Enter & View

Queen's Hospital, Romford

Rom Valley Way
Romford RM7 0AG

Emergency Department (A&E)

Announced visits: 30 January and 19 September 2018 Unannounced visit: 9 March 2018

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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

Queen's Hospital – background

The term "Emergency Department" is used increasingly within the NHS to describe the department previously termed "Accident and Emergency" and, before that, "Casualty Department". The term "Emergency Department" has yet to gain such currency among the general public as "Accident and Emergency" or "A&E", so in this report the term "A&E" will be used to avoid confusion.

Queen's Hospital is one of the largest and busiest hospitals in London, if not in the UK – in consequence of which, its A&E is also among the busiest in London, with an annual footfall in 2017 of 174 thousand patients, of whom nearly 50 thousand were brought in by emergency ambulance, principally by the London Ambulance Service (LAS) but also by the East of England Ambulance Service and various private and voluntary ambulance services. It draws patients not just from Havering and its neighbouring London boroughs of Barking & Dagenham and Redbridge, but from areas of Essex that also neighbour Havering – a population of, broadly, one million.

Across England, hospitals are increasingly coming under what are termed "winter pressures" – a significant rise in attendances at A&E that coincides with the winter months and particularly the Christmas/New Year period. Whilst clearly the adverse weather conditions most likely to be experienced then can affect anyone, but especially the elderly, the rise that has been experienced cannot be explained by weather alone: many other factors affect the position.

Queen's Hospital opened in December 2006. From the beginning, A&E came under pressure, pressure that has increased steadily ever since.

In an attempt to relieve some of that pressure, the public access to A&E was re-designed and rebuilt, opening in early 2018; the re-building resulted in changes to the pre-treatment processing of patients, that evolved during 2018. The system has evolved; patients are now (at the time of publication of this report) seen by a streamer (simple stream) initially who will then stream the patient to Triage (complex stream), Minor Injuries, GP or Majors/Resuscitation. The patient is registered to the appropriate area following this simple streaming process [1].

Queen's Hospital is provided and managed by the Barking, Havering and Redbridge University Hospitals Trust (BHRUT), which also manages King George Hospital (KGH), Goodmayes, where there is a smaller A&E department (now termed an Urgent Care Centre). It remains a long-term (but controversial) ambition of the NHS to close the A&E at KGH and concentrate A&E activity at Queen's Hospital.

Why Enter and View?

Healthwatch Havering carried out an Enter and View (E&V) visit at A&E in June 2016, and colleagues from Healthwatch Redbridge visited in April 2015 as part of a project across North and East London to assess how "friendly" A&E departments were to patients who had hearing impairments.

The visits now reported were carried out in part because Healthwatch wished to review progress since those earlier visits, in part to observe how the winter pressures in 2018 had been addressed, and in part to ascertain what, if any, effect the rebuilding of the access area had had on the department.

Initially, only a single announced visit was planned but, as will be seen from the report, issues emerged which it was judged could better be understood by carrying out a further, unannounced, visit a month or so later. These visits were followed up by a further announced visit in the

[1] This streaming is undertaken by a separate organisation, PELC (a co-operative of GPs). A separate report on streaming will be published following this report.

autumn of 2018.

The team would like to thank all staff and patients who were seen during the visits for their help and co-operation, which is much appreciated.

They enjoyed taking time to understand the new system now in place, and the challenges the staff are facing. With numbers attending increasing all the time (summer 2018 was simply a continuation of the 2017/18 "winter pressures") and with the prospect of considerable population growth in Havering and the surrounding areas, a robust system is needed. The team felt that the third visit was a much more positive experience, were encouraged to see and feel an improving atmosphere and felt that staff were to be congratulated on the way A&E is progressing and moving forward.

It should also be acknowledged that the changes in A&E that began in January 2018 have been constantly developed since then, and the arrangements in the Department have changed markedly since then and continue to change. Many of the points made in the accounts of the visits now reported on have since been addressed or are to be dealt with as part of continuing improvements.

BHRUT's Action Plan following the visits is appended to this report.

Announced visit, 30 January 2018

The Healthwatch team arrived at Reception at 8.30am on a Tuesday morning and were met by a member of the Patient Experience Team, who introduced the Matron (who had been in post for only 7 weeks).

Although the team did not see a security guard on duty in the Urgent Treatment Centre part of A&E during the visit, BHRUT have confirmed that the A&E department has a security guard 24 hours a day, 7 days a week and that the area is routinely covered by security staff who patrol regularly. All public areas had CCTV, and all bays had panic buttons.

