healthwatch Portsmouth healthwatch Hampshire

Emergency Department Walk-Through Visit

Date of visit: 14 March 2025

Queen Alexandra Hospital

Executive Summary

Healthwatch Portsmouth and Healthwatch Hampshire undertook on 14th March 2025 a 'walk-through' from the front door of the Emergency Department (ED) through to the new Urgent Primary Care Service facility at Queen Alexandra Hospital to observe patient experience, review accessibility and communication, and identify practical improvements. The visit formed part of Healthwatch's role as a critical friend, ensuring that patient and public feedback is used to inform service development.

Following the visit, Healthwatch submitted a series of recommendations to Portsmouth Hospitals University NHS Trust (PHUT). PHUT provided a formal response outlining actions taken, work underway, and areas for further review.

Several practical improvements have been initiated or are under consideration as a result of this engagement, particularly in relation to signage clarity, clarity of use of digital display, staff role identification, discharge processes, and access to services for patients with communication needs.

PHUT expressed that the insights from the visit were valuable in informing their planned improvements for urgent and emergency care and confirmed that patient and service-user voice is being considered in ongoing developments. As reflected in their correspondence to us, "*PHU values the information and insight that Healthwatch partners bring to learn from and improve care for our patients. We have used the valuable insights from this visit to ensure the patient and users' voice is captured in our planned improvements for urgent and emergency care.*"

This report sets out each topic area discussed, summarises Healthwatch's recommendations, outlines PHUT's response and progress to date, and identifies any further actions or monitoring required.

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1. Introduction

The purpose of the walk-through visit was to observe the patient journey through the Emergency Department and Urgent Care services, including arrival, registration, waiting experience, streaming, discharge, and accessibility. Particular attention was paid to clarity of information, privacy, wayfinding, equity of access, and support for vulnerable groups.

The visit comprised both strategic engagement and observational activity. The Healthwatch Area Director and members of the Healthwatch Portsmouth and Healthwatch Hampshire Advisory Boards met with the senior management team in the Emergency Department (ED) to discuss system pressures, operational challenges, and service developments. In parallel, a separate group of HW Portsmouth volunteers and Advisory Board members, supported by engagement staff, observed the Emergency Department environment and spoke directly with patients to gather real-time feedback on their experience.

This report reflects the recommendations made by Healthwatch Portsmouth and Healthwatch Hampshire ("Healthwatch") , the formal response provided by PHUT, and how PHUT has taken these recommendations into account to inform progress and service improvements. It aims to provide transparency regarding how patient feedback has been considered and acted upon.

Strategic and operational meetings between Healthwatch and PHUT take place on a quarterly basis. Progress against the recommendations outlined in this report will be monitored through these forums, with updates incorporated into ongoing public reporting to demonstrate improvement.

2. Key Findings and Service Developments

2.1 Signage and Naming Clarity at the Emergency Department Entrance

During the visit, Healthwatch observed potential confusion arising from the Trust's use of different terminology at the hospital entrance, including references to the Emergency Department (ED), Emergency Care Centre (ECC), and Adult Urgent Care / Urgent Primary Care Service (UPCS). It was noted by PHUT that inconsistent naming may cause uncertainty for patients and relatives at the point of arrival, particularly during urgent situations.

Healthwatch recommended that signage across the front entrance and surrounding areas be reviewed to ensure clarity, consistency of terminology, and ease of navigation for patients and visitors.

PHUT confirmed that this matter had been referred to the Communications Team for review. PHUT will update Healthwatch once the signage review has been completed and any agreed changes have been implemented.

2.2 ED Wayfinding and Patient Information Board

Healthwatch noted the provision of a very useful ED Wayfinding and Patient Information Board in the lobby. Healthwatch recommended that additional similar boards be installed in other appropriate areas within the ED waiting area to further support patient navigation.

PHUT informed Healthwatch that **the placement of these boards is under review** and that opportunities to introduce additional wayfinding and patient information boards are being considered within the existing layout.

Progress on any agreed expansion of wayfinding provision will be reviewed through ongoing strategic and operational meetings between Healthwatch and PHUT.

