LAP assessment report

Ealing Hospital

LAP Assessment Report ID : LAP-01597

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

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Location findings

Ratings for this location

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

Overall location summary

Ealing Hospital urgent and emergency care (UEC) services consist of an adult care emergency department (ED) and an urgent treatment centre (UTC). The UTC treated patients of all ages who had minor injuries or illnesses. The ED did not treat acutely unwell paediatric patients. Any patients under the age of 16 years were stabilised and transferred to neighbouring emergency departments who were able to provide care to this group of patients. Between July 2024 and June 2025 Ealing's hospital ED saw 43431 patients and its UTC saw 55955 patients.

We carried out an unannounced assessment of Ealing 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 with breaches of regulation 10, dignity and respect and regulation12 safe care and treatment and regulation 17 good governance.

Ealing Hospital

Location findings

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 service did not always work with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored.

They did not always work together well to provide safe care that met people's individual needs.

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 service did not always assess or manage the risk of infection. They did not always detect and control the risk of it spreading or share concerns with appropriate agencies promptly.

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

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

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 sure that medicines and treatments were safe and met people's needs, capacities and preferences. They involved people in planning, including when changes happen.

The service always treated patients with kindness, empathy and compassion and respected 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. Staff involved people in decisions about their care and told them what had changed as a result.

Ealing Hospital

Location findings

During our assessment we identified areas for improvements and some breaches of regulation. We have requested an action from the trust.

Safe

Rating Requires improvement

Our overall rating of safe at Ealing 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 effectiveness at Ealing Hospital has remained and is rated as requires improvement. The Urgent and Emergency Care was rated as Good.

Caring

Rating Good

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

Responsive

Rating Requires improvement

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

Well-led

Rating Good

Our overall rating of safe at Ealing 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

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People's experience of the service

Patients, along with their families and carers, told us they felt staff treated them with kindness and provided good care and treatment. People were very positive about their interactions with staff and the support they received.

During our visit, patients explained that they were seen quickly on arrival by trained nursing staff, who carried out an initial assessment to understand the reason for their attendance at the service. Patients arriving by ambulance entered the department via a separate entrance and said they were seen promptly in the ED and triage service by a nurse and/or doctor.

Patient records indicated that patients received the necessary tests promptly following triage, and staff were available to offer assistance and support when needed. Patients reported feeling comfortable raising concerns and expressed that their voices were heard.

In the most recent NHS England Friends and Family Test (June 2025), 79% of respondents said they were ‘extremely likely’ to recommend the ED to others. With 93% reporting a positive overall experience. The Ealing Hospital urgent and emergency care (UEC) 2024 patient survey covered both ED and UTC. The key findings were that 85% of ED patients reported that staff helped control pain. In UEC 76% of patients reported they were able to get food and drink, and 87% of patients reporting staff communicated with them in a manner they could understand.

The Healthwatch Ealing 2024 patient experience report stated that the top 3 positive themes were quality of treatment, staff attitudes, and suitability of staff. While the top negative theme reported was waiting times, which included queuing on arrival. in ED.

Safe

Rating Requires improvement 

At our last assessment, we rated this key question as ‘Good’. At this assessment, the rating was ‘requires improvement’.

The service did not always work with people to understand and manage risks by thinking holistically. The service did not always make sure there were enough qualified, skilled and experienced staff. The service did not always assess or manage the risk of infection. The service had a good learning culture and people could raise concerns. The service made sure that medicines and treatments were safe and

met people's needs, capacities and preferences.

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.

The service used an electronic system all staff could access, and staff told us this was easy to do and were clear about the type of incidents which should be reported. 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. Data showed that 92% of incidents reported by ED and 90% reported by UTC were categorised as low or no harm.

Staff who had reported an incident could request individual feedback once the investigation was completed. However, leaders did not know how frequently this option had been used. There was a no blame approach to reporting incidents, which empowered staff to report any issues without fear of negative consequences. Staff felt lessons were learned from patient safety incidents and changes were made to reduce risks. They understood their responsibilities relating to duty of candour and when this should be applied. They knew this involved an apology to those affected as well as an investigation into certain adverse events.

There were multiple channels for sharing lessons learned, including ED communications such as newsletters, visual feedback on incidents displayed on staff notice boards, and discussions during daily safety huddles.

There were systems in place for staff to access debriefs after incidents. This included verbal debriefs for those involved, end of shift briefings and individual supervision. The senior staff we

spoke with said these were helpful for staff learning and development.

When appropriate the department participated in multidisciplinary investigation. For example following a patient safety incident the department along with the acute medical unit (AMU), the area the patient was transferred to and other partners, completed a multidisciplinary investigation, learning and areas for improvement were identified and an action plan developed. For example ED and AMU staff along with staff from two neighbouring mental health trusts worked together to develop a new physical restraint policy that had been implemented in the ED and other clinical areas.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They did not always make sure there was continuity of care, including when people moved between different services.

Urgent and Emergency Care (UEC) services had been reconfigured, there was now one booking in and patient streaming service for both the ED and the UTC. Patients and their families were greeted by the 'Hello Nurse' at the main entrance, serving as the 'front door' to UEC services. This approach was taken during peak times, 10am to 10pm, to facilitate flow through the department. Outside these hours an UTC emergency nurse practitioner (ENP) covered this role. This role was introduced to ensure patients were greeted, assessed and treated in a timely manner based on their clinical needs. This may be to the UTC or ED, or in some cases directly to the clinical decisions Unit (CDU), rapid access treatment (RAT), or same day emergency care (SDEC) service. There was clear guidance on what injuries were directed to which department for example fractures that needed manipulation under sedation would be directed to ED, while fractures that required no manipulation would be treated in the UTC.

There were 2 separate SDEC care pathways. The ED SDEC, which was run as part of the ED,

required a clinician-to-clinician discussion before patients were transferred from other areas of the UEC service. When patients were referred to Same Day Emergency Care (SDEC), which was managed by the Emergency Department (ED), their time in the department continues to be recorded on the Electronic Patient Record (EPR). However, these patients are not included in the 4-hour ED target. This was consistent with Emergency Care Data Set reporting guidance

The medical SDEC pathway required a referral and agreement between the ED team and the acute medical team before patients could be transferred there. Staff we spoke with said they found the medical SDEC difficult to access, calling it 'process-driven', because of the referral processes, and stated patients were often declined. This impacted on the flow through the department and on patient waiting times.

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 does not collect data on the number of times the Full Capacity Protocol is enacted. However, the enactment of the full capacity protocol was reported in the 4 times daily site situational report.

The service had a standard operating procedure (SOP) for patients cared for in temporary escalation (TES) areas. However, the policy was not always adhered to. All ambulances accessed the ED via a separate entrance and were handed over to either a nurse or a member of the medical staff who staffed the 'pit stop' area. When this area was full, patients were held in a Temporary Escalation Space (TES) areas including the 'cohort', a 5-bedded curtained area, in the corridor, and when these areas were full, patients were held in the back of an ambulance. Handover to the ED staff was not always undertaken in a timely manner. We observed that some ambulance crews were kept waiting despite no patients being in the RAT area. The receiving RAT nurse when they returned to the desk, did not acknowledge the paramedic, who had been waiting over 15 minutes, and were about to leave the area without completing the handover, until they were challenged, whereby the nurse then took the handover. This meant that transition between services was not always undertaken in a timely manner and was not in line with the trust's temporary escalation space (TES) procedure.

