Queen Alexandra Hospital

Inspection visit date(s): 6th, 7th, & 10th May 2025

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Queen Alexandra Hospital
Location findings

Ratings for this location

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Overall location summary

We assessed Queen Alexandra Hospital from 6 to 10 May 2025.

At this inspection we inspected 2 assessment service groups: urgent and emergency care and medical care including older persons' medicine. We also reviewed progress made against a warning notice served on the provider following the inspection of urgent and emergency care in October 2019. We found that the service had made improvements and had met the actions of the warning notices

We visited the following areas as part of the assessment:

Urgent and emergency services, medical wards and the endoscopy department.

We rated the location as Good.

The hospital was in breach of legal regulations in relation to premises and equipment (waiting and escalation areas in the emergency department), staffing (training), person centred care (learning

disability), and good governance (contemporaneous records and identifying and assessing risks).

Safe

Rating Good

Urgent and emergency care was rated as requires improvement. Medical care, including older persons medicine, was rated as good.

We have aggregated the ratings of safe in assessment service groups from previous inspections and the ratings from this inspection to determine overall rating. Our overall rating of safe at Queen Alexandra Hospital is good.

Effective

Rating Good

Urgent and emergency care was rated as good. Medical care, including older persons medicine, was rated as good.

We have aggregated the ratings of effective in assessment service groups from previous inspections and the ratings from this inspection to determine overall rating. Our overall rating of effective at Queen Alexandra Hospital is good.

Caring

Rating Good

Urgent and emergency care was rated as requires improvement. Medical care, including older persons medicine, was rated as good.

We have aggregated the ratings of caring in assessment service groups from previous inspections and the ratings from this inspection to determine overall rating. Our overall rating of caring at Queen Alexandra Hospital is good.

Responsive

Rating Good

Urgent and emergency care was rated as requires improvement. Medical care, including older persons medicine, was rated as good.

We have aggregated the ratings of responsive in assessment service groups from previous inspections and the ratings from this inspection to determine overall rating. Our overall rating of responsive at Queen Alexandra Hospital is good.

Well-led

Rating Good

Urgent and emergency care was rated as good. Medical care, including older persons medicine, was rated as good.

We have aggregated the ratings of well-led in assessment service groups from previous inspections and the ratings from this inspection to determine overall rating. Our overall rating of well-led at Queen Alexandra Hospital is good.

Medical care (Including older people's care)

Medical care (Including older people's care)

Overall	Good
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Our view of the service

We carried out this assessment on 6 and 7 May 2025.

We carried out this assessment as a responsive inspection, due to concerns we had received about the service. We assessed 5 key questions; safe, effective, caring, responsive and well led.

The inspection team comprised of CQC Inspectors, Specialist Advisors, an Expert by Experience and a Clinical Fellow. We spoke with members of staff and senior leaders. We carried out remote interviews with staff and teams. We also requested evidence from the service which was provided by the trust between 30th May- 17th July 2025. We rated medical care as good overall because:

The service had a good learning culture and people could raise concerns. Managers investigated incidents. Patients were protected and kept safe. There were mostly enough staff with the right skills, qualifications, and experience.

People were involved in assessments of their needs. Staff reviewed assessments taking account of

people's communication, personal and health needs. Care was based on latest evidence and good practice. Staff worked with all agencies involved in people's care for the best outcomes and smooth transitions when moving services, such as at discharge. Staff made sure people understood their care and treatment to enable them to give informed consent.

People were involved in decisions about their care. The service provided information people could understand.

Leaders and staff had a shared vision and culture based on listening, learning and trust. Most leaders were visible, knowledgeable, and supportive. Staff were treated equally, and most staff with protected characteristics felt supported. Staff understood their roles and responsibilities. There was a culture and structure for continuous improvement being embedded into the service.

However, patient flow through the service was a challenge, which resulted in a poor experience for some patients. The service did not do enough to support autistic people and people with a learning disability to reduce the risk of inequity in experience and outcome. Managers did not ensure all staff received timely appraisals.

At this inspection, we found the service breached legal regulations about staffing and person-centred care. An action plan will be requested upon publication of the final report.

People's experience of the service

Most patients and their family or carers with them were all positive about the staff treating and caring for them. They said staff treated them well and with kindness and "nursing staff are very compassionate." Most said communication with them was good. They felt informed about their procedures and care, staff "take time to explain everything to you" and "I am involved in decisions of care." Most patients were satisfied with the provision of meals.

During the inspection patients spoke positively about how staff supported them to meet their individual needs. However, feedback from some patients in the Friends and Family Test results showed that some felt appropriate reasonable adjustments had not been put in place for them.

Safe

Rating Good 

Acute services

Medical care (Including older people's care)

At our last assessment we rated this key question Good. At this assessment the rating has remained good. This means we looked for evidence that people were protected from abuse and avoidable harm.

The service was in breach of legal regulation in relation to staffing (training).

Learning culture

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service had a proactive and positive culture of safety, based on openness and honesty. They listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually identify and embed good practice

Trust policies and procedures gave staff guidance about reporting, managing, investigating, and learning from incidents. The trust's incident reporting and management policy was published on their website and met the requirements of the National Patient Safety Incident Response Framework. The Patient Safety Incident Response Framework (PSIRF) is focused on learning from incidents to provide safer care to patients. Following the requirements of the PSIRF, the trust published their Patient Incident Response Plan on their website. Following their analysis of reported incidents, the trust identified patient safety priorities for the next 12 to 18 months and outlined how they would respond to them. This included responding and making improvements in relation to the management of pressure injury, infection control, medication incidents, inpatient falls, mental health and maternity incidents. The medical services division completed a local safety profile and identified the most frequent incidents reported were pressure ulcers, patient falls, medication errors and violence and aggression from patients. Information provided by the medical service, including minutes from meetings and discussions with staff, demonstrated the service was aware of the priorities, kept them under review and took action to make improvements.

Between 1 November 2024 and 1 May 2025 across the medical and older persons medicine

services and the acute medical unit a total of 4,595 incidents were reported. Of these, 17 resulted in severe harm to the patient and 15 were reported a harm level of death. The highest number of incidents were patient slips, trips and falls (1098), tissue damage (1,122). The trust patient safety incident plan had identified these as areas for improvement.

Review of incident investigation reports provided by the service, showed areas for learning and improvement were identified and action plans were developed. Action plans had clear timescales for completion of actions with a designated responsible person or group. The service provided evidence that Duty of Candour was carried out. The Duty of Candour legislation requires healthcare organisations, including hospitals, to be open and honest with patients when things go wrong during care. This means being transparent about what happened, offering an apology, and explaining any investigations or actions being taken. It ensures patients are informed and involved in the process of addressing the incident. Records provided by the service showed patients and relatives received both written and verbal duty of candour information about the incident and the outcome of the investigation. However, the information provided showed that the service did not always offer the opportunity of a meeting with patients and/or their relatives to discuss the findings of the investigation. This is an area where improvements could be made.

Staff we spoke with understood the patient safety incident response framework. They knew what incidents they needed to report and how to report them. Multiple processes were used to share learning from incidents with staff. This included handover headlines, Share, Learn, Improve learning from safety incidents newsletter and staff huddles. Examples of learning from incidents included action plans for improving pressure ulcer prevention, ensuring the ‘This is me’ documents were provided to patients’ next of kin to complete and reminders to staff to ensure care plans were personalised to meet patients’ individual needs.

Morbidity and Mortality meetings were used to identify any learning from patient outcomes. The trust’s Learning from Deaths Policy gave guidance about what deaths must be reviewed, about the management of morbidity. Mortality meetings including who should attend, frequency of meetings, and what the outputs of the meeting should be, for example learning for clinical practice. Review of morbidity and mortality meeting records provided by the service demonstrated staff identified areas for learning.

The trust had a process for responding to central alerts about safety, which included processes for notifying the medical services about national safety alerts. Between 1 November 2024 and 1

May 2025, the medical service had not received any external safety alerts specifically for them to action, but they had been included for information on 6 national alerts.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. Although the service experienced significant challenges with patient flow, they worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They acted to ensure there was continuity of care, including when people moved between different services.

Trust wide, there was a policy to support staff to manage patient flow through the hospital safely. However, this meant that patients were cared for and treated in areas in the medical services not designed for patient accommodation and care. Challenges with patient flow through the hospital meant that most medical patients admitted through the emergency department did not have an inpatient bed allocated to them in a timely manner. This meant many spent the first day of their hospital experience in the emergency department and not on a ward. Staff followed processes to ensure patients received the treatment and investigations they needed in the emergency department, so there were no delays to their treatment.

Staff said that due to the patient flow problems, the acute medical unit (AMU) was no longer used as intended. Although, the precise role of an AMU can vary from hospital to hospital, its core functions include the assessment, investigation and stabilisation of patients with an acute medical need and determining the next steps for the patient, which may include discharge with follow-up care or transfer to a specialist ward. The typical length of stay of a patient in an AMU is 72 hours. Staff told us that most patients had already started their care treatment with a specialist medical team before being transferred from the emergency department. This was because they had spent a long period of time in the emergency department waiting for a bed to become available. Staff also said many patients spent more than 72 hours in AMU, with some remaining in AMU for weeks. However, staff statements about patients' length of stay on AMU

could not be corroborated as we did not request data from the service to demonstrate how long patients remained on AMU.

Staff followed trust processes to ensure patients received timely review by consultants once accepted into their specialised care. This is called the post-take review and would normally be carried out on a specialised medical ward once the patient was admitted. Information provided by the service demonstrated they consistently achieved 70% to 80% compliance with the national time frames for post take reviews. However, the same information detailed that most of the post take reviews were carried out in the emergency department. This was due to challenges with patient flow from the emergency department to the medical wards.

The trust had processes and policies to support staff working in the medical services to manage the discharge of patients safely. Observations showed that plans and progress for patient discharges were discussed by the multidisciplinary staff teams (medical staff, nursing staff, therapists, and discharge coordinators) at board rounds. Discussion with senior leaders demonstrated they had identified some ward areas where board rounds did not always support effective and timely discharge planning. They were working with staff in those areas to make improvements.

The hospital had a matron and a team of registered and unregistered staff who supported with the discharge pathways for patients who had complex needs and those patients, such as those who were at the end of their life and wished to die at home, who required fast track discharges. They described there were ongoing challenges with external partner organisations making decisions about which organisation would fund ongoing care for patients with complex care arrangements at their discharge. This increased the number of patients whose discharge was delayed and negatively impacted in patient flow through the hospital.

To support improvement with patient flow through the hospital, the trust was undertaking a trust-wide workstream called Transforming the Take, with one of the areas focused on discharge. The focus was on providing enhanced support to board rounds across all inpatient wards, including medical care wards with a view to improve discharge processes. This work was aligned with the Discharge Standard Frameworks which had been implemented by the ICB and has a set of key performance indicators.

Safeguarding

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. They concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

The trust had a safeguarding policy that referenced relevant national guidance. It provided clear guidance about the actions staff needed to take if they were concerned a patient had been subject to abuse and clear guidance about action staff needed to take in the event of an allegation of abuse. The service provided evidence that it referred safeguarding concerns to the local authority,

Policies were also in place to guide staff about the use of restraint and restriction to ensure they were not used inappropriately. This included the legal frameworks for restraint, who could or could not carry out restraint, and the training requirements for people who could carry out restraint. Physical restraint was only carried out by appropriately trained security staff and the police if needed. Our review of the records from the last 6 restraint events demonstrated that least restrictive practices were considered and acted on before restraint was used. The records demonstrated chemical restraint was used, (sedative medicine), and no physical restraint was used. The service reported there had been no incidents of rapid tranquilisation in the 6 months prior to the site inspection.

Staff received training about safeguarding. Data provided by the service showed that staff completed safeguarding training at levels that were relevant to their roles. Most staff groups had reached the trust target group of 85% compliance with safeguarding training.

Staff we spoke with had a good understanding about safeguarding, and knew the actions they needed to take in the event they suspected a patient may have experienced abuse or be

exposed to abuse. Staff knew how to contact the safeguarding leads in the trust for advice and guidance.

Staff reported safeguarding concerns to the local authority safeguarding team. In the 6 months prior to the onsite visit, 118 safeguarding adult referrals had been made to external safeguarding services by the service.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service worked with people to understand and manage risks. Staff provided care to meet people's needs that was safe and supportive.

Staff had access to policies and procedures to support them with assessing risk of harm and deterioration of patient's conditions. Treatment escalation plans were used by staff to record and communicate patients personalised and realistic goals for treatment, particularly when their condition may deteriorate.

Staff used a nationally recognised tool to identify deteriorating patients and escalate their conditions to medical staff. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. Our review of documents showed staff completed scores correctly. When a concerning score was calculated, the patient was escalated for medical review. Staff demonstrated a good understanding about the use of NEWS2 and when and how to escalate a deteriorating patient to medical staff.

The service monitored compliance against vital signs completion, staff response to deteriorating patients, management of suspected sepsis, management of acute kidney injury and the use of Martha's rule. However, the service could not be fully assured staff followed the NEWS2 process because they did not monitor or audit the NEWS2 process. This is an area that could be improved.

Data provided by the service showed an improving trajectory for staff completion of patients' vital signs, (pulse, respiratory rate and blood pressure). Although, the compliance rate did not meet the trust target of 80%, compliance had improved to 79% in March 2025.

Information provided by the service showed that between 1 January 2025 and 31 March 2025, 88% of patients with NEWS2 score 5–6 were seen within 1 hour and 83% of patients with NEWS2 score of more than 7 were seen within 1 hour. However, this did not demonstrate the service had a process that was in line with the Royal College of Physicians National Early Warning (NEWS) 2 guidance. The threshold for triggering a senior medical review was higher in the service than that detailed in national guidance. This detailed that a NEWS2 score of 5 or more was a key threshold that should trigger an urgent clinical review. The document detailed that a NEWS2 score of 7 or more should trigger a high level clinical alert, namely an emergency clinical review and that the response team for this clinical review must include staff with critical care skills including airway management.

The service provided detail of compliance with the sepsis pathway in the medical services. For October, November and December 2024 the service was 100% compliant with the sepsis pathway. For the previous January to March 2024 there had been no episodes of hospital acquired sepsis in the medical services. For those patients admitted to the medical services with community acquired sepsis, their treatment was started by the medical staff in the emergency department.

Systems were in place for patients and their families, friends, or carers to escalate concerns about their conditions. Martha's rule of detecting deterioration enabled patients and their friends, family, or carers to contact the critical care outreach team if they felt their condition was getting worse and was not being addressed by the staff on the ward. Posters advertising this service were visible on the wards.

Staff completed risk assessments for each patient on admission using nationally recognised tools. This included a range of risk assessments, for example, falls, pressure areas, sepsis, nutrition, and venous thromboembolism (VTE). When actions or plans were required to reduce the level of risk, patient records showed these had been completed.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always detect and control potential risks in the care environment. They did not always make sure equipment and facilities supported the delivery of safe care.

The provision of oxygen and suctioning equipment on the acute medical unit (AMU) had the potential to delay access to this equipment when patients required it. In the multiple occupancy bays, there was only 1 oxygen port and 1 suction port between 3 beds. At times when a, Your Next Patient space was used in the multiple occupancy bays, this could mean there was 1 oxygen port and 1 suction port between 4 patients. This was not in line with national guidance. The Department of Health's Medical Gases Health Technical Memorandum 02-01: Medical gas pipeline systems published in May 2006 recommended 1 oxygen terminal per bed in multi-occupancy bays. Staff raised concerns with the inspection team about a potential risk to patients due to limited access to oxygen if they were not positioned near the oxygen terminal. However, staff did not describe any incidents or harm to patients because if this.

There was no evidence the service had considered any potential risks to patients because of the provision of oxygen and suctioning equipment in the AMU. We requested environmental risk assessments, including the provision of oxygen and suction on AMU wards. Following their receipt of the draft inspection report, the service provided risk assessments for the use of Your Next Patient (YNP) spaces. These included an assessment of the risk associated with no permanent oxygen and suction terminals available for patients accommodated in YNP spaces. However, there was no assessment of potential risk to patients because of the lack of provision of oxygen and suction terminals in the bays in AMU.

Ward environments were generally tidy and free from 'clutter.' Staff completed daily safety checks on all specialist equipment including the resuscitation equipment and records of this were completed. Electrical equipment in each ward area had been safety checked and

maintained so was safe to use. Most equipment had a sticker attached which detailed when it was next due for servicing.

To reduce the risk of patients using the environment to harm themselves, an annual ligature point environmental assessment was carried out. Ligature cutters were available on the wards and staff knew where to find them.

Most patients could reach call bells to call for assistance. Call bells were positioned by patient beds, but not always in escalation areas. We observed that staff responded to call bells quickly and the noise from unanswered call bells was minimal. Patients said that most of the time staff responded to call bells promptly. However, comments in the Friends and Family Test results indicated that patients accommodated in escalation areas did not always have a tool to call for assistance., they sometimes had to verbally attract the attention of a nurse who walking past them.

