LAP assessment report

Northwick Park Hospital

LAP Assessment Report ID : LAP-01598

Inspection visit date(s): 15 July 2025, 16 July 2025

Table of contents

Northwick Park Hospital
Location findings

Ratings for this location

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

Overall location summary

On 15 and 16 July 2025 we carried out an unannounced inspection at Northwick Park Hospital. This assessment looked at urgent and emergency care which we rated as requires improvement. The rating of urgent and emergency care has been combined with the ratings of the other services from our previous inspections. See our previous reports to get a full picture of all the other services at Northwick Park Hospital. This is the first time we have assessed the Urgent Treatment Centre as part of the urgent and emergency care assessment service group as another provider previously ran it.

The rating of Northwick Park hospital has remained the same, requires improvement with breaches of regulation 10, dignity and respect and regulation 12, safe care and treatment.

In our assessment of Urgent and Emergency Care, we found.

People could not always access care, support and treatment when they needed it with some patients waiting over 12 hours in the emergency department.

In temporary escalation areas there was no privacy. Patients did not have access to call bells should they need assistance and staff were not always visible in the areas we visited.

The service did not always assess or manage the risk of infection. Staff did not always wash their hands between patients.

Not all staff had completed safeguarding training, and several staff groups fell below the trust target completion rate of 90%.

Children were not streamed by a paediatric nurse when they arrived in the department leading to some patients with similar injuries being streamed differently.

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.

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 always treated people with kindness, empathy and compassion but in some areas did not always respect their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

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.

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 service fostered a positive culture where people felt they could speak up and their voice would be

heard.

Safe

Rating Requires improvement

Our overall rating of safe at Northwick Park Hospital has stayed the same and is rated as requires improvement. Urgent and Emergency Care was rated as requires improvement.

Effective

Rating Requires improvement

Our overall rating of safe at Northwick Park Hospital has stayed the same and is rated as requires improvement. Urgent and Emergency Care was rated as good.

Caring

Rating Good

Our overall rating of caring at Northwick Park Hospital has stayed the same and is rated as good. Urgent and Emergency Care was rated as good.

Responsive

Rating Requires improvement

Our overall rating of responsive at Northwick Park Hospital has stayed the same and is rated as requires improvement. Urgent and Emergency Care was rated as requires improvement.

Well-led

Rating Requires improvement

Our overall rating of responsive at Northwick Park Hospital has stayed the same and is rated as requires improvement. Urgent and Emergency Care was rated as good.

Urgent and emergency services

Urgent and emergency services

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

Our view of the service

We carried out an unannounced assessment of Northwick Park Hospital on 15 and 16 July 2025 in line with our assessment priorities. We assessed the following assessment service group.

Urgent and emergency care

Overall, the service was rated as Requires Improvement.

The emergency department (ED) had previously been inspected in November 2019. At this inspection the urgent treatment centre (UTC) was operated by a different provider. This was the first inspection of the service that included both the emergency department and UTC as a service provided by this trust. At our last inspection the emergency department was rated as requires improvement.

The department had different areas where patients were treated including, urgent treatment centre, majors, minors, resuscitation, rapid assessment unit, and paediatric emergency department. The department was open 24 hours a day 7 days a week to both walk in patients and those arriving by

ambulance.

People could not always access care, support and treatment when they needed it with some patients waiting over 12 hours in the department.

Some patients were seen and assessed in temporary escalation areas where there was no privacy, and patients did not have access to call bells should they need assistance and staff were not always visible in the areas we visited.

The service didn't always work well with people and healthcare partners to establish and maintain safe systems of care. This means we looked for evidence that people were protected from abuse and avoidable harm.

The service did not always assess or manage the risk of infection. Staff did not always wash their hands between patients.

Not all staff had completed safeguarding training, and several staff groups fell below the trust target completion rate of 90%.

Children were not streamed by a paediatric nurse when they arrived in the department, leading to some patients being streamed differently with similar injuries, placing them at risk of not receiving timely treatment.

The service had a shared vision, strategy, and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion and engagement. However, not all staff were aware of the vision, and it was unclear if this had been developed in collaboration with staff.

The service always treated people with kindness, empathy and compassion, however, in some areas their privacy and dignity was not always respected. Staff treated colleagues from other organisations with kindness and respect.

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.

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.

The service fostered a positive culture where people felt they could speak up and their voice would be heard.

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.

People's experience of the service

People, their families, and carers were positive about their interactions with staff and the treatment they received. All people we spoke with reported that staff were welcoming and friendly, and that they were treated with compassion and kindness. Patients felt listened to and knew what the plan for their care was. The friends and families test showed that 98% of people had a positive experience in the department. However, there was a low response rate to this survey. Leaders told us the low response rate was due to issues in delivery of the survey. A new system has been implemented with automated messaging after each patient visit.

Patients told us they had been waiting in the department for a long time and did not know how long they may have to wait. Wait times were not displayed in the department.

The waiting area was noisy and there were not enough chairs for patients to sit on when the department was busy, meaning some patients sat on the floor or stood while they waited to be seen, leaving some people uncomfortable.

Some patients in the temporary escalation spaces (TES) told us they had not been offered food or drink while in the department, although it was not clear how long they had been waiting. The department provided food and drink 5 times a day at mealtimes including patients in the TES area.

Safe

Rating Requires improvement 

At our last assessment we rated this key question good, at this assessment the rating changed to 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.

Urgent and emergency services

The service did not always work well with people and healthcare partners to establish and maintain safe systems of care. 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. They did not always detect and control potential risks in the care environment and make sure equipment, facilities and technology supported the delivery of safe care. The department did not always have enough staff with the right skills to safely care for patients.

The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly and people were protected and kept safe. Leaders embedded a culture of openness and collaboration. Staff managed medicines well and involved people in planning any changes.

Learning culture

Score

3. Evidence shows a good standard of care

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.

There was a no blame culture meaning staff were confident that any incident reported would result in shared learning. Staff we spoke with knew what incidents to report, how to report them and were encouraged to do so by senior leaders, they gave us examples of when they had reported incidents and the actions that had been taken. The service used an electronic system all staff could access, and staff told us this was easy to do. The data we reviewed showed that the service was reporting a range of incidents including no harm incidents and those that had resulted in severe harm. On average the division reported around 700-800 incidents per month with around 93% of these incidents being categorised as low or no harm. We were not provided with specific data that showed how many incidents the ED and UTC reported. The service reviewed these incidents under the new incident framework in line with the NHS standards.

Staff spoke about incidents that had occurred in the department, they stated they received feedback and learning following an incident was shared with all staff. Learning was cascaded through team meetings, handovers, safety huddles and emails. Where an incident related to a specific member of staff, individual meetings would be arranged for personalised feedback and learning. There was evidence that changes had been made as a result of the outcome of investigations and staff were able to give a range of examples. For example, following a serious incident, changes were made to the department with the introduction of the sepsis room creating an additional space for patients to have intravenous antibiotics administered quickly.