There were specific designated waiting areas for ED, UTC and a separate paediatric waiting room. The paediatric waiting room was not restricted access, and we observed other patients accessing this area. The waiting rooms were visible to staff based in these areas, including main reception staff and the security guard. We were told safety rounds, had been introduced and took place 6 times a day, to mitigate the risk of patients that might deteriorate in the waiting room. However, patients were not routinely given updates on likely waiting times. Data demonstrated that 96.3% of patients were triaged within 15-minutes, and 93% of patients were seen by a clinician within 1 hour of arrival, this was in line with national standards.

At the time of our visit, on the 15th July 2025 64.3%, and 64.9% on the 16th July 2025 of patients spent less than 4 hours in the UEC. This was below the national performance target of 78%. ED and UTC performance was reported via the department's performance reports, the internal daily BI performance tracking email, and at the daily operational 0945 meeting where performance was reviewed. Performance was also tracked and improvements identified at the trust-level flow board and reported to the trust board monthly.

The ED did not provide a paediatric ED service. There was signage that the ED did not treat children. However, if a child arrived and needed urgent care or resuscitation, the nursing and specific medical staff were suitably trained to provide emergency treatment and stabilise the child, before they were transferred, in line with the trust's paediatric transfer policy, to a suitable paediatric ED. An incident form was completed for children arriving at ED to record numbers and the outcome for the child. Children were seen in UTC. We were told the emergency Practitioners (EPs) in UTC had completed advanced training in the assessment and management of paediatric patients presenting with minor injuries and minor illnesses. We saw the content of this course but were not provided with the percentage of EPs who had completed it.

The hospital did not have a hyper-acute stroke unit, (HASU) all patients presenting at the ED who had had a stroke were transferred to the HASU to Northwick Park hospital. There was a standard operating procedure for these patient transfers that provided guidance on who to transfer. The trust does not collect data on the number of HASU transfers from Ealing ED to Northwick Park ED. A previous snapshot audit undertaken in 2022 and 2024 demonstrated that there were on average 10 referrals per week in 2022 and 9 referrals per week in 2024.

Imaging facilities, such as MRI, CT and x-ray were located close to the ED. There were protected

ultrasound slots for ED, out of hours there was limited access to MRI and no facilities at weekends. To ensure there was access to MRI for patients with time sensitive conditions through collaborative working and agreed transfer policies with the Northwick Park site as well as with a neighbouring NHS trust. There was a clear process for oversight of imaging, a named consultant was responsible for ordering and reviewing imaging. The report of the results from the patient imaging, were added to the patient's records. All records were on a unified electronic patient record (EPR) which meant access to patient records was available in both ED and UTC. The trust submitted evidence of how incidents involving imaging errors, such as undetected fractures, were reviewed and used for staff learning, to reduce the risk of similar incidents occurring.

To improve patient privacy in the 'cohort' TES area, we were told by senior staff that curtains had been fitted, which acted as partitions for improved patient privacy. However, there were no screens to provide privacy when patients were cared for in corridors. Patient safety risks in this area were not always mitigated. For example, during our visit, we observed a patient in the cohort bay at 18:45 hours, despite there being suitable space for this patient, available in staffed areas of the ED, such as 2 empty bays in ED 'Pitstop'. No nursing staff were present in the cohort area when we arrived and the patient was alone without relatives, for at least 15 minutes with the doors to the cohort area closed, as were the doors in the nearby pitstop. This was not in line with the trust's TES procedure, that states patients in TES areas must be in the line of sight of nursing staff. The patient did not have access to a call bell, or other means of summoning staff for help apart from raising their voice or making a loud noise. The patient's notes indicated they had come in with chest pain and had a known learning disability with epilepsy. The patient had had some clinical observations recorded and had had an ECG, which showed some minor changes. During our visit, we raised this issue with the provider, but by this stage, the patient had been moved to CDU prior to discharge home.

There was a clear pathway for patients with mental health concerns, which had been developed in partnership with colleagues from a mental health trust. Where a patient needed help for a mental health crisis, a triage nurse would be assigned to them urgently to assess their needs. We were told all triage nurses had received appropriate training for this role. Staff would then request the psychiatric liaison team to attend the department to carry out a mental health assessment and risk assessment. All staff we spoke with could describe the pathway for mental health patients, including risk assessment and management.

Whilst mental health patients were initially assessed and triaged in a timely manner they could experience long waits for a transfer to specialist mental health services. We noted in the period May to July 2025, 80-82% of patients waiting for a psychiatric review were seen within the priority time of 1 hour, this was below the national target of 95%. Psychiatric liaison staff members were involved in ED care plans to outline how patients should be cared for to meet their individual needs whilst in the ED. Mental health assessment and monitoring documentation was not always completed. The randomised documentation audit undertaken by the trust for June and July 2025, showed mental health assessment forms were completed in 90% of case notes in June 2025 but this reduced to 80% in July 2025. The behavioural charts were completed for 80% of case notes in June 2025 and 90% in July 2025. The department's expected compliance rate for these measures was 90%. To support this the trust was in the process of recruiting to a Lead Mental Health nurse for the ED who will have a focus on improving compliance with mental health related documentation.

The service had a patient flow lead coordinator for all patients using the UEC service. Their role was to ensure that UEC patient lists flowed through the correct care pathway for their needs. This meant patients were directed to the most appropriate clinical care pathways for their needs, supported flow through the department and improved ED performance.

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. However, not all staff were compliant with the required level of safeguarding training.

Staff we spoke with could describe how and when they would raise a safeguarding concern and

access the safeguarding policy and protocols. The staff in the ED demonstrated a good understanding of safeguarding including who to contact, how to complete referrals and how to take appropriate and immediate action when needed. In the 12 months July 2024 to June 2025 the department made 408 adult safeguarding referrals and 331 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 94% of ED medical staff and 100% of UTC medical staff had completed their safeguarding training, which was above the trust target of 90%. Not all other staff groups had met the 90% target. ED nursing staff had met the target for safeguarding adults' level 3, 92% had completed this training. However, for children's level 3 training, 85.5% were compliant. The UTC nursing staff did not meet the target for safeguarding adults' level 3, 75% were compliant or for children's level 3 training, 80% were compliant. All administration staff had met the target for safeguarding adults' level 2, 100% and children's level 3 training, 100%.

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. 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.