2.3 Use of the Digital Display and Supported Access to Services

Healthwatch asked how patients with sight or hearing impairments would know when it is their turn to be assessed or treated. It was noted that a significant amount of other information was also displayed on the digital screens, so it was not immediately clear or noticeable when patient calls or waiting updates were shown.

PHUT confirmed that **the content of the digital displays will be reviewed** and that the volume of non-essential information will be reduced to ensure that waiting times and patient calls are more clearly visible and displayed more frequently.

2.4 Privacy at Registration Desk

Healthwatch recognises that maintaining privacy at the point of registration is essential to protect patient dignity and confidentiality. We recommended

introducing a visible floor marker to improve privacy and confidentiality at the ED registration desk as we noticed that conversations at the desk could be easily overheard by other patients nearby.

PHUT confirmed that **this recommendation is being considered as part of their plan to change streaming and booking process at the front door.**

2.5 Staff Role Identification

During the visit, Healthwatch did not observe information in the Emergency Department reception or waiting area explaining staff uniform colours or role designations. It was not clear which members of staff held clinical responsibility within the waiting area.

Healthwatch observed that basic observations were being undertaken by staff wearing grey uniforms; however, it was not clear what role these staff held. Distinct clinical uniforms were only observed within the separate Minors area, which appeared comparatively well staffed at the time of the visit.

Healthwatch recommended the introduction of a visible staff uniform identification board to help patients understand who is caring for them in which area of ED and to provide reassurance regarding clinical oversight.

Patients generally expressed a wish for someone to attend to them during their long waits, which could range from 6 to 24 hours, to provide updates on expected waiting times and offer some reassurance during these periods.

PHUT confirmed that a staff uniform identification board will be installed within the Emergency Department and that arrangements are underway to source and display this information.

2.6 Mental Health Liaison and Access to Support

During the walk-through visit, Healthwatch heard positive feedback about the Mental Health Liaison Service based at the QA site. However, it was also reported that patients living within the PO1–PO6 postcode areas appeared to experience quicker access to mental health support compared with patients attending QA who reside outside these areas. Healthwatch therefore asked whether this difference in access was linked to PHUT

Emergency Department referrals from the Portsmouth Mental Health Hub which supports residents living in Portsmouth postcode areas PO1-PO6.

PHUT confirmed that Solent NHS Trust and Southern Health NHS Foundation Trust are now jointly part of HIOW Healthcare. While there remain some differences in ways of working and operational parameters across teams, PHUT confirmed that there is an ongoing review of working arrangements across HIOW Healthcare to help ensure greater consistency, so that patients receive equitable treatment and access to services irrespective of where they live.

2.7 Refreshments for Patients Experiencing Long Waits

Healthwatch recognises that it is important for patients waiting for extended periods in the ED to have access to consistent and appropriate refreshments. We recommended that a more consistent refreshment offer be provided for triaged patients waiting longer than four hours, including low-cost healthy snack options.

PHUT confirmed that water is available at all times and that tea and sandwich rounds are currently in place. The Trust also confirmed that **the frequency of refreshment rounds will be reviewed and that options for introducing healthier vending provision are being explored to support the existing offer.**

During the visit, the Healthwatch team spoke with patients in the waiting area. We identified that although water, hot and cold flasks, biscuits, and vending machines were available, not all of the waiting patients were aware of these provisions. We observed that the volunteer-led trolley service provided drinks; however, its availability was described as irregular rather than scheduled. It was also noted that vending machine options were predominantly high in fats and carbohydrates, with limited healthier alternatives.

2.8 Corridor Care and Improving Patient Flow

During the Healthwatch visit (mid-morning on a Friday), between 14 and 18 patients were being cared for in the corridor of the Majors unit as all treatment bays were occupied. The corridor has capacity for up to 30 hospital beds positioned in line. While the space is wider than the previous Emergency Department corridor and offers a comparatively improved

physical environment, it remains not an ideal setting for the delivery of care or ongoing monitoring of patients. Healthwatch noted that designated staff were present to manage corridor patients and that seating was available for relatives. However, emergency call buttons were not observed in this area. Healthwatch therefore sought clarification on the future Portsmouth and Southeast Hampshire (PSEH) system plans to manage and reduce the use of corridor care.