Staff understood how important it was to be open and transparent with patients and their relatives and that this was an important part of the learning process. However not all staff knew this was called duty of candour. The trust had an up-to-date duty of candour policy that staff could access. We saw duty of candour screen savers on computers helping make staff aware of the policy.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work well with people and healthcare partners to establish and maintain safe systems of care. They did not always manage or monitor people's safety. They did not always make sure there was continuity of care, including when people moved between different services.

Between July 2024 and June 2025 there were 119,618 attendances to the emergency department (ED) and 78,744 to the urgent treatment centre (UTC). The service accepted patients who were conveyed by ambulance, who walked in and were referred by their GP.

On arrival in the department all walk in patients joined a queue to be streamed by the 'hello' nurse. Patients were often queuing outside the door; we observed a wait time of around 15 minutes before people entered the department. The area was monitored by a security officer who would prioritise patients if they thought it was necessary, however they were not medically

trained and this was inconsistent, we observed a young child being prioritised when they joined the queue and at other times children joining the back of the queue when they arrived and not prioritised. During busy times we did not see any additional clinical support at the front door to help streamline patients meaning critically unwell patients may not be prioritised and escalated therefore delaying treatment and impacting on patient care.

The hello nurse could refer very unwell patients straight to resuscitation and streamed all other patients between the ED and UTC. Patients were triaged at reception by a senior registered nurse. Children were not triaged by a paediatric nurse; however, this is not a requirement as per national guidance but is considered best practice. Senior leaders told us staff received additional training in triage for adults and children and were signed off as competent. Data showed that 100% of band 7 nurses had completed their training and had been signed off as competent. We noted 95% of band 6 nurses had completed their training with 88% signed off as competent. While 61% of band 5 nurses had completed their training only 13% had been signed off as competent. However, senior leaders told us triage is only undertaken by a band 6 or band 7 nurse who are signed off as competent, those who are not signed off were not allocated to this area. We saw an example of 2 paediatric patients with similar injuries being streamed differently resulting in different care being provided. Senior staff told us that refurbishment works to the entrance area of the department, which commenced the week of the inspection, would resolve this issue as all paediatric patients would be sent directly to the paediatric ED and triaged by paediatric staff away from the main reception area. This would mean a consistent approach to triaging paediatric patients.

NHS England set the standard that all patients should be assessed promptly within 15 minutes of arrival in the department and within 1 hour by a clinician. The service assessed 91.3% of patients within 15 minutes and 91.2% of patients were assessed by a clinician within 1 hour whether they arrived by ambulance or were a walk-in patient.

Adult patients had a falls assessment completed and if necessary, they were provided with yellow socks to help identify them to staff caring for them. This meant mitigating actions could be taken to reduce the risk of these patients falling. Falls in the department were monitored at the quality and risk committee. There had been 6 falls reported in ED during July 2025 but none in SDEC or UTC.

The trust used a nationally recognised triage system to ensure patients received a consistent

and structured assessment. The system used icons to flag individual patient needs or risks. This system did not require a mental health assessment for all patients attending however, staff could add notes to the comments section if a patient presented with a mental health concern. The system did not prompt staff to ask patients undergoing chemotherapy whether they were at a higher risk of infection however staff told us they always asked but there was a risk this might go unrecorded. The department had neutropenic sepsis pathway in place and staff told us they had a chemotherapy policy for the waiting room to follow.

Patients waiting in ED were seen in the rapid assessment unit (RAU) where investigations were ordered and patients placed on pathways, for example escalated to resuscitation for higher level care. Patients were seen by a senior clinician to initiate early treatment. In the patient notes we reviewed, we found appropriate referrals for imaging and specialist services, such as orthopaedics. Patients arriving by ambulance had a separate entrance to the department and were assessed in an area known as the pitstop. Patients were assessed by a doctor and nurse and triaged appropriately. The aim of this area was to take over from the ambulance crews in a timely manner and release the crews with minimal delays.

When patients were referred to ED same day emergency care (SDEC), managed by the ED department, which may be the most appropriate place for these patients to receive care, the time they were in the department continued to be recorded on the electronic patient record but they were no longer reportable on the 4-hour target in line with national SDEC pathways.

Not all patients were transferred to the ward under a speciality team in a timely manner. On the day of the inspection one patient had waited more than 19 hours to be transferred and admitted to a ward which breached the 12-hour national standard set by NHS England, which sets trusts the target that no more than 2% of patients should wait 12 hours or more from the time of arrival at an ED before being admitted, discharged, or transferred. In the last 6 months 14.4% of patients breached the 12-hour national standard. The flow programme board was established in May 2025 to track the departments flow. At the time of the inspection there were a number of open actions on the action log, for example exploring the possibility of extending the opening hours of the same day emergency care (SDEC) ward. We attended a site meeting where breaches were discussed with the other services in the hospital and plans were made to admit patients to the appropriate services.

The trust had a full capacity protocol (FCP), to assist in the management of overcrowding in the

ED. Senior leaders acknowledged that the department had to adapt and operate differently in these situations to manage the risk and ensure patient safety. The FCP included the criteria for activating the protocol, actions to be taken including the escalation processes. This facilitated patients receiving timely and appropriate treatment and improve patient flow by using all available resources effectively. The trust reported the FCP during the submission of Operational Pressures Escalation Levels (OPEL) score 4 times a day.

The medical and nursing handovers we attended, were informative and responsive to the department's needs. The medical handover immediately allocated medical staff to start bringing down the wait times in the department, to ensure patients received timely treatment.

Safeguarding

Score

3. Evidence shows a good standard of care

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 had training on how to recognise and report abuse, and they knew how to apply it. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to describe how they would submit a safeguarding alert using the electronic system and gave examples for what to look for including recognition of exploitation. In the 12-month period July 2024 to June 2025 the department made 622 adult safeguarding referrals and 2061 children's referrals showing staff knew how to recognise and report abuse.

Staff received training in adults' and children's safeguarding as part of their mandatory training, the level of training was dependent upon their role. At the time of the inspection, data showed that over 97% of medical staff had completed their safeguarding training, which was above the trust target of 90%. However, not all other staff groups had met the 90% target. Nursing staff

had not met the target for safeguarding adults' level 3, 80.95% had completed this training and for children's level 3 training, 87.4% were compliant. The divisional director of nursing chaired a monthly mandatory training meeting with the area leads to review training compliance and explore what was being done to improve compliance rates. It was acknowledged that some gaps in compliance were down to staff on long term sick leave and availability of training. The department presented a breakdown of their compliance and highlighted where additional capacity for different training was required. We were not provided with evidence to demonstrate that plans were in place to address the shortfall in the provision of some training. An internal mandatory training tracker was used by senior staff to record communication with non-compliant staff and included dates for future training. This meeting validated and challenged the data entry to ensure the online platform was being updated correctly having previously identified an error with the learning platform.

