

<b>Report Title</b>	NHS Trolley Waiting times - to what extent does this issue impact on local people?
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<b>1</b>	<b>Background scope and purpose of the review</b>
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The purpose of this review is to gain a level of understanding an insight as to what extent, the national issue of NHS Trolley waiting times effects people in East Sussex.

This is the first of two planned visits by Healthwatch Authorised Representatives to acute Accident and Emergency departments at Eastbourne District General Hospital. The second wave of visits to the Conquest Hospital will take place in January 2014.

These finding should be read along the report published in September 2013 looking into patient pathways to urgent care.

<b>2</b>	<b>What Information already exists?</b>
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<http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>

Winter pressures sees an increasing demand on our services, especially for A & E to treat and either discharge or admit within the designated four hour period. A&E services this winter are under closer scrutiny than ever before; the BBC is even publishing weekly A&E attendance rates on their website

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**How we gathered the insight?**

We met with ward manager prior to the visits to talk about how the department operates as well as working out the practicalities of the visits so as not to compromise any care or get in the way.

We requested information in advance from the Trust about staffing levels. We circulated the prompt and recording sheets to be used to gather the insight ahead of the visits.

Ten volunteers visited the A & E Department over seven days from 2.00pm - 10 pm to observe up 4 patients each on their journey through the department.

The focus for the survey was to determine the waiting times for patients arriving by ambulance to the A and E Department. The waiting time was broken down into a number of stages;

- From time of arrival to waiting corridor
- From time in waiting corridor to treatment bay
- From treatment bay to discharge from A and E.

Whilst in the treatment bay, patients would sometimes be transferred for tests in other parts of the hospital, such as X Ray and occasionally would be moved to a different treatment bay. We logged, wherever possible, these movements. We liaised with hospital staff to ascertain, where possible, what was happening for each patient, in order to fully assess the patient's pathway through A and E. We also met with a senior member of staff in pathology, subsequent to the visits, to obtain a greater understanding of what takes place in that department. We did this because we observed blood samples waiting to be sent for analysis. We also observed that waiting for results could potentially be a factor in the treatment times for patients.

Throughout this report Authorised Representatives will be referred to as 'ARs'.

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**What we found out?**

**From time of arrival to waiting corridor**

No delays were observed in patients arriving at the hospital and transferring to the waiting corridor. Patients were observed to be taken straight to the corridor immediately outside the treatment area.

One issue raised by some ambulance personnel was that the door reserved for ambulance patients to access A and E has been broken for at least a month. They felt it could pose a problem, although some nursing staff spoken with felt it was not necessarily an issue. However, it did mean that all patients, including those brought to the hospital by ambulance, had to come through the main doors into the A and E area.

### **From time in waiting corridor to treatment bay**

We logged the time that the ambulance personnel arrived (ie when they took the patient into the corridor outside the treatment bays) and the time they transferred the patient from the ambulance trolley to a hospital trolley and the time they were logged into the hospital system by the shift coordinator. In essence, this was the waiting time in the corridor, waiting for a treatment bay to be identified. Our observations and recordings indicate that there is generally a short wait in the corridor. The results were:

- 25 of the 75 patients (34%) waited between 0-9 minutes
- 13 of the 75 patients (17%) waited between 10-19 minutes
- 12 of the 75 patients (16%) waited between 20-29 minutes
- 12 of the 75 patients (16%) waited 30 minutes or more
- 13 patients; the information was not collated

Some of the delay may be because the shift coordinator was busy and there may have been a delay in inputting the information on the system. Also, the time the patient was transferred from the ambulance trolley to hospital trolley may have been delayed as the patient required some treatment prior to the transfer from one trolley to another.

From discussions with hospital and ambulance personnel, the waiting time to transfer into a treatment bay has much improved in the last 12 months, although no one could supply a reason for this. All staff spoken with stated that patients are rarely left in the ambulance due to no room in A and E.

