Healthcare Improvement Scotland

NHS Greater Glasgow and Clyde Emergency Department Review

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Foreword

We would like to thank all the staff within NHS Greater Glasgow and Clyde who participated and contributed to this review for their courage and willingness to share their experiences and concerns with honesty and openness. We recognise that staff are striving to deliver the best care they can despite the unrelenting pressures, difficulties and circumstances within which they are working.

Every member of staff to whom we spoke, at every level of the organisation and from every discipline, were clear in their ambition to improve the current situation for patients and their families. It was evident that all staff are committed to delivering high quality and safe care.

We have conducted this review at a difficult time for the health and care system across the whole of Scotland. The NHS in Scotland is asking teams to deliver consistent high quality care in an ever increasingly complex landscape. At a time of financial and resource constraint, public bodies such as the NHS rely on the goodwill of staff to deliver services. When staff do not feel valued and respected, goodwill is eroded and an effective strategy is required to reduce demand and give hope for better times for staff and patients.

Emergency departments reflect the pressures of the whole system as they are a key point of entry for the public to access healthcare. Stresses in these departments are a marker of challenges across the whole health and social care system from first presentation of illness to final discharge destination.

This review within NHS Greater Glasgow and Clyde has considered relevant national data, and drawn on strengths and learning identified in each of the three emergency departments, to share understanding of good practice together with opportunities for improvement.

We were clear that it was important to hear the views of patients that had accessed the three emergency departments during the relevant time period, and we would like to thank all of the patients that responded to our bespoke patient survey.

In response to the concerns and issues raised in this report, the review has made a range of recommendations for NHS Greater Glasgow and Clyde to take forward.

The review also recognised that the wider urgent and unscheduled care system is also under pressure and is struggling to meet demand. This can only be changed by national, strategic intervention. A coordinated multi-agency response is needed, with clear priorities and strong effective leadership. This intervention must happen quickly to deliver sustained improvements in the quality and safety of care for patients and our communities. The review has therefore set out wider recommendations for the Scottish Government and several national bodies.

As Co-Chairs, we have aimed to conduct this review in a respectful and compassionate manner to encourage staff to feel able to come forward and candidly share their views. We acknowledge this was not always easy for them to do, and we hope that the review findings and recommendations will initiate the journey towards improvement. The time and commitment taken to inform and undertake this review is greatly appreciated and we hope that it can be used as a lever for positive change. We would encourage all NHS boards across Scotland to consider the recommendations made for NHS Greater Glasgow and Clyde within their own systems to identify any opportunities for improvement locally, with their health and social care partners.

Dr Pamela Johnston
Co-Chair

Prof Hazel Borland
Co-Chair

Executive Summary

People rely on urgent and unscheduled[1] care at some of their most vulnerable moments. Having access to urgent and unscheduled care and knowing that care is available if they face a serious or life-threating illness or injury is a priority for the public.

Yet NHS Scotland's emergency departments – like those elsewhere in the UK – are facing sustained and substantial pressures. These pressures are reflected in deteriorating waiting times, patient flow and quality of care. A key issue for emergency departments is crowding due to the inability to admit patients to hospital wards in a timely way.

NHS Greater Glasgow and Clyde is similarly experiencing a range of pressures. Despite this, staff are extremely committed to providing the best care possible in challenging circumstances. However, patients are clear that long waits in emergency departments are difficult and distressing. One patient illustrated this by saying: *"I spent the night on the trolley in A&E. I was not updated on the expectation of how long I would be there for. It was very cold due to the doors constantly opening. I asked for a second blanket and was kindly given one, as was a drink of water when I asked. But neither the blanket nor water was offered without asking, neither did anyone ask if I was ok, nor any food offered."*

Purpose of the review

This review was initiated in response to significant concerns raised by consultants within the emergency department at the Queen Elizabeth University Hospital. NHS Greater Glasgow and Clyde agreed to fully support the review and to work with Healthcare Improvement Scotland throughout the review process.

The review provides an independent and evidence-based analysis of the key challenges facing the main receiving emergency departments in NHS Greater Glasgow and Clyde at the Queen Elizabeth University Hospital, the Royal Alexandra Hospital and the Glasgow Royal Infirmary. Since NHS Greater Glasgow and Clyde is Scotland's largest NHS board, it is also anticipated that the review will inform wider learning for NHS boards across Scotland.

The review focused on three key areas: patient experience, quality of care and patient safety, and leadership and culture. It considered a range of data and other information about quality of care, patient safety, performance, workforce and inspection reports. It drew on professional and clinical standards. It was also informed by expert opinion, and structured engagement with both staff and patients.

[1]What is urgent and unscheduled care? What is urgent and unscheduled care? - Overview - About urgent and unscheduled care - Urgent and unscheduled care - Healthcare system - Public Health Scotland. Public Health Scotland. October 2024.

Summary of findings

This review found that NHS Greater Glasgow and Clyde is facing similar challenges of crowding and poor patient flow as other emergency departments across Scotland and indeed across the UK.

Within NHS Greater Glasgow and Clyde however, there is a need for an explicit, stronger and practical demonstration of whole system working across urgent and unscheduled care. This includes between the three hospitals in the review, between emergency departments and other specialties, and between the NHS board and its associated health and social care partnerships and primary care providers. This needs to be underpinned by compassionate, proactive, respectful and positive leadership at all levels of the organisation, with a commitment to listen and appropriately respond to concerns raised by staff in a timely manner.

The review also found that there has been a serious breakdown in relationships between and within emergency department staff groups at the Queen Elizabeth University Hospital and between emergency department staff and senior leadership/management[2] in NHS Greater Glasgow and Clyde which is impeding potential solutions.

Patient experience

Patients that responded to a bespoke patient survey carried out for this review reported a largely positive experience of care in emergency departments in NHS Greater Glasgow and Clyde. The majority of patients felt staff provided care in a person-centred way, and that they were treated with dignity and respect. This contrasted with staff perception of patient experience and their view that care was not of a standard they would want to provide.

The improvement to care patients most wanted to see was to reduce waiting times in emergency departments. Where waits occur, there is a need to improve patients' experience of waiting. This includes ensuring patients are given clear communication about how long they may wait, both at arrival and frequently during their wait, and to ensure patients are appropriately supported while they are waiting. Some patients raised concerns about how safe they felt around other patients and visitors to the emergency department.

Quality of care and patient safety

Similar to other emergency departments across Scotland, the sustained and substantial pressures in emergency departments have resulted in an unacceptable normalisation of care in non-standard bed areas (such as in emergency department corridors and other ward spaces) in the Glasgow Royal Infirmary and the Royal Alexandra Hospital. A different approach has been taken in the Queen Elizabeth University Hospital where ambulance stacking has become a normalised solution for emergency department crowding – this is also unacceptable. Both approaches pose risks to patients and are contrary to the requirement that all patients are treated with dignity and respect. We acknowledge that neither approach is unique to NHS Greater Glasgow and Clyde, but it cannot and should not be tolerated.

[2,2,3] Senior leadership/management here refers to leadership/management at sector director level and above.

The current situation within the emergency departments in NHS Greater Glasgow and Clyde is having a negative impact on staff morale and wellbeing. Staff views reflected serious concerns about insufficient management support to frontline staff at various levels of management across the three hospitals. Staff also raised serious concerns about the quality of care they were able to provide, including patient safety.

The emergency departments are isolated from other specialties and there is insufficient collective ownership across all three hospitals to resolve the serious challenges for the delivery of quality patient care. All parts of the system must take a shared responsibility to develop whole system pathways to improve patient experience and safety in the delivery of urgent and unscheduled care. This includes wider health and social care partners.

Staff described feeling that their health and wellbeing was not explicitly supported during periods of high demand. The review found a need to build a more cohesive approach to the systemic challenges facing urgent and unscheduled care. Systems for learning were not found to be consistent to ensure that safety concerns and risks are identified and reflected on, including incident reporting, significant adverse event reviews and risk management. It was not evident that NHS Greater Glasgow and Clyde is able to consistently commit to investigating and responding to matters of concern in a timely manner and maintain a strong commitment to sharing wider learning with staff and making improvements.

Leadership and culture

The senior leadership at executive and director level of NHS Greater Glasgow and Clyde was not seen as visibly and actively engaged in positively addressing the serious challenges in urgent and unscheduled care. There must be commitment and investment from the Board in a clear programme of NHS board-wide cultural change for the benefit of all patients and staff.

The significant and sustained deterioration in relationships over several years both between teams in the emergency department in the Queen Elizabeth University Hospital, and between staff in the department and senior leadership/management[2] in NHS Greater Glasgow and Clyde is evidenced by disrespectful behaviours, poor teamwork and incivility.

Clinical leadership roles did not have effective support and appropriate investment to achieve their objectives. These roles are crucial in maintaining a focus on clinical effectiveness, innovation, quality of care, patient safety and experience, and the health, well-being and engagement of staff. Patterns of joint working across specialties and sectors within NHS Greater Glasgow and Clyde were not well established in order to better meet the needs of patients and improve patient flow through the whole system.

There is a strong perception among staff at the point of care that targets and budgetary matters have gained a greater priority for senior leadership/management[3] over the quality and safety of care.

Next steps

In summary, evidence examined during this review identified that the current model of urgent and unscheduled care is struggling both in NHS Greater Glasgow and Clyde and nationally; with patients who attend emergency departments suffering the consequences. This has resulted in pressure on acute services leading to non-standard bed care, including corridor care, which is directly impacting on the quality of care for patients. This review did not explore the impact on primary care and community health services.

The national data analysed during this review indicates that despite their best efforts, individual territorial NHS boards have been unable to make sustained improvements to performance in emergency departments in the recent past. This review found that this situation is of critical concern and the status quo cannot continue.

This review makes 41 recommendations, the majority of which are for NHS Greater Glasgow and Clyde and others are wider reflections for Scotland. A national, coordinated, multi-agency response is urgently required to improve the quality and safety of urgent and unscheduled care. With strong leadership, clear prioritisation and a wide commitment across Scotland, change can be achieved.

The recommendations for NHS Greater Glasgow and Clyde largely fall into four areas:

1. Establish a whole system response, and strengthen whole system models of care, to reduce crowding and improve safety in emergency departments. This includes improving patient flow across and outwith the hospitals, establishing a credible response to escalation, and better supporting patients during waits.

2. Improve clinical and care governance processes including systems for learning about safety so staff feel able to raise concerns about patient care and have confidence that actions have been taken forward as a result.

3. Address low staff morale, poor wellbeing and moral distress to drive a significant change to a more positive culture.

4. Improve relationships, leadership and team working at the Queen Elizabeth University Hospital. External mediation is required to re-build relationships within and between teams, and with senior management at director and executive level.

The wider reflections for the NHS across Scotland focus on three main areas:

1. Define new national standards for urgent and unscheduled care to underpin a whole system approach across specialties. This includes eliminating use of non-standard care areas such as corridor care and improving approaches to escalation.

2. Review the current workforce tools for safe staffing levels that are not sufficiently robust in today's context of urgent and unscheduled care.

3. Ensure systems are in place that underpin staff's ability to confidently raise concerns about patient safety.

In NHS Greater Glasgow and Clyde, taking forward these recommendations requires everyone – staff, management and Board members – to commit to building more positive relationships and to enable healing. This means everyone needs to act with humility and take a kinder, more compassionate approach in all interactions.

1. Recommendations

Patient experience

1. NHS Greater Glasgow and Clyde should improve waiting times in emergency departments. Where waits occur, communication with patients about waiting time length should be improved, both at initial arrival and through frequent updates during the wait. People should be appropriately supported during their wait.

2. NHS Greater Glasgow and Clyde should undertake specific engagement with people who are actively waiting in emergency departments to better understand the specific information and support people would find valuable while waiting.

3. NHS Greater Glasgow and Clyde should enable, expect and ensure that all staff involve patients in making decisions about their care.

4. NHS Greater Glasgow and Clyde should ensure patients are provided with information about their follow-up care, including who to contact if their condition worsens, before leaving the emergency departments.

5. NHS Greater Glasgow and Clyde should take action to reduce patients' concerns about personal safety around other patients/visitors in emergency departments to create a safer, more secure environment.

6. NHS Greater Glasgow and Clyde should provide more opportunities to ask patients about their experience of using emergency departments and clearly demonstrate how this feedback is valued and used to continually drive improvements and shape services.

7. NHS Greater Glasgow and Clyde should enable and expect all staff to treat patients with dignity and respect and provide suitable surroundings for this to occur.

Quality of care and patient safety

8. NHS Greater Glasgow and Clyde, and its six aligned Health and Social Care Partnerships, should strengthen their whole system unscheduled care plan to urgently reduce use of non-standard care areas, improve waiting times and reduce crowding by addressing:

- management of patient flow and redirection
- referral pathways to specialties from within and outwith the emergency departments
- delayed discharges, and
- models of care, same day delivery of care options and consideration of maximising 24/7 services including flow navigation.

9. NHS Greater Glasgow and Clyde should ensure its escalation and business continuity plans are practical and effective in addressing pressures at each hospital and are implemented across the whole system to ensure there is good awareness and ownership of them by teams across the hospitals. The effectiveness of the plans should be monitored and regularly reviewed through appropriate NHS board governance structures.

10. NHS Greater Glasgow and Clyde must demonstrate recognition of the low morale, poor wellbeing and moral distress among staff and take actions to address these. This should include engaging with staff in all three emergency departments to identify appropriate improvement actions needed beyond the other recommendations covered in this review.

11. NHS Greater Glasgow and Clyde must take action to protect the physical safety of staff from aggressive behaviour by patients.

12. NHS Greater Glasgow and Clyde should identify and make the necessary improvements to the physical environment in the emergency departments at Glasgow Royal Infirmary and the Royal Alexandra Hospital and to staff facilities, including spaces for teams to easily meet, across all three hospitals, to ensure the environment is as safe and supportive as possible for staff and patients.

13. NHS Greater Glasgow and Clyde must improve its systems for learning about safety concerns including the use of significant adverse event reviews, post-incident debriefs and incident reporting. It must enhance its processes for sharing learning and feedback with staff and making improvements in response to learning.

14. NHS Greater Glasgow and Clyde should review the risk management processes for emergency departments to ensure they provide an accurate and comprehensive assessment of current risks and steps being taken to mitigate these, with appropriate regular monitoring and oversight. The risks need to reflect the impact on quality and outcomes for patients rather than purely focusing on performance.

15. NHS Greater Glasgow and Clyde must undertake a comprehensive multi-disciplinary workforce review, utilising the Common Staffing Method, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

16. NHS Greater Glasgow and Clyde should prioritise introducing robust systems and processes for the assessment of real time staffing and the escalation and monitoring of severe and recurrent risk, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

17. NHS Greater Glasgow and Clyde should ensure that staff are given the time and resources to undertake required training to undertake their role, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Leadership and culture

18. NHS Greater Glasgow and Clyde's board must ensure that compassion and respect are at the centre of the leadership culture demonstrated through behaviours that enable the values of NHS Scotland to be consistently upheld.

19. NHS Greater Glasgow and Clyde should take urgent action to collectively heal the relationships across and within staff groups and sector and corporate management levels. This is a critical step to establish shared responsibility for the delivery of safe urgent and unscheduled care with visible leadership from the corporate management team and strong clinical leadership at a local level. The aim should be to devolve authority and responsibility as much as possible to team leaders at the service level, supported by greater availability, visibility and responsive support from senior and sector leaders. The solutions and outcome should be jointly owned by all involved.

20. NHS Greater Glasgow and Clyde should commission urgent and credible external mediation within and between Queen Elizabeth University Hospital emergency department professional teams (medical and nursing) and separately for mediation between the professional teams and senior management (sector and corporate) in NHS Greater Glasgow and Clyde to support improved professionalism and team working amongst consultants, nursing staff and management.

21. NHS Greater Glasgow and Clyde should ensure sector management at the Glasgow Royal Infirmary are engaged and responsive to the needs of staff at the point of care to ensure that patient care and safety receive the necessary management attention and intelligent action.

22. NHS Greater Glasgow and Clyde should ensure sector management focus at the Royal Alexandra Hospital appropriately balances emergency department performance and flow in line with maintaining and managing the quality and safety of care.

23. NHS Greater Glasgow and Clyde should ensure job plans appropriately reflect the time and support required to undertake the clinical director, deputy clinical director and clinical lead roles across all three sites.

24. NHS Greater Glasgow and Clyde should review the appropriate use of the clinical and care governance framework for systematically and consistently escalating serious concerns.

25. NHS Greater Glasgow and Clyde should strengthen multi-disciplinary input to the clinical governance arrangements as these currently appear to be too reliant on the singular voice and participation of the medical profession.

26. NHS Greater Glasgow and Clyde should ensure that all staff feel able to speak up and their voices are consistently heard at all levels of management – especially in matters related to safety – and that there is confidence that individuals will be protected, and their concerns acted upon. Specifically, there is a need to ensure that the current NHS Greater Glasgow and Clyde whistleblowing procedures are known, understood, effective and trusted. This is particularly relevant for staff at the Queen Elizabeth University Hospital. It is vital that staff have confidence in the board's commitment to the National Whistleblowing Standards and the Public Interest Disclosure Act 1998.

27. NHS Greater Glasgow and Clyde needs to enhance its governance of the operational management of urgent and unscheduled care. This includes ensuring robust documentation, transparency in decision-making, and greater involvement of clinicians in the design and delivery of care.

28. NHS Greater Glasgow and Clyde needs to adopt a balanced approach to sector leadership, ensuring that the quality and safety of care is not inappropriately overshadowed by other performance targets or financial considerations.

29. NHS Greater Glasgow and Clyde needs to ensure there is an active engagement and participation across the clinical leadership and wider community in the delivery of the Board's recently approved quality strategy.

30. NHS Greater Glasgow and Clyde should establish a stronger commitment to a unified approach across all sectors. This should be based on clearly defined care pathways and suitable admitting rights, supported by appropriate operational structures and a well-trained and nurtured workforce in all emergency departments throughout NHS Greater Glasgow and Clyde.

National Recommendations

Scottish Government

31. Scottish Government should commission Healthcare Improvement Scotland to lead the development of a national approach to improving the quality and safety of urgent and unscheduled care in NHS Scotland, consistent with the Quality Management System, including the development of national standards in partnership with a range of agencies including the Royal Colleges. This will build on work already commenced by The Centre for Sustainable Delivery and include urgent work needed to work towards eliminating the unacceptable use of non-standard care areas given the risks to patients and the impact on staff. This will require significant national focus and support.

32. Scottish Government should explore with Healthcare Improvement Scotland how best to gather patient views about experiences of accessing urgent and unscheduled care services and waiting in emergency departments to inform more detailed national recommendations on how to improve the patient experience and shape services for the future.

33. Scottish Government should engage with relevant national agencies to commission a review of the national guidance for specific health and care demand, capacity escalation and business continuity, which recognises the need to ensure a credible, robust and practical whole system response. This is essential and complementary to the current Multi Agency Major Incident Guidance.

34. Scottish Government should engage with relevant national agencies to commission a review of the professional advisory committee arrangements in NHS boards to ensure they have a transparent, independent and objective mechanism for the board to consider matters of safety and concern. There is an opportunity to refresh the previous national guidance and make these arrangements clearer and more open for all professions to understand.

Public Health Scotland

35. Reliable and comparable whole-system datasets are essential to support improvement in urgent and unscheduled care and optimise flow through the health and social care system. Public Health Scotland should be commissioned by Scottish Government to work with other national and local partners with the aim of progressing existing work and further developing datasets that are designed with, and available to NHS boards to support continuous improvement.

The Centre for Sustainable Delivery

36. The Centre for Sustainable Delivery should strengthen its collaboration with territorial and national NHS boards to engage in improvement activities aimed at:

- Reducing unwarranted variation in urgent and unscheduled care performance to enhance the quality and experience of care, as well as patient outcomes.
- Rethinking access to urgent and unscheduled care to ensure equity and that individuals are treated in the right place, the first time.
- Ensuring appropriate representation, including clinical leaders, in the recently formed Strategic Delivery Groups to drive improvement, set standards, and deliver change.
- Participating in the acute hospital site visit process to ensure that change is driven by clinical teams and tailored to meet the needs of local communities.

NHS Education for Scotland

37. NHS Education for Scotland should strengthen and further develop structured development programmes to identify and support clinical and non-clinical leaders in NHS Scotland. These programmes will enable NHS boards to focus on developing whole system multidisciplinary working and relationships which foster innovation, improvement and inclusivity in decisions that explicitly benefit quality of care and patient safety

38. NHS Education for Scotland should be supported by Scottish Government to explore the implications, and work towards the shift to whole time equivalent medical trainee recruitment in order to strengthen the learning experience, reduce gaps in service and build a more sustainable, effective medical workforce for the future.

39. The review has highlighted the critical role of effective and supportive leadership by the NHS Board. It is recommended that the Scottish Government commission NHS Education for Scotland to evaluate the current national and local induction and support arrangements for NHS Non-executive Board Members. This evaluation should aim to identify and implement any necessary improvements to ensure that Non-executive Board Members can perform their roles as effectively as possible, and consistent with the requirements set out in the NHS Scotland Blueprint for Good Governance.

Healthcare Improvement Scotland

40. The review has identified that the tools for appropriate staffing levels with regard to emergency departments are not sufficiently robust. Healthcare Improvement Scotland's Healthcare Staffing Programme should prioritise the development of new tools which reflect the current operating context and multi-disciplinary working to ensure safe and effective care.

41. Healthcare Improvement Scotland should collaborate with the Independent National Whistleblowing Officer, and other relevant bodies, to develop clear and unambiguous guidance for staff in NHS boards on the national routes for staff to raise concerns under Whistleblowing and the Public Interest Disclosure Act. This will enable NHS boards to ensure that they have effective arrangements in place and improve staff awareness and understanding.

2. The Review Structure, Scope and Methodology

This section provides information about the background, aim and scope of this review. It also sets out the methodology which was used to carry out the review.

Background

2.1. Healthcare Improvement Scotland announced this review on 4 April 2024. The original terms of reference for the review were to focus on the Queen Elizabeth University Hospital emergency department.

2.2. The subsequent and final terms of reference, published in July 2024 (see Appendix 2), extended the scope to include the Glasgow Royal Infirmary and the Royal Alexandra Hospital.[3]

Aim of the review

2.3. The aim of the review was to:

- Provide an evidence-based, balanced, objective and proportionate analysis of the key challenges facing the emergency department at the Queen Elizabeth University Hospital.
- Consider any wider implications for the emergency departments at the Royal Alexandra Hospital and the Glasgow Royal Infirmary.
- Offer support to NHS Greater Glasgow and Clyde to identify practical, evidence-based and sustainable actions that may be required to improve quality and safety in emergency departments in NHS Greater Glasgow and Clyde.
- Consider any wider evidence-based learning for emergency departments and NHS boards across NHS Scotland.

Scope of the review

2.4. The review was undertaken by Healthcare Improvement Scotland in the context of its existing legal powers and statutory duties.

[3] NHS Greater Glasgow and Clyde Emergency Department Review. GGC-ED-Review-ToR-July-2024.pdf. Healthcare Improvement Scotland. July 2024

2.5. The review has adopted the guiding principles and other appropriate elements of the Healthcare Improvement Scotland *Quality Assurance System Framework*[4] and the Healthcare Improvement Scotland *Essentials of Safe Care*[5]. The *Quality Assurance System* is underpinned by five core guiding principles, with the central principle being 'user focus'. This reflects that people's rights when accessing healthcare services, the outcomes of the care they receive, and their views and experiences of that care, are central to Healthcare Improvement Scotland's quality assurance work.

2.6. Consistent with the original terms of reference, the review has considered relevant national data and drawn on strengths and learning identified in each of the emergency departments to share understanding of good practice, along with potential improvements in:

- **Patient Experience:** the extent to which individuals receive timely, person-centred care; and the extent to which patient feedback and wider community engagement informs the planning and delivery of services
- **Safety:** the extent to which patients are treated in a safe environment and are protected from avoidable harm.
- **Leadership and Culture:** the extent to which the service is well led, supported by robust governance arrangements, effective working relationships and team working, and has a supportive culture both within and beyond the emergency department.

Approach

2.7. The review has focused on assessment and evaluation of relevant systems and processes within NHS Greater Glasgow and Clyde. It did not consider the detail of individual patient cases. The review has drawn upon the following:

- A range of sources of data and information including quality of care and patient safety data, relevant performance data, safe delivery of care inspection reports, patient experience data, workforce data and staff experience data. This has included publicly available data, data and evidence provided by NHS Greater Glasgow and Clyde, and data provided by Public Health Scotland.

[4] The quality assurance system and framework – Healthcare Improvement Scotland. Healthcare Improvement Scotland. 2022

[5] Essentials of safe care | Scottish Patient Safety Programme (SPSP) | ihub - SPSP Essentials of Safe Care. Healthcare Improvement Scotland. 2021

- Evidence from proportionate engagement with patients (primarily via a questionnaire with follow-up conversations if requested), a range of staff groups with a combination of group and individual discussions, a confidential mailbox and a staff survey, to obtain their views and perspectives on the safety and quality of care, culture, experience of raising concerns, and areas for improvement.
- Recognised professional and clinical standards where available, and relevant best practice principles and/or expert opinion to inform assessments of the above.

Leadership for the review

Core Review Group

2.8. A Core Review Group was established in May 2024 with terms of reference published in July 2024.[6] The Core Review Group was co-chaired by Dr Pamela Johnston, former Medical Director at NHS Tayside, and Professor Hazel Borland, former Nurse Director and Deputy Chief Executive, at NHS Ayrshire and Arran.

2.9. The Core Review Group comprised external and internal representatives and clinicians (membership at Appendix 3). The Core Review Group was responsible for the effective and efficient conduct of the review and the achievement of its aims within the agreed scope of the review. The Core Review Group was supported by dedicated programme management staff.

2.10. The Core Review Group formed three sub-groups to enable delivery of this work covering:

- Staff and patient experience
- Quality of care and patient safety
- Leadership and culture.

External Reference Group

2.11. An External Reference Group was also established, and the terms of reference were published in July 2024[7]. It was chaired by Professor Sir Lewis Ritchie OBE FRSE, James Mackenzie Professor of General Practice, University of Aberdeen.

[6] NHS Greater Glasgow and Clyde Emergency Department Review. GGC-ED-Review-ToR-July-2024.pdf. Healthcare Improvement Scotland. 2024

[7] NHS Greater Glasgow and Clyde Emergency Department Review. GGC-ED-review-ERG-ToR-July-2024-1.pdf. Healthcare Improvement Scotland. 2024

2.12. The External Reference Group has operated as a consultative body and worked closely with, and supported the work of, the Core Review Group through constructive challenge and provision of expert advice, sharing of specialist knowledge, expertise, and national or operational perspective. The intention of this input was to help assure that the review met its stated objectives and was of appropriate quality in respect of both the methodology and approach to how the review would be conducted, and the findings and outputs of the review.

2.13. The External Reference Group met on six occasions throughout the review offering advice, support and constructive challenge on the process, findings and recommendations of the Core Review Group. The Core Review Group also availed itself of the opportunity to seek the assistance of the specific expertise of individual members of the External Reference Group where appropriate. All External Reference Group members received a confidential copy of the draft Review Report. All members subsequently provided separate individual comments for consideration by the Core Review Group and Healthcare Improvement Scotland.

Executive leadership

2.14. The Executive Sponsor of the review was Robbie Pearson, Chief Executive of Healthcare Improvement Scotland. The Senior Responsible Owner was Lynsey Cleland, Director of Quality Assurance and Regulation, from 4 April until 31 October 2024 and Ann Gow, interim Director of Quality Assurance and Regulation, and Deputy Chief Executive, from 1 November 2024 to 31 March 2025. Jane Byrne, Head of Multiagency Inspections, was the Programme Director responsible for operational delivery within Healthcare Improvement Scotland.

2.15. Latterly the senior leadership of the review has been enhanced with leadership support from Clare Morrison, Director of Engagement and Change, at Healthcare Improvement Scotland.

Undertaking the review

Introductory meetings

2.16. Three introductory meetings took place at the beginning of the review process to discuss the terms of reference for the review, the planned approach for the review and to seek initial feedback.

2.17. On 30 May 2024, an introductory meeting (in-person) was held with the members of the NHS Greater Glasgow and Clyde executive team. Participants were:

- Co-Chairs of the review
- NHS Greater Glasgow and Clyde – Chief Operating Officer (acute), Executive Medical Director, Deputy Medical Director (acute), Executive Nurse Director, and
- Healthcare Improvement Scotland – Director of Quality Assurance and Regulation, Head of Multiagency Inspections.

2.18. On 30 May 2024, an introductory meeting (in person) was held with emergency department consultants at the Queen Elizabeth University Hospital. Participants were:

- Co-Chairs of the review
- NHS Greater Glasgow and Clyde – 13 emergency department consultants, and
- Healthcare Improvement Scotland – Medical Director, Director of Quality Assurance and Regulation, Head of Multiagency Inspections.

2.19. On 13 June 2024, a second introductory meeting (by MS Teams) was held with emergency department consultants at the Queen Elizabeth University Hospital. Participants were:

- Co-Chairs of the review
- NHS Greater Glasgow and Clyde – seven emergency department consultants, and
- Healthcare Improvement Scotland – Medical Director, Director of Quality Assurance and Regulation, Head of Multiagency Inspections.

High level findings meeting

2.20. On 6 February 2025, a meeting was held (by MS Teams) with representatives from NHS Greater Glasgow and Clyde to share the high-level findings of the review. Participants were:

- Co-Chair[8] of the review
- Chair of the Review External Reference Group

[8] Only one of the Co-Chairs attended on this occasion.

- NHS Greater Glasgow and Clyde – Chief Operating Officer (acute), Deputy Medical Director (acute), Deputy Nurse Director (acute), single point of contact for the review;[9] and
- Healthcare Improvement Scotland – Interim Director of Quality Assurance and Regulation and Deputy Chief Executive, Associate Director of Quality Assurance and Regulation.

Key lines of enquiry

2.21. In July 2024, each of the three review sub-groups defined key lines of enquiry that were used to identify the evidence that was required to be gathered. These were developed from the scope of the review as set out in the terms of reference, and the focus was refined where appropriate as the review progressed.

2.22. Staff and patient experience sub-group key lines of enquiry:

- What are staff's experience of working in the emergency department?
- What are staff's experience of the staffing provision/resource within the emergency department?
- What are staff's experience of NHS Greater Glasgow and Clyde's organisational leadership and culture?
- What are patients' experience of accessing the care and services they required?
- What are patients' experience on arrival at the emergency department?
- What are patients' experience of the care they received in the emergency department?
- What are patients' experiences of providing feedback on the care they received in the emergency department?

2.23. Leadership and culture sub-group key lines of enquiry:

- **Is the service well-led?** There is a clear and well-communicated vision and purpose that aligns with its goals and values. The services should be designed with collaborative input from staff, patients, and other stakeholders.
- **Are robust governance arrangements in place?** There is strong leadership promoting a positive culture, accountability, and transparency.

[9] The single point of contact for the review was a staff member nominated by NHS Greater Glasgow and Clyde to work with Healthcare Improvement Scotland to support the coordination of the review.

- **Is there effective team working?** There is collaborative working within and between teams, and involving all relevant stakeholders in the design and delivery of services.
- **Is there a supportive culture?** A supportive culture encouraging respect, collaboration, and well-being among staff.

2.24. Quality of care and patient safety sub-group key lines of enquiry:

- Do individuals receive timely, person-centred care when accessing the emergency department?
- Are patients treated in a safe environment and protected from avoidable harm when accessing the emergency department?
- What are the outcomes for people accessing care in the emergency department?
- How well is flow of patients through the emergency department monitored and managed (what and where are the barriers to flow)?
- Is staffing in the emergency department appropriate, numbers, skills mix etc?
- How are real time staffing concerns monitored and escalated within the emergency department, and what mitigations are in place?
- How are real time staffing concerns responded to and acted on?

Familiarisation visits

2.25. In order to understand the physical environment of the three emergency departments and to observe ways of working in each, the Core Review Group's Co-Chairs, along with medical and nursing members of the Core Review Group, conducted half-day visits to the three emergency departments during the day on 4 and 5 September 2024.

2.26. During these familiarisation visits, Core Review Group members spoke with staff who were on shift at the time. The time available during the visits meant there was limited scope to discuss matters in detail. In response, the Core Review Group decided it would be beneficial to offer an opportunity for any member of staff to be able to speak with a Core Review Group member, and this was arranged.

2.27. Members of the Core Review Group visited the three emergency departments again on Sunday 1 December 2024 to observe ways of working in the early to late evening period, and to speak with members of staff on shift at the time.

On-site visits

2.28. Core Review Group members visited the emergency department at each of the three hospitals for planned activities as follows:

- Queen Elizabeth University Hospital – 30 and 31 October 2024
- Royal Alexandra Hospital – 6 November 2024
- Glasgow Royal Infirmary – 7 November 2024.

2.29. The on-site visits were planned with the support of NHS Greater Glasgow and Clyde. The timetables for the on-site visits included visits to clinical areas; observation of hospital and department huddles; safety pauses and handovers; and planned discussion sessions with different groups of staff. Healthcare Improvement Scotland specified the groups of staff to include in these discussions, and staff in these groups were identified by NHS Greater Glasgow and Clyde. The on-site visits were promoted to staff via information bulletins.

2.30. In addition to the planned activities, site visits also included opportunities for any staff member to "drop-in" to speak confidentially with members of the Core Review Group. Additionally, Core Review Group members spoke with staff during visits to the clinical areas, and at the huddles, safety pauses and handover sessions.

2.31. A total of 128 staff were engaged with during the planned and drop-in sessions. Staff were within the following groups: emergency department consultants and medical management, emergency department nursing and nurse management, emergency department management (general, clinical services and sector), allied health professionals, Scottish Ambulance Service staff and hospital ambulance liaison officers, administrative and clerical staff, staff from facilities, domestic services and portering, partnership forum representatives, and human resources staff.

Individual staff discussions

2.32. Opportunities for staff to have individual, confidential discussions with members of the Core Review Group via MS Teams were offered to staff during October and November 2024. Staff were made aware of this opportunity through a written information bulletin circulated by NHS Greater Glasgow and Clyde on behalf of the review team. This bulletin also highlighted the other options for engaging with the review (on-site visits, email to a confidential inbox and staff survey).

2.33. Around 30 staff from all three emergency departments participated in individual discussions. This included a range of staff from medical, nursing and management roles. Since the discussions were confidential, staff roles are purposively described here at a high level. Whenever possible, the staff role was matched to the professional role of a relevant Core Review Group member to enable a peer-to-peer discussion.

Senior leadership discussions

2.34. The Co-Chairs of the Core Review Group met with members of the NHS Greater Glasgow and Clyde senior leadership team[10] during the weeks commencing 18 and 25 November 2024. In total, 15 meetings took place by MS Teams.

2.35. The purpose of the sessions was to understand senior leaders' perspectives on the issues that had been identified, and to seek clarification and further understanding on matters that had emerged during the review.

Confidential email submissions

2.36. A dedicated email mailbox was opened at the start of the review in April 2024 to enable staff to confidentially share information relevant to the review. The mailbox address was provided to emergency department consultants at a face-to-face meeting on 31 May 2024. It was subsequently shared with staff in all three emergency departments via information bulletins sent by NHS Greater Glasgow and Clyde. The mailbox address was also included in later materials shared with staff about the staff survey, such as on posters displayed in the emergency departments.

2.37. Sixty-seven submissions of information were sent to the confidential email mailbox during May to November 2024. Submissions were predominantly received from emergency department consultants from the three sites (85%) and a number made several submissions to the mailbox. A smaller number of submissions were received from other staff groups including nursing staff and other medical professionals. Since submissions were confidential, staff roles are purposively described here at a high level.

[10] NHS Greater Glasgow and Clyde senior leadership team members involved were: Previous Clinical Director, South, South Sector Director and Queen Elizabeth University Hospital Triumvirate, Chief Officers, West Dunbartonshire HSCP and Renfrewshire HSCP and Co-chairs of UUC Board, Clyde Sector Director and Royal Alexandra Hospital Triumvirate, Chief Executive, Director of Clinical and Care Governance, Executive Director of Nursing, Chair, NHS Greater Glasgow and Clyde , Chief Operating Officer, Chair of the Area Clinical Forum, Director of Human Resources and Organisational Development, Employee Director, Deputy Nurse Director, Medical Director and Chair of the Acute Clinical Governance Committee, Chair of the Area Partnership Forum. Sessions were also held with the Deputy Medical Director - Primary Care and the Clinical Director for GP Out of Hours Services in October 2024.

Staff experience survey

2.38. In addition to the on-site sessions and individual discussions, staff were also offered an option of sharing their experiences via a staff experience survey. The survey was available for the month of November 2024. The survey was highlighted to staff in an information bulletin shared by NHS Greater Glasgow and Clyde to all staff based in the three emergency departments, as well as on posters displayed in the departments which aimed to reach staff who worked in peripatetic roles but were regularly in the department (e.g. portering, administrative roles).

2.39. The staff survey primarily used an electronic MS Forms format and collected responses anonymously. A hyperlink to the form was included in the information bulletin or could be accessed via a QR code on the posters. A key reason for a staff survey being included in the range of approaches to gathering staff experience was to provide an anonymous option. To ensure accessibility, staff could also request a paper copy of the survey for completion.

2.40. The survey included a mixture of multiple choice and open-ended questions. Questions were adapted from three validated questionnaires that focused on safety in emergency departments: Petrino et al (2023)[11], SECUre[12] and safety in the wider healthcare environment – the Safety Attitudes Questionnaire (SAQ)[13]. The questions were developed to reflect the staff and patient experience sub-group's key lines of enquiry and were refined with the sub-group's input.

2.41. A Data Protection Impact Assessment was completed to ensure compliance with data protection requirements.

Patient experience survey

2.42. Patient experience was gathered from a random sample of patients who had a documented attendance at one of the three emergency departments included within the review.

[11] Petrino, R., Tuunainen, E., Bruzzone, G. and Garcia-Castrillo, L. Patient safety in emergency departments: a problem for health care systems? An international survey. European Journal of Emergency Medicine, 30(4), pp.280-286; 2023.
[12] Flowerdew, L. and Tipping, M. SECUre: a multicentre survey of the safety of emergency care in UK emergency departments. Emergency Medicine Journal, 38(10), pp.769-775; 2021.
[13] Sexton, J.B., Helmreich, R.L., Neilands, T.B., Rowan, K., Vella, K., Boyden, J., Roberts, P.R. and Thomas, E.J. The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. BMC health services research, 6, pp.1-10; 2006.

2.43. The primary method of gathering patient experience was using a survey that could be completed electronically (accessed via a link or QR code), by a paper questionnaire using a reply-paid envelope, or by telephone. Providing these different options was vital to avoid accessibility barriers to participating. In addition, patients were invited to opt in to participate in a follow-up individual interview if they wished to provide further information beyond the questions covered in the survey.

2.44. The survey included a mixture of multiple choice and open-ended questions. It was designed using the staff and patient experience sub-group's key lines of enquiry and was informed by the Care Quality Commission's emergency care survey.[14] Permission was sought from the Care Quality Commission to use and refine some of the questions from its survey, which was granted providing an acknowledgement was given in this report. The questions were developed iteratively with input from the staff and patient experience sub-group. The survey can be accessed here.[15]

2.45. The Care Quality Commission's survey provided a benchmark to estimate a 20% response rate to the survey. This provided an aim of 380 responses across all three sites which would give a +/-5% confidence interval (error rate) at the 95% confidence level. This is a standard level of feedback considered robust in statistical terms for a large population size in social research.

2.46. A stratified random sample of patients who had attended one of the three emergency departments included in the review was generated by NHS Greater Glasgow and Clyde from their patient records system using a sample frame provided by Healthcare Improvement Scotland. The sample required patients to have attended one of the specified emergency departments over the past year stratified by age and sex, and month and location of attendance.

2.47. An initial sample of 2,000 patients was generated for contact by post. Letters inviting patients to participate by paper/electronic/telephone with copies of the paper questionnaire were printed by a mail/print firm and supplied in pre-prepared envelopes to NHS Greater Glasgow and Clyde where labels were added to the envelopes which were then franked. The letters/questionnaires were posted to patients in batches between 31 October and 4 November 2024. The deadline for completing the survey was 29 November 2024, giving patients around three weeks to complete the survey. A second sample of 6,000 patients was sent a text message with a link to the electronic survey on 26 November 2024. We acknowledge NHS Greater Glasgow and Clyde's support for the sampling and distribution of the patient survey.

[14] https://www.cqc.org.uk/publications/surveys/urgent-emergency-care-survey. Care Quality Commission. 2024
[15] NHS Greater Glasgow and Clyde Emergency Department Review 2025 – Patient Experience Survey – Healthcare Improvement Scotland

2.48. A Data Protection Impact Assessment was completed to ensure compliance with data protection requirements.

Other sources of evidence

2.49. Initial information was gathered through four sources: information and data submitted via a Healthcare Improvement Scotland "Responding to Concerns" process[16] that led to this review; existing data and information relating to safe delivery of care hospital inspections in NHS Greater Glasgow and Clyde; information from NHS Education for Scotland about clinical staff training including medical trainee and student nurse feedback; and data from Public Health Scotland.

2.50. A gap-analysis of the evidence was then undertaken by the review's Co-Chairs, the three review sub-groups and subject matter experts. This resulted in bespoke evidence requests to NHS Greater Glasgow and Clyde.

2.51. The evidence sourced and reviewed included:

- Organisational arrangements in place in NHS Greater Glasgow and Clyde including organisational structures, bed numbers, capacity, governance arrangements, performance reporting and tracking.
- A range of relevant NHS Greater Glasgow and Clyde policies and operational processes including flow, redirection, escalation, risk assessment, staffing monitoring and escalation, on-call arrangements and patient pathways.
- Healthcare Improvement Scotland recent safe delivery of care inspection reports for the three hospitals included in the review.
- Minutes of NHS Greater Glasgow and Clyde meetings including: board meetings, emergency department meetings, partnership forum, area clinical forum, unscheduled care oversight board, acute clinical governance forum, acute strategic management group.
- Workforce information including workforce data, needs analyses, rotas, information on staff in training from NHS Education for Scotland, reports of staffing concerns, medical trainee and student nurse feedback.
- National datasets of key measures in emergency departments, mostly held by Public Health Scotland.
- Medical and nursing handover documents.
- Safety huddle notes.
- Incident and Datix reports.
- iMatter reports.

[16] Healthcare Improvement Scotland (HIS) process for responding to concerns. Healthcare Improvement Scotland. March 2024

Analysing the evidence

Initial analysis

2.52. The initial body of data and evidence was consolidated in a single location and in the first instance was reviewed for relevance to the areas of focus for the review. Subject matter experts within three sub-groups of the review assessed the initial evidence and undertook a gap analysis against their key lines of enquiry. Additional evidence identified through the gap analysis was sought either directly from NHS Greater Glasgow and Clyde or from other relevant sources. Areas where further information was required were followed up through engagement with NHS Greater Glasgow and Clyde.

2.53. An independent researcher commissioned by Healthcare Improvement Scotland supported the work of the Core Review Group by undertaking thematic analysis of qualitative data relating to staff experience. The researcher undertook the analysis from 30 October to 9 December 2024. The Core Review Group considered this analysis alongside the other evidence available to them when triangulating the key themes emerging from the review.

2.54. Relevant domains, criteria and indicators from Healthcare Improvement Scotland's Quality Assurance Framework and Scottish Patient Safety Programme Essentials of Safe Care were used to guide the assessment of the evidence. Additional references of relevance, such as the indicators of a high-quality care culture produced by The King's Fund[17] were mapped to the criteria as appropriate.

Review of medical and nursing shift handover documents

2.55. A number of medical and nursing shift hand-over documents were included in the body of evidence as described above. These documents describe each shift in the emergency department and contain information of relevance to hand over to the incoming emergency department teams at shift changeover.

2.56. During the course of the review, consultants from the Queen Elizabeth University Hospital proactively shared examples of handover documents as evidence of particular issues of concern within the emergency department on given days.

[17] Collins B. Staff Engagement; Six building blocks for harnessing the creativity and enthusiasm of NHS staff. The King's Fund – Improving NHS Culture; 2015.

2.57. A range of other nursing and medical hand-over documents were available to the review within evidence previously supplied for recent safe delivery of care inspections in the Queen Elizabeth University Hospital and Glasgow Royal Infirmary. These documents, amounting to approximately 120 examples, were considered by the Core Review Group. They also formed part of the qualitative dataset reviewed by an independent analyst. Themes and observations arising from the consideration of these have informed the review.

2.58. To allow a balanced and objective view of the general functioning of all three departments a further sample of hand-over documents was requested. The sample included periods of interest relating to safety, using 12 hour waits as a proxy measure. In addition, a sample drawn from mid-October – mid-November 2024 was requested from each site to correspond with the period of the review's engagement activity.

2.59. NHS Greater Glasgow and Clyde provided the requested sample for the Queen Elizabeth University Hospital and Glasgow Royal Infirmary. There was no sample supplied for the Royal Alexandra Hospital emergency department. It was advised that the Royal Alexandra Hospital emergency department does not record shift handovers in this way.

2.60. A systematic review of this further sample of 141 shift handover documents was carried out. This was with the aim of determining if these additional reports demonstrated: significant and persistent themes relating to patient safety and harm; commonly recurring themes related to other key lines of enquiry for the review, or any other recurrent issues of significant concern not previously identified.

2.61. The reports were reviewed for evidence of issues related to staffing, departmental congestion and reduced flow, safety concerns, escalations, impact on patients and impact on staff and rated as to whether the issues were considered significant, moderate or minimal as recorded in the reports.

2.62. There were differences in format and layout between the handover forms. The Queen Elizabeth University Hospital forms had better defined sections which made it easier for Core Review Group members to form an assessment. The Glasgow Royal Infirmary medical handover reports were less formalised making it more difficult to form assessments for many areas in the same way.

2.63. Completion of the shift handover documents was also inconsistent across and within the hospital sites. Some contained large amounts of information, and some were more limited in terms of content. Those reviewing the reports did not make assumptions based on their subject matter expertise. The assessments and ratings were based solely on the information available within the reports. Where reviewers were unable to determine a rating based on the information available, they did not allocate one. Across the entirely of the sample and the question range, reviewers were unable to determine a rating in just under a third of cases.

2.64. It is important to note that the handover documents in and of themselves may only represent one element of the data, reports and information shared within the emergency department team and the wider hospital, related to the daily functioning of the emergency departments.

Analysis of national datasets

2.65. An iterative process of exploratory data analysis, consideration of this and further analysis was undertaken over several months. The quantitative data used for the review were sourced from existing Scotland-wide datasets, mostly held by Public Health Scotland. Some of the underlying data are publicly available, and others were provided on request. The methods for analysing the data were chosen specifically for the purpose of informing this review, and some further details of methods and data sources are included. The analysis has been carried out so that the data for the three relevant hospitals in NHS Greater Glasgow and Clyde can be considered over a period of time, and to enable comparison with selected peer hospitals in Scotland. This analysis has been considered throughout the review and was also updated so that the most recently available data can be included in this report.

2.66. To enable consideration of the data for NHS Greater Glasgow and Clyde's hospitals in the context of emergency departments in Scotland more generally, a peer group of ten other emergency departments in Scotland was established, using the number of unplanned attendances to select an appropriate group. The ten hospitals included in the peer group are set out in chapter 4.

Staff experience survey

2.67. Responses to the staff experience survey were gathered electronically using MS Forms which resulted in an output of quantitative data as tables and charts in Excel format.

2.68. The survey was distributed by email to around 540 staff across the three emergency departments. It was completed by 114 staff in the following groups:

- 23 (20%) emergency department consultants
- 10 (9%) resident doctors
- 67 (59%) nurses

Smaller numbers (<5% each) of the following staff groups also responded to the survey:

- Allied health professionals
- Healthcare support workers
- Managers
- Administrative roles

- Other – clinical (e.g. pharmacy) role, and
- Preferred not to disclose.
- Agenda for Change banding of staff was: 2% Band 8a and above, 12% band 7, 48% band 5/6, 4% band 2/3/4, 30% medic and 4% preferred not to say.
- Staff had worked in an emergency department for: 13% less than 1 year, 19% 1-2 years, 20% 3-5 years, 47% more than 5 years and 1% preferred not to say.

2.69. Quantitative data were reported directly from the MS Forms survey.

2.70. A thematic analysis approach was undertaken to analyse the qualitative data gathered through the staff experience survey. Two researchers took the following steps:

1. Explore the data to identify potential themes.
2. Code and classify the data into themes and subthemes.
3. Explore relationships for similarities, differences, patterns and associations between the different themes and sub-themes.
4. Interpret the data by developing possible explanations for the patterns observed in the data.

2.71. The analysis included a comparison of themes emerging from each of the three sites and amalgamating the findings. Involving two researchers in the analysis provided triangulation and quality assurance of the findings.

Patient experience survey

2.72. The total response to the patient experience survey was 571 responses from 8,000 patients plus two qualitative interviews. The response rates for different methods of contacting patients are shown in Table 1 below and were:

Method	Number of responses from 2,000 letters	Number of responses from 6,000 texts	Total number of responses
Web Link	4	385	389
QR Code	22	-	22
Telephone Interviews	1	1	2
Postal Returns	160	-	160
Total Returned	**187**	**386**	**573**
Response Rate	**9.4%**	**6.4%**	**6.4%**

Table 1: Patient experience survey response rates by method of contact

2.73. Equality monitoring questions included in the survey demonstrated a good spread of responses across different demographics. Male patients were slightly under-represented (45%) compared with females who were slightly over-represented (54%), and 1% of respondents selected 'Prefer not to say'. There was a good spread across age groups, although an over-representation of older patients compared with younger patients. The time of year the patient attended the emergency department was spread from August 2023 to November 2024 with a good response in most months.