PHUT confirmed that reducing reliance on temporary escalation spaces in the ED corridor is a priority and acknowledged that this requires a coordinated system response focused on admission avoidance and reducing discharge delays. PHUT explained that a newly established Portsmouth and South East Hampshire Hospital Discharge and Admissions Group (PHSE DAG) is overseeing discharge pathways (0–3) in line with national guidance, identifying themes in system performance and addressing challenges. PHUT confirmed that an improvement plan is in place, informed by data analysis and a detailed review of discharge delays. This improvement work includes clarifying the role of the Transfer of Care Hub within the discharge pathway, improving coordination and frontline access to information, enhancing discharge planning processes, reviewing the Discharge to Assess pathway, and considering closer alignment of transfer and discharge decision-making across mental and physical health services. PHUT also confirmed that this forms part of a wider 18-month programme, alongside work to expand Same Day Emergency Care and strengthen board and ward round processes to improve patient flow. (HW were invited to join the PHSE DAG to contribute intel and support to help improve system working.)

2.9 Reducing Frailty Admissions and Discharge Planning

During the visit, Healthwatch expressed concern about the admission of mainly frail elderly patients to acute wards from Majors, including via corridor care, particularly where patients were already medically fit for discharge and may have benefited from a less acute step-down setting. Healthwatch highlighted that this may be especially relevant for patients living with dementia where a more appropriate care environment could support better outcomes. Healthwatch also asked whether a care plan is routinely developed with patients and carers on admission in preparation for discharge. This clarification was sought to support Healthwatch's ongoing contribution to the developing HIOW ICB Frailty Strategy, where Healthwatch is a partner.

PHUT confirmed that Basic FIT (Frailty Interface Team) assessments are completed for patients with a Clinical Frailty Score (CFS) of 4 or more on arrival in the Emergency Department or Acute Medical Unit. These assessments consider the views of family or carers where appropriate and with patient consent. For patients with a CFS of 5 or above, a Comprehensive Geriatric Assessment (CGA) is undertaken, typically led by the Frailty Interface Team alongside a geriatrician or frailty-experienced clinician.

For patients deemed Medically Optimised for Discharge (MOFD) who do not require an acute medical bed, discharge home with urgent care response, admission to an acute frailty virtual ward, or transfer to a community bed are considered by the multidisciplinary team in conjunction with community partners. PHUT further confirmed that, as part of its Frailty Programme, the Older Person's Medicine Care Group has developed business cases to expand Same Day Emergency Care and the Frailty Interface Team to increase frailty support at the front door. Plans are also being developed to expand the short-stay offer to include younger frail patients. PHUT indicated that these developments will be implemented incrementally and will require investment and potential repurposing of funding. The Older Person's Medicine team is working collaboratively with community partners to support a more seamless and future-proofed pathway for this patient cohort.

2.10 Medically Fit for Discharge and Hospital Flow

Healthwatch heard that there are a number of patients within QA Hospital who are medically fit for discharge (MFFD) or have no criteria to reside (NCTR), which is impacting acute hospital flow. Healthwatch asked whether there are plans in place to address this and expressed interest in visiting the Discharge Lounge to better understand the challenges associated with reducing the MFFD/NCTR cohort and the potential impact on patient flow.

PHUT acknowledged that there are currently higher numbers of patients who no longer meet the criteria to reside and are discharge ready. The Trust recognised that this has implications both for patients waiting to return home and for those requiring access to acute care. PHUT confirmed its commitment to working with partners across the Portsmouth and Southeast Hampshire (PSEH) system to reduce discharge delays and decrease the number of acute beds occupied by patients who are medically optimised for discharge. PHUT indicated that much of this work requires coordinated system working, as outlined in the broader discharge and admission improvement programme.

Healthwatch also asked what action is taken if, upon reaching the Discharge Lounge, it becomes apparent that a patient does not have sufficient care arrangements in place, lacks a support plan, has emotional wellbeing needs, or is frail and requires additional assistance. PHUT confirmed that the Discharge Lounge team can refer patients back to the clinical department if discharge is considered unsafe or further support is required. The Discharge Lounge is staffed by registered nurses who have access to the full multidisciplinary team, including the Discharge Matron, and can escalate concerns to access wider system support where appropriate.

