LAP assessment report

Queen Elizabeth Hospital

LAP Assessment Report ID : LAP-02013

Inspection visit date(s): 24 to 27 February 2026 and 18 to 30 March 2026

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Queen Elizabeth Hospital
Location findings

Ratings for this location

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

Overall location summary

Date of assessment: 24 and 25 February 2026 and 18 and 19 March 2026. Queen Elizabeth Hospital is part of Lewisham and Greenwich NHS Foundation Trust and offers a wide range of hospital services to people living in Lewisham and Greenwich. This assessment looked at urgent and emergency care, medical care, outpatients and diagnostic imaging to assess the quality of the care received by patients using those services. The rating of urgent and emergency care, medical care, outpatients and diagnostic imaging have been combined with the ratings of the other services from the previous assessments. See our previous reports to get a full picture of all the other services at Queen Elizabeth Hospital. The rating of Queen Elizabeth Hospital has improved to good.

Safe

Rating Requires improvement

At our last inspection we rated this key question as requires improvement. At this assessment the rating has remained

requires improvement. This meant people were not always safe and protected from avoidable harm.

Effective

Rating Good

At our last inspection we rated this key question as good. At this assessment the rating has remained good. This meant the effectiveness of people's care, treatment and support consistently achieved good outcomes.

Caring

Rating Good

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

Responsive

Rating Good

At our last inspection we rated this key question as requires improvement. At this inspection the rating has changed to good.

Well-led

Rating Good

At our last inspection we rated this key question as good. At this assessment the rating has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Acute services

Diagnostic and screening services

Diagnostic and screening services

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

Our view of the service

We carried out an announced comprehensive inspection of Diagnostic Imaging services at Queen Elizabeth Hospital on 18 and 19 March 2026. We inspected all the quality statements in this assessment across the five key questions: safe, effective, caring, responsive and well-led.

During our inspection we visited: x-ray, computed tomography (CT), dual-energy x-ray absorptiometry (DEXA) scanning, breast clinic, and magnetic resonance Imaging (MRI).

We spoke with over 26 members of staff including radiographers, radiologists, imaging assistants, sonographers, receptionists, and managers.

People's experience of the service

During the assessment we observed patient care and spoke with people using the services. We received feedback from 15 patients and carers. Patients, family members, and carers we spoke with

were all positive about their treatment and said they were treated with warmth and kindness. We found patients were provided with effective care and treatment. We also reviewed information the provider collected to monitor the quality and safety of their service.

People felt outcomes were consistently good. People said they were well-supported, cared for and treated with dignity and respect. People could access care to meet their needs. People told us communication with them was generally good. We observed that staff provided clear explanations in a way patients could understand and they were offered reassurance when required.

Safe

Rating Good

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected. We also looked at systems and processes which kept people safe from harm.

At this assessment we rated this key question as good. This meant people were safe and protected from avoidable harm.

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 managed patient safety incidents well and lessons were learnt to continually improve practice. Staff told us when they reported incidents, they were usually involved in investigations and asked for their input. We saw evidence of multidisciplinary team (MDT) review of incidents and specific incident case review panel meeting minutes which demonstrated a holistic approach to incident review, understanding and development of

learning. Staff told us they received feedback from incidents they reported, and they were involved in the development of learning post incidents which was shared in team meetings, huddles and by email. Staff told us they did not feel blamed and were not treated negatively when things went wrong. Staff told us they were supported by their managers and colleagues and were treated with understanding. They said lessons were learned from safety incidents and changes were made to reduce risks. Incidents were discussed at governance meetings. For example we saw within the minutes from the governance meetings review of shared learning about discrepancy on paediatric head CT and a missed fracture by a radiologist during a busy duty session

There were up-to-date policies and procedures to support incident investigation and duty of candour (being open and honest with patients when things went wrong). Staff understood the types of incidents that needed to be reported and the importance of duty of candour. In the 12 months prior to our assessment of the service there were no serious incidents, and no incidents relating to radiation that required reporting under Ionising Radiation (Medical Exposure) Regulations.

Leaders told us they encouraged staff to report all incidents to ensure risks could be identified and action taken. We observed and were told that there was a culture of prioritising patient safety and learning across the department. Staff told us they felt the service was responsive to concerns and there were processes in place to enable information to be shared with everyone in a timely way. Staff told us the teaching environment was positive and supportive, and they were encouraged to participate in training opportunities.

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.

There were clear processes to make sure that registered healthcare professionals who requested imaging as part of their routine or extended practice had the right training and authorisation to do so. Staff said that radiographers reviewed referrals to confirm that imaging was needed. A radiologist was available for advice through a “hot seat” system, and modality leads provided support when staff had questions.

‘Pause and check’ posters were in all imaging areas we visited. They were designed to act as a reminder of the checks that needed to be made when any diagnostic imaging examinations were being performed. However, they were not always the correct ‘pause and check’ poster for the area they were displayed in. For example, the ‘pause and check’ posters in the x-rays rooms were for referrers not for clinical imaging examination. We raised this matter with the service, and they were making progress with changing the posters during our assessment.

The service had appropriate local rules and employer procedures in place to restrict radiation exposure to staff and patients, and to support the safe use of ionising radiation. Where local rules were due for review, these had been completed. The service ensured that the radiation protection adviser (RPA) and the medical physics expert (MPE) were accessible and available to provide advice on radiation safety. Radiation protection supervisors (RPS) were in place in all departments where ionising radiation was used.

Staff understood the processes for escalating unexpected or significant findings identified during imaging examinations and reporting. Patients were provided with information about how and when they would receive the results of their imaging.

Outpatient and GP referrals were prioritised and appointments booked based on the urgency of the referral. The trust’s centralised booking team coordinated the booking of appointments using booking policies and exclusion criteria.

During our assessment on most occasions, we saw radiographers ensuring the other radiographer was behind the shield prior to initiating the X-Ray. However, on one occasion we witnessed an incident in which a radiographer pressed the X-ray button whilst another radiographer was only partially shielded. This was fed back to the leadership team who actioned this immediately. Feedback was given to the radiographer however it does demonstrate that some staff were not always following processes.

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. Staff 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 took appropriate steps to safeguard people from abuse and improper treatment. The service worked with people and relevant partners to understand what being safe meant to them and to promote a culture where people were protected from abuse, discrimination, harassment, avoidable harm, and neglect.

People using the service said they felt safe and well supported.

Staff had received appropriate safeguarding training for adults and children. The service monitored compliance with mandatory training, with over 96% of diagnostic imaging staff having completed safeguarding adults training and over 97% having completed safeguarding children training. Staff were able to recognise potential signs of abuse and knew how to raise concerns in line with local safeguarding procedures. They were able to explain the actions they would take to protect people at risk of harm or experiencing abuse.

Staff demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and 99% of staff had completed mandatory training in DoLS, MCA, and best interests. This supported staff to act in people's best interests where there were concerns about a patient's capacity. There had been no safeguarding concerns or referrals in the 12 months prior to the assessment.

The service had up-to-date safeguarding policies and procedures in place to protect adults and children from abuse and unsafe care. Safeguarding information was readily available for staff, who knew how to access policies, procedures, and safeguarding advice electronically.

Staff told us the safeguarding training they received supported them to identify concerns and

gave them confidence to raise and escalate safeguarding issues appropriately.

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.

Where service provision was affected or disrupted at the location (for example, due to faulty equipment), the service took action to ensure people could access suitable alternative appointments at other locations belonging to the trust. The service had appropriate processes in place to respond to medical emergencies, and clinical staff had received training in basic life support. However, we raised concerns that reception staff without basic life support training were tasked with the oversight of patients in waiting areas. We raised this concern with the Trust during the assessment and were informed they are working to find a solution to this issue. The training data provided by the trust showed that there was variable rates of completion of basic life support training across the department and staff groups. Two groups of staff had not met the trust target of 90%, they were medical staff – radiology achieving 80% compliance and the ultrasound staff achieving 60% compliance.

Staff completed risk assessments for people using the service and responded appropriately when risks changed. People we spoke with were aware of the use of radiation and the associated risks. Clear information was displayed in all waiting areas explaining the benefits and risks of radiation exposure. Safety checks were completed, including checks to confirm pregnancy status, in line with regulatory requirements.

We observed staff following recognised safety guidance, including the Society of Radiographers' "pause and check" process, to confirm patient identity and verify critical information before carrying out examinations or administering injections.

In MRI, staff completed forms to confirm patient identity and undertook comprehensive MRI safety screening for patients and any accompanying persons. Audit data showed staff were compliant with this process.

During the assessment, we observed staff consistently following safety protocols. Staff told us they could easily contact the radiation protection supervisor (RPS) and medical physics advisers for guidance on radiation protection when needed.

The service made reasonable adjustments to ensure care was delivered safely and accessibly, taking account of the different needs of people using the service.

Safe environments

Score

3. Evidence shows a good standard of care

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

During the assessment, we observed staff using equipment safely and appropriately. Clear signage was in place to warn people when ionising radiation was being used. Scanning and x-ray rooms were secure, with lockable doors to prevent unauthorised access, and were designed to protect staff and patients from unnecessary radiation exposure.

Staff wore radiation dose monitoring badges in designated areas, and the service monitored these to identify any risk of over-exposure.

The service stored chemicals and substances hazardous to health safely and in line with guidance. Portable electrical equipment safety testing had been completed. Fire safety arrangements were in place, with clear evacuation routes and fire extinguishers stored appropriately. Staff understood their responsibilities in the event of emergencies, including fire or flood.

The service involved people in managing risks by providing accessible information about diagnostic imaging. Information posters were displayed in waiting areas explaining the risks and benefits of imaging procedures, including specific guidance for people who were pregnant

The service was registered with the Health and Safety Executive (HSE) to use ionising radiation and had effective systems in place to protect people from exposure. Staff completed routine quality assurance checks on imaging equipment to confirm it was safe for use. There were clear processes for reporting faults and requesting repairs, and staff understood the importance of reporting equipment concerns promptly. These arrangements supported the safe delivery of care and reduced the risk of harm to people using the service. Records showed that scanning and x-ray equipment were serviced and maintained by approved third-party providers to ensure they remained safe and fit for use.

Lead aprons and protective equipment were readily available, and routine checks were carried out to ensure they were safe to use. During the assessment, we identified two lead skirts and one lead apron that showed signs of wear or had not been hung correctly to avoid risk of unseen damage to internal not visible lead. The service acted immediately to address these concerns, which reduced the risk to people and staff.

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 ensured there were enough qualified, competent, and experienced staff to deliver safe care and treatment. Staffing levels and skill mix were planned and reviewed to support safe care and to ensure staff did not work excessive hours. During the assessment, staffing levels and skill mix were in line with planned arrangements.

Staffing pressures were monitored and escalated through daily operational meetings, including morning huddle meetings, and the site team was kept informed of any staffing risks. At the time of the assessment, the diagnostic imaging department employed 152 staff, including consultant radiologists, medical staff, sonographers, radiographers, radiology department assistants, and administrative staff. There were 12.4 whole-time equivalent consultant radiologists in post.

The service had effective processes to ensure staff who required professional registration, including with the Health and Care Professions Council (HCPC) and General Medical Council (GMC), held valid and appropriate registration. Recruitment records confirmed that all required pre-employment checks had been completed, including enhanced Disclosure and Barring Service (DBS) checks.

The service had up-to-date policies to support safe recruitment and staff performance management. Staff received a structured induction and completed mandatory training relevant to their roles, including training on autism and learning disabilities. Systems were in place to monitor mandatory training compliance and to plan refresher training where it had expired. Staff received annual appraisals, which supported professional development and safe practice.

Sickness data provided for the diagnostic imaging department showed there was enough radiologists, radiographers, and support staff to meet service demand. Staff said they felt supported and reported they were able to manage workload safely with the current staffing levels.

At the time of the assessment, the service had been without a permanent general manager and head of imaging for an extended period, with interim arrangements in place. The trust had successfully appointed a general manager who was due to commence shortly. Although recruitment to the head of imaging role had not yet been successful, the trust was exploring interim secondment arrangements to support leadership and oversight. These arrangements had not adversely impacted the safe delivery of care**.**

The service had a comprehensive programme of development initiatives for radiographers during 2025/26. They were broken down into four groups: ‘A forever learning culture’, training governance, digital training and upskilling. Each group provided radiographers with opportunities to develop their practice. We received positive feedback from staff about these programmes. Data regarding the use of bank and agency staff was provided by the trust, it

demonstrated the service used mainly bank staff to cover areas of short fall in staffing levels.

Infection prevention and control

Score

3. Evidence shows a good standard of care

The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

During the assessment, the environment was visibly clean, tidy, and well maintained. Fixtures, fittings, and patient positioning foam pads were free from damage and designed to be easily cleaned. However, the vinyl covering on the table in the dual energy x-ray absorptiometry (DEXA) scanning room was cracked and could not be effectively cleaned. This was raised with the service during the inspection, and the trust provided assurance that a replacement cover had been ordered and that enhanced cleaning protocols had been implemented until the repair was completed.

The service promoted good hand hygiene. Clear signage was displayed throughout clinical areas, and hand sanitiser dispensers were readily available and adequately stocked. Handwashing facilities were accessible in clinical areas. Staff followed ‘bare below the elbow’ guidance and were observed carrying out hand hygiene and cleaning equipment appropriately between appointments. Personal protective equipment (PPE) was available in sufficient quantities to support safe practice.

Clinical waste was segregated, stored, and disposed of safely. We observed staff applying waste management procedures correctly. The service had processes in place to ensure the routine cleaning of the environment and equipment, and staff had received appropriate infection prevention and control training. Up-to-date policies were in place to reduce the risk of infection and support safe care delivery.

Sharps bins were available at the point of use and were assembled and used correctly. All sharps bins we observed were dated when first used and were temporarily closed when not in

use, reducing the risk of sharps injuries.

The service involved people in managing infection risks. The booking process identified people with known or suspected infections so that appropriate appointment planning could take place. Staff told us people with infections were scheduled at the end of the day to reduce the risk of transmission and said they had sufficient time between appointments to complete enhanced cleaning. Staff were aware of who to contact for additional infection prevention and control advice. However, X-ray staff told us they frequently received patients who were infectious without prior notification or completion of the form and that this interrupted their lists.

Cleaning schedules were completed as planned and demonstrated that all areas were cleaned regularly. We observed "I am clean" stickers on equipment, which were in date and provided assurance to people that equipment had been appropriately cleaned. These arrangements supported safe care and minimised the risk of infection-related harm.

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 appropriate systems in place to ensure medicines, including contrast media, were prescribed, stored, and administered safely. Warming cabinets used to store contrast media were temperature-controlled, with temperatures clearly displayed and routinely monitored. This helped ensure contrast media remained effective and reduced the risk of harm, including extravasation (the accidental leakage of contrast agents from a vein into surrounding tissue, rather than into the bloodstream).

We observed staff completing safety checks before all imaging procedures, including those

involving contrast media. Staff completed appropriate documentation, which included recording relevant medical history, confirmation of consent, and details of cannulation. These checks supported the safe care and treatment of people using the service.

The service had patient group directions (PGDs) in place for radiographers and sonographers, which provided a safe and lawful framework for the administration of medicines within their scope of practice. We reviewed these PGDs and found they were up to date, version controlled and had been reviewed in line with organisational requirements.

Staff we spoke with demonstrated clear knowledge of the processes for recognising and responding to adverse reactions to contrast media. This supported timely intervention where needed and reduced the risk of avoidable harm to people.

Effective

Rating Good

We looked for evidence that people had the best possible outcomes. We checked that people's care, support and treatment reflected their needs and ensured 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.

At this assessment we rated this key question as good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing needs

Score

3. Evidence shows a good standard of care

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.

People using the service told us it was accessible and met their needs.

The service had processes in place to assess referrals to ensure imaging was appropriate, clinically justified and prioritised according to need. People's needs were reviewed at booking, and where appropriate extended appointment times were offered to allow more time for staff to respond to and meet people's needs.

Staff carried out pre procedure assessments to identify people's clinical history, risks and any factors that could affect the imaging examination. The service assessed individual risks, including pregnancy status, allergies and safety considerations specific to the imaging modality required.

Most staff identified and responded to people's communication and information needs, including those with sensory loss, cognitive impairment or a learning disability, and made reasonable adjustments where needed.

The service assessed pain, comfort and distress, and adjusted imaging procedures to support people who were anxious, uncomfortable or unable to tolerate standard positioning. We saw the use of positioning aids which helped people who were in pain to be able to tolerate the positioning required for a successful scan to be completed.

People with additional or complex needs were identified, and staff took steps to put appropriate support or adjustments in place.

Staff told us they had enough time to meet people's needs during appointments.

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 service delivered imaging care and treatment in line with current legislation and national

guidance, and recognised best practice. During the assessment we observed staff following safety protocols. Checks included confirming people's identity and selecting ionising radiation exposure to be as low as reasonably practicable (ALARP), a risk management principle requiring that risks be reduced to the lowest level possible without the cost or effort being grossly disproportionate to the safety benefit.

Staff used up to date policies, protocols and clinical pathways to guide imaging practice across all modalities. We reviewed a selection of policies and found them to be up to date, have a review by date and were version controlled. The service had systems in place to review and update guidance in response to changes in evidence or national standards.

Imaging procedures were clinically justified, and staff followed agreed referral and protocols to ensure people received the right investigation at the right time. Staff were trained and competent to deliver imaging care safely and effectively in line with evidence-based practice.

Clinical audits and quality checks were used to monitor practice and support continuous improvement in imaging services. We reviewed the audits undertaken by the service and found them to have mostly been completed on time. The service completed an annual audit programme including for example, audits of MRI imaging for suspected cauda equina syndrome, skeletal survey reporting time from study to report, and GP compliance in paediatric neck ultrasound referrals.

Care and treatments were adjusted where needed to reflect people's clinical needs and to support safe and effective outcomes.

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.

Diagnostic and screening services

Staff worked collaboratively across imaging modalities, including radiology, ultrasound, CT and MRI to meet people's diagnostic and treatment needs. Clear lines of communication supported effective day-to-day coordination of activity.

The service had positive and constructive working relationships with external partners, which helped develop the service and meet people's needs. Care was well coordinated between hospital teams and across the wider Trust. We observed staff discussing patients and heard there was good communication about people's needs. This included effective coordination of care for people with learning disabilities. However, we were not always assured about the service followed their own processes for people who lacked capacity/ability to consent for imaging. Following an observation of an incident we saw during the assessment where we saw a patient who was nonverbal and unable to consent having a scan. We raised our concerns with the trust and were provided with their policy and reassurance in regard to this incident.

The service worked closely with referring clinical teams, including emergency care, outpatients, wards, and specialist services, to prioritise imaging requests appropriately and support timely diagnosis and treatment.

Information was shared effectively between staff to support continuity of care. Relevant clinical information, previous imaging results, and safety information were accessible to staff delivering care. This reduced the need for people to repeat their clinical history.

Staff worked closely with multidisciplinary teams (MDTs)including radiology and hospital wide specialty medical teams to support patient management. Imaging staff contributed to MDT discussions and provided timely reports to inform clinical decision making.

Clear escalation and handover arrangements were in place. Staff knew how to raise concerns, request urgent clinical input and escalate unexpected findings to relevant clinicians to ensure people received prompt care. Imaging results were communicated in a timely way to support safe onward care and discharge planning.

The service worked effectively with external organisations where required, such as community services, to maintain continuity of care and avoid unnecessary delays.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduced their future needs for care and support.

Staff supported people to understand the purpose and outcomes of diagnostic imaging investigations. Information was provided in a way that helped people make informed decisions about their care and next steps in their treatment pathway.

Staff supported people to live healthier lives by delivering effective diagnostic imaging, recognising risks early and contributing to coordinated care that promoted positive health outcomes.

During the assessment of the service, we saw leaflets in waiting areas that provided information to support patients to live healthier lives.

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 consistent, and that they met both clinical expectations and the expectations of people themselves.

The service monitored key clinical and operational outcomes, including image quality, reporting turnaround times and adherence to referral and screening pathways. This helped staff identify variation and take action to improve performance.

Quality assurance processes were in place to review the accuracy and quality of imaging and reports. This supported safe and timely diagnosis and helped ensure outcomes met recognised clinical standards.

The service reviewed performance data and audit findings to inform service improvement. Where shortfalls or risks to outcomes were identified, actions were taken and monitored to improve care. During one set of minutes re reviewed we saw a review of the getting it right first time (GIRFT) guidelines to ensure compliance procedures are met in regard to QA processes.

Outcomes were reviewed for different groups of people where appropriate, including those attending requiring repeat or complex imaging. This helped ensure outcomes were equitable and consistent throughout the service.

The service used internal and external benchmarking, where available to understand its performance and support improvement. The service had started work to join an accreditation scheme. For example there was confirmed by royal college and QSI that the trusts community diagnostic centre sites had met benchmark to qualify for QSI stamp accreditation, achieving this halfway through the process and therefore ahead of schedule.

Learning from audits, incidents and feedback was shared with staff. We reviewed the service's newsletter where feedback was presented, and staff told us they found the newsletter was accessible and very informative. This supported continuous improvement and helped staff understand how their practice contributed to better outcomes for people.

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.

During the assessment of the service, we saw the majority of staff gaining consent from people

to perform all types of diagnostic imaging procedures. The majority of staff understood the importance of consent and whether a person had the capacity to make a decision about undertaking a diagnostic imaging procedure. The service could raise any concerns they had to the referrer about a person's capacity.

Staff generally understood how and when to assess whether a patient had the capacity to make decisions about their care. Mandatory training data we reviewed showed 99% of staff had completed training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DOLs). This meant that staff were able to assess a person's capacity to provide consent.

However, on 1 occasion during our assessment we observed staff did not raise concerns about a patient who lacked capacity. The patient was also unable to verbally give consent for their diagnostic imaging procedure. We reviewed the patients' record and there was no best interest's decision-making process documented. We highlighted this concern to the service leadership who took prompt action to address this. We also found x-ray request forms did not have contact details of the referrer which would make it difficult to contact them if needed.

Staff explained imaging procedures, including the purpose of the examination, any associated risks (such as radiation exposure or contrast administration), and what people could expect during and after the procedure. Information was provided in a way that people could understand, allowing them to make informed decisions about their care.

The service respected people's rights to give, refuse or withdraw consent. Staff understood that consent was an ongoing process and checked consent at the point of care, particularly where procedures were invasive or involved contrast agents.

Written consent was obtained when required, including for higher-risk procedures, contrast-enhanced imaging, and screening procedures. The approach taken was proportionate to the level of risk associated with the examination.

Reasonable adjustments were made to support people to understand and give consent. This included using clear language, allowing additional time, and adapting communication for people with sensory impairment, learning disabilities or those whose first language was not English.

Consent processes were supported by clear local policies aligned to national guidance. Staff were aware of these policies and could describe their responsibilities for obtaining and documenting consent.

People's consent decisions were documented accurately in imaging records and booking systems. Records showed that consent discussions had taken place before procedures and that staff acted in accordance with people's wishes.

Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. We checked that people's privacy and dignity was respected. We 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. We also looked for evidence that staff wellbeing was valued, and that staff were supported and enabled to deliver consistently person-centred care.

At this assessment we rated this key question as 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.

Staff treated people with courtesy and respect at all stages of their appointment, including at reception, during imaging procedures, and when providing post-procedure information. Interactions were kind, calm, supportive and professional. People using the service told us staff

were “kind, caring and very supportive”.

People’s privacy and dignity were respected. Staff ensured doors, curtains and changing areas were used appropriately, and people were given adequate time to prepare for procedures without feeling rushed.

We saw staff communicate clearly and sensitively, using language people could understand. They took time to explain procedures, check understanding, and respond to questions or concerns, which helped reduce anxiety.

People were supported with compassion when they felt anxious, uncomfortable, or distressed. Staff were attentive to people’s emotional needs and responded promptly and kindly, particularly during invasive, noisy, or potentially frightening imaging procedures.

The service recognised and responded to individual needs. Reasonable adjustments were made for people with disabilities, sensory impairments, learning disabilities or anxiety, including flexibility with positioning, appointment pacing and the presence of carers where appropriate.

The service had a chaperone policy which was in-date, version controlled, and appropriate. We were told, when personal care was given by a member of staff of the opposite sex to the patient, patients were offered the option of a chaperone. Staff ensured, where possible, that chaperones were the same sex as the patient.

We observed that confidentiality was maintained. We saw staff handling personal information discreetly and ensured discussions about care were held in private settings, protecting people’s dignity at all times.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service treated people as individuals and made sure people’s care, support and

treatment met people's needs and preferences. They took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

We saw staff take time to understand people's individual needs and preferences prior to imaging procedures. This included recognising anxiety, mobility issues, sensory needs, and previous experiences, and adapting their approach accordingly.

People's communication needs were identified and met. Staff used clear language, checked understanding, and adjusted how information was given to support people to engage meaningfully in their care and imaging appointments. The electronic booking in system at reception was available in over 20 languages and language line was used for patients who did not speak fluent English.

Reasonable adjustments were made to support people with disabilities, learning disabilities, or long-term conditions. This included allowing additional time for appointments, supporting positioning during scans, and enabling carers or family members to be involved when appropriate. Families and carers we spoke with told us that it was very important to them that they could support their family member and that staff had been very proactive in letting this happen when needed.

The service recognised and respected people's cultural, social, and religious needs. Staff were sensitive to dignity requirements, gender preferences, and cultural considerations, and took these into account when delivering care.

Appointments and care pathways reflected individual circumstances. Staff showed flexibility where possible, including adapting appointment times or imaging approaches to reduce distress or discomfort and improve people's experience.

People were involved in decisions about their care. Staff encouraged questions, listened to people's views and wishes, and ensured individuals felt in control of their diagnostic process.

Independence, choice and control

Score

3. Evidence shows a good standard of care

The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.