2.74. The response rates in each of the three sites is shown below in Table 2, with a slight difference from the attendance rates:

Emergency department	% Response to survey	Actual % attendance 2023/24[18]
Queen Elizabeth University Hospital	47%	41%
Glasgow Royal Infirmary	26%	35%
Royal Alexandra Hospital	31%	25%

Table 2: Patient experience survey site response rates

2.75. An analysis of the responses to the survey questions from the three emergency departments showed only a slight difference in responses to some questions: all of these differences were within the margin of error.

2.76. A total of 571 responses to the patient experience survey gives a confidence interval (error rate) of +/- 4.1% at the 95% confidence interval. The survey was designed to achieve a +/-5% confidence interval, making the sample slightly more robust than aimed for. All comparisons made from the patient experience survey are statistically significant unless otherwise stated. This ensures that the differences observed are due to actual differences in opinions or experiences rather than random chance.

2.77. The survey included one open-ended question. Responses were coded into response categories to enable frequency analysis to be undertaken. A list of thematic response categories or "codes" were created from an initial reading of the responses. The coding process then involved assigning each response to a code. Responses were coded into multiple categories where more than one point is communicated.

[18] Attendance rates sources from NHS Greater Glasgow and Clyde Board Report 30 April 2024. NHSGGC Board Meeting Documents - 30 April 2024 - NHSGGC. NHS Greater Glasgow and Clyde; April 2024

2.78. To consider whether the recommendations drawn from this patient experience survey had a wider applicability across NHS Scotland, an analysis of Care Opinion[19] stories about urgent and unscheduled care was undertaken. Stories were extracted from January 2022 to December 2024. Urgent and unscheduled care was defined as emergency departments and minor injury units. Care Opinion stories are tagged by the person writing the story and by Care Opinion moderators. These tags identify what was good (positive experiences of care) and what could be improved (negative experiences of care). The percentage of all tags about specific aspects of care in NHS Greater Glasgow & Clyde and the rest of NHS Scotland was compared. Wilson Score confidence intervals were calculated to identify any differences. Within this review, a total of 2,899 distinct stories with a "what was good tag" and 1,218 distinct stories with a "what could be improved" tag were included. Of these, 834 and 313 respectively were about NHS Greater Glasgow and Clyde.

Evidence search and summary

2.79. An evidence search and summary service was conducted by information scientists within Healthcare Improvement Scotland's Research and Information Service. This was a rapid summary of evidence to answer the following questions:

- What solutions are UK health and care services employing to respond to crowding in emergency departments, with resultant impact on safety and quality of care?
- How effective are those solutions?

2.80. A systematic search focused on the specified questions was conducted in MEDLINE[20] and the Health Management Information Consortium. The results from this main search were augmented by a previous search on crowding conducted by NHS Ayrshire and Arran library service using Trip database, Cochrane, Medline, Embase, the Health Management Information Consortium, the Royal College of Emergency Medicine and Google, and by input from several members of the External Reference Group convened by Healthcare Improvement Scotland. In total, over 800 articles were retrieved. These were screened to filter down to systematic reviews which included UK studies and published from 2022 onwards, i.e. post-Covid 19 pandemic.

[19] https://www.careopinion.org.uk/services/nhs-scotland. Care Opinion. 2022 – 2024
[20] MEDLINE, National Library of Medicine

Inclusion of quotes from NHS Greater Glasgow and Clyde staff in this review report

2.81. A range of mechanisms were used during this review process to hear the views and experiences of relevant NHS Greater Glasgow and Clyde staff that have a role in relation to the three emergency departments considered by the review. This included receiving submissions from staff to a dedicated confidential review email inbox, meetings between staff and members of the Core Review Group, and a staff experience survey as outlined above. This review report includes quotes drawn from across the breadth of that staff engagement. Not all quotes have been included in this report, but all have been read and considered. Care has been taken to protect the anonymity and confidentiality of staff who engaged in the review process within the representative sample of quotes for inclusion in this report. This includes, for example, omitting where possible the staff role and the relevant hospital site associated with the quotes and in some instances redacting elements of the quotes. The convention […] indicates where text has been removed.

Report structure and commonly used terms

2.82. For chapters 5-7, the report is structured so that for each a section a summary of the findings is provided in bold, followed by an explanation and more detailed findings underneath.

2.83. We use the term urgent and unscheduled care throughout this report with the exception of in Chapter 5. When we say urgent and unscheduled care we mean one of the following:

- care that may be needed to treat an injury following an accident
- care for serious life-threatening conditions, or
- for less serious conditions that will get worse if left untreated (particularly during the night or at the weekend, when other types of healthcare services are not available).[21]

Urgent and unscheduled care is provided by a range of services including emergency departments and minor injury units.

2.84. In Chapter 5 we use the term 'emergency care' which refers to urgent and unscheduled care as described above. This was the terminology adopted for the patient experience survey.

[21] What is urgent and unscheduled care? What is urgent and unscheduled care? - Overview - About urgent and unscheduled care - Urgent and unscheduled care - Healthcare system - Public Health Scotland. Public Health Scotland. October 2024.

3. Emergency Department Provision in Scotland

This section provides context regarding emergency department provision in Scotland and outlines:

- **a general overview of emergency departments and emergency medicine**
- **information on emergency departments and trauma centres and trauma units in Scotland**
- **the UK-wide context.**

General overview of emergency departments and emergency medicine

3.1. The following descriptions of emergency departments and emergency medicine have been summarised from the Royal College of Emergency Medicine.[22]

Emergency medicine

3.2. The specialty of emergency medicine provides round the clock care to patients of all ages, who present with symptoms of acute illness and injury. In the UK, emergency medicine as a specialty is continually adapting and developing. This may be in response to external pressures, such as changes in the provision of out of hours and acute care, changes in medical practice, expectations of patients, or government targets, including waiting time targets. There is also ongoing discussion and debate about the future direction of urgent and unscheduled care.

3.3. Emergency medicine has evolved significantly over the years and is very different to how it was in the 1960s and 1970s when "casualty surgeons" first emerged. It now includes critical and acute care for a much wider range of challenges. When patients first present at emergency departments, there is often no clear diagnosis, and there may be little information available beyond what the patient can tell healthcare staff, what is known about the patient's history, what can be learned on initial examination and bedside investigations. It can be very challenging to provide rapid and appropriate treatment within the first hours of the patient's arrival but ensuring that there is effective early diagnosis, and treatment can make a big difference in short and longer-term outcomes in many cases.

3.4. Since it is not possible to have experienced staff from every hospital specialty or sub-specialty standing by in the emergency department, emergency physicians have developed expertise as "specialised generalists". This enables them to make

[22] Home | RCEM, Royal College of Emergency Medicine

working diagnoses and start appropriate treatment, and where appropriate refer on to other specialists. Many emergency physicians now sub-specialise, for example, they may become experts in the fields of children's emergencies, acute medical emergencies, poisoning, life-threatening emergencies needing critical care skills, and emergencies in the pre-hospital setting.

3.5. Many departments are increasing their capacity for practising observation medicine where patients remain in a ward style environment for up to 48 hours under the care of the emergency medicine consultant. This allows time for more detailed investigation and treatment, or support for those who have a temporary condition that prevents them being safe at home after discharge.

3.6. Emergency medicine has a well-developed curriculum and specific examinations. Resident doctors in the emergency department receive high quality training and experience under direct supervision of senior doctors who are dedicated to medical education and to the development of emergency medicine as a specialty.

Emergency departments

3.7. Emergency departments are based at the "front door" of a hospital and specialise in the care of acutely ill and injured patients who need immediate treatment. Most emergency departments provide care for patients of all ages and with all conditions, although there are some that see only children or only adults, or only patients with eye problems. Most emergency departments are open 24 hours a day, 7 days a week. All will have resuscitation facilities for people who are critically ill, cubicles to see patients, and access to investigations (such as blood tests and x-rays) to help make diagnoses.

3.8. Various advanced healthcare practitioners work in emergency departments, including nurses, allied health professionals (AHPs), mental health nurses, and doctors. The care in emergency departments is supervised by specialists in emergency medicine (emergency physicians) whose job is to ensure that patients receive care of the highest possible standard.

When someone visits an emergency department they can expect to be asked for their personal details (such as name and address) and to be registered onto the computer system. They may be seen by a nurse briefly before seeing the doctor or nurse practitioner. This process is sometimes called "triage" or "assessment". The purpose is to find out who can best deal with the problem and in which part of the department, whether any treatment or investigations can be started, and whether there is a need to be seen very urgently. Sometimes patients can be treated on the spot or directed to a more appropriate service. Most emergency departments will allocate each patient to a "triage category", which indicates the order in which patients should be seen. This process also allows patients to be given pain killers as soon as possible.

3.9. When a patient is seen by a doctor or nurse, their condition will be assessed and a decision made on the best treatment for their condition including whether they need to be seen by a specialist or by their own GP after discharge. Some patients can be treated and discharged, and some will need to be admitted to hospital. Many emergency departments have their own wards to which patients can be admitted for short periods of observation or treatment. They may also be referred to other hospital specialists for advice or treatment. This is because other specialists may be able to provide the right care for a particular problem as well as providing follow up care to ensure the condition responds to the treatment.

Emergency departments in Scotland

3.10. Collectively the term "accident and emergency services" includes the following site types:

- emergency departments
- minor injury units,
- community accident and emergency departments or community casualty departments that are GP or nurse-led.

3.11. There are 30 consultant-led emergency departments in Scotland and around 60 minor injury units.[23]

Scottish Trauma Network

3.12. In 2016, the Scottish Government followed through on a commitment to develop four major trauma centres in Scotland, including one for the West of Scotland to be based in the Queen Elizabeth University Hospital.

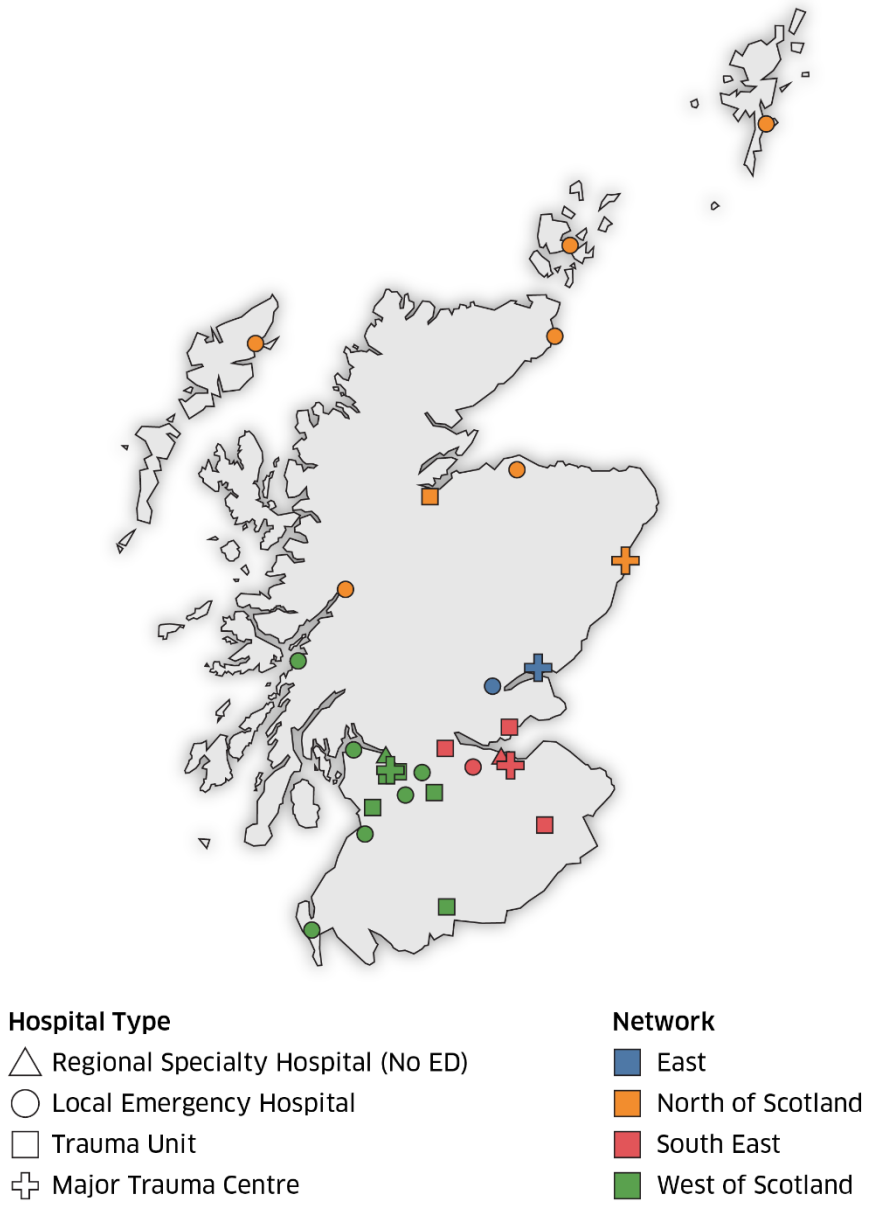
3.13. The Scottish Trauma Network was established in 2017 by the Chief Medical Officer with the aim of "Saving lives, Giving life back"; establishing an integrated trauma care system across Scotland which would improve the delivery of care from prehospital intervention through to rehabilitation.

3.14. Central to this plan was the creation of four major trauma centres to cover the North, East, South-East and West of Scotland.

3.15. The Queen Elizabeth University Hospital opened as the West of Scotland major trauma centre on 30 August 2021 following postponement of original opening in March 2021 due to the ongoing Covid 19 pandemic and high Covid prevalence across the West of Scotland at that time.

[23] Overview - Accident and emergency - Urgent and unscheduled care - Healthcare system - Public Health Scotland. Public Health Scotland; October 2024.

3.16. All neighbouring West of Scotland trauma units (NHS Lanarkshire, NHS Ayrshire & Arran, NHS Dumfries & Galloway) required to be operational when the Major Trauma Centre opened. These units feed into the Queen Elizabeth University Hospital major trauma centre.

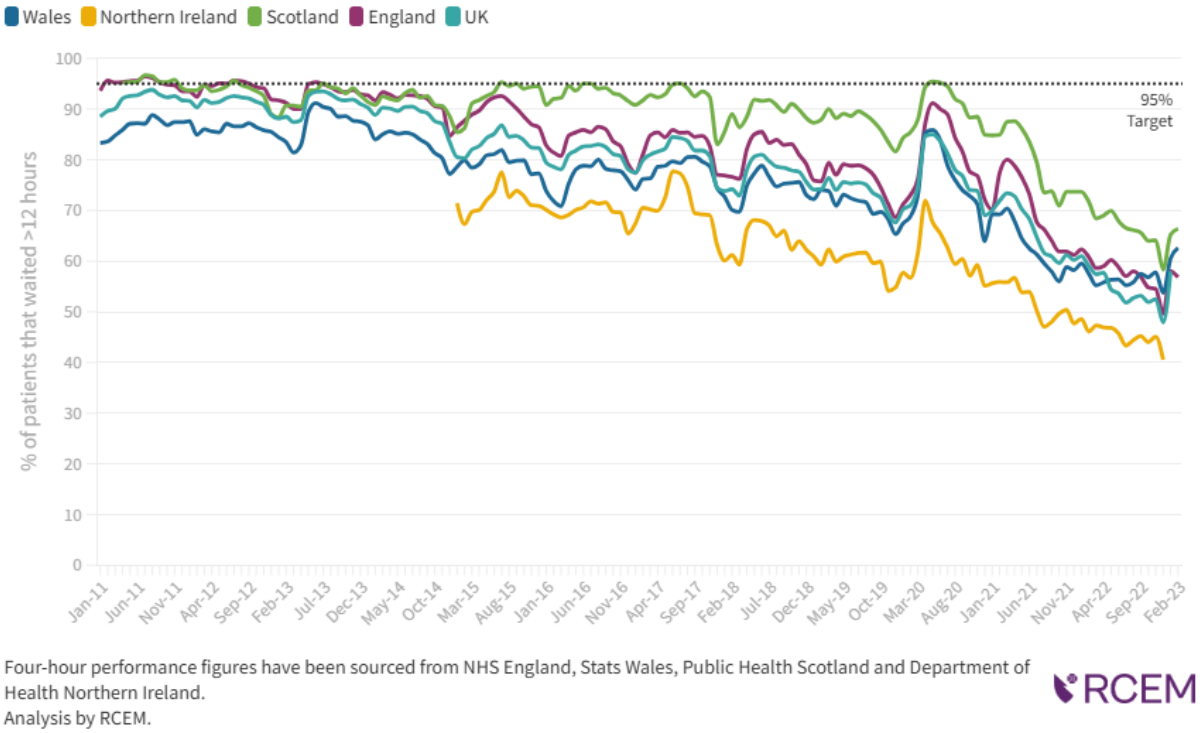


- **Trauma centres** provide high quality specialist services within a 45-minute journey time from the incident. The estimate is that 86% of the Scottish population are within 45 minutes of one or more of the trauma centres.
- **Trauma units** provide high quality specialist services to patients significantly over the 45 minutes maximum travel time. Many of these will be initially admitted to a trauma unit and may then require a secondary transfer to the trauma centre.

UK-wide and general context

3.17. In terms of the UK context, the Royal College of Emergency Medicine provides a UK performance tracker[24] to describe attendances and four-hour and 12-hour waits in the four home nations. Each devolved health system operates under a different model and therefore direct comparisons cannot necessarily be attributed to "better" or "worse" performance. The data does, however, provide some context as to how each health system is functioning over time.

3.18. The figure below (Figure 3.1) shows that each nation has broadly followed a similar pattern over time. The Royal College of Emergency Medicine explained that emergency department attendances across the UK are now relatively stable and consistent with pre-Covid pandemic levels. However, each of the four UK countries has shown a broadly similar declining trajectory on performance in relation to the four-hour standard.



Four-hour performance figures have been sourced from NHS England, Stats Wales, Public Health Scotland and Department of Health Northern Ireland.
Analysis by RCEM.

Figure 3.1: Four-hour performance across the UK

3.19. The King's Fund in 2024[25] concluded that the sustained decline in performance in relation to the four-hour standard is a clear marker of the growing and significant pressures on emergency departments and the wider health and care system. These pressures are felt by the patients and families who use, and the staff who work in, these services.

[24] Data & Statistics | RCEM. Royal College of Emergency Medicine. 2024
[25] What's Going on with A&E Waiting Times. What's Going On With A&E Waiting Times? | The King's Fund. The King's Fund; 2024.

3.20. When considering waits exceeding 12 hours from arrival at the emergency department, data from each UK nation shows an increase in recent years, with more patients than ever before now experiencing extremely long waits.

3.21. Twelve hour waits represent a significant failure of the healthcare system and under normal conditions would prompt a review of how and why each one came to be, with the aim of learning and improving. When these very long waits are relatively rare occurrences there is more opportunity to conduct such reviews. However, a system where such waits occur more frequently may not be able to conduct these reviews and therefore miss crucial learning to avert future instances.

3.22. According to the Royal College of Emergency Medicine UK performance tracker, NHS Scotland appears to consistently have the lowest Type 1[26] emergency department attendances per 1000 population (matched by NHS Wales), the highest percentage of patients meeting the four-hour emergency department standard, and the lowest percentage of patients waiting more than 12 hours. The 12-hour wait measure is perhaps the most striking among these: before the Covid 19 pandemic, Scotland was the only nation that was seeming to keep 12-hour waits under 1% of waits, whereas all other nations were non-zero (between 1% and 4%) and rising (to between 4% and 11%) from June 2018 to January 2020. Since mid-2021, Scotland's percentage of 12-hour waits climbed to 7.6% up to December 2022 (the last month where data from all four nations is available in the tracker), with the other nations operating at a level between 14% and 19%. At this point the UK level of 12-hour waits stood at 14.6%.

Emergency departments in Scotland – performance data

3.23. Feedback from NHS boards suggests that, following the Covid 19 pandemic, there has been an increase in the complexity and acuity of patients presenting to hospital, such as patients with multiple co-morbidities or presenting at a later stage of disease or deterioration. Some evidence that is consistent with this view is provided by analysis, recently carried out by Public Health Scotland looking at the case-mix of hospital admissions post-Covid (April 2022 – March 2024) compared with pre-Covid (April 2018 – March 2020). This analysis found that post-Covid, a significantly higher proportion of patients admitted to hospital are: (i) aged 60 years and over, and (ii) have a higher number of prior morbidities (prior morbidities are based on the main condition recorded as a result of previous hospital admissions). This analysis focused on acute inpatients/day-cases (and not attendances at emergency departments) and provides some

[26] The Royal College of Emergency Medicine defines Type 1 emergency departments as major emergency departments that provide a consultant-led 24-hour service with full facilities for resuscitating patients.

evidence that post-Covid there is greater pressure on hospital services resulting from an increase in the complexity/acuity of admissions.[27]

National initiatives to improve performance

3.24. The national Urgent and Unscheduled Care Collaborative was refreshed in June 2022. This whole system approach is part of the Scottish Government's wider Recovery Plan which seeks to reset NHS services following the Covid 19 pandemic; with the understanding and renewed commitment to making the necessary system changes to modernise the NHS in Scotland.

3.25. The Collaborative's programme of improvement activities is being taken forward by the Centre for Sustainable Delivery, which has been commissioned to support NHS boards to implement a range of measures to reduce emergency department waiting times and improve patient and staff experience.

3.26. The Centre for Sustainable Delivery's Unscheduled Care programme delivers implementation support, develops national tools, and manages system capacity and capability diagnostics to help NHS boards improve unscheduled care delivery. Its strategic priority is to define best practice in key areas within unscheduled care which improve the timeliness and safety of patient care and patient and staff experience. Current national improvement workstream areas include:

- Strategic programme development
- Community urgent care
- Flow navigation
- Hospital at home
- Front door medicine
- Optimising flow[28]

[27] Unpublished analysis (management information). Public Health Scotland. 2025

[28] Centre for Sustainable Delivery Annual Plan 24/25. CfSD Annual Plan 2024-25. Centre for Sustainable Delivery; 2024

4. The Delivery of Urgent and Unscheduled Care in NHS Greater Glasgow and Clyde

This section provides context for the delivery of urgent and unscheduled care within NHS Greater Glasgow and Clyde. It explains the current urgent and unscheduled care provision in the Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital, set within the overall operating context for NHS Greater Glasgow and Clyde.

This section also includes performance data for all three hospitals on:

- **Performance against the four-hour standard**
- **Number of attendances**
- **Percentage of unplanned attendances with over eight hours or over 12 hours wait**
- **Percentage of unplanned admissions from the emergency department into the hospital**
- **Ambulance turnaround times**
- **Length of stay**
- **Delayed discharges**
- **Bed occupancy.**

Observations are included where relevant about what this data may suggest for the areas of focus for this review i.e. care provision and safety; staff and patient experience; and leadership and culture.

NHS Greater Glasgow and Clyde board overview

4.1. NHS Greater Glasgow and Clyde is the largest NHS organisation in Scotland and one of the largest in the UK. It serves a population of approximately 1.2 million people, equating to over a fifth (21.7%) of Scotland's total population, across six local authority areas: East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde, Renfrewshire and West Dunbartonshire.

4.2. According to preliminary 2022 census data, the population of Greater Glasgow and Clyde is increasing faster than Scotland as a whole (3.6% since the previous census in 2011 compared to 2.7% for Scotland).

4.3. There are 23 hospitals of different types across NHS Greater Glasgow and Clyde. The NHS board employs around 41,000 staff with around 22,500 of those working within acute services. The NHS board has an annual budget of £4.4 billion.

4.4. There are six Health and Social Care Partnerships. These are formal partnerships between each of the six Local Authorities and NHS Greater Glasgow and Clyde. The Health and Social Care Partnerships are responsible for jointly planning and delivering community health and social care services for people in their areas.

4.5. There is wide demographic variation both between and within these Health and Social Care Partnerships. Life expectancy varies across the NHS board area from 73.4 years in Glasgow City to 80.5 years in East Dunbartonshire, a difference of 7.1 years. Life expectancy Scotland-wide (data from 2021 – 2023) is 80.8 years for females and 76.8 for males[29].

4.6. Healthy life expectancy (years of life an individual lives without any life-limiting illness) is lower in NHS Greater Glasgow and Clyde when compared with much of the rest of Scotland, 58.0 years for males and 58.7 years for females, compared to 60.4 and 61.1 respectively for Scotland (data from 2019 – 2021). [30]

4.7. Paragraphs 4.7–4.10 are extracts from NHS Greater Glasgow and Clyde's public health strategy 2018-2028[31] which highlights that this is explained by life circumstances, chiefly socio-economic factors which impact across the life-course, starting in the antenatal period and influencing education, employment, health behaviours and patterns of healthcare use.

4.8. Inequalities in income, health and quality of life persist and in some parts of NHS Greater Glasgow and Clyde are widening. There are specific concerns regarding the health and wellbeing of population groups such as lone parents, children and young people in low-income families, and frail isolated older people. There are also growing concerns about mental health and wellbeing across all age groups. All of these factors contribute to increasing demands on the health and social care system.

4.9. Unhealthy behaviours are common across all communities in NHS Greater Glasgow and Clyde. However, poverty increases the higher risk of illness and premature mortality through factors which are related to unhealthy behaviours. Those living in poverty are more likely to follow trajectories of limited school attendance and educational attainment, limited job opportunities and unemployment, and are more likely to smoke, consume hazardous or harmful levels of alcohol, have a poor diet and have limited physical activity.

[29] Life Expectancy in Scotland 2021-2023 - National Records of Scotland (NRS)
[30] Healthy Life Expectancy 2019-2021 - National Records of Scotland (NRS)
[31] Public Health Strategy 2018-2028 - NHSGGC. NHS Greater Glasgow and Clyde; 31 March 2023

4.10. While health inequalities as a result of poverty may be partially explained by risk factors such as smoking and diet, it is likely that use of and access to health services also underpin this issue. Across all countries, healthcare costs and use rise steeply with age and with the prevalence of long-term conditions. Poverty is strongly associated with patterns of emergency and unscheduled care; 72% of the variation in unscheduled care is explained by poverty and social factors, not by system factors. This appears to be true in both primary and secondary care. These findings are found across a number of different health systems and relate to accessibility of services, but also how patient-centred such services are and the culture of how people use services.

Right Care, Right Place model

4.11. NHS Greater Glasgow and Clyde implemented the national "Right care, Right place"[32] (2021) model for all urgent and unscheduled care. This model aims to ensure patients access the most appropriate care quickly and safely and will help protect the accident and emergency departments so they can look after those patients with life-threatening conditions such as strokes, heart attacks, head injuries, breathing difficulties or severe bleeding.

4.12. Emergency department attendances across the NHS Greater Glasgow and Clyde board area from 2021- 2024[33] are shown in Table 3 below. Attendance data specific to the three emergency departments included in this review is presented later in this chapter.

Year	2021–22	2022–23	2023–24
Emergency department attendances	431,125	465,199	494,201

Table 3: NHS Greater Glasgow and Clyde board-wide emergency department attendances by year

4.13. While overall emergency attendances (including to minor injuries units) have increased year on year since 2021 (7% over 2021–22 to 2022 –23 and 6% over 2022 –23 to 2023 – 24) they remain lower than pre-pandemic levels.

[32] Accessing The Right Care From The Right Place. NHS Scotland. December 2021.
[33] NHS Greater Glasgow and Clyde Annual Report and Consolidated Accounts 2023-2024 Annual Report and Consolidated Accounts 2023-2024 - NHSGGC. NHS Greater Glasgow and Clyde. October 2024.

NHS Greater Glasgow and Clyde's clinical strategy

4.14. NHS Greater Glasgow and Clyde's medium to long-term clinical strategy called "Moving Forward Together" is aligned to its delivery plan, corporate objectives and operational priorities. The key principles established through the strategy are summarised in the graphic below:

4.15. The "Moving Forward Together" vision is described by NHS Greater Glasgow and Clyde as a holistic approach to healthcare focused on integration across primary, community, specialist and acute care, supported by the right infrastructure. A revised clinical vision and roadmap[34] have been produced to support this. Moving Forward Together was not mentioned by staff that engaged in this review process in their discussions with members of the review group.

Capacity in the emergency departments and hospitals at April 2024[35]

4.16. Glasgow Royal Infirmary

- Resuscitation – 5 spaces, including a paediatric bay, a negative pressure room and a decontamination room with external direct access.
- Majors A – 19 spaces including 3 side rooms and 2 monitored bays. Further 5 labelled trolley spaces around the zone.
- Majors B – 11 spaces including 2 side rooms.
- Corridor – up to 7 labelled trolley spaces are used in extremis.

[34] Moving Forward Together Clinical Road Map. Greater Glasgow and Clyde dated August 2024
[35] NHS GGC overview of hospitals provided as evidence

4.17. Royal Alexandra Hospital

- Total capacity is now 34 spaces due to the recent addition of a minor injury area.
- Resuscitation – 5 spaces, including 1 single room.
- Rooms – 10 spaces.
- Cubicles – 19 spaces.
- Corridor – up to 7 trolley spaces in corridors for lower acuity patients (depending on staffing) are used in extremis.

4.18. Queen Elizabeth University Hospital

- The emergency department has a total capacity of 53 spaces.
- Resuscitation – 7 spaces.
- Emergency department high dependency – 16 spaces (all cubicles).
- Majors – 25 spaces.
- Minor injury unit – 5 cubicles (plus small waiting area).
- No corridor care, but there is a "cohort room" with a capacity of two trolleys that can be used in escalation to cohort two patients to release ambulance crews.

4.19. The NHS Greater Glasgow and Clyde emergency departments have some admitting rights to general medicine, but these are not consistent or comparable across the three sites. An electronic "SBAR" report comprising situation, background, assessment, recommendation is used to hand over patients. Depending on acuity, a patient may be seen by a doctor in the emergency department before being transferred. For all other specialties, the emergency department will contact the specialty doctor for review before being accepted for a bed within the specialty. If a patient needs to be transferred to another site, a referral is made by the emergency department doctor or consultant to the specialty team who would "accept" the patient, and bed management teams are made aware to plan for the offsite transfer.

Comparison with other emergency departments in Scotland

4.20. The Core Review Group agreed it was important to consider analysis of national data for emergency departments to provide context for the review. For the purpose of providing context, some established indicators were selected, and the data were analysed i) so the data for the three relevant hospitals in NHS Greater Glasgow and Clyde can be considered over a period of time, and ii) to understand how these three sites compare to other hospitals in Scotland. Some of the data presented here highlight challenges being experienced by healthcare systems across Scotland. In such instances, even if the data for the three NHS Greater Glasgow & Clyde sites are not markedly different from other hospitals across Scotland, the challenges for these three sites remain relevant.

4.21. It is important to note that, for the separate purpose of NHS Greater Glasgow and Clyde's work locally to understand and redesign/improve services, a fuller array of whole system measurement is required – together with the in-depth knowledge of local systems to use these data. While this is not the purpose of this section of the review, it is noted that the Centre for Sustainable Delivery has developed a data pack, specifically for use by NHS boards locally as part of their whole system redesign and improvement work.

4.22. To identify whether or not the data for the three emergency departments in NHS Greater Glasgow and Clyde are different from other hospitals, a valid comparator group was established. A peer group of ten other emergency departments in Scotland was established, as listed below, using the number of attendances to select an appropriate group.

4.23. Owing to the size of NHS Greater Glasgow and Clyde, it often has a notable influence on a dataset. For this reason, the NHS Greater Glasgow and Clyde sites are excluded from any measure of spread in the following analyses. The intention is to describe the performance of the peer group and then overlay the data for the NHS Greater Glasgow and Clyde sites onto this, to observe where NHS Greater Glasgow and Clyde sites fall in comparison to this range.

4.24. The peer group was selected by analysing the distribution of the monthly attendances for all emergency departments, to isolate the cluster of emergency departments related by the highest number of unplanned attendances.

4.25. The following ten hospitals were considered to comprise an appropriate peer group for the analysis carried out for this review:

- Aberdeen Royal Infirmary, NHS Grampian
- Forth Valley Royal Hospital, NHS Forth Valley
- Ninewells Hospital, NHS Tayside
- Royal Infirmary of Edinburgh, NHS Lothian.
- St John's Hospital, NHS Lothian
- University Hospital Crosshouse, NHS Ayrshire & Arran
- University Hospital Hairmyres, NHS Lanarkshire
- University Hospital Monklands, NHS Lanarkshire
- University Hospital Wishaw, NHS Lanarkshire
- Victoria Hospital, NHS Fife

4.26. Whilst these emergency departments are selected for broad similarity on number of attendances, there will also be differences among these hospitals on factors including demographics of the local population, case-mix, and models for delivering unscheduled care. In particular, implementation of the redesign of the urgent care pathway in late 2020, discussed in Paragraph 6.23 has varied across Scotland both in terms of how pathways are operating, and how related accident and emergency data is coded.[36] For more information on comparability of emergency department data, please consult Public Health Scotland's metadata page which has provided invaluable information for the purposes of this review.[37]

4.27. The figures included in this report are based on 'unplanned' emergency department attendances only, which has been standard for reporting accident and emergency activity. From February 2025 Public Health Scotland accident and emergency statistics include new 'planned' scheduled attendances by default.[38]

4.28. This method was devised to fulfil the specific objectives of this review of NHS Greater Glasgow and Clyde emergency departments and does not attempt to define an appropriate method for analysis of emergency department performance across NHS Scotland.

Four-hour waits

4.29. Figure 4.1 shows the performance of Queen Elizabeth University Hospital, the Royal Alexandra Hospital and Glasgow Royal Infirmary against the four-hour standard between 2017 and 2024. While this time is routinely referred to as a "wait", it describes the time spent in the emergency department until admission, transfer or discharge, including any time spent on treatment within the emergency department itself.

[36] Executive Summary - Health - redesign of urgent care: evaluation - main report - gov.scot. Scottish Government. January 2025.
[37] https://publichealthscotland.scot/healthcare-system/urgent-and-unscheduled-care/accident-and-emergency/metadata/data-quality/. Public Health Scotland.
[38] Performance monitoring - Overview - Accident and emergency - Urgent and unscheduled care - Healthcare system - Public Health Scotland. Public Health Scotland.

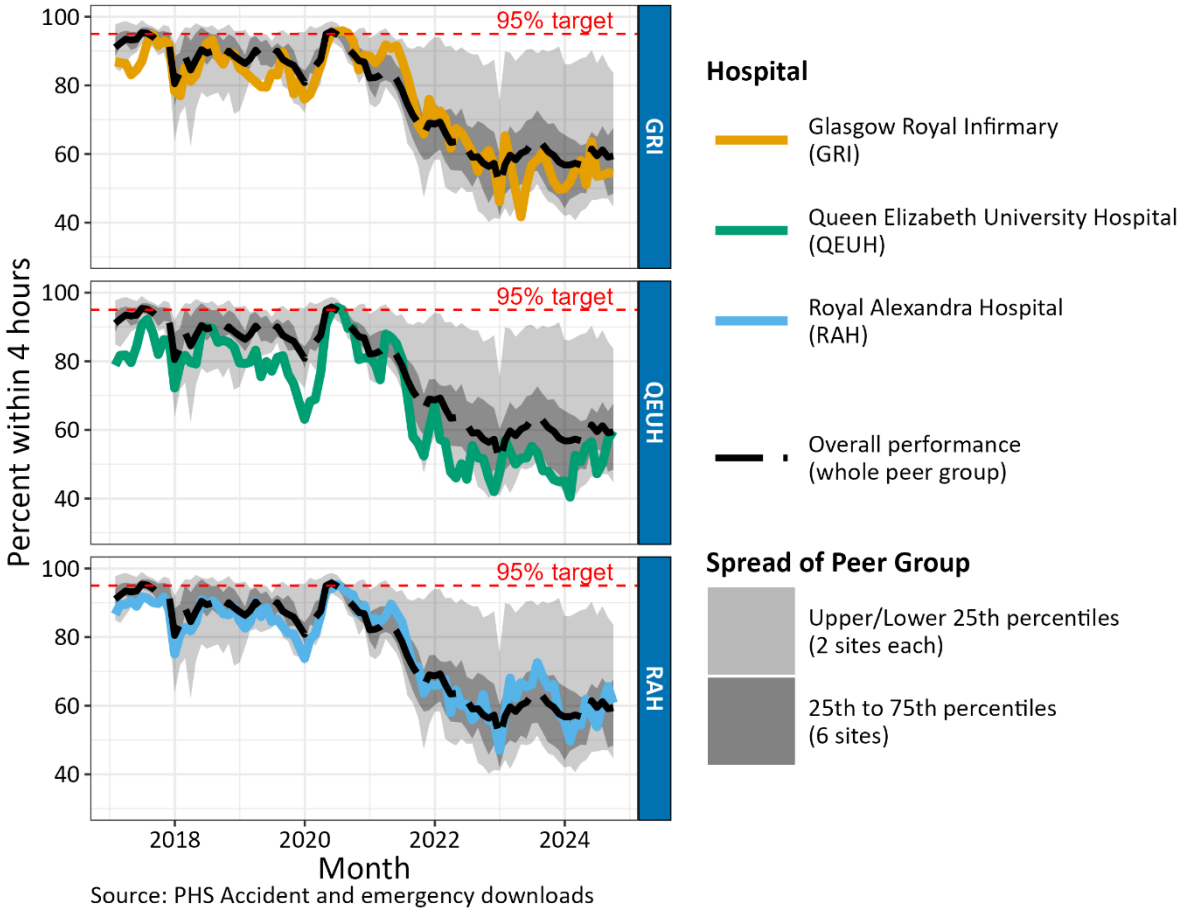


Figure 4.1: Emergency department performance among sites with highest attendances: percent admitted, transferred or discharged within 4 hours

4.30. The peer group is represented by the dashed black line (the overall performance of the emergency departments in the peer group) together with the grey shaded area. The shaded area shows the spread of the peer group and provides a background range of performance for the ten other Scottish emergency departments experiencing the highest numbers of attendances. We have used the interquartile range: for each month the dark band shows the range of the six sites in the middle of the peer group, while the lighter band either side shows the range of the two highest and two lowest sites. We have also presented this range over time: the order of sites can vary from month to month as each site's measure varies.

4.31. This allows analysis of the measures in two main ways. One is comparison of the NHS Greater Glasgow and Clyde emergency departments against a background distribution of emergency departments with similar numbers of attendances, showing where sites sit relative to each other. The other is comparison of the measures at different timepoints, both for the NHS Greater Glasgow and Clyde emergency departments and the peer group, showing whether the measure has gone up or down. A number of key observations were made from this chart:

The performance for this group of 13 highest attendance emergency departments in Scotland (three Glasgow plus ten peer group) in relation to the four-hour standard can be described in three phases:

- A pre-Covid phase during 2017 to 2019, where performance for the peer group overall and for each of the three NHS Greater Glasgow and Clyde sites was typically between 80% and 99%. The original 95% target (red dashed line) was consistently missed by a subset of the peer group and also all three sites.

- A peri-Covid phase where, similarly to time trend analysis for many healthcare metrics over this period, normal trends were severely disrupted. In this case, significantly reduced numbers of emergency department attendances (see later information on attendances) at the start of the 2020 national Covid 19 lockdown resulted in high performance on the four-hour standard. This was followed by a steep downward trend: by mid-2022 each of the three NHS Greater Glasgow and Clyde sites, as well as the peer group overall, had reached or passed below 60% on the four-hour standard.

- A post-Covid phase where, from early 2022, performance stabilises at a level lower than pre-Covid levels – varying between 40% and 75% for the three NHS Greater Glasgow and Clyde sites, and a wider range for the peer group.

4.32. These phases are relevant context, and they enable us to observe and compare the states of healthcare systems over time. The trends observed for this group of Scottish hospitals broadly mirror the trends in England. The King's Fund's conclusion that the sustained decline in performance in relation to the four-hour standard is a clear marker of the significant pressures on the health and care system also appears to be relevant for these Scottish hospitals. In addition, the post-Covid stable period is selected as a time period for closer analysis of all other measures used in this review.

4.33. There are also some important observations about how, over time, the data for each of the three NHS Greater Glasgow and Clyde sites compare with the peer group for the four-hour standard:

- Queen Elizabeth University Hospital's performance on the four-hour standard can be observed to be consistently lower than the overall peer group performance. This is particularly so in the pre-Covid phase where over three separate periods it sits below the range of the peer group. These periods of deviation from the peer group would be considered evidence that a site is performing at a level that is exceptional relative to the peer group. Post-Covid, Queen Elizabeth University Hospital remains largely within the grey shaded area below the overall performance, spending a roughly equal proportion of months in the

lower quartile (light grey band) and the interquartile range (dark grey band), putting it among the lowest-performing sites. There are two periods where Queen Elizabeth University Hospital is the lowest-performing site relative to the peer group: March, April and June of 2022 and January 2024.

- Glasgow Royal Infirmary can be observed to roughly track the overall performance of the peer group largely falling within the dark band. One major exception to this is in April 2023 where Glasgow Royal Infirmary's performance sits outside that of the peer group.
- The Royal Alexandra Hospital's performance tends to fall within the dark band, putting it in the middle of the peer group performance, particularly post-Covid.

4.34. Variation observed on the data over time also shows seasonality, with performance on the four-hour standard tending to be lower in winter than in summer. This is a known phenomenon in healthcare, also observed for hospitals in England.

4.35. These data demonstrate a marked drop against the four-hour standard among the largest emergency departments in Scotland. The exception to this is Ninewells Hospital, Dundee which despite resisting the large drop in performance over Covid, sees between 80% and 90% of unplanned attendances within four hours over the latter period of the data presented. Waiting time measures are reasonable indicators of problems within a system, but they do not provide explanations as to what the problems are, why they are occurring and how they might be addressed. While certain challenges may be shared between sites, no two sites will have an identical set of challenges with an identical set of solutions, and the challenges are unlikely to reside solely within the emergency department. Deeper analysis of the underlying data, conducted with and by those with knowledge of the local systems, processes and practices, is an important part of understanding and improving the situation in emergency departments both in NHS Greater Glasgow and Clyde and across Scotland. We present here a set of analysis that seeks to contribute to this process of understanding and improving. As mentioned previously, the Centre for Sustainable Delivery has produced a set of analysis at a more detailed level specifically for use by NHS boards locally as part of their whole system redesign and improvement work.

Longer waits

4.36. The standard for emergency department performance focuses on unplanned attendances that are admitted, transferred or discharged from the emergency department within four hours of arrival. Waits are also reported under eight-hour and 12-hour thresholds. These represent waits that are, progressively, potentially less safe. For some patients, increased delays to

assessment/treatment might result in them experiencing greater harm. A recent study by the Office for National Statistics found a relationship between time spent in emergency departments over and above two hours and the risk of post-discharge mortality, for patients requiring non-immediate care[39]. This risk was greater the longer time the patient spent in the emergency department, up to twelve hours and above. As such, the percentages of these longer waits are relevant when considering the safety of the healthcare system. The data presented below include only waits in emergency departments themselves, but the urgent and unscheduled care system involves a variety of pathways where waits can occur outside of the emergency department. These pathways, and the recording of waits and activity, varies by site across Scotland and are not routinely monitored or reported in the Public Health Scotland data.

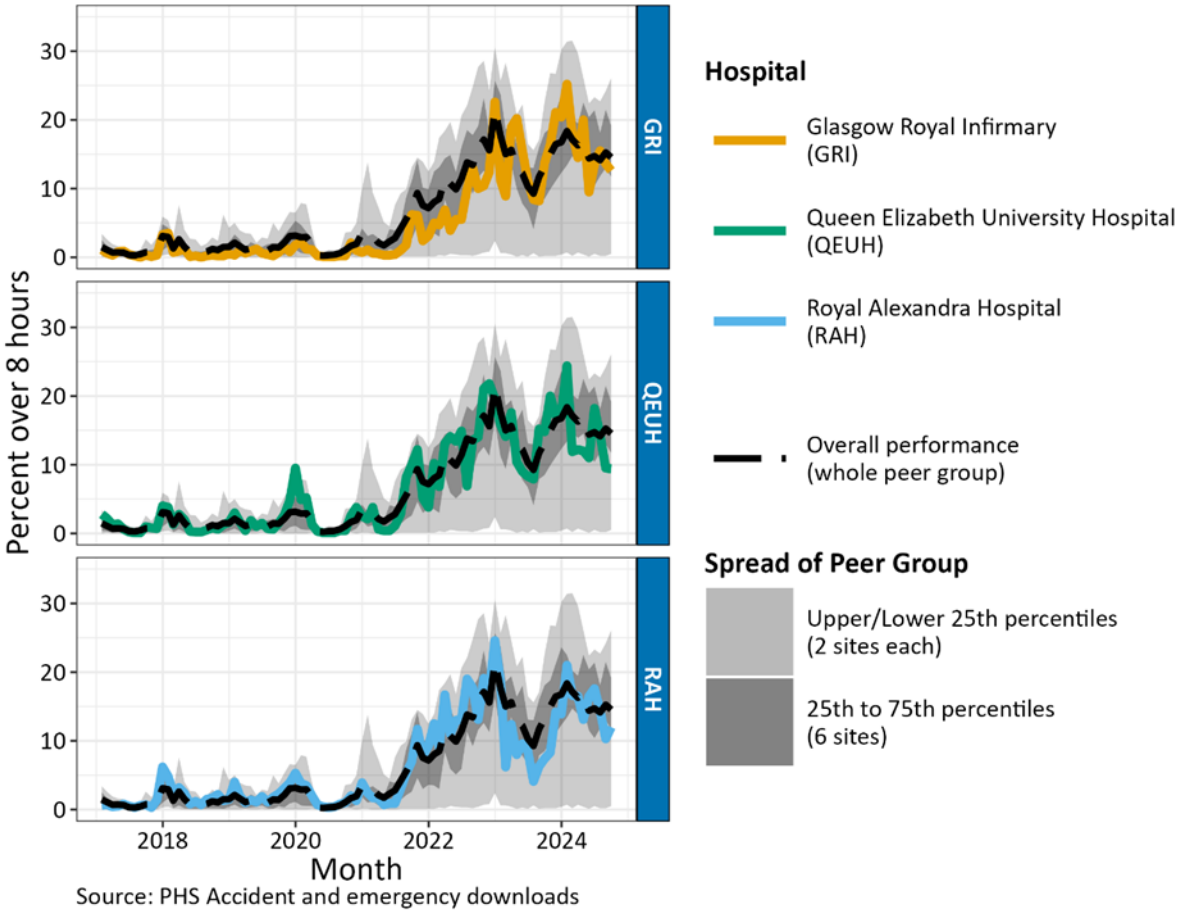
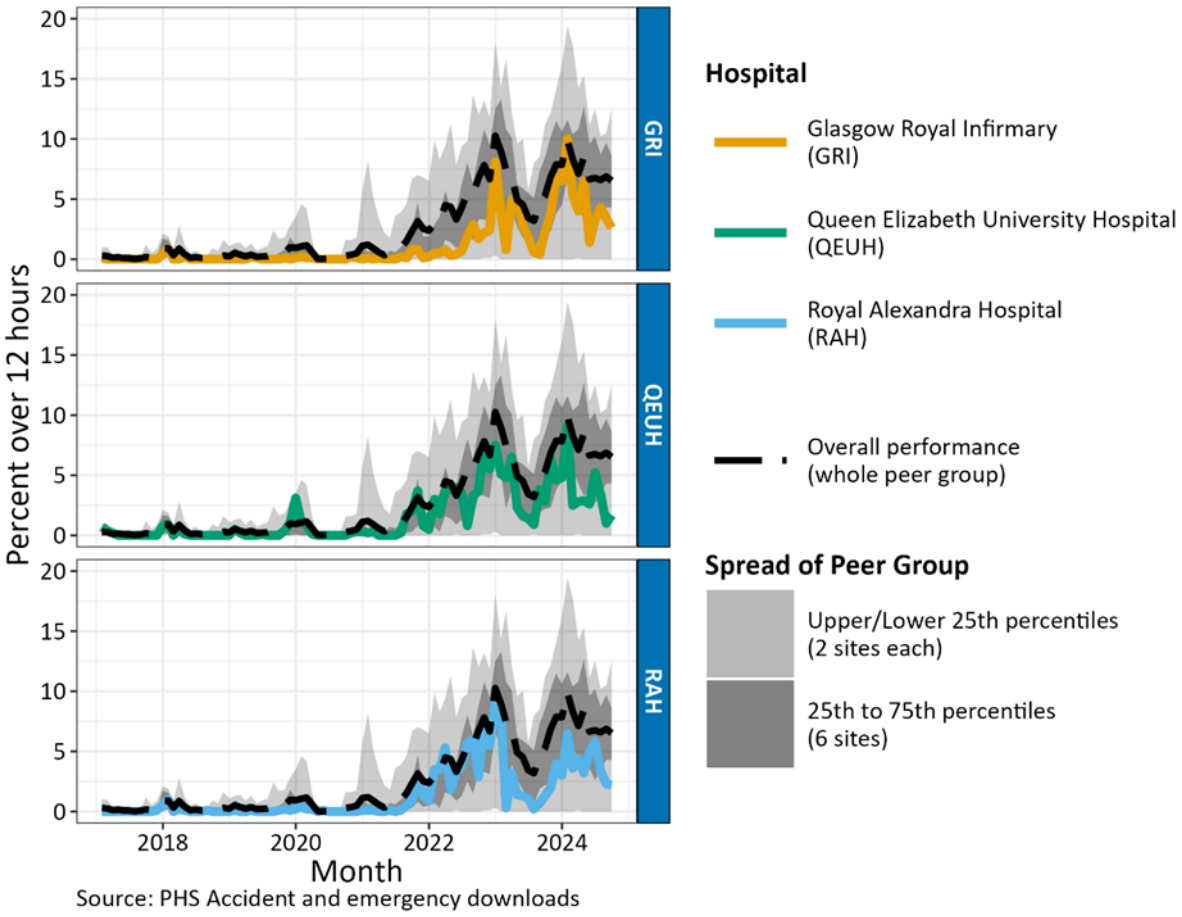


Figure 4.2: Emergency department performance among sites with highest attendances: percent admitted, transferred or discharged over 8 hours

[39] ONS website, statistical bulletin. Association between time spent in emergency care and 30-day post-discharge mortality, England: March 2021 to April 2022. Office for National Statistics (ONS). 17 January 2025. See also Jones S, Moulton C, Swift S, et al Association between delays to patient admission from the emergency department and all-cause 30-day mortality Emergency Medicine Journal 2022;39:168-173

4.37. Pre-Covid, emergency department waits of eight hours or more were a relatively rare occurrence. While they still happened every month since 2018, they peaked at around 10% of attendances at the very worst, with the overall peer percentage never exceeding 5%. The NHS Greater Glasgow and Clyde sites mirrored this pattern. Since 2021 these have risen steeply, and in the post-Covid phase, eight-hour waits are a more common occurrence. The overall percentage for the ten peer group sites has ranged from around 10% to 25% since 2022. Each of the three NHS Greater Glasgow and Clyde sites roughly tracks this overall percentage for the peer group.