Staff disposed of clinical waste safely. Waste was segregated and labelled in accordance with the trust policy.

Staff said they had sufficient equipment to carry out their work safely. This included sufficient infusion pumps, monitoring equipment, moving and handling equipment and IT equipment. However, conversations with staff and information provided by the service indicated there could be some challenges for staff accessing equipment and aids to support patients with a learning disability.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not make sure there were staff who had the skills and experience to support and provide safe care and treatment to meet the needs of autistic patients and patients with a learning disability. Not all staff received timely appraisals. However, processes were followed to

ensure there were sufficient numbers of staff to provide care and treatment to patients and staff received support and development.

The service did not ensure staff had the skills and knowledge to support and provide safe care that met the needs of autistic patients and patients with a learning disability. Not all staff had received training about learning disability and autism. All NHS services are legally required to ensure their staff received training about learning disability and autism appropriate to their role. This was to equip staff with the right skills and knowledge to provide safe, compassionate and informed care to autistic patients and patients with a learning disability. Across the medical care group and older persons medical care group there was a 90% and 94% compliance rate with part 1 e-learning about learning disability and autism. However, for tier 1 training only 40% in the medical care group and 27% in the older persons medical care group had completed the training. For staff who required tier 2 training only 23.7% and 23.2% had completed the training. The service advised that the ability of staff complete tier 2 training was limited by the stakeholder who provided this training. There was no detail about what the service and the trust were doing to influence improved availability of this training.

Following their receipt of the draft inspection report, the service provided updated details about the provision of this training. This demonstrated they were taking action to improve the completion of tier 2 face to face training about learning disability and autism. However, although this showed an improving trajectory for all tiers of this training, compliance rates for tier 1 and 2 remained below 50% and there was no reason given for why the compliance rate for tier 1 training was low.

Staff confirmed they received training and appraisals. All staff completed mandatory training appropriate to their roles. The trust set a target for 85% of staff to complete mandatory training. Data provided by the service showed, that within the medicine care group, 3 out of 11 staff groups did not meet the trust target of 85%. The main group of staff that did not meet the target were medical staff. In the older person medicine care group, 4 out of 10 staff groups did not meet the trust target of 85%. The main group of staff who did not meet this target were ‘other scientific, technical and therapeutic staff. No data regrading completion of mandatory training was provided for staff working in the Acute Medical Unit. Improvements were still needed in staff compliance with mandatory training.

Managers calculated the number and grade of nurses and healthcare assistants required. The

service used a nationally recognised safe staffing tool to calculate the number of nursing and healthcare support works required to ensure there were sufficient staff to meet the acuity and needs of patients on the wards. Using the tool and professional judgement, the service reviewed staffing level requirements twice a year and made recommendations to the trust board about staffing requirements.

Planned and actual staffing numbers were displayed on wards. It was observed that not all wards met their planned staffing numbers. Staff said that often staff were moved to other wards to lessen risk of insufficient staffing.

The service used locum and bank staff to lessen risks of staff shortages. Prior to our site visit we had received comments from staff that requests for bank staff were often unfilled because of a complicated request process that involved multiple levels of authorisation. At the time of our site visit, the process for requesting bank staff had been simplified and staff reported requests for bank shifts were more frequently being filled. At the time of our site visit, there were no vacancies in the nurse work force in the medical care services. Agency nursing staff were not used, and bank staff were used to fill vacant shifts due to sickness or to fill shifts that were required to provide one to one observation and care for patients who required it. There was an orientation process followed when staff were moved to different wards in order to support patient safety.

In the 3 months prior to our site visit across the medical and older persons medical care groups, the use of medical locum staff was 9.7% of the workforce, use of nurse bank staff was 16.7% of the workforce and healthcare support worker bank staff were 27.3% of the workforce. There was no use of agency nurses or healthcare support workers.

We did not receive any concerns from patients or staff about access to medical staff. However, because there was a range of medical teams reviewing their patients on the acute medical unit, this meant nursing staff did not always know when patients were planned to be reviewed by medical staff.

Infection prevention and control

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

Staff had access to an infection prevention and control policy and supporting guidance. The policy and guidance reflected national guidance such as that from UK Health Security Agency, the National Institute for Clinical Excellence and the Infection Prevention Society.

Most areas were visibly clean and had suitable furnishings which were visibly clean. Cleaning staff were visible in all areas. Observation showed staff washed their hands between patient interactions, cleaned equipment between patients use and wore clothing that ensured they were bare below the elbows. Equipment on the wards had ‘I am clean’ stickers on them, which detailed the date and time they were last cleaned.

Staff had access to personal protective equipment, such as disposable gloves and aprons, as required for the areas they worked in. We observed that staff used personal protective equipment appropriately.

There was an infection prevention and control audit programme that included standard precautions, use of personal protective equipment and hand hygiene. Data provided by the service showed all wards and departments were compliant with hand hygiene process. Use of personal protective equipment audit data provide by the service showed that for 6 of 14 wards assessed in April and March 2025 personal protective practices were not always fully followed by all staff. However, during our site visit we did not observe any concerns with staff use of personal protective equipment.

Infection Prevention and Control audits required a compliance rate of 90% with the infection prevention and control standard precautions. Three of the 14 ward areas assessed were below the 90% target (80% and 85%) in April 2025.

Staff on wards and departments completed a daily cleaning and infection prevention and control list to support consistent adherence to infection control protocols. Staff also completed cleaning audits monthly. The sample of cleaning audits provide by the service showed that most wards and departments met the target of 90% compliance with cleaning. The service followed the NHS England National Standards of Healthcare Cleanliness, cleaning audit score. These national standards reflect modern methods of cleaning and infection prevention and control. They aim to drive improvements in cleanliness by focusing on a collaborative approach in maintaining cleanliness and a required star rating to be displayed giving patients, staff and the public a visual score about the standard of cleanliness. We observed these scores displayed in wards and all achieved the highest score.

The decontamination of reusable medical devices policy gave staff guidance about the decontamination and disinfection of reusable devices. The policy referenced relevant national guidance. Leaders said an “Endoscopy Units – Decontamination Policy” was going through the approval process with an anticipated approval date of June 2025. Observations during the onsite inspection did not identify any concerns with the process staff followed to decontaminate endoscopy equipment.

Medicines optimisation

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service made sure that medicines and treatments were safe and met people’s needs, capacities and preferences. They involved people in planning, including when changes happened.

The medical care services followed the trust’s systems for the safe prescribing, administration, and storage of medicines. Across the observed wards and departments, staff demonstrated compliance with national guidelines including those from the National Institute for Healthcare Excellence (NICE) and used electronic tools to support safe and effective medicines management. Medicines reconciliation practices varied between wards but were generally aligned with Trust policy, with dedicated pharmacists and pharmacy technicians playing key

roles in this process. Medicines reconciliation is the process of accurately listing a person's current medicines. There were staffing pressures within the pharmacy department, affecting timeliness of medicines reconciliation.

All patients' notes and prescription charts we reviewed were complete with necessary fields completed, such as allergy status. Records demonstrated staff administered patients prescribed medication within the correct time frame.

Staff had access to medication advice and supply of medicines seven days a week. Staff were aware of the avenues for contacting pharmacy to arrange in-patient discharge medication for patients.

On wards, medication was stored safely and in appropriate areas, except for 1 oxygen cylinder on 1 ward. Keys for controlled drugs (CD) cupboards were kept with appropriate members of staff and access was restricted to staff involved with administration of controlled medicines.

Ward staff monitored medicine fridge temperatures. Our review showed that on some wards there were occasions when at a ward level medication fridge temperature were not recorded.

Training and competency checks for staff were comprehensive and consistent across all areas with mechanisms to investigate and report on medication errors and share the learning of such events. There was a clear presence of clinical pharmacists and pharmacy technicians contributing to medicines reconciliation and medication safety. Patient Group Directions (PGDs) were in place to allow for appropriately trained staff to administer medicines within a specific framework.

The service completed audits about medicines storage, fridges, missed doses, critical medicines and bedside cabinets. Trust wide the auditing of medicines management was undergoing review with the aim to streamline the process as the current process was lengthy and time consuming.

Medicines reconciliation was part of the pharmacy improvement work. Trust wide there was a plan to digitalise this as they believed the existing method gave unpredictable results which they did not believe reflected the actual completion of medicines reconciliation on the wards.

Effective

Rating Good

This means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last assessment we rated this key question good. At this assessment the rating has remained good.

Assessing needs

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.

During the onsite inspection we reviewed 20 patient care records. This showed staff used nationally recognised tools to assess patients' conditions and needs. We saw staff reviewed care plans to ensure they still met the needs of patients. Discussion with patients indicated their conditions and needs had been discussed with them and their views about how to best meet their needs taken into consideration.

Patient's pain was assessed and staff administered pain relieving medicine when needed. Patients we spoke with confirmed staff gave them pain relief and said their pain was well managed. The service used a nationally recognised tool to assess pain in patients who were not able to verbally communicate, for example patients living with dementia or patients who had a learning disability.

The mental health liaison team, who were employed by a local community, mental health and learning disability NHS trust, provided support with assessing patients who had mental health conditions and guidance to staff about how to support patients with their mental health needs.

Learning disability liaison nurses, employed by a local community, mental health and learning

disability NHS trust, were available to assess and provide guidance to staff about who to support and care for patients with a learning disability. However, this was a limited service, and the learning disability liaison nurses had a limited scope about which patients they could provide support for. More detail about this is in the responsive section of this report.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

Staff had access to policies and procedures that were in line with national guidance. The sample of policies and procedures provided by the service demonstrated they were kept under review and referenced relevant national guidance and practice. Staff were updated about changes to guidance in policies and processes in several ways, including electronic formats and in meetings.

Review of patient records showed staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and used this to inform planning and delivery of care. Patient requiring special diets for clinical reasons, were assessed and advice given. Staff ensured that foods for special diets, such as a soft diet or low residue diet were provided.

Review of patient records showed staff used nationally recognised tools to assess patients pain levels.

Review of patients' records showed staff used a nationally recognised tool to assess and monitor patients skin integrity. This identified whether a patient was at risk of developing pressure damage to their skin and staff used relevant pressure relieving aids, such as special mattresses, and processes to reduce the risk of skin damage.

Staff had access to the full range of specialists required to meet the needs of patients in the service. This included staff employed by the trust such as physiotherapists, speech and language therapists, physiotherapists, pharmacists, and an Admiral nurse who provided support and guidance about the support of patients living with dementia. Staff also had access to professionals employed by other NHS trusts who worked for the trust such as the mental health liaison team and the learning disability liaison team. These specialists helped to ensure patients received care and treatment that was in line with national guidance. However, the Learning Disability Liaison Service was limited, more detail about this is in the responsive section of this report.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service worked well across teams and services to support people. They mostly made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within the medical care services. There were regular multidisciplinary meetings during the day where doctors, nurses and allied health professionals discussed patient care, ongoing treatment, and discharge plans.

Discharge policies and processes gave staff guidance to ensure relevant patient information was shared with external providers, including GPs and other care providers. However, CQC had received information from external sources, including patient relatives and adult social care service, about poor discharge information.

Staff shared information about patients during effective handover meetings within the team, such as shift to shift handovers.

Staff referred patients with acute mental health conditions to the mental health liaison service which was provided by another NHS trust. Staff said the mental health team was responsive and available to support patients with mental ill health and their treatment plans. Support and guidance from the mental health team was available 24 hours a day 7 days a week.

Staff had access to a learning disability liaison team that was employed by another NHS trust. However, the availability of the learning disability liaison team was limited. The learning disability liaison team had put tools and guidance about the support of patients with a learning disability on the trust intranet. However, they were no longer able to access the trust intranet to update this guidance and tools. This presented a risk that staff would not have access to current guidance to enable them to support patients with a learning disability effectively

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduce their future needs for care and support.

The trust had processes in place to support patients manage their health that medical care staff could access. This included access to a smoking cessation service. Data provided by the trust showed increasing numbers of patients who were referred to this service had successfully ‘quit’ smoking. However, there was no detail to determine how many of these patients were medical care patients of other specialties within the hospital.

Wards had patient information leaflets about some aspects of self-care management, including reducing the risk of developing pressure ulcers and reducing the risk of deep vein clots. Specialty areas had and displayed information about self-care management, for example there was a cardiac rehabilitation board on the cardiology ward. Information was avaible to patients in leaflets and on displays on wards to external support groups that could support them to live healthier lives.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

The service participated in relevant national clinical audits and benchmarking programmes. Outcomes for people were mainly positive and mostly met expectations.

The stroke service took part in the Sentinel Stroke Audit Programme (SSNAP). The most recent results from this national audit (October 2024 to December 2024) showed the service had an overall score of B, (A being the best score and E the worst score). Detail provided by the trust showed they had an overall score of B consistently from October 2023.

The neurorehabilitation service submitted data to the UK Rehabilitations Outcomes Collaborative (UK ROC). UK ROC collates patient level data from all the specialist (Level 1 and 2) rehabilitation units in England about their needs for rehabilitation, the inputs provided to meet those needs, and the outcomes that result, including gains in functional independence and cost-efficiency, in terms of savings in the cost of ongoing care to offset the initial costs of rehabilitation. Results from the audit showed outcomes were similar to that of other similar neurorehabilitation units.

The service used the NHS England Getting it Right First Time (GIRFT) programme to benchmark the service against national standards and identify areas for improvement. This included monitoring patients' length of stay in hospital, monitoring the number of patients waiting more than 52 weeks and 62 weeks from referral to start of treatment. The service developed and followed action plans with the aim to reduce length of stay for patients and bring waiting times for treatment in line with national standards.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Staff had access to a consent policy. The policy was kept under review by the trust and referenced relevant legalisation and national guidance. There was clear guidance for staff about when and how to obtain consent, how to manage consent for a patient who lacked capacity to give informed consent about a specific decision. The policy gave detail about how to access interpreting for people who did not speak English as their first language and whose first language was British Sign Language. The policy also gave detail to staff about how to access consent information in easy read, large print or braille.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. For interventions that required written consent from patients, the service used an electronic consent process. For patients who preferred a paper based consent form, the consent forms could be printed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Most staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. However, some staff said assessing patients' capacity to make decisions was the role of medical staff. This indicated that not all staff had a full understanding about whose role it was to assess the capacity of a patient.

Staff understood the use of Deprivation of Liberty Safeguards. Discussion with staff demonstrated they had a good understanding about the use of Deprivation of Liberty Safeguards, and when and how they should apply for a Deprivation of Liberty Safeguard for a patient.

Most staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and they knew who to contact for advice.

Patients confirmed in conversations staff had provided them with information to enable them to understand and make an informed decisions about their treatment.

Although the service did not carry out formal audits of the consent process, the electronic consent platform provided data about the number of digital consent episodes. The system also gathered feedback from patients to gather their experience of the digital consent process.

Caring

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service always treated people with kindness, empathy and compassion and respected their privacy and dignity.

Throughout the inspection we observed staff of all roles and grades interacting with patients in a kind and supportive manner, treating them with dignity and respect.

On wards we observed all staff were very friendly and helpful. For example, they supported patients to mobilise in a gentle and reassuring manner. We observed staff reassuring patients who were distressed and agitated in a calmly and respectfully.

Patients we spoke with during the site visit said staff treated them well and with kindness. Comments from patients during the onsite inspection included, “they’re so polite and caring, nothing is too much trouble,” and “nursing staff are very compassionate.”

Friends and Family Test feedback was generally positive, with 88% of patients detailing they had a good experience of care and treatment in the medical services at Queen Alexandra Hospital. Comments included, “all the staff were so kind and considerate”, “at all times I felt that the staff, from catering to medical, had my wellbeing in mind”, “there is a genuine feeling of empathy and care not just from individual members of staff but from the whole cardiology department”, and “the treatment by nursing staff was kind, compassionate and in short, just wonderful.”

Patients were mostly supported to maintain their privacy and dignity. Observation during the site visit showed patients were suitably covered, protecting their dignity. Staff made sure curtains were fully closed round patients when providing personal care.

However, some patients were accommodated in a Your Next Patient space, which increased the risk of privacy and dignity of patients not being protected. Your Next Patient spaces are where, due to challenges with patient flow, patients were allocated to a temporary non dedicated care space on wards, which could be a chair, trolley or bed in a ward corridor or an additional bed in a ward bay. Staff spoke about challenges with protecting the privacy and dignity of patients allocated to Your Next Spaces which included supporting patients with personal care and providing treatments, such as intravenous infusions.