The team interviewed the matron and felt she was open, honest and enthusiastic, and a real joy to talk to.

At this first visit, the team were told that, within 15 minutes of arrival, patients were registered and were simply streamed to be seen either by a GP or a triage nurse (complex stream), depending on whether their condition was simple or complex, or if in a serious condition were streamed to Majors/Resuscitation. The terms "simple" and "complex" are set out in Royal College of Emergency Medicine guidelines of February 2017.

If assessed as needing the simple stream, the patient would go on to see a relevant healthcare professional staff; complex cases, requiring blood tests or X rays etc. would return to the waiting room until called.

From time to time streamers would observe the waiting room to see if anyone needed immediate attention.

The team were told that an IT system known as Symphony was used to provide an overview of the patient's journey in real time, tracking patients throughout the A&E department unless the patient was to be seen by a GP, where a separate system called Medway was used to track patients. Neither system was able directly to communicate with the other, or with the Medway IT system, in use in the rest of the hospital. BHRUT has given assurance that its administrative teams are fully trained to help interlink between the two systems.

Patients who had intolerances, dementia, learning disabilities or who were otherwise vulnerable, were flagged to alert all staff to their individual special needs. Vulnerable patients would be sent straight to Majors, and there was a room specifically designed for patients presenting with mental health problems to undergo assessment; staff were supported for this purpose with a security camera. Patients are given comfort rounds whilst waiting for a member of the liaison staff.

There was one room allocated for isolation and gynaecology issues in Majors.

Patients that required treatment and care in Majors and the resuscitation area were assessed for conditions over and above their medical needs (for example, to determine the presence or otherwise of pressure sores) and a management plan would be put in place to reduce risk if required. Once a clinician had determined that a patient was medically-fit for discharge, dependent upon their mobility and social needs, other agencies and teams would assist with a safe discharge e.g. the FOPAL Team (Frail Older People Liaison) and the Community Treatment Team (CTT).

When asked if patients were turned away or signposted to other agencies, the Matron replied, "We don't turn anyone away as we have a duty of care". There was a GP on site and patients were also advised to contact their own GP, to consult a GP through NHS111 or the GP Hub or to see a pharmacist, using the most appropriate services and clinicians to deal with the patient's needs.

4 bedded Male and 4 bedded female observation bays were also available.

Children coming into A&E had to initially register alongside adults but were then signposted to the children's patient waiting area, which is separate from the adult patient waiting area.

On a busy day, 12-18 ambulances could attend within one hour to the department. Patients do not wait in the ambulance but are at times waiting to be transferred from the ambulance trolley bed to an available trolley bed in A&E. Penalties are imposed if an ambulance crew are waiting in A&E for more than an hour to transfer their patient.

Patient experience

The team spoke to a number of patients who were awaiting treatment.

Most patients had been directed correctly from other pathways and were aware of NHS 111, the Polyclinic and the HUB.

The flow of registration and streaming appeared to be going very smoothly and patients were happy with this.

However, patients told the team that they would have preferred more privacy at the point of streaming. Since this visit took place, changes have been made to the streaming pods to address this point.

Patients had been waiting around 30 minutes at most for blood tests after streaming and were content to do so; they were also aware of what tests they were waiting for.

Generally, all patients spoken to during this visit were happy with the service.

Unannounced visit, 13 March 2018

This visit was intended to observe A&E at a different time to the first, to ascertain how different it might be. After mid-day, the number of people coming through the doors increases as the day wears on. At the time of this visit, there were up to 70 people in the room, with many more patients waiting for treatment – for example, the associated Urgent Care Centre was almost full, with patients likely to experience a long wait before being seen.

The team arrived at about 3.30pm. On their arrival at the internal door to the area, it was immediately apparent that people arriving were confused by directions given to continue on to Ambulatory Care, Children's A&E, Majors etc. There was a long walk to those areas and, seemingly, no one was on hand to guide people to them. While carrying out an initial discussion, the team observed the "comings and goings". They remarked to staff that wheelchairs for patients' use would be useful, volunteers/staff to help people find their way about, and porters ought to be available to take patients in wheelchairs where they needed to go. Again, there did not appear to be security guard on duty in case of disruption (although, as already noted, BHRUT has given assurance that one is on duty at all times and undertakes regular patrols).

