healthwatch Havering

Enter & View

Queen's Hospital, Romford: Accident & Emergency Services

Streaming and Urgent Treatment, Ambulance Reception and Emergency Department

November 2024

Healthwatch Havering is the operating name of
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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.

Note: there may be some repetition of information between the sections of the report relating to the interview with the manager and the report of the actual visit, reflecting discussion as it took place and the observations made during the visit.

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Introduction

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 reception area to which patients are brought by ambulance (predominantly by the London Ambulance Service [LAS] but also by the East of England Ambulance Service and providers of private and voluntary ambulance services).

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 visited all three centres in September 2022 and found them to have been significantly improved in comparison with the arrangements that had been in place before the COVID disruption began in 2020. We conducted a further Enter & View

visit in December 2023 – described in this report – but, almost immediately afterwards, the accommodation for the services provided by PELC (the UTC, OHGP and Streaming) changed, with the result that our observations were superseded. This report now focuses on the new arrangements.

It is important to note that this report reflects the situations observed by our team on the dates and at the times of each visit – the position within A&E is constantly changing and, on a different day or time, what was observed might have been very different.

Population served

Queen's Hospital is still one of the busiest hospitals in London, if not England, and its A&E services are consequently always very busy. In the period 1 April 2023-31 March 2024, the Emergency Department (ED) alone saw over 200,000 patients, while the Streaming Team at the PELC UTC saw 76,087 patients, of whom 1,127 were referred to the OHGP service, 62,216 were seen in the UTC and 17,143 were referred to the ED. [1]

Queen's Hospital opened in the mid-2000s. The population of Havering alone has grown significantly since 2011: between the Population Censuses of that year and 2021, the population increased by 10.4%, from around 237,200 in 2011 to 262,000 in

[1] Sources: BHRUT and PELC. See Appendix 1 for data comparisons for Hospital A&E services across North East London.

2021; since 2021, the population has continued to grow, because of increasing large-scale housing development, particularly in the south of the borough. This was higher than the overall increase for England (6.6%) and neighbouring boroughs have experienced similar growth rates. The result has been that the hospital now serves a significantly higher population than it was designed to [2]; and further intensive development, not only in Havering but across North East London, will lead to further population growth over the next decade or more.

Queen's Hospital has a large catchment area in addition to Havering, providing services for residents of the London Boroughs of Barking & Dagenham and Redbridge and the neighbouring districts in Essex of Brentwood, Epping Forest and Thurrock, a total population approaching 1.2 million [3]. Although most patients brought in by ambulance are conveyed by the LAS, some are conveyed by the East of England Ambulance Service as well as private and voluntary services.

Of the hospitals in North East London that provide A&E services, by numbers of patients attending, Queen's Hospital is the busiest – see Appendix 1 to this report.

[2] In 2001, the population was about 225,000 – some 15% lower than in 2021 – source: **London Borough of Havering Demographic Profile JSNA 2023-24**
[3] Office for National Statistics (ONS), released 23 November 2023, **ONS website, statistical bulletin**

Reporting on the visits in December 2023 and subsequently

Ordinarily, we produce stand-alone reports on our Enter & View visits, aiming to publish them within three months or so of the visit taking place. In the event, it did not prove possible to do so in the case of our visits in December 2023.

Not long after our visits took place, BHRUT, working with PELC and the LAS, were able to undertake a substantial re-design of the accommodation arrangements for all three parts of the total A&E provision at the hospital, going some at least to meet many of the points that would have been mentioned in conclusions and recommendations arising out of the visits in December.

In addition, our ability to publish a report was constrained by the pre-election "Purdah" periods before the London Assembly elections in May and the national General Election in July.

This report therefore includes not only the findings of the visit in November 2024 but also summaries of the December 2023 visits, an outline of the proposed improvements as reported to our team by the Chief Executive of BHRUT (CEO) at a meeting in February 2024, and the outcome of a further, informal, visit in October. Some of our visiting team also conducted an informal visit to the A&E department at King George Hospital (KGH), Goodmayes, the sister hospital of Queen's. Members of the team also had occasion to visit A&E services outside their activities with Healthwatch, and some observations reported by them have also been reflected in this report.

Summaries of the December 2023 visits

Streaming, Urgent Treatment Centre and Out of Hours GP Services - PELC

This service is provided by the PELC. When visited in December 2023, the team found that there were difficulties with space constraints and room availability for their meeting with staff. Issues with signage, cleanliness, and waiting time displays were noted during their visit.

The team saw that the atrium was relatively clean, but there were concerns about the lack of toilet tissue in some female toilets and blockages. Seating was available for patients after registration. Support for patients with special needs, including those with learning disabilities, autism, and dementia, was discussed, highlighting services like language support and visibility toilets.

They were told that the daily attendance at the Centre averaged between 300 and 400 patients, of whom a significant portion were considered "inappropriate attenders" who could have sought care elsewhere. Challenges with the accommodation available, including space constraints and overcrowding, were noted.

Priority patients, such as children, older people, patients living with dementia or mental health issues, those with safeguarding concerns, hospital passport holders, and cancer patients, were identified and given priority. The team were told about the

patient registration and streaming process, compliance rates, and concerns about patient calling methods.

Issues related to children's care, staff retention, porter availability, long queues, wellness checks on waiting patients, dietary options, targets, IT systems, contract terms, GPs on duty, same-day primary care, aftercare, and overall concerns about space constraints, staff absence, and patient experiences were discussed with the team.

Patient encounters and observations were shared, highlighting various experiences and challenges faced by individuals waiting for care. The team acknowledged both positive aspects and areas for improvement, emphasising the need to address space constraints and enhance patient experiences at the UTC.

Ambulance reception – LAS

During the December 2023 visit, the team met representatives of the LAS and discussed various aspects of patient care and hospital protocols. It was noted that the Ambulance Receiving Centre (ARC) at Queen's Hospital (which had been an important feature of the LAS' work at the hospital when the previous visit was undertaken in September 2022) had since closed, owing to extended handover times. A 45-minute handover agreement had since been implemented at hospitals across London to streamline patient transfers efficiently and allow ambulance crews to respond promptly to new emergencies.

Moreover, the Physician Response Unit (PRU) equipped with a specialist doctor and a specially trained LAS clinician offered non-ambulance care for patients who may not have required hospital transport. The Remote Emergency Access Coordination Hub (REACH) operated during specific hours, providing guidance to paramedics and directing them to suitable alternative care pathways as required. The Community Treatment Team included urgent community responders who were occupied by the afternoon, emphasizing the demand for such services.

Mental health services were also highlighted, with dedicated support for patients with mental health issues and crisis intervention at the Goodmayes mental health hub. Patients with heart failure were directed to St Bartholomew's Hospital (Barts) in central London to alleviate pressure on Queens Hospital.

The role of Emergency Medical Technicians (EMTs) in delivering pre-hospital care and responding to emergencies was underscored.

Concerns were raised about the significant presence of elderly patients in hospital corridors, prompting discussions on their care and monitoring needs. LAS staff told the team of their "wish list" for more accommodation and a frailty unit tailored for ambulance services. The team noted the need to meet the specific requirements of elderly patients who had been brought in to the hospital by ambulance and ensuring adequate nurse-

to-patient ratios for effective monitoring patients while they awaited admission to a ward.

Emergency Department - BHRUT

It was clear to the team that visited the Emergency Department (ED) in December 2023 that it faced significant challenges because of its being one of the busiest in the country. The ED comprised various areas such as Resus, Majors, Rafting, and SDEC to cater for differing patient needs. Capacity issues occasionally led to internal incidents being declared, with over 240 patients present during peak times.

The team were told that staffing levels at the ED were adequate, with a diverse team including recruited nurses, Healthcare Assistants (HCAs), and Assistant Directorate Administrators (ADAs). These staff members underwent thorough training and induction processes to ensure they were well-prepared for their roles. The ED used a range of IT systems including System C, Cyber Lab, Pax, and Careflow to ease patient care and safety monitoring.

Patients arriving at the ED received pain relief during their initial assessment and underwent screenings for conditions such as HIV, Hepatitis B & C, and Sepsis. Efforts were being made to improve the accuracy of triage screens, with the introduction of leaflets to help patients understand waiting processes.

Pharmacists were available across all areas of the department, ensuring that patients' drug charts were checked regularly.

Special attention was given to patients with specific needs, including those with mental health issues, frailty, and dementia. Discharge processes were streamlined, with a focus on palliative care and arrangements for follow-up care. The ED team expressed a need for improved flow, more waiting room space, and increased capacity to enhance operational efficiency in the future.

Overall, the visit to the ED was positive, with no specific recommendations believed necessary. The team commended the ED staff for their efforts in managing a challenging environment effectively, highlighting their dedication and commitment to providing quality care to patients in need.

Subsequent informal visits and observations

Meeting with Matthew Trainer, Chief Executive Officer (CEO)

In February 2024, the team met the CEO, who gave them every opportunity to explore ideas and shared concerns about what they had seen during the December visits. As part of the meeting, the CEO went with the team on an informal visit to the ED, which showed a busy but not overwhelmed department, although there appeared to be some overcrowding in the PELC area (at the time, occupying the same accommodation as it had been in December).

