



**Patient experiences of using the
Emergency Department at the Royal
Sussex County Hospital**

May 2016



Executive Summary

This project was prompted by the Care Quality Commission visits to the Royal Sussex County Hospital (RSCH) in 2014 and 2015. The purpose of this report is to offer the Brighton and Sussex University Hospital Trust (BSUHT) and the CQC a lay view of RSCH A&E (Emergency Department/ED) from the perspectives of patients and their friends and families, as a contribution towards the CQC inspection in April 2016. We include suggestions that might improve people's experience.

Our visits to the Royal Sussex County Hospital ED took place between November 2015 and February 2016 and we observed the following:

- Reception at the Urgent Care Centre (UCC) was often very busy with long queues. The UCC was often overcrowded. Concerns included lack of visible staff, uncomfortable chairs, limited information for patients and an insufficient triage system;
- Our observations in the Cohort Area echoed the previous CQC finding that 'overcrowding in the cohort area of the ED meant the privacy and dignity and needs of patients were not consistently met';
- Overall in Majors care was good and although many people had been waiting for long periods, mainly for test results, they were generally very complimentary about the staff.

HWB&H proposes Improvements for Patients Including


The Urgent Care Centre (UCC)

- Triage to take place at the earliest possible stage in admission
- Staff to be more visible and enabled to have oversight on patients' needs
- Updated information to patients about their assessment and care
- Clearly visible waiting times
- Ensure comfortable chairs are provided
- Increased recruitment and roles for volunteers

We have been told that the upgrade plan for the UCC has been approved and work will start in the summer of 2016. We hope that this will address most of the environmental issues raised in this report and provide a quicker and safer model of care for patients.

Majors

- A focus on reducing times waiting for test results, including clinical input
 - Improvements in communications to patients about what is happening to them
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- Older people, those with long term conditions, including terminal care may need some case management and flagging systems
 - Direct access to specialists could improve care and reduce delays for some people
 - The interaction between general practice and hospital admission was evident and improvements for some patients may be secured by more linkage of ED with other community based initiatives such as Better Care, Proactive Care and Integrated Care
 - The voluntary and community sectors could offer some solutions

People who use the ED also have responsibilities to use the service only when they really need it, and we will continue to promote alternatives to ED as well as deliver on our commitment to continue our work so that the patient experience can be embedded in redesign, planning, delivery and monitoring of ED and other hospital services.

Acknowledgments

Healthwatch Brighton and Hove would like to thank the patients and their families and friends who were willing to talk to us, often at a stressful time. Their contribution has been invaluable in providing detail and depth to the patient's personal perspective.

We would also like to thank the hospital for allowing us to spend time in the ED and talk to their staff and patients. We appreciate their honesty and openness and commitment to respond positively to patient feedback and our recommendations. We would like to give particular thanks to Kate Rogers, the Matron on ED and Clare McGregor, former Chief Nurse Manager on ED.

Introduction

This report was prompted by the Care Quality Commission (CQC) findings following their inspections of the Royal Sussex County Hospital (RSCH) in May 2014 and June 2015. Their investigations highlighted concerns about the ‘safety and experience of patients requiring unscheduled care using emergency pathways’.

‘The pressures on the emergency department were significant and connected to the flow issues; the department does not have enough physical space to deal with the number of patients that attend and ‘is consistently failing to meet the target to admit, transfer or discharge 95% of patients within four hours.’

The CQC recommended that the trust “Evaluate the effectiveness of the current patient flow and escalation policy and implement mechanisms to improve patient flow within the Emergency Department (ED) and other wards across the trust and review the current cohort area within the ED to ensure the privacy and dignity of patients”

CQC BSUHT Quality Report 8th August 2014

The patient experience of urgent care services has been a priority for Healthwatch Brighton and Hove (HWBH) since its inception in April 2013.

This report reflects recent stories and observations of patients in the Emergency Department (ED) since the CQC Urgent and Emergency Services Quality report in October 2015 and after the new structure and practices were put in place by the Brighton and Sussex University Hospital Trust (BSUHT) in September 2015.

The purpose of this report is to reflect back the contemporary patient experience and to inform the ongoing change processes in the department. Primarily it offers the Trust and the CQC a lay view of the RSCH A&E/ED from the perspectives of patients and their friends and families, and the impact of the systems on patients, as a contribution to the CQC inspection in April 2016.

