healthwatch Havering

Enter & View

Queen's Hospital, Romford: Accident & Emergency Services

Streaming and Urgent Treatment, Emergency Department and Ambulance Receiving Centre

September 2022

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
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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 Community Interest 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?

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 voice, 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.

Before the Covid pandemic began in early 2020, we had visited Accident & Emergency services at Queen's Hospital on several occasions and made suggestions for improvement.

Visiting after the Covid pandemic

During the period of the Covid pandemic, the Enter & View programme was inevitably suspended. Now that the pandemic is largely over, we have been able to resume the programme but with safeguards to ensure the safety of the users and staff of the facilities we visit and of our members who are conducting the visit.

For that reason, visits will be conducted by a small team, who will wear personal protective equipment (PPE) appropriate to the facility they are visiting and take sensible precautions such as the use of hand sanitiser.

We have also changed our approach to conversations with the management, staff and users of the facility. Previously, this would have been done face-to-face on the day of the visit but, after Covid, that is no longer practicable. So, we will hold such conversations, where possible in advance of the visit, using an online video meeting.

The visit that is the subject of this report was conducted in accordance with this innovative approach.

Glossary of terms used in this report

This is an extensive report, with numerous abbreviations and acronyms, some familiar and some not so. For ease of reference, those most used are listed here:

A&E - Accident and Emergency (collective reference to ED, ARC and UTC – see as follows)

ADA - Accident department Assistant.

AGP - Aerosol Generating Procedures

ARC – Ambulance Receiving Centre (pronounced "Ark")

BHR - Barking and Dagenham, Havering, and Redbridge

BHRUT - Barking, Havering and Redbridge University Hospitals NHS Trust

CCU - Critical Care Unit

CEO - Chief Executive Officer

ED - Emergency Department

FOPAL - Frail Older Persons Advice & Liaison service

HCA - Health Care Assistant

LAS - London Ambulance Service

LD - Learning Disability

NEL – North East London

NHSNEL – NHS North East London (the Integrated Care Board for the region)

NIV - Non-invasive ventilation

OHGP – Out of Hours General Practitioner service

PELC - Partnership of East London Cooperatives

PRU - Patient Response Unit

RAFT - Rapid Assessment and First Treatment

SDA - Single Dose Analgesia

SDEC - Same Day Emergency Care

SDPC – Same Day Primary Care

SNAPP - Sentinel Stroke National Audit Programme

Type 1 - Ambulance arrival

Type 2 - PELC Arrival

Type 3 - Walk in.

UTC - Urgent Treatment Centre

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1 Introduction: Accident and Emergency Services at Queen's Hospital

For the purposes of our visit and this report, we have used the umbrella term "Accident and Emergency Services" to cover three distinct centres of operation within Queen's Hospital:

- the hospital's own Emergency Department (ED), provided by the Barking, Havering and Redbridge University Hospitals Trust (BHRUT);
- the Streaming, Urgent Treatment Centre (UTC) and out of hours GP (OHGP) service, provided by the Partnership of East London Co-operatives (PELC); and
- the Ambulance Receiving Centre (ARC) provided by the London Ambulance Service (LAS).

These centres are co-located within the hospital and work together as seamlessly as possible from the patient's perspective; indeed, some staff work together on a common basis, for example in streaming patients to the ED, UTC or OHGP.

We have visited both the ED and the UTC/OHGP service (but not the area used by the LAS for ambulance arrivals and waiting) in the past but that was before the Covid disruption [1]. At those times, the arrangements for patients' reception and streaming were significantly different: it became clear during the Covid disruption that major changes were needed in those arrangements, and it is reasonable to say that the arrangements now in place – although themselves far from ideal - are a significant improvement upon what went before

[1] See for example - **Queen's Hospital, Emergency Department (A&E) Announced visits: 30 January and 19 September 2018 Emergency Department (A&E) Announced visits: 30 January and 19 September 2018 Unannounced visit: 9 March 2018 Unannounced visit: 9 March 2018** [click here to view]

(especially during the initial stages of the Covid disruption) and it would be unfair to compare them.

Queen's Hospital is one of the busiest hospitals in London, if not England, and its A&E services are consequently nearly always very busy. In the period 1 April 2021-31 March 2022, the Emergency Department alone saw 59,244 patients (an average of over 160 per day).

Queen's Hospital opened 16 years ago. The population of Havering alone has grown in the last ten years (in Havering, the population size has increased by 10.4%, from around 237,200 in 2011 to 262,000 in 2021. This is higher than the overall increase for England (6.6%)) and neighbouring boroughs have experienced similar growth rates. This means that the hospital now serves a significantly higher population than it was designed to.

Moreover, Queen's Hospital has a larger catchment than Havering alone, providing services for residents of the London Boroughs of Barking & Dagenham and Redbridge and the neighbouring districts of Brentwood, Epping Forest and Thurrock.

Pre-Visit interviews with senior staff

Before the visit, members of Healthwatch met by video conference:

- Sabine Mohammad, Head of Operations of PELC, about Streaming, UTC and OHGP;
- Ben Evans, Assistant Director of Operations, and Tiffany Wishart, Senior Clinical Lead, of the LAS about the ARC; and
- James Avery, Improvement Director, Emergency Care of BHRUT about the ED

These meetings gave us an opportunity to discuss the accident and emergency services at Queen's Hospital and to set the scene for the visit.

We are grateful to all these staff for meeting us and for so helpfully setting the scene.

The visit

We carried out the visit over three days at the end of September 2022. The visiting teams comprised volunteers and our Community Support Officer.

It should be noted that, because of the over-lapping nature of the work undertaken in the three centres, some of the content in this report may appear to be repetitive.

