LAP assessment report

Central Middlesex Hospital

LAP Assessment Report ID : LAP-01663

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

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Central Middlesex Hospital

Location findings

Ratings for this location

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

Overall location summary

Central Middlesex Hospital provides a range of NHS hospital services. This assessment looked at urgent and emergency care, which we rated as good. The rating of urgent and emergency care has been combined with the ratings of the other services from the last assessments. See our previous reports to get a full picture of all the other services at Central Middlesex Hospital. This is the first time we have assessed the urgent treatment centre under the assessment group (ASG) of urgent and emergency care, as it was previously run by a primary care provider. The rating of Central Middlesex Hospital has improved to good. In our assessment of urgent and emergency care, we found

- 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 worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They made sure there was continuity of care, including when people moved between different services.

- The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.
- The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.
- The service always treated people with kindness, empathy and compassion 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. They involved people in decisions about their care and told them what had changed as a result.
- The service made sure that people could access the care, support and treatment they needed when they needed it.
- The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.
- The service fostered a positive culture where people felt they could speak up and their voice would be heard.

However,

- 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.

Safe

Rating Good

Central Middlesex Hospital

Location findings

Our overall rating of safe at Central Middlesex Hospital has stayed the same. Urgent and Emergency Care was rated as good.

Effective

Rating Good

Our overall rating of effective at Central Middlesex Hospital has stayed the same. Urgent and Emergency Care was rated as good.

Caring

Rating Good

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

Responsive

Rating Good

Our overall rating of responsive at Central Middlesex Hospital has improved to good. Urgent and Emergency Care was rated as good.

Well-led

Rating Good

Our overall rating of well led at Central Middlesex Hospital has improved to good. Urgent and Emergency Care was rated as good.

Urgent and emergency services

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

Our view of the service

The urgent treatment centre (UTC) operated 7 days a week, between the hours 8am and midnight. Outside of these hours people would be treated at Accident and Emergency departments at neighboring hospitals. Between July 2024 and June 2025 there were 46,173 attendances to the UTC. The UTC only treated people with minor injuries and illnesses who self presented ,or were referrals from 111. They did not accept any people bought in by ambulance.

This is the first time we have assessed the UTC under the assessment group (ASG) of Urgent and Emergency Care, as it was previously run by a primary care provider. We have rated it as good.

In our assessment of Urgent and Emergency Care, we found the service had a positive culture of safety, built on openness and honesty. Staff listened to concerns, investigated incidents, and learned lessons to improve practice. They worked closely with patients and healthcare partners to maintain safe systems of care and ensured continuity when people moved between services.

Teams collaborated effectively so individuals only needed to tell their story once, with assessments

shared across services. Care and treatment were routinely monitored to drive improvement, with outcomes that met both clinical standards and patient expectations.

People were treated with kindness, compassion and respect for their privacy and dignity. Staff supported each other and colleagues from other organisations with the same approach. The service also promoted staff wellbeing to enable the delivery of person-centred care.

Patients could easily share feedback or complaints, were involved in decisions about their care, and were told what had changed as a result. Access to care, treatment and support was timely and well managed.

Leaders at all levels were inclusive, skilled and credible. They understood the service context, embodied organisational values, and led with integrity and openness. Staff felt confident to speak up, knowing their voices would be heard.

However, the service did not always manage infection risks effectively. It did not consistently detect or control the risk of spread, nor always share concerns with the right agencies promptly.

People's experience of the service

Patients, their families, and carers were very positive about their interactions with staff and the treatment they received in the urgent treatment centre. All reported that staff were welcoming and friendly, and that they were treated with compassion and kindness. People felt communication from staff was good, with clear information provided on waiting times, care options, and treatment plans.

Patients and their families felt there were adequate and visible staff in the department, and that the environment was clean and tidy. We observed compassionate care being provided to a patient and their family while explaining that their condition required immediate transfer to an Accident and Emergency care facility.

National patient survey data from May 2025, taken from the Family and Friends Survey, showed 100% of respondents gave positive feedback, with 81% rating their care as ‘Very Good’. This was echoed in feedback collected directly by the service from patients at the end of their visits.

Acute services

Urgent and emergency services

Safe

Rating Good

This is the first assessment for this service. This key question has been rated good.

This meant people were safe and protected from avoidable harm.

