healthwatch Havering

Enter & View

Queen's Hospital, Romford:

Accident & Emergency Services

Follow-up visit to Emergency Department

October 2025

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.

In November 2024, we visited the Accident & Emergency (A&E) Services at Queen's Hospital (the sixth full Enter & View visit we have carried out there since 2016) – that visit is referred to in this report as "the main visit". In addition to the Emergency Department (ED) provided by the hospital trust, Barking, Havering and Redbridge University Hospitals Trust (BHRUT), A&E comprises an Urgent Treatment Centre and Streaming service provided by PELC (the Partnership of East London Cooperatives, a GP-lead provider) and the ambulance reception area, served mainly by the London Ambulance Service (LAS).

In the report of our 2024 visit, we made suggestions for improvement, as follows:

1 That communication between A&E and local GPs be improved in order to dissuade people who could be treated elsewhere from going to A&E unnecessarily

2 That better information be made available about the alternatives to A&E

3 That the space available for A&E be expanded as opportunity arises

4 That dimmable lighting be provided in the corridors accommodating patients awaiting admission

5 That means of keeping patients occupied while awaiting admission be explored

6 That improved means of calling patients from the waiting area for treatment be explored

7 That the re-use of soiled bedlinen be avoided and the corridor area be kept clean, with infection control observed.

*[**Note –** suggestions 1 and 2 above are outside the responsibility of BHRUT, PELC and the LAS and therefore outside the scope of this visit and report]*

BHRUT subsequently provided a detailed Action Plan in response to those recommendations and the follow-up visit now reported was intended both to see how the Action Plan had worked, and to observe how A&E services, and especially the ED was coping, one year on from the main visit. The report of the main visit, including the Action Plan in full, is available at https://www.healthwatchhavering.co.uk/sites/healthwatchhavering.co.uk/files/A%2BE%20Visit%202023-24%20report%20Final_1.pdf

This visit

On arrival, the team were met by a Patient Experience Facilitator, with whom they first discussed the availability of wheelchairs for patients' use. He advised that although there had been a problem previously, as a good number of wheelchairs had been sent away to be serviced, currently there were no problems.

Following this, he took the team to meet the Senior Sister on duty that morning.

Implementation of the Action Plan

Following up the recommendations from the main visit, and the Action Plan, the team:

1) Asked about lighting in the corridors (recommendation 4) where patients are being nursed. At the time of the visit, they were told that it was considered that changing the lighting would be expensive but BHRUT has subsequently advised that lighting in the corridors must remain bright owing to fire safety considerations that require hospital corridors to remain fully lit always to ensure safety. Patients are issued with eye masks to give them respite from the bright lights.

2) Noted that, to help keep patients occupied while waiting in the corridors (recommendation 5), word search puzzle

books, colouring books, and Sudoku puzzle books are now available

3) Noted that, following the opening of the St George's Health and Wellbeing Hub in Hornchurch and the transfer there of the renal dialysis unit, the space formerly occupied by the unit next to the ED is now being used the Frailty Same Day Emergency Care (FSDEC) service (which is closely associated with the A&E service) [1] (recommendation 3).

4) Were pleased to note that "comfort rounds" are now undertaken regularly to ensure patients' hygiene needs are met appropriately, and a weekly audit undertaken to ensure that this is maintained (recommendation 7)

5) Noted however that the system for calling patients continued to be unacceptable although the Outpatient 2 department does have a buzzer system which has an assigned number, which lets the patient know there is a 10-minute wait for their appointment (recommendation 6).

At the time of the visit, 98 patients had been seen in the ED that morning, of whom 32 were still being treated, and 48 awaiting the availability of a bed on the relevant ward as a result of delays in arranging the discharge of existing patients. The team

[1] See our report on the Frailty Ward and FDEC at https://www.healthwatchhavering.co.uk/sites/healthwatchhavering.co.uk/files/Frailty%2BSDEC%20Visit%202025%20report%20Final.pdf (Healthwatch Havering, October 2025)

were told that the discharge process still does not work as well as it should; particular difficulty arises from the need to ensure that vulnerable patients can be discharged safely, which for elderly patients presenting in ED following a fall, requires assessment by an occupational therapist, and may necessitate finding them a place in a care home rather than returning to their own homes.

The team visited the High Dependency Unit (HDU) corridor, at which time there was only one patient on a trolley, although they were informed that it would probably be full by the evening.

It was noted that, if there were too many patients awaiting admission, there is an agreement with the LAS that two steps would be implemented:

Step 1: patients would be taken to King George Hospital in Goodmayes

Step 2: patients would be taken to other hospitals

The handover time from LAS crews is now 15 minutes (previously it had been 45 minutes).

