A REVIEW OF THE URGENT CARE PATHWAY AT THE QUEEN ALEXANDRA HOSPITAL PORTSMOUTH.

SUMMARY REPORT

OBSERVATIONAL DATA COLLECTED BY
HEALTHWATCH PORTSMOUTH REPRESENTATIVES

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AIMS AND OBJECTIVES

Healthwatch Portsmouth is an independent statutory body that gathers the views and experiences of local people, enabling them to have a chance to speak up about health and social care services in their area. We collect local evidence-based information through community engagement to ensure that the people who plan, commission and check services listen to the people who use those services.

Healthwatch Portsmouth visited the QA Hospital in March 2016 to better understand the pathway through the Emergency Department and related departments to see how the patient experience might be improved. As a snap-shot, the team made a number of recommendations that may enhance the quality of care and improve the 'flow' through these areas. Key themes centred on:

- The knock-on effect of one change in the pathway on others areas further up the 'flow' – that this is not always a positive one.
- The importance of patient and staff engagement in planning and implementing change.
- Information and communication with patients before, during and after their admission.
- The need to increase discharge options.
- The need to improve the environment which patients wait to leave the hospital.

This report was shared with Portsmouth Hospitals Trust (PHT) ahead of being made available to the public and other stakeholders via the Healthwatch Portsmouth website and other media.

One recommendation from the report was for Healthwatch Portsmouth to return to the QA Hospital at a later date to review progress. This 'revisit' took place in November 2016, with a review meeting with senior QA staff being held in January 2017 to discuss key findings. The aim of this report is to summarise the findings and recommendations that arose from these activities.

Healthwatch Portsmouth would like to take this opportunity to thank the Healthwatch board members and QA staff who took part in and supported this process.

METHODOLOGY

The aim of the visit by Healthwatch Portsmouth in November was to form a view about how patient experience had developed and improved along the urgent care pathway since March.

The visit, undertaken by two Healthwatch Portsmouth board members and two staff members, was arranged with QA staff so that Healthwatch representatives were accompanied throughout. The representatives used the feedback and comments from the original visit to form the basis for a pro-forma to capture observations during this second visit.

The representatives were able to visit each of the following departments, observe activities and ask questions of staff:

1. Emergency Department
2. Acute Medical Unit (AMU)
3. Ambulatory unit
4. Wards D2 and D3
5. Discharge lounge.

Following completion of the visit, the representatives met to summarise key observations and findings. These were then shared with senior QA staff during a meeting in January 2017 to gain further clarification.

This report was then drafted and provided to PHT to comment and feedback on prior to its wider publication on the Healthwatch Portsmouth website and other media.

FINDINGS & RECOMMENDATIONS

In summary, Healthwatch Portsmouth representatives felt there had been improvements in the overall feel of the different departments, with there seeming to be better morale across the staff team and important items, such as signage, improving.

A full, more detailed breakdown of observations and comments can be found in appendix one to this report. The key themes for each department are as follows:

1. Emergency Department (ED)

Overall, it was felt the 'Navigator Nurse' was a helpful role, triaging patients on arrival and then directing them to the in-house GP, other appropriate Emergency Department staff, their own GP, a pharmacy or in fact home. It was also observed that signage had improved and the use of the patient information card very effective in providing more context of patients' circumstances. However, it was observed that more information about waiting times at the St Marys Treatment Centre for alternative care and treatment could be provided to help patients choose whether to wait at the QA or seek assistance at this other location, helping to ease pressure on ED.

Whilst there were patients waiting on trolleys in corridors, and Healthwatch Portsmouth were reassured patients were monitored by designated staff, it was still felt more proactive interaction could be put in place with patients to give them ample opportunity to highlight a concern or need where necessary, instead of potentially feeling not able to 'bother' busy staff.

There was uncertainty at the time of the visit over how the wait time was measured and if measured under one heading or category, this might mask how long patients are waiting specifically on trolleys in corridors.