The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly and patients were protected and kept safe. The service worked with patients and healthcare partners to understand what being safe meant to them and the best way to achieve that. Staff managed medicines well and involved people in planning any changes. However, the service did not always assess or manage the risk of infection well.

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 had a positive culture of safety and learning. There was a no blame approach which empowered staff to report any issues without fear of negative consequences. Staff understood their responsibilities to raise and record safety incidents, concerns and near misses, and were encouraged to do so by senior leaders. Staff reported incidents through an electronic system which could be accessed by all staff, including bank and agency staff. The service had reported no serious incidents for the previous 12 months.

The service ensured that lessons were learned, and improvement was made when things went wrong. Staff received feedback on incidents they reported, and learning was shared through handovers, emails, and safety huddles, which were attended by both clinical and administrative staff. The trust had a culture of cross -site learning from incidents, where learning from serious incidents from all emergency departments within the trust were shared

across all sites through a weekly emergency department newsletter. Learning from incidents was also a regular agenda item at team meetings.

We saw examples of how the service had implemented changes as a result of incidents. For example, we saw that an emergency response pathway had been put in place following a person who presented in established labour and gave birth at the urgent treatment centre (UTC), as the site does not have any maternity services.

All staff we spoke with could articulate the complaints and compliments process and would proactively share this information with people. The service had an up-to-date complaints policy in place. Each staff member, both clinical and administrative, would aim to gather written feedback from 10 service users each shift to capture any concerns or compliments. All feedback we saw during the assessment was positive. From July 2024 to June 2025 the service did not receive any formal complaints.

The trust had a culture of cross-site learning from complaints, where learning from complaints from all emergency departments within the trust were shared through a weekly emergency department newsletter, and any actions taken in response to complaints were implemented across sites. For example, the patient group for sickle cell patients gave feedback that they felt their voice was not heard in the emergency departments and there were delays in providing them with pain relief. In response to this the trust held a cross-site sickle cell week, to raise awareness of sickle cell disease and introduce ACT NOW, an NHS guide to improve clinical outcomes and care experience of patients in sickle cell crisis. At the most recent listening event there was lots of positive feedback relating to patients' treatment and the time taken to receive analgesia.

Staff understood the duty of candour. They were open and transparent and gave patients and their families a full explanation if and when things went wrong. The service had an up-to- date duty of candour policy in place.

Risks were managed by senior leaders within the service. Senior leaders told us the top risks were staffing recruitment, and finance. This was reflected in the service's risk register. Action plans were in place to mitigate the risk, including recruitment drives and the use of temporary staff to ensure shifts were filled.

Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They made sure there was continuity of care, including when people moved between different services.

The urgent treatment centre (UTC) only treated people with minor injuries and illnesses who self-presented, or were referred from 111. They did not accept any patients bought in by ambulance.

On arrival at the UTC, patients were booked in by reception staff, who immediately alerted clinical staff if a person appeared unwell or required urgent attention. Once booked in, patients were streamed and triaged by an emergency nurse practitioner (ENP) using a national triage tool. The Royal College of Emergency Medicine (RCEM) recommends all patients are triaged within 15 minutes of arrival. We saw the service achieved 97.4% compliance with this standard over the previous 12 months.

After triage, patients waited in either the adult waiting area or, if under 18, the separate secure paediatric waiting room, until they were seen by an ENP or a General Practitioner (GP). At times of high demand, clinical staff were deployed to reception and triage to undertake rapid assessments, ensuring patients were seen in a timely way. We saw that over the previous 12 months, 95% of patients were seen, treated, or referred within four hours of attendance which was above national accident and emergency targets.

Reception staff regularly updated people on current wait times. However, there was no signage available, including in other languages, to inform people of current waiting times.

The service used an electronic patient notes system that was used by hospitals, GP's and other health services across the region. This meant staff could instantly access a patient's previous notes when assessing a patient, and also allowed the service to instantly share notes with other services, for example a neighbouring accident and emergency department if a person required

emergency transfer, or a specialist department if requiring a specialist service review such as paediatrics.

The computer system had an effective flagging system. We saw patients with dementia, learning disabilities and Parkinson's disease flagged on the system. This alerted staff that these patients may require additional support while in the UTC. The system also flagged if any patients were at risk of sepsis and would not let staff proceed with documentation until the alerts had been acknowledged and addressed.