At the end of the report are some thoughts and recommendations. The work of A&E is highly technical and Healthwatch is not a position to comment on practices and procedures that are dependent upon the skills of medical, nursing and paramedic staff. There are, however, some practical points that would improve the experience from the patients' perspective and we hope that these thoughts and recommendations will help in making further improvements.

It should be remembered that this report is a "snapshot" of the position at the end of September 2022. Some innovations were then due but had yet to be implemented, and others may well have emerged since then. The report therefore does not necessarily reflect the way in which any of the centres is now operating.

National statistics

Useful statistics about the number of A&E Attendances and Emergency Admissions are available from NHS England by clicking here.

2 Streaming, Urgent Treatment Centre and Out of Hours GP Service – 27 September

Pre-visit interview

Although the Streaming (also known as triaging), Urgent Treatment Centre (UTC) and Out of Hours GP (OHGP) Services are located within the Queen's Hospital premises, they are provided by a separate organisation, PELC (the Partnership of East London Co-operatives) – a co-operative organisation of general practitioners – under a contract with NHS North East London. PELC are not part of BHRUT but provide a 24hr urgent care service at Queen's Hospital.

PELC also provides urgent care at four Urgent Treatment centres which are:

- Queen's Hospital UTC, Romford
- King George Hospital UTC, Goodmayes
- Barking Hospital UTC, Barking
- Harold Wood UTC, Harold Wood

In the period 1 April 2021 to 31 March 2022, over 109,000 patients were streamed by PELC at Queen's Hospital.

The time that elapses between a patient's arrival and streaming varies but PELC aim to register and stream patients within 15 to 20 minutes of arrival at the most. This target is set by the NHSNEL Commissioners. They appear to be operating at safe staffing levels. Steps are taken to identify urgent cases, which are taken to the front of the Streaming queue to be fast tracked to the appropriate area. This can be useful when the queues are large.

From the time of registration being completed, the aim is that observations are completed within 15 minutes.

Not all clinicians working on Streaming do so at the same pace. The average time to see a clinician varies, but it is generally within an hour. Streaming is the biggest clinical risk, so it must be tackled quickly. Waiting for blood tests and X-Rays etc. can obviously lengthen waiting times.

Staffing is at nationally recommended levels. Staff have different skill mixes and include, for example, prescribing pharmacists. With winter approaching, they are trying to recruit more staff.

An unreliable IT system meant that they were having to use a paper system for observations, but a new system was due to be installed soon afterwards that would enable all observations to be entered electronically, thus leading to a smoother and quicker operation, and ensuring the safer running of the area.

PELC can redirect patients to the extended access hubs when there are appointments available - the hubs are commissioned by NHSNEL and are open 8am to 8pm Monday to Sunday and include the Harold Wood Polyclinic. Patients are only sent to their GP if they need a follow up. A discharge summary for every patient who attends hospital is sent to their GP.

The clinicians in Streaming decide who goes to the ED, following the relevant clinical pathways and guidelines which are identified by coloured cards The clinician also decides whether a patient needs a blood test.

PELC are aware when the ED is busy, and staff regularly meet every day. If the ED is overwhelmed, PELC will let the clinicians know.

As ambulance waiting times can be lengthy, patients with more serious issues are being brought to the hospital by friends or

relatives, which is a cause of concern for safety. If need be, such patients are taken straight to the Resuscitation area and, if need be, the Crash Team would be called. They have access to Trolleys and Wheelchairs; there is a long distance from the Streaming area to the ED and can be time critical.

The target for Streaming to the UTC is four hours and, at the time, they were reaching 70-80% being seen within that target time. Arranging appointments for patients to be seen by their GP can be challenging but is done wherever possible. Some patients who have attended (known as "the worried well") but require no treatment are sent home to rest and recover.

To see the OHGP, patients must have an appointment, which is normally booked through the NHS111 service, but must still go through the registration process (which some find confusing, given that they have an appointment). Patients can also be referred to the OHGP directly from Streaming too.

One GP is always on duty during the night; during the day, between two and four GPs are on duty. A minor injuries Doctor is also in attendance until 2am in the morning.

Waiting times to see a GP vary and the UTC will assist if need be.

The number of people attending the unit varies but can often be more than 400 with Mondays being particularly busy; unsurprisingly, the larger the number of patients attending, the longer it can take for an individual to be seen.

The visit

Our visiting team met with the Site Manager and the Staff Manager. They were very open and went through everything with us, including how they had changed the system to speed things up, knowing that winter pressures were rapidly

approaching. They explained that arrangements were being made to give the system more sustainability in the future.

The Site Manager had been in post for only three months but had much relevant experience to call on. She did not regard the current accommodation as ideal.

Approximately 3000 patients go through Streaming each week, at least 400 per day. Following streaming, most patients are directed to the ED or the UTC, but some are referred elsewhere or sent home. Patients who arrive by ambulance are taken directly to the ED (see later in the report).

Our visiting team were taken through Streaming.

There are two concierge desks where patients in the queue register - their details are recorded, and they are given a form to take into the Streaming area. Given the lack of confidence in the IT system, a paper-based system was in use, despite the obvious risks of taking longer to complete and of forms being lost. A new system was due to be introduced shortly after the visit.

The concierge desks have a list of patients' conditions which are to be prioritised and taken to the front of the Streaming queue that includes those who have a learning disability, frail and elderly, babies, cancer patients, and those with suspected fractures.

Following registration, the patient's basic observations (vital signs - blood pressure, pulse etc) are taken by a healthcare assistant (HCA), and they are given a numbered ticket to await assessment by a Streamer. There is a seating area available to avoid patients standing around. If patients are classed as urgent, they go straight to the front of the Streaming queue. If a blood test is required, the Hospital's pathology department processes it, but a delay is inevitable while that takes place. A

Streamer then assesses the patient's need and either sends them to the ED, the UTC or releases them to go home. Coloured tickets are used here to denote to which area they are to go.

