LAP assessment report

King's College Hospital

LAP Assessment Report ID : LAP-02458

Inspection visit date(s): 12 May 2026, 13 May 2026 and 11 June 2026

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King's College Hospital
Location findings

Ratings for this location

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

Overall location summary

King's College Hospital is part of King's College Hospital NHS Foundation Trust and offers a wide range of hospital services to people living in Southwark and Lambeth. This assessment looked at urgent and emergency care and children and young peoples services to assess the quality of the care received by patients using those services. The rating of urgent and emergency care and children and young people's services have been combined with the ratings of the other services from the previous assessments. Our assessment of children and young people's services focused on safe and well led only. See our previous reports to get a full picture of all the other services at King's College Hospital. The rating of King's College Hospital remains requires improvement.

Safe

Rating Requires improvement

Our overall rating of safe at King's College Hospital remains requires improvement. We looked urgent and emergency care and children and young people's services only. We rated safe for urgent and

emergency care and children and young people's services as requires improvement.

Effective

Rating Good 

Our overall rating of effective at King's College Hospital has remained good. We looked at urgent and emergency care
services only and rated effective as good. We did not assess effective for children and young people's services at this assessment.

Caring

Rating Good 

Our overall rating of caring at King's College Hospital has remained good. We looked at urgent and emergency care
services only and rated caring as good. We did not assess caring for children and young people's services at this assessment.

Responsive

Rating Requires improvement 

Our overall rating of responsive at King's College Hospital has remained requires improvement. We looked at urgent and emergency care services only and rated responsive as requires improvement. We did not assess responsive for children and young people's services at this assessment.

Well-led

Rating Requires improvement 

Our overall rating of well led at King's College Hospital remains requires improvement. We looked urgent and emergency care and children and young people's services only. We rated well led for urgent and emergency care and children and young people's services as requires improvement.

Acute services

Urgent and emergency services

Urgent and emergency services

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

Our view of the service

King’s College Hospital is run by King’s College Hospital NHS Foundation Trust. The urgent and emergency care services at King’s College Hospital include an adult emergency department (ED) and a paediatric emergency department. There is also an Urgent Treatment Centre (UTC) on-site which works closely with the ED. However it is registered separately and run by a different provider, so we did not review it on this assessment. The department provided emergency care 24 hours a day, 7 days a week to patients arriving by foot and by ambulance. It is a major trauma centre for both adults and children.

We carried out an assessment of urgent and emergency care services at King’s College Hospital on 12 and 13 May 2026. This was a short-notice announced assessment. We returned for an unannounced assessment on 11 June 2026. During these visits we spoke with 47 members of staff, 10 patients and 2 family members, and reviewed the notes of 71 patients. We visited all areas of the department.

Overall, this service was rated as requires improvement. This was because the service did not always provide safe, responsive, or well-led care. For example, the service did not always ensure staff followed

infection prevention and control procedures, the service did not always ensure corridor care was delivered as safely as possible, the service did not have a dedicated pharmacy service, the service did not always ensure that equipment was safe for staff to use, care was not always provided in a timely and equitable manner due to overcrowding and long waits, and the service did not have a dedicated play specialist in its paediatric ED. However, for some of these issues, the service had made significant improvements between our visit in May 2026 and our visit in June 2026.

There were also areas of good practice. For example, the service had a positive culture in which staff were able to raise concerns and ask for help, the service regularly monitored its outcomes to improve them, the service worked well in partnership with external organisations, and staff were kind and understanding to patients.

During this assessment, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were for regulations 12 (safe care and treatment), regulation 15 (premises and equipment) and regulation 18 (staffing). An action plan will be requested from the trust to address these breaches upon the final publication of this report.

People's experience of the service

Patients and families told us that the care they received was compassionate and respectful. They told us that staff listened to them, responded to their needs, and talked to them in a kind manner. However, the service's feedback for the NHS 'Friends and Family Test' (FFT) was 71% positive for April 2026. This was below the England average of 80%.

People's experiences were often affected by systemic pressures on the service. Patients told us that they waited a long time for care. Waiting times were not displayed. Patients requiring admission had to wait long periods for beds to become available. This was also true for patients with mental health needs who were waiting for a bed at a different NHS trust. Some patients were cared for in the corridor due to a lack of space within the department, often for long periods of time. The department was loud and very busy because of these systemic pressures. Food and drinks were provided to patients who were in cubicles or in the corridor while waiting for a cubicle.

Safe

Rating Requires improvement

Acute services

Urgent and emergency services

We looked for evidence that people were protected from abuse and avoidable harm. 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.

The service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 12 (safe care and treatment) for inconsistent application of patient wristbands, for unsafe provision of corridor care, for the control of substances hazardous to human health, for infection prevention and control issues, for issues regarding venous thromboembolism (VTE) risk assessments and prophylaxis, for issues regarding the timely administration of medicines, and for issues regarding Patient Group Directions (PGDs) used by the service. The service was in breach of regulation 15 (premises and equipment) for concerns about the service's equipment. The service was in breach of regulation 18 (staffing) for not employing dedicated pharmacy staff and for the completion rates of some staff mandatory training.

We informed the trust of some of these issues in May 2026. When we returned in June 2026, we found improvements in the way the trust delivered corridor care, infection prevention and control standards, the safety of equipment available to staff, the application of patient wristbands, and the control of substances hazardous to human health.

There were also areas of positive practice. The service had a culture of reporting and learning from patient safety incidents, staff understood and reacted to safeguarding concerns, and the service was generally well-staffed.

Learning culture

Score

3. Evidence shows a good standard of care

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

Staff members understood what incidents were and how to report them. Staff members told us they were encouraged by senior staff to report patient safety incidents. This was reflected in the 2025 NHS Staff Survey, in which 91.2% of Emergency Department (ED) staff stated that they were encouraged to report errors, near misses, and incidents (this was a Trust-wide survey and therefore included staff at another ED run by the same trust). Staff members from the psychiatric liaison team, who were employed by a different NHS trust but were present in the ED, had access to the incident reporting systems of both trusts, ensuring that they could report incidents to either or both.

The service recorded a total of 1,156 patient safety incidents from May 2025 to April 2026. Most of these incidents resulted in no patient harm. Six incidents resulted in severe harm or death. The service had systems in place to ensure incidents were reviewed and started investigations where appropriate. We saw examples of changes made because of the recommendations of previous investigations, such as the use of point-of-care troponin testing for patients with chest pain, which was in place at the time of our inspection.

Learning from incidents was communicated in multiple ways, including individual feedback after submitting an incident, newsletters, emails from senior members of staff, teaching from practice development nurses, and through the ‘Big 5’ (a monthly list of areas for staff to focus on, which was emphasised at handovers). Staff were able to recall specific incidents and changes made as a result.

However, some staff members expressed concern that not all episodes of violence and aggression from patients were reported by staff. These members of staff told us that staff members often would not submit an incident for low-level violence and aggression incidents because the incident reporting form took too long to complete when compared with the high number of incidents they dealt with. They expressed concern that the recorded incident data for violence and aggression did not accurately reflect the frequency of incidents occurring in the department.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work well with people to establish and maintain safe systems of care. They did not always manage or monitor people's safety.

From May 2025 to April 2026, the service saw 105,820 adults and 21,637 children. This is a higher number of attendances than the service was designed for. Of these attendances, 4,956 and 419 respectively were primarily for mental health reasons.

During our visit in May 2026, patients were receiving care in the Emergency Department (ED) without identity wristbands being applied. The service had a policy that wristbands should be applied when first seen by a triage nurse or immediately when a patient arrives by ambulance. This policy was not being followed. We saw many patients without wristbands after they had been triaged, and observed staff not applying wristbands during triage. We saw staff administering medications, including controlled drugs, to patients without wristbands on multiple occasions. Staff relied solely on verbal identification for administering these medicines. This increased the risk of misidentification of patients, and therefore of medication errors. It also increased the risk that patients would not be able to be identified if they became unresponsive. When we raised this with the trust, they made immediate improvements. When we returned in June 2026, all patients we saw had a wristband on, and the trust provided evidence of a new daily wristband audit which also showed 100% of patients were now receiving wristbands.

Patients requiring admission were not transferred to wards in a timely manner. This was true for patients requiring a bed within the hospital and for patients requiring a bed at mental health hospitals run by another NHS trust. This was because of operational pressures on the service. There was higher demand for inpatient beds than the hospital or the local mental health NHS trust had available. While we were on site, there were 26 patients waiting for a bed, 8 of whom were waiting for a mental health bed. This resulted in patients waiting in the ED for long periods of time. Staff were aware of and were concerned about this issue and expressed

frustration about not having the power to resolve it. The high numbers of mental health patients remaining within the ED impeded the ability of staff to do their work. We observed a trauma call in the resuscitation area in which staff provided life-saving care to a patient while being shouted at by mental health patients in a nearby bay. Staff told us about other instances where they were distracted from caring for other patients (for example, incidents in which mental health patients entered the cubicles of other patients).

However, there were clear systems in place for when patients needed to be admitted, and staff told us that referral systems to specialty teams were easy to understand and easy to use. Medical staff also told us it was easy to refer patients to outpatient clinics if needed.

The service used the Manchester triage system to review walk-in patients. This was used appropriately and patients were subsequently guided to different areas of the department or to the on-site Urgent Treatment Centre (UTC) based on their clinical need. The service's electronic patient record system allowed staff to add icons/flags to patient profiles, allowing triage staff to identify specific patient needs straight away. There was guidance in place for when triage times were high or when large numbers of patients were waiting for triage. However not all triage nursing staff we spoke with were aware of this guidance or when to escalate to senior nurses. The service also had clear systems in place for receiving patients from ambulances.