The CEO pointed out to the team an area which would become free when the dialysis service moved to the new St George's Health & Wellbeing Centre, Hornchurch, later in 2024. The CEO commented that he was also keen to develop the area next to Queen's Hospital that was formerly occupied by an Ice Rink area if BHRUT were able to buy it.

He also indicated that BHRUT would also be prepared to consider taking on a GP/Primary care service model.

The team noted that the possibility of developing the Ice Rink land would take some years to come to fruition and would require substantial capital resources to be made available but were pleased to be told of the active consideration being given to the proposal, which – if it could be brought about – would significantly improve the provision of A&E service at the hospital.

The team remained concerned about the facilities for children and patients with mental health needs but agreed to await the outcome of the proposed changes in accommodation to see what is then available.

Informal visit to ED at King George Hospital

Following the visit to A&E at Queen's Hospital arrangements were made for some members of the team to visit the A&E at its sister hospital, KGH, Goodmayes, where the department had recently undergone a complete building renovation.

The team noted that, as at Queen's, patients were triaged at the PELC area to determine the urgency of care needed, with priority being given to patients with dementia, children, mental health issues, and learning difficulties.

Different areas within the A&E departments included rafting, Majors A, Majors B, Same Day Emergency Care, and Resus. Patient flow was seen to be calm, efficient, and smooth during the visit. Patients appeared content, those with mental health issues were managed calmly, and there was ample seating and beds available with specific rooms for vulnerable patients.

Ambulance teams were able to meet the 30-minute target for patient handover using an efficient system.

Sisters and staff were knowledgeable, calm, and explained how they managed busier times and complex situations. The

building layout and organization were credited for the efficiency and smooth operation of the A&E departments.

Other informal visits and observations

Availability of wheelchairs

On several occasions, Healthwatch members calling at the hospital (not on Healthwatch business) have seen patients attending A&E services in distress because wheelchairs were not available for their use. Anecdotally, we understand that this lack of wheelchairs is a common occurrence: it seems that people use wheelchairs for their intended purpose of enabling less mobile patients to move around the hospital (which is a very large building, with multiple corridors, several storeys high) but fail to return them to the muster point when they are finished with; and it does not appear to be anyone's specific task to gather them up and return them on a regular basis. This can leave patients – especially those who have a priority need (shown by a hospital passport) – stranded.

Referrals to A&E by GPs

There is also the oft-heard assertion that patients have been sent to the UTC by their GPs owing to the difficulties many patients complain of in arranging face-to-face appointments with the GP. While this is anecdotal evidence rather than the

outcome of surveys, there seems little doubt that this is a commonplace experience. There appears to be a lack of communication, in that patients often assume that their arrival at Streaming should be anticipated as "the doctor has told you to expect me", only to find that Streaming is not expecting them as the message to do so has not been passed on or has been received in the ED rather than in Streaming.

Lack of beds

As noted earlier in this report, the use of corridors around the A&E departments as a holding area for patients awaiting admission to wards is commonplace. This is a situation that is repeated in many other hospitals nationwide and, whilst inevitable in current circumstances, is unacceptable as it leaves patients vulnerable and lacking dignity: their stoical acceptance of the situation does make in acceptable. On one occasion, a Healthwatch member saw over 20 trolley-beds in corridors with patients awaiting admission (in addition to those being seen in the ED).

Informal visit, October 2024

The team were met by the Trust's Chief Nurse, who introduced them to the ED Matron and the ED lead nurse. They then met another ED nurse and an ED consultant.

The team then went on a tour of the ED wards and areas used within the A&E. On this particular day it was not unduly busy, the atmosphere was calm and the staff were attentive to the patients' needs. It was arranged that the team would follow a patient's journey during the visit, the first point of call being registration and then streaming.

First point of call for patients is the triage system from which they are passed to the various areas such as SDEC, majors or in the corridor.

The new system in place seems to be working, although the volume of attendances was at a low level on the day of the visit: higher volumes of attendance natrually increase the pressure on staff and patients, lengthing their stay in ED.

Same Day Emergency Care (SDEC)

The SDEC area (Same Day Emergency Care) is a unit based on a system developed and used at the Royal London Hospital, from where an ED consultant was seconded to help with development at Queen's Hospital. The aim is to help those patients who have particular medical conditions to see the correct doctor for their condiiton, have tests undertaken and, if their condition so allows, then go home and return to the hospital at another time for further investigation/treatment.

Rapid Assessment and First Treatment (Rafting)

There were a number of patients in this area.

The corridors were divided into two sections; those patietns waiting to be seen by a doctor, and those waiting for a bed. The matron explained that, in the corridor, there is a policy that for every 10 patients there is a nurse who oversees their condition and looks after their needs; for example, at night the patients are given eye masks and ear plugs to help them sleep on the trollies. Each section has a room for them to use which has bathroom facilities and is private. However, the team were told that there were rooms previously used as relatives' rooms etc - the team did not go into these rooms as they were informed they were difficult to access owing to the size of the door frames (which apparently caused the staff some difficulty when using them).

Frailty area

There is a fraility area for elderly patients and those who have mobility issues, who need a bed/day bed because of mobility issues and those who have dementia. At the time of the visit, there was a calm atmosphere, with a few patients listening to their phones, and it did not seem too crowded.

Patients who have mental health needs are assessed and, if they need a separate quiet space, there are rooms available. Security staff are on hand to deal with more disruptive patients.

Staffing issues

The team were told that, at the time of the visit (November 2023), retention of nursing staff was good because there was a flexible approach to employment and the Trust were currently employing more Advanced Nurse Practitioners and Clinicians.

The team were told that, although the Departments were comparable in size, the ED at the Royal London Hospital had around twice as many clinical staff as that at Queen's Hospital despite Queen's A&E having a higher patient-load [4]. While appreciating that staffing is an issue outside the remit of Healthwatch, and the financial position may preclude speedy attention, the team felt that there should be a strategy in place to increase the staffing numbers in the ED as the opportunity arises.

[4] See the statistics table in **Appendix 1**

Enter and view visit, November 2024

Streaming, Urgent Treatment Centre (UTC) and Out of Hours GP Services

The team were met by the Manager and Operational Manager very promptly, and taken to the office, who spoke openly and honestly. It became obvious that everything was running very smoothly and with a calm and positive atmosphere, which presented much better than had been experienced during the previous visit.

It was clear the various strategies that had been put in place following that last visit, and the four-hour turn around, was working very well. The team were told that a breach of this was rare now, and mainly due to waiting for blood test results to come back. A "pit stop" meeting was held every morning for engagement and assessment.

In addition to the services at Queen's Hospital, PELC provides UTC services at Harold Wood Polyclinic [5] (also managed by the Manager at Queen's Hospital) and at King George and Barking Hospitals, which are run by another Manager. At Queen's Hospital, PELC directly employ Emergency Nurse Practitioners to carry out streaming, sometimes assisted by doctors; there is also a Nurse who is mental health trained and up to twelve Doctors are available. Many patients have been sent there by

[5] See https://www.healthwatchhavering.co.uk/report/2024-03-06/urgent-treatment-centre-harold-wood-polyclinic-enter-view-visit

their GP. The 111 system gives patients a time slot when to arrive, which confuses them as they think they will be seen then! Some patients attend as they have been unable to get a GP appointment.

PELC does not have paediatric doctors available but paediatricians can be sought form the Emergency Department when needed.

For diagnostic purposes, PELC can only offer blood tests and X-Rays, anything more serious is triaged to the BHRUT Emergency Department, including those who are Cancer or Hospital Passport patients. Suspected DVT patients have a D-dimers blood test, which has recently been introduced in the UTC.

The area of the hospital used by PELC is split into three zones. A, B, and C (respectively: adults waiting to see the GP or injury nurse; children awaiting treatment; and patients waiting for investigations, blood tests, ECGs etc). Areas A and B are in the atrium, and C is nearby. All patients are watched over for deterioration. Water is available. This particularly applies to children. All suspected major fractures are passed to the Emergency Department. Patients often turn up for stitch removal, as they cannot get an appointment elsewhere. The team were told that PELC is in discussion with NHS North East London about stitch removal services.

Patients with special needs are seen promptly and assistance is offered to patients who are deaf, partially sighted, or living with

autism, dementia etc. This is part of the concierge of priority patients. Measures are in place for diabetic patients. Any patients needing to be referred on to BHRUT or a GP are emailed appropriately.

Shifts are worked from 8am to 10pm by all staff (GPs, Doctors and Nurses); overnight, there are two nurses on duty from 10pm to 1am and one nurse from 1am to 8am. These are contracted and bank staff. Staff retention is good, and vacancies are filled promptly. Emergency Department Doctors are always willing to work extra shifts. The Clinical Staff are given fifteen-minute time slots with patients. Porters come from BHRUT and effort is made to ensure that at least three wheelchairs available.