We have made suggestions throughout the report of what might improve patient experience: they mainly relate to improving the physical environment, communications and systems around testing and diagnosis.



Healthwatch Brighton and Hove (HWBH) visits to the Royal Sussex County Hospital Emergency Department in late 2015 - early 2016

Undertaking work on patient experience in ED has its challenges. Whilst there are many people waiting and subsequently potentially available to speak to a HWB&H interviewer, some are too ill or tired to do so.

HWB&H Observations

Visits took place on the 6th, 16th and 30th November 2015, 10th December 2015 and 8th February 2016 after some pilot work in August and September 2015. Nearly all the visits took place early on a Monday evening and were undertaken by the same two person team who were trained as authorised Enter and View Representatives. The representatives were also trained in Sit and See methods - a systematic approach to observation, covering all aspects of care through communication to environmental issues.

The timing was advised by the Matron as it was busy, so we could see the system under pressure. It avoided Friday and Saturday nights, when A&E could be more volatile and HWB&H volunteers could get in the way of staff. All visits were cleared at a senior level and we were linked to the senior nurse on duty on the day as well as relevant staff, all of whom were very helpful.

This report covers the Urgent Care Centre (UCC), the cohort area, assessment bays and cubicles in the areas known as 2a and 2b. We did not address Resus, though we could see this occupied many staff especially when there was a major incident. We also did not carry out any work in the Clinical Decisions Unit or Surgical Assessment Unit.

The practice visits indicated that the most effective way of reaching patients was to randomly talk to them whilst waiting in any part of ED, unless they were obviously having an assessment or treatment. This worked and most people approached were able and willing to talk and thanked us for approaching them.

We talked to 32 patients and their companions. The interviews covered reasons for people coming to ED, immediate circumstances and why they chose ED; what had happened since they had arrived; how long they had waited; what they were waiting for; what they thought was happening to them now; and general care and communications.

In the course of writing this report, no individuals have been identified to ensure confidentiality. The interview work was complemented by observations, particularly in the cohort area and the Urgent Care Centre. We observed dozens of people in the cohort area and hundreds in the UCC. We also talked to staff.

The following observations are collated from patients' perspective of their journey as they attended ED and observations of observers. They are followed by suggestions that might improve the patient experience.

On the 17th March 2016, we followed up our findings with the Matron in ED who provided a brief update on some initiatives, which we have included in this report.

SECTION 1

Admission to the Emergency Department through the Urgent Care Centre (UCC)

Reception

Patients arrive at ED either by their own means or by ambulance. Those who arrive by ambulance enter the hospital at a separate entrance and go straight into triage. Generally, those who make their own way to the hospital have to register at the reception. The reception area serves a dual purpose both for people to queue to register their arrival as well as for people who are waiting from other parts of ED to be discharged and go home. The reception area is also a corridor to other parts of the hospital.

Our Observations

The reception area was usually very busy and had long queues. On one visit, there were 13 people, including two people in wheelchairs, three with walking aids and many appeared to be experiencing physical discomfort and pain and had been waiting a long time. On most occasions when we visited there was at least one person who presented with challenging behaviour.

Although reception staff were very courteous, there seemed to be no system of identifying those who may need immediate attention, from those who just needed to sit or lie down. Frequently, the area had insufficient chairs for people to sit on.

The Urgent Care Centre

Once inside the Urgent Care Centre, patients' experiences could vary depending on how busy it was. On one occasion, there were no vacant seats with people lying across chairs and many presented as disoriented and agitated. On another occasion there were at least 16 people standing in the Urgent Care Centre, with people over-flowing into the reception area.

Staff come out of the interview rooms at the periphery of the UCC waiting area and frequently there were no staff visible within the UCC. When busy, the assigned staff member providing triage (i.e. seeing patients for an immediate risk assessment) appeared to be working flat out to keep up with a constant stream of patients to assess. From a patient's perspective, it was difficult to comprehend what the system is or what is happening and who to ask about what is going on.

These recent observations mirror those in our HWB&H Report, Patient Stories on Urgent and Emergency Services at Royal Sussex County Hospital (November 2015), which include concerns about waiting times for older people and problems with the triage system.

Refreshments

Whilst there is a water dispenser in the UCC, the only refreshment machine is in reception and many people may not know that it is there, cannot get there, or risk losing their seat if they get up for a drink.