The department was divided into different areas to serve different patient needs, including (but not limited to) a majors area, a resuscitation area, a dedicated paediatric area, an area for low-risk patients who could sit in a chair, and an area for low-risk psychiatric patients. There were clear guidelines in place for which patients could go to which areas and patients were streamed to these areas appropriately.

The service had systems in place to ensure that life-saving emergencies were prioritised and treated quickly. The service used trauma calls, stroke calls, and cardiac arrest calls to ensure that relevant staff attended in those circumstances. We observed a trauma call and found that all required team members were present and that the patient was stabilised and prioritised for a scan within 15 minutes. The service also had a 'code 10' call in place for patients with an acute behavioural disturbance, which alerted senior staff and security. If the patient arrived by ambulance, this could be activated before their arrival to allow for quicker assessment.

Mental health services within the ED were provided by a different NHS trust with expertise in

mental health assessments. Members of staff from this trust were always present within the ED to provide services such as mental health nursing and psychiatric liaison services. There were systems in place to ensure that these staff could provide good care (for example, these staff had access to the electronic records systems of both trusts, allowing them to see medical as well as psychiatric information).

Staff handed over information about patients to each other at the beginning and end of each shift. These handovers were of a high quality.

Safeguarding

Score

3. Evidence shows a good standard of care

The service worked with people and healthcare partners to review and act on risks to people's safety. Staff understood what safeguarding meant and protected people's rights to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

Staff had access to trust-wide adult and paediatric safeguarding policies. These policies were clear in how safeguarding responsibilities were divided and included examples of safeguarding concerns. There was also guidance specific to the Emergency Department (ED) available on the trust intranet.

There were clear systems in place to report safeguarding concerns. Safeguarding referrals were sent via the service's electronic patient record. These were received by the hospital's safeguarding team, who reviewed them and notified the local authority if necessary. The safeguarding team referred 501 adult ED safeguarding concerns to local authorities within the 12 months prior to our inspection. Service leaders told us they were unable to give a precise figure for children due to the volume and frequency of discussions with external bodies. However, they suggested trust-wide data indicated that on average between 70 and 90 children's safeguarding cases progressed to formal multi-agency discussions every 3 months.

Staff understood what safeguarding meant. Staff knew and understood how to raise concerns and were able to give examples of safeguarding concerns they had raised in the past. Staff gave appropriate responses when asked how they would respond if they had urgent concerns about a patient's safety (for example, if an at-risk patient absconded). Staff located in the ED but employed by a nearby NHS mental health trust also had a good understanding of safeguarding procedures.

The service offered mandatory safeguarding training to all relevant staff groups. Safeguarding adults level 2 training and safeguarding children level 2 training had been completed by 90% and 83% of medical staff respectively, and by 100% and 96% of nursing staff respectively.

There was effective oversight of safeguarding procedures. There was a designated 'safeguarding lead' clinician who could provide advice when required. There were also weekly adult and paediatric safeguarding meetings. Paediatric safeguarding meetings were attended by external stakeholders, such as health visitors and youth workers.

Between May 2025 and April 2026, 11.8% of children who attended the service re-attended within 7 days. The service ran a programme named 'Needs Evaluation & Support Team for Emergency Department Attendances' (NESTED) to support children who attended the ED regularly. As part of this programme, the service held monthly multi-disciplinary meetings to discuss the issues these children were facing. Outcomes from these meetings included raising safeguarding concerns with the local authority, additional support for families in the form of nursing follow-up calls, and advisory letters to the patient's GP.

Involving people to manage risks

Score

1. Evidence shows significant shortfalls in the standard of care

Quality Statement Score: 1

The service did not work well with people to understand and manage risks. Staff did not always provide care to meet people's needs that was safe and supportive.

The service cared for some patients in the corridor during periods when patient demand exceeded the space available within the department. Corridor care was given in 2 areas – within the main majors corridor, where there were many non-numbered chairs and armchairs, and within the 'ambulance offload area' (a corridor near the ambulance entrance), where there were 7 numbered spaces for patients on trolleys. We consistently saw patients within these areas and staff members told us that they provided corridor care in these areas every day.

Despite this, at the time of our initial visit in May 2026, the service did not have any policies for providing corridor care in the Emergency Department (ED). Staff were not aware of any guidance about which patients could and could not receive care in the corridor. This led to patients receiving care in the corridor when this was inappropriate. During our visit in May 2026, we saw 2 patients with dementia, 2 high-risk mental health patients (both of whom were subject to section 2 of the Mental Health Act 1983), and 1 patient with a National Early Warning Score 2 (NEWS2) score of 6 (indicating that they were unwell) receiving care in the corridor. This is contrary to NHS England corridor care guidance.

We raised these corridor care concerns with the trust and they made some immediate improvements. A trust-wide corridor care policy was signed off and published after our initial visit in May 2026. This included guidance specific to the ED and a list of 'exclusion criteria' (patient characteristics which indicate the patient is unsuitable to receive care in the corridor), such as having dementia, having a NEWS2 score of over 3, or having a confirmed communicable disease/infection. The trust told us it was training staff on how to use this policy.

We returned to the department in June 2026 to review these changes. ED staff were aware of the new corridor care policy, but not all had read it. Not all staff were able to tell us what types of patients the policy excluded from receiving corridor care. However, a poster of these exclusion criteria had been stuck to the wall by the ambulance handover area for quick reference. Staff members told us they had received informal training on this policy through discussions with managers, but no formal training. Staff told us that, since our first visit, the culture around corridor care had improved. They told us that managers listened to their concerns more and this resulted in vulnerable patients being moved to cubicles more often. When we reviewed the notes of patients receiving care in the corridor during our June 2026 visit, we had fewer concerns than in May. However, we still observed 1 patient with infectious diarrhoea who had been in the corridor for over 9 hours after this had been identified. This presented a risk to other patients in the area. We also observed 1 patient with mental health

needs who had attended following an attempted suicide and found no documentation as to whether they met the policy's exclusion criteria or not.

Nursing risk assessments were not always completed, even when patients had been in the department for a long time. We reviewed the notes of 10 patients in the majors area, each of whom had either been referred to a specialist team (with the shortest length of stay being 5 hours) or had been present for at least 7 hours. Of these, only 7 had a falls risk assessment completed. However, pressure ulcer risk assessments were completed more consistently, with this being completed for 9 of the 10 patients. Of the 10 patients reviewed, only 3 met the clinical criteria requiring a sepsis risk assessment, and all 3 had a sepsis risk assessment completed in accordance with the Trust's NEWS2 policy. The service provided evidence of internal auditing of some of these assessments, which showed similar results. However, sepsis risk assessments were not included in these audits. This meant service leaders were unaware of rates of completion of this risk assessment, and therefore could not implement any necessary changes.

Venous thromboembolism (VTE) risk assessments were not always completed. We reviewed the notes of 6 patients who had been in the Emergency Department (ED) for over 12 hours, all of whom had been referred to the medical team but had not yet been admitted to a ward. Of these, 0 had a VTE risk assessment completed and only 1 had VTE prophylaxis prescribed. This led to an increased risk of ED patients developing VTEs. We discussed this with senior leaders who told us that these assessments and prescriptions were the responsibility of specialist teams, and that patients staying in the ED for long periods after they had been referred to specialist teams had made the oversight of tasks like this more difficult. However, we were not told about any work being undertaken with specialist teams to improve this metric.

The service used appropriate warning scores, such as the National Early Warning Score 2 (NEWS2) for adult patients and the Paediatric Early Warning Score (PEWS) for children, to help staff assess patient observations. The service audited adult patient observations monthly – these audits showed compliance of 90% or above for the 12 months preceding the inspection. We reviewed the notes of 10 adult patients and found that 2 had not had observations repeated when they should have been. The service provided evidence of internal audits of PEWS scores between April and June 2026, in which 90 patient records were reviewed. These showed 100% compliance with PEWS requirements.

Risks to patients were identified at triage. For example, patients presenting with mental health

concerns were identified and moved to the majors area so that they could be observed more easily. If these patients then left the department, clinicians were therefore aware of the risk this posed. Nurses who undertook triage duties were expected to undergo triage training. For the adult ED, 100% of nursing staff with triage duties had completed this training. For the paediatric ED, we were informed that 69.7% of all nurses had completed this training, and that nurses who had not completed this training did not undertake triage duties.

We observed that all patients had call bells, so could alert nursing staff if they needed help.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

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

The service did not always ensure that chemicals that posed a risk to patient safety were kept securely. We found one cleaning product which is classed as a 'substance hazardous to human health', and is therefore subject to Control of Substances Hazardous to Human Health (COSHH) regulations, within an unlocked cupboard in an unlocked sluice room within the majors area. This resulted in a risk that a patient may consume or otherwise interact with this substance. This risk was heightened by the high number of patients with mental health concerns who were nearby. The service immediately removed this chemical when informed. We also found iodine-based antiseptic solutions stored on windowsills and in cupboards in areas where patients were present. This resulted in a risk that patients may consume them and suffer adverse health effects (however these items were not subject to COSHH regulations).

Sharps bins were not always safe for staff to use. We observed 3 overflowing sharps bins, resulting in a risk of needle-stick injuries to staff.

Processes for the checking of a difficult airway trolley in resus were unclear, resulting in staff

confusion about when they were supposed to review the equipment kept in this trolley. As a result, we found 2 out-of-date items in this trolley, which again posed a risk that patients would be treated with faulty equipment.

There were significant issues with the emergency procedural kit boxes in resus. These were boxes of equipment needed in specific emergency situations, such as emergency Caesarean sections. Their intention is to ensure that staff have fast and easy access to all the equipment they would need in such a scenario. Some of these boxes were not sealed, some were broken, and some were sealed only with tape. This meant they could be accessed at any time for their contents without prompting a check or re-stock. Daily checks of these boxes were inconsistent and often incomplete. This resulted in it being unclear what these boxes contained. It also resulted in these boxes containing out-of-date equipment which again posed a risk to patient safety.