QA subsequently confirmed:
"We measure in accordance with the NHS England guidance which states The clock starts from the time that the patient arrives in A&E and stops when the patient leaves the department on admission, transfer from the hospital or discharge.

Patients should be counted in this category where their total time in A&E is 04:00:01 hours or greater. Patients with a total time of 04:00:00 hours or lower should not be counted.

For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to hand over 15 minutes after arrival that patient is nevertheless deemed to have arrived and the total time clock started."

QA stated they were doing much better to recruit whilst still needing to take a daily overview across the hospital and direct team members to where need is most, whilst not having a negative impact on the wards 'sending' staff elsewhere. The QA confirmed there is a senior nurse in place to review staffing levels who will move staff between areas to ensure safe cover. However, it is unclear how this is progressing and what impact, if any, this is having on staff and patients.

The impact of mental ill health seems to still be a concern for staff, with regards the wellbeing of patients experiencing illness as well as staff time to provide reassurance and support. QA confirmed there is liaison between departments to improve a response to this, including a training programme and risk monitoring processes. However, it was unclear if there had been a review of this in relation to patient experience, staff time and departmental performance.

With reference to 'Silver Command', Healthwatch Portsmouth representatives were unsure if and how the protocols for escalating concerns at different times had been communicated to all staff.

With regards to IT software, staff seemed confident over the use of the current system in the recording and monitoring of patient welfare and that this was not a unique arrangement to Portsmouth only. However, it was unclear how the system directly interfaces with other packages used, for example, by the ambulance service and GPs.

Recommendations:

i. Installation of a direct phone-line to St Marys Treatment Centre for patients to check waiting times as might encourage visits there instead if long waits taking place in ED.
ii. Awareness raising with staff re importance of proactive interaction with patients waiting on trolleys.
iii. Confirmation over how trolley waits are treated in the performance measures and whether measured as individual wait indicator.
iv. Allow time for training and risk assessments to be improved through liaison between departments and then review the possible impact of mental ill health on the patient experience and staff ability to provide care and treatment.
v. Confirmation re the suitability of IT software with other key providers of patient care and treatment in the system.
vi. Staff focus groups to explore front-line experiences and opportunities for improvement.

2. Acute Medical Unit (AMU):

It was observed that patients still have to wait on arrival into this department – however, as they have already been assessed by their GP, the QA staff felt they have relevant information about the medical circumstances and therefore the appropriateness of any wait before treatment.

QA staff stated that ambulance crews no longer need to wait with patients before handover to the AMU staff as dedicated AMU staff are available to do this.

Again it was observed that signage had improved as had the visibility of the nurse's station on the ward.

QA staff believed that all external calls into AMU were picked up by the main QA switchboard if there were no staff available in AMU itself.

QA confirmed:
"The process is that if a call in unanswered or engaged when transferred from switchboard, the call is returned to switch. One further attempt is made automatically, and if not successful caller asked if they would like the operator to try again or if they would like to try again later."

However, there was uncertainty over the patient/family member experience of this and whether patients' family/friends were actually successful in speaking with a staff member about the well-being of the patient.

We were informed that use of a number of emergency unfunded bed spaces was to help when there was a need for more capacity in the department. However, it was observed that these seem to be in use all of the time rather than as and when required, which queried whether there was incentive to reduce bed usage in this department.

Recommendations:

i. Research into the patient experience of admission into AMU to understand the route in and how handover and use of AMU supports patient outcomes.
ii. Healthwatch Portsmouth to undertake a 'mystery shopping' activity to assess how calls into AMU are handled.
iii. Confirmation over the ongoing use of emergency unfunded beds – part of usual daily bed capacity or still only used as and when needed?

3. Ambulatory Unit

Healthwatch Portsmouth representatives felt there was still an issue over the Unit not working at full capacity – not seemingly full of trained staff or best use made of the layout and size of the department. QA stated they were still to plan in and improve the environment and equip the team but other issues within the hospital had taken priority.

