'wait for a bed' delays in A&E departments. For example, in NHS Tayside, where the bed occupancy rate was 79.8 per cent, only 1.7 per cent of attendances waited longer than the four-hour standard and the percentage delayed waiting for a bed was slightly lower than the total for Scotland in 2012/13. In NHS Forth Valley, where the average bed occupancy rate was 91.3 per cent, 10.2 per cent of attendances at A&E departments waited longer than four hours and the percentage of delays due to 'wait for a bed' was slightly higher than the Scotland percentage.

Exhibit 18

NHS board performance against the four-hour standard and average bed occupancy, 2012/13

NHS boards with higher average bed occupancy generally have lower performance against the standard.



A Ayrshire and Arran
B Borders
C Dumfries and Galloway
D Fife
E Forth Valley
F Grampian
G Greater Glasgow and Clyde
H Highland
I Lanarkshire
J Lothian
K Tayside

Note: Excludes the island NHS boards.
Source: ISD Scotland, A&E datamart and (S)1 data

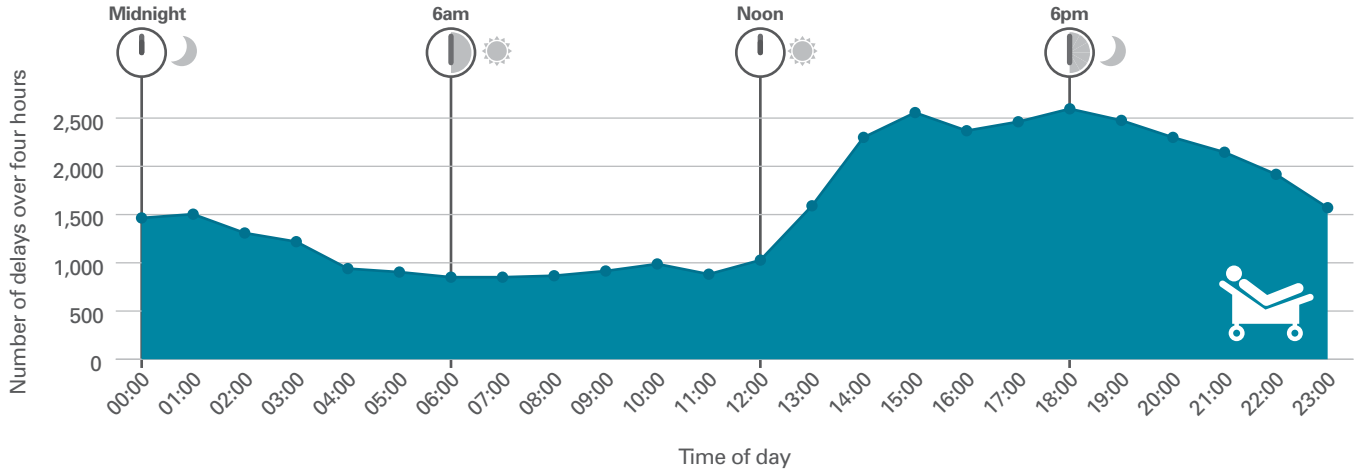
42. Most NHS boards highlighted bed occupancy and the challenges of having enough beds available at the right time to meet demand as a significant pressure in their 2013/14 Local Unscheduled Care Action Plans (LUCAPs).[36]

43. The process that hospitals have for discharging patients from wards also affects A&E performance. Attendances at A&E departments are highest on Mondays and Tuesdays. Delays due to people waiting for a bed are more likely on these days, since fewer inpatients are discharged at weekends. Discharges from hospital generally take place in the afternoon. Across Scotland, 'wait for a bed' delays are highest at 6pm (Exhibit 19).

Exhibit 19

Wait for a bed delays in A&E, by time of the day, 2012/13

Delays due to waiting for a bed are affected by the time of day the patient is seen in the A&E department.



Source: ISD Scotland, A&E datamart

Most delays for first full clinical assessment happen during the out-of-hours period