The service had an onsite x-ray department that was open from 8am to 8pm. Outside of these hours patients needed to attend a neighbouring accident and emergency department, or if clinically stable, could return the next morning.

The service was able to undertake basic point of care testing such as blood sugars and urinalysis. The service did not have an onsite pathology service, therefore any blood tests were required to be undertaken at other services, and results followed up by the patient's GP. Although there was no mental health service at the hospital, the service had close links with the local mental health service and could seek advice and in person support if required.

The service had a transfer of care policy in place for patients who required higher level or more urgent treatment at an emergency department. Although not an emergency department, the UTC would initiate lifesaving treatment until the ambulance arrived to transfer the patient to another service. The site also had a critical care outreach team available for inpatient areas, who would attend the UTC if support was required for a critically unwell person. We saw the critical care team attend the UTC regularly during the assessment to offer support if needed.

During the assessment we saw an acutely unwell patient transferred effectively and without haste to an emergency department for further treatment, in line with the policy. We saw effective communication to the receiving hospital by a GP being undertaken simultaneously with an urgent request of an emergency transfer being made by another member of staff, while urgent care was being delivered by other staff. We saw staff not involved in the emergency situation were deployed to triage so that people continued to be observed and assessed within 15 minutes of arrival.

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.

There were systems, processes and practices in place to keep people safe, and these were well communicated to staff. Staff were aware of how to make safeguarding referrals to the local authority where necessary and spoke confidently about safeguarding issues including recognition of exploitation, gangs, and female genital mutilation (FGM). The electronic system flagged if a patient had a child protection plan in place, or if a patient frequently accessed services throughout the area. The trust had named safeguarding leads across the hospital who staff could access for advice regarding safeguarding matters. All staff we spoke with knew who the leads were and how to access them.

The service had an up-to-date safeguarding policy in place. Staff could give examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Most staff had training on how to recognise and report abuse, and they knew how to apply it. All medical staff had received Safeguarding Adults Level 3, and Safeguarding children level 3 training. All reception staff had received Safeguarding Adults Level 1, and Safeguarding Children Level 1 training in line with their role.

Not all nursing staff had completed safeguarding training at the required level. At the time of assessment, 57.14% of nursing staff had completed Safeguarding Adults Level 3 training and 71.43% had completed Safeguarding Children Level 3 training. As the nursing team was small, this equated to three members of staff. Leaders were aware of the gaps and explained they were linked to long-term sickness and recent staff appointments. We saw that staff without the

required training were already booked onto upcoming sessions. All staff we spoke with were able to describe how to recognise and report safeguarding concerns.

All staff were aware of how to recognise people with learning disabilities and encouraged the use of individual care passports. These passports helped staff understand each patient's specific needs and how best to support them while in the department. All staff knew how to refer a person to the learning disability team. Patients with learning disabilities were flagged on the electronic system, and the trust learning disability team would receive notification if the person had presented to the UTC so that they could follow up with the person if required. We saw 100% of staff had received Oliver McGowan Mandatory Training on Learning Disability and Autism.

Mental Capacity Act training was incorporated into the safeguarding training modules. We saw examples of staff assessing patient's capacity, and documenting it within the person's notes. All clinicians were able to articulate how they would assess a patient with mental health issues including the appropriate risk assessment. Although they did not provide a mental health service, the UTC had a two doored ligature light room available if required, while a patient was waiting a mental health assessment from the local mental health service, or transfer to another service provider.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with people with communication difficulties. For example, in each examination room we saw posters for an available translation service for those people whose first language was not English, as well as hearing loop availability. All

patients we spoke with told us they were involved with the decision making about their treatment. Patients, their families and carers, said the clinicians had been very helpful and explained things well.

Staff used a nationally recognised tool to identify deteriorating people and escalated them. Observations of vital signs were recorded by staff and the national early warning score (NEWS2 for adults, PEWS for children) was calculated. These were recorded electronically. The service had a clear escalation policy for the deteriorating patient, including the transfer of their care to an emergency department.

Staff knew about and dealt with any specific risk issues such as possible sepsis. All clinical staff received sepsis training, and the service had an up-to-date sepsis policy in place, including the transfer of their care to an emergency department.

Safe environments

Score

3. Evidence shows a good standard of care

The service detected and controlled potential risks in the care environment. They made sure equipment, facilities and technology supported the delivery of safe care.