The key factor in longer waiting times to move into a treatment bay is the lack of a free treatment bay. Therefore, at busy times, the wait will be longer. This is not necessarily due to the number of ambulances, but the pressure on A and E from people arriving at the hospital by their own means.

Ambulance personnel reported that they are able to continue to treat the patient whilst in the corridor, to an extent, but clearly this is not good practice and lacks privacy for the patient. One AR reported that at one time there were five patients on trolleys in the corridor. This was the highest number observed. The AR reported that this resulted in a maximum wait time to move into a treatment bay of about an hour. As a result, the AR observed that staff made a concerted effort to 'clear' treatment bays and this speeded up the process of patients moving out of the

corridor and into the treatment bays. An AR observed something similar occurring on another occasion, with some patients being moved into vacant beds in the Clinical Decision Unit (CDU) in order to free up treatment bays.

### **From treatment bay to discharge from A and E.**

We logged the time of arrival at the hospital and the time the patient left. The results were:

- 19 of the 75 patients less than 4 hours
- 8 of the 75 patients more than 4 hours
- 48 of the 75 patients unknown

The vast majority of the latter 48 patients were “unknown” as they were still at the hospital when ARs left, at 10pm. Many of these would have been coming to the end of their 4 hour wait, and so the number of patients being at the hospital for more than 4 hours would be higher than 8. For example patients had arrived at 17.06, 17.55 and 17.55 and were still in A and E at 22.00, when the ARs left.

We recorded the time that nurse or doctor went to see the patient to begin treatment. This was generally within 10-15 minutes.

We logged, when possible, the medical interventions, particularly the taking of blood samples, the waiting time for the results to be returned and also patients being taken to X ray and CT scans.

We observed the system for blood samples to be taken to the pathology department. They are placed in a tray by the shift coordinator/nurses' station. There were occasions when we observed a number of blood samples waiting to be taken to pathology department.

We discussed this with nursing staff. They reported that there can be a delay in sending the samples, as it is dependent on a porter being available to take them. The latter may sometimes wait for a number of samples to be ready to be delivered, rather than just one at a time. We observed that blood samples could be left in the tray for quite some time. For example, one AR observed a number of samples in the tray for about one hour before they were taken to pathology.

We were aware that A and E has a dedicated porter, 24 hours every day. We observed a replacement usually being provided from the general portering service when the A and E porter had a break. We concluded that the A and E porter was constantly working, taking patients to X Ray, patients to wards and taking samples to pathology.

One AR spoke with a team leader of the portering service. The team leader explained that A and E can ask for a porter if they are busy. The AR was aware that the A and E porter was busy at that time and there were blood samples to be

taken to pathology. There were at least four porters in the porters lodge, waiting for work. At another time, when the A and E porter had just taken a patient to a ward at the far end of the hospital, and so would be away from A and E for about 15 minutes, an AR noted that there was at least one porter in the porters lodge, even though there were patients in A and E waiting to be taken to X Ray and blood samples to be taken to pathology.

Nursing staff were asked whether they ever contacted the general portering service at busy times. They replied that they rarely got a positive response. Whilst accepting that the general portering service may also be busy, the view obtained was that as A and E has its dedicated porter, it could not expect any further support from the general portering service.

Nurses and the senior manager from pathology both explained the hydraulic chute system in place to get blood and other samples to pathology. There were slightly differing views about this system.

Nursing staff stated that they had not used this system for some time and some nurses stated that it no longer worked. They explained that there had been times when blood samples would not arrive at pathology but may go to another department. This would mean it could be lost and another blood sample having to be taken from the patient. They explained that this would not be good practice and would impact on the patient. The nurses spoken with explained that there was also a problem with the blood samples, as sometimes it could not be used for analysis and so, again, blood had to be retaken. They concluded that this was caused by the hydraulic chute system.

We spoke with a senior member of staff in the pathology department. He explained the systems in place. Blood samples are delivered to pathology by A and E staff and when out of hours (after 5.30pm) they are dropped through a 'letter box'. A tray is in place below the letter box to collect the samples. A and E staff reported to ARs that one problem is that the samples can drop behind the tray and be 'lost'. However, our observations were that this looks unlikely, although possible.

