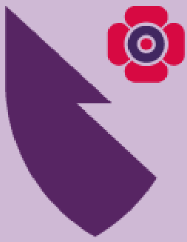

RCEM
Royal College of Emergency Medicine

NATIONAL ETHNICITY REPORT 2020/21

NATIONAL QUALITY IMPROVEMENT PROJECTS

ETHNICITY REPORT 2020/21

Published:
June 2022

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Executive Summary

Aim of this report

The report aims to look at ethnicity data gathered on the Quality Improvement Project (QIP) platform over a 6-month period. It aims to investigate any inequalities in care based on patient ethnicity for EDs across the UK.

This is the first national ethnicity report produced from the QIP data. Future QIP data also will be analysed and reported in a National Ethnicity Report.

Overview

The Royal College of Emergency Medicine (RCEM) would like to thank every Emergency Department (ED) that participated in our QIPs during the 2020/2021 cycle and contributed to the data used within this ethnicity report. Over a period of 6-months these 3 RCEM QIPs have accumulated 42,322 individual patient cases from 158 EDs nationwide.

The purpose of this National Ethnicity Report is to monitor and expose disparities in documented care between different populations within the UK. This can then help inform service design, training and awareness when it comes to care delivery affected by cognitive and organisational biases. To gauge a better understanding of how different ethnic groups have experienced patient care within EDs across the United Kingdom.

This report provides an opportunity for the College Quality team to review the platform, to consider improvements to the data collection, the live presentation of the data and the delivery of the reports.

Key Results

- Infection Prevention and Control- It is especially important currently that patients are screened for the safety of staff and patients in the emergency department.
- Pain in Children - Black children are waiting longer to be given analgesia
- Fractured Neck of Femur – There was very little diversity in the patient group, unfortunately we are unable to draw conclusions from this sample.

Key recommendations

- EDs should be taking every opportunity to capture ethnicity data as part of their records for patients.
- Departments should consider whether they have the staff and training in place to promote fair and equal treatment for all.
- Departments should routinely review their processes around the delivery of care to their diverse populations locally, paying special attention to protected characteristics (such as ethnicity) and social deprivation.
- EDs without any local guidelines for ethnicity should consider developing these

Conclusion

Using this data as a starting point we challenge you; to have difficult conversations about our biases and prejudices, to develop better policies, and to advocate for more resources to address care inequalities in relation to ethnicity. With this increasing understanding of how different groups may experience the ED, we encourage departments to engage directly with the patients to inform service design, especially the most marginalised and disadvantaged who are more likely to receive lower quality care. This is the first time RCEM has gathered data within its QIPs on ethnicity, with much of the data still incomplete. We are taking steps to understand the barriers to gathering this, to improve the power of the data going forward as we expand work in this space. Addressing care inequalities, as well as raising overall care standards are of the highest priority for RCEM. The College will endeavour to adapt to emergency care's increasing complexity to ensure we remain at the forefront, to continue the support and development of our departments and profession.

Foreword

Dr Katherine Henderson, RCEM President

This National Ethnicity Report builds on the 2020/21 cycle of gathering data specifically for ethnicity in our 3 Quality Improvement Projects (QIPs) for the first time. These are Pain in Children, Infection Prevention and Control, and Fractured Neck of Femur. This report establishes a starting point and allows us to see the progress currently being made in establishing appropriate standards and measures to ensure all patients and ethnicities are as safe as possible in our Emergency Departments.

It is vital we continue to review the performance of emergency departments for all patients, and this report investigates for the first time whether there are areas of health inequalities against ethnicity. The College is dedicated to improving the quality of care in our Emergency Departments through these important QIPs, undertaking all obligations to ensure the best measures of patient safety are obtained.

The RCEM Quality Assurance and Improvement Committee are dedicated to continually evaluating the QIPs data and improving them to best support you and improve patient care. We are aware that there are improvements we can make to strengthen local QI support, provide clearer data visualisation, and better communications. We welcome your feedback, ideas, and experiences to help us moving into 2022 and beyond.

Dr Katherine Henderson,
RCEM President

Dr Simon Smith,
Chair of Quality in Emergency Care Committee

Dr Dale Kirkwood
Co- Chair of Quality Assurance & Improvement Subcommittee

Dr Fiona Burton
Co- Chair of Quality Assurance & Improvement Subcommittee

Introduction

Background

The purpose of the RCEM 2020/21 QIPs is to improve patient care by providing measurement to track change but with a rigorous focus on action to improve.

The College is committed to assessing health inequalities relating to patient ethnicity in supporting departments to provide high quality care to all. The purpose of this report is to collect ethnicity data and monitoring for systemic inequalities and reporting this at a national level.

This is the first time the Royal College of Emergency Medicine has captured and recorded patients' data on ethnicity. By including this information within the QIPs, discrepancies with ethnicity can be identified, enabling a baseline measure to act as a starting point for improvement.

This year's National Ethnicity report outlines key issues in the UK and help to improve the quality of care in our EDs by reducing care inequalities.

Specific objectives

- To reanalyse the data collected from the 2020/21.
- To identify differences in documented care quality with regard to patient ethnicity.
- To create a baseline for ethnicity data, which can be developed in the future to monitor trends and target policy and resource.

Ethnicity sample

The sample of patient cases used within this ethnicity report excludes cases which fall within the not stated category e.g. unwilling to state to ensure the data is correct, consistent, and usable. For this reason, the sample used within this data analysis may differ from the total sample in the QIP report.

The 2021 Census does not include a 'not stated' ethnicity category therefore this has been excluded. The percentage of cases in the QIPs not stated were: Pain in Children 24.2%, Infection Prevention and Control 17.80% and Fractured Neck of Femur 19.16%.

Ethnicity groups

The ethnic groups within this report cover 5 groups. These have been adapted from the Office of National Statistics and the 2021 Census, and align with ECDS. The College Equality, Diversity and Inclusion committee are working to establish which categorisation will be most appropriate going forward as this body of work develops.

Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

Black, Black British, Caribbean, or African
- Caribbean
- African
- Any other Black background

Mixed or Multiple Ethnic Groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

White
- White British
- White Irish
- Any other White background

Other Ethnic Group
- Any other ethnic group

Methodology

Nationally, 42,322 cases from 158 EDs were included in this National Ethnicity Report.
This is broken down below by each of the three QIP topics.

The results in this report are not a self-report measure. It is reported by the data enterer about the patient, based on hospital records. RCEM does not have any control over if the hospital record is self-described.

	Pain in Children		**Infection Prevention**		**Fractured Neck of Femur**	
	Number of relevant EDs	Number of cases*	Number of relevant EDs	Number of cases*	Number of relevant EDs	Number of cases*
National total	168/239 (70%)	10,873	154/239 (64%)	17,500	159/234 (67%)	13,949
England	149/184 (81%)	10,215	145/184 (79%)	16,615	146/184 (79%)	12,862
Scotland	5/29 (17%)	133	2/29 (7%)	283	2/29 (7%)	179
Wales	9/13 (69%)	269	4/13 (31%)	412	6/13 (46%)	556
Northern Ireland	4/10 (40%)	196	3/10 (30%)	190	4/10 (40%)	330
Isle of Man	1/3 (33%)	60	0/3 (0%)	0	1/3 (25%)	22
*Analysis includes complete cases only						

Intervention

All Type 1 EDs in the UK were invited to participate in June 2020 for the 2020/21 QIPs cycle. Data samples were submitted using an online data collection portal. Participants were asked to collect data from ED patient records on cases who presented to the ED between 5 October 2020 – 2 April 2021. 5 cases per week was recommended. For the questions used within the QIP reports please see reports published on our website here.

Standards

Fundamental: need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels and service provision need to be in accordance with at least these fundamental standards. No provider should provide any service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

Developmental: set requirements over and above the fundamental standards.