44. The other most common reasons for delays in A&E departments across Scotland in 2012/13 were:[37]

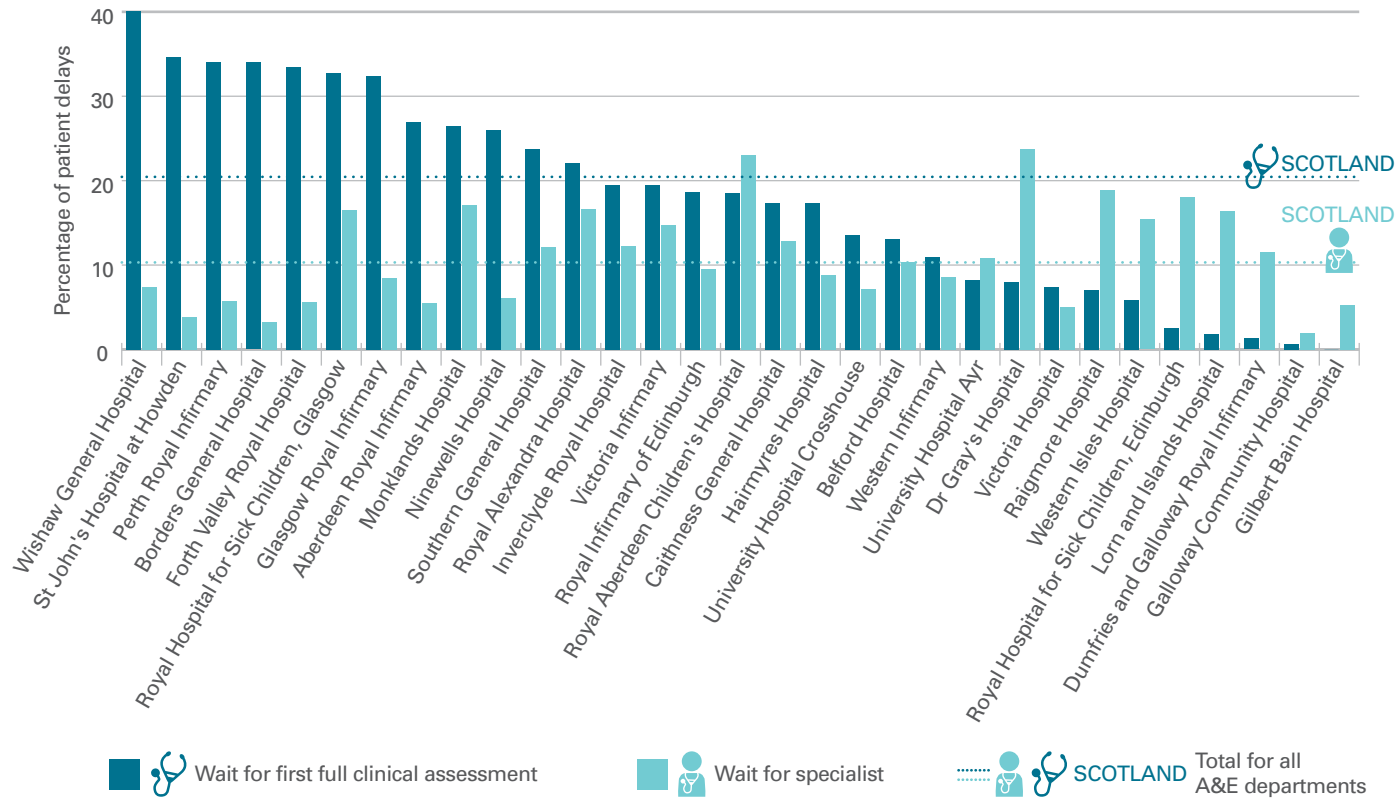
- 'wait for a first full clinical assessment' (21 per cent), which has trebled from 6,395 patients in 2008/09 to 20,942
- 'wait for a specialist' (10 per cent), which has more than doubled from 4,580 in 2008/09 to 10,025.

45. These two reasons for delay vary by A&E department (Exhibit 20, page 33). Delays due to waiting for a first full clinical assessment may be because of issues with patient flow, for example delays in accessing a hospital bed for an A&E patient mean the next patient cannot be brought into the A&E department for assessment. But delays in clinical assessment may also relate to staffing in the A&E department. Fifty per cent of 'wait for first full clinical assessment' delays occur between 9 pm and 4 am, peaking at 1 am. NHS boards need to ensure staffing levels are flexible enough to cope with varying demand. Data for A&E medical staffing is available nationally at NHS board level only, so this means we are not able to comment on how staffing levels at A&E departments affect local performance.

Exhibit 20

Delays waiting for first full clinical assessment and waiting for specialist by A&E department, 2012/13

Around 30 per cent of all delays are due to patients waiting for a first full clinical assessment or waiting for specialist input, although this varies significantly across A&E departments.



Source: ISD Scotland, A&E datamart

Consultant numbers have increased but NHS boards still face staffing challenges

46. The number of emergency medicine consultants in post across NHS boards has increased by 63 per cent since we last reported, from 94.8 whole time equivalent (WTE) posts in September 2009 to 154.5 WTE posts in September 2013.[38] The number of emergency medicine doctors in training has fallen from 347.7 WTE in September 2009 to 300.0 in September 2013 (Exhibit 21, page 34).[39] This fall in doctors in training numbers partly reflects the change towards services being delivered by fully trained doctors.[40] Recruiting and retaining doctors in training is still a challenge. Data on how boards use locums and manage sickness absence levels is not centrally available.