The service had 6 consultation rooms, 3 within the adult area, and 3 within the paediatric area. The service had a separate, secure, paediatric waiting area in line with Facing the Future standards. Treatment rooms in the paediatric area were often used to see adult patients. This meant adults had to walk through the paediatric waiting area in order to access these rooms. The service mitigated the potential risk to any children as the area could only be accessed by secure entry, and all adults were escorted by a member of staff for the entirety of their walk from the adult waiting room to the consultation room.

The service had an assessment bay which had three trolleys where patients requiring short term treatment such as nebulisers could receive their treatment. This area also allowed patients requiring closer observation and more urgent treatment to be adequately assessed

and monitored while waiting transfer to an emergency department.

The UTC environment was well laid out, light and airy, and was visibly clean and tidy. Equipment was stored appropriately and well maintained. We saw evidence that all items had been regularly PAT tested. Staff knew how to report faulty equipment and told us that replacements were provided quickly. Where replacement equipment was not available at the Central Middlesex Hospital, it was sourced promptly from larger hospitals within the trust.

The service had a resuscitation trolley with both paediatric and adult equipment available to use in an emergency. We saw this was checked daily to ensure it was equipped and ready for use in the event of an emergency.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

The service made sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development. They worked together well to provide safe care that met people's individual needs.

The service planned and regularly reviewed staffing levels and skill mix to ensure people received safe care and treatment. Staffing requirements in the UTC were planned using guidance from the Royal College of Nursing and the Royal College of Emergency Medicine (RCEM). The service employed GPs, emergency nurse practitioners (ENPs), and reception staff in line with the function of an urgent treatment centre.

During our assessment we did not observe any staff shortages. All clinical staff were qualified in both paediatric and adult urgent care. There was a good skill mix of GPs and ENP's on duty. Shift times were staggered to ensure more clinical and reception staff were available in the evening, when the UTC was busiest. We saw that staff were allocated to triage in two-hour time slots, which meant staff were rotated through the role, helping to reduce fatigue while also allowing staff to undertake patient assessments.

The service had a medical staff vacancy rate of 68%, and a nursing staff vacancy rate of 50%. Leaders told us that this was due to the recent change of service provider, and difficulties in recruiting specialist staff due to a national shortage. Recruitment plans were in place, and we saw the service was undertaking interviews for ENP's on the day of our assessment. Leaders told us they used regular agency staff to fill the staffing gaps while recruitment was being undertaken. This was evidence by a 98% shift fill rate meaning that the service was very rarely short staffed.

All staff we spoke with told us they enjoyed working at the service. One member of staff, who had worked at the service over several decades, continued to work in a part-time capacity because of their enjoyment of the role. The service had a low staff turnover rate of 14%, with low sickness rates of 2% among medical staff and 3% among nursing staff. At the time of our assessment, there were no vacancies or sickness absence among administrative staff.

Agency staff we spoke with had received induction to the service and told us they regularly worked at the service as their preferred temporary employer.

Staff had received and were up to date with appropriate mandatory training. Staff received training on data security and protection; equality, diversity and human rights; fire safety; freedom to speak up; health and safety; infection control; manual handling; PREVENT; and various levels of life support specific to their role. The training was appropriate for the patient group using the service. We saw 100% of administrative staff, 94% of medical staff and 90% of nursing staff had completed mandatory training. We saw that only 75% of medical staff had completed the modules of Fire safety, manual handling, and basic life support, however due to vacancies this equated to one member of staff. We saw plans in place for the member of staff to complete their training. Similarly, we saw not all nursing staff had completed fire safety, basic life support, manual handling and safeguarding children, with these rates being 72%. Due to low staffing numbers this equates to three members of staff. We saw plans in place for these staff to complete their training. Agency staff received mandatory training through their agencies and told us their agency prevented them booking shifts if any required training had not been completed.

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 or share concerns with appropriate agencies promptly.

All ward areas were visibly clean, had required furnishings and were well-maintained. Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.

Staff maintained equipment, however it was not always kept clean. During our assessment we observed 6 observation machines that were visibly dirty and dusty and had used thermometer probes in place. These were in all clinical areas of the department including paediatric examination rooms, adult examination rooms, and the observation bay. We found a used urinalysis test on top of a trolley that was used for clinical procedures. The trolley was visibly dirty and dusty. The service had 'I am clean' stickers' available to show that equipment had been cleaned and was ready for use, however these had not been used on any equipment.

