Why are we waiting?

Snapshot surveys of the impact of emergency pressures on patient care

Jane Ball, Employment Research
Michelle Dixon, Corporate Affairs, RCN
Brian Dolan, Nursing Research Fellow, King's A&E Primary Care Service, London
Lynda Holt, Nurse Consultant (Emergency Care) / Chair, RCN A&E Nursing Association
Rosie Wilkinson, A&E Nursing Advisor, RCN
and, for Casualty Watch report,
Angeline Burke, Project Officer, ACHCEW

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Foreword

This report recognises and seeks to contribute to the several initiatives underway that have the capacity to bring real change in the longer term, not least of which is the National Beds Inquiry. But, more importantly, this report highlights and offers solutions to end the immediate problems in the NHS. These solutions are sometimes more about an organisational will to create change and challenge old systems than about extra funding. But we also need a strong commitment from Government, the public and staff that these are our priorities. If that commitment is there – and the signs are, it is – excessive waits can become a thing of the past. Why are we waiting?

There is a clear consensus that emergency admissions made a sharp impact on the NHS this winter. Essentials of care - dignity, privacy, nutrition and hygiene - have suffered. Some patients have also had investigations and treatment delayed. In addition, staff have been working at a pace that is simply not sustainable – physically or emotionally.

There is growing recognition, too, that this is now a year-round issue, merely accentuated by winter pressures. Again, our findings support this view.

There has been less agreement about the causes of the problems. Was this winter's increase in 'flu cases an epidemic that was always going to cause difficulties or simply a seasonal increase that should have been managed? Do we have too few hospital beds? Should primary care and community health services be ensuring more people are treated without the need for hospital admission? What is the impact of staff shortages and sickness as well as staffing numbers and skill mix?

Many of these issues are long-term problems, indeed they were documented in two previous RCN reports – *Waiting for a bed* (1994) and *Still waiting for a bed* (1996). They therefore require longer term planning and solutions. But some things can not wait. Elderly and frail people waiting on trolleys in accident and emergency departments have become a painful symbol of an NHS in crisis. Experienced nurses becoming totally exhausted is another. This can and should be ended very quickly.

Christine Hancock
General Secretary
Royal College of Nursing

Donna Covey
Director
Association of CHCs for England and Wales

Introduction

Accident and emergency units are one of the key interfaces between patients and the health service. In addition, A&E units have to accommodate a diverse range of activity and face a considerable amount of uncertainty as to the demands that will be put upon them at any one time. They are therefore a logical place to begin to explore the perceptions of increased pressures on the whole of the NHS.

The context for this exploration is the large increase in emergency admissions of medical patients over several years coinciding with a reduction in hospital beds. Whilst bed numbers have declined by two percent since 1980 there has been a long-term increase in acute and general admissions of almost 3.5 percent a year.[1] This has long been recognised as impacting A&E services – in 1994, the RCN called for an end to trolley waits and gave recommendations.

This winter, despite co-ordinated and careful planning by the NHS, many areas still found it difficult to cope and maintain service levels and quality. In some trusts, nurses usually based in non clinical settings, such as directors of nursing and risk managers, had to work in ward areas, such was the severity of the problem. Pressure on staff was, and continues to be, excessive.

However, even a cursory analysis indicates that emergency pressures are not attributable to any one cause but rather to a complex mixture of factors. In order to unpick some of these issues, the RCN joined with the Association of Community Health Councils for England and Wales to consider the problems emergency pressures cause in A&E units and the possible solutions, particularly those which could have an immediate impact.

For the past three years, ACHCEW has run a nationwide Casualty Watch, a census of patient waits in A&E units at a given point in time. This year, ACHCEW joined with colleagues in Scotland and Northern Ireland to co-ordinate a UK-wide Casualty Watch survey on 31 January 2000. The initial results, published on 1 February, gave some indication of how the problems caused by emergency pressures are impacting on patients in A&E.

To explore these waits further, the RCN undertook a parallel snapshot survey on 31 January 2000 to capture data on the factors that may cause problems at a practical level. It also sought the views of the nurses who run accident and emergency departments on the causes of the problems and, most importantly, how they thought the problems could best be tackled.

This report combines the findings of both the nationwide Casualty Watch survey and the parallel RCN survey of A&E nurses. It seeks to identify the problems caused by emergency pressures on service delivery in A&E in order to identify and develop solutions. More specifically, the report aims to explore the relationship between the patient's experience and local variables, such as staffing levels and access to other services.

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[1] *Department of Health (2000) Shaping the future NHS: Long term planning for hospitals and related services. Consultation document on the findings of the national beds inquiry – supporting analysis.*

Methodology

Data on patients waiting in A&E were collected at 4.30pm on 31 January 2000 as part of the nationwide Casualty Watch organised by ACHCEW and colleagues in Northern Ireland and Scotland. CHC members and staff collected information in 176 units in the UK.

The RCN liaised with ACHCEW to plan a survey of staffing in A&E to coincide with the nationwide Casualty Watch. This survey was carried out in two parts:

- a 'snapshot' survey to identify staffing levels at the time of the nationwide Casualty Watch (undertaken on the late shift of 31 January)
- a survey to establish the context of A&E service delivery (undertaken in the fortnight before Casualty Watch).

Data in the RCN survey was supplied by nurses in charge of A&E units via lead RCN stewards. This approach was successfully implemented in September 1998, when a snapshot of general medical wards was conducted.

Nurse executives at all acute Trusts were informed of the RCN survey and the Casualty Watch survey was widely publicised in advance.

A total of 264 RCN stewards were contacted to collect data from the nurses in charge of A&E units throughout the UK. The RCN survey results presented in this report are based on returns from 109 A&E units (representing a 41 percent response rate, and around a third of all A&E units in the UK).

The RCN survey was administered and data analysed by Jane Ball of Employment Research.

Section I

Results

Background information on accident and emergency units

Response

The number of A&E units across the UK responding to the RCN survey is shown by region in table 1a. (Not all respondents completed all data – the number of respondents in each section is made clear.)

Table 1a: Number of A&E units in the UK, in the survey and responding by region

	Total no of A&E units	A&E units surveyed	A&E units responding
South East	37	33	19
London	36	33	8
Eastern	22	18	7
South West	23	16	8
West Midlands	23	20	12
Trent	20	18	7
North West	39	35	17
Northern and Yorkshire	35	25	7
Wales	20	17	6
Scotland	40	34	13
Northern Ireland	18	14	5
Totals	313	263	109

Source: Employment Research/RCN Emergency Pressures Survey 2000

Throughput

Patient throughput in the A&E units participating in the survey ranged from over 100,000 patients in the year 1 April 1998 to 31 March 1999 to fewer than 1,000; the average was 50,643. The variation in throughput is given in table 1b.

Table 1b: Throughput (number of patients in year to 31 March 1999)

	Percentage of units
Less than 20,000	9
20,000 – 40,000	23
40,001 – 60,000	34
60,001 – 80,000	23
Over 80,000	11
Total	100% (n=88)

Source: Employment Research/RCN Emergency Pressures Survey 2000

Meanwhile, the size of units, as indicated by number of beds/cubicles, varied from three beds/cubicles to 41. Just over half had up to 12 beds/cubicles. Size and environment have a considerable impact on the demands made of an A&E unit. For example, a unit that was built for a projected new attendance rate of 30,000 patients is clearly going to be very stretched when the attendance rate reaches 90,000.