The Streamers decide who needs blood tests, x-rays etc. Patients obviously must wait for results to come back, before being seen by a doctor.

Paediatric Service

Once registered, children have their own waiting area. There are plans to make the area more child friendly. A GP who specialises in paediatrics is on duty from 12 noon to 8pm.

Same day primary care (SDPC)

There are same day appointments, usually booked through 111. There are four appointments an hour with a GP. 10am - 4pm, 4pm - 10pm. The patients go home and come back at their appointment time.

Patients who have a Learning Disability

These patients are prioritised and taken straight to the front of the queue. Their forms are marked Urgent for the Streamer.

Priority Patients

PELC has a home visiting service for elderly and vulnerable patients. This service is accessed through NHS111 and operates from 6.30pm - 8am Monday to Friday and for 24hrs at the weekend.

Once the call has gone through NHS111, the doctor rings the patient, if the problem can't be sorted over the phone, the

doctor will make a home visit. PELC employs drivers to take doctors to patients' homes.

Operational issues

The team discussed with the managers issues/suggestions that had been noted on previous visits. One suggestion was that clinical Staff should introduce themselves by name to patients, and inform them of their role, such as taking basic observations, since many patients were unfamiliar with health service processes and doing so would be reassuring.

An issue was also raised about the time it takes for Doctors and Nurses to find their next patient. At the time of the visit, they called out the name in a large open area, where it was not always possible easily to be heard. Our team suggested that it would be preferable to make use of monitors to display names or ticket numbers as relying on calling out names is not only time wasting, but it does also not present a professional image. The managers advised that this was being investigated, adding that patients very often do not sit in the areas they have been asked to.

A Streamer to whom the team spoke told them that he had been doing the job for 2 years and enjoyed it but advised that there is a big turnover of Streamers, and they often left because they did not like the job. He said that his colleagues that day were all new in post. He worked three days a week from 8am - 1pm. He also expressed concern about what he considered to be inadequacies in cleaning and equipping the cubicles in which the Streamers worked.

3 Emergency Department – 28 September

Pre-visit interview

The Emergency Department is provided by the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) as part of their Queen's Hospital service.

As previously noted, patients arriving at Queen's Hospital are first Streamed by PELC. Approximately 100 patients a day are subsequently referred to, and treated at, the ED.

While it is important not to miss any patients with critical care needs, some patients who arrive at Queen's Hospital do not have an ED issue and should not be there. A recent survey suggested that 70% of attendees in A & E services had contacted some type of NHS facility such as NHS111 or their own GP before attending but were anxious and wanted to be seen the same day.

Some 70% of patients requiring treatment are seen and dealt with in the UTC; the remaining 30% are streamed by PELC to the ED and are treated there, of whom 60% are subsequently admitted to the Hospital.

Waiting Times

The waiting time target for patients in A&E is currently 4 hours from arrival to admission, transfer, or discharge.

Only about 35% of patients were being seen within this four-hour target, including patients arriving by Ambulance and walk-ins.

There are obviously surges in attendance and this would affect treatment times: 10 – 15 people extra an hour attending or five

or six ambulances arriving would lead to an increase in assessment times and therefore treatment.

The queue is regularly reviewed with PELC, and any concerns are discussed.

The team meet up three times a day 9am, 12pm and 3pm for a review on waiting times. A Doctor, Nurse and the Senior team will all attend. Data tracking is in use and there is a full capacity protocol to ensure that patients are moved on.

At the time of the visit, the biggest cause of delay in treating a patient was a shortage of available beds.

Patients diagnosed with a Critical Care need are taken to Resus (where people are taken if they need immediate life-saving treatment). If a patient's treatment pathway does not require urgent attention, they will be seen in as timely a manner as possible, but this can mean a wait of up to twelve hours.

Holding Area

Whilst patients are waiting for ward beds, they are transferred to a hospital bed watched closely, tests and observations given and recorded. They are given food and drink if needed. As an example, a patient with Sepsis can be treated whilst waiting, so there are no delays in their treatment pathways.

Staffing

BHRUT have employed 100 extra nurses since March within the ED department and have also employed ED assistants.

Cardiac Care

Patients with heart problems, are directed immediately to St Bartholomew's Hospital in central London which is a centre of excellence for cardiac care. This reduces unnecessary delays in getting the patient to the best source of treatment.

Stroke Care

The hospital has a pre-alert system for stroke patients. Where patients travel to hospital via ambulance, the sending of a 'pre-alert' message to the ED can significantly improve the timeliness of treatment upon arrival in hospital.

The stroke service provides a 24-hour, seven day a week service for thrombolysis. This is a regional service, so they also accept patients from local hospitals who do not provide thrombolysis outside normal working hours.

The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards nationally. All stroke patients admitted to the Queen's Hospital Stroke Service will have data relating to key performance targets entered the SSNAP data set by the SSNAP coordinator

The SNAPP audit has given BHRUT an excellent rating for their rapid arrival and rehabilitation services. It has been appraised as a good, effective service.

Ambulance Arrivals

The Ambulance Receiving Area (ARC) (about which, see more below) has improved the patient experience. Patients can begin to receive treatment as soon as they arrive at this unit. Patients would be fast tracked, if necessary, based on the clinical lead's decision.

The result is that no one would be left in an ambulance outside. No ambulance outside would have a patient inside. All patients are assessed on their clinical urgency. This service has been recognised as an exceptional national example for treatment of patients arriving by ambulance.

