West Middlesex University Hospital
Urgent and Emergency care
Enter & View Report

Healthwatch Richmond
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healthwatch Richmond upon Thames

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Introduction

In August 2019, Healthwatch Richmond conducted four Enter and View visits to Accident & Emergency and Urgent Care Centre (UCC) at West Middlesex University Hospital. This Hospital is part of Chelsea and Westminster Hospital NHS Foundation Trust. The lead provider of the UCC is Hounslow and Richmond Community Healthcare (HRCH) alongside Greenbrook Healthcare as a sub-contractor. Throughout the report A&E will be referred to as the Emergency Department (ED). This report details the feedback we received from patients/relatives and staff, as well as the observations made by our team.

Healthwatch Richmond is the independent NHS and social care watchdog for residents in the London Borough of Richmond upon Thames. We help to shape, challenge and improve local health and social care services. Healthwatch Richmond was set up by the Health & Social Care Act of 2012. The Act and its regulations granted Healthwatch the power to:

1. Enter and View premises that provide health and/or adult social care services.
2. Request information from health and social care providers and receive a response within 20 days.

The reports for Healthwatch Richmond's Enter & View visits can be found on our website - www.healthwatchrichmond.co.uk - or are available from our office. Please contact us on 020 8099 5335 or info@healthwatchrichmond.co.uk for further details.

Background

In 2018 we decided to conduct a review of the Urgent and Emergency care services available to residents in the Borough of Richmond upon Thames. This project was undertaken as throughout 2017, a high proportion of the feedback we received related to Urgent and Emergency care. We have previously visited the Emergency Department at Kingston Hospital and the Urgent Treatment Centre at Teddington Memorial Hospital; the reports are available on our website (www.healthwatchrichmond.co.uk). To complete our work in this project we carried out a series of visits at West Middlesex University Hospital.

The ED and UCC at West Middlesex University Hospital is open 24 hours a day, seven days a week. ED is for seriously ill patients with critical or life threatening emergencies either as a result of an accident or a medical/surgical emergency. If you are less seriously ill, but still require urgent treatment, you will be seen in the UCC. The UCC provides care for patients with a minor injury/illness or condition that is not critical or life-threating. They can treat sprains, broken bones, bites or stings, as well as assess and treat wounds. They can access a range of tests, and refer patients with acute conditions to specialists.

Our primary aim was to gain an understanding of service quality based on patient feedback and, if appropriate, make recommendations about how the services may be improved. Secondly, we aimed to find out why people choose to attend these services and whether they were aware of the alternatives.

Clinical Streaming

Patients walking into the Department register first with the co-located UCC desk, if the patient is considered to have a serious medical problem that needs immediate attention they are sent through to the ED reception for triaging. Otherwise the patients are seen by an Emergency Nurse Practitioner for 'clinical streaming' this is a process where the patient is assessed and will occur within a 20 minute target. Based on this assessment the patient is either streamed to the UCC for minor illnesses or injuries or more seriously unwell patients are streamed to the ED. A third group of patients presenting at the Department are redirected to a different, more appropriate, health service. A member of staff called the Patient Champion can assist patients with registering with a GP if they aren't already, booking a GP appointment, and providing health promotional information.

This process is under the responsibility of, and is carried out by, the UCC staff. If a patient is streamed to the ED they then need to register at the ED reception desk and wait for triage.

Urgent Care Centre (UCC)

As previously mentioned, the lead provider for the UCC is HRCH but it is sub-contracted to Greenbrook Healthcare. In terms of staff employment, HRCH employs the Nurses and Receptionists, and Greenbrook Healthcare recruits the Doctors, Bank/Agency staff, Administrative staff and the Service Director. The UCC is currently seeing and treating an average of 230 patients per day. In addition to the waiting room, registration and streaming desks, the UCC has a clinical area and this is made up of three cubicles and nine private consulting rooms.

Emergency Department (ED)

The Department has different areas for treating patients depending on their needs. It sees over 6,000 patients a month with serious and life threatening emergencies. A resuscitation area has four bays in which one bay is designated for use with children. This area has full facilities for resuscitating critically unwell patients, for example a patient with a serious injury. There are 28 cubicles and rooms in Majors, a six bed Observation Unit and a Clinical Decision Unit for seated patients awaiting test results (maximum 12 patients). A separate paediatric ED has its own waiting area and nine patient bays, including one bay that can be used for a child stepping down from the resuscitation area. The paediatric ED deals with emergency attendances for young people up to age 16. It is Trust policy that 16 year olds who do not have complex needs or conditions attend the adult ED.

The ED and UCC can be found at the following address:

West Middlesex University Hospital
Twickenham Road
Isleworth
Middlesex
TW7 6AF

Methodology

Prior to undertaking our visits, we carried out a comprehensive review of pre-existing patient data on both the ED and the UCC. This included:

- Healthwatch Hounslow reports on UCC (2017)
- Latest CQC reports from most recent inspections: ED (2017/18) and UCC (2018)
- Patient reviews left on the NHS website
- Our patient experience database from January 2018- July 2019

This preliminary research, alongside our discussions with the Hospital, helped us to decide on the areas of particular interest. We carried out semi-structured conversations with patients on the pre-agreed topics of interest but also allowed patients to lead according to their individual experiences shown in 'Appendix 1- Patient questions' (page 29). We anticipated that some patients in the waiting room would be at the start of their visit in the Department, therefore to ensure we could collect the patient's full experience we prepared a follow up survey shown in 'Appendix 2- After your A&E/UCC visit' (page 30). During the visits we sought consent to contact the patient through their preferred contact method (by post, email or telephone) with the survey about a week after our visits.

We also used a pre-prepared checklist shown in 'Appendix 3 - Observation checklist' (page 31) to guide our own observations throughout the visits. We developed a list of questions for staff members shown in 'Appendix 4- Staff questions' (page 33). We produced a paper survey after realising that our opportunity to speak to staff during our visits would be

limited. Paper surveys were placed in the staff rooms of both the ED and UCC, and to protect anonymity a lockable post box was provided for the completed surveys. The surveys and box were *in situ* for one week to allow staff to complete a survey at the convenience.

After liaising with Greenbrook Healthcare and West Middlesex University Hospital, the timings of the visits were planned for when the Department was likely to be busy:

Monday 16 August 2019: 9:00- 11:00 and 19:00- 21:00

Friday 19 August 2019: 15:30- 17:30 and 19:00- 21:00

Posters were displayed in the Department prior to our visits to advertise our presence to patients and staff. Our Enter and View authorised representatives maintained an ongoing presence in the Department's waiting room and we also accessed the following areas in the ED: Majors, Observation Unit and Clinical Decision Unit. We were not able to speak to patients in Resus as these patients were not suitable to be interviewed.

The visit was planned in accordance with Healthwatch Richmond's Enter and View Policy and undertaken in the spirit of partnership and openness. Each visit was conducted by a team of Healthwatch Richmond's Enter and View authorised representatives and led by a member of staff. Enter and View authorised representatives undergo a thorough recruitment process that includes the completion of: a written application, references and interview; DBS check; and relevant training in safeguarding adults and conducting Enter and View visits.

Analysis

We spoke to 40 patients from the UCC and 38 patients from the ED. We gained consent from 18 patients for the follow up survey to which we had nine responses. In addition to the Service Director and two ED matrons with whom we had regular contact, we collected feedback from seven UCC members of staff and nine ED members of staff.

The useable, qualitative data we collected was analysed as follows:

1. Individual comments and observations were assigned a sentiment (e.g. positive, negative or insufficient data).
2. The experiences were separated according to the overarching 'themes'.
3. The frequency, specificity, emotion and extensiveness of individual issues were examined. A descriptive summary was then prepared for each theme.

The feedback from the follow up survey was also incorporated into the resulting themes. The overall results were reviewed, conclusions drawn and recommendations made.

Limitations

The experiences and observations in this report relate to four visits conducted by Healthwatch Richmond. The report cannot be representative of the experiences of all patients, relatives and staff; only those who were able to contribute within the restricted time available. While every attempt has been made to provide a sense of scale to the issues raised by patients, the employed methodology does not allow for issues to be robustly quantified.

We visited in August which is a quieter period for the ED but this was necessary due to CQC activity planned for the Autumn. Due to the CQC activity the timeline for these visits was moved forward by two months reducing the time available for the planning period.

The number of patients who provided consent to be contacted with the follow up survey was lower than hoped for, however a 50% response rate to the survey showed that those who consented were motivated to participate.

Environment of shared waiting room

We had 11 responses about the waiting room environment, out of these 9 comments were positive. Two patients described it as *"good"* and a patient commented on the positive changes to the Department since their last visit a year ago, *"the Department is much bigger, nicer and more organised"*. During our visits we agreed that the Department was well lit and well presented.