People were given clear information about their diagnostic imaging procedures, which enabled them to understand their options and make informed choices about their care. Staff encouraged questions from patients and their families, and supported people to express preferences about how their care was delivered.

The service supported people to maintain independence wherever possible. Staff encouraged individuals to do what they could for themselves and provided assistance only when required, promoting dignity and confidence during imaging procedures.

People were involved in decisions about appointment arrangements, including timing and reasonable adjustments. Where possible, flexibility was offered to support choice and reduce anxiety or discomfort. People we spoke with said that they had been given an appointment at a time that was suitable for them.

We saw that staff respected people's rights to have support from family members or carers where appropriate. People were enabled to involve others in their care when this supported their understanding, comfort or decision-making. Family members and carers we spoke with told us that this was the case and they were grateful for it.

Staff adapted the way they communicated with patients and their families and carers to support choice and control. We observed staff checking understanding throughout the appointment and adjusted their explanations to ensure people could engage in decisions about their care.

The service provided appropriate equipment and support to maximise independence, including aids to assist with mobility, positioning and comfort during imaging procedures.

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.

We saw staff responding promptly and appropriately when people required support, reassurance or assistance before, during and after imaging procedures. Patients told us staff were "caring and kind" to them.

We witnessed staff anticipating people's needs, including anxiety, pain, discomfort, mobility limitations, and sensory needs, and adjusted their approach to minimise distress and promote comfort. We saw staff providing foam wedges to support people who were suffering from pain when placing them prior to diagnostic imaging procedures.

People were supported to feel safe and reassured during imaging procedures. We saw staff explaining what would happen during the procedure to patients, checked understanding and provided reassurance throughout examinations.

Staff demonstrated an awareness of non-verbal cues, such as signs of distress, confusion or discomfort, and took timely action to respond to these indicators.

Reasonable adjustments were made without delay for people with disabilities, long-term conditions, learning disabilities, or additional needs. This included allowing extra time for appointments, supporting positioning during scans and enabling carers or family members to be present when appropriate.

We saw that people's dignity was consistently maintained throughout their diagnostic imaging procedures. Staff were sensitive to cultural, gender, and religious needs and took steps to protect privacy during examinations.

Relatives and carers were supported to be involved in people's care where appropriate. Staff

recognised when their presence helped meet people's immediate emotional or practical needs. People were offered comfort measures where needed, such as positioning aids, blankets, or rest breaks, and staff checked regularly that people were comfortable.

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.

The service recognised the importance of staff wellbeing and supported staff to deliver kind, compassionate and person-centred care consistently. Staff felt supported by leaders and managers and told us they had access to support when they were under pressure or required additional help.

Staffing arrangements allowed staff to take appropriate breaks, and suitable rest facilities were available to support staff wellbeing and safe working. Staff had access to wellbeing initiatives, such as emotional support and stress management resources and knew how to access these when needed.

Leaders and managers encouraged open communication. Staff described feeling able to raise concerns, share feedback and suggest improvements without fear of blame. Staff were supported through supervision, appraisal and training, which helped them feel confident, valued and able to meet people's needs effectively.

We saw that the teams within the service worked well together, and staff treated one another with respect. This positive team culture contributed to a calm and supportive environment for people using the service. Staff morale was positive and high. We observed staff engaging respectfully with one another and remaining approachable, calm and attentive when providing care to people.

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.

At this assessment we rated the key question as 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.

Staff communicated with people in ways that met their individual needs and helped them to understand their care, treatment, conditions, and any advice given. Information was available in easy read formats, and staff used professional interpreting and translation services where required, including sign language interpreters. This supported people to be involved in decisions about their care and ensured communication barriers were appropriately addressed.

Staff understood the importance of listening to feedback and treated complaints as opportunities to learn and improve patient experience. Staff in X-Ray shared an example where learning from a complaint had been used to reinforce the importance of maintaining patient dignity. We saw evidence that learning from complaints led to improvements in care and treatment where appropriate. Learning was shared with staff through a range of formal and informal mechanisms, including daily huddles, monthly staff meetings, monthly governance

meetings and departmental newsletters. This demonstrated a responsive approach to improving care based on patient feedback.

The service made reasonable adjustments to meet people's individual needs. This included extending appointment times when required and offering flexible, tailored approaches to care. Staff were focused on delivering person-centred care and consistently treated people as individuals. For example, staff were able to play music during MRI scans to help people who felt anxious or claustrophobic to feel more comfortable. All staff were able to explain the additional support available for people with a learning disability or autistic people. Compliance with Oliver McGowan level 1 mandatory training was high, at 93.3% for radiology medical staff and 100% for nuclear medicine staff. This supported staff to understand and respond appropriately to people's individual needs**.** Data provided by the trust also showed they had exceeded NHS England's target for completion of each tier of Oliver McGowan training.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

The service delivered care that was well coordinated and joined up with other services. The service worked effectively with referring clinicians, clinical teams and other departments to ensure people experienced coordinated and timely diagnostic care. Referral information was reviewed appropriately to support safe and efficient pathways, and results were shared promptly to support continuity of care. This helped ensure people moved smoothly between services without unnecessary delay.

Leaders and staff demonstrated a clear understanding of how the diagnostic imaging service fitted within local pathways and the wider NHS system. The service engaged with system partners to support effective patient flow and continuity, including escalation processes when capacity pressures affected access or timeliness.

The service adapted care delivery to meet individual needs, including making reasonable adjustments and prioritising urgent or time-critical diagnostics where required. This supported continuity of care and timely onward treatment. The approach reflected an understanding of the diverse needs of the local population.

Systems were in place to ensure accurate information followed people through their diagnostic pathway. Diagnostic reports were provided in a timely manner and shared securely with referring clinicians, supporting informed decision-making and reducing the risk of delays in treatment.

The service considered the needs of people at greater risk of a poorer experience, including people with protected characteristics. Pathways and communication processes were adapted where needed to support equitable access and continuity of diagnostic care.

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.

People were given appropriate information before, during and after their diagnostic or screening appointment. Information was given to patients explaining what would happen, how to prepare, what the procedure involved, and how results would be communicated. This supported people to understand their care and reduced any anxiety they might have. Information was provided at the right time to support informed decision making. We observed staff explaining procedures clearly and responding to questions appropriately. Patient feedback confirming information was clear, easy to understand and provided in good time. Friends and family test survey results showed people knew what to expect from their diagnostic imaging or screening appointment and how and when they were likely to receive their results.

The service identified and recorded people's individual information and communication needs and took action to ensure these were met. Information was available in accessible formats, including easy read and alternative languages were required. Interpreting and translation services, including language line were used to support people who did not speak English fluently. This approach was in line with the accessible information standard and supported equitable access to diagnostic services. We observed staff explaining procedures clearly and responding to questions appropriately. We saw use of interpreters or accessible information on checking in screens in the receptions of the diagnostic imaging departments.

Staff took time to explain diagnostic procedures in plain English and checked patient's understanding before they proceeded. Where appropriate, staff provided reassurance and responded to any questions that patients or their families had. People were told how and when they would receive their results and who to contact if they had any concerns. We saw in records we reviewed that communication needs were identified and flagged. This supported a positive and responsive experience of care.

Information explaining how to provide feedback, raise concerns or make a complaint was available and accessible throughout the service. We saw posters in all areas detailing this information. Staff encouraged people to share their views and explained how feedback would be used to improve services. This helped people feel listened to and informed about how to raise concerns.

The service handled people's information in line with data protection requirements. People were told how their personal information and diagnostic results would be shared with relevant healthcare professionals to support their ongoing care and treatment. This supported continuity of care while respecting people's rights and choices.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

Whilst the service made it easy for people to share feedback and ideas, or raise complaints

about their care, treatment and support. However, they were not meeting their own complaints response targets. They involved people in decisions about their care and told them what had changed as a result.

The service sought feedback from people using diagnostic and screening services through a range of accessible methods, including the NHS Friends and Family Test (FFT), local patient satisfaction surveys, and informal feedback following imaging appointments. FFT results for the previous 12 months showed that over 90% of patients would recommend the service. Information explaining how people could provide feedback or raise concerns was displayed clearly within imaging departments, and people told inspectors they understood how to share their views. Staff encouraged feedback at the point of care and routinely checked people's comfort, understanding, and experience during and after imaging procedures.

Staff involved people in decisions about their care and treatment. They explained imaging procedures clearly, including what would happen during the scan, why it was required and what people could expect afterwards. People were given time to ask questions, and staff responded in a way that was easy to understand. Where appropriate, people were offered choices about appointments and adjustments, including positioning, scanning pace, and additional reassurance to support people who experienced anxiety, claustrophobia or physical discomfort.

The service had arrangements in place for managing concerns and complaints, which were consistent with NHS complaints standards. Staff understood how to recognise and escalate concerns and were confident in discussing feedback with people in a respectful and compassionate way. Complaints and negative feedback were treated as opportunities to learn and improve the service. We reviewed the 64 complaints that were partly or completely related to radiology for Queen Elizabeth Hospital during the 12 months preceding the assessment. The service consistently did not meet the requirements for complaints responses and resolutions as laid out in the Trust's complaints policy. Themes and trends were reviewed through governance processes and actions were implemented to address identified issues. Themes were related to appointment times, communication and attitude of staff. Learning from complaints and feedback was shared with staff through team meetings, governance forums and local communication channels including the departmental newsletter.

Staff worked with carers and advocates where appropriate and acted in line with the Mental Capacity Act when people required support to be involved in decisions.

Equity in access

Score

3. Evidence shows a good standard of care

The service tried to ensure the majority of people could access the care, support and treatment they needed when they needed it.

The service provided CT scanning and x-rays for the hospital's emergency department's (ED) out of hours service and was operational 24 hours a day, 7 days a week for emergencies. There was a walk-in x-ray service for outpatients. The service leaders told us of plans to extend both CT and MRI to 7-day services in conjunction with workforce transformation. Staff told us that not having 24/7 MRI provision made it difficult to provide an effective cauda equina syndrome service. National guidance states that patients with suspected cauda equina syndrome should receive an emergency MRI scan within 4 hours of referral. However, the Trust does provide MRI for suspected cauda equina between 8am-8pm, 7 days a week. After 8pm suspected cauda equina cases would be transferred to the local tertiary centre. DEXA scans are provided Monday to Friday from 9am to 5pm.

Patients could generally access the service in a timely way. The percentage of patients waiting over 6 weeks for diagnostic tests was below (better than) the England average. Data we reviewed showed in many areas performance exceeded 90% of patients receiving their diagnostic test within 6 weeks of referral. Staff and leaders told us of increasing demand across many areas of the service, and it was a struggle to meet the demand at times. This impacted on the performance of the diagnostic imaging services, the ability to be responsive to patients and consistently meet their needs in a timely way.

The Imaging Department had implemented daily huddles to closely monitor and manage performance across all modalities. This ensured patients who were at risk of breaching the 6-week diagnostic waiting time standard were identified and diagnostic appointments were scheduled within target timelines where possible. Patients on cancer pathways and patients who had been waiting for long periods were highlighted as part of this process.

Staff told us of ongoing work to improve capacity. This included working with local community

diagnostic centres, writing business cases for capital funding to purchase an additional MRI scanner, and undertaking lists on weekends. The service used teleradiology services to meet reporting demands. Leaders also informed us that radiologists employed by the service often undertook voluntary bank shifts as part of a plan to reduce reporting backlogs. The service provided data regarding reporting turnaround times; which demonstrated they were meeting the NHS England diagnostic imaging reporting turnaround times targets for the vast majority of the modalities for the 4 months from December 2025 to March 2026.

The 'did not attend' (DNA) rates for patients were relatively low, equating to 4.33% of scans completed in the 12 months from February 2025 to January 2026. Staff told us they had procedures in the event of patients not attending for appointments. A text reminder service was used to help improve attendance and the scheduling team made efforts to re-book vulnerable patients who missed appointments, in accordance with departmental process and the trust Access Policy.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

The service actively sought to understand whether people were at risk of experiencing inequality in their access to, experience of or outcomes from diagnostic and screening services. Staff used information gathered at referral, booking and pre-procedure stages to identify people who may require additional support, including people with protected characteristics, people with disabilities, people with learning disabilities, people with sensory impairment and people experiencing health inclusion needs. This information was used to tailor care and support so that people received equitable experiences and outcomes.

Staff demonstrated awareness of groups who could be at increased risk of poorer experiences

or outcomes and described how they adjusted care in response. Reasonable adjustments were made to imaging pathways, including extended appointment times, use of interpreters, alternative communication formats and support from carers or advocates where appropriate.

The service monitored feedback and experience data to identify any variation in experiences across different population groups. Leaders and staff reviewed this information through governance processes to understand whether inequalities were present and to determine whether additional actions were required. Where people raised concerns about discrimination or unfair treatment, staff understood how to respond, escalate concerns and provide appropriate support.

Staff involved people, and where appropriate their carers, in discussions about their care and made sure decision-making took account of personal circumstances and communication needs. When people required support to be involved in decisions, most staff acted in line with the Mental Capacity Act and ensured best-interest decision-making was documented and appropriately managed. However, we did find an example where this was not documented in a patients records.

The service used learning from feedback, complaints and individual experiences to improve equity in care delivery. Actions taken to address identified inequalities were shared with staff and incorporated into service planning and delivery. Overall, the service demonstrated that it listened to information about people most likely to experience inequality and tailored diagnostic imaging services so that experiences and outcomes were equitable.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

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.

At this assessment we rated this key question as good. We saw evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. 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.

The service and the trust 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 reflected the trust's vision and values of being responsive, working together, learning, respect and compassion, and improving quality. The strategy for the trust's diagnostic imaging service had a core priority which included extending the provision of X-ray services in the local area.

Leaders and staff told us values were embedded in training and were built into appraisals. This ensured everyone knew what was expected.

All staff we spoke with felt supported, respected and valued. This was reflected in the 2025 staff

survey results, which showed an increase in staff agreeing that their work was valued by the organisation. It was clear from speaking to staff that they felt their work was important to them, and they felt passionate about their contribution to the care and treatment they provide for people.

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.

Whilst we understand that there were vacancies within the leadership team which were being recruited to at the time of the assessment, we found that the leaders were inclusive and understood the context in which the service delivered care, treatment and support. They consistently demonstrated the values and culture of the organisation and led the service with integrity, openness and honesty. Leaders had the appropriate skills, knowledge and experience to lead effectively and were credible to staff working within the service. This supported a positive culture where staff felt respected, valued and encouraged to deliver high-quality care.

The service had a clear management and leadership structure, with defined lines of responsibility and accountability. Leaders understood their roles and how these contributed to the safe and effective running of the service. Robust recruitment processes were in place to ensure staff were appointed fairly and had the necessary competence and experience for their roles. These arrangements supported effective leadership and ensured staff were appropriately deployed.

Leaders met regularly through established governance and management meetings to review performance, risks and priorities. Minutes from governance meetings showed leaders had good oversight of the service and were knowledgeable about key issues affecting care delivery.

Leaders used these forums effectively to make decisions, agree actions and cascade information to staff within the service, ensuring communication was timely and consistent.

Leaders and staff told us they felt well supported to carry out their roles. Staff said leaders were approachable and visible, and that they felt listened to. Concerns raised by staff were taken seriously and acted on where required. This demonstrated a compassionate leadership approach and contributed to a supportive working environment where staff felt confident to speak up and raise issues.

Freedom to speak up

Score

3. Evidence shows a good standard of care

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

The service had a Freedom to Speak Up process supported by an up-to-date policy and named Freedom to Speak Up Guardians. The service's policy provided information on how to raise concerns internally and external to the service. Staff knew how to access support and raise concerns.

Staff and leaders actively promoted staff empowerment to drive improvement. The culture supported staff to speak up without fear of detriment. Leaders encouraged staff to raise concerns and promoted the value of doing so. Staff told us that they felt comfortable to raise any concerns and were confident that their voices would be heard and demonstrable action taken.

The service had established freedom to speak up arrangements. Information about the guardian and how to contact them was available on the intranet. Whilst not all staff knew the name of the trust's freedom to speak up guardian, they knew how to raise a concern.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

The service valued diversity in their workforce. They work towards an inclusive and fair culture by improving equality and equity for people who work for them.

Staff understood equality and diversity and its importance in building a strong workplace culture. Staff felt they were treated equitably, which was reflected in the latest staff survey. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff had training in equality and diversity. Staff understood the need to give everyone the same rights and opportunities and to value and respect people's differences. Recruitment practices were inclusive. The provider recruited staff through a range of processes.

Leaders took steps to ensure that staff and leaders were representative of the population of people using the service. Staff told us they had equal access to ongoing professional development. Opportunities to develop were advertised and staff completed an expression of interest.

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.

Diagnostic and screening services

The governance and management structure of the service was part of the trust's wider structure. This meant that management, risks and planning of the service included all of the trust's diagnostic services.

There was a clear management structure. Leaders and staff understood their roles and responsibilities. Leaders monitored the quality and safety of the service and identified where actions should be taken. Risks were monitored and reviewed. There was a clear reporting structure, from the service to the trust's board, with various meetings reviewing the quality and safety of the service. The service held specific meetings relating to the provision of ionising radiation services.

There were processes to monitor the performance of externally contracted support services. Information was kept secure between referrer, the service and the third-party provider reporting on out-of-hour scans.

There were capital investment plans across the trust's diagnostic imaging services that included purchasing a second MRI scanner for the department. Leaders encouraged staff to report concerns, incidents, and breakdowns to support decision making on capital investments.

The service had business continuity plans should the service be impacted by power cuts, fire or floods. Leaders told us the service was accessible and people who used the service provided positive feedback.

Information gathered about patients or others was held in secure systems which met data protection legislation requirements. Access to computerised patient records was password protected with a secure login.

Managers ensured radiation incidents were fed into risk management structures, and for accidental and unintended exposures, they notified the CQC in line with legislation.

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.

Leaders understood their duty to collaborate and work in partnership so that diagnostic and screening services worked seamlessly for people. The service worked constructively with internal departments and external partners to support coordinated care and timely access to imaging. This included primary care referrers, clinical services within the trust and system partners involved in diagnostic pathways.

Leaders and staff shared information and learning with partners to support service improvement and continuity of care. Relationships with partner organisations were used to identify pressures within the diagnostic pathway and to agree actions that supported safer and more effective services for people. Staff understood how partnership working supported person-centred care and improved outcomes, particularly where people required care across multiple services.

The service engaged with local systems and network partners to support planning and delivery of diagnostic imaging services that meet the needs of the local population. Leaders demonstrated an understanding of the local communities they serve and used partnership arrangements to contribute to service development and improvement. Learning from system working was shared within the service and used to inform local decision-making and priorities.

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.

There were effective systems in place to ensure leaders had oversight of incidents in the service, through trust radiation incident review. The meeting minutes we reviewed showed evidence of incidents being reviewed and lessons learned shared across all sites within the trust.

Leaders had created a culture where learning, continuous improvement and innovation were encouraged and embedded within diagnostic imaging services. Staff were supported to develop professionally, extend scope of practice and contribute to service improvement activity.

The service invested in workforce development and sustainability, including advanced clinical roles, practice development teams and apprenticeship pathways, to address capacity challenges and support high-quality patient care. These initiatives were aligned with local and national priorities for diagnostic services. The service supported innovation in clinical practice, including role development within sonography and imaging, and encouraged staff to test and adopt new ways of working safely. This helped improve access to diagnostic services and supported timely care.

Leaders had used structured impact reporting to evaluate whether learning and innovation activities improved staff capability, patient experience, service resilience and clinical productivity. Findings were shared to inform future planning and improvement work. Staff were encouraged to participate in learning beyond mandatory training, including communication skills, leadership development and specialist clinical education. Learning opportunities were tailored to service need and staff roles.

Medical care (Including older people's care)

Medical care (Including older people's care)

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

Our view of the service

Lewisham and Greenwich NHS Trust provide medical care services at both the Lewisham Hospital and Queen Elizabeth Hospital sites. The Queen Elizabeth Hospital has 15 medical wards and 377 inpatient beds.

We last inspected medical care services at Queen Elizabeth Hospital on 11 February-11 March 2020, and we rated the medical care service at this inspection as good overall.

We conducted this announced assessment on 24 and 25 February 2026 as part of our winter pressure programme, which meant we looked at a reduced number of quality statements. We visited 5 wards, a discharge lounge, and same day emergency care (SDEC). We spoke with 45 members of staff, including healthcare assistants, ward clerks, domestic workers, nurses, matrons, doctors, and senior leaders.

We rated the service as good. The service had made improvements to medicines management, mandatory and safeguarding training, out of hours medical cover and the planning and management of the service experiencing full capacity. However, we found 5 breaches of the regulations in relation to

safe care and treatment and governance. Patients who were no longer suitable for corridor care were not transferred in a timely manner, risk assessments were not always completed in line with trust guidance, clinical areas did not always follow national fire safety guidance infection, prevention and control (IPC) principles were not always followed, and patient confidentiality was not always maintained.

We have requested an action plan in response to the above breaches from the provider at the time of publication of the formal report.

People's experience of the service

Patients, their families, and carers were positive about their interactions with staff and the treatment they received. All patients, carers and families we spoke with reported that staff were friendly, and that they were treated with compassion and kindness. Most patients were aware of the plan for their ongoing treatment, and the reason for their admission was explained to them in a manner they understood.

Patients we spoke with reported that staff were very respectful, very caring and patients never felt rushed as they take their time to explain things.

Patients knew how to make complaints and give compliments about the service. The Family and Friends test had an average rate of 325 responses each month across all medical inpatient wards. Data for the last 12 months showed that 94% of respondents were positive about the care received and only 2% of patients reported experiencing poor care.

Safe

Rating Requires improvement 

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also ensured that people’s liberty was protected when it was in their best interests and in line with legislation.

At our last assessment, we rated this key question as requires improvement. At this assessment the rating has remained requires improvement. This meant some aspects of the service were not always

safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At the previous inspection the service was in breach of safe care and treatment in relation to medicines management. At this assessment, the service was in breach of safe care and treatment, relating to management of corridor care, risk assessments and infection prevention and control.

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. The service fostered a culture of 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 via the trust intranet. This system was available to all staff, who also reported that they were debriefed and received support after a significant patient safety event.

The service ensured that lessons were learned, and improvements made when things went wrong. The service had a Patient Safety Incident Response policy in place which supported staff to identify which learning response would be the most appropriate depending on the patient safety event. These learning responses included patient safety incident investigations (PSII), after action reviews (AAR), case reviews, multidisciplinary (MDT) reviews, structures judgement reviews (SJR) and mortality and morbidity reviews. The service had reported 4 significant patient safety events in the past 12 months, all of which were under investigation as PSIIs, and none had exceeded the trust's 6 month completion timescale.

Staff reported that they received feedback on incidents they reported, and learning was shared through handovers, emails, safety huddles and team meetings. The service also facilitated learning events where incidents, and the changes made as a result, were discussed. For example, we saw targeted training on recognising and responding to deteriorating patients using assessment tools and clinical judgement had been introduced following a serious incident. Staff also reported that a quality improvement (QI) project resulted in the introduction of a new type of dressings on the respiratory ward. The QI project was commissioned after staff observed an increase in pressure ulcers on patients ears due to their oxygen masks.

All staff we spoke with were aware of the complaints and compliments process. We observed posters on the wards advising people how they could make a complaint if needed. The service monitored complaints and made appropriate changes in response. An example of this was an increase in complaints from patients and their families about corridor care within the unit due to a lack of inpatient beds. In response, the service introduced a formal letter for all patients in corridors, explaining the reason for their placement and the plan going forward. The service reported a positive response from patients following to this introduction.

Staff understood the duty of candour. They were open and transparent and gave people and families a full explanation if and when things went wrong. The service completed formal duty of candour for incidents and had a 90% compliance in the last 12 months. The service did not identify the trust target.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the 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. However, the service did not always ensure patients who were no longer suitable for corridor care were transferred in a timely manner and we observed breaches in length of stay in clinical areas.

Most patients were admitted to the service from the emergency department, while others were referred directly by hospital departments or their general practitioner (GP). Patients would either be sent to the acute assessment unit (AAU) or directly to a medical ward. The AAU opened in November 2025 and comprised several areas, including the Acute Assessment Unit (AAU), Frailty Same Day Emergency Care (Frailty SDEC), the Acute Frailty Unit (AFU), and the Acute Medical Unit (AMU). The area was a specialised short-stay unit for assessing, diagnosing, and treating patients with acute illnesses before being discharged or transferred to an inpatient ward. Each area within the unit had defined inclusion and exclusion criteria and a targeted time for patients to stay (length of stay).

During the assessment we observed the longest length of stay within the unit was 7 days, which was outside the trust's target of 3 days. The service had introduced patient flow co-ordinators to monitor and manage patient flow, who were available in the unit 24 hours a day, 7 days a week. Flow coordinators used the electronic bed system to monitor admissions into the area, transfers of patients to inpatients wards, and oversaw the discharge of patients. They were physically on the AAU every shift and monitored the electronic bed management system that all areas within the service had access to, to facilitate flow. Flow coordinators reported having good relationships with all areas to facilitate flow throughout the service.

February 2026 data showed that the average length of stay in AAU was 28.8 hours, against a target of 24 hours. The average length of stay in AFU and AMU was 72.2 hours, against a target of 72 hours. The service reported that the increase length of stay in AAU was due to patients being discharged directly from this area, as opposed to being transferred to an inpatient ward and occupying a bed for a longer period. This meant that although the length of stay was increased, discharges were being facilitated quicker due to increased medical staffing in AAU.