Source: PHS Accident and emergency downloads

Figure 4.3: Emergency department performance among sites with highest attendances: percent admitted, transferred or discharged over 12 hours

4.38. A broadly similar pattern can be observed for the percentage of waits that are over 12 hours. In Figure 4.3 above, each of the three NHS Greater Glasgow and Clyde sites can be seen to consistently stay below the overall peer group in the post-Covid period.

4.39. It must be noted that these are waits of 12 hours and above, meaning that these data do not quantify the total length of wait.

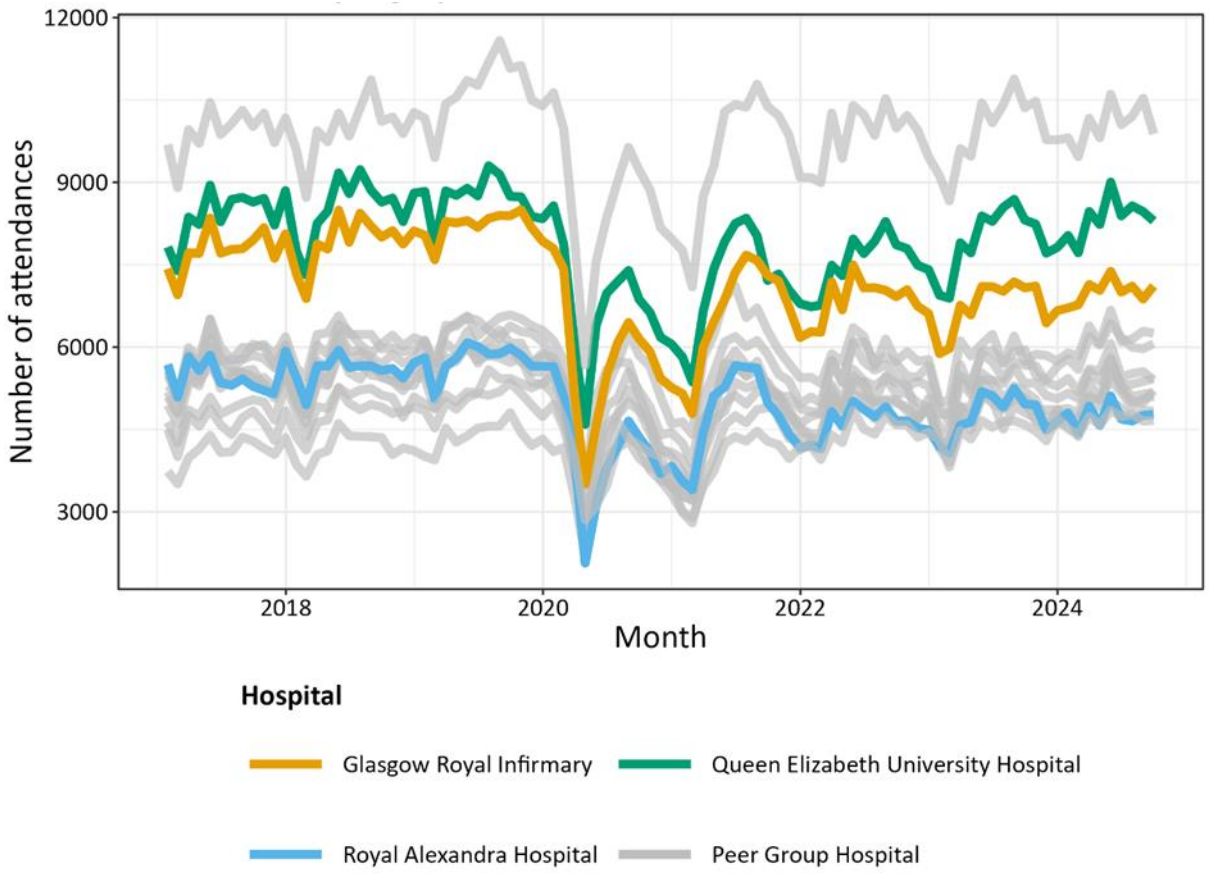
4.40. If eight-hour and 12-hour waits can be considered to be good proxy indicators of emergency department safety, then these data provide some evidence that, across Scotland, emergency department care is likely to be less safe now overall than it was pre-Covid. The three NHS Greater Glasgow and Clyde sites do not have a higher level of eight-hour and 12-hour waits compared with the peer group overall and indeed have a consistently lower percentage of 12-hour waits. By themselves, these data do not provide evidence that the emergency department care systems in NHS Greater Glasgow and Clyde are less safe compared with the peer group of hospitals from across Scotland. The data do, however, provide some evidence that in absolute terms the emergency department care systems in each of the three Greater Glasgow and Clyde sites have become less safe over time – as they have in the peer group. That long waits have been at this level for three years or more risks contributing to a perception that this is a normal state of affairs. In later chapters, the risks associated with the normalisation of potentially unsafe care is a common theme for the review.

4.41. It is important to note that this analysis of emergency department waiting times focuses on the percentage of all attendances for which the wait exceeds eight or 12 hours. However, these data do not describe which patients are experiencing these long waits or why they waited that long. To more fully understand the implications for patient safety associated with these long waits, then knowledge of local decision making needs to be considered. For example, to what extent do triage processes and hospital flow result in the most unwell patients being admitted, transferred or discharged from the emergency department without waiting excessively long? Discharges home after a long wait can indicate a lack of access to observation beds. What is clear is that the increase in waits of over eight and 12 hours represents a significant challenge to patient safety across Scotland.

Number of unplanned attendances at emergency departments

4.42. It was important to select an appropriate peer group in order to discuss the NHS Greater Glasgow and Clyde sites in context. These are large hospitals which, especially in the case of the Queen Elizabeth University Hospital, provide specialist (“tertiary”) care to patients from across Scotland. Number of unplanned attendances was used to select this group and is shown below.

4.43. Figure 4.4 shows the attendance pattern over time since 2017, as measured by the number of unplanned attendances to the emergency department for the three NHS Greater Glasgow and Clyde sites and the ten hospitals in the peer group.



Source: PHS Accident and emergency downloads

Figure 4.4: Number of emergency department unplanned attendances over time: NHS Greater Glasgow and Clyde sites and peer group sites

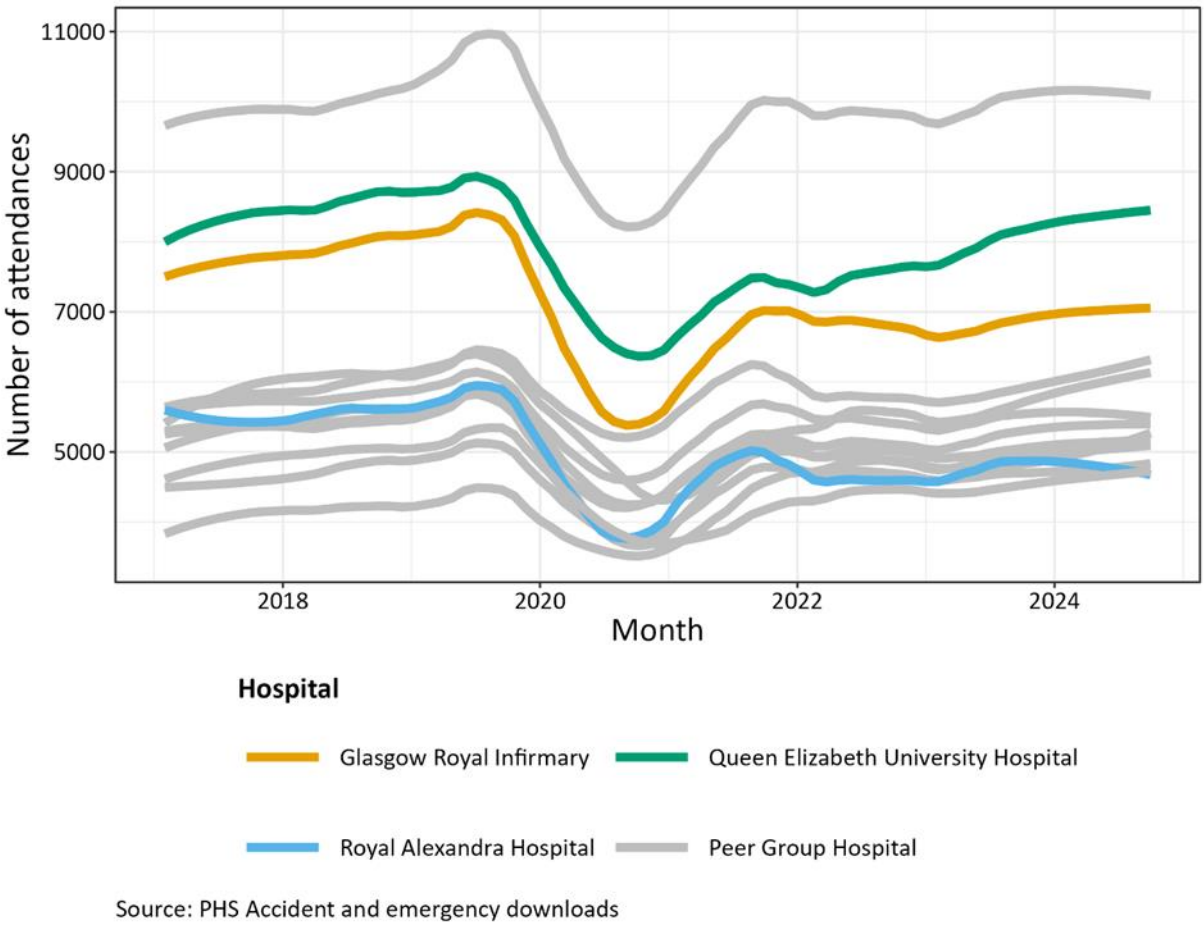
4.44. A number of key observations can be made:

The three phases described above, when considering performance on the four-hour standard, can also be observed here:

- Pre-Covid, attendances tended to increase.
- Peri-Covid, attendances dipped sharply, then cycled through peaks and troughs corresponding to national Covid lockdowns.
- Post-Covid, attendances restabilised.

4.45. There is strong seasonality, with higher numbers of emergency department attendances in summer. Although there are fewer emergency department attendances in winter, the King's Fund[40] highlighted that at this time of year there is increased demand for more intensive medical care and hospital admissions. This results in people waiting longer in emergency departments during the winter months. It is important to bear in mind that not every emergency department attendance is equal in terms of acuity and complexity, nor are the models of service delivery.

[40] https://www.kingsfund.org.uk/. The King's Fund.



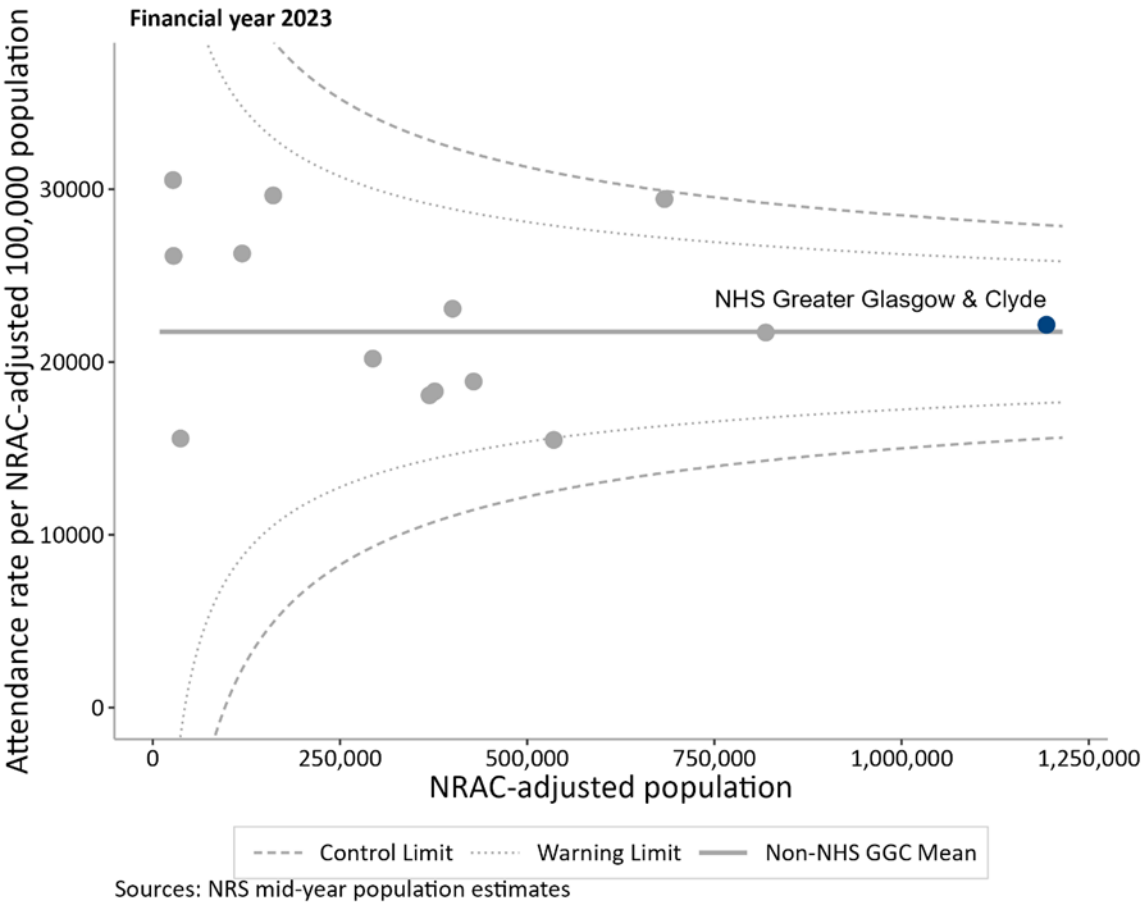
Source: PHS Accident and emergency downloads

Figure 4.5: Number of unplanned emergency department attendances over time: NHS Greater Glasgow and Clyde sites and peer group sites (smoothed)

4.46. In Figure 4.5 above, the attendances have been smoothed in order to get a sense of the underlying pattern. The post-Covid increase in emergency department attendances can be seen to be strongest for Queen Elizabeth University Hospital, where it is still climbing. Whilst this may relate to the change in the Queen Elizabeth University Hospital status to a Major Trauma Centre, it has significant implications for emergency department flow. For Glasgow Royal Infirmary and the Royal Alexandra Hospital, the number of emergency department attendances post-Covid has stabilised at a lower level than pre-Covid.

4.47. These data describe only volume of attendances and give no indication of the acuity or complexity of attendances. Some indication of acuity or complexity is provided in this section, for example a comparatively high admission rate from Queen Elizabeth University Hospital emergency department attendances, and later some indication that unscheduled length of stay is comparatively long for NHS Greater Glasgow and Clyde as a whole. Whilst there is no one "measure" for complexity or acuity for the range of conditions, episodes and/or injuries that an emergency department might encounter, paragraph 3.23 refers to some early indications that a significantly higher proportion of patients admitted to hospital

(from anywhere) are: (i) aged 60 years and over, and (ii) have a higher number of prior morbidities.



Sources: NRS mid-year population estimates
PHS Accident and emergency downloads
PHS Resource Allocation Formula (NRAC) 2023/24

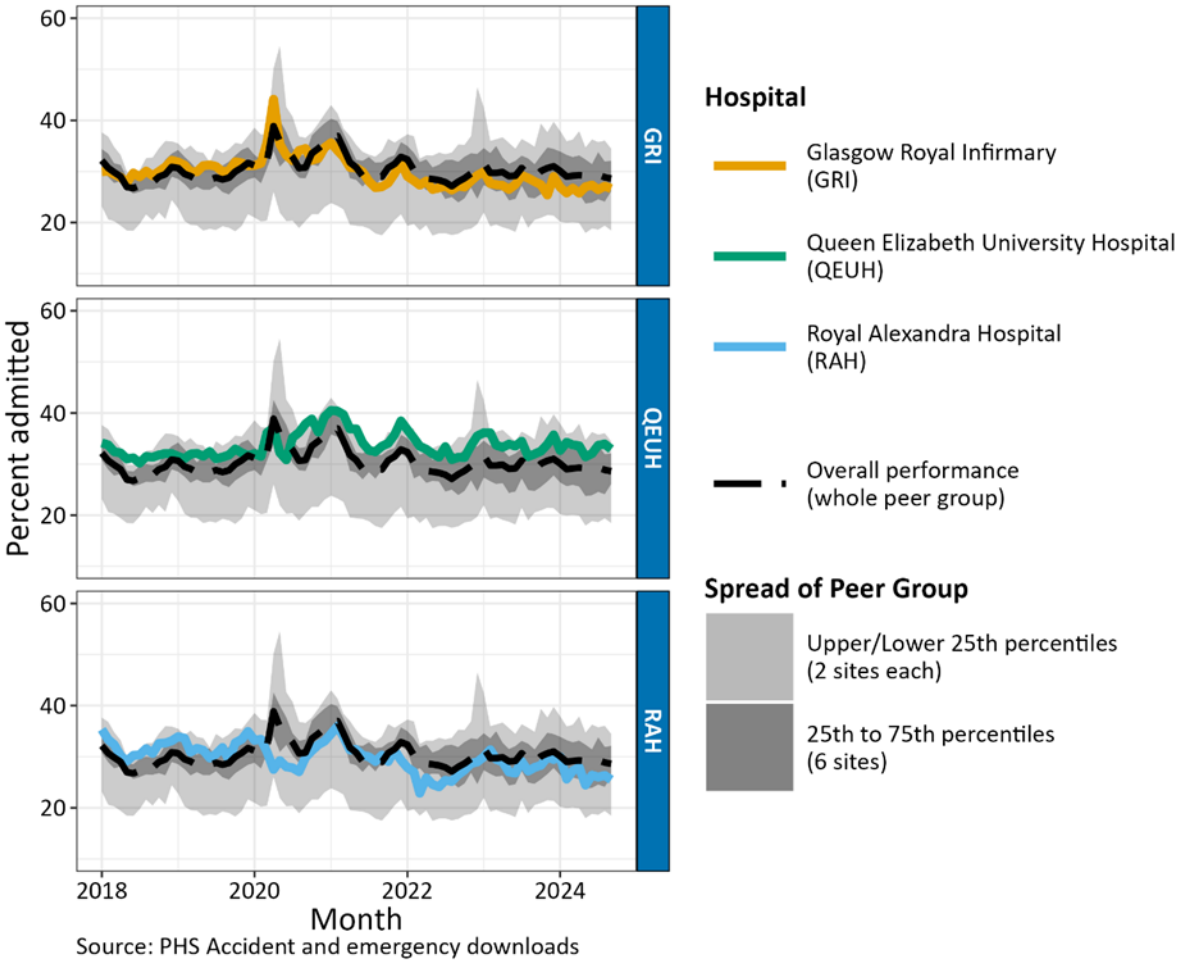
Figure 4.6: Rate of emergency department attendances by NRAC-adjusted population

4.48. Figure 4.6 above shows emergency department attendances per 100,000 head of population. The populations of each NHS board have been adjusted by the national resource allocation formula (NRAC) which normalises populations on age, sex, morbidity and life circumstances and rurality. As with all comparisons produced in this report, NHS Greater Glasgow and Clyde is not included within the calculation of the measure of spread, it is overlaid onto the chart afterwards. Whole NHS boards are presented, and all NHS boards are included within the funnel plot, as the measure is adjusted for population.

4.49. Despite NHS Greater Glasgow and Clyde not being included within the calculation of the measures of spread, it sits almost exactly on the mean for emergency department attendances for other NHS boards across Scotland. This suggests that, taking into account some important characteristics of local populations, the rate of emergency department attendances is not unusual for the population of NHS Greater Glasgow and Clyde.

Admissions from the emergency department to the hospital

4.50. Also considered were data on the percentage of emergency department attendances that were subsequently admitted to the same hospital as inpatients/day-cases. Interpretation of the percentage admitted from the emergency department depends on the service and the pathways in operation. The measure is sensitive to policies that are effective at redirecting patients away from the emergency department and streaming patients towards the emergency department. Figure 4.7 below shows that, following the onset of the Covid 19 pandemic, the Queen Elizabeth University Hospital appears to be admitting a higher percentage of patients from its emergency department than it was pre-Covid. During the time period corresponding to the Covid 19 pandemic, Queen Elizabeth University Hospital had among the highest rate of admissions following an attendance at the emergency department relative to the peer group. Post-Covid the Queen Elizabeth University Hospital rate of admissions remains high relative to the peer group, though this is not as pronounced as during Covid.

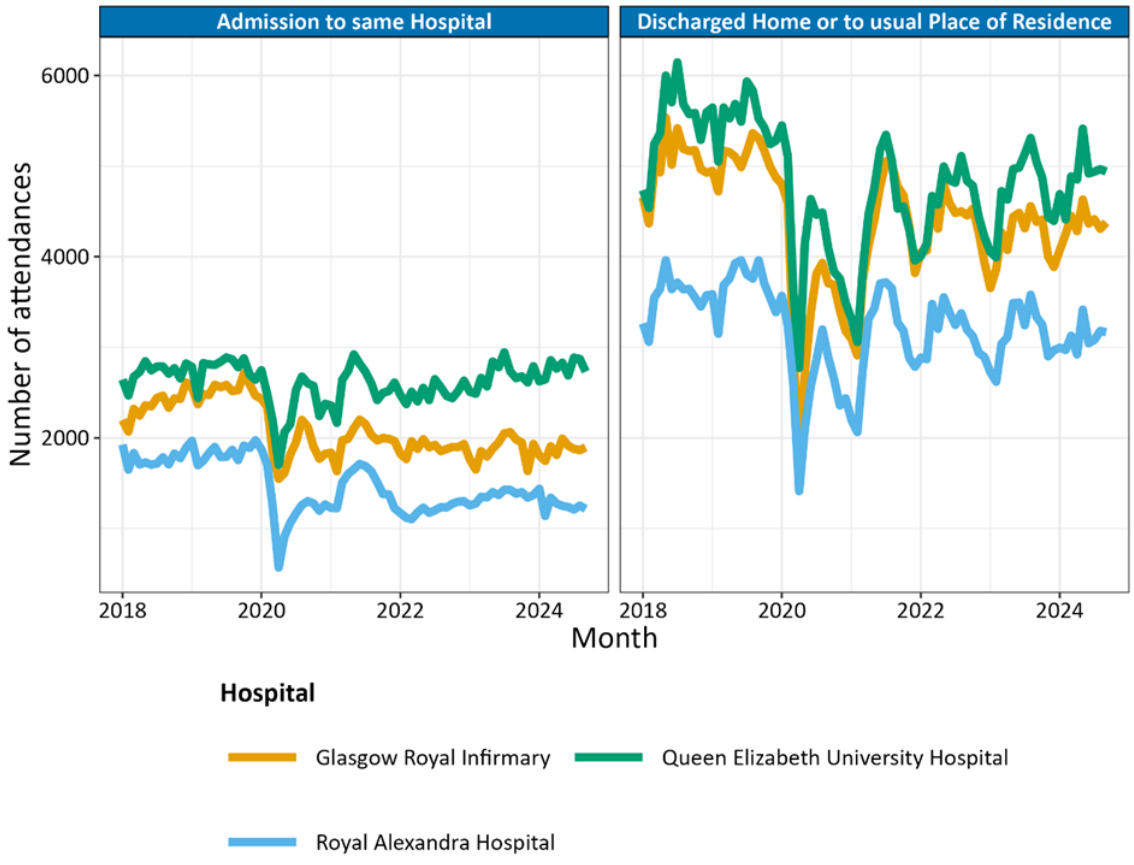


Source: PHS Accident and emergency downloads

Figure 4.7: Percentage of emergency department attendances admitted to same hospital: NHS Greater Glasgow and Clyde site against peer group spread

4.51. Again, knowledge of the local system is required to understand which factors are influencing the level of emergency department attendances at the Queen Elizabeth University Hospital that are then admitted to hospital. Other pathways for unscheduled care that do not pass through emergency departments exist. Additionally, and as noted in paragraph 4.26, recording of activity in short stay urgent and unscheduled care services is not consistent across Scotland, therefore comparisons with other sites should be treated with caution.

4.52. Attendance at an emergency department can primarily result in admission to hospital or discharge home or to usual place of residence. In Figure 4.8 we can see the divergence of the NHS Greater Glasgow and Clyde sites on percentage admissions to same hospital is based on the balance between these two destinations. While the number of admissions to Glasgow Royal Infirmary and the Royal Alexandra Hospital drops during the Covid 19 pandemic and settles at a level lower than before, Queen Elizabeth University Hospital's admissions drop to a much lesser extent, and by 2024 had rebounded to the same level as pre-Covid. There was a concurrent drop in the number of attendances that were subsequently discharged from all three sites. This may be a result of redirection policies aimed at providing care via an alternative to the emergency department, resulting in fewer attendances that result in discharge.

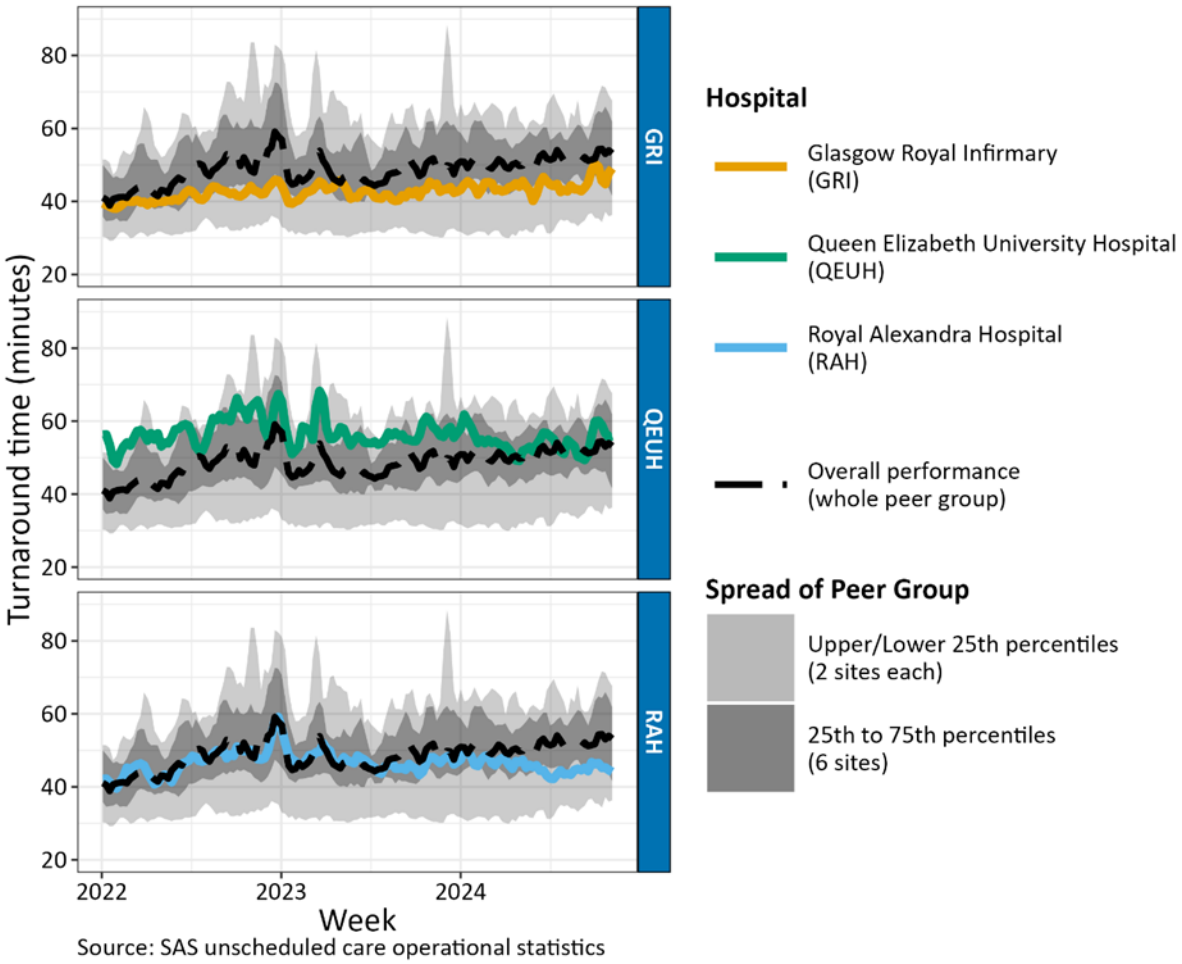


Source: PHS Accident and Emergency downloads

Figure 4.8: Number of emergency department attendances by destination

Ambulance turnaround times

4.53. Ambulance turnaround times can also be useful indicators of how the healthcare system is performing. Ambulance care (the Scottish Ambulance Service calls this pre-hospital care) aims to assess, stabilise and convey patients to the hospital, where they can be further assessed and treated appropriately. Ambulance care should end almost immediately on arrival at the emergency department; however, delays can occur when ambulances are unable to hand patients over due to departments having no capacity to receive them. Ambulances stacking outside emergency departments is indicative of blockages to patient flow through the hospital site signalling significant pressures on the healthcare system. Along with the associated challenges of patients being assessed and treated timeously, so is the urgency of enabling ambulance crews to promptly get back on the road to attend to other patients.



Source: SAS unscheduled care operational statistics

Figure 4.9: Ambulance turnaround times: Three week rolling mean of weekly median turnaround time, NHS Greater Glasgow and Clyde sites and peer group

4.54. Median turnaround times for each NHS Greater Glasgow and Clyde site have been compared against the peer group. Turnaround times are published as weekly medians; therefore, a three-week rolling average has been used to smooth the granular weekly numbers whilst maintaining broad trends in the data and significant peaks/troughs. Each data point is the mean for that week and the week either side.

4.55. Ambulance turnaround times are consistently higher for the Queen Elizabeth University Hospital than for the peer group overall throughout 2022 and 2023, occasionally sitting above the range of the peer group, before dropping to meet the peer group median in 2024 at 50-55 minutes. March 2023 appears to be a particularly challenging time for the Queen Elizabeth University Hospital, with turnaround times peaking above 65 minutes. This is shortly prior to the time of the initial letter to Healthcare Improvement Scotland raising concerns (see Appendix 1). This was also preceded by a period of higher turnaround times at all three NHS Greater Glasgow and Clyde sites, as well as the peer group, at the end of 2022 which appears to be a time of significant pressure across the country.

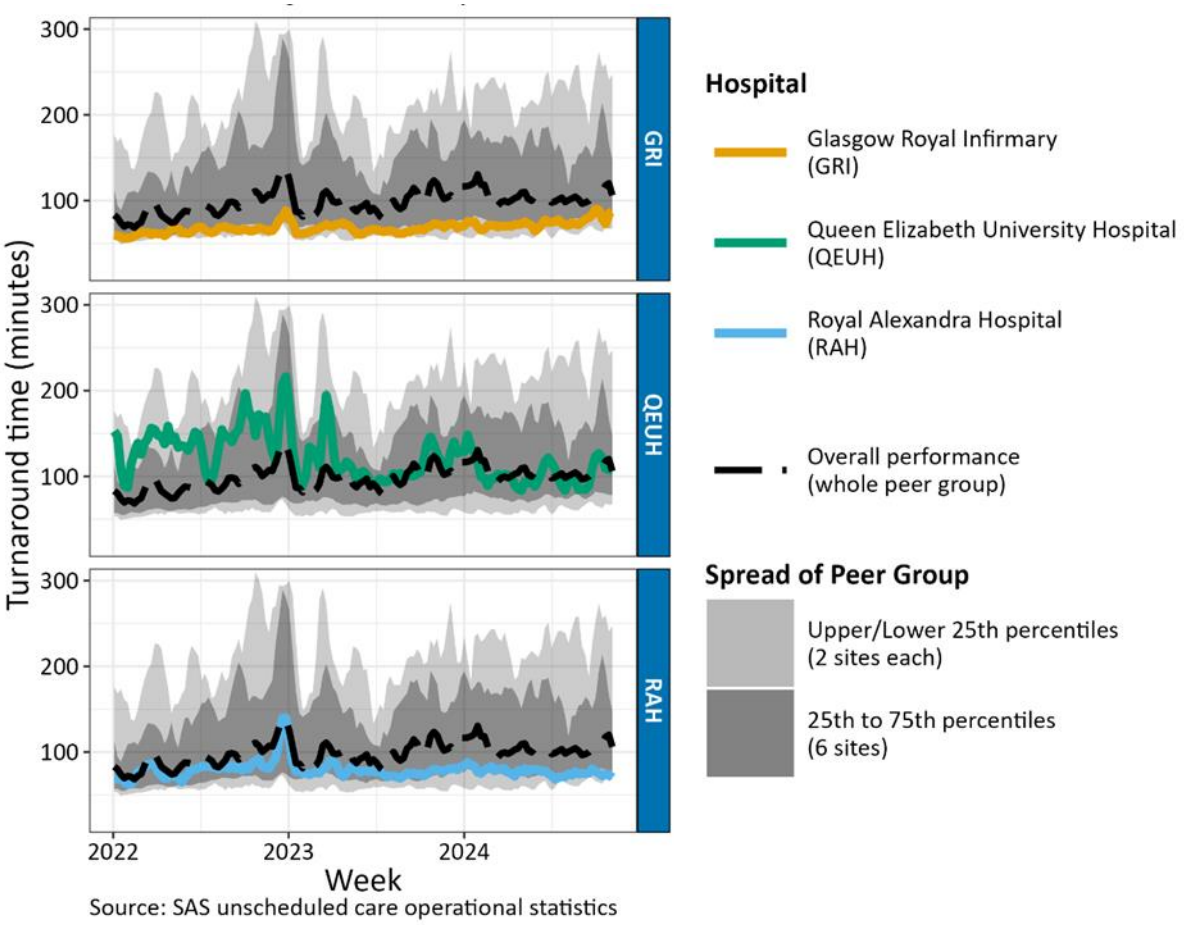
4.56. Whilst initially the Royal Alexandra Hospital tracks the median for the peer group, from mid-2023 it has consistently shorter ambulance turnaround times. Turnaround times for the Glasgow Royal Infirmary have risen steadily over the three-year period. For both these hospitals, turnaround times throughout 2024 have been around 45 minutes.

4.57. In terms of the waiting times statistics, the official start time for the four-hour standard (for those patients arriving by ambulance) is the time at which the ambulance arrives at the emergency department. The turnaround time includes any time spent waiting to hand over the patient, and also the time it then takes to prepare the ambulance to leave the emergency department (cleaning down, replenishing supplies etc). In an optimally performing system, the turnaround time would represent only the time taken to refit the ambulance, with a minimal time taken to hand over the patient after arrival. There is a long-term aim for handover of a patient conveyed by ambulance to hospital of 15 minutes[41].

4.58. Approaches to corridor-care, cohorting and offloading differ between NHS boards and indeed between sites. Whilst approaches like cohorting and corridor care may offer some level of surge capacity in exceptional circumstances, they are unlikely to have a significant impact on turnaround times. It is generally understood that variation in ambulance turnaround times relate to the ability of emergency departments to provide cubicle space, which is in turn a product of upstream (demand), downstream (acute hospital) and on-site (emergency department capacity) factors.

[41] Principles for Safe Transfer to Hospital: Ensuring the Timeous Handover of Ambulance Patients

4.59. Whilst median turnaround times show the middle value of turnaround times, 90th centile turnaround times show the length of time above which 10% of the longest waits occur. 90th centile turnaround times are sensitive to extreme situations where ambulances are unable to offload patients and are forced to wait outside hospital. Figure 4.10 below shows that Queen Elizabeth University Hospital was high relative to the peer group for much of 2022, though within the range of values experienced by the peer group. Two periods, the end of 2022 in particular December of 2022, and March of 2023, demonstrate particularly high 90th centile turnaround times. By the middle of 2023 these had returned to levels resembling the peer group median.



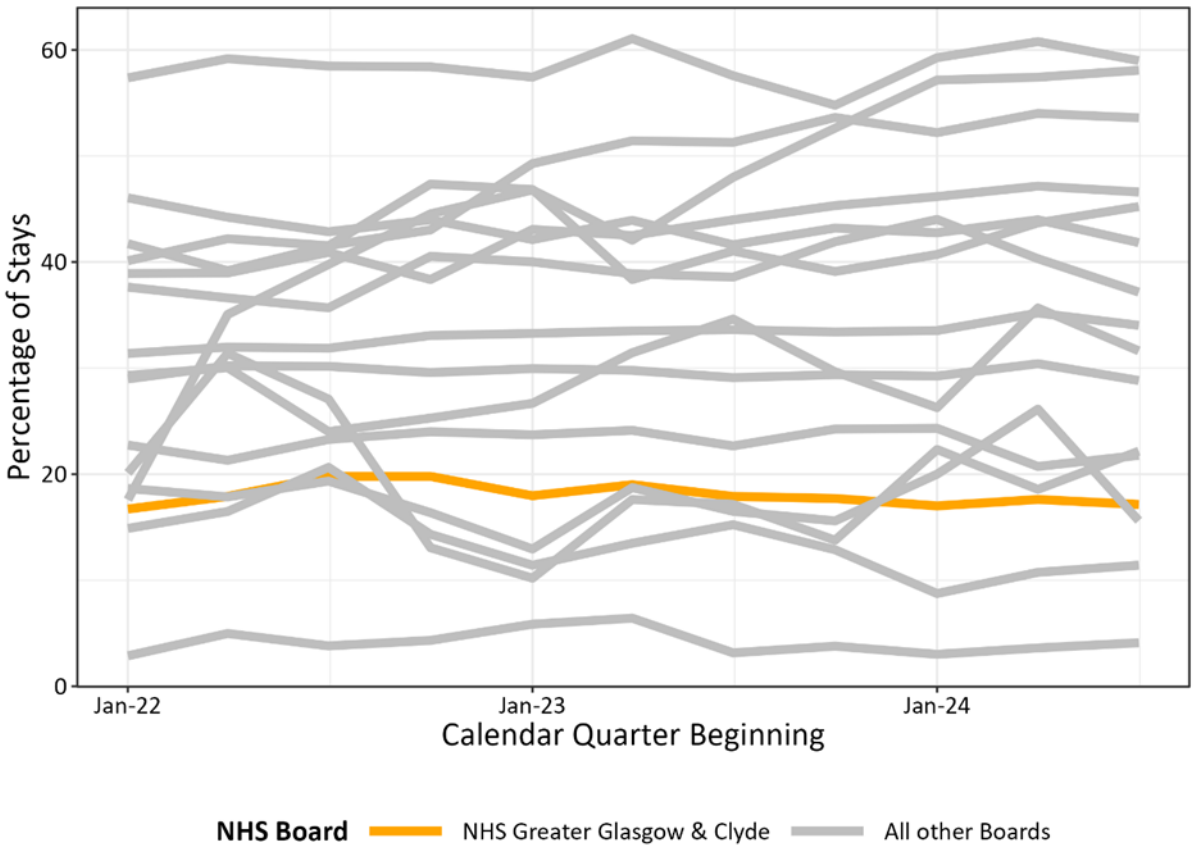
Source: SAS unscheduled care operational statistics

Figure 4.10: Ambulance turnaround times: three week rolling mean of weekly 90th centile turnaround time, NHS Greater Glasgow and Clyde sites and peer group

4.60. This consistently high level of 90th centile turnaround times in 2022 and into 2023 described an emergency department that was experiencing significant difficulties accepting patients into the emergency department. 90th centile turnaround times then improved and have remained close to the level for the peer group overall.

Length of stay

4.61. Length of stay refers to the amount of time (usually measured in days for inpatient care) a patient spends in a particular care setting – this can be a single specialty, a single hospital, or an entire care journey involving multiple settings. How long a patient stays in hospital will be strongly related to the acuity and complexity of their condition, but it can be affected by external factors such as delays to discharge (see paragraph 4.71). Generally, both patients and clinical staff have an interest in minimising length of stay, as outcomes worsen with increasing length of stay even after accounting for acuity (i.e. it would be expected that sicker patients have longer stays). In addition, minimising length of stay also helps with hospital flow. This is because a higher turnover of patients means beds become free faster, and also wards can plan and allocate better in terms of discharging patients to admit others. Length of stay is therefore particularly relevant to managing the flow of unscheduled patients into the hospital from the emergency department.

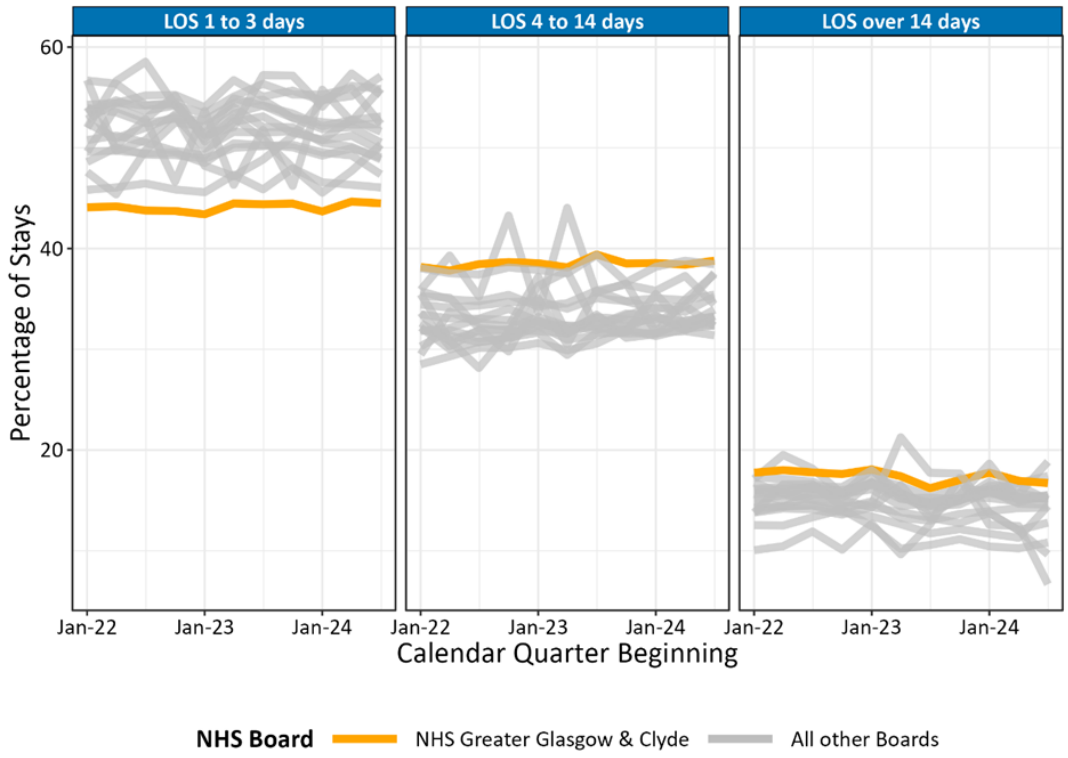


Source: PHS Discovery CIS length of stay (treatment)

Figure 4.11: Percentage of continuous inpatient stays with zero day length of stay: all zero day CIS beginning with an unscheduled admission to the NHS Greater Glasgow and Clyde sites

4.62. Figure 4.11 above shows the percentage of continuous inpatient stays lasting less than one day for stays resulting from an unscheduled admission, reflecting the delivery of same day care for unplanned admissions. These data are representative of acute and community sites across the entire of NHS Greater Glasgow and Clyde, but the three sites included in this review make up the vast majority of the admissions represented in the data. NHS Greater Glasgow and Clyde can be seen to show a quarterly percentage of between 16% and 20% for the years 2022 through 2024, meaning that between one in five and one in six unscheduled admissions are discharged on the same day. This is towards the lower end of all NHS Scotland boards. Same day care can be a reflection of acuity and complexity, but it can also be influenced by local processes and senior decision makers. Understanding whether a higher percentage of same day care could be delivered, and in which specialties, could provide opportunities to improve flow, to the benefit of both patients and the emergency department.

4.63. In Figure 4.12 below, the length of stay for unscheduled admissions for each NHS board is shown, in bands of short (1-3 days), medium (4-14 days) and long (over 14 days). Stays of less than one day are removed from the data for the purpose of calculating percentages of total stays. The location of continuous inpatient stays is based on the location of admission, but it is important to note that a continuous inpatient stay can consist of multiple spells in different locations, including different hospitals and NHS boards.



Source: PHS Discovery CIS length of stay (treatment)

Figure 4.12: Percentage of continuous inpatient stays by length of stay: All non-zero day CIS beginning with an unscheduled admission to the NHS Greater Glasgow and Clyde sites

4.64. For all NHS boards, roughly half of all non-zero-day unscheduled stays last between one and three days, with progressively fewer stays lasting between four and 14 days, and over 14 days. In the national context, NHS Greater Glasgow and Clyde has the lowest proportion of stays lasting between one and three days, and among the highest proportion of stays lasting four days or more.

4.65. Since case-mix, demographics and other factors will influence length of stay, this relative positioning of NHS boards using non-adjusted percentages might be expected: as a regional admitting centre NHS Greater Glasgow and Clyde sites will admit higher acuity cases, and Glasgow's population experiences more deprivation than many other places in Scotland. However, since long stays are likelier to result in worse outcomes this presents a significant challenge to unscheduled care in NHS Greater Glasgow and Clyde.

4.66. This pattern represents a challenge to flow within NHS Greater Glasgow and Clyde. Regardless of whether this relative positioning is expected, a higher degree of longer stays makes it more difficult to plan and allocate the finite number of beds, staffing and equipment required as part of a hospital stay. Faster turnover for stays of one to three days means higher throughput, meaning that receiving wards are more able to accept patients from the emergency department. Slower and more variable turnover for stays lasting four days or more means patients move through the hospital system at a slower rate, leading to blockage of beds for patients transitioning out of the emergency department (and between wards). A deeper local analysis of specialty-level length of stay may provide opportunities to examine where bottlenecks in the system might be arising. The Centre for Sustainable Delivery have been conducting such analysis for use locally as part of conversations directed towards improvement.

Bed occupancy

4.67. Bed occupancy is the percentage of beds occupied and is a key indicator of pressure in a hospital. There is no agreed standard for bed occupancy, but pragmatically hospitals with occupancy of more than 90% are operating at maximum capacity.[42] [43] High bed occupancy throughout a hospital can be expected to make it hard to find beds for unplanned admissions, increase delays in emergency departments, cause patients to be placed in non-standard care areas, reduce the nurse-to-patient ratio, and increase the rate of hospital-acquired infections.

[42] https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/
[43] https://www.nice.org.uk/guidance/ng94/evidence/39.bed-occupancy-pdf-172397464704

4.68. Before 2020, the average available staffed acute beds (for both planned and unplanned admissions) that were occupied for each of the three NHS Greater Glasgow and Clyde sites in this review was approaching 90%. During the Covid 19 pandemic, bed occupancy fell but then increased above pre-pandemic levels. During 2022/23 and 2023/24, occupancy for each of the three sites averaged over 90%. These hospital-wide occupancy rates can obscure the fact that some specialties are consistently operating above this figure, and that it is likely that there are periods when some specialties experience occupancy of 100%.

4.69. These trends correspond with performance against the four-hour standard and lend support to the concept of exit block within NHS Greater Glasgow and Clyde emergency departments. Exit block in this context of this report refers to inability to move patients out of the emergency departments into hospital beds. Further analysis may explore what underlies the rise in occupancy above levels that would allow for good flow. Has the number of staffed beds changed over time or is this a factor of efficient use of beds in the wider hospital? The use of community beds as a whole-system resource is an avenue for relieving occupancy within a system that at a high-level is operating at maximum capacity.

