# Inequalities, Health and the Accident & Emergency Response

## NHSGGC A&E Attendances Steering Group

## Final Report

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**Acknowledgements**

Over the course of the project over 80 people took part in one-to-one interviews or focus groups to provide quantitative and qualitative data related to this work.

My thanks to all NHSGGC staff who participated in the project by providing information and offering their perspectives on the care of attendees who have additional health and social care needs, into, through and out of, Accident and Emergency services.

Thanks also to representatives of partner services based both within and outwith NHSGGC, for their particular insights into the challenges and opportunities of providing seamless care.

My sincere thanks to the service users from Glasgow Mental Health Network, South-East Recovery Group, Glasgow Women"s Aid and ACUMEN, who met with me and shared their experiences of care and offered their views on care provision.

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# 1 Introduction

NHSGGC aims to provide a safe, effective and efficient Accident and Emergency service that is resourced and able to meet the immediate and acute healthcare needs of the population it serves. The service is also aware of the pressing need to enhance prevention and anticipatory care approaches in order to improve health and prevent unnecessary hospital admissions.

People with a range of additional health and social care needs make up a substantial portion of A&E service users for a variety of reasons. To ensure that people with additional needs are getting the right care, in the right place, at the right time and to inform the Shifting the Balance of care agenda a review of the use of A&E services by people with additional needs has been undertaken. While not comprehensive the report offers insights into the characteristics and healthcare needs of this group of A&E service users, the challenges, gaps and good practice in meeting their needs and the perspectives of managers, frontline workers, partner services and service users on care remit and provision.

# 2 Background

Over the last 4 years NHS Greater Glasgow and Clyde has seen an exponential rise in emergency activity within its services, on average an increase of 3.2 % per annum. To counteract the upward trend in emergency department activity across Scotland, the Scottish Government has set a target for NHS Boards to achieve agreed reductions in the rates of attendance at A&E. To achieve this, the Heat T 10 Target aims to support a shift in the balance of care from acute care management to preventative and anticipatory approaches to care.

The NHSGGC A&E Attendances Steering group has been set up to oversee the development of an integrated response to the Heat T 10 Target. A range of initiatives have been developed to improve the management of demand through streamlined care processes and to build community capacity in the provision of anticipatory care.

To support this programme of work and to pilot new initiatives the Scottish Government has made funding available on an annual basis. This report forms the output of one such an initiative.

## 2.1 Caring for people with multiple or complex needs

NHSGGC aims to become an inequalities sensitive health service. This means that both the causes of poor health as well as the outcomes will form the basis of action. It is known that discrimination on the grounds of low income, social class, gender, ethnicity, disability, age and sexual orientation is linked to poor health and low social status.

Policy and planning frameworks have been developed to help the organisation tackle discrimination, address health inequality and respond effectively to the needs of marginalised groups such as homeless people. To support this goal practitioners are required to develop an inequalities sensitive approach to care.

Inequalities sensitive practice is a person centred approach that understands the impact of social inequalities on health and applies this understanding in response to the needs of service users and carers.

## *2.2 Inequalities, Health and the Accident and Emergency Response*

Accident and Emergency Departments are key access points to health care for people experiencing the health symptoms of social inequality such as poverty, violence, gender-based violence, acts of racism, homelessness and asylum. Health symptoms can include mental health problems, addictions and injuries. The experience of social inequalities can also often account for the preferential use of A&E services over other alternatives either because of the times at which incidents occur, because of difficulties in accessing primary care services or because of previous experiences of primary care services.

This pattern of use places a considerable burden on A&E departments both in terms of demand and in determining an appropriate response to the presenting problem. Similarly the experience of attending A&E for

the patient can be unsatisfactory and have limited impact on their core health problems.

In recognition of the issues a piece of work was proposed that aimed to:

Examine the extent to which the efficiency and effectiveness of unscheduled care might be improved by responding systematically to the needs of a diverse population and identifying ways of consolidating inequalities sensitive practice into A&E departments

Consider the extent to which an understanding of the nature of inequalities might be used to identify ways of reducing attendance at A&E departments

### 2.3 Scope of the proposed work

The aim of the project was to assess the key challenges for staff in caring for people with additional or complex needs and to investigate service user reasons for attendance at A&E.

The objectives of the processes were to:

- Describe and quantify the extent to which A&E services are utilised by people experiencing different forms of social inequality and their rationale for attending.
- Quantify the range of current service developments aimed at providing alternative responses to people experiencing social problems attending A&E departments.
- Explore examples of innovative practice in responding to such patients both in Greater Glasgow and Clyde and beyond.
- Identify ways in which A&E services can improve efficiency by improving communication with people with communication and language needs.
- Bring forward a plan for practice development of A&E staff.
- Identify ways in which A&E can be seen as an integral part of a package of care for the health consequences of social inequalities.

A temporary post of Planning and Development manager in the Corporate Inequalities Team was created to take the project forward. The post-holder was appointed in January 2010 for a period of 9 months.

## 3 Project Design and Development

Three main data gathering exercises were undertaken to provide evidence in relation to the following suite of questions that emerged out of the project specification:

- What are the pertinent policy drivers in A&E care?
- Who attends A&E?
- Why are people with additional needs attending A&E?
- What are the drivers and challenges to service providers in caring for attendees who have additional health and social care needs?
- What is working well, what not-so-well and where are there gaps in care provision?
- What does Inequalities Sensitive Practice look like in A&E?
- What kind of infrastructure supports sensitive practice?

The report will conclude with a discussion on the implications for planning and practice based on the findings to these key questions

The quantitative and qualitative methodologies applied in the gathering of evidence are described below.

## 3.1 Local and national policy review

Currently the key drivers of performance in NHS services are Scottish Government health policies and targets. A review and summary of the policies and targets that have resonance for Accident and Emergency services, particularly in relation to the care of people with additional needs, was undertaken.

## 3.2 Systemic enquiry approach

A systemic action research model was applied to the design of the data gathering phase of the project (Burns, 2007). The validity of the perspectives of all stakeholders involved in A&E care and associated services, underpins this whole system approach. The approach takes account of the multiple realities that exist for individual stakeholders which are influenced, for example, by personal values, lived experience, social circumstances or the position an individual holds within an organisation. Enquiry aimed to understand how service providers interpret policy and how policy is translated into practice.

A snowballing style of information gathering was utilised. Interviews with senior managers at the outset paved the way for subsequent access to practitioners working in A&E services. Other information sources were suggested by interviewees or were determined by the issues that were raised. As issues emerged, lines of enquiry were developed that involved a range of stakeholders including A&E managers and practitioners, partner services within the Acute Division and within Community Health and Social Care Partnerships, Health Board workers, Third Sector agencies and service user networks. Over 80 people were involved in the consultation process. Participation was through individual and group interview ( Appendix 1).

## 3.3 Quantitative Data Analysis

Quantitative data was gathered primarily from statistical reports of A&E activity available through Information Services. Two distinct data management systems are currently in operation within A&E services in

NHSGGC, the EDIS system within the North Glasgow hospitals and HISS in the South. The systems have similar but not identical functions and there is currently no IT interface that allows for information flow or joined up data gathering. The A&E Information Manager has responsibility for collecting and collating information from both systems to provide a coherent picture of service provision across NHSGGC.

Information on the characteristics of A&E attendees in relation to dimensions of equality and inequality were accessed. Much of the gathered data is partial however, its collection being dependent on the correct and routine recording of certain characteristics. Staff appetite for recording data that is not contained within a compulsory field is limited. Thus many patient characteristics that are pertinent to an inequalities analysis are not well recorded. For example, it is accepted that there is significant under reporting of alcohol related presentations. Currently the only compulsory fields relating to alcohol attendances are for the recording of a diagnosis of “Intoxication” or “Withdrawal”.

The available demographic data, along with information on key diagnoses does offer some insight into the social circumstances and characteristics of the attending population.

## 4. Findings

The findings are reported as responses to the questions raised by the project objectives.

### 4.1 What are the pertinent policy drivers in A&E care?

In common with most NHS Departments, health improvement and service development in Accident and Emergency services is driven by policy frameworks and targets set locally and nationally, particularly the Scottish Government HEAT targets. NHS Boards’ performance is measured against the HEAT targets.