Faulty equipment took a long time to repair. While were on-site we observed a toilet that had been blocked for 3 days and a macerator that had been broken for a month. Audit documents provided by the trust showed additional examples, with one audit making note of a macerator that was broken “for months” and a “very slow response” to toilet concerns.

The service provided care for children within a separate area behind a locked door. To access this area staff had to swipe their identification card and members of the public had to ring a doorbell. The paediatric Emergency Department (ED) included a separate waiting area with toys for children to play with. However, consumable equipment within the paediatric ED was not always safe to use. We found 5 items with open or broken packaging and 7 out-of-date items in this area. This resulted in a risk that staff would use contaminated or faulty equipment when delivering care to children.

We informed the trust of these issues and they made immediate improvements. On our return in June 2026, we found no further chemicals subject to COSHH regulations kept in patient-accessible areas. However, we did find a surgical scrub solution (for which the manufacturer advised keeping out of reach of children) kept on a low shelf in an unlocked sluice room within the paediatric ED, which presented a risk that a child may consume it. We found no out-of-date or open consumable items anywhere within the ED (including the paediatric ED). We found no overflowing sharps bins. Service leaders had mostly clarified expectations around the checking of difficult airway trolleys and emergency procedural kit boxes in resus. However, it was still not

clear on which days staff were expected to perform some monthly checks. We found no out-of-date items inside. The emergency procedural kit boxes had been transferred into new plastic boxes, which were sealed, and had a new system ensuring inventory checks were completed. We did not find any faulty equipment that had been reported more than 1 day previously.

The service provided rooms for the assessment of paediatric and adult patients with mental health needs. However more adults presented with mental health needs than there were such rooms available. For adults, these rooms were ligature-free and met Royal College of Psychiatrists guidelines. There was also an additional ligature-light cubicle available in resus to provide care to patients with joint physical and mental health needs. For children there were 2 rooms available, 1 of which had anti-ligature fittings and anti-barricade functions, and 1 of which was 'ligature-light' and was designed for joint medical and mental health care.

There were 2 waiting rooms for adult patients. Patients awaiting triage sat in the 'blue waiting room', which was a corridor near the ED entrance. Patients who were awaiting assessment after triage, but who did not require a space in majors, sat in the main waiting room. No members of staff were permanently housed in either of these spaces. However, both areas were relatively small, and staff regularly entered these areas to use them as corridors or to call patients. When staff called patients, they had sight of all areas of these waiting rooms. We were therefore assured that this provided adequate oversight of patients in these areas.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always ensure staff had undertaken adequate training to enable them to provide care that met people's individual needs. However, the service ensured there were enough staff within the department.

The service provided mandatory training to all members of staff. Topics for mandatory training differed depending on the responsibilities of the role. Although we did not review the training provided, the topics were relevant and appropriate. Medical staff (doctors) had completion

rates of 46% for 'Sepsis in Adults' training, 64% for 'Blood Transfusion' training, and 65% for 'Suicide Awareness' training. Administrative and clerical staff had completion rates of 61% for 'Data Security Awareness' and 42% for Oliver McGowan training (this is a training package regarding patients with learning disabilities). This meant not all staff had the most up-to-date information on these topics and led to a risk that staff may not be aware of changes to local processes. Training rates were generally higher (over 90%) for nursing staff.

Most staff members told us that they did not have concerns regarding staffing levels. They told us there were enough staff to do their job and that senior leaders generally found cover for absences. However, some members of staff reported that practice development nurses (PDNs) were often asked to cover nursing staff vacancies, and that this prevented them from focusing on staff education and training.

We reviewed staffing figures and rotas provided by the service. The overall vacancy rate across all positions in April 2026 was 5.0%, which was below the NHS England March 2026 average of 6.5%. Some of this was due to vacancies within the healthcare assistant (HCA) and nursing staffing groups. The service was funded for 23.87 full-time equivalent (FTE) band 3 HCAs, of which 8.27 positions were vacant. However, the service had an additional 1.61 FTE band 2 HCAs over its establishment. The service was funded for 89.14 FTE band 5 nurses, of which 12.98 were vacant. Vacant shifts were usually covered by bank staff. Of all nursing shift vacancies in April 2026, 77% were covered by either bank or agency staff. Most other role types, including consultant and resident doctors, were filled at or near their FTE funding. Medical shift vacancies were also filled by agency or bank staff 77% of the time in April 2026.

Nursing rotas for the previous 3 months showed that managers had calculated the types and numbers of staff required for adult and paediatric areas, and that these were met most of the time. Medical rotas were arranged so that there was in-person consultant cover from 8am to 12am, which was compliant with Royal College of Emergency Medicine (RCEM) guidance. The service employed 27.95 FTE consultants in April 2026 against an establishment of 27.80, while there were 127,457 attendances in the 12 months prior to this. This resulted in a ratio of 1 consultant per 4,560 attendances. This is less than the 1 consultant per 3,600 – 4,000 attendances recommended by the RCEM. However resident doctors did not describe lack of access to consultants as being a problem. The trust rostered 3 mental health nurses (employed by a different mental health NHS trust) on all shifts.

Annual turnover of most staff groups was relatively low (4% for band 6 nurses, and 0% for consultant doctors) but was higher for band 5 nurses (17%). Sickness was also relatively low, with an overall sickness rate of 3.9%.

Staff had received adequate training in managing medical emergencies and cardiac arrests. In April 2026, 90% of nursing staff had a valid Basic Life Support (BLS) or Immediate Life Support (ILS) qualification, and 96% of doctors who were required to completed an Advanced Life Support (ALS) qualification had done so (not all doctors are required to have a valid ALS qualification due to differing levels of experience). Of the 33 nurses employed by the paediatric ED, 31 had a valid paediatric life support qualification such as Paediatric Immediate Life Support (PILS), and the service had scheduled training for the remaining 2 nurses. The service ensured there was always a doctor with a valid Advanced Paediatric Life Support (APLS) certificate rostered on the paediatric ED.

Most clinical staff received an annual appraisal. In the 12 months to March 2026, 96% of nursing staff and 80% of medical staff had received an annual appraisal. This figure was lower (55%) for administrative and clerical staff.

Infection prevention and control

Score

1. Evidence shows significant shortfalls in the standard of care

The service did not adequately assess or manage the risk of infection. Clinical areas were not always clean, and staff engaged in poor hygiene practices. However, the service made significant improvements between our May 2026 and June 2026 assessments.

Following our visit in May 2026, we had significant concerns about the cleanliness of the service. Floors in all areas of the department were generally unclean, with significant amounts of dust collecting in corners and along skirting boards. Work surfaces were often unclean. For example, we found pieces of bread on top of a resuscitation trolley. We also found many dirty and dusty pieces of equipment, such as ultrasound machines and blood glucose monitors. Probes on blood gas machines were noted to be covered in significant volumes of dried blood.

Toys and chairs for children in the paediatric Emergency Department (ED) waiting area were scuffed and dirty. Sofas in multiple areas of the department had cracked and fraying covers, meaning it was not possible to clean them. Boxes meant for storing equipment in resus were dusty. Some of these concerns were relayed to us by staff, who said they had noticed long-term issues with cleanliness.

The service did not have clear oversight of cleaning processes. The service outsourced some cleaning duties to an external company. Staff members from this company operated using a work schedule rather than a signed checklist. Oversight of this cleaning was supposed to be achieved through a weekly cleaning audit, however the audit for the week we were present (12 May -18 May) showed 94.8% compliance despite the problems we identified during the assessment. It was not always clear whether certain cleaning duties were the responsibility of this external company or of ED staff. For example, the work schedule for the external cleaning company stated electrical items were cleaned daily, however ED leaders told us that this was a nursing responsibility. A volunteer within the ED also told us that they were sometimes given cleaning duties, despite this not being an official part of their role.

We were not assured that there were systems in place to prompt ED staff to complete cleaning duties allocated to them. Nursing staff were expected to sign ‘daily cleaning and checking’ sheets as a record of their cleaning. These sheets were different for different areas of the department. Some of these sheets did not prompt staff to clean, only to ‘check’ various areas and add comments. Some also did not include mobile equipment such as ECG machines or observation machines, the cleaning of which was the responsibility of nursing staff. The service did not consistently record cleaning allocated to nursing staff any other way (for example, by using green ‘I am clean’ stickers). Additionally, the nursing ‘daily cleaning and checking’ sheets were regularly incomplete or empty in majors.

Staff did not always adhere to ‘bare below the elbow’ practices, which are designed to decrease the risk of infection. We observed several staff wearing sleeves and watches. Some of these staff members were not employed by the ED and were instead from other care groups, however we did not see any ED staff members challenge these practices. We observed some ED staff walking around and opening doors with gloves on, and we observed one member of staff drop a glove on the floor and then continue to use it to remove an intravenous cannula. The service regularly completed hand hygiene audits in which senior members of staff reviewed compliance with hand hygiene policies. These took place in both the adult and paediatric areas

and showed compliance rates of between 84% and 100% in the 3 months prior to our assessment.

We raised these concerns with the trust and they made immediate improvements. When we returned in June 2026, floors and surfaces were generally cleaner and less dusty. Sofas with cracked and broken covers had been removed. Equipment was visibly much cleaner than previously. The service had started using timed sign-offs for reviewing the cleanliness of patient toilets. The service had started using dated green 'I am clean' stickers on equipment in some areas, but this was not standardised across all areas of the department and there was still not a clear record of how mobile equipment was cleaned in majors. All staff were bare below the elbow, and the service had put posters on the walls reminding staff of the importance of this. We observed no staff walking around with gloves on. The service had removed some toys from the paediatric ED waiting area, however many of the remaining toys were still scuffed and dirty. ECG machines across the department were noted to be covered in sections of medical tape, which made cleaning difficult.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure that medicines and treatments were safe and met people's needs and preferences. People did not always receive their medicines as prescribed, the service did not employ any pharmacy staff directly, and there were issues with the service's use of Patient Group Directions (PGDs).