It was also shared that the Unit was used as an 'overflow' at night from the Emergency Department (ED). Although it was last on a list of alternative destinations for ED patients, there was concern over how this impacts the ability of the Unit to function effectively at the beginning of each day whilst waiting for ED patients to be discharged or moved to more suitable locations. It was

questioned how this was measured and in turn how this was impacting the patient experience within the Unit.

Recommendation:

i. Confirmation of timescales and plans for developing the team and environment.
ii. Review of the impact on the Unit and other departments within the QA over its use at night as an 'overflow' from ED including how many beds lost because of this and the knock on effect to overall patient experience.

4. Wards D2 and D3

Healthwatch Portsmouth representatives were encouraged to hear about the use of the "carers' contracts" by staff to highlight the importance of involving relevant family / friends of patients appropriately in their individual care and discharge. However, at the time of the visit, it was unclear how effective these contracts were from the viewpoint of patients and carers.

QA confirmed:
"…this initiative was in its very early stages at the time of this visit. Training has been provided and will continue to be by the carers team to ward staff to help increase understanding and awareness. This will be assessed during carers week in June 2017."

As with the Emergency Department (ED), the need for support around mental ill health was highlighted as an issue currently impacting on the ability of staff to provide good patient care. Following the visit, QA confirmed that a new liaison consultant has now started to improve this situation.

With reference to discharge, it was recognised that work is underway to integrate medical and social work teams to increase the number of timely and effective discharges. However, it was not clear how staff felt this was progressing and whether social workers were an integral part of the 'on ward' process as there was no mention of them in the ward's information leaflet for patients (this was also the case for the Red Cross Support at Home service, funded to help patients return home). It was unclear how effective referral routes and communication were between the different teams. There was also uncertainty over the effectiveness, to date, of the 'discharge to assess' programme.

In terms of options for discharge, it was also not clear what discussions were being had with partner agencies regarding care homes only accepting local authority payment rates, what other alternatives were being developed as locations for discharge or discussions over better use of aids and adaptations to help patient get home quicker.

Recommendations:

i. Review of the effectiveness of carers' contracts.
ii. Review with patients and staff progress with identifying discharge locations and the impact of local authority care rates, use of aids and adaptations and the progress of the discharge to assess programme.
iii. Review with staff progress with the integration of staff teams, social workers and utilisation of the Red Cross service.

5. Discharge lounge.

The size and location of this area was felt to have improved since the last visit in March 2016. However, Healthwatch Portsmouth representatives were still unsure how the processes had improved during this period – particularly regarding whether there was better communication between the Discharge Lounge team and the ambulance officer overseeing patient transport and whether patients are getting home in a timely manner with staff not having to stay on past their normal working hours whilst waiting for all discharges to be completed.

Representatives observed the environment still did not seem to provide much privacy for waiting patients and we reflected whether there had been much patient / staff engagement beforehand with regards the layout. It was also observed how the patterned floor may also prove challenging for people with sight impairment and/or dementia.

During the last visit, we also queried how much information is provided to patients ahead of discharge to help them understand the discharge process, particularly around transport. We are unsure how much progress has been made as this could be useful in helping to answer queries patients may have and manage expectations.

Recommendations:

i. Confirmation of how processes and communication to arrange transport and timely discharges had improved.
ii. Review design and layout of the lounge to better support patient privacy whilst waiting to leave the QA.
iii. Confirmation over what is information is provided to patients/family and when with regards to the discharge process, particularly the use and limitations of the transport service.

6. General observations:

With reference to the website, following the last visit, QA staff stated that patients and carers would be consulted with regards how user-friendly the site is.

It was also observed how information boards positioned around the hospital were full of lots of different information and it was queried how they add to the patient experience in navigating around the hospital and providing meaningful information. We understand feedback about information boards has also been provided in other formats separate to this visit.