Information

There was no written information or any other material in the UCC, despite a TV screen being available. HWB&H has produced information about community based and other services that may provide alternatives to ED but this has not been used. In addition, we have never observed the screen being switched on during our recent visits. Although we are in negotiation with hospital staff to resolve these issues, we recommend this is considered as priority during the refurbishment of the area.

Chairs

When busy, the chairs are insufficient. They are extremely uncomfortable, especially for ill or older people, and when waiting for long periods. Though this may seem a minor issue in the face of all the problems in ED, it is one of the most frequently raised concerns for patients.

On busy days, if someone gets up to go to the toilet or to get refreshments, they may lose their seat.

The problem with chairs was raised as a concern with BSUHT in our Urgent Care Report of October 2013 and again in our report in December 2014. It was also brought to the attention of the senior management team in March 2015. We understood that this issue was taken seriously and the chairs will be changed as part of the improvement plan to take place in June 2016 and we are very reassured by this.

Toilets

During our visits we found that the toilets were regularly out of order. On one occasion, of the three women's toilets, one had an 'out of order' sign on the door with a note saying it had been reported 5 days previously, and another was missing a toilet seat. The toilet for people with disabilities was also out of order. One man in a wheelchair said that this had caused him great distress. Large numbers of people use the toilets so it is very important that they need to be kept in good order. Patients have also asked us why toilets are used by staff when there are so few available.

Young People

The age range of people who use the UCC appears more varied and younger than the Major Trauma part of ED. Some younger people appeared to arrive in large groups.

Proposed Improvements that would improve the experience of patients using the Urgent Care Centre

- Triage or immediate assessment to take place at the earliest possible stage in admission
- Staff should be more visible and enabled to have oversight on patients' needs
- A designated staff member to co-ordinate people through the system
- Information and clear pointers so that patients know who they can approach to ask questions




- Updated information to patients about their status in terms of their assessment and care
- Clearly visible waiting times so patients know how long they may have to wait
- Information needs to be kept up to date and clearly visible
- Use of the TV screen for patient information and assurance that it is regularly switched on
- Alternative treatment routes for people with minor ailments need to be available (such as pharmacies, Walk-in Service at Brighton Station Health Centre,)
- Consideration of the development of an App for people with minor ailments, particularly targeting younger people
- Provision of public information in places where there are large numbers of younger people such as universities about alternatives to ED - this should include information about the difficulties of attending with large groups of friends
- Allocated space for people who may present with challenging behaviour in the reception area
- Consideration of volunteer trolley service for refreshments
- Ensure sufficient comfortable chairs are provided
- Given the level of need of patients, the disability toilet should be available at all times and clear notices need to be in place to indicate where there are alternatives

Update: We have been told that the upgrade plan for the UCC has been approved and work will start in the summer 2016. People arriving will be triaged immediately and then checked in at reception. There will be a central console for staff so they can see patients, who will be treated in the rooms around the periphery of the UCC. Upgrading will include toilets and new chairs. HWB&H is assured to hear this and will visit at the end of summer to consider the improvements from the patient perspective.

SECTION 2

The Cohort Area

Patients who arrive by ambulance are admitted to an area called Majors. They are immediately triaged for essential risk in a two-bedded bay and then transferred to Resus, redirected to the UCC or allocated to a cubicle in Bay 2a or Bay 2b, the main assessment and treatment areas of ED.



If a cubicle is not available, the admitting paramedic/s wait with the patient in the cohort area until a hospital nurse can take over. There are very live concerns that paramedics are inordinately detained in ED because they cannot leave their patient until there is a formal handover when the department is very busy. When there are lots of patients in the cohort area, care and communications with patients is also compromised.

Concerns about the cohort area contributed to the Care Quality Commission rating of ED as 'inadequate'. 'Overcrowding in the cohort area of the ED meant the privacy and dignity needs of patients were not consistently met'.

(Ref: CQC RSCH Quality report 23/10/15)

HWB&H Observations

During our visits, HWB&H saw variations in use of the cohort area from empty to full including a time when 9 trolleys were wedged into a small area with no space between them. We also saw patients being treated in the corridor and cubicles in the main assessment areas. The situation is volatile and changes quickly if ambulances bring in a lot of patients in a short space of time.

On all occasions, HWB&H witnessed good care from paramedics helping out with care tasks and a good atmosphere between hospital and ambulance staff, though this can be stretched at times when ambulance crew are inordinately detained.