Mondays are always very busy – on the Monday before the visit some 485 patients attended up, many of whom were told to go to a chemist for advice; as the week continues, patient numbers fall, on the Thursday, 300 patients had been seen out of 357, the rest of whom were told to find other alternatives, such as a chemist.

There is evidence to suggest that many people for whom English is not their first language are unaware that pharmacists are able to give advice on many ailments and go to hospital for even quite minor cases.

The atrium of the hospital is going to be redecorated [6] and it is possible that CCTV will be installed to monitor the area. Patients

[6] The atrium has subsequently been redecorated, and the pre-COVID reception desk has been reinstated.

continue to be called for attention rather than use a loudspeaker system or ticketing system owing to data protection concerns (even though many health settings use electronic screens or loudspeaker systems to call patients for attention).

With the imminent transfer of some services to the recently opened St George's Health and Wellbeing Centre in Hornchurch, PELC are hopeful that some of the vacated space will become available to them to improve the UTC and streaming area. Winter pressures really do not apply as last May was their busiest month, falling off during July and August. An out of hours doctor is available to see patients at home, by a car with a driver.

The IT system in use is Adastra, which is compatible with the system used by BHRUT. There are four workstations in use. The area is cleaned by Sodexo [7] staff and NELFT are responsible for the re-stocking of supplies.

The team considered that the centre was running well and found the visit enjoyable.

Note: Subsequently to the visit, PELC have advised us that:

[7] Sodexo is the provider of outsourced facilities management services, including cleaning and security for BHRUT

(a) A CCTV system has been installed in the atrium of the hospital to enhance clinical oversight of waiting patients and

(b) they are exploring options to improve communication with the patients waiting in the atrium.

BHRUT Emergency Department (ED)

The team were met by representatives of the PALS team who then called the senior nurses on duty in the ED (the matron was not on duty that day).

Preliminary discussion

There was then a "question and answer" session prior to the team being taken on a tour of the department.

In response to a question about the management of the "corridor ward", the team were advised that this area was used only when the ED became so full that there was no alternative and the decision to use this space was made at executive level, at which time arrangements were made to draft in extra nursing staff - usually HCAs - and consultants of all specialties were asked to review management and progress of all patients through the department. The initial corridor provided spaces for 10 trollies and patients allocated to this area were, as far as possible, deemed to be in less acute need. This part of the ED had all bed-head services – socket outlets and call buttons etc. A big problem for this area was that it was not possible to reduce the lighting intensity and a business case was being put forward seeking a remedy for this problem; in the meantime, patients were offered eye masks and earplugs as a means of reducing any distress. The issue of bathroom facilities was dealt with by a specific bed bay and toilet being allocated to provide some

privacy and dignity although it was accepted that this was not ideal. Bottled water was offered to all patients. Once this area was filled the next section of corridor, adjacent to the HDU, was used, with similar management decisions. Thereafter the corridor leading to the exit was used for patients remaining in the care of ambulance staff. Following various trial of dealing with ambulance arrivals, it had been agreed that ambulance staff should have a maximum wait of 45 minutes with their patients and this appeared to be relatively successful with good relations between ambulance personal and hospital staff ensuring that this time limit was not exceeded. At the end of the visit it was noted that there were only 4 ambulances waiting in the bay.

In the event of an emergency requiring evacuation of any area, there was an evacuation policy which had recently been reviewed and updated in accordance with the overall hospital policy to move patients and staff through two fire doors which have a minimum of 30-minute retardancy. Staff ensure that there is always at least one wheelchair available for staff use and Sodexo staff help to ensure that this happens. Wheelchairs remain problematic due to families/friends abandoning them in car parks etc rather than returning them to the central pick-up point.

In response to protocol for dealing with young people arriving with mental health issues, the team were advised that the ED has only one room dedicated to this purpose (with static furniture etc.) and that this has been a major issue at times. The ED

currently has access to two psychiatric nurses per day and all staff have had some mental health and conflict resolution training. If further accommodation is required, one or more of the side rooms is made safe for these patients. It was noted that the mental health service was very slow to respond to what could be a potentially critical situation and that there had been times when hospital security had been required to ensure the safety of patients. Occasionally, patients had remained in the department for more than 24 hours without appropriate medical care. There are no direct admission facilities at Goodmayes Hospital [8] except for patients taken there by police for their own safety under section 136 of the Mental Health Act ("sectioned").

As far as possible, the records of patients with hospital passports are flagged so that this is known even when patients arrive without their own passport. This also applies to patients holding red cards, indicating that they are undergoing cancer treatment. There is a pathway checklist that is followed and the appropriate team is then called to the ED.

A leaflet was put on trial recently, which informed patients of their individual pathway in the ED indicating what was planned and where they were on the pathway. Unfortunately, this did not meet with any great success, creating more confusion than it solved. This has now been replaced with wall charts indicating how everyone can expect to progress through the ED and further

[8] The regional mental health hospital, provided by the local community services NHS Trust, NELFT

consideration is being given to how this may be developed into a new leaflet.

The team were advised that a large proportion of the 100 nurses who were recruited last year remained in the ED and that it is currently fully staffed – the best it has ever been. Very few agency nurses were now required and most shifts could be covered in-house. The senior team operates an open-door policy so that staff can discuss any issues they have on a timely basis. The 100 new recruits announced recently were to be used over the rest of the hospital.

The practice of testing all new arrivals for HIV/hepatitis/sepsis in one test was still occurring unless any patient refused to take advantage of this scheme. Currently, the uptake was 78% which was excellent compared with other hospitals (it was understood that the rate at the Royal London was only 28%).

Two pharmacists were usually dedicated to the ED but currently only one pharmacist and a technician were available as one pharmacist had recently left; this post was currently being recruited to.

Every effort is made to transfer trolley patients to beds within 6 hours of arrival or as soon as possible, except when specific tests make this inappropriate.

The "Same Day Emergency Care" (SDEC) service was working well, with most patients undergoing treatment and returning home the same day. There may, however, be long waits in the ED due

to the demand. The use of this system has increased the departments KPIs. The team noted that several patients were in reclining chairs to ensure that they were as comfortable as possible whist awaiting treatment.

The former policy of fast-tracking elderly patients to the Frailty Unit is not possible at the present time due to the high demand and non-availability of beds in the main hospital.

The Rafting Area where ambulance arrivals were assessed was working well, with all patients being assessed within 15 minutes. There is an agreement that ambulance personnel should wait no longer than 45 minutes and there is good rapport between nursing and ambulance staff to ensure that this is not exceeded.

The team were advised that, by next June, it is expected that an integrated IT system will be in use and that this will enable staff to keep patients informed of test results and progress.

Tour of Department

The team then undertook a tour of the ED noting that, despite the official winter season not having been reached, there were already 18 patents being accommodated in the main corridors and there were also two patients still accompanied by paramedic staff and awaiting handover. No patients were making use of eye masks but this may have been because of the time of day and the fact that there was considerable footfall through the corridors. Initial assessment was carried out in the

Rafting Area where decisions to admit/treat or discharge were made.

The SDEC area had been furnished with recliner armchairs to provide more comfortable accommodation for patients who are undergoing treatment prior to being discharged home. This area appeared to be full; patients there are offered hot meals and regular snacks and drinks.

There are 24 cubicles in the Majors department, all of which were occupied. It is sometimes necessary to convert one or more of these cubicles into accommodation for mental health patients, with all movable equipment/fixtures being removed to ensure patient safety.

During the tour, the team were shown areas where corridor-accommodated patients can use facilities and where they can shower if necessary. This seemed less than ideal, particularly as it was sometimes necessary for patients to pass through controlled doors to reach their destination and staff may not be on hand to assist in this.

The team noted that a dedicated member of staff was available to provide liaison services between staff/patients and families who enquire about progress of patients, etc. All patients here are served meals and drinks as required.

Conclusions

Over all, the team were impressed by the generally calm and well-ordered management of the ED, despite the severe pressure under which staff were working. However, the team were a little concerned that, when decisions were made to increase staff numbers due to the corridors being populated, only basic grade HCAs are recruited where so many of patients seen in these areas appeared to be very unwell and the ratio of patients to staff seemed a little high for one person to cope with possible sudden emergencies.

The team were also concerned at the apparent lack of speedy response from NELFT to requests for assistance in dealing with mental health admissions. Queen's Hospital does not have a mental health/psychiatric facility or an establishment of staff to provide appropriately trained staff to deal with these admissions in the short term. Therefore, this is an unbudgeted cost to an already overspent department. The team were shocked to learn that, on occasions, it had been necessary to provide security staff, in addition to nursing staff, over considerable lengths of time to care for these patients.

London Ambulance Service – ambulance reception

On the day of the visit, no LAS crews were at the hospital as all patients had been handed over and they had returned to "the road" to pick up more as needed (the only ambulance crews present were from other ambulance providers, who obviously could not speak for the LAS). Following discussion with LAS staff, a meeting between Healthwatch and local senior LAS officers was subsequently arranged.