Recommendations:

i. Feedback from the patient / carers' review of the QA website and how these comments had influenced the layout and design.
ii. Confirmation of any plans to review layout and content of information boards. QA confirmed that *"This is complete with new boards up in all wards from this week."* (week beginning 13/3/17)

SUMMARY & CONCLUSION:

Healthwatch Portsmouth undertook a visit to the QA Hospital in November 2016 to gain insight into the patient experience along the urgent care pathway.

During this visit, the team visited five key departments and observed a range of tasks and processes being undertaken by the staff teams in seeking to provide care, advice and treatment to patients.

We then met with senior QA staff in January 2017 to discuss our observations and key findings.

In general, it was felt that the feel, and possibly the morale of staff, had improved since our last visit, along with other important factors such as signage and information to patients in ED. It was also recognised that staff work in a very busy and demanding environment, dealing with patients with a range of different and contrasting needs. This report aims to support these activities by seeking to promote greater engagement to improve wellbeing and outcomes for patients, carers and staff.

Key recommendation themes from this activity are:

- Options for more information to be provided to patients / carers, particularly with regards waiting times at the alternative location of St Mary's Treatment Centre along with details about what to expect with the discharge process (including access to patient transport).
- A review of the impact of mental ill health on patient experience and the pathway, the impact of the new liaison consultant and whether still this requires additional resources.
- Departmental design/layout, confirming plans for the Ambulatory Unit and whether privacy options can be improved in the Discharge Lounge.
- Review of performance data, in particular trolley waiting times and the impact on the Ambulatory Unit and ED of use overnight as an overflow ward.
- Confirmation of progress with discharge processes, including achievements of the discharge to assess protocols, integrated teams and the identification of alternative discharge locations and options for speeding up discharge performance.
- Review of patient, carer and staff experiences of the urgent care pathway and how their feedback might improve processes in the future *(underway)*.

NEXT STEPS:

Healthwatch Portsmouth will publish this report on its website and share the findings across its networks, including Healthwatch England and the Care Quality Commission, to support improvements to the urgent care pathway and the overall patient/carer experience.

We will also explore opportunities to progress the recommendations with relevant patient/carer groups, QA staff and other interested parties (including other local Healthwatch), with options including:

- Engagement with patients following discharge and with those medically fit to be discharged but unable to leave the QA for a range of reasons *(NOTE: planning meeting with QA staff and other local Healthwatch has already taken place with plan to involve Healthwatch volunteers to survey patients who left the hospital during quarter 1 of 2017/18)*.
- Conversations with carers regarding their experiences and the carers' contract.
- Staff focus groups to collate additional feedback to improve key processes.

We will then revisit the key themes from this report to ascertain overall progress achieved and options for further engagement with patients, carers, QA staff and relevant organisations.

APPENDIX ONE: Full summary of observations & comments

(ED): Observation / Recommendation March 2016	PHT response following March 2016 walk-through	HWP observation 17/11/16 & from review meeting with QA staff 19/1/17
1. Review the user-friendliness of the check-in technology to see if improvements can be made.	The technology used for checking- in is in place to maintain the patients' privacy. Prior to this method (similar to that used in Post Offices etc.) patients would form a queue close to the person in front of them who were often trying to explain about embarrassing / personal conditions. The method we currently have enables one person to be at the desk at a time affording them as much privacy as possible. The signs at the front door have been assessed and will be improved in an attempt to make the system smoother.	• On arrival, prior to be booked in, patients see the 'Navigator Nurse' who then signposts / refers them on to the in-house GP, ED, own GP, pharmacy or home. • Recognised that signage has improved and the check in machine is no longer in use. • Patient information card – for use whilst in ED area, in place since September. Patient takes with them – good information re context of situation. Hand in at end of ED time.
2. Make information clearer re expected waiting times and what they relate to.	The Department is looking into purchasing a screen above the front door of the entrance to Minors. This will display the waiting time in Minors and Majors, also the times at Gosport Minor Injuries Unit. We are unable to display the time at St Marys Minor Injuries Unit. We would like to provide the telephone number to enable potential patients to call. This will help inform the patients and ensure a longer wait time does not come as a surprise – it may enable them to make an informed decision about where they go.	• No waiting times displayed – recognised that there are pros and cons of displaying times as it can depend on what issue patient has and its urgency in relation to others in ED. No plans now to do so as everyone is told on arrival after initial navigation assessment where they are going and estimated time of wait. • No phone line in place to St Mary's Treatment Centre – **could this be an option to help divert people there?** • Staffing information – not felt reassuring where gaps shown on noticeboards but understand it is a legal requirement for this information to be shared with the public.