Fast Track to Frailty

A new initiative had been implemented in the four weeks prior to the visit. There is now a rapid pathway to the frailty facility, enabling two patients an hour to be moved onto the frailty ward. Paperwork has been streamed, and the process made more efficient. This has dramatically reduced the waiting time for elderly patients in ED. The frailty unit now has more nursing and medical staff enabling to be treated in a more efficient way.

As of 10.30am every day the ED would have moved 5-6 patients into the frailty unit.

Same Day Emergency Care Unit

20 plus patients a day are seen at the Same Day Emergency Care Unit (SDEC).

As an example, a patient who is short of breath with a suspected pulmonary blood clot can have a lung scan be given anticoagulant medication and then discharged. They may return the next day, or they could go to see their own GP. Now it is housed where the Children's ED area used to be. The Trust are pleased with the SDEC model and are keen to expand it.

Other points

It was accepted that waiting times of 12 hours was not a good sign, but care was good once the patient had been put on a

pathway. Patients whose case was urgent were seen as a matter of urgency.

Bed blocking because of having to await social care was delaying discharge but prescriptions, once written, did not take a long time to dispense.

Asked whether having two organisations (PELC and BHRUT) caused barriers, the response was that it could be, but the organisations were working very closely and were in regular contact around the streaming model.

The visit

At the time of their arrival, the team noted as an aside that there were only four people waiting to register with PELC; and when they left, there was nobody waiting to register.

Staffing

Team were told that, since the pandemic, the footprint of the ED had changed considerably. The layout had been improved to enable the most to be obtained from the dedicated area provided. There had also been several changes in management and structure in ED; many improvements had taken place over the last year and, much had changed even in the last month. It is recognised that ED is a particularly high-risk challenging area.

Financial constraints prevent more staff being employed. This also restricts the Trust employing agency staff as they are expensive. Those agencies with better calibre staff charge the highest fees and are, therefore, not on the approved list.

Bucking the trend, however, the ED had not lost a lot of staff during or since the Covid disruption – the pre-covid staff

vacancy rate had stood at about 30% at time of writing (the end of September 2022) the vacancy rate was about 7%.

There was a good retention rate for staff, and overseas and placement interns were encouraged.

Although some staff may leave the ED because they may not be suited to the environment of the department, in most cases they are deployed to other areas and, after gaining more experience, a few may return to the ED.

14 new staff were due to start in November, with more to follow in the future.

Health Care Assistants (HCAs)

HCAs wear red tabards. ED have recruited 12 new intern HCAs who must have at least "Care Certificate" status (the Care Certificate is an identified set of standards that health and care professionals adhere to in their daily working life) or the status of Band 3 (2 years' experience): if they do not have a Care Certificate, they can be employed and can train to obtain one, which takes 6–12 months. All staff complete a two-week induction, with orientation and shadowing take place. HCAs are able and perform cannulation and venepuncture on patients. Blood tests are taken and time to get results varies between 1 and 1 1/2 hours if a specialist test is required.

Arrival Tests

All Patients are tested for HIV unless they want to opt out.
This was piloted in April this year and is now a regular test on admittance. Hepatitis B & C tests are proposed to be a regular admittance test and will be rolled out soon once funding and laboratory capacity has been identified.

Every patient is also screened for Sepsis on arrival. There is a protocol for detecting Sepsis.

Referral for treatment

After Registration and Streaming by PELC, patients referred to the ED are then triaged by a doctor and transferred to one of the ED sub-units **Majors B, SDEC, Resus, Rapid Assessment and First Treatment (RAFTing), Frailty Unit or Critical Care.** Patients are also brought in by ambulance. Care is prioritised with the elderly and very sick taking precedence and, if necessary, fast tracked to the appropriate ward.

Patients could have already waited one and a half hours in PELC by the time of arrival at ED, which some patients find frustrating.

Nurses from ED sometimes help with streaming. Following patients' comments that there is a lot of duplication in reporting, PELC, the ED and doctors now have a system where patients only need to tell their "story" once at initial assessment, which has reduced duplication.

After triage in ED if appropriate patients can be referred to their own GP.

Despite all reasonable efforts to meet the four-hour target, some days it is impossible to do so.

Majors A

The Majors A ward is for patients who are admitted with more acute conditions or injuries and has 24 beds.

The ward is in a circle with two Doctor's stations and a pharmacist station. Nurses have a clear view of all vulnerable

patients. Cubicles 1 -7 have walls dividing them, as opposed to curtains, and are used for patients requiring isolation. Cubicles 21 – 26 have walls and doors that close and are used if there is need for any patients to be quarantined.

At the end of each bed is a dementia friendly sign in yellow and black. These signs are for used for those patients who are confused, have poor mobility or at high risk of falls. Ordinarily, an HCA is deployed to observe patients who are at high risk of falling. There is a sign that reads *"please call we don't want you to fall."*

Patients who have a learning disability (LD patients) are fast tracked. There is a resource trolley for LD patients that contains patient information leaflets, checklists, passports and activities. The team were assured that reasonable adjustments were made for LD and autistic patients.

An administrative worker is available, whose role is talk to relatives to give updates on patients. Each patient has a contact list from which contact is made and, if a patient has been admitted from a care home, the home will also be contacted. Relatives can call the designated staff member themselves for a live update on patient. This model was introduced during the Covid disruption and has proved so popular it was decided to continue using it, resulting in many fewer complaints about communication between ward and relatives, and freeing up nursing staff to continue with their duties.

The Frail Older Persons Advice & Liaison service (FOPAL) is also located here.

One room is set aside for patients with mental health problems, with a special bed and ligature free. The team was told that more accommodation of this sort would be useful, given the

increased number of patients who present who have mental health problems.

Majors B

Two dedicated pharmacists are based in Major B ward in the ED. The pharmacists complete two drug rounds a day, 7-days a week.