This member of staff gave a slightly different view of the hydraulic chute system. He stated that some wards still use the system as it is the most efficient method of getting blood and other samples to the pathology department. It was recognised that it is an old system, about 20 years old, and that there are three sections. One is noted to be more unreliable than the other two. When there is a blockage in the system, this can result in samples being sent to the wrong 'drop point'. If it is out of hours, this could be in an area which is closed and so the blood sample will not be seen. A and E will be unaware that it has not arrived at pathology and the latter would not know that it has been sent. It was uncertain which of the three sections

A and E is on and so uncertain whether the samples from A and E are more or less prone to being sent to the wrong 'drop point'.

The time to carry out the analysis of blood and other samples is dependent on the type of analysis requested. It could be completed within about a minute, but some tests take about 20-30 minutes. There may be occasions when a test may need to be repeated or a slightly different one requested once the initial test has been carried out.

Patients and their relatives and supporters in A and E told us that they had been informed that the blood test would take about 1 hour 30 minutes. Our observations confirmed that this was often the case.

There is a very steady flow of blood samples that need to be taken to pathology. One AR estimated that it could be about 15-20 samples per hour.

Therefore, one factor in a potential delay in waiting times and time spent in A and E is the length of time to obtain blood test results. Another factor is that the results are inputted directly into the patients electronic notes and so are readily available to nursing and doctors to assess their impact on the patient and form part of the diagnostic process. However, the nurses and doctors are unaware that the results are available. They have to check every patient's file and notes on a regular basis in case they have been returned. We were informed that this will soon improve, as a new system is to be introduced which will alert staff that the results are available.

Getting X ray results follow a similar process, but these tend to be inputted on the system much quicker. Generally, by the time the patient has been returned to the treatment bay, the X Ray results will be available. Therefore, the nursing staff and doctors will know to check that patient's file for the results. However, getting patients to and from X-ray can be a problem, when the A and E porter is busy. One patient waited over an hour from the time they were informed that an X ray was needed to the porter taking them for their X-ray. On one occasion an ambulance personnel took a patient to the X ray department, due to the delay. On another occasion a nurse was observed to push a patient back from their CT scan to the treatment bay.

Some patients had to wait some time to be seen by a doctor. For example, one person arrived at the hospital at 18.25, was logged into the hospital system by the shift coordinator at 18.30, was seen by a nurse at 19.00, but still waiting to see a doctor at 20.00.

Nursing and ambulance staff both stated that they thought a factor in waiting times in A and E is the lack of beds in wards, preventing and/or delaying patients from being admitted to the hospital. This resulted in patients waiting in a

treatment bay, preventing a newly arrived patient from being able to access a treatment bay.

One AR reported that they had been told that there can be a delay in a treatment bay being deep cleaned. If so, this will have an impact on waiting times.

<b>5</b>	<b>Additional Observations</b>
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A number of additional comments and observations were made to and by ARs, some not directly related to trolley waits:

- All staff spoken with commented on the very good and positive working relationship between ambulance and hospital staff. This was observed by ARs. This was exemplified by, sometimes, the ambulance personnel assisting taking patients to X ray.
- Parents of an injured person complained about the noise in the ward. It was mainly about the crashing of the bins.
- We were aware that a Clinical Commissioning Group has agreed funding for a GP to be based in A and E. From discussions with nursing staff and doctors, they were unaware of this service being available and did not know where the GP was based. Some reception staff were also unaware of the GP based service in the hospital.
- One patient required Barrier Nursing. There was no sign above the cubicle alerting staff to the process.
- Another observation involved a patient with D & V who was transferring to MAU. There were no isolation beds available and the patient had to wait in the corridor.
- 35 patients tracked were aged 65 or over, based on a visual assessment by ARs. This is about 50% of those patients tracked.
- One AR reported that “There was more abuse than anticipated” with this mostly being from relatives of patients.
- Many patients were very complimentary of the nurses and doctors. They knew that they would have to wait some time in A and E.
- One AR reported “inappropriate arrivals via ambulance, one patient clearly fractured jaw, bloody and bones displaced, walked into the department, patient with ingrown toenail arrived via ambulance”.