3.	Provide patients in corridors with call buttons to summon assistance if required.	We aim to move patients rapidly to negate the need for queuing patients in the corridor. We employ 2 technicians from the ambulance service to ensure that the people in the queue are observed. There is also a trained nurse overseeing these technicians. It is expected that the nurse or technician makes themselves visible to the patients and is available to provide assistance.	• Patients were in corridor – confirmed as responsibility of 'Pitstop' team to monitor and respond (in-house PHT staff not ambulance technicians used). • Observed water being offered and slipper put back on for a patient. • No call button provided – QA state they need to ensure interaction with patients waiting in corridors is pro-active/explicit to give patients the opportunity to highlight if need any help. **Staff briefing sessions and wireless call buttons required?** • How is the experience for patients – QA confirmed this is measured through 'friends & family test' and obtain excellent results (satisfaction higher than national average). However, recognise need to focus on those who state will not recommend others to the QA and find out why. Also benefit from volunteers who survey patients via telephone and informal conversations and who can escalate concerns if necessary to senior staff. **Healthwatch surveys for patients / carers following discharge?** • How is wait time measured – is it all in one block at moment rather than X time in corridor, X time in cubicle etc? **Is this hindering a true measurement of performance.**
4.	Use a pool of Healthcare Assistants to support patients re toilet and refreshment needs, take basic	The Emergency Department is currently reviewing the workforce and we will be employing staff to track the passage of patients through the department. This will then release time for the Support Workers to care for patients needs and also to assist with essential nursing care. We will also be	• Increase use of healthcare support workers – rolling recruitment ongoing along with training but this is impacting other areas of the hospital (transferring from other departments then leaving those areas short). QA state they are now doing better with the planning of recruitment processes and have low nurse

	observations, move to other departments (in absence of porters), provide reassurance re anxiety.	altering the way we work in the Emergency Department which will reduce the number of times a patient is moved. This will also help with on-going care of patients as it gives the nurses time to develop a rapport with their patient rather than moving from the queue into majors.	vacancy rates, with more Healthcare Assistants due in post shortly. QA take a daily view of staffing across the hospital and state they will not take staff from one area and use in another if detrimental to services in the area providing these staff. • **Has use of staff in this way been successful? What is the impact on other departments?**
5.	Confirm if 'Jumbulance' is used and in what circumstances.	I can confirm that the "Jumbulance" is no longer in use and will not be used in the future.	• Confirmed no longer in use.
6.	Provide triage/treatment where appropriate in ambulances ahead of admission into ED.	Presently the nursing team do go out to the ambulances and carry out ECGs and observations. The ECGs are then read by one of the senior doctors in the Department. If the patient needs any treatments the patient will be brought in to the Department. If it is appropriate, that patient will then be given the next available space.	• Three advanced care practitioners support the triage process for those patients waiting in ambulances. • Mental ill health still an issue for patients in the department – patients can reportedly wait 6 hours for an assessment and 3 days for a bed – **what is the impact on patient, department and staff time?**
7.	Confirm specific role of 'Silver Command'.	The Department has an "Escalation Policy" and the role of Silver command is described in that document. It would be expected that each senior nurse responsible for taking charge of the Department would be aware of this. A communication will go out to the senior nurses advising them of this and it would be expected that this information would be passed on to the teams of nurses.	• Silver Command in place – **how does it work? How has this been communicated to staff?**
8.	Confirm reasons for	The decision to implement this system	• Staff feedback they feel the IT system works for their