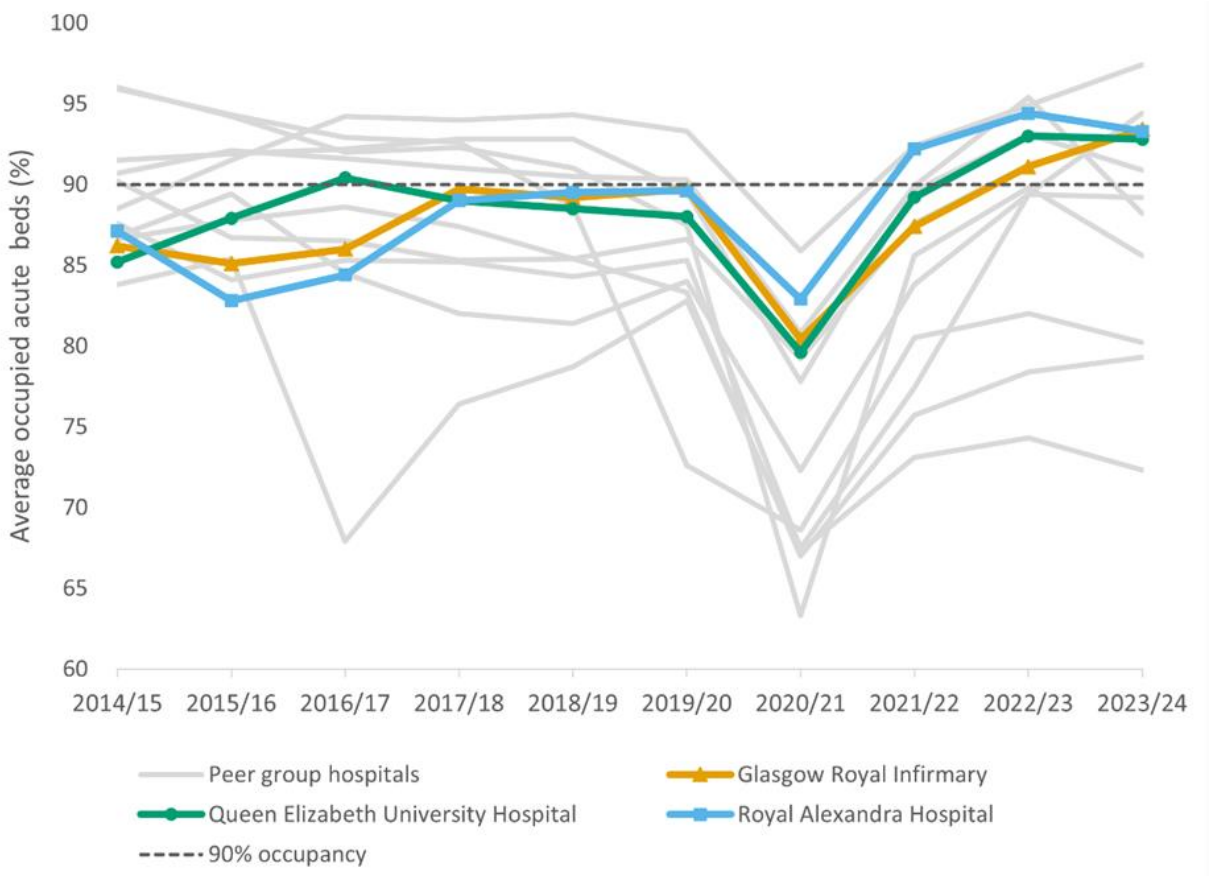


Figure 4.13: Average percentage of occupied acute staffed beds (planned and unplanned admissions)
Source: PHS ISD(S)1

Delayed discharges

4.70. When patients are not discharged from hospital when they are ready, fewer beds are available for new patients who need a bed, including patients coming from an emergency department. Reasons for delays come under three categories: *Health and Social Care reasons* where a person remains inappropriately in hospital after treatment is complete and is awaiting appropriate arrangements to be made by the health and social care partnership for safe discharge; *Patient, family and carer related reasons* which includes delays due to legal reasons and disagreements; and *Code 9 complex reasons* where it is acknowledged that some discharge arrangements may be more complex due to the specific care needs of the person. Delays at discharge from the acute hospital can lead to longer waiting times for patients in the emergency department who need to be admitted.

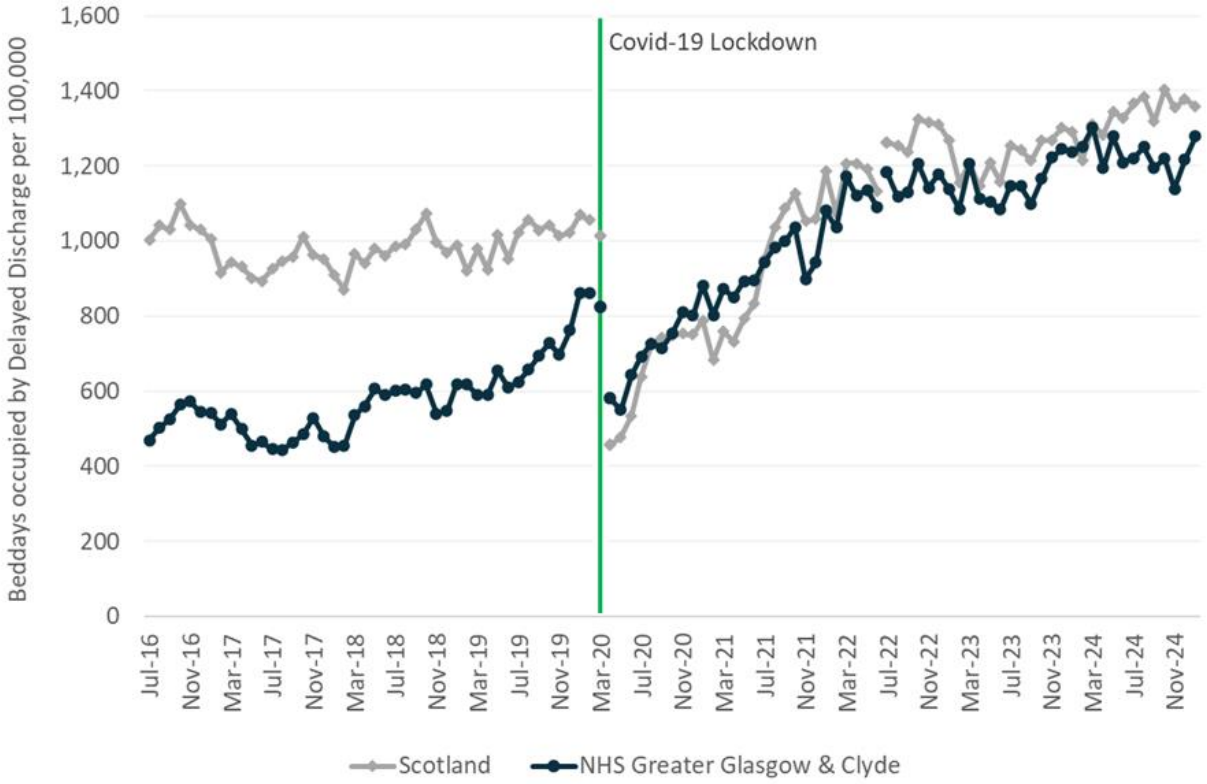


Figure 4.14: Bed days occupied by delayed discharges, adjusted for population

4.71. In NHS Greater Glasgow and Clyde, the number of bed days occupied by patients delayed at discharge started to increase pre-Covid, from around 4,500 bed days a month in 2017/18 to over 8,000 bed days at the start of 2020. With admission to hospital restricted during Covid, bed days occupied by delayed discharges fell abruptly, before increasing steadily and in 2024 reaching almost 12,000 bed days a month. The published delayed discharge figures presented in Figure 4.14 cover both acute hospitals and mental health services meaning these are not exclusively delays experienced as part of an acute stay. This near tripling of the bed resource occupied by patients waiting to leave hospital since 2017/18 in this NHS board must be treated with caution, however it is likely to represent a significant challenge to good patient flow. Figure 4.14 above shows these numbers as a rate per population. NHS Greater Glasgow and Clyde had a level of delayed discharges that was consistently lower than the national level before the pandemic, and it has then had a similar rate to Scotland over the subsequent four years.

5. Patient Experience

This section sets out the results of a bespoke patient experience survey carried out for the review. The survey was designed to obtain a representative sample of patients' views on the care that they received in the emergency departments at Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital. It also includes recommendations based on the survey findings.

Patients reported a largely positive experience of care within the three emergency departments in NHS Greater Glasgow and Clyde. This is a powerful validation of staff's commitment to caring for patients despite the challenges they face. Care was broadly reported to be provided in a person-centred way, delivered with dignity and respect. However, a quarter of patients did not receive a positive experience of care, with some reporting serious concerns. Patients want to see improvements in waiting times in emergency departments and on the communication, they receive about waiting. Patients had mixed feelings about how safe they felt in emergency departments: they reported feeling safe with staff, but less so around other patients or visitors.

Introduction

This chapter reports patients' views of care in the three emergency departments in NHS Greater Glasgow and Clyde. Importantly, views were collated from a randomised, stratified sample of patients with a recorded attendance at one of the three emergency departments to ensure they reflected experiences at these specific locations and to minimise self-selection bias. To consider whether these findings could be applicable in other NHS boards in Scotland, a comparison of patient experience was undertaken using published stories from other NHS boards. This found that patient experience was similar in all boards and therefore it is likely that many of the recommendations from the patient experience survey in NHS Greater Glasgow and Clyde could apply to other emergency departments experiencing high demand.

Patient experience survey: key findings

5.1. Most patients reported a positive experience of care at the emergency departments. Three quarters of respondents (75%) rated their care as very good or good, 9% as neither good nor poor, and 16% rated their care as poor or very poor.

5.2. The majority of patients reported being treated with dignity and respect while receiving care at the emergency department. Almost 9 in 10 (88%) felt they were 'yes, definitely' treated with dignity and respect or 'yes, to some extent'. In terms of privacy, around the same figure (89%) felt they 'yes, definitely' had enough privacy or 'yes, to some extent' when discussing their condition with staff.

5.3. Patients wanted to see improvements around waiting in the emergency department, in terms of both communication about waiting times, the length of the waiting and the care provided while waiting: 45% felt uninformed about their wait time. 56% reported they were not kept updated during their wait. 64% reported they received appropriate care while waiting (meeting all or some of their needs), however 25% reported not receiving appropriate care.

5.4. The majority of patients reported that staff delivered person centred care: 89% felt staff 'yes, definitely' or 'yes, to some extent' listened to them. 87% 'yes, definitely' or 'yes, to some extent' understood the explanations given about their condition. 82% 'yes, definitely' or 'yes, to some extent' had enough time to discuss their care. 71% 'yes, definitely' or 'yes, to some extent' felt involved in decision-making regarding their care although almost a quarter (24%) said they were not involved in decision-making regarding their care.

5.5. In terms of patients' perception of their personal safety in the emergency department, 83% responded that they definitely felt safe with staff. In contrast, only 58% of patients definitely felt safe with other patients and visitors to the department, with 28% feeling safe to some extent, 1 in 10 (11%) saying they did not feel safe, and 3% of respondents did not know or could not remember.

5.6. When asked about follow-up care before departure 68% of respondents said staff 'yes, definitely' or 'yes, to some extent' discussed follow-up care before departure, while around a quarter (24%) stated this did not occur, and 8% did not know or could not remember.

5.7. In terms of giving feedback about their experience, almost three quarters of respondents (72%) said they were not asked for feedback by staff. Just over 1 in 10 (12%) said they were 'yes, definitely' asked for feedback or were to some extent. Of those that gave feedback 3 in 10 (30%) felt their feedback was 'yes, definitely' valued or valued to some extent, with around the same proportion (27%) feeling it was not valued. A further 43% did not know or could not remember if their feedback had been valued.

5.8. Respondents were asked to highlight suggestions for improvement in an open question box, and many people used this box to provide general comments. Of the 383 comments received (from 571 total respondents), the following were the main themes:

- Long waiting times (38%)
- Good quality of care (28%)
- Poor communication (13%)
- Concerns about care quality (11%)
- Negative staff approach (10%)
- Positive staff approach (9%)
- Physical discomfort (9%)
- Staffing issues (6%).

Background

5.9. The NHS Scotland Patient Charter[44] defines what is expected of people who use and provide NHS services. It covers peoples' rights when they access NHS services, communication, privacy and feedback.

5.10. NHS bodies have a legal duty on public involvement. Meaningful engagement leads to improved understanding, higher quality and safer services, and better health and care outcomes.[45]

5.11. Patient experience was gathered directly and specifically from patients who had a recorded attendance at one of the three emergency departments included within the review. A survey was distributed to a stratified, randomised sample of patients in November 2024. This was undertaken after patients had attended the emergency department, with multiple options for how to respond and with equality monitoring to ensure a response across different demographics. A paper survey was sent to a sample of 2,000 patients (response rates 9.4%) and a text message to a sample of 6,000 patients (response rate 6.4%). For further details on methodology, see Chapter 2, paragraphs 2.42–2.48 and 2.72–2.78.

5.12. The results presented in this chapter are aggregated feedback from all three sites: there were only slight differences between sites, and these were within the margin of error. All comparisons made in this chapter are statistically significant unless otherwise stated. The percentages for responses to questions have been rounded and some may not add to 100%.

5.13. Patients had attended the emergency departments over the previous 16-month period (August 2023 to November 2024), with feedback being well-distributed over the period.

5.14. 45% of respondents stated that they attended Queen Elizabeth University Hospital, 30% Royal Alexandra Hospital, and 25% Glasgow Royal Infirmary's emergency departments.

5.15. Almost 4 in 10 (37%) respondents were taken to the emergency department by ambulance. Of these, 65% waited under an hour for their care to be handed over, while 15% waited 1 - 2 hours. Of the 63% who did not arrive by ambulance, a third (33%) of respondents were spoken to by staff within 5 minutes of arrival, 29% waited between 5 -15 minutes, 13% waited between 15 and 30 minutes, and 20% waited over 30 minutes for initial triage. A further 5% did not know or could not remember how long they waited.

[44] The Charter of Patients Rights and Responsibilities | NHS inform. NHS Scotland. May 2023
[45] https://www.hisengage.scot/equipping-professionals/why-engage/

Patient experience survey detailed findings

The first section gathered information about which emergency department the patient attended, when and how they attended.

Which emergency department attended

5.16. The first question (Figure 5.1) asked which emergency department site they had most recently attended. A total of 558 people answered this question, although a few answered more than one site giving 579 responses in total. Almost half of the responses were from Queen Elizabeth University Hospital (45%), followed by 3 in 10 from Royal Alexandra Hospital (30%) and just over a quarter from Glasgow Royal Infirmary (25%).

Answer Choices			Response Percent	Response Total
1	Queen Elizabeth University Hospital		45%	261
2	Royal Alexandra Hospital		30%	171
3	Glasgow Royal Infirmary		25%	147
			answered	579

Figure 5.1: Which emergency department patients attended

5.17. After an analysis of the responses to the survey questions from the three sites there was only a slight difference by each site to some questions. Where there are differences, they are within the margin of error.

Date of attendance

5.18. Respondents were asked to enter the date they attended the emergency department. This was to ensure feedback was considered from patients who experienced the emergency department services at different times of the year. We received 530 responses to this question with the most during July 2024 with 50 responses (9.4%) and the least in August 2023 with 17 responses (3.2%). Table 4 below shows when respondents used the emergency departments over the 16 - month period from August 2023 to November 2024 in four month sections and shows a good spread of respondents throughout this period.

	Aug – Nov 23	Dec 23 – Mar 24	Apr – Jul 24	Aug – Nov 24	Total
No. of responses	91	137	171	131	530
% of responses	17%	26%	32%	25%	100%

Table 4: Spread of patient survey responses by month and year of attendance

Route of attendance

5.19. When attending the emergency department, just over a third (37%) said they were taken there in an ambulance and nearly 2 in 3 respondents (63%) said they were not.

Ambulance handover

5.20. Question: Once you arrived at this emergency department, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?

5.21. Of those that arrived at the emergency department by ambulance, nearly 2 in 3 respondents (65%) told us that they waited under an hour with the ambulance crew before their care was handed over to the emergency department staff. 15% waited between 1–2 hours, with 1 in 20 (5%) participants waiting 4 hours or more. A further 4% waited between 2–3 hours and 2% between 3–4 hours. 9% of respondents did not know or could not remember how long they waited.

Triage

5.22. Question: When you first arrived at the emergency department, how long was it before a member of staff talked to you about the reason you were there?

5.23. Patients were asked when they first arrived at the emergency department, how long it was before a member of staff talked to them about the reason for attending. 1 in 3 respondents (33%) said they waited less than 5 minutes, 29% waited between 5 and 15 minutes, and 1 in 5 (20%) waited over 30 minutes. A further 13% waited between 15 and 30 minutes for initial triage. 5% of respondents did not know or could not remember how long they waited.

Care received while waiting

Patients reported poor experiences of waiting in the emergency department: nearly half were not informed about how long they would have to wait, two-thirds were not updated during their wait and many expressed concerns about their care while waiting.

Informed about waiting time

5.24. Question: Were you informed how long you would have to wait to be examined or treated?

5.25. Patients were asked if they were informed how long they would have wait to be examined or treated. Nearly half of respondents (45%) said they were not informed on how long they would have to wait to be examined or treated, compared to just over 1 in 4 (27%) who were kept informed to some extent and 16% who said they were 'yes, definitely' kept informed. 13% of respondents did not know or could not remember.

Updated during wait

5.26. Question: Were you kept updated on how long your wait would be?

5.27. Only 1 in 3 respondents said they were kept updated on how long their wait would be (13% said 'yes, definitely', 21% said 'yes to some extent') compared to over half of respondents (56%) who did not agree that this had happened. 10% of respondents did not know or could not remember.

Appropriate care while waiting

5.28. Question: While you were waiting, was there appropriate care if you needed it?

5.29. Respondents were then asked if they had received appropriate care if they needed it whilst waiting. Of the respondents, 37% stated they did receive appropriate care, just over 1 in 4 (27%) said that some but not all of their care needs were addressed, and a quarter (25%) disagreed. 11% of respondents did not know or could not remembers. In terms of care while waiting: 31% of all females stated they did not get appropriate care while they were waiting compared with 18% of all males.

Assistance for using a toilet

5.30. Question: Could you get assistance to go to the toilet if needed?

5.31. When asked if assistance was available to go to the toilet if needed, respondents were positive that this was the case (36% said 'yes, definitely', 18% said 'yes to some extent'), whereas nearly 1 in 4 (23%) were not offered assistance and 24% did not know or could not remember. 29% of all females could not get assistance to go to the toilet compared with 16% of all males.

Accessing food and drink

5.32. Question: Were you able to get food and drink if required?

5.33. Half of respondents said they were able to get access to food and drink when required whilst they were waiting in the emergency department (26% said 'yes to some extent', 24% said 'yes, definitely') compared to 1 in 3 respondents (34%) who said this was not the case. A further 16% did not know or could not remember. 43% of all females could not get food and drink if required compared with 25% of all males.

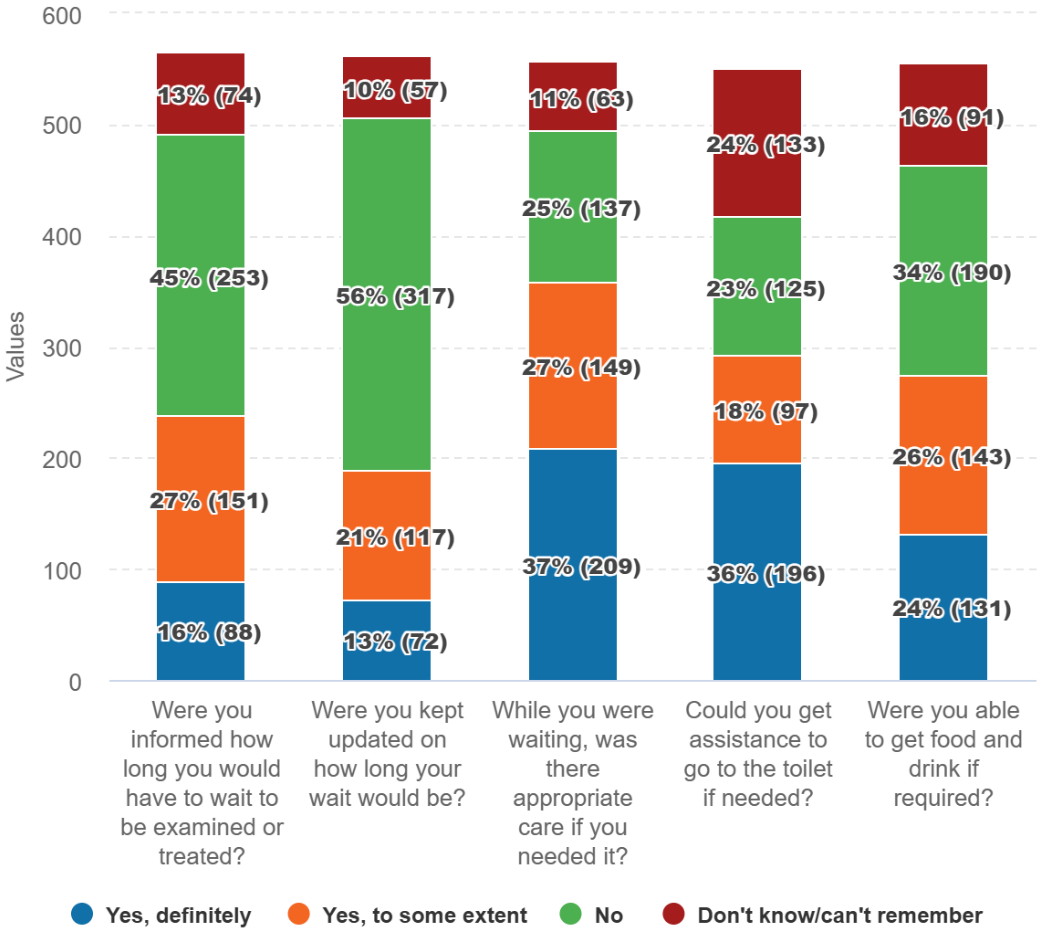


Figure 5.2: Care received while waiting

Recommendation 1: NHS Greater Glasgow and Clyde should improve waiting times in emergency departments. Where waits occur, communication with patients about waiting time length should be improved, both at initial arrival and through frequent updates during the wait. People should be appropriately supported during their wait.

Recommendation 2: NHS Greater Glasgow and Clyde should undertake specific engagement with people who are actively waiting in emergency departments to better understand the specific information and support people would find valuable while waiting.

Person centred care and communication

Patients reported positive experiences of person-centred care, including feeling that staff listened to them, explained information and provided time for a discussion. Less positive was patient involvement in decision making and a quarter of patients were not given information about follow-up care for after discharge from the emergency department.

Staff listening to patients

5.34. Question: Did staff listen to what you had to say?

5.35. Almost 9 in 10 participants (89%) said that staff listened to what they had to say, with 68% saying 'yes, definitely' and 21% saying 'yes, to some extent'. Around 1 in 10 (8%) said that staff did not listen to what they had to say and 3% did not know or could not remember. 61% of all females stated 'yes, definitely' compared with 77% of all males.

Staff explaining information to patients

5.36. Question: Did staff explain your condition and treatment in a way you could understand?

5.37. Most participants (87%) said that staff explained their condition and treatment in a way that they could understand, with 65% saying 'yes, definitely' and 22% saying 'yes, to some extent'. 10% answered 'no' to this question and 3% did not know or could remember.

Time for discussion

5.38. Question: Did you have enough time to discuss your condition and treatment with the staff?

5.39. Most participants (82%) said that they had enough time to discuss their condition and treatment with the staff, with 61% saying 'yes, definitely' and 21% saying 'yes, to some extent'. 14% answered 'no' to this question. 4% did not know or could not remember.

Patient involvement in decisions about care and treatment

5.40. Question: Were you involved in decisions about your care and treatment?

5.41. Just over 7 in 10 respondents (71%) said that they were involved in decisions about their care and treatment, with 45% saying 'yes, definitely' and 26% saying 'yes, to some extent'. However, nearly one quarter of participants (23%) said they were not involved in decisions about their care and treatment. 5% of respondents did not know or could not remember.

Answer Choices	Yes, definitely	Yes, to some extent	No	Don't know/can't remember	Response Total
Did staff listen to what you had to say?	68% 387	21% 120	8% 44	3% 18	569
Did staff explain your condition and treatment in a way you could understand?	65% 367	22% 125	10% 56	3% 18	566
Did you have enough time to discuss your condition and treatment with the staff?	61% 346	21% 121	14% 80	4% 22	569
Were you involved in decisions about your care and treatment?	45% 254	26% 148	23% 133	5% 31	566
				answered	570

Table 5: Patient involvement in decisions about care and treatment

Communication support needs

5.42. Question: Did you require any communication support during your attendance at the emergency department? Please select all options that apply to you.

5.43. When asked whether they required communication support during their attendance at the emergency department, most participants (93%) said they did not have any communication needs (n=558).

5.44. In terms of communication support, 2 participants said they needed translation or an interpreter, 2 said they needed Sign language or Braille materials, 8 needed Easy read materials and 4 Large print materials. Some respondents offered other communication needs such as support required due to hearing difficulties (7) dementia (6), and brain injury (3).

Staff support for communication needs

5.45. Question: If you needed communication support, did staff help you with your communication needs?

5.46. People who needed communication support were asked if staff helped them with their communication needs. Over half of those who answered this question (54%, n=45) said that staff did help them with their communication needs, with 27% saying 'yes, definitely' and 27% saying 'yes, to some extent'. However, over a third of those who answered this question said 'no' (36%) and 11% did not know or could not remember.

Answer Choices		Response Percent	Response Total
1	Yes, definitely	27%	12
2	Yes, to some extent	27%	12
3	No	36%	16
4	Don't know/can't remember	11%	5
		answered	45

Figure 5.3: Staff support for communication needs

Family/friend/carer involvement

5.47. Question: If a family member, friend or carer wanted to talk to staff about your care, did they have enough opportunity to do so?

5.48. When asked if a family member, friend or carer had enough opportunity to talk to staff about their care if they wanted to, over half of the participants said that they did have this opportunity (54%), with 36% saying 'yes, definitely' and 18% saying 'yes, to some extent'. Nearly a third of participants said that they did not need this (31%). 12% said 'no'. 2% of respondents did not know or could not remember.

Answer Choices		Response Percent	Response Total
1	Yes, definitely	36%	206
2	Yes, to some extent	18%	99
3	No	12%	69
4	I did not need this	31%	177
5	Don't know/can't remember	2%	14
		answered	565

Figure 5.4: Family/friend/carer involvement

Follow-up care

5.49. Question: Before you left the emergency department, did a staff member talk with you about follow-up care? This may have been about how to take care of yourself at home and what to expect, or whether you needed a follow-up appointment.

5.50. Participants were asked whether a staff member talked with them about follow-up care before they left the emergency department (n=562). This may have been about how to take care of themselves at home and what to expect, or whether they needed a follow-up appointment. Most participants (68%) said that staff had discussed this with them. However, nearly a quarter of participants (24%) said that this did not happen. 8% said they did not know or could not remember.

Recommendation 3: NHS Greater Glasgow and Clyde should enable, expect and ensure that all staff involve patients in making decisions about their care.

Recommendation 4: NHS Greater Glasgow and Clyde should ensure patients are provided with information about their follow-up care including who to contact if their condition worsens before leaving the emergency departments.

Patient experience of safety

Patients felt safe with staff in the emergency department, however there were some concerns about safety around other patients and visitors.

Safety in the emergency department

5.51. The first of the questions explored how safe patients felt in the presence of other patients or visitors, and question two asked about feeling safe in the presence of staff.

5.52. Just under 6 in 10 patients (58%) said they definitely felt safe in the presence of other patients and visitors, 28% said they felt safe to some extent, whereas 1 in 10 (11%) said they did not feel safe. 3% did not know or could not remember.

5.53. In relation to staff, just over 8 in 10 respondents (83%) reported that they definitely felt safe whilst being treated by staff, 12% said they felt safe to some extent, and 3% said they did not feel safe whilst being treated by staff. 2% did not know or could not remember.

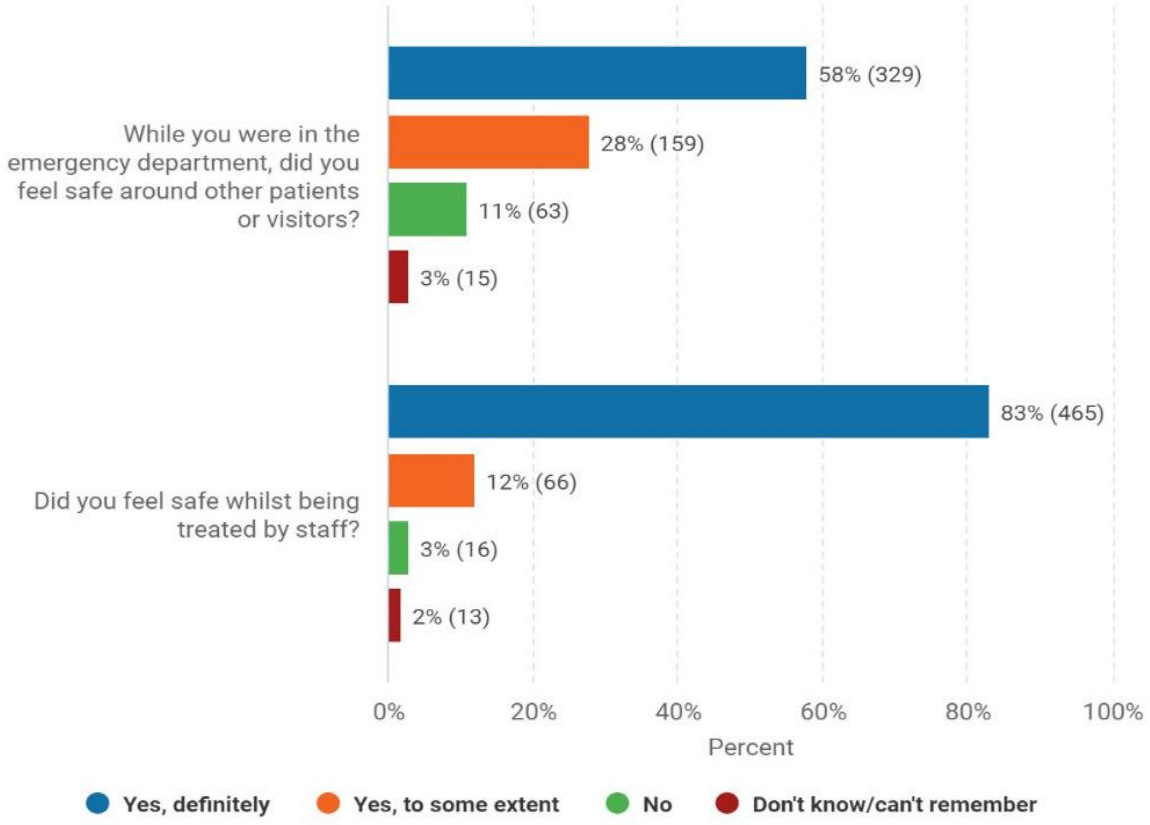


Figure 5.5: Safety in the emergency department

Recommendation 5: NHS Greater Glasgow and Clyde should take action to reduce patients' concerns about personal safety around other patients/visitors in emergency departments to create a safer, more secure environment.

Patient feedback

The majority of patients were not asked by staff for feedback about their care, and they had concerns that feedback is not valued.

Offering feedback to staff

5.54. Question: Did you offer to give feedback about your care to staff?

5.55. Respondents were asked if they had offered to give feedback to staff about the care they had received (n=561). 14% answered they definitely offered this, 13% said they had offered feedback to some extent, and the majority, 57% or almost 6 in 10, said that they had not offered to give feedback to staff. Less than 2 in 10 (16%) responded they didn't know if they had offered or could not remember if they had or not.

Staff asking for feedback

5.56. Question: Were you asked by staff to give feedback about your care?

5.57. Respondents were asked whether staff asked them to give feedback about their care (n=564). Only 7% answered with a definite yes, 6% responded they were asked to some extent, whereas a large majority of over 72%, that is 7 in 10 respondents, answered 'no'. A further 16% didn't know or had no recollection of being asked to provide feedback by a member of staff. 81% of all females were not asked for feedback by staff compared with 61% of all males.

Value of feedback

5.58. Question: If you provided feedback, did you feel your feedback was valued by staff?

5.59. The last of the questions in relation to feedback, asked about respondents' perception of how their feedback was received by staff. 3 in 10 participants in the survey felt that their feedback was either definitely valued (18%) or valued to some extent (12%). A similar number, 27% did not think their feedback was valued, and 43% did not know or recall if their feedback had been valued. 31% of all females did not think their feedback was valued compared with 23% of all males.

Answer Choices		Response Percent	Response Total
1	Yes, definitely	18%	76
2	Yes, to some extent	12%	48
3	No	27%	112
4	Don't know/can't remember	43%	180
		answered	416

Figure 5.6: Value of feedback

Recommendation 6: NHS Greater Glasgow and Clyde should provide more opportunities to ask patients about their experience of using emergency departments and clearly demonstrate how this feedback is valued and used to continually drive improvements and shape services.

Dignity and respect

Patients reported that they were treated with dignity and respect, and that their privacy had been respected.

Treated with dignity and respect

5.60. Before the questions about dignity and respect, respondents were offered a brief definition of what dignity and respect encompasses in the context of health and care:

"Dignity and Respect focusses on the value of every individual, respecting their views, choices and decisions, not making assumptions about how they want to be treated and working with compassion."

5.61. Question: Overall, did you feel you were treated with dignity and respect while you were in the emergency department?

5.62. The first question enquired about respondents' overall impression of whether or not they had been treated with dignity and respect during their stay in the emergency department. Of the 568 responses received, 67% said they were definitely treated with dignity and respect, whereas 21% felt they had been treated with dignity and respect to some degree, with the two answer choices combined accounting for 88% (just under 9 in 10 participants) of the response total. However, 10%, or 1 in 10 respondents, reported that they had not been treated with dignity and respect and 2% did not know or could not remember. 60% of all females stated they were definitely treatment with dignity and respect compared with 76% of all males.

Privacy in discussions

5.63. Question: Were you given enough privacy when discussing your condition with the staff?

5.64. Of the 567 respondents to this question, 70% said they had definitely experienced enough privacy when discussing their condition with staff, and 19% felt they had enough privacy to some extent. Again, with a combined figure of 89% or 9 in 10 respondents, this accounts for the majority of responses, leaving only 8% feeling they did not have enough privacy. 3% did not know or could not remember.

Privacy in examination and treatment

5.65. For the third question, respondents were asked if they felt they had had enough privacy when being examined or treated. Of the 566 patients responding to this question, 78% agreed that they were definitely afforded enough privacy whilst being treated and 16% said that they had had enough privacy to some extent. 4% of respondents felt they did not have enough privacy and 2% did not know or could not remember.

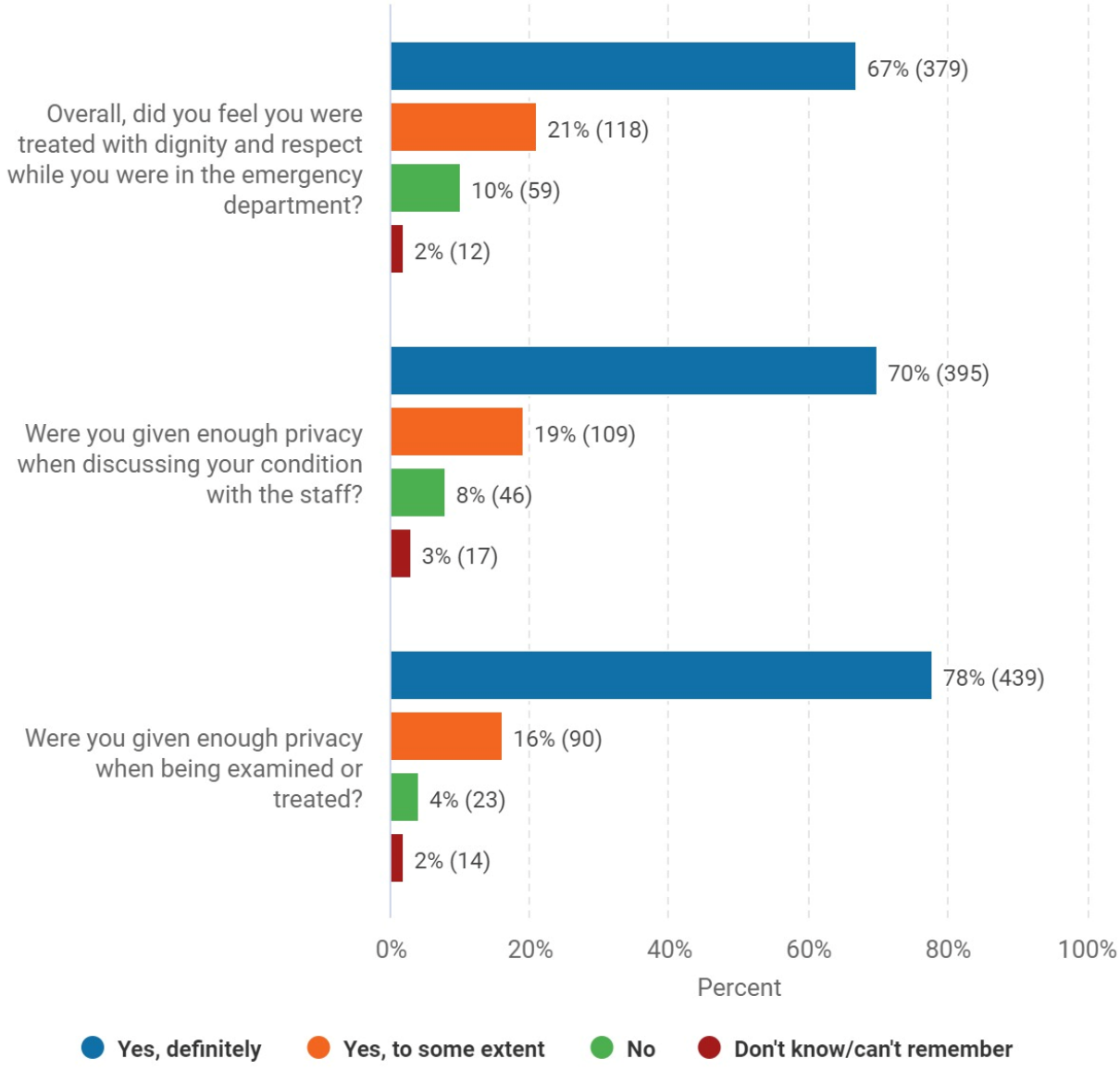


Figure 5.7: Privacy in examination and treatment

Recommendation 7: NHS Greater Glasgow and Clyde should enable and expect all staff to treat patients with dignity and respect and provide suitable surroundings for this to occur.

Overall rating of care

Patients rated their care positively, with three-quarters rating it either very good or good.

Rating of care

5.66. Overall, how would you rate the care you experienced at this emergency department on this occasion?

5.67. Respondents were asked how they would rate their care at the emergency department. Figure 5.8 below shows that of the 561 respondents that answered this question, three quarters (75%) rated their care as very good or good, 16% rated their care as poor or very poor and 9% rated it neither good nor poor.

5.68. There were large differences between males and females to how they rated their care. Whilst 7 in 10 (70%) females rated their care as very good or good, over 8 in 10 (82%) males rated their care as very good or good. Over double the rate of females rated their care as very poor (9%) than males (4%).

Answer Choices			Response Percent	Response Total
1	Very good		53%	297
2	Good		22%	126
3	Neither good nor poor		9%	50
4	Poor		8%	46
5	Very Poor		7%	42
			answered	561

Figure 5.8: Rating of Care

Improvements to care

The patient experience survey included an open -ended question in which patients were invited to make suggestions about what would improve the care they received in the emergency department. Some patients used this question to provide comments. The most frequently suggested improvement was to tackle long waiting times. The second most frequent comment was to praise the quality of care and individual staff.

5.69. Out of the 571 patients who responded to the survey, around two thirds of respondents answered this question (383 responses). An analysis identified 17 themes highlighted in Figure 5.9 below. Comment on the main themes is given after the chart to briefly explain the theme and provide specific quotes attributed to the themes to understand in more detail patients' views. It should be noted that while some people attempted to answer the question directly, others gave their view on their experience and other comments didn't relate directly to the question.

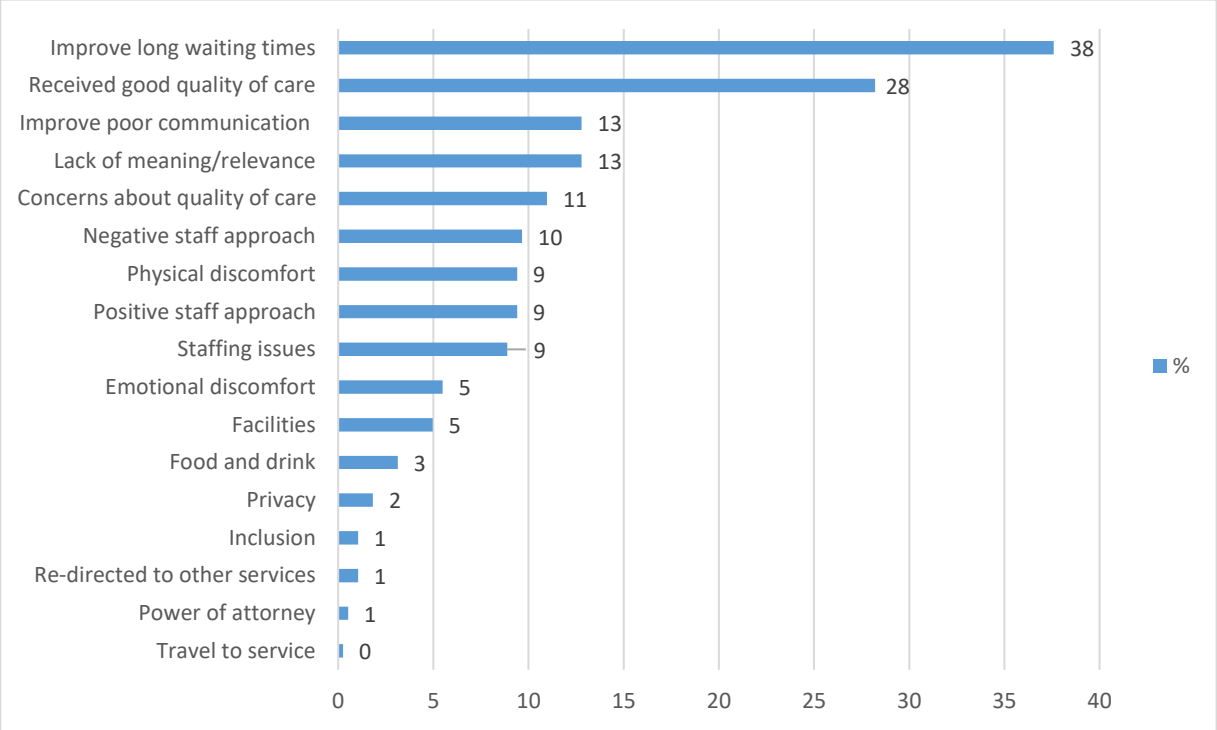


Figure 5.9: Themes for suggested improvements to care

Improve long waiting times

5.70. This theme was mentioned 144 times (38% of respondents).

5.71. A significant number of patients expressed dissatisfaction with the long waiting times in the emergency departments. Many reported waiting anywhere from several hours to over 12 hours before being seen by a doctor. This theme recurred throughout the feedback, with many comments directly referencing the need for shorter wait times.

Patients said:

- *Improvement to waiting times would eradicate a lot of anxiety and worry - knowing what is wrong with you takes away a lot of worry.*
- *I had to wait nearly 12 hours to be admitted, luckily after about 6 hrs I got to lie on a trolley. All members of staff once I got to see them were very kind and compassionate.*
- *Shortage of staff was evident, but the attitude was excellent, if the time waiting was shortened that would help everyone.*

Received good quality of care

5.72. This theme was mentioned 108 times (28% of respondents).

5.73. While there were many complaints about waiting times, patients praised the quality of care they received once they were seen. Many described the individual staff and teams as kind, caring, and professional, indicating that the treatment they received in the examination room or ward was satisfactory.

Patients said:

- *The treatment I received was very good, professional, friendly and efficient. It was a busy A&E so waiting was expected, if my condition had deteriorated, I believe the hospital would have stepped in asap.*
- *Nothing. I was treated exceptionally well. And was admitted to hospital for continued care.*
- *Care was first class and much appreciated.*

Improve poor communication

5.74. This theme was mentioned 49 times (13% of respondents).

5.75. Many patients felt that communication could be improved, particularly regarding updates on waiting times and the status of their care. Several mentioned feeling left in the dark about how long they would have to wait and expressed a desire for more frequent check-ins from staff. Related terminology such as 'listening', 'understanding', 'talking to'; or texts descriptive of person-to-person situations where communication was an issue were also noted.

Patients said:

- *Just to have been kept more informed of what was happening.*
- *Communication in the emergency waiting room could be a lot better. We lost my mum for a good while and nobody knew where she was.*
- *The nurse needed to listen to the symptoms I was describing, as she would then have realised, they didn't match the diagnosis she was giving. In general, she was incredibly rude and invalidating and it felt like her priority was getting me to leave, rather than helping.*

Concerns about quality of care

5.76. This theme was mentioned 42 times (11% of respondents).

5.77. Several patients reported dissatisfaction with the treatment they received, including misdiagnosis or inadequate assessment of their conditions, some leading to further complications.

Patients said:

- *I felt that the priority was to give me painkiller and crutches and get me out. There was no advice about what to do if I did not improve. Two days later my GP sent me back to A&E. This was little better.*
- *Was told I had undiagnosed infection, discharged then collapsed at home that night. Very ill all night. Called GP for home visit who immediately called ambulance, and I was readmitted to A&E.*
- *I was in great distress at the time. I had to wait hours. There was no water machine or anything. What upset me the most is that I was clearly distressed, in pain, with pus running down my face. Nurses would just walk by me… a simple acknowledgment from a nurse, cup of water, a seat, a smile, would have made all the difference. I had to ask for a dressing.*

Negative staff approach

5.78. This theme was mentioned 37 times (10% of respondents).

5.79. It highlights patient narratives focusing on staff behaving, acting or communicating in a way that impacted on respondents' perception of being cared for in an appropriate and safe manner.

Patients said:

- *Triage nurse huffed and puffed and was shaking her head like I was a pest for being there.*
- *Left in corridor on trolley for 7 hours. With broken pelvis in great pain. Deranged man in chair next to me tried to inject himself with drugs and the doctor told me to mind my own business.*

Positive staff approach

5.80. This theme was mentioned 36 times (9% of respondents).

5.81. It highlights patient narratives focusing on staff behaving, acting or communicating in a way that impacted positively on respondents' perception of being cared for in an appropriate and safe manner.

Patients said:

- *Waiting time was about 6 hours, which was too long, other than that staff were great and supportive even when being so busy and under pressure.*
- *I was delighted with the care I received. Obviously, there was some waiting around (and it was really cold in the A&E main waiting room) but when I did get seen every member of staff I encountered was cheerful and respectful. A scan was organised, and I could wait for results. I felt I had the best care – only waiting times could be improved and everyone already knows this.*

Physical discomfort

5.82. This was mentioned 36 times (9% of respondents). Some patients reported experiencing physical discomfort (including pain) because of circumstances which from their perspective should have been avoided.

A patient said:

- *I was left alone on a trolley in severe pain on trolley. Doctor had prescribed Oramorph, but there was a delay in being given it. Cot sides were up, and I had to shuffle to end of trolley to get help and collapsed. Another patient had to go and get help.*

Staffing Issues

5.83. This was mentioned 34 times to this question (9% of respondents).

5.84. Numerous responses highlighted a lack of staff, which contributed to the long wait times and patients feeling neglected. Some comments indicated that staff were overworked and overwhelmed, which affected the quality of care provided.

A patient said:

- *On this occasion my level of care was very good. However, I did notice that there's not enough staff to attend patients' needs. Nurses and doctors are under so much pressure.*

Qualitative interview findings

5.85. Two people expressed a desire to take part in an interview discussion about their experience of the emergency department, one at Queen Elizabeth University Hospital and the other at Royal Alexandra Hospital. A short summary of their experience is given below and chimes with some of the findings from the open question above.

5.86. Both participants reported positive experiences overall, feeling safe, cared for, and respected during their visits. They praised the cleanliness of the facilities and the helpfulness of the staff, with one participant noting that they felt reassured about their visit's necessity.

5.87. However, there were some highlighted issues, particularly related to communication and waiting times. One participant experienced a discrepancy between being told they would be seen immediately and having to wait 30 minutes, while another mentioned a 2 hour wait. They expressed concerns about reception staff's awareness of their urgent needs and noted that communication is essential.

5.88. Both participants felt safe during their visits but mentioned that their experiences could vary significantly depending on the time and day they visited. They also noted that they were not asked for feedback regarding their care.