A lack of staff behind the Reception Desk was noticeable. The number of staff registering patients varied between one and two; a third person sitting typing at a desk in the background did not move to support the front of house staff (on the previous visit, there had been three Receptionists at all times). The atmosphere was quite calm, but a disabled patient with learning disabilities, who was also diabetic, was shouting out asking for food and drink – no staff went to their assistance while the team were observing.

BHRUT has commented that the third person referred to above may have been engaged on duties precluding their offering assistance to colleagues.

Interaction with patients

Although staff regularly and frequently carried out observations to see if any very ill people needed to be fast-tracked through the system, patients in the waiting room were not necessarily aware of that and some felt left to their own devices for long periods of time. During this visit, as soon as the public realised they could approach the team, they were spoken to on numerous occasions asking for help and advice. The following three cases exemplify what was seen:

- At one point, the team were approached by a lady whose husband had four weeks previously suffered a stroke. She was desperate for some help for him; he was very agitated and obviously very unwell, and his wife was concerned that he was about to pass out – while the team were with him, the colour drained from his face. The team told his wife to speak to the desk staff, to no avail. A member of the team then also spoke to the desk staff.

  Staff reacted inappropriately, behaviour that was observed for the rest of the time they were there. There appeared to be no procedure in place for dealing urgently with patients whose condition was deteriorating. It took 8 minutes for staff to respond

to the team's calls for help, and even then, the man was required to walk to receive attention rather than being placed in a wheelchair or on a trolley.

This event did raise the question of what sort of training had been given to desk staff.

- Another couple who spoke to the team had been waiting since 10am, having been sent by their GP as the wife had presented to him three times with the same problem and he could no longer help her. They had been waiting over six hours and eventually found out they had been missed out on the system during triage etc. and were dismayed at having a nurse say to them "you should not even be here" and then being told to register anew and start the whole process over again!
- A third family told the team that they had "waited 45 mins to be triaged", then had a further wait of two and a half hours for an ECG; they had then been waiting for almost another hour to see a doctor for the results.

The team asked a few patients how the new arrangements in A&E compared with the old, but none was able to give an answer to that.

In response to these points, BHRUT has expressed disappointment that patients were unhappy with their experience. It has stated:

> "Patients are always prioritised by their medical need and they are managed accordingly. This can result in longer waits for those with minor conditions. The sickest patients are prioritised, but unfortunately at times with high volumes of patients attending the Emergency Department, streaming can go over time.
>
> "The receptionists are not medically trained therefore they would alert the streamer or nursing staff if a patient required more urgent assistance. All staff are briefed regularly and processes are reiterated to them."

Conclusion

It was not the purpose of the visits or this subsequent report to be critical of A&E staff who clearly carry out difficult tasks under great pressure. At the time of the first two visits, there were insufficient staff because of recruitment issues but an ever-increasing patient-load.

It cannot be over-emphasised that staff were doing an excellent job despite the pressures they were faced with.

But it was obvious from only the cursory experience of these visits that there remained organisational issues, not least when a revamp of the Department to improve patient-flow had (at least on the evidence of the visits) not met expectations.

It seemed to the team that carried out the visits that a number of possible improvements could usefully be introduced:

1. A fast track arrangement at entry for emergency registrations
2. Registration of children separately from adults
3. Provision of a TV set in the children's waiting area to distract them while waiting for attention
4. Staff be briefed and kept up to date with directions to other departments and useful locations within the hospital so that they can guide patients with confidence
5. Provision of more wheelchairs to assist patients who have limited mobility, whether the result of a pre-existing condition or of their present injury/illness
6. That staff carrying out streaming be more conscious of patients' privacy
7. That better ways of calling patients be explored, perhaps by installing an electronic calling/pager system
8. Provision of improved signage, to avoid confusing and

disorienting patients and other visitors

It was also clear to the team that the inability of the IT systems, Symphony, Medway and Adastra, to communicate with each other was a potential disadvantage to patients. Processes were in place to ensure that patients were not adversely affected by this, but it was not ideal. This clearly could not be resolved simply or, probably, at moderate expense – but it was also clear that patients could be disadvantaged, not least because of the possibility (however remote) of vital information being missed, or misinterpreted, during the process of updating one system manually with information from the other. While Healthwatch was not in a position to make specific recommendations in that respect, efforts to find a way forward that avoided unnecessary duplication would be welcomed.