Accident and Emergency services are often regarded as the front door into hospital care for many patients. It is a key access point for planned admissions, emergency admissions and referrals from a number of

sources, including self referral. As such the pressures on the system are great and rising in tandem with the incremental rise in A&E attendances year on year. While local and government priorities are set to drive up care standards, the effect of what can be regarded as competing priorities, may be disabling and disheartening for staff working in an already overstretched system. NHSGGC services are under pressure to meet the 4 hour waiting time target which, to achieve, requires streamlining, efficiency and selectivity in care provision. At the same time a number of national targets require A&E services to widen their portfolio of care to include focused interventions. The pressure to perform on all fronts can create a tension between a drive for efficiency and the drive for quality of care, as set out in the Healthcare Quality Strategy for Scotland.

A range of such policy initiatives have been developed through the Scottish Government Health Department both to drive up quality standards in A&E in relation to waiting times and to exploit A&E's role as a key access point to identify and address a range of issues that can make people vulnerable to ill-health. A number of these policy drivers are described below:

### 4.1.1 4 Hour Waiting Time Target

In 2004 the Scottish Government announced a new waiting times target for Accident & Emergency (A&E) departments, stipulating that by the end of 2007 at least 98% of patients attending an A&E department should be seen within four hours, i.e. admitted, discharged or transferred elsewhere. This maximum wait also applies to emergency care in minor injuries units and areas of assessment units where trolleys are used.

### 4.1.2 HEAT Target: Alcohol Brief Interventions (ABIs)

The ABIs target aims to help tackle harmful and hazardous drinking, which contributes significantly to Scotland's morbidity and mortality and social harm. Health Boards are required to achieve an agreed number of alcohol screenings (34,902 in 2010/11 in NHSGGC) using a setting-appropriate screening tool and brief intervention.

Brief interventions should be carried out within the three identified priority settings of primary care, A&E and antenatal care.

### 4.1.3 HEAT Target: Suicide Prevention Training

The Suicide Prevention HEAT target aims to increase the number of people most likely to be in contact with those feeling suicidal, trained in the necessary skills to help.

The national target is to reduce the suicide rate between 2002 and 2013 by 20 per cent. To support this Health Boards are required to ensure that 50 per cent of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency have undertaken suicide assessment and prevention training by 2010.

### 4.1.4 HEAT Target: Dementia Awareness

This target aims to increase the early diagnosis, recording and treatment of dementia. Performance is measured by the increase in the number of people with a diagnosis of a dementia on the Quality and Outcomes Framework (QOF) dementia register by March 2011. Each NHS Board will initially respond to a target increase of 33%.

### 4.1.5 Gender-Based Violence Action Plan

The aim is to improve the identification and management of gender-based violence across NHS Scotland. Four key deliverables have been agreed for health boards:

- Implementation of routine enquiry of abuse within priority settings
- Dissemination of revised guidance to staff on abuse
- Production of an employee policy on gender-based violence
- Multi-agency collaboration on gender-based violence particularly on child protection and homelessness

Accident and Emergency services have been identified as a priority setting for this work.

### 4.1.6 HEAT 10 Target: A&E Attendances

As an indicator of a shift of care provision from acute into community based care and prevention, NHS Boards are required to achieve agreed reductions in the rates of attendance at A&E. A specific target is to be set in November 2010 and will be based on the number of unplanned A&E attendances per 100,000 population per month.

### 4.1.7 Healthcare Quality Strategy for Scotland

Along with specific performance targets an overarching policy on quality of care, The Healthcare Quality Strategy for Scotland was published in May 2010 and sets out the values and principles upon which all health care delivery should be based. The vision for NHS services as set out in the strategy is to achieve:

- Caring and compassionate staff and services
- Clear communication and explanation about conditions and treatment
- Effective collaboration between clinicians, patients and others
- A clean and safe environment
- Continuity of care
- Clinical excellence

This vision will be achieved by ensuring that care is person-centred i.e responsive to the needs, values and preferences of patients and carers, safe, evidence based and effective, efficient, equitable and timely.

All other policy initiatives are subsumed into this new narrative of health care with its primary intent of improving the health of the whole Scottish population, improving the quality and experience of healthcare and reducing health inequalities. A key strand of the Quality Strategy is its commitment to equality and the furtherance of actions to address health inequalities i.e. understanding the needs of different communities, eliminating discrimination, reducing inequality, building good relations, and addressing barriers that prevent people from accessing care. Person-centred care in particular offers the potential to address the health problems of many of those who carry a disproportionate burden of ill-health in our communities.

This commitment to quality is reflected in NHSGGC Policy and Planning Framework. Equality issues are driven locally through the Tackling Inequality Planning Framework, the Equality Scheme and the 10 Goals of an Inequalities Sensitive Health Service.

## 4.2 Who attends A&E?

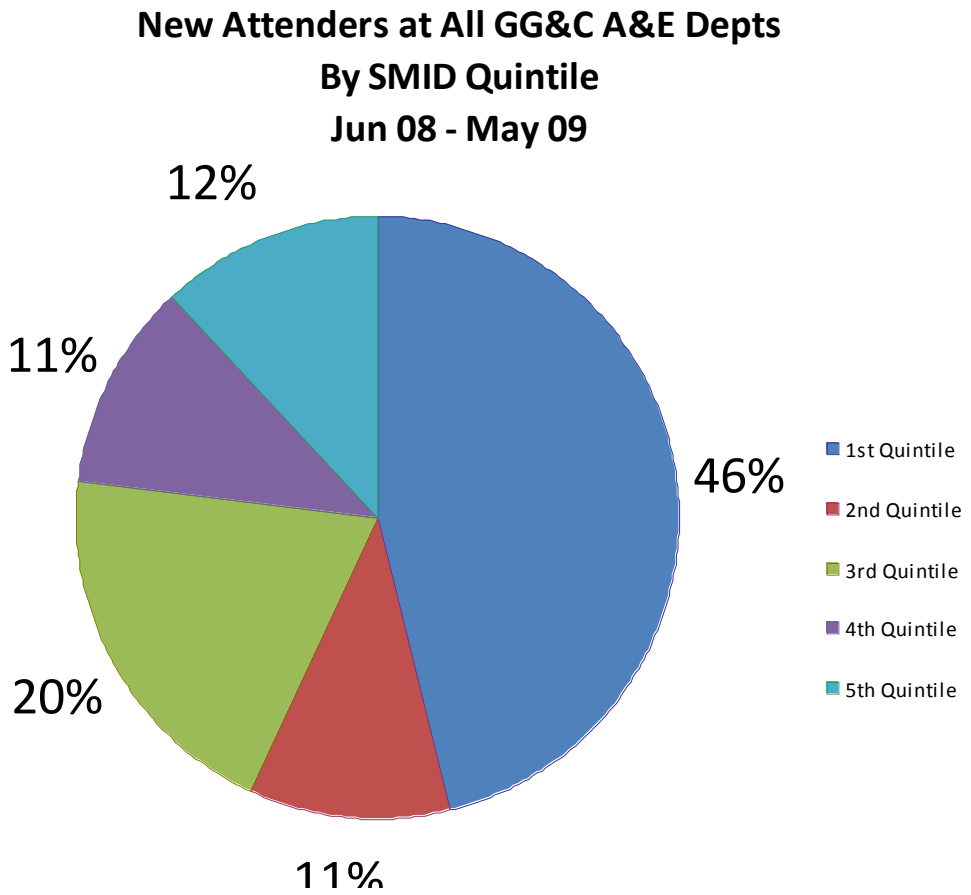
From an interrogation of NHSGGC data it is clear that high end users of hospital services, including A&E, are majorly represented by equality groups. That is:

### 4.2.1 People from the poorest communities who have high rates of disability and chronic ill-health.

Deprivation is a feature which is spread across all Glasgow City Community Health and Care Partnership areas. The north and the east of the city have the highest proportion of people living in deprivation. Over 140,000 residents of these communities are living in areas which are considered to be the most deprived 15% in Scotland (Scottish Index of Multiple Deprivation).