Staffing levels are based on the number of patients being cared

Overall, the team felt that there had been a positive improvement in the ED arrangements. The overall atmosphere that day was calm and all seemed to be running smoothly.

On this particular day, Step 1 had been implemented so that patients who did not require specialist treatment identified at Queen's Hospital, who were already travelling in ambulances, were being diverted to King George Hospital. The Matron informed the team that there were potentially more patients coming into A&E later in the day as they had already been signposted there. The senior sister took us on a detailed walk around the area since our last visit. Her role is safety and governance.

Staff

The team observed that plenty of nurses were available. They were told that retention of nurses in the ED was very good and that there was no need for outside bank staff as the ED had their own pool of extra staff who knew the systems, policies, culture etc of the ED. One of the main reasons for this retention is that the Leadership Matrons have been instrumental in making sure the nurses are happy in their work, that their hours can be flexible (particularly if they have family commitments) and that their team are given the training, and are equipped, to deal with the variety of situations that may occur within the ED. This gives staff the confidence to manage issues such as an unexpected influx of patients and the procedures that should be adopted to ensure that the patients are cared for and monitored throughout the ED as a whole, but particularly in the corridors.

There are regular training sessions and debriefings when things get too pressurised or there is an issue/problem that has come up. Staff are also encouraged to discuss with the Matrons the stress problems related to the pressures involved in this department. All these positive actions are helping the nurses to feel valued and informed and the many security staff on the ward help them to feel safe to do their job.

These measures have been put into place as there are now a good many mental health patients in the form of walk in's and dementia patients. Dual qualified nurses to maintain the mental health patients – at times these patients can be waiting for up to 7 days for Nelft to arrange a place of safety and treatment. Recently they have also been a number of young people who are homeless and they have need to spend time in the hospital until they could be relocated in a home.

Corridor care & Rafting

"Corridor care" is a regrettable but unfortunately unavoidable current feature of A&E services – not only at Queen's Hospital but at many hospitals nation-wide; a consequence of demand for A&E services outstripping the ability of the NHS to meet it.

The ED do not screen for TB but if a patient is symptomatic of Covid or Flu A they would then be screened and patients known or suspected to be infectious are put into a side room.

Patients presenting with mental health problems are placed in an inside room - if very disruptive, they are placed into the secure room with a security guard (but which has no *en suite* toilet facilities).

The team were told that, under the Violence and Aggression policy, patients who behave inappropriately are given a yellow card and told that violence and aggression towards staff is unacceptable. A patient who receives 2 yellow cards is given a red card; patients who have been given a red card will only receive lifesaving care.

HDU corridor patients are provided breakfast, lunch and dinner (as appropriate) and water rounds are undertaken and staff ensure that patients are warm.

In the corridor there are now plugs on the wall and some beds have trolleys so patients can put their personal possessions on them. There is a staffing ratio of 1 nurse to 9 patients and there is always a nurse on duty recording patient details and monitoring them. The patients have access to a toilet near the corridor and those who need assistance are wheeled into it. Food and drink is also provided to the patients on a regular basis.

Patients' views

The team were able to speak to five patients who were being treated in the corridor. Of them:

- One elderly patient said she had experienced a delay in being able to access the toilet, which had caused her some distress and anxiety, and it made her feel undignified as she didn't want to embarrass herself. However, her daughter did say they had been very pleased to receive a food bag, had been treated well and it was 'what they had expected' positioned in the corridor
- Another elderly patient had been brough to the hospital following a fall. They were impressed with the doctors and how they had been treated; but were not impressed with the fact that they had been back and forth to the X-ray Department 4 times due to incorrect information being supplied, and that the CT scan they were due to have had been delayed as the wrong form had been used
- One elderly patient's daughter complained that her mother had been waiting in the corridor for 3 days without being washed; however, while the team were there, she did have a wash, which left her very happy
- A very elderly male patient's daughter told the team that, as her father was deaf, he had not heard the trolley coming round and so had missed out receiving food. Furthermore, no dignity had been offered when he required

use of the toilet; he was pushed into a cubicle to use a commode but no hand-washing facilities were available.

Patients also made general comments such as:

- Insufficient staff were on hand
- There was a lack of communication while they were waiting
- More resources were needed to improve conditions for patients

Two patients told the team that there was a lack of information regarding their conditions and one of them commented on the lack of pain medication such as paracetamol. One of them, a younger man who had been in Queens for three days in total, felt bored but did not appear to be interested in the magazines that were available.