Discussion with BHRUT

Following these two visits, the conclusion was discussed at length with A&E and other BHRUT staff. BHRUT had clearly recognised that the new arrangements in A&E were not working optimally and that the changes that had been introduced needed to be refined in the light of experience. Healthwatch therefore agreed that, rather than publish the report of the two visits while changes were being made, it would be better to postpone doing so until change had been effected and then carry out a third visit with the intention of comparing the then current position with the previous experiences.

On the question of staffing, BHRUT have advised that vacancies in A&E have reduced from the time of the first visit, when there were 50 whole time equivalent (WTE) band 5 vacancies, to 34 WTE band 5 vacancies. At the time of the first visit there were 16 WTE Band 2 vacancies; that is now 2 WTE band 2 vacancies. And active efforts continue to recruit to vacancies.

Announced visit, 19 September 2018

Introduction

This visit followed up the challenges faced by A&E identified during and following the two prior visits.

The team were met by the Deputy Matron, who was pleased to have the chance to talk, to share her knowledge, and to show them around. She explained the process of triaging patients, and that the streamers' target for completion of streaming before registration was within 15 minutes of a patient's arrival. Patients were given cards and sent to the area appropriate to their treatment needs: waiting times depended on the degree of a patient's need, in some cases of perhaps two hours and others up to the guideline limit of four hours. Patients who needed little more than reassurance would be referred back to their own GPs at this stage.

The team were told that various systems had now been put in place in the new area/room accommodating A&E, to promote the flow of patients through the system. As with all A&E Departments, people turned up with all manner of different complaints and injuries resulting in a number of different areas being needed within A&E into which to channel patients. This involves Rapid Assessment & First Treatment (RAFT) which most arriving ambulances book into, Majors, Majors lite, Ambulatory Care, the Urgent Treatment Centre (UTC), a GP Unit, Resuscitation (Resus) for very seriously ill people, and the Children's A&E Unit.

During the previous visits, the team had been very concerned about the triaging system that was then in place and one reason for this third visit was to see what actions had been taken to improve the triage system and area from the patients' point of view and how much safer were the newer arrangements.

The team were pleased to learn that the discussions with BHRUT and suggestions of triaging patients before registration, as well as internal review by BHRUT itself, had led to significant changes.

The team felt that the new approach provided a safer method of initial assessment, that was less likely to result the more seriously ill patients (who would inevitably be less vocal than those who were not so ill) being missed out – but did not avoid that possibility altogether. They felt assured that the new stand-up queuing system was constantly being checked to see if anyone waiting to be streamed to the correct service by a simple triage assessment was in a deteriorating condition and needed priority attention.

A&E streaming was run by PELC (Partnership of East London Cooperatives), which had originally run the local NHS111 system (which had now been taken over by the LAS (London Ambulance Service)). BHRUT's A&E staff worked together with PELC, as commissioned by the CCG, to deliver the whole of the A&E service [2].

Patients' initial contact on arriving at A&E was with "streamers" working in individual cubicles known as "pods". These pods provided a degree of privacy for patients.

The streaming process

The team noted that the streamers tended to call 'next please', when they were supposed to walk to the queue and approach patients (who, in an attempt at more privacy, were now a reasonable distance from the pods). Having the streamers go out and visually scan the queuing patients was an important part of the safety system, especially in order to identify seriously ill patients who might not be vocal enough to alert staff to their condition themselves. It was also noticeable that the security guard was sitting down in one of the patient seats at the entrance to A&E, when he should have been walking around. For patients over 75, the Frail & Older Persons Assessment and Liaison team (FOPAL) may be involved after streaming, with some patients being given access to Team 3 of the Outpatients' Department at a later

[2] **Note**: the authorisation for this Enter & View visit did not extend to the area run by PELC so a separate visit has been undertaken and will be reported on after this report

date. They are assessed and given a nationally recognised frailty score. Care plans and body mapping were undertaken as a matter of course on vulnerable patients, and all pressure sores were documented in patient records but for those assessed at level 2 and above a formal report would be completed. Unfortunately, some walk in patients arrived with pressure sores, of which staff were not always made aware as walk in patients were not routinely checked for pressure sores.

The team were told that there were no plans to register children separately; but, once registered, they were referred to Children's A&E, which is run by BHRUT, where there was a TV available.

The queuing system for patients on arrival was now behind a barrier at the back of the A&E reception room, which means the two TVs on the wall by the reception desk are now visible within the whole area. The timings of messages etc., on the screen had been increased and so everything was more readable and information more accessible. The drinking water fountain had to stay where it was because of plumbing difficulties. It was noted the 'Hearing Loop' sign had not been enlarged or moved to be more easily seen.