There was no dedicated pharmacy service for the Emergency Department (ED). Pharmacists were instead shared with other care groups. This was not compliant with Royal College of Emergency Medicine (RCEM) guidance, which states that all emergency departments must have a dedicated pharmacist and a dedicated pharmacy technician 7 days a week. This meant clinical pharmacy service provision was reactive rather than proactive.

People did not always receive their medicines as prescribed due to medicines not being

available to ED staff in a timely manner. We reviewed the records of 10 patients and saw missed and omitted doses that had been marked as not given retrospectively, due to 'drug not available'. These included antipsychotics, antidepressants, and medicines for epilepsy. This could have a negative impact on a patient's physical or mental health. When we discussed this with the trust, we were told that some of the reasons for these omissions included medicines not being stocked, ordered medicines not being collected by porters, and staff not correctly documenting when patients refused medicine. The trust told us it had made some improvements, including stocking within the ED some of the medicines that we had identified as having been omitted.

Staff told us that they had access to digital systems that allowed them to securely view important medical information, and were therefore able to reconcile medicines that people were taking in their own home. However, patients who had prescriptions altered while in the ED did not always have their prescriptions or discharge medicines verified by a pharmacy staff member before discharge.

Patient group directions (PGDs; written instructions used to supply or administer medicines to patients without a prescription) were in place. These were used mainly by triage staff to administer medicines before a patient had been seen by a prescriber. These PGDs were in-date and regularly updated. However, they were not easily accessible on the Trust intranet. This meant that staff administering medicines using these PGDs could not check them for reference (for example, to check for exclusion criteria). We raised this with senior staff who told us that they will usually send copies of PGDs by email to individuals who use them. The service did not keep up-to-date records of which members of staff had read and were authorised to use these PGDs. We were therefore not assured that all staff using these PGDs to administer medicines had received up-to-date training and were aware of relevant updated guidance.

Controlled drugs (CDs) were stored safely and securely. They were managed appropriately in line with CD legislation. Medicines cupboards were unlocked behind a swipe access door; however senior leaders told us that this had been risk-assessed and there had been no incidents as a result.

Effective

Rating Good

This means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. At our last assessment we rated this key question good. At this assessment the rating has remained good.

The service planned and delivered people's care and treatment in an evidence-based manner, with best practice guidelines in mind. Staff worked effectively together. The service monitored outcomes consistently. Staff understood consent and the Mental Capacity Act 2005. However, there were issues with venous thromboembolism (VTE) risk assessments and the prescription of VTE prophylaxis.

Delivering evidence-based care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always ensure that patients were provided with prophylaxis for venous thromboembolisms as per national guidelines. However, the service otherwise had systems in place for staff to deliver people's care and treatment as per best practice and national guidelines.

Patients who are admitted to hospital should have a risk assessment for venous thromboembolisms (VTEs; a group of conditions involving blood clots in the veins, which can be caused by long stays in hospital). These risk assessments often lead to the prescription of VTE prophylaxis (preventative treatment to stop VTEs from developing). We reviewed the notes of 6 patients who had been in the Emergency Department (ED) for over 12 hours, all of whom had been referred to the medical team but had not yet been admitted to a ward. Of these, 0 had a VTE risk assessment completed and only 1 had VTE prophylaxis prescribed. This was contrary to National Institute for Health and Care Excellence (NICE) recommendations, which state that, for patients not yet admitted to wards, these risk assessments and the resulting treatment should take place within 12 hours. We discussed this with senior leaders who told us that these assessments and prescriptions were the responsibility of specialist teams, and that patients staying in the ED for long periods after they had been referred to specialist teams had made the oversight of tasks like this more difficult. However, we were not told about any work being

undertaken with specialist teams to improve this metric. The lack of VTE risk assessments and prophylaxis presented a risk that ED patients would develop VTEs.

The service had high-quality guidelines available for clinical staff to use. We reviewed 10 such guidelines. These were generally easy to find, relevant to staff responsibilities, up-to-date, and developed in line with national guidance and best practice. For example, the 'Management of Spontaneous Pneumothorax' guideline was in-line with and referenced British Thoracic Society guidance. The service kept track of updated guidelines in its medication safety meetings, which were held on a two-monthly basis, and in its ED 'Patient Outcome Group' meetings, which were held monthly.

Initial reviews by ED doctors (known as 'clerkings') were generally of a high quality. We reviewed these in the notes of 10 patients. All 10 were easy to find and assigned to a named doctor. All 10 clerkings contained a clear plan and included documentation of current treatment, 9 had a clear impression/working diagnosis, and 8 contained a clearly documented past medical history.

Members of the psychiatric liaison team completed comprehensive bio-psychosocial assessments as per best practice. The psychiatric liaison service had received its Psychiatric Liaison Accreditation Network (PLAN) accreditation from the Royal College of Psychiatrists (RCP). The RCP judges a service against 111 quality standards to award this accreditation.

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 patients. There was effective multidisciplinary working within the department.

Emergency Department (ED) staff worked well together to deliver patient care. Doctors and nurses described a supportive environment in which they were viewed as being on the same team.

Security staff were responsive and compassionate. Clinical staff consistently gave very positive feedback about the help security staff provided when patients were violent or aggressive. We observed security staff actively checking in with clinical staff. Security attended quickly when required and attended code 10 acute behavioural disturbance calls.

ED staff and staff from the psychiatric liaison service worked well together to manage the risks posed by having high-risk mental health patients present within the department for long periods. Psychiatric liaison staff had a daily morning ward round to review patients who had remained in the department, and had morning safety huddles with ED staff to discuss risks. The Emergency Physician In Charge (EPIC) doctor carried a list of mental health patients in the department for quick reference. This included each patient's legal status (for example, whether they were under a section of the Mental Health Act 1983) and was passed onto the next EPIC doctor on shift.

ED staff worked well with staff from other care groups. There were clear referral pathways to specialist services and staff told us that they were generally responsive to these referrals. ED staff and specialist staff worked well together during emergency calls. For example, we observed intensive care staff facilitating transfers to and from imaging departments when patients needed scans during some types of emergency calls. ED staff also worked well with staff from in-reach services, such as frailty nurses and the alcohol care team. Paediatric ED staff described having good working relationships with the inpatient paediatric team.

Patients requiring admission were not transferred to wards in a timely manner due to systemic pressures. The trust had a corridor care policy (previously the 'Trust Boarding Policy') which set out the circumstances in which patients from ED should be transferred to specialist wards to receive corridor care there, with the goal of decreasing ED overcrowding. However, some senior staff told us that they believed some care groups resisted receiving corridor care patients, and that this resulted in the ED remaining full. As we did not inspect any other adult services at the same time as this inspection, we did not review whether the corridor care policy was being used equitably in other areas of the hospital.

Medical and nursing handovers were well-structured and comprehensive. Staff were encouraged to hand over important information about their patients and were given time to ask questions.

We observed ED staff and ambulance staff working well together. ED staff took detailed

handovers from ambulance staff and ambulance staff helped to take observations during these handovers. Staff from the local ambulance NSH trust provided positive feedback about working with ED staff.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

The service routinely monitored people's care and treatment to attempt to continuously improve it. There was a culture of trying to improve outcomes using data. Staff took the time to engage in quality improvement projects despite systemic pressures on the service.

The service participated in multiple Royal College of Emergency Medicine (RCEM) quality improvement projects (QIPs). These included projects for mental health patients, such as the 2026 'Adolescent Mental Health' QIP. When involvement in these audits had spanned multiple years, improvements in some metrics were identifiable. For example, the RCEM 'Care of Older People in the Emergency Department' audit showed an improvement in the rates of delirium screening for at-risk patients from a mean of 19% in the first year to 39% in the second year.

The service ran internal monthly nursing audits into compliance with best practice and local policy. Subjects included in these monthly nursing audits included hand hygiene, infection prevention and control, intravenous lines, documentation, and medicines management. We saw evidence of action plans generated from these audits and some evidence of improvements following these action plans. For example, following an audit of falls risk assessments which identified low compliance, a digital prompt was introduced into the service's computer system and learning was reinforced with staff – this led to compliance increasing from 43% in September 2025 to 80% in March 2026. However, these audits did not include compliance monitoring of sepsis risk assessments, which the service did not review in any other way.

In addition to these monthly nursing audits, doctors within the service had developed a robust system for managing internal QIPs. At the time of our inspection, there were 7 ongoing non-RCEM QIPs within the adult ED service, with more that had recently been completed. Subjects

of ongoing QIPs included the service's management of hypertension, and a review of the service's pathway for patients presenting with Bell's palsy. The service kept track of these QIPs through a spreadsheet and ensured that each had a named lead clinician. Action plans were developed following each QIP and progress for these actions was noted at monthly ED 'Patient Outcome Group' meetings. We were provided with evidence that QIP results were presented at relevant meetings and occasionally at external conferences. There was evidence of changes introduced following these QIPs (for example, creation of local guidelines that were uploaded onto the service's intranet and alerts added to the service's patient notes system).