However some patients felt that the waiting room could be more comfortable. One said that it was *"very warm"* and another described the wooden seats in the waiting room as *"very hard for a long wait"*. During our visits we also thought that the seats would not be comfortable for long periods. Additionally, seating at different heights had not been provided to ensure suitable seating for patients with different needs, for example some patients may find it hard to sit at a low level.

The other concern we had in the waiting area was the presence of nine broken seats. The seats were broken on the first day of the visits and had not been fixed when we concluded our work six days later. This is a considerable amount of time for a significant number of seats to be out of use. Six of these broken seats were in the ED waiting room. As there is limited seating in that area this is a considerable proportion of the total available. During one evening visit we observed patients and relatives being forced to stand in the ED waiting room as there were no seats remaining. Four ED streamed patients told us that there were not enough seats in the waiting room due to the broken chairs. One member of staff reported that due to the lack of seating *"many people will stand and some will sit on the floor"*. It is therefore clear that people would also have had to stand at other times when we were not present.

Recommendation: Due to the large numbers of chairs that were broken, the fact that they were observed and reported to be uncomfortable, and the fact that people are not always able to sit whilst waiting for admission to the ED we are not assured that the seating in the ED is fit of purpose. We therefore recommend that the Hospital:

- review the seating in the waiting room and ensure that comfortable, reliable seating is provided
- set up a process that ensures that broken chairs are fixed in a timely manner

Response: The providers told us:

"There is a process for reporting estates issues such as these. At times this can be problematic for the UCC due to cross charging and lack of account numbers. However, in the instance of shared areas this would be escalated to Trust colleagues to support.

In ED there is a reporting system for broken equipment, and there is a Matron's weekly walk around of the department where issues will be picked up and escalated further.

Additional seating has been added to the ED waiting room."

Further recommendation: Whilst it is good that additional seating has been added, and this will go some way to mitigating the challenges, it is still unclear if a process to enable chairs to be fixed in a timely manner has been put in place. We therefore ask the providers to work towards achieving this.

Provision of food/drink

There is a vending machine for hot and cold drinks, and food available in the waiting room. The water dispenser was in the corner and due to its small size and small height it was not very obvious to patients. One patient did not know where to get water and asked one of our Enter and View authorised representatives for help. All other patients that were asked knew where to get food/drink if they needed some.

Cleanliness

The Department was clean and we observed cleaning staff carrying out their duties during our visits. The toilets have regular cleanliness checks and a patient we asked felt that the *"facilities were clean including the toilets"*. However one patient reported that there was litter in the waiting room and we observed a ladies toilet located in the waiting room that was in need of cleaning.

There were two hand sanitiser dispensers available in the UCC waiting room but were not positioned in easily seen locations and we did not see the hand sanitisers being used. There was a hand sink that was available for staff to wash their hands.

Accessibility to the Department

The Department where the UCC and the ED is located is accessible up a sloped ramp. The Department is clearly signposted from the Hospital entrance on Twickenham Road. The entrance was level and wide to allow for easy access of wheelchairs and mobility scooters. There was room to move around the reception area but the waiting area was more confined. Patients in wheelchairs might be limited with where they could wait.

There appeared to be a problem with providing mobility aids to patients. One patient said that they were unhappy with the doctor they saw as when they asked for a walking stick they were reportedly refused one. They also asked at reception and they weren't given one. The patient felt *"that as an older person they did not receive the same concern as a younger patient"* and that the staff came up with excuses not to give them a walking stick.

The patient champion said they have to hide at least one wheelchair in the UCC otherwise they go missing and they need access to one in case a patient can't walk. Therefore the Department may need to look at a more secure way to store wheelchairs so they can always know there is a wheelchair available.

We asked the Hospital to take steps to ensure that mobility aids including wheelchairs can always be obtained for people who might need them. The Hospital told us that *"Patient Champions asked to ensure that a wheelchair is always available"*.

Further recommendation: The initial response does not provide us with assurance that mobility aids and wheelchairs will be available to patients. We therefore ask the providers to take appropriate action for good wheelchair storage and to provide assurance on this within 3 months of the date of publication.

There are 17 disabled parking spaces in car park P2 which is the closest to the Department. Disabled patients do face an upward slope to access the hospital entrance that may be challenging. The Hospital told us that estates would facilitate wheelchair access to the Department.

Another patient expressed anxiety over the car parking charges, their stay in A&E was long and they were worried the car parking charges would be so high that they might not be able to pay. They felt that car parking company should take this into account and waive the fee for those in the ED where the duration of the stay is unknown. The worry this patient had about parking charges was *"unnecessary"* in addition to the stress of being in the ED. They told us that the worry would be lessened if the charges for car parking was well-advertised in and around the Department so they would know the maximum fee.

In response to this the Hospital told us that there is no cap on car parking charges but that patients are encouraged to access the hospital via public transport which is signposted via the Trust's literature and on the internet. They have placed a poster in the waiting room to remind patients of charges and where to pay.

Clinical Streaming

Clinical streaming is the process of assessment after arrival in the Department that is performed within 20 minutes for adults and 15 minutes for children. It involves taking a brief history and, if appropriate, performing basic observations. This is then used to determine if a patient will be seen in the UCC (minor illness/injury) or the ED (major illness/ injury) and what priority the patient is seen in. We asked patients from both the Urgent Care Centre (UCC) and the ED for their feedback about the streaming process they experienced after arriving at the Department.

Waiting times for streaming

We asked people how long they waited to see the Emergency Nurse Practitioner for streaming. 12 out of 13 patients said that they were streamed within 20 minutes, almost half of these patients (five patients) were seen by the Emergency Nurse Practitioner in less than five minutes. One patient told us that he/she waited for 30 minutes without seeing the Emergency Nurse Practitioner before raising concerns about worsening chest pains at the reception desk.

Feedback about staff

All the UCC streamed patients we asked (16 out of 16 patients) thought the UCC receptionists were friendly and helpful. One patient also commented that *"they asked too many questions"* which they thought caused unnecessary panic however they still gave a positive feedback. Out of the ED streamed patients, 14 out of 15 felt the ED receptionist was friendly and helpful. The staff we observed during our visits at the UCC and ED reception appeared to be helpful and caring towards the patients. Some patients spoke positively of the staff members *"[the] streaming process was polite, courteous and respectful"* and *"very nice"*. There was one negative comment about an Emergency Nurse Practitioner who was described as *"abrupt and unhelpful"*.

Was the process straightforward?

31 out of 37 patients felt the process of registering and streaming was easy to understand. Patients reported it was clear what they needed to do when they arrived in the Department and this was due to good information provided by staff and clear signage. One patient reported that they *"walked in and found the registering process straightforward"*, and a patient was happy with the *"quick turnaround of [the] check in process"*. Another patient found the process straight forward as there was no queue on arrival. Four (of these 37) patients had previously used the service so the process was already known to them. One patient did express confusion after arriving at the ED and reported that *"they walked around to find a sign as the entrance to the Department did not feel like an A&E"*.

A patient had arrived at reception, was registered and told to take a seat. After a 30 minutes wait without having a streaming assessment, family members raised concerns with reception regarding the patient's chest pains. The patient was then streamed directly to the ED. It is possible this patient may have misunderstood the instruction from the staff member and this is highlighted further in section 'Confusion around re-registering with the ED' (page 9). Another patient found the streaming process very frustrating as they had a letter from their GP sending them to the ED. Despite this the ED receptionist sent them for streaming in the UCC. They felt this receptionist was mistaken in not accepting their GP's letter. After seeing the Emergency Nurse Practitioner they were sent straight back to the ED, the patient felt there were unnecessary steps in this non-straightforward process and that it *"shouldn't be about following protocols"*.

Recommendation: We asked the Hospital what should happen when a patient presents to the ED reception when referred to the ED by their GP.

Response: The providers told us that:

"Not all patients sent to the UCC/ED need ED support; some of these patients can be managed in the UCC and referred to a Specialty team if required. Patients are booked in and streamed by UCC if their letter is not addressed to a Specialty team and they are not critically unwell.

The UCC has asked for the CCG to support in developing a standardised referral letter in order that community GPs can adopt a standardised approach to referring to Speciality teams to reduce any ambiguity.

From 09/12/2019 all children under 16 years of age who have been seen by their own GP with an illness and have a letter will be 'waved through' to ED.

Once these patients have come through to ED, we have fast track systems for surgical patients to Surgical Assessment Unit and medical referrals will be fast track to Acute Medical Unit, dependant of clinical conditions and beds permitting."

Patients also reported confusion about what would happen during and after the streaming process, further information is found in section 'Urgent Care Centre: Patient Information' (page 12). These experiences are typified by one patient who said they had been told to *"have a seat"* by the Emergency Nurse Practitioner but did not know the next step.