Some of the team's questions needed to be verified by the PELC Team, hence the subsequent visit there. As with all systems, it took time for change to bed in. This present triage system had now been in place since 1 September. From the very short time that the team observed triage in operation, they felt it was much calmer, and gave confidence that everything was much improved.

It was, however, noted that the logging in and out time of patients in A&E did not comply with national guidelines. The registering of patients on the Medway system flags up arrival times. At King George Hospital (also run by BHRUT) there was a ticket machine for patients to record their arrival.

BHRUT have subsequently commented that clinically it is more beneficial to stream patients first before they are registered.

However, the time of streaming is logged and this time is booked onto either Symphony or Adastra and therefore the national guidelines are being adhered to. A ticket machine similar to the one at KGH which logs arrival times is being procured.

Referral elsewhere for treatment

Not all cases presenting at A&E and accepted for treatment were dealt with at Queen's Hospital. Injuries and eye problems that needed to be dealt with by other hospitals were assessed, and then either sent to the appropriate hospital by patient transport services (available throughout the day, every day) or appointments were made for the patient to be seen there within the next day or two. Hospitals referred to in this way included Broomfield at Chelmsford (for limb nerve injuries or plastic surgery) or Moorfields Eye, or one of the major London Hospitals. The Queen's Outpatient A&E Eye Unit, located elsewhere in Team 2, was only open from 8am-4pm Monday to Friday.

Accommodation and facilities

Food was not available in the waiting area, but there are commercial food outlets available in the main Atrium entrance of the hospital. A&E staff were able to order food from the kitchens if needed urgently, and tea/biscuits were regularly offered in the BHRUT-run parts of A&E. It was also pointed out to the team that people who had eaten recently could not always be assessed/treated optimally.

The team were assured that staff were well informed about directions to the various departments within the hospital, including the "Hot Clinics" (surgery and ENT) but there was no signage to them. The team felt that patients would find colour-coded, easy-to-follow guide lines, on floors or walls, indicating the directions to specific areas helpful.

Majors had 26 beds, with 1 infection control room, and a psychiatric room available. There were 8 beds in Resus and 9 beds and 2 infection

control beds in Children's A&E. Staff were well aware of the lack of space in all areas, and that re-designing the area including RAFTing and the Children's A&E was desperately needed. The team noted that the financial position facing BHRUT meant that major alterations were unlikely but were told that a bid had been made on central funds for this work. The team felt the staff were trying exceptionally hard, and under great pressure to keep the service on an even keel. As previously noted in other reports, staff retention has been a difficult area and lots of ideas were being tried out in an effort to improve retention, along with a refreshed recruitment drive for nurses.

The lack of space was a particular problem when it came to moving trolleys, wheelchairs etc. through A&E. One trolley was kept in the UTC, although it was unclear what would happen if this trolley was in use; lack of trolleys or wheelchairs was also a major issue. The distance from the new A&E area to the areas within the old A&E, where the units still were, was another problem for sick patients to cope with. The team felt that this was far from ideal and hoped that when the re-design of A&E finally happened, it would lead to improvements.

The Team were also told that patients, or their carers, departing after treatment, often left wheelchairs in the car park areas and no one appeared to be responsible for retrieving and returning them to the main hospital building. This inevitably led to an unnecessary shortage of wheelchairs for patients in need of them. BHRUT have observed that arrangements are in place for wheelchairs to be "rounded up" regularly.

The team felt that signage, or lack of it, was an issue that need to be addressed. They were told that internal signage was being looked at, and some funding might be available. The external signage was another problem, with a lot of ideas needing to be thought about. For example, many patients who needed A&E and who had come out of the car park had no idea where to go and ended up in the main Atrium. The access road from Oldchurch Road going past A&E was reserved for

use only by emergency vehicles and buses, so the only vehicular access for patients arriving by car or taxi was through the main entrance in Rom Valley Way, where signage was needed. There was also no signage directing patients in cars to the drop off point (past the old entrance). The team felt the small notices at the ring road entrance were not sufficiently clear, and the lack of direction once past them was very poor.

BHRUT has subsequently advised that, following review, new internal signage has been ordered; external signage is under review.

Privacy in all areas of A&E was a well-known problem throughout the country. It seems that staff are well aware of this, but lack of space does not permit a very good response; curtains between beds particularly allow very little privacy.