Leaders and staff in the ED told us that staff undertaking streaming and triage at the front door to the UEC services always had safeguarding on their radar, remaining alert to any potential signs of abuse or neglect. Senior ED staff told us the trust safeguarding team were 'extremely responsive', making direct contact with UEC staff teams in a timely manner when referrals had been made or queries raised. However, not all staff undertaking streaming and triage were compliant with safeguarding training.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work with people to understand and manage risks by thinking holistically. 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 did not always understand or manage risk well. In our review of patient records, we saw frequent gaps in the recording of patients' pressure areas. Monthly documentation audits showed that skin assessments were not consistently completed, with the worst performing months so far this year, were March 2025 showing 56.7% of eligible patients had a skin assessment completed and May 2025, showing only 26.7% of eligible patients had a skin assessment completed. This was a known issue and was discussed at the divisional quality and risk meeting. We were told there were plans to address this, including discussing the importance of documentation in nursing handovers, more frequent audits to monitor the trend closely, and encouraging staff to share information on the challenges they faced in completing documentation. We were told there was no specific ED action plan to address these issue as they participated in the trust-wide prevention and management of pressure ulcers programme to improve care in this area. Information provided by the trust did show improvements for June 2025, where 78.3% of eligible patients had a skin assessment completed and July 2025 showing 86.7% skin assessment completed.

The psychiatric liaison team was based on-site at the hospital and responded to referrals from the ED to assess mental health patients. This team was available 24 hours a day, 7 days a week. There was a pilot planned to have a member of the liaison team based in a room in the ED at all times, and the staff we spoke with welcomed this initiative. At the time of our assessment this initiative had not yet commenced.

ED staff told us they were aware of the procedures and mitigations in place to keep mental health patients and staff safe in the ED, but there were times when staff did not feel safe, due to a lack of skills and knowledge. Specific mental health-related policies had been developed, and

mental health training had been made available to staff. We were also told there was dedicated daily support from a mental health nurse. As these improvements had only recently been implemented, their impact had not yet been seen.

Whilst waiting for ED and UTC triage, patients seated in the waiting areas were visible to staff, including main reception staff and the security guard, and staff passing in and out of this area. To mitigate the risk of deteriorating patients not being identified in a timely manner, the trust had introduced 6 daily waiting room checks.

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.

All areas visited were visibly clean, but not all were well-maintained. For example we saw an isolated example of chair seats being torn. We were told these were due to be removed on the day of our visit. There were also areas of damage to the flooring observed within the main ED clinical area, which presented a potential trip hazard, we were informed that these were due to be repaired, but staff were not able to give a timescale when this would be completed.

There were specific designated waiting areas at the main front door for ED, UTC, and a children's waiting room within the same area. This caused confusion for patients as these waiting areas were not clearly defined, and the patients we spoke with were unclear which service, ED or UTC, they were waiting for, and exactly which parts of the service were managing their care. The paediatric waiting room was not restricted access. We observed other patients accessing this area. Therefore, we could not be assured children were safe while in this area and unauthorised people could easily access the area.

The ED had several ligature points which were a risk to mental health patients. The risks were managed through risk assessments, management plans, observations and use of ligature light

rooms, when available. The trust were aware of this risk, and this was highlighted on the trust risk register. The ED had recognised the need for safer, ligature light spaces to safely support patients in a mental health crisis. There were two ligature light rooms available, one with a ligature light en-suite. Staff from the health and safety team of a neighbouring mental health trust were involved in environmental reviews of the ED and liaised with and advised staff at the trust. This approach ensured risks were identified and mitigation implemented.

There was no ligature-light communal bathroom available for patients. When the ligature light en-suite bathroom was occupied, mental health patients had access to a bathroom opposite the nursing office. This had several ligature anchor points. To mitigate this risk, staff said they would accompany the patient into the bathroom; while this may compromise patient dignity, this was considered against the level of risk. However, we could not see an assessment or plan in the patient's records to identify if this supervision when using the bathroom was required. This meant there was a risk that a patient could have access to a room with ligature anchor points without appropriate supervision. We were told the trust's health and safety team were meeting in July 2025 to discuss this matter.

The department had several resuscitation trolleys; however, the TES areas did not have a resuscitation trolley. A risk assessment had been undertaken, and cardiac arrest trolleys were located in the department so that they could be accessed within 30 to 40 seconds from all areas that they cover. The logs of the resuscitation trolleys we reviewed showed they were checked daily by staff and signed off as being appropriately stocked.

The ED had considered its layout in relation to the security and safety of mental health patients. For example the department had moved an area used for mental health patients, as this had been close to an exit door.

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 service did not always make sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development. They did not always work together well to provide safe care that met people's individual needs.

Senior nursing staff told us the trust used the Royal College of Nursing (RCN) staffing model for ED of 1 nurse to 4 patients. External consultants had recently reviewed nurse staffing and had recommended appropriate nurse staff numbers for each shift. This included staff cover for the shift lead role, triage, 'pit stop/ ambulatory, resuscitation, majors, patients who self-presented, the clinical decision unit and the ED SDEC. There were no funded posts for the TES area. However, the daily staffing model included the TES area. Additional bank shifts were added to the rota to have additional support for the 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. At busy times this ratio was not achieved, therefore the TES areas were not always safely staffed in line with the trust's policy and placed patients at risk of harm.

At the time of our inspection, nursing vacancies were 8.9%, this had improved over the past 12 months from a previous vacancy rate of 24.7%, in July 2024. We noted in June 2025 that for nursing staff the turnover was 2.1% and the sickness level was 7.13%, which was above the national average of 5.4%, for nurses' sickness. Vacancies and sickness was covered by bank staff to ensure the department had appropriate staffing levels.

There was a matron for ED, and appropriate cover for this post by the trust's UEC head nurse. There was an identified lead nurse assigned for each shift, who provided local leadership. Each area in the ED had specific staff allocated that had the appropriate skills and experience. For example, the resuscitation area was staffed by 2 qualified, experienced nurses, who had the skills and knowledge to deliver care to this group of patients.

All nursing staff worked 12.5-hour shifts, it had been identified that between 14.00 and 22.00, more staff were required. To cover this period a twilight shift had been introduced. Gaps in

rotas were filled using bank staff in line with the trust's safer staffing and escalation policy. We noted bank staff at times exceeded 20% per shift, potentially meaning staff may be unfamiliar with the environment but this was mitigated by the ED's own staff often filling these bank shifts.

The Royal College of Emergency Medicine (RCEM) 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 10.85 consultants. However, this is guidance, and the complexity of the patients and department size needed 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 department did not meet this recommendation as the ED had a medical staff vacancy rate in June 2025 of 26.2%. The medical staff in the department had a sickness rate of 3.32% in April 25, which was above the national average of 1.6%. We were told ED consultants, and locally employed doctors (LEDs), predominantly at registrar level, usually worked cross-site. This approach provided resilience and ensured there were always 2 consultants present in the ED, one lead consultant who remained in majors, supported by a staff grade doctor and another who oversaw the CDU and RAU/ED SDEC. The doctors we spoke with described the ED consultants as being very approachable, accessible, and supportive. However, some of the junior doctors reported that some of the registrars were less approachable than the consultants when they had queries and concerns.

There was a dedicated mental health nurse on duty in the ED between 7 am and 7 pm, 7 days a week. We were told by the ED staff that they would routinely cover the mental health nurse for breaks, complete close observations of mental health patients, deliver care for these patients.