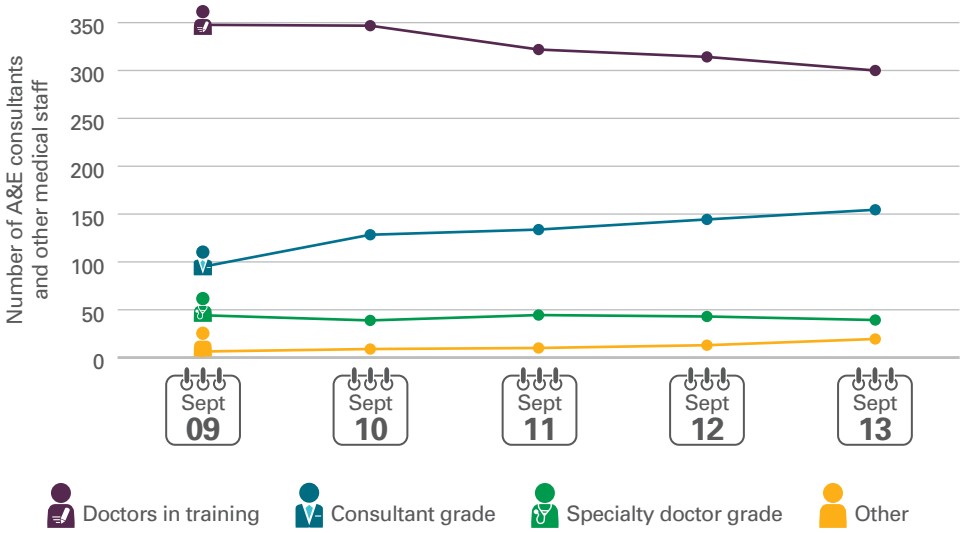
47. In their 2013/14 LUCAPs, NHS boards highlighted significant challenges around staffing. These include challenges because of:

- the lower numbers and grade of staff at weekends compared to during the week
- difficulties filling vacancies across various grades
- fewer senior decision-makers working late in the evening and overnight.

Exhibit 21

Number of A&E consultants and other medical staff, September 2009 – September 2013

Over the past five years, the number of emergency medicine consultants has increased but the number of doctors in training has fallen.



Note: Staff in the specialty doctor grade includes associate specialist; clinical medical officer; specialty doctor and staff grade. 'Other' includes salaried GPs.

Source: ISD Scotland and NHS Education for Scotland.

48. A&E medical staff sometimes ask for the opinion of doctors in the relevant specialty to which the patient is being admitted. Waits for this specialist input to the clinical decision-making process range from two per cent of delays at Galloway Community Hospital to 24 per cent at Dr Gray's Hospital. These delays can be the result of the competing commitments of the specialist teams or the timing of specialist teams' ward rounds. Initiatives such as protocols that allow senior A&E staff to admit patients to more specialties themselves, without needing to consult staff in the inpatient specialty, may help reduce delays.

A range of factors contribute to better waiting times performance in NHS Tayside

49. Ninewells Hospital and Perth Royal Infirmary are two of the five A&E departments that have consistently achieved the four-hour waiting time standard most months.[41] A range of factors combine to contribute to this performance (Case study 1, page 35). The Scottish Government has recently recommended NHS Tayside's policy on signposting patients to other services when appropriate as good practice.[42]

Case study 1

A&E waiting times performance at Ninewells Hospital in NHS Tayside

NHS Tayside performs consistently well against the 98 per cent four-hour standard. Since 2008/09, performance for Ninewells Hospital has ranged from 99.4 to 97.2 per cent and Perth Royal Infirmary has ranged from 99.7 to 96.7 per cent. Both have performed consistently above the 95 per cent interim target since it was introduced in 2013. Many factors can affect A&E performance (Part 2, page 20). This case study highlights some of the ways that NHS Tayside has improved the flow of patients through the A&E department at Ninewells and contributed to better waiting times. All of these working practices are underpinned by good communication and collaborative working between the A&E clinicians, nursing staff and senior management, and a focus on the quality and safety of patient care.

The A&E department in Ninewells Hospital is a consultant-led, 24-hour service. It has trauma services and a clinical observation unit consisting of eight beds for patients who need a further period of assessment or observation. Annual attendances are around 48,000. In common with other A&E departments, patients are 'streamed' at the A&E department. This involves directing patients, according to the severity of their illness or injury, into appropriate areas with dedicated staff. This allows patients with more minor illnesses or injuries to be seen and treated at the same time as patients who are acutely ill or seriously injured. Ninewells Hospital has an acute medical unit and an acute surgical unit.