Although most patients spoke positively about how staff protected their privacy and dignity while accommodated in a Your Next Patient Space, there were some comments in the Friends and Family Test results that showed not all patients felt their privacy and dignity was upheld when accommodated in a Your Next Patient Space. Comments included, when a patient arrived in the ward where they had been told they had a bed, they found it was “a chair in a corridor outside the wards where I was supposed to sit until my bed was available…The nebuliser I was on was on was pulled across a ward entrance and people were complaining that I was in the way and causing a hazard.” A second patient commented they were “moved out of ward D1 at 10.40 at night to C5 and left in a corridor no privacy or dignity no sleep for 3 long days and nights.” A third patient commented “I spent my few nights in hospital on the ward in a corridor space, this didn’t feel like the best place to be staying whilst being sick but it was a bed so got to

take the win." A fourth patient commented "After a few days I was moved to a made up bed space right in the doorway. It was so cramped doctor/nurses had to pull out table to get to me to take obs. I had to climb out the gap at the end of the bed to go to toilet. This really stressed me."

Staff worked to protect patient confidentiality. However, the practice of using Your Next Patient spaces presented challenges in protecting patient confidentiality. For example, there was potential for patients accommodated in corridors to overhear staff conversations about other patients care and treatment.

Treating people as individuals

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. They mostly took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Managers and staff were aware of patients' individual needs, and this was shown through their risk assessments and the pre-admission assessment process. Patients spoke positively about how staff supported them to meet their individual needs. This included meeting patients emotional and psychological needs.

Patients could access the chaplaincy service who could provide support for patients of all and of non-religious beliefs. Prayer spaces were available for patients of all religious beliefs, all of which had Muslim prayer mats and facilities for ritual ablutions.

Staff had access to translation services, including British sign language interpreters. With the support of the trust Admiral nurse the use of "This is me" booklets for people living with dementia was embedded into the service. Use of the "This is me booklet" gave staff the tools to respond to a person's needs in a person-centred and timely way. However, we were told that at

times staff had to be encouraged and reminded to complete the booklet with patients' relatives if the patient did not have one. For patients with a learning disability, learning disability passports gave staff the tools to respond individual needs in a person-centred and timely way.

Staff made sure patients living with mental health conditions and dementia, received the necessary care to meet all their needs. Staff could access support and guidance from specialist nursing teams, such as the Admiral nurse employed by the trust and the mental health liaison team that was provided by another NHS trust.

However, the Friends and Family Test results indicated that some patients did not have a positive experience, and reasonable adjustments were not put in place. One patient commented they were, "unable to have my carer with me on C6 and CDU despite being disabled and needing support with recalling and retaining information due to a neurological condition." A second patient commented, "being hard of hearing and frail I didn't feel that I was tended to gently or appropriately and communications to me should've been also relayed to my next of kin more timely as I was unable to relay due to not understanding what was being said."

Access to the learning disability liaison team was limited. The service was provided by another NHS trust but had only been contracted by Portsmouth Hospitals University NHS trust to provide a service of 2 nurses, 30 hours a week spread over 5 days. This increased the risk that due to lack of support, patients with a learning disability might not have their immediate needs met appropriately on initial admission to hospital.

Independence, choice and control

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.

Patients were supported to have choice and control over their own care and make decisions about their treatment and wellbeing. They said they felt informed about their procedures and care, and staff supported them to make informed decisions about their care and treatment. Comments from patients included, “[staff] take time to explain everything to you”, “[I am] involved in decisions of care”, “doctors have been very good, I know what’s happening and why” and staff “explained all the treatment and care”.

Most patients expressed satisfaction with the provision of meals and drinks. Patients commented positively on the choice and quality of food.

Responding to people’s immediate needs

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service listened to and understood people’s needs, views and wishes. Staff responded to people’s needs in the moment and acted to minimise any discomfort, concern or distress.

Feedback from patients said they were listened to, spoken to in ways they could understand, with staff taking time to talk with them and address any needs promptly. Comments made by patients in the Friends and Family Test results indicated staff gave information and explanations to patients in a manner they could understand. Comments included, “they explained everything I had to do and everything we'd do in the long run. They did everything at my pace and reassured me when I wasn't overly confident at times”, “The doctors explained what they were doing and why. They also took time to answer all of my questions”, “Staff on D1, D3 and G5 were all exceptional in their care and their willingness to listen and work with me when drugs were reacting adversely.”

Patients commented their pain was well controlled, and staff provided pain relief when they needed it.

We observed during the site visit that patients had access to call bells to summon assistance

and call bells were generally promptly answered. However, not all patients accommodated in Your Next Patient spaces were provided with bells to summon assistance from staff.

Staff observed patients and intervened where they saw patients were uncomfortable, uncovered or distressed. Patients appeared well cared for, clean and with the items they needed such as glasses or walking aids close by.

Staff made sure patients living with mental health conditions and dementia, received the necessary care to meet all their needs. Staff could access support and guidance from specialist nursing teams, such as the Admiral nurse employed by the trust and the mental health liaison team that was provided by another NHS trust. However, the Learning Disability Liaison Team had limited availability to provide guidance to staff about supporting patients with a learning disability.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

The trust had several resources that medical services staff could access to support their wellbeing. This included access to musculoskeletal therapy service, access to psychological support and counselling and debt advice. Staff were informed of wellbeing resources through newsletters and there were dedicated health and wellbeing champions.

All staff we spoke with spoke positively about how their immediate leaders supported their wellbeing at work. Ward managers demonstrated in conversations a commitment to support and promote their staff's wellbeing.

Responsive

Rating Good

Acute services

Medical care (Including older people's care)

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people's needs mostly were met through good organisation and delivery.

The service was in breach of legal regulation in relation to person centred care.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure people were at the centre of their care and treatment choices and they did not always work in partnership with people, to decide how to respond to any relevant changes in people's needs.

There was a lack of resources to support patients with a learning disability. Access to the learning disability liaison team was limited. The service was provided by another NHS trust but had only been contracted by Portsmouth Hospitals University NHS trust to provide a service of 2 nurses, 30 hours a week spread over 5 week days. This increased the risk that due to lack of support patients with a learning disability might not have their immediate needs met appropriately on initial admission to hospital. The learning disability liaison team had criteria for whom they could provide support for; they only provided support for patients who had a diagnosed learning disability and whose IQ was under 70 exclusively. However, we were advised by specialists in this area that neurodiversity diagnoses do not provide IQ scoring. Therefore, patients may not be able to access services solely on the basis that they had not undertaken IQ testing. They also did not provide any support for patients with autism. This meant there was no access to additional support for patients with an undiagnosed learning disability, those with a learning disability but an IQ over 70 and no access to additional support for patients with autism. At the time of the inspection the learning disability champions were no longer active in the service, which further added to the lack of resource for patients with a learning disability

The learning disability liaison team said that all wards had been provided with a resource box by an external stakeholder with equipment and activities to support patients with a learning disability. The resources included activities to occupy patients and tools to reduce stimulation and distress of patients. However, ward staff did not demonstrate an awareness of where these resources were located. When we asked the service for assurance about how they ensured there was always appropriate equipment available to meet the individual needs of patients with a learning disability there was no detail about the learning disability resources boxes. They said sensory lights and toys were provided to patients in the emergency department and these could be shared with inpatient wards in the medicine division when required.

The service did not equip staff with the skills and knowledge to enable them to support and provide person centred care for autistic patients and patients with a learning disability. They had not ensured all staff had received training about learning disability and autism that was relevant to their role and in line with legal requirements.

However, staff had good access to specialist teams to support patients with mental health conditions and dementia. The mental health liaison team were provided by a different NHS trust. The Admiral nurse was employed by Portsmouth Hospitals University NHS Trust. The Admiral nurse supported a team of dementia champions, who were available to support and guide staff in supporting patients living with dementia. During our onsite inspection we asked staff about resources for patients living with dementia. Staff described they would contact the Admiral nurse to provide support and activities to support patients.

Processes were followed to provide on to one care and observation for patients who required enhanced observation and support. This included some patients living with a dementia and some patients with mental health conditions.

Staff, patients, and carers could access interpreters including British Sign Language interpreters when needed.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

Processes were in place to support joined up care. Discharge planning processes supported continuity of care once the patient was discharged and the trust had a process to make improvements to the discharge processes across all services, including the medical care services.

Access to specialist teams such as the learning disability team, the mental health liaison team, the dementia team and the integrated discharge team supported staff to ensure patients received continuity of care for their other conditions, rather than just the medical concern they were admitted with. However, limited access to the learning disability team meant there were risks that patients with a learning disability might not receive care that was joined up.

Providing information

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

The service provided a range of leaflets for patients that provided advice and guidance about their admission to hospital and about the discharge process. Leaflets were able to be translated into different languages, including braille.

The trust website had a tool that allowed all information on the website to be translated into different languages. There was also the ability to change the font size and colour of the background to support people who had trouble reading or recognising the written word. However, there was no facility on the website for the information to be read aloud for patients with impaired vision. This had the potential to negatively impact on visually impaired people ability to access to information about the medical service and the hospital and was an area where improvements could be made.

Staff had access to interpreters. Staff had guidance in the Interpreting and Translation Service policy. Translation services were available for patients whose first or preferred language was not English or who had a hearing impairment that required the use of an interpreter or lip speaker. Staff confirmed they had access to interpreting facilities and followed best practice guidance not to use patient family members as interpreters.

Listening to and involving people

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. They involved people in decisions about their care and told them what had changed as a result.

Detail about how to give feedback about care and treatment was detailed on the trust website. This included compliments, concerns, and complaints feedback processes.

A trust wide complaints policy gave staff guidance about managing and responding to complaints. Data provided by the service showed that for the months February, March and April 2025 the medical division had received a total of 21 formal complaints and the older persons medicine division had received a total of 11 formal complaints. No data was provided for the acute medical unit. Data provided by the service showed there were variable rates for completing complaints investigations and responses within the trust timescale. For the

medicine division this averaged 76.86% and for the older persons medical division this averaged 33.33%

The top 4 themes from the complaints over this period included poor communication, poor attitude of some staff, discharge process and dissatisfaction with patient care.

The service also used the Friends and Family Test to get feedback and support improvements to the service.

Learning from complaints was shared with staff in team meetings, governance meetings and through presentations by the practice educators. The practice educators used patient experience stories to demonstrate how patients were affected by their experiences in hospital. The sample of patient experiences provide by the service showed the service received complaints about the use of Your Next Patient spaces and the effect that had on patients. One of the common themes was that staff did not explain to patients the reason why they were accommodated in Your Next Patient spaces. Feedback we received from patients during the onsite inspection suggested this was not fully resolved.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

Patient flow throughout the hospital meant patients were not always accommodated in the relevant specialty ward for their care and treatment and some patients were accommodated in areas not designated for patient care.

Processes did not always ensure people received care and treatment in a timely manner. Data provided by the service showed that between 1 November 2024 and 25 April 2025 only, 52% to

54.5% of patients on the waiting list commenced their treatment within in 18 weeks of referral. This was significantly below the national target of 92%.

There was a mixed experience for patients with suspected cancer and for those with cancer waiting to start treatment. For the period April 2024 to April 2025, the service mostly met the NHS England target for the 28 day faster standard. The national target was that 75% of people should have cancer ruled out or receive a diagnosis within 28 days of an urgent cancer referral. The service met this target except for January and April 2025 when 72.4% and 72.3% of people had cancer ruled out or received a diagnosis within the 28 days.

Performance against the 31 day standard had improved. The national target was that 96% of people with a cancer should begin their treatment within 31 days of the decision to treat their cancer. Data provided by the service showed that between April 2024 and April 2025 they had met this target, except for April 2024, January, February and April 2025 when they achieved 92.5% to 94.5%. This was an improvement from the April 2023 to April 2024 when they did not meet the target in any months.

Performance against the 62 day standard did not meet the national target for any of the months between April 2024 and April 2025. The national target was that 85% of people with a cancer should begin their treatment within 62 days of an urgent referral.

Patients experienced delays in admission to wards from the emergency department. Data provided by the service showed patients frequently spent more than 4 hours in the emergency department after the decision to admit to a ward.

Data provide by the service showed that between November 2024 and April 2025 across medicine, older person medicine, regional cancer and renal and transplant there were a total of 2,333 patient bed moves between 10pm and 6am. Across the urgent care service there was a total of 2,746 patient bed moves between 10pm and 6pm. However, the service could not identify how many of these were for non- clinical reasons and could not detail how many patients experience multiple non- clinical bed moves. Patient bed moves, particularly when frequent, can lead to disorientation, increased falls risk, loss of belongings, and communication breakdowns between care teams.

There were significant numbers of patients who experienced delayed discharges. There were

significant numbers of patients who experienced delayed discharges. Data provided by the service showed that between November 2024 and April 2025 18.5% to 19% of patients on medical wards experienced a delayed discharge. This equated to 1938 to 2064 patients per month who experienced a delayed discharge. This had a major impact on how the service managed patient flow through the hospital.

The ward environment supported people living with dementia to have equal access to facilities. Toilet and shower rooms had dementia friendly labelling. Door frames and toilet seats were of a contrasting colour to the walls and floors to make them clearly visible for both patients with dementia and for patients who were visually impaired.

Equity in experiences and outcomes

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. Staff and leaders did not always actively listened to information about people who are most likely to experience inequality in experience or outcomes. This meant people's care was not always tailored in response to this.

The trust and the service did not take steps to ensure there was equity of experience for all patients.

Patients with a learning disability were at risk of a poor experience because access to the Learning Disability Liaison Team was limited. There was no provision of specialist support for autistic patients or for patients with a mild learning disability, which increased the risks they might not have their specific needs met and would not have a positive experience. This did not demonstrate that the trust and the service took account of the national Learning Disabilities mortality review 2022 that identified more people with a mild learning disability died from an avoidable death than those with a moderate, severe or profound learning disability. However, the service did follow the national Learning from Lives and Deaths -People with a Learning Disability and Autistic People (LeDeR) programme. Death of patients with a learning disability

or autism were reviewed and any learning shared with staff to support improvements in the care of patients with a learning disability or autism. The service did not provide any examples of improvements made because of this process.

Learning disability champions within the trust had not been actively developed and this meant local level knowledge on supporting these patients was not always available. Leaders told us that these roles would be relaunched to allow local level knowledge availability about supporting these patients.

The service had not carried out any reviews to identify whether patients with protected characteristics received care and treatment in a timely and equitable manner as compared to patients without protected characteristics.

However, there were processes in place to support staff to deliver care and treatment that did not put other patients with protected characteristics at disadvantage. Staff said measures were in place to support patients with mental health conditions, this included support from the mental health liaison team provided by a mental health trust. There was guidance for the use of rapid tranquilisation and restraint, to ensure staff understood the legal framework for the use of them. Trust policy was that only security staff who had completed required training and the police could carry out physical restraint.

For patients living with dementia, staff had support and guidance form an Admiral nurse who was employed by the trust. Admiral nurses are specialist dementia nurses who predominantly provide free, expert advice, support and understanding to help families care for their loved one. The trust had employed an Admiral nurse to provide support and guidance to staff as well as to families of people living with dementia. The service used the nationally recognised “This is me” document. The ‘This is me' document helps health and social care professionals better understand who the person really is, which can help them deliver care that is tailored to the person's needs. It can therefore help to reduce distress for people with dementia and their careers. It can also help to overcome problems with communication and prevent more serious conditions such as malnutrition and dehydration. However, the use of this was not yet fully embedded into the service and the Admiral nurse was working with staff and dementia champions to address this. Dementia champions had been trained and were present throughout the service to also support this patient group. The trust had employed an admiral nurse to support this patient group and their families and were making meaningful impact in this area.

Planning for the future

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life

Staff supported patients to make decisions about their care and treatment and their future. The service followed the Portsmouth Hospitals University NHS Trust Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy. Compliance with the policy across the trust was audited in November 2024, with 50% of the records audited being in the medical and urgent care services The results showed improvements in form completion compared to the previous year and identified areas for further improvement, but no areas of concern, DNACPR forms we reviewed during the onsite inspection identified they were completed appropriately and where able included the patient in the decision making process.

Planning ahead for end of life which included patients' preferences for place of care in last days or weeks of life and patients' priorities at the end of life were predominately undertaken by the palliative care team. Anticipatory care forms were completed by clinicians on the trust electronic patient records system.

Well-led

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant the service was consistently managed and well-led.

Shared direction and culture

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service had a shared vision, strategy and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

The trust had developed a strategy “Working Together, Improving Together”, that set out the trust vision, values and aims. The trust vision was “Working together to deliver excellence in care for our patients and communities.” The vision a supported by the trust values of working together for patients, working together with compassion, working together as a team and working together always improving. The vision and values aimed to support the trust strategic aims of meeting the needs of the community, supporting safe, high quality patient focused care, responsibility for the delivery of care now and in the future, supporting their people to deliver the trust vision and enabling teams to deliver the best care.

During inspection both senior leaders and some staff spoke about the strategy, vision and values. All staff described how they were motivated to give the best care possible to their patients.

Most staff commented positively about the culture at a local level, describing it as supportive, with lovely colleagues and supportive managers

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service had

inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.

The trust had an overarching executive leadership team. The trust managed its services through clinical divisions led by a Divisional Director, Director of Operations and Divisional Nurse Director. Most of the medical services were managed by the medicine and cancer and renal division, in which there were several care groups. This included the medicine, older persons medicine, regional heamatology and oncology and the Wessex Kidney centre (including the dialysis unit and 7 satellite dialysis units) care groups. The acute medical unit (AMU) was managed by the Urgent Care Group. Each care group was led by a Care Group Director, Care Group Manager and Senior Matron.