Pain In Children

Standards	Grade
1. Pain is assessed immediately upon presentation at hospital	**Fundamental**
2. Patients in moderate or severe pain (e.g., pain score 4 to 10) should receive appropriate analgesia within 30 minutes (or in accordance with local guidelines) unless there is a documented reason not to	**Fundamental**
3. Patients with moderate or severe pain should have documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic	**Developmental**

Infection Prevention and Control

Clinical Standards	Grade
1. All patients should be screened on arrival for the symptoms of COVID-19 (and other infectious diseases which need isolation), as well as for those conditions considered to make them extremely vulnerable (and who will have been shielding themselves at home).	**Fundamental**
2. Patients with identified vulnerability should be isolated in a side-room as soon as possible	**Developmental**
3. Patients who are identified as potentially infectious must not be placed in a nonclinical area following triage.	**Developmental**

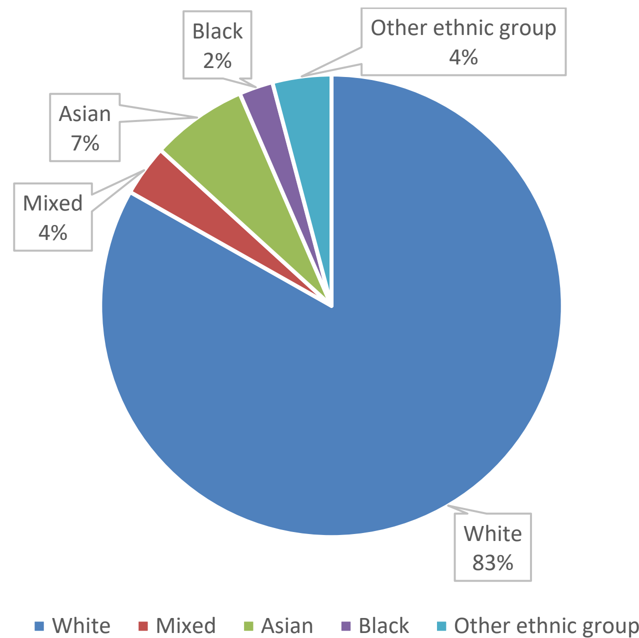
Fractured Neck of Femur

Standards	Grade
1. Pain is assessed immediately upon presentation at hospital	**Fundamental**
2. Patients in moderate or severe pain (e.g. pain score 4 to 10) should receive appropriate analgesia within 30 minutes (or in accordance with local guidelines) unless there is a documented reason not to	**Fundamental**
3. Patients should have an X-ray at the earliest opportunity	**Developmental**
4. Patients with severe or moderate pain should have documented evidence of re-evaluation and action within 30 minutes of receiving the first dose of analgesic.	**Developmental**

RESULTS

Pain in Children

Breakdown of ethnic groups within the ethnicity analysis for pain in children

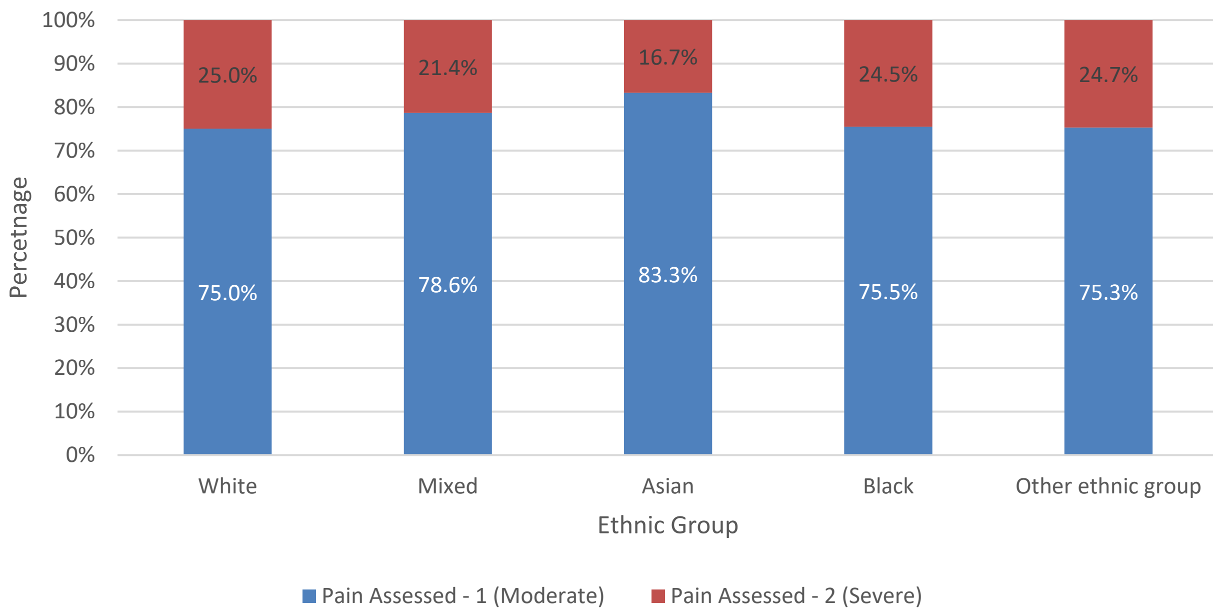


Sample: All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?
Q1.4: Ethnic category

Commentary
This data represents the percentage of patients for each ethnic group which took part in the Pain in Children QIP. This consisted of cases who presented to the ED between 5 October 2020 – 2 April 2021. The ethnic groups within this report have been taken from the ONS data. 83% of patients in the sample were identified as White, 7% Asian, 4% Mixed, 2% from Black ethnic groups and 4% from Other ethnic group.

Pain assessed on arrival (within 15 minutes) was Moderate or Severe, by ethnic group.



Sample: All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?

Q1.4 Ethnic category

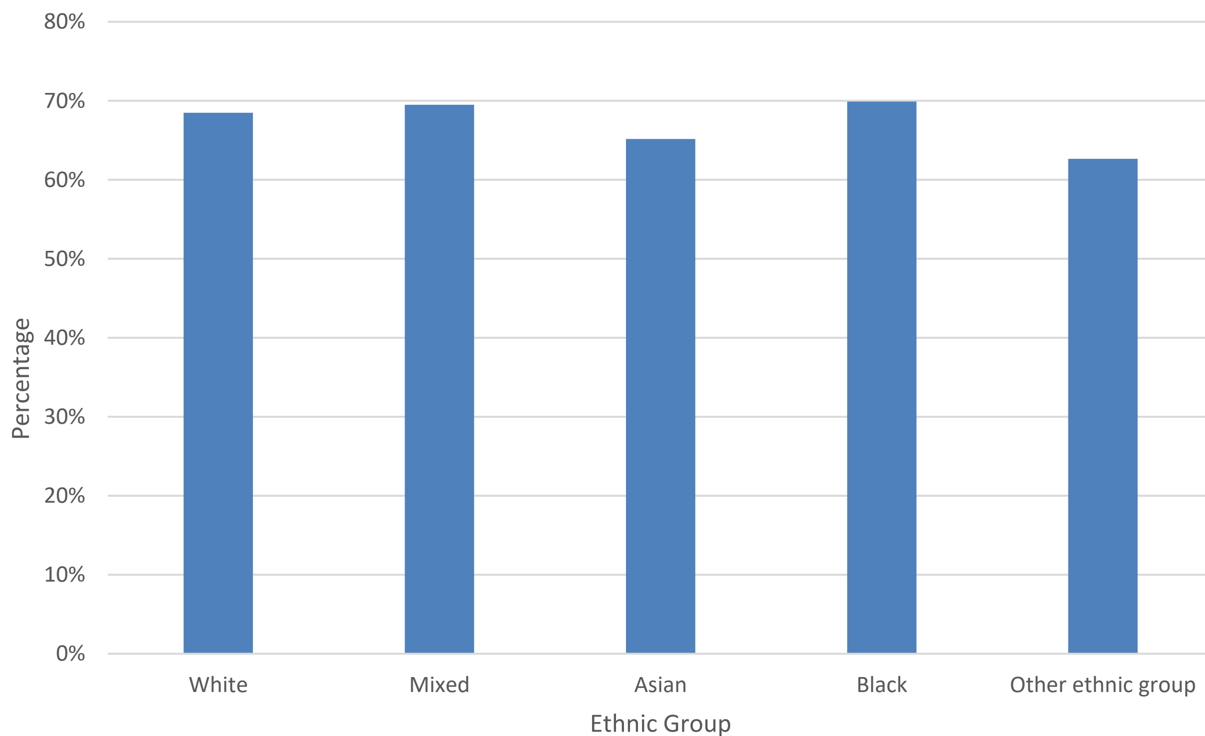
Q2.1 Was pain assessed on arrival (within 15 mins) If yes, select option Moderate or Severe