Patient referrals

The estimated proportion of patients arriving in A&E from each referral route is shown in table 2. Most patients, on average nearly two thirds, are self-referrals. Approximately one in five arrive by ambulance and 16 per cent are referred by their GPs.[2]

Table 2: Average proportion of patients from each referral route

	Average % of all cases seen in A&E[3] (n=82)	Min-Max %
Self referral	62	20-91
Ambulance	19	0-50
GP referral	16	0-50
Off-site minor injury unit	2	0-15
Via NHS Direct	1	0-40
Other	4	0-42

Source: Employment Research/RCN Emergency Pressures Survey 2000

Table 3 shows where patients are discharged to from A&E units, as estimated by A&E nurse managers. Most return home (68 per cent) whilst on average just over a fifth (22 per cent) are admitted to other departments within the Trust. Again there is wide variation between different units. This is largely to be expected as some variation will be due to the nature of the communities they serve, for example, rural or urban communities.[4 5]

Table 3: Average proportion of patients discharged to each destination

	Average % of all cases seen in A&E (n=83)	Min-Max %
Admitted within Trust	22	0-85
Home	68	20-98
Other Trust	3	0-29
Other health/social care	4	0-46
Mortuary	2	0-10

Source: Employment Research/RCN Emergency Pressures Survey 2000

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[2] *Audit Commission (1996) By accident or design: Improving A&E services in England and Wales*
[3] *Numbers do not add to 100 as an average has been taken in each case.*
[4] *Audit Commission (1996) 'By accident or design: Improving A&E services in England and Wales*
[5] *Emergency Care Project Steering Group for the NHS in Anglia and Oxford Region, (1995) Emergency care handbook*

"Our main problem is that we are unable to transfer patients to the wards and thus ensure free flow of patients through the A&E department. We have sufficient staffing levels to cope with our A&E workload but frequently we are having to look after patients 10-16 hours while they wait for beds..... This is when care suffers and nursing staff are under the greatest amount of pressure. Many of our problems would be alleviated if we could just improve patient flow."

"The care of patients is continually being compromised by having to retain emergency admissions in A&E for extended periods ... patients are having to be examined and treated in unsuitable areas, as cubicles and trolleys are occupied by patients waiting for admission."

These results show that long patient waits and heavy staff workloads are not simply due to the number of admissions (although this was one reason given by about half of all units). Nor is it primarily related to lack of staff resourcing these services. The central theme that emerges is that long waits stem from lack of patient throughput due primarily to lack of beds but also to problems accessing other staff and services to enable discharge from A&E.

Respondents repeatedly commented on the fact that they are not designed, equipped or resourced to provide ongoing 'ward' care. For example, in 40 per cent of units (37 out of 94), the catering department does not provide hot meals for patients in A&E. And only half of the units (47 out of 94) reported that they have facilities for making patients food and drinks.

Yet when patients are waiting in A&E units for as long as 40 hours, they will obviously need feeding, washing, toilet facilities, pain relief, pressure area care and clinical observation, as a minimum.

"We often seem to be a medical ward, but have neither the facilities or staff to look after these atients properly."

"If we have no patients in the department waiting for beds in the ward, the level of care can usually be maintained for the patients arriving in the department. We are not staffed to look after ward patients".

This situation inevitably has a direct effect on the quality of care patients receive and the pressure placed on nursing staff. The lack of available beds (reported by almost every unit) has a knock on effect on the services provided. Having large numbers of patients waiting in A&E for beds means that the facilities, space and staff required to deliver emergency care are no longer available. Clearly this can have very serious consequences.

"No where and / or no trolleys available for patients"

" We have patients on beds in the waiting rooms"

"Lack of resuscitation space and equipment due to presence of too many patients for too long. ...."

After lack of beds, medical staffing problems were the second most frequently cited cause of patient waits.

" Doctors on call doing clinics not available until much later in the day, likewise the doctor 'on take' in theatre is unable to come."

Conclusions

Combined, the nationwide Casualty Watch and RCN survey results create a powerful image of the reality of services for patients and staff in many A&E units across the UK. The picture is of A&E units full to overflowing, with nurses and other staff often unable to provide even the essentials of care.

More urgent cases are waiting to be admitted to wards elsewhere in the hospital while less urgent cases are waiting for treatment before they can go home. In a vicious circle, nurses are too busy trying to provide ongoing care for patients waiting for beds elsewhere to manage the less urgent cases in A&E. A&E facilities, such as resucitation rooms, are also taken up in providing ongoing care for patients who are waiting to be admitted.

However, one other strong finding to emerge from the surveys is the enormous variations between A&E units, from everything from the length of patient waits to staffing, grade mix and access to support services and facilities. It is clear that some A&E units are coping much better than others and that there is no simple explanation for why that should be so.

The wider implications and effects

It is clear that the problems faced by A&E units have implications for other parts of the health service – it is a 'whole system' issue. NHS efficiency drives means that, where possible, departments and other resources are run at close to their full capacity. If the system experiences an increase in demand or increased difficulty in passing the patient on to the next part of the system the resulting chaos will be worse than if the system was operating more slowly. The situation is worse where queues that operate at different speeds are mixed together as they will tend to interact to slow each other down. Ideally those patients categorised with non-urgent and standard needs should be seen, treated and discharged with staff dedicated to meeting their needs.[9] The analogy of a motorway helps illustrate the effect. During busy periods on the M25, traffic is required to stay in lane and observe a mandatory speed limit, this smoothes the flow and prevents chaotic effects rippling through the traffic queue.

Initial causes

The findings from the nationwide Casualty Watch and RCN surveys separately support the conclusion that problems initially arise for a number of reasons:

- delays in bed availability elsewhere in the Trust
- difficulties in accessing appropriate medical staff
- difficulties in accessing other support services, such as radiography, psychiatry and social services, especially out-of-hours

It is clear that nurses in charge of A&E departments are also concerned about staffing levels and grade mix. A&E units are not staffed to provide 'ongoing' care for patients and nor should they be – that care should be provided on wards or in other appropriate settings. But in the context of

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[9] *Edwards N (2000) 'Planning and policy for the emergency services' presentation given at Royal Society Medicine Conference 'Forum on quality in healthcare: Improving quality measures in the emergency services' February 2000. London*

increasing and more complex A&E case loads and the expansion of nurses' roles, there is evidence that A&E units are not appropriately staffed for their core role. Some units were reporting that less than 60 per cent of nursing staff were registered nurses. Reliance on bank and agency nurses was also alarmingly high in some units.

'Staffing levels and skill mix are not adequate to meet the needs of the patients. We have an increase in number of attendances, expectations of the public have risen, and the emergency nurses have taken on many other roles. With all the enhanced roles the A&E nurse is expected to deliver, basic nursing care can be compromised.'

Root causes

This report supports existing evidence that problems in A&E need to be tackled as part of a 'whole systems' approach. The NHS Executive's Emergency Services Action Team[10] suggest that 'whole system planning should involve joint planning of all agencies including primary care, social services as well as the services within the acute area.' The National Beds Inquiry[11] has recognised that there are 'too few staffed beds, and community care services are inadequate.'

The whole systems approach cannot work without consideration of the shortage of nurses and other staff, particularly with medical staff. Many of the respondents to the survey referred to the problems of recruitment and retention of staff.

"Current vacancies impact on skill mix – difficulty in recruiting trained A&E nurses."

"Staff are leaving due to increased pressures and stress – it is becoming more difficult to fill the posts."

Many of the wider difficulties and comments reported in this survey reflect the concerns expressed by the A&E community and noted in the A&E Modernisation Programme regional workshops[12] - including how much strain will be absorbed by primary care. It is unclear how many of these waiting in A&E could have been cared for more appropriately in other settings in the community.

A lack of organisational will to create change also arose as an underlying cause of A&E pressures. This is supported by evidence that senior management in some Trusts ensured that patients were not kept in A&E for unacceptably long periods around the nationwide Casualty Watch period but that this effort was not maintained following the study. In other Trusts, nurses were discouraged from taking part in the RCN survey. Where Trusts do prioritise reducing pressure on A&E unit longer term, nurses report positive results.

"I do feel the hospital and Trust have tried to address the winter pressures and help us, for example one extra healthcare assistant for every shift. Bed management extended from 17.00 hrs to 21.00 hours Monday to Friday. Discharge lounge and discharge facilitator in place. Help from the hospital team, 5-day ward opened 7 days, 24 hours. Money allocated for extra

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[10] *NHE Executive (1999) Emergency Services Action Team 1999 Report*
[11] *Department of Health (2000) Shaping the Future NHS: Long term planning for hospitals and related Services. Consultation document on the findings of the national beds inquiry – supporting analysis.*
[12] *NHE Executive (1999) Emergency Services Action Team 1999 Interim Report October 1999*

nurses at times of pressure (we have huge numbers of patients waiting overnight). There is low sickness amongst staff and excellent team work that maintains morale."