All staff spoke positively about the local leadership and told us they had good working relationships. On the wards and units, we observed strong clinical leadership from the ward managers and the lead nurses. Most staff said the senior leadership team was visible and supportive.

Leadership training was available for leaders, including aspiring leaders. Ward managers were committed to developing their staff. This included providing leadership opportunities to equip their staff to progress onto leadership appointments.

Freedom to speak up

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service fostered a positive culture where people felt they could speak up and their voice would be heard.

The trust had a freedom to speak up process that allowed staff to speak up/raise concerns about anything that got in the way of patient care or affected their working life. The trust had

recently appointed an external organisation to provide the Freedom to Speak Up Guardian service. A Freedom to Speak Up Guardian is a designated individual in an organisation who supports workers to raise concerns they may have, especially when they feel unable to do so through normal channels. The guardians act as a safe point of contact and help ensure that workers are heard, their concerns are addressed, and feedback is provided on any actions taken. Staff we spoke with knew about the Freedom to Speak Up process and how to contact the Freedom to Speak Up team.

Information provided by the service showed that staff had contacted the Freedom to Speak up Guardian for a variety of concerns and relevant advice and guidance had been given to the staff members contacting the guardian.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service valued diversity in their workforce. They work towards an inclusive and fair culture by improving equality and equity for people who work for them.

The trust had an Equality, Diversity and Inclusion policy that set out their commitment to diversity and inclusion. Staff had access to a reasonable adjustments policy. This gave guidance about how to support staff with reasonable adjustments to enable them to work and reduce the risk of staff experiencing discrimination due to protected characteristics.

Staff had access to support from several staff network groups. These included a Disability Staff network, a LGBT+ staff and allies' network, a race equality network and a women's network. The network chairs produced a quarterly equality, diversity and inclusion newsletter that gave staff information about events and where to seek support and advice from.

The service provided the current ethnicity breakdown for nursing staff in the medical and older persons care group. However, this did not include any figures for previous ethnicity break down

so it could not demonstrate any improving or deteriorating trends for ethnic minority nursing staff achieving senior posts in the service.

The service provided examples of the induction programme for internationally trained nurses. This included pastoral, wellbeing as well as clinical induction. However, some staff in some areas of the service expressed concern about the current induction process for internationally trained nurses. They said that due to the staffing pressures, the length of time internationally trained nurses remained supernumerary on the wards had been reduced. They explained this increased the pressure on the internationally trained nurses who were still adjusting to working in England.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service had clear responsibilities, roles, systems of accountability and good governance. They used these to manage and deliver good quality, sustainable care, treatment and support. They act on the best information about risk, performance and outcomes, and share this securely with others when appropriate.

There was a governance structure with lines of accountability through wards/departments, the care groups to clinical divisions and through to the trust board. All care groups had a governance lead.

Records of governance meetings at care group and divisional levels demonstrated the quality, performance and safety of the service were monitored and reviewed. This included monitoring and review of safety incidents, risks, staffing and training.

Our review of the risk register showed risks described by staff were included on the risk register. This included risk associated with the use of Your Next Patient spaces and risk associated with the environment, including ligature risks. However, risk associated with the provision of only

one oxygen and suction port between 3 patients in AMU was not detailed on the risk register. Following receipt of the draft report the service informed CQC that the risk associated with lack of available oxygen points and suction points was due to delays in planned works to resolve the issue. Detail had previously been on the risks registered and had now been re-added to the risk register. The risk of patients with a learning disability receiving inequitable care due to the lack of provision of specialist support was not included on the risk register. However, detail in one of the governance meeting records demonstrated that there was an awareness that more training and support need to be provided to staff to equip them with the skills to effectively support these patients. Details on the risk register evidenced that leaders regularly reviewed the risks and took actions to lessen them.

The service followed processes to gather information to gain assurance that staff were delivering safe and effective care that followed national guidance. This included but was not limited to matron assurance rounds, auditing of vital signs compliance, response to deteriorating patients, compliance with sepsis policy, medicine management audits and infection prevention and control audits. However, it was identified during the inspection that the service did not monitor or audit staff compliance with the NEWS2 process.

Staff did not always ensure all patient records were held securely. We observed in some ward areas that patient records were held in unlocked trolleys that had the potential to be accessed by unattired persons. Improvements could be made in this area.

Partnerships and communities

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service understood their duty to collaborate and work in partnership, so services work seamlessly for people.

The service provided examples of how they were collaborating with external and internal partners to support and improve the healthcare experience of patients. This included involving estates, infection prevention and control and communication departments in the planning and working on the new endoscopy unit and working with the patient collaborative to inform

changes within the older persons medicine care group.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service focused on continuous learning, innovation and improvement across the organisation and local system. They encouraged creative ways of delivering equality of experience, outcome and quality of life for people. They actively contribute to safe, effective practice and research.

The service used the trusts quality improvement programme Delivering Excellence Every Day (DEED) to support quality improvement at all levels of the service. At the time of the inspection different areas of the service were at different stages of embedding this process into everyday practice. We saw this process was embedded into the older persons medical care group, with improvement huddles identifying small changes that could lead to further improvements.

Other innovations and improvements included the lung cancer screening programme, which since 2022 had seen improvements in early diagnoses of lung cancers. The rates had increased from 27.4% in 2021/11 to 42.9% in of lung cancers being diagnosed at an early stage with over 80% of the diagnosed cancers through this programme being at a curative stage.

Wards participated in accreditation schemes. The trust had developed an Accredited Clinical Environment (ACE) scheme which ensured a consistent approach to ward and departmental quality reviews and supported a continuous improvement pathway. It allowed recognition of best practice that could be shared to improve patient care and staff wellbeing across the services. Examples were provided by the service to demonstrate how wards had improved their quality of service after an ACE assessment had identified areas for improvement.

The Trust was undertaking a Trust-wide workstream called Transforming the Take, with one of the pillars focused on discharge. The workstreams current focus was providing enhanced support to board rounds across all inpatient wards with a view to improve discharge processes such as increased use of the discharge lounge, discharges earlier in the day, increased

discharges on patients discharge ready date and improved processes regarding tablets to take home (TTO) completion.

Urgent and emergency services

Urgent and emergency services

Overall	Requires improvement
Safe	Requires improvement
Effective	Good
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Good

Our view of the service

Urgent and Emergency Care Services at Queen Alexandra Hospital are provided by Portsmouth Hospitals University NHS Trust. We carried out an unannounced assessment of urgent and emergency care (UEC) services at Queen Alexandra Hospital on 6, 7, & 10 May 2025. We carried out this inspection in response to concerns we received around the service. The assessment focused on all quality statements under the safe, effective, caring, responsive, and well led domains.

The inspection team comprised of CQC Inspectors, Specialist Advisors, an Expert by Experience and a Clinical Fellow. We spoke with over 50 members of staff and senior leaders. We also carried out remote interviews with staff, leaders and specialist teams. We requested evidence from the service which was provided by the trust between 30th May- 17th July 2025.

We rated the service as requires improvement. The service had made some improvements since the previous inspection. However, we found 5 breaches of the regulations in relation to premises and equipment (waiting rooms and escalation areas), staffing (training), person centred care (learning disability), and good governance (contemporaneous records and identifying and assessing risks).

Premises were not always suitable or equipped for the purpose they were being used for. The service had not adequately ensured their employees received learning disability and autism training appropriate to their role. Patients with a Learning Disability and/or Autism did not have access to resources and specialist input to support their care and treatment. There were not always safe and effective systems to identify and assess risks to the health, safety and welfare of people who used the service. Staff did not accurately, complete contemporaneous records in respect of each patient.

People's experience of the service

We spoke with over 50 patients and their loved ones throughout our assessment of the service. We used feedback from Experts by Experience in our assessment evidence. We also reviewed patient feedback, Friends and Family test scoring, and CQC national patient survey data. Patients spoke to the assessment team warmly; about all staff they were treated by and how they valued them. However, while people we spoke with expressed, they were happy with their care, our assessment found care did not meet the expected standards. There were inequalities in the way care was provided for some patients.

Safe

Rating Requires improvement 

At our last inspection we rated this key question requires improvement. At this inspection the rating remains requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

The service was in breach of legal regulations for learning disability training and safe environments.

Learning culture

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service had a proactive and positive culture of safety, based on openness and honesty. They listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually identify and embed good practice.

All staff we spoke with knew what incidents to report and how to report them. There was dedicated training on reporting incidents and the policy to support it was available to staff on the intranet. Staff reported all incidents in line with policy. Where possible, staff were debriefed and received support after a serious incident. We spoke with staff who told us 'Hot' debriefing sessions happened soon after incidents, to discuss the incident and to provide wellbeing support. Further 'cold' debriefs were also initiated by leaders to identify ongoing concerns or learning opportunities. These debriefs were then fed into incident investigations.

Daily huddles occurred, these included departmental matrons, and governance leads and discussed ongoing incident investigations, shared relevant updates and next steps to be taken. Also, the first meeting of the week was longer, to include incidents reported over the weekend. This meant if immediate actions from incidents were needed, leaders and staff could rapidly implement these.

Additionally, there were weekly patient safety meetings to discuss newly reported and ongoing incidents in detail. Patient safety cases that had been raised were escalated from this meeting to the Trust Patient Safety Incident Review Groupfor investigation.

The department shared learning outcomes during staff handovers which happened 4 times a day. Leaders facilitated a monthly Mortality and Morbidity meeting. Staff members were encouraged to attend and discuss both positive experiences and incidents from which the department could learn from. This was shared through digital and visual communications, and during staff meetings. Handover headlines were discussed twice daily in huddles to ensure all staff shifts were informed of essential information and learnings. We reviewed materials shared

in these meetings and saw that they contained a range of patient safety and practice education messages. For example, learning relating to aortic aneurysms and dissection and what red flags to look for. Leaders told us patient journey stories were shared to improve understanding of the patient experience. We also heard how lessons learned from an incident prompted changes to the pre alert system. Following the incident, all pre alerted patients went directly to resus and then were 'stepped down' to majors when appropriate. This meant pre alerted patients were triaged sooner and could access more timely treatment.

Staff told us violence and aggression from patients and their carers was a commonly reported incident. We reviewed all incidents related to this in the 12 months prior to inspection and saw that where possible learning outcomes had been actioned and communicated to staff involved.

However, data we reviewed showed there were 3,318 incidents reported by staff in the 12 months prior to inspection. The most reported incidents were capacity issues, and this represented 48% of all incidents reported from November 2024 - May 2025. We reviewed 50 moderate or greater harm incident summaries from the Adult Emergency Department. Of these incident investigations, 5 had been completed, 14 incidents were pending final approval and 31 were still being investigated. Additionally, there were 3 incidents with open investigations for over 6 months. Of these incidents, all those related to capacity issues were yet to be completed. We also reviewed 6 incident summaries from the Emergency Care Centre from the time period of November 2024-May 2025. Of these incidents, no investigations had been completed in full. The oldest incident that had not yet been completed was from December 2024. We saw no evidence to detail how specific updates had been communicated to staff in the time since these incidents had been reported.

Frontline staff did not always feel they received updates for ongoing incident investigations in a timely manner. Sometimes, when incidents related to wider concerns, such as capacity or patient flow, these were not always discussed with staff directly. This led to some staff feeling that their concerns were not escalated and acted upon. In the case of capacity concerns leaders told us how this fed into wider work being done within the trust to improve flow and therefore work to resolve this may not feel to staff as personable as when they reported specific incidents.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They made sure there was continuity of care, including when people moved between different services.

Staff involved all necessary healthcare and social care services to ensure patients had continuity of safe care, both within the service and following discharge. The urgent and emergency care department utilised a separate patient records system to the main hospital. When a patient was admitted to a ward, an electronic record of the patient's emergency department notes was sent into the main patient records system. This included relevant information such as details of ongoing treatments and discharge planning if needed. This meant essential information was available to all staff to facilitate joined up care.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Patients who attended the emergency department for treatment that could be sought elsewhere, for example through their GP, were redirected.

In urgent and emergency care, a discharge checklist had been implemented to outline essential information that patients and their care givers should be informed of, at the time of discharge. This included safety checks, such as ensuring cannulas had been removed, ongoing medicines provided and the most recent clinical observations. This checklist had been discussed in handover headline meetings to ensure it was well understood by staff. Leaders and staff from discharge planning told us this was working well and positively received.

If a patient was discharged directly from the urgent and emergency care department, discharge information was sent electronically to patients' GPs. This meant GPs were aware the person had been in hospital advised of any ongoing treatment and prescriptions required to continue care. If an electronic discharge summary could not be sent electronically, this was printed and sent by mail. The service told us that discharge summaries contained results of investigations,

the reason for admission (diagnosis), details of the treatments given and recommendations for follow-up care. Follow-up care recommendations included referrals to specialists and additional testing necessary for continued patient recovery. Patients or their care givers were provided with a printed discharge summary.

Safeguarding

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. They concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

Staff we spoke with knew how to make a safeguarding alert and did this appropriately. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. We saw evidence of safeguarding referrals made by staff at the service. These were made in line with policy and escalated to the appropriate services. In the 12 months prior to the inspection, there were 507 adult referrals and 620 referrals for persons under 18.

Staff we spoke with told us that safeguarding concerns were routinely discussed in safety huddles and meetings. We saw evidence of learning and outcomes from safeguarding referrals being shared with staff. For example, the March 2025 update focused on domestic violence referrals and the outcomes achieved. This meant staff could be assured their concerns were actioned and vulnerable person were safeguarded effectively. Staff spoke positively about the safeguarding team and the work they did to support patients and staff.

Staff followed safe procedures for children visiting the service. This included a dedicated paediatric emergency department which was securely accessed to ensure the safety and privacy of all children and young people using the service.

Team leaders oversaw compliance with training, which included discussions at appraisals and in monthly 1 to 1 meetings. The department safeguarding leads gave face-to-face training in Level 2 safeguarding training for adults, and Level 3 update training for child safeguarding.

The trust advised that the target for completion of safeguarding was 85%. However, data supplied by the service showed that not all staff had undertaken mandatory training in safeguarding. We saw staff who were required to undertake adult safeguarding training in level 1 & 2, and for children level 2 this met the target. But for level 3 adult safeguarding this was below target at 62%.

Level 3 training in child safeguarding is usually required in staff who have a significant role in safeguarding children, including those with direct responsibility for investigating, reporting, and recording safeguarding concerns. However, the level of compliance with this training was below target at only 51%. Overall, the combined percentage of staff who had completed training aligned with their clinical role was 81%.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always work well with people to understand and manage risks. Staff did not always provide care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

Patient record systems recorded how long patients had been waiting to be seen since arriving, and their clinical priority. The service aimed to triage all patients within 15 minutes of attending the department. At times of high demand, this was not achieved. Staff told us increases in

demand meant they could not always meet this target. We saw patients waiting beyond 15 minutes throughout our inspection. Time to triage (TTT) data between February and April 2025 showed the average TTT exceeded 15 mins. However, this was by a small amount of time. For example, in February 2025 - 18 minutes, March 2025 - 17 minutes, April 2025 - 16 minutes. The trust advised that TTT was discussed in clinical and operational huddles, site assurance meetings, and monitored by the care group team. We were told these would be escalated if they indicated there were concerns.

Patients attending via ambulance were reviewed and triaged in a dedicated Rapid Assessment and Treatment (RAT) area upon arrival. A senior ED doctor or advanced nurse practitioner led decision making in this area. This was to ensure timely senior clinician assessment, early recognition of critically ill patients, and prompt initiation of necessary investigations and treatments. Leaders advised us that all patients arriving via ambulance or walk-in with time-critical presentations should be considered for RAT. However, during our assessment we saw periods where a medical doctor did not staff this area. Instead, patients were assessed solely by the nurse who was also in charge of also managing ambulance intake. Staff told us there was not always a doctor available for this area. This meant some patients did not receive a review upon admission, which could delay timely care and treatment.

The latest NHS England data, in February 2025 showed 36% of patients at the trust, were treated within 60 minutes compared with 22% for England and the South-East Region. However, in January 2025, only 65.6% patients at the trust were seen within 4 hours, this was below the England average of 73%. This meant less patients had a decision about their overall care planning within 4 hours compared to the national average. Throughout our assessment we saw patients who had been awaiting a medical review for over 12 hours.

The department had processes and tools for assessing patients when they first presented to the department and monitored patients for signs of deterioration when they remained in the department for extended periods of time.

When patients were seen staff communicated with patients so that they understood their care and treatment. The trust used the National Early Warning Score (NEWS 2) to assess adult patients at risk of deterioration which supported staff to take appropriate action. In the paediatric department, staff used, an acuity tool approved by the Royal College of Paediatrics and Child Health (RCPCH). Staff could describe how to escalate patients that needed clinical

review.