Commentary

This data shows a difference in the ethnic groups of patients who were assessed for moderate or severe pain. This data shows Asian patients were more likely to be assessed for moderate pain (83.3%), compared to 75% of White patients. For severe pain 25% of White patients were assessed, compared to a lower proportion of Asian patients, with a figure of 16.7%.

It was a fundamental standard of the QIP that children are assessed immediately upon presentation at hospital (within 15 minutes).

The percentage of validated pain assessment tool used, by ethnic group.

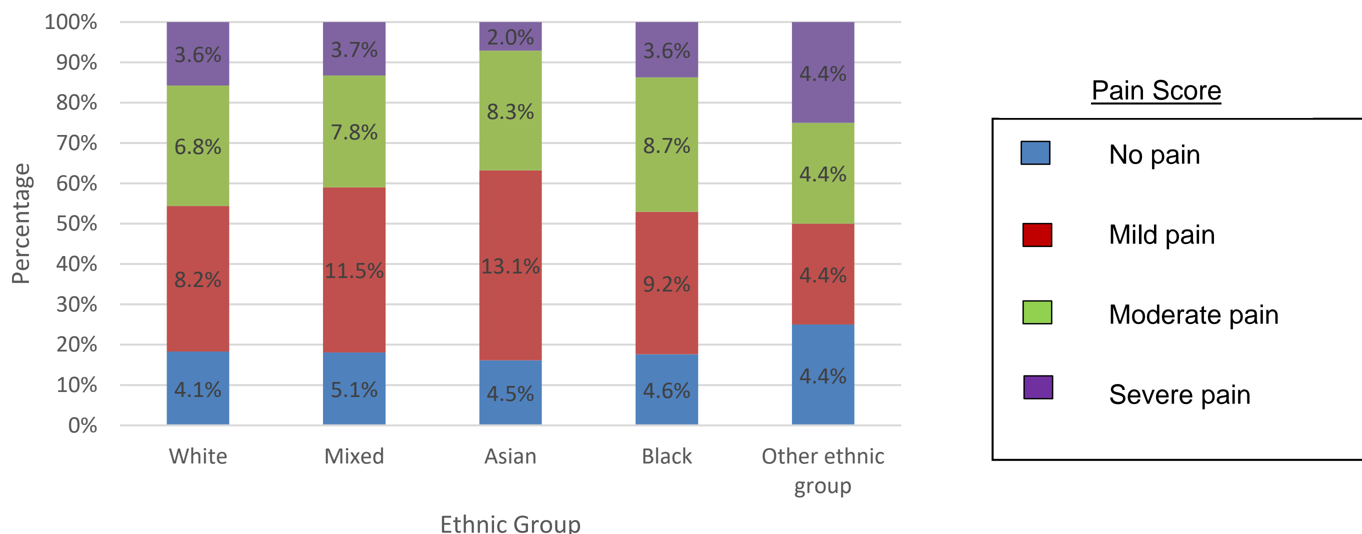


Sample: All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?
Q1.4 Ethnic category
Q2.2 Was a validated pain assessment tool used?

Commentary
This data shows a difference across ethnicities in the use of a validated pain assessment tool for the Pain in Children QIP. The highest ethnic group where a pain assessment tool was used was Black (69.9%) compared to the lowest being Asian (65.2%).

Pain score at reassessment, an average score by ethnic group

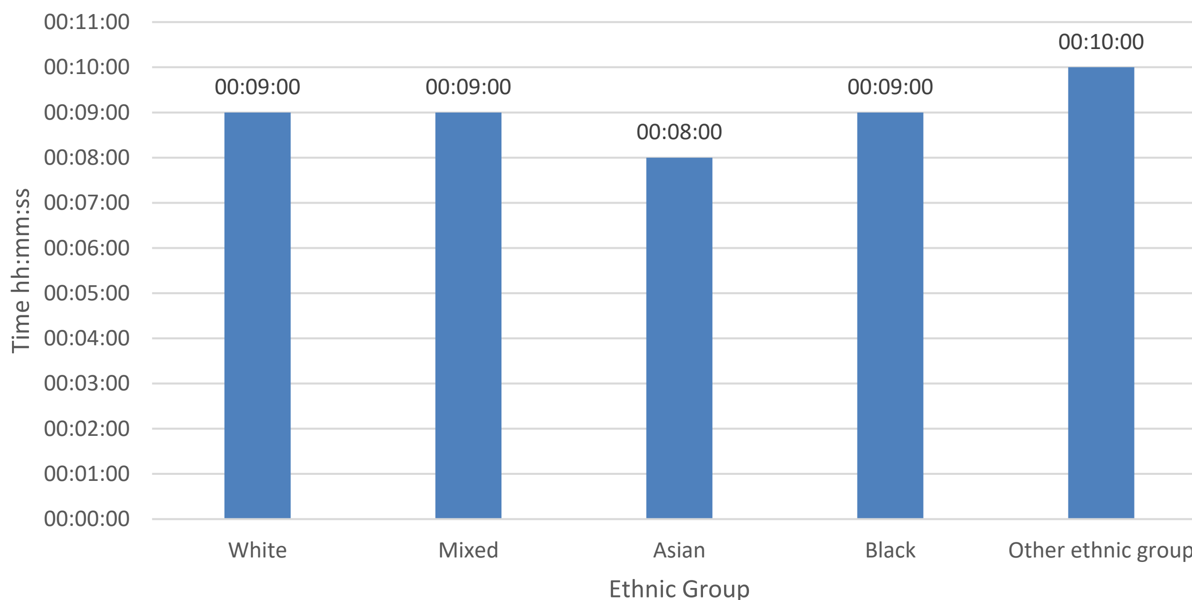


Sample: All patients included in the ethnicity analysis (n = **1909)**

What questions were used for this analysis?
Q1.4 Ethnic category
Q2.4 Was pain re-assessed in the ED?

Commentary
This data shows the difference across ethnic groups in reassessment. A clear difference was observed, particularly in mild pain with Asian having 13.1% and any Other ethnic group having 4.4% of pain score at reassessment.