The electronic system flagged if a patient had a child protection plan in place, or if a person frequently accessed services throughout the area. The trust had named safeguarding leads across the hospital who staff could access for advice regarding safeguarding matters and staff we spoke with knew how to access them.

The trust had a safeguarding policy in place that was in date and referenced national guidance. Staff knew how to access this.

Staff received training on learning disability and autism. Compliance across all staff groups met the trust 90% target, with several staff groups 100% compliant.

Mental Capacity Act training formed part of the safeguarding modules. Capacity was documented in patients notes and risk assessments were carried out to ensure patient safety. The service employed two registered mental health nurses providing support to staff in the department. Their rota provided cover for the day shifts, 7 days a week and all but 2 days a month were covered. There was no mental health nurse on duty on the night shifts. When the mental health nurses were not on shift the nurse in charge would provide support for staff.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

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.

The service introduced the managing vulnerable patients in the cohort queue policy. This set out who was considered a vulnerable patient and who to prioritise but did not include what actions staff should take. We observed a vulnerable patient at the back of the cohort queue waiting to be assessed and had not been prioritised. It was unclear what actions should have been taken and how compliance with this policy was monitored.

The service had a standard operating procedure (SOP) for patients cared for in temporary escalation (TES) areas. Leaders told us while they did not want to normalise corridor care, an SOP had been implemented so there was a clear direction for staff to maintain patients' safety. However, the policy was not always adhered to. Most patients were located in a corridor directly alongside the rapid assessment unit where staff were located. Later in the day when the department was at its busiest, patients were placed in a corridor behind a closed door. There were no staff members caring for patients in this area, placing patients at risk of harm if they deteriorated as this would not be identified in a timely manner. This was not in line with the policy that stated all patients must be in the line of sight of the nursing team. Staff told us these patients had not yet been handed over to them by the ambulance service. The trust had a standard operating procedure with the ambulance service where the department could request support from paramedic crews to assist cohorting patients before they were handed over to nursing staff, allowing other ambulance crews to be released. However, at the time of our inspection there were no paramedics present in this area. As these patients were in the department it was the trust's responsibility to care for these patients but not all staff we spoke with understood this.

Patients in TES areas did not have access to a call bell or other method of seeking assistance.

On review of the trust's patient safety data, we could not find any incidents reported relating to patient harm as a result of patients not having access to a call bell in the TES areas. However, this did place patients at risk of potential harm. Following the inspection leaders told us the area had been risk assessed with environmental factors taken into consideration. The service used national guidance to assess the area and produce the standard operating procedure for the department.

It had been highlighted at a quality and risk meeting that the issues around the TES areas and that some metrics such as ambulance conveyances, blue light conveyances and cohort numbers were not collected. It was unclear from the minutes if the department had plans to collect this data and when this would commence. Leaders told us issues in TES were reported at the Integrated Performance and Quality Report (IPQR). We reviewed the slides and saw metrics were discussed however this was not the metrics discussed in the quality and risk meeting minutes.

Patients could request a chaperone to accompany them, however there was no information displayed regarding this; therefore patients may not realise this was an option. Leaders told us staff would discuss this with patients individually. However, we did not observe this during the inspection as we were not present during the clinical assessment with patients.

Staff used a nationally recognised tool to identify deteriorating patients. Observations of vital signs were recorded by staff, and the national early warning score (NEWS) and paediatric early warning score (PEWS) was calculated and recorded. The service had a clear escalation policy for deteriorating patients and staff we spoke with understood the importance of escalating patients quickly.

Staff understood how to deal with specific risk issues such as sepsis. The emergency department had a dedicated sepsis treatment room with all necessary documentation and equipment, including medicines for the rapid assessment and treatment of sepsis. There was national guidance for how quickly patients should receive treatment for sepsis based on their presentation, known as the Sepsis 6. This included giving antibiotics to a patient with suspected sepsis within 1 hour of arrival in the ED. The data we reviewed showed a significant improvement in patients receiving antibiotics within 1 hour of arrival in the ED. In July 2024, before the introduction of the sepsis room, 30% of patients received antibiotics within 1 hour. In June 2025 this had risen to 95%, demonstrating the positive impact the sepsis treatment room had had on patient safety.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

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

The department had several areas for patients to be cared for and treated in depending on their acuity. Patients were assessed and moved accordingly.

The waiting area was small and accommodated patients waiting for the emergency department (ED) and urgent treatment centre (UTC). The department was due to undergo building work to redesign the layout of the entrance and waiting areas immediately following the inspection. During busy times there was not enough seating, and we observed people sitting on the floor or standing. When the department started to get busy, the security staff restricted the number of people accompanying the patient to only one person to reduce the numbers in this area. There were 3 security staff in the waiting area who assisted staff in observing the area. The area was very loud and at times it was not possible to hear names being called by staff or announcements on the public address system. Due to the layout of the waiting area and the number of people waiting, it was not possible for triage staff to observe all the patients for any signs of deterioration. However, to mitigate the risk of deteriorating patients being missed there were 6 rounds a day where patients were assessed and staff walked through the waiting area continuously. However, while most patients were seen and assessed by a clinician within 60 minutes, some patients did wait longer than 4 hours in the waiting room and therefore could deteriorate in between the regular rounds and their deterioration may not be identified in a timely manner.

Some patients arrived at the department when an appointment with a primary care service was more suitable. The UTC engaged with patients and helped them register with a GP and access appointments at a local medical centre. This encouraged people to use the different health settings more appropriately.

The waiting area for paediatric patients could only be accessed using a swipe card meaning

access was limited to paediatric patients and their relatives. The paediatric waiting area was small and used for patients waiting for the ED and UTC. Staff in this area were located behind a locked door and the window which looked out over the waiting area was covered in posters, meaning staff might not be able to observe all patients in the area. We were told about a paediatric patient who deteriorated whilst waiting, this was not identified in a timely manner as staff did not have full oversight of the area. Despite this incident, at the time of the inspection the window was still covered in posters meaning the waiting area was not clearly visible.

Patients arriving by ambulance entered the department by a different entrance where ambulance crews could check patients in with a nurse in an area known as the pitstop. The crews provided a verbal handover and staff in the pitstop were able to prioritise patients requiring urgent attention. At busy times we observed patients waiting in the foyer of the department to be admitted into the department and to have their initial assessment as there were no pitstop cubicles to transfer these patients to. The ambulance crews we spoke with told us this was not unusual, and they often had to wait in the foyer to handover or keep the patient in the back of the ambulance while waiting to handover. This not only delayed the ambulance crews and impacted on their ability to respond to other calls, it placed the patient at risk of not receiving timely care and treatment. Leaders told us fire safety regulations limited the number of patients they could accept into the department. Once this threshold had been reached the department could not accept any more patients and surge calls were held with the ambulance provider to discuss the possibility of diverting patients to other emergency departments.