Staff described a rise in the number of mental health patients accessing the ED and the mental health liaison team stated they had seen a steady rise in their referral numbers. During our visit, we saw mental health patients who required certain levels of observations. For example, constant observation from a staff member with eyesight of the patient. Staff confirmed that there were times when there were more patients needing observations than staff available to provide it and would cohort these patients so one member of staff could observe more than one patient. The trust had recognised that there was pressure in meeting the level of mental health observations required in the ED and was in the process of developing several workstreams to improve this. They were also putting in place initiatives to encourage and support improved integration between ED staff and the mental health liaison team. For

example, from August 2025, the liaison team manager would be attending the emergency department monthly team meeting. The mental health liaison team had delivered several training sessions to ED team leaders to develop their knowledge and assist in meeting the needs of this group of patients.

The UTC and ED were staffed separately. The UTC was led by General Practitioners (GPs) and Emergency Nurse Practitioners (ENPs), both employed by the trust and operated 24 hours a day, 7 days a week. Between 10 am and 6 pm, there was a UTC 'Hello nurse' based at the entrance to the UEC, who triaged patients at the front door. We were told this role was carried out by ENP's. Outside of the Hello Nurse hours, we observed that the Hello nurse not only directed patients to the correct area, but also triaged, took observations and escorted patients to other specific areas. This meant the front door was not always covered by staff, and triage was delayed during their absence, resulting in increased waiting times. The ED team did not routinely flex and assist the UTC triage nurse when queues were developing or when the UTC nurse needed to leave their position. The 'Hello Nurse' initiative was aimed at improving flow and patient experience but at times resulted in delays in patients booking in, patient frustrations and potential risk of missing critically unwell patients. Staff told us the scope of the Hello nurse was too wide, and that the role should be staffed in addition to UTC staffing numbers. We were told by staff there was no specific training for the UTC "Hello nurse" for this streaming role. Following our inspection, we were told all registered nurses undertaking the 'Hello nurse' role had completed specific competencies related to the streaming guidelines. There was guidance on which patients should be directed to ED and which ones went to UTC. This facilitated patients being seen in the most appropriate area. Following our inspection the trust stated that the 'Hello' nurse project had been evaluated. However, the evidence provided did not provide assurance that the project had formally been evaluated.

On the day of our visit, the UTC had 3 GPs and 3 ENPs on duty. The team was supported by a HCA who did the more routine tests, like ECGs, urine tests etc and by dedicated UTC reception staff who clerked patients at the main reception desk. The UTC team held a huddle at 10am to discuss a range of issues, including staffing, number of patients in the department, and the number of 'breeches', where patients had been in the department for longer than the 4-hour target. The ED and UTC staff both attend the daily divisional Sitrep meeting where issues such as staffing were discussed, escalated and an action plan developed

The trust recognised the importance of having safe systems in place around physical

intervention. We were told the security staff, employed by a private provider, were trained in physical intervention and would support the ED staff if this intervention was required. Training was also planned for ED staff in physical intervention, as this had been recognised as being required to develop safe care to patients. A safety pod, which aimed to minimise the need for physical restraint, reduce injuries, and support de-escalation techniques had recently been purchased.

Staff had access to training and supervision. The service was compliant with mandatory training and appraisals. In UTC, 100% medical and administrative staff had completed their mandatory training. In ED 93.75% of nursing staff,97.62% of medical staff and 96.13% of administrative staff had completed their mandatory training. The ED medical staff appraisal rate as of July 2025 was 94%.

Medical staff had access to additional training. For example, all ED consultants, registrars who were in charge of the department and specialty trained doctors had completed Adult Life support (ALS), 54% had completed Advanced Trauma Life Support (ATLS) and 91% had completed European Paediatric Advanced Life Support (EPALS). We were not provided with information about how the numbers of medical staff who had completed ATLS would be increased. Following our inspection the trust stated that the lead registrars in ED, working at night in the senior decision maker role, must have ATLS. If they did not they were moved to a non-lead shift until they were compliant.

Children were not seen in ED but were seen in UTC. We were told the Emergency Practitioners (EPs) in UTC had completed advanced training in the assessment and management of paediatric patients presenting with minor injuries and minor illnesses. Nursing staff also had access to additional training. Data provided showed 71.42% of band 6 nurses and 66.60%. of band 7 nurses had completed paediatric Immediate Life Support (PILS) training. Compliance figures for immediate Life Support (ILS) training showed 88% of band 6 and 77.80% of band 7 nurses had completed this training. We were told that due to training capacity and clinical need, band 5 and below nursing staff did not routinely receive paediatric training and this training had been prioritised for band 6 and above nurses. ENPs triaged children under the age of 16 in the UTC. Following our inspection, we were told ENPs had completed an advanced training qualification in the assessment and management of paediatric patients presenting with minor injuries and minor illnesses, which includes triage. However, we were not provided with the percentage of staff who had completed this training.

The practice development nurses (PDNs) supported the service, taking an active role in managing the education programmes for nursing at various levels. Their programme of learning was based on a needs analysis. Staff we spoke with stated they were unable to increase the number of courses provided due to capacity.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always assess or manage the risk of infection. They did not always detect and control the risk of it spreading.

During our visit to the ED, we observed clearly marked bins for waste segregation and sharps disposal across areas such as RAT and CDU, where all sharps' bins were closed, dated, and signed. Linen skips were used appropriately and regularly emptied. The department was generally tidy, with clean floors and with most areas maintained. However, there was an area in the department where the flooring was cracked presenting an infection control risk as it may not be able to be cleaned effectively. We were told work was planned to address this but not provided with a timescale for completion of this work. Equipment was not consistently cleaned and labelled as clean after use. Therefore, it was not possible for staff to identify that equipment had been cleaned and was ready for use. Cleaning staff were frequently visible, although cleaning schedules were not consistently displayed, for example, public toilets in the UTC and CDU lacked signage indicating when they were last cleaned or next due for cleaning.

To reduce cross-infection, there were isolation rooms available and in use for infectious patients. However, these were not always used in line with best practice to effectively manage the risk of cross infection. For example, a patient with an isolation sign on the door to their room and documentation identifying an infection control issue had the door to their side room left open. We observed staff did not use appropriate Personal Protective Equipment (PPE) to enter the room or close the door, to mitigate the risk of cross infection.

PPE, including gloves, masks and aprons, were available inside side rooms in line with trust

policy. We observed a patient who attended ED by ambulance with query an infectious respiratory disease, at 8.21pm not isolated until 3.41am, the next morning. At which point the patient was placed in a side room with the appropriate respiratory isolation signage on the door and the door kept closed.

There were missed opportunities for enhanced IPC screening at the front door of the UEC. Staff did not ask patients attending the UEC about IPC risks or about recent travel, during their assessments. We noted that numerous staff wore wrist watches and hand washing did not always take place in between patient's care, or when staff left and/or entered a clinical area. When these issues were raised with staff during our visit, senior staff told us that infection protection and control (IPC) lapses could not be attributed to a lack of knowledge, as all staff received IPC training. The senior staff told us IPC issues could be attributed to staff 'burnout'. Where the constant and high flow of patients within the ED could have contributed to the staff lapses observed, in maintaining more optimal IPC standards. The recent staff survey showed 44.2% of staff reported they often felt tired, 35% reported they felt a 'high degree' of burnout and 39.2% reported they always felt worn out at the end of their working day. 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. This high level of compliance did not support our findings during our visit. And MRSA screening compliance was 84.7%.