Median time to pain assessment, by ethnic group

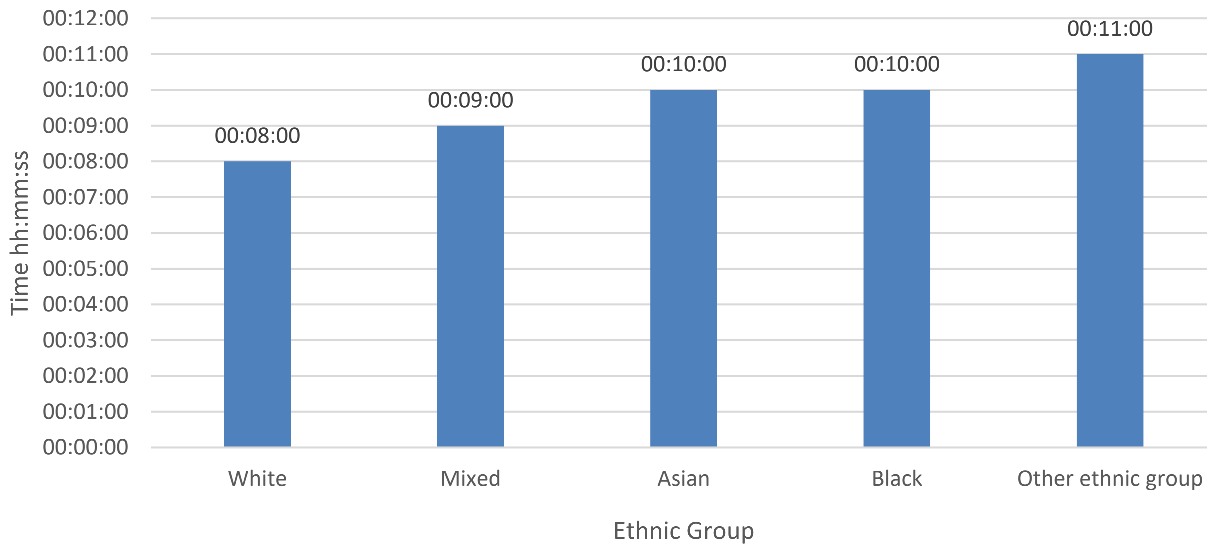


Sample: All patients included in the ethnicity analysis (n = **8256**)

What questions were used for this analysis?
Q1.4 Ethnic category
Q2.1 Was pain assessed on arrival (within 15 mins?)

Commentary
This data shows a difference across ethnicities in the Median time to assessment for the Pain in Children QIP. The lowest median can be seen in the Asian ethnic group of 8 minutes whereas Black, White and Mixed all show a median of 9 minutes.

Median time from assessment to analgesia



Sample: All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?

Q1.4 Ethnic category

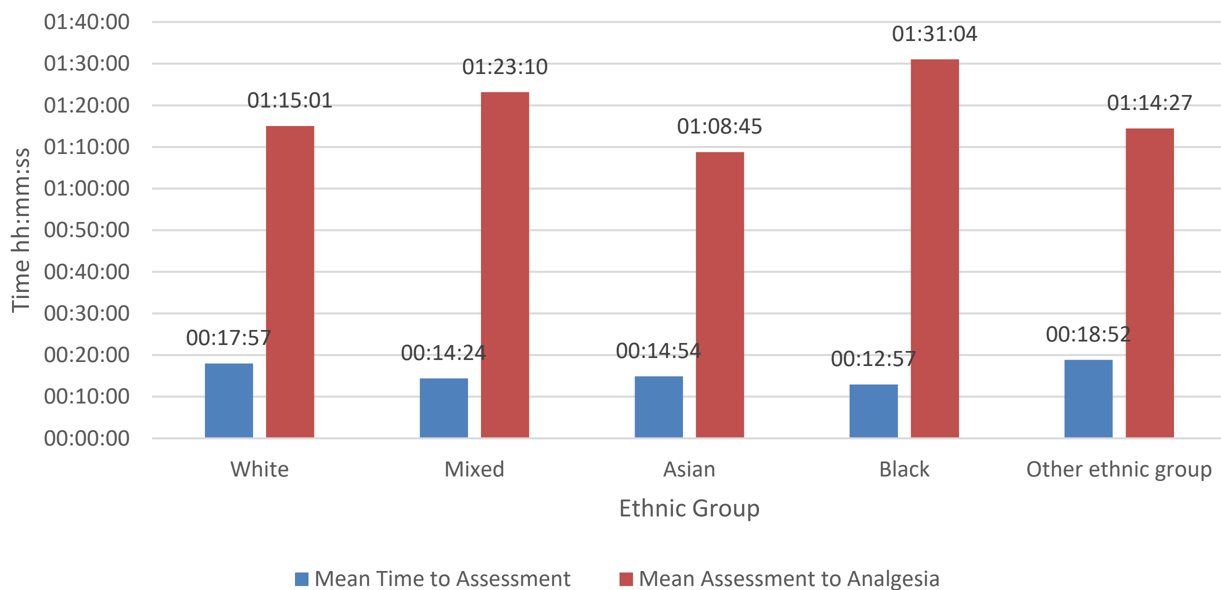
Q2.1 Was pain assessed on arrival (within 15 mins?)

Q2.3 Was analgesia administered in the ED?

Commentary

This data shows a difference across ethnicities in the Median assessment to analgesia time for the Pain in Children QIP. The lowest median can be seen in the White ethnic group with a time of 8 minutes compared to the longest time in the Other ethnic groups of 11 minutes.

The mean time to assessment and mean time from assessment to analgesia by ethnic group



All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?

Q1.4 Ethnic category

Q2.1 Was pain assessed on arrival (within 15 mins?)

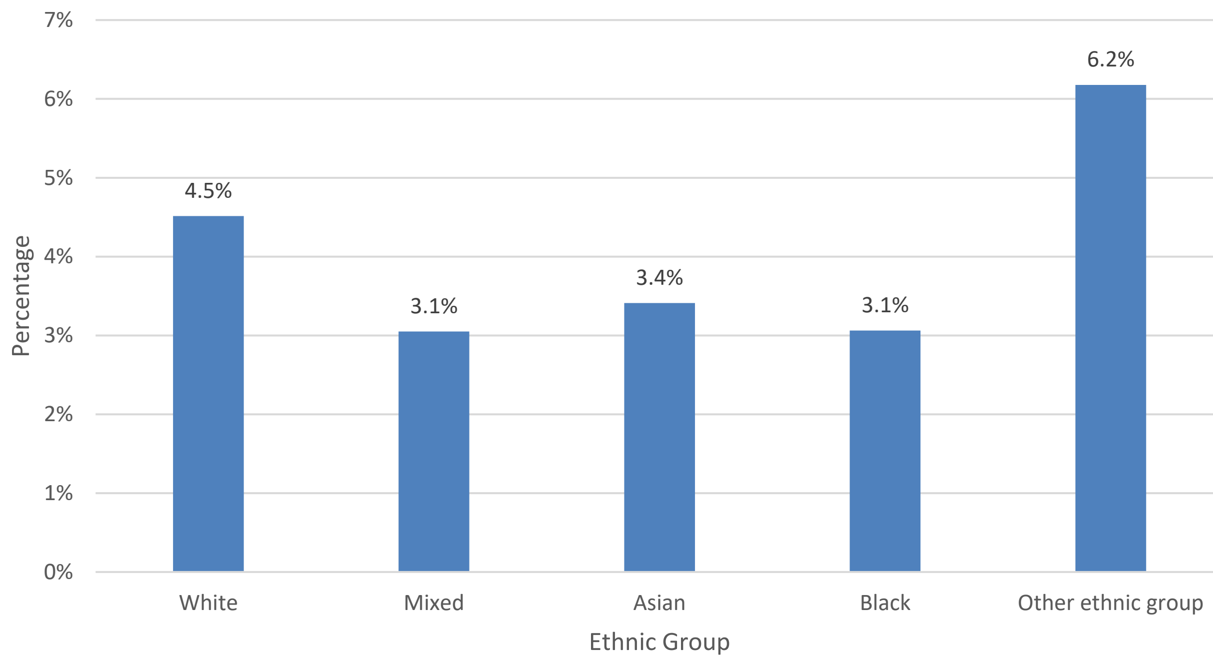
Q2.3 Was analgesia administered in the ED?