Factors that contribute to better performance against the four-hour standard at Ninewells Hospital include:

- **Seniority and availability of clinical decision-makers.** Ninewells analysed the number of A&E attendances by hour of the day and day of the week and designed their staff shift patterns to match expected demand. It has two senior clinical decision-makers working in the A&E department in the morning, three working until midnight and one working overnight.[1] As well as ensuring there are enough senior clinical decision-makers on duty in the A&E department, NHS Tayside has formal procedures in place that make it mandatory for senior medical staff to be involved in specific cases. For example, if blood tests or an X-ray of more than one part of the body are requested in the A&E department, a senior member of medical staff is required to assess the patient. Overall, around 50 per cent of minor patients and 75 per cent of all patients are reviewed by a senior member of staff at the A&E department in Ninewells. Early input from experienced medical staff means that patients get the right type of care quickly. NHS Tayside's review of this working practice found that patients are less likely to be admitted to hospital and less likely to be inappropriately discharged from A&E.

Cont.

Case study 1 (continued)

- **Starting the process of A&E admissions early and improvements in the acute medical unit**. A&E patients are initially triaged by a nurse and if the patient is likely to need a bed in the hospital, the nurse contacts the acute medical unit coordinator to advise them at this early stage. A bed is then allocated to the patient, or if there is not one available at that stage, the A&E triage nurse actively follows this up. There is a process to escalate this if a bed is not available for the A&E patient within specific timescales. Overall this has reduced the potential for delays due to 'waiting for a bed'. There has also been a focus recently on increasing the number of staff and beds in Ninewells' acute medical unit which has helped to accommodate this movement of patients out of A&E. The acute medical unit is also working on processes to discharge patients earlier in the day so there are beds available during the day for patients who need to be admitted.

- **Patients referred by their GP for admission bypass A&E**. NHS Tayside has a long-established policy that allows GPs to refer emergency patients directly to wards. This is well established across the main specialties such as Paediatrics, Obstetrics and Gynaecology and Ear, Nose and Throat. This avoids patients attending the A&E departments when they do not specifically need these services.

- **Signposting patients attending A&E to other services, where appropriate**. For 16 years, NHS Tayside has had a policy of assessing and redirecting patients who attend A&E, but who should be attending a more appropriate service. For example, patients who have experienced their symptoms for three days or more are reviewed by a senior clinician in A&E and may be advised to see their GP or redirected to out-of-hours services for treatment.

All of these factors have contributed to NHS Tayside having a better managed service which is also likely to be more positive for staff. NHS Tayside has reported improvements in retaining junior doctors in A&E.

Note: 1. Shifts can be provided by either a consultant or senior doctor in training.

Source: Audit Scotland

Part 3

Action by the Scottish Government

Reducing A&E delays is part of the Scottish Government's focus on improving unscheduled care

50. In winter 2012/13, the NHS in Scotland's performance against the four-hour standard fell to the lowest it has been since monitoring began in 2007. This prompted the Cabinet Secretary for Health and Wellbeing to launch the National Unscheduled Care Action Plan in February 2013. The aim of the Action Plan is to improve urgent and emergency care in Scotland. This work builds on other Scottish Government policies and initiatives on A&E and unscheduled care (Appendix 2, page 45). Much of the Scottish Government's initial work has centred on the acute hospitals. The Scottish Government has indicated that it has recently established a Steering Group and a Programme Board to develop a more integrated, whole system approach to improving unscheduled care.

51. NHS boards were required to submit Local Unscheduled Care Action Plans (LUCAPs) to the Scottish Government in June 2013. These are three-year rolling plans on how each NHS board will deliver unscheduled care in their area and, as part of this, how they will progress towards achieving the four-hour standard. NHS boards are due to submit their second LUCAPs in summer 2014.

the Scottish Government and NHS boards are taking steps to deal with the causes of A&E delays

NHS boards set out a range of actions in their local plans to tackle A&E delays

52. The Scottish Government encouraged NHS boards to work closely with the Scottish Ambulance Service and NHS 24 in developing their initial LUCAPs. As well as setting out a longer-term plan for unscheduled care services, NHS boards were required to outline specific actions to improve performance against the A&E target and reduce the variation in performance. NHS boards also outlined their bids for funding from the Scottish Government to support these improvement initiatives. Initiatives outlined in their LUCAPs to tackle delays and improve the flow across the system include:

- introducing acute assessment units, or where these are already in place, extending the opening hours
- reviewing referral processes for GP emergency admissions to hospital
- changing hospital processes for discharging patients from wards and assessment units, for example planning early morning discharges instead of later in the day
- recruiting additional posts to provide cover seven days, for example increasing consultant and nursing staff at weekends in A&E

- increasing skill mix so there are more emergency care nurse practitioners and senior paramedics
- more frequent ward rounds and including a consultant on the team who undertakes the ward round so that decisions about discharging patients are taken earlier
- processes for redirecting or signposting patients away from A&E to more suitable services where relevant.