The service also regularly collected other data which was not part of formal QIPs or audits. This data, including performance standards such as ambulance handover times, and outcomes such as reattendance rates, was reviewed and discussed by service leaders within their regular meeting schedule. For example, paediatric reattendance rates were discussed in a monthly multidisciplinary meeting delivered as part of the service's 'Needs Evaluation & Support Team for Emergency Department Attendances' programme. However, the service's performance for these standards did not always meet national targets. For example, in May 2026, 70.7% of patients who attended the ED were seen and discharged or transferred within 4 hours. This was below NHS England's target of 78%. However, it should be noted that this data does not include patients who attended this ED and were subsequently streamed to the on-site urgent treatment centre (UTC), and that NHS England's target of 78% applies to all patients regardless of how they are streamed.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

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

Staff understood what consent meant. Staff were also able to explain the concept of mental capacity to us and understood their responsibilities under the Mental Capacity Act if they believed a patient lacked capacity to make a decision about their care. Relevant members of

staff were able to explain how they would perform a capacity assessment. There were clear processes and policies in place to guide staff through consent and capacity issues. Staff in the paediatric Emergency Department (ED) understood concepts specific to paediatric consent to treatment, such as Gillick competency and the Fraser guidelines.

Patients told us that staff gained consent verbally before performing care. Portable translation services (through an electronic tablet) were available for all clinical staff to use. This meant that consent could be gained when caring for patients who did not speak English.

Mental health staff had a good understanding of mental capacity and took this into consideration when reviewing patients with mental health conditions. Staff described using common law and the Mental Capacity Act 2005 to stop patients leaving the department if they felt that they would go on to harm themselves or others.

The service used restraint techniques when patients presented a risk to themselves or others and other de-escalation techniques had failed. The service recorded every instance of this as an incident. From February to April 2026, the service used restraint 185 times (all of these were chemical restraints, with some also including physical restraint). This reflects the high number of patients presenting with acute behavioural disturbances. We did not see any instances of inappropriate use of restraint while we were present. The service had policies and prescribing guidance for restraint.

Security staff, who often engaged with patients who lacked capacity, received training in restraint, supporting patients with mental health needs, and the Mental Capacity Act 2005.

Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people were treated with kindness and respect and involved as partners in their care. Staff worked hard to meet people's immediate needs. Patients provided positive feedback about staff.

However, patient dignity was not always preserved for patients receiving care in the corridor. Staff faced high levels of violence and aggression from patients, which affected their wellbeing and morale.

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

Patient dignity was not always maintained due to overcrowding in the department. However, the service treated people with kindness, empathy and compassion. Staff treated colleagues from other organisations with kindness and respect.

Due to systemic pressures on the service, patient dignity was not always maintained. We observed one patient in a trolley in the corridor who was receiving care dressed only in their underwear. We discussed this with service leaders who told us that staff should have used temporary dividers and that they would reinforce this with staff. Patients in chairs in the corridor of the majors area did not have a surface on which to eat the food provided to them. We observed one patient eating their lunch on the lid of a bin.

Staff treated patients kindly. We spoke with 10 patients and 2 family members of patients. They provided positive feedback about their interactions with staff. They told us that staff introduced themselves before providing care and that they listened to them. One patient told us, “I would never go to another hospital”.

We observed many positive and kind interactions between staff and patients. Nursing staff greeted and introduced themselves to every patient arriving by ambulance. We observed patients being triaged and noted that nurses providing this service were considerate and understanding. Paediatric staff were kind to children and explained to them what was happening.

During our initial visit in May 2026, the service did not have enough toilets for the number of patients in majors. There was 1 toilet available for 2 patients in mental health rooms, but otherwise all patients in majors had access to only 1 toilet. This resulted in long queues and patient frustration. We saw 1 patient lose control of their bowels while in the corridor queuing for this toilet, which did not preserve their dignity. At this time, the provider was already in the process of building a second toilet in majors. On our return in June 2026, the building work was complete, and the second toilet was functioning. We saw no patient queues on this visit.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

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

The service provided food and drinks, including hot food options, to patients in cubicles and in corridors. Patients told us that they received enough food. Water tanks were available in waiting rooms for hydration, but we saw that they didn't always have cups available.

Staff were responsive to the mobility needs of patients. Patients requiring wheelchairs told us that staff got these for them. We saw reception staff collect wheelchairs from a porter's office to assist patients who were struggling to stand when booking in. Reception staff also assisted patients who struggled using the electronic booking-in system and instead booked them in directly.

The service used 'flags' on its electronic patient record system to alert staff of immediate patient needs. Examples of flags we saw included learning disability flags and flags informing staff of previous episodes of violence and aggression.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

Staff often felt unsafe at work due to high levels of violence and aggression from patients, which was partly due to long waits for patients waiting for mental health beds. However, the service cared about and promoted the wellbeing of staff, and systems were in place to reduce the risk violence and aggression posed to staff.

Urgent and emergency services

Staff faced very high levels of violence and aggression from patients, a significant portion of which was from mental health patients waiting for a mental health bed. Many members of staff emphasised how they did not feel safe at work and how this impeded their work. We saw examples of violence and aggression while we were on site. For example, a member of staff was bitten by a patient during our May 2026 visit. The service only provided us with incident data for patient safety incidents (which did not include violence and aggression incidents), but senior staff estimated 250 incidents of patient violence and aggression were received each month. Staff members told us the real number was likely to be much higher because low-level incidents were not always reported.

These issues were reflected in the 2025 NHS Staff Survey, in which 119 Emergency Department (ED) staff (including staff at another ED run by the same trust) answered questions about their work. Over the previous 12 months, 60.5% of ED staff reported experiencing physical violence from members of the public, 82.4% reported experiencing harassment, bullying or abuse from the same group, and 33.1% reported experiencing unwanted behaviour of a sexual nature from the same group. Staff were more likely to report they found their work emotionally exhausting (91.5% said this occurred sometimes, often or always) or to feel burnt out (81.4% for the same responses) than the trust average. However, staff we spoke with told us that they enjoyed working in the department despite these issues.

The service had systems in place to reduce the risk violence and aggression posed to staff. Staff wore personal alarms, which they could activate if in danger. These automatically connected to sensors in an ED-wide system, so it was clear in which area an alarm was pulled. Security staff wore body cameras so that episodes of aggression and restraint could be reviewed. Patients with a history of violence or aggression had a ‘flag’ added to their electronic patient record so that this could be easily identified at the start of the next presentation. Psychology support was available to staff, including security, and this was promoted through newsletters. The service had a ‘violence and aggression’ lead clinician who oversaw work to reduce the impact of violence and aggression on staff and who worked with police and ambulance services. However, we were told that trust-wide initiatives that were intended to reduce the risk of violence and aggression were not working as intended. For example, a senior member of staff told us that exclusion panels (meetings in which senior trust staff can decide to deny a patient access to non-life-saving medical services following incidents of violence) were often delayed or not held. This led to ED staff having to continue to treat patients that had been extremely

aggressive or violent towards them (we were given an example of a patient who had sexually assaulted a member of staff, for whom staff had not been able to get an exclusion panel discussion).

Staff within the service ran social activities to promote wellbeing. Examples included volleyball and running clubs for doctors, and study groups open to all members of staff.

The service had a positive reporting system named 'King's Stars' which allowed staff to nominate colleagues they thought had provided exceptional care. Staff had submitted 40 reports from May 2025 – May 2026, highlighting rapid diagnoses and patience in difficult situations.

Resident doctors within the department took part in self-rostering, which allowed greater flexibility in working times.

Responsive

Rating Requires improvement 

We looked for evidence that the service met people's needs. At our last assessment we rated this key question requires improvement. At this assessment the rating has remained requires improvement. This meant people's needs were not always met.

The service did not employ a play specialist in the paediatric ED, for which they were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 18 (staffing). The service did not always supply necessary information, such as waiting times, to patients. The service was severely affected by overcrowding and there were limited beds available for patients requiring admission. This resulted in long waits and meant that patients could not always access care in a timely manner.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always make sure people were at the centre of their care and they did not always work in partnership with people to decide how to respond to people's needs.

The paediatric Emergency Department (ED) did not employ a play specialist. Staff told us that they sometimes asked play specialists employed by the inpatient paediatrics team to come to the ED and assist, but that this was done rarely. This is contrary to guidelines issued by the Royal College of Paediatrics and Child Health (RCPCH), which states that all EDs must have access to play specialists and that large EDs should directly employ dedicated play specialists. The lack of a play specialist led to a risk that paediatric care within the ED was not person-centred, especially for children with complex needs, and that children would not engage with care.

The service had systems in place to help deliver safe care to patients with learning disabilities. Staff told us that patients with learning disabilities were prioritised for cubicles and that, if they were present in areas without beds (for example, in waiting rooms), they could be given an assessment cubicle if they were showing signs of distress. We did not see any patients with learning disabilities receiving care in the corridor on either visit. However, the trust's corridor care policy (released after our first visit in May 2026) did not specifically include the presence of a learning disability as an exclusion criterion for receiving care in the corridor (NHS England guidance states that corridor care "must be avoided" for patients with learning disabilities). The service used 'flags' on their electronic patient record system to inform staff that patients had a learning disability. Staff were aware of the hospital's learning disability team and how to contact them. However, completion rates of Oliver McGowan training (a training package regarding the treatment of patients with learning disabilities) were inconsistent across staff groups, with nursing staff having a completion rate of 87%, medical staff 59%, and administrative and clerical staff 42%.

The service used risk assessments, such as falls risk assessments and pressure ulcer risk

assessments, to identify issues patients were facing and to personalise their care. However, these risk assessments were not always completed, resulting in a risk that these issues may not be recognised early in a patient's admission. We reviewed the notes of 10 patients in the majors area, each of whom had either been referred to a specialist team (with the shortest length of stay being 5 hours) or had been present for at least 7 hours. Of these, only 7 had a falls risk assessment completed. However, pressure ulcer risk assessments were completed more consistently, with this being completed for 9 of the 10 patients. Of the 10 patients reviewed, only 3 met the clinical criteria requiring a sepsis risk assessment, and all 3 had a sepsis risk assessment completed in accordance with the Trust's NEWS2 policy. The service provided evidence of internal auditing of some of these assessments, which showed similar results (although sepsis risk assessments were not included).