Commentary

Black patients are waiting longer to get the pain relief after they have been assessed.

This data shows Black patients mean from assessment to analgesia was higher than any other ethnic group with 1 hour and 31 minutes, compared to Asian patients at 1 hour and 8 minutes.

Percentage of each ethnic group who waited over 1 hour for an assessment

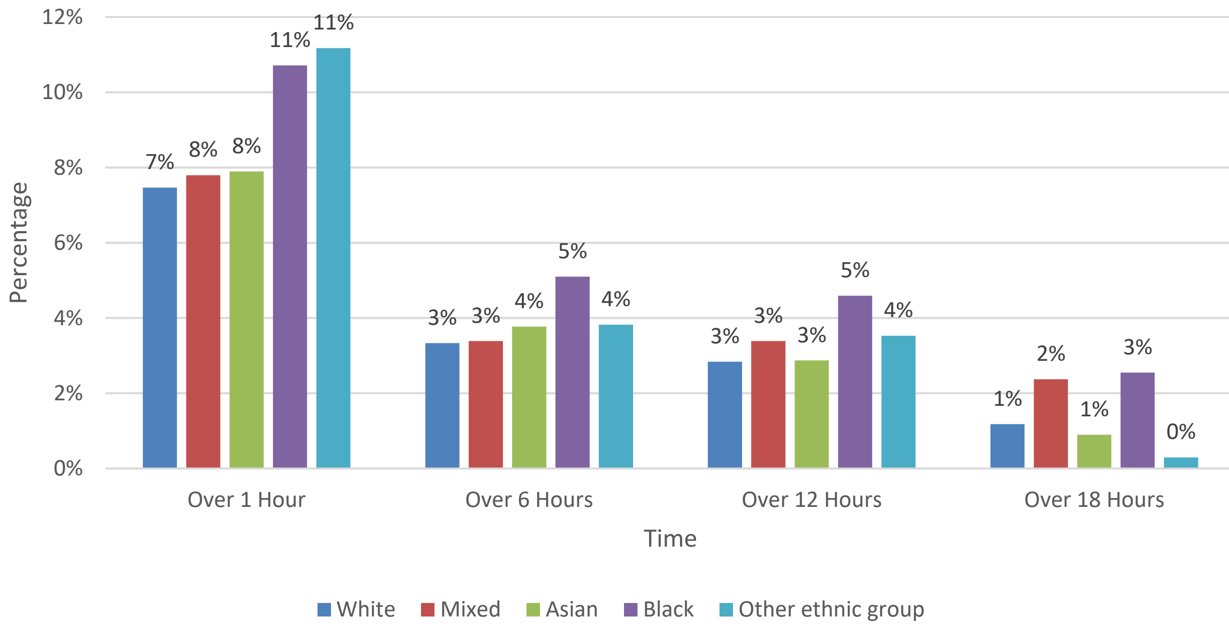


All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?
Q1.4 Ethnic category
Q2.1 Was pain assessed on arrival?

Commentary
This data shows a difference across ethnicities and highlights 6.2% of other ethnic groups waited over an hour for an assessment, less so for White, Asian, Black and Mixed.

Time from assessment to analgesia



All patients included in the ethnicity analysis (n = **8256)**

What questions were used for this analysis?
Q1.4 Ethnic category
Q2.1 Was pain assessed on arrival (within 15 mins?)

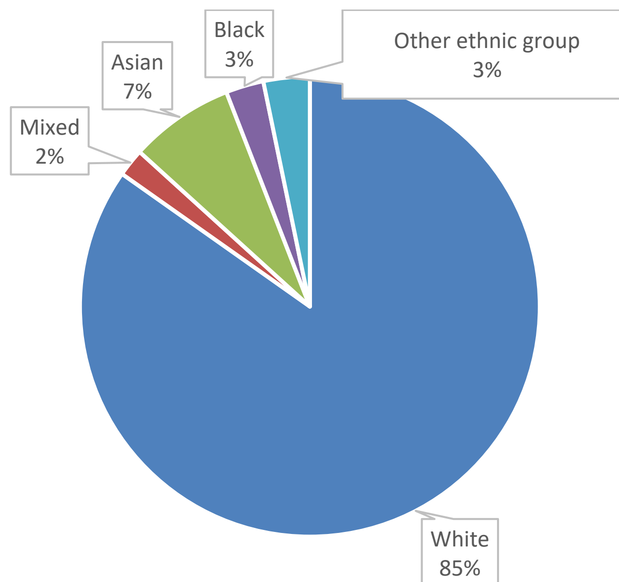
Commentary

This chart indicates that as a Black child who attends an ED for pain you are more likely than other ethnic groups to be waiting a long time from pain assessment to getting analgesia. It is also observed patients are more likely to be waiting longer from assessment to analgesia if you are black across all times.

This data shows a difference across ethnicities in the time from assessment to analgesia for the Pain in Children QIP. Black patients show a consistently longer waiting time. Asian patients had the lowest waiting time from assessment to receiving analgesia.

Infection Prevention and Control

Breakdown of ethnic group within the ethnicity analysis for infection prevention and control



Sample: All patients included in the ethnicity analysis (n = **14710)**

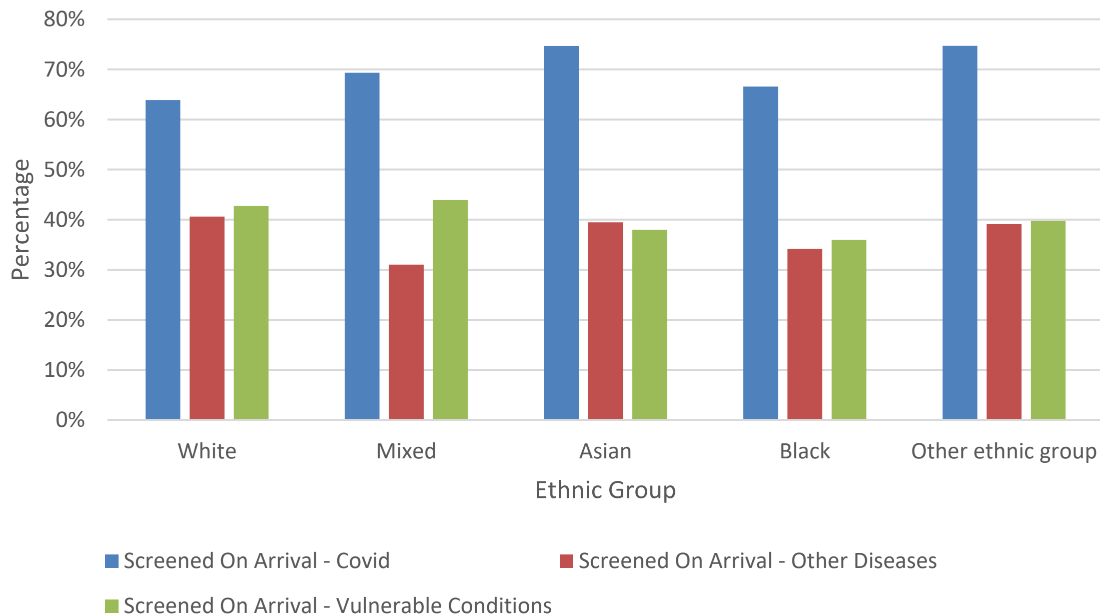
What questions were used for this analysis?

Q2. Ethnic category

Commentary

This data shows a difference in the ethnic groups of patients in this QIP. 85% of patients in the sample were White compared to 3% of Black patients, 7% of Asian and 2% of the patients were from the mixed ethnic category.

Breakdown of screening for covid, vulnerable conditions and other diseases, by ethnic group.



Sample: All patients included in the ethnicity analysis (n = **14710)**

What questions were used for this analysis?