PHUT welcomed a suggested Healthwatch visit to the Discharge Lounge and suggested that a visit to the Transfer of Care Hub would also be valuable to understand system discharge planning arrangements. Healthwatch has since arranged a visit for March 2026. The Healthwatch Area Director and Advisory Board members will meet with senior leaders to discuss discharge processes, system pressures and opportunities for improvement. In addition, a separate team of Healthwatch volunteers, supported by Engagement Officers, will observe the patient environment and speak with patients while they are waiting for discharge. The insights gathered will help inform Healthwatch's understanding of current practice and identify areas for potential improvement.

2.11 Medication Complications and Discharge Medicines Service

During the visit, Healthwatch discussed the issue of avoidable admissions related to medication complications, which can account for a significant proportion of emergency presentations. Concerns were raised regarding patients on long-term prescriptions and polypharmacy, particularly in the context of reduced routine annual medication reviews in primary care. Healthwatch suggested that Hampshire and Isle of Wight ICB promote the routine offering of a pre-discharge medication review, including liaison with the patient's GP, as part of the nationally funded Hospital Discharge Medicines Service within NHS acute trusts.

PHUT confirmed that it is in the final stages of testing a digital interface 'PharmOutcomes', which will enable direct referral to Community Pharmacies for follow-up medication reviews for high-risk patients as part of the Discharge Medicines Service. PHUT mentioned that, once testing is complete, work will progress on finalising the process and publishing the service, with implementation planned from October '25.

2.12 High Intensity Users and Multi-Agency Support

Healthwatch was informed that patient flow from Majors (32 bays and 16 overflow chairs) to acute wards during the first part of 2025 averaged approximately 50–60 patients per day. Healthwatch noted that very regular hospital attenders (more than three times per week), referred to as High Intensity Users, continue to place pressure on acute flow. Healthwatch therefore asked what plans are in place to support High Intensity Users to access more appropriate support and treatment from health and care teams outside of the Emergency Department.

PHUT confirmed that a multiprofessional team supports High Intensity Users. This work is led by an Emergency Department consultant with dedicated time within her job plan and is supported by an ED matron, Alcohol Specialist Nurses, and Mental Health Liaison teams. The team reviews and plans care for complex patients and frequent attenders in line with the Royal College of Emergency Medicine (RCEM) Best Practice Guideline, *Delivering Interventions and Services for High Intensity Use* (March 2024). PHUT also confirmed that specific alerts are placed on electronic care records for High Intensity Users, enabling attendances at ED to be audited and care plans to be accessed by multidisciplinary teams, with the aim of supporting prevention of avoidable admissions and repeated attendances.

2.13 Emergency Department Waiting Area Survey and Patient Experience

Healthwatch was invited to conduct a short survey with patients waiting in the Emergency Department (ED) waiting area. The situation observed during the visit raised concerns relating to patient welfare, dignity, communication, compassion, and safety.

Among those spoken to, 63% reported that they had called or attempted to obtain a GP appointment before attending ED, 42% had contacted NHS 111, and 10% had been directed to ED via an Urgent Treatment Centre. None had sought advice from a pharmacy, while 16% stated that they chose to attend ED directly as their default point of access. In relation to waiting times, 63% had been waiting longer than four hours and 84% had not received information about the likely length of their wait. Almost half (47%) said this was their first ED visit within the past 12 months.

When asked what would improve the waiting experience, patients highlighted the need for more chairs and more overall space, a more

comfortable environment for long waits, access to music or television, clearer information about the availability of water flasks and regular refilling of these, and better communication about next steps in their care. All patients spoken to were unclear about what would happen next in their pathway, including whether they were waiting to see a doctor or nurse, or for investigations such as blood tests or scans.

Healthwatch observed what appeared to be limited visible coordination and communication between staff and patients. Several patients described feeling intimidated or that their symptoms were not being taken seriously. Some expressed concerns about a perceived lack of compassion in interactions. Healthwatch was also concerned about confidentiality and respect, particularly where personal questions were asked in open areas where conversations could be overheard.

The team did not observe staff proactively checking on all patients on a regular basis in the waiting area, and many patients appeared to be waiting without support. Although Healthwatch was informed that checks were undertaken every two hours, several patients reported that they had not been reviewed for well over 12 hours. Healthwatch had also been told that two Health Support Workers were routinely present in the waiting area to monitor vital signs; however, the team noted a lack of visible senior or trained clinical presence to provide oversight and assurance of patient safety and welfare. One Healthwatch colleague reflected that they felt compelled to raise concerns directly before clinical attention appeared to be given.