Patient experience: comparison with other NHS boards

5.89. To consider whether the recommendations drawn from the patient experience survey in NHS Greater Glasgow and Clyde could be more widely applicable across NHS Scotland, an analysis of Care Opinion posts about emergency care in all boards was undertaken. The purpose was to understand whether patient experience was similar in all boards. Care Opinion stories about emergency care (which includes emergency departments and minor injury units) from January 2022 to December 2024 were included (see Chapter 2, section 2.78).

Positive experiences of emergency care

5.90. The most positive common themes about people's emergency care experience are provided below (Figure 5.10). The qualities patients identified as "good" care are similar in NHS Greater Glasgow and Clyde and the rest of Scotland.

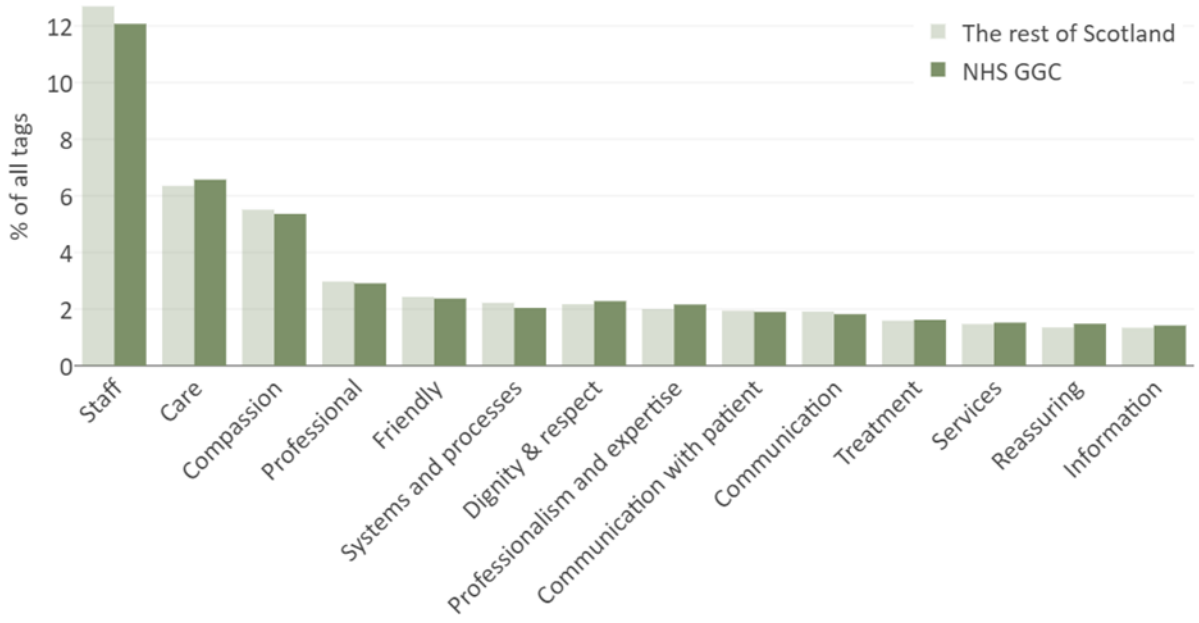


Figure 5.10: Positive qualities about care in the emergency department

Negative experiences of emergency care

5.91. The most common negative themes about people's emergency care experience are provided below (Figure 5.11). The issues patients identified that could have been better were similar in NHS Greater Glasgow and Clyde and the rest of NHS Scotland, with "communication" mentioned more often in NHS Greater Glasgow and Clyde although this difference was not significant.

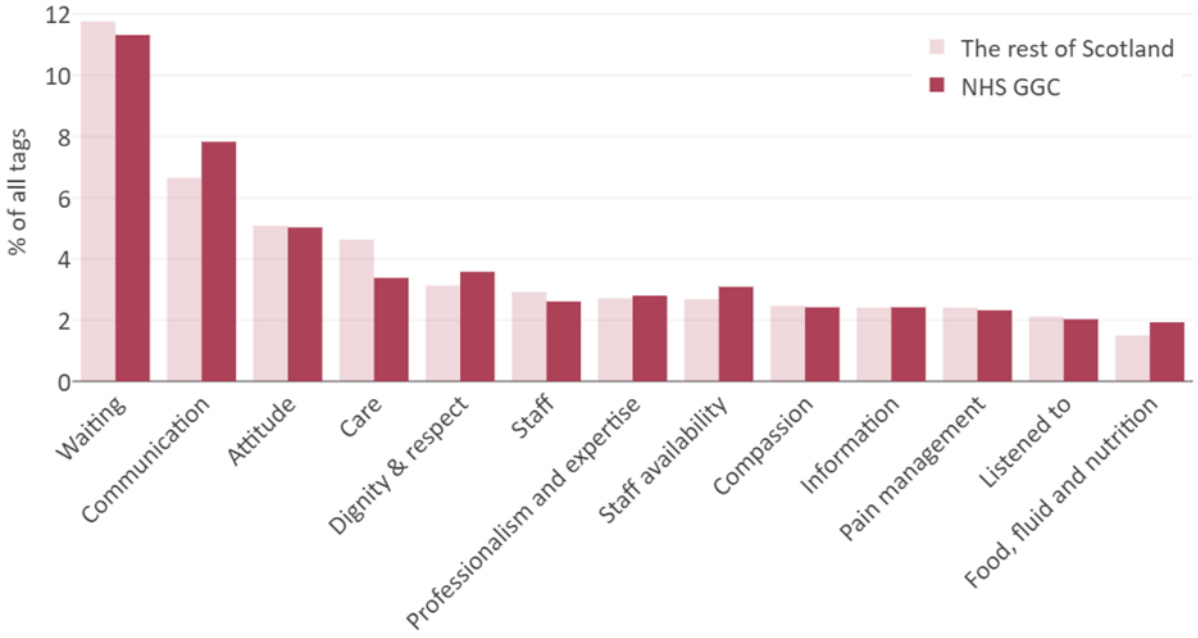


Figure 5.11: Negative themes about care in the emergency department

5.92. This analysis of Care Opinion data indicates that patient feedback about emergency care experience is similar in NHS Greater Glasgow and Clyde and the rest of NHS Scotland. From this, it likely that many of the recommendations from the patient experience survey in NHS Greater Glasgow and Clyde could apply to other emergency departments.

Patient Experience: conclusions

5.93. The patient experiences gathered for this review provide vital insight into patients' experience of care in the three emergency departments in NHS Greater Glasgow and Clyde. It is likely that this learning will be useful for other emergency departments however, to be able to draw wider recommendations for the whole of NHS Scotland, further engagement work across the country is needed. In particular, focused engagement on patients' experience of waiting in emergency departments (which patients highlighted as the area in greatest need of improvement) would be especially useful.

5.94. In the context of this review, it is also useful to reflect on patients' rights when receiving health care in NHS Scotland, which are defined in the Patient Rights (Scotland) Act 2011[46] and described in the Charter of Patient Rights and Responsibilities.[47]

5.95. These rights include that patients have a right to be treated with dignity and respect, and be provided with all the information and time they need to be able to participate fully in decisions relating to their care. [48] They also state that NHS boards must encourage patients to provide feedback, comments, concerns and complaints about their experiences of care.[49] The patient experience survey indicated neither of these rights were universally experienced by patients.

[46] Patient Rights (Scotland) Act 2011. Legislation.gov.uk. 2011.
[47] The Charter of Patients Rights and Responsibilities | NHS inform. NHS Scotland. May 2023
[48] Patient Rights (Scotland) Act 2011 (section 2) and Patient Rights (Scotland) Act 2011 (section 12,13)
[49] Patient Rights (Scotland) Act 2011 (section 14). Legislation.gov.uk. 2011

6. Quality of Care and Patient Safety

This section addresses issues relating quality of care and patient safety in the emergency departments at Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital. It includes:

- **the views of staff working in the three emergency departments on the quality of care and patient safety**
- **consideration of relevant processes including flow, escalation and incident reporting**
- **data on safe staffing and staff views on levels of staffing.**

It also includes recommendations based on the review findings.

Introduction

6.1. Ensuring high quality, safe care improves outcomes for patients and reduces the risk of harm. The Scottish Patient Safety Programme is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm.

6.2. To assess the quality and safety of care within this review, Healthcare Improvement Scotland has used the Scottish Patient Safety Programme's Essentials of Safe Care[50] as a framework for this element. The Essentials of Safe Care are evidence-based and were originally defined with partners across the health and care system in Scotland. The framework consists of four sections:

- Person centred systems and behaviours
- Safe communication
- Leadership to promote a culture of safety
- Safe consistent clinical and care processes.

6.3. The Essentials of Safe Care have been mapped against the more recently published Patient Safety Principles[51,] produced by the Patient Safety Commissioner in NHS England. They have also been compared with the seven foundations for patient safety (published in What Good Looks Like in Patient Safety[52]) produced by the UK charity Patient Safety Learning. Both of these

[50] Scottish Patient Safety Programme Essentials of Safe Care. Essentials of safe care | Scottish Patient Safety Programme (SPSP) | ihub - SPSP Essentials of Safe Care. Healthcare Improvement Scotland. 2021
[51] Hughes, H. Patient Safety Principles. PSP-A3-Principles. Patient Safety Commissioner. 2024
[52] What Good Looks Like in Patient Safety. 'What Good Looks Like' in patient safety - Patient Safety Learning. Patient Safety Learning.

documents reinforce the Scottish *Essentials of Safe Care* which provides assurance of their relevance for use as a framework for this element of the review.

6.4. Two aspects of the *Essentials of Safe Care* – safe communication and leadership – are explored in greater depth in Chapter 7 of this review (Leadership and Culture). This is due to significant concerns being found in these areas which necessitated a more detailed analysis.

6.5. This chapter contains a selection of anonymised quotes in *italic* text from staff that shared their views and experiences during the review process (see 2.81 above). These quotes may have been drawn from the staff survey, submissions to the confidential mailbox or from discussion sessions with staff.

Essential of Safe Care 1: Person-centred systems and behaviours

Long waiting times, poor flow, non-standard bed care and crowding are impacting on the quality and safety of care across all three emergency departments, and none of these concerns are unique to NHS Greater Glasgow and Clyde. Healthcare Improvement Scotland's safe delivery of care inspections have found similar issues across Scottish hospitals. There is a need to review how patient flow and redirection are managed within all three emergency departments so that this is not normalised.

6.6. This section includes consideration of structures and processes that enable care, inclusion and involvement, and workforce capacity and capability.

Prioritisation of patient safety

6.7. Staff raised concerns that patient experience and safety was not at the standard they hoped to provide. The staff survey identified a difference between the three emergency departments about whether patient safety and care is seen as coming first (Figure 6.1). Respondents from the Royal Alexandra Hospital perceived that patient safety comes first 'always' or 'usually' 91% of the time, in comparison to 45% of Queen Elizabeth University Hospital respondents and 69% of Glasgow Royal Infirmary respondents. It is of concern that 53% of Queen Elizabeth University Hospital respondents indicated that patient safety 'rarely' or 'never' came first.[53]

6.8. The review of shift handover documents identified safety concerns that were rated as significant within the reports across both the Queen Elizabeth University Hospital and Glasgow Royal Infirmary sites on nearly every day of the week.

[53] NHS Greater Glasgow and Clyde Emergency Department Review - Staff Survey. Healthcare Improvement Scotland. 2025.

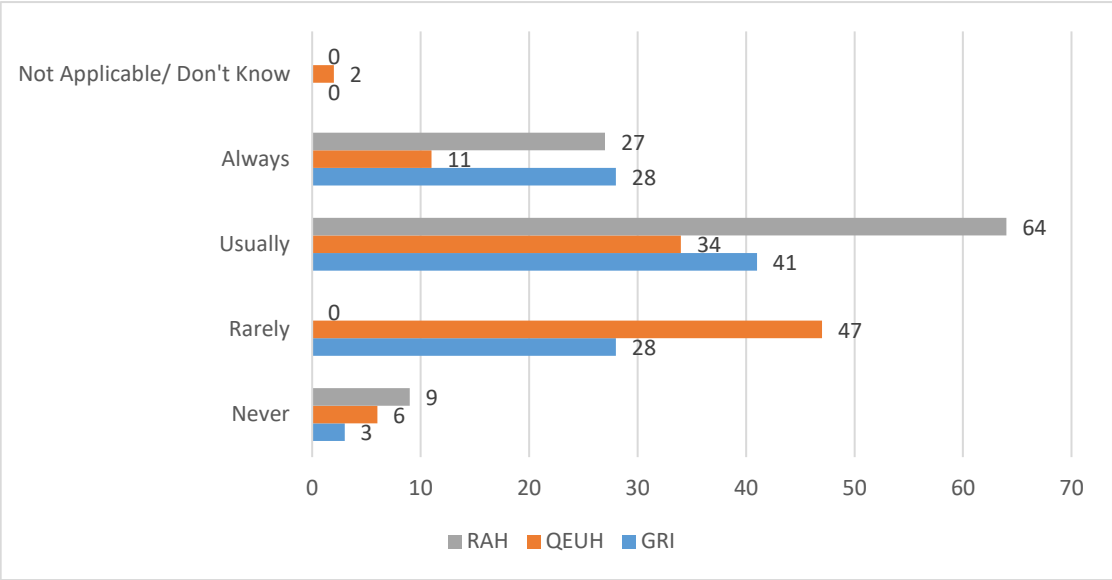


Figure 6.1: Staff views on prioritisation of patient safety and care (% of staff)

Appropriate and timely care

6.9. Performance against the four-hour standard across Scotland has dropped considerably since 2018 (see Chapter 4). In terms of the three emergency departments within this review, performance against the four-hour standard at the Queen Elizabeth University Hospital is consistently lower than that of an overall peer group across Scotland, with Glasgow Royal Infirmary and the Royal Alexandra Hospital tracking the centreline of the peer group. For waits of eight hours or more, all three emergency departments roughly track with the percentage for the peer group, while they consistently have a lower percentage of 12-hour waits.

6.10. Staff perceived that patient experience in the emergency department is commonly negative. No major differences were noted in responses from across the three sites regarding how often patients receive appropriate and timely care (Figure 6.2). Taking the three sites together, around two thirds (66%) of survey respondents felt patients 'rarely' or 'never' received appropriate and timely care.[54]

> *Have virtually no time to have conversations with patients anymore. Too many tasks, not enough staff to keep patients safe, […] I miss talking to patients and delivering holistic care, it currently feels like I'm doing bare minimum for everyone and it's so deflating.*

[54] NHS Greater Glasgow and Clyde Emergency Department Review - Staff Survey. Healthcare Improvement Scotland. 2025.

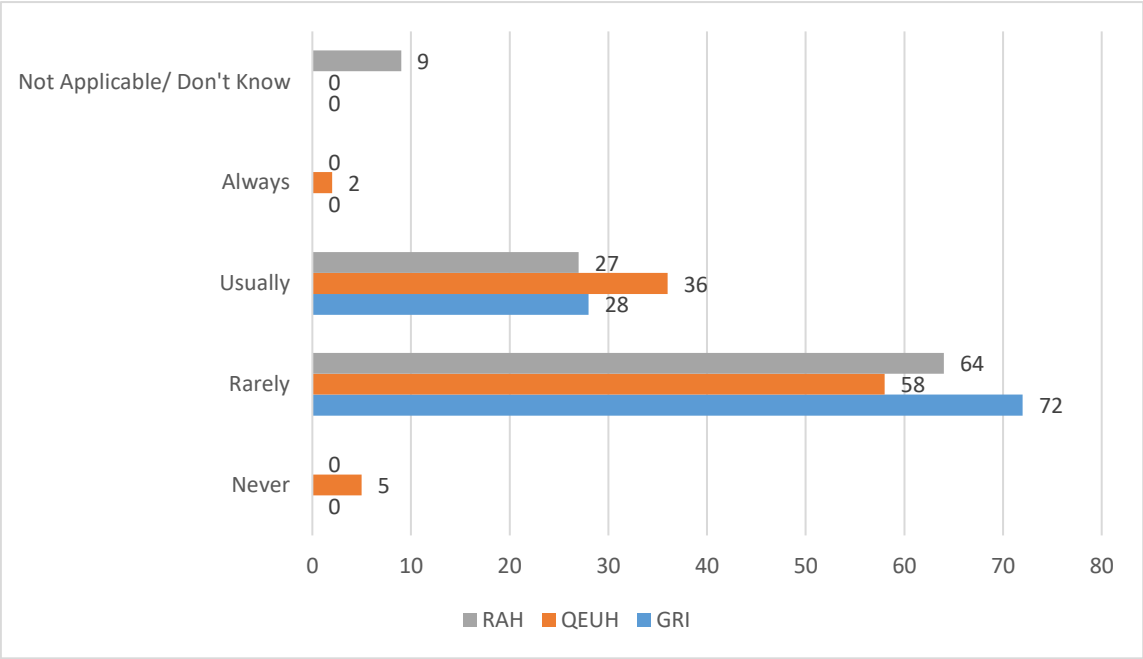


Figure 6.2: Staff views on provision of appropriate and timely care (% of staff)

6.11. A member of staff described waiting times as *"unacceptably long"*. Another staff member acknowledged: *"We are rarely able to give patients the care that they deserve"*. Staff at the Glasgow Royal Infirmary were more likely to provide patients with regular updates about their care, reporting that this usually happened 74% of the time compared with 39% at the Queen Elizabeth University Hospital and 27% of the time at Royal Alexandra Hospital (Figure 6.3).[55]

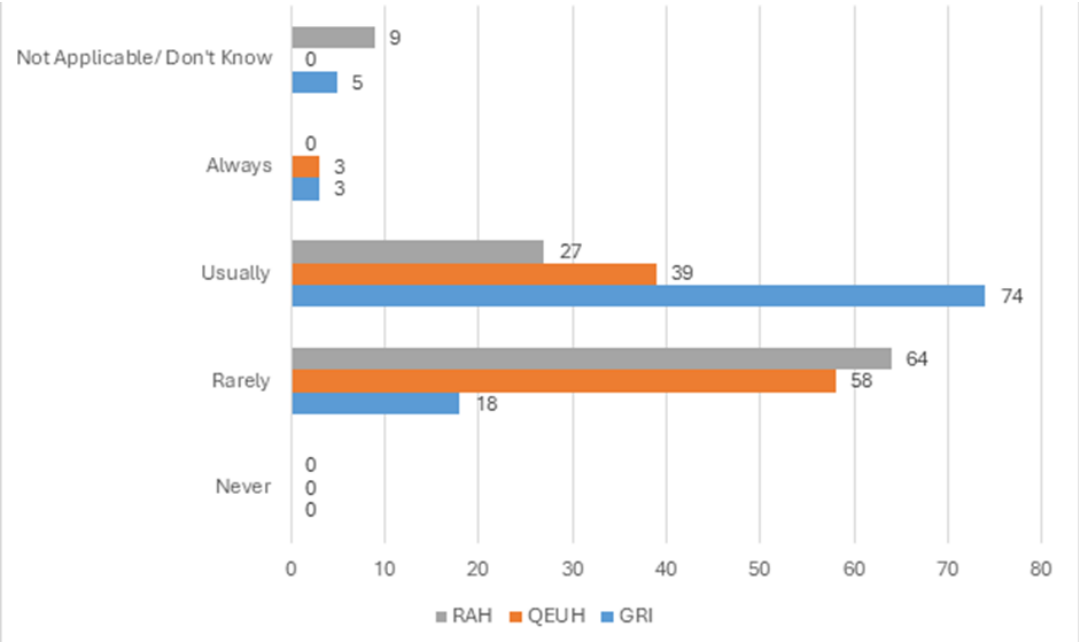


Figure 6.3: Staff views on provision of regular updates to patients (% of staff)

[55] NHS Greater Glasgow and Clyde Emergency Department Review - Staff Survey. Healthcare Improvement Scotland. 2025.

Patient Flow: GlasFLOW model

6.12. Patient flow models are used to support the movement of patients through a hospital from admission to discharge. Some of these models mandate that at times of pressure a set number of patients are moved from the emergency department to inpatient wards regardless of immediate bed availability but based on predicted patient discharge data. This aims to free space in the emergency department and spread the risk and responsibility for patient care throughout a hospital. However, it can result in patients placed in additional beds taking wards above capacity or in non-standard care areas (areas not designed for patient care) such as corridors or treatment rooms. This has implications for the ability of staff to provide safe, dignified patient care. A range of flow models have been introduced across NHS Scotland and the UK.

6.13. In December 2022, NHS Greater Glasgow and Clyde introduced its continuous flow model. This is known as GlasFLOW at the Queen Elizabeth University Hospital and 'continuous flow' at Glasgow Royal Infirmary and the Royal Alexandra Hospital, however the function is the same. The model works in supporting the appropriate flow of patients to downstream wards and away from the emergency department. This was a positive step by management to improving flow in the hospitals in response to safety concerns, capacity issues and long delays in accessing inpatient beds. However, there are some potential improvements that should now be considered.

6.14. It was noted that the continuous flow model only functions in Glasgow Royal Infirmary and the Royal Alexandra Hospital during the day (until 6:00 pm). GlasFLOW is used 24/7 in the Queen Elizabeth University Hospital with an initial planned phase and then additional moves based on escalation status. There tends to be a build-up of patients in the latter half of the late shift and through the night on all three sites. During the review we also noted difficulties in increasing admissions over the GlasFLOW numbers per hour. This apparent lack of flexibility in GlasFLOW does not allow the system to react dynamically to aid management of surges in emergency department attendances. A significant issue of concern, particularly for staff on the Glasgow Royal Infirmary site, is the impact of transferring patients into inappropriate environments in downstream wards and into non-standard patient areas, which needs to be balanced with the lack of space in emergency departments and delays in offloading ambulances.

6.15. Staff reported poor flow out of the emergency department, crowding, feeling overwhelmed and a sense that the system is chaotic. This led to a perception of a negative impact on quality and safety of care. Different working hours and arrangements of different specialties was a barrier to flow, with some evidence of reduced services at weekends especially, resulting in fewer ward rounds and discharges at these times. At the Royal Alexandra Hospital, medical admissions after 5pm are diverted to the emergency department for triage with consequent impact on emergency department workload.

6.16. Significant issues with departmental congestion and reduced flow were apparent in the shift handover documents reviewed for both the Queen Elizabeth University Hospital and Glasgow Royal Infirmary. Across both sites, and both staff groups, significant issues with congestion and flow were evident in the reports on every day of the week.

6.17. During our engagement with staff, we heard that despite existing agreements already being in place between the emergency departments and specialties, these arrangements were often not followed, leading to "*daily sources of conflict with receiving specialties".* By way of examples, patients were often attending the emergency department with a GP letter, but the relevant specialties were not taking responsibility for them. Additionally, GP and out of hours services were often unable to contact relevant inpatient teams for referral with the consequence of patients attending the emergency department as the only route into the specialty team.

> *General lack of flow, things gradually getting worse and worse, like we are in eternal winter. It's probably a lack of flow through the hospital, no slack in the system, lack of social care options for patients ultimately getting home. Improved efficiencies might make a little bit of difference, but only partly and for a short time, then the work will expand to fill the gaps. There is an increasing old and frail population, with multiple co-morbidities.*

> *I think that emergency department is more challenging with the volumes of patients and is severely impacted by the hospital flow […].*

> *Specialty referrals being triaged and then waiting in the emergency department for hours so we cannot manage our own substantial workload, push back from specialties when GPs have referred patients to them so they end up being sent to the emergency department with no specialty taking ownership, specialties asking that junior emergency department staff arrange further investigations for their patients that are not indicated whilst in the emergency department.*

Redirection

6.18. The aim of redirection is to support patients to use the services that are most appropriate for their healthcare needs. People often self-refer to emergency departments when they have a healthcare need, and it is recognised that some of these patients do not require this type of urgent and unscheduled care. Appropriate care and support could be provided closer to home by other

services, for example by a pharmacy or GP practice providing care or support to self-manage with appropriate advice. Effective redirection can help release capacity enabling the emergency department to provide care for people most in need, reduce delay in assessment and treatment for clinically urgent cases, and reduce risk of crowding in the departments. To ensure redirection is a safe and well governed process, it must be performed by an appropriately trained workforce with dedicated senior decision maker involvement.

6.19. A national framework for redirection[56] was published by the Scottish Government in December 2021. It includes a definition of redirection as: "The referral of patients who are assessed as not requiring emergency care away from the emergency department. This may be to another service or with self-care advice". Feedback sought during in the development of this framework suggested all emergency departments in Scotland undertook some form of redirection, but arrangements were often informal and inconsistent in application.

6.20. NHS Greater Glasgow and Clyde introduced the national redirection framework in 2023 as a step to address the volume of Flow 1 patients. In NHS Greater Glasgow and Clyde, redirection is carried out by senior nurses, with escalation as appropriate to emergency department medical staff. The AE2 A&E Data Recording Reference Manual version 2.6[57] defines Flow 1 as minor illness or injury and includes care provided in emergency departments, minor injury units and through schemes such as "paramedic see and treat". In practice however, the mechanism for categorising patients as Flow 1 is retrospective and allows inclusion of patients who may have required extensive investigations to exclude major illness. For example, a negative computerised tomography (CT) scan result to rule out subarachnoid haemorrhage. These flow categories do not reflect changes in current emergency department practice and research allowing earlier discharge of patients who would previously have required admission to hospital, or the increased use of ambulatory pathways developed to aid flow and capacity.

6.21. The Board performance reports[58] highlight the significance of Flow 1 for the achievement of the four-hour standard. Staff feedback was that the focus on Flow 1 patients meant that these patients could be seen at the expense of other more acutely unwell patients who ended up waiting longer to be seen – and that this made staff uncomfortable.

[56]Emergency Department Signposting/Redirection Guidance. Supporting documents - Emergency Department signposting/ redirection guidance - gov.scot. Scottish Government. 2021.
[57] AE2 A&E data recording reference manual v2.6. AE2. Public Health Scotland 2024
[58] Board Performance Report. NHS Greater Glasgow and Clyde. Dated 30 April 2024

6.22. In addition, NHS Greater Glasgow and Clyde has established two minor injury units co-located at the Queen Elizabeth University Hospital[59] and Glasgow Royal Infirmary, and a separate dedicated minors area at the Royal Alexandra Hospital. This is in addition to other standalone minor injury units for example at New Stobhill Hospital and the Vale of Leven Hospital. Minor injury units aim to provide access to treatment for patients with less severe injuries such as cuts and minor burns and scalds. Patients can be safely redirected to these units from emergency departments which reduces pressure on the emergency departments so they can focus on serious and life-threating cases.

6.23. Scottish Government launched the Redesign of Urgent Care Programme in December 2020. Establishment of flow navigation centres was one of the key national changes for NHS boards as a result of this programme. Flow navigation centres seek to minimise the need to attend emergency departments and bring an element of scheduling to the traditional model of urgent and unscheduled care. Every mainland NHS board operates a flow navigation centre. They are configured differently in different NHS boards. Some operate on a 24/7 basis, some do not. Flow navigation centres are still developing in response to local requirements. Some have evolved to be a hub for coordination of primary care referrals into secondary care sites or to reflect other region-specific pathways. A recent evaluation of the redesign of the urgent care pathway highlighted variations between NHS boards in the scope and scale of flow navigation centre input to the pathway.[60]

6.24. NHS Greater Glasgow and Clyde's flow navigation centre is also known as "virtual accident & emergency".[61] It provides virtual urgent and unscheduled care appointments via NHS 24 111. NHS 24 can arrange scheduled arrival times for the minor injury units or emergency departments if it is deemed that a patient requires face-to-face assessment. The flow navigation centre covers the whole of NHS Greater Glasgow and Clyde and is not a 24-hour service. It operates seven days a week between the hours of 10am to 10pm.

6.25. Staff perception of redirection is that the whole system is under pressure and there are limitations arising from the redirection policy. This may mean the potential value of this process is not being fully realised. Some staff suggested that patients came to the emergency department because of difficulties accessing primary care. Others highlighted that to see a specific specialist at the Queen Elizabeth University Hospital who may be already treating the patient, an assessment must first be undertaken by either a GP, or within the emergency department. NHS Greater Glasgow and Clyde advised that whilst there are some pathways in place to ensure patients seeking specialist services avoid the

[59] Minor Injuries Unit - NHSGGC. NHS Greater Glasgow and Clyde.
[60] Redesign of Urgent Care (RUC) Evaluation Main Report. Redesign of Urgent Care (RUC) Evaluation Main Report. Scottish Government, January 2025.
[61] Virtual Accident & Emergency (A&E) - NHSGGC. NHS Greater Glasgow and Clyde

emergency department, some patients under specialists at the Queen Elizabeth University Hospital do require an assessment first by a GP or within the emergency department. This adds further pressure on the Queen Elizabeth University Hospital emergency department. Evidence seen and heard by the Core Review Group indicated that there are few specialty pathways that provide direct access for their patients without the need for the emergency department to be used as a 'gatekeeper'.

6.26. NHS Greater Glasgow and Clyde supplied redirection data for the Queen Elizabeth University Hospital (Table 6) and Glasgow Royal Infirmary (Table 7) as evidence to inform this review. This data had been prepared on an ad hoc basis for specific NHS Greater Glasgow and Clyde internal purposes. At the time of the review, NHS Greater Glasgow and Clyde did not have similar data for the Royal Alexandra Hospital hence there is no associated data table in this report. A redirection dashboard was under development, with the anticipation it would be published to the live environment by the end of November 2024.

6.27. In reports and data supplied for September to November 2024, NHS Greater Glasgow and Clyde had identified that at the Queen Elizabeth University Hospital[62] and Glasgow Royal Infirmary[63] redirection numbers are lower than they would expect. The Queen Elizabeth University Hospital report stated that: "The number of patients recorded as a minor injury or illness redirection remain low with inconsistency in weekly data recorded. There is still opportunity to improve on-site Trak recording processes to more accurately reflect the numbers. Positively, in those records with a redirection outcome, the majority are being redirected off site to primary care. The number of records with an 'unknown' outcome has also reduced during October".

6.28. It is of concern that for 64% of redirected patients at the Queen Elizabeth University Hospital no known outcome was recorded between the start of September and end of November 2024. It is therefore difficult to ascertain the efficacy or safety of the model for patients.

[62] QEUH DWD & Redirection update. NHS Greater Glasgow and Clyde Dated week ending 24 November 2024.
[63] GRI DWD & Redirection update. NHS Greater Glasgow and Clyde Dated week ending 24 November 2024.

Week commencing	01/09	08/09	15/09	22/09	29/09	06/10	13/10	20/10	27/10	03/11	10/11	17/11	24/11
Redirection refused	0	0	0	0	0	0	0	0	0	0	0	0	0
Redirection to community pharmacy	1	0	0	0	0	0	1	1	2	0	0	5	0
Redirection to minor injury unit	0	1	2	0	1	0	5	0	9	0	2	8	1
Redirection to primary care	9	11	22	5	3	5	19	19	28	11	15	8	14
Redirection to self-care	4	3	1	5	1	1	15	10	10	4	4	3	12
Number of patients records of redirection	**14**	**15**	**25**	**10**	**5**	**6**	**40**	**30**	**49**	**15**	**21**	**24**	**27**
% of Flow 1 patients redirected	**1.9%**	**2.0%**	**3.5%**	**1.4%**	**0.7%**	**0.8%**	**5.5%**	**4.9%**	**7.0%**	**2.4%**	**3.2%**	**4.2%**	**4.5%**
Unknown outcome recorded	48	57	45	48	66	79	71	23	17	15	13	11	17

Table 6: Queen Elizabeth University Hospital minor injury or illness redirection data September to November 2024

Week commencing	01/09	08/09	15/09	22/09	29/09	06/10	13/10	20/10	27/10	03/11	10/11	17/11	24/11
Redirection refused	0	0	1	0	0	0	2	0	0	0	0	0	0
Redirection to community pharmacy	1	1	1	0	1	1	0	2	1	0	1	1	1
Redirection to minor injury unit	4	19	17	12	12	22	16	14	15	28	20	17	4
Redirection to primary care	4	10	6	4	11	7	22	7	24	21	14	20	12
Redirection to self-care	1	2	3	1	1	3	9	3	4	2	3	5	3
Number of patients records of redirection	**10**	**32**	**28**	**17**	**25**	**33**	**49**	**26**	**44**	**51**	**38**	**43**	**20**
% of Flow 1 patients redirected	**1.9%**	**5.3%**	**5.5%**	**2.8%**	**4.9%**	**6.3%**	**9.4%**	**4.8%**	**7.8%**	**10.2%**	**7.2%**	**8.6%**	**4.2%**
Unknown outcome recorded	14	12	11	15	18	15	15	14	19	10	16	15	14

Table 7: Glasgow Royal Infirmary minor injury or illness redirection data September to November 2024

6.29. Other NHS boards have introduced "hot clinics" in parallel with redirection arrangements and have found this to be effective. Hot clinics are a rapid access clinic to enable quick access to a specialist review to facilitate early discharge or prevent unnecessary admission after an assessment in the emergency department.[64] Hot clinics exist, but the review did not see evidence that they are consistently used across the three relevant sectors in NHS Greater Glasgow and Clyde.

Demand, crowding and non-standard care

6.30. The issues around crowding in emergency departments are not unique to NHS Greater Glasgow and Clyde. Crowding occurs when demand outstrips capacity and needs to be viewed in the context of the wider system. The Royal College of Emergency Medicine does not view crowding as inevitable and states that it worsens mortality and morbidity for patients and increases stress, burnout and sickness for staff.[65] The Royal College of Emergency Medicine calls for local leaders to adopt good practice and reduce unwarranted variation.

6.31. Crowding in the emergency department impacts the ability of ambulances to transfer patients timeously and safely. This causes ambulance queues and ultimately limits access to ambulance services for acutely unwell patients. The Scottish Ambulance Service set a longer-term aim of handover of patients within 15 minutes with a maximum wait of no longer than an hour by August 2023. Median of three-week rolling average of weekly ambulance turnaround times during 2024 across the peer group of Scottish hospitals was between 48 and 55 minutes. Within NHS Greater Glasgow and Clyde, ambulance turnaround times were consistently higher in the Queen Elizabeth University Hospital than the peer group, and lower in the Glasgow Royal Infirmary and the Royal Alexandra Hospital. This may be due to differences in use of non-standard bed care (see Chapter 4 and non-standard bed care section below).

6.32. Despite the data demonstrating that the volume of demand in the emergency departments has not increased, staff perception was of increased demand on the available capacity which was impacting on the quality and safety of care. Higher acuity/complexity and crowding were seen by staff as impacting on the quality and safety of care at all three sites. Every respondent to the staff survey reported that the number of patients in the emergency department either 'always' or 'usually' exceeded the department's capacity (Figure 6.4). Staff do not feel they are delivering the best care they can due to capacity.

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[64] Imtiaz, MR, Sreelekha, A, Shatkar, V. Surgical Hot Clinic – An Effective Pathway of Reducing Emergency Admissions and the Associated Costs. Surgical Hot clinic – an effective pathway of reducing emergency admissions and the associated costs. International Journal of Healthcare Sciences (Online) Vol. 4, Issue 2, pp: (198-205), Month: October 2016 - March 2017.

[65] Emergency Department Crowding | RCEM. Royal College of Emergency Medicine. 2024

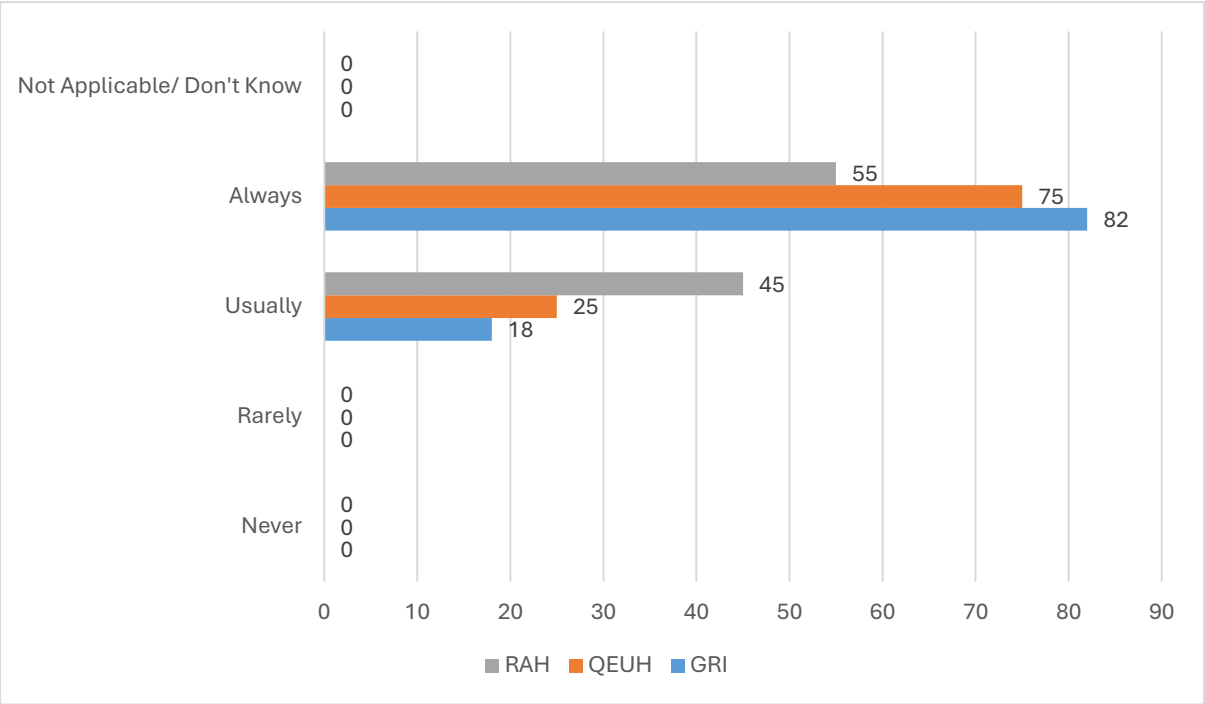

Figure 6.4: Staff views on capacity being exceeded in the emergency department (% of staff)

6.33. As a result of this high demand, most staff across all three emergency departments said they did not have enough time to spend with patients (Figure 6.5).

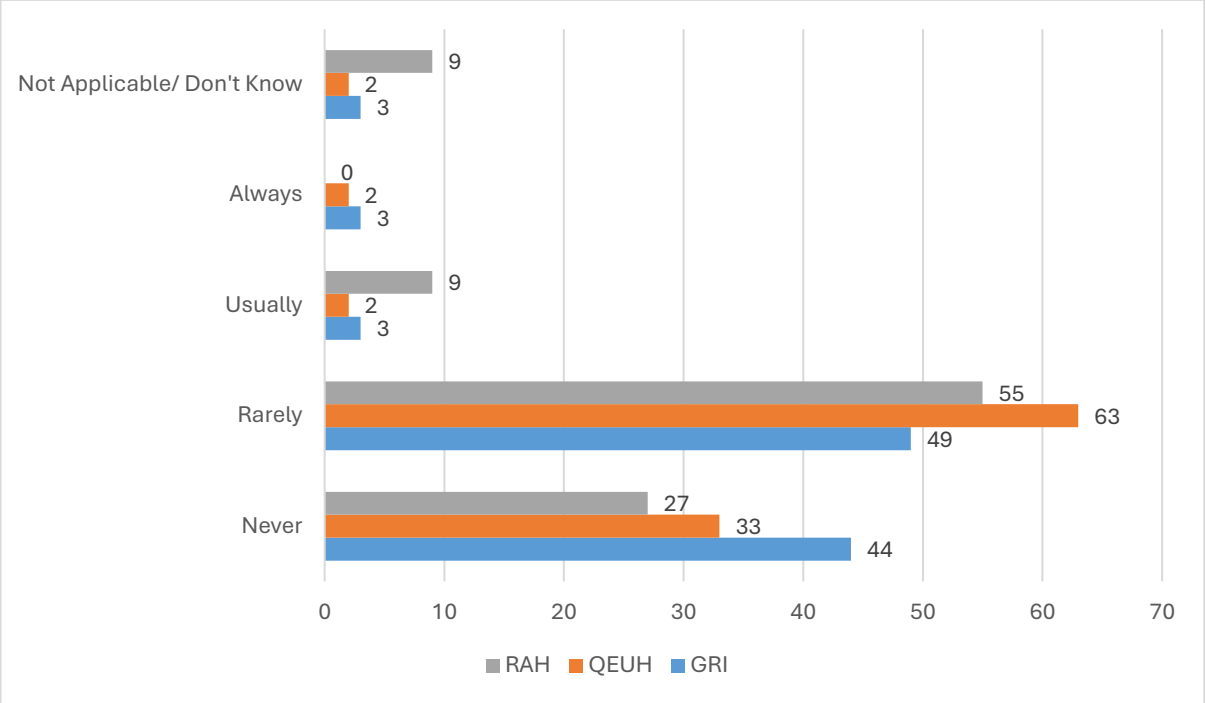

Figure 6.5: Staff views on having enough time to spend with patients (% of staff)

6.34. A number of staff highlighted the focus on emergency departments to resolve waiting times at the front door was the wrong approach, and that a focus on flow across the whole hospital would be more useful. Without this, they noted that patients are waiting for hours in the emergency department to be admitted to a ward. Some staff reported that previous attempts to escalate these concerns had been unsuccessful.

> *We are overwhelmed on a daily basis, and the wider organisation does not appear to care […]. Quite simply, there is insufficient capacity in the system for the demand placed on it. And the truly galling part is the impression given that if we just all worked a bit harder it would be solvable.*

Non-standard bed care

6.35. Hospital crowding can lead to care of patients in non-standard care areas. This can include: placement of extra beds in wards or in ward corridors, placement in emergency department corridors, patients receiving care while placed on chairs, care in treatment or non-clinical rooms and patients awaiting treatment in ambulances and waiting rooms.

6.36. The Royal College of Nursing[66] highlighted in a report "*Corridor care: unsafe, undignified and unacceptable*" that: "Patient privacy and dignity can be compromised when care is provided in inappropriate settings. Access to life-saving equipment such as oxygen, suction and monitoring can be unavailable, and patients can have limited or no access to toilet facilities and handwashing provision. Emergency call buttons are unavailable. Infection prevention controls are compromised. Health and safety regulations are breached. Medication cannot be stored safely, and patients' personal belongings are not secured."

6.37. Furthermore, the Royal College of Emergency Medicine said in a statement[67] about corridor care in December 2024: "It is not possible to provide safe and good quality care in temporary escalation spaces such as corridors. Where such spaces are in use it is inevitable that this will be associated with long waits in emergency departments. We know that long waits in emergency departments are associated with measurable harm to patients. Care will therefore not be safe." Long emergency waits have been found to be associated with a doubling of risk of death.[68].

[66] Corridor Care: unsafe, undignified, unacceptable Publications | Royal College of Nursing. Royal College of Nursing. June 2024

[67] 'Normalisation of the dangerous' – RCEM hits back at NHSE 'Corridor Care' guidance | RCEM. Royal College of Medicine. 16 December 2024.

[68] British Medical Journal News. https://www.bmj.com/content/388/bmj.r119. British Medical Journal. 20 January 2025.

6.38. Use of such spaces has previously been noted by Healthcare Improvement Scotland in safe delivery of care inspections across NHS Scotland boards. They can be a planned feature of flow models to minimise pressure on emergency departments in extremis. However, we heard from staff, and both the Royal College of Nursing and Royal College of Emergency Medicine have stated, that use of non-standard care spaces is being "normalised" with the Royal College of Nursing report (January 2025) *"On the Frontline of the UK's Corridor Care Crisis"*[69] stating that 66.81% of respondents reported caring for patients daily in non-standard areas with 90.8% stating that care and safety were compromised.

6.39. NHS Greater Glasgow and Clyde use corridor beds and chair spaces across the Glasgow Royal Infirmary and the Royal Alexandra Hospital to increase capacity in the emergency department, but not at the emergency department in Queen Elizabeth University Hospital. It is also a feature in downstream wards in all three hospitals as part of the GlasFLOW/continuous flow models. Data on the use of these spaces is not routinely collected either at national or local level in Scotland. In 2024, the Scottish Executive Nurse Directors group carried out a snap-shot day of care audit of non-standard bed space/care area use across acute inpatient and mental health units to try to ascertain the size of the issue; however, NHS Greater Glasgow and Clyde did not take part in the audit, and the opportunity to understand the position across NHS Scotland was lost. NHS boards need to monitor these additional patients requiring care so that appropriate additional staffing can be put in place.

6.40. Staff within NHS Greater Glasgow and Clyde have raised a range of DATIX reports about crowding, corridor care and patient safety concerns associated with delays in providing care. The negative impact of corridor care was highlighted by many staff in terms of insufficient staffing, dignity, privacy, direct view of patients and consequent harm. These descriptions reflected a common observation that patient experience was impacted by high workload which meant staff were unable to spend time providing person-centred care.

Recommendation 8: NHS Greater Glasgow and Clyde, and its six aligned Health and Social Care Partnerships, should strengthen their whole system unscheduled care plan to urgently reduce use of non-standard care areas, improve waiting times and reduce crowding by addressing:

- management of patient flow and redirection
- referral pathways to specialties from within and out with the emergency departments
- delayed discharges, and
- models of care, same day delivery of care options and consideration of maximising 24/7 services including flow navigation.

[69] On the Frontline of the UK's Corridor Care Crisis Corridor care crisis | Publications | Royal College of Nursing. Royal College of Nursing. 16 January 2025.

Essential of Safe Care 2: Safe communication within and between teams

A lack of safe communication within and between teams is one of the most significant issues identified by this review. There was a lack of awareness of escalation plans, and they were not used robustly or effectively.

6.41. This section includes communication skills and practice, including the format, content and tools used, and management of communication in critical situations.

6.42. Due to the significance of the lack of safe communication within and between teams, this issue is explored in depth within the Leadership and Culture chapter. However, its significance is noted here because of the evidence-based link between civility within teams and patient safety. This evidence is captured by the charity Civility Saves Lives[70] which states that when a team values and respects its members, benefits include not just improved staff satisfaction and health but also reduced hospital standardised mortality rates and reduced patient complaints. Incivility is rude or unsociable behaviour, such as shouting, aggression, belittling, talking over others and being difficult.

How staff feel management respond to patient safety concerns

6.43. Staff expressed concern that management did not adequately address patient safety concerns raised and instead placed more focus on achieving targets (Figure 6.6).

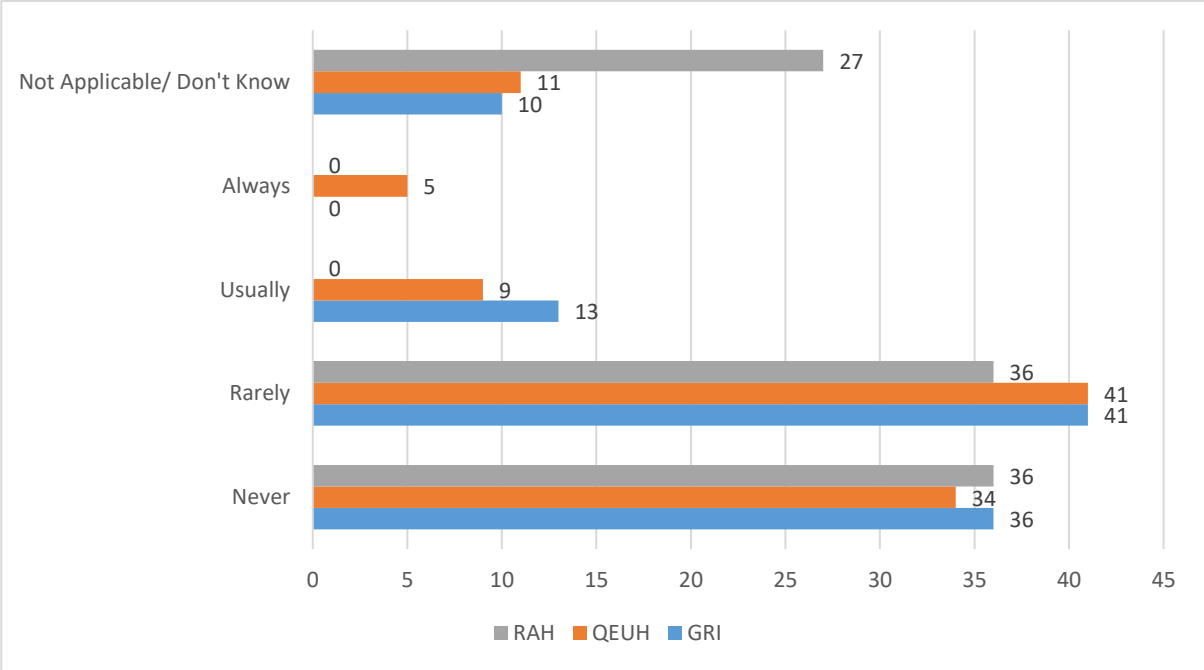

Figure 6.6: Staff views on whether management prioritise patient care over achieving targets (% of staff)

[70] The Evidence | Civility Saves Lives. Civility Saves Lives.