Once made aware of the short falls in the cleaning of equipment, the service immediately rectified this, and inspectors found that all equipment had been cleaned to a high standard, and 'I am clean stickers' had been used to show staff that the equipment had been cleaned, ready for use. Leaders had added cleaning of equipment to the daily huddle agenda to ensure the issue did not reoccur. and we observed this being discussed.

We observed staff following infection, prevention and control (IPC) principles, including the use of personal protective equipment, effective handwashing and being bare below the elbows. Hand hygiene signage was displayed throughout the UTC. All waste was observed to have been segregated and managed appropriately.

Infection prevention and control training compliance for all staffing groups was 100%.

The service regularly audited hand hygiene and environmental cleanliness and consistently achieved above the 90% target for the trust.

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 used an electronic prescribing system. Medicines were stored securely in automated dispensing cabinets which were integrated with the electronic prescribing system and patient's notes. Emergency medicines could be accessed in the event of an emergency. Lockable fridges were available for those drugs needing refrigeration. Processes for monitoring medicines fridge temperatures included automated remote monitoring and local record keeping. Record logs confirmed that fridge and room temperatures were checked daily and were within range.

Staff explained how they ordered medicines and prescription pads (FP10's) from the hospital pharmacy. We saw prescriptions and controlled drugs were stored securely in the dispensing cabinets and required two members of staff to authorise their removal. Removal of medications and prescriptions were automatically recorded electronically and could be audited by leaders, or remotely by the pharmacy.

The service had systems in place to ensure medicines could be accessed in the event of failure of the automated system.

The service had a process for the supply of medicines To Take Out (TTO) as well as patient group directions (PGDs). PGDs were used by specifically trained staff to prescribe and supply medicines for routine or minor ailments. We saw all PGDs were reviewed in line with the service's policy. Staff told us they could seek medicines advice from the pharmacy department when needed.

We saw that patient's allergy status were accurately documented in patient's notes.

The service undertook quarterly medicines management audits, including controlled drugs,

temperature monitoring, and medicines security, and results consistently scored above the trust target of 90%. We saw that any actions needing to be taken were carried out promptly, for example when a member of staff did not know where the override key for the electronic dispensing cabinet was stored.

Effective

Rating Good

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people’s care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

This is the first assessment for this service. This key question has been rated good. This meant patient’s outcomes were consistently good, and people’s feedback confirmed this.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people’s care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

Staff assessed and met patient’s needs for hydration, and jugs of water were available in the department. As patients were not typically in the UTC for longer than four hours, food provision was not required. Where patients had specialist nutrition or hydration needs, staff ensured these were met.

Staff followed up-to-date policies to plan and deliver high-quality care in line with national

guidance. Policies and treatment guidelines were stored electronically and accessible to all staff. They were based on best practice from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) and were regularly reviewed and updated. Staff protected the rights of people subject to the Mental Health Act and followed the Code of Practice.

The team had access to a full range of specialists to meet the needs of patients using the service. In addition to doctors and nurses, staff could access support and advice from mental health teams, occupational therapists, social workers, pharmacists, speech and language therapists, dieticians, and various community services, with referral pathways in place where needed.

Staff were experienced, qualified, and had the skills and knowledge required to meet the needs of the patient group. All clinical staff were either qualified ENPs or GPs, trained in both adult and paediatric emergency care, in line with the function of the UTC.

All medical and administrative staff (100%) had received an appraisal within the last 12 months. For nursing staff, appraisal rates were 85%, which was slightly below the trust target of 90%. However, this shortfall related to 1 member of staff who was on long-term sickness leave. We saw their appraisal had been scheduled to be completed on their return.

Managers identified the learning needs of staff and provided opportunities for them to develop their skills and knowledge. For example, we saw that UTC-specific training was delivered to staff in small groups, enabling all staff to participate while ensuring shifts remained fully covered.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

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

When patients moved between services, all necessary staff, teams and services were involved in assessing their needs to maintain continuity of care. Staff worked well across the team and with other services to support people. Advice and referrals were sought appropriately. For example, we saw advice was sought from an emergency department when a patient's condition had deteriorated, and effective communication maintained until the patient was transferred to that department.

We saw that any patient with a learning disability that presented to the UTC was immediately flagged to the learning disability team so that they could follow up with the patient either during or after their presentation.