The trust had increased bed occupancy rates of over 96% between February 2025 and January 2026, which coincided with the national picture of increased demand for care. Trust-wide, there was an acuity tool, internal flow and escalation policy and multiple bed management and flow meetings throughout the day, to safely manage patient flow through the hospital. Due to ongoing national challenges with patient flow, staff reported that additional patients were sometimes cared for in areas designed to accommodate fewer patients. This was done through boarding, where additional beds were placed in bays or ward corridors. During the assessment we observed 4 wards boarding patients. Data showed the number of patients using escalation beds was 274 in November 2025, 277 in December 2025 and 577 in January 2026. This data

showed an increased demand on the service, particularly in January 2026.

The decision to initiate corridor care was made by senior leaders, who followed the trust policy process which includes a risk assessment for each patient. According to the trust, patients being cared for in a corridor should have a regular risk assessment completed. This included but was not limited to assessing whether the patient was suitable for the area, privacy and dignity was maintained, there was access to a call bell and locker and whether routine observations were carried out. Evidence submitted by the trust showed that these risk assessments were completed regularly. However, transfer of patients who began to deteriorate whilst being boarded in corridors was not always done in a timely manner. During the assessment we observed a patient who was originally assessed as suitable for corridor care deteriorate. Due to lack of capacity within the service the nursing team were unable to move the patient to a patient designated area immediately, which impacted the patient's dignity. This was escalated to the nurse in charge, and the patient was appropriately moved to an inpatient bed.

Staff involved all the necessary healthcare and social care services to ensure patients had continuity of safe care, both within the service and post-discharge. Each clinical area held daily multidisciplinary board round meetings where patients were discussed in detail including their discharge plans. We observed a board round meeting which was led by the nurse in charge and included representatives from the nursing, therapy, medical and discharge teams. Patients' needs were thoroughly assessed and discussed at the meeting, and support for discharge was identified early and actions put in place. We observed how the team spoke respectfully to one another and were knowledgeable about each patient's individual circumstances and took early action to prevent issues with discharge.

The service used an electronic patient notes system that was used across the wider trust. This meant all staff could access patients historic and current care records securely and instantly. Staff also had access to diagnostic testing, which were requested via an electronic system and staff did not report any issues with access or delays.

Staff planned for patients' discharge; the trust had a discharge team and a transfer of care team to facilitate discharges and reduce readmissions. Both teams liaised with clinical staff, social services, local authorities daily, to facilitate discharges to the community, care homes or specialist units. Electronic discharge summaries were provided to appropriate care providers

on discharge to inform them of the patient's admission to hospital, medications, and any follow up care that may be required.

Data showed that the service was able to consistently discharge over 80% of patients before 5pm between November 2025 and January 2026. Delayed discharges were monitored. The average delay for patients, after being declared medically fit for discharge was 6.6 days in September, 6.3 days in October and 6.3 days in November 2025, against a trust target of 6.5 days. Staff reported the most common reasons for delayed discharges were lack of appropriate placement in the community including rehabilitation placements and social issues.

The service had an ongoing action plan in place to avoid delayed discharges. This included but was not limited to the development of a weekend discharge planning structure, introduction of 7 day working for social care and discharge teams and the introduction of a new discharge system.

Safeguarding

Score

3. Evidence shows a good standard of care

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

Staff knew and understood how to identify people at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

We observed patients with vulnerabilities such as safeguarding needs, specific mental health needs, learning disability needs, autism and cognitive impairment being identified in patient

notes. The trust had a safeguarding team in place, and staff knew how to contact them for advice and support. They also knew how to make a safeguarding referral.

The trust had a Safeguarding Adults policy and a Safeguarding Children, Young People and unborn policy in place both of which were in date and comprehensive. Staff had a good understanding of deprivation of liberty safeguarding practices (DoLS) and the mental capacity act (MCA). Staff were able to show us completed DoLS forms on electronic patient records (EPR) and could explain how they were managed.

The service provided safeguarding training on how to recognise and report abuse and had the appropriate level training for their role. Overall staff compliance with safeguarding adults training level 1 to 3 was 94% and 91% for children and young people level 1 to 3. Both of which exceeded the trust target of 90%. However, within the figures we noted areas of poor compliance particularly for rotational medical staff and neurology nurses who both had 70% compliance. In response to this the service reported that they had sent a reminder to the leads for all areas and temporary bank staff.

The trust provided MCA and best interest training as part of mandatory training, with compliance exceeding the trust target of 90%. The trust is also providing Oliver McGowan training. Compliance for tier 1 and tier 2 training was 88% and 60% respectively, both of which met the NHS England (NHSE) target of 30% by the end of April 2026.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

Staff provided care to meet people's needs that was supportive and enabled people to do the things that mattered to them. However, risk assessments were not always completed in line with trust guidance.

Staff had access to policies and procedures to support them with assessing risk of harm and deterioration of patient's conditions, which included the type of risk assessment and how often

they should be carried out. However, staff did not always complete risk assessments for each patient using nationally recognised tools.

Risk assessments included, but were not limited to, falls prevention and assessment, pressure ulcer, waterlow, sepsis and pain. We reviewed 7 patient records which showed good compliance with risk assessment completion. However, audit data showed falls prevention and assessment compliance was 72% in November 2025, 58% in December 2025 and 63% in January 2026, which was below the trust target of 90%. The service had an action plan to address the poor compliance. This included but was not limited to the introduction of ward-based education sessions, daily spot checks by senior nurses and development of fall prevention champions for each ward.

Audit data for pressure ulcers also showed poor compliance of 63% in December 2025 and 64% in January 2026. The service had an action plan to address the poor compliance. This included but was not limited to increased senior oversight through daily audits.

Staff we spoke with reported that they received up to date training on sepsis and the management pathway for patients with septic symptoms. However, we did not observe any patient notes that required this pathway to be triggered, and the service did not provide sepsis audit data. This meant that we could not be assured that the service was adhering to national guidance of sepsis management.

Staff used a nationally recognised tool to identify deteriorating patients. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. NEWS2 charts reviewed during the assessment were completed, scored and escalated appropriately if required to medical staff. Audit data showed over 90% compliance between the months of November 2025 and January 2026. However, we observed a patient's notes with an increased NEWS2 score with no record of escalation to medical staff.

Patient pain levels were documented in all patient records we reviewed. Audit data showed pain assessment compliance was 88% in December 2025, 98% in January and 97% in February 2026 against a 90% target.

Staff communicated with patients and their families so that they understood their care and treatment, including finding effective ways to communicate with people with communication

difficulties. Staff informed us that translation services were available for people whose first language was not English, as well as hearing loop availability for people with hearing impairments. All patients and families we spoke with told us they were involved with the decision making about their treatment.

Systems were in place for patients and their families, friends, or carers to escalate concerns about their conditions. The service had implemented 'Martha's rule' which allowed patients and their families to contact the critical care outreach team, if they felt their condition was getting worse and was not being addressed by the staff on the ward. Posters advertising this service were visible on the wards however, this was only available in English. Which meant patients whose first language was not English may not utilise this function if required.

Safe environments

Score

1. Evidence shows significant shortfalls in the standard of care

The design of the environment followed national guidance. However, staff did not follow national fire safety guidance.

Fire safety risks were not always mitigated in clinical areas. We observed the door to the dirty utility room, which was also a fire door, being wedged open. This was not in line with national guidance as this was a fire door and should have been kept shut at all times. We also noted that the utility room was overloaded with boxes and equipment, which was another fire safety risk. This was escalated to the nurse in charge, and the fire door was immediately closed, and staff attempted to arrange the room appropriately. We also observed a fire exit within a clinical area being obstructed by a bed, and saw this was resolved by moving the bed to an appropriate location. However, the service did have an in-date fire safety policy, and each area had a fire safety folder which included a fire safety risk assessment.

We also noted that an inpatient ward had not completed the recommended actions in response to a ligature risk assessment. This was escalated and the service reported that the emergency response to a self-harm attempt and the location of ligature cutters were being discussed at

staff huddles.

Doctors reported space constraints in clinical areas and difficulties with clinic room availability. We observed this concern being discussed at the January 2026 divisional governance meeting, which reported that the trust was reviewing space utilisation.

Patients could reach call bells and staff responded quickly when called. We observed staff ensuring all patients had call bells within reach as well as other equipment, for example walking aids. Patients we spoke with told us staff mostly responded to them quickly.

The design of the environment followed national guidance. Security arrangements were in place to ensure only authorised personnel entered wards. Staff gained access to wards and clinical areas with electronic swipe cards. Visitors gained access using an intercom system, which enabled staff to monitor visitors and patients entering the wards.

All wards we inspected were arranged to ensure separate male and female bays, with separate toilet and washing facilities allocated to each bay. Piped or portable oxygen and suction equipment were available at each bed space.

Staff generally carried out daily safety checks of specialist equipment. Emergency equipment was easily accessible and were available on each ward and clinical area. There were tamper proof tags on the drawers used to store equipment and medication. Checks were recorded electronically and compliance was monitored by management. Resuscitation equipment we reviewed onsite were checked daily and all items were present and in date.

The maintenance and use of equipment kept patients safe. Electrical appliances and equipment we checked during the inspection had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show that this had taken place.

Staff managed clinical waste well. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. We observed cleaning equipment stored securely in locked cupboards.

However, we noted that an inpatient ward had not completed the recommended actions in response to a control of substances hazardous to health (COSHH) risk assessment conducted. This was escalated and the service reported that ward managers were working with the health

and safety team to close all actions, with a target for completion in March 2026.

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.

Medical and nursing staffing met planned numbers on both days of the assessment. Staffing charts were clearly displayed on all wards, showing both the planned and actual staffing levels. Trust data showed staff fill rates were consistently over 100% between September and November 2025.

The service planned and regularly reviewed staffing levels and skill mix to ensure people received safe care and treatment. Leaders used recognised staffing tools to ensure that there was enough staff to deliver care and treatment and completed a staffing exercise biannually. However, staff did not always feel that the staffing exercise and adjustments to staffing as a result were always reflective of the clinical pressure. Staff felt comfortable raising their concerns to senior leadership and leaders adjusted the staffing template where possible after consultation with staff.

Staff reported that temporary staffing was used to cover consultant vacancies. The vacancy rate for consultants was 11% as of October 2025, which exceeded the trust target of 10%. The current average vacancy rate for nursing and medical staff within the service was 10%, which met the trust target.

Senior leaders reported that they are currently recruiting which should mitigate against some of the vacancies. Bank and agency staff received induction to the service and told us they regularly worked at the service as their preferred temporary employer.

Medical staff reported that there was adequate 24-hour medical cover. Data submitted by the

service showed medical cover between 12am and 8am was 96% in November 2025, 86% in December 2025 and 99% in January 2026. This was an improvement from the last inspection in 2020.

All staff we spoke with told us they enjoyed working at the service. The staff turnover rate within the service was 9.25% in September, 9.13% in October and 9.32% in November 2025, which was below the trust target of 9.5%. The current average sickness rate for nursing and medical staff within the service was 4%, which was in line with the trust target of 4%.

Staff had received and were up to date with appropriate mandatory training. Mandatory training included topics such as conflict resolution; equality and diversity; fire safety; health and safety; infection control; information governance; medicines management and moving and handling. Mandatory training compliance for all staff was 91% which exceeded the trust target of 90%. and was an improvement from the last inspection.

All staff we spoke with told us they received yearly appraisals. Appraisal compliance for all staff was 94% which exceeded the trust target of 90%.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always manage the risk of infection spreading.

Staff did not always follow infection, prevention and control (IPC) principles, including the use of personal protective equipment and being bare below the elbows. Patients with infections were nursed in side rooms with appropriate signage displayed to reduce the risk of spreading infection. Apron and gloves were stationed near to all side rooms to ensure that both patients, relatives and staff were protected. However, we observed staff entering side rooms without using the appropriate personal protective equipment (PPE).

Hand hygiene signage was displayed throughout wards and the service regularly audited hand

hygiene. Hand hygiene data between November 2025 and January 2026 showed an average of 95% against a trust target of 95%. However, during the assessment we observed staff members were not always bare below the elbow, and some staff had false nails, which is against the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. This was escalated to senior leaders on the first day of the assessment and we observed a reminder being given to staff at handovers the next morning.

Clinical areas were not always visibly clean. Cleaning was carried out against a cleaning schedule and records we reviewed were up to date and demonstrated that all areas were cleaned regularly. However, we observed trolleys with visible layers of dust, clinical areas with blood on the floor and a door to a dirty utility area being left open. This was escalated to senior management and rectified immediately. The service had suitable furnishings which were well-maintained.

The trust monitored key metrics in relation to infection rates, including Clostridioides difficile (C. Difficile), Methicillin-resistant Staphylococcus aureus (MRSA), Escherichia coli (E. Coli). In November 2025 the trust reported 2 cases of C. Difficile, 0 cases of MRSA and 4 cases of E. coli. All cases were monitored and managed in line with the trust policy.

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.

Medicines, including controlled drugs, were stored in secure storage areas with access restricted to authorised staff.

In records we reviewed, we saw that people received their medicines as prescribed, including medicines that were time sensitive.

We also saw the Venous Thromboembolism (VTE) assessments were completed and prophylaxis prescribed where appropriate. Staff recorded information about patient allergies.

Wards were supported by pharmacy team members including pharmacists, pharmacy technicians and pharmacy assistants. Whilst there was not always enough staff to support every ward, the service used a flexible cluster support system to direct clinical support the areas that needed further support. There were twice daily meetings to discuss areas of need, learning and ad-hoc training. The pharmacy team support was embedded on the wards. We saw positive interactions and interventions from the pharmacy team with ward-based staff. On all the areas we visited, people's medicines were reconciled in line with national guidance. (Medicines reconciliation is the process of accurately listing a person's current medicines and comparing them with the current list in use to reduce the risk of medicine related patient safety incidents). Evidence provided by the service showed that they performed generally well across the hospital in regard to medicines reconciliation. According to data provided by the trust, 70% of patients had their medicines reconciled within 24 hours of being admitted. Where people did not receive medicines reconciliation, pharmacy technicians supported timely completion of drug histories and prioritised patients for further review.

We saw that medicines to take away (TTAs) were supplied in a timely manner. We saw that the pharmacy department consistently met trust targets for timely turnarounds of TTA medicines. The service used satellite dispensaries to support people being discharged in a timely manner. However, staff told us that pharmacy space was limited and this could affect capacity to safely dispense medicines.

Staff told us they could access medicines they needed in a timely way, including medicines that were not routinely stocked. The service had a process for staff to obtain medicines during out of hours.

People were offered regular pain relief. We saw that the service completed regular audits around pain management where most areas scored consistently above the service target of 90%.

The service completed regular quarterly audits and medicine management compliance checks. We saw that areas that were not compliant were discussed at the medicines management working group with actions to improve in non-compliant areas.

Staff told us they had access to trust medicines guidelines and policies. They had also access to medicines related national guidance and resources.

Staff received regular and ad hoc training medicine related training including weekly focussed sessions held on teams. Pharmacy team members were supported to develop and supported to complete clinical diplomas.

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.

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

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The service planned and delivered people's care and treatment with them in line with best practice.

Staff planned and delivered care in collaboration with patients and their families, ensuring that treatment was personalised and aligned with best practice standards. Care and treatment were provided in accordance with national guidelines and evidence-based practice, with staff demonstrating a strong understanding of clinical protocols. We saw evidence of clinical guideline introduction and updates being discussed regularly at monthly governance meetings

and action plans being developed to monitor this.

The service was involved in national audits which included but was not limited to the myocardial ischemia national audit, chronic obstructive pulmonary disease audit and the national cardiac arrest audit. These audits aimed to improve the quality of diagnosis, treatment and management of conditions by collecting, analysing and disseminating data collated by various hospitals. They also allowed the trust to benchmark themselves against other trusts. The service was not a negative outlier in any of the medicine related audits.

The service also conducted local audits to monitor clinical outcomes, these included but were not limited to admission rates, average length of stay, readmission rates overall and for specific conditions. The service then used this data to drive improvements and changes within the service. Evidence of this was the introduction of the acute medical unit model in November 2025 in response to increased length of stay. The new model incorporated the acute assessment unit, acute medical unit, frailty same day emergency care (SDEC) and acute frailty unit in one clinical area. Since the introduction of this model the service audits have shown a reduction in patients' length of stay within the area.

The service was actively involved in quality improvement projects to improve the quality of care and treatment. Following a pilot project the service introduced yellow jugs and cups for adult patients on fluid restrictions, to provide a visual prompt to remind staff to monitor the patient's fluids intake and output.

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.

Staff demonstrated effective collaboration between teams and services, ensuring continuity of care and patient safety. Nursing, medical, physiotherapy, SaLT (Speech and Language Therapy), discharge and specialist care teams were all visible during our assessment to support patients.

We observed effective working relationships. A team-based approach was particularly evident during ward rounds and board rounds, where staff worked together to review treatment plans, assess progress, and identify any ongoing support needs.

Staff described good working relationships with colleagues in the division with medical staff being accessible when needed.

Staff had access to an electronic system that recorded patient pathways and care plans, which they reported as effective in maintaining clear communication and coordination between different teams.

Patients we spoke with reported that staff were supportive, actively involved them in their care and gave them the opportunity to discuss their worries and concerns. The service had a frailty service which included the frailty same day emergency care unit and the acute frailty unit. Frailty services had dedicated medical staff during the day and was covered by general medicine medical staff overnight. The service worked closely with outpatients and community services to ensure elderly patients had support as inpatients and in the community. Outpatient and community services included perioperative care of older people clinics, fall and frailty clinics and memory services.

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 using quality improvement projects, introduction of new initiatives and technology.

The service actively submitted data to the getting it right first time (GIRFT) dashboard. This allowed the service to analyse outcomes over time and benchmark themselves against other services within the integrated care board and nationally. Staff we spoke with were aware of this dashboard and areas that required improvement. For example, GIRFT data showed the service’s readmission rate between November 2025 and January 2026 was 12.5%. This was

slightly higher than the national target of 11.1% however, senior leaders were aware of this and reported ongoing work to reduce this figure which included, the introduction of a frequent attender lead in the emergency department and a new review system to monitor trends in readmissions.

Staff demonstrated good use of risk assessments to identify the needs of patients in relation to their nutritional needs. We observed mealtimes being protected and red trays being used to easily identify patients who needed extra support.

Staff used technology to support patients effectively. Through audits it was identified that staff did not always categorise pressure ulcer wounds appropriately. In response the service introduced a protected app that allows staff to take pictures of pressure ulcers with patients consent and store them in patient notes. This allowed staff to confirm categorisation and track wound healing or deterioration to improve outcomes.

The service carried out quality improvement (QI) projects to improve patient experience and outcomes. An example of this was an optimising lumbar puncture for acute medical patients QI project. The project aimed to reduce inefficiencies caused by equipment availability and distribution, by introducing pre-made lumbar puncture packs. Findings showed a significant reduction in time required to collect equipment, visits to other departments and missing equipment. The service continued to monitor the upkeep and usage of the premade packs.

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-centered care and treatment.

Staff took all practical steps to enable patients to make their own decisions. Patients and families were provided with verbal and written explanations of procedures, including potential risks and benefits. Staff were observed taking the time to thoroughly explain treatments,

ensuring that patients understood the nature of the procedure before providing consent.

The service had systems in place for obtaining consent for patients with communication difficulties. This included translation services for patients whose first language was not English.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes. Staff were easily able to identify patients under Deprivation of Liberty Safeguards (DoLS) and the mental Capacity Act (MCA) and reported that multidisciplinary discussions were used to make decisions for patients.

All patients we spoke with told us they had an opportunity to ask questions about their care and treatment and understood it. One service user told us that staff were patient and gave allowed the time to "take everything in", which allowed them to be actively involved in all decision making.

Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. We checked that people's privacy and dignity was respected. We 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. We also looked for evidence that staff wellbeing was valued, and that staff were supported and enabled to deliver consistently person-centred care.

At our last assessment we rated this key question good. At this assessment the rating has remained as 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; However, confidentiality was not always maintained.

Staff treated people with kindness and compassion. We observed caring interactions across the wards. Staff approached patients calmly, introduced themselves, explained what they were doing and checked people's understanding before continuing care. Patients told us staff were kind, respectful and responsive to their needs. One patient described staff as "so helpful and wonderful." We also saw "thank you" cards displayed on the wards praising staff for the care they provided.

Staff communicated with patients clearly. They took time to answer questions and help people understand their treatment. Patients told us staff answered their questions and kept them well informed about their care. However, 1 patient told us they did not always receive the information they needed.

The service monitored patient experience through the Friends and Family Test (FFT), which showed consistently high levels of satisfaction across the inpatient wards. The FFT had an average rate of 325 responses each month across all medical inpatient wards. Positive scores were 96% in November 2025 and 93% in both December 2025 and January 2026. Although the December and January results fell slightly below the trust's 95% target, the feedback still indicated that most patients reported a good overall experience.

Staff showed a good understanding of patients' individual needs. We observed staff who knew patients preferences and backgrounds and used this knowledge to provide personalised and compassionate care. Patients told us they were supported to keep in touch with family and friends. Staff also described systems that helped people remain connected with those important to them, such as the use of carers' passports. Although we observed many family members and friends visiting patients, we did not see evidence of carers' passports being used in the patient notes we reviewed. Chaplaincy services were available, and we saw the chaplain visiting patients. Patients were given information about the chaplaincy service in the 'Your Stay in Hospital' leaflet, which provided patients with key information about their admission to the hospital.

Staff could raise concerns without fear of the consequences. Staff told us they understood the escalation routes and knew how to contact the Freedom to Speak Up Guardian. Information

about the Guardian was clearly visible throughout the department.

Staff promoted privacy and dignity. We saw staff closed curtains and doors during consultations to maintain patient privacy. However patient confidentiality was not always maintained. In some areas, board rounds took place in corridors, where staff discussed sensitive patient information without sufficient privacy. This was escalated to senior leaders, who reported they would remind staff the importance of confidentiality.

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 identified and responded to changing patient needs. On wards with patients at higher risk of falls, patients wore anti-slip socks and staff displayed clear information for staff and patients on how to minimise falls.

We saw board rounds were comprehensive and discussed changes in patients' needs. We observed intentional rounding and staff supporting patients through mealtimes. Patients told us they had access to specialist teams like speech and language therapy (SaLT) and physiotherapy to support when needed.

Doctors involved patients in discussions during daily ward rounds, ensuring that both medical and social needs were reviewed with them. Risks and benefits of treatments were clearly explained. We observed this during a discussion with a patient who wished to be discharged, clinicians encouraged the patient to ask questions and take an active role in decisions about their care.

We observed staff respond promptly when people used their call bells or requested assistance. People said they felt listened to and supported, and staff took steps to ensure patients were

comfortable.

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-centered care.

Staff were supported and felt positive and proud of their work. Staff at all levels told us they felt well supported in their roles. One staff member told us they enjoy their work because of the great teamwork. We saw leaders encourage staff to document and report incidents of abuse from patients, which showed a proactive approach to supporting staff and promoting a respectful working environment.

Staff had access to support for their physical and emotional health needs. The trust had several wellbeing initiatives in place, including a stop-smoking clinic and a wellbeing trolley that provided food and drinks during shifts. Staff told us there was a dedicated wellbeing team available and a wellbeing at work policy they could refer to.

Staff were recognised for their contributions to the service, with initiatives such as the 'Lewisham and Greenwich Trust Star Awards'. Nominations were submitted across the trust by patients, relatives, and carers, and recognised nurses and support workers who provided exceptional care. Staff were then presented with a certificate and thank you card.

Staff had regular one-to-one meetings with their managers and received annual appraisals, which was corroborated by appraisal rates exceeding the trust target of 90%. Staff told us they had good access to ongoing development and were encouraged to take up learning opportunities. For example, staff said leadership supported attendance at away days, and the Chief Nurse delivered a session as part of the programme.

Responsive

Rating Good

Medical care (Including older people's care)

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.

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

Staff used structured assessment processes to ensure that patients received care tailored to their individual health, wellbeing, and communication needs. Patients also felt empowered to make their own decision about their care with the support of the service. For example, the service had a patient requiring both respiratory and maternity input and facilitated the patient's wishes to remain on the respiratory ward antenatally due to the positive rapport that had been built. The service worked closely with staff on the maternity unit to facilitate this and ensure the patient received safe care.

We reviewed 7 patient records during the assessment and found that care plans were personalised, holistic and updated when necessary. Multidisciplinary ward rounds that we observed were comprehensive and we observed risks and benefits of care options being discussed to ensure patients could make informed decisions.

The service took steps to support carers of patients, recognising the importance of their physical and emotional wellbeing. Patients received support from the therapies teams as

required. The service also facilitated visitors of end-of-life patients to have unrestricted access.

We observed staff treat all patients equally and with dignity and respect. Equality and diversity was part of staff mandatory training, training compliance rates were 95%, which exceeded the trust target of 90%.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

The service supplied appropriate, accurate and up-to-date information however, this was not available in multiple formats that were tailored to individual needs.

We observed several information boards and leaflets throughout the service that patients and their families had access to. This included but was not limited to information on dementia, tissue viability, infection prevention and control and pressure ulcer wounds. However, there were limitations in the availability of information in different formats and languages. While translation services were available, there was no evidence of and staff did not mention any access to printed materials in other formats or in languages other than English.

Staff provided patients and their families with precise and current information, helping them understand their care, treatment options, and any changes to their treatment plans. We observed clinicians dedicating time to answering patients' and families' questions, ensuring that information was clearly explained and understood.

The trust had a smoking cessation team that were running a ‘Swap to Stop’ campaign to eliminate smoking and reduce health inequalities. This included recommending vaping as a safer alternative to smoking tobacco as concluded by independent expert research.

A principal health psychologist was also awarded a grant to tackle gaps in mental health and obesity care. This will allow a study focussed on reducing mental health inequalities in access to obesity treatments, starting with patients with binge eating disorders.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

The service encouraged people to share feedback and ideas, or raise complaints about their care, treatment and support. However, complaints were not always managed in a timely manner.