> *It's a constant battle to keep patients and staff safe, it is clear there is no support from management about patient safety and they often care more about 'breach reports' than the patients we have in ED.*

Communication in critical situations: escalation

Escalation plans are intended to ensure a graded response to pressures from rising demand in emergency departments, for example due to high volume of patients, complex patients or lack of workforce. The issue of escalation was one of the most significant issues raised by some staff during the review. Although all three hospitals covered by the review have an escalation plan, there did not appear to be sufficient awareness of them, robust use of them, ownership by teams nor any perceptible impact of their deployment by in-patient teams on the pressures in the emergency departments. There were concerns about their ability to practically and credibly address serious and immediate pressures.

6.44. Staff viewed the escalation plans as being very reactive to the situation rather than being proactive in anticipating difficulties. They described variability across the three sites in the systematic engagement with staff within the emergency departments or the wider specialties in their development. There was no clear evidence of any specific escalation plans within other acute assessment areas outwith the emergency departments. In the absence of a cohesive multidisciplinary approach to development of escalation plans, there will be a lack of understanding of capacity issues between the emergency departments and the rest of the hospital, leading to further isolation of the emergency department.

6.45. Escalation policies typically use a colour-coded classification where green status is the lowest level of pressure on the system moving through amber to black status which indicates the highest level of pressure. It was noted by staff that, if an emergency department is in an amber position in the morning it will always escalate over the day as no additional actions are triggered or being performed by the rest of the hospital by this amber status. The review team noted that amber appeared to be 'the new green' which meant that the emergency department was always in a state of escalation which has become the new norm. On the other hand, the impact on most in-patient teams and specialties only appeared to occur at black level. Earlier action throughout the day may help alleviate the issue and prevent escalation to black.

6.46. The escalation at black did not seem to have an effect to reduce the level of risk and was therefore perceived to be meaningless and too late by emergency department teams. Often the escalation cards showed poor engagement by in-patient medical specialty teams which manage the majority of wards and impact the most difficult flow pathway. It was not clear to the review whether in-patient specialties fully understood the status of the emergency department at any point in time or the actions that were expected of them in each stage of escalation (and vice versa). It was also unclear whether job planning within specialty teams allowed the capacity for them to be responsive to such actions required to alleviate capacity issues across the site.

6.47. It was also noted that there appeared to be a discrepancy as to the use of patient divert between hospitals. The escalation cards suggested discussions between clinicians and that if hospitals are in black status no diversions occur. However, this was contrary to the experience of the teams in the Royal Alexandra Hospital and the Glasgow Royal Infirmary.

6.48. There was a strong view expressed that the diversion of a relatively small number of patients disproportionately impacted each receiving emergency department more than benefitted the transfer for the base hospital.

6.49. There was concern expressed by staff that escalation was becoming normalised, without adequate understanding of the implications of escalation, and that the process did not have a material impact on the situation for staff or patients in emergency departments.

6.50. There have been attempts by consultants in emergency medicine at the Queen Elizabeth University Hospital to declare "major incidents". [71] Under the existing legislation and guidance this would not, in itself, provide additional resources. The expectation would be that emergency responder partners across the entire health and care system would adjust to support any hospital under sustained and serious pressure. NHS Greater Glasgow and Clyde has not been unique in this as a health board.

6.51. This issue highlights the need to have far clearer statement of how hospitals in extremis are supported by the whole health and care system and the objective assessment of triggers for practical escalation and business continuity.

6.52. There are currently three levels of response as set out in the Scottish Government national guidance on incident response levels (Figure 6.7 below).[72]

[71] 17 June 2024 Handover Notes. Greater Glasgow and Clyde ED Consultant. Dated 17 June 2024.
[72] National incident response levels: guidance for health boards - gov.scot. Scottish Government; 02 May 2024

Incident response levels are defined as:

(a) Business Continuity Incident – an event or occurrence that reduces or might reduce, a health board's normal service delivery to below acceptable levels and would require special arrangements (such as temporary re-deployment of local / regional resources and mutual support) to be put in place until services can return to an acceptable level. There may also be impacts from wider issues such as supply chain disruption or provider failure.

(b) Critical Incident – any localised incident where the level of disruption results in a health board losing its ability to deliver critical services, or where patients and staff may be at risk of harm. It could also be linked to the environment potentially being unsafe and requiring special measures and support from other agencies to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/disruption to operations delivered by the health board. Unlike a major incident, a critical incident does not have any actions prescribed by either legislation or national guidance that must be taken as a result.

(c) Major Incident – is defined in the Joint Emergency Services Interoperability Principles (JESIP) as: "An event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder."

Figure 6.7: Incident Response Levels

6.53. In summary, the feedback indicates that staff perceive the system as often chaotic. This may foster a 'command and control' leadership culture, and which may in turn lead to staff pushing back against any offers of solutions. The perception of staff was that the emergency departments were permanently in 'black status' and as such this status had become irrelevant, with staff becoming de-sensitised to this. The NHS Greater Glasgow and Clyde emergency department escalation plan is perceived to be ineffective, and little can be done to prevent deterioration or even predict deterioration. This results in feelings of 'learned helplessness' and an inability to improve the situation.

6.54. The review of shift handover documents provided further evidence of issues rated as significant being escalated across both sites and by both staff groups on nearly every day of the week. Medical handover documents from the Queen Elizabeth University Hospital showed the highest incidence of escalations rated as significant. It could not be determined solely from the review of the handover documents whether actions had been taken in response to escalated issues, or if the outcome of any actions had been fed back to the emergency department teams. Significant issues with staffing were also evident across both sites and both staff groups to varying degrees on every day of the week. The issues related to both staffing gaps and skills mix. The handover documents indicated that staff

were being impacted by the various pressures in the emergency departments. Impact on both medical and nursing staff was assessed as significant across both sites, to varying degrees, on every day of the week.

6.55. The situation presented in NHS Greater Glasgow and Clyde is a manifestation of emergency departments under sustained pressure and without the identification of whole system solutions. This reinforces the sense of frustration and has an impact on staff morale and wellbeing.

Recommendation 9: NHS Greater Glasgow and Clyde should ensure its escalation and business continuity plans are practical and effective in addressing pressures at each hospital and are implemented across the whole system to ensure there is good awareness and ownership of them by teams across the hospitals. The effectiveness of the plans should be monitored and regularly reviewed through appropriate NHS board governance structures.

Essential of Safe Care 3: Leadership to promote a culture of safety at all levels

Staff morale is low within the emergency departments, with indications of moral distress. Management has not taken sufficient action to improve staff experience and wellbeing, and psychological safety has been negatively impacted by poor teamwork in the Queen Elizabeth University Hospital emergency department. There are significant gaps in the systems for learning about safety from incidents and concerns raised. This includes ensuring concerns are heard, investigated and the learning shared. Staff at the Queen Elizabeth University Hospital felt less able to raise safety concerns than staff in the other two emergency departments.

6.56. This section includes psychological safety, staff wellbeing and systems for learning. Due to the significance of the review's findings on leadership and culture, a separate chapter is considering this in greater depth. This chapter focuses solely on safety aspects of leadership.

Physical safety

6.57. Staff reported a perceived increase in aggressive behaviour from some patients which impacted on the physical safety of staff and other patients. These concerns were expressed at the Glasgow Royal Infirmary and the Queen Elizabeth University Hospital, but not at the Royal Alexandra Hospital. They were compounded by limited security presence which could often take some time to attend the department. Multiple DATIX reports have been made about poor behaviour from patients, many resulting from frustration due to delays.

> *Increase in aggressive and abusive behaviour from patients – no emergency department security. This has a massive impact on both patients and staff as the nursing team have to try and de-escalate this behaviour despite multiple threats and incidents of physical violence.*

6.58. This was reflected in employee reported DATIX incidents, where violence and aggression was the most common category reported overall with 1,070 (56%) out of the total of 1918 incidents:[73] Some incidents are not reported so this may be an under-estimate of the issue.

Hospital	% of incidents are violence and aggression
Glasgow Royal Infirmary	63
Queen Elizabeth University Hospital	57
Royal Alexandra Hospital	41

Table 8: Reported incidents involving violence and aggression

6.59. Staff frequently reported concerns about the physical environment that have impacted on safe care, including broken equipment and either an ageing or unsuitable estate. Most respondents to the staff survey reported that the physical environment of the emergency department 'always' or 'usually' impacted on their role, and this was true across all three sites (Figure 6.8).

Corridor care was cited as a particular concern with staff describing it as unsafe and undignified.

> *[…] patient flow issues often lead to patients being moved into corridors, which compromises their privacy and safety and hinders effective monitoring, while limited space raises concerns about infection control.*

[73] *Unscheduled Care Incident Report Oct 19 – Sep 23 Cover Paper* and *Unscheduled Care Incident Report Oct 19 – Sep 23 Full Paper*. Greater Glasgow and Clyde. 08 April 2024.

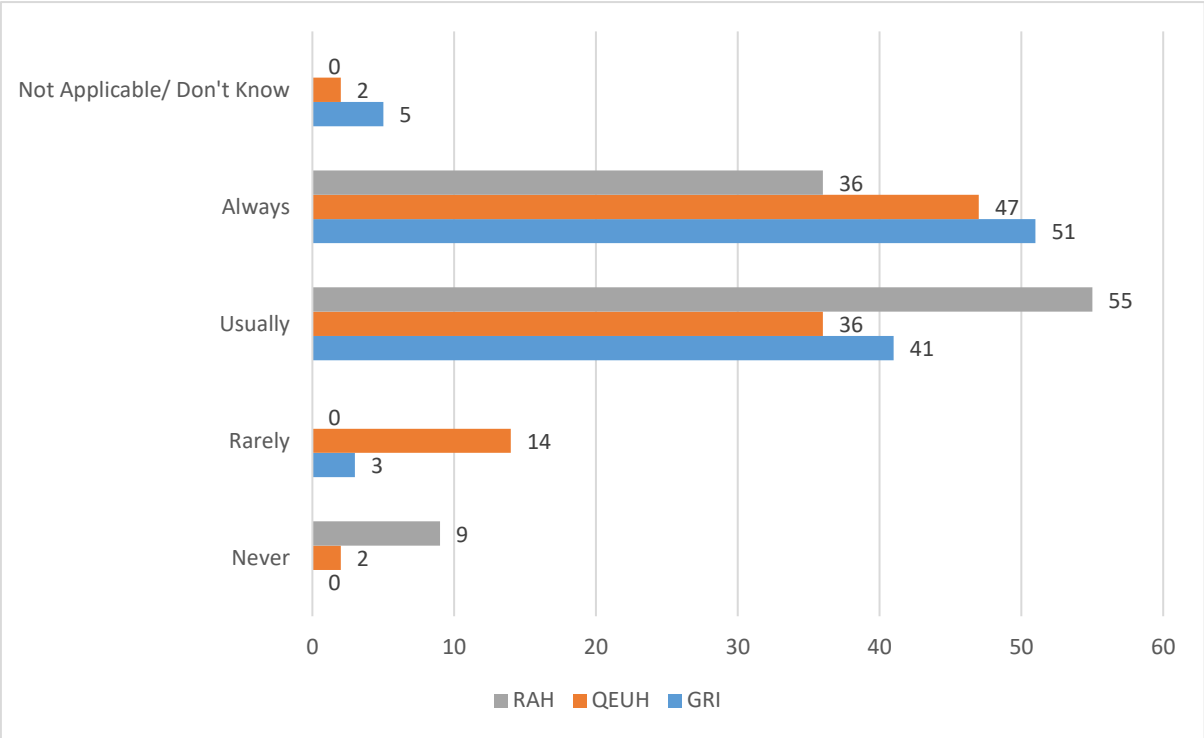

Figure 6.8: Staff views on the physical environment impacting on their ability to undertake their role (% of staff)

6.60. Poorly designed building layout was highlighted as an issue by staff in both the Queen Elizabeth University Hospital and the Royal Alexandra Hospital, with staff unable to always see patients which was described as a safety risk. Meanwhile in the Glasgow Royal Infirmary, staff reported that the estate was ageing with a need for capital investment to tackle issues such as a leaking roof and rising damp in the basement, and small and uncomfortable waiting areas. Broken lifts were also highlighted as causing portering delays. Limited and distant staff facilities were an issue for emergency department staff at the Royal Alexandra Hospital, along with the state of disrepair of the portacabin used there. The distance between the emergency department and minor injuries unit at Glasgow Royal Infirmary hindered effective working. Consultants cited the difficulties of access to office space on a number of occasions as the main reason for working from home. This has the potential to cause further isolation from colleagues and loss of cohesion within teams.

6.61. Concerns were also raised about accessing appropriate equipment and sundries, particularly at the Glasgow Royal Infirmary. Few staff reported problems with accessing digital and clinical systems.

Staff satisfaction and morale

6.62. Staff having job satisfaction was rated as 'rarely' or 'never' by over two-thirds of respondents to the staff survey (Figure 6.9). Views on whether the emergency department is a good place to work differed in the different sites, with 71% of Queen Elizabeth University Hospital staff saying 'rarely' or 'never' compared with 54% at the Royal Alexandra Hospital and 34% at the Glasgow Royal Infirmary.

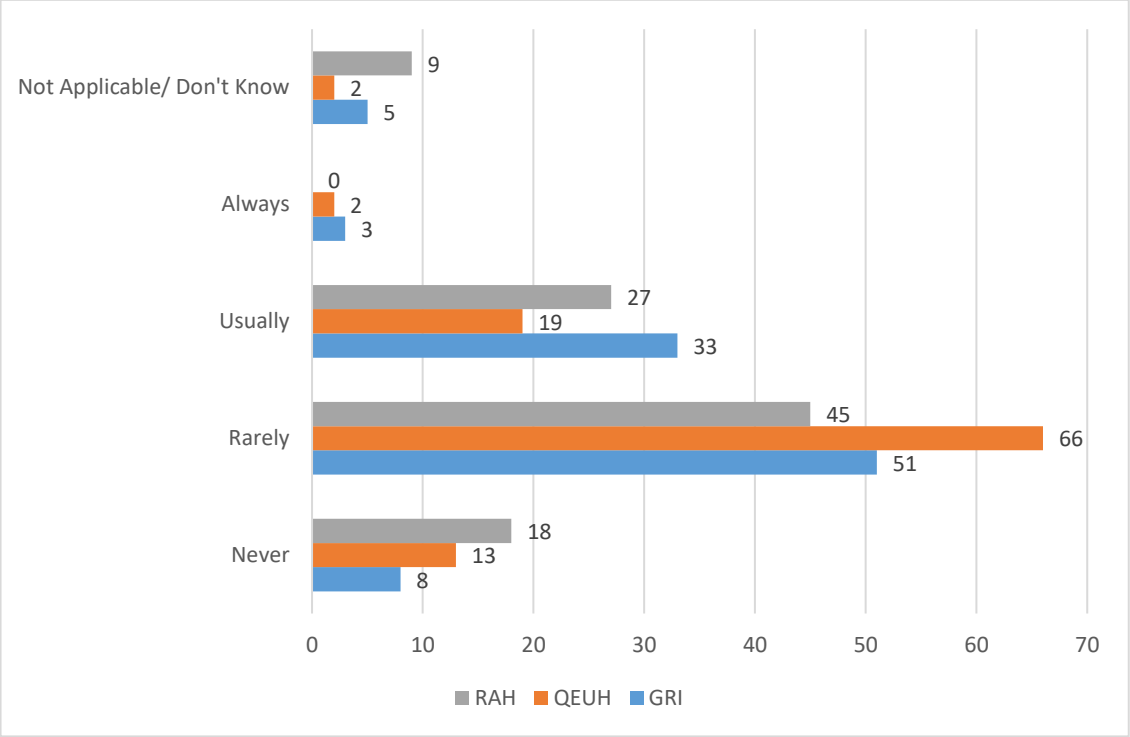

Figure 6.9: Staff sense of satisfaction from their work (% of staff)

6.63. Staff morale in emergency departments was found to be low by the staff survey, with the majority of participants saying morale was 'rarely' or 'never' high. There was a difference between sites, and an indication that low staff morale may be a more pervasive problem in Queen Elizabeth University Hospital, given the disproportionate percentage of 'never' responses (Figure 6.10).

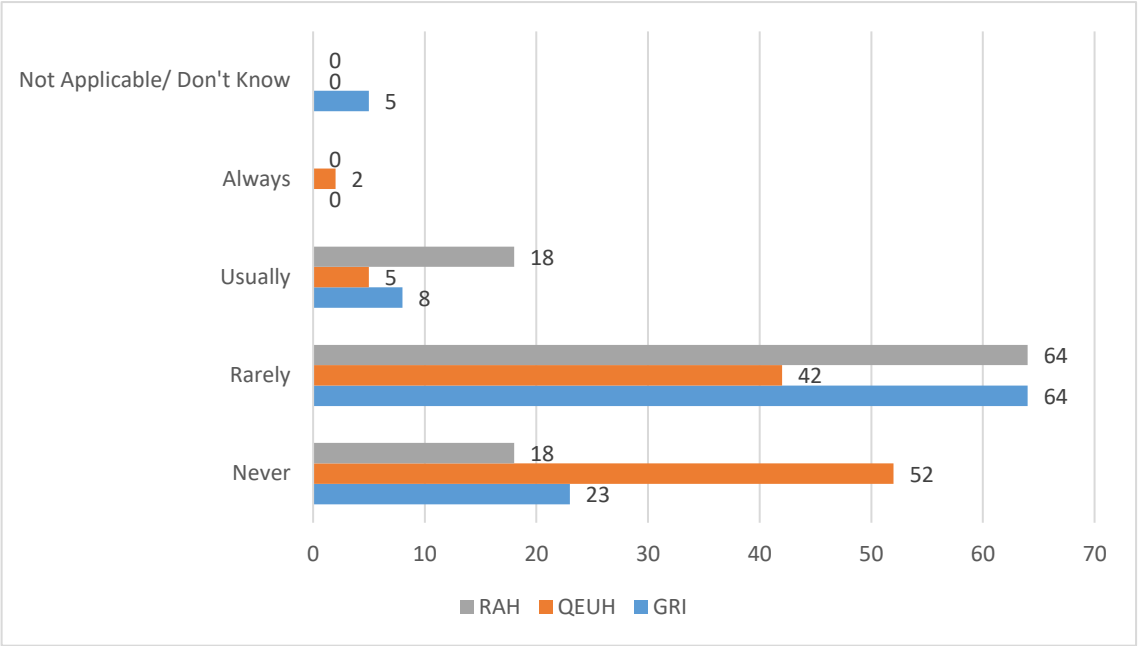

Figure 6.10: Staff reporting morale in the emergency department to be high (% of staff)

6.64. The quantitative data from the survey were supported by qualitative data, which also tended to be more negative from staff at the Queen Elizabeth University Hospital than the other two sites. Some staff described the working environment in the Queen Elizabeth University Hospital as 'brutal' and 'inhumane'. Staff talked about the moral distress[74] caused by circumstances within the department that led to them not being able to provide what they described as basic levels of care. One staff member described being 'haunted' by some patient care experiences that had led to harm. Back-to-back trauma cases were described as 'horrific' with a perceived lack of space to decompress after adverse events. These staff experiences may be impacting on sickness absence rates (see paragraphs 6.101. and 6.125).

> *I used to love emergency medicine, and in many ways I still do. […] We are losing experienced staff all the time, because they don't feel valued or supported.[…]*

> *Multiple staff members have been off with stress recently and a large influence on that has been having to do the job of three nurses every shift. We keep getting told to prioritise basic care, prioritise investigations, prioritise treatment, prioritise infection control, prioritise flow, prioritise documentation, prioritise nursing assessments as we are failing on all fronts.*

[74] Moral distress is the psychological distress of knowing the right thing to do but being constrained from pursing the right course of action. Jameton A, 1984. Nursing practice: the ethical issues. Englewood Cliffs, NJ: Prentice Hall, p6.

> *We are failing on all fronts because we are fighting fires on most shifts. Emergency nursing is an amazing specialty, most of us chose it as it's an area where we feel we can make a difference, we can support the most unwell and most vulnerable patients. But realistically we are barely keeping our heads above water.*

6.65. Despite the majority of feedback from staff being negative, there were some positive comments about why working in the emergency department can be positive and fulfilling.

> *We care for some people in their most vulnerable times. In my time in the emergency department, I have felt I have made a difference.*

6.66. However, many staff expressed concerns that they could not do their jobs properly, leading to moral distress. Nursing staff reported to be burnt out and worried about making mistakes. Emergency medicine consultants reported feeling undervalued. Clinicians feel responsibility for harm that comes to patients from long wait times and corridor care, and staff reported that after some shifts, they could feel eroded of energy with a low feeling of worth.

Management action to improve staff experience

6.67. Staff perceived that they are not valued by management and that communications from management can cause anxiety. Although there was some wellbeing support available (for example, a wellbeing room), staff reported having little or no time to take up this support or even take a break.

6.68. All three emergency departments have developed their own wellbeing multidisciplinary groups with support from departmental management. Departmental management had also arranged for monthly psychological support for staff in the Queen Elizabeth University Hospital emergency department. This arrangement was in place until December 2024. A business case for continuing this on a permanent basis had been put forward.

> *[…] Feels like constant criticism from higher up all the time, never feel valued or part of a team. Don't want to come into work knowing the state of the place. The fact that higher-up management have no idea what the job entails and continuously cut staffing makes me want to quit. It makes me feel so devalued and I feel it's a slap in the face to the nursing profession.*

6.69. The staff survey found staff had mixed views on whether emergency department management took appropriate action to ensure positive staff experience and wellbeing, with a more negative response from the Queen Elizabeth University Hospital (Figure 6.11). A similar pattern was found when staff were asked if management teams provided feedback to recognise effort, with 36-46% of staff across the three sites saying it was 'rarely' done and the highest number of 'never' responses at the Queen Elizabeth University Hospital.

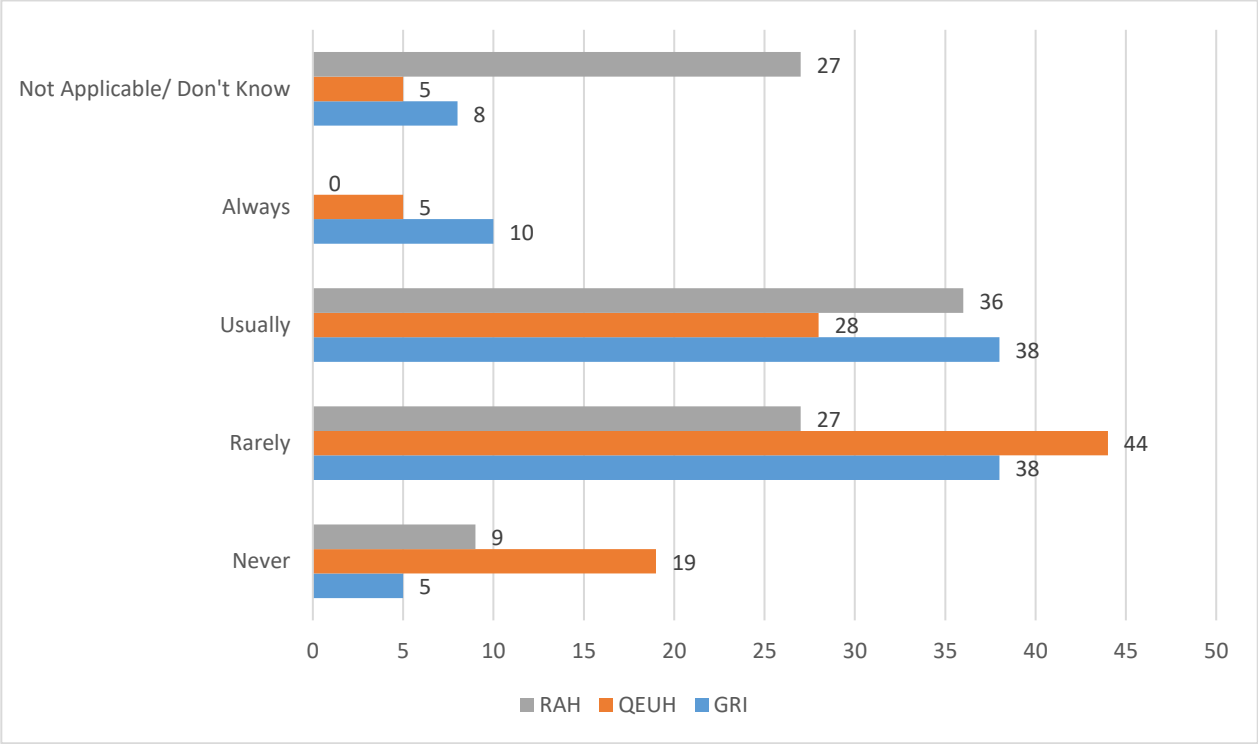

Figure 6.11: Staff views on management action to improve staff experience (% of staff)

> *Staff feel like they are not listened to by senior management, the level of burnout throughout all grades is at an all-time high… Management rarely check in on staff despite knowing about challenging shifts.*

> *When staff have had to cope with majorly traumatic events they are expected to move onto the next patient and not given or told to have any time to reflect which has ultimately resulted in staff struggling to cope for an extended period of time. Management have been known to dismiss/not take staff seriously when they have been approached by struggling staff members.*

Recommendation 10: NHS Greater Glasgow and Clyde must demonstrate recognition of the low morale, poor wellbeing and moral distress among staff and take actions to address these. This should include engaging with staff in all three emergency departments to identify appropriate improvement actions needed beyond the other recommendations covered in this review.

Recommendation 11: NHS Greater Glasgow and Clyde must take action to protect the physical safety of staff from aggressive behaviour by patients.

Recommendation 12: NHS Greater Glasgow and Clyde should identify and make the necessary improvements to the physical environment in the emergency departments at Glasgow Royal Infirmary and the Royal Alexandra Hospital and to staff facilities, including spaces for teams to easily meet, across all three hospitals, to ensure the environment is as safe and supportive as possible for staff and patients.

Systems for learning: significant adverse event reviews

6.70. Significant adverse event reviews are a structured process to analyse significant incidents and to learn from them to implement improvements. Table 9 below shows the number of Category 1 significant adverse event reviews commissioned by NHS Greater Glasgow and Clyde between 2020-2024 (The figures for the year 2024 are to October 2024 only) for the board as a whole and for emergency departments specifically.

6.71. The Healthcare Improvement Scotland Adverse Event Framework published in 2019[75] sets a target for the completion of the most significant adverse event reviews (Category 1) within 90 working days. The table also has in italics the number completed within the 90-working day target for each of the years.

Total SIGNIFICANT ADVERSE EVENT REVIEWs Commissioned and Completed (%) 2020-2024					
	2020	**2021**	**2022**	**2023**	**2024***
NHS Greater Glasgow and Clyde	158 (87%)	178 (93%)	232 (80%)	256 (49%)	262 (3%)
Completed within 90 working days (%)	*14 (8.86%)*	*7 (3.93%)*	*0 (0%)*	*2 (0.78%)*	*1 (0.38%)*
Accident and Emergency	8 (75%)	14 (93%)	13 (62%)	10 (60%)	12 (0%)
Completed within 90 working days (%)	*2 (25%)*	*2 (14.29%)*	*0 (0%)*	*0 (0%)*	*0 (0%)*

** 2024 figures to October 2024 only*

Table 9: Category 1 Significant adverse event reviews: Total commissioned and completed (%) 2020-2024 as notified to Healthcare Improvement Scotland

[75] https://www.healthcareimprovementscotland.scot/publications/learning-from-adverse-events-through-reporting-and-review-a-national-framework-for-scotland. Healthcare Improvement Scotland. 2019

6.72. The review heard concerns from staff about the length of time it took to commission a significant adverse event review, the timescale for its completion and whether significant adverse event reviews were always commissioned appropriately. The backlog of open significant adverse event reviews was a repeated concern raised in the Acute Services division clinical governance forum minutes. However, these issues are not unique to NHS Greater Glasgow and Clyde: the position in Table 9 mirrors serious challenges across NHS Scotland in ensuring significant adverse event reviews are completed in a timely manner.

6.73. The review identified variation across the three sites with regards to commissioning of significant adverse event reviews. Of the 101 commissioned in 2019-2023: 40% of significant adverse event reviews were commissioned in Clyde Sector, 31.6% in North and 28.4% in South[76]

6.74. NHS Greater Glasgow and Clyde openly acknowledged the challenges associated with feedback and learning from significant adverse event reviews. At the Acute clinical governance forum in April 2024, it noted in a paper covering significant adverse event reviews and DATIX since 2019 that: "The percentage of actions generated from all significant adverse event reviews closed in the reporting period is 91%. While the number of actions being closed off on DATIX is increasing, the quality of data remains poor with little evidence the actions taken to share learning across the organisation and what has been put in place to reduce the chance of a similar incident occurring in the future. This is similar across NHS Greater Glasgow and Clyde and not confined to unscheduled care areas."[77]

6.75. Staff raised concerns about the lack of feedback on submitted DATIX reports and no information about whether action or wider learning had taken place, including for issues raised about capacity. The Queen Elizabeth University Hospital emergency department's clinical governance group noted in the February 2024 minutes that: "Datix issues – staffing issues are not being commonly recorded, thought to be due to the acceptance of understaffing. Staffing issues should be recorded on Datix as they can affect patient care. It is important that those who submit a Datix feel that they have been heard. A response should be provided in email form, and a face-to-face response can also be arranged if required."[78]

[76] *Unscheduled Care Incident Report Oct 19 – Sep 23 Cover Paper* and *Unscheduled Care Incident Report Oct 19 – Sep 23 Full Paper*. Greater Glasgow and Clyde. 08 April 2024

[77] *Unscheduled Care Incident Report Oct 19 – Sep 23 Cover Paper* and *Unscheduled Care Incident Report Oct 19 – Sep 23 Full Paper*. Greater Glasgow and Clyde. 08 April 2024

[78] Clinical Governance Meeting Minutes. Greater Glasgow and Clyde. 1 February 2024.

Staff experience of learning from incidents and raising concerns

6.76. Staff reported varied opportunities for post-incident debriefs, with 88% of staff at the Queen Elizabeth University Hospital stating they 'rarely' or 'never' had the opportunity for a debrief compared with 36% at the Royal Alexandra Hospital and 23% at the Glasgow Royal Infirmary (Figure 6.12) where it was demonstrated that debriefs were used.

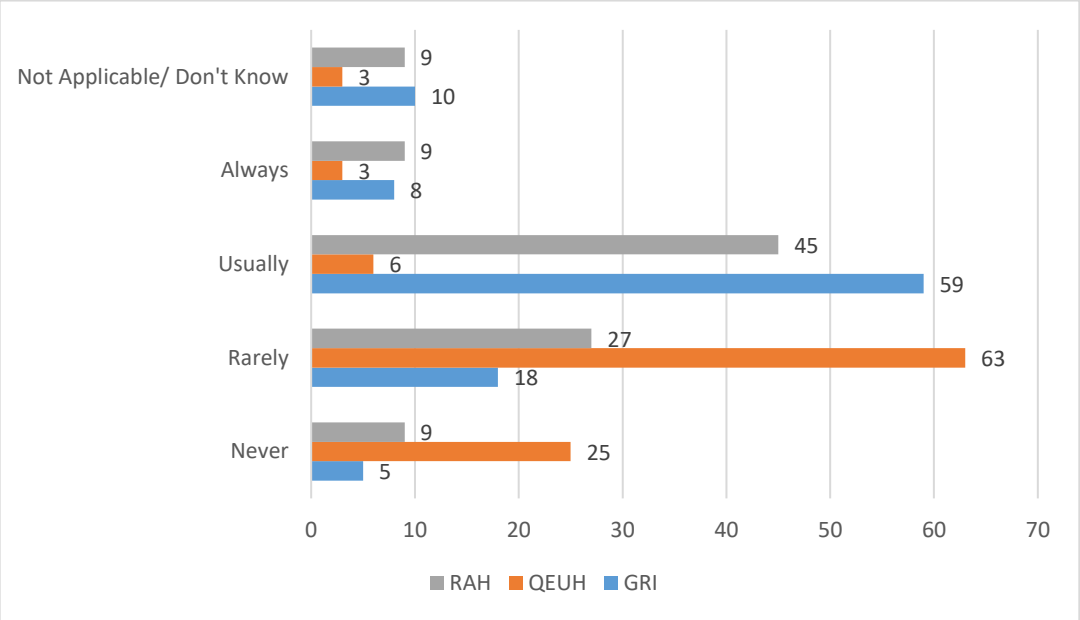

Figure 6.12: Staff reported opportunities to have post incident debriefs (% of staff)

6.77. Similarly, more staff at the Queen Elizabeth University Hospital said that incident reporting was not used for improvement, compared with staff at the Royal Alexandra Hospital or Glasgow Royal Infirmary (Figure 6.13).

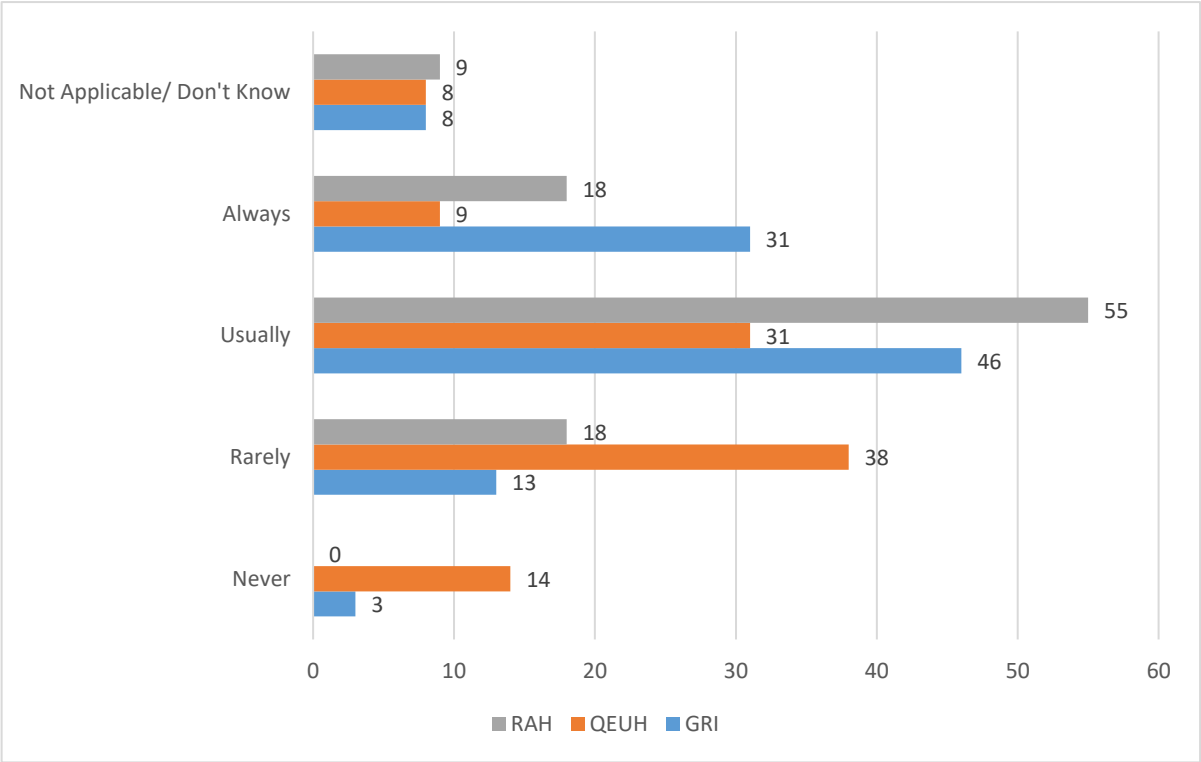

Figure 6.13: Staff reported use of incident reporting for improvement (% of staff)

6.78. Taken together, these questions indicate a need to improve the use of debriefs and incident reporting at the Queen Elizabeth University Hospital. These findings were backed up by qualitative data. The extent to which staff felt that their concerns regarding the quality and safety of care were addressed appeared to vary depending on the level of seniority to which the concern was raised. Some staff reported that although the leaders directly above them took reports of adverse events and safety concerns forward, they were concerned that at a certain level nothing progressed further. At the Queen Elizabeth University Hospital, staff reported that their concerns were unheard by both clinical management teams and site management teams.

6.79. Some staff at both the Royal Alexandra Hospital and the Queen Elizabeth University Hospital reported a perceived reluctance and resistance of some managers with regard to the reporting of adverse events relating to the emergency departments. The review team did not find further evidence to substantiate this staff survey feedback, nonetheless this has been formally raised with NHS Greater Glasgow and Clyde.

> *[There have been] deliberate attempts by senior management and board to downplay and cover up instances of harm (not unique to emergency medicine).*

> *I feel well supported when I raise concerns about patient safety by my immediate managers but feel let down when their escalation is ignored.*

6.80. Some staff reported feeling unable to raise concerns about patient care to more senior staff. Staff at the Queen Elizabeth University Hospital felt less able to raise concerns than staff at the other two sites: 52% of Queen Elizabeth University Hospital respondents felt 'rarely' or 'never' able to do so, compared with considerably lower figures for the Royal Alexandra Hospital (18%) and the Glasgow Royal Infirmary (21%) (Figure 6.14).

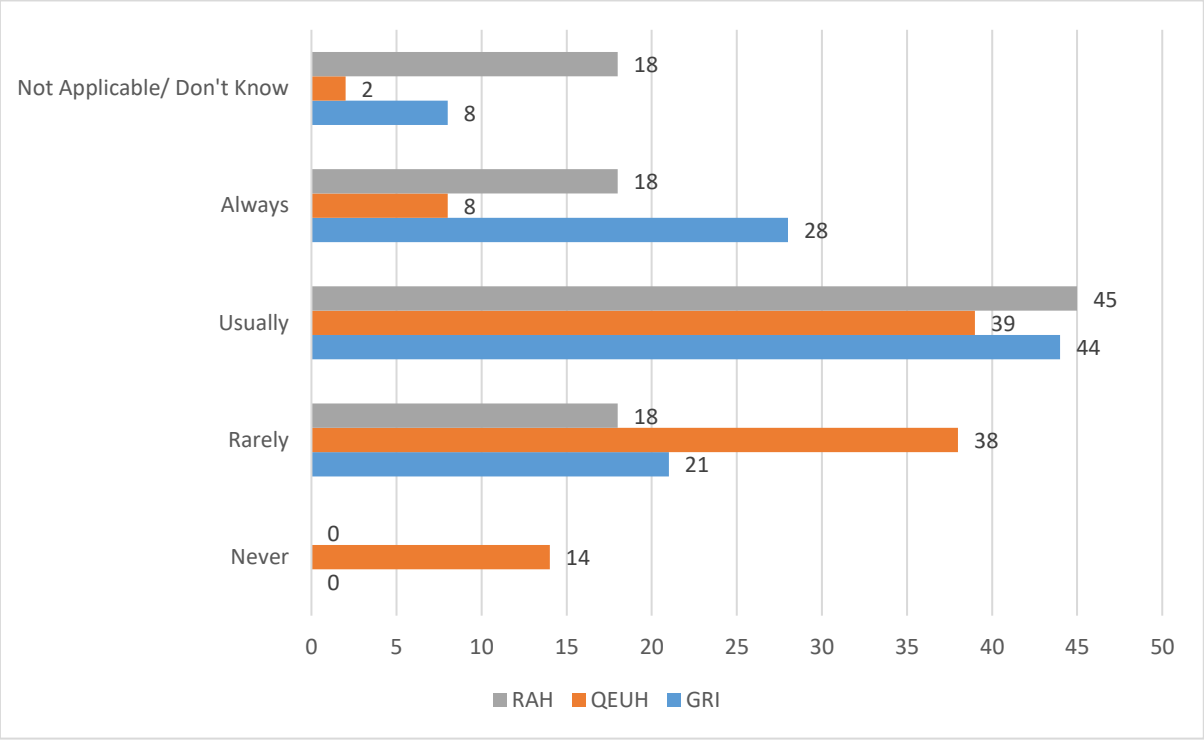

Figure 6.14: Staff reported ability to raise concerns about patient care (% of staff)

Risk Management

6.81. NHS Greater Glasgow and Clyde provided the review with its board level risk register[79] for urgent and unscheduled care. The risk is described as a potential failure to deliver urgent and unscheduled care standards and targets. The initial risk was determined to be a red rating of 'very high' with a likelihood level of 4 and an impact level of 5 generating a score of 20. The maximum rating score for each is 5 with a maximum risk score of 25 (i.e. 5 x 5).

6.82. The risk rating was subsequently amended to 'high' taking into account the board's views of the controls that were in place. The last review of the risk in the documentation provided was in November 2024. The impact level was reduced from 5 to 4, with the combined score falling to 16 (i.e. 4x4) and the risk rating falling from red to amber status.

6.83. The review notes that the consideration of the risk is focused on the delivery of performance metrics and there is no mention of impact for patients or the quality of care.

6.84. The Queen Elizabeth University Hospital risk register[80] was also provided for urgent and unscheduled care. All the review dates had passed for the update of risks on the register (date range from 21 February 2022 through to 1 August 2024). The latest update to the risk register against a specific risk was carried out on 1 February 2024.

6.85. Despite the serious nature of the risks (four of the seven risks were categorised as very high) covering patient safety, crowding and staffing, it was clear that many of the actions and operating context in the risk register were considerably out of date. It indicates that the risk register was not used as a meaningful tool for the identification and management of risk nor was there appropriate oversight of it.

6.86. The Glasgow Royal Infirmary risk register was regularly updated. The risk register identified difficulties since its inception in 2022 in resourcing the staff wellbeing team. It also identified the shortfall in nurse staffing since the 2024 inspection, with the expectation of 18 trained nurses per shift including the nurses required to care for patients placed in corridors. The risk register notes as of October 2024, "that nursing staff numbers in the emergency department are only operationally able to escalate staffing to 16 trained nurses. Workforce tool completed and submitted to CD / ACN for escalation to facilitate the protected/ allocated nursing roles on shift".

[79] Acute and Board UUC Risk Register (Datix listing report). Greater Glasgow and Clyde. 11 November 2024.
[80] Q1 – 2 QEUH ED Risk Register Nove 2024. Greater Glasgow and Clyde. November 2024.

6.87. The Royal Alexandra Hospital's risk register was also more up to date than the Queen Elizabeth University Hospital with regard to urgent and unscheduled care. It covered a range of risks related to service delivery, patient experience and staffing. The two red risks related to sufficiency of senior decision makers and the environment in the hospital.

Recommendation 13: NHS Greater Glasgow and Clyde must improve its systems for learning about safety concerns including the use of significant adverse event reviews, post-incident debriefs and incident reporting. It must enhance its processes for sharing learning and feedback with staff and making improvements in response to learning.

Recommendation 14: NHS Greater Glasgow and Clyde should review the risk management processes for emergency departments to ensure they provide an accurate and comprehensive assessment of current risks and steps being taken to mitigate these, with appropriate regular monitoring and oversight. The risks need to reflect the impact on quality and outcomes for patients rather than purely focusing on performance.

Essential of Safe Care 4: Safe, consistent, clinical and care processes

Emergency medicine has changed considerably since the workforce tools for defining safe staffing levels were developed. This includes significant differences in patient flow, capacity and crowding in departments, acuity of presenting patients, changes in medical educational policies and careers, and staff sickness absence rates. These changes raise questions about whether the workforce tools are adequately robust for the current context. Although an analysis of staffing levels in three emergency departments using the tools found staffing levels met national recommendations, there is a lack of confidence that the current tools can provide reliable assurance on safe and effective staffing levels.

6.88. This section includes the reliable implementation of processes and safe staffing.

Safe staffing: introduction

6.89. The Royal College of Emergency Medicine states that effective staffing is a function of capacity, capability, sustainable working and resilience. Insufficient staff numbers result in longer waits, crowding, compromises to safe practice, reduction in the quality of care, and poor experience of patients and staff.[81]

6.90. The Royal College of Nursing states an appropriate workforce is the key factor for providing safe, effective, high quality urgent and unscheduled care in a timely, cost-effective and sustainable manner. This requires a balanced team of nurses, doctors, allied health professionals and support staff, with appropriate knowledge and skills.[82]

[81] https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Consultant_Workforce_Document_Feb_2019.pdf. Royal College of Emergency Medicine. February 2019.
[82] file:///C:/Users/CAROLI~1/AppData/Local/Temp/MicrosoftEdgeDownloads/8365cfdf-dc2a-4f30-bbe1-34d6fcdeb6ca/Nursing-workforce-standards-for-Type-1-EDs-Oct-2020%20(2).pdf

6.91. The Health and Care (Staffing) (Scotland) Act 2019[83] commenced on 1 April 2024. It legally requires NHS Scotland boards to be appropriately staffed. It aims to ensure provision of safe high-quality care, to improve outcomes for service users and put patient safety at the fore. Healthcare Improvement Scotland has a duty under the Act to monitor compliance with the duties as cited in the legislation.

6.92. The Health and Care (Staffing) (Scotland) Act 2019 mandates that emergency departments should apply the Common Staffing Method to help determine appropriate staffing in terms of both medical and nursing staff. Current national recommendations from the Royal College of Emergency Medicine and the Royal College of Nursing can be incorporated into the triangulation process, alongside relevant available data and intelligence to inform decision making. The Emergency Care Provision staffing level tool and professional judgment tool are mandated for use as part of Common Staffing Method application.

6.93. Throughout this review, staff reported concerns about both staffing levels and skill mix in all three emergency departments in NHS Greater Glasgow and Clyde. The board has previously used the recommended staffing tools above to inform staffing levels in their emergency departments. However, there were concerns about the historical application of the tools and their contemporaneous relevance which resulted in a lack of assurance about the reliability of the outputs (see following paragraphs for detail).

Emergency medicine context – safe staffing

6.94. Emergency medicine has changed considerably since the tools for defining safe staffing levels were developed. The Emergency Care Provision tool was developed in 2013 and updated in 2019. The Royal College of Emergency Medicine guidance which uses patient attendance numbers to inform workforce requirements was developed in 2018. Specific changes that are not accounted for within the tools and which may impact on the accuracy of their output are listed below.

6.95. Performance against the four-hour standard across Scotland has dropped considerably since 2018 (see Chapter 4), which is associated with poorer flow, and increased crowding in emergency departments. The tools allocate a predicated number of care hours based on the patient complexity on the principle of patients moving smoothly through emergency departments.

6.96. Patients presenting in emergency departments frequently have greater complexity and length of stay than when the tools were developed. In NHS Greater Glasgow and Clyde this is accentuated by having a structure of separate minor injuries units which results in the main emergency department being predominantly focused on more complex frail patients with multiple

[83] Health and Care (Staffing) (Scotland) Act 2019: overview - gov.scot. Scottish Government. Last updated 1 November 2024.

comorbidities, or in the case of the Queen Elizabeth University Hospital with major trauma. This group of patients tends to require an increased length of stay within the emergency department and the need for inpatient admission which may involve a wait for a bed and in some cases, this also results in use of non-standard bed care. During this wait, ongoing care must be provided by nursing staff and resident doctors in the emergency department which can include investigations, prescribing and administration of medicines, personal care and review with senior decision makers. Not all emergency department nurses will have experience of providing complex ongoing care that involves ward or high dependency pathways. This introduces an element of risk to patients while waiting for a bed on a ward.

6.97. The senior decision maker in emergency departments is a bespoke and critical role which is essential in emergency departments. They are usually a consultant, senior doctor or advanced practitioner responsible for making critical clinical decisions (regarding investigations, treatment and disposal), and leading and guiding the clinical team. In extremely busy emergency departments this person may be solely focused on trying to manage flow which can impact on their ability to fulfil the full senior decision maker role required of them. Roles such as emergency physician in charge have evolved over the past years to allow management of risk, capacity and flow across the whole department.

6.98. Changes in medical educational policies and working patterns has resulted in fewer trainee hours available as clinical hours within the emergency departments, which increases the workload for the medical workforce who have to cover this shortfall.

6.99. There is a national shortage of suitably trained middle-grade doctors. Clinical development fellow posts have become essential members of the emergency department staffing structure, but they are funded by non-recurring funding which can result in delays to recruitment. There was evidence of clinical development fellows being used to fill gaps in middle-grade rotas without these staff members having the necessary skills to provide the level of role required (senior decision maker).

6.100. Medical careers have changed, with increasing numbers of doctors opting for portfolio careers. It is often unclear from rosters whether these staff are included as whole time equivalent despite having less than full time clinical sessions. The national shortage of middle grade doctors has impacted on recruitment to vacancies and covering staff shortages. Additionally, more doctors are opting to work less than full-time which can have an added impact on the available workforce.

6.101. Sickness absence rates have risen. Sickness absences are lower in medical than nursing staff groups across all three sites (although it is recognised that recording processes are different). The lowest sickness rates were seen at the Royal Alexandra Hospital. The highest average sickness rates for consultants were seen at the Glasgow Royal Infirmary (2.95%) and healthcare support workers (17.9%), and the highest sickness rates for registered nurses was seen at the Queen Elizabeth University Hospital (8.35%).

6.102. NHS Greater Glasgow and Clyde acknowledges that its existing systems do not fully support the assessment and monitoring of real time staffing, along with capturing the identification of mitigation and the escalation of staffing risks to fully comply with the duties of the Health and Care (Staffing) (Scotland) Act. Practice differs across the three sites in terms of real time staffing assessment. Although there is no timescale to resolve this, the board does have a long-term plan to implement the Safe Care Live system.

Medical workforce

Queen Elizabeth University Hospital conclusions

6.103. The funded establishment for consultants has increased from 30 to 31.1WTE from January 2023 to August 2024 (increase of 1.1WTE). Although this is higher than the Royal College of Emergency Medicine recommended 24.7 to 27.5WTE, based on the number of emergency department attendances, this may not provide adequate provision for the patient complexity due to Queen Elizabeth University Hospital being a major trauma centre. There is a requirement to factor in additional trauma consultant cover, across the seven days, over and above the core emergency department consultant staffing numbers.