Patients were regularly waiting in temporary escalation (TES) areas. The department used 2 corridors to cohort patients waiting. Privacy screens were not used in TES to protect patient privacy when being examined and conversations could be overheard. Patients in this area did not have access to a call bell. Patients waiting in TES and HDU did not have access to a toilet and would have to leave the area to find one. It was not clear for patients where the nearest facilities were.

The department had several resuscitation trolleys, for example the rapid assessment unit had a resuscitation trolley located in a trauma bay for patients acutely unwell waiting to be transferred to another area. The trust had risk assessed the department and resuscitation trolleys were within 30 to 40 seconds of all areas, including the temporary escalation area. We reviewed the logs of 3 resuscitation trolleys and found they were checked daily by staff and signed off as being appropriately stocked.

The environment was well laid out, was visibly clean and tidy and most of the areas we visited had enough space and appropriate equipment. We observed that areas were uncluttered and had appropriate storage, equipment was stored properly and well maintained. Staff knew how to report faulty equipment and told us when they did it was resolved quickly.

Rooms and bays had curtains and doors to maintain privacy. The service had a ligature light room which met the national guidance for areas that patients at risk of harming themselves should be cared for in. It had an observation window, two-way doors, and access to a toilet. There were also 2 other rooms which could be converted from being set up for acutely unwell patients to a room suitable for a patient with a mental health condition.

We observed that all handovers were undertaken in a designated area where patient confidentiality could be maintained.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always make sure there were enough qualified, skilled and experienced staff in all areas of the department. They did not always make sure staff received effective support, supervision and development. They worked together well to provide safe care that met people's individual needs.

Managers had calculated the number and grade of nursing staff required using a nationally recognised staffing tool and reviewed staffing levels twice a year. This provided evidence-based decision making on workforce requirements. There were 5 levels of care with associated descriptors to determine the level of care a patient needed. This allowed staff to measure how unwell a patient was and how reliant they were on nursing care to have their needs met. The tool generated a recommended establishment of staff required to safely manage the department. The department worked to a ratio of 1 nurse to 4 patients and 1 nurse to 2 patients in resuscitation.

The TES area was not part of the substantive staffing model but was counted in the daily numbers of staffing. Additional bank shifts were added to the rota to have additional support for the TES area. We observed only 2 registered nurses looking after 22 patients in the temporary escalation (TES) areas. The department had a TES procedure which stated a ratio of 1 nurse to 5 patients, this was in line with NHS safer staff recommendations. This meant the TES areas were not safely staffed in line with the trust's policy and place patients at risk of harm.

At the time of our inspection, nursing vacancies were 0.8% and leaders were proud they were almost at their full establishment of 31 nurses. The fill rate of shifts was between 96% and 99% for nurses and 85% to 96% for healthcare assistants between January 2025 and June 2025. Gaps were filled with bank staff and the service did not use agency staff. The fill rates for medical staff was 99.7% which included 26 consultants. Medical staff had a staggered shift start and included 8 senior decision makers per day. The Royal College of Emergency (RCEM) medicine suggests 1 consultant per 4000 annual attendances. Based on the number of patients attending ED over the last 12 months, using this ratio it suggests the department should have 29 consultants. However, this is guidance, and the complexity of the patients and department size needs to be considered. The department was not a major trauma centre; therefore, the ratio of consultants had taken this into account when identifying the medical staffing establishment.

The clinical lead recently undertook a data analysis of patient attendances against staffing and factors that impacted performance. They found that rather than the total number of ambulances, it was the arrivals by blue light that impacted performance. As a result, the rota was reviewed and opportunities identified to redeploy staff from another of the trust's sites which led to improved performance. This analysis supported a business case to increase the number of advance care practitioners and was supported by executives. At the time of our inspection funding had not been agreed for the additional posts.

Most staff we spoke with said they thought the department had enough staff to safely care for patients. Staffing numbers were discussed at the morning site huddle and staff moved across the division accordingly, in line with the safe staffing and escalation policy. However, at times staffing numbers did impact on patient care, for example we observed a patient's medication being delayed as a result of there not being a second member of staff to assist administering medication. An area of concern raised with us was healthcare assistants being moved to provide one to one support leaving gaps in the area they had been working in.

All staff received mandatory training. Data showed that across all staff groups, compliance stood at over 80%, with 97.71% of medical staff and 93.75% of nursing staff having completed their mandatory training.

Staff received additional training depending on their role. We reviewed the compliance rate for the additional training that some staff were required to complete. We noted that 81% of band 5 nurses, 93%, band 6 nurses and 89% of band 7 nurses had completed their paediatric immediate life support (PILS) training and 90% of band 5 nurses, 93% of band 6 nurses and 94% of band 7 nurses had completed their immediate life support (ILS) training. Medical staff received additional levels of life support training. The compliance rates for medical staff based at Northwick Park Hospital and those who worked across sites, were in excess of 75% for advance life support, advance trauma life support, and European paediatric advance life support.

The service was supported by a team of security officers. They were employed by an external agency and received appropriate training including safeguarding and conflict resolution. All staff we spoke with told us security officers were an invaluable part of the team and spoke highly of them. Staff told us they were able to defuse situations and support staff to provide one to one care for patients if required.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

The service generally assessed and managed the risk of infection. They did not always detect and control the risk of it spreading or shared concerns with appropriate agencies promptly.

Staff maintained equipment well and kept it clean. We observed the use of ‘I am clean’ stickers indicating equipment had been cleaned and was ready for use. Staff told us they knew how to report broken equipment, and it was usually resolved quickly.

All ward areas in the emergency department and urgent care centre were visibly clean, and

furnishings were well-maintained. We saw cleaning staff in the department throughout the day helping maintain a clean environment.

The matrons worked with cleaning contractors to audit different areas of the department for cleanliness. The auditing tool they used produced a failure analysis report so they could review where improvement was needed. We reviewed the analysis report, which recorded 81 instances of dust on surfaces over the past 12 months. Actions were taken as a result, and we saw these were followed up at the governance meeting. For example, matrons carried out daily walkabouts of the area alongside housekeepers and nursing staff to ensure improvements were maintained and any issues were identified and resolved promptly. The department had Infection Prevention and Control Assurance audit Improvement plans, staff were assigned actions and reported to the ED matron. The actions in the plan were on track for completion by the agreed dates. Learning was shared at staff huddles and infection prevention control nurses carried out daily walk abouts to review the environment and engage with staff.

Most staff adhered to infection control principles, including handwashing and being bare below the elbow. We observed staff cleaning their hands and using hand gel, which was available throughout the department. However, we observed some staff moving between patients taking observations without washing their hands which was a potential infection risk.