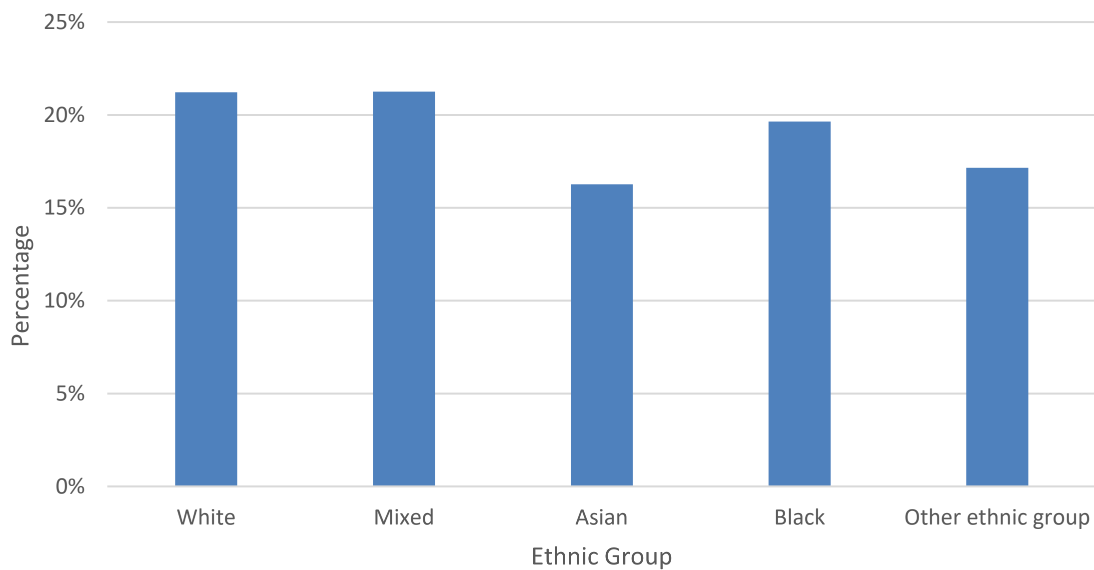
Q2. Ethnic category

Q4. Was the patient screened on arrival?

Commentary

This chart highlights discrepancies across the data, differences can be seen within each screening. Asian and Other ethnic groups were more likely to be screened for covid on arrival.

Percentage of patients who were not screened on arrival at the emergency department.



Sample: All patients included in the ethnicity analysis (n = **14710)**

What questions were used for this analysis?

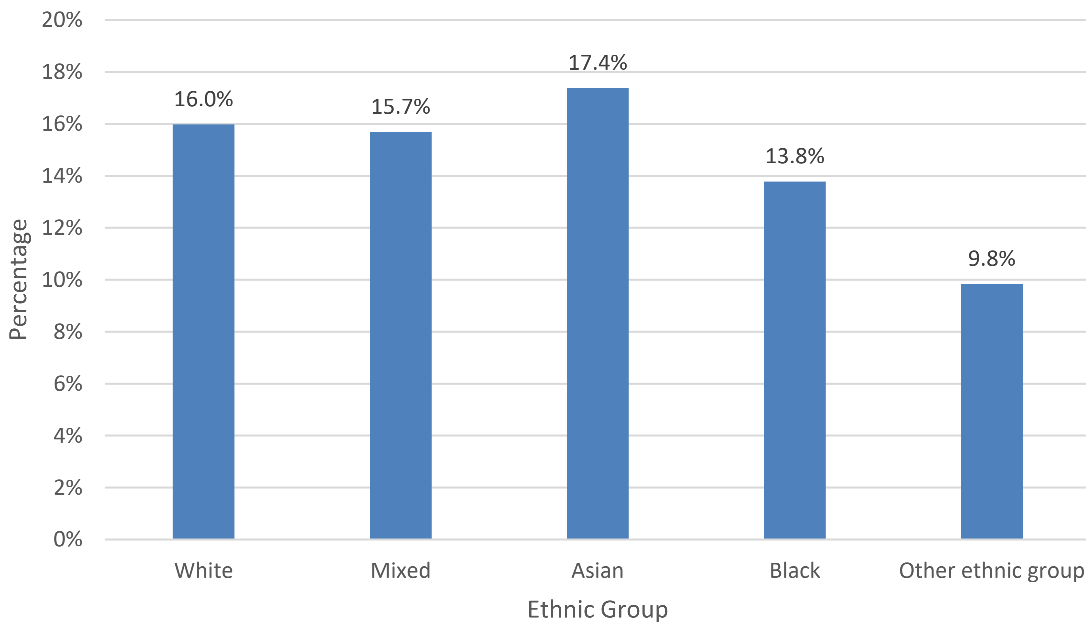
Q2. Ethnic category

Q4. Was the patient screened on arrival

Commentary

This chart shows the proportion of patients who were not screened on arrival at the emergency department. Asian and other ethnic groups were most likely to be screened for COVID-19 symptoms, other infectious diseases, and vulnerable conditions.

This data represents the patients who were isolated due to a vulnerability in the ED.



Sample: All patients included in the ethnicity analysis (n = **14710)**

What questions were used for this analysis?

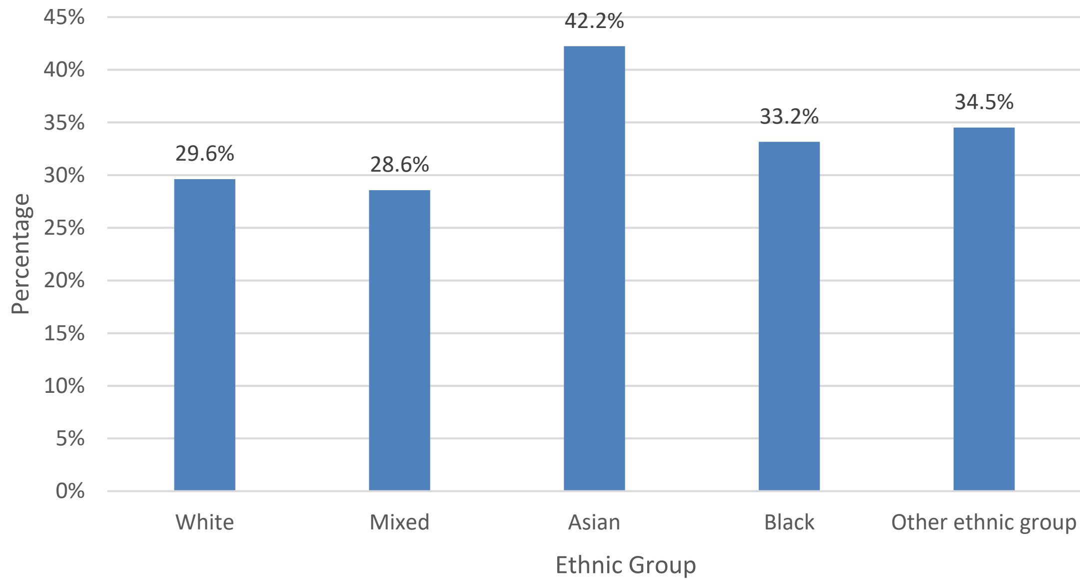
Q2. Ethnic category

Q5. Patient with an identified vulnerability was isolated in a side-room.

Commentary

The chart shows Asian patients were most likely to be isolated due to a vulnerability with an average percentage of 17.4%.

This chart shows a breakdown of ethnic group, with the average percentage of patients who were infectious.