On most occasions there were large numbers of ambulance crew present. On one visit, we witnessed between 6 and 9 crew in the cohort area for some time, even though there was never more than 2 patients. We also witnessed a doctor, with courtesy and apologies, clerking a distressed patient in the cohort area. At the time the area was so crowded that he could stand only at the end of the trolley and certainly could not examine the person. At the same time, a woman was having bloods taken in the corridor, again with apologies.


Many people waiting were very old and often alone and at times appeared to remain in the cohort area for long periods with no obvious attention.

Regularly there was someone who presented with challenging behaviour and was noisy or volatile, which was sometimes frightening for other patients. HWB&H did not observe trolleys being cleaned, though clean sheets were put on.

SECTION 3

Admission to Cubicles and Bays

Most of the interviews took place in the assessment bays around the nursing console in ED called 2a as well as the adjacent ward, 2b. During the period HWB&H was doing interviews, a new admission system was being introduced.



Ward 2b had been designated as a ‘medical assessment area’ for people who had been referred by their GP with a medical condition, but required further tests or specialist medical consultation.

When we visited, it was difficult to see what the difference was between the medical patients in 2a and 2b; and on one occasion there were empty beds in 2b and three people waiting in the cohort area. The new arrangement put the responsibility for patients in 2b with the hospital medical team and in principle seemed a good idea. However, because of the ebbs and flows of admissions, streaming arrangements like this seemed difficult to implement.

We spoke to two young women both with suspected appendicitis, who might be expected to have been on the surgical assessment unit, but were actually in 2b.

HWB&H has been told that new assessment cubicles are to be made available and a ‘patient assessment team’ comprising a doctor, nurse and carer will put into place an immediate care plan. We have been advised that this will be a safer system for patients. We are unsure how this initiative will affect handovers and the use of the cohort area. The date for this initiative has yet to be determined. The streaming of patients in 2a and 2b has been abandoned. Single clerking has been introduced, so that different doctors do not ask the same questions of patients.


Long periods spent in the ED

Almost everyone spoken to had spent long periods in ED and said they were ‘waiting’ for the results of tests and admission as an in-patient where appropriate. Patients were generally receiving some treatment for their symptoms, e.g. pain management, but there was widespread uncertainty about what was happening next and when things were likely to happen. Often people did not know why they were waiting or what for. Others were waiting to go for a test, usually blood tests, or an X-ray, but mostly they were waiting for results, which would provide a diagnosis and determine whether they were to be admitted or go home. Most people told us that they had been in ED for over 4 hours.

This feedback suggests hospital staff were not effective in communicating to patients how they were being treated and what the likely timeline of progress would be. There were also obvious concerns about the long periods spent in ED and the delays in transfer to a hospital ward for in-patient treatment.

We had particular concerns about older people, and talked to one who had been in ED for over 9 hours. Another woman in her 80s had been asked to return to collect a new prescription. She had already been up all the previous night in ED and felt exhausted. She had returned, still poorly, and was sitting in a chair. Though she had been a patient of ED on the same day, she appeared to be going through the same booking and waiting processes as everyone else.

Though many people had spent long periods in ED, they were generally complimentary about the staff and felt they were caring and doing their best under a difficult situation with limited resources.



The amount of time patients are spending in ED appears excessive. Though patients are philosophical and generally uncomplaining about the wait, it is not a positive experience.

For the patients we talked to, it seemed that tests were done in a timely way, but that there could be a long wait before results were known. This waiting compromises the hospital's ability to meet the target waiting times for people waiting no longer than 4 hours in ED and unfortunately this is currently well below the national target.

One older man, who occupied a bed, told us that he had been admitted with chest pain five hours previously and was now waiting for test results. He received his test results and an hour later was later spoken to in reception waiting for a lift as he had been advised he could go home. He had changed from being a patient to being a person able to carry out his normal life in minutes, but in the meantime had been occupying a bed.

Not sure what's going on

Alongside needing to wait for test results, it appeared that very few people knew what was happening to them even when they had received the results of tests. Some seemed to be waiting for a bed in what appeared to be the Acute Medical Unit, but were unsure. The uncertainty is possibly caused by the pressure for beds in the main hospital with staff having to actively manage discharges in order to release capacity for new patients. This can be a very fraught process for the hospital, but besides creating longer waits for patients in ED, many patients were worried about what was going to happen to them.