Recommendation: Given that significant numbers of patients are unclear about what is going to happen next we asked the Hospital to ensure that patients are kept informed of what is going to happen at every step in the process.

Response: The providers told us:

"There is signage at the entrance and a comprehensive pathway poster on the wall however, it is acknowledged that enhanced clear step by step information would be helpful for some patients.

The UCC will explore additional roller banner displays to explain 'next steps' and small wall mounted posters for reception and streaming areas.

The UCC to explore if it is possible to add announcements to the large TV screen in the waiting area explaining 'next steps' and brief current public health information including seasonal information/themed health promotion.

There are large format displays throughout ED and in every cubicle to inform patients about their expected journey once they are in ED."

Further recommendation: Whilst this is an improvement, we ask the providers to remind staff to explain to patients what the next step is and to audit compliance with this.

Difficulty hearing being called for a streaming assessment

We identified concerns from several patients about being able to hear their name when called to the streaming desk. An elderly patient with a mobility aid was anxious as he/she was worried they would not be able to hear the Emergency Nurse Practitioner when they were called, this patient was asking the patients around them which name had been called. Another patient commented about the difficulty in hearing the Emergency Nurse Practitioner when they call you forward. We observed it could be hard to hear staff calling you forward when the waiting room is noisy. Two patients suggested that a sign which flashed up the patient's name as they are being called by the staff would be helpful.

Confusion around re-registering with the ED

Staff told us that patients streamed to the ED get confused and can't understand why they are then being sent to re-register at the ED desk. This was confirmed by feedback from three patients and our own observations. We observed that it was insufficiently clear to patients when they are directed by the UCC receptionist, or streamed to the ED that they need to re-register at the ED reception. Therefore there is a risk that patients are facing delays as a result of this lack of clarity and consideration should be given to clarifying or ideally removing the need to re-register.

During our visits a patient had an experience of being streamed to the ED but failing to re-register at the ED desk. They were sat in the ED waiting room for 30 minutes before a staff member approached to ask what they were doing there. They found the process and communication about it *"not clear and confusing"*. They were frustrated as they had now wasted 30 minutes of their time.

A further patient who reported waiting for 30 minutes without being seen by the Emergency Nurse Practitioner described a situation where they should correctly have been directed to the ED in the first instance. It is therefore unclear whether this person was indeed waiting to be streamed for 30 minutes or whether they might instead have been sent to the ED reception on presentation but misunderstood the instruction.

At times during the visits, we observed two or three people waiting at the ED reception with one member of reception staff on duty. This appeared to be a bottleneck during the process of streaming. This area was in a confined space that meant, if there was a queue, the level of privacy was reduced for patients at the desk. There was nowhere for a patient to sit down if they felt unwell, and multiple times we observed patients struggling to stand in this queue.

Recommendation: There is a need to address the confusion around needing to re-register at the ED reception desk and also to address the issue of the queue to improve patient flow through the system.

Response: The providers told us:

"Unfortunately, there is no possible IT work around given the two different operating systems.

Different coloured paper is now in use at Streaming to ensure that the chance of patients sitting in ED waiting area without registering is minimised (bright yellow).

Once patients are in the ED system the patients will follow the ED journey, Staff are reminded to update patients at regular intervals through their time in ED with the next steps of the process."

Further recommendation: Whilst we recognise the technical challenges faced by providers we believe more can be done to avoid the confusion that patients have described over the need to register a second time at the ED reception. We therefore recommend that providers set out further signage, perhaps with a floor or eyelevel trail, to a clearly signposted the ED reception point. This would both support patients to take the necessary action and prompt staff to direct them to the ED reception.

Problems with the layout of the streaming desk

Lack of seating

At the streaming desk there is nowhere for the patient to sit down as they are being assessed by the Emergency Nurse Practitioner. The lack of seating was particularly challenging for a parent attending with a child under three years old. They balanced the child on the counter of the desk to allow the Emergency Nurse Practitioner to see them. We also observed patient having observations being taken while the patient was standing

such as the pulse oximeter. Another patient with a head injury was having difficulty standing through the whole process of registering and streaming. A patients said that walking back and forth between registration and streaming desks had been challenging due to their head and neck injury.

Dignity and privacy

An Emergency Nurse Practitioner made the suggestion to have a cubicle for streaming assessments which would be more private and help reduce the background noise from the waiting area. Our Enter and View authorised representatives also thought that the level of privacy allowed during this process could be considered low.

One patient felt that *"no one could overhear"* during streaming however another said that the streaming area is *"too open"* and *"not private"*. The patients stood on the other side of the desk from the Emergency Nurse Practitioner forcing the conversation to be at a higher volume. During our visits our observations were that the streaming desk did not sufficiently maintain the dignity and privacy of patients.

Recommendation: We asked the providers to change the streaming assessment area into a cubicle style that would allow patients to more easily speak to Emergency Nurse Practitioner and to provide a seat for patients.

Response: As a result of this the providers set up acoustic side panels in the streaming kiosks to improve privacy, put up signs offering a more private assessment for any patient that wanted further privacy and placed chairs in streaming kiosk so that patients can sit should they need.

We welcome these improvements and look forward to seeing them in due course.

Staff feedback

We spoke to a total of 16 members of staff across the ED and the UCC.

Urgent Care Centre staff

Three Emergency Nurse Practitioners who responded to the staff survey felt the streaming system worked well. The Emergency Nurse Practitioner *"felt able to stream very ill patients quickly for urgent attention"* and another felt *"it is efficient. Well placed. Uses [her/his] skills"*.

Another staff member felt that streaming is challenging for reception staff but thought that the Emergency Nurse Practitioners are approachable for guidance to ensure this staff member could send patients on the correct pathway. It was reported that the patient's emotional stress during streaming can get very difficult to manage. Patients rush up to the desk with concerns and this *"slows down the process"*. The staff member thought the Patient Champion is a useful role to help with this as they can respond to patient queries/questions and free up the reception staff.

A staff member reported to us that NHS111 will direct patients to the UCC and will often tell patients that they need to be seen within one hour. This is not always possible in the UCC and patients are not happy when this happens. The staff member thinks it is misleading of NHS111 to tell patients this. The staff member reported that patients will get streamed when they arrive and will be seen based on priority, and as a result doesn't feel the patient is in any danger.

ED staff

The feedback from ED staff about the streaming process was more negative than staff from the UCC. We were told that *"patients who are direct referrals to specialist teams are sometimes not sent directly to the ED"*. The staff member reported this caused a long wait for these patients. Another staff member felt that there were delays for sicker patients to reach the ED as the UCC *"will stream but do not do a meaningful assessment"*.

Feedback provided by a staff member thought the Emergency Nurse Practitioners were predominately adult nurses and *"were not confident assessing children"*. Therefore they did not feel the streaming process was working for paediatrics. Our understanding is that a discussion to change the paediatric streaming pathways has occurred at a meeting between Hospital and Greenbrook Healthcare senior staff however plans are still in their infancy.

At the end of the interview/questionnaire we asked staff to suggest improvements that would mean they could provide a better service. Two comments (out of five) wished to have more control over streaming for the Department. The staff members told us to get the *"ED to run UCC and manage streaming"* and the stronger view of *"get rid of UCC"*.

Patient Champion

The UCC has a Patient Champion who can answer patient queries, help patients to register at a GP practice if they attend the service unregistered, and can book GP appointments for the patient if needed. This is a fantastic role that can improve the experience of patients in the UCC but patients would find it hard to know what this role did unless they were directed there by another member of staff. The desk is partially obscured by a pillar with only a small sign giving the job role.

Two of our visits took place whilst the Patient Champion was working. We did not observe the Patient Champion interacting with any patients during this time and no patients provided feedback about having spoken to the Patient Champion. Our observations recorded that during this time some of the patients in the waiting areas were observably upset and in need of support and we were unclear as to whether the Patient Champion's role would include supporting patients in the waiting room.

Allocated slots are supposed to be held specifically for UCC patients to be able to be redirected back to a GP appointment. A Patient Champion member of staff reported that this system doesn't work effectively because few Richmond GP surgeries have signed up to this and whilst, most practices in Hounslow have, the allocated slots are not always kept open for them to book appointments for patients. GP practices do not always answer when the Patient Champion calls them and do not always call back. This limits the number of patients who can be streamed away from the UCC.

Recommendation: The Patient Champion role should be better highlighted to patients. The desk should be more visible, approachable and welcoming to patients. The Patient Champion should proactively engage with patients, perhaps undertaking intentional rounding when not actively engaged with patients.

Response: The providers told us that:

"The expectation is that the patient champion is a visible welcoming presence in the waiting area and this feedback will be incorporated into on-going development.

Signage is being designed with support from the CCG to advertise the role the patient champion plays in accessing primary care (GP) facilities."