We saw systems and processes in place for multidisciplinary cross site discussions regarding people highlighted as having safeguarding concerns, and those that frequently reattended to the emergency services across the trust.

We saw appropriate community referrals made for patients who may require further treatment or follow-up in the community, such as to the mental health team or local GP services. Discharge summaries and documentation were shared appropriately, which ensured that patients received the necessary support after leaving the service.

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.

The service consistently met the national emergency waiting time outcomes, with over 95% of patients being seen and discharged or care transferred to other facilities within 4 hours.

Staff participated in clinical audit, benchmarking, and quality improvement initiatives. The service's audit programme included audits such as a monthly review of clinical notes and a daily review of x-ray outcomes. The review of clinical notes assessed documentation such as medical and medication history, presenting complaint, physical and mental health, red flags, allergies, safeguarding, and safety-netting. Results consistently scored above the trust target of 90%. Where an individual clinician did not achieve 100%, action was taken, starting with an initial discussion with the clinician.

Daily x-ray checks were undertaken to ensure no fractures were missed. The service performed well in this area. In the rare event that a fracture was not identified, radiology staff contacted the clinician involved to ensure any learning was undertaken and the patient was appropriately followed up.

The service was included in trust wide audits including GIRFT (getting it right first time). The trust was aware of population factors that may contribute to trust wide poor emergency department performance, and leaders told us they were addressing flow constraints and inpatient capacity to improving trust wide performance against national targets. Service leaders told us that meetings were held daily to determine if patients with minor injuries and illness at emergency departments within the trust could be treated at the UTC, to reduce the wait time and increase capacity and flow.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

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

Staff gained consent from patients for their care and treatment during triage in line with

legislation and guidance and this was clearly recorded in patient records.

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

Caring

Rating Good

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 is the first assessment for this service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service always treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

Patients, their families, and carers were very positive about their interactions with staff and the treatment they received in the urgent treatment centre. All reported that staff were welcoming and friendly, and that they were treated with compassion and kindness. People felt

communication from staff was good, with clear information provided on waiting times, care options, and treatment plans.

We observed compassionate care being provided to a patient and their family while explaining that their condition required immediate transfer to an emergency care facility. We saw all staff protecting the privacy and dignity of patients during interactions and examinations.

National patient survey data from May 2025, taken from the Family and Friends Survey, showed that 100% of respondents gave positive feedback, with 81% rating their care as ‘Very Good’. This was echoed in feedback collected directly from patients at the end of their visits, with comments highlighting staff friendliness, efficiency, and the quality of care. Respondents noted that they received quick and efficient service, that staff were very helpful and approachable, and that the environment was clean. Some even remarked on the engaging and friendly interactions, describing them as much-needed banter that enhanced the overall experience.

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.

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

Staff we spoke with understood the emotional and social impact that a patient’s care, treatment, or condition had on their wellbeing and on those close to them. Staff supported and involved patients, families, and carers to understand their condition and make decisions about

their care and treatment. Staff talked to people in a way they could understand, using communication aids where necessary.

A mother who's child had learning disabilities told us staff were compassionate and kind to both her and her child and took the time to understand how to best meet her child's needs and alleviate any possible distress.

Workforce wellbeing and enablement

Score

3. Evidence shows a good standard of care

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

Staff felt respected, supported and valued. All staff we spoke with felt positive and proud about working for the provider and their team. One member of staff who had worked at the service for several decades told us she continued to work there because it's a great place to work and the team were like family.

Staff felt well supported by local managers and knew they could raise concerns and provide feedback if required. Staff had regular team meetings with local managers who were aware of the need to support colleagues and advocate on their behalf.

There was a wellbeing hub for staff which was advertised in multiple places across the hospital, including the service's staff room and hospital coffee shop. Staff had access to a variety of wellbeing services such as physical wellbeing support with a physiotherapy service, occupational therapy, weight management, stopping smoking, keeping fit. There were mental health wellbeing service providing stress management, staff psychology service, counselling, wellbeing hubs, access to NHS digital applications and national support services. Financial wellbeing services were available to staff with instant pay options, cost of living advice, money saving tips, support accessing food banks, NHS discounts, salary sacrifice, and opportunities to access financial support. Flexible working, access to Freedom to Speak Up Guardians, a pension scheme and advice service, retirement scheme and advice, pastoral and multi-faith

support, coaching, mentoring, and mediation were also available.