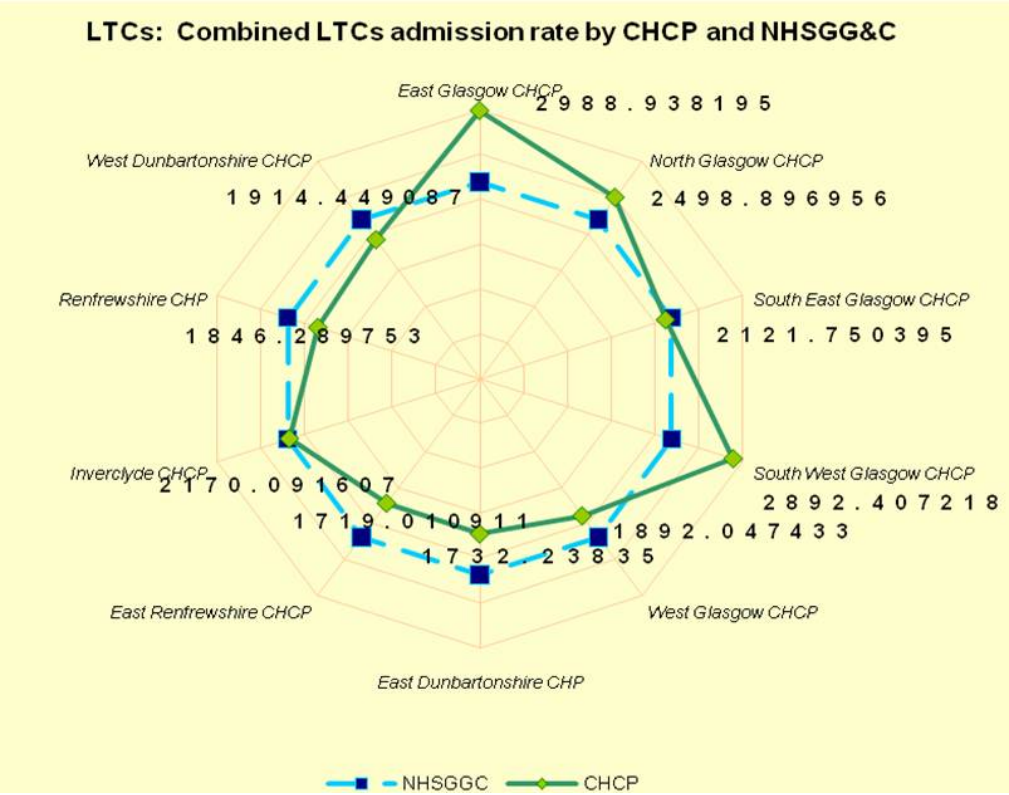
The majority of all new attenders (449,717) at GG&C A&E Departments from June 08 - May 09, across all age categories, came from the Scottish Index of Multiple Deprivation (SIMD) (2006) most deprived communities. Almost half of this population,(46.5%), were resident in SIMD Quintile 1 (most deprived). See Pie Chart 1 below. An analysis of ‘self referrers’ within this group results in an almost identical picture.

Pie Chart 1




Another indicator of comparative poor health in the most economically deprived communities in Glasgow, is the admission rate across CH(C)P's for Long Term Conditions. Graph 2 below illustrates the admission rate for a combination of Long Term Conditions (LTCs) which comprises the combined rate of Chronic Obstructive Pulmonary Disease, Coronary Heart Disease, Diabetes and Asthma, by CHCP and NHSGGC. Across all NHSGGC CH(C)P's admission rates for all LTCs are higher in the most deprived CH(C)P areas of East Glasgow, North Glasgow and South-West Glasgow.

Graph 1




### 4.2.2 People with mental health problems

There is considerable variation across NHSGGC sites, in the data that is collected on attendances at A&E in relation to mental health problems. However figures from Glasgow Royal Infirmary provide an indication of prevalence. 3094 (8.4%) attendees that attended the North Glasgow A&E services in the 6 month period from October 2009 - March 2010 were of people with mental health problems. The following broad diagnostic groupings were used in this analysis:

- All psychiatric diagnoses
- All drug / alcohol diagnoses
- All deliberate self harm
- All overdoses (mostly contained in the 2 above)
- All 'no abnormality detected' patients

### 4.2.3 People with Drug and Alcohol Use Problems

While a number of this group are contained within the category above, it is useful to look more closely at this particular group as for a high proportion of A&E attendees, substance use, and alcohol use in particular, is a significant aspect of their presentation.

The extent of the problem however is difficult to estimate because of the sizeable under reporting of alcohol related presentations. A&E services record attendances where alcohol use has resulted in intoxication or withdrawal symptoms. It is less clear if and when alcohol, as an associated feature of the presentation, should be recorded.

An indication of the annual morbidity associated with substance use can be drawn from the SMR01 Addictions Report (2008) which shows that in 2008, out of 171,526 admissions of Greater Glasgow and Clyde residents to Glasgow hospitals, 11,667 (7%) were with a drug or alcohol diagnosis. Broken down into CH(C)P areas, of these 82% of admissions came from the Glasgow CH(C)Ps. While drug and alcohol use has significance for all CHCP's, admission rates were highest in the East and South-West.

Table: All Alcohol and Drugs Admissions by Glasgow CHCP

| CHCP | A&D Admissions (%) |
|---|---|
| East | 24% |
| North | 17.5% |
| S. East | 19.5% |
| S.West | 24% |
| West | 15% |
| Total | 100% |

The SMR01 report (2008) found a significant association between drug and alcohol diagnoses and repeat attendances at A&E services.

Multiple morbidity and the intermingling of psychological and physical illness are reported as the dominant feature of frequent attendees reported by A&E Units across Scotland (EADT 2008). This combined analysis indicated that frequent attendance was associated with:

- Alcohol and associated injuries
- Psychiatric and behavioural problems with a strong element of self-harm
- Exacerbations of long-term conditions

Attendees at NHSGGC A&E units more often come from the poorest communities in Glasgow, including marginalised groups such as asylum seekers and refugees, where chronic ill-health, reduced personal resources and problematic lifestyle behaviours are both the cause and consequence of an experience of poverty, social exclusion and poor social support.

### 4.3 Why are people with additional needs attending A&E?

A&E departments are for this group of vulnerable individuals, a key access point in times of crisis (physical, psychological and social) and as such may be viewed by them as a resource for daily living. There a number of factors that contribute to the routine use of A&E by disadvantaged groups. The perceptions of frontline staff support such an analysis.

#### 4.3.1 Perception that their ailment merits A&E attendance

The A&E Self-Referrers Survey (NHSGGC, 2010) reported that the majority of self-referrers attend because they perceive that their ailment is best dealt with by an Accident and Emergency service e.g. the need for an x-ray, the acute or serious nature of the health problem. Only 13% reported convenience as one of the factors considered in this decision making process.

*“For some people, what is a minor incident may feel major. The perception of the significance of symptoms differs” (Senior Nurse)*

*“Patients always have a reason why they are in the right place. Very small number by-pass the system” (Senior Nurse)*

### 4.3.2 Chronic poor health

Exacerbations of chronic conditions contribute to attendances at A&E. The high level of morbidity that exists in poor communities (see above) is a key factor. The findings of 2 audits undertaken by the East Glasgow and West Dunbarton CHCPs respectivel, indicated that many of the people who attended A&E units frequently, also attended their GP practice frequently. This may be an indication of the chronic nature of the underlying problems that are re-presenting.

*“Society is changing. There”s a reduction in trauma e.g. car accidents, but much more chronic illness” (Senior Nurse)*

### 4.3.3 Morbidity, chaotic lifestyles and accidents associated with substance use

Many people with dependencies on alcohol or drugs are vulnerable to critical episodes related to their substance use and require the care of A&E staff.

*"The majority of homeless acute admissions are emergencies as their lifestyles are not stable enough for elective care. Health problems become acute before they seek help" (Liaison service)*

*"People with addiction issues go to A&E because it is the emergency service for health and wellbeing. It is appropriate that they go to A&E when not coping or out of control" (Community Addiction Senior Team)*

A number of people however, present to A&E as drunk and incapable, placing a huge demand on services. Their needs could potentially be met by a less intensive service.

### 4.3.4 Health Literacy

People living in poverty are less well resourced to deal with unusual or problematic health issues. Living with high levels of chronic stress can have a direct impact on physiological functioning, particularly mental processing. This in turn may result in a reduced ability to assess and respond to problematic situations in a systematic and measured way. A lack of knowledge and understanding of the healthcare system, or dislocation from services due to transient lifestyle may be compounding factors. Communication and language needs further reduce the options available for support as does the lack of financial resources.