Feedback about the Urgent Care Centre

We spoke to a total of 40 patients who had been streamed to the Urgent Care Centre (UCC) and their feedback is incorporated in the sections below.

During our visits we mainly spoke to patients in the waiting room who had not completed their visit and could not provide complete feedback. Therefore to help combat this problem we asked patients for their consent to send them a follow up survey a week after their visit to collect their full experience. The survey is provided in 'Appendix 2' (page 30). The feedback provided is incorporated into the sections below.

Reason for choosing service

We asked patients if they had contacted another health service (for example their GP or NHS111) before attending the UCC. We wanted to gauge how patients were using the service and how informed they were about alternative Urgent and Out of Hours services available.

Table 1 shows the breakdown of patients who did or didn't contact a service before attending. There was a similar number of patients who didn't contact any service beforehand versus those that did. The breakdown of the service that they contacted is then shown in Table 1, GP (primary care) was overwhelmingly the most common service that patients contacted before coming to the UCC.

Table 1: Patients who did/didn't contact a service before attending UCC with a breakdown of the service contacted

	No. of patients		**No. of patients**
Contacted service before attending	14	Did not contact /attended on their own decision	12
Breakdown:			
GP	11		
NHS111	1		
Urgent Treatment Centre	1		
Ambulance	1		

Four patients who did not contact a service and came straight to the UCC, were not aware of any other options as they attended outside of GP working hours. One patient felt the wait for a GP appointment was too long so they often used the UCC service instead. Three patients felt that the UCC had a specialised service (e.g. x-ray, plaster casts) that they needed, therefore they had no choice but to go there. The final four patients did not indicate why they had chosen to not contact another service.

Patient information

10 out of 17 patients were positive when asked if they have been given information on what will happen next in their assessment and treatment. They knew the next steps and felt informed about the process.

The seven negative respondents felt they had not been told what to expect next. Two out of seven negative responses were from patients waiting to be streamed while the remaining five patients had been seen by the Emergency Nurse Practitioner and were waiting to be seen. One patient reported they had been told to *"have a seat"* by the Emergency Nurse Practitioner but did not know the next steps. Two patients shared the

sentiment of feeling like they were low priority in the queue, for example a patient felt the staff thought [their condition/illness] is minor but to him/her it is not minor.

There was a patient journey sign in the waiting room that detailed the steps in the process. This was positioned on the wall behind some chairs in the waiting room and was not easily readable from a distance away because of the volume of text. Whilst the information is available it may not be well used by patients. There was a sign that indicated that multilingual services are available. For patients streamed to the UCC the relevant PALS department is HRCH PALS and not the Hospital's PALS department. Since the waiting room is shared with the ED the HRCH PALS was not signposted in the waiting room but was signposted in the UCC's own clinical area.

It would be helpful for patients if there was a sign that indicated the number of Emergency Nurse Practitioners and GPs on shift that day/night (expected vs actual numbers). This could help manage expectations of the patients and it also demonstrates transparency.

We observed that when patients entered the queue for the reception desk they did not always stand behind the line despite the sign on the floor and the signs on the reception desks. During our visits we observed reception staff directing members of the public back behind the line on several occasions. Maintaining this distance is important for protecting the patient's privacy during the registration process and staff were very good about protecting this. However they would have to interrupt their interaction with the patient at the desk to tell the next patient to step back and this takes up valuable staff time.

We requested that the Hospital install a more visible sign asking patients to stay behind the line (e.g. a freestanding or ceiling hung sign) to ensure that this line is respected. The Hospital informs us that the signs have been requested and are being costed.

Waiting times

Most commonly patients told us that they had been waiting more than one hour but not more than two hours. Only one patient we spoke to told us they had waited over 4 hours and they reported that other patients were complaining to staff at the time about the long wait. We asked patients what would have improved their experience and two patients suggested making the process *"quicker"* with *"less waiting"*.

Only two out of 18 patients we asked had been given an indication on how long they expect to wait; one patient was waiting to be streamed while the other was waiting to see the doctor. The feedback collected from a staff member told us that reception staff will inform patients about the waiting times when the UCC is really busy to manage patient's expectations but they don't routinely inform patients about the estimated waiting time.

In the follow up survey a patient waited more than four but less than five hours and this appeared to negatively impact their experience as they rated their overall experience as poor. They commented that they had approached the receptionist to get an indication of waiting time and was *"just told that [the UCC] was very busy"*.

A member of reception staff had the suggestion to have an electronic sign to let patients know the current estimated wait time in the waiting room. This sign would need to be connected with the computer system so it is updated automatically.

Recommendation: We asked the providers to consider whether they could implement a system that advised patients of approximate waiting times and whether the same system could incorporate the earlier suggestion of showing patient names to help those who struggled to hear when they were called (issue identified in Section 'Difficulty hearing being called for a streaming assessment' page 8)?

Response: The providers told us that:

"HRCH and Greenbrook have worked closely with the providers of the clinical IT system to obtain a live feed of the waiting times. This has been displayed on a large screen in the waiting room. Unfortunately as it was an average of the last 24 hours waiting times and was not split by illness and injury it proved to be inaccurate and was therefore turned off.

An alternative plan is being worked on to display number of patients in the illness and injury queues with an average wait for the last hour which is expected to be more useful and accurate. There is not currently a date for go live (discussions commenced on 9th December)."

Further recommendation: We are not assured that providers have addressed the need to have a visual cue for patients who struggle to hear when they are called by staff members. It is recommended that providers consider combining the above system with a screen advising when they are called to help address this.

Clinical staff

We asked patients during the visits and in the follow up survey if they were happy with the doctors and nurses they had seen. To this question we had nine responses, we recognise that this is a low number of patients and this is because we spoke to people in the waiting room who were often at the beginning of their journey through the UCC. Seven out of nine responses were positive, patients had *"good care"*, *"received good attention"* and a patient who had been a few times reported they were *"always happy with doctors and nurses"*.

A patient who gave negative feedback reported they were *"generally unhappy"* with the care, this patient also felt they were *"low priority"* and was very unhappy with the situation they were in. This patient had attended four times that week after being sent by their Hounslow GP surgery for daily post-operative dressing changes. These daily dressing changes are required for 6-8 weeks. The surgery has not had a practice nurse available on the previous four occasions necessitating the patient to go to the UCC. He/she was spending up to five hours per day travelling to and from the UCC and getting the dressings changed. He/she *"feels it was unnecessary pressure"* as they were not feeling well after the operation one week prior, and they have depression and diabetes.

Recommendation: This patient could have been picked up by the Patient Champion to see if alternatives are available for this patient. To have patients attending the UCC for regular dressing changes does not seem to be appropriate use of the service. We asked the providers whether this was a regular occurrence and, if so, what can be done to combat this undesirable outcome for post-operative patients.

Response: The providers told us:

"Considerable work has been done between UCC and community providers to reduce the number of patients attending the UCC for this type of care. If there is no community capacity and the patient requires a dressing change (often this type of wound has a time dependency) then the UCC will do it and attempt to book subsequent appointments in the community before the patient leaves.

Hounslow CCG and the UCC have been working closely to improve access to community establishments and extended access hubs. The UCC now has a clear escalation link within the CCG for any issues with redirection."

The second patient with negative feedback to this question felt they had a *"better service in other departments [in the hospital]"*. They reported similar feelings of being treated as low priority and they told us that they *"would like [the staff] not to assume something*

he/she is feeling is minor when it is not minor to him/her". The two negative responses seemed to both be caused by the feeling that staff were not taking the patient's problem seriously.

Communication with staff

Similarly to the feedback about the clinical staff there were not many responses when we asked if patients had been given the support they needed, and if they were happy with the explanations given about their injury/treatment. Four out of six patients felt supported and were happy with the explanations. One patient felt that *"whenever I attend I am given the support I need"*. One patient was unsure that they received the support they needed.

Pain management

When it was relevant, we asked the patient if they had been offered pain relief. Out of 8 patients who were in pain, six patients had been offered pain relief and were asked to rate their pain and two patients were not offered pain relief. Staff reported that they ask patients to rate their level of pain from 1 to 10 and this *"works well"*.

Staff feedback

We collected feedback from seven members of staff: five spoke to our Enter and View representatives and the final two staff members filled out the paper survey we provided.

Patients with additional needs

We asked staff if they felt equipped to support patients with additional needs (e.g. learning disabilities, dementia, mental health and non-English speakers). We had five responses to this question, and staff mainly reported feeling equipped to support these patients. One member of staff mentioned their years of experience would help them in that situation. They also reported that patients with additional needs mostly attended with a carer/family member who can advocate for them. A staff member had received dementia training so had particular confidence in communicating with dementia patients.

Staff told us that to support patients with limited English they had access to 'LanguageLine' but also reported that *"90% of patients will attend with someone who can translate for them"*. One new member of staff was unsure and felt that using Google Translate would help them support the patient.