Following our visit, the service reported several measures introduced to strengthen infection prevention and control (IPC). These included IPC team 'spot checks', daily walkarounds by senior ED staff, and plans for a more systematic use of checklists to help maintain high IPC standards. Regular IPC reminders were being shared through ED communications. As this action had been taken following our visit we were unable to assess the impact.

Staff used the sepsis 6 bundle and the records we reviewed showed that most patients with suspected sepsis, were assessed and treatment provided within an hour. This meant by providing rapid treatment, it improved their chances of survival.

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 involved people in planning, including when changes happen.

The service had safe systems in place for the appropriate and safe handling of medicines. Medicines were managed in line with best practice and national guidance. Staff told us they had access to local medicines' policies, procedures, and guidelines. The policies we saw were up to date and in line with best practice.

Medicines were stored securely in line with national guidance and only accessible to trained staff. Emergency medicines could be accessed in the event of an emergency, meaning patients received medication in a timely manner. Medical gases for example, oxygen cylinders, were stored securely in line with best practice. We noted empty cylinders were kept separately ready for collection and which reduced the risk of failure to provide essential respiratory support to patients.

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.

The service used an electronic prescribing system, and we noted that all medicines were also recorded on the electronic patient record. Medicines were administered as prescribed, following national guidance and local policies. We observed all medicine omissions, for example, if the patient was asleep, the medicine was out of stock, or the medicine was refused, were clearly documented on the patient's electronic record. This ensured there was a clear record of what had been prescribed and what had been administered.

Staff we spoke with told us they had received specific training in the management and administration of medicines. Only those staff assessed as competent to administer medicines to patients undertook this task.

The patients we spoke with told us they were given information about their medicines, especially when there were changes to their medicines. This was provided in both written and verbal information, providing an opportunity for patients to ask the ED and pharmacy staff any questions about their medication. Allergies were recorded in patient records, and they were given coloured wrist bands to wear, indicating to staff that they had an allergy. The department had prepared 'to take away' (TTA) packs of medication which could be given to the patients to avoid delays in discharge.

Staff had access to pharmacy support, including an out of hours on call pharmacy support service, pharmacy team and the trust's Medication Safety Officer (MSO). Staff we spoke with stated that the pharmacy team were responsive to queries staff may have.

Regular medicines management audits were carried out, which included medicines reconciliation, missed and delayed doses, and compliance with relevant patient safety alerts. Quarterly controlled drug audits were completed and any areas for improvement identified.

Staff we spoke with knew how to report any medicine incident and that these incidents were discussed regularly at departmental meetings and learning shared. For example, in response to an incident the trust had developed and implemented a protocol for the use of rapid tranquilisation in the department. This included the requirement for hourly physical health monitoring, such as consciousness, pulse, blood pressure, rate of respiration, after the administration of rapid tranquilisation. However, the patient record for a patient who had received rapid tranquilisation, did not include evidence that their physical health had been monitored in line with the trust's protocol. This placed the patient at risk of timely intervention not being provided in the event their physical health deteriorated.

Effective

Rating Good

At our last assessment we rated this key question as Requires improvement. At this assessment, the rating improved to Good. Care and treatment were delivered in accordance with evidence-based practice. Consent was managed in accordance with legal requirements and staff training.

We looked for evidence that patient and communities had the best possible outcomes because their needs were assessed. We checked patients' care, support and treatment reflected these needs and any protected equality characteristics, ensuring patient 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.

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 and the frailty team. Divisional meetings included broad representation from allied specialist services, reflecting a collaborative and integrated approach to care.

Policies and guidelines were stored electronically and accessible to all staff. The policies we reviewed 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.

Nursing staff showed an awareness of their responsibilities and professional standards of care to which they were required to adhere. Staff were aware of legislation and guidance that protected patient's rights and knew how to apply this in practice. This included mental capacity and safeguarding.

The previous assessment of the department found issues with the use of CDU and with patient' case note documentation, where clinicians' grades were not consistently apparent. These issues were not observed during our visit, demonstrating the actions taken following this previous assessment had been effective.

The triage and time to treat patients for both the ED and UTC were within NHS targets.

However, the ED's was not meeting the four-hour target of 78% of patients being admitted, transferred or discharged within four hours of arrival. The trust was above the local and national average for the four hour target for the last 6 months.

How staff, teams and services work together

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work 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.

The UTC and the ED operated separately. During our visit, we found that despite the UTC being busy at the front door, this was not supported by the ED team. The 'Hello nurse' was part of the UTC team and staffed from the UTC staff complement. We were told, about 50-60% of 'walk-in' patients, who self-presented at the main reception, would be seen by the UTC. UTC staff we spoke with described a lack of collaborative working with ED based colleagues. For example, a member of staff said on occasions when they had 'a queue out of the door' no one spontaneously came to help from other UEC areas. Although another staff member said that at busy times; after reviewing the UTC lists, help could be sought directly from ED based clinicians, such as the ED consultants but was sometimes dependent on relationships between staff members. We observed that the overall role of the ED nurse in charge did incorporate the UTC, but when the department's status was described, it focused solely on the ED and did not include an overall update that incorporated the UTC. Therefore, risks across the whole emergency care pathway may not be considered and mitigated.

The senior UEC team explained that the UTC was run by trust-employed GPs and ENPs, worked closely with medical staff from the ED, and both departments asked for advice from each other. We did not observe this close working relationship during our visit. ED staff did not attend the UTC huddle, to gain an oversight of the UEC. When we spoke with ED leaders, there was uncertainty about how all UTC processes worked. There was an SOP that outlined the processes for transferring adult patients as well as unwell patients under the age of 16 round

from the UTC to the ED. There were also daily bed meeting at which patient numbers in the ED and UTC were discussed.

The ED was able to stream to the ED same day emergency care (SDEC), if this service could better meet the patient's needs. The ED SDEC care pathway was managed by the ED team with a senior decision maker at registrar level or above based in this service. We found that the ED and ED SDEC teams worked closely together within an agreed criteria for which patients were likely for same day discharge and should be transferred to this service. Admission criteria included patients over 16 years old, clinically stable in terms of their observations, appropriate for sitting in the clinical area, able to attend to their basic self-care and personal hygiene needs. We were told these criteria allowed teams in this area more time to assess, treat and diagnose. This approach was reported to be beneficial to patients, and these patients were always discharged home from the ED on the same day. The length of time the patient was in both the ED and SDEC was recorded in their EPR.

Patients from the ED could also be transferred to the medical SDEC via a centralised referral system, this service was managed by the acute medicine team. Some ED medical staff we spoke with told us it was 'difficult' to refer patients to this area, as it was protocol-driven, had an inflexible admission criteria and patients were often declined. Feedback from ED staff was that they felt the medical SDEC pathway should be made more accessible to the ED team. Enhancing access would not only align with NHS strategic aims of supporting more appropriate alternatives to ED-based care, but also improve patient flow and avoid unnecessary hospital admissions.

The frailty team attended the ED to carry out patient reviews and conduct geriatric assessments (CGAs), providing targeted support as part of their role. We observed this service allowed patients to have an earlier discharge home rather than being admitted to hospital. We found that ED staff were clear on how they accessed this service and were very complimentary about it. The ED and frailty team had clear processes for assessing frailty, which helped identify those patients at most risk from frailty factors and in need of enhanced support from community-based services.