Most areas we observed had access to hand washing facilities including the TES areas so staff could easily wash their hands. However, where patients received and initial streaming by the ‘hello’ nurse, there were no hand washing facilities available. This area was due to change within the next 6 weeks as refurbishment works had started the week of our inspection and staff would have access to hand washing facilities.

Infection Prevention and Control data was shared at the divisional quality and risk meeting. For example, in April 2025 the hand washing audit reported 90.7% of staff were compliant with hand washing. And MRSA screening compliance was 84.7%. We were not provided with action plans to demonstrate how the department planned to improve these compliance rates.

Medicines optimisation

Score

3. Evidence shows a good standard of care

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.

Staff followed good practice in medicines management and did so in line with national guidance. Patients were given information about their medicines and received medicines as prescribed. Allergies were recorded in patient records, and they were given coloured wrist bands to wear indicating to staff that they had an allergy.

Medicine management was discussed at the Emergency Medicine Clinical Governance and Resuscitation Meeting. At the meeting it was highlighted that there was a national shortage of certain medicines and that different medicines were available. This ensured medicines that were not in stock were not prescribed.

The service used an electronic prescribing system. Medicines were stored securely in automated dispensing cabinets which were integrated with the electronic prescribing system and patients notes. Emergency medicines could be accessed in the event of an emergency meaning patients received medication in a timely manner. The pharmacy team had worked with the service to agree on how to store and access medication in the sepsis room in a way that kept medication safe and provided clinical staff with easy access in the event of an emergency.

The department had prepared 'to take away (TTA) packs of medication which could be given to the patients to avoid delays in discharge. However, audits showed these had been underutilised. A review of the stock and usage was underway at the time of our inspection and depending on the results action would be taken to improve this service.

Medicines, including controlled drugs, were disposed of safely when no longer required and suitable records kept. Records of Controlled Drugs handling were accurate and made in line with legislation, best practice and local policies.

Quarterly medicines management audits were carried out, these included controlled drugs and room and fridge temperatures. Audits demonstrated that medicines were managed safely, such as medicines reconciliation, missed and delayed doses and relevant patient safety alerts.

Effective

Rating Good

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work. 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 requires improvement. At this assessment the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

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.

The team had access to the full range of specialists required to meet the needs of patients in the service. Including social workers, pharmacists, speech and language therapists, the frailty team, high intensity user team and registered mental health nurses.

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 referred to the psychological and emotional needs of patients, their relatives, and carers. The notes we reviewed for mental health patients demonstrated that they had had a review by a member of the psychiatric team and a plan had been developed.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. The compliance rate for medical staff receiving their appraisals in July 2025 was 94.6%, this had not dropped below the 90% trust standard for the last 12 months. Appraisals were included in mandatory training for other staff groups. At the time of the inspection 93.75% of nursing staff had received an appraisal in the last 12 months.

Policies and guidelines were stored electronically and accessible to all staff. We reviewed over 10 policies and found they were in date and referred to national guidelines. They were based on best practice from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). Staff we spoke with knew how to access policies and were told about updates in newsletters and at team meetings.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff we spoke with told us about additional training they had received which enhanced their skills. University accredited training was available for staff and advertised on a staff notice board. Training included ‘recognition and management of the seriously ill child’.

The service was included in trust wide audits including GIRFT (getting it right first time). Action taken as a result of these audits included the implementation of a new standard operating procedure and patient pathway for patients living with Cauda Equina Syndrome, a spinal condition needing emergency treatment. This included protecting imaging slots available to patients and meant patients could access diagnostic testing rapidly improving outcomes for patients.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

Staff held regular and effective multidisciplinary team (MDT) meetings. There were systems in place for cross site MDT meetings to discuss patients including, the transfer of care and safeguarding concerns. This meant a patient attending an urgent care centre (UTC) who might require a higher level of care, could be discussed with clinicians in the emergency department and a pathway agreed.

Staff shared information about patients at effective handover meetings. Nursing and medical handovers were informative and comprehensive. Patients with additional needs were highlighted and arrangements made, for example we observed discussions around patients who required one to one care.

Staff in the emergency department and UTC could easily transfer patients between the services. Staff told us this process had improved since the UTC became part of the trust. The team worked closely together, and UTC staff told us they were able to ask for support from clinical staff in the ED if they needed to ensure patients received the safest possible care.

The service worked well with other providers when patients needed further support. The service used a referral system to access support from a mental health provider and the child and adolescent mental health services (CAMHS) visited the department daily to review patients. The service attended fortnightly meetings with the NHS ambulance provider. These meetings were minuted which showed ideas for improvements were discussed and what actions had been taken, for example returning of trolleys to ambulance crews once a patient had been moved into a hospital bed.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

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.

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. Staff recorded patient observations using the national early warning score (NEWS) tool for adults and paediatric early warning score (PEWS) for children. Staff we spoke with understood the importance of recording observations which helped determine if a patient's health was deteriorating. In the 10 sets of patients notes we reviewed, we saw NEWS scores were calculated correctly and documented and in two cases care was escalated and the patient was treated with IV antibiotics in line with the trust's sepsis policy.

The department ensured patients received care in the most appropriate service and had a range of agreements with local tertiary centres. For example, the ED was not a major trauma centre, to ensure these patients received timely care from the most appropriate service there was a major trauma transfer that covered all age groups in place. This supported staff to communicate and transfer the patient to the most appropriate local major trauma centre.

The service introduced a dedicated sepsis room in May 2024, an area where any patient who was extremely unwell with suspected sepsis could begin immediate treatment. According to the National Institute for Health and Care Excellence (NICE) sepsis guidelines, intravenous antibiotics should be administered within 1 hour of arrival to hospital for patients with suspected severe sepsis. Following the implementation of the sepsis room, compliance with this standard significantly improved. For example, in July 2024, only 24% of patients received antibiotics within 1 hour; by July 2025, this figure had risen to 89%.

The department referred approximately 300 patients a day for imaging. Audits were carried out to check for discrepancies in reporting the images. Any discrepancies found were presented at

the mortality and morbidity meetings to share learning with others.

The service carried out audits of patients' notes reviewing whether notes, forms and risk assessments had been completed. Each month trends were identified showing areas for improvement. Over the 6-month period February 2025 and July 2025, data showed a up and down trend indicating there were instances of improvement and decline. Action was taken to improve this. A monthly poster was created called the 'Big 4'. This listed the 4 risks in the department and completing documentation became a standing item. The service launched a 'perfect week' which was an initiative for nurses and healthcare assistants to reinforce basic care for patients and implement learning from the outcome of complaints and audits. This included completing a checklist of documentation recorded.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

Staff used a recommended summary plan for emergency care and treatment (ReSPECT) forms to record patient's preferences for their care. We were told doctors of any grade could complete the form, but it needed to be ratified by a registrar or consultant. During our review of the patients EPR, we did not see any examples where it had been necessary for the form to be ratified by a registrar or consultant. ReSPECT forms were stored in the electronic patient record. This did not automatically open or flag when staff accessed patients' notes and staff had to proactively look for this. This meant staff could miss any recorded preferences.