However, the department did not undertake any audit monitoring of either the adult or paediatric acuity tools to measure effectiveness and compliance. This meant leaders could not identify whether these tools were used well or if there were areas for improvement. The service did not demonstrate effective oversight of patient acuity and deterioration. This posed a risk to patient safety.

In addition to this, we reviewed 10 sets of nursing records and found they contained omissions of care records and poor documentation. There was minimal documentation of nursing care and poor compliance with fluid balance records. We also saw instances where staff did not increase how often they monitored and recorded observations following increased NEWS 2 scores. This did not comply with national best practice guidance and local policy, which meant patients who had become increasingly unwell were not reviewed as frequently as they should have been. There were also omissions in medical clerking, and poor compliance with insulin administration records. Omissions in insulin administration records meant patients with diabetes were at risk of not receiving the right amount of insulin. We raised these issues with the provider directly. Following the inspection, leaders increased observation and auditing of nursing records to highlight areas of poor compliance. We were also told that, following our inspection the ED Practice Education Team had conducted a nursing documentation scoping exercise to improve nursing documentation

For children and adults that self-presented to the emergency department there was a triage process in place to determine patient clinical priority. A team completed this process which comprised of nursing support staff, registered nurses and a doctor. This team was responsible for escalating cases that required admission. This opportunity was also used to redirect patients to alternative services, such as the Urgent Treatment Centre, Emergency Care Centre, or Urgent Primary Care.

Clinical staff did not perform manual restraint on patients and people at the service. If manual restraint was required, this was undertaken by security staff. Security staff had received training in how to manage violence and aggression, de-escalation and least restrictive restraint. The trust advised this training was refreshed annually and was certified as complying with the Restraint Reduction Network's training standards.

Safe environments

Score

1. Evidence shows significant shortfalls in the standard of care

The evidence showed significant shortfalls. The service did not always detect and control potential risks in the care environment. They did not make sure that equipment, facilities and technology supported the delivery of safe care.

The department was often crowded, with patients cared for in inappropriate spaces such as corridors and non-clinical spaces. Corridor care made it difficult to use necessary medical equipment such as portable patient monitoring devices and emergency equipment. In addition to this, these spaces had no dedicated areas for personal care and only 1 toilet at the end of the corridor which had 28 bed spaces. There were also no patient call bells. This created a falls and ongoing safety risk to all patients in this area. We heard from staff how in the weeks prior to our inspection, a patient had fallen from a temporary bed space in this area which resulted in a serious injury.

The corridor was continuously brightly lit and offered no privacy. Whilst staff were aware and managed some risks of corridor care, the environment in the cohort areas were not appropriate for patient care. The environment also reduced the space for other patients being moved through the areas or being brought in by ambulance. The use of this corridor to hold patients also meant that in the case of an evacuation movement of beds from other areas such as majors could be delayed. The service had not undertaken scenario training for fire evacuation since moving to the new building. All staff we spoke with throughout our inspection told us their main concern was delivering corridor care and capacity.

During our assessment we saw how laminated cards had been applied to walls in the corridor to assign these as designated patient spaces. Throughout our assessment, we saw patients being cared for in the corridor despite having mobility restrictions and fall risk alerts on their electronic record that meant these spaces posed a risk to their safety.

There was no clearly defined policy in place to identify risk restrictions for patients in this area beyond infection prevention and mental health crisis. During our assessment we saw a patient

who was attending the department via ambulance, they did not speak English as their first language and had a diagnosis that affected their level of comprehension, despite these potential safety and communication concerns they were placed in an escalation area due to lack of capacity in other areas. We also observed a patient in an escalation area that had an increasing National Early Warning Score (NEWS). The National Early Warning Score (NEWS) 2 determines the degree of illness of a patient to prompt response and intervention. Staff were not aware of this and took action to move this patient to the resus area when we raised this.

Urgent care team staff strongly opposed the use of the corridor for patient care. Staff told us how they had agreed to deliver care to a maximum of 6 corridor spaces, for patients who fit a strict set of criteria. This was a compromise due to the wider pressures of the increased number of patients accessing the emergency department and to support rapid offloading from ambulances. However, staff said this had since developed into the use of 28 corridor spaces, all of whom had varying levels of acuity, which they felt represented a large patient safety risk. We also saw evidence of staff and leaders raising concerns around the high risk of missing pathology due to the limitations of these spaces. All staff we spoke with told us they felt helpless when it came to patients being in escalation areas who they felt should not be there.

In the Emergency Care Centre, there were spaces available for up to 12 patients overnight. This was due to the fact that chairs were removed from waiting areas to increase capacity in the evenings. However, this meant these spaces did not have access to call bells which meant patients were not easily able to call for help when they needed it. There was also access to 1 toilet and no showering facilities. The ECC was located to the side of the main hospital and exited onto a road. Staff told us they were concerned that the location of the area meant that the door to the department lead directly outside, which could be a risk overnight if patients were confused and tried to leave. We heard that there had been instances where patients had become confused, got out of bed and walked out of the hospital. We reviewed the risk register for the department and saw that the remote location and use of ECC had been documented by leaders as 2 separate risks in April 2025. There were mitigations documented including the development of a standard policy to determine patient suitability. However, this was not yet in place at the time of inspection and no immediate actions had been taken to reduce ongoing risk.

In Resus, Majors and Adult Urgent care, there were dedicated single space patient areas that were spacious and offered privacy and good patient care. Staff utilised computers on wheels

(COWs) to ensure they could remain in these areas while undertaking patient charting and ensure constant supervision. There was also mixed care area in the major's area, this was spread over 4 dedicated sub wait area which each had 4 recliner chairs. There was also a seated sub wait area in adult urgent care which held 4 patients. This area also had recliner chairs, however it was cramped and offered little privacy. There was also a disabled toilet in the corner of this area which was poorly accessible when all patient areas were in use. There was an accessible toilet in the main waiting area, which also had a changing places bathroom. However, to access these a wheelchair user would require the support of a staff member to open the door back into the waiting area as doors were not power assisted. This meant the environment was not always well designed or utilised for the needs or comfort of patients using it.

There were separate areas in the department to care for people who required support and treatment for their mental health (MH). This was intended to provide a more private and dignified patient experience. However, Specialist mental health staff told us the rooms did not conform to best practice standards and guidelines such as Psychiatric Liaison Accreditation Network (PLAN) standards. These had been presented to the trust before the department had opened to support creating spaces that met these standards. We observed how 1 of these areas contained significant static ligature risks from piping in both corners of the ceiling. Also, the doors to the room did not open in both directions. This meant if patients attempted to self-harm and blocked these doors, staff would not be able to enter the room. Additionally, all MH assessment rooms contained tannoy speakers that could not be muted and could add to patient distress. The additional MH crisis space in use at the time of assessment also had a broken sink and damage to wall areas. In the paediatric assessment room, there was an oxygen attachment plugged into the wall outlet which could be used as a ligature point. We alerted staff to this, and they removed the oxygen outlet in the paediatric room.

Staff told us the ligature risk and additional concerns with the new mental health assessment spaces had been raised and escalated to leaders on multiple occasions since the department had opened in November 2024. We also heard this had also been escalated to leaders by staff who worked for specialist mental health NHS trusts. All staff told us they had not seen any changes made as a result of raising these concerns. We reviewed the risk register for the department and saw that there were 2 separate risks escalating the concerns regarding ligature points and lack of PLAN compliance.

At the time of our assessment there were no risk assessments in place for any of the mental health assessment areas. These shortfalls in the design and management of specialised mental health treatment areas presented a risk of ongoing and increased harm to vulnerable patients.

Following our inspection, leaders said works had been undertaken to 'box in' piping in these areas. We were provided with risk assessments for these spaces that were undertaken following our inspection. These assessments gave details of mitigating actions to be taken to keep patients safe while they were in these spaces. However, there was also no clear timeline in place to complete works removing all ligature risks fully and to make the assessment rooms PLAN compliant and in line with national guidance. This meant the trust could not be fully assured these spaces were safe for patient use prior to our inspection and they remained not in line with national best practice standards.

The paediatric ED was a separate department for children and families. In the main area there was adequate space and there was no overcrowding in the department during our assessment. Within the main department there was a central nursing station which supported constant direct audio-visual monitoring of patients.

There was a direct passage of access from the paediatric ED to the radiology department, meaning that these patients would not have to encounter adults if they required diagnostic imaging. However, when patients were admitted from the paediatric ED to a ward, they would be taken through a space which also held escalation area patients and their families or carers.

Most environments were designed to be accessible and supportive. This included ramps, handrails, and easily navigable spaces that allow individuals to move freely and safely. However, these were not always well designed. Hand washing facilities were often placed close to toilets, despite large empty spaces in front of mirrors, this was seen throughout the department. This meant the space needed to access the toilet was restricted and may pose a risk to people with mobility conditions.

The adult waiting area contained 32 chairs which were closely placed together. This waiting area often became crowded with little personal space between patients. There were no designated areas for patients in wheelchairs which posed a risk of blocked walkways in seating areas. We observed patients in wheelchairs struggling to find a safe waiting space that they felt did not impede the movement of others. Patient feedback also raised this concern.

The chairs in the adult main waiting area were a mix of high and low back chairs. During our assessment we heard from several patients who had been in this area overnight who spoke of discomfort and 'bad backs'. We also received feedback prior to our assessment from family members who raised concerns about the comfort of patients waiting in this area for long periods of time. During our assessment, we observed an instance of patient collapse in this area; staff took measures to shield the patient by moving screens which previously surrounded the triage area. Due to the close proximity of all patients and size of this area, sensitive medical information including reason for attendance could easily be heard by other patients.

We saw how patients received care and treatment in waiting areas, such as intravenous medicines. Staff were unable to move these patients into areas designed for care and treatment as they were already fully occupied. Staff told us this frequently occurred. This meant patients sometimes received care and treatment in an environment that did not promote dignity and was not designed for the care and treatment that was being delivered.

Staff told us there has been numerous instances where the number of patient and their families in this area exceeded over 100 people. We also received numerous patient feedback concerns where patients reported they had stayed in this waiting area for extended periods of time and in some cases overnight. Data we reviewed supported that this occurred frequently. We reviewed data for the 3 months prior to assessment which showed that the average number of patients, waiting overnight between 12am-7am in this area was 29, this did not include anyone attending with them. There were 297 instances, in any 1-hour period between 12am-7am from 1st February- 18th May 2025 inclusive, where patients waiting in this area exceeded the number of seats. Data also shows that the highest occupancy of patients waiting during this period, when counting only patients and not anyone accompanying them, was 72.

Staff told us they felt this area was not big enough to function in the way it did currently. However, if it was functioning in the way it was designed to, with effective streaming and flow than it would be more than adequate. Although staff and leaders were able to see the number in patients waiting in each area, they were limited in taking steps to reduce the numbers waiting due to poor patient flow. Services that some patients may be redirected to, such as ECC or UTC, were also not available overnight. This was further impacted by poor flow from the adult's waiting area into the adult emergency care department.

There were no formal risk assessments to manage overcrowding or an identified maximum safe

occupancy limit for the adult waiting area or any other areas in isolation. Fire assessments undertaken in the department focused on solely on capacity of the whole UEC building, and not individual areas of the department. This meant the department was unable to safely manage or have oversight of overcrowding risks in the adult waiting area.

The department had opened in November 2024, and fire safety and other emergency systems were tested and maintained. However, in all areas, we saw fire evacuation plans that were not adequately fixed to walls and were temporary carboard images that remained from during building works and were leant against surfaces. Staff had also not undertaken any fire evacuation scenarios.

The facilities were otherwise well maintained, and any equipment used with patients was in good working order and used safely to support the delivery of safe care. Hazardous and clinical waste was responsibly managed. Staff wore personal protective equipment in line with trust policy when patients were immunocompromised or posed infection risk. Staff had also undergone scenario training for major incident response.

Records of maintenance and portable appliance testing were held centrally. All the equipment we checked in the department including emergency equipment appeared clean and had been tested.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure there were enough qualified, skilled and experienced staff. They did not always make sure staff received effective support, supervision and development. They did not always work together well to provide safe care that met people's individual needs.

Overall demand for UEC at the service had increased since February 2023. The total number of attendances for all A&E types was 8.5% higher in 2024/25 than it was in 2023/24. This increase

of 8.5% was higher than observed across England (5.9%). Senior leaders told us staffing was planned in advance to anticipate the levels of staff required. This was to ensure planned staffing was sufficient to maintain staff to patient ratios and considered risks associated with staff shortages. The department also used a Safer Nursing Care Tool (SNCT) alongside patient metrics to determine and plan staffing levels. The tool used by the trust was in line with National Institute for Health and Care Excellence (NICE) and NHS England (NHSE) guidance.

When necessary, managers deployed temporary staff to meet safe staffing levels. When this occurred, nursing staff from the NHS Bank staff were prioritised and the Trust did not employ any agency nursing staff. This was to ensure staff were as familiar with the trust policies and process as possible. On the day of assessment 9.8% of medical shifts were filled by locum doctors. Leaders told us that the trust would be undertaking a benchmarking process to compare the findings of the SNCT acuity findings against recommendations from the RCEM.

During our inspection we reviewed nurse staffing levels for the day and saw this showed the number of registered staff matched planned numbers. However, non-registered staff levels were below planned numbers. During February and March 2025, both registered and unregistered nursing staff levels in both adult and paediatric departments were below planned numbers. In April 2025 staffing levels for adult emergency care were also below planned numbers. This meant the service did not always make sure there were enough nursing staff for each shift.

Nursing staff told us that they worked on a ratio of 1 nurse to 6 patients. During our inspection we saw that nursing staff had patients allocated via whiteboards and this did not exceed 6. However, staff reported that nurses cared for more than 6 patients in the corridor spaces when there was increased emergency department attendance. Changes to ambulance arrivals meant that rapid admission in the UEC could not be controlled by ED staff. Ambulance staff were required to handover patients within 45 minutes. The dynamic nature of ambulance attendances meant that in some cases patients were allocated to escalation areas and nursing ratios exceeded 6 to 1. We heard from several staff members there were often times when they had been caring for more than 10 patients in escalation areas. We heard how as there were 28 corridor spaces, there was often periods where nursing staff were providing care at a 1 to 12 nurse to patient ratio.

We reviewed the average nursing staff to patient ratios for the 90 days prior to inspection. For

25 days during this period, the nursing to patient ratio exceeded 6 patients to 1 nurse. This meant that at times of pressure, nursing staff were caring for more than 6 patients on average at any one time. The days where nursing ratios exceeded 6 patients per nurse also directly correlated with days where the department had increased attendance.

Staff would escalate increased nursing to patient ratios to leaders, who would reallocate staff from other areas in the trust to majors and UEC staff moved to care for patients in the corridor. However, we heard from staff that this was not always rapidly achieved. Staff told us they felt that redeployment, due to escalation areas being used, created uncertainty and damaged morale to all staff. Staff described being sent staffing rotas where staff were allocated to escalation areas in advance. Despite this, the safe nursing ratio was exceeded an average of once every 3 days. Staff told us they felt that staffing overnights could be particularly difficult for nursing staff.

When staff were redeployed for the first time, staff members completed the Trust's local induction checklist in collaboration the nurse in charge of the shift. This checklist was designed to familiarise staff with the department, ensuring they were aware of with essential policies and procedures relevant to their roles. The trust had also redesigned the new staff induction checklist to ensure that new staff were orientated to the department in advance of redeployment.

Data we reviewed for non-consultant doctors also showed that on these dates, the numbers of patients being cared for by each staff member increased due to high attendance rates. Consultant to patient attendance data showed they were responsible for an average of 52 patients at a time. This increased with demand and on 3 occasions, consultant doctors were allocated over 75 patients. This was the same for all medical UEC staff and was directly due to the demands faced by the service which were dynamic and fast changing. This meant safe staffing levels could not always be accurately predicted. Hospital leaders said staffing was discussed regularly at staff huddles and urgent staffing requirements could be escalated through matrons. Unplanned staff absence was discussed in huddles with actions taken by leaders to source staff.

We reviewed data on staffing for the trust which showed that during April & May 2025 the staff sickness rate was 4.6%, this was below the national average of 4.9%. In March 2025 the Urgent and Emergency care (UEC) workforce monthly sickness rate was 4%, this was lower than

comparable trust departments within the region. The most common reason recorded for staff sickness in UEC staff was stress and anxiety, this which was similar to other NHS Trusts in the region.

All NHS trusts are legally required to ensure their employees receive learning disability and autism training appropriate to their role. This is to ensure the health and social care workforce has the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. However, mandatory training in Learning Disability and Autism level 1 had only been completed by 41% of staff. For staff who required tier 2 training this had only been completed in 17.5% of staff. The trust advised that the ability for staff to complete tier 2 training was limited by the stakeholder who provided this training.