Most patients had obtained a drink and something to eat. On the odd occasion where patients were less satisfied, they cited not being told what was going on or not being listened to as their main concerns.

Waiting for a specialist hospital appointment

We interviewed people who had been diagnosed with a problem in ED and been referred to a specialist. However, before they had got an appointment they had experienced acute problems again, so returned to ED. This had been the experience of a man with kidney stones who also had a terminal illness, and a young woman who had been referred to a digestive disease specialist and was still waiting to be seen. There are problems with waiting times for referral to some hospital specialisms and so it is possible that the situation could have directly impacted on ED.

Proposed Improvements for Patients' experience

- We understand that the streaming of patients in ED is a work in progress, but whatever the final model, it needs to ensure that all beds in cubicles are available for patients. There should be a strong drive to reduce the use of the cohort area as a result of handover delays.
- It would appear that focusing on speeding up testing and analysis of test results, including clinical input, could significantly improve patients' experiences and, for the hospital, could release beds with some people being discharged home safely. This would in turn ease the pressure in the cohort area.

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- The model of everyone being funneled through ED, even when they have been sent in by their GP, does not work for patients and creates delays in the system. Direct access to specialists would be a better and quicker experience.
 - In a busy department, it is easy to see how keeping people regularly informed can be overlooked especially if the problem is waiting for a hospital bed to be released. However, having someone allocated to do this consistently would provide significant improvements in reassurance and experience for patients, especially those who are older.
 - The excessive wait for appointments to some specialists has been previously been raised by [HWB&H](#) . Consideration might be given to flagging people who have attended ED with conditions that require a specialist appointment so attendance at ED might be one of the criteria for determining priority for a specialist appointment.

The Patients

Whilst every patient had their own individual problem, there were common themes.

Terminal Conditions

A number of people had diagnosed terminal conditions. Although people with terminal conditions will have emergencies, particular attention may need to be paid to those at the end of their life.

Older People

In general, the age of people in Majors appeared older than in the UCC. During our visits we observed a large proportion of admissions to ED. Majors were people aged from their mid-80s into their nineties and many were alone. We had expected to see people who had been admitted from nursing homes, but there were none on these occasions. A number of older people had fallen and it was not the first time. They appeared not to have broken bones but were bruised or battered. Many seemed to have lost some confidence, but also wanted to get home. Relatives tended to be with people who had fallen and were very worried.

Age UK Brighton and Hove (AUKB&H) recently completed a report on older people's experiences in Accident and Emergency. *Ref: Older Peoples Experience of Accident and Emergency Services Age UK Brighton and Hove (December 2015)*. Many of their observations and recommendations concur with our own including lack of communication about what was going on; lack of privacy in the cubicle area; and assumptions that there was someone at home to collect/look after them after being discharged.

HWB&H supports their recommendation of more active care management and diversion pathways for older people, which includes better use of the Rapid Access Clinic for Older People (RACOP). When someone has just fallen, it is a good time to talk to them about their condition and to restore confidence quickly. There are schemes available that provide such services such as that provided by AUKB&H which might help improve wellbeing and avoid a repeat admission.

Consideration might be given to volunteers checking on older people, providing some social contact and providing a drink if allowed. Certainly, many patients commented on being

assured that HWB&H volunteers were visiting the department. We understand that the hospital has had volunteers but they tend not to remain long in the role.

Frequent ED Attenders

Many people we interviewed had been admitted to ED in the recent past for the same or similar problems as they were presenting with at the time of our observations. During our visits these people tended to be younger. These patients seemed to have longer term conditions with flare-ups. For instance, a young man with a chronic bowel disease who was feeling depressed about his condition and inability to work. A younger woman, who called herself a 'frequent flyer', had been coming in to ED two or three times a week for months for pain management. Another young man with chronic asthma was admitted with chest pain and was a recurrent attender.

GP Referrals to A&E

A prevalent theme for people we spoke to in areas 2a and 2b was that they had been to their GP and had been sent into A&E. Staff told us that this was one reason for high volumes of admission on a Monday evening and was a regular occurrence. They felt that because surgeries closed over the weekend, patients waited until Monday to call the doctor and in some cases people were then quite poorly and so their GP sent them straight to A&E.

A number of patients had recently been to their GP, such as a man in his eighties who had been to his doctor twice in the previous week with pain in his foot and had been sent into ED with circulation problems; a man who had 'gone off his legs' going into his doctor's surgery; and a person with suspected appendicitis.