The aim is to give patients a bed within the first 6 hours of arrival.

At the time of the visit, there were 75 patients in the ED, of whom 41 were waiting for admission to the main hospital and 24 waiting to see speciality GPs.

Triage waiting room for Majors B

On the televised screen, the team noticed that the indication that there were 74 patients waiting had not changed since 7.40am even though it was by then 11am. It also indicated that there was a 6.57 hour wait.

Adjacent to this was a waiting room for people who were able to sit. The team were told that an HCA monitored this room every 15 minutes and every hour patients' observations were checked, ensuring that they were having help or care that is needed; the HCA would assess patients and keep nurses updated with observations taken and if necessary, ask the GP to authorise comfortable pain relief. SDA (Single dose Analgesia) may be used, which all nurses are trained to administer.

Same day emergency care (SDEC)

SDEC, launched in July 2021, is one of the many ways BHRUT is working to provide the right care, in the right place, at the right time for patients. The service aims to reduce waiting times and

hospital admissions, where appropriate, and has 10 patient spaces to which patients are admitted from Majors B.

Under this care model, patients presenting at the hospital with appropriate conditions can be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if it is clinically safe to do so, will go home the same day.

Patients in this department have their own care pathway and are only admitted to a ward if there is a change in their health that requires it. They are sometimes referred to specialist surgical teams, and Orthopaedic, Medical, and Surgical consultants attend this area. 20 to 40 patients are seen in the department per day.

Meetings are held three times a day where Matron, Nurse in Charge, Consultant in Charge, PELC and Operational teams meet to discuss the status of queues and admissions to each area of ED.

Patients will be signposted if necessary to see their own GP.

Frailty Unit

Patients aged over 75 and not in need of immediate emergency care will be taken to the frailty unit at Queen's Hospital, bypassing the ED route to provide the specialist care they need and reduce waiting times for other ED patients.

The frailty unit is staffed by geriatricians, nurses, and therapists, who can give the care pathways these patients need. This unit was opened in May 2021.

Fast track to the frailty ward

One or two patients are sent to this ward every hour. This "encourages" staff on ward to progress patients already on the

unit to permanent wards or to their homes, if appropriate, unless a pause is put in place if the ward is nearing capacity. The day before our visit, a pause was out in place at 11am, with another at 5pm; and the last admittance would have been at 7pm.

Rapid Assessment and First Treatment (RAFT/RAFTing)[2]

The RAFTing area is where most patients who arrive in hospital by ambulance receive their first clinical assessment. From here ED staff can decide on a treatment plan and move patients to the right area of the department or hospital to continue their care.

The two ARC cubicles, staffed by LAS paramedics, are here (see below for more details). Once seen here, patients either go to Majors B or for attention; this releases Ambulance staff back into the community.

The most vulnerable patients are seen first.

It is not uncommon for LAS ARC staff to do a 12-hour shift. Often, LAS staff on the unit are returning from sick leave and this is regarded as a way of bringing them back to full duties in a less stressful way.

As the left, they noted that there were four ambulances in the ambulance waiting area.

Cohorting

This is a new model that is only just coming into use. LAS staff look after patients in conjunction with the ED. At the time of the visit, there was only one patient waiting with a member of the ambulance crew. We spoke to the LAS member of staff who

[2] Note – since the visit was undertaken, the RAFT process has changed from that described here

had been working for the LAS for 31 years. He was working on a laptop writing up patient details. He advised that he had been with his patient for 10 minutes.

Resus – Resuscitation Ward

This ward has 8 booths and 4 nurses, with the Dedicated Trauma Bay and two isolation cubicles. Procedures such as: AGP (Aerosol Generating Procedures) and NIV (Non-invasive ventilation) are performed in this ward.

Stroke patients may arrive here and be transferred to either the Stroke team or Stroke Unit in Harvest B ward or be taken to theatre.

Critical Care

The Critical Care unit has a 1–1 or 1-2 ratio of staff to patients.

Critical care is medical care for people who have life-threatening injuries and illnesses. It usually takes place in an intensive care unit (ICU). A team of specially trained health care providers gives 24-hour care.

Relatives Room

The team noted that the Relatives Room was due to be redecorated and repaired. This room would be used as waiting room for relatives in the event of a major incident.

Information Technology (IT)

The Careflow IT system has taken over from Symphony.

ED staff all use Careflow but not all of them have access to the more sensitive patient data recorded in it.

Physician Response Unit (PRU)

At the time of the visit, the department was about to introduce the PRU, a pioneering Community Emergency Medicine service which aims to deliver safe, effective, and patient-centred emergency care in North East London, delivered in partnership with Barts Health NHS Trust, London's Air Ambulance Charity and the London Ambulance Service.

It is staffed by a senior emergency medicine doctor and an ambulance clinician, like the air ambulance, and carries advanced medication, equipment and treatments usually only found in hospital. The service responds to 999 calls, treating patients in their homes who would otherwise have often required an ambulance transfer to hospital.

This unit would consist of a an Emergency Medical Technician (EMT) or Emergency Ambulance Crew (EAC) member and a consultant doctor, in a car in the community.

Trust Chief Executive Officer (CEO)

The team was told that the CEO regularly visits the ED. He has helped on wellbeing visits, distributing water to staff and patients. The manager was confident most members of staff would recognise him.

Staff morale

The team was told that, overall, staff morale was holding up and that staff were resilient. Staff found it frustrating that they could not always complete their work, leading to feelings of guilt. Most

staff are in nursing because they have a caring nature and for the right reasons; they want to help other people.

The matron told the team that she felt proud of her department and all her staff. They work as a team, helping each other. Nurses found it hard to go home and leave patients waiting on the corridors only to find when they the next morning that those patients were still there.