decision to implement stand-alone IT system rather than one that used by other health agencies in the city.	followed a period of consultation and discussion and robust tender process in line with NHS procurement and also visits to observe other Emergency Departments and the systems employed. It should be understood that the system was employed for the Emergency Department and works very well for this. We are continually updating and refining the system to fit the specific needs of the ED.	needs. • However, **does this interface well with other systems for SCAS / GPs / Treatment Centre etc?**
(MAU) March 2016	**PHT response following March 2016 walk-through**	**HWP observation 17/11/16 & from review meeting with QA staff 19/1/17**
1. Revisit to confirm if performance has improved since introduction of referral direct into MAU from GPs – confirm with ED and South Coast Ambulance Service (SCAS)	No response to HWP report.	• Has performance improved since March 2016? QA states that patients do have to wait on arrival at AMU but they have already been assessed by their GP prior to arrival. If urgent, then patient will be responded to more quickly. **Is there patient experience data to share on this?** • Observations that signage has improved, much better visibility of the nurse station • Query over how unit referred to - seems to be AMU by staff working there but MAU for staff elsewhere in QA – confusing for patients, visitors, staff, other departments. QA state that signage being updated so referred to consistently as AMU as it is nationally.
2. Use of a pool of Healthcare Assistants to support patients on arrival via ambulance to free ambulance crew	Action: Additional HCSWs requested for late shifts to work with Take Teams and commence investigations for GP patients arriving in AMU	• Nurses are undertaking this role to free up ambulance crews to leave department and respond to needs in the community.

up to attend another call.		
3. Implement phone messaging / handling system for the public.	We will suggest this to the Senior Management team and plan to discuss with our Administration Team.	• Informed that calls are directed to front desk at MAU – but we were unsure if this was covered 24/7 and what happens if relative phones and no one on desk, just rings and rings as previously? QA state that central switchboard can recover all calls if not answered and then take a message. Is this a good patient / carer experience? **Healthwatch Portsmouth to 'mystery shop' to see if still an outstanding issue?**
4. Confirm reasons why funding not available for 8 unfunded beds.	As this area is utilised when there is a higher demand for additional beds, it is only staffed when the bed space is required. The resources for this flexibility are not within the departmental budget.	• It seems that 5 unfunded beds are in constant use. **Is there still interest / incentive to reduce bed use and therefore not use these?**
5. Make signage dementia friendly.	We are currently working with Department of Medicine for Older People to look at ways to improve both dementia care and environment on AMU.	• Recognised that signage much clearer and friendlier now.
(Ambulatory Unit) March 2016	**PHT response following March 2016 walk-through**	**HWP observation 17/11/16 & from review meeting with QA staff 19/1/17**
1. What are the plans to upskill staff team to increase capacity of the unit to take more referrals?	Staff will rotate to ensure exposure to skills required for the ambulatory area. In addition to this our Nurse Consultant and Senior Sisters are working together to establish competencies of staff working in ambulatory area.	• This still seems to be an issue and means that unit potentially not working at full capacity or as efficiently as it could be. • We were unsure what the vision is for the unit as seems to have stalled and not be prioritised? Vision for staff? What is realistic aim for the unit? Has initial vision been watered down? QA state that plan is still to