Proposed Improvements for Patients

- Consideration might be given to identifying the people who are frequent attenders in ED and connect them to the GP led Proactive Care Program and/or a scheme with a case management/ integrated care approach. We understand that the small number of frequent attenders do have ED management plans.
- Consideration might be given to flagging patients with terminal conditions so that they can be progressed through ED quickly. This issue is a serious concern and should also be raised at Cancer Network meetings.
- Clearly some people who attend their GP need urgent hospital attention. Looking at some case histories of what happens to patients now could throw light on what might be needed in the future. The issue should be raised at strategic groups in the city.

There is a great deal of work going on in the city to avoid unnecessary hospital admissions, including extended primary care services and GP roles. This is a complex area but there are opportunities with new ways of working in general practice to see whether some of the admissions might be avoided by using the new service models.



Our Methodology and Partnerships

Our observations are partial and a 'snapshot'. All were followed up with discussions with staff and cross-referenced with stories from HWB&H Helpline and website and other recent patient experience work in the hospital. We have also examined data and intelligence from Brighton and Sussex University Hospitals Trust Complaints Team and Brighton and Hove Independent Complaints Advocacy Service (ICAS).

The BSUHT Complaints Team received over 178 comments about A&E in the period from March 2015 - March 2016 and these included a number of compliments as well as complaints. We understand that due to the nature of A&E in providing unplanned medical assessments and treatment for people, it does induce a very stressful and fraught environment.

BSUHT data indicates that the nature of the complaints in this period included attitudes of staff, mis-diagnosis, loss of personal valuables. The majority were complaints about triage and the treatment pathway. Compliments included commending staff for their kind attitudes and care. These observations chime with the report findings presented here.

Brighton and Hove Independent Complaints Advocacy Service (ICAS) provided advocacy to 4 clients in the period between March 2015 and March 2016 who wished to complain about their treatment at RSCH A&E: two related to waiting times, one for staff attitudes and lack of privacy and dignity and another challenged the decision for non-admission to hospital.

Each person received a response to their complaint which explained the clinical decision making processes and triage and their subsequent treatment at A&E. All received an apology recognising that they had found their experiences at A&E stressful, suggesting that good communications and keeping people informed might avert some problems.

Conclusions

The issues that we found concur with previous CQC reports, reflect BSUHT and Clinical Commissioning Group (CCG) data, ICAS data issues raised in hospital complaints and those received by HWB&H through our Helpline and website. Despite the concerted efforts of staff and management at BSUHT and other stakeholders in health and social care, the issues remain broadly similar to those identified over two years ago; namely that when there is poor flow of patients in ED, it impacts on the direct care of patients.

We are heartened to hear that a major improvement plan is about to be implemented in the UCC and it appears that this will address most of the environmental issues we have raised in this report and provide a quicker and safer model of care for patients - especially a speedier triage system and better visibility of staff. For the large volume of people who use this service this should be a real improvement. We have also made some suggestions about admissions avoidance in the UCC that we hope will be considered by BSUHT and others.

The environment in Majors remains unfit for purpose and this impacts on patients, staff and paramedics who frequent the department. Until there is a major increase in the space available, significant improvements cannot be attained. It is a credit to hospital staff and



paramedics that they are able to provide a service at all in what is clearly an inappropriate area.

The measure of how well the ED is working for patients must be that there would be no need for a cohort area as patients would be taken straight into a bed or a bay. This seems some way off and in the meantime handovers from ambulance staff to hospital staff need to be within waiting targets as the cohort area does not provide a good experience for patients or staff. Though we understand that some environmental improvements are under consideration, it is not clear whether they will impact on the cohort area and when they might take place.

Many of the problems of the cohort area lie somewhere else in the system; we understand that it is difficult to control the flow of patients into ED. Data indicates that it has remained fairly stable over the last year but people who attend ED are more poorly, so their care needs will be more complex.

The speed at which patients can leave the cohort area is dependent on cubicles being available which in turn relates to the speed that test results are returned and acted upon and whether beds are available in the hospital for those who need them, or help is available if people need to go home with support. There are issues within the main hospital, but our work suggests that patient experience could be improved by speedier test results and analysis.

The problems of getting flow through ED are the responsibility of the whole health and care system. That it appears resistant to improvement, even with the attention currently being paid to problems, suggests that a radical approach is required with a different model and we have made suggestions that an admissions pathway for patients referred by their GP should not automatically be punctuated by a visit to ED.