53. The NHS in Scotland plans to invest £50 million in unscheduled care between 2013/14 and 2015/16. Over this period, the Scottish Government is making £9 million available to NHS boards each year to support some of the initiatives outlined in their 2013/14 LUCAPs. NHS boards are also expected to invest at least £23 million in unscheduled care over the three years, from their cash-releasing savings. Our recent report on the financial performance of the NHS highlights the challenges that NHS boards face in making increased savings.[43] The Scottish Government is monitoring NHS boards' progress against the initiatives outlined in their LUCAPs and success measures for this investment include:

- a reduction in the number of patients waiting longer than four hours in A&E
- a reduction in the number of patients waiting longer than eight and 12 hours in A&E
- a reduction in A&E attendances and hospital admissions
- improved recruitment and retention of staff
- patient satisfaction and a reduction in patient complaints.

54. The Scottish Government plans to share any initiatives it considers as good practice with NHS boards, through a good practice website and national learning events.[44]

The NHS in Scotland has taken steps to help tackle causes of delay in A&E

55. NHS boards can take measures to ensure that A&E departments are working efficiently to deliver timely care to patients. But reasons for delays in A&E departments are complex and wider than A&E, which means NHS boards' approaches need to reflect this. It is too early to comment on the impact of the National Unscheduled Care Action Plan. From our review of the 2013 LUCAPs, it is clear that NHS boards are not just looking at A&E departments in isolation but are also considering the wider urgent and emergency care system, such as improving early coordination of care plans for patients who need support to return home from hospital. For example, NHS Fife has been working with Fife Council to improve discharge planning and reduce delayed discharges from hospital (Case study 2, page 39).

56. Overall the Scottish Government and NHS boards have been doing a lot of work on identifying the pressures and are taking steps to address some of the main causes of delays in A&E departments. Performance against the four-hour waiting times standard has improved since winter 2012/13, but is still lower than when we last reported (paragraph 16, page 13). There is also still significant variation across A&E departments.

Case study 2
NHS Fife and Fife Council's discharge hub

In August 2013, NHS Fife and Fife Council introduced a system at the Victoria Hospital in Kirkcaldy to improve the way patients are discharged home from hospital. A team of experienced health and social care staff plan the discharge of patients from all wards across the hospital from a single hub. The team assesses the needs of patients who are ready to return home following treatment in hospital and coordinates additional support, such as rehabilitation, homecare or accommodation for those who need it. The number of bed days occupied by delayed discharges fell from 9,306 in the quarter ending December 2012, to 9,138 in the quarter ending December 2013. The average length of stay at the Victoria Hospital also reduced from 6.6 days in January 2013, to 6.2 days in January 2014.

Source: Audit Scotland based on information published by NHS Fife

57. We highlighted in our previous report that there was limited quantitative evidence about the impact of redirecting patients from A&E to other services, for example to primary care. The Scottish Government has recently issued national guidance to NHS boards on how to implement a policy similar to NHS Tayside's on signposting patients away from A&E if they do not need emergency treatment (Case study 1, page 35). However the Scottish Government and NHS boards need to ensure that alternative services have enough capacity to deal with these additional patients.

The Scottish Government is progressing issues we identified in our last audit

58. Some of the recommendations which we made in our last report are now being taken forward as part of the Scottish Government's overall approach to improving unscheduled care.

59. We recommended that the Scottish Government provides a clearer strategic direction for emergency and urgent care services underpinned by a review of the services provided, including the workforce required. We also recommended that the Scottish Government work with NHS boards to develop guidance on best working practices to help inform how services should be organised, including assessment units. The Scottish Government has not yet issued guidance on best practice around different models of emergency care or use of assessment units. As part of the recent National Unscheduled Care Action Plan, the Scottish Government is working with the Royal College of Physicians to gather information on how NHS boards deliver emergency care. This includes looking at the role of A&E departments and the availability of assessment units.

60. We recommended that the Scottish Government provides benchmarking information and guidance to help NHS boards with decisions about appropriate staffing levels and the mix of medical and nursing staff on different grades. NHS boards highlighted issues around the availability of senior staff at the right time in their 2013/14 LUCAPs. There has been a strong focus on increasing the number of consultants. The Scottish Government made £1.8 million available to fund 18 additional emergency medicine consultants. All of these have now been appointed. As highlighted in paragraph 46 (page 33), there is also a need to

focus on other staff, for example problems with recruiting and retaining enough doctors is adding to pressure on A&E departments. NHS Education for Scotland launched the Strategy for Attracting and Retaining Trainees (StART) Programme in 2013. This aims to improve the recruitment and retention of medical trainees to specialty training programmes from 2014 onwards.[45]

61. The Scottish Government has indicated that a number of NHS boards are now using the Emergency Department and Emergency Medicine Workload Tool to help plan staffing levels in A&E departments and assessment units.[46] Across Scotland, services provided by A&E departments vary to meet the local health needs. While there is no 'one size fits all' approach to staffing an A&E department, benchmarking information would help NHS boards with decisions about appropriate staffing levels and skill mix.