The service had mechanisms for patients, families, and carers to provide feedback, including formal complaint procedures, the friends and family test, and direct feedback to staff. However, complaints were not always managed in a timely manner. The hospital offered many ways for people to share their experiences. Most patients we spoke with were aware of how to raise a formal complaint but reported not needing to.

Ward managers reported that complaints made to the patient's advice and liaison service (PALS) were referred to them to be managed locally and escalated to the complaints team if they were not resolved. Between February 2025 and January 2026, the service had received 278 formal complaints, of which 1 had been referred to the ombudsman in the last 12 months.

The service's response rate against the agreed timeframe did not always meet the trust target of 80%. The response rate was 71% in September, 100% in October and only 50% in November 2025. Complaints were discussed at monthly governance meeting however, meeting minutes did not identify plans to improve compliance or how delays are communicated to patients.

Staff reported that learning from complaints were disseminated through emails, daily ward huddles and learning events. Staff were also able to give examples of changes made to the service in response to complaints. An example of this was the introduction of a visitor's passport that identified patients next of kins and provides them with authorisation to visit the ward outside of hours. This ensured that all staff would be aware of the agreement and avoid unnecessary challenge. We also observed positive feedback and compliments being shared at monthly governance meetings.

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 were able to access care when required as the service was open 24 hours a day, 7 days a week. Data showed that bed occupancy within the service was consistently high however, the trust utilised corridor care on wards to combat demand.

The average length of stay for patients within the service was 9 days in November, 9.9 days in December and 10.8 days in January 2026. This exceeded the national average of 6.9 days. The service reported ongoing work to reduce increased length of stay. This included but was not limited to daily length of stay reviews by matrons, development of a weekend discharge planning structure and a review of the discharge lounge structure to increase optimisation.

We observed staff making reasonable adjustments for patients. This included walking aids being provided and accessible bathrooms with shower chairs for patients who required them.

Staff reported having adequate medical cover day and night and that doctors could attend the ward quickly in an emergency.

The service had access to virtual wards which was facilitated by a partner NHS trust, which would allow patients to be discharged sooner as they would receive acute care monitoring and treatment at home. However, senior leaders reported that this service was underutilised. Data for January 2026 showed that the service received 120 referrals per weighted 100,000 population, against a national target of 180 referrals per weighted 100,000 population. Senior leaders, they were working with the local authority to improve this.

Planning for the future

Score

3. Evidence shows a good standard of care

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Staff ensured all relevant healthcare professionals and other relevant bodies were involved in planning the care and treatment of people with complex needs. We observed discussions about complex cases and referral arrangements during multidisciplinary board round meetings.

Staff supported patients and their families in making informed decisions about their future care, ensuring that patient with complex or life-limiting conditions received the necessary support and planning for their ongoing needs. Staff reported that where treatment options were changed, limited, or withdrawn, they communicated openly and sensitively with families, ensuring that decisions were made collaboratively and in line with what mattered most to the patient and their carer's.

Patients and their families were encouraged to express their wishes about care interventions, including preferences around cardiopulmonary resuscitation (CPR), with opportunities to review and revise their decisions as needed. We observed evidence of treatment escalation plans (TEP) being discussed and documented appropriately.

We observed multidisciplinary teams working to coordinate care and supporting patients and their families to navigate important transitions in care.

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.

At our last assessment we rated this key question good. At this assessment the rating has remained as good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At the previous inspection the service was not in breach of regulation. At this assessment, the service was in breach of good governance, relating to the management of patient confidentiality.

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 established a clear and shared vision for the medical service. The medicine division followed the trust wide vision and values but also had their own vision and strategy. The vision for the division was commitment to quality care, culture of excellence and learning, focus on health equity and digital transformation and partnerships. The strategy to accomplish this vision was broken down into 6 priorities:

High Quality Safe Care

Patient Flow and Access

Improving Patient Experience

Workforce Development

Digital Excellence and Data

Governance and Assurance

The service did not however, identify when the vision and strategy was developed or whether it was created in collaboration with stakeholders. Staff we spoke with could not remember each individual priority within the vision and strategy but could explain how the service was working to deliver high quality care.

Staff described the culture within the service as positive, with strong collaboration across departments. Staff reported feeling valued and empowered, with access to training and development opportunities to support their ongoing professional growth, such as upskilling courses and the opportunity to be involved in quality improvement projects.

We observed genuine engagement between staff, patients, and carers, with clear communication and a commitment to patient-centred care. Staff demonstrated a well-developed understanding of equality, diversity, and human rights, ensuring that these principles were actively upheld in daily practice. Leaders also worked to support an inclusive environment for both staff and patients.

The service performed at or above trust average in 7 out of 9 areas of the NHS staff survey. This included; we are compassionate and inclusive, we each have a voice that counts, we are always learning, we work flexibly, we are a team, staff engagement and morale. The service was slightly below the trust average in; we are recognised and rewarded, and we are safe and healthy. The service identified themes and actions in response to the staff survey, which included staff feeding into the trust violence and aggression group and ensuring all divisional colleagues are nominated for trust wide awards.

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.

The medical division was led by a triumvirate of a divisional medical director, divisional director of operations and divisional director of nursing and governance. They were supported by clinical directors, general managers, heads of nursing and clinical governance managers.

Leaders in the service had the skills, knowledge, and experience required for their roles. They demonstrated a clear understanding of the service they managed, the risks and could explain how their teams worked to deliver high-quality care, including managing patient flow and maintaining safe staffing levels. The triumvirate reported having monthly meetings and structured systems to access the board. However, the service did not provide meeting minutes to confirm whether there was a standing agenda or what was discussed.

Staff reported leaders were visible and approachable, regularly engaging with staff in clinical areas. Leaders encouraged open communication and made them feel supported in raising concerns or suggesting improvements.

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 told us they were aware of freedom to speak up (FTSU) guardians and processes. They knew where to access information if they didn't know and how to navigate the guidance. Managers and leaders encouraged staff to openly talk about concerns as well as incident reporting.

The FTSU guardian produced a bi-annual report with trust wide data. Data showed that between April and September 2025, the FTSU guardian had received 77 concerns. The themes

included but were not limited to; management issues, systems and processes and behaviour and relationship. Recommendations were produced for the trust to take on board.

People and carers had opportunities to provide feedback on the service in ways that reflected their individual needs.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the standard of care

The service had clear responsibilities, roles, systems of accountability and good governance. However, patient confidentiality was not always maintained.

Staff did not always prioritise patient confidentiality. We observed multiple instances of computers on wheels being left open and unattended with patient records visible, which posed a risk of unauthorised access to patient information. We also observed an electronic whiteboard with confidential patients' details being left unlocked and visible in a public area, which did not protect people's confidentiality. This was escalated to senior leaders, and they reported that they would remind staff the importance of confidentiality when using equipment with patient information.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, due to increased clinical demand, managers did not always have enough time to complete their administrative tasks in a timely manner. This had been reported to matrons, and they provided support where possible however, due to their own workload this had minimal impact on managers volume of work.

The service had a clear governance structure, with lines of accountability from wards and departments, clinical divisions and through to the trust board. Nursing staff reported that they had monthly ward meetings where they could escalate concerns to management when required. Medical staff reported that they had direct access to clinical directors and felt

comfortable escalating concerns. This would then feed into the divisional governance meeting as required.

The service held monthly divisional governance meetings that followed a set agenda. Records of governance meetings demonstrated the quality, performance, and safety of the service were monitored and reviewed. This included discussions on learning from serious incidents and complaints, the risk register, patient experience and national and local clinical guidelines and policies.

The service had a risk register that currently had 34 risks open. Each risk had a risk score, a risk owner and the date for the next review. These risks were reviewed monthly at a risk review meeting. Our review of the risk register showed a majority of the risks we identified onsite, and risks described by staff were included in the risk register. This included patient flow, corridor care and workforce vacancies. The service had mitigations in place for the risks identified on the register.

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.

Staff recognised the importance of collaboration and partnership working to ensure seamless, high-quality care for patients. The service engaged with external stakeholders such as commissioners, specialist healthcare providers, community organisations and their local system. They reported positive and collaborative partnerships with all stakeholders.

The service actively engaged with Healthwatch which is an organisation that works with NHS leaders to ensure the patient's voice is heard to improve care. Healthwatch regularly visited wards and produced an insight report for the trust.

Patients could meet with members of the provider's senior leadership team. We saw evidence of patient attending the trust public board to present their 'patient story' to members of the board and senior leaders.

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.

Staff were given the time and support to develop opportunities for improvements and innovation and this led to changes in care delivery. An example of this was the introduction of the nursing associate apprenticeship project, which was designed to bridge the gap between registered nurses and health care assistants. Of the 126 apprentices trust wide who commenced on the programme, 5 continued their training and are planned to complete and join the NMC register before the end of the financial year 2025/26.

Staff used quality improvement methods and knew how to apply them. The service had a wide Quality Improvement (QI) program that leaders actively championed. For example, the service introduced the rapid diagnostic clinic to assess patients with vague but concerning symptoms of possible cancer. Results showed an improved cancer conversion rate and complex diagnosis's being identified quicker than through traditional NHS routes.

Staff reported that wards participated in accreditation schemes relevant to the service and learned from them, which improved staff morale.

According to the trust website the service is involved in clinical research however, staff did not inform us of any active research within the medicine division.

Outpatients

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

Our view of the service

Queen Elizabeth Hospital (QEH) is one of the 2 acute sites operated by Lewisham and Greenwich NHS Foundation trust. The trust serves a population of over approximately 1 million people and provides outpatients services primarily for the people living across the London boroughs of Lewisham, Greenwich, and Bexley. QEH employs approximately 7,500 staff. The hospital's outpatient's department (OPD) provide a wide range of services and clinics; all located on the ground floor for easy access. These services and clinics include Cardiology, ENT, Gynaecology, Neurology, Respiratory, Rheumatology, Gastroenterology, Dermatology, Urology, Paediatrics, Endocrinology, pain management, amongst other specialities clinics and has a dedicated phlebotomy test clinic in the OPD. The OPD operates from 8:30am to 6:00pm, Monday to Friday. When there is a demonstrated need, additional clinics are scheduled in the evenings and at weekends.

This was the first time OPD at Queen Elizabeth Hospital had been inspected and rated as a standalone acute service group (ASG). Previously, OPD had only been rated as part of the combined outpatients and diagnostic imaging service during the inspection carried out from 7 to 10 March 2017. In March

2017, we conducted a comprehensive inspection of all domains. Safe, caring and well-Led were rated as good, responsive was rated as requires improvement and there was not sufficient evidence to rate effective. As a combined ASG of OPD and diagnostic imaging assessment, this service was not previously in breach of any regulations.

We therefore undertook this announced comprehensive inspection on 24 and 25 February 2026 as the first independent assessment and rating of the OPD service at QEH.

During this inspection, we engaged with a range of staff working across OPD specialties, including nurses, healthcare assistants, administrative teams, phlebotomists, matrons, safeguarding leads, specialist directors, service managers, consultants, student nurses, practice development nurse, chief operating officer, and senior clinical leaders. We also received feedback from 21 patients and relatives using the service.

People's experience of the service

Most people we spoke with said they felt well cared for and had good experiences in the OPD. They described staff as kind, reassuring and approachable, and said clinicians explained treatment clearly and checked understanding. Relatives told us they were welcomed and involved when appropriate. We observed consistently positive interactions, with staff offering help, answering questions and supporting people who appeared anxious or confused. People with additional communication or accessibility needs also felt supported, with staff using interpreters, language tools and easy-read information. The trust had improved outpatient letters, increased font size and offered easy-read and braille versions, which consultation groups said helped reduce inequalities. Improvements to signage and wayfinding had also made it easier for people to navigate the department.

However, some patients and relatives told us their experience varied depending on the clinic and time of day. Of the 21 people we spoke with, 14 described concerns about aspects of their visit. We observed that unclear signage, unfamiliar self-check-in kiosks and crowded waiting areas sometimes caused confusion or frustration. Several people said they were unsure where to go on arrival, and some reported that delays were not always explained, which affected their confidence in the service.

Privacy was not always maintained. This was particularly evident in phlebotomy, where curtains were sometimes left open, and in reception areas where personal conversations could be overheard. These issues indicated that people’s experience did not always fully meet expected standards, despite

generally positive feedback.

Feedback gathered during the inspection reflected a mix of views. While many patients and relatives described excellent care and said staff went “above and beyond”, the concerns raised by a majority of those we spoke to highlighted inconsistencies in privacy, responsiveness and clarity of information. Our assessment found that, although many people were satisfied with their care, some aspects of the service did not consistently meet expected standards.

Safe

Rating Good

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also ensured that people’s liberty was protected when it was in their best interests and in line with legislation.

At our last assessment, we rated this key question as good. This key question has remained the same and has been rated good. This meant people were safe and protected from avoidable harm.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always have a proactive and positive culture of reporting safety events and investigations of incidents. Lessons were not always learnt to continually identify and embed good practice.

During the assessment, some staff were unclear about escalation pathways and lacked confidence in challenging unsafe practice, limiting learning and sustained improvement. Leaders acknowledged this longstanding issue and were reviewing it at senior trust level. However, other staff said they could escalate and share immediate incidents, were familiar with the electronic reporting system, and understood how reports progressed through health and

safety and clinical governance teams, with outcomes shared with managers, patients, and staff. Staff also understood the duty of candour and said they were open with patients and families when things went wrong. Staff described receiving informal debriefs and emotional support from colleagues after incidents, and the practice development matron supported staff to reflect and update competencies.

In the last 6 months, there had been 36 incidents, with 6 closed, while 34 remained open and 2 were unassigned. The Trust's policy requires incident investigations to be completed within four weeks unless exceptional circumstances are documented, but most were overdue. This meant investigations were not progressing within required timeframes, reducing assurance that learning cycles were completed or that improvement actions were being driven promptly. Staff said feedback often took longer than expected, and incidents were discussed only during infrequent safety huddles, limiting timely reflection and action.

Some organisational systems also affected how well learning could be embedded. The main OPD booking office managed most new routine and urgent appointments, providing a centralised structure for scheduling. Clear booking rules were set through standard operating procedures (SOPs), including standardised clinic templates and escalation processes for urgent requests. Did-Not-Attend (DNA) processes were defined, with first-appointment DNAs automatically rebooked, second consecutive DNAs discharged to GPs, and subsequent DNAs requiring clinical review. However, our review of documentation demonstrated that the service did not always identify themes and patterns of how well DNA patterns or booking-system themes were fed back into learning discussions, which limited understanding of system-level issues such as communication gaps or avoidable delays.

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 referral and admission processes in place enabled staff to receive the information needed so they could safely meet people's needs. Staff reviewed clinic lists, room requirements and equipment before each session, and we saw routine checks of clinical rooms, emergency equipment and storage areas. These checks helped staff prepare safely and supported informed decision-making.

The service had a centralised booking office, which coordinated most routine and urgent outpatient appointments. Appropriate systems were in place to ensure essential information was received at the start of the patient journey, helping staff allocate the correct clinic, room and equipment for each appointment. Clear booking rules and standardised clinic templates, set out in the OPD's SOP, supported consistent and safe scheduling across services. Processes for urgent requests, room prioritisation and standardised systems to help reduce variation and ensured patients were booked into clinically appropriate slots. The booking office worked closely with OPD teams to manage room conflicts, cross-site capacity, and last-minute changes, contributing to safer flow and reducing the risk of patients being placed in unsuitable clinics.

The service had clear emergency-escalation pathways, requiring staff to make immediate external referrals to 999 or the Emergency Department and document all advice and urgency in the clinical record. Processes also existed for maintaining pathway continuity through a clinic cancellation escalation SOP, with cancellations monitored by the performance and information team, reviewed monthly, and escalated where repeated or late, to minimise disruption and ensure clinics were delivered safely and consistently.

The service worked effectively across specialties to maintain safe pathways during OPD visits. Staff directed people between consultation rooms and phlebotomy to ensure no one waited without information or oversight. Different clinic types, such as dermatology minor procedures and phlebotomy, had clearly defined requirements, and staff ensured the right room, equipment and support were available. Focus-group discussions showed that daily huddles were used to identify risks, adjust staffing and confirm pathway changes so patients moved safely between stages of their care.

Gynaecology OPD staff described strong networks across south east London. They said hysteroscopy training, once only available in another region, was now offered locally, strengthening joint working with community gynaecology teams, General Practitioners (GPs)

and the south east London Cancer Alliance. Staff acknowledged there was more progress to make but noted that foundations for safer and more consistent pathways were actively being developed.

Continuity after appointments was also supported. Aftercare information following blood tests clearly set out expected symptoms, signs of complications, when to rest, when to seek help, and how results would be communicated, helping people understand next steps and when to escalate concerns at home.

Staff involved appropriate healthcare teams, such as specialist nurses, practice educators and clinical leads, when patients required additional support. They said ongoing digital improvements to booking and scheduling aimed to improve patient flow and reduce variation across the OPD. Staff also reported that the trust was developing plans to strengthen the Referral to treatment (RTT) pathway as part of a wider elective-improvement programme. Proposals included enhancing specialist advice, improving Referral Assessment Services (RAS) triage to support and refine complex care pathways in line with Getting It Right First Time (GIRFT) reassessments. These changes aimed to reduce waiting times from summer 2026 and improve the consistency and safety of elective care pathways.

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 appropriately, although some staff did not always feel confident escalating safeguarding concerns.

The safeguarding training compliance across the OPD. Nursing, systems and rescheduling teams all achieved 100% compliance. Admin team achieved 94.8% and Macmillan Brook OPD

achieved 88.9%, below trust target of 90%. Safeguarding Children and Young People training followed the same pattern, with most teams again reaching 100% compliance. Staff were mapped to Level 3 safeguarding requirements and monitored monthly. This showed strong organisational oversight, although high training compliance did not always translate into confident safeguarding practice.

Safeguarding posters were displayed in staff rooms and included clear contact numbers for the safeguarding team, helping staff know how to escalate concerns. Staff told us they could contact safeguarding leads easily and seek advice at any time. Safeguarding leads were accessible and staff knew where to find safeguarding resources.

Staff were also aware of their responsibilities for safeguarding children attending the department. Although the OPD department at this site does not attend to children under 10 years old, staff had access to child safeguarding referral pathways and were required to follow the same escalation processes as staff in emergency or inpatient services. Staff understood the need to consider risks to children when adults attended the service, including situations involving domestic abuse, parental mental health needs or substance misuse. The trust had a child and infant abduction policy that applied to OPD, outlining staff actions, escalation routes and security procedures in the event of a suspected abduction. However, while staff had access to safeguarding pathways for children over 10 years old attending the department, we did not always find consistent evidence that some OPD staff were familiar with or could describe the specific child-abduction procedures, as required by the trust's policy.

Furthermore, staff had guidance on restraint and restrictive practice for situations where a person lacked capacity and was at immediate risk. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy explained that any restraint must be the least restrictive option, time-limited and clearly documented. While restraint is uncommon in OPD, this guidance helped staff understand how to respond safely to complex situations.

However, some staff we spoke with in OPD did not always feel confident identifying or escalating safeguarding concerns, despite high levels of safeguarding training. Several staff were unable to clearly describe what should be considered a safeguarding issue, what should happen after they raised a concern, or how to apply requirements such as the MCA or DoLS. Interview evidence showed that adult safeguarding and Mental Capacity Act (MCA) decision-making remained challenging for some staff, creating a risk that concerns could be missed. The Trust was aware of these gaps, and the safeguarding team had taken action by

providing bespoke face-to-face training, micro-teaching, improved MCA templates and targeted support to strengthen staff understanding. Safeguarding records and Trust-wide data showed that concerns were being raised and referred when thresholds were met, and safeguarding advisors remained accessible for advice. Despite variation in confidence, staff knew how to escalate concerns, policies were current, training compliance remained high across the organisation, and there was information displayed in the department providing signposting and support for people experiencing domestic violence.

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 helped patients understand their care and manage risks. Procedures were explained clearly, and staff adapted communication for people with additional needs, including providing written information or checking understanding. When communication fell short, complaints showed that managers reviewed concerns and reinforced expectations with staff.

Patients were encouraged to give feedback, supported by a dedicated "Give Feedback" page on the trust website and posters in the department. Staff also received verbal feedback in clinics. Complaints were investigated and responded to, and completed investigations showed that learning was shared and practice followed up, demonstrating that the service acted on issues raised.

Staff supported people to make informed decisions, including those making advance refusals of treatment. Staff generally communicated well with patients, checking they understood their care and treatment and providing clear information during procedures. We saw aftercare guidance that explained symptoms, risks and when to seek help, supporting people to keep themselves safe at home. Consent and mental capacity policies were accessible, and staff

escalated complex decisions to senior colleagues. They also recognised when advocacy would be helpful and complaints documentation showed some patients used independent advocates, and the trust responded promptly to their enquiries.

Staff knew what to do if a patient became unwell during an appointment. They described confidence in escalating concerns and seeking help to manage deterioration. All nursing staff were compliant with adult and paediatric basic life support training, helping ensure emergencies were managed safely. The World Health Organisation Surgical Safety Checklist was used in dermatology minor procedure clinics, supporting safer practice through consistent checks and communication before procedures.

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 to deliver safe care.

The suitability of the OPD environment varied, and several issues increased risks to privacy, dignity and patient flow. We observed staff smart cards left in computer terminals and electronic patient records open in public areas, meaning confidential information could have been accessed by others. Senior staff were notified at the time and took immediate action to reduce this risk.

Clutter in some clinical rooms, stock stored in corridors and blocked spaces also made some areas harder to clean and increased the risk of falls. Environmental audits showed inconsistent cleanliness and equipment checks. Phlebotomy scored 91.45% overall, with some rooms scoring between 83.3% and 86.7%, where dust, limescale, stained surfaces, unclean dispensers and cluttered low-level areas were found. Area C scored 96.48%, with consultation and waiting rooms scoring 90% to 100%, though several toilets scored 92.9% due to dusty vents, limescale and waste-bin contamination. In contrast, the Minor Ops Room scored 100%, showing high standards were achievable when routines were consistently followed. These findings showed

that important checks were not always completed in the same way across all areas.

Other risks were identified during the assessment. Confusing signage, cluttered check-in points and repeated booking-in failures left some patients feeling stressed and unsure of where to go. Some clinic rooms were small, cluttered and difficult to work in, restricting movement and reducing emergency access. We also found that some rooms were used for informal storage. Cleaners' rooms containing liquids were occasionally unlocked and accessible to the public. Several waiting areas lacked child-friendly spaces, bariatric seating or baby-changing facilities, and information displays were not always well-positioned or kept up to date. Staff also said some equipment, such as suction units and sharps bins, was not consistently stocked or checked.

Despite these concerns, there were strengths in the OPD area. Fire safety arrangements were mostly strong; we reviewed the fire risk assessment for outpatients and found it was completed and in date. Fire doors, extinguishers and signage were in place and staff described their evacuation routes clearly. There were 2 readily available resuscitation trolleys in Areas C/D and E, as well as portable defibrillators, which was correctly stocked and in date. However, resuscitation daily checklists were not available on either resuscitation trolley at the time of inspection. These checklists support routine checks to help ensure that emergency equipment is available, functional, and appropriately stocked.

Most patient-facing areas and clinic rooms observed on the day were clean, well maintained and suitable for consultation and colour-coded zoning of the OPD supported navigation. Many rooms scored highly in audits, and the minor operations room had consistently achieved 100% in cleaning checks. Most equipment's was in good condition, stored safely and PAT-tested, showing it had been checked for electrical safety. Emergency call bells were fitted in clinical rooms, and staff told us they could use them to summon help if a patient collapsed or if they felt unsafe. Although CCTVs were not seen in the OPD areas, safety call buttons were also available, which supported staff to call for assistance quickly if an incident occurred, and phlebotomy rooms were equipped with panic alarms to support staff safety. Staff said they escalated environmental issues, including cleaning concerns or broken equipment, and that estates teams usually responded quickly.

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.

Most staff told us that leaders were visible, supportive and responsive to staffing pressures. Medical cover was adequate throughout the day, escalation routes for deteriorating patients were clear, and medical colleagues responded promptly to urgent queries. Staff also described strong teamwork, which helped clinics run safely even when activity increased or staff needed to be moved between areas.

Although, staffing pressures continued to affect the OPD service, with sickness absence at 15.12% and a turnover rate of 12.98%, compared with a twelve-month average of 19.27%. The service had 144.46 WTE staff in post against a twelve-month average of 141.84 WTE, with 13.40 WTE vacancies amounting to a 9.25% vacancy rate, and staff said this often resulted in colleagues being moved between clinics at short notice or starting shifts earlier than their contracted hours. However, staffing levels in OPD were generally safe. Rotas were reviewed daily to check the needs of each clinic, and staffing was adjusted to ensure shifts were safe. Staff said this process helped them maintain safe care even during periods of sickness or unexpected absence.

Mandatory training performance across nursing and allied health teams was strong, with 100% compliance across all required modules. Data provided by the trust showed they had exceeded NHS England's target for completion of each tier of Oliver McGowan training. The only exception was the Macmillan OPD team with Oliver McGowan Tier 2 compliance of 55.56%. The administrative team compliance of 71.46% was below the trust's 75% target for this module. Senior staff had actions in place to improve these figures through targeted sessions and additional reminders. Staff said training was relevant to their roles, and new starters received trust-wide and local induction, followed by buddying and supervision to build confidence.

Appraisal compliance was strong at 93.5%, above the trust target of 90%, showing effective oversight of staff development. Staff explained that high turnover was partly due to Band 2 staff being deliberately upskilled to Band 3 roles, after which they often moved to other directorates for career progression. Senior leaders ensured temporary staff received local induction and were familiar with the area before supporting clinics, and staff told us they felt confident escalating staffing concerns and that managers responded quickly to maintain safe cover.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always assess and manage the risk of infection well. Staff did not always adhere to infection-control principles including effective hand hygiene. However, where processes were working, staff maintained equipment safely, kept areas clean and well-maintained.