The complexity of the needs of people arriving at ED by ambulance, especially older people, suggest a focus on this particular group may have benefits including improved linkage with the city's Better Care Programme, Proactive Care activity and redesign of primary care services.

Whilst many people will need a hospital admission, coordinated alternatives may avoid this and represent a better experience for patients. The voluntary and community sectors are in a position to offer alternatives and whilst this is partially used there is much more room for development. Our work and that of AUKB&H suggests improvements in how older people are attended to whilst in ED needs attention. These comments also apply to those with terminal illnesses.

Some solutions are long term but in the meantime keeping people informed about their care and where they are in the system needs immediate attention.

HWB&H also acknowledges that people who use the ED also have responsibilities to use the service only when they really need it, so HWB&H will continue to promote alternatives to ED and share these messages.

Next Steps

This report shows that the longer term focus on areas of concern at the BSUHT enables robust observation on behalf of patients. HWB&H would like to discuss this report with senior managers in BSUHT and the CCG with a view to proposed improvements being considered in future plans.

HWB&H will deliver its commitment to continue this work in ED on behalf of patients. As always we will aim to adopt an approach of open and constructive dialogue to help with service improvements at every level.

HWB&H would like to formally consolidate our programmes within BSUHT so that the patient experience can be embedded in redesign, planning, delivery and monitoring of ED and other hospital services.

Appendix 1

Our Commitment to improving the patient experience

HWB&H has previously reported on a survey of people's experiences of urgent care services in October 2013. Essentially the report highlighted public awareness and use of alternatives to A&E, but also included feedback on their use of A&E.

Issues and concerns included long waiting times, problems with car parking, dissatisfaction with cleanliness of the space, discomfort of chairs and some felt unsafe in the waiting area due to other patients' behaviour. Many praised staff for their care and compassion, but felt there were not enough staff present.

Our follow up report in December 2014 recorded responses to our recommendations from the hospital and commissioners: they included work in progress to improve the waiting area, increase security presence over weekends and increased cleaning rotas.

HWBH Urgent Care Report (October 2013) & HWBH 'What happened after Urgent Care report' (follow up one year on from previous report) (December 2014)

- 'A Guide to Health and Support Services over Christmas and the New Year' is published each year to promote alternatives to A&E. HWB&H promotes this widely through our mailing list and during each bank holiday we promote information about using alternative to A&E services on social media, our website and our answer phone message
- **Events** - We run our HWB&H stall at numerous community and health themed events each year across the city. We always have information on alternatives to A&E services, including booklets published by the CCG - promoting the 'Great Choices Make Heroes' campaign
- **A&E Screen (PowerPoint)** - We have provided information about community groups and services in the city which may improve people's health and prevent them from needing to use A&E in the future. This includes slides in an easy read format for A&E to use on their PowerPoint screen
- **Articles in HWB&H monthly magazines** - HWB&H has regularly run features on urgent care services and provided updates on changes taking place at A&E in our monthly magazine




Appendix 2

History of HWB&H work related to ED

Care Quality Commission activities to inspect Royal Sussex Community Hospital	Healthwatch Brighton and Hove (HWB& H) response	Healthwatch B&H Actions
CQC BSUHT listening event December 2013	HWBH Urgent Care Report (October 2013)	Consulted with the public on their understanding and experiences of alternatives to A&E in Brighton and Hove and fed into process
CQC BSUHT Inspection 21-23, 27 & 30 th May 2014	HWBH Annual Report (2014/15): with article about concerns	Social Media and call out campaigns for patient experience
CQC BSUHT Quality Report 8 th August 2014	HWBH Urgent Care Report : follow up one year on from previous report (December 2014)	
CQC RSCH - Urgent and emergency services inspection 22nd & 23rd June 2015	Press release in response to CQC report Call out to general public July - September 2015 to comment on their experiences of A&E Contribution to NHSE Risk Summits In June and October 2015	Feedback from HWB&H Helpline and call out - produced A&E Report which was shared with BSUHT





CQC RSCH - Urgent and Emergency Services Quality report 23 rd October 2015	HWBH observation visits , using Sit and See methods and interviews with patients in ED (November and December 2015 and January and February 2016)	HWBH report Patient Stories on Urgent and Emergency Services at Royal Sussex County Hospital (November 2015)
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