The trust provided 1 ALS and six online ALS courses per year. Two places on each course were allocated to UEC, more would be offered to nursing staff if spaces became available. Prioritisation for places was given to nursing staff within the trust to ensure the most appropriate staff received training. We were told how there was a rolling Programme of Basic Life Support which was overseen by the Practice Education Team. Basic Life support training had been completed by 93% of nursing staff in adult emergency care, and 93% of staff in paediatric emergency care. The high uptake in training was also credited to the department implementing 'in house essential skills training days'. Intensive life support training had been undertaken by 44% of staff, pre booked training meant this was planned to increase to 57%.

Within UEC 72% of medical staff had completed training in Advanced Life Support (ALS). The trust told us that many Consultants and registrar-level doctors, were also ALS instructors. We were told that the trust ensured that all working shifts included at least 1 ALS-trained doctor. This was to ensure consistent access to senior resuscitation expertise. Nationally, Doctors who commenced training after 2021 were not required to undertake ALS training. Despite this, 59% of this staff group had independently completed ALS training which reflected a strong commitment to providing safe emergency care.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always assess or manage the risk of infection. They also did not always detect and control the risk of it spreading.

During our inspection we saw that staff mostly adhered to infection control principles, including handwashing. Staff mostly followed infection prevention and control (IPC) guidance and washed hands between patient contact and wore appropriate PPE. However, some staff were observed completing patient records immediately after examination and before undertaking hand hygiene. In escalation areas there was also limited access to hand washing facilities and wall mounted hand sanitisers for staff, patients and their visitors. Additionally, in the adult urgent treatment area, 3 of the 5 wall mounted hand sanitiser dispensers were not functional. Staff advised us these had been reported.

Staff from the IPC team undertook audits to monitor compliance with IPC and identify areas for improvement. These audits showed mixed compliance outcomes. For example, the hand hygiene audit for February 2025 identified multiple areas of non-compliance and had a compliance rate of 68%. We reviewed an action plan created in response to this, with identified areas to improve compliance. The completion date for this was early March 2025. However, there was no evidence of the audit being undertaken again in March 2025 to determine if the action plan was effective. In addition to this, when this audit was repeated in April 2025, although compliance had improved overall, the same areas as previously identified such as undertaking hygiene before and after patient contact were 89% and still below a pass rate. Following our inspection the trust supplied an IPC plan which identified work that was ongoing to drive improvement around the areas where there was an ongoing lack of compliance with IPC issues.

The PPE audit for February 2025 also identified poor hand hygiene practice with 80% compliance. The action plan for this contained similar actions as the hand hygiene action plan

with the review date set for mid-March 2025. We saw no evidence that this audit was undertaken in March or April 2025, so it was unclear how effectiveness or compliance with the action plan was being monitored.

We reviewed the compliance rates for the standard precautions audit, this looked at a range of areas such as linens, hand hygiene, and sharps. In February 2025 this audit also identified poor hand hygiene practice and cleanliness with a compliance rate of 85%. We reviewed the action plan for this and saw it contained improvement targets including staff communications, the review date for this was mid-March 2025. We saw no evidence that this audit was undertaken in March 2025, so it was unclear how effectiveness or compliance with the action plan was being monitored. In addition to this, although the audit undertaken in April 2025 showed improvement in some areas this was still below target at 87%. This audit also showed a decrease in compliance with cough etiquette. Following our inspection the trust supplied an IPC plan which identified work that was ongoing to drive improvement around the areas where there was an ongoing lack of compliance with IPC issues.

The results of the March IPC Audits were discussed in the March Quality Safety and Risk management meeting (QSRMM). The minutes showed no improvement actions for the areas falling below the expected standard in the audits. At the June QSRMM leaders did not discuss IPC audit outcomes, IPC action plans or the IPC plan supplied following our inspection, this was despite the concerns raised in the previous meeting. This meant that we were not assured that there was effective oversight of these audits or implementing effective improvement in IPC. This demonstrated leaders failed to effectively use monitoring tools to improve infection prevention and control practices.

In the escalation area, there was restricted access to bins, and we saw empty drink cups and food wrappers on chairs at the end of still in use patient trolleys. Patients were unable to dispose of these items themselves as their movement was often restricted. A patient told us they ‘did not feel able to bother staff to take them away as they were so busy’.

Staff reported patients who needed to be cared for in isolation due to infection or a supressed immune system, were provided with a single room to manage effective barrier nursing. At times when no single spaces were available, this was achieved by moving a patient from their single room into the escalation area. This process was referred to by staff as ‘requeuing’. Staff told us how they did not like to use this process as it posed a risk of deterioration to patients who had

previously been stable in designated spaces.

Staff told us that when an infectious patient arrived by ambulance, it was expected that they would be held on an ambulance until a dedicated single use space was available.

However, we heard how, due to ambulance 45 minute handover targets, there were instances where patients who posed an IPC risk were offloaded immediately from ambulances before dedicated spaces were available. We also saw instances of this occurring during our assessment. Incident reports also demonstrated that this had occurred previously. When this occurred and no dedicated bay could be allocated, these patients were held in the assessment area until a space became available. Staff told us they felt unable to challenge this with ambulance staff directly as patients had already been offloaded. We did not see any evidence of this practice being raised by leaders with the ambulance service directly, to reduce this occurring. This posed a risk to the safety of all patients and staff as they were unable to ensure IPC risks were controlled effectively.

We saw staff undertaking thorough decontamination cleaning of a patient bay which had been occupied by an infectious patient. Staff ensured they donned the appropriate protective personal equipment (PPE) before undertaking this and disposed of this in line with policy. The service shared concerns with appropriate agencies promptly.

Patient admission areas such as majors and the adult urgent care area were clean, had required furnishings and were well-maintained. We saw housekeeping staff continually undertaking cleaning in patient areas such as patient bays. These areas were clean and well maintained. Housekeeping staff were friendly and respectful to patients including when undertaking cleaning in a patient bay while patients were present.

Staff maintained equipment well and kept it clean. Any ‘I am clean’ stickers were visible and in date. We saw staff cleaning equipment following patient contact and in line with policy. On mobile, non-patient contact equipment such as mobile computer stands, all ‘I am clean stickers’ were from the day of assessment, this demonstrated cleaning had been performed recently.

Medicines optimisation

Score

3. Evidence shows a good standard of care

3. We scored the service as 3. The evidence showed a good standard. The service made sure that medicines and treatments were safe and met people's needs, capacities, and preferences. They involve people in planning, including when changes happen.

The department maintained robust systems for the safe prescribing, administration, and storage of medicines. Staff followed good practice in medicines management and did it in line with national guidance. We saw that medication was stored safely and in appropriate areas. The UEC used an electronic medicine dispensing system. This system ensured all medicines were stored correctly and access was restricted.

There were staffing pressures within the pharmacy department, that affected timeliness of medicines reconciliation. All patients' prescription charts reviewed were complete with necessary fields completed, such as allergy status. There was a dedicated medication advice and supply service available seven days a week.

Emergency medicines and equipment were available. There were tamper evident seals in place to ensure they remained secure. Staff recorded weekly safety checks on emergency medicines and equipment to ensure they were safe to use if needed in an emergency. All expiry dates we checked were in date. Fridges were monitored centrally by the pharmacy team and also monitored locally. We saw these records were accurately completed in full in all areas.

Training and competency checking for staff were comprehensive and consistent across all areas with mechanisms to investigate and report on medication errors and share the learning of such events. There was a clear presence of clinical pharmacists and pharmacy technicians contributing to medicines reconciliation and medication safety. Patient Group Directions (PGDs) were in place to allow for appropriately trained staff to administer medicines within a specific framework.

Across the department, staff demonstrated compliance with national guidelines including those from NICE and used nationally recognised tools to support safe and effective medicines

management. Medicines reconciliation was monitored by dedicated pharmacists and pharmacy technicians who played key roles in this process. Pharmacy staff could remotely monitor stock and dispensing practices.

Effective

Rating Good

At our last assessment we rated effective as good. At this assessment the rating has remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing needs

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing, and communication needs with them.

Staff followed care pathways based on national guidelines in order to provide appropriate care and treatment to patients. Staff understood how to access clinical pathways and guidance when needed. Senior managers told us they participated in local and national clinical audits and findings were reviewed and shared.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies and treatment guidelines, stored electronically. Policies and procedures were based on best practice from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine guidelines (RCEM). These were regularly reviewed and updated both centrally and at trust level.

Guidelines and protocols were available to staff to follow for the most common symptoms

patients would attend the emergency department for. These were noted to be in date.

There were recognised pain management systems suitable for both adults and children. Staff used a range of pain scoring models to adapt to individual patient needs. These included the FLACC Scale (Face, Legs, Activity, Cry, Consolability) in infants and non-verbal patients, Pain passports, and Visual grimace scoring. Pain scores were documented at triage and routinely reassessed. The service had relaunched a 'pain passport' within PED in May 2025. This tool would be used to help children cope with pain and distress during medical treatment. The document that allowed patients to record their pain levels, coping strategies and preferences for pain management. This was hoped to allow medical staff to better understand and address the child's pain leading to more effective care.

Patients presenting with moderate to severe pain should be assessed promptly and received appropriate analgesia within 15 minutes of arrival, in line with national standards. Nursing staff were able to dispense analgesia under Patient Group Directives (PGDs), and we spoke with patients in the Adult and Child waiting areas who confirmed they had been offered pain relief but were unsure if this was within 15 minutes of arrival. Staff recognised that giving treatments in AUC could be challenging when it was overcrowded and this had affected the ability to give analgesia to patients in significant pain. The AUC working group were reviewing ways to improve the timeliness and quality of analgesia administration in AUC. The trust worked alongside a specialist NHS trust to provide support to people with mental health needs in the emergency department. This enabled staff to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

However, leaders did not always check to make sure staff followed guidance. For example, there were no auditing of essential guidance such as NEWS2 or deteriorating paediatric patient guidance. There was also poor practice in nursing documentation which had not been identified prior to our assessment.

We also heard how specialist teams to support patients with a learning disability were unable to access essential systems to identify patients within UEC that may have benefitted from early therapeutic input and onward referral.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

Staff assessed and met patients' needs for food and drink and for specialist nutrition. Patients said their nutrition and hydration needs had been met during the course of their wait in the emergency department, regardless of the area they were boarded or waited. Patients and their relatives who were waiting for treatment in the waiting area had access to jugs of water and a selection of snack items. There was a hot drinks service that moved through the department to supply hot drinks to all areas.

Staff told us they followed care pathways based on national guidelines in order to provide appropriate care and treatment to patients. They knew how to access clinical pathways and guidance when needed. Senior managers told us they participated in local and national clinical audits and findings were reviewed and shared.

Staff had access to policies and treatment guidelines, stored electronically. Policies and procedures were based on best practice from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine guidelines (RCEM). These were regularly reviewed and updated. Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The trust had an agreement in place with the neighbouring mental health trust to provide psychiatric and mental health support to patients in the emergency department. This enabled staff to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Managers ensured that staff had access to regular team meetings. These meetings were minuted and stored electronically so they could be accessed if staff were unable to attend. Staff

also received essential safety and practice based updates electronically and were able to acknowledge they had reviewed these.

Managers provided new staff with appropriate induction and all staff within the trust, regardless of department, undertook emergency department familiarisation.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff had annual appraisals with managers. Staff appraisals serve as a structured process to review individual performance, identify development needs, and align personal goals with organisational objectives. They are a key component of staff development, contributing to improved patient care and the overall effectiveness of the NHS. We reviewed data regarding appraisal and saw that 70% of UEC staff had received an appraisal, this was below the trust target of 85%. The lowest uptake in appraisals was in advanced clinical practitioners (ACPs), of who 28% had received one. Advanced clinical practitioners (ACPs) are healthcare professionals, educated to master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for.

There was a weekly teaching session for the resident doctors and a separate teaching session for middle grades. In addition to this, all advanced care practitioner had a 1/2 day of teaching monthly. This meant medical and specialised healthcare professionals were supported to remain up to date with best practice.

However, there was little provision for adult patients with a learning disability in the adult emergency department. We spoke with specialist staff who advised that there were unable to access patient care information for patients in the Urgent and Emergency care department. This was because they did not have access to the patient system that the department utilised. The trust advised that there were resources to support patients with LD. However, no staff we spoke with were able to locate this or determine its location. The high demand for patient areas also meant there were limited areas that could be utilised if a patient became overwhelmed while awaiting treatment.

How staff, teams and services work together

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always work well across teams and services to support people. They did not always share their assessment of people's needs when people moved between different services.

The number of emergency admissions waiting more than 12 hours from decision to admit to admission at the trust between February 2024 and January 2025 was 880, more than 4 times as many as February 2023 and January 2024. This was despite there being fewer overall emergency admissions via A&E in 2024/25 compared to the previous year. Staff told us that when it was decided a patient had a decision to admit (DTA), admission to the appropriate ward or clinical area was often not possible as the ward was full.

Patients had to wait either in the emergency department or in an escalation space in the corridor. During our assessment we saw patients waiting in excess of 12 hours with a DTA. On day 2 of our assessment there were over 14 patients who had waited more than 15 hours in the emergency department following a DTA. The patient who had waited the longest had been waiting over 22 hours, despite having a DTA within 1 hour of arriving.

The trust had interprofessional standards in place to outline standards and behaviours that underpinned staff expectations, but these were not always upheld in practice. Delays were often experienced for patients who were referred to some specialties and required a speciality review. The medical team worked to see patient who had waited in the emergency department for a long period of time as part of regular ward rounds. Staff told us that this was not consistent amongst all specialities, particularly surgical, which led to surgical patients experiencing delays of specialist care and treatment.

We also heard how the medical same day emergency care department often contained patients overnight awaiting admission, which meant it could not function to support flow from the main emergency department. Patients being held overnight were also observed in the Emergency Care Centre (ECC), this was not the intention of this area. This meant that redirection of patients

from the main emergency department could not occur as there was no space for them to be reviewed and assessed. During our assessment we saw that patients were held overnight in this area on all 3 dates. We heard from staff that the ECC often was unable to take patients before 11am due to bedded patients from the previous night. Minutes we reviewed from safety meetings also highlighted this as an ongoing concern.

Some patients experienced delays as wards would not admit them until diagnostic tests had been completed. For example, any investigations ordered by the speciality team whilst the patient remained in emergency department, remained the responsibility of the emergency department to follow up before they could be admitted into the main hospital. Internal professional standards state the emergency consultant has admission rights if the patient has not been seen within 1 hour however we heard how admitting teams were reluctant to take responsibility for patient admissions resulting in frequent disagreements. This meant some patients experienced delays in admission while hospital teams agreed on the best course of action.

Staff had also raised concerns regarding the admission of patients aged 16 to 17 who were being admitted to adult acute medicine unless they were previously known to the paediatric department. Trust policy stated that the admission to either the acute medical ward or the paediatric ward would be the choice of the patient and their family. However, this was seldom upheld due to resistance from the paediatric ward. This meant there were long delays for these patients in the emergency department, even when beds were available. This translated as a patient being seen in the paediatric department by paediatric emergency doctors but then being admitted to the adult acute medicine ward. We saw incident reporting that had occurred due to this happening. Staff also felt this added to patients in this age range leaving the service before receiving treatment. We reviewed education presentations that had been given to medical staff, including case studies, to improve understanding of this issue among staff to consider how best to admit these groups of patients. This meant there were poor coordination of transitions of care for these patients.

Leaders told us that an admissions criterion was being developed and shared with all trust areas, to identify which ward areas patients held the admission responsibility of a patient dependent on their primary presenting complaint and diagnosis

Furthermore, we heard how the learning disability (LD) team were unable to see if patients they

could support were in UEC. This meant they often were only aware of these patients once they had been admitted to the wider hospital. The LD team had put tools and guidance about the support of patients with a learning disability on the trust intranet. However, they were no longer able to access the trust intranet to update this guidance and tools. This presented a risk that staff would not have access to current guidance to enable them to support patients with a learning disability effectively.

Staff held regular and effective multidisciplinary meetings. Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide safe care. Staff held regular and effective multidisciplinary meetings to review patients and improve their care. We saw multidisciplinary working with services, such as frailty teams, patient care coordinators, nursing and medical staff.

Staff shared information about patients at effective handover meetings within the team. These occurred at regularly at designated times to maximise attendance.

Staff were observed as working well together and putting the patients' needs first. There were some established admissions criteria within the main hospital wards such as patients who presented with fractured neck of femur. Additionally, the older persons same day emergency care (OSDEC) would support the main emergency department by actively pulling patients from the emergency department when they anticipated a rapid assessment and discharge.

The frailty team had a static base within the emergency department. We heard how they undertook daily reviews to assess patients who could be cared for in the hospital wards. They aimed to aim to rapidly assess patients with mobility or occupational issues so that they could be discharged. The acute oncology service took acute presentations during the day, including Metastatic spinal cord compressions.

The teams had some effective working relationships, including good handovers, with other relevant teams within the organisation (for example, care co-ordinators, discharge teams, and specialist teams). Staff described a particularly good relationship between the emergency department and the anaesthetic and intensive therapy unit (ITU) teams with 3 of the emergency department consultants being dual accredited ITU consultants.