Recommendations

There has already been an acknowledgement by Government that acute beds may have been cut to levels that are not sustainable and the National Beds Inquiry[13] is seeking views on a strategy for managing the demand and the long term future of NHS beds. The RCN/ACHCEW surveys indicate a need, at least in the medium term, for an increase in staffed beds in order to enable patients to be admitted promptly when appropriate. This will require additional funding and additional nurses and other healthcare staff.

But there is also much room for improvements as a result of action taken at local level, not least of which is a strong organisational will to support nurses and other staff in ending unacceptable waits in A&E departments. There is no reason why all Trusts cannot commit to ending excessive A&E waits before this winter. The aims and targets detailed in the recent nursing strategies [14, 15] and human resources strategy will, if achieved, have a enormous impact on improving services for patients and conditions for staff.

In addition, each NHS Trust should ensure that they have made the most of proven solutions. There follows a digest of initiatives and actions, many of which do not require substantial additional resources, that will bring improvements to A&E units, both in terms of improving care and ending unacceptable pressures on staff. There is a clear role for collaboration, between managers, nurses and other staff, CHCs and other patient groups, to ensure that local problems are identified and local solutions implemented. CHCs, in particular, are well placed to help ensure the public are aware of how best to access care in the most appropriate part of the NHS.

Immediate initiatives and actions

The key message to emerge from this report is that trolley waits are a Trust-wide rather than an A&E problem. Emergency admission rates and, by extension, trolley waits, depend as much on the configuration of services and the organisation of care as they do on the demographic characteristics of the population or the prevalence of disease. For this reason, waits can be 'managed' but the full support of the Trust Chief Executive is essential. This section describes some core initiatives that can be used to manage waits to acceptable levels and is intended to act as a checklist by which Trusts can benchmark their own actions. It is very clear from this research that nurses working in A&E have ideas on how to tackle local problems.

Core initiatives

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[13] *Department of Health (2000) Shaping the future NHS: Long term planning for hospitals and related services. Consultation document on the findings of the national beds inquiry – supporting analysis.*

[14] *Department of Health(1999) 'Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare' July 1996 HMSO*

[15] *National Assembly for Wales (1999) Realising the potential: a strategic framework for nursing, midwifery and health visiting in Wales*

Trust management

- Executive management should be fully involved in the management of A&E waits waits, with daily reports and strategic service reviews.
- Consider how activity can be re-profiled, undertaking a larger proportion of elective inpatient work at times when emergency admissions are predictably lower, for example in the summer months to allow for a larger proportion of day case surgery and medical acute admissions over the winter months
- Employ up-to-date IT systems that support bed allocation and clinical activity and that provide auditable information.
- Closer liaison and collaboration with community and social services to identify trends and service plans to prevent unnecessary admissions and improve discharge.
- All possible local action to recruit and retain nursing and other staff should be taken, including consideration of employee friendly and health and safety policies. Patient workload and its impact on patient care should be monitored regularly. While improving the skill mix is an important consideration, recognising and supporting staff under acute pressure is an important managerial priority.
- Principal specialties, including emergency operating theatres, should be available 24 hours per day
- Paperwork should be kept to a minimum while ensuring safe standards of care and record keeping. Multidisciplinary notes should be used.

Bed management

- Bed managers should be designated and provide 24-hour cover; they should have the appropriate responsibility and authority to manage rather than simply allocate beds and should be accountable to a member of the executive management team, such as the director of nursing.
- All admissions to wards, whether from A&E or direct from GPs, should be routed through the designated bed managers.
- The designated bed managers should work in liaison with the medical referee (see below).

Medical staffing

- Consultant ward rounds should be undertaken on a daily basis.
- There should be medical 'on-take' teams who take responsibility for all patients admitted to that specialty that day. These medical teams should not be otherwise involved in theatre, outpatient or other clinical activities.
- Where consultant-allocated beds still exist, they should be made available to the whole Trust.
- GPs should be able to refer direct to consultant/senior registrar for advice/referral.
- A medical consultant referee with authority to discharge patients should work closely with bed managers and ward staff to assess those patients who might be discharged home.

Medical major incident management

- Introduce medical major incident protocol for managing excessive A&E waits - this works the same as normal major medical incident plans but is triggered by excessive A&E waits and bed pressures rather than a medical incident. The protocol should identify the predetermined number or length of waits that act as the trigger as well as what the hospital-

wide response entails. It would include diverting other medical resources to A&E to assess and treat patients.

Nursing

- An expert review of A&E staffing and skill mix based on current demand and case mix should be undertaken as a matter of urgency where this has not happened in the past five years.
- Implement protocols for nurse discharge, for example, for patients after minor head injury, should be developed to reduce unnecessary delays in patient discharge.
- Extending appropriate use of nursing expertise could also include nurse assessment/referral of patients within specific criteria, such as fast-tracking patients.
- Consider employing community psychiatric nurses to work within A&E

Supporting services

- Ambulance services should have regular updates of waiting times in A&E departments and, where possible and appropriate, re-route ambulances to other less stressed departments temporarily.
- Dedicated portering and clerical staff should be available to A&E, 24 hours a day where possible
- Expanding the multi-disciplinary team in A&E to include physiotherapists, occupational therapists for example.

New ways of working initiatives

Direct A&E impact

- Implement care pathways – agreed protocols for managing the care of specific conditions
- Consider development of clinical decision units - 6-24 hour assessment units where a range of tests can be performed to reduce unnecessary admissions.
- Access to urgent out-patient clinics, for appropriate patients, as opposed to admission. The facility for next day patient review in A&E/assessment units/clinical decisions unit for patients who may need admission or could be managed at home with follow-up.
- Trusts and local health commissioners should consider the use of rapid response teams – teams of community nurses and others providing intensive care and support to patients in their own homes rather than a hospital bed.

Wider service developments

- Consider development of discharge lounges - nurse-staffed unit where patients awaiting transport can wait in comfort with the availability of medication, meals and supervision etc.
- Access to GP out-of-hours service should be available within or near A&E unit.
- The development of ' hot and cold' bed allocation could be considered where Trusts are based on split sites with one unit managing all elective work while the other focuses on emergency admissions and treatments
- Short stay units, where patients requiring 24-72 hour stays for elective work, could be developed along the same models as day case units
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Section II

Nationwide Casualty Watch 2000

Introduction

Waiting times in hospital accident and emergency units came under the spotlight during *Nationwide Casualty Watch 2000* organised by The Association of Community Health Councils for England and Wales (ACHCEW) on Monday 31 January.

176 Community Health Councils in England and Wales, Health and Social Services Councils in Northern Ireland and Local Health Councils in Scotland visited their local A&E units to survey how long patients had been waiting. They recorded how many people were waiting for treatment, how long they had been waiting at 4 30pm that day and whether they were in beds, on trolleys or in chairs.

Since 1981, the number of new attendances in accident and emergency departments has risen by an average of 2 per cent per year.[16] A & E departments have become over-stretched and many find it difficult to cope with increasing demand. In addition to rising attendances many A & E Departments also face problems because of difficulties in other parts of their hospitals. Problems over which hospitals have no control, such as social services provision, also affect the running of A&E departments. As a result of these problems A&E departments are sometimes forced to leave patients waiting for many hours.

Nationwide Casualty Watch has been developed in response to these problems. By providing a snapshot of how long patients are waiting in A&E departments this survey highlights where things are working well and where there are problems. The survey attracted substantial media interest with extensive television, radio and newspaper coverage locally and nationally – all the national daily newspapers carried reports.