6.104. The total emergency department medical workforce at the Queen Elizabeth University Hospital is 78.7WTE, with a non-consultant establishment of 42.1WTE. This is aligned with national recommendations for a large emergency department. The non-consultant medical staffing levels are higher than the recommendation from the recent Scottish Emergency Care Provision Staffing Level tool which recommended a total medical workforce of 45.7WTE with a non-consultant workforce of 31.1WTE. However, the professional judgment tool recommended non-consultant staffing is considerably higher at 59.4WTE which would require a significant uplift to the current establishment. As stated in paragraphs 6.94-6.102 there are quality assurance concerns about the reliability of these conclusions. In addition, they do not reflect the additional workforce requirement for a major trauma unit.

6.105. The actual number of in-post medical senior decision makers is 41.2WTE. Additionally, the Queen Elizabeth University Hospital includes an advanced nurse Practitioner, who is classed as a non-medical senior decision maker, within their current senior decision maker complement. This combined total of 42.2WTE is

just above the Royal College of Emergency Medicine's minimum recommendation for a large major trauma centre of 42WTE. Once the 3WTE current vacancies are filled, this would exceed the minimum recommended level and may promote a more even spread of senior decision makers across the seven-day period.

6.106. It is recognised that changes in patient presentations, compounded by increased length of stay, and the complexities of medical staff working arrangements, which have occurred since the national guidance and tools were developed, have contributed to staff's perception that the workforce is insufficient for the site. This is supported by the finding of the professional judgement tool and the observed long-term gaps in rotas which would require more non-consultant workforce, in particular middle grade doctors, than the site currently has within its establishment. This is supported by the finding of the professional judgement tool and the observed long-term gaps in rotas, requests for locum cover and the staffing huddles and handover sheets that indicate medical workforce as a challenge. This would necessitate a larger non-consultant workforce, in particular middle grade doctors, than the site currently has within its establishment.

6.107. From the sample of the Queen Elizabeth University Hospital medical handover documents reviewed staffing issues, rated as significant, were identified in 38% of the documents reviewed.

Glasgow Royal Infirmary conclusions

6.108. The number of funded consultant posts has remained unchanged since January 2023 at 20WTE. However, the number of consultants in post has consistently exceeded the funded establishment varying from 22 to 24.1WTE (average 23.2WTE). This is in line with the Royal College of Emergency Medicine recommendations, based on the number of attendances, of 20.0 to 23.2WTE.

6.109. While the funded emergency department consultant and total senior decision maker workforce (consultant and non-consultant) at the Glasgow Royal Infirmary appears to be in line with the Royal College of Emergency Medicine's workforce recommendations, it is recognised that due to changes and complexities of role and responsibility that this may not be sufficient for the site (as described in paragraphs 6.94-6.102). This is supported by the observed reliance on locums at resident grade to cover the medical rotas. As above, the allocation of emergency medicine middle grades by NHS Education for Scotland and can vary in terms of WTE on each six month/annual allocation. This can impact on the available hours available to cover rotas and impact on the overall availability of senior decision makers.

6.110. The total emergency department medical workforce at the Glasgow Royal Infirmary is 68WTE, which is above the Scottish Emergency Care Provision staffing level tool's recommended medical staffing of 46WTE. However, the

professional judgment tool recommended total medical staffing is considerably higher at 71.8WTE which would require a significant uplift to the current establishment. Although it is recognised that these tool outputs may not reliable due to quality assurance concerns (as described in paragraphs 6.93-6.107) including the use of additional non-standard bed care areas.

6.111. The actual number of senior decision makers is 31.5WTE, just above the Royal College of Emergency Medicine's minimum recommendation of 30WTE for a medium sized emergency department. However, there have been notable vacancies within the consultant workforce which have been vastly improved since January 2023 (from a variance of 27% to 1.3%, an increase of 8.98WTE consultants). There have also been vacancies among non-consultant senior decision makers (3WTE vacancies) which has impacted on the availability of senior decision makers to fill rotas resulting in an observed reliance on locums.

6.112. Other evidence that the staffing establishments are insufficient was seen within the safety pause logbook with approximately 50% of entries citing medical staffing challenges, many of which include consultant level staff.

6.113. From the sample of medical handover documents reviewed staffing issues were rated as significant in 12% of the reports reviewed. There was a strong positive correlation in the data related to the medical handover documents from Glasgow Royal Infirmary between staffing and reported safety concerns.

Royal Alexandra Hospital conclusions

6.114. There has been contradictory information provided in terms of consultant establishments, with both actual and funded establishment WTE varying by as much as 10WTE. This may be due to the number of consultants working for the Emergency Medical Retrieval Service as part of their job therefore not providing direct clinical care for the Royal Alexandra Hospital or Inverclyde Royal Hospital. Regardless, even based on the lower figure provided, which indicated that there were 21.9WTE consultants, this would meet the Royal College of Emergency Medicine's recommendation of 21.8-24.2WTE, based on the number of combined attendances across the Royal Alexandra Hospital and Inverclyde Royal Hospital.

6.115. While the total emergency department medical workforce at the Royal Alexandra Hospital (including additional staffing through the staff bank) appears to be in line with national workforce recommendations, it is recognised that due to changes and complexities of role and responsibility that this may not be sufficient for the site. A further complication for this Royal Alexandra Hospital calculation is that the medical workforce covers the emergency departments at two sites (at the Royal Alexandra Hospital and the Inverclyde Royal Hospital), so combined attendance figures for both sites were used. This is a challenge

because the two sites require a minimum level of medical staffing and senior decision makers regardless of patient attendances.

6.116. The total combined emergency department medical workforce at the Royal Alexandra Hospital and Inverclyde Royal Hospital is 60.1WTE, with additional staffing provision through the staff bank bringing the total provision of 66.6WTE (August 2024 bank figures). This is in line with the combined output of the Scottish Emergency Care Provision staffing level tool's recommended medical workforce of 58.5WTE. This could in part be attributed to the high complexity of patients recorded during the period the tools were run. The recommendations from the Professional Judgement Tool were considerably lower with a recommended total medical workforce of only 40.2WTE. However, the complexity and length of patient stay within the departments and the additional considerations in terms of ensuring appropriate numbers and skill mix of medical staffing across the two sites needs to be factored and is likely to be contributing to medical staff's perception that staffing is insufficient to meet the needs of patients. The significant reliance on medical staffing provision through the staff bank needs to be considered in terms of a future sustainable medical model across the sites.

6.117. The actual number of senior decision makers is 29.5WTE, just below the Royal College of Emergency Medicine's minimum recommendation of 30WTE for a medium sized emergency department, however it is noted that there are significant non-consultant senior decision maker vacancies which when filled will bring the full establishment to 34.7WTE. However, as above, the allocation of emergency medicine middle grades is reliant on the allocation from NHS Education for Scotland and can fluctuate every six months/annually dependent on the WTE of the staff allocated. It is also noted that there is a significant reliance on locums and clinical development fellows, particularly at the Inverclyde Royal Hospital where almost 50% of middle grade shifts across the 24-hour period were covered by locums and clinical development fellows. There was also a notable high level of late shift and night shift cover provided by either clinical development fellows or locums across both sites. This will add additional pressure to consultants and senior decision makers.

Nursing workforce

6.118. No significant average establishment variance (+/-10%) was noted at any of the sites for all grades of nursing staff over the 20-month timeframe covered in the review (January 2023 to August 2024). However, there is a current significant variance at the Royal Alexandra Hospital within band 5 nursing staff which is 30% (9WTE) below full establishment. This is partly due to current over-establishment of band 6 and band 7 nursing staff (4.4WTE) but requires some supplementary staffing to cover remaining hours.

6.119. The Royal College of Nursing recommends an emergency nursing workforce skill mix of 80% registered nurses to 20% unregistered nurses (healthcare support workers). Within this, 30% of the total nursing workforce should be charge nurses (band 6 and above) and a further 40% of the total nursing workforce should be competent emergency nurses. All three NHS Greater Glasgow and Clyde sites meet or exceed these recommendations currently, with a caveat that staff have fed back that due to the number of newly qualified and new staff recruited to the band 5 nursing workforce there is a lack of competent emergency nurses which is putting pressure on the more experienced and senior nurses.

6.120. The nursing workforce across the week was found to remain relatively stable in terms of numbers. It is acknowledged however, that the skill mix of the nursing workforce was unclear to the Core Review Group, along with how this is spread across the 24/7 period to ensure adequate knowledge, experience and seniority to enable effective decision-making and patient safety.

6.121. Supplementary staffing is used across all three sites. This generally seems sufficient to cover the establishment roles.

Queen Elizabeth University Hospital conclusions

6.122. The total emergency department nursing workforce at the Queen Elizabeth University Hospital of 161.6WTE seems appropriate for an emergency department as a major trauma centre. This figure exceeds the workforce requirement calculated by the Scottish Emergency Care Provision staffing level tool and professional judgment of staff during the recent staffing level tool run. There is a recognition that the validity of the tool outputs will have been impacted by the quality of the data and low level of patient complexity recorded which did not seem correct. Given the patient complexity, length of stay and additional roles being undertaken by nursing staff, there are other factors to consider to ensure that the nursing workforce is appropriate.

6.123. The Queen Elizabeth University Hospital nursing workforce also exceeds the emergency department standard recommendations for nursing workforce skill mix, with a ratio of 82% registered nurse to 18% unregistered nurse and 38.7% of the nursing workforce is at band 6 or above.

6.124. The findings of the systematic review of the sample of nursing handover documents found that the Queen Elizabeth University Hospital had the highest incidence of recording of staffing issues rated as significant (61% of reports reviewed). The issues related to both staffing gaps and skills mix.

6.125. The Queen Elizabeth University Hospital has the highest average rate of sickness absence (8.35%) for registered nurses of the three sites. In addition, there is a very high sickness absence rate within healthcare support workers, averaging at

15.3% since January 2023. The staffing gap has been mitigated by an increase in supplementary staffing, mainly through the staff bank.

6.126. There were some notable positive workforce developments within the nursing workforce with the introduction of a nurse educator and advanced nurse practitioner roles. These roles are not replicated at either Glasgow Royal Infirmary or the Royal Alexandra Hospital. Staff indicated that redirection was having a less favourable impact on role developments because it impacted on the capacity of senior emergency nurse practitioners within the main emergency department. Staff also raised concerns that the training provided did not adequately equip them to undertake the role.

Glasgow Royal Infirmary conclusions

6.127. The total emergency department nursing workforce at Glasgow Royal Infirmary of 105.1WTE seems appropriate for an emergency department of this size. This figure exceeds the Scottish Emergency Care Provision staffing level tool recommendation but is below the professional judgment of staff during the recent staffing level tool run. However, given the complexity and pressure experienced, there are other factors to consider: staff appear to be feeling pressure at the Glasgow Royal Infirmary due to non-standard bed care, expectation to provide redirection and lack of flow out of the department.

6.128. The Glasgow Royal Infirmary nursing workforce also exceed the emergency department standard recommendations for nursing workforce skill mix, with a ratio of 83% registered nurse to 17% unregistered nurse and 44.9% of nursing workforce is at band 6 or above.

6.129. There were concerns about the extent to which the professional judgement of nursing staffing was being reflected in the decisions about staffing. Specifically, that there were 16 registered nurses on shift, compared to an expected complement of 18 registered nurses, and often it is 14 on shift. This includes the requirement to support corridor care in Glasgow Royal Infirmary.

6.130. From the systematic review of a sample of Nursing handovers from Glasgow Royal Infirmary 43% of the documents reviewed identified staffing issues rated as significant, however 30% of the Glasgow Royal Infirmary nursing reports were unrated due to insufficient information. The issues related to both staffing gaps and skills mix.

6.131. There is insufficient recognition in the staffing model of the need to accommodate sudden surges in acuity and patient volumes and the associated requirements in resuscitation. The review noted that there was a high risk of resuscitation areas being under-staffed especially in the context of multiple attendances of urgent patients with high levels of acuity.

6.132. In addition, new roles to manage redirection in each site have been taken from the core establishment rather than met with additional funding to support the changes required.

6.133. NHS Greater Glasgow and Clyde confirmed that they had sought to obtain a tighter control on expenditure at Glasgow Royal Infirmary given that expenditure on nurse staffing was over-budget. Nursing management acknowledged that the workload was having an impact on morale and that financial constraints prevented filling vacancies when absence levels rose above the 4% budgeted contingency. There was an open recognition that staffing levels were a matter of concern and had implications for the delivery of safe care, especially to those patients with more complex needs. The position was accentuated by the use of bank nursing staff who may not be familiar with the roles, and which created a further level of stress for existing staff.

Royal Alexandra Hospital conclusions

6.134. The total emergency department nursing workforce at the Royal Alexandra Hospital of 67.8WTE seems appropriate for an emergency department of this size, once fully staffed with band 5 staff. This figure exceeds the professional judgment of staff during the recent staffing level tool run however, conversely with the other sites, it is lower than the Scottish Emergency Care Provision staffing level tool recommendation. However, given the complexity and pressure experienced, there are many other factors to consider to ensure that the nursing workforce is appropriate.

6.135. The Royal Alexandra Hospital nursing workforce meets or exceeds the emergency department standard recommendations for nursing workforce skill mix, with a ratio of 80% registered nurse to 20% unregistered nurse and 48% of nursing workforce is at band 6 or above, the highest of all three sites.

6.136. The Royal Alexandra Hospital has the lowest registered nurse to patient ratio of the three sites which is compounded by vacancies among registered nurses, particularly at the band 5 level, which is supported by the over-establishment of nurses at band 6 and 7 and healthcare support workers.

6.137. The Royal Alexandra Hospital has introduced new roles not seen at the other sites (band 4 non-registered nursing workforce and advanced physiotherapy practitioner).

Staff views

6.138. Staffing levels were a universal concern reported by staff who felt staffing levels contributed to unsafe care and poor staff wellbeing. Staff were also concerned about skill mix, with suggestions that some inexperienced staff were staffing areas with little support.

> *Being told that we are "staffed" because the number of nurses on the floor is correct with no appreciation given to the skill mix which we have been told we are not allowed to comment on.*

6.139. Across the entirety of the sample of the Queen Elizabeth University Hospital and Glasgow Royal Infirmary nursing and medical handover reports reviewed issues with staffing, as recorded in the documents, were rated as significant in just over a third of the reports. Across both sites and both medical and nursing staff groups, issues with staffing rated as significant were identified to varying degrees on every day of the week. The higher levels of issues rated as significant recorded in the reports (38-47% of documents reviewed) occurred towards the end of the week and over the weekend (Thursday – Sunday).

6.140. Staff also raised concerns in the staff survey that there is a lack of support and training for junior staff, and this was leading to unsafe patient care. Newly qualified staff need educational support and structured mentoring. Figure 6.15 shows many staff at the Queen Elizabeth University Hospital and the Glasgow Royal Infirmary felt newly qualified, new staff and students were rarely supported and supervised well, compared with a more positive picture at the Royal Alexandra Hospital. This may in part be attributed to the low numbers of nursing staff from the Royal Alexandra Hospital who completed the survey.

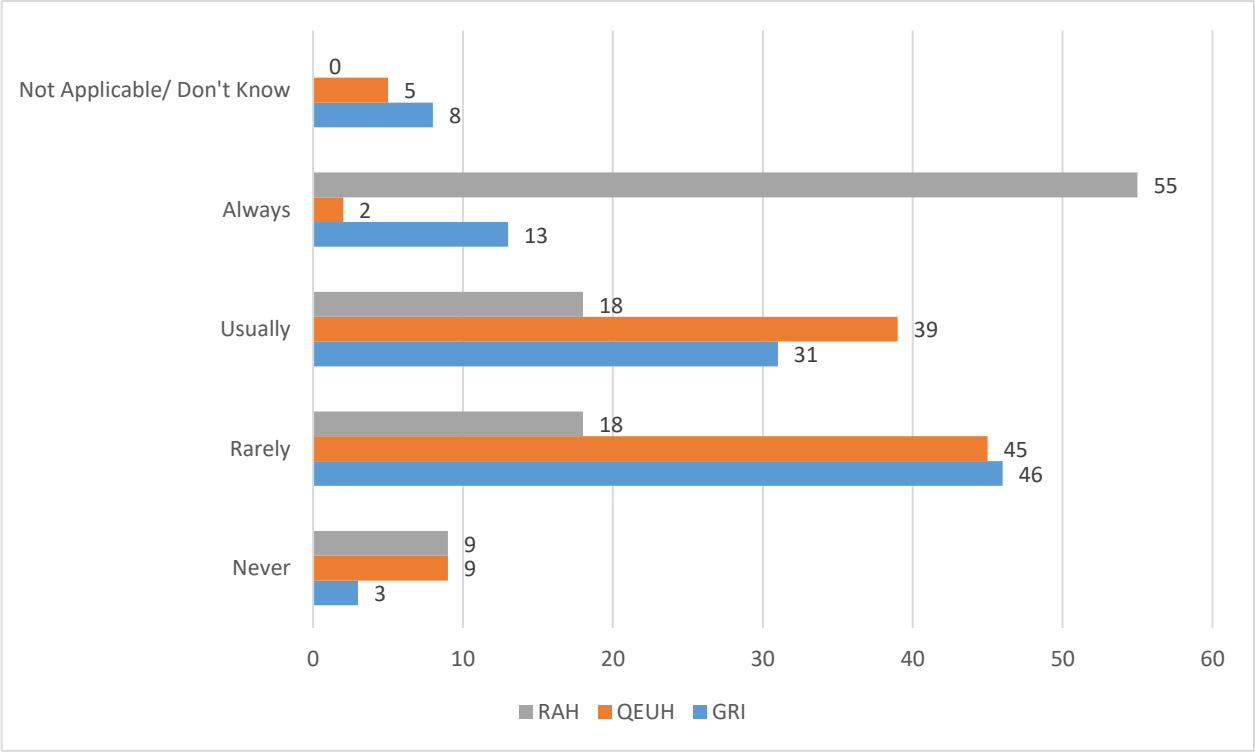

Figure 6.15: Staff views on how well junior staff are well supported and supervised (% of staff)

Recommendation 15: NHS Greater Glasgow and Clyde must undertake a comprehensive multi-disciplinary workforce review, utilising the Common Staffing Method, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Recommendation 16: NHS Greater Glasgow and Clyde should prioritise introducing robust systems and processes for the assessment of real time staffing and the escalation and monitoring of severe and recurrent risk, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Recommendation 17: NHS Greater Glasgow and Clyde should ensure that staff are given the time and resources to undertake required training to undertake their role, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

7. Leadership and Culture

This section provides information on the importance of leadership and culture in a healthcare context. It addresses specific aspects of leadership and culture for the emergency departments at Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital to explore the extent to which:

- **the service is well led**
- **there are robust governance arrangements**
- **there is effective team working**
- **there is a supportive culture.**

Why Does Leadership and Culture Matter?

7.1. Over many years, separate healthcare related reviews and inquiries across the UK have emphasised the critical importance of leadership and culture.

7.2. John Sturrock KC in his review of NHS Highland[84] cited a *British Medical Journal* article in an attempt to define what culture meant in practice:

"An article in the *BMJ* was drawn to my attention which seeks to tease out what culture means and how this relates to service performance, quality, safety and improvement. Its key messages remind us that:

- Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations.
- Healthcare organisations are best viewed as comprising multiple subcultures, which may be driving forces for change or may undermine quality improvement initiatives
- A growing body of evidence links cultures and quality, but we need a more nuanced and sophisticated understanding of cultural dynamics
- Although culture is often identified as the primary culprit in healthcare scandals, with cultural reform required to remedy failings, such simplistic diagnoses and prescriptions can lack depth and specificity."

[84] Sturrock J. Report to the Cabinet Secretary for Health and Sport into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland. Scottish Government; 2019.

7.3. In his review report, he also referenced the Francis Inquiry and the comment by Sir Robert Francis:

'There can also be various cultures within the same organisation. Different teams, different departments, and different hospital sites can all 'feel' different. A whistleblower interviewee described the contrast between teams in the same organisation, where one had good leadership that allowed people to address mistakes directly and question one another, and the other had a command and control style with 'an individualistic dynamic and a blame culture'.

7.4. The King's Fund[85] in its report in 2015 cited the importance of six characteristics of culture as crucial to delivering high quality care, from sharing an inspiring vision and values through to collective leadership.

7.5. In the context of Scotland, the Cabinet Secretary for NHS Recovery, Health and Social Care has emphasised the need for the NHS to live up to its long-standing principles and values in how it treats and supports its staff[86]. This commitment is also reflected in the Staff Governance Standard and the Blueprint for Governance for NHS Scotland which describes the need for a culture which underpins these values in everyday practice. The Blueprint emphasises that: "To support the delivery of this organisational culture, the leadership of the organisation has to be seen as competent and credible, act in the best interest of stakeholders, act at all times with integrity and are reliable in their decisions and actions, in other words they are trustworthy."[87]

7.6. In undertaking this review, it is acknowledged that "leadership is the most influential factor in shaping organisational culture and ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental."[88]

7.7. The review has therefore spent a considerable amount of time gathering and considering evidence about the nature of the leadership values and culture within NHS Greater Glasgow and Clyde and across the three emergency departments.

[85] Collins B. Staff Engagement; Six building blocks for harnessing the creativity and enthusiasm of NHS staff. The King's Fund – Improving NHS Culture; 2015.
[86] Message from the Cabinet Secretary for NHS Recovery, Health and Social Care. Scottish Government; online.
[87] The Blueprint for Good Governance in NHS Scotland, Second Edition. Scottish Government; 2022.
[88] West M et al. Leadership and Leadership Development in Health Care: The Evidence Base. The Faculty of Medical Leadership and Management; London. 2015.

Background to this review

7.8. This review was prompted by concerns raised by the consultants in emergency medicine at the Queen Elizabeth University Hospital. Between 2021 and 2023 there were a series of written and in-person exchanges between the emergency medicine consultants and NHS Greater Glasgow and Clyde senior management which ultimately led to the escalation to Healthcare Improvement Scotland (see Appendix 1). This section of the review report describes the background by capturing some of the more significant exchanges between 2021 to 2024 and which led up to the current situation.

7.9. It is important to emphasise that the current situation has not arisen in a short space of time. Since 2021, there has been a sustained deterioration in morale and relationships in the Queen Elizabeth University Hospital emergency department, as the system emerged from the Covid 19 pandemic. This is reflected in the iMatter staff experience surveys for the emergency medicine consultants in the Queen Elizabeth University Hospital.

7.10. The latest iMatter survey provided by the emergency medicine consultants at Queen Elizabeth University Hospital showed a 62% response rate (23/37) with an engagement index score of 45[89]. The overall score of the experience in working in the organisation was 2.4 (on a scale of 0-10). The yearly reports between 2021 and 2024 show a decline in scores across all iMatter survey questions,[90] apart from one question in relation to clarity on role and responsibility, the answer to which the score has remained static.

7.11. In August 2021, the emergency medicine consultants at the Queen Elizabeth University Hospital wrote to NHS Greater Glasgow and Clyde senior management, identifying a range of concerns covering crowding and the implications for patient safety.[91] In their letter, they asked for three actions:

- A recognition at board and government level of the severity of the current situation and an immediate program to decongest the emergency department and mitigate the risk to patients and staff.
- An escalation plan to address the imminent increase in emergency department activity throughout the transformation of trauma services and the winter period.
- The formation of a board level task force to implement the core structural and process changes required to redistribute the responsibility of unscheduled care across the hospital and specialties.

[89] iMatter ED Consultants Team Report. 2024.
[90] iMatter ED Consultants Team Yearly Components Report. 2024.
[91] Letter from Queen Elizabeth University Hospital emergency department Consultant Team. Dated 23/08/21.

7.12. The response from NHS Greater Glasgow and Clyde senior management[92] described a range of actions intended to address those concerns. However, while it acknowledged the pressures related to staffing shortages and delayed discharges, it did not provide substantial measures to effectively mitigate the issues highlighted by the consultants.

7.13. In December 2022, the consultants again wrote to the Medical Director expressing serious concerns about the absence of an escalation policy and an emergency action plan which they understood had been promised in April 2022. The letter also expressed concern about poor communications. The response from the Medical Director described a range of actions that were being taken[93]. These actions were ultimately regarded by the consultants as being insufficient to address their fundamental concerns and led to the escalation to Healthcare Improvement Scotland in May 2023.

7.14. After a meeting in January 2024 between emergency medicine consultants at the Queen Elizabeth University Hospital and the emergency department management, relationships worsened. The meeting focused on winter pressures, the medical leadership structure of the department and the consultants were told that some of the recommendations from a review of staffing (particularly in respect of the frequency of weekend working) could not be implemented. This news caused significant disappointment and frustration. The meeting was recorded and later viewed by others, leading to accusations of poor behaviour from both sides and a further decline in trust between consultants and senior management.

7.15. It was reflected to the Core Review Group that the meeting in January 2024, was for many a 'pinch point' but not the sole reasons for the deterioration in relationships. There had been an accumulation of events from 2021 onwards, with matters coming to a head as a result of this meeting.

Key lines of enquiry on leadership and culture

7.16. Healthcare Improvement Scotland has drawn on its *Quality Assurance Framework* in undertaking this review. The Healthcare Improvement Scotland *Quality Assurance Framework* is not a checklist. It is a reference guide to support and inform reflection, evaluation and decision making about how best to improve outcomes for users of services. It is also underpinned by leadership and culture as described in the Healthcare Improvement Scotland, *Essentials of Safe Care* and the Sharing Health and Care Network (SHCIN) *Analytical Framework*.

[92] Letter to Queen Elizabeth University Hospital emergency department Consultant Team. Dated 06/09/21.
[93] Email to Queen Elizabeth University Hospital ED Consultants. Dated 14 December 2022.

7.17. From these documents, the Core Review Group distilled four key lines of enquiry upon which to frame this aspect of the review.

Is the service well-led?

- There is a clear and well-communicated vision and purpose that aligns with its goals and values.
- The services should be designed with collaborative input from staff, patients, and other stakeholders.

Are robust governance arrangements in place?

- There is strong leadership promoting a positive culture, accountability, and transparency.

Is there effective team working?

- There is collaborative working within and between teams and involving all relevant stakeholders in the design and delivery of services.

Is there a supportive culture?

- A supportive culture encouraging respect, collaboration, and well-being among staff.

7.18. The Core Review Group drew on evidence from NHS Greater Glasgow and Clyde, the staff survey, team and individual staff discussion sessions, written evidence provided by a confidential mailbox, and on-site visits.

7.19. This chapter contains a selection of anonymised quotes in italic text from staff that shared their views and experiences during the review process (see paragraph 2.81 above). These quotes may have been drawn from the staff survey, submissions to the confidential mailbox or from discussion sessions with staff.

General observations

The review identified exceptional hard work and commitment by staff delivering services on all three sites. However, the three emergency departments in this review are working under considerable stress and it is having a detrimental impact on staff wellbeing. There are examples of poor behaviours including incivility which are undermining team cohesion, with concerns expressed about staffing levels, as well as the appropriateness of skill mix to meet the acuity and complexity of patient need.

7.20. There is ongoing pressure on unscheduled care in NHS Greater Glasgow and Clyde and across NHS Scotland. An ageing population, more complex patients, and higher demands on primary and community health services are straining the system, leading to overcrowded emergency departments.

7.21. Despite these challenges, many staff members from all disciplines, be that managerial or clinical, are working hard to provide the best care possible under extreme pressure and identify solutions to such complex and intractable issues. The Core Review Group met dedicated individuals across all levels and disciplines who are committed to meeting demand, even in difficult circumstances. However, not being able to provide the desired level of care is affecting their wellbeing and causing moral distress (see paragraphs 6.64 and 6.66).

7.22. Before turning to the specifics in this section, several points of serious concern must be highlighted, as set out in paragraphs 7.23–7.25 below.

7.23. The Core Review Group heard from staff in person during onsite activity and individual MS Teams conversations; and corroborated from the staff survey, that in the Queen Elizabeth University Hospital emergency department there are examples of significantly poor professional behaviours, instances of alleged bullying and a lack of respect that has the potential to lead to patient harm and increasing impact on staff health and wellbeing, including leading to staff sickness. All these behaviours impact on the ability of the emergency department multi-disciplinary team to function effectively for the benefit of patients and carry serious risks to patient care if they are left unaddressed.

7.24. The level of stress and distress among staff at all levels in the three emergency departments was palpable, with several staff members becoming visibly distressed in sharing their experiences with the Core Review Group. This included managers, medical and nursing staff, many of whom described a relentless and unforgiving environment with expectations that exceeded reasonable limits for prolonged periods. Reports of disrespectful and inappropriate behaviours were conveyed to Core Review Group members, which, despite potentially stemming from stress, were deemed unacceptable. There was no tangible evidence that these behaviours were being addressed either peer to peer or through line management routes.

7.25. Core Review Group members engaged with nurses from all three emergency departments both in person and via MS Teams sessions. During these interactions, nurses described specific scenarios that underscored their profound anxiety regarding their ability to deliver safe care due to workforce gaps and the perceived inability to secure supplementary staff in a timely manner because of a convoluted approval process. Furthermore, Core Review Group members received reports of a perceived lack of senior professional support, which contributed to nurses feeling that neither they nor their work were valued or recognised as essential.

7.26. Healthcare Improvement Scotland escalated concerns regarding these matters to the Chief Executive of NHS Greater Glasgow and Clyde in December 2024.

7.27. Based on the evidence over the course of the review, the Core Review Group observed that NHS Greater Glasgow and Clyde appears to have allowed an abrasive culture to develop, with evidence of poor and disrespectful behaviours, which makes it very difficult for staff at all levels of the organisation to feel safe to challenge and appropriately address this culture. This was observed on all three sites and was not exclusive to the Queen Elizabeth University Hospital.

7.28. The experience reported by a range of staff during this review is not in line with the shared values that are expected of all involved in the NHS in Scotland, which are:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

Well Led

Leadership and operational governance arrangements

7.29. The NHS Greater Glasgow and Clyde board, led by the NHS Board Chair, has established lines of governance and accountability. The NHS Greater Glasgow and Clyde corporate management team is the senior executive team, led by the Chief Executive, which reports to the NHS Board.

7.30. At the level below the corporate management team, an acute services division is led by the Chief Operating Officer and supported by a Deputy Nurse Director and Deputy Medical Director.

7.31. There are six sectors in NHS Greater Glasgow and Clyde which oversee the operational delivery of acute services. The sectors with adult emergency departments are Clyde, North and South

Sector	Services
Clyde	Royal Alexandra Hospital, Inverclyde Royal Hospital, Vale of Leven Hospital
North	Glasgow Royal Infirmary
South	Queen Elizabeth University Hospital

Table 10: Distribution of main acute hospitals by sector in NHS Greater Glasgow and Clyde

7.32. NHS Greater Glasgow and Clyde follows a triumvirate leadership model – nursing, medical and general management – which is replicated in some other NHS boards in Scotland and elsewhere in the NHS in the UK. Each sector has a sector director, chief nurse and chief of medicine.

7.33. At an operational level, each of the three sectors has at least a general manager, lead nurses and a clinical director for emergency medicine and at a hospital level, most departments have a general manager, clinical director and lead nurse which is consistent with the triumvirate model.

Engagement and visibility of leadership

There is insufficient engagement and responsiveness by the senior leadership of NHS Greater Glasgow and Clyde – by the board and the corporate management team – in compassionately supporting staff to meet the challenges facing the emergency departments across all three sites.

7.34. The board and the corporate management team of NHS Greater Glasgow have a significant and challenging role in leading and supporting the service to meet the demand whilst ensuring safe, effective and person-centred care. The corporate management team of NHS Greater Glasgow and Clyde shared the significant challenges that had arisen since the Covid 19 pandemic, including the complexity and acuity of patients presenting to the emergency departments.

7.35. The review recognises the requirements of NHS Greater Glasgow and Clyde – alongside all NHS boards – to meet their statutory duties and to deliver high performance. However, such duties need to be balanced with other statutory duties regarding the quality of care and involving staff and patients in decisions that affect them. NHS Greater Glasgow and Clyde need to ensure that they meet their obligations in a balanced way and to be transparent, honest, visible and engaging with staff and patients in meeting these obligations.

7.36. Notwithstanding the demanding agenda facing the senior leadership, there was a consistent message heard by the review that the senior level leadership – above the management tier at sector level – was perceived as distant and remote. This was reflected in the perception of a 'command and control' culture and poor communication between the corporate leadership and point of care services.

7.37. NHS Greater Glasgow and Clyde shared examples of their visits to different parts of the system by board members and directors. Despite this, concern was expressed to the Core Review Group about the understanding of the most senior leadership in NHS Greater Glasgow and Clyde about the most serious and pressing issues facing the emergency departments. As such, compassionate leadership was not consistently evident in recognising the pressures facing the service.

7.38. Concerns were raised during the review about the reactive nature of senior management, which hindered a strong strategic focus. As a result, operational and tactical matters seemed to dominate. This was perceived as reinforcing a 'command and control culture,' stifling local decision-making and autonomy within the three sectors. The corporate management team's pressure on sector leadership, driven by the focus on finance and service performance such as the four-hour target and elective surgery management, created tensions. There did not appear to be a climate where issues would be well-received when escalated, and there was not a perception of a respectful and supportive dialogue.

7.39. The review particularly acknowledges the important role of the NHS Board in providing effective and compassionate leadership and in fostering a culture where concerns are heard and acted upon. This is reflected in the National Whistleblowing Standards[94] which state that "Board members have a critical role in setting a tone and culture in their organisation that values the contributions of all staff, including the need for changes through speaking up. This leadership role should not be underestimated and is a critical function of the board when it comes to concerns raised about safe and effective service delivery".

7.40. The review does not deny the considerable strategic and operational challenges for NHS Greater Glasgow and Clyde given its size and complexity. However, there is a need to urgently address the cultural, behavioural and leadership issues which are impeding a more positive and healthier working relationship between the Board/corporate management team and point of care urgent and unscheduled care services.

Recommendation 18: NHS Greater Glasgow and Clyde's board must ensure that compassion and respect are at the centre of the leadership culture demonstrated through behaviours that enable the values of NHS Scotland to be consistently upheld.

Recommendation 19: NHS Greater Glasgow and Clyde should take urgent action to collectively heal the relationships across and within staff groups and sector and corporate management levels. This is a critical step to establish shared responsibility for the delivery of safe urgent and unscheduled care with visible leadership from the corporate management team and strong clinical leadership at a local level. The aim should be to devolve authority and responsibility as much as possible to team leaders at the service level, supported by greater availability, visibility and responsive support from senior and sector leaders. The solutions and outcome should be jointly owned by all involved.

[94] The National Whistleblowing Standards. Independent National Whistleblowing Officer. 2021.

Whole System Leadership for Urgent and Unscheduled Care

There is a siloed approach to the delivery of urgent and unscheduled care which impedes the development of integrated solutions and shared ownership of issues.

7.41. The review noted that there is a heavy emphasis on urgent and unscheduled care performance by NHS Greater Glasgow and Clyde. The board approved its whole system winter plan at its board meeting in October 2024 and received an update at its meeting in December 2024. The plan describes different components of the system and how they will inter-relate in managing demand for urgent and unscheduled care and in protecting planned care. The review noted, with concern, that there was very little reference to the three emergency departments in the winter plan and their contribution to addressing pressures or maintaining their resilience.[95] While there was a strong focus on unscheduled care, the focus was on performance, especially Flow 1 patients.

7.42. There was an absence of genuine whole system leadership and working in urgent and unscheduled care. Each sector operates largely independently of the other two sectors, and aspects of the response under pressure reflect local policies and approaches such as escalation. The siloed nature of each sector undermined the ability to foster a genuinely cohesive and collegiate approach to the systemic challenges facing NHS Greater Glasgow and Clyde, and at operational level resulted in the diversion of patients to other hospitals when under pressure and a lack of ownership of individual patients by receiving specialties. A member of staff remarked in the survey that: *"There is a complete lack of strategic leadership as experienced in the emergency department. There is no sign of a plan to make our experience better other than simply muddling through on a daily basis."*

7.43. The review acknowledges the strategic role of the Urgent and Unscheduled Care Oversight board, but it is unclear what impact this board has yet delivered in monitoring service improvements and better outcomes for patients. There is a need to build a stronger culture of integrated working which would benefit and support the achievement of the NHS board's urgent and unscheduled care aims.

Multi-disciplinary relationships in Queen Elizabeth University Hospital emergency department

There is evidence of poor working relationships between and within staff in management roles, emergency department consultants and the nursing team in the emergency department at the Queen Elizabeth University Hospital. NHS Greater Glasgow and Clyde has not adequately led interventions which address the deterioration in relationships over the past several years.

[95] NHS Greater Glasgow and Clyde, Whole System Winter Plan, October 2024

7.44. From the outset of the review, Core Review Group members observed extremely difficult relationships between the emergency medicine consultants at the Queen Elizabeth University Hospital emergency department and senior management at various levels (sector, acute services division, and corporate management team) within NHS Greater Glasgow and Clyde. There was a climate of distrust and dysfunctional working, negatively impacting relationships across the entire multi-disciplinary team. The consultants felt that senior management lacked visibility, openness, and honesty, which eroded their faith and trust in the leadership. Conversely, senior management expressed concerns about the behaviour of a small group of emergency medicine consultants.

7.45. The staff survey highlights a very challenging working environment in the Queen Elizabeth University Hospital emergency department.

7.46. The deterioration in relationships has led to what has been described as a 'stand-off' between sector and corporate management and the consultants. Over time, consultants have felt that their concerns were not being heard or addressed, although actions were taken by senior leaders these were not felt to address the issues. Many of these concerns persist, resulting in significant frustration, tension, and, in some cases, visible anger among the consultants. There is a prevailing sentiment that the emergency department consultants feel 'disempowered' and unable to 'influence anything in the emergency department.'

7.47. Some medical staff have also said that they would be slow to raise complaints at the time of events as they feared they might be branded a troublemaker as "there would be repercussions". The implication was that it would prevent any further advancement in management. This comment was not unique to the Queen Elizabeth University Hospital.

7.48. Although the Core Review Group received some opinions suggesting that the concerns were primarily raised by a small number of emergency medicine consultants, the evidence from written submissions, iMatter, the staff survey, and meetings indicates that the discontent and concern were widespread among the consultants in emergency medicine. While some consultants may be more vocal and assertive in expressing their views, the review found no reason to doubt that these views were held by many other consultants regarding the functioning of the Queen Elizabeth University Hospital emergency department.

7.49. The review noted the heavy reliance on communication by email. For practical reasons this is understood, especially when face to face contact may be limited and individuals may not be on shift together for long periods of time. The Core Review Group acknowledges the substantial challenges associated with communication across a large site and with many individuals. However, there was a risk that seemingly harmless emails and 'reply all' responses could escalate to difficult, confrontational and, at times, unprofessional exchanges. The default

to email, especially in relation to the highly charged matters associated with the emergency department, has accentuated difficulties and diminished the fostering of a climate of openness, civility, trust or respect.

7.50. The review also heard concerns about some tensions within the consultant cohort. A small number of the emergency medicine consultants felt bullied and undermined and felt that their voice was not heard amongst other consultant colleagues.

7.51. NHS Greater Glasgow and Clyde senior management made reference to the various attempts to engage with the emergency medicine consultants. These included drop-in sessions, 1:1 meetings and updates via newsletters. NHS Greater Glasgow and Clyde sector management held a series of sessions with staff in early 2024 to explore the issues in the Queen Elizabeth University Hospital emergency department.[96] These sessions did not engage effectively with the consultants and the output was then subject to criticism of both the approach and its conclusions. The review noted the reference in the south sector Partnership Forum minutes of May 2024[97] that organisational development in the board had developed plans for a series of sessions to address tensions in the department, with a "focus on helpful behaviours, language and attitudes in the department".

7.52. Despite this being a growing problem since 2021, the measures pursued by NHS Greater Glasgow and Clyde have thus far not been successful in securing a sustainable and positive approach to engaging with the consultants.

7.53. While the primary focus has been on the relationships between the emergency medicine consultants and management, the review believes there are broader concerns. It has identified fractured working relationships between and within the medical, nursing, and managerial teams responsible for the emergency department at the Queen Elizabeth University Hospital. This is not an issue confined to a single discipline or individual and in addition to posing risks to patient safety and quality of care, could have professional conduct consequences if not addressed promptly.

7.54. The Core Review Group observed that many nursing staff seemed nervous during engagement drop-ins and needed reassurance about confidentiality. Some nurses identified that they were actively looking for other jobs. Nursing staff felt that there was a lack of supportive leadership, negative behaviours from leadership had been experienced by nursing staff. These behaviours included inapproachability, undermining behaviours, favouritism and unfair treatment. Unfairness and favouritism were seen to manifest through promotion of those perceived to be 'yes' people, whilst others thought their 'face didn't fit' and

[96] Output from engagement sessions – Queen Elizabeth University Hospital emergency department. Dated 05 March 2024.
[97] South Sector Partnership Forum Meeting Minutes. NHS Greater Glasgow and Clyde. Dated 14 May 2024.

were ‘picked on’ or ‘ignored’ leading to isolation of staff. These experiences have led to mistrust of management and for some high anxiety due to the culture within the department. There was concern about the repercussions of raising these issues.

> *Nursing staff do not feel heard from nursing management – the management do not feel approachable majority of the time and comes across more 'depends in what mood they will be in' on how they will react to staff coming to them with problems. […]*

7.55. A consistent challenge highlighted in this review across all three emergency department sites is the ability of sector leadership and managerial roles below the sector level to effect change and improve the experience for staff and patients. The managerial response was typically described as ‘reactive’ or adopting a crisis-management approach. Additionally, the review team observed a lack of collaboration between and within sectors and an inability to escalate matters upwards.

> *Management who make themselves available to the department appear powerless to do anything about the fact the hospital is more or less permanently at full capacity. Constant crisis management inhibits innovation and creates an error-generating environment. The system has failed due to permanent high hospital occupancy with no efforts to create more beds or facilitate more discharges. The solutions that management propose are always focussed on what we can do in the emergency department (redirection etc) without addressing the failures of the consultant-led-ward-round culture in medicine.*

7.56. In summary, the review heard evidence of a significant and sustained deterioration in working relationships since 2021 at Queen Elizabeth University Hospital between the emergency medicine consultants and management. The decline in relationships went beyond this, to include relationships within and between different staff groups in the emergency department. There were also instances of confrontational and undermining behaviours by different staff groups. These behaviours were inconsistent with the principles and values of the NHS in Scotland and undermined inter-personal relationships, organisational cohesion and team working.

7.57. Whilst there have been numerous attempts to understand and address the collapse in trust and working relationships, the passage of time and subsequent unfolding of events reflects the need for urgent prioritisation or robust interventions codesigned and delivered at a departmental, sector and board level.

Recommendation 20: NHS Greater Glasgow and Clyde should commission urgent and credible external mediation within and between Queen Elizabeth University Hospital emergency department professional teams (medical and nursing) and separately for mediation between the professional teams and senior management (sector and corporate) in NHS Greater Glasgow and Clyde to support improved professionalism and team working amongst consultants, nursing staff and management.

Multi-disciplinary relationships in Glasgow Royal Infirmary emergency department

There was feedback that there were insufficient levels of management support to staff at Glasgow Royal Infirmary and a perception by staff that there was an undue focus on finance and performance over patient care.

7.58. There were a range of comments about the level of sector management support in the Glasgow Royal Infirmary. There was concern expressed about the level of support afforded to staff, especially when under pressure and the associated focus on performance targets.

> *It's a constant battle to keep patients and staff safe, it is clear there is no support from management about patient safety and they often care more about 'breach reports' than the patients we have in the emergency department.*
>
> *Lack of senior management support/ understanding of the pressures you are under whilst working at the front door, frustration that senior management see patients as numbers on a screen and not human beings.*

7.59. The review noted the need for stronger support to local management on the Glasgow Royal Infirmary site. Decision-making was perceived as centralised and, as a result, undermined the autonomy of local management teams. The lack of a supportive culture could also be manifested in a lack of trust and respect from more senior management directed towards sector level management and below especially with regard to budgetary matters.

7.60. The Core Review Group heard a consistent message about the need to strengthen the visibility and support of senior nursing leadership, especially with regard to ensuring appropriate staffing levels, and the safety and quality of care.

Recommendation 21: NHS Greater Glasgow and Clyde should ensure sector management at the Glasgow Royal Infirmary are engaged and responsive to the needs of staff at the point of care to ensure that patient care and safety receive the necessary management attention and intelligent action.

Multi-disciplinary relationships in the Royal Alexandra Hospital emergency department

The review noted concerns expressed about the visibility of management and the emphasis on finance and performance over patient care at the Royal Alexandra Hospital emergency department, while also acknowledging positive feedback regarding aspects of team collaboration at all levels.

7.61. The staff survey for the Royal Alexandra Hospital raised similar issues to the Glasgow Royal Infirmary about the focus of management on aspects of performance and budgetary matters at the Royal Alexandra Hospital. There was some concern expressed about the presence of sector level senior management and the understanding of the serious challenges facing unscheduled care.

7.62. There was a strong sense of a supportive culture within the hospital which reflected its scale and operational/clinical relationships, as described in the team working section.

Recommendation 22: NHS Greater Glasgow and Clyde should ensure sector management focus at the Royal Alexandra Hospital appropriately balances emergency department performance and flow in line with maintaining and managing the quality and safety of care.

The Clinical Director role and multi-disciplinary clinical leadership

The review noted the exposed nature of the clinical leadership roles, specifically but not exclusively the Clinical Director position. There was a lack of support in undertaking the duties and insufficient time to build and sustain relationships with the departments or beyond with other specialties.

7.63. Clinical leadership roles are critical in ensuring professional, credible, and effective leadership within specialties including the emergency departments. Individuals in these roles play a significant part in maintaining a strong clinical voice, developing team working, and aligning efforts. The roles are essential for advocating for the needs of both patients and staff, ensuring high standards of care, and driving continuous improvement. However, these roles can be isolating without the right support, making it crucial to provide adequate resources, mentorship, and opportunities for collaboration to sustain their effectiveness and well-being.

7.64. The review noted the resignations of previous Clinical Directors for emergency medicine at the Queen Elizabeth University Hospital and more recently the resignation of the Deputy Clinical Director on the same site. At the Queen Elizabeth University Hospital, a new interim Clinical Director for emergency medicine has been appointed for the emergency medicine specialty.

7.65. Job plans are part of medical contracts of employment. They are an annual agreement that sets out duties, responsibilities, objectives and agreed supporting resources. Job plans include the detail of programmed activities (often referred to as PAs). These are blocks of time, usually equivalent to four hours in standard time and three hours in premium time, in which contractual duties are performed. There are four basic categories of contractual work: direct clinical care; supporting professional activities; additional responsibilities and external duties[98].

7.66. The Clinical Director for emergency medicine in the Queen Elizabeth University Hospital has two programmed activities allocated to deliver this additional responsibility, matched by two programmed activities for the Clinical Director for medical specialties. Collectively, this presents significant time constraints and a lack of flexibility to have the presence and service development time these crucial leadership roles require. There is a lack of senior clinical leadership support to these roles within the Queen Elizabeth University Hospital and across medicine in NHS Greater Glasgow and Clyde. Significant opportunities exist to strengthen this, and ensure the clinical body feels heard and supported, and the leaders and leadership roles are developed further.

7.67. At the Glasgow Royal Infirmary there was a general view expressed that communication, and governance was good at a departmental triumvirate level between General Manager, Lead Nurse and Clinical Director but there was criticism of the level of communications at the level beyond the sectoral leadership.

7.68. At the Royal Alexandra Hospital, there was positive feedback about the triumvirate relationships, the strength of clinical leadership in emergency medicine and that of the sector level leadership.

7.69. This review recognises the need for Clinical Directors to have sufficient time to perform their duties effectively and to be provided with the necessary tools and support. The significance of the Clinical Director role, especially given the magnitude of the issues highlighted in this review, requires a more fundamental consideration of how leadership is resourced and supported within NHS Greater Glasgow and Clyde.

[98] An overview of job planning. British Medical Association . Updated 18 September 2023

7.70. Given the complexity and demands of these roles, it is crucial to ensure that clinical directors are adequately developed and supported to handle their responsibilities. This includes providing comprehensive training, mentorship, and ongoing professional development opportunities. Additionally, there should be a structured pathway for identifying and nurturing future clinical leaders within NHS Scotland. Strengthening this pathway will help ensure that individuals are well-prepared for leadership roles. This should be further explored with NHS Education for Scotland.

Recommendation 23: NHS Greater Glasgow and Clyde should ensure job plans appropriately reflect the time and support required to undertake the clinical director, deputy clinical director and clinical lead roles across all three sites.

Robust governance arrangements

Clinical governance arrangements

The review noted that the clinical and care governance arrangements in place included a strong level of senior medical representation, with more limited representation of senior nursing staff. However, there was no clear evidence of escalation of concerns raised by the Queen Elizabeth University Hospital consultants through the clinical and care governance framework of NHS Greater Glasgow and Clyde.