During the meeting, the team were told that, since the previous visits, the way in which patients brought in by ambulances to the ED were handled had undergone significant change because of moves to improve the turnaround time for handing patients over to ED staff within a maximum of 45 minutes of arrival. The result of this was that, at most, 45 minutes from the arrival of an ambulance, a full handover of the patient must take place from ambulance crews to ED staff, which means that a member of ED staff is on hand to coordinate the reception of patients (a task previously and temporarily undertaken by ambulance staff based at the hospital called the Ambulance Receiving Centre but no longer in operation).

In consequence, LAS crews (and other services' staff) only remain at the ED if they have been unable to hand a patient over. The 45-minute patient handover process was introduced in 2023 and has gradually expanded across London. It is now a standard procedure across all EDs in London. The team noted

that NHS England also supported this procedure and was working towards implementing it nationally.

The Team was pleased to learn that this change of approach had led to the LAS service at Queen's Hospital moving from being one of the worst performing in London to one of the best. With support from NHS England, BHRUT had made additional staff available, which had reduced the need for LAS staff to provide cover.

Turning to the demands on the LAS generally, the team were told that, in the current winter period (2024/25), across London, the LAS had already experienced one day when over 7,000 emergency 999 calls had been made. A robust winter plan was in place this year, including a 10% increase of staffing hours, enabling around 60 additional ambulances to be on the road.

To reduce the demand for ambulance attendances, the LAS was operating more of its "Hear and Treat" service – whereby, when a 999 call is received, the call handler may conclude that it is not necessary to dispatch an ambulance immediately but would transfer the caller to a specialist team at the Clinical Hub who would provide direct clinical advice to the caller enabling the condition to be treated in the most suitable way for the patient – which would not always mean attending an ED by ambulance. Generally, around 20-24% of patients had received help and advice this way.

A team of senior LAS duty managers worked 24/7 to assist in spotting pressures, liaising with internal and external partners to deal with any peaks in demand across the capital..

The team were also told that, in November 2024, the average response time to a Category 1 call was 7 minutes 42 seconds, the target being 7 minutes.

As of November 2024, for category 2 calls, which included patients experiencing strokes and heart attacks, the response time in North East London had been 43 minutes 44 seconds (and across all London, 41 minutes 50 seconds) against a national target of 18 minutes and North East London target of 30 minutes

Locally, if Queen's Hospital was full and a patient arriving by ambulance would not be handed over in a reasonable time frame and therefore ultimately the patient experience and journey may be poorer, it was often possible that patients would be conveyed to the next nearest hospital (usually KGH), although in some circumstances, a patient may still be conveyed to Queen's Hospital if specialist treatment only available there was required or the patient needed to see a specific doctor. This process was managed 24/7 by the LAS duty managers in the Control Room. It was emphasised that, although KGH may not be convenient for some patients (or their families) to get to, the priority for the LAS was to ensure that the patient was treated as promptly as possible and to ensure

patient safety without delays. It was noted that public transport links between most of Havering and KGH were poor, with only one direct bus route between Romford Town Centre and the hospital.

Crews were also able, with patients' agreement, to avoid conveying them to hospital either by dealing with the injury/illness at the scene or by taking the patient to somewhere other than hospital, such as an urgent treatment centre. Crews had access to specialist advice from the Control Room if needed.

Patients' views

Finding out what patients think of the health and social care services they use is central to the work of the Healthwatch network and so we always try to ask what patients think when we carry out visits. Obviously, the level of response we get depends on the ability of patients to respond, which in turns depends on how unwell they are or how busy the service is.

On this occasion, we were able to get 17 patients to respond to our survey of their views – see Appendix 2.

In addition, two patients separately gave us reports of their experiences during stays in the ED following personal accidents or illness. Their accounts are set out in Appendix 3.

Conclusions and Recommendations

The Accident and Emergency services at Queen's Hospital are the busiest in North East London and among the busiest in Greater London, and indeed England as a whole. Queen's Hospital now serves a population far larger than that envisaged when it was planned some 25 years ago. This increased population is a primary cause of the pressures under which the hospital operates, although cultural changes – especially since the COVID disruption of 2020/21 – among the population also play their part.

That said, most staff working in A&E want to do the best they can for their patients and find the constraints that they face frustrating - one staff member told our team that *"it's hard to leave a shift and go home knowing you hadn't given the care you wish you could. It's even harder to return the next day, and nothing has changed!"*.

These constraints have no specific cause: the growth in population could not have been foreseen; the lack of space is an inevitable consequence of having to deal with more and more people in accommodation that is hampered by its physical environment. There are mitigations in hand: the transfer to the recently opened St George's Health and Wellbeing Centre in Hornchurch provides an opportunity for vacated accommodation to be repurposed for use either directly or indirectly by freeing up space for A&E services.

Changes have been made during 2024 and further changes are planned for 2025, which we will observe with keen interest.

Although at times in the past, relationships between to BHRUT, PELC and the LAS might have been strained on occasion, that appears no longer to be the case (other than for the occasional, minor misunderstanding). This can only be beneficial for patients.

In terms of recommendations, the management of A&E services is clearly complex and there is little that we can recommend that has not been thought of already.

It is often, however, the little things that make a difference.

As the two case studies related in Appendix 3 demonstrate, it is easy for individual patients to feel overlooked, and even to feel obliged to help others despite their own problems. People are often unwilling to complain – not for fear of retribution, but simply because they do not want to seem "ungrateful" or to "be a nuisance" – even though complaints are often the only way of drawing attention to problems that could be solved. That said and granted that the staff are very hardworking and focussed on dealing with patients' clinical needs, much could be achieved by staff displaying a more empathetic and compassionate approach – the patients' stories set out in Appendix 3 both provide examples of clinically-correct care that could have been improved by a little more thoughtfulness.

There are also suggestions that some facilities are left in an unhygienic condition – the pressures on turnaround for patients cannot excuse the continued use of soiled bedlinen, as experienced by the patient referred to in Case 1 of Appendix 3 nor the potential compromises of good standards of hygiene and infection control that could thereby arise.

Moreover, simple improvements to the environment in A&E would also be beneficial. Three examples illustrate this:

- The lighting in the corridors used to accommodate patients awaiting attention or transfer to wards is very bright (it was designed for a corridor environment, not a treatment area) – softer lighting would undoubtedly reduce patients' stress
- Patients are called by name when it is their turn to be treated, despite the area where they are waiting being noisy and busy (and few staff having a "parade-ground voice" that can cut through); a screen-based calling system, or even the use of a Tannoy-type loudspeaker, would be easier for staff and patients but their use is resisted despite the fact that many other healthcare facilities make use of screens – for example, the new St George's Centre has numerous patient call screens for exactly that purpose – and the risk that people who are hard of hearing may not hear their names and not come forward for treatment

- Patients waiting in the corridor, often for long periods, seem to be left to their own devices (as illustrated in Appendix 3). While clearly clinical staff are "working flat out" in the ED and may not have time to oversee the patients in the corridor on a full-time basis, it would be helpful if volunteers could be assigned to the area to keep patients under informal observation and to call clinical staff to attend to any who might be experiencing difficulties. It would also be helpful if some means of entertainment were available to alleviate the boredom of waiting for what must sometimes seem an interminable period.

Suggestions for improvement

Arising from the visits, the team wish to put forward the following suggestions for improvement (not in order of any priority):

1 That the Havering Place-based Partnership (HPbP) take the lead in working with BHRUT, PELC and local GPs to improve local communication to persuade those patients who do not need hospital care that they can be treated without the need to go there – this would reduce the volume of patients going into A&E and reduce the bottle necks in the discharge process and lessen the number of patients in the corridors.

2 That the HPbP work to raise public awareness of the alternatives to A&E for minor health issues, such as social

prescribing and the presence of ARRS/Allied Healthcare staff in surgeries such as pharmacists, physiotherapists and paramedics.

3 That as more space becomes available in the hospital (following the activation of the St George's Centre in Hornchurch), the accommodation available to A&E services be expanded in order to provide better facilities for patients.

4 That lighting within the corridors used as auxiliary facilites for the ED be made dimmable so as to reduce the night-time glare that can adversely affect patients [9].

5 That the possibility be explored of providing low-level means of entertaining patients who are waiting in the corridor area to be transferred to a ward – perhaps through the provision of one or more TVs, magazines or books.

6 That the system for calling patients for attention be improved by the installation of a loud speaker system or, preferably, of screens on which names can be displayed.

7 That attention be paid to ensure that soiled bedlinen is not re-used, that the area is kept clean and that infection control measures are continuously implemented.

[9] Note: since the visit, we have been told that this possibility is being actively pursued by BHRUT

Action Plan

In response to the suggestions for improvement set out above, BHRUT have drawn up an action plan, which is included in this report as Appendix 4 following.

Acknowledgments

We would like to thank everyone providing A&E services at Queen's Hospital – BHRUT, PELC and LAS - for their ready co-operation with these visits.