On two occasions, Healthwatch representatives raised immediate concerns with staff due to shared worries about patient welfare and safety. It was also noted that patients appeared to be informally supporting and watching out for one another during prolonged waits. In addition, no free wheelchairs were visibly available for use at the time of the visit, and Health Support Workers confirmed that none were available in ED that morning.

In response, PHUT acknowledged the feedback and expressed regret that some patients and relatives felt unsupported or that visible coordination from a registered nurse was not evident in the waiting area. **PHUT recognised that further work is required to address these concerns and strengthen the safety and experience of patients using Adult Urgent Care.**

PHUT confirmed that a dedicated working group has been established to focus specifically on the safety, effectiveness, and experience of patients using this service, with a key priority of reducing overcrowding in the department.

PHUT further confirmed that a trained nurse coordinator role has been introduced to provide senior clinical oversight within the waiting room. This role is currently operating during daytime hours, and its impact and benefit are being reviewed, with consideration being given to extending the role overnight.

The Trust informed Healthwatch that work is underway with primary care partners to amalgamate the Emergency Care Centre and the GP service into a designated co-located area on site. This redesign is intended to enable more effective streaming by reducing the number of options available to the streaming nurse to a single point of entry to both services. PHUT explained that co-location will allow Emergency Nurse Practitioners to support GP access to diagnostics, and that the service was due to start operating from the end of September.

Healthwatch had previously queried whether closer integration between ED Minors and the Emergency Care Centre (ECC) was being considered, particularly in relation to patient streaming and pathway clarity for those who do not meet Urgent Treatment Centre (UTC) criteria.

Healthwatch notes that this redesign may help streamline pathways for patients who do not meet UTC criteria but have an urgent primary care need and reduce complexity within ED streaming. The operational impact of this change will become clearer as the new model is implemented.

PHUT indicated that it values the information and insight that Healthwatch partners bring in order to learn from patient experience and improve care and expressed its commitment to ongoing engagement and collaboration.

Conclusion

This report reflects Healthwatch Portsmouth's Emergency Department walk-through observations, patient survey findings, and the formal response provided by Portsmouth Hospitals University NHS Trust (PHUT). It demonstrates constructive engagement between Healthwatch and PHUT, with a shared commitment to improving patient experience, safety, dignity and system flow.

A number of practical environmental and operational recommendations arising from the visit have been acknowledged and are being progressed. These include

- review and enhancement of privacy arrangements at the registration desk
- expansion of wayfinding and patient information boards
- review of digital display content
- strengthening refreshment provision for patients experiencing long waits
- introduction of a trained nurse coordinator role to provide senior clinical oversight in the waiting area

Service redesign through GP and Emergency Care Centre co-location is also underway to improve streaming and reduce overcrowding.

Alongside the immediate environmental and operational changes identified, PHUT has outlined a coordinated programme of system-wide improvement focused on patient flow, discharge pathways and front door frailty support. The Trust described work underway across admission avoidance, discharge planning and community coordination, indicating both short-term operational actions and longer-term system transformation is aimed at reducing pressure on the Emergency Department.

The findings from the waiting area survey highlighted important themes relating to communication, compassion, coordination, confidentiality, and clinical oversight. **PHUT has recognised these concerns and confirmed that a dedicated working group has been established to focus specifically on safety, effectiveness and patient experience within Adult Urgent Care.** These developments represent an important opportunity to strengthen real-time patient experience and operational resilience.

Healthwatch welcomes the Trust's openness, acknowledgement of areas requiring improvement, and stated commitment to learning from patient voice. Continued engagement, including a planned visit to discharge services and ongoing strategic and operational discussions, will provide opportunities to understand how these actions translate into measurable improvement for patients and families.

Healthwatch remains committed to undertaking its critical-friend role and to working collaboratively with PHUT and system partners to ensure that patient insight continues to inform service development and improvement across urgent and emergency care.

Report ends. 4.3.2026

Healthwatch Portsmouth
Healthwatch Hampshire