Background

In January 1998 ACHCEW carried out the first Nationwide Casualty Watch to coincide with the regular monthly Casualty Watch organised by Southwark CHC (Appendix 2 The aim was to find out whether the problems experienced in London were replicated throughout the country. Community Health Councils in England and Wales, and Health and Social Services Councils in Northern Ireland took part. The Nationwide Casualty Watch was the first of its kind. There were many anecdotes about problems in A&E departments but there was no systematic evidence to support them. The project was successful in detailing the scale of the problem. In January 1999 the second Nationwide Casualty Watch covered England, Wales and Scotland. On this occasion CHCs and Local Health Councils visited almost 200 A&E Departments and recorded details for nearly 3000 patients.

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[16] *Audit Commission, 1996, By Accident or Design – Improving A&E Services in England and Wales. HMSO. London*

Nationwide Casualty Watch 2000

The Nationwide Casualty Watches in 1998 and 1999 confirmed that many A&E departments throughout the UK are experiencing problems. They may be as a result of problems within hospitals such as staff shortages or they can also be as a result of problems experienced by social services departments. Increasingly, patients, many of them elderly, are forced to remain in hospital because social services departments are unable to provide or arrange appropriate care for them in the community. Problems such as these have a knock-on effect in hospitals and may mean, for example, that A&E departments are prevented from moving patients from their departments to the appropriate wards within the hospitals under the care of the appropriate consultants. Problems within the hospitals and with social services departments frequently manifest themselves in patients experiencing unnecessarily long waits in A&E departments.

For the Nationwide Casualty Watch 2000 ACHCEW joined forces with the Royal College of Nursing (RCN). The purpose of this collaboration was to take the exercise a step further than in previous years. Joint work allowed the two organisations not only to highlight the recurring problems in A&E departments, but also to look for possible solutions. Details of this collaboration are outlined earlier in this report. The collaboration is also an acknowledgement of the fact that CHCs, Health and Social Services Councils and Local Health Councils recognise that staff and managers are being forced to work under increasingly difficult circumstances. Resolving the problems detailed in this report will be to the benefit of patients, staff and managers.

Methodology

At 4.30pm on 31 January representatives from CHCs in England and Wales, Local Health Councils in Scotland and Health and Social Services Councils in Northern Ireland visited their local A&E departments to see how long patients had been waiting from the time of their arrival in A&E until 4.30pm. The time waiting is calculated from arrival rather than the time of a decision to admit. By monitoring this wait it is evident that some patients not only have to wait for extended periods of time before a decision to admit is taken, they then have to wait for what can sometimes be hours before they are actually admitted. Although the decision to admit may be reliant upon test results, so a period of waiting would be required, in some cases it is usually evident from the time of arrival that admission will be necessary. An example of this type of case would be a patient who had suffered a stroke. The delay between arrival and decision to admit is often because the appropriate consultant, who would take the decision, is not available because of commitments elsewhere in the hospital.

For each patient in England and Wales A&E staff were asked to provide the following details: gender, age, time of arrival, provisional diagnosis/reason for attending, plan for patient, time of decision to admit (where applicable), reasons for any delay in admission, and whether patients were sitting on a chair or lying on a trolley or a bed. In
Northern Ireland additional information, such as mode of referral and mode of transport was recorded. This has not been analysed for the purposes of the Nationwide Casualty Watch.

The information was faxed to the ACHCEW office where it was recorded and analysed using an Access database.

Initial results of the longest waits were published on Tuesday 1 February based on information that had been processed by 11pm on the previous evening. Before releasing this information to the media the relevant Trusts and Councils were asked to confirm that it was accurate. The full results[17], analysed below, are based on all of the information received.

Results

See also Appendix 3

The following information has been compiled from data given to CHCs, Local Health Councils and Health and Social Services Councils by A&E staff.

It is important to note that although in this survey patients are recorded as 'waiting' in A&E departments it does not in any way imply that whilst patients are waiting they are not receiving appropriate care and treatment. Some patients are waiting for the results of tests which will indicate the most appropriate care required. A statement from the A&E Manager at Greenwich District Hospital, where a 63 year old male patient with diverticulitis had been waiting in the department for over 6 hours illustrates this point: "...Baseline observations were recorded and the patient was placed in priority order to see the A&E doctor...the patient was seen and examined by the A&E doctor, who undertook a thorough examination, following which she deemed it necessary to commence investigations to assist her diagnosis. These included, blood tests, chest x-ray and abdominal x-ray....On receipt of all test results the A&E doctor reviewed the case and made the decision to contact the on-call surgeons..."[18]

One hundred and seventy-eight Community Health Councils in England and Wales, Local Health Councils in Scotland and Health and Social Services Councils in Northern Ireland took part in the survey (Appendix.3). Members and staff from the Councils visited two hundred and thirty-two A&E departments. The total number of patients recorded was 3, 983.

The longest recorded wait was at Northwick Park & St Mark's Hospitals, where Harrow CHC reported that a 71 year old female with a fractured pubic bone had been waiting for over forty hours.

The second longest wait was recorded at Epsom General Hospital where it was reported that a 68-year-old male with chest pains had been in the A&E department for almost forty hours because a bed was not available for his admission.

At Good Hope Hospital a 66-year-old female with chronic obstructive pulmonary disease had been in the A&E department for over 23 hours. However, North Birmingham CHC reported that

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[17] *The full list of results has been published separately. The details for all of these cases have not been checked by ACHCEW*

[18] *Note from Cathy Pullen, A&E Manager Greenwich District General Hospital. 2 February 2000*

the patient was "on a bed in a high dependency unit in A&E at the consultant's request because of the clinical need for monitoring and observation".

A number of long waits were recorded because of problems with the interface between hospitals and social services departments: at North Middlesex Hospital an 85-year-old female with dementia/confusion who had been waiting for almost seventeen hours could not be discharged because plans for a 'safe discharge' could not be made; at Good Hope Hospital a 62-year-old male assault victim had been waiting almost sixteen hours. He could not be discharged until arrangements had been made for him to be rehoused by social services.

At the Royal Surrey County Hospital the average wait for patients had been over fourteen hours. At the King George Hospital, Redbridge the average wait had been over ten hours and at Watford General Hospital it had been just over nine hours. At nineteen percent of A&E departments the average wait had been one hour or less.

At 4.30pm the vast majority of patients (83%) had been waiting in A&E departments for under four hours; 15% of patients had been waiting for between four and nine hours; 1% of patients had been waiting for between 10 and 20 hours; and 1% of patients had been waiting for more than 20 hours.

The majority of the longest waits were in A&E departments in England. See Appendix for longest waits in England, Northern Ireland, Scotland and Wales.

Twenty-seven percent of patients waiting were 70 years old and above. 74% of these patients had been waiting for less than 4 hours, and 23 percent had been waiting for between 4 and 9 hours. Under-sixteens accounted for 14% of those waiting. Of these, 95% had been waiting for less than four hours and none had been waiting for more than nine hours.

In those cases where the reason for any delay in admission was given, by far the most common reason was problems with bed availability.

There were no patients waiting at Caithness General Hospital and Stracathro Hospital in Scotland.

Admissions and Assessments Wards

The use of admissions and assessments wards was highlighted as an area of concern in previous Nationwide Casualty Watch reports, and remains an area of concern. Many patients who had been waiting for long periods on admissions or assessment wards were not included in the results of this year's survey because it is considered by some that this would be misleading. The problem here is that the services and the quality of care can vary enormously on these wards. Some wards are essentially for 'warehousing' patients, and other wards provide wholly appropriate care and assess how best patients should be treated. The Audit Commission share concerns about the use of these wards and their report *By Accident or Design* concludes: "Thus, in terms of quality of nursing care, admissions wards are necessarily second best, unless only used for admissions at night. A patient does not retain the same named nurse throughout their

stay in hospital and information important to care planning and the possibility of a stress-free hospital stay may be lost unless nursing documentation is meticulous. Some patients find mixed-sex wards distressing. However, the advantages of enhanced levels of medical cover and more flexible management of beds may outweigh these considerations."