Staff capacity

We asked staff if they felt that there is enough staffing capacity to safely meet patients' needs, and crucially we also asked if there are enough permanent, experienced staff. The Service Director informed us that the UCC was working at a staff vacancy rate of 50% but this is increased to 97% through the use of "regular" agency/bank or permanent staff who have been trained and know the UCC's streaming procedures are familiar with the ward.

This view was not shared by clinical members of staff. Four out of seven indicated a problem with staffing capacity of Emergency Nurse Practitioners and difficulty getting staff to cover shifts. All identified that a lack of permanent staff in this staffing group was a concern with agency and bank staff having to come in to help cover shifts. A staff member also felt that a lack of permanent staff can mean *"less loyalty and continuity"*. A staff member told us that they had to miss a Basic Life support workshop as there were not enough staff to cover. An Emergency Nurse Practitioner reported it was difficult to recruit Nurse Practitioners as very skilled nurses are needed. A member of staff told us that HRCH had not replaced Nurse Practitioners who had left, they felt that the staff had left due to the pressure and stress of the job.

When asked 'What changes could be made to help you/the department provide a better service?' three out of seven staff members identified increasing levels of permanent staff. One staff member was *"aware that recruitment is difficult"* and that there *"should be more appropriately trained staff in the UCC"*.

Just one member of staff (out of the seven that we spoke to) felt there was a *"full team of staff"* with an ability to cover due to staff sickness. This member of staff had a non-clinical role.

Recommendation: There is a reliance on agency and/or bank staff to provide cover for Nurse Practitioners and this has a clear impact on the other staff. Please can you set out what the permanent/agency staffing numbers are for the unit and what initiatives have been carried out to improve recruitment and retention?

Response: The providers told us that:

"The rota fill is consistently over 95% and this includes additional hours for times of surge/increased attendances.

A comprehensive recruitment strategy is being worked through which includes Greenbrook Healthcare running bespoke University accredited training courses which has provided 12 new Emergency Nurse Practitioners across Northwest London in 2019 with an additional 24 planned for 2020.

In addition to the above programme, Greenbrook Healthcare offers a consolidation post which will be advertising for in the New Year."

Support from senior staff

We asked staff how well they felt supported by senior staff in doing their job. Three out of four members of staff who gave us feedback confirmed that they felt supported. They told us that they had regular meetings which meant they have *"help when [they] need or ask for it"*. A member of staff felt senior staff were *"very supportive"* and *"easy to approach"*.

One member of staff did concede that senior staff were not always able to take on-board what staff are suggesting. A staff member felt that senior staff were not supportive and told us that *"it was all about blaming more than supporting which does not help in developing career"*.

System for monitoring patients

We asked staff if there is a good system for monitoring patients for deterioration and pain management. All staff who responded to this question (five members of staff) felt the system for monitoring patients worked well. Staff reported that staff in the waiting area had eyes on the patients in the waiting room and would, if necessary, find a nurse. A member of staff told us that patients can approach the reception desk and tell a member of staff themselves. The Patient Champion can also *"pick up distressed patients"*.

During our visits we observed a mother with a young baby who was visibly distressed. After five minutes a member of staff approached them and asked if they wanted to wait in the paediatric ED waiting room. A patient with a head injury was showing visible signs of difficulty during the registration process. They were seen by the Emergency Nurse Practitioner and streamed to the ED within three minutes and this did not allow this patient to deteriorate further.

Raising incidents and safeguarding concerns

Every member of staff (seven staff members) we asked felt that the UCC is good at supporting the team to learn from incidents/complaints. There were no concerns raised about reporting incidents/concerns including those related to safeguarding. A staff member told us *"incidents are dealt with well and learning is encouraged"*. A staff member informed us that they can report in DATIX and this is reviewed on monthly basis in a clinical governance meeting.

We also asked about the process of reporting a safeguarding concern. Staff felt that it worked well and there is a health visitor on site 9am- 3pm to discuss concerns and signpost if necessary. We have also been informed that there is 24 hours offsite access to Greenbrook Healthcare's Medical Director who is the named lead for safeguarding, and a safeguarding nurse is available off site from 9am – 5pm.

Feedback about the Emergency Department

We spoke to 38 patients streamed to the ED and their experiences are represented in the sections below.

We asked patients for their consent to send them a follow up survey a week after their visit to collect their full experience. This was to help combat the problem that during our visits we mainly spoke to patients in the waiting room when they had not completed their visit and could not provide complete feedback. The survey is provided in 'Appendix 2' (page 30). We had six responses to this survey from patients who had been streamed to and were treated in the ED. Their feedback has been incorporated under the headings in the following sections.

Reason for choosing service

We asked patients if they had contacted another health service (for example their GP or 111) before attending the UCC, the findings are shown in Table 2. We wanted to gauge how patients were using the service and how informed they were about Urgent and Out of Hours services. Most patients had contacted a service before attending the ED. The most common service contacted by patients was GP (primary care) and the next most common service was the Ambulance service.

Table 2: Patients who did/didn't contact a service before attending the ED with breakdown of the service contacted

	No. of patients		No. of patients
Contacted service before coming	21	Did not contact /attended on their own decision	5
Breakdown:			
GP	10		
Ambulance	5		
NHS111	2		
Another UTC/UCC	2		
District nurse	1		
WMUH outpatients	1		

The patients who attended on their own decision shared their reasons for not contacting a service before they attended. Two patients felt they needed to come to the ED due to the severity of their symptoms, one patient felt they needed an x-ray, and one patient had previously had good experiences at the Hospital so chose to come. The final patient was an EU citizen so had limited access to other health services.

We also asked people for their borough of residence. Unfortunately we did not collect sufficient data to enable us to report on any differences based on borough of origin.

Triaging process in the ED

Patients that are streamed to the ED from the UCC will then be triaged by triage nurses in the ED to carry out a more in-depth medical assessment. Most patients had positive experiences with triaging including one patient who was happy to be seen so quickly (within 5-10 minutes). Another patient had a long wait for triage but felt that the staff were friendly. A further patient felt that the current triaging system worked well.

One patient had a negative experience while being triaged. A second triage nurse entered the triage room and discussed another patient in front of them, and they felt this was inappropriate. No personal details were divulged but the patient still reported on this negatively. Another patient with negative feedback felt that the triage process was *"long and repetitive"* as they felt they had to answer the same questions that they had answered during the streaming process.

We asked patients how long they waited for a triaging assessment. Half of patients had waited for less than 30 minutes, with the other half of patients waiting between 30 minutes and 1 hour for triage.

We also asked the staff for feedback about the triaging system in the staff survey. A staff nurse felt it worked well and thought that they *"managed to triage patients effectively and on time"*. Another member of staff felt an *"additional technician [is needed] in the Department to be assigned only to triage"*. At the moment an ED tech is being shared between Majors C and triage. They also felt that another improvement to triage would be *"the rapid assessment and treatment of ambulance patient led by an adult nurse practitioner will definitely be a better option"*.

Transfer by Ambulance

Eight patients gave feedback about the London Ambulance Service that had brought them to the ED and about the Ambulance transfer process. Patients described the transfer process as *"really good, smooth and quick"*. Two patients were taken straight to a cubicle within ED Majors. Four patients described the paramedic staff as *"fantastic"* and *"excellent"* when handing over to the ED team, and this facilitated an easy transfer of care.

Two patients reported a queue when they arrived and this delayed transfer of care, with a patient telling us they were in the Ambulance outside the ED for 30 minutes. These patients still gave positive feedback about the process despite this delay.

Environment

Clever compartmentalisation and specialised use of rooms in the ED makes good use of a relatively small space. Majors A, B and C were all clean and tidy, there was an excellent plan to turn one private patient room in Majors C into a 'butterfly room' to support patients. A 'butterfly room' provides privacy, dignity and space to patients, families and carers during end of life or through a miscarriage. In the Clinical Decision Unit there is a TV and books available for patients to read, which we feel is a great initiative. The Observation Bay was well organised and was also clean and tidy. However in the disabled toilet, located opposite Clinical Decision Unit, there was no toilet seat or a hand rail. We raised this issue with the Hospital and it was confirmed the problem has been resolved.

The paediatric ED was clean and tidy, the paediatric waiting room was effectively decorated and had wall mounted toys. The seating provided was a wooden bench with back cushions set into it. However the bench did not have a cushioned seat and a patient told us that the seating in the waiting room was uncomfortable.

20 out of 23 patients were happy with the facilities provided. Patients described it was *"spacious and light"*, *"well maintained and tidy"* and *"very good"*. A patient cubicle was well equipped with monitoring systems which made the patient feel reassured. A patient joked that the environment was so nice that *"I would come here for a holiday"*. The negative feedback (two out of 22 patients) was that the environment was *"chaotic"* and *"not very calm"*. One patient was anxious that there were no call buttons to use if the patient needed urgent help.