Communication

Looking at the System as a whole, the need for a loud-speaker system for calling patients was apparent (with some form of pager for those patients who were hard of hearing). Such a system would help both staff and patients. For staff to call patients for attention in the current way is unacceptable. It was also felt a process chart should be displayed, to help with directions and so that patients can see the various services that may be directed to.

Multiple IT Systems (Symphony, Medway and Adastra (used by PELC)) were in use but did not readily communicate with one another. The team felt that this lack of inter-communicability could be detrimental to patients, with vital information being missed or duplicated unnecessarily, possibly leading to errors with potentially devasting effects. This needed to be addressed for safety reasons and the team felt that this needed to be addressed as a matter of urgency.

BHRUT has subsequently confirmed that a loud=speaker system is to be installed.

It was noted that relatives of patients could ask the reception staff in A&E for the whereabouts of their loved ones, which is available on the Symphony system but not the others.

Recommendations:

1 That, when eventually the re-design of A&E areas takes place (which it is accepted will be a massive task) opportunity be given for staff, patients and members of the public to be involved in all stages of planning.

2 That further consideration be given to means whereby streamers can identify seriously-ill patients at an early stage in order to avoid delay in their receiving attention.

3 That the need for all IT Systems to be compatible with one another, so as to avoid mistakes etc., be addressed as a matter of urgency.

4 That both internal and external signage be improved, again as a matter of urgency; and the possibility of providing "guiding lines" on floors or walls to provide easy-to-follow, colour-coded directions to specific areas.

5 That the arrangements for the availability and storage until required of trolleys and wheelchairs be reviewed to ensure that so far as possible, a sufficient supply is available to meet patients' needs.

Disclaimer

This report relates to the visits on 30 January, 9 March and 19 September 2018 and is representative only of those patients and staff who participated. It does not seek to be representative of all service users and/or staff.

APPENDIX

BHRUT: QUEEN'S HOSPITAL EMERGENCY DEPARTMENT (A&E)

ACTION PLAN

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
1	ED	That, when eventually the re-design of A&E areas takes place, opportunity is given for staff, patients and members of the public to be involved in all stages of planning.	ED Service Manager	April 2019	There is a Patient Partner involved in the meetings for the new rafting area.	
2	ED	That the need for all IT Systems to be compatible with one another, so as to avoid mistakes etc, be addressed as a matter of urgency.	ED Service Manager	September 2018	Process changed with streamer. Admin staff are trained to interlink between the systems, to help improve the flow of patients.	
3	ED	That both internal and external signage be improved, again as a matter of urgency.	ED Service Manager Estates management	March 2019	Internal signage has been reviewed and improved signage is on order. Estates are reviewing the external signage, some of which are not covered BHRUT.	

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
4	ED	That arrangements for the availability and storage until required of wheelchairs be addressed, including arrangements for the prompt retrieval of wheelchairs left by users in areas away from the main buildings and their return to a central point from which they can be collected when needed by incoming patients	ED Service Manager Estates management	March 2019	Sodexo carry out three sweeps throughout the car park daily. ED alongside Maternity and Oncology do their own separate sweeps. Estates will be auditing this for compliance. However, this is not an action that can be completed without support from those who use the wheelchairs in returning them.	
5	ED	A fast track arrangement at entry for emergency registrations	ED Service Manager	September 2018	The process of streaming allows patients to be prioritised and emergency registrations	
6	ED	Registration of children separately from adults	ED Service Manager	15th January 2019	Any child that goes through to children's ED will be registered in children's ED. Any child that needs GP will be registered in reception.	
7	ED	Staff be briefed and kept up to date with directions to other departments and useful locations within the hospital so they can guide patients with confidence	ED Service Manager	October 2018	There are daily briefings currently in place.	
8	ED – PELC	That staff carrying out streaming be more conscious of patient's privacy	ED Service Manager	September 2018	The streaming pods have been moved to improve privacy	

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
9	ED	That better ways of calling patients be explored, perhaps by installing an electronic calling system	ED Service Manager	April 2019	As part of Rafting there will be a tannoy system in place, due March 2019	
10	ED - PELC	Enlarge/move the 'hearing loop' sign at the registration desk.	Estates management	January 2019	To move the 'hearing loop' sign so it is more visible to visitors. Completed 04.01.19	

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

Healthwatch Havering is the operating name of
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