Many hospitals have protocols stating how admissions and assessment wards should be used and the maximum length of time that patients should stay on them. It is, however, clear from data submitted for the survey that some patients are spending extended periods of time (often in excess of the times stated in protocols) on these wards largely because of problems experienced in the hospitals or because of difficulties in discharging patients. Patients should be admitted to specialist wards where this is appropriate with as little delay as possible.

Comments from CHCs

The following were included in comments made by CHCs on their survey forms:

"Patients on trolleys have to share a cubicle with one other patient"
Newham General/Newham CHC

"Staff very helpful as always. Unit busy, but well managed"
Oldchurch Hospital/Barking, Dagenham & Havering CHC

"Hospital on 'Red Alert' regarding availability of beds"
Ipswich Hospital NHS Trust/East Suffolk CHC

"Results incomplete. Staff tried to help but were just too busy"
Charing Cross Hospital/Hammersmith & Fulham CHC

"Working area very cramped due to number of trolleys. Ambulance staff waiting to retrieve trolleys"
Kingston Hospital/Kingston CHC

"No long waits – only 5 patients in the department"
Royal Lancaster Infirmary /Lancaster and Morecambe CHC

"Refurbishment of the department is nearly completed, and its is obvious that this makes a difference to the running of the department – beneficial"
Medway Hospital/Medway CHC

Mid Surrey CHC noted that at Epsom General hospital there were 5 patients on chairs because there were no trolleys available

North Tees CHC noted that at North Tees General 10 patients had been admitted to the hospital via A&E on 31 January and that none of these had waited for more than one hour.

"Casualty at Stamford (Lincolnshire) closes at 5pm. Patients after 5pm need to travel to Peterborough (14 miles) or Grantham (20 miles)"
Stamford Hospital/South Lincolnshire CHC

Members of North Birmingham CHC have asked their chief officer to write to Good Hope Hospital to "thank the staff and managers for their efforts over the holiday period and to congratulate them for maintaining services against a background of high levels of flu amongst staff."

Longest waits – England

Hospital	Council	Gender	Age	Arrival Time	Provisional Diagnosis/ Reasons for Attending Casualty	Plan for Patient	Time of Decision to Admit	Reasons for delay in admission	Trolley Chair Bed	Total wait so far
Northwick Park & St Mark's	Harrow	F	71	23:50 29/1	Fractured pubic bone	Failed discharge response			T	40:40
Epsom General	Mid Surrey	M	68	00:38 30/1	Chest pain	Admit		No bed	T	39:52
Royal Surrey County	SW Surrey	M	71	00:56 30/1	Abdominal & back pain	Admit	16:00	Awaiting ward bed	B	39:34
Northwick Park & St Marks	Harrow	F	69	09:59 30/1	Atrial fibrillation			Waiting for bed	T	30:31
Royal Surrey County	SW Surrey	M	53	10:02 30/1	Short of breath	To be discharged and sent home			B	30:28
W atford General	SW Herts	M	37	11:00 30/1	Abdominal pain	Waiting for ward	14:00			29:30
Royal Surrey County	SW Surrey	M	41	13:49 30/1	Inflamed right leg	Admit			B	26:41
King George, Redbridge	Redbridge	F	46	14:49 30/1	Abdominal pain/vomiting	To be admitted for surgery	17:30	No beds available	B	25:41
Royal Surrey County	SW Surrey	F	76	14:59 30/1	Chest infection	Admit to ward	17:00	Awaiting vacant bed	B	25:31
King George, Redbridge	Redbridge	M	73	16:03	Asthma	Refer to medics	08:00		B	24:27

Longest waits – Northern Ireland

Hospital	Council	Gender	Age	Arrival Time	Provisional Diagnosis/ Reasons for Attending Casualty	Plan for Patient	Time of Decision to Admit	Reasons for delay in admission	Trolley Chair Bed	Total wait so far
Lagan Valley	Eastern Health & Social Services (EHSSC)	F	37	17:47 30/1	Chest Pain	Admission	16:00	No bed	B	25:43
Antrim	Northern Health & Social Services (NHSSC)	M	84	19:51 30/1	Generally unwell	Admission	21:00	No beds	T	20:39
Ulster	EHSSC	M	42	09:36	Chest Infection	Admission	10:55	No beds	T	06:54
Ulster	EHSSC	M	53	09:49	Pleural effusion	Admission	11:30	No beds	C	06:41
Ulster	EHSSC	M	76	11:22	Shortness of breath	Admission	14:00	No beds	T	05:08
Mater	EHSSC	M	45	11:25	Psychiatric assessment	Awaiting psychiatrist			C	05:05
Ulster	EHSSC	M	33	11:36	Faecal loading	Discharge			C	04:54
Royal Victoria	EHSSC	M	12	11:47	Pain in wrist	Waiting x-ray to be seen			C	04:43
Mater	EHSSC	M	50	11:48	Chest pain	Admission	13:00	Waiting for bed	T	04:42
Royal Victoria	EHSSC	M	14	11:48	Painful toes	Waiting to be seen by doctor			C	04:42

Longest waits - Scotland

Hospital	Council	Gender	Age	Arrival Time	Provisional Diagnosis/ Reasons for Attending Casualty	Plan for Patient	Time of Decision to Admit	Reasons for delay in admission	Trolley Chair Bed	Total wait so far
Western Infirmary	Greater Glasgow	F	39	12:02	Right arm flare up	Admit		Awaiting speciality review	T	04:28
Royal Alexandra	Argyll & Clyde	M	77	12:51	Alcohol withdrawal				B	03:39
Royal Infirmary, Edinburgh	Lothian	M	58	12:51	Prolapsed disc	Admit to ward		No bed available		03:39
Royal Infirmary, Edinburgh	Lothian	F	61	12:55	Chest pain	For discharge			T	03:35
Victoria Hospital – Kirkcaldy	Fife	M	82	12:55	Shortness of breath	Admission	14:00	Transfer to ward	T	03:35
Borders General	Borders	M	89	13:00	Abdominal pain	Admission	15:30		T	03:30
Dumfries & Galloway Infirmary	Dumfries & Galloway	F	52	13:02	Fractured femur	Admit to ward	15:00		T	03:28
Glasgow Royal Infirmary	Greater Glasgow	F	22	13:05	Bite to left hand	Discharge			C	03:25
Glasgow Royal Infirmary	Greater Glasgow	F	80	13:10	Abdominal pain	Being seen by surgeon			T	03:20
Western Infirmary	Greater Glasgow	F	70	13:11	Ankle complaint	Discharge home			T	03:19

Longest waits - Wales

Hospital	Council	Gender	Age	Arrival Time	Provisional Diagnosis/ Reasons for Attending Casualty	*Plan for Patient*	Time of Decision to Admit	Reasons for delay in admission	Trolley Chair Bed	Total wait so far
Princess of Wales	Bridgend County Borough	F	75	08:10	Shortness of breath	Admission		No medical beds	T	08:20
Royal Gwent	South Gwent	F	51	08:21	Collapsed	Referral to medics to be admitted			T	08:09
Princess of Wales	Bridgend County Borough	M	87	08:45	Weakness in legs	Admission, monitor		No medical beds	T	07:45
Princess of Wales	Bridgend County Borough	F	85	09:46	Chest infection	Admission, treatment		No medical beds	T	06:44
Royal Gwent	South Gwent	F	85	10:02	Vomiting and gastric pain	Awaiting admission under medics			T	06:28
Wrexham Maelor	NE Wales	F	89	10:09	Ankle injury	Admit to care of elderly	12:35	Awaiting bed	B	06:21
Wrexham Maelor	NE Wales	F	98	10:32	Unwell	Admit to care of elderly	13:16		B	05:58
Princess of Wales	Bridgend County Borough	M	31	10:37	Renal colic	Admission for treatment		No medical beds	T	05:53
Princess of Wales	Bridgend County Borough	F	48	10:54	Collapse, chest pain	Admission, analgesia		No medical beds	T	05:36
Princess of Wales	Bridgend County Borough	M	75	10:57	Query deep vein thrombosis	Doppler scan		No medical beds	C	05:33