Thanks go especially to:

- Matthew Trainer, Chief Executive of BHRUT, for his frank and open discussion with the team about BHRUT's plans development of A&E services at the Hospital
- Steve Rubery, Chief Executive of PELC and his colleague Sheryl Saunders
- Alex Ewing, LAS Associate Director for North East London and Dabs Lynch, Operational Lead for Havering

We are also grateful to all the staff who facilitated the informal visits during 2024.

Appendix 1

Attendances at Hospital Emergency Departments in North East London

The following information has been provided by Barking, Havering and Redbridge Hospitals (BHRUT), the Barts Health NHS Hospitals Trust (Barts) and Homerton Healthcare Trust in response to Freedom of Information requests. The three trusts together provide all NHS Hospital A&E services in North East London [10]. The data provided is for the year 1 April 2023-31 March 2024 and is ranged in order from the largest number of attendances to least:

Hospital (and Trust)	Attended for Treatment	Arrived by Ambulance	Admitted to Ward
Queen's (BHRUT)	204,267	34,912	53,414
Royal London (Barts)	201,083	27,883	26,404
Newham (Barts)	154,838	20,815	13,411
Whipps Cross (Barts)	154,177	24,448	20,321
Homerton	125,286	17,019	20,363
King George (BHRUT)	120,440	19,086	28,804

The table is not intended to be definitive but to give a general picture of the use made of A&E services across the ICB region.

[10] It should be noted that some patients are conveyed to most of these hospitals from areas outside North East London as well as from its constituent London Boroughs.

Appendix 2

Patients' views - survey

Finding out what patients think of the health and social care services they use is central to the work of the Healthwatch network and so we always try to ask what patients think when we carry out visits. Obviously, the level of response we get depends on the ability of patients to respond, which in turns depends on how unwell they are or how busy the service is at the time of our visit.

On this occasion, we were able to get responses from 17 patients, most of them while in the A&E area, although two responded subsequently.

The patients came from the following areas:

Havering	7
Barking & Dagenham	5
Redbridge	1
Brentwood	2
Elsewhere	2

Waiting times

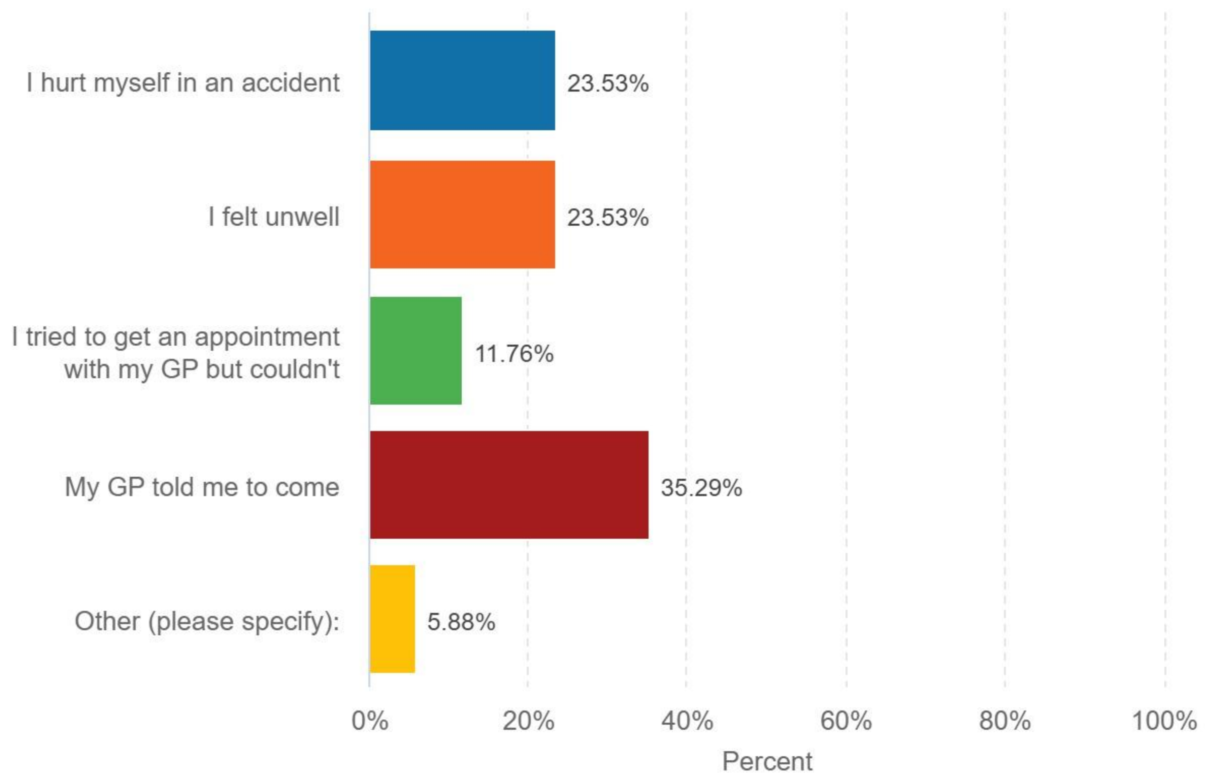
Most patients we spoke to had arrived in the past hour or so but several had been waiting longer.

One told us that they had arrived at 10am the previous day (and had thus been waiting well over 24 hours – we have no means of verifying that claim).

Two others had arrived the previous evening (the visit was in the late morning) and had thus been waiting for around 12 hours.

Reason for attendance

We asked why patients had come to A&E; they told us:



Did you seek advice before coming to A&E?

We asked whether they had sought advice before coming to A&E.

- 7 patients had consulted their GP and 4 had spoken to NHS111; 1 had taken the advice of a friend or relative.
- 4 others had come because they wanted help and A&E seemed the best place to go.
- I patient declined to respond.

The 7 patients who had consulted their GPs said that the GP (or someone at the practice) had told them to come to A&E. 5 of them had contacted their GP practice in the morning after 8am; 1 in the evening before 6.30pm and 1 after 6.30pm. 2 had spoken to their GP face-to-face, 1 by telephone.

The 2 who had contacted NHS111 were told that an appointment had been made for them at A&E, another 2 were simply told to go to A&E; and 1 had been told there was no need to go to A&E but came anyway.

Are you the patient or accompanying the patient?

11 patients were on their own, 3 were with children under 18, 1 was accompanying an adult under 70 and 2 adults 70 or older.

Do you (or the patient) have special needs?

1 had a chronic illness, 1 was living with dementia, 1 had a hearing impediment and 2 were elderly or frail.

The remainder had no special need or did not respond.

Only 1 person told us that something had been done relating to their special need while in A&E. 3 told us they would have appreciated having some means of indicating they had a special need, for example by having a specially coloured wristband.

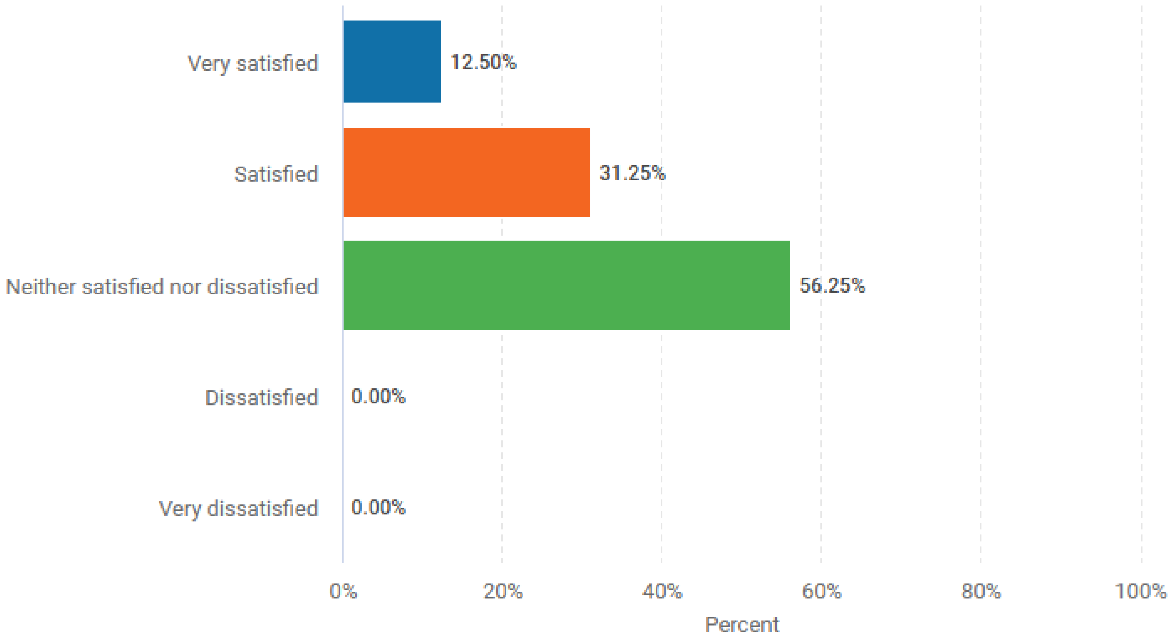
What could have been done to improve your experience today?