62. We also highlighted in our previous report that patients' needs might be better met by admitting patients directly to inpatient specialties and we recommended that NHS boards examine the scope for patients to bypass A&E.[47] A number of NHS boards have outlined plans to look at referring patients more directly to wards. As highlighted in paragraph 34 (page 28), there is wide variation among NHS boards in the percentage of emergency admissions that go through the A&E department and this can affect performance against the four-hour standard.

Endnotes

1 ISD Scotland, Scottish Health Service Costs, year ended March 2013.

2 The Scottish Executive established the target in 2004 that, by the end of 2007, 98 per cent of A&E patients should wait no longer than four hours from arrival to admission, transfer or discharge. This applies to A&E departments and to minor injury units. The target became a standard in March 2008. Standards are used for targets that are past the target date, but are maintained to monitor progress or for other purposes such as benchmarking.

3 The units will be based at Royal Infirmary of Edinburgh, Ninewells Hospital in Dundee, Aberdeen Royal Infirmary and the new Southern General Hospital in Glasgow.

4 *Emergency departments* (PDF) Audit Scotland, August 2010. Data in this report was for 2008/09.

5 *A Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

6 *Management of patients on NHS waiting lists: Audit update* (PDF) Audit Scotland, December 2013.

7 Our previous audit analysed ISD Scotland's published and unpublished data on A&E activity and cost. We also collected information directly from A&E departments across Scotland and analysed data from the Scottish Ambulance Service and NHS 24. We use the term A&E departments to refer to sites that provide a 24-hour emergency medicine consultant-led service. ISD Scotland refers to A&E departments as emergency departments. It uses the term accident and emergency departments to cover both emergency departments and minor injury units.

8 A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place.

9 ISD Scotland, A&E datamart. This excludes the island NHS boards.

10 There could be differences across A&E departments in how they record referral sources. For example, some may record patients who come into A&E by ambulance as 'self referrals', and some may record these as '999 emergency services'.

11 ISD Scotland, A&E datamart. This is the number of patients who waited longer than four hours at A&E departments and MIUs.

12 ISD Scotland, A&E datamart.

13 The median is the number in the middle when the values are put in order from lowest to highest.

14 Patients were either discharged home, admitted to hospital or transferred to another hospital after treatment.

15 ISD Scotland, A&E datamart.

16 This analysis does not include MIUs.

17 Flow 1 minor injury and illness; flow 2 acute assessment; flow 3 medical admissions; flow 4 surgical admissions; and flow 5 out-of-hospital care.

18 In 2008/09, Belford Hospital, Caithness General Hospital and Lorn and Islands Hospital did not provide detailed data on patient flow categories. To help us compare like with like, we have removed these A&E departments from this calculation.

19 *Reshaping care for older people* (PDF) Audit Scotland, February 2014.

20 ISD Scotland, A&E datamart. ISD data is subject to any caveats described by ISD Scotland.

21 To help us compare like with like, we have removed Belford Hospital, Caithness General Hospital and Lorn and Islands Hospital from this calculation. In 2012/13, the total number of admissions from A&E to the same hospital was 365,723.

22 Galloway Community Hospital has fewer admissions (11.2 per cent) as it does not have an acute surgery department.

23 ISD Scotland, A&E datamart.

24 Assessment units are often referred to as acute medical units.

25 *The right person in the right setting – first time,* Royal College of Physicians, 2007.

26 ISD Scotland, SMR01.

27 Excluding NHS Western Isles where only 38 patients were recorded in ISD's A&E datamart as GP referrals for admission and Galloway Community Hospital that does not provide acute surgery.

28 Some A&E departments may record 'GP referrals' under 'GP referrals for admission'.

29 The first full clinical assessment is defined as a clinical assessment that results in positive progress of the patient through the A&E department. It is made by either a doctor or emergency nurse practitioner. This may be when the decision to treat is made.

30 In 2008/09, Galloway Community Hospital, Belford Hospital, Caithness General Hospital and Lorn and Islands Hospital could not provide data on reasons for delays in A&E because they did not have the systems in place to collect this detailed data. To help us compare like with like, we have removed these hospitals from this calculation. The total number of 'wait for a bed' delays in 2012/13 is 38,007.

31 ISD Scotland data on waits for patients classified as flow 2 (acute assessment), flow 3 (medical admissions) and flow 4 (surgical admissions).

32 ISD Scotland, (S)1 data. Data is subject to any caveats described by ISD Scotland.

33 ISD Scotland, (S)1 data. Annual occupancy rates are calculated by dividing the total number of days when each bed was occupied by a patient by the number of days the bed is available for the year. Data is subject to any caveats described by ISD Scotland.