*"The poor are unable to self-assess and self manage problems…. unable to defer health service attendance or get time off to attend the GP. They use A&E when problem becomes significant…. People experiencing poverty do not have landlines. NHS 24 cannot be accessed freely by a mobile phone, so that acts as a barrier to its use" (Partner service)*

*"Patients here have huge problems with health literacy… find it difficult even to articulate what is wrong….People panic and their immediate response is to go to A&E…There is a tradition of going to the hospital to get sorted out" (Senior Nurse)*

### 4.3.5 Historical and cultural reasons

For historical and cultural reasons hospitals are regarded as trustworthy, accessible and effective sources of healthcare support. Proximity and open access to care may also be factors for people on a reduced income.

*"People use A&E a lot because it is familiar, effective and immediately accessible" (Clinician)*

*"There is an institutional bias against poor people. Open system works best for workless people but an appointment system works best for working people. Only a handful of GP practices in Glasgow operate an open system" (*GP)

## 4.4 What are the drivers and challenges to service providers in caring for attendees who have additional health and social care needs?

### 4.4.1 Perspectives on the role and remit of A&E services

Pressure on A&E services are reported to result from a number of key drivers, in particular the increased workload caused by rising numbers of attendees and the pressure to deliver the service within the 4 hour waiting target. Along with these key drivers a number of Scottish Government initiatives and HEAT targets related to the care of vulnerable groups e.g. suicide prevention and alcohol brief interventions are reported as added pressures. While these pressures are understood and shared by all staff groups, different weights are assigned to their importance for service delivery by management and frontline staff.

This differing appreciation of what is important is reflected in a range of perceptions of the role and remit of A&E services - who should be able

to access services, what services should be available and how services should be provided.

Managers charged with meeting targets and containing service provision within a limited budget, tended to be more concerned with reducing inappropriate attendances and meeting the 4 hour waiting target. In their view, responsibility for the increased use of A&E services was viewed primarily as the province of community based health and social care services. These services were not currently providing the type of services and primary interventions required to meet the health and social care needs of the local population. Managers were clear that it should not be the remit of A&E  departments to care for inappropriate attendances and that there was limited capacity for staff to identify and address the health and social care needs of attendees.

“There is a revolving door for people with non-organic needs which are not currently being met by community based services. When they pitch up at A&E there”s a duty to exclude organic causes. This is time wasting for staff and not effective support for patient. The onus is on these (community based) services to be more accessible and acceptable, with appropriate needs-led provision” (A&E Manager)

“Problems are upstream….A&E can only pull them out the water, patch up and return to the community” (A&E Manager)

On the other hand, while acknowledging the pressures on A&E services, frontline workers and partner services were more likely to express an understanding of the circumstances of peoples” lives as a key factor in their attendance at A&E. Practitioners were also more likely to view the pressure on services as a burden shared across the primary and secondary care system.

“I can see someone, make an assessment and treat, or even just reassure them, in the same time it would take me to intercept them at the front door, explain to them why I am not treating them and send them away. Often it”s just a bit of reassurance they need” (Clinician)

“People shouldn”t start with “inappropriate referral”. Patients always have a reason why they are in the right place” (Senior Nurse)

“I”m aware that community staff are probably as hard pushed as hospital staff – just how it is. So difficult to see how things could change” (Senior Nurse)

“Our role is to care for people who have assessed themselves or have been assessed by others as in need of emergency care” (Clinician)

*“I”m no good at turning people away, as most people are worried about something” (Senior Nurse)*

### 4.4.2 Views on Inequalities Sensitive Practice

Currently all attendees at A&E are assessed and their immediate care needs addressed. The degree to which A&E staff can or should have a wider role in identifying and addressing underlying health and social care issues is contentious. Due to the pressures on service delivery most managers reported that inequalities sensitive practice had a very limited place in A&E care provision.

*“The rising numbers of attendees, patient acuity and HEAT targets require A&E to be sleek, focused on trauma and with a swift throughput. Staff do not have capacity for therapeutic interventions” (A&E Manager)*

*“Brief interventions are inappropriate in A&E” (A&E Manager)*

Clinical staff were cautious about the degree to which they could be engaged in this kind of intervention but were more likely to report having a prescribed role in addressing underpinning care needs. Staff resources, pressure on time and insufficient supporting IT infrastructure were reported as limiting their capacity for intervention. Emergency Nurse Practitioners working in minor injuries units were felt to be well placed to be inequalities sensitive practitioners.

*“We”re frontline…. It”s our job to undertake a social assessment and refer on where appropriate” (Senior Nurse)*

*"Staff are aware of attendees stresses and anxieties about money, the kinds of thing that can precipitate overdose. But not appropriate, or no time to enquire and advise. Need to rely on services downstream picking up on this" (Nurse Manager)*

*"Staff in A&E services have a role to play in identifying underpinning social care needs and endeavouring to facilitate responsive care" (Nurse Manager)*

"Staff can"t do everything that is asked of them. Some staff are able to do this well because of their interest and personality, others not….Like ABI (Alcohol Brief Intervention) we will consider what part of the intervention we can do and try to tailor to the department – like raising a concern with the attendee and giving them information" (Senior Nurse)

"Staff in the MIU (Minor Injuries Unit) are well placed to undertake inequalities sensitive practice due to the experience of staff and the person centred approach. Require information to give them and clear pathways of care into support services" (Nurse Manager)

### 4.4.3 Balancing Scottish Government imperatives

More than one respondent said, 'A&E can't do it all'. There is a prevailing sense in management that A&E is being overstretched by Scottish Government expectations of their role in opportunistic care. While A&E is a key access point into healthcare for people who experience disadvantage there is limited capacity within the system to meet needs other than immediate healthcare needs. There is a clear tension between the 4 hour waiting time and the kind of time intensive early intervention initiatives, such as Alcohol Brief Interventions, being requested by the Scottish Government.

*"Feels as if the Scottish Government departments don"t speak to each other with one lot demanding quicker throughput and others asking more of staff in terms of content of care" (A&E Manager)*

*"Question my role and job satisfaction. Constant pressure. It"s not cars we are parking here. 4 hour wait coupled with no beds and increased attendance. These are the biggest drivers" (Nurse Manager)*

*"Need to prioritise. What is most important? What should staff do and not do? Can"t do it all especially with a 4 hour waiting target" (A&E Manager)*

"The ticking clock can influence the outcome of an assessment … targets are priority over quality" (A&E Practitioner)

"Important to try and integrate all the initiatives into a single broad response pathway" (A&E Manager)

From responses it would seem that A&E are stuck between a rock and a hard place. There seems to be no coherent plan in place to manage the competing demands and expectations. Staff wish to do a good job providing quality care but are constrained by pressures of the 4 hour target and limited resources.

### 4.5 What is working well, what not-so-well and where are the gaps in care provision?

A&E waiting times are not key drivers of quality for many partner services, and while important for service users, they are not viewed as the whole story. As stakeholders in the A&E care pathway partners and service users have particular perspectives on A&E practice and performance. Continuity of follow-on care and the quality of the care provided in A&E are reported as equally important issues.

Many issues of concern are shared across disciplines with some issues having more resonance for some stakeholders than others. Of these a number were reported as particularly important. These included the Out of Hours Mental Health Service, care pathways for attendees who have drug and alcohol problems and care provision for marginalised groups. Reducing inappropriate self referrals into A&E services was a particular issue for managers.

### 4.5.1 Access to Out of Hours Mental Health Services

A&E staff reported high levels of satisfaction with the 9-5 service provided by the Acute Liaison Psychiatry Service. Daytime psychiatric referrals from A&E are generally seen by the service within half-an-hour. In contrast, A&E respondents reported a general dissatisfaction with early evening and out-of-hours Mental Health Services where the response time was assessed as problematically slow. This lack of a timely response was reported to impact on the quality of care for the patient, staff workload, and potential breaches of the 4 hour waiting target.

While A&E departments are a key access point for people with acute mental health problems, A&E staff did not always see mental health care provision as their remit and at times resented A&E"s holding or containment function in the out-of-hours care pathway. Staff reported being dissatisfied with the quality of the support provided by the Out Of Hours (OOHs) Crisis Team particularly in relation to response times and their refusal to consult to A&E referrals if they were intoxicated.