Staff have access to a well-furbished staff room complete with a kitchen that is within the ED. There is a focus on staff wellbeing with notices to remind staff to 'take a moment'.

Two staff members (out of five) requested a telephone in the staff room *"so that if anyone is tannoyed one could respond quickly"*.

Recommendation: The Hospital could consider the addition of an internal phone in the staff room.

Response: The Hospital told us that they will arrange for this to happen.

Privacy and Dignity

We had feedback for this question from 20 patients and all felt that their privacy and dignity had been respected. A patient felt that the patient cubicle in Majors offered enough privacy to meet their additional mental health needs, they had anxiety and were prone to panic attacks in busy environments.

We observed that curtains were available around the patients' cubicles, the curtains fitted well and the staff ensured they were used appropriately. There was also a relatives' room available for private discussions. We also note that there are plans to redecorate the relatives' room with artwork by a local photographer, update the furniture, and have tea/coffee and water facilities. This will be hugely beneficial and it is good to see the ED undertaking quality improvement that will positively impact the patients and patients' families experience in the the ED.

Provision of Food/Drink

A stock of sandwiches and drinks are held in the Department and a member of domestic staff brings them round at 7:30-8:00, 12:00-13:00 and 18:00-19:00. There were no signs to inform the patients about what and when food is offered to patients. It would be useful to have information with the opening times of shops that sells food and drink onsite.

Nine patients out of 24 had not been offered food or drink and were not aware of the arrangements. Out of these nine patients, four patients had made their own arrangements for food/drink. The remaining 15 patients had been offered food and/or drink or were aware of how to get it.

Recommendation: We asked the Hospital to consider improvements they could make to ensure patients are aware of the provision for food and drink in the Hospital.

Response: The Hospital told us that:

"There are vending machines for snacks and drinks in the waiting area. Opening times of the shops have been put up in the waiting room."

Patient information

In addition to the patient journey sign available in the waiting room there was an updated patient journey sign in the Clinical Decision Unit and Observation unit to reflect the stage they were now at. Patient information leaflets for common conditions were available in the ED. The ED was also in the process of displaying their DATIX and audit results within the ED. This demonstrates the Department's drive to be transparent when things had gone wrong but also can demonstrate improvement and lessons learned.

We asked patients if they were given information on what will happen next in their assessment and treatment. 25 out of 27 patients were clear about what was happening and what was going to happen next. A patient felt that staff *"were good at taking them through everything"* and another patient felt *"well informed of progress/next steps"*. This appeared to be true for patients at every stage of the process, for example whether they were waiting for triage or whether they were waiting for final discharge in the CDU.

There were two negative pieces of feedback and they related to ambiguous information given and/or patients not being given updates. One patient was unsure what would happen next as they had thought the doctor was going admit them to a ward but was

unclear. A patient and their spouse had been told they would be sent to have an X-ray but had been given no time frame, so the spouse was unsure whether they had time to go and get them food.

Waiting times

We asked if patients had been given an indication on how long they can expect to wait. Only one patient out of 28 had been given an indication of the time frame for their waiting time. Four patients who had not be given a time frame indicated that this would be helpful to them as, while they felt informed at each stage, *"a waiting time would provide extra clarity to the process"*. One patient wanted to be given an estimated time frame for tests/scans.

Not informing patients about estimated waiting times could cause understandable frustration if the patient has to wait a considerable length of time with no indication when they will be seen. Research carried out by Healthwatch England[1], along with the findings of our wider service reviews, has shown that if patients are not told how long they might have to wait, it negatively affects how they feel about the waiting time. They also found that even when estimated waiting times are not achieved, patients find it helpful to have some idea of the length of wait.

One patient who waited for more than 5 hours felt this waiting time did not meet with their expectations, but conceded that the length of visit was partly due to the *"full body scan"* they had which they described as *"worth doing to make 100% sure [there were] no major problems"*. Two further patients were understanding about the length of their wait reporting that *"they were kept until they were stable and [staff] were thorough with treatment"*. Another patient told us that there were delays due to an emergency high priority patient and although this was described as *"unfortunate"* the patient was completely accepting of this and felt this was uncontrollable.

A patient had been told that the doctor needed to confer with a colleague, two hours had passed since that conversation and they had not be reviewed or updated by a member of staff. This patient was feeling like they had been forgotten.

We asked patients to consider if there are any changes that would improve the service, out of 12 patients, four patients felt that a shorter wait would improve the service and their experience.

Recommendation: We asked the Hospital to consider routinely informing patients about the expected waiting times.

Response: The Hospital told us:

"The triage nurse in the ED will give the patients an estimated wait time once they have been triaged."

Clinical staff

We observed staff speaking to the patients politely and calmly, and we also felt staff were pleasant, friendly and helpful. On a few occasions we observed staff explaining to patients what was happening and/or going to happen in a clear way. The staff were all wearing a uniform and name badges that made them easily distinguishable to patients.

33 out of 35 patients had positive feedback either during the visit or via our follow up survey about the clinical staff they had interacted with during their visit to the ED. Patients mentioned that staff had made them feel comfortable including in the situation

[1] Full report: https://www.healthwatch.co.uk/report/2019-03-11/peoples-views-ae-waiting-times

of a patient who was particularly anxious. Staff were praised for their courtesy, understanding and cheerfulness.

A selection of the comments made to us about the clinical staff are given below:

“Nurses were lovely and very professional”

“All staff are 10/10. Amazing service, made comfortable and welcomed”.

“Oh, my goodness! I can’t fault them! Absolutely happy!”

"1st class service [and staff seem] very on the ball"

“nurses/doctors and all staff need commending for the good job they do”

“Staff were very sensitive to emotional side and [the patient] thought they were outstanding”

“Team work by the staff in looking after me was tremendous “

One of the two patients who gave negative feedback about staff described them as *“alright”*, they also felt the staff were *“very busy”*, and this contributed to the negative impression this patient. The other patient with negative feedback described the nurses as *“not wanting to know”* as they had not checked up on them. They had reported needing help with their catheter, an hour had passed but a nurse had not been in to help them. This was exacerbated as they did not have a call bell to get the staff’s attention and as a result felt *“completely lost”*. A patient responding to our follow up survey felt they needed a call button for staff, as during their visit the staff did check up on them but patient wanted the extra ability to call staff.

We asked the Hospital to explain why there are no call bells in the ED and they told us that there are call bells in all cubicles that are checked for working order at start of every shift.

Further recommendation: Whilst call bells may be in place it is clear that not all patients are aware of them. Staff should be reminded to routinely give patients call bells on admission to the unit.

Communication with staff

We wanted to understand if patients felt the communication they had with staff was good and if staff communicated with them in a way they could understand. 22 out of 27 patients were happy with the explanations given to them by doctors and nurses. A patient felt they were *“brilliant at communicating the next steps and the cause behind their symptoms”*. A patient felt that staff described information in a way that was *“very down to earth”*. Explanations were described as *“comprehensive”* and a patient felt that the interactions *“did not feel rushed”*.

Six out of 28 responses either during the visit or the follow up survey expressed negative views about the explanations given by doctors and nurses. Five of these related to poor communication between the doctor and the patient with one doctor described as being *“vague in their explanations”*. A patient told us that they were discharged without any real idea of what the ED had achieved. They did not know the results of the tests and left hospital not knowing *“what my problem was [or] why I had a problem in the first place”*. They further added that the Department is a *“get it fixed operation”* and they were then handed back to the GP for further advice.

A patient with a hearing impairment struggled to hear and understand a doctor as the doctor spoke softly with an accent. The patient also felt that the staff used language that was *"difficult to follow"* and this may refer to staff not putting explanations in a language that can be understood by a person with no medical knowledge. They felt that staff were too busy to answer questions and this would have helped the patient understand the explanations they had been given. The final patient with negative feedback related to poor communication between doctors during handover which meant that questions the patient was being asked can then feel very repetitive. The patient also reported that when a junior doctor needed input from a senior registrar/consultant it caused significant delay in treatment.

During our visits we witnessed a member of staff in a pale blue uniform come into the cubicle, introduce themselves, and say they needed to give an *"IV"* and ask if that was OK. After the patient agreed, the staff member left and re-entered the cubicle twice as there appeared to be a problem with the IV. During this exchange the patient didn't understand what was going on, and asked our Enter and View authorised representative several times *"where had [staff member] gone now?"*, enquired how long staff member would be gone for, what an IV is and what it was being given for. The pace of the exchange and lack of clearly given information about what was happening had left the patient confused.

We also wanted to know if patients were given the support they needed, and 12 out of 15 patients felt that they had. Out of these patients, three patients felt that even though they were having to wait a long time they felt supported, and this mitigated the negative impact of the long visit.