Appendix 1 – Glossary of terms

Acute Services	Medical and surgical interventions provided in hospitals
Admissions /assessment ward	A small bedded ward usually adjacent to the A&E department where patients can be admitted for observation and a short stay until a bed is available elsewhere.
Bed manager	An individual with the responsibility for identifying available empty beds within the trust.
Discharge lounge	A comfortable area staffed by nurses where patients can wait until transport or relatives arrive to escort the patient home.
Emergency admission	A patient admitted to hospital at short notice because of clinical need or because alternative care is not available.
Fast tracking	A system whereby some patients who fulfil certain criteria are able to be admitted directly to the ward, e.g. patients with a fractured hip.
GP referral unit	Ward, usually adjacent to A&E department, where patients are taken directly for specialty medical team investigations, diagnosis and/or admission/discharge
Intermediate care	An umbrella term used to describe services that promote independence, prevent hospital admission and or enable early discharge. Intermediate care typically provides community based alternatives to traditional acute hospital care.
Minor injuries unit	Facility may be part of a main A&E unit or sited separately where patients with minor injuries or illness have their clinical condition managed by nurse practitioners or doctors.
Primary care unit	Service attached to A&E unit, may include GPs working to meet clinical needs of primary care patients attending A&E
Rapid response team	A team comprising a number of health care professionals and others whose care aims to support an individual to enable them to stay at home, may include a carpenter for example

Appendix 2

Background to Casualty Watch

Casualty Watch was started in 1989 by Camberwell CHC (now Southwark CHC) as a result of concerns about patients having to wait for up to twenty hours on trolleys in the A&E department at King's College Hospital. Fears mounted when two patients died in such circumstances. The CHC initiated Casualty Watch, on a monthly basis, to obtain a snapshot of how long people were waiting in A&E Departments.

At 4 30pm on the last Monday of each month a representative from the CHC visits the local A&E Department to collect details about the patients waiting in the Department. For each patient the CHC visitor collects, from a member of staff – usually the nurse in charge, the following details for each patient: age, gender, postcode (only the first part to preserve the patients' confidentiality), arrival time, time of decision to admit (where applicable), the provisional diagnosis, the treatment plan for the patient, whether they are sitting on a chair or lying on a trolley or bed, and how long they have been waiting by 4 30pm. Patients' names are never recorded and neither are patients interviewed. Casualty Watch is designed to be quick and efficient and above all to cause minimal disruption to the running of A&E.

Collecting the data from King's College Hospital on a monthly basis has allowed Southwark CHC to monitor the A&E Department over a number of years and to relate the data to other service changes. It has become a powerful tool with providers and commissioners and has enabled the CHC to press for better services, more beds and more humane treatment for seriously ill people. It has also given the CHC the opportunity to press for more resources from central government and helped to win capital to redevelop the A&E Department at King's College Hospital.

In 1992, the Tomlinson Report on the NHS in London called for further bed reductions. This led CHCs across the capital to work together to collect consistent data, which is collated into a single Casualty Watch report on a monthly basis. The first simultaneous multi-site Casualty Watch took place in April 1994 with CHCs monitoring thirteen A&E Departments. Other CHCs joined in subsequently, so that the monthly Casualty Watch has included many hospitals in London, Kent, Sussex, Surrey, Hertfordshire, Birmingham, Liverpool and Newcastle. Today, 32 CHCs take part in the monthly Casualty Watch.

Appendix 3

Nationwide Casualty Watch

Waiting Time versus Hospital for period 29 January 2000 to 31 January 2000

		Waiting Time		
Hospital	*Average*	*% > 1*	*% > 2*	*%> 4*
ABERDEEN ROYAL INFIRMARY	0.49	9.1%	0.0%	0.0%
ADDENBROOKES	1.68	59.4%	34.4%	6.3%
AINTREE NHS TRUST	4.60	86.0%	76.7%	55.8%
AIREDALE GENERAL	1.24	45.5%	18.2%	9.1%
ALDER HEY	1.98	61.5%	46.2%	15.4%
ALEXANDRA HOSPITAL	1.44	66.7%	20.0%	6.7%
ALTNAGEVLIN AREA HOSPITAL	1.01	27.3%	18.2%	0.0%
ANTRIM HOSPITAL	2.97	69.2%	30.8%	7.7%
ARROWE PARK	2.56	73.8%	59.5%	21.4%
ASHFORD HOSPITAL - MIDDX	3.20	87.0%	65.2%	34.8%
AYR HOSPITAL	0.96	36.4%	9.1%	0.0%
BARNET GENERAL	3.70	91.4%	68.6%	34.3%
BARNSLEY DISTRICT GEN	1.72	73.9%	34.8%	4.3%
BASSETLAW DISTRICT GEN	1.37	75.0%	25.0%	0.0%
BEDFORD GEN	1.01	36.8%	21.1%	0.0%
BELFAST CITY HOSPITAL	0.67	33.3%	0.0%	0.0%
BELFORD HOSPITAL	0.42	0.0%	0.0%	0.0%
BISHOP AUCKLAND GEN	0.22	0.0%	0.0%	0.0%
BLACKBURN ROYAL INFIRMARY	1.63	62.5%	25.0%	12.5%
BLACKPOOL VICTORIA	3.14	100.0%	80.0%	20.0%
BOOTH HALL CHILDRENS	0.56	0.0%	0.0%	0.0%
BORDERS GEN	1.06	28.6%	28.6%	0.0%
BRADFORD ROYAL INFIRMARY	0.80	37.9%	3.4%	0.0%
BRISTOL ROYAL HOSPITAL FOR	1.04	50.0%	12.5%	0.0%
BRISTOL ROYAL INFIRMARY	2.44	70.0%	43.3%	13.3%
BROMLEY HOSPITAL	4.58	100.0%	91.7%	50.0%
BRONGLAIS GENERAL	1.65	100.0%	25.0%	0.0%
BROOMFIELD	2.58	86.2%	62.1%	17.2%
BUCKLAND	0.22	0.0%	0.0%	0.0%
BURNLEY GEN	0.84	33.3%	0.0%	0.0%
CENTRAL MIDDLESEX	3.53	100.0%	83.3%	41.7%
CHARING CROSS	2.57	28.6%	28.6%	28.6%
CHASE FARM	3.14	100.0%	75.0%	37.5%

CHELSEA & WESTMINSTER	2.78	78.8%	54.5%	21.2%
CHESTERFIELD AND NORTH	2.02	75.9%	44.8%	3.4%
CHORLEY & S RIBBLE TRUST	1.61	53.3%	26.7%	13.3%