*"Excellent service provided by liaison psychiatry but only in hours. Between 5 and 8pm cover is provided by Gartnavel Royal but it is not an appropriate service. The doctor on call cannot leave the premises so patients would need to be sent up by ambulance which is more difficult to arrange so tend to wait until CPN service commences at 8pm. The problem can be that the patient may leave rather than waiting for 3 hours. If the patient is at risk however they will be prioritised" (Senior Nurse)*

*"Pathway is problematic. CPNs refuse to see patient if they have been drinking as they say they cannot do a proper assessment. Need therefore to hold on to patient until sobers up or admit, as cannot take the risk of letting them go. CPNs should respond to all requests…We need a one-stop phone call for mental health consultation, whether an adolescent self-harm or adult mental health problem" (Senior Nurse)*

*"CPN service may respond slowly and opt not to attend if patient using substances or if near end of shift" (Senior Nurse)*

*"OOHs often give advice over the phone if the attendee has been drinking…Some inconsistency in service provision…Difficult to tell without seeing the patient whether alcohol use will get in the way of making an assessment" (Liaison Psychiatry)*

For their part, the Out-of-Hours Crisis Service do not regard themselves as an emergency service primarily, but rather a secondary Mental Health service. They view their main remit as preventative care in the community, supporting treatment plans and maintaining vulnerable individuals in the community during the out-of-hours period. Crisis service staff resources are limited, with a minimum of 4 on duty at any time. This resource is further constrained by the need to undertake visits in pairs for safety reasons. The team provide a service across a wide geographical area including Glasgow City CHCPs, West Dunbarton and East Renfrewshire and to a wide range of service users - NHS 24, Out-of-Hours GP services, police, homelessness services, addictions services, forensic services, duty psychiatrists and patients in their homes, as well as to A&E. The team reported being aware of, and seeking to work within the 4 hour waiting target. However, patients that were in police custody or in A&E care, were regarded by the OOHs service as being in a place of safety. The needs of patients in the A&E did not take precedence over the needs of a service user in the community.

*"The OOHs service cannot be compared with the liaison psychiatric service as this service covers a city wide remit and offers service to people in their own homes as well as offering a service to other agencies…To provide a similar measure of input would require each A&E having CPN staff on site" (OOHs Service)*

*"OOHs service is often asked by A&E to see people who are intoxicated – staff making the referral are not always truthful about the level of intoxication. At times this can place unnecessary demands on OOHs staff"s time and staff are unable to carry out a proper mental health assessment which means they then have to return at a later time to carry this out" (OOHs Service)*

*"The 4 hour waiting target in A&E departments puts pressure on OOHs as they are expected to respond as an emergency service, which they are not, rather than a secondary mental health service" (OOHs Service)*

There seem to be misunderstandings between staff about the role and remit of OOHs and A&E services in relation to the care of people who have mental health crises out-of-hours and a lack of reciprocal working. Frustrations are experienced by staff on both sides of the equation particularly in relation to the care of people who are intoxicated and are at a risk of self-harm. Staff in A&E services report being unskilled and the service as being ill equipped to care for people with mental health crises, generally viewing their role in terms of containment rather than as part of the therapeutic pathway of care. This may explain in some part the ambivalent response to Scottish Government initiatives around suicide prevention training.

*"Key challenge is a pathway of care and appropriate holding arrangements for attendees who are considering suicide…Need a better screening tool in triage to assess risk and determine care. Currently attendees are put in a room separate from everyone else and left to wait for potentially hours until a CPN arrives" (Suicide Prevention Trainer)*

The view that A&E is not well equipped to provide optimum care to people with mental health crises is borne out in the reported experiences and views of service users. Service users reported poor care, a lack of understanding and discriminatory attitudes.

*"I think they are in the dark ages about mental health. A couple of years ago I was very suicidal and overdosed. While I was behind a curtained area in A&E I heard one nurse say to another "These people who take overdoses, I just wish they would do it properly" (Mental Health Support Group)*

*"Staff will say things to you like "We"ve got ill people to see" (Mental Health Support Group)*

*"I phoned NHS 24 and they told me the Crisis Team would see me at the hospital…I sat there in the waiting room getting worse and worse with people coming in and out…After 4 1/2 hours a CPN arrived" (Mental Health Support Group)*

*"You really should be seen in minutes, if you are suicidal you really should be seen soon" (Mental Health Support Group)*

*"Why is it that mental health is not seen by staff in A&E as a trauma?" (Mental Health Support group)*.

Respondents who self-harm report that staff have a lack of understanding of this health issue which can result in poor treatment.

*"They saw everybody else before me and when they did come to stitch the wound they were quite brutal" (Mental Health Support Group)*

"You come back from A&E and you hurt yourself again because they make you feel so bad" (Mental Health Support Group)

All Mental Health respondents cited staff education as the most important way of improving their care. A number suggested that having a CPN based in A&E would be very helpful.

"Staff training is just not hitting the button…. Mental health should be in at the beginning. They need to re-think their own practice" (Mental Health Support Group)

### 4.5.2 Pathway into Drug and Alcohol Services

Substance use and alcohol use in particular is viewed as a significant factor in presentations to A&E services both as a primary cause and as an associated secondary factor. The extent of the problem is unknown due to current under reporting of alcohol related presentations.

Problematic drug and alcohol use is associated with chronic ill health, injuries and accidents, mental health problems including self-harm and overdose, violence and intoxication and is therefore a key contributing

factor in frequent attendances at A&E. It can also be associated with challenging behaviours that are a drain on staff resources.

From a public health perspective, alcohol use contributes significantly to the burden of ill health in the Scottish population and requires to be actively addressed through action on a number of fronts. Identifying problematic drinking and offering motivational support to the individuals concerned is one such action. A&E has been identified as a priority setting for undertaking Alcohol Brief Interventions (ABIs). Through the routine use of an alcohol screening tool, people with problematic alcohol use can be identified, information provided and where appropriate, be signposted or referred into, support services.

While alcohol use is acknowledged as a big health issue, a number of A&E staff report uncertainty about the appropriateness and effectiveness of ABIs in this setting. However, where good links and relationships with alcohol liaison services have been established, and where simple protocols have been put in place, staff report being motivated and able to identify problematic drinking, seek patient consent for referral and refer on.

*"No time for staff to undertake brief interventions. May be possible through fracture clinic but not in ED" (A&E Manager)*

*"Alcohol is a key issue. If attendee is intoxicated it is difficult to identify their needs, then difficult to get them into the services they need. The only recourse is to alert the GP through the GP letter" (Clinician)*

*"One view in A&E is that ABIs will not make any difference as for many people a long term alcohol plan is required. Brief interventions are regarded as a tick box exercise rather than embraced as a contributory intervention" (Nurse Manager).*

*"All staff here do alcohol screening and interventions…. Alcohol assessment leads to informed consent for referral to the alcohol liaison nurse. Works well… There"s no time for staff to do the intervention themselves…just identify and refer on" (Senior Nurse)*

A gap that was identified by addiction services was the lack of a referral pathway from A&E into addictions services, both for information sharing around attendees who are already open to services and for referral of attendees who are not connected into services. Community Addiction Teams (CATS) report that many of their service users attend A&E with problems related to their dependency but this information is never passed on. There is a reported failure to identify CAT service users and a failure to communicate with CATs about their attendance. This failure prevents CAT services from taking responsive action and has been linked to fatal outcomes. For example, of the 101 drug deaths in Glasgow City in 2006, 15 had been admitted to A&E with symptoms of overdose in the previous year. No onward referral had been recorded for 11 of these individuals.

Concern is also raised by Glasgow Addictions Service about the recording and reporting of drug overdose. An audit undertaken in North Glasgow by the Drug Death Prevention Co-ordinator revealed a lack of standardisation in the coding and recording of overdose. The codes commonly used are reported as not accurate enough to inform onward referral and treatment.

“The quality of the information provided in the GP letter is very poor. Junior doctors prefer to use no-specific categories for diagnoses rather than offering specificity. For example, a diagnosis could be “recreational drug related incident” even where opiates are involved. The ability of the GP to undertake pro-active responses is limited by this lack of information” (Addictions Researcher)

“There can be an assumption by staff that an opiate overdose is accidental. But staff need to ask attendee and, as is the case with other drug overdoses such as paracetamol, get appropriate help i.e. psychiatric assessment” (Addictions Liaison Team)

While A&E services report that the key care pathway for people with drug and alcohol problems is through the GP, Addictions services report that they cannot rely on information being passed to them in a timely fashion, if at all, through the GP. On the other hand, GPs report that

referral processes into CATs are slow. A system for direct referral of attendees with drug and alcohol dependencies is felt to be vital and overdue.