		improve the unit and equip the team but recognise other pressures in the hospital have delayed some of this work. **What are the timescales for improvements to be implemented?**
2. What are the plans to improve the environment to make it more comfortable and warm for patients during their wait and treatment?	We currently have building/redesign plans in draft format – we are awaiting funding approval and before work to go ahead.	• There do not seem to be any plans to improve / refurbish the unit at present time. • Understand the unit also used for overnight overflow from ED – how does this impact subsequent use during the following day? QA recognise this not ideal as can impact use of Ambulatory unit the following day. Ambulatory Unit last on list of other departments used as 'overspill' from the emergency Department where more beds required. **How is performance affected – how many Ambulatory Unit beds / days lost because of this? Is the situation improving?**
(D2/D3) March 2016	**PHT response following March 2016 walk-through**	**HWP observation 17/11/16 & from review meeting with QA staff 19/1/17**
1. Consistent roll-out and use of the 'This is me' protocols.	The 'This is me' documentation is only required for patients with a cognitive impairment and/or dementia. All patients have care plans which are individualised plans of care and cover activities of daily living.	• Staff implementing the 'carers contract' which looks at person-centred services involving other key people in life of patient.
2. Access support for patients with mental ill health.	Mental Health services can be difficult to access due to the criteria set by the service. As an organisation, we are working in partnership with Mental Health care provision to make improvements to access for all patients.	• Access to external/additional mental health support for patients has not improved although a role is being developed in D3 to reduce delays in accessing relevant services. **What steps are being taken to address this?**

3. Investigate barriers to discharge to nursing homes with local authority colleagues.	No response to HWP report.	• Question over the importance placed on partnership working to enable patients to leave QA quicker and to right place. **What is the connect with Social Workers - how are they utliised?** Social Workers not mentioned on the ward information leaflet. • Feedback suggests residential care homes not accepting PCC payment rates and therefore QA not able to discharge to these homes – **are options available for discharge actually reducing?**
4. Explore other housing options for re-ablement with local authority colleagues and what works in other localities (including via www.housinglin.org.uk) .	No response to HWP report.	• Understand that QA and Adult Services co-located at the hospital but **query over whether integrated working – what is view of staff?** • **How is 'discharge to assess' programme performing and making a difference?** • What is the experience of patients of the discharge process? QA confirm that quarterly review of patient experience providing some insight but not richness of data re outcomes and ways of improving the process. Interest in working with Healthwatch to review patient satisfaction and opportunities to improve. **Independent surveys to confirm that patients / carers saying about their discharge?** • **What options have been explored with CCG/PCC re alternative locations for discharge – converted properties, aids & adaptations?**
5. Improve awareness of the role of carers and carers support networks.	We are working with the Patient Experience team to implement the Trust wide work streams supporting Carers. This includes utilising the carer support team that are	• Good news that staff implementing the 'carers contract' – recognises the need to involve carers and helping to increase their value and significance to care plans and treatment provided. QA state carers were

	based at the hospital.	involved in design of contract documentation and Head of Patient Engagement visits community groups specifically re the experience of carers. New carers centre to be launched soon. • **Staff feel 'carers contract' helps but do patients? Do carers?**
6. Greater engagement with patients and staff over potential changes and impact of these changes further up the pathway.	Little was known about the service, because at the time of the visit, the changes to D2 were in the infancy of planning. Our staff are kept up to date at all stages of planning to ensure they are involved in the change process.	• Staff seem to feel more engaged in processes and changes – **is this the response QA have received through own staff feedback mechanisms?**
Other queries / comments? • Staff seem to believe the majority of D2 patients have a better understanding now of the temporary nature of the ward but still seem to be remaining in the ward past the 72 hour target. Weekend discharges still a problem. • Question over whether the Red Cross 'Support at Home' service and other similar initiatives are used to the best of their capacity – **are staff aware of services? Referral route known? Any blockages?** Red Cross not referred to on the ward information leaflet.		
(Discharge Lounge) March 2016	**PHT response following March 2016 walk-through**	**HWP observation 17/11/16 & from review meeting with QA staff 19/1/17**
1. More control over transport arrangements by discharge lounge team.	The discharge lounge team is working with South Central Ambulance service; we have an ambulance liaison officer from SCAS is available on site Monday to Friday. Their role is to assist with patient concerns the discharge lounge team may have about specific patients that require priority in certain circumstances.	• HWP unsure how process for accessing transport has improved since March as still reports of delays in transport arrangements meaning staff have to stay on past shift. **Could this lead to transport (and therefore discharge) being cancelled?** • Didn't see the ambulance officer – where based? **How accessible for staff? Reactive or pro-active service**