<b>6</b>	<b>Statistical Data</b>
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Information was collected from 75 patients over the period the volunteers attended the Accident & Emergency department. A total of 37 patients were

observed between 14:00-18:00 and 35 were observed between 18:00 - 22:00. A further 3 patients did not have time of volunteer shift recorded against them.

Times were reviewed, where recorded, as follows;

- Arrival time in Ambulance to the time the patient was logged by the shift co-ordinator
- Time the patient was logged by the shift co-ordinator to discharge.

Where patients had no discharge time recorded against them, volunteers reported that they were still awaiting treatment at the time they finished their shift observations.

To further outline this, table 1 overleaf shows the shifts and the times of arrival by ambulance to the times logged by the A&E coordinator.

	0-9 Minutes	10-19 Minutes	20-29 Minutes	30 Minutes or more	Unknown	Total
14:00-18:00	12	8	7	6	4	37
18:00-22:00	13	5	5	6	9	38

**Table 1: Times by shift from ambulance to A&E log**

As can be seen similar trends can be seen from each shift in the timing of moving a patient from the care of an ambulance crew to the care of A&E. **32%** of patients, where recorded, waited for more than 20 minutes across the shifts to be logged into the care of A&E, causing delays in releasing ambulances. **17%** of patients had no recorded time of logging their move, with **23%** of the numbers of patients observed on the later shift not being recorded.

Timings of patients being logged by the co-ordinator to their discharge were also recorded where possible. Table 2 below shows these findings.

	Less than 4 hours	More than 4 hours	Unknown/no time recorded	Total
14:00-18:00	12	7	18	37
18:00-22:00	7	1	30	38

**Table 2: Times by shift from A&E log to discharge**

Overall many patients were not recorded as being discharged at the end of each of the observer's shifts. Where possible the information was further reviewed to try and correlate this information further by reviewing the logging times, where able, against any unknown discharges. It was found that for the 14:00-18:00 shift a further **3** patients were experiencing a wait of over 3 hours and for the 18:00-22:00 shift a further **9** experienced a wait of at least 3 hours. If an assumption were to be made that these patients were waiting more than 4 hours then a total

of **26%** of patients would be waiting more than 4 hours for discharge. Without this assumption the figure is slightly lower at **10%**.

Where some of the figures shown above are shown against a certain amount of assumption modelling, there does seem to be some areas of recording which would help to improve this picture, although it is acknowledged that it was difficult for the observers to track patients, especially on the later shift.

Interestingly when asked, Ambulance staff on average reported a waiting time of approximately 17 minutes to handover patients. However in some instances waits of 50 minutes to over an hour were reported by ambulance staff. In many cases however the ambulance service did note improvements in the times it took to hand over a patient in the last few months;

*“Improving waiting times at this hospital”*

*“6 months ago - 4.5 Hours. Now much better. Longest wait 30 minutes”*

*“Longest time 4 hours. Better now - year ago 11 ambulances would be waiting.”*

However they did acknowledge that some issues were wider and ongoing;

*“Occasionally - unfair on hospitals - bed shortages. A&E is too small”*

*“Not necessarily hospital fault. GP's send in when not needed.”*

*“DGH longer than other hospitals. Doors for ambulance have been broken for a month.”*

Information was also gathered before the project was delivered to review the information published by ESHT nationally, to provide some background and further understanding of the scope of the project. Weekly data is published via the Situation Reporting data (Sitrep's) and can be found here:

<http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/>

From A & E weekly activity figures submitted by ESHT to inform national activity:

For week ending 8<sup>th</sup> December 2013:

> 4 hours but < 12 hours = 24

> 12 hours 1

For week ending 1<sup>st</sup> December 2013:

>4 hours but < 12 hours = 15

>12 hours = 0

For week ending 24<sup>th</sup> November 2013:

>4 hours but < 12 hours = 15

>12 hours = 0

For week ending 17<sup>th</sup> November 2013:

>4 hours but < 12 hours = 13

>12 hours = 0

**Staffing levels** - When asked, volunteers were informed the full complement of Registered Nurses on duty for the day time shift running from 08.00 - 20.00 hours, is ten.