“The key pathway into addictions services care is through the GP letter. There is no additional referral or information letter to addictions services….If it is not a 24hour service then it doesn”t happen. Rely on GPs to inform services” (Senior Nurse)

“The pathway to the Community Addiction Teams is poor. A&E think that the GP should be the link to the CAT. There is no senior management buy-in” (Addictions Manager)

“It can take a GP 7 weeks to get a patient seen by a CAT. If people with drug or alcohol problems can be fast tracked into services then that would be great” (GP)

“CATs need to be able to receive referrals from A&E quickly and take responsive action including assertive contact with clients” (Addictions Researcher)

Respondents from a Community Addiction Team suggested that the development of a protocol of practice for A&E staff might be helpful. For example, the protocol could include:

- Enquiry into current or past links with drug and alcohol services
- Action to inform the Community Addiction Team of a current service user”s attendance, or, where attendee has no current links with the CAT, action to gain consent for referral into CAT.
- Where attendee declines referral into CAT he/she should be provided with information about harmful substance use and about CAT services
- The recording of diagnosis, supporting information and care plan

“Nurses don”t routinely ask patients with drug or alcohol use issues if they are open to a CAT or whether they need help with their issues…fearful of opening a can of worms. But anyone can refer into a CAT” (Addictions Liaison Team)

“Many people with dependencies get to a stage where they don”t care what happens to them when they use….kind of Russian roulette. So all harmful overdose should be reported to the CAT” (CAT Senior Team)

The Acute Addictions Liaison Team currently has a remit for in-patients only. Developing their role in A&E was suggested as a way of supporting better continuity of care.

“The Acute Addictions Liaison team has helped re-connect inpatients to services but there seems to be a gap in the link and relationship with A&E” (CAT Senior Team)

“Acute Liaison’s Team don”t come near the A&E Department. But it would be useful for links, training, ongoing contact” (Senior Nurse)

“Link nurses provide a model of partnership working that supports continuity of care. However, some health issues are less popular than others e.g. alcohol. It can be difficult to get staff to take a lead role” (Senior Nurse)

Staff report a lack of interest in training and development around addictions. However respondents from a drug and alcohol dependency recovery group reported receiving poor care from A&E staff.

“Staff make assumptions about people with drug and alcohol problems…less well treated. Everything is put down to the drug or alcohol use”

“There”s a discriminatory factor in the care…you”re treated like cattle”

“As soon as they found out I was a drug addict I was treated like a leper”

“The first rule of medicine is to do no harm, but the way addicts are treated does them harm”

While the group understood that it could be difficult for staff dealing with patients who were abusive, most felt that staff should always be respectful in their approach. Respondents felt that staff in A&E should

also be better at linking attendees with drug and alcohol problems into supporting services.

### 4.5.3 Staff knowledge and competence in dealing with marginalised groups

People from marginalised groups may use A&E services in preference to, or along with community based services, for a variety of reasons. For example they may be not registered with a GP due to the transient nature of their lifestyle, they may be unfamiliar or uncomfortable with the community based healthcare system, or they may be anxious to maintain anonymity. People such as asylum seekers and refugees or people from some European Union countries, may perceive that A&E services best suit their needs. A number of issues in relation to the use of services were raised by practitioners and partner agencies.

**Case Example: The Roma Community in Govanhill**

The issues raised around the care of the Roma community in Govanhill provide an example of the kinds of challenges involved in looking after people from minority ethnic groups such as ASRs and migrant groups.

This marginalised group are reported to present particular challenges to primary care services. Differences with respect to use and expectations of health services are reflected in the high DNA rate for GP services. The Roma people have been used to an open access system of healthcare where care needs are addressed within the same day. They are are less likely to attend an appointment made for the next day or two days later. This can result in wasted time for doctors and interpreters and inappropriate attendance at A&E services. While women and children tend to be registered with a GP, they may be put off the register for not turning up for appointments. Roma men are less likely to register, self medicating where necessary and using A&E services when the problem becomes acute.

“The Chec migrant community find accessing the GP service problematic. It can take 2-3 days to get an appointment if interpreting has to be arranged. Sometimes a woman can be sitting at home for 2-3 days nursing a sick child. People don”t know about emergency

appointments and telephone consultations are not an option because of language difficulties" (Community Health Worker)

"The DNA rate is the same for 7% of the practice that are made up of Roma as it is for the 93% rest of the practice population. In a practice that operates more of an open access system, DNAs are reduced. But we cannot change the whole system to accommodate to this minority" (GP)

"Continually not turning up at the GP can result in them being put off the register…some have been through all three of the practices in Govanhill….Big issues with Roma men, majority are not registered with a GP…their priority is income generation…most have to work in low paid, casual labour. Poor adult health generally and when really unwell go to A&E" (Health Visitor)

Where there is dissatisfaction with the GP, community members would go straight to A&E. However it was reported that Roma may wait over 4 hours if an interpreter is required. For this reason family members are often asked to interpret.

Attendance by Roma women at the health visitors" clinic is much better as clinics have adapted to meet their needs i.e. clinics operate an open access system or next day appointments, have interpreters on hand and provide easy access to health advice, immunisations and benefits information. Health visitor key concerns are to do with public health in relation to overcrowding and lifestyle behaviours and children"s safety and wellbeing. Keeping track of families is reported as problematic due to their transient lifestyles.

For both EU nationals and asylum seekers and refugees (ASRs), navigating their way round the complex NHS system presents a challenge. Accessible information and orientation sessions, as provided through the ASR Induction Centre can help. Hospitals however, are a familiar and traditional construct and for these and other reasons many will continue to gravitate there for health care.

“Some are illegal immigrants who are not often registered with a GP as they try to avoid contact with official statutory services for fear of deportation. They may use A&E as an access point for health” (Health Visitor)

Supporting the communication and language needs of attendees at A&E is reported to be hit and miss. Staff attitudes towards asylum seekers and refugees, awareness of patient rights and knowledge of the Communication Support and Language Plan are reported as wanting.

“Some A&E staff are very judgmental and feel strongly that asylum seekers and refugees should not be here and are not entitled to healthcare or access to interpreting services…. Some feel that it is their moral right as a citizen of the UK to report illegal immigrants arriving in A&E to the police. They are unaware that such action goes against healthcare ethos and is directly in breach of the Data Protection Act and Human Rights” (ASR Worker)

NHS staff working with ASR groups report that A&E staff would benefit from cross-cultural training in order to help them understand different culturally appropriate ways of expressing distress and in tailoring care to meet the needs of ASR or migrant people.

*“Staff need to know and practice their moral and legal duty to maintain confidentiality…. And to personalise care to meet ASR needs - engaging, listening and linking to appropriate services” (ASR Worker)*

For a range of excluded groups the ability to access services that suit their particular needs is compromised because of health literacy issues. Recent social research suggests that a significant number of people who self refer to A&E services are unaware of the alternative sources of healthcare support that are available to them. The survey of self-referrers in NHSGGC was undertaken in early 2010 with the stated purpose of understanding ‘why people who self refer ‘by pass’ other healthcare services and turn up at a regional emergency unit’.

Two in five participants reported that they could think of no alternative sources of medical help or advice in addition to the A&E they had attended. For a number of people the GP was not regarded as an option for care because of real or perceived access issues or because of the nature of the ailment. Self assessment and perceived treatment needs are reported as largely driving self-referral to A&E. This is the case for the many disadvantaged individuals that access A&E care.

“See if there”s blood, I take my kids straight to the hospital… Staff are good…calm you right down. …Speak to you as a person… don’t speak down to you” (Respondent, Community Group)

It is clear that health literacy is a key component in the use of A&E by people with additional needs. Lack of knowledge of alternative services or poor experience of services, along with limited ability to self assess and decide what care is most appropriate, limited ability to access services, limited ability to make their healthcare needs known and limited ability to negotiate care, are barriers to community based sources of care and support, and are likely to be drivers of self referral to A&E. And while most GP practices are able to offer an appointment within 2 working days for many people who are isolated, anxious and unsupported, waiting 48 hours is not always an option.