Three patients out of 15 patients did not feel supported with one patient telling us they felt *"completely forgotten about"*. Similarly, a patient felt they would have preferred more frequent check-ups from nurses to check on how they were feeling. They thought that *"care seems limited to getting through the system quickly"*.

We asked patients if they had a suggestion that would improve their experience, five out 12 patients had an improvement that related to the clinical staff. Four patients wished for more regular contact from staff to check up and monitor them during their time in the ED. One patient felt that better communication was needed between doctors particularly in the handover process.

Pain management

When it was relevant, we asked patients if they were offered pain relief. All patients we asked (nine patients) had been offered pain relief if they needed/wanted it. All respondents felt their pain was well managed with staff asking them to rate their pain and monitoring their pain level at intervals after the medication was given.

Mental Health

Mental health patients often face long stays in the ED as they wait for psychiatric assessment and, when required, a bed in an inpatient mental health unit. The ED is making changes to meet the increased demand of these patients. There is a dedicated Mental Health nurse on every shift. The two mental health rooms were being renovated with mood lighting, USB charging ports and Wi-Fi.

A mental health patient attending the ED during our visit was happy to provide their feedback. They attended the ED after calling 999 and being told to attend an ED. They were positive with their feedback about staff describing reception staff as *"genuinely friendly and caring"*, after visiting several times in the last three months they felt staff were always friendly and approachable. They thought that there needed to be a greater availability of the psychiatry liaison team, as this patient has experienced long waits in the Department. They were very satisfied with the level of support they had been offered and felt this made the long wait for the psychiatry team easier.

They had been placed in a dedicated mental health room and therefore their privacy and dignity had been respected, they felt this wouldn't have been the case if they were assigned a patient cubicle. The room was more contained and they felt better protected from the occasional chaotic environment with *"people constantly walking back and forth"*. They did note the loudspeaker announcements could seem quite loud and intrusive and questioned whether the volume could be lowered.

If a patient needs inpatient mental health support they will be transferred, and the place of transfer depends on which borough they live in. Lakeside Mental Health unit run by West London NHS Trust is onsite and available for patients who are Hounslow residents. If the patient is a Richmond resident their care lies with South West London and St George's Mental Health NHS Trust. A member of staff told us that supporting mental health patients *"can be tricky but has improved"*. The length of time the patient is waiting for psychiatric assessment and a transfer to inpatient mental health unit is an important consideration, and this is often longer if the patient is not a Hounslow resident. Our separate report into Crisis Care makes recommendations in this area.

During one of our visits several police officers were present as a medical clearance was needed before the patient could be admitted to an inpatient mental health unit. The requirement to have a medical clearance means that the police officers can spend a significant time accompanying a person under a 136 section to hospital. Police officers told us during the visit that they had been there for two and half hours and were still present when we completed the visit. They felt that this was a tactic to buy time due to pressures on the West London Mental Health Trust's capacity rather than as a result of a clinical need. Notably the patient involved was in a cubicle on Majors and not in the dedicated Mental Health room.

Staff feedback

Patients with additional needs

We had six pieces of feedback from staff about how well they felt equipped to support patients with additional needs such as mental health, learning disabilities, dementia and non-English speakers. Four (out of six) staff members felt equipped to support these patients and commented that the *"mental health training is good"* and the Department has got *"qualified professionals that can support patients with unique needs"*. A staff member had attended new training for learning disabilities and felt this training will help the Department support these patients. A staff member told us that when 'LanguageLine' interpreters are available they could support non-English speakers. A staff member reported that a number of staff speak other languages and are valuable in this situation.

Two members of staff did not feel equipped and reported that *"much more training needs to be done in this area as understanding of these conditions are very complex"*. Secondly a staff member felt there were *"no learning disability or dementia friendly areas"* in the Department.

Staff capacity

We asked staff if staffing capacity safely met the patients' needs, and crucially we also asked if there were enough permanent and experienced staff in the Department. Two (out of seven) members of staff who responded to this question in the survey were positive about staffing. They felt that *"every area was covered with staff"* and *"there is a good skill mix of Band 5, Band 6 and Technicians"*. The Matron informed us that the ED is working at zero vacancies therefore the use of agency/bank staff is not a concern.

Two members (out of seven) of staff were mixed in their feedback as they recognised that the ED had enough permanent staff. However for these staff members adequate staffing capacity depended on how busy the ED was. They, therefore, felt that there was more that could still be done. The negative feedback about staffing capacity also cited the

challenge on staff of the increasing number of patients coming to the Department. However a staff member also reflected on the improvements to staffing levels over the past two years. One member of staff gave particularly negative feedback and told us that *"[the Department] cannot seem to hold onto staff and [staff] morale"*.

Support from senior staff

Every member of staff who provided us with feedback (eight members of staff) felt well supported by senior staff. Staff mentioned having good training and valuing having a mentor for help when they needed. Staff reported that since the merge with Chelsea and Westminster NHS Foundation Trust, professional development has improved as the staff have access to more shared resources. Staff also spoke about other staff in the team being *"like a family"*, *"friendly and supportive"*, *"ready to assist or help"* and *"helping one another"*.

A member of staff felt the ED had an *"excellent matron"*. A further member of staff commented that: *"Matron Scuse has been extraordinarily caring towards staff. She is honest but can be strict and straightforward. She will do her best to support her staff"*. After our conversations with Matron Scuse her commitment to improving the ED was clear, for example through regular senior quality rounds. She was committed to getting the best out of staff and giving a good service to patients.

Senior staff in the ED have been proactive regarding staff counselling, for example when a member of staff died in a tragic accident a group counselling session was held for the staff and the Director of Nursing also supported the team.

System for monitoring patients

All staff members who responded to this question (six) felt there was a good system for monitoring patients including the patient's pain level. Staff told us the Department is equipped with monitors and patients are regularly being assessed. The staff member assigned to monitor patients will call for immediate attention in a specific cubicle. Staff members valued having the handover procedure, using news scores and Cerner to help with patient monitoring.

Raising incidents and safeguarding concerns

Staff felt that the Department is good at supporting the team to learn from incidents/concerns. A member of staff is allocated to a serious incident and feedback is provided to all those involved.

We asked about how effective the system was for reporting safeguarding concerns and staff told us that *"there is a new system now that was so far effective"* and that it is *"getting better"*. One staff member thought it is *"very good but there is always room for improvement"*. Finally, a staff member was confident this was dealt with well by staff.

Conclusions

Overall patient experience was positive. 63% of patients were positive about the streaming process with compliments given to reception staff, and patients reporting clear understanding of what they needed to do upon arrival in the Department. Almost all patients were streamed within 20 minutes. We identified an issue when patients arrived with a letter from their GP referring them to the ED and we sought clarification about this from the provider. The provider told us that not all patients sent to UCC/ED by their GP need ED support, therefore if they are not critically unwell and/or if their letter is not addressed to a speciality team, patients are booked into the UCC and have a streaming assessment. However children under 16 years old who have a GP letter will be sent through to the ED.

For patients streamed to the ED there was confusion over having to re-register at the ED reception this caused some patients frustration, and in one case a delay in treatment. The providers told us that different coloured paper is now in use to minimise the risk of patients sitting in the ED waiting area without registering. After reflecting on the provider's response we further recommend that providers set out signage, perhaps with a floor or eyelevel trail, to a clearly signposted ED reception point. Some patients were unclear about the next steps in their journey through the Department, therefore the providers will explore an option of additional roller banner displays and add announcements to the large TV screen in the waiting area.

We also observed the challenge of a streaming desk, as opposed to a streaming cubicle, since patients were not able to sit down and the assessment was open to those in the waiting room. We asked the provider to review the use of the streaming desk as although it is efficient in the use of space, there does not appear to be a benefit to the patient. As a result, additions have been made to improve privacy by adding side panels to the desk and a chair will be available for patients who need it.

It was clear from patient feedback that being given an estimated waiting time when patients arrive at the Department would be valued. Work to introduce a sign providing the estimated waiting time is in the early stages, and we encourage the providers to pursue this to completion, as it would go a long way to improving the experience of patients in the Department. The ED will ensure that the triage nurse gives patients an estimated wait time once they have been triaged.

Unfortunately there were a considerable number of chairs in the waiting room that were broken and out of use during our visits. The provider's response to this highlighted that the process for reporting estate issues can be problematic, but the Matron's weekly walk around of the Department can pick up and escalate issues. The Hospital has put additional seating in the ED waiting room, and this is a welcome change as the broken chairs exacerbated the already limited seating in this area. However it still remains unclear if a process to enable chairs to be fixed in a timely manner has been put in place, therefore we have recommended that the provider address this.