One patient also flagged up the lack of security. She explained that the previous evening, in Rafting, two people had come in 'off the streets' and had run around causing havoc; security guards had run after them in circles and eventually caught them. This disturbance caused her to feel frightened and intimidated. She also gave another example of a security breach - a friend of hers on site for another reason, knowing the patient was in hospital, had decided to visit her on the corridor at 2am; she was able to do so without being challenged by anyone: this lack of security and being alone on a trolley bed,

unwell and without her husband as a companion had distressed and frightened her.

The team subsequently discussed the apparent lack of security with Patient Experience staff seeking an improvement. They were told that the urgent care door off the street is closed at 10.00pm.

In addition, we have received two reports of individuals' experiences while receiving "corridor care": one from a user who wished to remain anonymous, the other from a Healthwatch volunteer who attended the hospital as a patient on two recent occasions (and is herself a retired nurse).

The anonymous service user told us:

> "I spent 40 hours on a trolley in a corridor in Queen's Hospital, Romford. There was no dignity when using a bedpan or receiving treatment. No refreshments were offered to me. For a solo pensioner, it was very scary. The man in next trolley to me died while I was there.
>
> It was hard to access help and support and my experience of care was poor."

Our volunteer's report is set out in the Appendix to this report.

ITN broadcast about "war zone" corridor care at Queen's Hospital

In December, some weeks after the follow up visit now reported, Independent Television News (ITN) broadcast a news item [2] about conditions in corridor care. Their findings echoed the conditions observed by our teams, both during the original visit referred to in the main report, and more recently during the visit which the report results from. The experiences of patients reported by ITN were similar to those reported to our teams by patients, their visitors and companions, and staff during the visits.

Conclusions

As the Secretary of State has acknowledged, this is not a problem unique to Queen's Hospital, nor indeed to London. There is no simple solution to over-crowded A&E services – and although it is clear that action has been taken to ameliorate conditions in the corridors for patients, we consider that more could be done at relatively little cost.

Queen's Hospital was designed to serve a much smaller population in its catchment area than is now resident there. The number of patients seen in A&E is now around double that of the

[2] See https://www.itv.com/news/2025-12-03/footage-reveals-warzone-corridor-care-at-nhs-hospital

designed capacity, even though action has been taken to re-use for A&E (or associated services) accommodation vacated by the Dialysis service following its relocation to St George's Health and Wellbeing Hub in Hornchurch. Healthwatch fully supports the campaign by the BHRUT leadership for funding to develop a new A&E block, but that is clearly not going to be available in the short term.

While acknowledging that steps have been taken to ameliorate conditions for patients in corridor care, there are more that could be taken – for example:

- More could be offered to "entertain" patients – magazines etc have been provided but perhaps televisions or radios could also be made available to distract patients from the obvious boredom of long waits
- Keeping the corridors open as thoroughfares for other patients, visitors and staff leaves patients without privacy, dignity or safety and security (as comments made to our team clearly show). Closing the corridors to all but patients awaiting admission, their visitors and A&E staff and directing others to alternative routes would be most helpful and can be achieved at little or no cost.

The lighting in the corridors remains too bright, although the provision of eye masks to reduce the glare effect is welcome. We accept that lighting must remain bright in order to satisfy

fire precautions requirements but consider that eye masks are an inadequate answer, not least because they may make some patients distressed or anxious as they cannot see what is going on around them. Since it is obvious that the use of "corridor care" is not going to be eradicated in the short term, we urge BHRUT to seek a better compromise between maintaining fire safety and ensuring the comfort of those patients who are receiving corridor than simply handing out eye masks.

We do not consider that it would be appropriate at this stage to offer further recommendations – BHRUT's management are well aware of the inadequacy of the present arrangements and of the need for improvements but are hindered by the lack of space within the hospital. We hope, however, that the suggestions for further changes we have made in this report – relatively minor but potentially much improving the comfort of patients who have to wait – will be considered and acted on.

Acknowledgements

Healthwatch Havering are grateful to the staff and patients in the A&E Services on the day of the visit for their co-operation and responses.

APPENDIX

Report of a Healthwatch volunteer

This report has been provided by a Healthwatch volunteer, who is a retired nurse and is thus familiar with the processes and procedures that should be observed in any hospital setting. The details in the report as now produced have been edited and anonymised to protect the identity of the volunteer, but are otherwise taken from her account of her experiences.