Responsive

Rating Good

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.

This is the first assessment for this service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

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.

Patients, their relatives and carers, told us they felt confident that clinical staff had assessed their individual needs, and these were understood. For example, a patient with long term respiratory problems felt staff listened to her when she described previous treatment that had worked well for her, which she felt would be a good treatment choice now.

People were encouraged to use a hospital passport ,which helped inform hospital staff about the needs of the patient with a learning disability and how to support them.

Multidisciplinary teams reviewed and planned care for complex patients and people who attended the department often. This was in line with The Royal College of Emergency Medicine

(RCEM), Best Practice Guideline, Delivering Interventions and Services for High Intensity Use Frequent March 2024.

The environment of the paediatric waiting area was child friendly. The room was large enough to park children's buggies to allow children to rest if needed.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Staff were aware of the diversity of the local population and the people they treated and understood how to access communication support while considering cultural and religious needs. The department always had access to a translation line, which included British Sign Language, and there was also the option to request face-to-face interpreters. We saw posters advertising the translation service in each consultation room. Although not displayed in the waiting room, staff had access to patient information leaflets available in multiple languages.

Patients we spoke with told us they had been given clear information from staff regarding their treatment, including any follow-up procedures or appointments that might be needed. Staff also explained the pathway through the department. Reception staff informed people of the approximate wait timing and would keep people in the waiting room informed if the waiting time was increasing. However, there were no electronic screens or signage available for people to view the most up-to-date wait times, nor was this information provided in different languages.

Discharge letters were sent electronically to GPs and other professionals if required, for example to community nursing teams. The London Care Record meant different professionals could see key information about patients to ensure their care was planned and transition between services was managed. Patient records were held on a secure electronic patient record

system which was accessed by staff using individual log in details.

We noted 100% of staff had received General Data Protection Regulation training (GDPR). This training ensured staff were aware of their roles and responsibilities when handling personally identifiable data.

Listening to and involving people

Score

3. Evidence shows a good standard of care

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

Patients, their families and carers felt staff listened to them and cared. The staff were friendly and communicated well with people. People were able to provide feedback about their experiences with the service through patient surveys. Each member of staff was asked to share the surveys and obtain feedback from 10 people each shift. We saw this feedback was overwhelmingly positive. Signs in reception signposted people on how they could make a formal complaint if needed. The service had received no formal complaints for the previous 12 months.

All staff reported that they felt able to raise concerns with leaders if needed, and that their concerns would be listened to and acted upon. Staff felt safe to speak up without fear of negative consequences and gave examples of changes that had been made following their input. For example, staff told us about changes to the stock ordering process, which had helped ensure supplies were more readily available and reduced delays in patient care.

Equity in access

Score

3. Evidence shows a good standard of care

The service made sure that people could access the care, support and treatment they needed when they needed it.

Patients had equal access to care, treatment and support. The service considered the needs of people with different protected characteristics and made reasonable adjustments to ensure patient's individual needs could be met. This included making reasonable adjustments for disabled people, having a quiet room available for those with sensory concerns, and addressing communication barriers. The premises were purpose built and fully accessible with appropriate facilities and equipment to support people who were physically disabled.

Patients could access services, and care was managed to take account of people's needs, including those with urgent needs. Waiting times for both triage and consultation were managed appropriately. Patients were kept informed of any disruption to their care.

The service consistently met the national emergency waiting time outcomes. Over the past 12 months over 95% of patients were seen and discharged or care transferred to other facilities within 4 hours, and 97.45 % of patients were triaged within 15 minutes of arrival. The service had an escalation policy in place so that in times of busy periods, all staff ensured people were seen within these times.

Well-led

Rating Good

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.

Acute services

Urgent and emergency services

This is the first assessment for this service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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.

Leaders had a clear shared vision and strategy that guided the trust and its services. The trust's strategy, Our Way Forward (2023–2028), focused on working closely with NHS and social care partners, building on lessons from the Covid-19 pandemic, and responding to current and future challenges. It aimed to deliver high-quality, timely, and equitable care while supporting staff to provide safe, compassionate services.

The trust's HEART values (Honesty, Equity, Accountability, Respect, and Teamwork) were central to how staff worked and were well communicated and understood. During the assessment, 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 also had opportunities to take part in discussions about service strategies, especially when changes were being made, and could explain how their work contributed to delivering high-quality care.