Patients told us:

- Separate area for accidents
- In Zone B would be great to have a calling system as it is noisy and not always clear to hear who is being called out
- Friendly receptionists
- Think disabled should be a priority
- Quicker pace
- Would like a separate clinic for the elderly

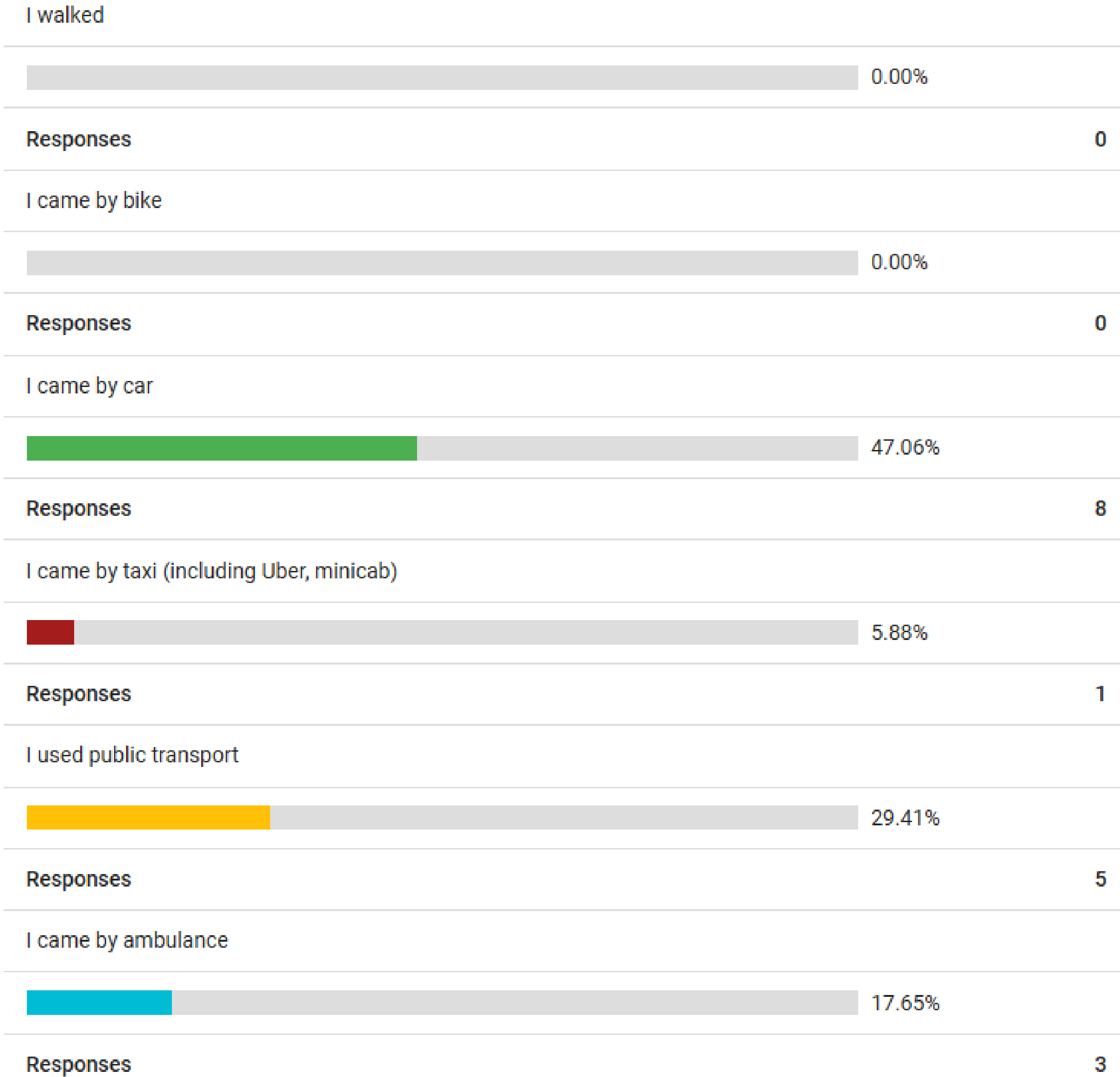
- If I am led to believe that I am expected by the medical team, then make sure that happens. If it is not possible don't advise patients that it is.
- Too long to go into. People above need to sit in A&E for a week to see how it could change. Going to different places (triage) before you are seen is silly.

What do you think of your experience today?



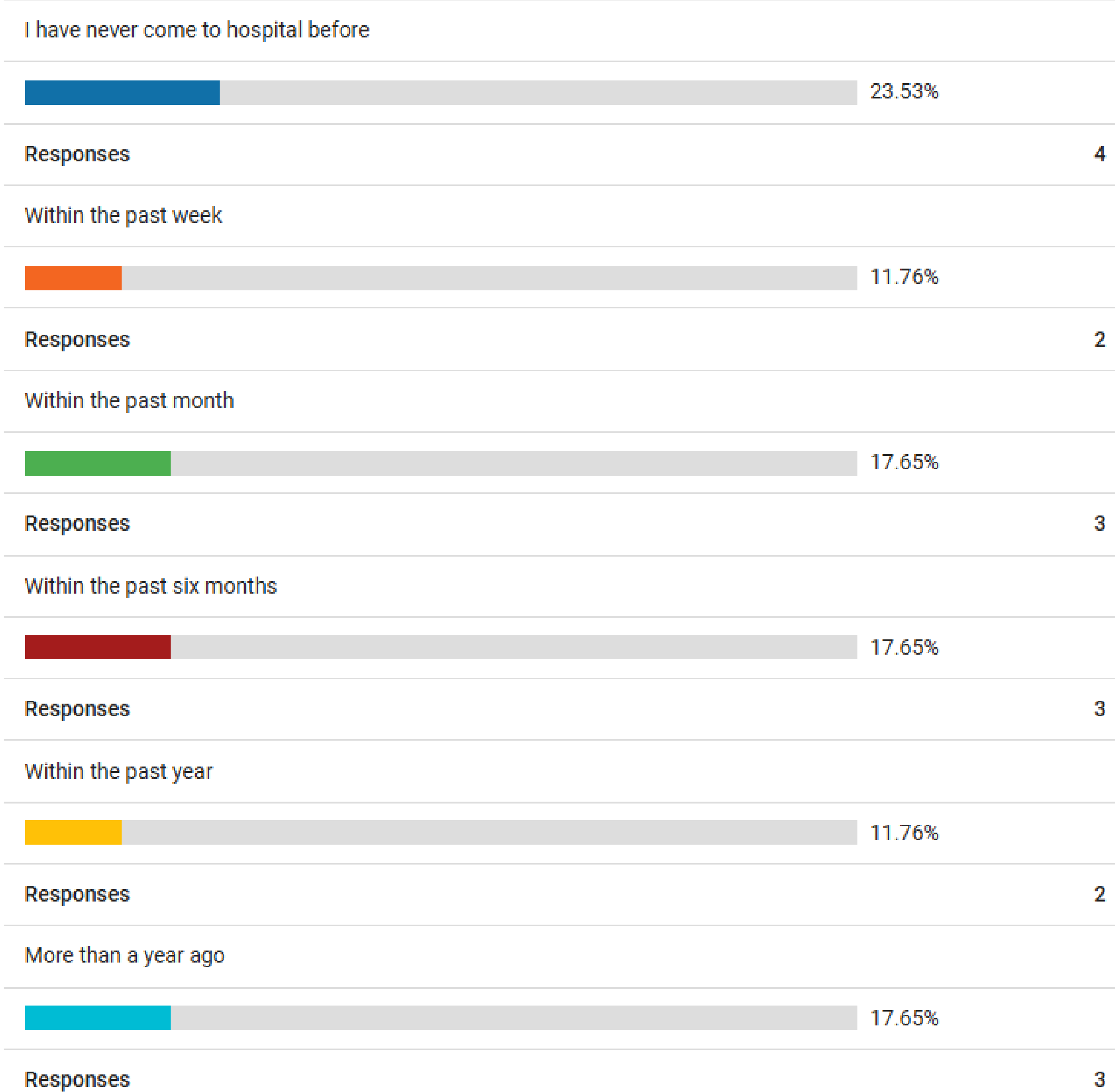
1 patient did not respond to this question.

How did you get here today?