The audit data in the January 2026 decontamination standards audit for the main OPD area scored 83%, ranking 63 out of 76 areas trust wide. The highest scoring areas achieved 100% for hand hygiene, correct PPE use and use of appropriate cleaning products. However, Staff were not always observed to be following safe infection control (IPC). We observed poor hand hygiene, with some staff not consistently washing hands or using gel before and after patient contact. Some staff wore jewellery and were not bare below the elbow, and we saw medical staff wearing gloves and not changing them between patients, which increased the risk of cross-contamination. These lapses showed that IPC standards were not applied reliably in all areas of the department.

Despite these concerns, clinical areas were visibly clean and well-maintained. Rooms, waiting areas and treatment spaces were tidy, and furnishings were in good condition. Cleaning records were up to date and showed that rooms were cleaned regularly throughout the day. Most curtains in observation rooms were also clean and displayed appropriate labelling.

Equipment was kept clean, with ‘clean’ stickers visible and in date. Staff described following appropriate processes to prepare rooms and equipment between clinics and at the start of

shifts, and we saw that most items were ready for use. Personal Protective Equipment (PPE) was available, and staff used gloves and aprons during procedures, although not always in line with best practice. Hand-gel stations were accessible throughout the department, and staff told us that monthly IPC audits took place in some specialities, supported by an IPC link nurse who was currently on leave.

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. Staff followed good practice in the storage, administration and recording of medicines where systems were embedded, in line with recognised national guidance.

Staff followed safe and appropriate medicines management processes. Medicines were stored securely in a locked fridge, and daily temperature checks were completed to ensure safe storage conditions. Staff used approved cleaning products and followed national guidance for preparing, handling and disposing of medicines. These checks were overseen by senior staff who monitored compliance and ensured temperatures were escalated if they fell outside expected limits.

Prescriptions were written or generated electronically and sent directly to the hospital pharmacy, so medicines were available when patients arrived for their appointments. Staff kept accurate records, checked expiry dates, and ensured stock was rotated and ready for use. Medicines used during procedures were documented in the patient record, and any items requiring disposal were managed through the correct clinical waste routes. Overall, systems for storage, transport, prescribing and disposal were well managed and supported safe patient care.

Effective

Rating Good

We looked for evidence that people had the best possible outcomes. We checked that people's care, support and treatment reflected their needs and ensured 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.

At our last assessment, we did not rate this key question. At this assessment we have rated it good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing needs

Score

3. Evidence shows a good standard of care

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them. Staff listened to people and assessed their health, care and communication needs in line with good practice. They used information from assessments to plan care that met people's needs and supported good outcomes.

Healthcare assistants completed height and weight checks immediately after check-in, ensuring baseline observations were not delayed. Clinicians then carried out comprehensive health assessments so that people's physical and clinical needs were fully explored.

Translation support was available in more than 170 languages, enabling effective communication with people who spoke different languages or dialects. This helped ensure assessments were accurate and inclusive. Translation services were clearly promoted in the department, and information resources encouraged people with communication needs or autism to share their preferred communication style so assessments could be tailored to individual needs.

Care plans reflected the needs identified during assessment, and people were routinely reassessed at each appointment to identify any changes in their health, preferences or support needs. Staff encouraged people to recognise and report changes in their own health, which

supported timely help-seeking and promoted independence.

A review of 15 care documents showed they were clear, complete and accurately recorded, demonstrating a consistent approach to documenting assessed needs and updating care plans appropriately.

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.

Nurses in the OPD clinics ensured protocols aligned with recommendations from the National Institute for Health and Care Excellence (NICE) guidelines. Staff took part in clinical audit, including the Central Venous Access Devices (CVAD) audit, which showed 100% compliance across key standards for aseptic technique, line care and IPC, demonstrating consistent adherence to evidence-based processes.

The service had access to a broad range of specialists who supported patients across OPD pathways. Active multidisciplinary (MDT) working across clinics, with input available from doctors, nurses, allied health professionals and pharmacy teams to ensure coordinated care.

Staff were trained and competent. They completed mandatory subjects such as safeguarding, infection control and health and safety, and nurses described gaining wider clinical skills by working across different OPD specialties. All new staff completed corporate and local induction, and nursing staff were aware of their responsibilities to maintain current professional registration and revalidation. Pain relief was available when minor procedures were undertaken, for example, in dermatology clinics, and staff checked that patients were comfortable and informed.

However, we found several trust policies, including the dress code, discharge, RTT access, falls

prevention and patient identification policies were out of date. Although the impact on OPD was low, these gaps created a risk that staff might not be working to current clinical guidance and the trust not routinely checking policies against national standards.

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.

The service demonstrated good practice in how staff and services work together. Staff described strong teamwork within their own clinical areas. They held regular huddles two to 3 times a week to share updates, discuss incidents to share learning, and they used these meetings to coordinate care and respond to issues arising during clinics.

Teams reported effective working relationships with consultants and specialist nurses, with clinicians readily available for advice and support when needed. Some specialities held their own multidisciplinary meetings, which included senior nurses and consultants, and staff were invited when their patients were being discussed.

Handover within teams was clear and took place through regular huddles and direct communication between nurses, HCAs and medical staff. Staff also described good links with site managers, safeguarding teams and other teams involved in patient flow or onward referral, helping ensure coordinated care when patients needed admission or additional support.

However, staff did not always experience consistent communication between specialties, and some teams described gaps in cross-specialty working that affected information flow across OPD pathways. Staff also said that reception changes and the removal of local desks increased the number of patient queries directed to clinical teams, adding pressure and affecting effective handover in busy clinics.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduced their future needs for care and support.

Staff supported people to live healthier lives by offering clear health information and signposting patients to reliable support services. Posters in OPD areas encouraged patients to check their blood pressure during their visit, promoting early detection of cardiovascular risk. Staff also provided accessible dietary guidance, including information for people using GLP-1 weight-loss or diabetes medicines, helping them manage side effects safely and maintain a healthy diet

Patients were supported to stop smoking through the Lewisham Stop Smoking Service, which offered free, specialist behavioural support, nicotine-replacement therapies, and e-cigarette-based quitting options. OPD staff signposted patients to local drop-in clinics, phone support and culturally tailored resources such as the Ramadan-focused smoking-cessation flyer.

People living with or beyond cancer were directed to the “Next Steps” programme, a structured course providing advice on nutrition, fatigue, emotional wellbeing and self-management following treatment. Staff also made accessible health information available for specific groups, including an easy-read children’s blood test guide and antenatal notes designed for people with learning disabilities, helping patients understand their care, appointments and screening needs.

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 demonstrated good practice in improving outcomes. Audits were routinely carried out across OPD services to check whether staff were following good clinical practice. When audits identified areas that needed improvement, actions were agreed and reviewed at re-audit points, showing a clear cycle of monitoring and improvement. Each clinical service unit was responsible for its own programme of clinical audits and benchmarking, which helped ensure that specialty-specific risks and outcomes were monitored by the most appropriate teams.

The patient booking team used effective digital systems to monitor clinic attendance, identify missed appointments and improve the use of clinic slots. Staff also used electronic systems to access investigation results promptly, including blood test results, which helped them provide timely information and support to patients. This use of technology enabled staff to respond more quickly to changes in a patient's condition and supported safer clinical decision-making.

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. They assessed mental capacity appropriately and acted in people's best interests when required.

Staff supported people to make their own decisions about their care. Clinicians explained the purpose of appointments, the nature of examinations and any proposed procedures, ensuring patients had enough time and information to understand their options before agreeing to treatment. We observed doctors clearly explain each step of an examination and apologise for delays before checking whether patients were happy to continue.

Staff appropriately assessed and recorded mental capacity for people who may have impaired capacity. Assessments were decision-specific and reflected each person's ability to understand, retain and weigh information at the time decisions were made. When patients lacked capacity, staff acted in their best interests, considering their wishes, feelings, culture and personal history, and involving relatives or carers where appropriate. Staff also followed the trust's escalation processes for more complex cases.

Chaperones were available for intimate examinations, and staff understood when to offer one. We saw good practice where clinicians asked patients whether they wanted a chaperone and confirmed they were comfortable with the person provided. On occasions where a chaperone was brought in automatically, staff corrected this when prompted and ensured the patient's preference was respected.

Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service treated people with kindness and respect. Staff listened to people, supported them with compassion. People were involved in conversations and felt safe and valued. However, staff did not always maintain dignity during care were not always upheld.

Most patients told us staff treated them well, and we observed many kind, calm and supportive interactions. Staff were discreet when sharing information, responded promptly when people needed help, and offered reassurance when patients appeared anxious or confused. We noted particularly warm communication in OPD area A, where staff took time to explain care and help patients feel at ease. Patients generally felt respected and valued, and staff demonstrated good awareness of cultural, social and religious needs, adjusting care by involving families, offering privacy and ensuring the right support was available. For example, staff supported a patient with a learning disability and her mother throughout a procedure with clear explanations, emotional reassurance and practical help. Recent accessibility improvements, including clearer signage, hearing loops and accessible information, further strengthened dignity for disabled patients.

Staff told us they could raise concerns about disrespectful or unsafe behaviours without fear, and they understood the importance of confidentiality. We usually saw patient information handled appropriately, and isolated lapses were escalated and resolved at the time. This contributed to an environment where patients generally felt safe, supported and treated with dignity.

However, some patients did not consistently experience care that upheld privacy and dignity. In the phlebotomy area, 4 rooms operated as double-occupancy spaces with privacy curtains, but none were drawn whilst attending to patients during the assessment, and room 6 had no curtain at all. This meant some patients did not have their privacy fully protected, exposing elements of consultations.

Some staff behaviours also affected people’s experience. We witnessed a consultant shouting

at staff in a public area, which distressed nearby patients and did not reflect respectful or compassionate practice. Staff reported periods of poor teamwork at reception, which negatively affected the experience of people waiting.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The service treated people as individuals and made sure people's care, and treatment met people's needs and preferences. They took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics. However, communication support upon check-in was not always readily available to meet individual needs.

Staff used clear impairment notices to encourage people with hearing or sight difficulties to inform staff, helping them provide the right adjustments. Patients who did not speak English had easy access to interpreters, supported by posters listing 28 languages so staff could quickly identify the required language, and interpretation services were available at no cost to patients. Information was provided in accessible formats. Easy-read appointment letters were available, written in simple language with pictures to support children and people with learning disabilities. Standard appointment letters also told patients how to request alternative formats such as braille, large print or increased font size. Patients received clear information about treatments, their rights, how to complain and how to access PALS

The service respected cultural and religious needs. Staff supported patients with dietary requirements and involved carers appropriately, particularly for people with learning disabilities, who also received tailored communication support from learning disability liaison nurses. Patients and carers reported that these reasonable adjustments helped them feel included and understood.

However, some patients did not always receive personalised communication at the first point of contact, which meant that not all individual needs were identified promptly. We observed that some people struggled to navigate the department because their communication needs

were not recognised early enough. For example, patients whose first language was not English sometimes became confused about where to go before staff realised they needed interpreting support, even though language identification tools and telephone interpretation were available. During busy periods, patients who found the self-check-in kiosks difficult to use, particularly older people or those unfamiliar with technology, were seen waiting or appearing unsure without immediate support, meaning their need for tailored communication or practical assistance was not identified until later.

Independence, choice and control

Score

3. Evidence shows a good standard of care

The service supported people to have independence and control over their care. Staff listened to what mattered to people and helped them make informed decisions. People were given choices and felt involved throughout their appointments.

Most people said they were fully involved in their care and treatment. They told us that staff listened to them, checked their understanding, and clarified information when needed, which helped them feel informed and confident. People were also able to attend appointments with someone of their choosing, supporting their comfort and sense of control.

The trust had developed guidance to support staff in planning reasonable adjustments for people with additional needs. This guidance focused on recognising individuals and ensuring people have a voice throughout their appointment. Staff used this approach to help patients feel prepared and involved in decisions about their care. Patients were also supported to make choices during examinations or procedures, and chaperone guidance displayed in OPD areas clearly explained patients' entitlement to request a chaperone at any time, helping them feel safe and supported.

However, some people told us they needed additional clarification when attending

appointments and did not always feel fully prepared or in control initially. At times, staff did not immediately identify when a person had additional needs, such as dementia or a learning disability, which meant reasonable adjustments were not always put in place early. When this happened, people occasionally became confused or anxious before staff were able to offer support or clearer communication. This indicated that personalised information was not always provided early enough to consistently support people's independence.

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 understood specific risks such as falls or pressure-related harm and planned care accordingly. Where risks changed, staff adapted how they supported people, ensuring patients did not wait without being monitored. Improvements made within the OPD also strengthened the service's ability to respond quickly. Remapping kiosks, improving their placement and adding clear signage reduced confusion, meaning patients could get to the right area faster and staff had more capacity to focus on people who needed immediate support.

The wider OPD improvement work, including updated signage, clearer appointment letters and better accessibility features, further supported staff to identify and respond to patient needs earlier. Feedback gathered through patient consultation groups showed that the service acted on concerns about accessibility and clarity, which helped staff recognise when patients required extra support and intervene sooner.

However, some patients did not always have their immediate needs recognised as quickly as they could have been. At busier times, the check-in process created delays, and some patients needed support because kiosks were mapped incorrectly or were not accessible in all areas. These issues meant staff had to step away from other tasks to manually check patients in, which limited the time available to identify changing risks early. Once staff were aware of

concerns, they responded promptly and took appropriate action to keep people safe.

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.

Most staff said they felt respected, supported and valued by their managers. They described positive team cultures across OPD and said they were proud to work for the trust. Staff reported that their appraisals took place consistently and included discussions about wellbeing, career development and setting future goals. Staff wellbeing was strongly supported across the trust. A wide range of wellbeing resources was available, including physiotherapy, yoga, pilates, meditation, sound-bath sessions, gym discounts and financial wellbeing support. Staff could also access emotional and psychological help through the Employee Assistance Programme and could self-refer to Occupational Health services for assessments, vaccinations, Musculoskeletal (MSK) support and advice. Regular wellbeing clinics operated at both hospital sites, and staff networks and wellbeing champions were available to provide peer support.

The trust also promoted a culture of recognition. Staff achievements were celebrated through schemes such as the LGT Star Awards and regular wellbeing events across sites. Staff told us they felt able to speak up without fear and were confident their managers would listen and act. This contributed to a positive working environment where staff felt valued and able to deliver high-quality care.

However, some staff told us that frequent service changes and busy clinic environments could be challenging, and this sometimes affected their day-to-day wellbeing. Staff also described pressures related to patient aggression, and sickness levels meant some teams relied regularly on bank staff to maintain safe cover. Although staffing pressures were present, managers ensured bank workers used were familiar with the service, which helped maintain stability during periods of higher absence. Staff said that despite these pressures, they continued to feel supported when raising concerns.

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 characteristics.

At our last assessment, we rated this key question as requires improvement. This key question has improved and 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.

Most patients described staff as kind, respectful and focused on what mattered to them. Clinicians generally explained care clearly and checked understanding, helping people make informed decisions. Patients said they felt listened to, and staff adapted care to individual needs, including arranging translators when required. One patient with rheumatoid arthritis told us she consistently received a next-day appointment when she called for support, which helped her feel in control of her care.

People with learning disabilities received personalised adjustments that supported choice and involvement. Staff told us that they used patient passports to understand individual communication needs, clinical histories and personal preferences, particularly for people with learning disabilities, autism or complex needs. These passports helped staff adapt their

approach, including allowing extra time, reducing sensory triggers, using visual prompts or adjusting the order of procedures to help the patient feel calm. Staff told us these documents helped them avoid repeating distressing questions and ensured they did not overlook important details about how each person preferred to receive care. However, examples of passport use were not available for review at the time of this inspection. Learning-disability liaison nurses also told us that helped staff use simple language, speak at eye level and involve carers in discussions. Carers described staff as patient, kind and reassuring, and these adjustments helped patients understand and agree to treatment. The OPD also accommodated people who used wheelchairs or required specialist equipment, demonstrating strong partnership working and a commitment to shaping care around individual needs.

Holistic Needs Assessments helped people discuss what mattered to them at key points in treatment and supported personalised care planning that considered physical, emotional and social needs. Staff held supportive conversations and signposted people to local services, helping ensure care fit within the context of people's lives.

However, some people did not always find the OPD environment easy to use, which affected how person-centred the experience felt. Confusing signage, unclear reception layouts and unreliable self-check-in kiosks made it hard for some to navigate independently, and older patients in particular reported feeling unsure about where to go without staff support. Some people also received repeated appointment texts and letters, which caused confusion and did not meet individual communication needs.

Care provision, integration and continuity

Score

3. Evidence shows a good standard of care

The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

The service used clear systems to support integrated, patient-focused care, including face-to-face, telephone and video appointments to meet individual needs. These virtual

options helped people avoid travel, reduced late arrivals linked to parking concerns and supported continuity for those who struggled to attend in person. Clinicians were expected to plan and record outcomes in real time so that follow-up care could be booked before patients left clinic, supporting smooth transitions between appointments.

The booking office worked across both hospital sites to manage new and follow-up appointments by using referral systems and patient-initiated follow-up (PIFU) pathways to direct patients to the right service at the right time. Where patient needs changed, some clinics offered short-notice appointments when a condition worsened, helping people receive timely review. Weekend clinics were also used for urgent demand, fast-track pathways and elective recovery, helping patients avoid long waits.

The service monitored attendance and non-attendance closely. Data from booking systems was used to identify trends in DNA and barriers to attendance, which supported services to adjust clinics or offer alternative appointment types. The structured 6-4-2 process and weekly room audits helped ensure clinics had the space, staff and records they needed so that appointments could run safely and efficiently.

However, some areas of care did not consistently meet expected standards. During the assessment, several clinics were running considerably behind schedule, including long waits in the phlebotomy area. Leaders were aware of these delays and had begun planning improvements to clinic flow. Some staff highlighted that OPD services had previously struggled with responsiveness and punctuality, and that the department continued to face pressure from high demand and complex pathways. Some patients faced delays or confusion because clinic space was not always used efficiently, particularly when rooms were booked but left unused or when clinics were cancelled at short notice. Short-notice clinic changes also required services to contact patients directly, increasing the risk of miscommunication and late notice changes that could affect continuity of care.

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. Information helped people make informed decisions about their care.

Patients received clear details about treatments, rights, complaints and local support through posters, leaflets and clinic discussions. Information leaflets covered a wide range of conditions, and interpreters were easy to access, supported by posters listing 28 languages. Interpretation was free, and some staff spoke commonly used local languages.

The service met the Accessible Information Standard. Appointment letters were available in braille, large print, increased font and easy-read formats, and staff knew how to arrange these. Families and carers were kept updated where appropriate, and information sharing followed secure governance processes.

In the clinic areas, patients said that staff regularly updated them on waiting times when clinics were running behind, either by speaking directly to people in the waiting area or by checking in with individuals who had been waiting for longer. Staff told us that they proactively monitored waiting lists on the clinic boards and that nurses often walked through the waiting area to explain delays, reassure people, and make sure nobody had been missed. In areas where patients had difficulty hearing their names being called, staff adapted their approach by checking in more frequently or calling names more clearly to avoid confusion. These updates helped people understand what to expect and reduced worry about being forgotten.

However, some people told us that information within the department was not always easy to follow, especially when trying to locate clinics. Patients said the signage was confusing, and some posters and signs were not positioned in a way that helped people move around safely or confidently. Staff recognised this and had commissioned a full review of signage to make it easier for people to find their clinic. Reception staff and volunteers helped people who were unsure where to go, but the long walk from the main entrance to several clinic areas meant patients needed to remember directions, which increased the chance of getting lost. Staff also told us that clinic signs used letters rather than naming the specialty, which made navigation harder.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make it easy for people to share feedback or raise concerns. Staff did not always respond to issues in a timely or sensitive way. This meant people's concerns were not always acted on effectively.

Some people told us that when they raised concerns, the service did not always respond in a timely or sensitive way. One complaint described a relative receiving an automatically generated letter about a missed OPD appointment shortly before the patient had died, which caused distress. The relative also struggled to reach the booking office, and an email replying to their message about the death incorrectly rebooked another appointment. This showed that staff had not always reviewed information properly before responding. Another patient reported that during a glucose tolerance test they experienced poor communication, a lack of dignity, and inadequate clinical practice, and later learned that one of their blood samples had been lost. This caused avoidable distress and reduced confidence in the service.

Although patients could give feedback through the Trust's usual routes, such as Friends and Family Test surveys and comment cards, these were not always visible within outpatient areas, and some people told us they were unsure how to provide feedback unless they escalated their concerns through PALS or the formal complaints process.

The trust investigated complaints and identified that most complaints in the last 12 months related to staff attitude, communication, and appointment issues, showing clear themes across OPD, including Phlebotomy. Phlebotomy services were an outlier and accounted for most complaints, with 28 of the 42 complaints in the period reviewed. Appointment delays, rude or dismissive interactions, and failures in communication were the most common concerns. No complaints from the previous 12 months had been referred to the ombudsman.

Despite these concerns, the service had a wide range of methods through which people could give feedback, including FFT surveys, comment slips and feedback cards, national surveys, email, PALS and the formal complaints route. Patients could also share their experiences

through the Trust's Patient Story programme or during listening events. OPD had recently carried out a listening exercise to better understand patient experience, and this feedback was used to create a structured improvement plan, such as introducing supported seating, adding an email contact option, strengthening interpreting arrangements, and completing equality impact assessments with patient involvement.

The service investigated complaints and provided feedback to people who raised them. Where issues were identified, the service apologised, addressed staff behaviour through appropriate management actions, and took steps to prevent recurrence. Complainants were kept informed and confirmed they were satisfied with the outcomes.

Patients were given clear information on how to complain, including contact details for the Complaints Team. Staff understood the complaints process and were encouraged by managers to address concerns promptly at a local level to avoid unnecessary escalation. Staff explored issues with people raising concerns, documented actions taken, and acted professionally to protect people from discrimination or unfair treatment. Leaders shared learning with teams, reinforcing expectations around introductions, clear communication, maintaining privacy, and handling patient information appropriately.

Equity in access

Score

3. Evidence shows a good standard of care

The service did not always make sure everyone could access care when they needed it. Some people experienced delays or barriers linked to the environment and waiting times.

Some patients still faced barriers when accessing appointments. People told us that unclear signage and long distances between reception and the OPD made independent navigation difficult, particularly for those with reduced mobility. Staff and volunteers frequently guided disoriented patients, meaning the environment did not support equal access for all.

In phlebotomy area, staff reported that the digital waiting-room display had been

non-functional for a year, requiring manual calling of patients. Some patients and relatives told us they did not hear their name being called and waited up to an hour. This manual system attributed to delays and long queues witnessed by us in the phlebotomy area. Managers explained they had attempted to replace the display, but budget constraints had prevented progress. The trust informed CQC that a business case that incorporated a new call system was in development.

RTT performance data also showed that although access had improved overall, with the service is performing better than the London regional average, several specialties continued to experience longer-than-planned waits. The trust's 52-week waiting list remained above expected levels for several months, and first outpatient waits in some specialties continued to exceed national thresholds. These issues indicated that access was not always equitable.

Despite these concerns, the service had made clear progress in improving access. The OPD was wheelchair accessible, and staff provided practical support by escorting patients to clinics and responding quickly when physical or wayfinding barriers were identified. A full signage review had been commissioned following patient feedback to improve independent navigation. The trust's Elective Access Policy (EAP) set expectations for fair access, and weekly oversight of long waiters helped ensure people did not slip through the system.

RTT performance improved steadily across 2025–26. The number of people waiting over fifty-two weeks fell from around 2,950 in April 2025 to about 2,450 in February 2026, a 17% reduction. Eighteen-week performance rose from about 46% to 51%, showing a gradual recovery in timely access. "Wait to First OPA" data also showed around a 20% reduction in the longest waits over the 12-month period, with waits over 50 weeks falling. The "Wait to First OPA by Booking" dataset showed similar improvements, with performance increasing by roughly four percentage points from the start of the year. These gains reduced variation across specialties and supported more consistent access to assessment.

The trust also strengthened equity through targeted outreach. Screening initiatives in breast, prostate, and other cancer pathways focused on groups with historically lower uptake, helping to reduce preventable delays and improve access to early diagnosis for communities less likely to come forward.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

The service listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

Some staff and leaders promoted an open culture where people felt able to speak up. The service strengthened feedback mechanisms through improved telephone access via electronic systems and clear clinic information on how to raise concerns or suggestions. Staff described an environment that encouraged people to discuss their experiences and people with additional needs benefited from improved communication support as the service used communication tools to help remove barriers. Managers reinforced respectful and compassionate communication through local engagement work and the OPD Respect and Compassion principles, supporting more equitable interactions.

Policies and procedures were reviewed to ensure they did not disadvantage people with protected characteristics. Equality impact assessments were completed for key OPD processes, including e-outcome forms and room-management procedures. Staff completed mandatory equality, diversity and human rights training, with most allied health staff achieving 100% compliance.

The planned rollout of a new e-outcome form was expected to reduce inequity by improving follow-up and increasing visibility of clinical updates, particularly for people who found complex appointment systems difficult to navigate. The set-up of clinics reflected the needs of the local population, and the service continued to work with partners to improve equity of experience.

However, Patients told us they find the layout of the OPD structure challenging to navigate. Equity in outcomes were not always consistent for people with more complex communication needs. Staff said these tools were not yet embedded across all OPD areas, leading to variation depending on where people were seen. Training compliance also varied: Tier 2 Oliver McGowan

training stood at 55%, below the trust's 75% target, and equality, diversity and inclusion training compliance in Macmillan OPD was 88.89%, below the 90% trust target. This meant not all staff had completed the enhanced training required to effectively support people with cognitive, communication or sensory needs, and the slight shortfall in EDI compliance meant the service could not assure itself that all staff in Macmillian OPD had the depth of knowledge required to recognise and appropriately respond to the diverse cultural, communication and accessibility needs of people using the service, increasing the risk of inconsistent or less personalised care for those who may already face barriers in accessing outpatient services.