Leaders had developed an improvement plan for the urgent treatment centre to maintain high standards while supporting capacity and flow across the trust. Staff confirmed they understood the plan and were actively following it, helping to improve efficiency, patient experience, and team working within the service.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

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

Leaders in the service had the skills, knowledge, and experience required for their roles. They demonstrated a clear understanding of the service they managed and could explain how their teams worked to deliver high-quality care, including managing patient flow and maintaining safe staffing levels. Leaders were visible and approachable, regularly engaging with staff in the department, attending team huddles, and supporting problem-solving in real time.

Staff reported that accessible leadership encouraged open communication and made them feel supported in raising concerns or suggesting improvements. Leadership development opportunities were available and actively promoted, enabling staff to take on new responsibilities and lead projects such as audits, which contributed to service improvements and monitoring of quality standards.

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.

Staff could describe how concerns were reported, investigated, and followed up, with feedback shared through various forums. Leaders maintained an open-door policy and were actively

engaged in supporting and addressing staff concerns.

The trust's Freedom to Speak Up (FTSU) Guardian worked independently to promote a positive speaking-up culture, providing confidential advice and support to staff regarding patient safety or concerns about how issues were managed. The department also had a FTSU champion, who was well-known to staff, with a poster displayed in the staff room explaining the policy and how to raise concerns.

Patients 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. 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.

The service formed part of the trust's emergency and ambulatory care division. Although a smaller service focused on patients with minor injuries and illnesses, governance structures ensured the service was fully integrated within the wider trust. Leaders and staff were included in trust-wide meetings, reporting structures, and decision-making forums, ensuring service delivery, patient safety, and staff development aligned with wider organisational standards.

As part of governance arrangements, the service took part in regular trust-wide meetings during busy periods and, when needed, supported other emergency departments within the trust by receiving some of their patients with minor injuries and illness. This helped to ease pressure and ensured patients continued to receive timely, high-quality care across the trust.

There were monthly local and divisional governance meetings that followed a set agenda.

These meetings included discussions on learning from serious incidents or complaints, the risk register, performance, national and local clinical guidance, policies and procedures, audit results, safeguarding, and training. There were also divisional and trust-wide meetings that reviewed a range of data and audit results to identify good practice and areas that needed improvement.

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 trust worked with commissioners and stakeholders and the local health and social care system and there were positive relationships. We saw evidence of regular meetings with other stakeholders to discuss pathways and any areas of concern. There was a desire to develop a shared understanding of the challenges in the system and identify ways to improve.

There had been ongoing trust level quality reviews of emergency care, where information was shared to encourage collaboration across departments and providers to improve quality, effectiveness and safety for patients using the service.

There was evidence of engagement with staff and stakeholders and patients to develop pathways and improved care for patients with certain conditions, including diabetic care.

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.

Improvement programmes for urgent and emergency care were implemented trust-wide to ensure consistency and to raise standards across all three sites. The trust was also participating in three national RCEM Quality Improvement programmes for 2025: *Time Critical Medications, Care of Older People, and Mental Health*.

Leaders were able to describe areas of improvement that had already been achieved. For example, the trust introduced the MISSED mnemonic to support the prompt identification and administration of time-critical medications on arrival. This includes medications for movement disorders, immune disorders, diabetes, steroids, epilepsy, and direct oral anticoagulants, with the initiative aimed at improving the timeliness of these treatments.

The trust had also undertaken focused improvement work in relation to sickle cell care. This included a "Sickle Cell Perfect Week" initiative, which culminated in a positive peer review carried out by a local patient-led sickle cell working group. As a result, emergency department standard operating procedures for the care of people living with sickle cell disease had been improved and were effectively communicated to staff.

The department was involved in education and research activities, including thematic reviews of patient cases, which were presented to the wider team to support learning and improve patient outcomes.

Leaders and staff described a recent trust-wide focus on staff wellbeing within emergency care, recognising the physical, mental and emotional pressures faced by those working in the emergency department. This commitment had led to practical improvements, such as enhanced staff break facilities and the provision of tea and coffee, creating more supportive rest spaces. Leaders and colleagues were also encouraged to share appreciation and gratitude, with initiatives such as the Digital Heart, the Greatix system and staff awards helping to build a positive and supportive culture.

Urgent and emergency services