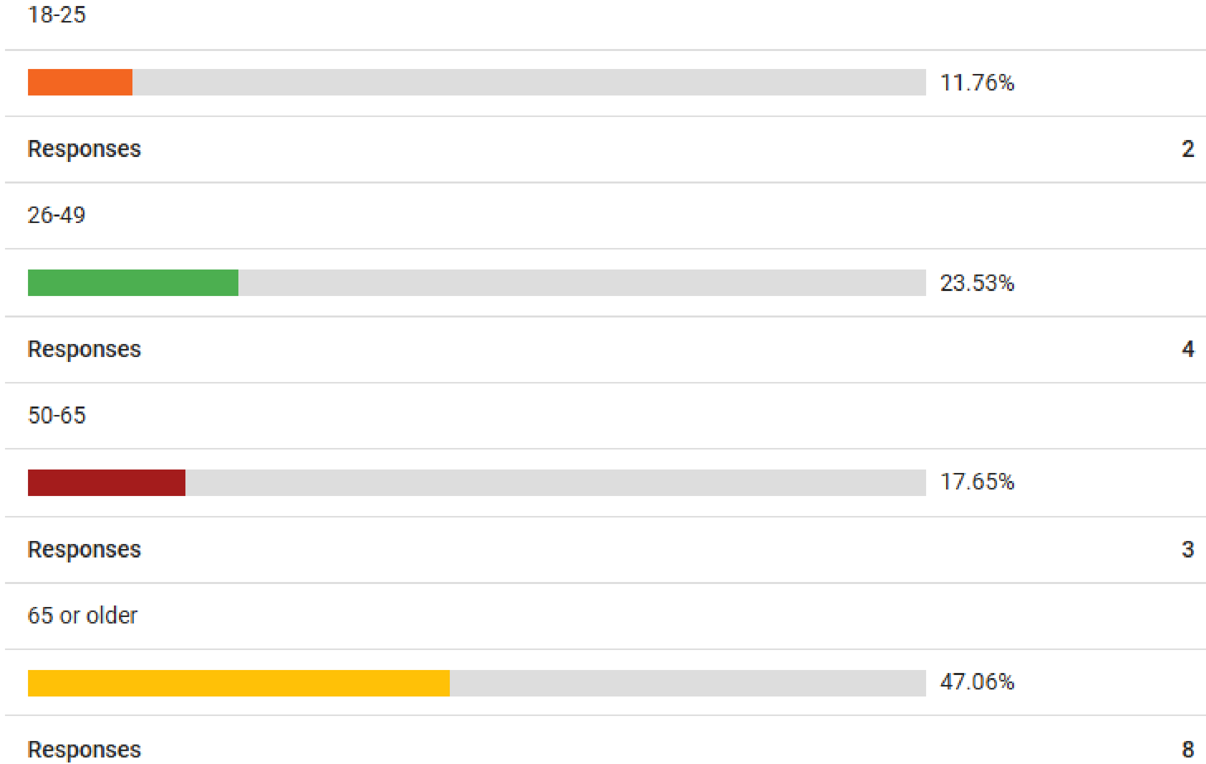


Of those who came by came by car, 4 (50%) experienced a problem in finding a parking space.

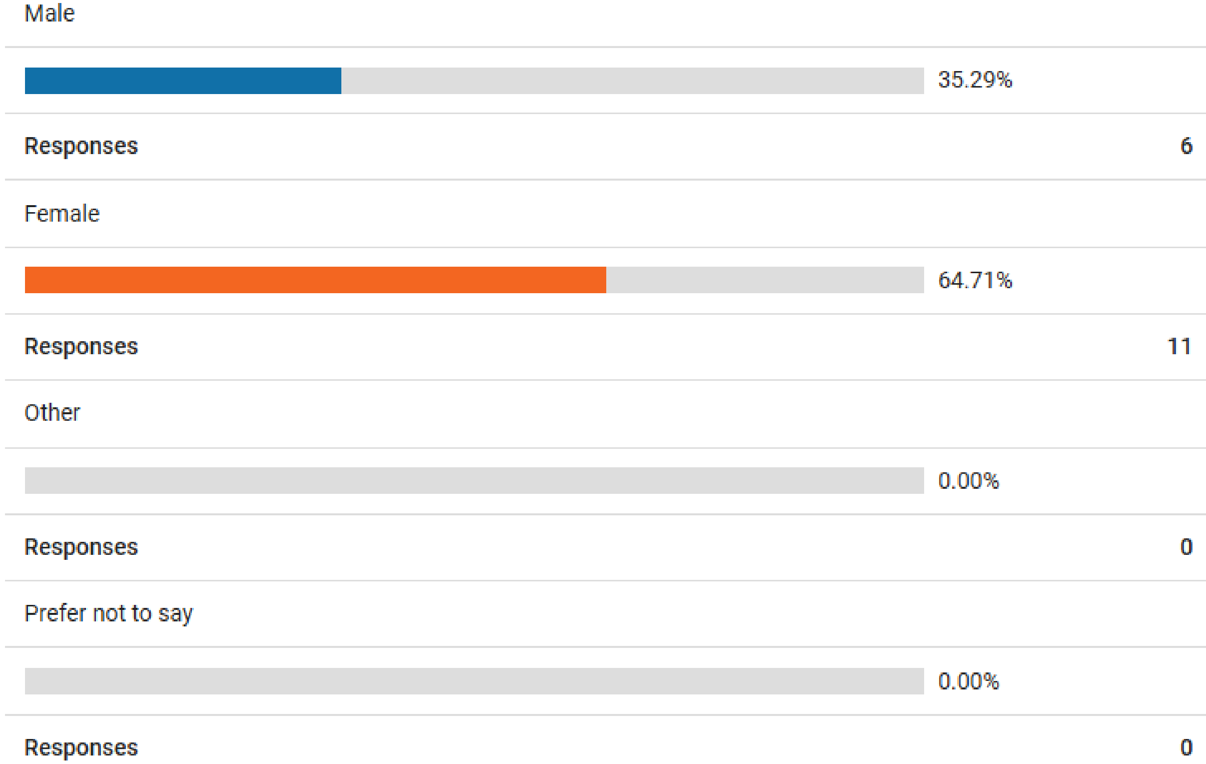
When did you last come to A&E?



What is your age?



What is your gender?



What is your ethnicity?

Ethnicity	%	Count
Asian or Asian British (including Chinese)		
Bangladeshi	0.00%	0
Chinese	5.88%	1
Indian	0.00%	0
Pakistani	5.88%	1
Any other Asian background	5.88%	1
Black or Black British		
Black African	11.76%	2
Black Caribbean	5.88%	1
Any other black background	0.00%	0
Mixed		
White and Asian	0.00%	0
White and Black African	0.00%	0
White and Black Caribbean	0.00%	0
White and Chinese	0.00%	0
Any other mixed background	0.00%	0
White		
British	64.71%	11

Appendix 3

Patients' views – specific issues

The following reports came from people who had been patients in A&E and who had found their experience distressing. The incidents occurred separately from our visits but at about the same time and are included here with the individuals' consent, although they have been edited to remove personal details (other than those that are relevant to the incident). Some minor editing has also been done for ease of reading but otherwise the words are the patients' own.

Both patients had previously worked in the NHS.

Note: some readers may find the details related in these accounts distressing but that is necessary for authenticity.

Case 1

One morning in late October I experienced severe abdominal pain and heavy rectal bleeding on more than one occasion. I phoned NHS111; I had 3 assessments and was then put to the top of the list for an ambulance, which arrived quickly. I was given pain relief and intra-venous (IV) access.

On arrival at Queen's A&E, I went straight in and was seen by a doctor who introduced herself. Bloods were taken immediately and I had a CT scan straight away and Oramorph IV fluids were started.

Then I was taken to a cubicle where I was given IV antibiotics; two members of staff stayed with me for some time. Then it was lunch time and I was given food.

I was assessed by two other doctors and then transferred to a corridor. I asked where the toilet was because when I had cramping pain, that was when I had a heavy blood loss. I was told to go and find one in another

department. I was feeling a bit wobbly after being given Oramorph in A&E and I was sweating profusely, and did not feel at all well. I found a toilet in another department close by. While there I had an episode of pain and heavy blood loss which I did not flush away because I felt it needed to be recorded and examined by a member of staff.

I told a nurse but she just looked at me; I requested she should look at it. She told another member of staff to have a look. This girl told me she was not a nurse but she came and looked and I was told to flush it away. It took three flushes to clear it so it was a significant amount.

I went back to my bed feeling a bit woozy and faint. I asked for some water and was given a paper cup to go and find a water cooler in another department. I went back to where the toilet was and found a water cooler. There wasn't a table so I had to balance it on the dado rail. I used paper towel in my pants in case I had an accident.

In the evening I thought my second dose of IV antibiotics must be due. I asked the nurse but she said no. My understanding of IV antibiotics therapy is that you have three doses in 24 hours then oral antibiotics. Someone came to give me something IV - I asked what it was she said "Codeine" to which I am allergic but someone shouted, "It's not, it's Paracetamol".

It was now nighttime. The bright lights were making my eyes sore: I felt like I had grit in my eyes and I had ulcers in my right eye. I was sweating profusely, my hair was wet with sweat., and there was a horrible musty smell. I thought it was me; I had asked previously for some wipes to clean myself. I went to the toilet to clean my body. I had a small towel which I had used in case I had an accident in the ambulance. I made this wet to put over by eyes. I found that I was lying there crying. I felt like I was being tortured and in total despair for being ill.

A doctor came and looked at me, and called the nurse who did not speak to me but gave me some eye shades. At 5am I had tea, went to the toilet

and when I returned looked at my bed. It was stained with the previous patient's body fluid or sick, that was what the smell was. I pulled the sheet and pillowcase off. I had been lying with my face on that. I was given a clean sheet and pillowcase.