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Nationwide Casualty Watch

Waiting Time versus Hospital for period 29 January 2000 to 31 January 2000

		Waiting Time		
Hospital	*Average*	*% > 1*	*% > 2*	*%> 4*
CITY GENERAL HOSPITAL-STAFFS	3.36	96.0%	80.0%	28.0%
CITY HOSPITAL, BIRMINGHAM	2.55	82.4%	58.8%	17.6%
COLCHESTER GEN	2.05	65.2%	43.5%	17.4%
COLERAINE HOSPITAL	0.94	50.0%	25.0%	0.0%
COUNTESS OF CHESTER	1.95	78.1%	43.8%	12.5%
COVENTRY & WARWICKSHIRE	1.53	56.3%	12.5%	6.3%
CRAIGAVON AREA HOSPITAL	1.19	50.0%	10.0%	0.0%
CRAWLEY HOSPITAL	2.64	80.0%	60.0%	26.7%
CROSSHOUSE, KILMARNOCK	1.04	40.0%	20.0%	0.0%
DAISY HILL HOSPITAL	0.61	33.3%	0.0%	0.0%
DARLINGTON MEMORIAL	0.80	42.9%	0.0%	0.0%
DERBYSHIRE ROYAL INFIRMARY	2.48	80.0%	52.7%	16.4%
DERRIFORD, PLYMOUTH	1.65	58.3%	29.2%	8.3%
DEWSBURY TRUST	1.76	72.4%	37.9%	3.4%
DOWNE HOSPITAL	0.35	0.0%	0.0%	0.0%
DR GRAYS, ELGIN	0.99	25.0%	25.0%	12.5%
DUMFRIES & GALLOWAY INF	1.66	50.0%	25.0%	0.0%
EALING HOSPITAL	2.43	87.5%	54.2%	16.7%
EAST SURREY HOSPITAL	2.84	66.7%	61.9%	19.0%
EASTBOURNE DGH	3.35	85.7%	71.4%	28.6%
EPSOM GENERAL	8.05	95.0%	75.0%	40.0%
ERNE HOSPITAL	0.57	0.0%	0.0%	0.0%
FALKIRK & DISTRICT INFIRMARY	0.84	25.0%	0.0%	0.0%
FRENCHAY HOSPITAL	1.24	50.0%	20.0%	5.0%
FRIARAGE, NORTHALLERTON	0.69	33.3%	0.0%	0.0%
FRIMLEY PARK	2.78	72.2%	44.4%	27.8%
FURNESS GEN	1.19	40.0%	26.7%	0.0%
GLAN CLWYD	1.83	80.0%	26.7%	13.3%
GLASGOW ROYAL INFIRMARY	1.65	66.7%	44.4%	0.0%
GOOD HOPE	5.52	84.6%	53.8%	38.5%
GRANTHAM & DISTRICT	1.64	85.7%	28.6%	0.0%
GREENWICH DISTRICT GENERAL	3.12	82.4%	70.6%	29.4%
HAIRMYRES, EAST KILBRIDE	0.85	40.0%	6.7%	0.0%
HAMMERSMITH	3.71	64.3%	64.3%	42.9%

HARROGATE DISTRICT	2.11	66.7%	50.0%	8.3%
HEMEL HEMPSTEAD GEN	1.23	45.5%	27.3%	9.1%

21 February 2000

Nationwide Casualty Watch

Waiting Time versus Hospital for period 29 January 2000 to 31 January 2000

		Waiting Time		
Hospital	*Average*	*% > 1*	*% > 2*	*%> 4*
HEREFORD GEN	1.41	61.5%	30.8%	0.0%
HEXHAM GEN	1.01	57.1%	0.0%	0.0%
HILLINGDON HOSPITAL	5.44	91.7%	75.0%	41.7%
HINCHINGBOOKE	2.73	79.2%	58.3%	25.0%
HOMERTON	3.66	100.0%	72.7%	45.5%
HOPE-SALFORD ROYAL	1.89	62.7%	39.2%	7.8%
HORTON GEN	2.70	87.5%	75.0%	12.5%
HUDDERSFIELD ROYAL INFIRMARY	0.97	12.5%	12.5%	0.0%
HULL ROYAL INFIRMARY	1.55	62.5%	28.1%	0.0%
INVERCLYDE ROYAL HOSPITAL	1.26	58.8%	23.5%	0.0%
IPSWICH NHS TRUST	1.02	41.7%	16.7%	0.0%
JOHN RADCLIFFE	4.71	84.6%	76.9%	46.2%
JOYCE GREEN, DARTFORD	2.47	91.7%	66.7%	16.7%
KENT AND CANTERBURY	2.13	53.3%	40.0%	26.7%
KENT AND SUSSEX	2.50	77.8%	48.1%	18.5%
KETTERING GEN	1.78	69.2%	46.2%	0.0%
KIDDERMINSTER GEN	0.97	50.0%	12.5%	0.0%
KING GEORGE, REDBRIDGE	10.32	86.4%	77.3%	63.6%
KINGS COLLEGE	2.98	75.0%	50.0%	27.5%
KINGS MILL CENTRE	1.28	66.7%	20.8%	0.0%
KINGSTON HOSPITAL	2.94	66.7%	55.6%	28.9%
LAGAN VALLEY HOSPITAL	4.28	83.3%	66.7%	8.3%
LAW, CARLUKE	0.58	0.0%	0.0%	0.0%
LEEDS GEN	2.50	81.1%	59.5%	13.5%
LEICESTER ROYAL INFIRMARY	1.89	66.0%	37.7%	9.4%
LEIGHTON, CREWE	1.30	70.0%	20.0%	0.0%
LINCOLNSHIRE COUNTY	1.39	63.0%	11.1%	3.7%
LISTER, STEVENAGE	2.34	76.0%	48.0%	16.0%
LLANDUDNO GENERAL HOSPITAL	0.26	0.0%	0.0%	0.0%
MACCLESFIELD DISTRICT GEN	2.25	83.3%	50.0%	8.3%
MAIDSTONE HOSPITAL	4.68	94.7%	73.7%	42.1%
MANCHESTER ROYAL INFIRMARY	5.53	92.3%	76.9%	46.2%
MANOR HOSPITAL	1.73	66.7%	28.6%	9.5%
MATER HOSPITAL	1.88	63.2%	36.8%	10.5%

MAYDAY UNIVERSITY HOSPITAL	3.43	88.2%	70.6%	35.3%
MEDWAY & MARITIME HOSPITAL	3.65	100.0%	81.3%	37.5%

21 February 2000

Nationwide Casualty Watch

Waiting Time versus Hospital for period 29 January 2000 to 31 January 2000

		Waiting Time		
Hospital	*Average*	*% > 1*	*% > 2*	*%> 4*
MID ULSTER HOSPITAL	0.41	25.0%	0.0%	0.0%
MIDDLESBOROUGH GEN	1.18	27.3%	18.2%	9.1%
MONKLANDS, AIRDRIE	0.85	33.3%	13.3%	0.0%
MORRISTON HOSPITAL	1.42	51.6%	35.5%	3.2%
NEVILL HALL	0.96	38.5%	7.7%	0.0%
NEWARK HOSPITAL	0.48	10.0%	0.0%	0.0%
NEWCASTLE GENERAL	1.70	73.9%	34.8%	0.0%
NEWHAM GENERAL	4.29	95.7%	82.6%	52.2%
NINEWELLS, DUNDEE	1.19	25.0%	25.0%	0.0%
NORFOLK & NORWICH	0.80	42.1%	5.3%	0.0%
NORTH HAMPSHIRE NHST TRUST	1.60	53.6%	25.0%	17.9%
NORTH MANCHESTER GEN	2.52	77.8%	66.7%	22.2%
NORTH MIDDLESEX	4.81	80.0%	55.0%	35.0%
NORTH TEES GENERAL HOSPITAL	1.20	60.0%	40.0%	0.0%
NORTH TYNESIDE GEN	1.57	66.7%	33.3%	0.0%
NORTHAMPTON GEN	2.06	76.5%	41.2%	5.9%
NORTHWICK PARK & ST MARK'S	8.78	94.7%	89.5%	57.9%
OLDCHURCH, ROMFORD	2.99	81.5%	59.3%	33.3%
ORMSKIRK & DISTRICT GEN	2.31	80.0%	60.0%	13.3%
PERTH ROYAL INFIRMARY	0.62	28.6%	0.0%	0.0%
PILGRIM, BOSTON	3.72	100.0%	100.0%	0.0%
PINDERFIELDS	1.10	57.1%	7.1%	0.0%
PONTEFRACT GEN INFIRMARY	1.35	71.4%	14.3%	0.0%
PRESTON ACUTE HOSPITAL	1.45	66.7%	33.3%	0.0%
PRINCE CHARLES	2.77	75.0%	68.8%	31.3%
PRINCE PHILIP	1.42	100.0%	0.0%	0.0%
PRINCESS ALEXANDRA HOSPITAL	3.00	80.8%	46.2%	26.9%
PRINCESS MARGARET HOSPITAL -	3.09	88.9%	88.9%	22.2%
PRINCESS OF WALES	3.82	77.8%	72.2%	50.0%
PRINCESS ROYAL HOSPITAL	0.80	33.3%	0.0%	0.0%
Q ELIZABETH II, HERTS	2.25	68.2%	45.5%	22.7%
QUEEN ELIZABETH THE QUEEN	3.26	72.0%	48.0%	32.0%
QUEEN ELIZABETH UH,	1.27	41.2%	29.4%	0.0%
QUEEN ELIZABETH, GATESHEAD	1.17	56.3%	6.3%	0.0%