We observed that specialty teams were often in the ED assessing their patients who were awaiting a bed in their service. There were clear responsibilities for these patients who remained under the care of the ED team whilst in the ED. The ED team were responsible for

responding to changes to the patient's physical status, whilst the clinical responsibility for the patient remained with the specialty team. This meant the ED team effectively managed urgent medical needs while the oversight of their speciality needs was provided by the specialty team.

The ED staff told us that the on-site mental health liaison psychiatry completed their own assessment for those patients with mental health needs, based on feedback from ED staff. Staff stated the response for these assessments was swift and they provided ED staff with guidance on the care of the patient's mental health needs. The psychiatry liaison team also saw other patients in other departments in the hospital and at other trusts, and their input could be delayed if they were in another department or trust. ED staff told us they felt the team could be 'more visible' and provide more resources for 1:1 support for patients. When we visited, we saw that patients with mental health needs were experiencing extended lengths of stay. For example, the patient records for the 4 patients with mental health needs that were in ED, showed 3 of these patients had been in the department more than 24 hours, one of whom had been in the department over 65 hours awaiting a bed. The 4th patient had been in the department over 22 hours, awaiting a mental health act assessment after medical investigations had been completed. This delay of obtaining suitable mental health beds is a national issue and the trust were working with partners to identify suitable mental health beds.

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. The documentation audits for the last 3 months demonstrated that all records reviewed included NEWS and PEWS and that they were

correctly calculated and appropriate actions were taken when the NEWS or PEWS was above 5.

There was evidence to show the service routinely monitored patient's care and treatment to continuously improve it. For example, the use of TES was identified as a risk on the local and trust-wide risk registers following staff feedback regarding safety concerns, and senior managers had made a commitment to reduce the use of this space. However, due to demand on the service this was not always possible. The use of TES was supported by a standard operating procedure (SOP) to inform the safe use of these spaces, this included escalation processes, with exclusion and inclusion criteria to help mitigate risk and ensure patient safety. However, TES areas were not always used in line with the trust's TES procedure.

Following Royal College of Emergency Medicine (RCEM) audits, the trust had made changes to processes in relation to radiology imaging, which had allowed for more checks and clearer lines of responsibility, sought to avoid prolonged waiting times and reduce disruptions to the radiology registrar's ability to focus on reporting on the imaging. The new systems had allowed imaging information to be shared centrally, where it was available for daily review by a consultant and appropriate actions taken. Whilst checking the imaging, if there were any clinical concerns or a missed x-ray result the consultant would action this and the patient would be called back to the ED for further review. All missed x-rays would then be fed back to the clinician involved for individual learning and into the wider staff forums for wider departmental learning. The trust provided us with examples of where such discussions had taken place to demonstrate learning. The results of the other RCEM audits had also resulted in improvement work in areas such as sepsis management, trauma imaging oversight, and timely analgesia documentation.

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 process in place that covered all age groups. This supported staff to communicate and transfer the patient to the most appropriate local major trauma centre.

The trust used 2 measures, the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) to monitor mortality rates. The data ending March 2025 demonstrated the mortality indicators remained statistically significantly low for HSMR and similarly, low for the SHMI. There were monthly mortality meetings, open to the whole clinical team where mortality was discussed, and learning identified. The meeting was minuted

and the notes shared with staff who could not attend.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

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

Mandatory training included mental capacity and deprivation of liberty, which included capacity and informed consent. Staff we spoke with were aware of their responsibilities for obtaining consent and the trust's processes they should follow.

During our visit, the patients we spoke with did not raise concerns regarding their consent to treatment. Staff facilitated patients to make their own decisions. During triage consent was gained and recorded in their patient record.

Some staff in the department wore body camera's, which had been introduced to reduce violence against staff. We were told the staff would inform patients and complete an electronic incident record whenever they turned on body camera technology. CCTV was observed, and we were informed that this was monitored by security staff. However, not all CCTV signage was clearly visible in all areas. For example, signage within one of the designated mental health rooms was not clear, and patients may not have known they were being monitored and images recorded within this space.

Caring

Rating Good

At our last assessment, we rated this key question Good. At this assessment, the rating remained 'Good'. This meant patients felt well-supported, cared for, and were generally treated with dignity and respect.

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.

Almost all the patients we met said staff treated them well. Staff were kind and acted with respect in the interactions we observed. Most patients had their privacy and dignity maintained, however, at times patient's privacy was not always maintained. In some of 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 when being cared for in the corridor. However, in response to staff feedback the 5 bedded cohort area had had curtains fitted, which acted as partitions for improved patient privacy.

Staff were respectful, spoke in a kind and caring manner and assisted patients as necessary. We observed a patient wanting to leave and getting agitated, staff were responsive and caring, whilst arranging medications to facilitate the patient's discharge. The friends and families test data for June 2025 were unavailable due to the number of patients responding. In July 2025, data showed that 77% of people had a positive experience in the department. However, the department's response rate was low and below the national average response rate of 16%. We were told the reason for the low response rates to the friends and family test was due to the implementation of this by the new provider. Recent data demonstrated an improvement in the feedback rates.

We observed trust staff working collaboratively with staff from other organisations, including the ambulance, speaking in a respectful manner.

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.

Patients assessed by the rapid access team (RAT), had a plan of care developed, tests identified, ensuring any immediate needs such as pain relief or time-critical medication, were identified and administered.

There were a range of meetings that took place daily to discuss information such as bed numbers, breaches, staffing etc. These included shift handovers, nursing and medical huddles where specific issues were discussed, including patient numbers and staffing, with issues escalated to the cross-site bed meetings that took place three times a day. Bed meeting discussed a range of issues including staffing, patient numbers, waiting times and breaches. Concerns raised at this meeting were escalated to tactical 'silver command' and strategic 'gold command' meetings that took place daily. Plans were developed to address issues escalated such as bed capacity, staffing levels and patient flow. Senior leaders worked closely with other partners such as social services, the ambulance service and mental health services. For example, we observed plans being made to ensure the needs of a CAMHs patient who had been in the department for a significant period of time, were met.

The patients we spoke with all knew how to call for help. There was some inconsistency in the provision of buzzers, for example we observed 2 patients, including a patient in the 'Cohort' who had been left without a buzzer with no reliable way of calling for help.

Between the hours 14.00 and 22.00 there was an allocated ED nurse whose sole responsibility was to ensure patients received their medication in a timely manner. This initiative had been

implemented following staff feedback that due to the demand in the department at certain times, time critical and other medication could be delayed or doses missed due to staff availability.

One of the top risks identified by ED staff, was the length of stay for mental health and medical patients. There was an escalation process in place. However, it was acknowledged that mental health patients could often be difficult to place due to the need for specialist beds. To ensure their needs were met while in the department, a range of actions had been taken including facilities to deliver personal care being introduced. Nurses had also been provided with specific mental health training to improve their skills, knowledge and confidence in delivering care to these patients. There were plans in place to recruit two permanent mental health nurses to the ED. These posts will be part of the ED team complement and will be employed by the trust. The trust also had close relationships with mental health trust teams supporting the department, who provided advice and input into the patient's care when needed.