34 *Inpatient admissions and bed management in NHS acute hospitals*, National Audit Office, February 2000.

35 NHS Ayrshire and Arran, NHS Fife, NHS Forth Valley, NHS Grampian, NHS Lanarkshire and NHS Lothian. This excludes the island NHS boards.

36 The Scottish Government required NHS boards to submit LUCAPs in June 2013.

37 To help us compare like with like, we have removed Galloway Community Hospital, Belford Hospital, Caithness General Hospital and Lorn and Islands Hospital from this calculation. In 2012/13, the total number of 'wait for a first full clinical assessment' delays were 21,009 and total number of 'wait for a specialist' delays were 10,107.

38 ISD Scotland workforce data. Staff in the director group (assistant clinical director, clinical director and medical director) are not included.

39 NHS Education for Scotland data. This is the number of doctors in training working in emergency medicine at the time the data was collected. Doctors in training grades include Foundation Year 1 and 2, doctors in training with a National Training Number (NTN) (Registrar, Senior Registrar, Specialist Registrar, Specialty Registrar), General Practice Specialty Training Scheme (GPST), Acute care common stem training programme and Doctors in training occupying locum posts.

40 This move to a service delivered by fully trained doctors is part of the Scottish Government's policy of 'Reshaping the Medical Workforce'.

41 Monthly A&E performance against the standard and interim target are shown in Exhibit 7 (page 16).

42 Scottish Government press release March 2014.

43 *NHS financial performance 2012/13* (PDF) , Audit Scotland, October 2013.

44 The Scottish Government plans to launch a good practice website in May 2014, and it plans to hold national learning events in May and another event later in 2014.

45 These posts will be spread across a range of specialties. It is not possible to estimate how many will end up in A&E as it will depend on applications.

46 This tool provides a WTE staffing requirement for doctors and nurses, based on actual workload, which includes numbers of patients and case-mix.

47 By inpatient specialties we mean an appropriate area in the hospital such as an acute assessment bed, where the patient can be assessed by the most appropriate healthcare professional.

Appendix 1

NHS Scotland A&E departments and minor injury units[1]

NHS board	A&E	MIU/Other
Ayrshire and Arran	University Hospital Ayr University Hospital Crosshouse	Arran War Memorial Hospital Davidson Cottage Hospital (closed May 10) Girvan Community Hospital (opened May 10) Lady Margaret Hospital (opened Oct 07)
Borders	Borders General Hospital	Hawick Cottage Hospital Hay Lodge Hospital Kelso Hospital Knoll Hospital
Dumfries and Galloway	Dumfries and Galloway Royal Infirmary Galloway Community Hospital	Castle Douglas Hospital Kirkcudbright Hospital Moffat Hospital Newton Stewart Hospital
Fife	Victoria Hospital	Adamson Hospital Queen Margaret Hospital (changed from A&E to MIU Jan 12) St Andrews Memorial Hospital
Forth Valley	Forth Valley Royal Hospital (opened Jul 11) Stirling Royal Infirmary (closed Jul 11)	Stirling Community Hospital (opened as MIU Jul 11) Falkirk Community Hospital (MIU closed Jul 11)
Grampian	Aberdeen Royal Infirmary Dr Gray's Hospital Royal Aberdeen Children's Hospital	Aboyne Hospital Chalmers Hospital Fleming Cottage Hospital Fraserburgh Hospital Insch and District War Memorial Hospital Inverurie Hospital Jubilee Hospital Kincardine Community Hospital Leanchoil Hospital Peterhead Community Hospital Seafield Hospital Stephen Cottage Hospital Turner Memorial Hospital Turriff Cottage Hospital

Cont.

1 This is ISD Scotland's classification of A&E departments and MIUs. We broadly use this in our report. We highlight where we have made any changes to this classification, for example when making comparisons with the data in our 2010 report.