The service had systems in place to support paediatric patients who attended the ED regularly. Rates of re-attendance within 7 days averaged 11.8% for paediatric patients from May 2025 to April 2026. The service ran a programme named 'Needs Evaluation & Support Team for Emergency Department Attendances' (NESTED) in which cases of paediatric reattendance were examined. Outcomes from these meetings included additional support for families in the form of nursing follow-up calls and advisory letters to the patient's GP.

The paediatric ED had tailored rooms for patients with specific needs. One room for mental health patients had panels which could light the room different colours and a projector for patients to watch films with. There was also a sensory room for patients with autism or learning difficulties.

We did not see any patients being given end-of-life care while we were present. However, the service had robust policies and guidance on how to deliver this care. This included guidance about specific problems encountered in end-of-life care, such as diabetes management. The service's electronic patient record included order sets (groups of related clinical orders and requests) for end-of-life care prescribing and a referral pathway to the hospital's palliative care team, about which clinicians were aware.

The service also had access to other in-reach services within the ED. Staff could refer patients to the hospital's alcohol care team between 8am and 5pm on weekdays. This team provided care and advice to patients struggling with alcohol dependence. Staff could also refer patients suffering from poor mobility due to frailty to the frailty team during the same hours. These services helped staff tailor care to the needs of their patients.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

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

The service did not provide waiting time estimates to patients in waiting rooms in any area of the department. This meant that patients did not know how long it would take until they'd be seen.

Signage around the department was not always clear. For example, the 'blue waiting room' was a corridor near the ED reception with seats along the walls. Walk-in patients were expected to wait in this area until they had been called into a triage room. However, the only signage for this area was in the form of laminated posters above some patient chairs. These were easy to miss and were often obscured by people sitting in these chairs. This, combined with the presence of another nearby waiting room for triaged patients, led to patient confusion. We saw one patient spend 2 hours in the wrong waiting room, delaying their care. However, the main waiting room contained a comprehensive poster titled "Your Journey Through the ED" which thoroughly explained the different areas of the department and how patients might move through them.

Translation services, including for British Sign Language, were available for all clinical staff in the form of electronic tablets. Staff provided positive feedback about these. However, receptionists told us that they did not have access to these services. If a patient did not speak English when attempting to book in to the ED, reception staff told us that they would use online translation tools on their mobile phones. This led to a risk of mistranslation and of patient misidentification.

The service provided information about patients' treatment in the ED in the form of discharge summaries. These were sent to the patient's GP and provided to the patient on request. We reviewed 10 discharge summaries and found they contained clear descriptions of the care that was given, clear descriptions of where the patient was being discharged to, and clear descriptions of any medication changes.

Patients told us that staff kept them informed about their progress and what they were waiting for.

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 patients and family members to give feedback and raise complaints. However, the service had systems in place for reviewing patient complaints when these were made.

Patients could make complaints about the service if they desired, but we saw no posters or prompts advising patients how to do this. The service received 92 complaints in the 12 months to May 2026. Service leaders reviewed complaints in a weekly meeting. There was a policy regarding how complaints should be handled. Complaints were graded for complexity as per this policy and had an assigned theme – the most numerous themes were 'staff values and behaviours' and 'communication'. The service met its targets for complaint responses. For example, the service closed 100% of its straightforward complaints within 3 months compared to its target of 95%. When asked for examples of changes made following complaints, the service provided examples of re-education of staff members (for example, further training on the use of infusion pumps following a complaint about an error programming this piece of equipment).

The service participated in the NHS 'Friends and Family Test' (FFT), in which patients can give feedback on their care. However, we did not see any posters or prompts for patients to engage with this feedback while we were on site. Relatively low numbers of patients provided feedback via this route (in April 2026 179 patients responded, but in May 2025 this was as low as 2). The overall FFT feedback was 71% positive for April 2026 (below the England average of 80%).

The service performed its own surveys of patient experiences. For example, following the introduction of the 'digital front door' (electronic tablets for walk-in patients to book themselves in) the service surveyed 279 patients to gain feedback about the process and

identify issues. Other surveys conducted by the service were not always large enough to gain any meaningful data. For example, the service provided evidence of an internal 'Emergency Department Patient Experience Survey' which recorded only 2 responses.

Patients were involved in discussions about their care. Patients told us that they were aware of what staff were planning and that their points of view were taken into account.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

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

Patients attending with mental health concerns remained in the Emergency Department (ED) for very long periods due to low availability of beds at a neighbouring mental health NHS trust. Between May 2025 and April 2026, median wait times for all mental health presentations (not just those requiring admission) were 6 hours and 56 minutes for adults and 7 hours and 3 minutes for children. During the same period, the longest wait in ED for a mental health patient within the last 12 months was 5 days and 12 hours. This had a detrimental impact on these patients due to the busy and noisy nature of an ED. This also resulted in overcrowding and higher rates of violence and aggression towards staff. However, the service assessed patients presenting with mental health concerns quickly. In March 2026, the psychiatric liaison team responded to 88% of referrals within 1 hour. Median response times for the psychiatric liaison team in April 2026 were 16 minutes for adults and 54 minutes for children. Psychiatric liaison staff conducted patient assessments alongside ED staff, rather than waiting until a patient was declared medically fit, which resulted in faster treatment for mental health issues.

Patients requiring admission due to physical health concerns remained in the ED for long periods due to low availability of beds on wards. In April 2026, the median waiting times for patients with a 'decision to admit' (meaning a specialist team had decided they needed to go to a ward) were 8 hours and 32 minutes for adults, 3 hours and 18 minutes for adolescents (16-17

years), and 4 hours and 50 minutes for children (under 16 years).

In May 2026, 70.7% of patients who attended the ED were seen and discharged or transferred within 4 hours. This was below NHS England's target of 78%. However, it should be noted that this data does not include patients who attended this ED and were subsequently streamed to the on-site urgent treatment centre (UTC), and that NHS England's target of 78% applies to all patients regardless of how they are streamed. However, the service did meet NHS targets of ensuring the proportion of patients waiting more than 12 hours within the ED is less than 10% (this was 7.8% in April 2026 when including both adults and children).

NHS England guidance states that patients arriving at an ED should have an initial assessment within 15 minutes. This target was met and exceeded for walk-in patients. The median time to triage for these patients for the 12 months prior to our inspection was 8 minutes for adults and 13 minutes for children. Significant improvements had been made within this period for adults (from 22 minutes in May 2025 to 3 minutes in April 2026). This was due to the introduction of the 'digital front door' (electronic tablets allowing patients to book themselves in instead of speaking to a receptionist). However, average handover times for patients arriving by ambulance were longer than this 15-minute target, with average times varying between 24 and 26 minutes from April 2025 to March 2026.

Well-led

Rating Requires improvement

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. At our last assessment we rated this key question requires improvement. At this assessment the rating has remained requires improvement. This meant the service management and leadership was not always consistent. Leaders did not always support the delivery of high-quality, person-centred care, as they had not recognised some issues with the way the service was operating. This resulted in risks to patients not being addressed. However, staff provided positive feedback about the culture within the service and described service leaders as approachable and helpful.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

Staff in the Emergency Department (ED) did not always feel valued by the trust for their work. The service had a shared vision, strategy, and culture which was based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. However, not all staff were aware of this.

Staff told us that they felt valued by their line managers and their colleagues, but not by the wider trust. This was reflected in the NHS Staff Survey 2025, in which only 31.1% of ED staff (including staff at another ED run by the same trust) said that they were satisfied that the trust valued their work (this was lower than the average of 40.4% for the trust).

The trust had a strategic vision for the years 2021 to 2026. The acronym of this strategy was 'BOLD', which stood for 'Brilliant people, Outstanding care, Leaders in research, innovation and education, and Diversity, equality and inclusion at the heart of everything we do'. The trust has since launched a new strategy for the years 2026 to 2031, which was not yet released at the time of our inspection. ED staff members were aware of the 'BOLD' strategy, however not all were able to recall what the letters stood for. Staff members told us that they did not believe the trust actually stood by these values. Staff members told us that they believed that the trust's primary motivation was cost-cutting. Staff members also told us that they believed that risk to patients wasn't shared across the trust, but was instead concentrated in the ED.

Leaders within the ED had clear goals for the department. Examples included increasing the proportion of paediatric patients streamed to the on-site Urgent Treatment Centre (UTC) and improving the ED environment through estates upgrades (some of which were underway while we were present).

Service-wide updates, such as current operational pressures, were not discussed on a day-to-day basis with staff, such as in handovers. However, this information was distributed on a longer-term basis through ED staff newsletters. These also included information about current financial pressures facing the service.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

The service's leaders did not always identify issues with the way the service was operating, which led to an increased risk of harm to patients. However, service leaders were inclusive, visible, and well-respected by staff.

The Emergency Department (ED) care group senior leadership team (SLT) consisted of a clinical director (a doctor), a head of nursing, and a general manager. The SLT had the skills and experience to lead the service. However, due to operational pressures on the service, service leaders did not always have the capacity to identify issues within the department that put people at risk of harm. For example, issues that were apparent on this assessment, such as staff not applying patient wristbands, issues with equipment available to staff, and issues with cleanliness, had not been identified prior and therefore continued to present a risk to patient safety. When the SLT had identified issues, such as the lack of a corridor care policy, these were not always present on the service's risk register, so it was not always clear what action had been taken to mitigate these risks. However, the SLT were responsive when we raised these concerns and took immediate action when required. Senior leaders had also already identified some of the issues identified on this assessment. For example, service leaders recognised that the service's lack of employment of dedicated ED pharmacists and play specialists presented risks to patients. Service leaders told us they had put forwarded a business case for the latter to the trust, but it had been rejected.