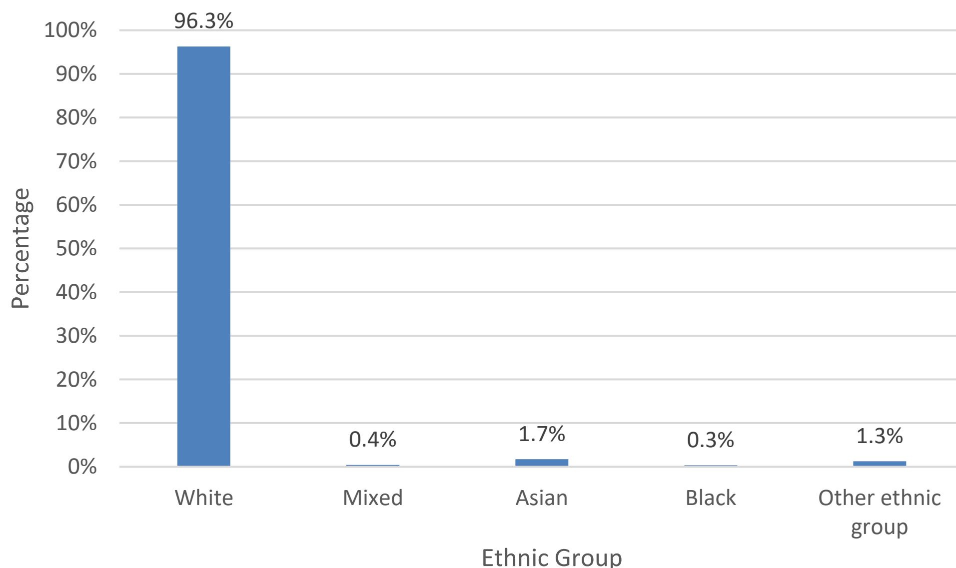
Sample: All patients included in the ethnicity analysis (n = **14710)**

What questions were used for this analysis?
Q2. Ethnic category
Q6. Was the patient identified as potentially or confirmed as infectious?

Commentary
The chart shows Asian patients were most likely to be infectious with an average percentage of 42.2%

Fractured Neck of Femur

Breakdown of ethnic group within the ethnicity analysis for Fractured Neck of Femur



Sample: All patients included in the ethnicity analysis (n = **11370)**

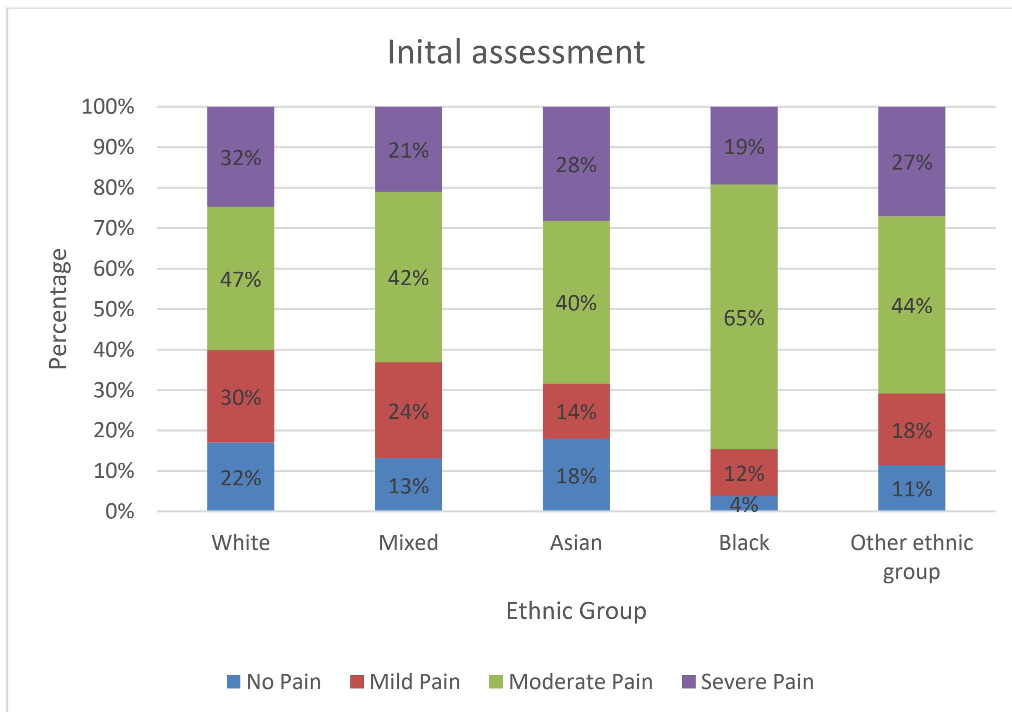
What questions were used for this analysis?

Q1.3 Ethnic group

Commentary

This data shows most patients within this QIP were from the White ethnic group with 96.3%, other ethnic groups made up between 0.4% and 1.7% of the cases. We must be cautious with recommendations from this QIP as we have a limited number of cases within the Mixed/ Black/ Asian groups, and this is not representative of the population.

Average pain score for each ethnic group on arrival.



Sample: All patients included in the ethnicity analysis (n = **11370)**

What questions were used for this analysis?

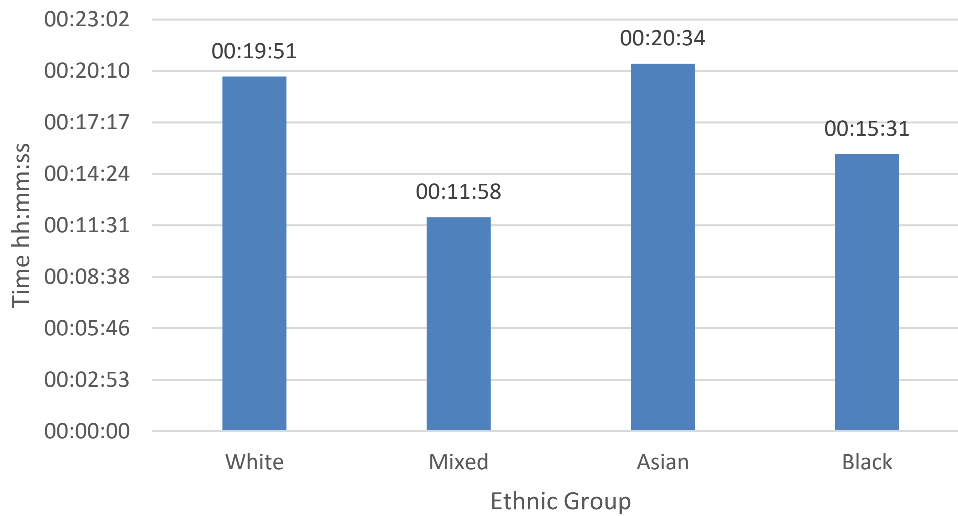
Q1.3 Ethnic group

Q2.1 Was pain assessed on arrival (within 15 mins?)

Commentary

When looking at the scores, these results may have limitations due to the low number of Mixed, Asian and Black cases within this sample.

The mean time from arrival to analgesia being administered



Sample: All patients included in the ethnicity analysis (n = **11370)**

What questions were used for this analysis?