Later in the morning I was transferred to MRU. There I stayed until next morning. After breakfast a man came told me to get my stuff together. The lady in the next bed asked him to help her to get out of bed to use the toilet but he responded, "I am not going to lift you, stand up". She had a boot on her right leg, which was on the bed, her other leg was off the bed. Her right arm was holding onto the rail. Fearing she would fall, I helped her out of bed onto her frame.

I was then transferred to the frailty ward where I was able to get clean pyjamas, was given shower gel toothpaste and toothbrush. While on this ward I made sure other patients were safe and able to reach their drinks, helping, if necessary, at mealtimes and, on one occasion dressing a lady and stopping her from getting out of bed.

At night the lights were dimmed. During the night a lady who was going home the next day was very frail. She was transferred to the departure lounge. Another lady came in her place she was very tearful. I spoke to her and she told me she had been in hospital for three days but had not had her hands and face washed during that time and she was still wearing the clothes she had on when she was admitted. I gave her some wipes. She had fractured vertebrae falling off a chair.

During my stay on wards I felt I had to keep the other patients safe from falling as two patients had already hairline fractures following falls and helping if they needed it with drinks and meals. Family members asked me to look after their relatives when they weren't there. When I got home, I received a text from a relative thanking me for looking after their mum.

As to personal care, during my stay, no one asked if I was in pain or if I was still bleeding and I never saw anyone else getting personal care. Most patients were still wearing the clothes they were wearing on admission.

I received my three courses of antibiotics over three days with oral antibiotic on discharge. I was still being offered Aspirin every day, which I refused. One good thing was I was swabbed for MRSA when changing areas.

The food on offer was good, with alternatives and fresh fruit. My discharge letter is not correct because of lack updating my records.

The staffing level is another matter. Although I wasn't impressed with the care, the conditions staff are working in are terrible. When I asked the nurse what she would do if there was a cardiac arrest she said, "There won't be" and she walked away. Is there a procedure? If there is, does she know what it is? I found that very worrying.

Everyone involved with Queen's knows it is happening. There is no way out of it because the hospital just can't cope it serves such a large area of the population which continues to increase because intensive building in Havering. Not only do patients suffer the staff are under pressure working in these conditions.

Case 2

In mid-October, late in the morning, I tripped and fell, knocking myself out and cutting my head. When I came to, someone was helping me and telling me that help was coming. I was taken to hospital by ambulance, with my clothing cut open and a needle in my arm. I was taken on a trolley into A&E Majors (I saw the sign) and left in a corridor. My husband was with me; the department was very busy. I was desperate to use the toilet but there was no one to ask for help so my husband helped me. When we

returned to the trolley someone else had been placed in the trolley in my place and I was told to sit on a chair; my head was still bleeding and I did not feel well.

After a while, someone – a nurse, I think – put me on another trolley and I was wheeled in to the corridor again. I asked for pain relief and was given two paracetamols. No one examined my head or washed may face clean of blood. I heard someone say, "CT scan and discharge". I felt really frightened as no had told me what was happening and more and more patients were arriving. I believe it was about 2pm when I again asked to go to the toilet and a nurse took me in a wheelchair. When she saw my clothes had been cut, she kindly gave me a hospital gown and a wrist band. Shortly after that I was returned to the majors unit and put in a blue-curtained cubicle where an assistant cleaned and dressed my head.

I was wheeled back into the corridor and was moved several times, once alongside what looked like staff lockers. The area was full of patients on trolleys.

Later my husband asked when I was to have a CT scan – to which the nurse replied, "I thought she had already had it". After a while, I was taken for a CT scan but returned to the corridor again.

I had told my husband to go home as it was very late and I really did not think that I would be sent home as I had a head injury. Many more patients came into A&E and trolleys and chairs were in short supply. I was rather thirsty but did not like to bother nurses as they were fully occupied. I asked when my head would be stitched but was told I had to wait for a doctor and there was none.

I eventually saw a doctor, who was very gentle and took me into the unit behind blue curtains and cleaned and sutured my head wound. I had thought I would be admitted for observation but no, back to the corridor on the same hard trolley!

I was discharged about 6-7am and told I would be taken home by transport. I had no discharge letter but was told my GP would have a letter with full details. I arrived home about 9am. I went straight to bed as I was exhausted, having spent so long on a trolley and had a bad headache.

On Monday morning, I telephone my GP surgery to check they had details of the accident, only to be told that had no details of the CT scan or the stitches.

I am really concerned that a situation I had no control over was not treated as I would have expected. The gentleman who initially helped was medically trained and said he gave full details to the ambulance crew – unconscious, fitting, blood loss approximately 250ml – but this does not seem to have been recorded. There was no blanket to cover me when my clothes were cut; I was not given a wristband with my personal details for a considerable time; and my wound was not inspected for several hours.

My GP advised me to return to A&E if I became unwell but no way would I return to such an overcrowded situation. I am an NHS pensioner after working 25 years and I am very sad that the service is so dangerously over-stretched.

Appendix 4

BHRUT response to the report

1 Chief Executive's letter

Ian Buckmaster
Healthwatch Havering
Queen's Court
9-17 Eastern Road
Romford
Essex RM1 3NH

Executive Office
Queen's Hospital
Rom Valley Way, Romford, RM7 0AG

Phone: 01708 435 000
www.bhrhospitals.nhs.uk
@BHRUT_NHS

13 February 2025

Dear Ian,

Enter & View – Queen's Hospital, Emergency Department unannounced visit, November 2024.

I am writing to thank you for your recent report following the unannounced visit to Queen's Hospital, Emergency Department, in November 2024.

We very much appreciate comments and support from our local Healthwatch community and therefore welcome the findings and recommendations detailed in your report.

Please see enclosed our action plan based on your report.

Should you require any additional information, please do not hesitate to contact the Patient Experience Team via email at bhrut.patientexperience@nhs.net who will be happy to assist you.

Yours sincerely,

Matther Trainer
Chief Executive

Chair: Sarah Betteley   Chief Executive: Matthew Trainer

2 Action Plan

Barking, Havering and Redbridge University Hospitals NHS Trust

UNANNOUNCED VISIT – HEALTHWATCH REDBRIDGE

EMERGENCY DEPARTMENT – QUEEN'S HOSPITAL

November 2024

ACTION PLAN

BRAG COLOUR	DEFINITION
BLUE	Completed
GREEN	On track to complete by target date
AMBER	Minor issues that may slow progress
RED	Unlikely to meet target closure date

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
1		Havering Place-based Partnership (HPbP) to take the lead in working with BHRUT, PELC and local GPs to improve local communication to persuade those patients who do not need hospital care and can be treated without the need to go there – this would reduce the volume of patients going into A&E and reduce the bottle necks in the discharge process and lessen the number of patients in the corridors.			**Healthwatch are taking forward.**	
2		The HPbP to raise public awareness of the alternatives to A&E for minor health issues, such as social prescribing and the presence of ARRS/Allied Healthcare staff in surgeries such as pharmacists, physiotherapists and paramedics.			**Healthwatch are taking forward.**	
3		That as more space becomes available in the hospital (following the activation of the St George's Centre in Hornchurch), the accommodation available to A&E services to be expanded to provide better facilities for patients.	Geriatric Triumvirate	January 2025	Opening of winter pressure support for frailty.	
			Acute and Emergency Medicine Triumvirate	June 2025	Develop long term plans for the development of the Emergency Department and Emergency Care Provision - this will not be completed for some time but the plans will be in place.	

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
4		The lighting within the corridors used as auxiliary facilities for ED to be made dimmable, to reduce the nighttime glare that can adversely affect patients.	ED service manager for QH with QH Maton ED Team	June 2025	Request to be made to Sodexo for a small works.	
					Awaiting review by health and safety.	
5		The possibility be explored of providing low-level means of entertaining patients who are waiting in the corridor area to be transferred to a ward – perhaps through the provision of one or more TVs, magazines or books.	ED Associate Service Manager	April 2025	To explore if possible to have magazines or books brought to ED to be used via Charity.	
					To explore printing of the ED.	
6		The system for calling patients for attention to be improved by the installation of a loudspeaker system or, preferably, of screens on which names can be displayed.	Estates and Facilities team QH Acute and ED triumvirate	Ongoing currently	Tannoy system within ED is being reviewed by Estates and Facilities to provide update.	
				December 2024	Discussed with Chief Operating Officer using screens to identify people and this is currently not permitted.	
				June 2025	To include in the operating models and plan for the redesign of the Emergency Department consolidation of waiting areas and processes for calling patients.	
7		Attention to be paid to ensure that soiled bedlinen is not re-used, that the area is kept clean and that infection control measures are continuously implemented.	QH ED Matron team with Infection Control Team and QH Acute and ED Head of Nursing	Ongoing	Regular IPC walkarounds IPC audit of department lead by ED Matron team	

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

healthwatch
Havering

Healthwatch Havering is the operating name of
Havering Healthwatch C.I.C
A community interest company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Call us on **01708 303 300**

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

Find us on Twitter at **@HWHavering**