“Homeless people are likely to have chronic complex problems that contribute to frequent attendance at A&E….While 80% of homeless are registered with a GP many assume their registration has run out” (Liaison Nurse)

“There”s always going to be a need for specialist services like A&E due to the chaotic lifestyle of some people who don”t engage with universal services” (Homelessness Worker)

“For people with mental health problems crises are most likely to be at night when other services are not able to be accessed. A&E is often all that is available to them” (Mental Health Group)

The buck, therefore seems to fall with A&E services. While other unscheduled care services such as the Out Of Hours GP services are well organised and report good use by all sectors of the population, the burden of care for the most disadvantaged in the community falls heavily on the shoulders of A&E. Public awareness of the OOHs service remains at low levels with less than one-third of respondents in the self-referrers survey mentioning the service as a possible alternative source of medical help and advice. Additional barriers to their use by excluded groups include accessible information, communication and language issues and the inability to access free calls to NHS 24 from a mobile phone.

### 4.6 What does inequalities sensitive care look like in A&E?

Two pathways of care have been reported by staff, partner agencies and service users as models of good practice in the care of attendees who have additional health and social care needs. The characteristics of this care have been drawn from descriptions of the models; Glasgow Royal infirmary Homelessness Care Pathway (GRI) and the Domestic Abuse Pilot in the Royal Alexandra Hospital (RAH).

#### 4.6.1 Motivated staff, attuned to patient context and knowledgeable of care pathways

Inequalities sensitive care requires knowledgeable, empathetic and skilled staff. Staff training is needed to raise awareness of the circumstances and experiences of A&E service users lives and to develop the interpersonal skills required to build trusting, empathetic relationships and reciprocal ways of working. Service users report the importance of non-judgmental and caring approaches.

*“Understanding the needs of homeless has been supported through training. Training has influenced the attitudes of younger staff, less so with the older group. There”s also training for junior doctors” (Acute Homeless Liaison Team)*

*“We need to know about all forms of violence and how we can help …who to get in touch with. Good for both of us, patients and staff – they get support, we get job satisfaction” (Nurse respondent, RAH Pilot)*

"I am asking about domestic abuse routinely now…Training does raise awareness… it brings it to the forefront of your mind…you think about it a bit more" (Nurse Respondent, RAH Pilot)

"How they do it is important. You can tell from the look on their face, like "okay, here we go". They have lost it then, they are not listening" (Domestic Abuse Survivor, RAH Pilot)

### 4.6.2 Protocols, developed in conjunction with staff, to guide practice and support follow-on care

Protocols provide staff with a simple step by step guide that incorporates identification of need, assessment and an agreed reliable course of action.

"A simple screen for homelessness enables holistic care…The protocol supports staff to identify need, make appropriate assessment and take action…Only need to make one phone-call for the support services to be mobilised" (Manager, Homelessness service)

"Being asked routinely about domestic abuse in a sensitive manner and gaining confidence in NHS staffs" ability to contain their information securely and address their needs responsively may help them (attendees) to seek support sooner. Seeking permission to share information with others, including the GP, is a key part of collaborative care" (Evaluation Report, RAH Pilot)

### 4.6.3 Application of a simple screening tool

Sensitive enquiry includes the use of an agreed set of assessment questions or screening tool to identify pertinent social care issues. Effective use is associated with the routine application of the screening tool.

*"It is important because we do not know if there is an underlying issue. If we don"t ask then they"ll be repeat attenders and keep coming back" (Nurse, RAH Pilot)*

*"Reception staff are trained to ask 'Is that a permanent address?' And note. The Homeless Liaison Team collect the contact details of people who attended the previous 24 hours" (A&E Reception Manager)*

### 4.6.4 Good links with liaison or partner services that proactively monitor attendances and provide support to attendees

The provision of high quality, respectful care is of value in itself but is unlikely on its own to make a substantial impact on an attendee"s ongoing care or wellbeing. To ensure that an individual"s wider health and social care needs are addressed, practitioners need to inform, or refer on to, partner services such as Women"s Aid or homelessness services.

*"Homeless liaison team offer an interface between health and homeless services and seek to address revolving door issues where attendees are treated and then returned unsupported to the same disabling environment" (Manager, Homelessness service)*

*"We have good links to homelessness liaison team. An ENP has developed the link nurse role and keeps the A&E team informed and aware of the issues" (Senior Nurse)*

It is acknowledged that in some instances this type of care may require more resource in the short term, with benefits such as improved wellbeing and less frequent attendances at A&E, being accrued in the longer term. This kind of longer term investment is already being developed in a number of Shifting the Balance of Care initiatives in NHSGGC.

## 4.7 What kind of infrastructure supports sensitive practice?

### 4.7.1 IT support

A number of practitioners reported that their ability to provide more holistic care and follow through would be helped by the use of a competent information management system. Very little patient information is currently available to clinicians in A&E to inform them of pertinent medical or social care issues. Clinical care and follow-on

support would be enriched by an IT system that could flag up an attendee"s history and care plan, enabling staff to offer greater breadth and depth in their understanding of patient needs and in the prescription of care options. A directory of local community services was reported as important to enable follow-on care and would save practitioner time.

*"A key issue is knowing what services are out there that we can link people into. It would be helpful to have a service directory where you can readily access the relevant services in a geographical area to refer patient to" (Clinician)*

*"It would be helpful if A&E consultants could access PIMS in order to source patient"s key worker and provide information about attendance at A&E" (Doctor, Acute Liaison Psychiatry)*

*"Could the Emergency Care Summary be linked to the CHI number and amended to flag up pertinent social care issues as well as contact data for staff working in A&E"? (Manager, NHSGGC)*

A number of lessons can be learned from the operation of the GP Out-Of-Hours Service (OOHs) where information management and the management of patient flow is enhanced by a dynamic, supporting infrastructure. The electronic system enables patient information from NHS 24 to be transferred to any site, the command and control of workload across the system, GP letters to be generated and sent through secure email on a daily basis and clinicians to have access to the Emergency Care Summary which provides a record of a patient"s repeat prescribing medication. There is also a flagging system that can be provided by GPs to inform OOHs of pertinent patient issues such as terminal care. The use of Special Patient Notes is currently under review. It is proposed that where patients have given consent the special notes could provide OOHs services with key background information such as main diagnoses, current issues and contact information on care providers.

Consultant access to information contained in special notes would support the efficiency and effectiveness of care management in A&E.

This could be further supported if special notes could be amended to include pertinent social care issues such as a patient"s communication support needs.

Sending GP letters through secure email offers GPs timely information and supports continuity of care The GP letter is regarded by A&E staff as the key vehicle for ensuring continuity of patient care. However the utility of the letter as an effective communication tool is contested. Some respondents report the content of the information as variable, frequently late, sometimes confusing and often incomplete. Documentation of clinical information and social care information was reported as incomplete. An example is given in the evaluation of the Domestic Abuse Pilot in the Royal Alexandra Hospital, where it is reported that out of 10 disclosures of domestic abuse, only 3 made it into the GP letter. The effectiveness of this system in supporting continuity of care, and the ability of GPs to undertake pro-active responses to flagged issues, is as yet unknown.

"Patient information needs to be concise, clear and flag up issues, so that GPs can respond proactively" (Manager, NHSGGC)

"Referrals or information from A&E will be considered but unless patient is coming and asking for help unlikely to do anything else" (GP)

"The role of the GP is to follow up where appropriate and co-ordinate care" (GP)

### 4.7.2 Support services

It is worth briefly mentioning other aspects of infrastructure that were reported as either enabling or inhibiting quality of care

Transport was reported as a factor in determining patient care and outcomes. This could relate to patient's ability to take up care or the patient's ability to get home.

*"PTS try to fit in unscheduled discharges from A&E but often not sufficient resource to do this. Out-of-hours they have no remit – but they may take a patient home to a nursing home. Need to rely on the*

*patient"s relatives or friends to come and get them or else need to admit" (Senior Nurse)*

"Hospital has a duty of care to get patients over to Paisley but no responsibility for getting them back. There is an expectation that people will get their own way back (2 bus rides or 2 train rides)…..Issue for people who are financially constrained or who have no car. Patients may be reluctant to attend because of this" (Senior Nurse)

Admission Prevention services such as MATCH in Renfrewshire and IRIS in North Glasgow have been shown to be effective and efficient in working collaboratively with A&E to prevent the admission of patients over 65 year old. The services provide a one hour response time to requests from A&E for assessment for supported discharge. Services are reported as being essential in supporting a shift in the balance of care. However the current reach and consistency of service provision is reported as problematic.