Staff took all practical steps to enable patients to make their own decisions. During triage consent was gained and recorded in their patient record. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. In the patient records we reviewed, we found that consent had been correctly recorded.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. The registered mental health nurses were available to support staff acting in the patient's best interest. Staff received training in the Mental Capacity Act as part of their mandatory training.

Staff in the paediatric emergency department told us they used different tools, such as the Gillick competency assessment, when assessing children's capacity to consent and understand their care and treatment.

Patients with capacity could self-discharge from the department. Patients were required to complete a form to document this, and this was stored in their patient record.

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.

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them. This means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

The service always treated people with kindness, empathy and compassion but did not always

respect their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Patients told us they found staff caring and considerate and were positive about the interactions they had with staff. We observed patients being spoken to with kindness and a smile. In the temporary escalation (TES) areas we observed staff treated patients with kindness but their privacy and dignity was not always maintained due to the lack of privacy screens.

The friends and family test survey was advertised throughout the department encouraging patients to respond. The data from the survey in June 2025 showed that 98% of respondents had a positive experience in the department and 103 of 123 respondents said their care was very good. However, the department's response rate was very low and below the national average response rate of 16%. Leaders told us the low response rate was due to a change in provider and response rate were expected to return to previous high response rates.

We observed trust staff working collaboratively with staff from other organisations, including the ambulance service and police. The tea and coffee trolley was made available to them in the rapid assessment unit encouraging a friendly working relationship between staff.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

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.

The service understood people's individual needs and recognised the diversity of their population. Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers and care planned for these accordingly. Patients had risk assessments completed and

recorded on the EPR. However, as this information was not easily visible or flagged on the record there was a risk the information and actions required such as accessing additional equipment to help position patients to avoid skin damage, may be missed resulting in harm such as patient falls or the development of a pressure ulcer.

The paediatric waiting area had toys for children to play with, and the play specialist had a designated area with toys and games for children in the emergency department. They worked with clinical staff to help children stay calm and keep them distracted if, for example they needed their bloods taken.

Staff at all levels of seniority across all professions demonstrated caring and attentive attitudes towards patients. We observed the lead clinician, who was walking through the department to a meeting and not on duty, responding to a patient's request for a cup of milk, this was done with kindness and without delegating to another member of staff.

We observed staff getting patients a drink when requested. Not all patients were happy with their care. Some patients we spoke with in the temporary escalation areas told us they were unhappy with their care. There had been a lack of communication and updates, and they had not received any food or water.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

Staff felt respected, supported and valued. Staff felt positive and proud about working for the provider and their team. Staff we spoke with told us the department had a positive culture working together with colleagues and they were well supported by their leaders and colleagues. Staff were friendly, caring and approachable to each other and patients, throughout the inspection.

Staff had access to support for their own physical and emotional health needs through an occupational health service and wellbeing initiatives which included discounted gym membership. An employee assistance program was free for staff and provided access to confidential help and support on several topics, such as finances.

The provider recognised staff success within the service, for example, through staff awards. At the time of our inspection staff were able to nominate colleagues for an award to be announced later this year.

Staff appraisals included conversations about career development and how it could be supported. Several staff members we spoke with told us about further education opportunities they had accessed through discussions in their appraisal, often leading to a promotion.

Responsive

Rating Requires improvement 

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

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics. This means we looked for evidence that the service met people's needs.

Person-centred care

Score

3. Evidence shows a good standard of care

The service made sure people were at the centre of their care and treatment choices and they

decided, in partnership with people, how to respond to any relevant changes in people's needs.

The trust had undertaken focused improvement work in relation to sickle cell care after complaints had been received from patients. In July 2025 they introduced ACT NOW, an NHS guide on how to improve care of patients in sickle cell crisis. A cross-site initiative, "Sickle Cell Perfect Week" culminated in a positive peer review carried out by a local patient-led sickle cell working group. As a result, the emergency department's standard operating procedures for the care of people living with sickle cell disease had been improved and all staff we spoke with stated these changes had been communicated to them via a range of ways including at handover, staff meetings and in the department's newsletter.

We observed 'call for concern' posters which encouraged patients to speak with staff if they were worried about their care. If the patient was still concerned, they could contact a senior nurse on a telephone number provided who would review their concerns independently. It was not recorded in the patient notes we reviewed that any patient had raised concerns about their care. Data showed that between May 2025 and July 2025 there had been 20 calls for concern made each call had a description and outcome so the department could identify themes. Staff told us they identified patients with additional needs such as those living with dementia to ensure they were cared for in a bay rather than temporary escalation areas. Staff were able to add comments to the patient's record to identify if a patient had additional needs. The electronic patient record included a flag system to alert staff to specific needs including dementia and learning disabilities. The system also flagged if any patients were at risk of sepsis and would not allow staff to proceed with documentation until the alerts had been acknowledged and addressed.

The trust had an admission policy for patients with learning difficulties and use patient passports to ensure patients' needs are met. The service has access to central care records where universal care plans are stored allowing the department to access and review a patient's pathway.

The service had access to an isolation room intended primarily for patients with infectious conditions. There was an external entrance to facilitate direct arrivals reducing the risk of spreading an infectious condition to other patients. The service had single occupancy cubicles meaning vulnerable patients could be isolated, for example patients undergoing chemotherapy due to their lowered immune system. On the day of the inspection, we spoke with a patient in a

single cubical who had been isolated due to infection risk.

The paediatric department had access to a play specialist to help children in the department. We saw several initiatives recently put in place for example, the paediatric ED had received funding for a handheld computer consol. At the time of the inspection, the department were applying for funding to raise money for boxes so each child could be given a box of activities to keep them occupied while they were waiting in the department.

The department had access to a chaplaincy service operating on a multifaith basis providing spiritual, emotional, and pastoral needs of patients, visitors, and staff, recognising the importance of holistic care and diverse religious and cultural beliefs. Patients had access to culturally and religiously appropriate meals that were allergy sensitive to carter for the needs of all patients.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always supply appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Patients could obtain information on treatment, and leaflets were available on a number of conditions including head injury, burns and wound care. Other posters used QR codes to direct people so they could access information on different injuries and in different languages. Staff could download leaflets ensuring patients received the most up to date information.

The department had access to language line at all times which included British Sign Language and face to face interpreters could be requested. The service had access to 3 portable telephones and were able to access language which enabled staff to communicate with patients where English was not the first language. However, not all staff we talked with knew there were portable telephones.

The trust's website was available in 106 different languages creating equitable access to healthcare information and removing language barriers. The trust had an accessibility statement on the website with information for patients how to access information in different formats including the ability to access the website using a screen reader.