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.

Local senior staff demonstrated a commitment to staff well-being and actively supported the delivery of person-centred care. A culture of teamwork and support was evident across all levels of staff, contributing to a welcoming and collaborative environment. Staff consistently described the support they received from colleagues as positive and inclusive. Senior nurses provided both professional and pastoral support to nursing staff, reinforcing a culture of care and respect. All staff we spoke with reported feeling well supported, and they consistently upheld internal professional standards in both their attitudes and practice.

Senior ED staff reported staff 'burnout' was an issue and contributing factors to this included intensity of patient flow through the ED. The latest staff survey showed 44.2% of ED staff

reported they often felt tired and 35% reported they felt a 'high degree' of burnout with 39.2% reporting they always felt worn out at the end of their working day. Staff told us they had systems in place to raise concerns about nurse-to-patient ratios, capacity pressures, and the frequency of patients presenting with mental health needs to their managers, as these factors had an impact on staff morale. There were initiatives to help boost staff morale by the provision of improved areas for staff to take their breaks in. However, as these initiatives had been implemented recently their impact on staff morale had not yet been measured.

We were told that the introduction of body-worn cameras was in response to concerns raised by staff in the recent staff survey. These were worn by triage staff and the nurse in charge, in line with trust policies and procedures. Security staff also had body cameras and used these in line with their employer's own protocols.

Responsive

Rating Requires improvement 

At our last inspection we rated responsive as Requires improvement. At this assessment, the ratings remained unchanged. This meant patient were not getting care and treatment in a timely way to meet their needs. There were significant delays in patient receiving care due to high demand, over-capacity across the hospital for beds leading to poor flow and crowding leading to long and unacceptable delays for patient.

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 electronic patient records (EPR) was accessible to all staff involved in the patient's care. Staff told us when they identified patients with additional needs such as risk of falls, this was recorded in their record and care planned to meet these needs. The EPR 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 ED staff were able to access support from the frailty team, dementia and LD nurses to ensure the patient's needs were met. Staff we spoke with were able to describe how they would access these specialist services and gave examples of when they had done so. We were told the ED also had lead nurses, who had additional skills and knowledge in the management of specific patients such as mental health patients. They provided support to staff ensuring person-centred care was delivered and the individual's needs were met.

Staff we spoke with were able to explain how they had used the specific learning disability (LD) training they had completed to deliver person centred care. We saw that LD sensory boxes had been introduced in the department, these aim to distract the patients while they waited to be seen and treated. Following our inspection the trust shared the admission policy and discharge checklist for patients with learning difficulties and confirmed they used patient passports for these patients to ensure their specific needs were met.

We observed that 'call for concern' posters were visible throughout the department. This provided patients and their families with information on the actions they could take and who they could speak with if they were worried about their care. This assisted patients and their families to raise concerns in a timely manner if they felt their specific needs were not being met. We were not provided with data of how frequently this process had been used by patients and

their families.

Patients had access to food and drink, that met their individual cultural and religious needs. We observed that food menus were provided in a range of formats, including picture menus. During our visit we observed food orders being taken, with support being provided to those individuals who required it.

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. However, information was available in a range of languages to individual needs.

There were an excessive number of signs throughout the area, with some notices outdated while others remained relevant. Some signs related to clinical areas that were no longer in use. This increased the risk of patients getting confused and lost. For example, one sign next to an alarm stated it was an alarm for the mental health room, the signage had arrows that pointed the wrong way and directed patients in the wrong direction. We were told that a project was due to commence the week following our inspection, which would review all signs and replace signs that were no longer required or directed patients to the wrong area.

There was no information about waiting times displayed in the waiting areas. Therefore, it was unclear to patients how long they could expect to wait to be seen.

CCTV was observed but it was noted that not all CCTV signage informing patients and visitors of the CCTV was clearly visible in all areas.

We were told that to improve the accessibility to the trust website the trust had accessed themselves using a specific tool to identify areas for improvement. The Trust's website was available in 106 different languages, ensuring essential information was accessible to meet individual's needs. We were told pharmacy information leaflets could be accessed in other

languages via an online resource, these were requested by patients on an individual basis. We were told this approach was taken rather than leaflets being printed out in different languages, to ensure the most up to date information was provided. Information was not always available in alternative formats, such as Braille, easy read, we saw a pictorial friend and family test scoring sheets, but staff told us these were not used.

Staff had access to a range of interpreting facilities including language Line, ability to book face to face interpreters. The trust was in the process of rolling out iPads to clinical teams to support the use of Card Medic, a digital translation tool. We were told staff who spoke different languages were used to communicate with patients experiencing language barriers, about their care and treatment. Family members or friends would also be used either face-to-face or on the telephone, to interpret for patients who did not speak or who had limited spoken English. This is not in line with NHS England (NHSE) guidance that professional interpreters should be offered when language is a barrier to care, with family or friends not used as interpreters, especially in sensitive situations like consent, trauma, and safeguarding.

Staff stated they took this approach to provide 'continuity of care'. They stated that there were instances when timely access to certain languages was difficult to obtain if the appropriate interpreters were not available within the local community. However, staff confirmed formal interpretation services such as language line, were available and staff were able to explain the processes for accessing these services. A member of staff reported using an automated tool to help translate. National Institute for Clinical Excellence (NICE) best practice guidance emphasises the need for accurate and impartial communication, recommending the avoidance of automated tools.

At the time of our visit there was no assistive technology or facilities to support those with hearing loss or other forms of sensory impairment observed within the UEC services, including the main reception. We did observe a member of the reception staff making efforts to ensure a hearing-impaired patient understood what was being communicated to them by leaving the reception desk and standing in close proximity to the patient when they spoke. Following our visit, we were informed that as part of 'project welcome' a hearing loop was now in place at the main reception.

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.

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. Staff involved people in decisions about their care and told them what had changed as a result.

There was signage throughout the service regarding how to make a complaint, which included information on how to get in touch with the Patient Liaison Services (PALs) and make a formal complaint.

Patients we spoke with had not been explicitly informed about the complaints process, but most were able to identify how they would access this information if needed. Information about making a complaint could be found on the trust's website and on posters within the ED. None of the patients we spoke with expressed concerns about the care they had received.

Complaints were responded to in line with the trust's complaints' policy. The nurses we spoke with knew about the complaints process and were able to describe it and how learning from complaints was shared. Complaints were an agenda item on the daily nursing handovers, and were included in the ED newsletter that was shown on a large screen during the handover and disseminated to staff via email.

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 on waiting times, was supported by what we saw during the inspection. We were not provided with trust information to show how this issue was being addressed.

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.

The service did not always make sure patients could access timely care, support and treatment when they needed it. Improvements had been implemented such as streaming patients away from the Emergency Department (ED), supported by protocols outlining care pathways and the reconfiguration of services. However, the department remained crowded at times due to both increased patient numbers, and the delays of identifying and transferring patients to the ward beds from ED. We were told the department could request that patients arriving by ambulance were diverted to a neighbouring hospital for a period of time to enable the department to move patients out to wards and address overcrowding issues. We were told safety rounds, had been introduced and took place 6 times a day, to mitigate the risk of patients that might deteriorate in the waiting room. However, patients were not routinely given updates on likely waiting times.