"There's not much of a service out of hours. There is a limited service from Stobhill and the Western where a patient can be sent home and followed up the next day. Otherwise a patient needs to be admitted and assessed in hospital the next day". (Supported Discharge services)

"Services can be a bit patchy. This is no good to A&E – we need accessible, consistent provision, 12 hours a day if possible. IRIS should provide the whole package of care including organising transport". (Senior Nurse)

"Services in South Glasgow are poor despite there being a great deal of evidence from the pilot that it is an effective service and much needed." (Senior Nurse)

A&E reception's role in the identification and flagging up of attendees who are homeless, is a key part of the Homelessness Care Pathway. It contributes to effective tailored responses in both A&E and follow-on care. There may be potential to develop the role of A&E reception in the collection of disaggregated equalities data and in the early identification

of attendees" communication and language support needs. Currently reception staff are not able to initiate interpreting support due to the perceived cost implication.

"Reception staff will establish that an attendee has communication or language problems and give a heads up to the triage nurse. As there is a cost involved in getting an interpreter it is the nurses responsibility to do this" (A&E Reception Manager)

## 5. Discussion

Systemic enquiry has provided multiple perspectives on the care of people with additional and complex needs as they journey into, through and out of Accident and Emergency care. It has highlighted the drivers that cause pressure on the whole service, tensions that are created by differing interpretations of policy and practice, areas of care provision that are not working well, models of inequalities sensitive practice that are working well and gaps in service provision. The report raises more questions than provides answers. However the wealth of information gleaned through the process is a good starting point for planners, managers and practitioners to begin to engage with the issues.

A shared understanding of the role and remit of A&E Departments in providing care to people with a range of health and social care needs is fundamental. There is no doubt that out of all the Scottish Government health targets A&E have focused heavily on attaining the 4 hour wait. In terms of quality of care, a reduction in waiting times is universally welcomed. All staff agree on the need to streamline care and make systems as efficient as possible.

However there is a clear feeling that other quality dimensions of care may be being compromised by the imperative of a speedy throughput. Some frustration is expressed that this target overrides the human relational aspects of care subtly revealed in the statement, “We” re not parking cars!”. Associated with this are questions around who should be seen in A&E and what constitutes quality care?

While it is important and necessary to develop care in the community that is responsive to people’s needs, there is currently a flow of people into A&E services from disadvantaged communities. Many of these individuals contain within them the scars of disadvantage – poverty, chronic, poor health and disability, mental health problems, drug and alcohol problems, physical and psychological trauma. Can we, or more importantly, should we stem this flow? Practitioners and service users agree that attendees are, for the most part, people who perceive themselves to be in crisis and in need of specialist A&E care. It is

acknowledged that for many people living with disadvantage and chronic stress, personal thresholds for containing anxiety and the ability to self-assess in relation to health events, is diminished. Deferring gratification of health care needs requires an element of self control and personal resource, something that is denied to people with multiple and complex needs. As has been reported, poor access to healthcare in the community is compounded by an appointments based system that best serves the needs of the working population. In their times of crisis where are marginalised people to go to be relieved of their pain and distress?

And when they do attend A&E with their immediate need for care, a sign itself of underlying health and social care need, what is it that A&E services can do? Managers are clear that caring for an attendee's immediate needs is all that services are resourced to do, practitioners are not so sure and partner services and service users disagree. For them quality is determined by whether care needs are identified, what care is provided, how and when care is provided and what ongoing care provision is put in place.

This view resonates with the vision of the Healthcare Quality Strategy for Scotland to embed person-centred care that has 'the potential to address the health problems of many of those who carry a disproportionate burden of ill-health in our communities'. What is A&E's role? The targets related to suicide prevention, alcohol brief interventions, dementia awareness and gender-based violence, demonstrate an expectation from the Scottish Government Health Department of A&E departments. As a key access point to people with additional health and social care needs, A&Es have a key role in identifying needs, providing support and information and linking in to follow-on care. These priorities of the Scottish Government are not as whole-heartedly embraced in current service delivery in NHSGGC as the 4 hour wait. How to move forward with this important dimension of care is a key challenge.

Part of this challenge may be for A&E services to envision themselves less as a separate acute care provision and more as a key partner and link service in wider health and social care provision. As a key partner in

multi-agency and multi-disciplinary care, A&E have a responsibility not only to ‘patch up and return to the community’ but to understand and affirm the population they serve and to work in partnership with others to support wellbeing and the transition of care from acute to community based care.

Working in partnership to improve out-of-hours mental health care and to improve the pathway into continuing care for attendees with drug and alcohol services are key priorities. Patients should not suffer because staff do not see mental health care as their job. At the present time, A&E is the receiving service for people with mental health crises out-of-hours. Action needs therefore to be taken to support staff and partner services improve care provision. Any ambiguities about professional roles and responsibilities need to be addressed, and associated learning and development put in place so that the safety and wellbeing of this vulnerable group of attendees is assured.

The development of a system to inform and refer on to addictions services attendees, who have accidentally or intentionally overdosed, is a life and death matter. At the moment we are failing in our responsibility to this vulnerable group by relying on GP services to pass on relevant information. This has been shown to be neither timely nor effective. A direct link into services should be developed as a priority action.

It is acknowledged that the current financial climate reduces the ability of A&E services to support staff learning and education. However, to fulfil the expectations and obligations of the Quality Strategy and Equality Legislation, staff should be properly supported to understand the impact of social inequalities on health and apply this understanding in response to the needs of attendees. A training package that could conflate learning from a range of government initiatives to support inequalities sensitive practice and the development of a single broad response pathway should be considered.

Accident and Emergency staff have a high pressured and often difficult task to fulfil. They deal with raw and harrowing issues and manage people from a range of backgrounds with a range of needs. They have

keys skills in managing health care in an efficient and effective manner and many have excellent interpersonal skills that support people through a crisis situation. With leadership and support these skills can be utilised in the provision of inequalities sensitive care.

## 6. References


1. Burns, D. (2007) Systemic Action Research, Policy Press: Bristol
2. Scottish Government, (2010) The Healthcare Quality Strategy for NHS Scotland, ISBN 9780755993239 (Web only), http://www.scotland.gov.uk/Publications/2010/05/10102307/0
3. Scottish Government, HEAT Targets, Scotland Performs: NHS Scotland http://www.scotland.gov.uk/About/scotPerforms/partnerstories/
4. The Scottish Government Heat Target, Alcohol Brief Interventions, http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/alcoholbriefinterventions
5. The Scottish Government HEAT Target, Suicide Prevention Training. http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/suicideprevention
6. The Scottish Government, HEAT Target, Dementia Awareness http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH/dementia
7. The Scottish Government, Violence Against Women National Training Strategy: Phase II: March 2009 – March 2011:Guidance for training Consortia http://www.scotland.gov.uk/Publications/2010/02/11120930/6
8. The Scottish Government, Accident and Emergency (A&E) Attendances http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/AEattendances
9. The Scottish Government, (2008) Emergency Access Delivery Team Rapid Appraisal Exercise Report: 7-14 Day Challenge: Frequent Attendees at A&E Units.
10. NHSGGC (2010) Report of the A&E Self Referrers Survey, George Street Research: Edinburgh
11. NHSGGC Corporate Inequalities Team (2010) Evaluation Report: Royal Alexandra Hospital, A&E, Domestic Abuse Pilot.
12. NHS Scotland, Shifting the Balance of Care http://www.shiftingthebalance.scot.nhs.uk/

# Appendix 1 Individual and Group Interviewees

## Service Providers

52 individual and 3 group interviews were undertaken with staff from A&E services and partner agencies. This included staff from:

Accident and Emergency services: General Managers, Clinical Services Managers, Lead Nurses, Clinicians, Nursing Staff; Education staff, Information and Administration services

Acute Care: Supported Discharge Services, Liaison Services

Corporate Services: Community Engagement, Corporate Inequalities, Keep Well, Mental Health Partnership, Policy and Planning

Community services: Community Health and Social Care Partnership Clinicians and health practitioners, Addiction Services, Out-of-Hours services

Third Sector agencies e.g. Glasgow Street Service, Poverty Alliance.

## Service Users

Focus groups and interviews were undertaken with 28 A&E Service Users recruited from:

Alcohol and Drugs Recovery Aftercare Group

Mental Health Users Groups (x 2)

Women"s Aid Refuges (x 2)

Tobacco and Inequalities Group