There was also an emergency pregnancy assessment unit and a surgical same day emergency care service, which were described as working well with direct admissions from the emergency

department.

Supporting people to live healthier lives

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always support people to manage their health and wellbeing, so people could not always maximise their independence, choice and control. Where resources were provided, these were done via digital formats which limited access for some groups of patients. This meant the service did not always support people to live healthier lives, or where possible, reduce their future needs for care and support.

Staff supported some patients to live healthier lives by referring patients to services where appropriate. We heard how all patients were Alcohol and Drug screened with referral to relevant support networks if required.

In recent years the trust had undertaken a trust wide smoking ban across the site. Patients were supported with referrals to smoking cessation services. Data provided by the trust showed increasing numbers of patients who were referred to this service 'quit' smoking. However, there was no detail to determine how many of these patients were UEC patients or other specialties within the hospital.

Patients were provided with information cards which could be emailed, accessed via QR code, or via a website. These covered areas such as wellbeing & healthier living. There were also digital resources for parents & cares of children and young people alike.

However, we did not see evidence of how patients who may not be digitally literate, may have a learning disability or may not have the means to access digital information could access these resources in a comparable way.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always routinely monitor people's care and treatment to continuously improve it. They did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves.

Data we reviewed showed that between February- April 2025, on average 25 patients per day reattended the department within 7 days, this was an improvement on previous performance. However, during December 2024, 7.1% of patients left UEC without being seen compared to 5.4% nationally and 5.1% for the region. In addition to this, some patients awaiting mental health assessment left before their treatment or assessment had been completed. On the first day of our assessment 2 Paediatric patients left before receiving treatment, and 1 left before an assessment could take place after waiting over 10 hours. In the Adult emergency department 21 self-discharged before treatment completion and 13 left before initial assessment (absconded).

Due to the lack of flow into the main hospital, an escalation area was in use in the corridor between resus and majors. This meant that patients could be in the area for long periods, on the first day of our inspection 23 people had been waiting over 15 hours, and 30 people had been waiting over 12 hours. Data provided by the trust showed between 1st February – 30th April, 5926 patients breach the nation 12 hour waiting times. The longest wait in the department in March 2025 was 48 hours and in April 2025 47 hours. The trust's percentage of patients spending over 12 hours in A&E was consistently higher than the England average from February 2023 to January 2025. In line with this Trust's estimated number of patients with delay-related harm was almost 2.5 times the England average in January 2025. This had increased considerably since our last inspection.

The service monitored people's care and treatment to continuously improve it. Staff used recognised tools to improve the detection and response to clinical deterioration in patients as a key element of patient safety and improving patient outcomes. However, it did not monitor

compliance with this guidance against best practice.

The department actively contributed to national audits and Quality Improvement Projects (QIPs). The trust participated in the RECM audits for consultant sign off audit, infection prevention and control 20223-23, & Mental Health (Self-Harm) 2022-23. The trust was also actively contributing to the 3 RCEM QIPs at the time of our inspection. These audits were in Time-Critical Medication, Care of Older People, Mental Health: Self-Harm.

Staff used technology to support patients effectively. Hospital systems gave staff access to diagnostic results. The main hospital patient record system held full copies of patient UEC records for staff to refer to.

Consent to care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 3. The evidence showed a good standard. The service told people about their rights around consent and respected these when delivering person-centered care and treatment.

Staff took all practical steps to enable patients to make their own decisions. All staff we spoke with were able to describe the process of consent according to trust and RCEM guidelines. They explained that this was used for any procedure performed in the emergency department.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They supported patients who lacked capacity to make their own decisions or when experiencing mental ill health. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment during triage in line with legislation and guidance and this was clearly recorded in the patients' records.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to

consent appropriately. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. They did this on a decision-specific basis with regard to significant decisions. The service had effective systems to ensure staff assessed the mental capacity of patients and recorded decisions made in a patient's best interest when applying to deprive the service user of their liberty. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Caring

Rating Requires improvement 

At our last assessment we rated this key question good. At this assessment the rating has changed to requires improvement. This meant people and staff did not always feel well-supported, cared for or treated with dignity and respect.

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. Service treated people with kindness, empathy, and compassion. However, they did not always respect their privacy and dignity.

Staff maintained the confidentiality of information about patients where possible, but this was not maintained throughout the service. Due to the lack of flow from the adult waiting area, some patients told us how staff had spoken to them or taken readings such as blood pressure, in the waiting area where this could be seen and heard by other patients. This meant staff were not always able to maintain privacy and dignity.

In escalation areas when personal care and examinations were required staff tried to move patients into the assessment bay, however this was not always possible. We also heard how if this area was used it reduced the ability to rapidly assess patients as they came in from

ambulances. Although privacy screens were available, we heard how these were cumbersome, ineffective and seldom used. We saw patients on trolleys in these areas through our assessment. We heard from staff how patients could spend up to 20 hours in the corridor on a regular basis. Staff told us, if patients were particularly elderly, then a bed would try to be sourced for them instead of a trolley. However, these could not be kept in the corridor because it was not wide enough, this meant moving other patients from majors onto the corridor. Additionally, escalation areas had insufficient facilities for the number of people being cared for. For example, there was one toilet, no handwashing facilities and no sanitation pumps in the corridor.

On the third day of our assessment there were 11 patients in the corridor receiving care, 2 of whom had a 'decision to admit'(DTA) of 9 and 14 hours respectively. An DTA means a clinical determination has been made that a patient requires admission to the hospital for treatment. This meant patients could spend long periods of time in areas of the department that did not enable staff to provide care with dignity and privacy. Staff and leaders acknowledged the difficulties in ensuring that dignified care was always upheld for patients in temporary escalation areas.

We also heard how communication between departments when signposting patients could be clearer. One patient told us how they had presented to the adult emergency department and were redirected to the Onsite GP. They were then advised that this service was too busy but as their presenting complaint was urgent, they were redirected to the Emergency Care Centre. This added to their anxiety and stress, and they had to explain their condition multiple times and attend 3 different buildings which with their condition meant they felt 'exhausted' moving between them.

We also heard from staff in other streaming areas how patients redirected to their area from the main emergency department had become frustrated by multiple triage assessments and they had to send patients back to the main department due to them not fitting the criterion for admission. The GP streaming service was also unable to access the monitoring system that showed capacity demands and therefore could not respond to increase in this.

Patients and their families told us they felt there were long periods of waiting where they did not know how long their next interaction would be. We heard how patients who were attending alone were not able to use the toilets in the waiting area as they had seen other patients miss

their turn. We also heard that at times of high capacity, seating would become scarce, and they felt unable to use a bathroom for fear of losing their seat.

Overall, patients were positive about staff and the service. Patients said staff treated them well and behaved appropriately towards them. All patients we spoke with told us how kind and considerate staff were. We heard a patient who told us how staff 'Talk things through and take time to ensure I understand".

The trust provided patients with a 'friends and family test' (FFT) to rate their experience of the service. In April 2025, around 79% of patients had a good experience of the Emergency Department.

We saw how all staff interacted with patients with kindness and respect. This was seen in all areas from reception to admission. Staff were discreet, respectful and responsive. They provided patients with help, emotional support and advice at the time they needed it.

Staff supported patients to understand and manage their care, treatment or condition. We saw staff explaining to patients the procedures they were undertaking and ensuring they understood. A patient told us how "Staff have been amazing, telling me what's going on".

Treating people as individuals

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. They mostly took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

The service made adjustments for some patients – for example, by ensuring people's access to premises and by meeting patients' specific communication needs. Signage within the department was clear and met accessible standards for those with visual impairments. Signs

were printed in braille to support patients who needed this. Wayfinding signage was in colours that supported people who might struggle to read easily.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to raise a concern.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Staff made information leaflets available in languages spoken by patients.

The information provided was in a form accessible to the particular patient group such as in large print font. Patients had a choice of food to meet the dietary requirements of religious and ethnic groups and to account for allergies and intolerances. Staff ensured that patients had access to appropriate spiritual support.

However, access to the learning disability liaison team and relevant resources was limited. The service was provided by another NHS trust but had only been contracted by the trust to provide a service of 2 staff, 30 hours a week spread over 5 weekdays. This team did not provide support to patients with autism. They were also unable to use systems to identify patients before they were admitted to a ward. This increased the risk that due to lack of support and resources, patients with a learning disability or autism might not have their immediate needs met appropriately on initial presentation to hospital.

Independence, choice and control

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always promote people's independence, so people did not always know their rights and have choice and control over their own care, treatment, and wellbeing.

We spoke with multiple specialist teams of staff who worked to alongside the trust to support their patients in the emergency department. We heard how education sessions and teachings

had improved staff awareness on how to support patients suffering with their mental health. The trust had used a mobile simulation environment to improve understanding of dementia patients and staff spoke proudly of the impact this had on staff. The dementia team also us meaningful trust wide learning had given staff a better understanding of the needs of this group of patients. However, when we asked about additional resources for dementia patients in UEC, such as fiddle mitts, staff were able to locate these.

We also saw no evidence of how adults with a learning disability were supported while in the UEC department. Staff were also unable to locate resources for adult patients with a learning disability. We were told how if additional resources were required, they could be sourced from the paediatric emergency department (PED). However, staff within PED told us that they were reluctant to loan expensive pieces of equipment as these were often damaged as they were not being used for the demographic of patients they were intended for. We also heard how face to face training around this group of patients was no longer a part of staff induction. Staff from the LD team told us they felt this reduced the understanding of this group of patients among staff and the decision to end this training had not been communicated with them. This meant patients with learning disabilities and autism may not always have their individual needs met or supported.

The emergency department had access to interpretation and communication services to facilitate contact with patients. There were hearing aid loops and interpreter sheets. We saw that signage on doors and to direct patients and families had braille text and featured colour grouping to support those with visual impairment. This meant this group of patients were supported to understand their rights, care and treatment by using different ways to communicate.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in

the moment and acted to minimise any discomfort, concern, or distress.

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs. Staff gave patients and those close to them help, emotional support and advice when they needed it. All contact between staff and patients was conducted professionally, sensitively and in a way which respected confidentiality and the emotional wellbeing of both patients and their relatives and carers.

In the adult urgent care waiting area there was a 'changing places' bathroom to support adults and their carers with essential personal care. This space was also used for when patients presented with severe chemical or heat burns to support rapid cleansing of skin.

Within the paediatric emergency department (PED) there was a separate room for patients with specific sensory needs, equipped with specialist audio visual equipment. We heard how this could be used by children, and their families should they require it. There was also a well-furnished family room in this area for them to take a break or step away from the clinical space for some quiet reflection.

Within the PED there was a well-equipped play area for patients to use while they are waiting for review or investigations. There were also at least three portable games consoles for older children. We spoke with staff who were proud of this area and how it supported patients. However, staff said the lack of plug sockets in this area meant that a newly purchased interactive floor projector, which staff had worked hard to gain funding for, could not be used in the department to benefit children who were waiting for treatment. The service had also failed to provide sufficient or dedicated storage areas for essential resources used by play therapists. Play therapists help children process difficult emotions and experiences, like trauma, anxiety, or grief, through play.

We observed how staff always introduced themselves and established a warm relationship with their patients. Staff across all professions demonstrated caring and compassionate attitudes towards patients.

Staff followed 'Care After Death' national guidance standard and had a trust policy which supported this. This provided guidance which included religious / cultural variation requirements, medical and legal processes, death certification and mortuary requirements, the

SWAN model of care, and provided detailed information for families.

There was a well-designed and furnished space for families to spend time with a loved one after they had passed away. We saw that this had been well designed to support families and loved ones in times of distress. There was a good stock of memorial keepsake items that would be supplied to families. This area was well positioned to ensure maximum privacy. Staff however raised concerns that the tannoy system for the department was active in this area. This meant calls for staff were broadcasted through speakers in this area and could cause distress. However there had been no known instances of families and loved ones using the room while announcements were made.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always care about and promote the wellbeing of their staff. This did not support or enable staff to deliver person-centered care.

Staff felt respected, supported and valued within their immediate team. However, throughout our assessment we heard how staff felt that leaders did not recognise and act upon the risks and pressure felt within the department. We heard how concerns had been raised regarding escalation areas and although these had been heard staff saw no changes to improve this or wider recognition throughout the trust of shared responsibility of risk. We heard from a staff member how they could ‘no longer cope with caring for patients in non-dedicated clinical areas and it is breaking me mentally because I can't look after patients well enough’. We heard staff use phrases such as ‘burn out’ and ‘overwhelmed’ to describe their feelings around work pressures.

We also heard how staff wellbeing was poor, particularly when they held patients overnight in areas that supported the main emergency department, and due to the continued use of escalation areas. Staff felt the pressures to get areas cleared of patients the following morning

and concerns around job security were adding to this. Concerns around staff wellbeing was also reflected in management meeting minutes.

The service's staff sickness and absence levels were similar to the provider average. Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service through staff awards and team praise. Staff appraisals included conversations about career development and how it could be supported.

There was a wellbeing hub for staff and access to a variety of wellbeing services such as physical wellbeing support with a physiotherapy service, occupational therapy, weight management, stopping smoking, keeping fit. There were mental health wellbeing service providing stress management, staff psychology service, counselling, wellbeing hubs, access to NHS digital applications and national support services. Financial services were available to staff with cost of living advice, money saving tips, support accessing food banks, NHS discounts, salary sacrifice, and opportunities to access financial support. There was access to Freedom to Speak Up Guardians, a pension scheme and advice service, retirement scheme and advice, pastoral and multi-faith support were also available.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. We also saw evidence that staff would report violence and aggression towards them from patients, and this would be investigated.

Responsive

Rating Requires improvement

At our last assessment we rated this key question requires improvement. At this assessment the rating remained requires improvement. This meant people's needs were not always met.

The service was in breach of legal regulation for person centred care.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure people were at the centre of their care and treatment choices and they did not always work in partnership with people, to decide how to respond to any relevant changes in people's needs.

The service did not consistently make sure people were at the centre of their care and treatment choices. The environment of the paediatric ED was well designed for younger children. Children could watch programmes on the television in the waiting area. Soft seating areas meant they could move around easily without risk of injury. There were ample play resources. There was water and juice available for children and parents. Snacks were also provided by a local charity. There was a dedicated play specialist within the paediatric ED who was dedicated and passionate about providing children with a wide range of resources while they were in the department.

However, a dedicated waiting area for older children and teenagers, was small and poorly designed with no resources beyond a television. The area had windows on 3 sides which offered little privacy and dignity. During our inspection, we saw that the television in this area did not function. We also heard how staff and families had raised concerns that it could not be used as the surrounding windows meant younger children could also see this television which restricted the programmes teenagers and young people could watch. We heard how a young person's feedback session had been held prior to the new department opening to determine the resources this group felt would be beneficial, however staff who undertook this work felt that there was little evidence this was considered when the waiting area was completed.

Specific patients' needs were identified on the electronic patient record. This allowed red flags to be placed on the patient record for patient with additional needs such as dementia. Staff knew how to contact the dementia care specialist nurse for support. However, time limitations meant staff were not always able to take meaningful action to support individual needs.

Patients living with dementia should ideally be placed in high visibility calm areas to enable good oversight of their needs. However, during our assessment, we saw patients with dementia placed in escalation areas, this did not meet their needs.

There was also no system for flagging patients with a learning disability (LD), and specialist teams were unable to access UEC patient systems. Patients were encouraged to use a hospital passport which helped inform hospital staff about the needs of the person with a learning disability and how to support them.

The LD liaison team said that all departments had been provided with a resource box by an external stakeholder with equipment and activities to support patients with a learning disability. The resources included activities to occupy patients and tools to reduce stimulation and distress of patients. Staff were familiar with the use of hospital passports; however, staff did not have awareness of where LD resources were located. The service was provided by another NHS trust but had only been contracted by the trust to provide a service of 2 staff, 30 hours a week spread over 5 weekdays.

In addition, they were contracted only to provide support for patients who had a diagnosed learning disability and who had an IQ under 70 exclusively. However, we were advised by specialists in this area that neurodiversity diagnoses do not provide IQ scoring. Therefore, patients may not be able to access services solely on the basis that they had not undertaken IQ testing. They also did not provide any support for patients with autism. This meant there was no access to additional support for patients with an undiagnosed learning disability, those with a learning disability but an IQ over 70 and no access to additional support for patients with autism. At the time of the inspection the learning disability champions were no longer active in the service, which further added to the lack of resources for patients with a learning disability. This increased the risk that due to lack of support patients with a learning disability might not have their immediate needs met appropriately on initial presentation and once admitted to the hospital. This meant the service lacked the capacity to provide care for patients with these needs.

In the CQC UEC Survey 2024 in response to the question ‘did you have confidence in the health professionals treating you’, the trust measured above the national average. Additionally, in relation to the question, ‘were you involved as much as you wanted to be in the decisions about your care and treatment’, the hospital scored better than national average. This meant

that for some patients, staff empowered them to make their own decisions about their care and treatment.