ED staff told us that they felt valued by the SLT and other ED leaders. They described a positive culture in which senior leaders were accessible and approachable. In the NHS Staff Survey 2025 (which included staff at another ED run by the same trust), 68.6% of staff said they felt valued by their team, 69.5% of staff said their manager valued their work, and 82.1% said they enjoyed working with their colleagues.

Matrons were respected and liked by junior nursing staff. Nurses told us that matrons had an 'open door policy', in which they could go to their office and ask for help if they needed it.

Nurses also told us that matrons supported them in upsetting situations, for example by organising debriefs after the death of a patient.

Resident doctors provided positive feedback about consultant doctors. They told us that consultants were available for advice when they needed it, and that they did not feel pressured to act outside of their scope of competence.

However, some members of staff told us that executive leaders from the trust were not very visible, and that they did not believe that the trust always understood key issues facing the service.

Leadership development opportunities, including external courses, were available to staff.

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 that they were able to speak up about their concerns without fear of retribution. They described a positive culture in which they were encouraged to identify and talk about problems. In the NHS Staff Survey 2025 (which included staff at another Emergency Department run by the same trust), 91.2% of staff said that they were encouraged to report errors, near misses, and incidents, and 72.9% said they would feel secure raising concerns about unsafe clinical practice. However, fewer staff (49.2%) said they felt confident that their concern would be addressed.

The service had access to a Freedom to Speak Up Guardian, who could listen to concerns if members of staff did not feel able to raise them with leaders. Staff members were aware of this option but told us they did not feel like they needed to use it. Within the 12 months prior to our inspection, the Freedom to Speak Up Guardian had been contacted 6 times by ED staff. We reviewed these contacts and found no repeated themes which would indicate issues raising a

certain topic with senior leaders.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the standard of care

Not all risks to the service had been recognised or addressed through governance systems. However, the service had clear responsibilities, roles, and systems of accountability.

The service had appropriate governance systems. For example, senior nurses, doctors, and operational staff met weekly to discuss issues specific to their staff group. These meetings fed into a weekly multidisciplinary 'core group' meeting of senior staff, in which incident themes, audits, patient outcomes, morbidity and mortality incidents, and performance data were discussed and reviewed. Incidents and complaints were reviewed by senior staff in separate weekly meetings. Medication safety meetings, which reviewed any incidents involving medicines, were held monthly. 'Mental health steering' meetings, which reviewed incidents and performance data for mental health patients, were held monthly and included staff employed by the nearby NHS mental health trust which provided the Emergency Department (ED) with its psychiatric liaison and mental health nursing services. Weekly safeguarding meetings were held for both paediatric and adult patients.

There were systems in place for the outcomes of these meetings to be provided to senior trust leadership. The emergency department sat within division B of the trust's 3 divisions. Divisional meetings were held regularly and included a monthly ED performance meeting and a monthly divisional quality and governance board meeting, in which high-level risks could be escalated.

Senior leaders operated a risk register that was specific to the ED. This was reviewed fortnightly in a dedicated meeting. Risks were rated for their perceived severity and mitigations for each risk were recorded. At the time of our inspection, the highest-rated risks were, 'Risk of patients spending a prolonged period in the ED waiting for assessment by specialties or beds for admission' and 'There is a risk that patients with Acute Behavioural Disturbance or Acute

Mental Health crisis will have a negative experience in the ED, and that there may be an impact on other patients and staff'. The risks on this risk register were reflective of issues faced by ED staff and patients.

However, the above systems had not identified all risks to patients using the service. This resulted in gaps in the governance of the service. For example, service leaders were aware that the service had no corridor care policy in place, but this had not been added to the risk register. This had prevented leaders from taking action to mitigate the risks this presented and resulted in patients receiving corridor care when this was not appropriate (see 'Involving People to Manage Risks'). The risk register also did not include the service's lack of a dedicated pharmacy service, despite this being contrary to Royal College of Emergency Medicine (RCEM) guidelines (see 'Medicines Optimisation'). This again meant that mitigation plans for this risk were not in place.

There were multiple 'clinical leads' for the management of different aspects of care (such as a governance lead, safeguarding leads for adults and children, and a patient outcomes lead). However, some leads told us that they were not allocated enough time to complete these aspects of their job.

The trust had clear emergency preparedness and major incident policies. These contained specific guidance and responsibilities for ED staff. There was also a clear protocol for ambulance handover delays, with clear criteria for escalation to the clinical site manager.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The service understood and carried out their duty to collaborate and work in partnership. They shared information and learning with partners and collaborated for improvement.

Service leaders within the local ambulance NHS trust provided positive feedback about working with Emergency Department (ED) staff. They told us that service leaders were easy to

contact, that they have regular meetings, and that senior staff engage well when there are incidents that involve both providers. We observed ED staff and ambulance staff working well together, including ambulance staff helping to take observations for nurses when handing over patients. However, we saw some ambulance staff waiting in the ED for up to 45 minutes even after they had handed over their patient. This was because they were waiting for their trolley to be returned, even though the patient was still using it and was unlikely to be moved off it.

The service worked well with staff from the nearby mental health NHS trust which provided its psychiatric liaison and mental health nursing services. Staff from this trust were able to access the notes and incident reporting systems of both trusts. Staff described a good working relationship with each other. ED nurses received training in mental health from this adjoining NHS trust. Staff from both trusts attended a monthly 'mental health steering' meeting, which reviewed incidents and operational data for mental health patients. Service leaders within the ED were involved in work with this trust to decrease the number of mental health patients presenting to King's ED.

The service worked well with the police to manage violence and aggression. Staff told us that new police recruits in local boroughs received tours of the department to familiarise them with it, and that senior ED staff had provided education sessions for police officers.

The service worked with charities to improve the outcomes of some population groups. For example, staff could refer patients under 25 who had been victims of violence (particularly gang-related violence) to a charity which provided psychological support. Volunteers from the King's College Hospital Charity were also present on our visits, helping to guide patients around the department. We saw evidence of independent domestic violence advocates (IVDAs) attending service safeguarding meetings.

Senior staff also attended the clinical governance meetings of the Urgent Treatment Centre (UTC), which was operated by a different provider but present on the same site.

The service used the same Electronic Patient Record (EPR) as another nearby hospital run by a different NHS trust. This allowed staff to review the notes and investigation results of patients who had previously attended that ED.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service focused on continuous learning, innovation and improvement. The service encouraged staff to think about how to deliver equality of experience, outcome, and quality of life for patients.

The service offered regular teaching and education to staff. All band 5 nurses were offered a course linked to Royal College of Nursing (RCN) level 2 competencies. Successful completion of this course was required to progress to band 6. The service had a team of practice development nurses (PDNs) who developed and delivered a teaching programme. This included 'bitesize' teaching offered every weekday morning, which was often tailored to staff requests or areas noted as requiring improvement in recent complaints or incidents, and weekly simulation training with a hypothetical clinical scenario. We saw evidence that these training sessions were being delivered and were well attended. Nursing staff provided positive feedback about these sessions. However, some PDNs told us that it was difficult to maintain this quantity of teaching because they were often asked to cover shifts in the Emergency Department (ED) due to vacancies.

Resident doctors, including those not on training pathways, told us they received a weekly 2-hour teaching session, as well as other paediatric teaching sessions. We were told these were rarely or never cancelled and that senior doctors ensured they had the time to attend.

Staff were encouraged to take part in audits and quality improvement projects (QIPs), and there was evidence that these resulted in changes to care delivery. For example, a 'management of hypertension in the ED' QIP resulted in an updated guideline being uploaded to the trust intranet for staff to review, and a Royal College of Emergency Medicine (RCEM) audit ('Care of Older People in the Emergency Department') showed an improvement in the rates of delirium screening for at-risk patients from a mean of 19% in the first year to 39% in the second year. There were systems for audit and QIP results to feed into governance meetings.

The service had recently implemented a 'digital front door' (electronic tablets on which walk-in

patients could book themselves into the ED without speaking to a receptionist). This resulted in significant improvements in the median time to triage for adult patients (from 22 minutes in May 2025 to 3 minutes in April 2026). As part of the introduction of this system, the service ran a survey of 279 patients who had used it, which showed 67% of patients used it without needing any additional support and that 58% of patients rated it as ‘good’ or ‘very good’.

Services for children & young people

Overall	Requires improvement
Safe	Requires improvement
Well-led	Requires improvement

Our view of the service

We carried out a short announced, responsive and focused inspection of services for Children and Young People on 12 and 13 May 2026 due to risk and follow-up on last assessment.

During our inspection we visited the following wards: Lion Ward, Princess Elizabeth Ward, Neonatal Intensive Care Unit, Paediatric Intensive Care Unit, Philip Issacs Day Case Unit, Rays of Sunshine Ward, Paediatric Short Stay Unit, Thomas Cook and Children's Outpatient Department. We spoke with 33 members of staff including nursing and medical staff of different grades, teachers of inpatient children, healthcare assistants, therapy specialists and managers. We spoke with over 16 patients and their relatives.

We rated the service as requires improvement. We previously found 3 breaches of regulation around incidents, mandatory training, staffing, records, risk assessment, culture, leadership and governance. Although leaders had started to take action to address areas of concern identified at the previous assessment, further improvements were needed to improve performance.

During this assessment, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were for regulations 12 (safe care and treatment), regulation 15 (premises and equipment), regulation 17 (good governance) and regulation 18 (staffing). An action plan will be requested from the trust to address these breaches upon the final publication of this report. These were around staffing, environment, mandatory training, records, risk assessments, incidents and governance. Staff did not always assess risks to people's health and safety or mitigate them where identified. Governance systems and audits were not effective in identifying or addressing

areas for improvement.

However, staff were up to date with their appraisal, and children and young people were treated with dignity, kindness, respect and compassion.