Planning for the future

Score

3. Evidence shows a good standard of care

The service supported people to make plans about their future care. Staff held clear discussions about treatment options and recorded people's wishes. Coordinated planning helped people understand what would happen next.

Staff supported people to make informed decisions about their future care. Personalised discussions helped patients understand their treatment options, and clinicians handled DNACPR decisions and other sensitive conversations with dignity, involving families and carers when appropriate. Care plans reflected each person's wishes, cultural needs and priorities.

People with complex needs received coordinated planning across multiple teams. Staff worked closely with specialist clinicians, nurses, physiotherapists and external partners to ensure that patients who required input from different services had clear, joined-up plans. This MDT approach seen for example in gynaecology pathways, supported timely decisions for patients with long waits or complex conditions, using shared assessments and up-to-date clinical information.

Digital improvements strengthened the safety and consistency of future planning. The new e-Outcome form reduced the risk of people being lost to follow-up by prompting appropriate next steps, improving clarity of referrals and ensuring clinicians could see what had been

agreed with each patient. Its clearer layout and improved logic also supported more accurate recording of investigations, appointments and treatment decisions.

However, some people told us they were not always clear about what would happen next, especially when future steps depended on specialist advice, further triage or updated investigations. In some pathways, delays or limited specialist capacity meant future plans took longer to confirm, creating uncertainty for people with complex or long-term needs. As a result, planning processes were not always consistent for everyone using the service.

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.

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

2. Evidence shows some shortfalls in the standard of care

The service did not always have a consistent shared culture based on equality and respect. Some behaviours and delays in organisational processes limited staff confidence in raising concerns. This meant the culture was not always supportive or aligned across all teams.

Staff reported that organisational values were not always modelled consistently across all

professional groups. Some consultant behaviours made it harder for nursing staff to challenge poor practice, creating a culture that did not always feel equal or supportive. We witnessed examples of inappropriate consultant behaviour and dignity breaches, which some staff described as long-standing concerns that had been raised before but had not always led to clear or timely action. These incidents showed that cultural expectations were not always upheld consistently across all teams, and that escalation processes had not always produced effective or sustained change. Staff told us that repeated incidents had affected morale and confidence, and some felt uncertain about whether concerns would lead to improvement. Leaders acknowledged that trust-wide processes for addressing bullying, harassment and cultural concerns were not always timely or robust.

There was also a gap between strategic aims and frontline understanding. Although OPD areas displayed the trust's 'Our Vision, Objectives and Values', not all staff could describe the detailed priority initiatives within the service strategy. Leaders understood these priorities well, but frontline staff gave limited examples of how they translated into day-to-day work. Some staff also told us that communication from leaders could vary between sites and teams, and that this sometimes made it harder to feel part of a single, shared direction.

Despite these gaps, some staff understood the core OPD vision and how their work supported timely, respectful, patient-centred care. Senior leaders communicated expectations clearly through regular governance meetings, team discussions and one-to-ones kept nursing, phlebotomy and administrative teams aligned to operational and strategic goals. Staff said leaders were visible and accessible, helping them understand how wider trust initiatives linked to their roles.

Some staff helped shape service development by contributing ideas through improvement programmes, redesigned patient-facing areas, tested new check-in approaches and improved accessibility materials. Access to the improvement hub and coaching supported some staff to turn ideas into measurable changes.

Operational changes were well understood by some staff, who recognised the appointments-based phlebotomy model delivered through healthcare appointment booking platform, as essential for safe flow, equitable access and upcoming community diagnostics centre plans. Some staff were also aware that long-term continuity was supported by three-year Integrated Care Board (ICB) back-funding from April 2023.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

The service had capable and supportive leaders who understood local challenges and priorities. They were visible, approachable and promoted a positive team culture. Staff felt encouraged to learn, develop and contribute to improvement.

Leaders were described as capable, experienced and knowledgeable about OPD services. Many had long-standing experience across Lewisham and Queen Elizabeth Hospital and demonstrated a clear understanding of clinical pressures, patient flow and operational challenges. Staff said leaders were visible in clinical areas, checked in regularly and could clearly explain service performance, digital developments and the OPD transformation programme. This gave staff confidence that leaders understood both challenges and priorities for improvement.

Leaders were also seen as approachable and supportive. Staff described an open-door culture where concerns were heard without fear, and they reported strong support from practice educators, senior nurses and managers who ensured regular supervision, huddles and governance meetings. This communication kept staff informed about incidents, learning and operational updates, helping them maintain safe and effective practice.

Leadership development was widely supported. Staff said they were encouraged to access courses, expand competencies and take on new responsibilities, including supporting students, upskilling HCAs and attending management training. Trust programmes and protected time for skills-based learning helped staff feel valued and able to progress.

Leaders also promoted a positive team culture through huddles, incident reviews and supervision strengthened learning, and staff consistently described feeling respected, supported and proud of their work. Many spoke positively about leaders' commitment to improving patient care, digital systems and service design, which helped build a compassionate, team-focused culture.

However, some staff said organisational values were not always modelled consistently across

all professional groups. They described behaviours from a minority of consultants that made it harder for nursing staff to challenge poor practice. Leaders acknowledged that trust-wide processes for addressing bullying, harassment and cultural concerns were not always timely or robust, which left some staff unsure whether issues raised would be acted on. Some staff were also uncertain about how concerns such as the removal of reception desks, rising patient aggression or operational pressures were resolved, leading to repeated issues. Slow organisational processes, siloed working and frequent clinic-set-up were cited by some staff as creating additional strain. Reliance on bank staff sometimes added instability, although leaders continued to recruit into vacancies. Staff described this as an ongoing challenge.

Freedom to speak up

Score

3. Evidence shows a good standard of care

The service fostered a positive culture where people felt their voice would be heard and leaders used feedback to make improvements and strengthen communication. However, some staff said they did not always feel they could speak up.

Most staff said they felt safe to raise issues with their managers and described an open-door culture where concerns were listened to without fear. Staff felt comfortable speaking up about safety issues, workload pressures and clinic incidents.

The service ensured patients and carers had accessible ways to give feedback, including text messages, Friends and Family Test (FFT) responses, PALS, compliments and direct conversations. FFT results showed 93.57% of OPD respondents rated their experience as Very good or Good, indicating most people felt treated with kindness and respect.

Managers used patient, carer and staff feedback to make improvements, which lead to changes such as having clearer signages, better communication materials and improved storage areas. Leaders shared outcomes through “You said, We did” updates, helping staff see how feedback influenced change.

Patients and carers were involved in service developments through improvement work, patient-experience forums and opportunities to speak with senior leaders during walkabouts. Leaders' visibility in clinical areas helped people feel heard and assured their feedback mattered.

Staff had multiple ways to engage senior leaders, including executive walkabouts, team meetings, Safe Space sessions and visits from the Freedom to Speak Up (FTSU) Guardian. Guardian visits across both sites ensured all staff groups had confidential support, which staff said increased their confidence to raise concerns and contributed to higher trust-wide reporting.

However, some staff were not always confident concerns would be acted on quickly or consistently. They described delays in follow-up after raising issues about clinic pressures and communication. Some staff also said they did not feel comfortable speaking up about consultant attitudes and behaviours due to their band, being new in the service and some staff told us that they raised concerns before but had not always led to clear or timely action. These experiences echoed trust-wide FTSU findings, where slow responses, limited updates and unclear outcomes were common themes. This sometimes left staff unsure whether speaking up would lead to change.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

The service valued diversity in their workforce. They work towards an inclusive and fair culture by improving equality and equity for people who work for them.

The service demonstrated good practice as staff described an inclusive culture and felt the service was becoming more supportive of diversity. The trust had active staff networks for LGBTQ+, disability and ethnic minority groups, offering events, forums and safe spaces that helped staff feel represented.

The trust workforce was highly diverse: by August 2025, 63.7% of staff were from Black, Asian or minority ethnic backgrounds, Band 6 and above, representation was higher at 49.6%, and 3.3% identified as LGBT+, reflecting the local communities in Lewisham, Greenwich and Bexley.

Staff said they could request flexible working and that managers were generally supportive of adjustments for caring responsibilities or health conditions. Training for managers on disability passports, reasonable adjustments and equality, diversity and inclusion (EDI) awareness helped them better support staff with additional needs. Workplace adjustments were being strengthened through new systems linked to the trust's EDI action plans.

Leaders also promoted development opportunities for underrepresented groups. Career-coaching days and leadership programmes were targeted at ethnic minority and disabled staff, with 66% of participants in non-mandatory training from ethnic minority backgrounds by late 2025. Staff said these opportunities encouraged them to progress.

However, some staff felt that trust-wide EDI initiatives did not always translate into day-to-day practice. Feedback across Allied Clinical Services (ACS) showed some staff wanted greater involvement in decisions, more collaboration between teams and better recognition. Some also reported delays in flexible-working processes, creating uncertainty for those with caring or health needs. Trust-wide EDI data showed 31.2% of disabled staff felt reasonable adjustments were not made quickly or consistently, creating a risk that some colleagues were less well supported to work safely and confidently. Furthermore, at Band 8a and above, 35.3% of staff were from Black, Asian or minority ethnic backgrounds, compared to 58% across the Trust workforce, showing there are room for improvement in ensuring equal opportunities for development.

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. However, risks were not reduced in a timely way and continued attention

was needed to ensure mitigations led to sustained improvements.

Governance arrangements were clear, and staff understood how information flowed through the service. Each outpatient clinical service had its own governance route, feeding into the monthly Outpatients and Phlebotomy meeting and then into divisional boards. Staff told us they understood how to escalate concerns, and governance records showed regular review of incidents, complaints, staffing pressures, estates issues and audit findings. Information shared at governance meetings was supported by daily huddles, where immediate issues were raised and actions allocated to responsible staff. This meant leaders had frequent oversight of operational pressures and the quality of care being delivered.

Learning from incidents and complaints was shared through meetings and action logs, and staff confirmed that resulting changes had been implemented. Governance minutes demonstrated that teams reviewed outstanding incidents to ensure they were closed promptly when actions were complete, and that lessons were considered at each meeting. Staff also told us that improvements to incident-routing processes, allocation lists and reception arrangements had been made in response to previous learning, and audit activity continued to be embedded in routine practice. Governance minutes also showed that mitigations were already in place for several of the recurring issues. Infection-prevention and health-and-safety reviews for Area G were underway, Fire-evacuation training for supervisors had been completed, with practical drills planned. Security improvements were also being addressed, with body cameras ordered for phlebotomy and delays escalated for action. Staff continued joint work with clinical specialties to manage clinic overruns, and request-list oversight processes were strengthened through the Request List Working Group. These mitigations showed that leaders monitored risks and initiated appropriate actions when concerns were raised

Staff understood how their work was linked with other teams, and governance documents showed effective collaboration with patient-experience, booking, rescheduling and estates teams. This included reviews of Friends and Family Test feedback, updates to clinic signage and layouts, and joint work on incident-mailing lists for shared areas. Services also worked with clinical specialties to reduce clinic overruns and improve waiting-time consistency across sites. Environmental audits and refurbishment work were used to support quality improvements, and the service had processes for reviewing risks linked to patient flow, accessibility, and estates.

Risk-management systems were accessible and understood by staff. Local risk registers reflected the concerns raised in clinical areas, including environmental constraints in Area A, patient-flow challenges, and fire-safety actions. Risks had assigned owners, review dates, and documented updates. Leaders ensured they had access to timely and accurate information to support safe decision-making, and governance papers confirmed that data on performance, incidents, staffing, outcomes and utilisation were monitored routinely. The trust remained compliant with the national Data Security and Protection Toolkit (DSPT), confirming safe handling of patient information.

Emergency and major-incident plans were in place and understood. Staff knew how to access the Trust's Major Incident Plan, command structures and continuity arrangements. Governance minutes confirmed that evacuation training had been completed, and further practical drills were scheduled. This supported preparedness for unforeseen events

However, despite the clear structure and regular oversight, we found that several governance risks remained unresolved. The most significant was the long-standing backlog of incomplete clinic outcome forms and missing RTT updates, recorded since July 2020. This created a risk of missed follow-ups and patients being lost in the system. Controls were in place, including full-time staffing to address the historic backlog, weekly monitoring of un-outcome activity by the transformation team, daily reports to clinics not managed internally, and training on 18-week RTT rules and correct outcome-form completion. Regular audits were used to identify whether errors came from incorrect clinical outcomes or administrative actions. Despite these measures, mitigations were only partially effective, and the risk remained high with a current score of 9 against a target score of 3. The issue had been escalated to divisional and executive levels, with monthly position reports circulated to maintain oversight.

Governance minutes also showed several recurring issues that had not been resolved quickly. These included ongoing clinic overruns in Area G, delayed infection-prevention and health-and-safety updates, and inconsistent progress with security arrangements, such as call-bell repairs and body-camera deployment. Estates-related constraints, including fire-safety work and layout challenges, reappeared across multiple meetings, and some actions remained incomplete for several months. This indicated that while risks were identified and recorded, the pace of improvement varied, and some mitigations were dependent on wider trust teams, which slowed progress.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service worked in partnership with other organisations to improve care and pathways. Leaders shared information with partners and collaborated to address system-wide challenges. Joint working supported more consistent and coordinated care.

Leaders had strong relationships with commissioners, primary care and system partners. Senior OPD leaders attended MDT system meetings where performance, waiting times, cancer pathways and operational pressures were openly discussed with ICB leads, trust managers, GPs, other providers and community teams. These forums showed clear senior engagement and joint planning to improve pathways and resolve interface issues.

Patients and staff could also share feedback through these partnership meetings. OPD performance data, experience themes and operational changes were presented at system boards, and primary care colleagues could raise concerns directly. The Greenwich and Bexley Interface Forum enabled community clinicians to escalate issues such as referral quality, pathway delays and communication gaps, supporting transparency and shared problem-solving.

Partnership work supported population needs. The trust worked closely with south east London partners to reduce long waits, improve quality and bring waiting times in line across the system. GIRFT, a national programme designed to improve NHS care by reducing unnecessary variation, supported this work by helping providers compare performance, share good practice and agree consistent pathways. Through GIRFT, trusts learn from one another, adopt better ways of working and reduce avoidable delays, unnecessary procedures and differences in how services are delivered. Within this partnership, the trust and its system colleagues jointly reviewed GIRFT recommendations, validated waiting lists and tested shared triage models. This helped improve pathway consistency across sites and supported better waiting-list performance, ensuring patients across the local population received a more reliable and coordinated outpatient service.

However, some system challenges remained. Primary care fed back that patient discharged from PIFU sometimes returned to GPs for support, highlighting gaps in communication and pathway understanding. External partners also noted variation in specialist advice use and lower diversion rates than other providers, resulting in more referrals into OPD and added pressure on waiting times. These issues indicated that some shared pathways and feedback processes still required strengthening.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service supported learning and improvement. Staff used quality-improvement methods and contributed to projects that improved patient flow and experience. Innovation was encouraged, although pressures sometimes limited capacity for improvement.

Staff were encouraged to innovate and use formal quality-improvement methods. The trust's 6-4-2 approach gave teams a clear structure to test changes and monitor impact, and staff were familiar with using it locally.

Improvement projects led to measurable results. At QEH, the kiosk-utilisation project used QI tools to address poor patient flow and introduced remapped kiosks, clearer signage, removal of generic clinic locations, and receptionist training. Check-ins increased from about 340 to 938 per week, reducing reception workload and improving access.

Staff also drew on national programmes such as GIRFT, Further Faster, elective recovery work, and digital initiatives. Governance records showed OPD involvement in patient-portal rollout, kiosk optimisation, and work to reduce missed appointments. These innovations supported more efficient care and gave staff opportunities to shape new ways of working.

The service contributed to national audits and used findings to improve booking processes, patient experience, and flow.

However, improvement work was not always consistent. Staff said clinical pressures sometimes limit their capacity to engage in QI, and issues such as generic clinic codes slowed progress. Some changes depended on wider system teams, which reduced the pace of innovation.

Urgent and emergency services

Urgent and emergency services

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

Our view of the service

Queen Elizabeth Hospital Emergency Department

The emergency department (ED) at Queen Elizabeth Hospital provides a 24-hour, 7 day a week service to the local population. The consultant led service is a member of a regional trauma network and is a designated trauma unit. The ED consisted of 14 ‘majors’ treatment trolleys, 9 ‘minors’ treatment trolleys, a 4 bedded resuscitation area with a paediatric resuscitation bay, a 9 bedded blue area used for rapid assessment and treatment (RAT), a green area which was being used to support care of patients with mental health and infectious patients consisting of 5 rooms, and a paediatric emergency unit consisting of 8 trolleys and a high dependency unit. There was also 2 triage rooms used for initial tests while patients wait for admission into the ED department. The ED also had a clinical decision unit (CDU) consisting of 2 bays with 5 beds each, 2 side rooms and 6 blue recliner chairs for patients. There is a designated unit for children and young people. There is a co-located urgent treatment centre which opened in November 2024 which is run by a different NHS service.

The Integrated Care Board (ICB) for Lewisham and Greenwich NHS Trust is NHS South East London

Integrated Care Board (SEL ICB). It is responsible for planning health services and commissioning care across the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark. Queen Elizabeth Hospital's ED is a trauma unit, part of the South East London, Kent and Medway (SELKaM) Trauma Network.

We conducted this announced assessment on 24 and 25 February 2026 as part of our winter pressure programme, which meant we looked at a reduced number of quality statements. We last inspected UEC in 2020 when we rated it as Requires Improvement. At this assessment the ratings improved to Good.

We assessed 25 quality statements across the safe, effective, caring, responsive and well-led key questions. We have combined the scores for these areas with scores from the last assessment to give the rating.

We spoke with 12 patients and 6 relatives/carers. We reviewed 14 adult patient records and 6 records of children and young people. We spoke with more than 52 staff which included: consultants, resident doctors, nurses, senior leaders, healthcare assistants, emergency department technicians, administration staff, chief pharmacist, deputy chief pharmacist, pharmacy technician, housekeeping staff and volunteers.

People's experience of the service

Most patients, families and carers we spoke with were positive about the staff, who treated them with warmth and kindness and provided effective care and treatment. Comments from patients included: staff were “helpful, friendly and kind”. One patient described feeling safe. Patients said communication with them was generally good although most patients were not given any indication of how long they would have to wait for treatment past the initial meeting with the doctor. However, patients were kept informed of their care and treatment and knew what they were waiting for.

Patients said they were seen quickly by trained nursing staff when they arrived and were asked appropriate questions to find out more about why they had attended the ED. Records we reviewed showed they were given the tests they needed usually promptly. We observed staff interacting with patients in a sensitive and kind manner. Patients were also offered food and fluids whilst waiting.

Safe

Rating Good

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also ensured that people's liberty was protected when it was in their best interests and in line with legislation.

At our last assessment, we rated this key question as requires improvement. At this assessment the rating has improved to good. This was because we found there was a positive learning safety culture where incidents were investigated, and learning was shared and embedded to promote good practice. Staff we spoke with were open and honest when things went wrong, and they had the opportunity to learn and gain experience. The environment was safe and well maintained. There were effective mechanisms to adjust staffing levels when needed to keep the department and patients safe. Staff mostly demonstrated safe medicines management. Risks to patient safety were mostly mitigated. Staff did not always practice high standards of infection prevention and control. Some staff had painted nails and rings on and did not always wash their hands.

Learning culture

Score

3. Evidence shows a good standard of care

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

The service ensured that lessons were learned, and improvements made when things went wrong. The service had a Patient Safety Incident Response policy in place which supported staff to identify which learning response would be the most appropriate depending on the patient safety event. These learning responses included patient safety incident investigations (PSII) and after-action reviews (AAR). Staff and leaders, we spoke with were aware of NHS England best

practice guidance: Learn from Patient Safety Events (LFPSE). They told us they were encouraged and supported to raise concerns, and felt confident that they would not be blamed, or treated negatively if they did so. However, some staff felt that they didn't report incidents that occurred frequently, such as verbal aggression, as the form was very long and they did not always hear back from incidents that they reported. Governance meeting minutes we reviewed identified that the senior team looked at incidents and highlighted any themes and trends. Incidents across the department and medical service were discussed so that learning was shared across these areas.

All staff described the ways in which information from incidents was shared with the department. This included the use of a private mobile messaging service group, emails, through a monthly newsletter and at handover. We were also advised that the noticeboards in the breakout rooms contained information on learning from incidents. However, we did not see a monthly newsletter, information in the breakout room or hear on handover about shared learning. Most staff used emails or the mobile messaging service group to make themselves aware of changes to practice following incidents. Staff described multiple mobile messaging service channels through which they received specific information such as training and development, social activities and notable news. Staff described that "hot" debriefs, those that happened as soon as practicable following an incident were more likely to happen than "cold" debriefs, those which happened sometime later when the incident had been investigated.

Staff were aware of the requirements for duty of candour and enacted this at a patient level when aware of a complaint or incident. The service used the learning from complaints and concerns as an opportunity for improvement. Senior members of staff and leaders were involved in reviewing complaints and incidents. For example, a leader within the Emergency Department (ED) told us that there had been a theme of complaints relating to the care of patients miscarrying whilst in the ED. In response to this a designated quiet area was allocated to patients who were at risk of miscarrying. This area had access to a private toilet facility. Staff were aware of this area and why it had been allocated for this type of care. The department now had a new pathway for patients who were miscarrying.

The risk register for the department shows 7 risks rated as high. This means that they scored above 16 in the risk scoring. These focused predominantly on the impact of poor performance of the department such as delays to care and treatment. These risks were regularly reviewed and had been so 16 days prior to our inspection.

Following incidents involving mental health patients, the trust will work with a mental health provider to decide whether to do individual or joint investigations. In November, a young person with mental health needs died after leaving the department. The trust has set up a group to review learning from this incident. They are reviewing all the data of absconding. Police liaison officer has arranged for the police team to visit and review the department. They are also considering how information on risk is communicated.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service mostly worked well with people and healthcare partners to establish and maintain safe systems of care. They made sure that there was continuity of care, including when people moved between different services. However, they did not always manage or monitor people's safety. The service lacked oversight of the waiting area and did not always monitor patients' condition whilst lengthy waits in this area. The service did not always apply wrist bands prior to further treatment being provided.

The department worked collaboratively with internal colleagues and external partners to maintain patients' safety. Continuity of care was maintained by effective handover of patients and communicating their individual needs. All patients entering the department on foot were required to sign in on an electronic tablet and then at the reception desk. This would initiate streaming by the GP provider that runs the urgent treatment centre who would then refer the patient to the most appropriate pathway. Assistance was given to patients who struggled with this system. Following streaming, the patient either went to a third-party provider for GP services, mental health services or were sent to be triaged by the ED service.

Patients we spoke with did not always understand their pathway. Receptionists at the front desk had to explain the process of streaming and triage to patients. The department had different coloured chairs for triage and streaming. However, patients were unaware of this and sat wherever and waited for their name to be called. Triage patients we followed were seen

relatively quickly in one of the triage rooms in operation. Initial observations, recorded on the electronic record, and tests were performed and then appropriate patients were returned to the waiting room to await being seen by a clinician. Children were sent through to the paediatrics waiting area following triage. Before this time, they waited in a sometimes very busy noisy waiting room. The waiting room was monitored by the clinicians in the triage rooms. However, this only included a cursory glance at those waiting to identify if anyone had deteriorated. Wristbands, with patients details on, were not applied at this point despite medication being given and a potential risk of deterioration whilst waiting. We were told that patients should be reviewed 2 hourly whilst in the waiting room. However, we did not see or hear of this occurring whilst we were on site.

Patients were called by clinicians from the waiting room to the appropriate area for assessment and treatment. We saw a mixture of paper and electronic records in place for patients. On paper records we noted that risk assessments were completed but national early warning scores (NEWS) 2 scores were not generated. Staff appeared to be used to the dual system of recording patient information. A member of staff in majors was designated to monitoring that all patients had their observations undertaken every 3 hours. This nurse checks with the nurse looking after the patient that observations, usually hourly in majors, had been undertaken. Whilst this was documented in a separate paper booklet, we did not see any safety rounding documentation in the patients notes. Audits demonstrated that falls prevention assessment was undertaken within the resuscitation and main areas of ED. Compliance in December 2025 was between 80 and 100%. The completion of the Waterlow (pressure area) assessment was low in December 2025 at between 60 and 67%. However, improvement to 100% was seen in January 2026. Ambulance handovers were completed on arrival or shortly after. These were detailed and information was relevant to the patient.

There were well known pathways of care for specific patients such as trauma patients requiring secondary transfer, patients who required neurosurgery, patients with burns and severely ill children would all be transferred to different hospitals. There were good communications systems in place to ensure a robust handover was given and patients received timely care on arrival. Staff reported good working relationships with the hospitals that they regularly transferred patients too.

The department had a clear pathway for patients with mental health needs. When people with mental health needs arrived in the department, triage nurses completed an initial assessment.

They referred the patient to a third-party mental health trust who could stream patients with mental health needs directly to other services, through a pathfinder role. The team undertook assessments in parallel, not waiting until a patient had been medically cleared to start assessments.

The department had a mental health assessment unit. This was provided by a third-party provider, but the patients in the unit remained ED patients. The unit had five bays and was staffed by mental health nurses and support workers 24/7. However, we heard that the third-party provider planned to shut the unit at the end of March 2026. The unit had clear criteria to guide which patients could use the unit.

Mental health trained security staff supported clinical staff when there was a risk of violence and aggression. Staff completed a risk assessment form, that detailed the legal framework and rationale, prior to restraining a patient. If a patient went missing the security team would undertake an approved search. There was a debrief following any restraint to which all staff involved were invited.