Conclusions

The ED is a "work in progress", working to make the patient experience better for each patient. A new more productive service and management team is now in operation.

Staff who work in the ED are passionate about their jobs.

The medical workforce is expanding and there should be new consultants arriving in post. The recent link-up with Barts Health is felt to be good, particularly in terms of medical staff provision.

At the time of the visit, although there was many patients in the department, everything appeared to be running smoothly and calmly.

4 Ambulance Receiving Centre – 29 September[3]

Introduction

The Ambulance Receiving Centre (ARC – pronounced Ark) at Queen's Hospital is provided by the London Ambulance Service (LAS) as a supplement to their role of providing the general accident and emergency ambulance response for the whole of London. Queen's Hospital also provides accident and emergency services for a broader hinterland extending into the Essex County districts of Brentwood, Epping Forest and Thurrock and ambulances from the East of England Ambulance Service and private and voluntary ambulance organisations also bring patients to Queen's Hospital.

It is worth noting that the ARC at Queen's Hospital was the first to be set up in the UK and was a response to the very high demand experienced at the hospital for patients being brought in by ambulance (often the busiest in London and among the busiest in the whole of England). The services provided there are evolving as experience is gained to the point that, at the time of our visit, preliminary care is offered to patients, including initial treatment procedures, such blood testing, canula insertion and other tests. The LAS and BHRUT have collaborated extensively in these developments; the effect has been the prompt release of ambulances for re-deployment and to ease pressures on the ED; LAS and BHRUT staff are now working together far more than hitherto. Patient feedback has been wholly positive. ARCs are now being developed elsewhere in North East London and the ARC at Queen's Hospital is becoming a blue print for elsewhere in England.

[3] Note – the model for the ARC has changed since the visit took place

Pre-visit interview

In recent times Ambulance waiting times have been mentioned in the media frequently. With the outbreak of Covid the NHS111 service has been brought to the forefront. Pre-Covid not many residents had even heard of this service; many people attend ED because they cannot get an appointment with their own GP.

The aim ideally is to reduce the number of residents taken to ED that do not need to go there, since if patients can be treated in the community, it is better for everyone.

The Ambulance Receiving Centre (ARC) is working with BHRUT to help reduce delays in ambulance crews handing over patients to the ED (Emergency Department)

From the LAS perspective, Queen's ED is one of the most challenging in London, so a pilot scheme was started at the hospital so that ambulances could hand over patients speedily and return to the community to help residents in need. The ARC was originally set up in May 2020 in an old Post room, which was equipped with ten bays and had staffing for 8 patients. This meant on average they could tend to 8.7 patients a day. As this room was not close to the ED department, it was soon decided to move the ARC to be within the ED footprint. This was clearly more efficient and enabled ambulance staff to get back "on the road" and to the community.

Since November 2021, 2,700, patients have "passed" though the ARC equating to the provision of 15,000 hours of care.

All ARC staff are employed by the LAS; some are on restricted duties or phased return to work staff. There is no manual lifting of patients in the ARC.

It would be difficult to define an exact length of time for patients waiting in the ARC. This varies tremendously, day by day and

hour by hour; at the last audit it was 7 1/2 hours per patient. Overall, the wait can vary between two and twenty-four hours.

Patients who are critically unwell would be fast tracked to the ED.

Ambulances are often seen apparently waiting at the rear of the hospital; the team were assured that these ambulances do not have patients inside waiting for handover but that their crews will be within the hospital area, perhaps taking a short break or completing essential patient records.

Cohorting

Another initiative the LAS and BHRUT had introduced shortly before the visit was Cohorting. This involves BHRUT staff working closely together to attend to patients in the corridors.

A third of patients admitted have experienced this and in just six days use of this initiative had released 38 ambulance crews earlier, equating to a minimum of 3 hours saved per patient, releasing least a 100 hours of ambulance staff time back in the community.

Several East of England and St John Ambulance vehicles arrive at the Hospital. The East of England Ambulances use a different IT system. BHRUT have arranged with the East of England ambulance service to use a paper system of recording information on their patients, to speed admission.

RAFTing

Another Model BHRUT are using is the RAFT (Rapid Assessment and First Treatment). Blood tests and observations can be taken, cannulas can be inserted, staff can record details on patient records ready for treatment and patients are assessed for their clinical pathway to begin. This quickens and helps the flow

through ED. Patients are transferred to a hospital trolley from an ambulance trolley which is more comfortable for them and reduces the risk of bed sores.

This is all positive for a good patient experience. Staff in RAFT are not authorised to prescribe medication.

The LAS are very keen to work with the trust together and collaborate with the BHRUT senior team at least three times a week to discuss issues arising that week. This is a process that is continuously improving, both for staff and the community. This proves to be a very good working model for all concerned.

Patient feedback has been positive.

The LAS realise this is a "sticky plaster" but are hoping in the future that the ARC will not be needed and the flow to ED will be a smoother quicker safer pathway.

The visit

At the time of their arrival the ARC was engaged in dealing with a serious incident and it was concluded that it would be inappropriate for the team to enter a very busy clinical area. Opportunity was taken therefore to discuss broad issues with the ARC manager, who was not needed to deal with patients.

The ARC was set up as a pilot scheme, originally for six months, but has been so successful it had so far been in place for over a year. During that time, it had changed considerably: it was first placed in a room not in the ED footprint, but now has two cubicles in RAFTing.

ARC handover times vary between 15 minutes and one hour depending on how busy the ED is. The busiest days seem to be Monday and Tuesday, perhaps because of beds not being vacated over the weekend.

The two ARC bays in the RAFTing area have 24-hour cover provided by two LAS staff in each of two 12-hour shifts per day.