QUEEN MARGARET HOSPITAL	1.00	45.5%	18.2%	0.0%
QUEEN MARYS SIDCUP	3.12	88.9%	77.8%	33.3%

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Waiting Time versus Hospital for period 29 January 2000 to 31 January 2000

		Waiting Time		
Hospital	*Average*	*% > 1*	*% > 2*	*%> 4*
QUEEN'S MEDICAL CENTRE	2.05	70.2%	40.4%	10.5%
QUEENS HOSPITAL - BURTON	4.06	62.5%	50.0%	33.3%
RAIGMORE, INVERNESS	2.75	100.0%	100.0%	0.0%
ROCHDALE HOSPITAL	1.92	60.0%	50.0%	10.0%
ROYAL ABERDEEN CHILDRENS	0.25	0.0%	0.0%	0.0%
ROYAL ALBERT EDWARD	2.11	68.4%	39.5%	15.8%
ROYAL ALEXANDRA HOSPITAL	1.28	44.4%	11.1%	0.0%
ROYAL BELFAST HOSPITAL FOR	2.19	84.6%	69.2%	7.7%
ROYAL BERKSHIRE	2.13	72.7%	45.5%	18.2%
ROYAL BOLTON HOSPITAL	2.79	65.0%	50.0%	30.0%
ROYAL CORNWALL, TRELISKE,	2.99	90.9%	81.8%	18.2%
ROYAL DEVON & EXETER	1.82	72.2%	38.9%	5.6%
ROYAL GWENT - NEWPORT	2.12	72.7%	31.8%	13.6%
ROYAL HAMPSHIRE COUNTY	2.43	68.8%	56.3%	18.8%
ROYAL HOSP FOR SICK CHILD,	1.53	66.7%	44.4%	0.0%
ROYAL HOSPITAL FOR SICK	1.11	50.0%	0.0%	0.0%
ROYAL INFIRMARY, EDINBURGH	1.45	58.1%	32.6%	0.0%
ROYAL INFIRMARY-STAFFS	1.72	64.0%	40.0%	8.0%
ROYAL LANCASTER INFIRMARY	0.89	40.0%	0.0%	0.0%
ROYAL LIVERPOOL UNIVERSITY	3.89	82.9%	62.9%	45.7%
ROYAL LONDON	2.18	59.1%	45.5%	18.2%
ROYAL SURREY COUNTY	14.40	87.5%	81.3%	68.8%
ROYAL SUSSEX COUNTY	3.39	76.3%	55.3%	28.9%
ROYAL VICTORIA HOSPTIAL -	2.26	77.5%	55.0%	12.5%
ROYAL VICTORIA, FOLKESTONE	0.23	0.0%	0.0%	0.0%
RUH BATH TRUST	2.84	89.3%	60.7%	28.6%
RUSSELLS HALL HOSPITAL	2.33	79.5%	52.3%	13.6%
SCARBOROUGH GENERAL	1.64	50.0%	50.0%	0.0%
SCUNTHORPE	0.98	58.3%	8.3%	0.0%
SELLY OAK BIRMINGHAM	3.45	90.9%	81.8%	45.5%
SOLIHULL HOSPITAL	1.22	53.3%	13.3%	6.7%
SOUTH TYNESIDE DISTRICT	1.18	60.0%	10.0%	0.0%
SOUTHEND DISTRICT HOSPITAL	2.83	91.7%	66.7%	33.3%
SOUTHERN GEN, GLASGOW	1.15	47.4%	26.3%	0.0%

SOUTHMEAD HOSPITAL	1.81	53.3%	40.0%	6.7%
SOUTHPORT & ORMSKIRK	1.55	50.0%	22.2%	11.1%

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ST GEORGES, TOOTING	3.55	80.0%	72.0%	52.0%
ST HELIER	2.78	69.6%	60.9%	21.7%
ST JAMES, UH LEEDS	2.18	100.0%	42.9%	0.0%
ST JOHNS, WEST LOTHIAN	1.29	56.3%	31.3%	0.0%
ST MARY'S HOSPITAL - LONDON	4.00	95.5%	81.8%	31.8%
ST MARYS, ISLE OF WIGHT	1.32	60.0%	33.3%	0.0%
ST PETER'S HOSPITAL- SURREY	3.01	80.6%	66.7%	36.1%
ST THOMAS	3.27	85.7%	60.7%	35.7%
STAFFORDSHIRE GEN	2.26	88.9%	66.7%	0.0%
STAMFORD HOSPITAL	0.72	33.3%	11.1%	0.0%
STEPPING HILL	2.07	60.0%	30.0%	20.0%
STIRLING ROYAL INFIRMARY	1.29	70.0%	20.0%	0.0%
STOBHILL GENERAL, GLASGOW	1.00	37.5%	12.5%	0.0%
STOKE MANDEVILLE	2.14	63.2%	39.5%	15.8%
SUNDERLAND ROYAL	1.71	66.7%	46.7%	0.0%
TAMESIDE GEN	2.38	66.7%	55.6%	22.2%
TAUNTON & SOMERSET HOSPITAL	0.41	0.0%	0.0%	0.0%
THE ROYAL OLDHAM HOSPITAL	2.24	75.0%	50.0%	8.3%
TRAFFORD GEN	3.01	72.7%	54.5%	36.4%
TYRONE COUNTY HOSPITAL	0.45	0.0%	0.0%	0.0%
UCH	2.28	73.3%	43.3%	20.0%
ULSTER HOSPITAL	2.60	72.7%	54.5%	27.3%
UNIVERSITY HOSPITAL OF WALES	2.04	65.1%	44.2%	11.6%
UNIVERSITY HOSPITAL- LEWISHAM	2.56	80.0%	61.8%	18.2%
VALE OF LEVEN HOSPITAL	0.65	20.0%	0.0%	0.0%
VICTORIA HOSPITAL - KIRKCALDY	1.58	75.0%	25.0%	0.0%
VICTORIA INFIRMARY - GLASGOW	0.64	12.5%	0.0%	0.0%
W CORNWALL, PENZANCE	1.10	54.5%	18.2%	0.0%
WALSGRAVE (CHILDREN'S EAU)	1.40	100.0%	0.0%	0.0%
WANSBECK GENERAL HOSPITAL	1.41	73.3%	26.7%	0.0%
WARRINGTON HOSPITAL	2.65	80.0%	66.7%	13.3%
WARWICK- SW TRUST	0.44	11.1%	0.0%	0.0%
WATFORD GENERAL	9.10	94.4%	88.9%	66.7%
WEST MIDDLESEX UNIVERSITY	2.95	94.1%	64.7%	23.5%

WEST SUFFOLK HOSPITAL	1.39	62.5%	25.0%	0.0%
WEST WALES GENERAL HOSPITAL	1.39	33.3%	33.3%	0.0%

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WESTERN INFIRMARY, GLASGOW	1.62	50.0%	44.4%	5.6%
WESTON GENERAL HOSPITAL	0.73	33.3%	0.0%	0.0%
WEXHAM PARK	3.07	73.3%	56.7%	26.7%
WHIPPS CROSS	5.20	88.4%	79.1%	62.8%
WHISTON	1.66	60.4%	33.3%	10.4%
WHITEABBEY HOSPITAL	0.73	25.0%	8.3%	0.0%
WHITTINGTON	2.92	70.6%	41.2%	23.5%
WITHYBUSH GEN	0.32	0.0%	0.0%	0.0%
WORCESTER ROYAL INF	1.82	55.0%	40.0%	15.0%
WREXHAM MAELOR TRUST	2.10	64.7%	35.3%	11.8%
WYTHENSHAWE	3.14	84.6%	84.6%	23.1%
YEOVIL DISTRICT HOSPITAL	2.14	57.1%	42.9%	28.6%
YORK HOSPITAL	1.64	75.0%	37.5%	0.0%
YSBYTY GWYNEDD, BANGOR	2.03	75.0%	31.3%	12.5%
Totals				