Multidisciplinary team reviewed and planned care for complex patients and people who attended the department often. This was in line with The Royal College of Emergency Medicine (RCEM), Best Practice Guideline, Delivering Interventions and Services for High Intensity Use Frequent March 2024.We heard how specific alerts on electronic care records for high intensity users, allowed their presentations to be audited and multidisciplinary team meetings to take place involving learning disability and Alcohol Liaison Services to plan for future attendances.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

Patient notes were shared across hospital systems to ensure they were accessible to both medical and nursing teams, this supported cross-team integration. GP and pharmacy services were provided with discharge information to support ongoing care.

Staff ensured all relevant healthcare professionals and other relevant bodies were involved in planning the care and treatment of people with complex needs. We were told how staff could refer or redirect patients to other services such as:

- Other services within the Organisation such as Older Persons Medicine, Maternity, Palliative Care, & Alcohol Team
- Charitable Organisations
- Counselling Organisations
- Community Services

- Social Care
- High Intensity User Groups (supporting those that attend ED frequently using a multi-agency approach)
- Schedule outpatient follow-up (primary care, palliative care, or social services).
- Offering contact information for services that can support life transitions (housing, transportation, disability services).

Providing information

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to raise a concern. Information provided was in a form accessible to the particular patient group (for example, in easy-read form).

The trust provided information leaflets available in languages spoken by patients. Information governance systems included confidentiality of patient records. Staff made notifications to external bodies as needed.

Staff ensured carers and families were regularly updated about the patient's progress. Due to the size of the department, reception staff provided visitors with wayfinding tickets which directed them to the area their loved one was in. This made it easier for any members of staff subsequently asked for the location of the patient, as the details were on the ticket.

Staff were responsible for providing discharge advice and ensured it was in an accessible format for the patient. When altering or adding medication, this was written down for the patient as well as communicated to their GP via electronic discharge letter sent straight to the

surgery. The hospital provided clothing for patients who may be unable to leave in the items they were brought to hospital in.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment, and support. However, they did not always tell them what had changed as a result.

Patients knew how to complain or raise concerns. Staff knew how to handle complaints appropriately. Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We saw how changes in requests for bloods, and the way prescription information was presented had changes implemented, following concerns raised by patients.

Patients and their families could give feedback on the service, and their treatment and staff supported them to do this. There was a ‘wonder wall’ in the main hospital building where patients could post praise around their care. The hospital policy aimed to complete complaint investigations and complete final sign off within 35 days. However, 8 complaints from February 2025 had not yet been closed and exceeded the expected resolution timeframe. When patients complained or raised concerns, they did not always received feedback in line with the hospitals’ own policy. These were missed opportunities for the hospital to make improvements and involve patients in this.

Within the children’s emergency department there was a board where children and parents could say what they felt had been ‘Tops’ or ‘Pants’ about their experience. This showed equal amounts of positive and negative feedback. There was also no evidence of how this feedback

was acted upon. In addition to this the 'You said, we did' board in this area had not been completed and was blank.

Leaders had access to the feedback from patients, carers and staff and this was used to monitor themes and implement changes. However, we did not see evidence that demonstrated how these theme and trends were acted upon more broadly.

We also heard how patients and carers were not always fully utilised in decision-making about changes to the service. Staff told us how listening events had been used to determine user needs for spaces such as the young person's waiting area and the MH assessment areas. We heard how these spaces had been designed with little consideration of these views, and it was not clear how they considered user voice.

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Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

Patients and their families we spoke with told us about long wait times they had experienced whilst in the emergency department. Patients waited long periods of time in the department after the decision to admit had been made. People and their loved ones told us that more clarity regarding wait times for admission to ward areas would have helped manage expectations and relieve any uncertainties they had.

People could not always access care, treatment, and support in a timely manner due to capacity constraints and patient flow across the hospital. The hospital operated in accordance with the Operational pressures escalation levels (OPEL) in conjunction with the continuous flow policy to support rapid discharge and movement throughout the hospital. However, throughout our inspection we saw evidence that this patient flow was not achieved in the department. This meant that this policy did not achieve the outcomes it was designed to achieve and patients waited longer in the department before moving to a ward.

Equity in experiences and outcomes

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. Staff and leaders did not always actively listen to information about people who are most likely to experience inequality in experience or outcomes. This meant people's care was not always tailored in response to this.

Patients with a learning disability were at risk of poorer experience because access to the Learning Disability Liaison Team was limited. The team supporting this patient group lacked the capacity to support all patients within the trust, so local level staff were key in ensuring resources and support was available. The trust did not develop learning disability local roles, and this meant local level knowledge on supporting these patients was not always available. Leaders told us that these roles would be relaunched, and staff supported to attend.

There was also no provision of specialist support for autistic patients or for patients with a mild learning disability, which increased the risks they might not have their specific needs met and would not have a positive experience. This did not demonstrate that the trust had took account of the National Learning Disabilities mortality review 2022, that identified more people with a mild learning disability died from an avoidable death than those with a moderate, severe or profound learning disability.

The trust had also failed to respond and act on concerns that spaces designed for vulnerable

patients in times of mental health crisis, did not meet Psychiatric Liaison Accreditation Network (PLAN) standards and posed an ongoing risk to patients. These standards provide benchmarks for best practices in psychiatric care, aiming to improve patient experience and treatment outcomes.

The service had also not carried out any reviews to identify whether patients with protected characteristics received care and treatment in a timely and equitable manner when compared to patients without protected characteristics.

Staff within the service and the wider organisation promoted a culture in which people using the service felt empowered to give their views but it did not always actively listen to them for all patients.

Staff were trained in equality, diversity, inclusion and human rights as part of mandatory training and 96% of staff had completed this.

We heard how dementia champions had been trained and were present throughout the service to support this patient group. The trust had employed an admiral nurse to support this patient group and their families and were making meaningful impact in this area.

Planning for the future

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Due to the dynamic environment of a UEC, supporting patients with life changes and life planning was not always achievable. Staff told us how patients who were on EOL pathways would be prioritised for admittance on to the most appropriate ward. Where possible the department used resources to support life planning.

Multi agency working ensured care for people who are nearing the end of their life was managed and communicated in a sensitive and dignified way. There were chaplaincy services available for all patients and their loved ones if required.

Patient discussion and their wishes along with registering referrals to services were recorded in patient's electronic notes and where possible information for services would be given to patients and their relatives.

We heard how staff looked for triggers that patients may require support with wider life changes. These included

- Chronic or life-limiting illness
- Frequent ED visits
- Serious diagnosis or new disability
- Geriatric patients or those with cognitive decline

Staff ensured all relevant healthcare professionals and other relevant bodies were involved. Where appropriate, staff could refer or redirect patients to other services in planning their care and treatment.

Well-led

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant the service was consistently managed and well-led.

The service was in breach of legal regulation in relation to good governance (contemporaneous records and identifying and assessing risks).

Shared direction and culture

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service had a shared vision, strategy, and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. The Trusts Values were incorporated into all aspects of an employee journey from recruitment to annual appraisals. We reviewed induction materials such as presentations and checklists which showed how these values and culture was embedded. Annual staff appraisals were undertaken alongside the values to ensure employees understood expectations and if their behaviours demonstrated this.

Staff could explain how they were working to deliver high quality care. We spoke with staff who told us how they worked to support patients in the department to ensure they were safe and cared for. Throughout our inspection we saw staff working hard to deliver care and provide the best possible outcome achievable.

Within UEC, the internal professional standards were used to outline standards and behaviours that underpinned staff expectations. We reviewed these and saw they clearly articulated the Trust's core principles aligned with values such as compassion, teamwork, and continuous improvement. However, while collaboration is mentioned, there was limited evidence of frontline staff contributing to strategic discussions. There was also limited evidence to support how the wider hospital supported meaningful work to improve patient flow and care from the emergency department.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. Leaders understood the context in which the service delivered care, treatment and support. The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support. However, they did not always take timely actions in response to risks which had a meaningful impact on staff and patients.

Leaders recognised the risks in the department and documented strategies and plans to address these. Risks were captured on a local and trust level risk register and were rated in terms of likelihood and consequence. The trust had risk management processes which meant that risks were escalated appropriately from the emergency department up to board level when required.

Staff and leaders at all levels demonstrated a good understanding of the risks within the emergency department and the action being taken to mitigate or remove risks. We discussed the top risks for the service with the leadership team. We heard how the top 3 risks were, Decision to Admit (DTA) and bed allocations not aligning with the continuous flow policy, risk of harm to Mental Health (MH) patients while they waited for assessment, and staffing.

The biggest risk identified was corridor care in escalation areas. There were 7 separate risks documented which related to the use of escalation areas and lack of patient flow. Despite mitigations, these remained of the highest risks on the departmental risk register.

Concerns regarding the environment for Mental health patients had been added to the risk register in 2022. Although this was prior to the department moving to a new building, a review of mediations had taken place since, yet it still remained one of the highest rated risks. This demonstrated that concerns with environments presented an ongoing risk which had not been resolved for over 3 years. Overall, 5 of the 23 active risks documented, related to the provision of services for mental health patients and that quality and safety of care could be compromised for those patients with mental health concerns.

In addition to this, we saw that 22 active departmental risks, only 5 had mitigations in place which had reduced ongoing risk. In addition to this, 5 risks had increased in RAG rating since they had been added. This indicated that although leaders had good oversight of the service they had not always taken appropriate or meaningful actions to manage risk and performance.

Local and Senior Leaders were visible in the service and approachable for staff. Staff felt that the executive team were present in the department and gave the example of the medical director who has shadowed a shift as well as the director of nursing. However, staff felt that senior leaders should be more present to engage directly with patients. We also saw this raised in staff wellbeing feedback.

Leaders had the appropriate range of skills, knowledge, and experience to carry out their roles. There was a triumvirate leadership structure with medical, nursing, and operational leads. There were clear reporting structures and key roles were supported by deputies or associate roles to support succession planning. Staff mostly told us they felt supported and guided by their immediate leadership team. Local leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. There were multiple daily safety huddles and bed management meetings which enabled sharing of information and escalation of patient risks and capacity and resource issues. Risks were discussed at safety huddles, board rounds and bed management meetings and leaders were proactively managing and escalating any concerns.

We also heard from staff that they felt there were limitations in translating this leadership presence and engagement into action and this was limiting their effectiveness to deliver the care they strived to achieve. The roles of staff and leaders were clear, and they understood their responsibilities and accountabilities. However further work was required to develop and maintain substantive and consistent improvement in patient flow and improve staff morale.

Freedom to speak up

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service fostered a positive culture where people felt they could speak up and their voice would be heard.

Leaders fostered a positive culture where people felt that they could speak up and that their voice would be heard and were able to describe how staff reported concerns and how these were investigated, then feedback given to staff, via various forums. The department had a well-established and evolving Freedom to Speak Up culture. Staff were encouraged and supported to raise concerns, and the transition to a 24/7 independent provider demonstrated a strong commitment to psychological safety, transparency, and continuous improvement. There were multiple channels for raising concerns including surveys and listening events.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service valued diversity in their workforce. They work towards an inclusive and fair culture by improving equality and equity for people who work for them.

Policies and processes were in place to ensure the service was inclusive and fair in the way it operated. Staff received training in equality and diversity and had a good understanding of cultural, social and religious needs of patients and demonstrated these values in their work. The trust had an Equality, Diversity and Inclusion Strategy in place this ‘pledged to address inequalities for our people, patients and communities with real purpose and action.

The provider undertook equality monitoring of staff within the service to ensure it was diverse in its make-up and representative of the patient group. The service promoted equality and diversity in daily work and provided opportunities for all staff to develop. There was a trust level Leadership programme called ‘Beyond Boundaries’ which worked to develop staff from ethnic minorities into leadership roles.

The trust held events like the Diwali Celebration and International Food Festival, these were

open to all staff and promote cultural understanding and inclusion. These events also fostered team cohesion and awareness. Within UEC there had also been an ED Cultural Celebration event.

There were equality and diversity champions within the service such as 'DisAbility' Staff Network, Race Equality Network and the Lesbian, Gay, Bisexual, Transgender + Staff and Allies Network. These networks worked alongside leaders to shape organisational strategies, policies and processes. It was hoped this would improve staff experience on a wide range of issues. There were wellbeing initiatives including forums, newsletters, and wellbeing lead updates.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the standard of care

We scored the service as 2. The evidence showed some shortfalls. The service did not always have clear responsibilities, roles, systems of accountability or good governance. They did not always act on the best information about risk, performance and outcomes.

The emergency department sat within the urgent care directorate. Staff told us feel that they did not always feel they were listened too. Staff also felt that staff facilities need to improve along with better lanes of communication provided.

Staff told us the senior trust leaders were present and listened to the concerns of clinicians on the frontline. However, they struggled to provide effective and solutions. Leaders told us they understood but did not always have resources and space to manage the priorities and issues the service faced. Capacity constraints within the service and across other parts of the hospital impacted on patient flow in the emergency department. We heard from staff that they felt frustrated that escalation areas were being used and that they could not see changes from these concerns being raised.

The hospital operated in accordance with the Operational pressures escalation levels (OPEL). This was used in conjunction with the continuous flow policy to support rapid discharge and

movement throughout the hospital. However, records showed the full capacity & continuous flow protocol was in place for 174 days out of the 186 days prior to inspection. Therefore, it was not clear if this policy was effective in efforts to improve flow and maintain safe care.

The number of ambulance handover delays over 60 minutes at the trust had improved considerably since September 2024 where it peaked at 40.5% which equated to 3,614.96 hours lost. This had reduced by to 23.43 hours in February 2025. Although staff recognised that changes to ambulance delays were needed, they felt that this moved the risk directly to them and that this was not well understood by other departments within the trust. Staff felt the clinicians throughout the rest of the hospital did not engage in mitigating the risk posed by overcrowding in emergency department by facilitating flow throughout the hospital and preventing emergency department attendances. It was not felt among staff the senior leaders had taken issues to address this and hold other areas of the service to account.

In response to changes within the trust the department had recently moved away from a divisional structure, meaning that the urgent care team now reported directly to their senior leadership team. Leaders described this as allowing a more direct line of sight and contact.

Most staff had access to the equipment and information technology needed to do their work. We saw that staff had ample access to computer systems both in patient bays and at mobile workstations. There was access to main hospital records, pathology and blood reporting systems, and patient records. Information governance systems included confidentiality of patient records.

However, we heard from some teams employed by another trust but that actively supported this services' patients, that they were unable to access all systems such as the staff intranet and UEC patient tracking.

There was a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Staff had implemented recommendations from reviews of deaths, incidents and complaints.

Senior staff maintained and had access to the risk register at a departmental level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. We reviewed the risk register for the department and saw that this contained concerns raised by staff such as staffing and the use of escalation areas.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. We saw evidence that resilience planning had taken place. This had been used recently in the hospital following an outbreak of contagious illness.

The service used systems to collect data from the department that was not over-burdensome for frontline staff. The patient record system in use was able to collect and retain information to monitor safety. Local leaders had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. This was actively used in huddle, safety and risk meetings.

During 'Green QI Month' staff were invited to contribute ideas for sustainability improvements via a QR code and direct email contact. The initiative was linked to national RCEM accreditation, encouraging team-wide participation and ownership.

Partnerships and communities

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. They share information and learning with partners and collaborate for improvement.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch. There was evidence of sharing information with stakeholders to improve patient outcomes. This included pathway planning, redesign and implementation.

There were quality reviews of the department, where information was shared to encourage

collaboration across departments and providers to improve quality, effectiveness and safety for people using the service. The department had undergone a review of patient experience via Healthwatch, but this had not been published at the time of assessment. Healthwatch is an independent government organisation responsible for ensuring that people's experiences and views are heard by decision-makers to improve services. The service was also working in partnership with the General Medical Council to improve the experience and meet guidance for international medical graduates employed at the trust.

We saw evidence of initiatives with other agencies that demonstrated multi-agency collaboration. These initiatives involve collaboration with housing, mental health, addiction services, and local authorities to support vulnerable patients.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service focused on continuous learning, innovation and improvement across the organisation and local system. They encouraged creative ways of delivering equality of experience, outcome, and quality of life for people. They actively contribute to safe, effective practice and research.

Staff were given the time and support to develop opportunities for improvements and innovation and this led to changes in care delivery. Staff were actively engaged in quality improvement and evidence-based practice, which are foundational to research-informed care. Staff used quality improvement methods and knew how to apply them.

The UEC department actively promoted service and quality improvement projects that were developed and undertaken by their staff. We saw evidence of multiple Quality improvement projects that had been developed that covered clinical and patient experience improvement.

Staff we spoke with were able to tell us about quality improvement projects in the department

such as improving the time it takes to assess a patient on arrival. Quality improvement projects were supported by the quality improvement lead in the trust. Projects were linked across departments and formed a strategic approach with increased executive support.

Mortality review group meetings were held monthly. Minutes showed appropriate discussion of identified cases and identified learning to feedback to teams. This included patient case studies and organisational learning.