The use of TES areas and the length of stay for mental health patients with physical health issues were both on the departments and the trust's risk registers, and both were graded at the highest level of risk with a recognition of all the risk factors for patients. The information provided showed that the length of stay for some patients, especially medical patients, awaiting beds exceeded the NHS recommendations with examples provided of some patients waiting more than 19 hours.

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. Over the last 4 months, the performance statistics for ambulance handover times within 30-60 minutes were within the England average of 16-20% There were fewer handovers taking longer than 60 minutes when compared to the national average of 5-15%.

The service considered the needs of people with different protected characteristics and made reasonable adjustments to ensure people's individual needs could be met. Staff we spoke with were aware of the resources and teams available to support patients with additional communication needs. For example, the learning disability team could advise and support staff. Some staff were aware that some patients would have a communication passport. One member of staff described how the team would aim to meet the requirements in the communication passport.

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 who 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. Information was escalated when issues at the bed meeting could not be resolved.

Well-led

Rating Good

At our last inspection, this well-led was rated as Good. At this assessment, the rating was 'good', The service fostered a positive culture where people felt they could speak up and their voice would be heard.

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.

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Shared direction and culture

Score

3. Evidence shows a good 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, engagement, and understanding challenges and the needs of people and their communities.

The service had a vision and strategy that worked alongside the trust's overall strategy, Our Way Forward (2023 – 2028). The service's strategy had been developed in consultation with staff and input from stakeholders. Local leaders escalated issues that impacted on patient safety to the senior divisional leaders and action was taken to improve patient safety. Actions to address issues raised were discussed and monitored via trust-level workstreams including the patient safety group.

We were told the emergency and ambulatory care divisional strategy fed into the trust's four priorities, of which priority one was to "reduce" how often temporary escalation spaces were used, to allow patients to receive "high-quality, safe care in the right place." This was monitored via the flow board.

The trust's HEART values (Honesty, Equity, Accountability, Respect, and Teamwork) were well communicated and understood by staff at all levels. These were central to how staff worked with each other and the patients they cared for. All staff we spoke with were aware of the trust's values and strategy and could give examples of how they applied them in their work, such as speaking up about concerns, supporting colleagues, and treating people fairly. Staff we spoke with told us they were proud to be in the team and how they all worked together towards

common goals. They provided examples of improvement they had seen over the last few years. For example, reducing the waiting time for lower risk patients by greater use of the pathways, directing these patients to alternative services such as their GP, when it was appropriate.

The culture within the department was open, transparent and inclusive, where staff were listened to, felt empowered to identify issues, resolve or be part of the solution. Patients and families not only gave feedback but were listened to and they were sometimes involved in developments. For example, the main themes from staff and patient feedback were regarding waiting times, accessibility and signage, lack of hearing loops at the ED reception.' We were told action was being taken to address these issues. However, at the time of our visit we were not provided with action plans to demonstrate how and when all issues would be addressed.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

Leaders at all levels understood the context in which they delivered care, treatment and support. They did not routinely monitor delivery of care and changes to identify their effectiveness.

Most leaders had the skills, knowledge and experience to lead and perform their roles. The senior divisional leadership team included a Divisional Medical Director, Divisional Head of Nursing and Divisional Director of Operations. They each spent time at each of the three times to promote visibility and accessibility. They understood the pressures in the department and how this could impact on staff. They monitored actions identified to address issues for effectiveness through the daily UEC Sitrep and bed meetings. Progress and effectiveness was reported up to the board through standing committees such as Patient Safety Group.

All staff we spoke with told us they felt local leaders were visible and accessible when needed. Describing their leaders as supportive and encouraging, which led to a positive working environment. Local leaders we spoke with acknowledged the high pressure environment that their staff worked in and the risks of staff burnout.

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.

Information about the Freedom to Speak Up (FTSU) guardians, including names and photographs, was displayed on staff computer monitors, with all trust staff having access to the FTSU policy which was available on the intranet. Staff were able to describe how and where to find information about the FTSU guardians and noted that FTSU champion walkarounds were conducted within the service. Staff also reported feeling able to raise concerns when necessary.

Patients, their families, and carers had opportunities to provide feedback on the service in ways that reflected their individual needs, including through surveys such as Friends and Family Test. Managers and staff had access to this feedback and used it to make improvements.

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 covered key areas such as risk, performance, audits, learning from incidents and complaints, training, and safeguarding. We were told data such as the use of TES areas was collected and used to inform changes to monitor their effectiveness and impact. However, we were not provided with evidence to demonstrate this.

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 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 local ambulance service to improve how the service responded in an emergency.

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.

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 worked with a range of stakeholders to improve services. They had worked closely with neighbouring mental health trusts to identify areas for development in the pathway for mental health patients accessing the emergency department. This included work with the psychiatric liaison team, who were able to contribute to discussions and policies impacting this patient group in this department, such as the rapid tranquilisation policy and restraint policy.

The department also worked with local charities. For example, a local charity provided warm clothing to ED for patients on discharge who were homeless or suffering financial hardship. This not only provided physical comfort but also restored the patient's dignity. Another charity provided donations of emergency food parcels, for patients on discharge who were in financial need.

The corporate objectives for 2025/26, included a specific objective for improved alignment with community-based neighbourhood teams, virtual wards. We were told this was currently being scoped and therefore we were unable to assess its impact.

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 contribute to safe, effective practice and research.

Staff 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. The service provided

examples of initiatives aimed at promoting equitable patient experiences, outcomes, and quality of life. These included the introduction of a dedicated nurse to administer medications, including time-critical medications.

Improvements to the service included staff wellbeing. 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.

The trust was participating in three national Royal College of Emergency Medicine (RCEM) 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.

Local, quality improvement audits included fracture documentation, which identified not all fractures were recognised at the time of reporting. In response to this a new process was introduced that included all imaging being requested under a lead clinician who was then responsible for reviewing, reporting and following up any missed fractures and discussing issues at the ED forum with the aim of improving governance and promoting staff learning.

ED staff provided DVLA fitness-to-drive advice to patients following seizures, strokes, visual impairment, or episodes of loss of consciousness. This is in line with the DVLA guidance relating to the responsibilities of medical professionals. Advice was given to the patients in line with National Institute for Health and Care Excellence (NICE) guidance relating to fitness to drive and this was documented in the patient's record.

To facilitate seamless service provision the trust were introducing a single point of access for GP's. This meant that when it was set up there would be one point where they could send GP referrals in, and work was ongoing with local GPs to develop a system where overnight the trust would have access to local GP appointments and would be able to re direct patients into these appointments the following day if appropriate. The trust were keen to ensure that there was governance around these appointments to ensure equality of access and the system was not abused. However, during our visit we were not provided with any information of when this initiative would be implemented.

The department had developed revised ED anaphylaxis guidelines, in response to the NICE recommendations relating to the management and treatment of anaphylaxis-related incidents.

Plans to raise awareness of these guidelines in the ED, had been implemented. As this was a recent change there was no data on compliance with the guidelines available.

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.