7.71. Clinical governance is defined as "A framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish."[99]

7.72. Clinical governance was introduced into the NHS in Scotland in 1998[100] with a duty on NHS boards to:

"…create a culture where the delivery of the highest standard possible of clinical care is understood to be the responsibility of everyone working in the organisation, and is built upon partnership and collaboration within health care teams and between health care professionals and managers;

"introduce structures and processes which assure them that this is happening whilst at the same time empowering clinical staff to contribute to the improvement of standards and involving patients and the public in this process".

[99] Scally, G, Donaldson, L. Looking forward: clinical governance and the drive for quality improvement in the new NHS in England. BMJ1998;317: 61. 1998
[100] MEL (1998) 75 Clinical Governance, Scottish Executive. 1998.

7.73. It was also enshrined subsequently in legislation with a duty of quality on NHS boards to have "in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals".[101] Clinical governance is an integral part of the governance arrangements in NHS Scotland.

7.74. The clinical governance arrangements are within the NHS Greater Glasgow and Clyde clinical and care governance policy. The NHS Greater Glasgow and Clyde clinical and care governance committee, chaired by a non-executive director, is at the pinnacle of the board clinical governance arrangements. Figure 7.1 below shows the relationships between the committee and the other elements of clinical and care governance.

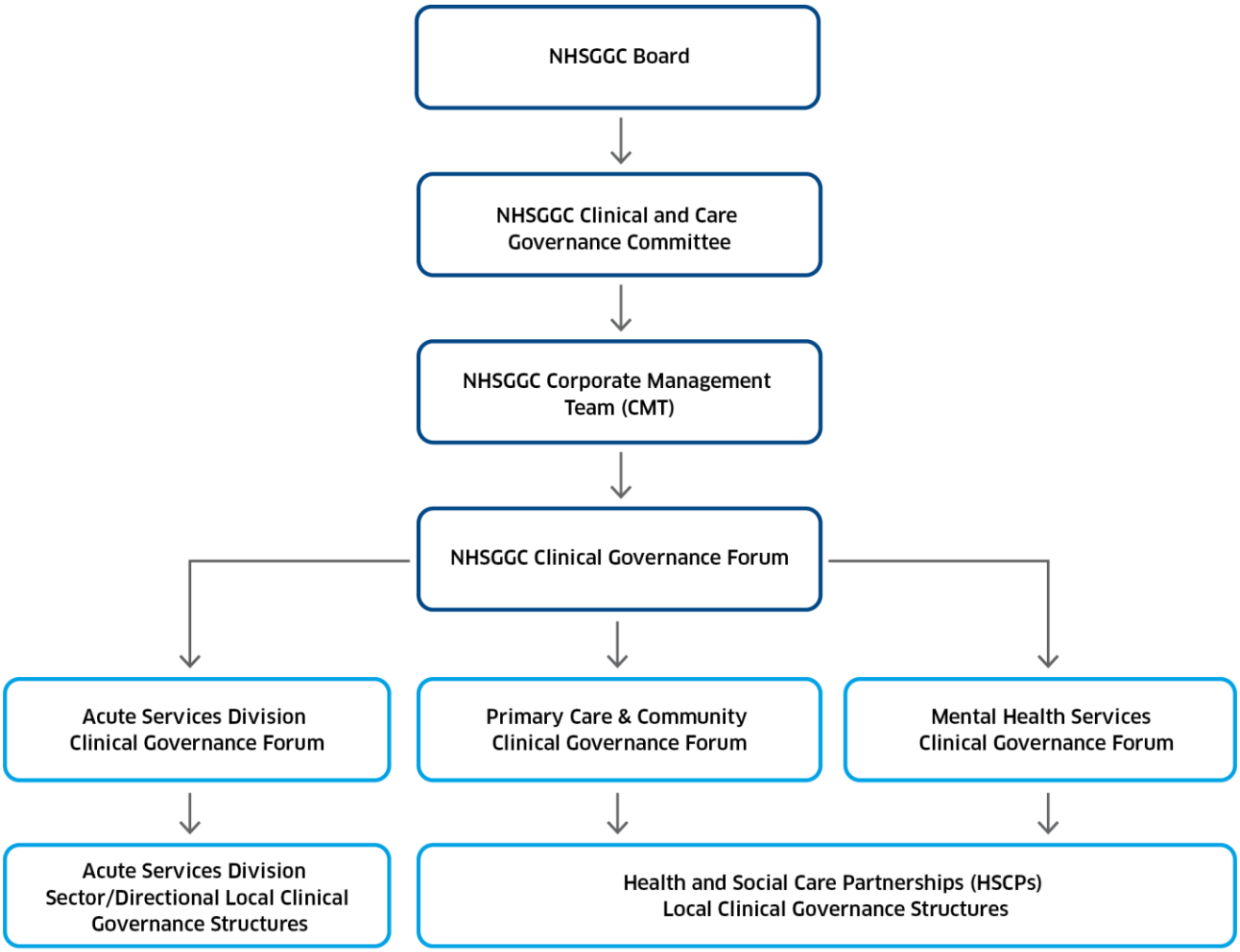

Figure 7.1: NHS Greater Glasgow and Clyde clinical governance structure [102]

[101] National Health Service (Scotland) Act 1978, section 12 H
[102] Overview of Board clinical governance arrangements. NHS Greater Glasgow and Clyde.

7.75. The review heard that clinical governance sits within the general management structure; with the Chief Nurses and Chiefs of Medicine for each of the sectors having professional responsibility for clinical and care governance within their role and representing their sector at the acute services division clinical governance forum. The NHS Greater Glasgow and Clyde clinical governance forum is chaired by the board Medical Director.

7.76. The board clinical and care governance committee is attended by the Medical Director and the Nurse Director as well as the Deputy Medical Directors. Beyond the Nurse Director, there is no further nursing leadership at the committee.

7.77. The review received minutes and papers from the acute services division clinical governance forum. The papers describe initiatives to drive improvements, to monitor compliance with policies and procedures as well as matters related to staff and patient risks (including DATIX). The papers are also open about clinical and operational challenges.

7.78. The review did not receive a sufficiently clear explanation as to how matters in each sector were formally and systematically escalated to the acute services division clinical governance forum and ultimately, where necessary, to the board's clinical governance forum or beyond.

7.79. In accepting the definition of clinical governance, especially with regard to 'safe-guarding high standards of care', the review team could find no documentary evidence that the concerns raised by the emergency department consultants had been formally escalated to the clinical and care governance committee and ultimately the NHS Greater Glasgow and Clyde Board ahead of the media coverage in March 2024.

7.80. The review noted the strong presence of medical leadership in clinical governance arrangements. However, it also identified an opportunity to enhance these arrangements by ensuring a multi-disciplinary contribution in the future. By involving a broader range of healthcare professionals, including nursing, the governance framework can benefit from diverse perspectives and expertise. This collaborative approach will support more comprehensive and effective decision-making. Encouraging multi-disciplinary involvement in clinical governance will help foster a culture of inclusivity, shared responsibility, and continuous learning and improvement within the healthcare system.

Recommendation 24: NHS Greater Glasgow and Clyde should review the appropriate use of the clinical and care governance framework for systematically and consistently escalating serious concerns.

Recommendation 25: NHS Greater Glasgow and Clyde should strengthen multi-disciplinary input to the clinical governance arrangements as these currently appear to be too reliant on the singular voice and participation of the medical profession.

The clinical voice, whistleblowing and raising concerns

The emergency medicine consultants at Queen Elizabeth University Hospital lacked confidence in the existing whistleblowing mechanisms. Similarly, concerns were not escalated through the professional advisory or staff partnership structures. It is essential to ensure that the clinical voice is consistently heard, especially on safety-related matters, and that individuals feel confident their concerns will be addressed, and they will be protected.

7.81. There is a national policy in NHS Scotland underpinned by legislation to support and protect individuals in raising concerns about patient safety.[103] Each NHS board has a whistleblowing champion who has responsibility to seek assurance that the systems and processes are in working effectively and crucially that staff are actively encouraged and supported to raise any concerns about patient safety.[104] The Independent National Whistleblowing Officer[105] (INWO) in Scotland can review any concern that has been raised through the National Whistleblowing Standards.

7.82. The Public Interest Disclosure Act 1998[106] (PIDA) provides legal protection for all 'workers' that make a 'protected disclosure' under the legislation. Any worker that has done so has the right not to be subjected to any detriment by their employer on the ground that they have made a protected disclosure.

7.83. Guidance for employers on whistleblowing notes*: "If an organisation hasn't created an open and supportive culture, the worker may not feel comfortable making a disclosure, for fear of the consequences. The two main barriers whistleblowers face are a fear of reprisal as a result of making a disclosure and that no action will be taken if they do make the decisions to 'blow the whistle'"*. [107]

7.84. In the original concerns, the Queen Elizabeth University Hospital emergency department consultants described a situation which they believed was leading to preventable harm and compromising patient safety. The consultants considered that the principal issues creating the situation arose from crowding associated with 'exit block' and insufficient staffing.

7.85. The emergency medicine consultants did not have confidence in current processes within NHS Greater Glasgow and Clyde to escalate their concerns via the established whistleblowing policy and therefore approached Healthcare Improvement Scotland.

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[103] The National Whistleblowing Standards. 2021. Independent National Whistleblowing Officer. 2021.
[104] Non-Executive Whistleblowing Champion. NHS Scotland, Scottish Government.
[105] Independent National Whistleblowing Officer – https://inwo.spso.org.uk
[106] Public Interest Disclosure Act 1998 – https://www.legislation.gov.uk/ukpga/1998/23/contents
[107] Whistleblowing Guidance for Employers and Code of Practice. Department for Business, Innovation and Skills. 2015. Pg 4

7.86. It is of concern that the consultants did not have sufficient confidence in the established local systems to raise concerns through the whistleblowing procedure and this was a manifestation of the poor working relationships between the consultants and the senior leadership in NHS Greater Glasgow and Clyde. It was also a consequence of the extent to which individuals felt that the system afforded them the level of protection required to raise concerns.

> *Consultants often feel like they are shouting into a void when the floor is very dangerous. I have heard them clearly express this to management multiple times and nothing changes.*

7.87. As regards advisory structures, each NHS board has an area clinical forum which is constituted of the clinical professional advisory committees, and they have been in existence since 2001. The most recent guidance issued by Scottish Government was published in 2010 (CEL 16 2010). The area clinical fora have a role in ensuring that a clinical perspective is brought to bear on the priorities and decision-making of NHS boards.

7.88. The Blueprint for Good Governance in NHS Scotland highlights the importance of the area partnership forum and the area clinical forum[108] especially regarding "identifying opportunities for the improvement of services and the wellbeing of the workforce".

7.89. Whilst the emergency medicine consultants at the Queen Elizabeth University Hospital did not escalate their concerns through this route, it was also noted that the area clinical forum and the area medical committee, whilst aware of the issues, did not seek to escalate or raise these concerns with the NHS Greater Glasgow and Clyde Board. Nor were these concerns escalated through the area partnership forum.

7.90. There is a broader observation to be made regarding the purpose of the advisory structures within NHS boards. It is crucial to ensure a clear understanding of their role and contribution, especially as nearly 25 years have passed since their establishment in NHS Scotland. These advisory structures were designed to provide expert guidance, support decision-making, and enhance the overall governance of healthcare services. However, their effectiveness and relevance may need to be reassessed to ensure they continue to meet the situation and take cognisance of other changes in the governance landscape in the past two decades. This includes evaluating their impact on patient care and staff

[108] The Blueprint for Good Governance in NHS Scotland, para 4.95. Second Edition. Scottish Government; 2022.

engagement, as well as ensuring that their purpose is well-communicated and understood by all stakeholders.

Recommendation 26: NHS Greater Glasgow and Clyde should ensure that all staff feel able to speak up and their voices are consistently heard at all levels of management – especially in matters related to safety – and that there is confidence that individuals will be protected, and their concerns acted upon. Specifically, there is a need to ensure that the current NHS Greater Glasgow and Clyde whistleblowing procedures are known, understood, effective and trusted. This is particularly relevant for staff at the Queen Elizabeth University Hospital. It is vital that staff have confidence in the board's commitment to the National Whistleblowing Standards and the Public Interest Disclosure Act 1998.

Performance and operational management

There was a strong emphasis on finance and delivery of key urgent, unscheduled and elective care performance targets in NHS Greater Glasgow and Clyde. The review frequently heard concerns that performance and financial management were prioritised over the safety and quality of care. Additionally, there was insufficient infrastructure to support multi-disciplinary collaboration and a lack of documented evidence of collaborative decision-making.

7.91. NHS Greater Glasgow and Clyde oversees performance and reports to its board and the governance committees via the performance assurance information framework[109]. Like all NHS boards, NHS Greater Glasgow and Clyde has a national target to meet with regard to four-hour waiting time performance. Waiting times are recognised by the Royal College of Emergency Medicine as an important indicator of safety: "Long waits in emergency departments are consistently associated with avoidable patient harms (including mortality), poor patient and staff experience".[110]

7.92. The review received sample copies of the weekly unscheduled care capacity and pressures reports which are submitted to Scottish Government.[111] These are produced by management for each of the sites and cover performance against the four-hour standard and progress against improvement initiatives.

[109] Performance Report to Corporate Management Team. NHS Greater Glasgow and Clyde. Dated 05 September 2024.
[110] Position Statement - Improving Quality Indicators and System Metrics for Emergency Departments in England. Royal College of Emergency Medicine. 2019.
[111] Weekly unscheduled care capacity & pressures report. NHS Greater Glasgow and Clyde. Dated 03 April 2024.

7.93. NHS Greater Glasgow and Clyde oversees performance through regular performance reports to its board[112]. In respect of the emergency departments, it has operational oversight of performance management through its acute services division and down through to sectors via the performance review groups for each sector.

7.94. The review was provided with action plans for each of the three sectors arising from the performance review groups. Almost the entire focus was on the financial performance, delivery of targets and sickness absence. Unless these meetings had only recently been instituted, the reports of the performance review groups supplied by NHS Greater Glasgow and Clyde did not have supporting actions, or status reports or targets for the delivery of the objectives.

7.95. The actions contained in the output from the performance review groups reinforced the impression of a strong focus on budgets and performance: "Ensure continued work in order to improve the unscheduled care performance include flow 1/usage of minors."[113]

7.96. NHS Greater Glasgow and Clyde provided evidence of their governance arrangements for the individual sectors and for the NHS board as a whole. These governance arrangements included the Urgent and Unscheduled Care oversight board and individual Unscheduled Care boards for the three sectors.

7.97. The Urgent and Unscheduled Care oversight board is jointly chaired by the Chief Operating Officer for acute services and the Chief Officer for the Glasgow City Health and Social Care Partnership. It has a membership of 24 individuals holding clinical and non-clinical managerial positions in NHS Greater Glasgow and Clyde. The minutes conveyed the impression of exchanging information and noting updates rather than actions related to tackling significant issues facing the service.

7.98. The review considered the minutes of sector level Unscheduled Care meetings that took place in 2023 and 2024. Based on the minutes and action notes from the three sectors there was:

- very poor attendance and almost exclusively those in managerial roles who were present
- episodic meetings (e.g. even accounting for winter pressures the north sector unscheduled care implementation group meeting had a gap of five months between the November 2023 and April 2024 meetings)
- incomplete terms of reference
- poor record keeping of discussions and points of agreement, and
- a lack of clinical engagement.

[112] Board Performance Report to NHS Greater Glasgow and Clyde Board Meeting. Dated 27 August 2024.
[113] South Sector PRG Action Plan. NHS Greater Glasgow and Clyde.

7.99. It was unclear how this aspect of the management infrastructure secured meaningful engagement and support to deliver on the intended outcomes.

7.100. The apparent lack of recording of meetings such as through minutes at an operational level was a theme from the feedback. There was an absence of formal documentation such as minutes and where they were generated, there did not appear to be circulation to ensure individuals were informed of actions and their and others' responsibilities.

7.101. There was considerable attention given to financial management in the feedback by staff, and the implications for the delivery of care and for some clinical staff it was a source of frustration. The review noted that there appeared to have been a shift in focus of management from operational performance to finance and there was a limited trade-off between budgetary discussions and patient safety.

> *Senior staff are not being listened to by senior hospital management, and it always comes down to finances and not patient/staff safety. It's unsafe, overwhelming, under supported and just not acceptable.*

> *We keep raising concerns about staffing levels, patient safety, lack of support but hospital management cares more about money than patient safety. Safe staffing levels are completely ignored, especially for a highly acute, critical area with a lot of clinically unstable patients. Refusing to cover short term sickness.*

7.102. The review noted the steps that had been taken in the past four years with initiatives such as the establishment of the flow navigation centre in 2020 and GlasFLOW/continuous flow in December 2022. The absence of a structured approach across the sectors to quality improvement within each of the emergency departments was noted. There were some important quality improvement initiatives such as in respect of frailty, which had demonstrated impact on co-ordination of care. Attempts to address pathway development with specialty inpatient teams had not achieved the same level of success.

7.103. The review noted that there appeared to be greater traction with regard to externally generated and supported improvements such as the frailty team improvement work, but less sustained improvement generated from internally driven approaches. It was commented that there is a "tendency to expect someone else to bring the solution, and services don't own the need to find the solutions."

7.104. Across all three sectors, there seemed to be a lack of mechanisms for developing solutions through multi-disciplinary collaboration. Where structures did exist, they appeared to focus on relaying information and reporting the situation rather than facilitating roundtable discussions to identify and implement solutions. There was also a lack of sustained follow-through on actions, causing initiatives to start but then drift away.

Recommendation 27: NHS Greater Glasgow and Clyde needs to enhance its governance of the operational management of urgent and unscheduled care. This includes ensuring robust documentation, transparency in decision-making, and greater involvement of clinicians in the design and delivery of care.

Recommendation 28: NHS Greater Glasgow and Clyde needs to adopt a balanced approach to sector leadership, ensuring that the quality and safety of care is not inappropriately overshadowed by other performance targets or financial considerations.

Recommendation 29: NHS Greater Glasgow and Clyde needs to ensure there is an active engagement and participation across the clinical leadership and wider community in the delivery of the board's recently approved quality strategy.

Effective team working

Team working within the Queen Elizabeth University emergency department

There was evidence of poor team working in the Queen Elizabeth University Hospital emergency department amongst those in management roles, consultants and nursing staff.

7.105. At the Queen Elizabeth University Hospital, the relationships between the emergency medicine consultants, management and nursing staff had clearly deteriorated and this had created tensions and was impacting on the working environment. There was also reference to the team dynamic changing depending on which individual was on shift in the emergency department.

7.106. It is clear from the on-site visits and the staff survey that there has been a marked decline in team working and trust precipitated by a range of factors. As stated previously, these tensions do not arise between two different groups alone but are a complex set of fractured relationships within and between individuals and teams.

Team working within the Glasgow Royal Infirmary emergency department

7.107. Staff working relationships within the Glasgow Royal Infirmary were generally described as positive in the delivery of care. There was a strong sense of team working across a range of professional groups.

> *I do love my team, how well we all work together and have always felt supported despite pressures of capacity.*
>
> *Good team working. Everyone's views and opinions regarding the patient are listened to and able to raise concerns to medical staff when needed. All staff are approachable.*

7.108. Crucially staff felt that they could make an impact: "We care for some people in their most vulnerable times. In my time in the emergency department, I have felt I have made a difference."

Team working within the Royal Alexandra Hospital emergency department

7.109. The review found the Royal Alexandra Hospital to be a generally positive working environment, with good working relationships between individuals, underpinned by mutual respect and appreciation. Information and feedback provided by staff suggested that relationships within the Royal Alexandra Hospital emergency department were perceived to be very good and very cohesive. There were also good links to the senior management team. These relationships were seen to stem from a smaller sized team which contributed to a good working culture and a good attitude. The Royal Alexandra Hospital emergency department is seen as a friendly place where people communicate well to solve problems.

Team working with the rest of the hospital

There is a lack of team working and ownership of the challenges facing the emergency departments across all three sites within the wider hospitals. As a result, emergency department staff feel undervalued and isolated, negatively impacting their morale and well-being. It is essential to establish a stronger whole-hospital ethos, supported by clear referral pathways and specialty support, so that all specialties have greater shared ownership of the issues and understand their contribution to the solutions.

7.110. Across all three sites there was a sense of physical isolation and a lack of collective ownership across the hospitals when the emergency department was under pressure.

7.111. There is a general lack of ownership by specialty inpatient teams for their patient pathways within each sector despite agreed pathways being in place. Often in-patient admissions areas are beyond capacity and patients are diverted to the emergency departments, by default, for the emergency department staff to review. This is particularly evident at the Royal Alexandra Hospital where all medical patients are triaged by the emergency department after 5pm and senior nurses and consultants often describe patients attending with GP letters but being refused for specialty team review.

7.112. Although orthopaedic patients at the Queen Elizabeth University Hospital have an assessment area for GP referrals and post operative patients re-attending this is not consistent across each sector.

7.113. There is reference to some post operative patients attending the emergency department instead of accessing their own team (e.g. patients with percutaneous endoscopic gastrostomy (PEG) tubes/nephrostomies not going directly to these teams for review) or early pregnancy issues not being seen directly in the early pregnancy assessment unit. Barriers were described as being put in place by in-patient teams to prevent admission and multiple additional requests for further investigations are placed prior to acceptance with teams requiring a confirmed diagnosis rather than a differential. Teams also reported they can only create new patient pathways by developing these within the emergency department and taking them to the specialty teams for review rather than those teams having responsibility for unscheduled patients.

7.114. A wider point was made to Core Review Group members about the extent to which emergency medicine had become by default a significant gatekeeper to the NHS and the resultant pressure on staff to meet expectations, whether it be in relation to exacerbation of chronic conditions or in complications from post-operative care.

7.115. In summary, the review has found the emergency departments feel under-valued and isolated. There is not the collective ownership of urgent and unscheduled care amongst specialties across the sectors. Combined with other pressures, such as rising complexity of patients and changes in the workforce, this means that a substantial level of pressure is being placed on the emergency departments.

Recommendation 30: NHS Greater Glasgow and Clyde should establish a stronger commitment to a unified approach across all sectors. This should be based on clearly defined care pathways and suitable admitting rights, supported by appropriate operational structures and a well-trained and nurtured workforce in all emergency departments throughout NHS Greater Glasgow and Clyde.

Supportive culture

7.116. The review considered two aspects of a supportive culture:

- the nature of support for individuals in their day-to-day experience within teams, and
- the climate of support from the top of the organisation in responding to pressures and demands.

7.117. Within teams there was highly variable levels of support across the sectors. Across all the feedback received by the review, there was a consistent theme of an absence of practical support and understanding about the demands on staff by NHS Greater Glasgow and Clyde, other than the staff mental health wellbeing support booklet for staff submitted within the evidence provided to the review. There was widespread reference to the impact of the serious pressures on the mental health of individual members of staff and teams, and evidence of moral injury[114]. There were also some references to bullying behaviours and 'burn out' associated with stress.

7.118. Despite the generally positive working relationships at the Royal Alexandra Hospital referred to above, the working environment for staff was an area of repeated concern with out-dated facilities and the delays for patients to reach in-patient care.

7.119. In the staff survey it was commented that there was an unsupportive environment at the Queen Elizabeth University Hospital.

> "The department is losing a lot of staff who have been assets to the team. Whilst some may leave for promotions others are leaving due to the way they are being spoke to on a regular basis and this type of culture being almost promoted amongst management. This is not why people wanted to be nurses, people can cope with a stressful environment if they are amongst a strong team who will all support each other, and this comes from above. We need more positive safe leadership. […]"

7.120. Nursing staff described sign posting to access statutory and well-being services alongside management support being offered, however this was time limited and sometimes fell away after a short period leaving staff members feeling unsupported and anxious.

7.121. Critical incident debriefs both post incident (hot) and as part of longer-term reviews are a commonly used process to support teams to share their experiences, emotions and identify immediate or future actions and support. Nursing staff particularly highlighted the lack of opportunity to undertake these post incidents. All departments highlighted limited opportunity to undertake these with little to no feedback from DATIX reports completed. On one occasion following a serious incident which involved staff members being physically assaulted at the start of a night shift, no opportunity to debrief or have time

[114] Moral injury: the deep emotional wounds that result in participating in or bearing witness to intense human suffering or cruelty. Gibbons, S.W., Shafer, M., Hickling, E.J. and Ramsey, G., 2013. How do deployed health care providers experience moral injury?. *Narrative inquiry in bioethics*, *3*(3), pp.247-259.

away was provided with nursing and medical staff having to complete their shifts in a traumatised state.

7.122. Across all departments a sense of being overwhelmed was expressed. Staff described high turnover and sickness within teams particularly nursing due to levels of stress leading to an imbalance within the workforce with a greater number of junior and less experienced staff on each shift. At charge nurse and senior charge nurse level concerns were raised about their ability to nurture, support and develop their junior team members due to limited downtime or scheduled training and learning opportunities. This resulted in these nurses feeling concerned about the quality of care they were providing.

7.123. Staff described limited department team or profession specific meetings or forums being held however highlighted this would be a good mechanism for issues to be explored and concerns be understood.

7.124. There was concern about the level of support that individuals in management positions received from the most senior management in NHS Greater Glasgow and Clyde, with aspects of behaviour not conducive to a respectful and supportive working environment. There was also a concern expressed by a clinical leader that clinical matters were not prioritised.

8. Wider Implications for Consideration in NHS Scotland

This review was commissioned to examine concerns raised by emergency medicine consultants in the Queen Elizabeth University Hospital. To do this effectively, the review has considered information from a wide range of sources both within NHS Greater Glasgow and Clyde and nationally (Scotland and UK wide).

The Core Review Group is very aware that emergency departments do not operate in isolation, and that the challenges they experience reflect the pressures across the health and care system. It was not within our remit to address the continued challenges that health and care systems face when trying to enable safe patient discharges back into the community, and the impact this has on all concerned. This includes patients who remain in hospital when they no longer require this level of care and patients who are not timeously assessed and treated in emergency departments and then transferred into inpatient hospital beds. This also applies to patients in the community awaiting delayed ambulance attendance and transfer to hospital when required, or to receive elective treatment as planned.

The Core Review Group also acknowledges that significant improvement work within urgent and unscheduled care has been taking place in NHS boards, together with their local health and social care partners, and with national support, since before the Covid 19 pandemic. This improvement work was beginning to deliver some positive changes for the benefit of patients when the pandemic struck in 2020. The changes described below require a recalibration of the improvements and changes needed to enable patient and needs-centred services.

This chapter shares wider system learning which reflects the breadth of experience and expertise of the Core Review Group and External Reference Group, as well as analysis of the national data accessed during the review. These observations are based on the evidence examined and are a synthesis of collective deliberations and judgement.

The primary focus of this review is on three of the emergency departments in NHS Greater Glasgow and Clyde: the Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital. However, we recognise that many of the recommended changes and improvements will not be possible for either NHS Greater Glasgow and Clyde or other territorial NHS boards without national direction and support from the Scottish Government. The changes and improvements needed will not happen without continued assistance from the national bodies named below that play a vital role in supporting the improvement of health and care services.

What has changed in recent years?

- Changing population demographics have resulted in population need becoming more complex, and the system has become more complicated for people to navigate. Patients have increased frailty, multimorbidity and may have multiple socioeconomic disadvantages.

- There is an increased burden of chronic disease management in primary care. The consequence of this impacts on the capacity of primary care to see urgent and unscheduled care presentations. This can lead to patients presenting directly to emergency departments or minor injury units rather than accessing general practice, NHS 24 111, NHS Inform, Pharmacy First or other alternative community-based services.

- Financial pressures are impacting on community-based services that have previously supported vulnerable groups, meaning people may have fewer safety nets to turn to.

- There have been changes in medical practice, for example:
    - same day/ambulatory turnaround of several conditions for example venous thromboembolism (VTE)
    - increased use and need for diagnostics, particularly radiological investigation.

- There are challenges to staffing affecting different professions and specialties across Scotland and these are having an impact across various services.

- A number of clinical services are signposting the public to other care options including support at home. This has an impact on community services to support these patients at home, especially where more complex interventions are required, such as Hospital at Home.

What has the impact been?

- Poorer outcomes are seen due to crowding in acute hospital sites. This has been highlighted in emergency departments but also affects acute receiving areas and downstream wards.

- Unwarranted variation in length of stay nationally for frail patients with multi-morbidity leading to high bed occupancy in some NHS boards that inhibits flow and leads to crowding at the front door in emergency departments.

- Unnecessarily long lengths of stay lead to physical and cognitive deconditioning that can increase the overall need for care in hospital and in communities on discharge.

- Lack of community-based services to support those with multiple disadvantages, impacting on healthcare services and leading to poorer outcomes.

- Lack of capacity for same day pathways has led to this work being performed within some emergency departments. This work usually requires longer than four hours to complete and therefore impacts on capacity within emergency departments to see and assess new patients. Emergency departments then evolve into acute assessment and diagnostic units.

- All parts of the system are experiencing higher demand which challenges the quality of care delivered, the experience of care, the experience of work and restricts the availability of clinicians to engage in service redesign.

- Tracking the effectiveness of the system is complex and data to help address this has not been developed consistently with the input of clinical teams at the point of care.

- The complexity of the system means that the quality and effectiveness of relationships between all service providers is more important and more challenging than ever.

What improvement is needed?

The collective expert opinion from the Core Review Group and External Reference Group has highlighted the following for improvement across the health and care system based on the available and growing evidence:

- Clinicians in leadership roles should have sufficient training in leadership skills and behaviours, management practice, workplace culture and change management. The quality of leadership is pivotal to successful complex whole system change.

- The importance of whole system multidisciplinary relationships must be emphasised and delivered in strategic forums as well as operational delivery. These relationships must include primary care, Scottish Ambulance Service, NHS 24, hospital services, and Health and Social Care Partnerships.

- Improvement efforts and funding decisions need to be taken with the whole system in mind to deliver realistic practice in the right place, first time so that value is maximised, and patients see the right clinician in the first instance.

- The principles for optimising flow, developed by the Centre for Sustainable Delivery should be adopted across Scotland. The model developed to reduce unwarranted variation should continue to create national clinical and operational consensus around core essential standards.

- There is good evidence supporting the safe discharge of many patients within 48 to 72 hours of admission. This practice can significantly reduce deconditioning and associated harm. Therefore, reducing unwarranted length of stay should be a primary national focus. The principles of ‘Discharge without Delay’ and ‘Realistic Medicine’ will support this focus.

- The complexity of practice means that hospital-based urgent and unscheduled care needs to be delivered in settings where there is multiprofessional, multispecialty support. In acute services this will require access to senior decision makers and diagnostic radiology on site seven days a week. Consideration also needs to be given to pharmacy and some other allied health professionals seven days a week to enable better outcomes for patients and improved flow.

- The use of data across Scotland needs to be standardised in collaboration with Public Health Scotland so that adequate benchmarking can take place.

- National bodies such as Healthcare Improvement Scotland and the Centre for Sustainable Delivery should share change ideas via learning networks and reduce unwarranted variation in practice and outcomes.

National Recommendations

Scottish Government

Recommendation 31: Scottish Government should commission Healthcare Improvement Scotland to lead the development of a national approach to improving the quality and safety of urgent and unscheduled care in NHS Scotland, consistent with the Quality Management System, including the development of national standards in partnership with a range of agencies including the Royal Colleges. This will build on work already commenced by The Centre for Sustainable Delivery and include urgent work needed to work towards eliminating the unacceptable use of non-standard care areas given the risks to patients and the impact on staff. This will require significant national focus and support.

Recommendation 32: Scottish Government should explore with Healthcare Improvement Scotland how best to gather patient views about experiences of accessing urgent and unscheduled care services and waiting in emergency departments to inform more detailed national recommendations on how to improve the patient experience and shape services for the future.

Recommendation 33: Scottish Government should engage with relevant national agencies to commission a review of the national guidance for specific health and care demand, capacity escalation and business continuity, which recognises the need to ensure a credible, robust and practical whole system response. This is essential and complementary to the current Multi Agency Major Incident Guidance.

Recommendation 34: Scottish Government should engage with relevant national agencies to commission a review of the professional advisory committee arrangements in NHS boards to ensure they have a transparent, independent and objective mechanism for the board to consider matters of safety and concern. There is an opportunity to refresh the previous national guidance and make these arrangements clearer and more open for all professions to understand.

Public Health Scotland

Recommendation 35: Reliable and comparable whole-system datasets are essential to support improvement in urgent and unscheduled care and optimise flow through the health and social care system. Public Health Scotland should be commissioned by Scottish Government to work with other national and local partners with the aim of progressing existing work and further developing datasets that are designed with, and available to NHS boards to support continuous improvement.

The Centre for Sustainable Delivery

Recommendation 36: The Centre for Sustainable Delivery should strengthen its collaboration with territorial and national NHS boards to engage in improvement activities aimed at:

- Reducing unwarranted variation in urgent and unscheduled care performance to enhance the quality and experience of care, as well as patient outcomes.
- Rethinking access to urgent and unscheduled care to ensure equity and that individuals are treated in the right place, the first time.
- Ensuring appropriate representation, including clinical leaders, in the recently formed Strategic Delivery Groups to drive improvement, set standards, and deliver change.
- Participating in the acute hospital site visit process to ensure that change is driven by clinical teams and tailored to meet the needs of local communities.

NHS Education for Scotland

Recommendation 37: NHS Education for Scotland should strengthen and further develop structured development programmes to identify and support clinical and non-clinical leaders in NHS Scotland. These programmes will enable NHS boards to focus on developing whole system multidisciplinary working and relationships which foster innovation, improvement and inclusivity in decisions that explicitly benefit quality of care and patient safety.

Recommendation 38: NHS Education for Scotland should be supported by Scottish Government to explore the implications, and work towards the shift to whole time equivalent medical trainee recruitment in order to strengthen the learning experience, reduce gaps in service and build a more sustainable, effective medical workforce for the future.

Recommendation 39: The review has highlighted the critical role of effective and supportive leadership by the NHS Board. It is recommended that the Scottish Government commission NHS Education for Scotland to evaluate the current national and local induction and support arrangements for NHS Non-Executive Board Members. This evaluation should aim to identify and implement any necessary improvements to ensure that Non-executive Board Members can perform their roles as effectively as possible, and consistent with the requirements set out in the NHS Scotland Blueprint for Good Governance.

Healthcare Improvement Scotland

Recommendation 40: The review has identified that the tools for appropriate staffing levels with regard to emergency departments are not sufficiently robust. Healthcare Improvement Scotland's Healthcare Staffing Programme should prioritise the development of new tools which reflect the current operating context and multi-disciplinary working to ensure safe and effective care.

Recommendation 41: Healthcare Improvement Scotland should collaborate with the Independent National Whistleblowing Officer, and other relevant bodies, to develop clear and unambiguous guidance for staff in NHS boards on the national routes for staff to raise concerns under Whistleblowing and the Public Interest Disclosure Act. This will enable NHS boards to ensure that they have effective arrangements in place and improve staff awareness and understanding.

Appendix 1 The concerns raised by the emergency medicine consultants

Background

This appendix sets out the original concerns raised by the emergency medicine consultants in the Queen Elizabeth University Hospital, Glasgow and the subsequent timeline of events, leading to the announcement of the review in April 2024. This is important in providing a context to the subsequent review.

In May 2023 a large body of emergency medicine consultants at the Queen Elizabeth University Hospital wrote to Healthcare Improvement Scotland outlining concerns about the safety and culture within the facility. The consultant body confirmed that the matters had not been raised through the NHS Greater Glasgow and Clyde whistleblower procedure as they had no confidence in local board processes and were therefore not willing to proceed in this manner. They requested that the concerns were considered through the formal Healthcare Improvement Scotlandprocess.

Action by Healthcare Improvement Scotland and response by NHS Greater Glasgow and Clyde

In accordance with their extant process, Healthcare Improvement Scotland wrote to NHS Greater Glasgow and Clyde seeking assurance with regard to the issues that the consultants had raised. In June 2023, Healthcare Improvement Scotland received a response from NHS Greater Glasgow and Clyde with evidence as to how they were addressing the issues raised. NHS Greater Glasgow and Clyde recognised that the concerns were not resolved, and work was continuing to drive improvement in these areas. While they were aware of the concerns and had provided detailed information including how they measure and monitor the quality of care within the emergency department, there remained some areas where further detail was required for full assurance.

In July 2023, Healthcare Improvement Scotland wrote to NHS Greater Glasgow and Clyde providing feedback on their response and highlighted the areas where it required further information. Given the nature of the concerns and the emergency medicine consultant body coming forward to raise these, Healthcare Improvement Scotland met with NHS Greater Glasgow and Clyde management to discuss the issues raised. Healthcare Improvement Scotland also wrote to the consultant group to provide an update on the assessment process and next steps and shared a copy of the letter with them.

Further to requesting this from Healthcare Improvement Scotland, the consultants received the response from NHS Greater Glasgow and Clyde. The consultants responded to refute some of the information, with the strongest aspect being the statement that NHS Greater Glasgow and Clyde said the consultants did not ask to meet prior to contacting Healthcare Improvement Scotland. The consultant group attached, for context, an iMatter survey team report.

In August 2023, staff from Healthcare Improvement Scotland met with management from NHS Greater Glasgow and Clyde. There was a presentation of evidence by the management to staff from Healthcare Improvement Scotland.

Subsequent to the meeting, Healthcare Improvement Scotland wrote to the consultants to advise that they had met with management at NHS Greater Glasgow and Clyde and received evidence and data from them. The consultants responded to say that they had received a request from NHS Greater Glasgow and Clyde to meet regarding the case and they asked for our advice, given the process was ongoing, if it was appropriate to meet and if so how any meeting should be structured in order that the enquiry is not compromised. Healthcare Improvement Scotland responded to say that the assessment being undertaken by Healthcare Improvement Scotland in response to the concerns raised should not prevent engagement between them (the consultants) and the executive management team within NHS Greater Glasgow and Clyde in relation to these matters. Healthcare Improvement Scotland also clarified that a meeting between the consultant group and the executive team did not compromise the assessment being undertaken by Healthcare Improvement Scotland.

In September 2023, Healthcare Improvement Scotland wrote to the consultant body to advise that after assessment the decision had been taken to close the case under consideration.

The consultant group responded noting concern that the case has been closed without the opportunity to discuss with or assess all data points and they were concerned that a number of key pieces of information have not been considered in the response. They also noted concerns about staff wellbeing and experience.

The consultant group offered to provide this information should it be useful in reconsidering Healthcare Improvement Scotland's conclusions. They also confirmed that having met with the management team recently they were satisfied that there was now an appetite for change towards improvement, and a willingness to work with them on many of the issues they have raised. They noted that this is only the beginning of the improvement work, and they retained the option of bringing further concerns to our attention if patient safety remains compromised in the department.

The complaint

A complaint was then received from the consultant group on 21 September 2023 and was dealt with through the Healthcare Improvement Scotland complaints process by the Medical Director and the Associate Director of Nursing and Midwifery. Following an investigation including a meeting with the consultants, the complaint outcome was issued from the Chief Executive on 10 January 2024.

Two out of the three elements of the complaint were upheld relating to the quality of the engagement with the consultants – one on not providing an opportunity to discuss the concerns directly with Healthcare Improvement Scotland, and another on not offering the opportunity to provide evidence to substantiate the claims. An unreserved apology for the shortcomings was offered together with a commitment to learn lessons and make improvements to the process.

Steps to this review

Action was subsequently taken to initiate a review of the original concerns raised under the Healthcare Improvement Scotland using the 'Responding to Concerns' process. In light of the significance of the issues raised, it was announced in April 2024 that Healthcare Improvement Scotland would carry out a wider review of the concerns raised about the quality and safety of patient care.

Appendix 2 Terms of reference for the review

Aim

This review has been initiated in response to concerns about the emergency department at the Queen Elizabeth University Hospital, Glasgow but in carrying out the review, will take account of relevant considerations in relation to safety and quality of care across the other main receiving emergency departments in NHS Greater Glasgow and Clyde.

The review will also consider and report on the national context and relevant comparable data from other emergency departments as appropriate to the issues highlighted in NHS Greater Glasgow and Clyde and identify any wider learning for emergency departments and NHS boards across NHS Scotland.

The aim of the review is to:

1. Provide an evidence-based, balanced, objective and proportionate analysis of the key challenges facing the emergency department at the Queen Elizabeth University Hospital.
2. Consider any wider implications for the emergency departments at the Royal Alexandra Hospital, Paisley, and Glasgow Royal Infirmary.
3. Offer support to NHS Greater Glasgow and Clyde to identify practical, evidence-based and sustainable actions that may be required to improve quality and safety in emergency departments in NHS Greater Glasgow and Clyde.
4. Consider any wider evidence-based learning for emergency departments and NHS boards across NHS Scotland.

Scope

The review will be undertaken by Healthcare Improvement Scotland in the context of its existing legal powers and statutory duties.
The review will adopt the guiding principles and other appropriate elements of the Healthcare Improvement Scotland Quality Assurance System Framework, and the HIS Essentials of Safe Care. It will consider relevant national data and draw on strengths and learning identified in each of the emergency departments to share understanding of good practice, along with potential improvements in:

- **Safety**: the extent to which patients are treated in a safe environment and are protected from avoidable harm.
- **Leadership and culture**: the extent to which the service is well led, supported by robust governance arrangements, effective working relationships and team working, and a supportive culture both within and beyond the emergency department.
- **Patient experience and responsiveness:** the extent to which individuals receive timely, person-centred care; and the extent to which patient feedback and wider community engagement informs the planning and delivery of services.

The review, whilst also taking account of and considering the national context and relevant comparable data from other emergency departments, will be focused on the following:

- The three identified emergency departments in NHS Greater Glasgow and Clyde.
- The current issues and strengths in each department, within the context of the scope.
- The overall experience of patient care in the three emergency departments.

An independent review of Healthcare Improvement Scotland's Responding to Concerns process (the mechanism by which the original concerns were raised) is ongoing and is separate to, and out with the scope of the NHS Greater Glasgow and Clyde emergency department review.

Approach

The review will draw on:

- A range of sources of data and information including patient safety data, relevant performance data, safe delivery of care inspection reports, patient experience data, workforce data and staff experience data such as iMatter.
- Evidence from proportionate engagement with patients and a range of staff groups (including Partnership groups and whistleblowing champions). The approach to this engagement will include a combination of group and individual discussions for both categories, to obtain their views and perspectives on the safety and quality of care, culture, experience of raising concerns, and areas for improvement.
- Recognised standards where available, and relevant best practice principles and/or expert opinion to inform assessments of the above.

The review will comprise:

- An initial scoping phase to establish an evidence base and identify the initial key lines of enquiry.
- A discovery phase to collect data from information systems, review relevant evidence and the information collected through engagement with staff and patients. Emerging themes will be considered as the review progresses and may identify further key lines of enquiry.
- An analysis phase to synthesise the data gathered and produce a report.

Structure to Support the Review

The Executive Sponsor of the review will be Robbie Pearson, Chief Executive of Healthcare Improvement Scotland. The Senior Responsible Owner will be Lynsey Cleland[115], Director of Quality Assurance & Regulation at Healthcare Improvement Scotland, who is accountable for the overall delivery of this work. Jane Byrne, Head of Multiagency Inspections (Quality Assurance & Regulation at Healthcare Improvement Scotland) will be the Programme Director responsible for operational delivery within HIS.

The review will have the following structural support:

- **Core Review Group**

  The review will be conducted by a Core Review Group comprised of external and internal representatives (membership at appendix A). The Core Review Group will be responsible for the effective and efficient conduct of the review and the achievement of its aims within the agreed scope of the review. The Core Review Group will be supported by a dedicated Healthcare Improvement Scotland review Programme Director and programme management staff. Healthcare Improvement Scotland members of the Core Review Group will mobilise staff within their Directorates to carry out the work of the review. The Core Review Group will also include appropriate subject matter experts.

- **External Reference Group**

  To provide advice, appropriate scrutiny, and validation of the work of the Core Review Group. This will consist of external experts and will be independently chaired.

The Core Review Group will report progress on a monthly basis to the Healthcare Improvement Scotland executive team and regular updates will be provided to the Healthcare Improvement Scotland quality and performance committee and Healthcare Improvement Scotland board for oversight and governance.

Any matters that require formal escalation during the course of the review will be taken forward through established processes.

Timescale

It is envisaged that the work of the review will be undertaken within six months, with Healthcare Improvement Scotland feeding back emergent findings that require action from NHS Greater Glasgow and Clyde or other relevant bodies during the review process, prior to publishing a report of findings and recommendations.

[115] Lynsey Cleland was Director of Quality Assurance & Regulation for HIS from the commencement of the review until October 2024, and Ann Gow was Director of Quality Assurance & Regulation from November 2024 until conclusion of the review

Appendix 3 Core Review Group

Name	Role
Prof (Hon) Hazel Borland	Co-Chair of Core Review Group
Dr Pamela Johnston	Co-Chair of Core Review Group
Jane Byrne	Head of Multiagency Inspections, Quality Assurance and Regulation, Healthcare Improvement Scotland (Review Programme Director)
Caroline Craig	Associate Director, Healthcare Staffing and Care Assurance, Healthcare Improvement Scotland
Michelle Cassidy (Membership from April 2024 – August 2024)	Project Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Lynsey Cleland (Membership from April 2024 – October 2024)	Director of Quality Assurance and Regulation, Healthcare Improvement Scotland (Review Senior Responsible Owner)
Kay Cordiner (Membership from May 2024 – August 2024)	Clinical Services Manager, Unscheduled Care, NHS Highland
Mary Cumming	Senior Emergency Department Nurse, NHS Tayside (retired)
Rhona Davies	Public Partner, Healthcare Improvement Scotland
Dr Simon Eaton	Associate Medical Director, Northumbria Healthcare NHS Foundation Trust
Jo Elliott	Review Programme Manager, Quality Assurance and Regulation, Healthcare Improvement Scotland
Ann Gow (Membership from November 2024 – March 2025)	Director of Quality Assurance and Regulation, Healthcare Improvement Scotland (Review Senior Responsible Owner)
Ann Hargie	Review Administrative Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Dr Jo Hughes	Consultant in Emergency Medicine, Northumbria Healthcare NHS Foundation Trust
Jo Matthews	Associate Director, Improvement and Safety, Healthcare Improvement Scotland
Sandra McDougall	Associate Director, Quality Assurance and Regulation Directorate, Healthcare Improvement Scotland
Tony McGowan	Associate Director, Community Engagement, Healthcare Improvement Scotland
Eileidh McIntosh	Public Partner, Healthcare Improvement Scotland

(Membership from May 2024 – September 2024)	
Wendy McKay	Administrative Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Iain Macleod (from October 2024)	Public Partner, Healthcare Improvement Scotland
Dr Clare Morrison	Director of Engagement and Change, Healthcare Improvement Scotland
Donald Morrison	Head of Data, Measurement and Business Intelligence, Healthcare Improvement Scotland
Shirley-Anne O'Hare	Senior Emergency Department Nurse, NHS Lanarkshire
Fiona Roberston	Chief Nurse, NHS Grampian
Moraig Rollo	Clinical Quality Lead East Region, Scottish Ambulance Service
Dr Julie Ronald (Membership from May 2024 – January 2025)	Emergency Department Consultant and Associate Medical Director - Acute Care, NHS 24, and Specialty Advisor for Emergency Medicine to the Chief Medical Officer for Scotland
Edel Sheridan	Review Programme Manager, Quality Assurance and Regulation, Healthcare Improvement Scotland
Gillian Smith	Project Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Dr Julie Thomson	Consultant in Emergency Medicine, NHS Fife
Dr Sian Tucker	Deputy Medical Director, Clinical Directorate, NHS National Services Scotland, and Primary Care Out of Hours Advisor to the Scottish Government

Appendix 4 External Reference Group

Name	Role
Professor Sir Lewis Ritchie	Chair of External Reference Group
Suzie Bailey	Director of Leadership and Organisational Development, The King's Fund
Andrew Carruthers	Associate Director of Care Quality, Professional Development and Improvement Scottish Ambulance Service
Dr David Chung	Consultant in Emergency Medicine, Royal College of Emergency Medicine
Professor Frances Dodd	Executive Nurse Director, NHS Forth Valley
Professor Andrew Elder	Chair, Academy of Medical Royal Colleges and Faculties in Scotland (from January 2025)
Dr Fatim Lakha	Consultant Public Health Medicine, Public Health Scotland
Dr Crawford McGuffie	Executive Medical Director, NHS Ayrshire & Arran
Dr Chris McKenna	Executive Medical Director, NHS Fife
Eileen McKenna	Associate Director, Nursing Policy and Professional Practice, Royal College of Nursing in Scotland
Dr Gordon McNeish	Consultant in Emergency Medicine, NHS Lanarkshire
Dr Irene Oldfather	Director Strategic Partnerships, External Affairs and Outreach, The Alliance
Rosemary Pengelly	Public Partner, Healthcare Improvement Scotland
Orla Prowse	Physiotherapy Head of Service, Acute Division, NHS Lothian
Martin Robertson	Public Partner, Healthcare Improvement Scotland
Adam Sewell-Jones	Chief Executive, East and North Hertfordshire NHS Trust
Lesley Sharkey	Director of Midwifery / Scottish Quality & Safety Fellow, NHS Tayside
Elaine Strange	Head of Service, Public Health Scotland
Dr Shobhan Thakore	National Clinical Lead, Unscheduled Care, Centre for Sustainable Delivery
Professor Steve Turner (until January 2025)	Chair, Academy of Medical Royal Colleges and Faculties in Scotland

Professor Emma Watson	Executive Medical Director, NHS Education for Scotland

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