Across the eight day period the number of Registered Nurses on duty did not fall below eight between the hours of 14.00 - 20.00 hours and only had the full complement of staff on duty on two occasions.

Between the hours of 20.00 - 22.00 when our observations ended, there were six Registered Nurses on duty each evening except for the last evening, where there were nine on duty.

Health Care Assistants were consistent across the period of three on each session.

Also consistent across the period was the number of Registrars on duty from 14.00 - 18.00 hours of three and from 18.00 - 20.00 hours, two.

Cover provided by Junior Doctors (listed on the information provided by the Trust as FY2, was at times not as consistent and frequently changing in one and two hour sessions.

\*This information was requested prior to the visits and was lifted from the rota into a separate document. We did not see a copy of the rota so cannot comment on levels of sickness, the use of Bank/Agency staff or the skills mix.

<b>7</b>	<b>Findings and Conclusions</b>
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The findings and conclusions set out in this report have been informed by actively engaging with patients, where appropriate, carers, family members, staff and

ambulance crew over of period of time in both acute Accident and Emergency departments in East Sussex.

It will provide a snapshot over a specified period of time about how long any impact the waiting times affect patients using East Sussex Healthcare NHS Trust provide emergency care.

### **Key conclusions and possible action points**

1. The doors to A and E, previously used by ambulance staff, have been broken for several weeks. Whilst some staff felt this did not have an impact on access to the hospital, it does result in everyone accessing A and E using the same entrance. It would be more efficient if the doors were mended. This needs to be investigated.
2. Some hospital staff were observed to be more effective in speeding up the discharge of patients to other areas of the hospital or from the hospital. It is uncertain why this is the case. However, this needs to be explored in order that any good practice from one set of staff can be passed onto other staff.
3. One factor in a delay in patients waiting in treatment bays is the length of time it can take for blood samples to get to pathology and potential delays in getting the results back. This can be due to pressure on the A and E porter, who may be doing other areas of work, and a lack of the hydraulic chute being used. There were examples of the A and E porter being very busy, but porters being in the porters lodge waiting for work to be allocated to them. There are conflicting views as to why the chute is not used and its impact on blood samples. Actions that need to be considered:
  - The portering system needs to be reviewed, to ensure there is best use of resources. Potentially, this could include ensuring that A and E is given priority or that two porters are allocated to A and E at pressure times. This could improve the time it takes to take blood samples to pathology, but also reduce delay in taking patients to such areas as X ray and CT scan.
  - The issues of the hydraulic chute needs to be investigated as potentially, if used, this would speed up the process of getting samples to the pathology department. The investigation needs to include whether A and E is in the section that is more unreliable.
  - There is the possibility of blood samples dropping behind the tray that is below the post box in pathology. It is not clear why the tray is there, unless it is used to carry all the samples to the right area in the pathology

department. If it is the latter, then the tray serves no purpose for 'catching' the samples and could be removed, to avoid any possibility of samples dropping behind it.

4. It is good that the system, for alerting A and E staff that the blood and other sample results are available, is to be improved. This could have an impact on treatment times.
5. The reported delay in arranging for a deep clean of treatment bays needs to be investigated.
6. A number of issues were identified that were not related to trolley waits. However, these also need to be investigated, especially the issues related to infection control.
7. It was good to note the good and positive working relationship between ambulance staff and hospital staff.
8. It was good to observe that no patients were kept in ambulances, but came straight into the hospital. It was also good to note that, generally, there was not a long wait before patients were taken into a treatment bay.