The trust had a substance misuse team. This service was available between 8am to 8pm Monday to Friday, but the trust was looking to extend this to cover the weekends. The team visited the ED daily to identify patients who they can support. They encouraged the championing of their service through the nurses working in the emergency department. Staff who advise, treat and see patients with mental health issues or dementia in-reach into the emergency department daily. The department had a process for supporting people subject to section 136 of the Mental Health Act.

The paediatric ED was supported to care for patients with a mental health need by the Children and Adolescent Mental health Service (CAMHS) team provided by a third-party provider. Staff told us that they often waited for CAMHS members of staff to attend the department and complete assessments. This was due to the workload of this service. However, the play specialist assisted to reassure and listen to patients who were in the mental health suite in the children's emergency department. The trust had reviewed its pathway for 16- and 17-year-olds, who now attend the adult ED. The psychiatric liaison team responded to most emergency referrals within one hour.

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. Patients we spoke with told us they felt safe and that if they had any concerns or issues, they would feel comfortable to tell someone.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm. Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies such as police and local authority safeguarding teams, to protect them.

Staff had training on how to recognise and report abuse, and they knew how to apply it. Data provided to us by the trust showed that compliance with all safeguarding training modules apart from safeguarding children level 1 were over the trusts target of 90% within the nursing staff. Whilst safeguarding children level 1 training did not meet the target; level 2 training was above the target set by the trust. This meant that staff receiving level 2 training would have covered the areas in level 1 training. Medical staff did not meet the target for any safeguarding training with children's safeguarding being particularly low. Doctors completing safeguarding adults training level 3 was 78% compliant with children's safeguarding at 58%. The lead clinician had plans to address this concern.

We observed the triage of a child attending with burn injuries. The patient's mother was treated with kindness, compassion and dignity. Safeguarding concerns were highlighted because of the nature of the injury. The nursing staff demonstrated sensitive questioning of how the accident had happened and what actions the mother had taken before deciding if there was a safeguarding risk. In this instance the mother was able to describe how this accident had occurred and had taken appropriate and effective action to minimise the extent of the burn. Staff displayed a good understanding of the need for safeguarding referrals and were not going to complete a referral in this case due to the immediate actions of the mother. However, they

were able to describe circumstances where a referral had been made.

Staff had access to safeguarding policies, which referenced appropriate legislation and best practice guidance. Safeguarding information was displayed throughout the department. Staff told us they were confident in raising safeguarding concerns and the process for referrals on the electronic patient record system and was easy to complete. Staff were able to tell us when they recently completed referrals. Staff told us there were safeguarding link nurses within the department who provided support and advice when needed.

The service shared concerns quickly and appropriately. Staff told us that Deprivation of Liberty Safeguards (DoLS) were not used within the ED, where applicable doctors completed Mental Capacity Assessments (MCA) for best interest's restrictions. The trust had delivered training courses on the Mental Capacity Act and DoLS, staff told us that they found the training helpful. The service had also arranged access to the Oliver MacGowan training which staff found very helpful in meeting people's needs. Oliver McGowan training is on learning disability and autism. Staff considered patient's capacity when assessing them. Staff recorded an assessment of capacity in one of the records we reviewed.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

Staff provided care to meet people's needs that was supportive and enabled people to do the things that mattered to them.

The department had effective processes and tools for assessing patients when they first presented to the department and monitored patients for signs of deterioration when they were taken into the main department. Patients we spoke with told us their wait for triage had been timely. Patients were triaged by trained triage nurses. Patients had their basic observations undertaken, National Early Warning Scores (NEWS) undertaken and any relevant tests were ordered. However, despite processes being in place to monitor the waiting room we did not see this occurring. The average wait for patients arriving by ambulance in January 2026 was just

over 23 minutes. This was better than many trusts in the area.

Leaders and staff could articulate what risk assessments they used to keep patients safe. Security staff were trained in least restrictive restraint. Restrictive restraint was only used as a last resort and was monitored by leaders. We noted one episode where rapid tranquilisation was required. Staff had not completed post-intramuscular rapid tranquilisation physical health observations for this patient for 4 hours. This incident was being investigated after we highlighted this. The trust had updated its rapid tranquilisation policy last year and is in the process of auditing currently.

Patients told us they felt safe and supported whilst they were in the ED. They could approach staff if they felt their health was deteriorating and they were confident staff would respond to their concerns. We saw posters about Martha's rule, a programme which enabled friends, relatives and patients themselves to make a direct referral to the outreach team if they felt the clinical condition of an adult or child patient was actively deteriorating. However, staff felt that this route was rarely used as family and friends would approach staff within the department first.

Staff we spoke with described the processes to assess and identify patients at risk and how they assessed and documented mental capacity. Staff had a person-centred approach and involved patients, where possible when completing risk assessments. During December 2025, the service monitored compliance with completion of the sepsis documentation. This demonstrated that different areas of the department were completing this at different rates. Compliance with documentation of the sepsis screening tool ranged from 40% to 75%. The level of compliance fluctuated widely in the department. Over the five-month period from September 2025 to January 2026 the average compliant rate was around 70%. We saw information in staff rooms about completing the sepsis documentation.

The service had a frailty team who worked with the department. The frailty service assisted patients to return to their homes as soon as possible by supporting patients to be at home. ED either referred patients to the frailty team or the frailty team in reached into the department to ensure that patients who met the criteria could access this service.

The department had a nursing notes booklet for patients with mental health needs. This booklet contained a range of sections, including on mental state and description, a mental health risk assessment, mental capacity assessment, enhanced observation recording, NEWS,

clinical institute withdrawal assessment and post dose rapid tranquilisation. Partners, such as psychiatric liaison reported they worked well with department staff. Several members of staff commented on the positive culture and working cohesively to ensure the patient was kept at the centre. However, staff highlighted that the rates of patients leaving the department had increased. They felt this was due to the amount of time people waited to access a mental health bed.

Safe environments

Score

3. Evidence shows a good standard of care

The equipment and facilities, in the main department, supported the delivery of safe care.

Patients told us they were well looked after by staff, despite long waits, crowded waiting rooms and cubicles being doubled up to care for 2 patients. There was a separate area for children and their families which was safe and secure and there were toys to keep children occupied and a play specialist who helped patients and families to remain calm and reduce stress

Computers were widely available throughout the department which meant that staff did not have to wait to access them. However, we observed several unlocked and unattended computers displaying confidential patient information on the inspection. We escalated this to leaders whilst on site. They took immediate action to remind staff to remove their access cards when not using the computers. White boards displayed where patients were within the department and had some information about the patients. Whilst these were predominantly for staff other patients and visitors could read these.

Staff had access to all the equipment they needed and guidance or instructions for using it. There was additional equipment available if required during busy periods. We saw environmental risk assessments were completed.

Planned preventative maintenance and electrical appliance tests were completed and recorded centrally. All electrical equipment we checked had undergone electrical safety checks

within the last 12 months. The department's fire safety equipment and emergency systems such as call bells, were tested and maintained appropriately. Fire exits were not blocked; evacuation routes were signposted.

The department had a resuscitation area which had capacity for 4 patients, including an area to treat children. Each bay had 2 trolleys in it to allow for an extended number of patients in the resuscitation area. Whilst the original bay was large enough to easily allow for a multi-professional team to care for and treat the patient, this was restricted when 2 patients used the same bay. The bay reserved for children was seen to have a large amount of equipment temporarily stored in it. However, we saw that this was quickly removed when a child was expected into the area.

Equipment, facilities, and technology supported the delivery of safe care. Each treatment area had standardised equipment. Standardisation of equipment aims to reduce the risk of harm to patients because staff who work between these areas will have greater familiarity with a smaller number of devices, thereby reducing the risk of error. Resuscitation trolleys were secure and checked regularly. We reviewed three trolleys and found that they had been appropriately checked, and this was recorded.

The department was split into defined areas each colour coded. The green area had cubicles which had been split using curtains into 2 bedded areas. There were mixed sex patients in each of these cubicles. There were numerous areas where extra areas had been created to see and treat patients. Curtains were often used to provide some sort of privacy screening but the effectiveness of this was not always robust. There was a policy on using escalation spaces which included where to use, how to care for patients in these areas. The department was not using escalation spaces during the inspection. In March 2026 NHS England requested that these temporary spaces were renamed Corridor Care. However, we did not see patients being cared for int he corridor on our inspection.

The department regularly used 2 rooms for supporting people with mental health needs. These rooms were at the end of a corridor and in a quieter area of the major's department. The rooms both had 2 doors that could open outwards, had strip alarms, did not contain any obvious ligature anchor points, had CCTV cameras and contained heavy furniture. They had lighting panels that could light the rooms in different colours.

The rooms had a connecting door, acting as the second door for 1of the rooms. This had a glass viewing panel that could not be closed. This meant that there was no privacy in the rooms. Psychiatric Liaison Accreditation Network (PLAN) standards (p.14) notes that rooms should "Have an observation panel or window which allows staff from outside the room to check on the patient or staff member, but which still provides a sufficient degree of privacy." In 1 room, the second door opened onto the corridor. This was kept locked unless needed. Both rooms had heavy couches. These were badly damaged and dirty, with multiple rips. Following our raising of these issues the trust sent us an action plan detailing that they had addressed the issues of privacy between patients and had ordered new couches for the rooms. People in the mental health rooms used the shower / toilet in the blue area. This room did not have anti-ligature fittings and contained potential ligature anchor points. The matron told us that staff would either wait outside the room or wait inside the room depending on the risk of the person. Ligature cutters were in the resus trolleys.

The paediatric emergency department had one room for supporting children and young people with mental health needs. The room had 2 doors. One opened into the adult area. This was kept locked unless needed. The room had trolleys previously. These had been replaced with a heavy bed, heavy armchair and safety pod. The door to the paediatric department had viewing panels and could open outwards. The room had some potential ligature anchor points, including the push alarm. The matron told us that they had funding to make the changes to the room, but the work had been delayed. The mental health head of nursing told us that staff would assess the needs of patients before placing them in the room. They could use a ligature free room on the paediatric ward if needed.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service made sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development.

The service had enough nursing staff to keep patients safe, and the nursing staff matched the planned numbers on the day. Skill mix was reviewed regularly and adjusted throughout the day. The department had 15 emergency consultants, of which 3 were part time. There was consultant cover in the department from 8am to 10pm 7 days per week which was followed by on call arrangements. This was below the national guidance recommended levels of consultant cover. Leaders understood this hot spot which demonstrated that a further 9 consultants were required and plans were in place. The service used regular locum doctors. The children's department was covered with doctors and nurses with the appropriate paediatric competencies. Cover was provided within the department from 8am to 5pm by a consultant and mid-grade. After this time the mid-grade doctor had access to the consultants in the main ED. During the nighttime was provided by a mid-grade ED doctor but the paediatric ward doctors generally based themselves in the ED overnight when the ward was quiet. There were 2 doctors with the Paediatric Emergency Medicine qualification who worked in the department. Most nurses had a qualification in paediatrics life support (86%) there were 3 nurses who were not currently up to date with this training. If children were due to stay for any length of time they were transferred to Hippo ward. Two paediatrics nurses were on duty at any one time. They were supported by a senior nurse during the day.

Staffing was flexed to meet the needs of the patients attending the different areas of the department. Huddles occurred regularly throughout the 24-hour period to review the needs of patients in the department. All staff felt that they had good access to training. This was encouraged through the mobile messaging service as a defined area of support.

There were robust and safe recruitment practices to make sure that all staff, including agency staff and volunteers, were suitably experienced, competent, and able to carry out their role. There was a suite of policies relating to safe recruitment and all new starters received a comprehensive induction. The department had a dedicated senior pharmacist and senior pharmacy technician in the department to help in reach into the department to review and flag for further review. This service was available 5 days a week. Medicines were reconciled during their time in the department.

The service used bank staff when necessary and regular agency staff, and ensured they were familiar with local systems and processes. We spoke with agency and bank staff who stated that they were regularly employed by the department and as such felt part of the team. They were included in secure information channels so that they received information like the trust

staff. These staff were aware of the issues we raised with them such as actions following complaints etc.

Leaders told us that there was good team culture within the department, that across the professions there was good training opportunities and multiprofessional relationships. We were told there was a culture of supporting staff to develop and progress. In 2022 the department had a vacancy rate of 40% but this had decreased to 15% for nursing staff and nearly 5% for medical staff by 2026. This was above the 10% target for nursing staff. The turnover rate for nursing staff over the 12-month period was 9.7% and 16.8% for medical staff. Whilst overall sickness rates were 6.7% the main cause of sickness was anxiety, stress and depression for nursing staff and coughs/colds and pregnancy for medical staff. All newly qualified nursing staff underwent a preceptorship programme which lasted 18 to 24 months. This was followed by undertaking a recognised course in nursing within the ED

During the assessment, the department was busy with more patients being cared for than the department was built for. This put inevitable pressure on staff. However, staff said they felt able to respond to increasing demand as staff supported one another well. We observed staff who were busy but upbeat and smiling. They could highlight the issues they faced but were resilient to these because of the support they received from leaders and other staff. Staff told us there was support and mutual respect among staff working in the department. We observed effective and cohesive teamwork. There was a culture of just “one team” and shared responsibility. We attended both nursing and medical handovers and found that the patients in the department were discussed along with ongoing plans for treatment and care. At the huddle in the middle of the day, we saw and heard cohesive working where medical staff prioritised patients nursing staff were concerned about.

Staff received mandatory training appropriate and relevant to their role. Overall compliance for adult nursing staff was 90%, and 73% for medical staff. The trusts target for training compliance was 90%. However, elements of training that were lower than the target included basic life support and moving and handling training. Most medical and nursing staff had a higher level of training than basic life support. There were actions in place to address areas of non-compliance.

The service had a process for carrying out effective appraisals, 99% of nursing staff had received an appraisal and 100% of medical staff had received an appraisal. Both were better than the

trust target of 90%.

Medical staff were supported by named supervisors. Resident doctors had protected time for teaching. Feedback from resident doctors was positive, they felt supported and invested in to develop and gain new skills.

Staff told us specialised mental health training was available to staff. Whilst mandatory training for nursing staff in issues relating to mental health training were above the trusts target for nursing staff and below it for medical staff. This included conflict resolution nursing staff 99% and 100% for doctors, Mental Capacity Act and Best Interest training 96% and 78% respectively, and restraint training 97% and 77% respectively. The senior medical team were aware of the shortfall in their team and had action plans in place to address this. All ED members of staff attended a day training course on mental health. This day includes sessions on mental health awareness, the mental health liaison team, conflict resolution, management of agitated patients, substance misuse and the application of the Mental Health Act in ED.

The trust rostered 2 mental health nurses on all shifts currently. At the time of the assessment, these were bank and agency members of staff. The trust was expanding its specialist mental health staffing. It had a mental health head of nursing and a band 4 mental health wellbeing practitioner role. It had recruited a mental health matron recently and was recruiting registered mental health nurses and mental health wellbeing practitioners. Once these staff had been recruited, they planned to have permanent registered nurses and mental health wellbeing practitioners on all shifts in ED.

The trust had funding for a capital nurse to develop their approach on enhanced therapeutic observation care (ETOC). They were looking to develop training for staff in how to improve the training offer. There were 4 mental health leads within the ED: bespoke mental health lead, matron mental health lead, consultant mental health lead, and clinical fellow mental health lead.

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 mitigate and control the risk of spreading infections through good hand hygiene and appropriate preventative actions, such as staff being bare below the elbow.

During the assessment we observed staff within the service did not always wash their hands in line with infection control policies and adhere to the uniform policy set out within the service. We observed that some staff had false nails, nail polish and jewelled rings on their fingers. This did not comply with the 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance. Following our inspection, we received an action plan from the trust which stated that they have reiterated and trained staff on infection control principles. The trust sent a newsletter to all staff reminding them of the principles of hand hygiene. Personal protective equipment and handwashing facilities were readily available. However, we also noted that gloves were not always changed appropriately and staff looking through multiuse patient equipment trolleys whilst wearing gloves. The risk from these practices is that infections could be spread between patients due to ineffective handwashing and mis use of personal protective equipment.

The service had an infection prevention and control policy, which staff were aware of, and which set out key information for staff to support maintaining infection, prevention and control standards 91% of nursing staff and 81% of medical staff were up to date with their training in infection prevention and control. Hand hygiene, local cleaning and infection prevention and control audits were undertaken by the service. The hand hygiene audit from November 2025 demonstrated that compliance was rated at 92%. The environmental audit in February 2026 equally scored 92% compliance.

Domestic staff were visible within the department. We observed both clinical staff and the cleaning staff diligently cleaning equipment and the environment. We saw 'I am clean' stickers placed on surfaces that had been cleaned. The floors were clean despite heavy foot traffic and

the constant movement of people and equipment. The cleaning schedule set out by the service was followed. We saw disposable curtains labelled with the date they were last changed. Cleaning records we saw were up to date and demonstrated all areas and equipment were cleaned regularly. Clinical waste was disposed of safely.

Clinical areas we saw were clean and had suitable furnishings which were mostly clean and well-maintained. During the inspection we informed the senior team that the sofa's in the mental health cubicles were ripped and stained. The damage prevented effective cleaning of the surfaces. The trust sent us an action plan which outlined that they had ordered new couches for these rooms.

A single negative pressure isolation room was available in the green area of the department, and a large tent was available outside of the service for any incidents requiring decontamination. The consultant we spoke with told us that they had had chemical, biological, radiological, and nuclear defence (CBRN) training about a year ago along with some nursing staff and other doctors.

Medicines optimisation

Score

3. Evidence shows a good standard of care

Medicines were kept secure and were only accessible by authorised staff. We saw improvements had been made around medicines management since the previous inspection.

Medicines were generally administered as prescribed. Staff had access to local and national electronic records. In records we reviewed, time critical medicines were given in a timely way. Patient records were flagged on admission to show if they needed time critical medicines or had complex needs. Where doses were missed due to medicine unavailability, they were highlighted in monthly reviews which was fed back to matrons and leaders in the areas to be discussed with nursing staff.

We heard that pain relief was not always timely when people arrived in the department. However, we saw pain relief being given to a patient in the waiting room. Whilst this addressed their pain, it was not done in line with the administration of medicines policy as the patient did not have a wrist band on. As patients moved through the department pain relief was given in line with the policy as a wrist band was applied and staff checked that patients were not in pain. Documentation audits demonstrated that patients received pain relief but that this was not always recorded as being assessed as to its effectiveness.

The service was part of a pan London pilot in collaboration with other hospitals and an ambulance service to improve support of people with time critical medicines. Work was ongoing, having just completed the data collection phase.

Whilst the clinical pharmacy service delivered to the ED was not in line with Royal College of Emergency Medicines (RCEM) guidance, the service used a prioritisation process for identifying and reviewing high risk patients. They had a dedicated senior pharmacist and new senior pharmacy technician in the department to help in reach into the department to review and flag for further review. However, this support was limited at weekends. Staff told us that the department was regularly supported by pharmacy staff from other areas. The service used a cluster model where there were twice daily briefings to discuss new admissions and urgent and complex cases. We saw good practice where pharmacist support was embedded in post-take rounds with other members of the multi-disciplinary team (MDT). Staff told us they were able to provide advice and interventions at the time of treatment planning in new patients attending the service.

Staff in the children's ED had ad hoc support from dedicated paediatric pharmacists. Staff told us that support was accessible if they needed it.

There was a process for supplying medicines on discharge from the department. Medicines were transferred with patients admitted to an inpatient bed, and the record system allowed medicines previously ordered to be sent to where the patient now was.

Staff received regular medicines training and the pharmacy team worked closely with practice development nurses to support staff in each area.

The service had a governance process in place to review incidents that occurred within the

department. The service produced quarterly medication safety reports and newsletters to share learning. There was regular monthly walk round audits of medicines management and controlled drugs in different areas of the department.

The service had ongoing improvement projects to medicine safety. For example, we saw examples of improvements made around improving safety when prescribing paracetamol. The service had also identified gaps in pharmacy interventions for mental health patients in the department and had started a programme to improve this.

The service had a process for receiving and actioning patient safety alerts.

Effective

Rating Good

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

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people's outcomes were good, and care reflected the needs of those using the service.

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 trust's intranet contained a comprehensive range of up-to-date policies and standard operating procedures which reflected current practice. It had guidance for staff around collaboration with multi-agency teams and for delegation of clinical tasks to ensure the right people delivered evidence-based care and treatment. There were numerous clinical pathways which were well known to staff.

The service planned and delivered patient'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. For example, we saw a patient who had had a fall have the appropriate investigations to ascertain the potential cause of their fall and who had been prescribed pain relief.

The trust submitted data to the Royal College of Emergency Medicine (RCEM) 3 Quality Improvement Programmes (QIPs) in 2025/26. These included self-harm in patients with a mental health issue, care of the older person and time critical medicines. The data submission date had passed the week before our inspection and the department was awaiting the results of their submission. The trust audited practice against evidence-based research.

Systems were in place to ensure staff were up to date with evidence-based guidance and legislation. Clinical records we saw demonstrated care was provided in line with current guidance. For example, we reviewed the records of a patient who attended with a head injury. We saw care and treatment provided was in line with NICE guideline: Head injury: assessment and early management May 2023. Triage questions were appropriate for the patient and their needs for example, people presenting with emotional needs were properly and sensitively assessed and specialist help sought early.

Patients said they had been offered something to eat and drink. We observed hostess staff offering patients refreshments. In response to patient feedback, hot food had been made available to patients. Patients were offered a range of food which met their dietary requirements.

The service worked with a third party to direct patients to other departments and organisations for patients who did not require emergency care. Within the emergency department there was good access to and use of treatment units, frailty services and same day medical and surgical units. The service had some volunteers who worked within the emergency department.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

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

Staff have access to the information they need to appropriately assess, plan, and deliver care, treatment and support in line with people's individual needs. However, this was often split across paper and electronic records. This meant staff had to review 2 documents to appraise themselves of the patients journey and changes in condition or observations. The service was moving to a new electronic patient record management system in the summer, and staff were keen for this to occur.

The service worked well across teams and services to support patients. Leaders told us staff were responsive across the organisation when requested to support the ED. There were specialist teams, such as the psychiatric liaison support team and the substance misuse team who in reached into the department to provide advice and support to the staff working in the ED.

There was a rapid assessment and treatment area (RAT) which only operated when there was capacity within the department. This service aimed to facilitate streamlined patient care and rapid discharge or onward care of a patient. However, due to delays in other departments and long waits for diagnostic tests this area did not function as expected. We saw this area open on the second day of our inspection, and it rapidly reached the maximum number of patients. Whilst some patients were seen, assessed and treated in a timely way others were awaiting tests.

The same day emergency care pathway had been redesigned and is described in the medicine report. These services had dedicated doctors to assess and care for patients. The units took patients from local GPs within a defined criteria. They also took emergency patients who were assessed as being of a lower risk than requiring emergency department intervention. If the

patient was assessed as needing a speciality referral they would be transferred to the relevant assessment unit where one existed. If it was decided that they required admission, they would remain on the appropriate unit until a bed became available. There was a “pull/push” model in place. This meant that staff in the main ED would assess if patients could go to one of these services and that the unit staff would monitor ED for any potential patients that could go to their units. This meant that patients followed the most appropriate care pathway.

Care was coordinated, and everyone involved in their care worked well together. We observed good quality, kind and compassionate interactions between staff and patients. Information was displayed on notice boards relating to care, advocacy access, information for carers, charities, mental health and feedback on care.

Staff worked well with external partners involved with patients. External partners, such as GPs, community nurses and social workers were involved to enable continuity of care and support for discharge. Staff reported good engagement with safeguarding partners.

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 told us treatment plans were evidence based and monitored for outcomes. Patients care was reviewed and updated, and appropriate referral pathways were in place to make sure that needs are addressed. Staff were able to tell us about when treatment had led to learning following debriefs and mortality and morbidity meetings. This included the lowering of the trauma threshold for scans following elderly patients with neck injuries.

Many patients told us that they were not kept up to date with how long they may wait. Yet in the Urgent Emergency Care Survey 2024 results, in response to were you kept updated on how long

your wait would be, was rated better than the national average. The next survey is currently having data submitted to it.

The service had completed an audit in March 2025, highlighting that people with sickle cell disease were not always given pain relief promptly. Whilst the service had highlighted actions to be taken through a quality improvement project, we did not see evidence of completion of the actions or performance improving through the project for it.

The trust percentage of patients reattending the ED within 7 days of the original attendance was 2.3% of all patients seen in the ED. This was lower than the national average between February 2025 and January 2026. The service regularly monitored the care of patients with mental health issues through attendance and presentation at their governance meetings of staff from mental health services. The audit programme and data oversight of mental health in the department seemed limited. The department is completing an audit of rapid tranquilisation currently. The governance meetings also included assigning leads to external audits and discussion of issues raised in audits or inspections.

The service had invited NHS England in to follow up on recommendations from the Emergency Care Intensive Support Team (ECIST) in 2023 to monitor progress and suggest further improvements. The leadership team is also working with the Getting It Right First Time (GIRFT) team to drive improvements to outcomes and patient care. These recommendations are embedded into the work programmes for the service and monitored through quality and governance meetings.

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.

Patients understood their rights around consent to the care and treatment they were offered.

Patients received information about care and treatment in a way they understood and had the appropriate support and time to make decisions. Staff had access to the trust consent policy and understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (1983), Mental Capacity Act (2005) (MCA), Deprivation of Liberty Safeguards, and the Children Acts (1989 and 2004). Staff knew who to contact for advice.

Staff had access to the mental health team 24 hours a day to support them and patients. We were told the team were responsive and supportive.