		provided? • Could taxis be used, where appropriate, to speed up discharge (in same way used for bringing into the QA) to improve the patient experience?
2. Greater patient and staff engagement over proposed changes – to give opportunity to explore impact and what works and does not work on the ground.	We are very pleased to say that the discharge lounge has since been relocated to a new unit, which offers a much more suitable environment for the care of our patients leaving hospital. At present work is underway in unison with patients, to further improve this area to ensure patient comfort, privacy & dignity, satisfaction and safety.	• New discharge lounge area since last visit in March - still open plan so no patient privacy. **What has been feedback on use of new area? What engagement took place in setting up new area?** • Location – seems isolated and a walk from where family might park to pick patient up – use of wheelchairs / navigating etc? • **Floor not dementia friendly – patterns – would this fail the PLACE test?**
3. Improve patients' understanding of access to patient transport and what they can expect if offered this service.	See response to item 1 above.	• Unsure if any information is provided to patients earlier on in discharge process to help manage patient expectation of discharge and transport arrangements. **Could this be implemented?**
General observations March 2016	**PHT response following March 2016 walk-through**	**HWP observation 17/11/16 & from review meeting with QA staff 19/1/17**
1. The pathway which patients come through the QA are varied – it might be helpful to produce information to confirm what the main routes are.	It is acknowledged that the routes by which patient access the hospital are varied. They are also flexible, depending on the patient's needs and as such any information provided would need to reflect that. We will work with our patients and families to review the information currently provided on our website to establish any additional information that is required.	• Recognised that the information / record card given to patients for use during time in ED was good, as was information leaflet in D2. • General signage has also improved. • **Have there been any further reviews of information provided or website?**

2. We were unsure of what information is provided to patients regarding each area of the hospital. It might be helpful to produce literature to explain the function of individual wards / units to help patients understand the aims of each and how they raise a query over their care. A 'What to bring to hospital' leaflet may also benefit patients/visitors for future admissions.	The internet site provides core information on each department. Some individual wards/ units have their own introductory leaflet and we are working towards a standard template based on feedback from our patients and their families. There is information at ward level ("What to do if you're worried" leaflet), on the website (PALS) and PALS leaflets which encourage patients and their families to ask questions and raise a query or concern if necessary. "What to bring" information is available on the trust website under the "Your hospital stay" section. Elective patients are also provided with the leaflet with their letter advising of admission date.	• Item not focused on during visit.
3. Dementia friendly signage was highlighted in the MAU but one key improvement for all sections visited would be the use of this signage for all patients and visitors, to help orientate people and inform them about the services and service standards they can	Currently, the Head of Nursing for our Medicine for Older Persons Department is working with MAU to look at how signage can be improved. These improvements will be added to the general improvement works that will be completed in MAU in the coming months.	• Recognised that signage has improved.

expect.		
4. With regards to the displaying of information, there seemed to be many different charts and posters on walls but we were unsure how meaningful this information was to improve the patient experience of being in the QA. Has this information been reviewed by patient representatives or is it aimed at staff? The challenge might be that walls are not viewed as key places to gain information as when a patient is travelling from one location to another in hospital, they may only be concentrating on getting to their destination rather than picking up data on the way	The ward information "dash boards" were designed in partnership with representatives of the local community last year. There is a mandated requirement for certain information to be publically available at ward/departmental level and we worked with patient representatives to ensure that we could make this as meaningful as possible. The information is also provided to provide families and other visitors with information about the wards which many have told us is useful.	• Recognised there are some items that need to be displayed but amount and assortment of information viewed as confusing. Does this add to or inform the patient experience? Issues with amount of information always fedback at quality reviews by range of participants that HWP attends. **Could there be core and then limited bespoke information needed for that particular area?**

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