Q1.3 Ethnic group

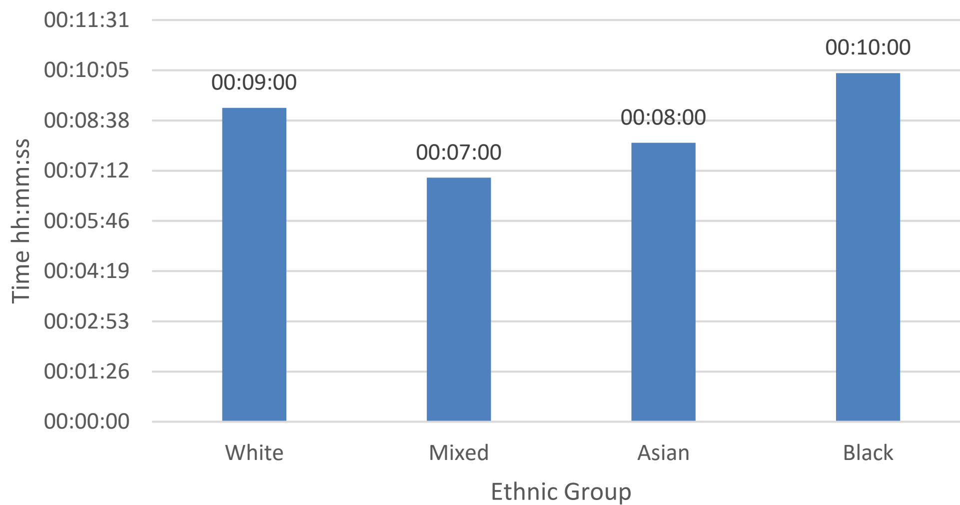
Q2.1 Was pain assessed on arrival (within 15 mins?)

Q2.3 Was analgesia administered in the ED?

Commentary

Patients from the Asian group waited the longest for analgesia to be administered, the Mixed ethnic group waited the least amount of time.

This chart shows the median time from arrival to analgesia being received, for each ethnic group.



Sample: All patients included in the ethnicity analysis (n = **11370)**

What questions were used for this analysis?

Q1.3 Ethnic group

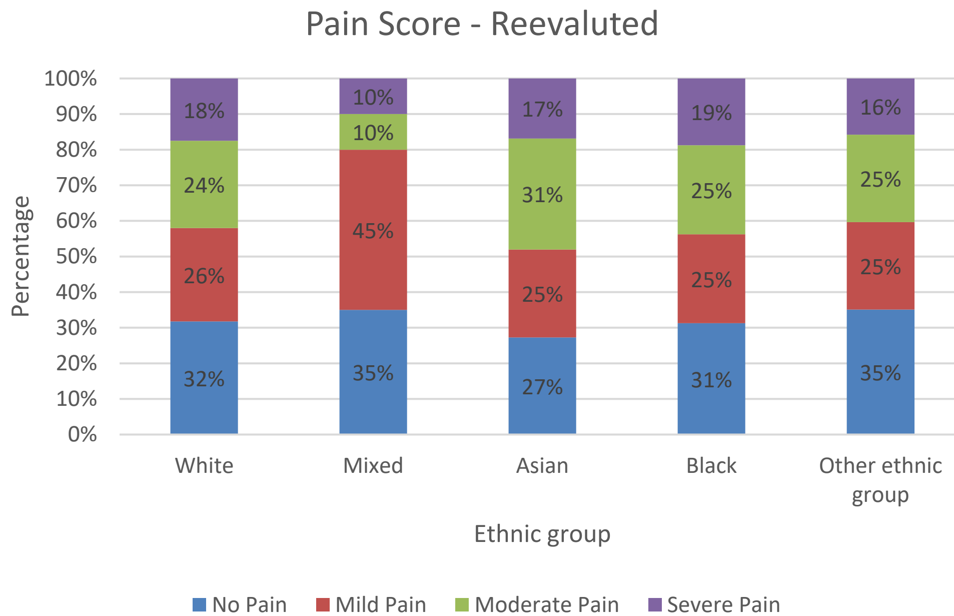
Q1.2 Date and time of arrival or triage – whichever is earlier

Q2.3 Was analgesia administered in the ED?

Commentary

This data shows patients in the Black ethnic group had the longest time period between arrival to the ED and being administered analgesia.

Was pain was re- assessed, a breakdown of the pain score by ethnic group



All patients included in the ethnicity analysis (n =11370)

What questions were used for this analysis?

Q1.3 Ethnic group

A2.4 Was pain re-assessed in the ED?

Commentary

This data represents the average pain score of each ethnic group when pain was reassessed in the ED.

Discussion

Summary

This national ethnicity report has accumulated 42,322 individual cases from 159 EDs nationwide.

The results of this national ethnicity report should be shared widely with staff who have a responsibility for looking after patients within EDs. In addition to the clinical team, RCEM recommend sharing the report with the clinical audit and/or quality improvement department, departmental governance meeting, ED Clinical Lead, Head of Nursing and Medical Director. Without having visibility of the data and recommendations we cannot expect to see improvements in practice.

RCEM is committed to producing a national ethnicity report for future QIP cycles, as this is the first year that this data has been collected on ethnicity. We do this in hopes of greater improvement over a longer time to address standards and ethnicity fully and efficiently, with more time allowed to effectively look at EDs processes.

For further QI advice and resources, please visit the RCEM Quality Improvement webpage.

Limitations

For the purposes of this report, the following patient populations were excluded from each QIP (along with patient notes):

Fractured Neck of Femur
For the purposes of this QIP, the following patient populations were excluded:

- Any patients 17 years of age or under
- Any patients who have multiple injuries or have other conditions which need immediate resuscitations
- Any patients with suspected occult neck of femur fractures requiring further imaging
- Any patients with a suspected but not diagnosed fractured neck of femur

Pain in Children

- Children aged 4 or under
- Children aged 16 or over
- Presenting to the ED with mild pain or no pain
- Dislocation with no fracture.

Infection Prevention and Control

- No exclusion criteria were set in this QIP and, information such as patient age and gender was not collected.
- Adult and paediatric patients are eligible.

There is no RCEM control over the quality of the interventions as they are locally owned.

Conclusions

RCEM now has a picture of national results across a wide range of EDs. As this is the first-time ethnicity data has been gathered and a report produced by the Quality team at RCEM on ethnicity, no comparisons to previous cycles can be made. It is encouraging that staff of all levels took part in this cycle of QIPs and submitted data on ethnicity as part in improving care.

From the data that was available during the 2020/21 QIP cycle there is improvement to be made, but that is the nature of ever-changing healthcare processes.

Key recommendations

- EDs should be taking every opportunity to capture ethnicity data as part of their records for patients.
- Departments should consider whether they have the staff and training in place to promote fair and equal treatment for all.
- Departments should routinely review their processes around the delivery of care to their diverse populations locally, paying special attention to protected characteristics (such as ethnicity) and social deprivation.
- EDs without any local guidelines for ethnicity should consider developing these

Further Information

Thank you to sites for taking part in the 3 QIPs for the 2020/21 cycle. We hope that you find the process of participating and results in this national ethnicity report helpful.

If you have any queries about the report, please e-mail quality@rcem.ac.uk.

Details of the RCEM national QIP Programmes can be found under the Current RCEM QIPs section of the RCEM website.

Feedback

We would like to know your views about this report and participating in the QIPs. Please let us know what you think by completing our feedback survey. We will use your comments to help us improve our future topics and reports.

Useful Resources

- RCEM Equality Diversity and Inclusion Committee- Position statement regarding terminology and labels used to describe ethnic groups.
- QIP Site-specific reports – available to download from the QIP portal (registered users only.
- RCEM Quality Improvement Guide - guidance on PDSA cycles and other quality improvement methods

Report authors and contributors

This report is produced by the Quality Assurance and Improvement Committee subgroup of the Quality in Emergency Care Committee, for the Royal College of Emergency Medicine.

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- Fiona Burton – Co-chair, Quality Assurance, and Improvement Committee
- Katherine Henderson - RCEM President
- Net Solving – technical partner providing the data entry portal and dashboard.
- Simon Smith – Chair, Quality in Emergency Care Committee
- RCEM Equality Diversity and Inclusion committee

Appendices

For methodology, inclusion criteria, definitions, references and full QIP results, please see the following reports:

- Pain in Children National QIP Report, RCEM, 2022
- Fractured Neck of Femur National QIP Report, RCEM, 2022
- Infection Prevention and Control National QIP Report, RCEM, 2022

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