Staff work in the ARC for multiple reasons. Some staff are seconded, some prefer to treat and assess patients, some for training and development, and some are on phased returns to work following sickness absence. There is no manual lifting in ARC.

Staff who work in the ARC complete at least one shift every two weeks on an ambulance.

It is not uncommon for patients to be in the ARC for between two to twenty-four hours. If patients are critical and there is a bed free in RAFTing, patients are transferred. The ARC team focus on Care treatment and are there totally for the patients. Patients can be discharged or go to the ward from the ARC. Patients placed in the corridor have more complex needs. This is called "Cohorting"

LAS staff meet three times a week with the Trust to discuss any issues occurring that week.

Cohorting

If the ARC and RAFTing areas are at capacity patients are moved to the corridor where they receive dedicated treatment from the ARC team. This enables Ambulance teams to get "back out on the road". The ARC team can tend to up to 8 patients in the corridor which is adjacent to the RAFTing area. This is better for the community, but patients can sometimes be in the corridor for up to 12 hours as they have no more space. This is not ideal; patients do not have privacy and if this can be avoided it is. Cohorting has only been in operation since the middle of September 2022 and has proved successful in getting LAS staff back out in the community to give care. The model is

under review, but it is estimated that 19,000 hours have been saved since January 2022.

Conditions requiring special treatment

Patients with Neurological conditions and paediatric patients are taken by ambulance to Queen's Hospital but patients who suffer heart failure are directed straight to St Bartholomew's Hospital, which relieves Queen's Hospital of much pressure.

Diverting ambulances to other hospitals

In response to a question about where an ambulance called to the new Beam Estate in Rainham would take the patient, the manager explained that LAS ambulances used a system called I.C. This system advised crews at which nearby hospital the waiting time was lowest, and a patient would be taken where the shortest queue was. For Havering, this could be Queen's Hospital, King George Hospital, Whipps Hospital or Newham Hospital.

The I.C system is used by the LAS only; East of England ambulances do not use this system. This can sometimes result in East of England vehicles outnumbering LAS vehicles in the ambulance waiting area and results in excess demand for the ED as London patients are dispersed but East of England patients are brought only to Queen's Hospital.

EMTs – Emergency Medical Technicians

EMTs assist in the delivery of pre-hospital clinical care, responding to 999 emergencies, hospital transfers and urgent hospital admissions. They attend emergencies, providing care and treatment for patients.

HALO – Hospital Ambulance Liaison Officer

The sheer volume of people coming into the ED throughout East London has prompted the need for a new service at the Hospital called HALO.

The Hospital Ambulance Liaison Officer (HALO) service operates from 12pm to 12am, to help redirect crews to utilise alternative care pathways instead of the acute based services. This will aid with ambulance crews' awareness and utilisation of alternatives services, and therefore, contribute to improved patient care by transferring patients to the most appropriate setting and ensuring that more patients are treated at the right place, at the right time, first time.

Summary

Although the ARC was clearly very busy, there was a calm atmosphere.

There has been a positive patient response to the ARC.

As elsewhere, and mentioned in this report, a lack of beds, problems with discharge procedures, the sheer numbers passing through the hospital and the inability of the hospital's facilities to meet the demand for services all create difficulties in delivering the level of service staff would like to achieve.

5 Patients' views

We had hoped to carry out extensive surveys of patients waiting to be seen in the Screening and UTC areas but, unfortunately, circumstances (unrelated to the centres we visited) precluded our doing so, not least because the high numbers of patients we had anticipated were simply not present during the times of our visits. We were, however, able to obtain the views of 10 patients. Whilst accepting that such a low number is statistically insignificant, their views are nonetheless worthy of inclusion in this report.

Of the ten interviewees:

4 were Havering Residents

3 were Barking & Dagenham Residents

2 were Thurrock Residents

1 was a Brentwood Resident

Their arrival times had been:

9-10am – 2

10-11am – 5

11-12noon – 3

At the time of interview, their waiting times had been:

Under 1 hour - 1

1-2 hours - 4

2-3 hours - 2

3-4 hours – 1

Not indicated – 2

The reasons given for attending the UTC were:

I hurt myself in an accident – 4

I felt unwell – 3

My GP told me to come here – 1

I contacted NHS111 - 1

Not indicated – 1

No one responded that they had come to the UTC because they had been unable to get a GP appointment

Asked whether they had contacted anyone for advice before coming to the UTC, they responded:

My GP – 3

Advised by NHS111 – 2

Did not seek advice - 3

Not indicated – 1

Four told us that they had contacted their GP but were told to come to the UTC.

Asked at what time they had contacted their GP, six responded:

Contact in the morning after 9am – 5

Contact in the afternoon before 6.30pm – 1

One person had spoken face-to-face with their GP; 3 had spoken by telephone to their GP; 1 had spoken to a receptionist who advised them to go to the UTC. Two had tried to contact their GP but could not get through.

One person contacted NHS111 who made an appointment for them.

Seven interviewees were alone; 2 were accompanying a child; and one was with an adult (under 69). Of those accompanying someone else, one companion was living with dementia: it was reported that nothing had been done for that person's special needs, but the interviewee felt that it would have been helpful for the person they were accompanying to be given a wrist band or the like to indicate they had a special need.

Asked to indicate their satisfaction with their experience on the day:

1 was Very Satisfied

4 were Satisfied

2 were Neither Satisfied nor Dissatisfied

1 was Dissatisfied

1 was very Dissatisfied

1 did not respond.

Of those who commented, two told our team that better communication was needed. One said the waiting time was too long and another had been seen by several staff before being examined.