We observed staff gain consent from patients for their care and treatment in line with legislation and best practice guidance. Staff received training on the application of the Mental Capacity Act for staff who would need to assess patients to give consent. When patients did not have capacity to consent, staff made decisions in their best interests and documented them. The service had a process for dealing with patients who were detained on a Section 136 of the mental Health Act. We saw police officers in attendance with patients that they had detained. Staff worked well with these officers and ensured that patients were aware of their rights whilst detained.

Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. We checked that people's privacy and dignity was respected. We 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. We also looked for evidence that staff wellbeing was valued, and that staff were supported and enabled to deliver consistently person-centred care.

At our last assessment we rated this key question good. At this assessment the rating has remained as good. This means staff treated patients with kindness, empathy and compassion and tried to ensure their dignity and respect was maintained. Staff always treated each other with kindness and respect. The majority of patients were positive about the care they received. Leaders promoted and supported the wellbeing of staff.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The service always treated people with kindness, empathy and compassion.

Staff treated people with kindness and compassion. Patients told us they felt reassured by the staff and were confident in their care. Friends and family survey results from 1 July 2025 to September 2025 indicated 66% of patients were satisfied with their care and treatment. The survey had had 1111 responses during these 3 months. The most frequently used words to describe care were kind, caring, reassuring and understanding.

Staff at all levels sought to accommodate patients' needs and demonstrated a caring attitude to people with mental health needs. The electronic and paper patient records system allowed for transparency in patient needs and cultural preferences. There were facilities and support available for patients with dementia, complex needs and those who were neurodiverse. There were boxes available for patients who were neurodiverse which contained items to provide calming stimuli. Staff were aware of the presence of these. The play specialist provided specialist toys to children who had extra needs.

Staff were able to access appropriate interpretation services to communicate with patients. However, staff told us that due to the diversity of the team, the staff adjusted the allocations so that a staff member who spoke the patient's language could treat the patient.

Staff worked to protect patient's dignity. There were shower facilities on-site for patients and we observed staff escorting patients to the toilet. Where two patients were sharing a bay originally designed for one, the service used curtains or screens to screen patients and protect their dignity. Whilst this helped it did not alleviate sounds and conversations about and with the patient.

There was a culture of collaboration and respect between internal and external colleagues. We observed staff interacting positively with ambulance staff during a handover, handling an urgent transition with patience. This positive culture allowed staff to provide compassionate care for patients.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or distress.

The department had processes and tools for assessing patients when they first presented to the department. Staff used a national triage tool to triage patients. Most patients were streamed (assessed) by the GP provider that runs the urgent treatment centre and sent to the appropriate services including Urgent Care Centre (UCC), Clinical Decisions Unit (CDU), Mental Health Assessment Unit and same day care units. Patients who required the services of the emergency department were then triaged and possibly treated by the triage team. The triage team further assessed the patients' needs and ordered tests to assist the clinical staff to treat the patient.

The service had a clear system to identify people with mental health needs and align to the appropriate pathway. During triage, nurses completed the mental health risk assessment and informed the mental health team on site. Psychiatric liaison members of staff completed assessments in parallel to emergency department members of staff.

The children's ED had access to the Children's Adolescence Mental Health service team (CAMHS) for an assessment and treatment of children and young people. The children's ED had a room in which children and young people could stay whilst they awaited further treatment or discharge. The play specialist helped to support these patients through tailoring activities to their needs and being available to listen to them.

There was signage at the ED front door that stated patients would be treated according to the severity of their condition. The triage team numbers were increased in line with activity throughout the day. This meant that patients awaiting further assessment or testing were seen as soon as possible.

There were mechanisms to address patient's comfort needs. Housekeeping staff conducted

comfort rounding to ensure that every patient was offered food and drink throughout their stay which met their needs. Staff told us nutritional needs including cultural and religious needs were identified during the comfort rounding. Staff told us patients were offered hot meals throughout the day.

Staff responded to patient's needs in the moment and acted to minimise any discomfort, concern or distress. We observed a nurse re-assess a patient's pain after discussing the care plan and provided pain relief in line with the patient's pain score. The Urgent and Emergency Care Survey 2024 did not reflect our observations as it stated that patients only rated this issue as 5 out of 10. The response to 'Do you think the hospital staff helped you to control your pain?' was worse than the national average. However, it did support what patients told us about waiting for pain relief.

There was clear signage in the waiting room and patient bathrooms for patients to raise a complaint. Staff were aware of the complaints process and provided examples of learning from patient complaints. For instance, there was patient feedback regarding lack of support for patients experiencing a miscarriage. As a result, an area had been allocated to give women increased privacy and ease of access to a toilet. Staff were aware of this change in process.

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.

There was an inclusive organisational culture which enabled staff to have a sense of belonging. Leaders told us staff wellbeing was important to them. They recognised that staff were often under pressure within a very busy department. Leaders encouraged staff to reflect on their working life but also supported staff to have a good work life balance. Several staff members told us they had worked at Queen Elizabeth Hospital for several years due to the work culture. Several staff members referred to the staff as a "family and one team."' Staff who had left the

hospital and returned said that they had done so because of the camaraderie of the team in the department and hospital.

There were mechanisms to collect staff feedback and reflect on staff concerns to deliver high quality person-centred care. Staff told us they felt listened to by leaders and were able to escalate concerns directly to them. The leadership team encouraged the staff to become involved in initiatives and offer the team a safe space to fail without fear of blame.

Staff told us they were able to influence change and contribute to decision-making in the department. Leaders empowered frontline staff to drive initiatives to improve quality and safety. For instance, in November 2024 they met with staff to look at the "rubbish rules" and agree which of these were not helpful to staff in their daily work. This refresh of the way in which staff worked was engineered by staff and therefore empowered them to manage change. Similarly, the trust was rolling out Compassion in Care, a programme of refreshing basic nursing care for patients to the emergency department. As part of this process, staff would be encouraged to drive an initiative that they felt was important for the care of patients. Staff we spoke to were aware of this and had already thought about changes that could be made.

The service supported staff onboarding and continued professional development. Newly qualified nurses received around 18 months of preceptorship and were offered the option to extend this period until they felt comfortable in their role. Training days were organised multiple times a year and focused on relevant areas. For example, there was an all staff invitation to governance meetings to discuss where things had not gone well and to learn from this. These were well attended by all grades of staff and an option to join online meant that staff could attend all or part of the meeting. Staff told us they were provided cover to attend the training. A mentorship programme was in place for staff to continuously identify and develop skills. All staff had one week a year not in the department to attend mandatory training.

Leaders had taken steps to recognise and meet the wellbeing needs of staff, which included the necessary resources and facilities for safe working, such as regular breaks and rest areas. There was adequate staffing coverage during shifts to allow for breaks. Staff told us the nurse in charge arranged or provided cover if needed so that nursing staff could take their breaks.

Leaders supported staff wellbeing through offering flexible shift scheduling to accommodate reasonable adjustments. Staff told us they were valued by leaders. There were support

mechanisms in place to support staff in the event of catastrophic events including a “hot” debrief in the immediate aftermath and a “cold” debrief once the incident had been reviewed. 90% of nursing staff and 85% of medical staff had attended the conflict resolution training. Staff told us violence and aggression incidents were increasing. Therefore, this training supported them to manage these situations.

The service valued the wellbeing of staff. The trust had a wellbeing strategy which encompassed six pillars including: Personal, Financial, Spiritual, Physical, Psychological and Work. Staff spoke about the support they received from leaders and peers. There was a communication channel which was dedicated to social activities. In the children’s ED we heard about staff going on trips, having picnics, camping, walking a marathon and playing rounders as ways of building the team and relieving stress.

The trust also had a star awards scheme which were presented to those nominated by their colleagues in the department. Alongside this were the excellence awards and employee of the month awards. These were all nominated by team members. Staff felt that these initiatives demonstrated that their work was valued. There were a number of support mechanisms provided by the trust which included, fast track physiotherapy sessions, psychological interventions, social spaces and wellbeing hubs, groups for specific issues and a trust choir.

Responsive

Rating Requires improvement 

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

Person-centred care

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. 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.

We saw the service had systems in place to deliver end-of-life care when necessary. We reviewed the notes of one patient who had recently passed away within the department. These showed the department worked with the hospital's palliative care team to ensure that the required medications were prescribed, and escalation plans were agreed. Staff had discussed this end-of-life care with the patient's family and had clearly documented this.

The service worked well with substance misuse teams within the hospital to ensure patients received person-centred care. Staff told us that there was a drug and alcohol team available on weekdays, which they found helpful. We observed the drug and alcohol team interacting with patients in the waiting room. Some staff were undertaking additional training with the drug and alcohol team to support them in their role. The service also worked closely with the hospital's tobacco dependence team to help patients stop or reduce cigarette smoking. This included talking to patients in the waiting room.

The service ensured children received appropriate care and support. Paediatric patients were assessed in a separate area with a separate waiting room. The paediatric area employed a play specialist for children and young people. There were toys available for a variety of age ranges. The department also occasionally organised special events and visitors, such as singers and magicians.

The service had systems to ensure neurodivergent patients received suitable care. This included neurodiversity-specific toys. However, training on autism and learning disabilities (Oliver McGowan training) was below the trust target of 90% for relevant adult emergency department employees (72% and 20% for tiers 1 and 2 of this training respectively, however it should be noted tier 2 training has only been offered relatively recently).

We observed patients in the waiting room were not given wristbands, and that some of these patients were being given medications such as painkillers. This meant that, if a patient had a reaction to a medication or became unresponsive for another reason, staff may not have been able to identify them or assess what medication they had taken and would not have been able to tailor their care appropriately.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

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

Discharge summaries should be provided to all patients when leaving the department. These provide information to patients about their care and treatment. However, we reviewed a number of discharge summaries which were completed after the patient had left the department. This resulted in delays in information being available to patients and their GPs. Patients also remained on the service's virtual 'board', after they were discharged.

Patients told us that staff did not always inform them of what was happening with their care. Some patients complained of feeling "in the dark" about what they were waiting for and told us they did not know what staff were planning.

Patients were not always provided with accurate information about waiting times and sometimes were provided with contradictory information. Waiting times were displayed on 2 large screens in the waiting room and these were updated every 10 minutes. However, the 2 screens did not always display the same waiting time. The largest difference we observed between the 2 screens was almost an hour.

The different areas of the department were clearly signposted to help patients find their way. We observed volunteers in the waiting room assisting patients with how to get around.

The service provided information to patients via posters in the department. These posters were available in multiple languages and included information on alcohol use and learning disability services. However, we did not see any signage about the availability and use of chaperones in some areas, such as the “red” major’s area.

Translation services were available for patients who did not speak English. These were available using portable electronic tablets. Video call options were available where required. Staff told us they found these helpful.

Listening to and involving people

Score

3. Evidence shows a good standard of care

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

Patients were given information on how to provide feedback on their care. We saw posters about the complaints processes in different areas of the department. This included information on how to make a complaint including information about the Patient Advice and Liaison Service (PALS). Posters were available in multiple languages. The service displayed posters with information about the Friends and Family Test (FFT). This is an NHS initiative through which patients’, friends or family can provide feedback. We requested further data around patient engagement and feedback in the department, but this was not provided.

The CQC periodically conducts nationwide surveys of patients to better understand their feelings about the care they receive. In the most recent urgent and emergency care survey, which was carried out in February 2024 and published in November 2024, patients scored Lewisham and Greenwich NHS Trust 6.7 out of 10 for being involved as much as they wanted to be in decisions about their care and treatment, and 8.1 out of 10 for feeling that doctors and nurses listened to what they had to say. When compared with other NHS Trusts, these were somewhat worse than expected and about the same as expected respectively.

We saw evidence that complaints to the service resulted in changes. For example, following a complaint the service had introduced a designated quiet area for patients at high risk of miscarriage, with private toilet access. Staff were aware of these changes and implemented them in their care.

Patients and their families were involved in difficult conversations. We saw evidence that escalation plans, such as the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, took into account patient preferences. When appropriate, this was also discussed with family members. Family members of seriously unwell patients were also involved in discussions about their care, and these discussions were clearly documented.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

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

The service provided 24-hour care 7 days a week for any patient presenting to it. However, patients could not always access care and treatment in a timely manner due to capacity constraints on the service. Patients told us they had waited a long time for care.

Service leaders were aware of capacity and flow issues. These issues were added to a risk register for the department, which was reviewed monthly. Service leaders had plans in place to mitigate these risks but did not always discuss these mitigations with more junior members of staff. Staff had regular meetings to discuss patient care and had handovers at the beginning and end of each shift. During these meetings, senior leaders did not discuss the pressures on the service with staff, nor did they discuss escalation strategies such as Operational Pressures Escalation Levels (OPEL).

The service provided corridor care when it ran out of space for patients. The service doubled up patients in some areas of the department (such as the ‘green’ area and resus) to free up space.

Staff told us that this was not ideal but worked well when required. We did not identify any patients receiving corridor care who should not have been due to their care needs.

The Royal College of Emergency Medicine (RCEM) recommends that all patients are triaged within 15 minutes. In the 6 months prior to this inspection (August 2025 to January 2026), the service's monthly average time to triage ranged from 47.8 minutes to 63.2 minutes, which is significantly longer.

Because of waiting times, some patients spent a long time in the waiting room. There was limited oversight of these patients, with no member of staff allocated to or permanently present in the waiting room. We were told that staff in the triage rooms monitored these patients for deterioration, however the only evidence we saw of this was a cursory glance over the heads of these patients when calling patients for assessment. We were told that triage nursing staff were expected to reassess the observations of patients in the waiting room every 4 hours, however this was not being done. This could have resulted in patients deteriorating without staff knowing, although we did not see any evidence of this during our assessment.

We observed nursing tools and checklists were not always completed. For example, the falls prevention and assessment form, the Waterlow pressure ulcer risk assessment score, and the adult sepsis screening and action tool were inconsistently completed in the patient records we reviewed. The service monitored the use of these tools through monthly audits. These audits showed variable rates of completion of these tools (for example, these audits showed that the adult sepsis screening and action tool was completed in 40% and 86% of records reviewed in December 2025 and January 2026 respectively). We did not observe any instances of missed or undiagnosed conditions because of this.

People who presented with mental health concerns often spent long periods of time in the department. The average length of stay for adult patients presenting with mental health concerns was above the department's 16-hour target for 7 of the previous 12 months. For children and young people presenting with mental health concerns, the length of stay was above the department's 10-hour target for 5 of the previous 12 months. Service leaders were aware of this issue and had added it to the divisional risk register. However, we found that the department worked well with the psychiatric liaison team, who completed mental health assessments in parallel with emergency department staff. We also found that patients with mental health needs were identified in the triage process, allowing for earlier referral to the psychiatric liaison team, who saw almost all emergency referrals within 1 hour.

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.

At our last assessment we rated this key question good. At this assessment the rating has remained as good. This meant we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Shared direction and culture

Score

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.

There was a positive safety culture where events were investigated, and learning was embedded to promote best practice. Staff said raising concerns was encouraged and valued. Staff felt listened to. Staff told us that sharing the learning occurred in many ways including emails, at safety huddles or handovers and via a secure messaging app. We saw examples of learning being shared through most of these channels. Staff felt involved in the direction of travel for the department and able to contribute ideas.

Staff were helpful, welcoming and professional in their communication with each other, patients and their relatives. Leaders described a positive and compassionate culture. Staff and leaders embodied a positive, compassionate, listening culture. We saw that this culture promoted trust and understanding between staff, leaders and people using the service and was

focused on learning and improvement.

Staff and leaders demonstrated a positive and compassionate culture with a focus on learning and improvement. The trust values of "Respect, Compassion and Inclusion" were displayed around the trust and department. We saw staff lived these values. We heard staff describe the culture as “all one team” and “all are our patients”. We saw numerous examples of this whilst on site.

Leaders fostered a culture of promoting equality, diversity and human rights to prioritise safe, high quality compassionate care. All but one of the NHS Workforce Race Equality Standard **(**WRES) Survey 2023 questions on Black, Asian and Minority Ethnic (BAME) staff experience scored better than the acute trust average. However, Black, Asian and Minority Ethnic (BAME) staff experienced more harassment, bullying or abuse from patients or relatives than their white counterparts.

Leaders had a shared purpose and strived to deliver and motivated staff to succeed. There were high levels of satisfaction across all staff, despite the challenges they faced. Staff told us that they would bring a family member to be treated in the department.

The leadership of the site and divisional team had changed between July 2024 and September 2025. They were focused on resolving the issues with an overcrowded ED but had had several organisations review the practices within the department to assist them to learn and improve. The team had yet to develop their vision and strategy for the department in a formal sense. The senior team had aligned work programmes to develop a strategic approach. These fell into performance improvement, financial programmes, leadership responsibilities, and a quality programme. The senior team and the wider ED staff understood the challenges of their population and were fully aligned working with partners in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. For example, working with system partners on alternative pathways to avoid ED attendances. The trust has a draft mental health strategy, which they hope to approve in the next couple of months.

The service was aware of the projected increase in the local population and the pockets of deprivation. The trust was working with partners to develop a strategy to manage these demands. The trust had access to community hospitals which allowed them to increase the flow through the hospital. Services in the community had been developed to support people in

their own homes including working with care homes and the ambulance services.

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.

The service had inclusive leaders at all levels who understood the context in which they delivered care. Leaders were aware of the issues that the department faced and had invited organisations into the department to assist them to resolve or manage these issues. We found that staff and leaders were aligned on the issues that the department faced.

The national staff survey demonstrated year on year improvement in all categories. The directorate scored in line with the trusts scores. The trust performed above average in five domains, at the national average in one domain and below the national average in three domains in the 2024 national staff survey.

There were processes to support staff and promote their positive wellbeing. Staff we spoke to felt proud to work in the service. Multiple staff told us they had worked at Queen Elizabeth Hospital for several years. Several staff stated the reason for remaining was due to the positive work culture. Data provided by the trust showed that the staff turnover rate was below 10% for the previous 12 months. Nearly half of all nursing leavers left due to relocation.

The service had undertaken an incivility and wellbeing survey by selecting a random 12 members of the nursing team to answer questions confidentially. This survey highlighted that whilst less than half of the respondents had occasionally personally experienced incivility they could highlight when, by whom and to whom this occurred. Episodes included being told off and senior staff being rude. However, respondents also reported that they felt able to challenge

and affect the behaviour.

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure that the leadership represented the diversity of the workforce.

There was a triumvirate care group leadership structure at departmental and divisional level with medical, nursing and operational leads in place. There were clear reporting structures and key roles were supported by deputies or associate roles to support succession planning. Staff understood the reporting structures and leaders understood their key roles and responsibilities.

Leaders demonstrated how they worked as part of a multidisciplinary team within the service and how they worked with external stakeholders, such as the local and regional commissioners, integrated care boards and local NHS ambulance and mental health trusts. Stakeholders such as local NHS ambulance and mental health trusts told us they worked collaboratively with the urgent and emergency services. They said they worked well together and there was regular engagement to review performance and identify improvements to services.

Staff told us the departmental leads and senior managers were approachable, visible and provided them with good support. There was support to the team from senior leaders in the trust, including the Chief Executive Officer and Chief Nurse, who were seen in the department.

All staff had opportunities to develop including for future leadership roles. There was inclusive recruitment and succession planning for the future. The trust had effective recruitment processes and ongoing checks to ensure all staff met the legal requirements to work in the trust.

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 and leaders actively promoted staff empowerment to drive improvement. The culture supported staff to speak up without fear of detriment. Leaders encouraged staff to raise concerns and promoted the value of doing so. Staff told us that they felt comfortable to raise any concerns and were confident that their voices would be heard and demonstrable action taken.

The service had established freedom to speak up arrangements. Information about the guardian and how to contact them was available on the intranet. Whilst not all staff knew the name of the trust's freedom to speak up guardian, they knew how to raise a concern. However, they didn't feel that they would use this route as internally within the department they felt that they could raise anything with leaders.

The number of contacts to the freedom to speak up service from the medicines directorate which includes the emergency department had 10 concerns raised in 2024/25 and 8 in the half year 2025/26. The freedom to speak up team received most concerns around systems and processes followed by management issues and behavioural issues. However, due to the confidential nature of this process these could not be identified as originating from within the ED. Anonymous concerns were at 12% which was slightly higher than the national average. In the year 2024/25 50% of staff wanted to remain anonymous. However, in the following six months this had risen to 66%. Whilst this may suggest that staff had less confidence in raising concerns within their area it reflects the national picture in that staff often feel empowered to raise concerns independently when supported by the guardian.

Patients knew how to make a complaint or raise concerns. The service clearly displayed information about how to raise a complaint. Managers investigated complaints, identified themes and shared feedback with staff. Learning from these was used to improve the service.

Staff understood the policy on complaints and were able to give examples of learning from complaints.

When something went wrong, people received a sincere and timely apology and were told about any actions being taken to prevent the same happening again. We reviewed learning responses which showed Duty of Candour was completed appropriately.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the 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. However, we did see that staff did not always remove their access cards from computer terminals which allowed anyone to access information.

Governance arrangements were reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes. Governance was used to learn, improve and innovate.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities. Audits undertaken included clinical effectiveness and compliance with guidance from the National Institute of Health and Care Excellence (NICE). The service was also complying with the 3 audits commissioned each year by the Royal College of Emergency Medicine, which included the administration of time-critical medicines.

The service had policies and procedures for escalation and care of patients to mitigate the main risks from crowding. The hospital had processes to monitor performance and quality against

national targets and standards.

Data systems enabled a good oversight of performance as evident in meeting minutes and in our discussions with staff. The trust had an effective digital system for logging risks that linked directly to the incident reporting system. Leaders tracked the risks in the ED effectively using this and had oversight of the risks and their mitigations. The trust's corporate risk register includes a mental health pathways and patient management as a risk. Remaining actions include the recruitment of mental health nurses and completion of the estates work to update the room in paediatric emergency department.

There were monthly emergency medicine clinical governance meetings. These discussed and addressed key areas of performance, risk, audit, culture and workforce. Minutes showed areas of concern were identified and actions were taken to learn and improve. Changes had been made when needed to improve the service. Good practice was recognised and celebrated.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The risk register was held centrally on an IT system all could access. We reviewed the risk register and saw that issues we had raised or noted had been identified by the service. Risks were regularly reviewed, had a named owner and new or closed risks were identified.

Information held about patients was held in paper and electronic copy. We saw a number of times that staff did not remove their access cards, and anyone could use the computer to access patient records. Paper records were stored in trays behind the nurse or doctor station. We saw these from discharged patients being collected at regular intervals for coding. On the electronic patient board, patients were not always discharged in a timely manner as doctors needed to complete discharge summaries and were being called to give advice on other patients. This meant that it was not always clear how many patients were in the department. Staff were aware of the issue of leaving id cards in computer terminals and removed them promptly when they returned to the terminal. Staff were part of the emergency preparedness network, and they had the strategies and guidance to respond to major incidents.

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.

Staff told us they felt listened to and heard by the relevant stakeholders and external partners. They were supported by clinical partners. For example, there was a good partnership with the local NHS mental health trust providing support to patients with mental health needs in the ED and staff said they were responsive and supportive.

The trust worked in partnership with the local system. This included the local community trust, the local ambulance trust, GP's and the Integrated Care Board (ICB). They met monthly to discuss system initiatives to ensure processes and schemes were joined up as well as to discuss healthcare safety investigations.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the people. There were learning events scheduled for after the winter period with system partners to identify what worked well and areas for improvement for the next winter period.

Staff reported positive relationships with the local police force and urgent treatment centre (UTC) which was co located but run by a different NHS provider.

The trust worked in partnership with the ICB and local GPs. For example, trying to increase shared care uptake. Shared care is a particular form of the transfer of clinical responsibilities between different healthcare partners.

Staff listened to patients using the services to improve services and the environment for patients and their loved ones. We saw in the patient experience annual report that this feedback was used to drive meaningful improvements. For example, the introduction of mobile charging stations in the emergency department to ensure patients could stay connected to

family and friends. The department utilised the youth board to assist in the redesign of the department. Following feedback from patients the department now had volunteers who ensured patients were provided with hot or cold meals and drinks during their stay in the department.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

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

There was a systematic approach to improvement, which made consistent use of a recognised quality improvement (QI) methodology.

Innovation was celebrated through award ceremonies and recognition in departmental newsletters. Leaders encouraged staff to speak up with ideas for improvement and innovation and actively invested time to listen and engage. There was a strong sense of trust between leadership and staff. Staff were supported to prioritise time to develop their skills around improvement and innovation.

The trust introduced a Compassion in Care Model (CIC) to support a trust-wide focus on common care themes raised by patients. We saw evidence of improvement from this approach in addressing the concerns of women having a miscarriage.

The service had strong external relationships that supported improvement and innovation. Staff and leaders engaged with external work, including research, and embedded evidence-based practice in the organisation.

The Queen Elizabeth Hospital urgent and emergency care improvement programme has been in place for just over a year. The programme consists of 3 structured workstreams, the front

door redesign, SDEC (Same Day Emergency Care) and short stay, Improving inpatient flow and discharge. Each workstream had an executive champion. Workstreams were supported by a central quality improvement hub. Improvements follow a PDSA cycle and were evaluated. The service had invited several partners into the department to assess and learn from others to drive improvements for patients. This had improved flow and streaming to different pathways to assist the department in managing capacity verses demand.

Regulation 12: Safe care and treatment

Service

Medical care (Including older people's care)

Regulated activities

- Nursing care
- Treatment of disease, disorder or injury

How the regulation was not being met

- The service did not always ensure patients who were no longer suitable for corridor care were transferred in a timely manner.
- The service did not always ensure risk assessments were completed in line with trust guidance.
- The service did not always ensure all clinical areas followed national fire safety guidance.
- The service did not always ensure infection, prevention and control (IPC) principles were followed.

Regulation 17: Good governance

Service

Medical care (Including older people's care)

Regulated activities

- Nursing care

- Treatment of disease, disorder or injury

How the regulation was not being met

- The service did not always ensure patient confidentiality was not always maintained.