Urgent Care Centre

We wanted to understand how people were using the UCC. There was a 50-50 split in patients contacting a health service before attending the UCC compared to those that didn't. It appeared that most people contacted their GP before attending, therefore when patients attended Out of Hours they reported having no choice but going to the UCC. This suggests patients were not well informed about alternative Out of Hours services, for example NHS111.

The majority of patients were positive in their feedback about UCC clinical staff but the feedback we were able to collect is limited. The negative feedback about staff stemmed

from the patient feeling overlooked and treated as low priority. We identified a patient who was regularly attending for post-operative dressing changes as their GP surgery did not have an appointment available. This does not appear to be an appropriate use of the service and involves a long wait for the patient who is still recovering from surgery. After raising this with the providers we have been told that when patients do attend, the UCC will attempt to book subsequent appointments in the community before the patient leaves.

Staff felt there was a good system for monitoring patients but we felt the support, particularly for distressed patients, could be improved by enhancing the Patient Champion job role. Greenbrook Healthcare told us that our feedback will be incorporated into the on-going development of this role. Staff feedback indicated concerns about staffing capacity with difficulty recruiting, and reliance on agency/bank staff for the Emergency Nurse Practitioner role being highlighted. Greenbrook Healthcare responded that they run bespoke University accredited training courses and plan to shortly advertise for a consolidation post.

Emergency Department

Unlike the UCC the majority of patients (~80%) had contacted a service before attending (most commonly their GP) suggesting patients preferred to get medical advice before using ED services. After a patient is streamed to the ED they have a triage assessment, most patients provided positive feedback about triaging. Staff felt able to triage patients effectively but did suggest that an ED technician should, during busy periods, be assigned directly to triage and not shared with Majors C as is the situation currently.

The environment of the Department was well proportioned and functional, and great thought had been taken with the refurbishment of mental health rooms. The patient feedback was positive and indicated their privacy and dignity had been respected. Patients were inconsistent with their awareness of where they can get food/drink during their time in the Department, the Hospital has now displayed signs of the opening times of the shops in the waiting room.

Patients felt they were given good information on what was happening and what will happen next. Most patients gave positive feedback about the ED clinical staff and felt they had good communication with them. The negative comments related to staff busyness and a wish for more regular contact with staff. Patients highlighted they were not aware of call bells so we felt staff should be reminded to routinely give patients call bells on admission to the unit.

It was clear from our visit that there is a challenge in supporting patients who attend the ED with mental health concerns, and the Hospital has acted to try to meet these challenges. These patients face long waits in the Department and their care involves the coordination with inpatient mental health providers. A mental health patient spoke very positively about the staff and the support they were given, and how this made the wait for the psychiatric liaison team easier.

A small number of staff identified a possible issue around having adequate staffing capacity to meet patient’s needs. This appeared to be in the context of the increasing demand on the ED as there is currently a zero vacancy rate in the Department. What was clear was there was good support from senior staff and staff had confidence in raising incidents, including safeguarding concerns.

Overall, following on from this report we hope that West Middlesex University Hospital and Greenbrook Healthcare continue to deliver the promised action plan in order to improve the experience of patients in the Department.

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Appendix 1- Patient Questions

healthwatch Richmond upon Thames

WMUH A&E and Urgent Care Centre
Enter & View: Prompts for Patient discussions

Please make it clear in your notes which areas of the department the patient's experiences relate to (e.g. Majors, Urgent Care Centre (UCC) waiting area etc.)

Topic	Suggested Questions
Streaming/triage process	When you arrived, was it easy to understand what to do and where to go? How long did you have to wait to see the triage nurse? Were you happy with the check in/registration system on arrival? (if relevant) Were you happy with the ambulance handover process?
Reception staff	Were the staff at reception friendly/helpful?
Reason for choosing service (For patients in UCC)	What borough do you live in? Before you came, did you see/speak to someone else first (e.g. GP, NHS 111)? Was this the only place you could have gone to get the treatment you need?
Information provision	Have you been given information on what will happen next? Have you been told how long you'll be waiting?
Wait times	After triaging, how long did you wait to first speak to a nurse or doctor? Did this meet with your expectations?
Pain management (if appropriate)	If you reported being in pain, were you offered pain relief? Did the staff ask you to rate your level of pain?
Clinical staff	Are you happy with the doctors and nurses you have seen? Were you given the support that you needed? Were you happy with the explanations they gave you about your injury/treatment?
Privacy and Dignity	Were you given enough privacy when you had discussions with staff? Do you feel that your dignity has been respected during treatment/examinations?
Environment and facilities	Are you happy with the facilities provided (seating, layout, cleanliness)? Would you know where to get food/drink if you needed some?
Other comments	Are there any changes you would like to see made at the UCC/A&E? Is there anything else you would like to add?

Appendix 2- After your A&E/UCC visit

healthwatch Richmond upon Thames

1. Where were you seen?

Urgent Care Centre ☐ Children's/Paediatric A&E ☐

A&E ☐ Don't know ☐

2. How long did it take from your arrival to being treated and sent home?

0-1 hours ☐
1-2 hours ☐
2-3 hours ☐
3-4 hours ☐
4-5 hours ☐
More than 5 hours ☐
I was admitted to a ward ☐

3. Did the waiting time meet with your expectations?

Yes ☐
No ☐

Comments

4. How satisfied were you with the nurses and/or doctors you saw?

Very unhappy ☐
Somewhat happy ☐
Neither happy or unhappy ☐
Somewhat happy ☐
Very happy ☐

5. How would you rate your experience today?

Very poor ☐
Poor ☐
Neither poor or good ☐
Good ☐
Very good ☐

6. Please share any other comments about your experience.

Appendix 3- Observation checklist

healthwatch Richmond upon Thames

WMUH A&E and Urgent Care Centre
Enter & View visits: Observation checklist

Authorised representative name:............................ Date & Time completed:..........................

Staff or location	Observation	Comments *(Please make it clear which specific areas and/or staff your comments refer to – e.g. Nurse in Majors)*
All Staff	Are staff wearing **name badges** that are **clearly displayed**? Are staff wearing clearly **identifiable uniforms**?	
All Staff	Are staff treating patients in a **friendly and caring manner?**	
All Staff	Are staff providing patients with **clear information**? (e.g. explaining what will happen next; what treatment patients are receiving & why)	
All areas	Are patients able to **discuss personal issues/concerns in privacy?**	
All areas	Is **patient dignity** protected? (e.g. whether curtains provide adequate cover and are used appropriately)	
All areas	Are patients responded to if they are clearly in **pain or distressed**?	
All areas	Is information appropriate for those with **language difficulties, sensory impairments or learning disabilities**?	
All areas	Is the department **accessible** for people with **mobility difficulties**?	

Staff or location	Observation	**Comments** *(Please make it clear which <u>specific areas and/or staff</u> your comments refer to – e.g. Nurse in Majors)*
All areas	Are there clear places for patients and staff to **wash their hands**?	
All areas	Are patients able to access **food/drink**?	
All areas	Is the department **clean**? (floors, walls, toilets)	
Waiting areas/ Reception	Is there **clear information** available to patients about the service provided here? (signs, display screens, leaflets) e.g. patient journey, PALS, multilingual services, accessibility	
Waiting areas	Are there **enough seats**? Are the seats **comfortable**?	
Waiting areas	Do **staff check on** patients in the **waiting areas**?	
Clinical areas	Are medical **supplies and equipment** safely stored? (e.g. medication left lying loose on surfaces)	
Outside	Are there **clear signposts/directions** to the department?	
Car park	Are there **enough spaces**? Are there **enough disabled spaces?**	

Appendix 4- Staff questions

WMUH A&E and Urgent Care Centre
Enter & View: Prompts for Staff discussions

healthwatch Richmond upon Thames

Please record the position of the staff member you speak to and which area they work in (e.g. Nurse Practitioner in UCC, A&E consultant)

Topic	Suggested Questions
Patient conditions	4. What are the most common patient conditions you see?
Patients with unique needs	Do you feel equipped to support patients with learning disabilities, dementia, mental health issues and non-English speakers? If these patients attend alone, what arrangements are in place to check if they need an advocate?
Service capacity	Do you feel that you have enough staff to safely meet patients' needs?
Staff mix	Do you feel that the department has enough experienced, permanent staff?
Streaming/UCC	Do you feel the streaming/triaging system works well?
Monitoring systems	Do you think there is a good system in place for monitoring if a patient is deteriorating? Is there a good system for monitoring a patient's pain level?
Support for staff	Do you feel well supported by senior staff in your role? Is there anything that would help make your role easier?
Learning from incidents/complaints	Do you feel that the department is good at supporting the team to learn from incidents/complaints?
Safeguarding	How effective is the process of reporting a safeguarding concern? Has there been any learning from the last safeguarding concern?
General improvements	What changes could be made to help you/the department provide a better service? Is there anything else you would like to add?