We saw a 'welcome to the department' notice board. It displayed pictures of the staff uniforms so patients could identify who they were being seen by and provided information on how to provide feedback on their care.

Information governance systems included confidentiality of patient records. Records were stored electronically and only accessible to staff via a log in. Throughout the inspection all computers we observed were locked when they were unattended.

Patients we spoke with told us they knew what they were waiting for and were informed by staff. However, at the time of the inspection patients did not know how long they would be waiting in the department and waiting times were not displayed. Patients were advised of the approximate waiting time when they were triaged but were not always kept updated.

Listening to and involving people

Score

3. Evidence shows a good standard of care

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.

The service reviewed complaints for themes so they could take action to improve. In the 12 months between July 2024 and June 2025 the department received a total of 209 complaints which was 0.07% of patients seen. The complaints were responded to in line with the trust's complaints policy. Action had been taken for the 3 most frequently identified complaints, these were lost property, hot meals and care for patients living with sickle cell. Actions included the development of a new lost property process where each item was logged in the lost property

book and the use of patient stickers to help reunite items with their owner. In response to the themes around treating patients living with sickle cell, patient groups told the service they felt their voice was not being heard and there were delays in receiving pain relief treatment. Following an awareness week, 'sickle cell the perfect week', feedback from patients at a recent listening event found they were more positive about their experiences in the service.

Patients and their families told us they felt listened to and that staff cared. We spoke with 15 patients and the majority of patients we spoke with told us they felt comfortable raising any concerns they had if they needed to and knew how to make a complaint. However, one person commented they were concerned if they made a complaint this might affect their ongoing care. Information about making a complaint could be found on the provider's website and in posters in the department.

Senior leaders visited the department for a 'temperature check' to see how patients and staff were feeling. Feedback from these visits was collated and themes presented to the board. We saw a poster in the department advertising this and it included the email address of a senior leader so people could contact them directly even if they hadn't been approached.

National surveys for the NHS were carried out periodically. In November 2024 the urgent and emergency care survey 2024 showed the trust was performing at a similar standard when compared to other trusts. The trust scored 9.4 out of 10, with 10 being the best possible score, by patients for feeling informed by staff about what would happen after the first assessment. However, they scored 2.8 out of 10 for receiving information on waiting times. This lack of information was supported by patients we spoke with and what we observed during our inspection.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

Urgent and emergency services

People could not always access care, treatment, and support in a timely manner due to capacity constraints and patient flow across the hospital and community services. Leaders and staff acknowledged the impact flow and capacity issues were having on patient's ability to access services. They told us delayed discharges for patients awaiting social care provision were partly responsible for this. They told us waiting room areas were not ideal for patients and posed a risk. To mitigate this risk, there were 6 waiting room rounds carried out throughout the day. A health care assistant would speak with each patient waiting and assess them for any signs of deterioration and escalate their care as necessary. Data showed that between January and June 2025 14.4% of patients spent longer than 12 hours in the department. At the time of our inspection, we identified a patient who had been in the department for 4 days, waiting for ongoing care to be put in place and be discharged. The service had risk assessed this patient and considered this the best place for the patient to stay while they waited for transfer to another service. Staff told us that to improve this patient's experience several staff had contributed to a voucher that could be used to order food for this patient while they waited as a treat as all food and drink were provided for them in the ward.

The service triaged 91.3% of patients within 15 minutes of arrival in the department which allowed the nursing team to promptly identify vulnerable patients and those with protected characteristics helping facilitate equitable access to services.

The service had worked hard to improve the length of time it took ambulance crews to handover to department staff. The department was not meeting the national standard for patients who arrive to hospital by ambulance being registered, handed over and transferred off the ambulance trolley within 15 minutes of the ambulance arriving at the ED. Data showed that the service was better than the England average for handovers between 30 to 60 minutes. Between 40 to 54% of handovers were achieved in 30 -60 minutes compared to the England average which was between 16% and 20%. They were better than the England average for handovers taking more than 60 minutes. Between April and June 2025 between 0% and 2% of handovers took longer than 60 minutes compared to between 5% and 15% for the region which meant most patients were handed over to the ED staff and assessed in under 60 minutes.

The executive team recognised that flow throughout the hospital was having a negative impact on the service and a Flow Programme Board was established in May 2025 with the aim of improving this. There were 4 programmes of work being delivered including wider work around admission avoidance and the introduction of virtual wards. As these were new initiatives their

impact had not yet been seen,

Department staff attended bed meetings and surge meetings throughout the day, so the wider hospital teams were aware of the pressures on the department and to escalate patients that urgently needed to be admitted to a ward area. We attended the site meeting and found that performance from the previous day was discussed including themes from patient breaches.

The service considered the needs of people with different protected characteristics and made reasonable adjustments to ensure people's individual needs could be met. This included making reasonable adjustments for disabled people and addressing communication barriers. Pathways were in place to support patients with different needs and support teams, such as the frailty team, who were available to help care for patients.

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. Leaders and the culture they created promoted high-quality, person-centred care.

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities. This means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

The service had a shared vision, strategy, and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion and engagement. However,not all staff were aware of the vision, and it was unclear if this had been developed in collaboration with staff.

The service had a vision and strategy that worked alongside the trust's overall strategy, Our Way Forward (2023 – 2028). However, not all frontline staff in the service were aware of the strategy and it was unclear if they had been involved in discussions about the strategy for the service. Local leaders escalated issues that impacted on patient safety to the senior divisional leaders and action was taken to improve patient safety. However, the actions were not always monitored for effectiveness.

Staff knew and understood the trust's values and how they were applied in the work of their team. Staff we spoke with were able to articulate the values and what this meant to them. They were able to give examples of the values in practice telling us how they supported their colleagues and the importance of raising concerns.

Leaders had a clear direction for the department. At the time of the inspection building work had commenced to redesign areas to improve the patient experience. The departments leaders were able to talk us through the plans, including how the changes would be reviewed and the work that would take place with staff to embed these changes. Staff told us they were excited by these changes as they hoped it would improve the patients' experience and manage the patient flow better at the entrance to the service. However, this project had not been completed at the time of our visit therefore we could not evaluate its effectiveness.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

Not all leaders at all levels understood the context in which they delivered care, treatment and support. Leaders at all levels mostly embodied the culture and values of their workforce and organisation.

Most leaders had the skills, knowledge and experience to lead and perform their roles. The senior divisional leadership team included a clinical lead, senior nurse and senior manager. They understood the pressures in the department and how this could impact on staff. However, some of the actions identified to address issues, were not always monitored for their effectiveness. Therefore, action may not be taken when actions implemented were not effective.