NHS board	A&E	MIU/Other
Greater Glasgow and Clyde	Glasgow Royal Infirmary Inverclyde Royal Hospital Royal Alexandra Hospital Royal Hospital for Sick Children, Glasgow Southern General Hospital Victoria Infirmary (A&E) Western Infirmary	Stobhill Hospital (from Mar 11 – no A&E on site) Vale of Leven District General Hospital Victoria Infirmary (MIU)
Highland	Belford Hospital Caithness General Hospital Lorn and Islands District General Hospital Raigmore Hospital	Aviemore Health Centre Campbeltown Health Centre County Hospital Invergordon Cowal Community Hospital Dunaros Hospital Dunbar Hospital Ian Charles Hospital Islay Hospital Lawson Memorial Hospital Mackinnon Memorial Hospital Mid Argyll Hospital Town and County Hospital, Nairn Portree Hospital Ross Memorial Hospital Victoria Hospital
Lanarkshire	Hairmyres Hospital Monklands Hospital Wishaw General Hospital	Kello Hospital Lady Home Hospital
Lothian	Royal Hospital for Sick Children, Edinburgh Royal Infirmary of Edinburgh St John's Hospital at Howden	Belhaven Hospital (opened Dec 07 – closed Oct 12) Edington Cottage Hospital (opened Dec 07) Western General Hospital (ARU) Western General Hospital (MIU)
Orkney		Balfour Hospital
Shetland	Gilbert Bain Hospital	
Tayside	Ninewells Hospital Perth Royal Infirmary	Aberfeldy Cottage Hospital (opened Sep 08) Arbroath Infirmary Blairgowrie Community Hospital Brechin Infirmary Crieff Community Hospital (opened Sep 08) Links Health Centre, Montrose Pitlochry Community Hospital St Margaret's Hospital (opened Sep 08) Whitehills Health and Community Care Centre
Western Isles	Western Isles Hospital	St Brendan's Hospital Uist and Barra Hospital

Appendix 2

National context for A&E and unscheduled care, 2004 to 2014

Policy, guidance or initiative		Date
Fair to all, personal to each	The Scottish Executive set a target that by the end of 2007, 98 per cent of patients should spend no longer than four hours in an A&E department from when they arrived to when they were discharged or admitted. This target also applied to minor injury or illness units.	2004
National Unscheduled Care Collaborative Programme	This three-year programme was launched by the Scottish Executive to help achieve and sustain the four-hour emergency access target. This was supported by funding of £25,000 for each NHS board and an annual allocation of £1 million for three years. NHS boards were encouraged to work with the national Delivery Team to identify the causes of delay and introduce new ways of working to improve the experience of patients using A&E.	May 2005
Building a Health Service Fit for the Future: A National Framework for Service Change in the NHS in Scotland	This set out steps that NHS boards and emergency care providers should take to redesign services in Scotland. It proposed looking at patient care across hospitals and community and delivering care as locally as possible. This involved using new ways of working, such as nurses having extended roles and using technology to help services to better join-up the care they provide. The report recommended changing the 'one size fits all' system where a whole range of people, many of whom could be dealt with elsewhere, were seen instead in busy hospital A&E departments.	May 2005
Delivering for Health	The Scottish Executive's action plan for implementing the National Framework for Service Change recommendations.	November 2005
Better Health, Better Care	This set out the Scottish Government's vision and five-year action plan for the NHS. It outlines the government's commitment to continue to develop a more integrated approach to the way unscheduled care was delivered in each local area.	December 2007
Emergency Access Delivery Team established	The team aimed to support boards in shifting the balance of unscheduled care so that patients receive emergency care at the most appropriate level of the care system, as quickly and conveniently as possible. As part of its work, the team helped boards develop locally agreed targets for reducing the number of A&E attendances and monitored their progress when they were working towards these targets. The team continued to monitor performance against the four-hour A&E standard.	2009

Cont.

Policy, guidance or initiative		Date
Shifting the Balance of Care Framework	Identified eight areas aimed at improving people's health and the health and care services that people use. One of these identified areas aimed to reduce unscheduled care by minimising avoidable attendances at A&E departments and reducing emergency admissions and the length of time people had to stay in hospital. HEAT target established for NHS boards to achieve agreed reductions in the rates of attendances at A&E departments over the period 2009/10 to 2010/11. This was extended for delivery in 2013/14.	July 2009
2020 Vision for health and social care	Set out a vision that, by 2020: • everyone will be able to live longer, healthier lives at home, or in a homely setting • an integrated health and social care system will focus on preventing health problems and helping people to do more to manage their own health • care will be high quality and safe • people will be treated and return home as quickly as possible The Route Map to the 2020 Vision for health and social care, published in May 2013, identifies actions to improve the patient pathway and reduce pressure on A&E departments.	May 2011
The Emergency Care Pathways Programme	This programme was established to: • improve emergency access as measured by the four-hour standard • provide some tailored performance support to NHS boards, such as input from experts from Scottish Government and other boards.	November 2011
	Emergency Access Delivery Team disbanded	2012
Unscheduled care programme	The Cabinet Secretary for Health and Wellbeing launched the Unscheduled Care Action Plan.	February 2013
Interim waiting time target	The 95 per cent interim target for four-hour waiting time was introduced, for delivery year ending September 2014.	April 2013
Signposting guidance	New guidance was sent to A&E departments to help them to signpost patients to the most appropriate service following an initial consultation with a senior A&E clinician.	March 2014

Accident and Emergency

Performance update

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0845 146 1010 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on Twitter or subscribe to our email delivery service:

@AuditScotland

Subscribe to updates

AUDIT SCOTLAND

Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0845 146 1010 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 909705 34 0 AGS/2014/3