Seven patients had come to the hospital by car (two of whom had experienced problems locating a parking space); one came by taxi; and one came by public transport (there is a bus station in the hospital grounds). One declined to answer.

Asked when they had last called at the UTC, they responded:

Within the last week – 2

Within the past month – 1

Within the past six months – 1

Within the past year – 1

More than a year ago – 5

Demographics:

Age group

Under 18 – 2

18-25 – 0

26-49 – 6

50-65 – 1

65+ - 1

Ethnicity:

Four patients were of White British ethnicity, and there was 1 each from the following ethnicities:

Bangladeshi

Black Caribbean

Mixed White/Black African

Other White

Another ethnic group

One person declined to state their ethnicity.

Six women responded, and four men.

6 Conclusions and suggestions

The physical environment of Accident & Emergency Services at Queen's Hospital has changed – mainly positively – beyond recognition since before the Covid pandemic. Despite the air of temporary arrangements that the Streaming area presents in the main Atrium of Queen's Hospital, it is a great improvement on what went before; and the ground-breaking Ambulance Receiving Centre means that patients arriving by ambulance for whom immediate treatment is not required, can be looked after in a better way than simply waiting in the vehicle until they can be seen.

It is obvious that all these arrangements are not permanent and that pressure on accommodation within the hospital means that these centres and services must inevitably compete with others for access to the spaces that are available. But equally, it is to be hoped that the improvements that have been made will be retained, if not built upon, in the more permanent arrangements that will follow once the Covid pandemic is fully over.

From a patient's perspective, the use of the Atrium is welcome – it is airy and spacious in stark contrast to the old A&E reception area which was cramped and very often over-crowded.

The following suggestions are put forward for consideration as means of securing an improved service from the patient's perspective.

Streaming, UTC and OHGP services

- It would be helpful if hospital volunteers could be deployed here to provide general support to those waiting to be seen

and to assist people referred to other parts of the hospital to find their way

- Provide some form of loud-speaker or monitor with names on to call patients. It is understood that since our visit the "next patient" number system previously used when the Streaming area was used for blood tests has been brought into use for Streaming but better means of calling patients to be seen in the UTC or by the OHGP service are still needed
- It would be helpful if a porter could be assigned to assist patients in the Streaming, UTC and OHGP area
- It would also be helpful for more wheelchairs to be available for those patients awaiting Streaming or to be seen in the UTC or by the OGP who are of limited mobility because of their illness or injury
- The Streaming process is vulnerable to being overwhelmed at times so it would be useful to arrange for additional Streaming points to be provided when demand is excessive, to avoid patients having to remain standing for prolonged periods
- In addition to the Streaming staff, a clinician should be available at times of high demand to observe the queue awaiting Streaming and to be alert to those who might require priority attention, whether due to the nature of their current illness or injury, or to their age or to a pre-existing condition such as frailty or disability (physical or learning)
- Although there is co-operation between Streaming staff in the UTC and the ED, closer involvement of ED staff in the Streaming process would assist the processing of patients

- Closer attention should be paid to the cleaning and general maintenance of cubicles in the Streaming area as they can sometimes present a poor impression.

Emergency Department

- Whilst capacity, within the department and the wider hospital, is the biggest challenge for the department, the lack of beds makes it a challenge to give patients the care and experience they deserve and, from our observations during the visit, is the single biggest cause of long waits in the department
- Discharge from hospital continues to be a cause of delay in getting patients from the ED to a mainstream ward as difficulties in transferring patients to settings where social care can be provided mean that patients may remain in hospital for longer than is clinical necessary, resulting in so-called "bed blocking"
- If patients could be discharged at weekends the rush for discharges on a Monday morning could be avoided
- The overlap between the UTC and ED means that some patients are still being inappropriately referred to the ED. Greater involvement of ED staff in the Streaming process might alleviate this.

As noted in the body of the report, the population served by the hospital has grown greatly over the period since its opening, but its physical capacity has not. Whilst measures to increase the capacity of the hospital are outside the scope of this report, it is to be hoped that NHSNEL and BHRUT will seize any funding opportunity that arises to ensure that the capacity of the hospital can be increased.

Ambulance Receiving Centre

Although the ARC is said to be temporary, there is no doubt that it is a considerable improvement on the arrangements that applied before its introduction. Whilst ideally patients should be taken straight from ambulance to the ED, for the foreseeable future some sort of holding arrangement will be needed and the ARC is important in that.

Closer liaison between the LAS staff in the ARC and BHRUT staff in the ED is welcome and to be encouraged.

Overall issues

The report reflects the visits that we undertook at the three centres that comprise A&E services at Queen's Hospital. However, these three centres, particularly as winter planning becomes an essential part of the overall care for patients, are highly dependent on a range of social care provisions.

These social care provisions are also a vital component of discharge and home care arrangements for patients, carers and their families. As a follow-up to this report, and to ensure that the complete picture is understood, we intend to work with BHRUT, social care and voluntary organisations to provide a comprehensive report on discharge arrangements.

7 Acknowledgments

We would like to thank everyone at BHRUT, PELC and the LAS who supported the visit; not just those to whom we spoke (both by video and on the days when we were in the hospital) but those who work behind the scenes to facilitate events such as this.

We also thank those patients who responded to our brief survey.

It should be remembered that this report is a "snapshot" of the position at the end of September 2022. Some innovations were then due but had yet to be implemented, and others may well have emerged since then. The report therefore does not necessarily reflect the way in which any of the centres is now operating.

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.

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.

Healthwatch Havering Friends' Network

Join our Friends' Network for regular updates and other information about health and social care in Havering and North East London. It cost nothing to join and there is no ongoing commitment.

To find out more, visit our website at https://www.healthwatchhavering.co.uk/advice-and-information/2022-06-06/our-friends-network-archive

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