Local leaders had an understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. All staff we spoke with told us leaders were visible and approachable finding them supportive and encouraging, leading to a positive environment to work in. We heard about a number of initiatives staff had felt empowered to raise at team meetings or directly with managers and this made them feel like and important part of the team. For example, the mental health registered nurse had been supported to seek funding for activity boxes for patients to help manage long waits in the department.

Leadership development opportunities were available, including opportunities for staff to attend leadership training courses and develop their skills. Some members of staff we spoke with told us they had progressed their career and found working in the department had supported them to gain promotions.

Freedom to speak up

Score

3. Evidence shows a good standard of care

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 (FTSU) policy and FTSU guardian. The service had a department champion; however not all staff we spoke with knew who the department champion was. The FTSU service was advertised on the intranet and staff could speak with a champion or guardian to access support and advice to raise any concerns they may have.

Staff told us there was a positive culture in the department and were confident they could raise any concerns with their manager or other leaders, and they would be taken seriously. Leaders were approachable and there was an open-door policy. A junior clinical staff member told us this was the most supportive environment they had worked in.

People and carers had opportunities to provide feedback on the service in ways that reflected their individual needs, including through surveys such as national NHS Friends and Family test and the Care Quality Commission urgent and emergency care patient survey but response rates were below the national average. Managers and staff had access to this feedback and used it to make improvements, for example, the introduction of buzzers for patients waiting for blood tests to be taken. Patients were given a buzzer to hold which would vibrate when it was their turn to have their blood taken and meant patients were less likely to miss their turn.

Governance, management and sustainability

Score

3. Evidence shows a good standard of care

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 clear management structure for the Emergency and Ambulatory Care Division. The triumvirate team had oversight of all 3 locations providing emergency and urgent care services and reported to the board. Under the divisional team sat local leadership with oversight at a location level providing a clear reporting line for staff.

The division had a governance structure showing how local meetings fed into the divisional quality board which reported into the trust board standing committees. There was a clear structure for information to flow from ward to the trust executive team. The governance meetings had set agendas, and we saw evidence of risk, performance, audits, learning from incidents and complaints, training and safeguarding being discussed. The trust introduced

formal reporting of the TES area as part of the Integrated Performance and Quality Report (IPQR) and data such as use of TES areas was collected so the department could audit changes and track progress.

The morbidity and mortality meetings were held monthly and the whole clinical team were invited to join the meeting. It was recorded for those who couldn't attend. There was a standing agenda including a review of patient deaths, patients admitted to the intensive care unit and re-attending patients. Learning points were discussed, and the meeting was minuted.

The division held a monthly emergency planning meeting with the trust's emergency preparedness, resilience and response (EPRR) lead to ensure the department was prepared to respond to a wide range of incidents that could affect patient care. A tabletop exercise was carried out 18 months ago to test the division's preparedness. The EPRR lead was working with partners including the Hazardous Area Response Team, a division of the ambulance service to improve how the service responded in an emergency.

Leaders maintained the directorate risk register and knew and understood the risks to the department. The leadership team were able to discuss the top risk and what mitigation had been put in place to try and reduce the risk score. However, mitigating actions were not always evaluated to demonstrate their impact. The risk register was reviewed and updated regularly at the clinical governance meeting. The risks staff identified matched what was on the risk register, for example, staff were concerned by the temporary escalation areas and waiting times for patients. This meant the concerns staff had about the department were reflected on the division's risk register.

The trust transitioned to the Patient Safety Incident Response Framework replacing the previous Serious Incident Framework for investigating incidents. The department conducted after action reviews and multidisciplinary team discussions to reflect and share learning. This was seen in the 'Big 4' which was sent to staff sharing learning and helping to embed change into practice.

Partnerships and communities

Score

3. Evidence shows a good standard of care

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.

The service was aware of the communities they served and were working with some patient groups to improve the service. For example, the sickle cell working group carried out a review of the department and had helped leaders to create and implement a sickle cell standard operating procedure.

The service worked in partnership with some external agencies, engaging with them to improve care for patients. For example, with a charity who worked closely with the paediatric ED and UTC department to support patients aged 12– 15 who were at risk or vulnerable. The trust had secured funding for a pilot project to have youth workers in the trust, who ED could access. As this pilot was ongoing its effectiveness had not yet been evaluated.

There were support teams within the department to help patients such as the homeless team and frailty team who worked with patients to assist them once they were discharged from the service. The department had worked in collaboration with a local charity to provide warm clothing for patients on discharge who were homeless or suffering financial hardship. This not only provided physical comfort but also restored the patient's dignity.

The service had improved the working relationship with some local health partners, such as the local ambulance service. We were told the trust met every two weeks with the local ambulance service to discuss issues. We were not provided with any evidence of any changes that had been implemented as a result of these meetings. The only example of change being made was regarding returning trolleys to the ambulance service and not about improving flow.

The UTC worked with local GP services, if it was more appropriate for the patient attending the department to be seen by a GP. A working relationship had been established with a local primary care centre and UTC staff could help patients book appointments with a GP at the

centre, support them to register with a GP if they did not have a GP, helping patients access the right care and improve waiting times in the department.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

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 contributed to safe, effective practice and research.

Some staff told us they were given opportunities, time and support to develop projects for improvements and innovation. Staff told us they were encouraged to suggest new ideas and ways of working and to implement pilot studies to see if they could improve the service. We saw a new handover process being piloted where if a patient met a certain criteria, they were eligible for a telephone handover to the ward. This meant a staff member did not have to leave the department to handover to staff on the ward therefore increasing the time spent seeing patients in the emergency department. We saw other examples of innovative practice, such as the sepsis room, and staff were proud to show us and discuss improvements that they had been involved in.

The trust was participating in three national Royal College of Emergency Medicine Quality Improvement programmes for 2025: *Time Critical Medications, Care of Older People, and Mental Health to help improve care for patients.* We were not provided with evidence of the impact these improvement programmes have had.

The mental health nurse was a new role in the department, having started in early 2025. The RMN had been encouraged by senior leaders to assist the department in improving care for patients experiencing a mental health condition. They had recently developed a risk assessment for staff to use when escorting patients outside the department for fresh air and was involved in creating training for staff to develop their practical understanding of caring for

mental health patients.

Leaders encouraged staff to share their appreciation of colleagues through an online platform where staff could leave messages such as highlighting good team working, helping build a positive culture.

Service

Regulated activities

How the regulation was not being met

Regulation 10: Dignity and respect

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

Regulation 10(2)(a) Patients privacy was not always maintained. Some patients did not receive care and treatment that protected their privacy and dignity. Conversations about care, treatment and support sometimes took place in areas where they could be overheard.

Regulation 12: Safe care and treatment

Service

Urgent and emergency services

Action plan requests

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

Regulation 12(2)(b) Risks to service users were not always assessed and control measures put in place to provide safe care and treatment.

Regulation 12(2)(h) There were not always robust systems in place to prevent, detect and control the spread of infections.