Background

I am 78 years old. In October, I experienced a serious fall while returning from a shopping trip, carrying multiple bags. I tripped on a cracked paving stone and fell face-first, sustaining injuries to my face and left elbow. A passerby assisted me and suggested calling an ambulance, but I opted to assess the situation myself. Upon closer inspection, I noticed significant swelling around my nose and decided to seek medical attention.

Initial Visit to Queens Hospital ED

I ordered a cab, picked up a friend en route, and arrived at the Emergency Department (ED) at Queens Hospital. The reception area was crowded, and I was in shock, unable to stand for long. Fortunately, my friend queued on my behalf. Had I been alone, I would have struggled to manage the process, including triage.

Upon registration, I was asked if I was the patient. Later, I discovered that the letter sent to my GP incorrectly identified my companion as a relative.

In triage, I received pain relief and was found to have elevated blood pressure. I was referred to the PELC area in the atrium, which was chaotic, with children running around and poor audibility of patient names being called.

I was eventually sent for an x-ray, which was handled efficiently. A doctor cleaned the blood from my face and confirmed no fractures. However, my blood pressure was recorded at 200/100 mmHg, prompting immediate referral back to ED.

A second doctor, possibly a registrar, questioned my blood pressure history. I explained my long-term use of Amlodipine 5mg and a previous ED visit in April. Her response was blunt and alarming: "You do know that with a B/P that high you could have a stroke or heart attack at any time." Despite my nursing background, this statement deeply unsettled me.

She prescribed a doubled dose of Amlodipine and expressed concern about medication confusion, implying I might mix up the tablets. I reassured her of my mental competence. She then made a casual remark about my upcoming birthday and asked if I was having a party. Before discharge, she mistakenly advised me to take the 5mg dose again, despite having just prescribed 10mg.

No consideration was given to how I would get home, nor was there any inquiry into my living situation. I live alone, with family far away. I had to order a cab and walk across the hospital grounds.

Psychological Impact and Medication Issues

The registrar's warning echoed in my mind for days. I became fearful of using my blood pressure monitor, even with company. A pharmacist later suggested I may have developed PTSD from the experience, a sentiment I strongly agree with.

The increased dose of Amlodipine caused adverse side effects, leading to a change in medication. In December, my GP initiated a new regimen requiring twice-daily blood pressure monitoring.

Second Visit to Queens Hospital ED

In early December, I recorded a morning blood pressure of 198/100 mmHg. After repeated readings, I decided to go to A&E with my son. We arrived around 10am and were quickly triaged, where my blood pressure was 214/105 mmHg. I was directed to SDEC A, supposedly expected, but upon arrival, I had to re-register and wait again.

The waiting area was small and poorly managed. A male patient in visible distress was vomiting and restless. An elderly gentleman, brought in by ambulance, was left unattended due to confusion over his destination. He was 92 years old and had been sent for a scan. We saw him multiple times, still without proper direction.

Despite my critical blood pressure, other patients were seen before me. I questioned this and was told patients were seen in order of arrival. Another patient even suggested I should be prioritised.

Eventually, I had an ECG and blood test, but no one communicated results or next steps. We waited for hours without updates. A woman with a broken shoulder was mistakenly given a CT scan of her head instead of an x-ray of her shoulder.

I was moved to a more comfortable waiting area, where relatives were not supposed to be present, yet many were. I was given a sandwich, crisps, and a drink. A young man with chest pain, blue-lighted in, was also left waiting.

My son asked about my status, and the Charge Nurse claimed I was being monitored, though no one had spoken to me or rechecked my blood pressure. Another elderly man with a full catheter bag repeatedly requested assistance, which was eventually provided in full view of others.

A fellow patient's mother remarked, "They don't look after the elderly very well here, do they?"

After another hour, my son requested a blood pressure check. It had lowered, so I chose to leave. I signed my own discharge form. As we exited, we saw the woman with the broken shoulder still waiting.

Reflections and Concerns

Queens Hospital ED is undoubtedly busy, but the lack of communication is a serious concern. Patients are left in limbo, with no updates or engagement. For me, a simple explanation of my ECG and blood test results would have made a significant difference.

I later asked my GP whether extremely high blood pressure warranted an urgent ED visit. She confirmed it did. My response: "Tell that to Queens A&E."

Conclusion

My experiences highlight systemic issues in emergency care, particularly for elderly patients. Communication failures, lack of empathy, and procedural confusion contribute to distress and undermine patient safety. I hope this account prompts reflection and improvement in patient care protocols.

Participation in Healthwatch Havering

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

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

Members

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

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

Healthwatch Havering Friends' Network

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

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

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