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

Leaders worked to improve the experience of people who accessed the service through various initiatives. This included engaging the young ambassadors to improve the service and hosting special visits of an author to visit children on the wards during the 2026 world book day.

The service had a ‘King’s Schoolroom that provided educational support and provision for children and young people that were inpatients or day patients, from reception to Year 13. We observed staff supporting secondary school children to undertake their national exams during the assessment. This ensured illness or medical treatment did not disrupt children and young people’s education.

The people we spoke with during the assessment spoke highly positively about staff, the service and care received. Staff were described as warm, helpful, kind, competent, professional, and respectful. We observed multidisciplinary staff treating children, young people and their relatives with compassionate care, respect and dignity throughout the assessment.

Children, young people and their relatives spoke positively about the food, playroom, youth room and parent room. Parents in the neonatal intensive care unit spoke positively about the dedicated breastfeeding support received. People felt listened to and felt staff were attentive and hygienic. Parents felt their questions were answered and staff kept them updated about their children’s care and treatment.

However, a few parents felt that sometimes plans progressed slowly, updates needed to be consistent, information needed to be timely and complete to reduce stress. Also, communication between teams could be improved and strengthened.

Safe

Rating Requires improvement

This means we looked for evidence that people were protected from abuse and avoidable harm and safety was a priority for everyone. At our last assessment we rated this key question requires improvement. At this assessment the rating has remained requires improvement. This meant people were not always kept safe and protected from avoidable harm.

The service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 12 (safe care and treatment), regulation 15 (premises and equipment) and regulation 18 (staffing). These breaches were in relation to incidents, staffing, records and risk assessments and safe environment of the service.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. Leaders did not always investigate incidents or close actions plans. This raised concerns that lessons were not always learnt in a timely manner to embed good practice. However, staff reported incidents and leaders had a positive culture of safety based on openness and honesty.

From 1 May 2025 to 30 April 2026, the service reported 1,373 incidents, which were mainly graded as no or low harm. The top themes from the incidents were medication errors, capacity issues, faulty equipment, delayed diagnosis, nutrition and hydration and patient identification.

At the time of our assessment, the service had 360 open incidents, of which 296 were overdue an investigation, closure or had unresolved recommendations; some dating before 1 May 2025. The reason for the backlog was reduced governance capacity and staffing shortages. This impacted on closing of incidents, embedding learning in a timely way, increased potential for avoidable harm to patients. However, the trust had an action plan in place to review and close the incidents.

Staff knew what incidents to report and how to report them. Staff told us they knew how to use the incident reporting system and were encouraged to report all incidents, including near misses. Most staff said leaders listened to their safety concerns. However not all staff felt leaders listened to their safety concerns particularly in the neonatal intensive care unit. Staff described adverse events that had been reported, including medication errors, clinical incidents in neonatal care and equipment faults.

Staff received feedback from incident investigations through handover, team meetings and internal communications. Staff told us they discussed incidents regularly, in a supportive environment, and reviewed themes and outcomes. Support was given to staff after serious incidents, including opportunities to reflect on practice

There was evidence that the service made changes following incidents and complaints. For example, the service launched quality improvement (QI) projects on preventing pressure ulcers, blood transfusion and total parenteral nutrition following recent incident investigations and learnings. The service had also developed a standard operating procedure for liver speciality patients being cared for on other paediatric wards. This was following an incident investigation that highlighted delays in decision making. The service had also developed an information leaflet on lumbar puncture following a complaint investigation.

Staff understood duty of candour. Staff told us they were open and transparent when things went wrong. They gave patients and families clear explanations and provided support throughout any investigations.

Overall, staff showed a positive approach to reporting and learning from incidents. However, the service had a backlog of overdue incidents and the delays in investigation processes limited the service's ability to demonstrate timely learning and improvement.

Safeguarding

Score

3. Evidence shows a good standard of care

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

The service had an up to date safeguarding and baby abduction policies and had improved their governance on management of safeguarding incidents and referrals, this was an improvement from the last assessments.

From April 2025 to March 2026, staff reported 3,020 safeguarding referrals in the service, which demonstrated active identification and escalation of risks. This was an improvement since the last assessment.

Staff could describe how to protect children and adults from harassment and discrimination, had awareness of equality and diversity and described how they supported patients and families with different needs. This included tailoring communication and recognising vulnerabilities in children, young people and families receiving care in specialist care settings.

Safeguarding was supported through regular meetings and multidisciplinary, working with internal and external stakeholders to manage risks and protect patients.

Staff followed procedures to support children and families visiting the service. Staff described how they supported parental involvement and ensured safe visiting arrangements. The service was able to protect patients from all unauthorised access using controlled access via video entry.

Staff demonstrated an understanding of restrictive practices and how to minimise their use. Staff described using de-escalation techniques and maintaining patient safety while reducing the need for restrictive interventions. There was a focus on maintaining dignity and supporting patients in the least limiting way.

However, not all staff had completed safeguarding training relevant to their specific role. Staff knew how to make a safeguarding referral, were aware of the safeguarding processes within the service and knew how to escalate concerns using established safeguarding pathways.

Data provided by the trust showed 88.4% of staff had completed their safeguarding adult and

children training and this was a slight improvement from the last assessment. However, we observed significantly poor compliance in some specialities such as neurology (60%), speciality nurses (60%), medical CCC (60%) and hepatology (69.2%). Also, the medical surgery compliance was 72.2% and medical secretaries achieved 78% compliance, which were below the trust target. The trust had an action plan in place to improve compliance to above 95% by 31 July 2026. Following the assessment the trust explained that lower compliance was due to the temporary absence of the named nurse for safeguarding and vacancies within the safeguarding team, which had affected the delivery of training. At the time of the inspection, the vacancies had been filled, and the named nurse had recently returned to post**.** As at 31 July 2026, compliance for Safeguarding Level 3 was 89.7%.

Involving people to manage risks

Score

1. Evidence shows significant shortfalls in the standard of care

The evidence showed significant shortfalls. The service did not work well with people to understand and manage risks. Staff did not provide care to meet people's needs that was safe and supportive.

Staff did not always complete risk assessments for each child and young person. There had been improvements in the undertaking of audit of patients' risk assessment to ensure compliance with local and national guidance to improve patient safety. However, compliance in the audits was poor.

Staff did not consistently complete nutrition screening tools. From November 2025 to 30 April 2026, staff achieved 23% compliance in the paediatric skin assessment audit and 32% in the nutrition screening audit. Poor compliances in the nutrition screening were mostly related to Toni & Guy, Princess Elizabeth, Ray Of Sunshine, Paediatric Short Stay Unit (PSSU) and Lion wards. This meant people at risk of malnutrition or dehydration may not have been identified promptly, and appropriate support, monitoring or referrals may not have been put in place in a timely way. This did not provide assurance that people's nutrition and hydration needs were always assessed, monitored and managed safely.

Staff did not consistently complete paediatric falls risk assessments. In the same period, the paediatric falls assessment audit showed an overall compliance of 42.4%. Rays Of Sunshine ward had significantly poor compliance in this audit and compliance ranged from 2.82 to 5.1%. No action in place to address areas of poor compliance. This meant children and young people at risk of falls may not have been identified promptly, and appropriate actions to reduce the risk of avoidable harm may not have been put in place. This did not provide assurance that falls risks were consistently assessed, monitored and managed safely.

Staff did not consistently complete paediatric pain assessments. In the same period, staff achieved between 60% to 70% compliance in the paediatric pain assessment audit and 58% to 66% in the scanning compliance audit. This meant children and young people's pain may not have been identified, monitored or treated in a timely way. This did not provide assurance that staff consistently assessed children's pain, acted on their needs, or reviewed whether interventions were effective.

Staff used a nationally recognised tool to monitor and respond to clinical deterioration. The Paediatric Early Warning Score (PEWS) was used to identify children and young people at risk, with appropriate escalation procedures in place. From November 2025 to April 2026, staff achieved between 83 to 97% compliance. However, there were significant gaps in the timeliness (25% to 45%) and completeness (65% to 84%) of PEWS. However, action plans were in place and to be completed by end of July 2026 to address low compliance and improve performance.

Staff did not consistently complete sepsis, MRSA and other required risk assessments. The compliance with sepsis and risk assessment tools ranged between 20% and 70%. Similarly, MRSA screening ranged between 35% to 100%, indicating inconsistency in admission, risk assessment and infection control processes. Overall, core safety risk assessments were not yet embedded to keep people safe. This meant risks to children and young people's health and safety may not have been identified, escalated or managed in a timely way. This included risks linked to clinical deterioration, infection prevention and individual care needs. This did not provide assurance that staff consistently assessed, monitored and acted on risks to keep children and young people safe from avoidable harm.

The vital observations audit compliance showed improvement and compliance was between 88 % and 96%. Between January and April 2026, staff achieved 96% compliance in the World Health Organisation (WHO) surgical safety checklist audit.

Staff communicated with children, young people and families, so they understood their care and treatment. This included involving parents in discussions about care and ensuring they understood treatment plans. Staff supported families to remain involved in care, which helped them to understand risks and contribute to decision-making. This included discussing treatment options and respecting patient choices where appropriate. Staff were aware of the need to support advance decisions, including decisions to refuse treatment, and used available information within patient records to guide care.

The service provided facilities to support families and carers, including overnight rooms, food preparation areas and quiet working pods. These helped carers stay with patients while managing other commitments. These arrangements enabled carers to remain present during care and treatment.

Families were encouraged to give feedback through conversations and meetings, and staff supported access to additional services, including advocacy where needed.

The service worked collaboratively with children, young people and their families to manage risks. For example, the service had invited school children from a neighbouring school to visit the service and take part in an educational session to help develop their first aid and cardiopulmonary resuscitation (CPR) skills. This enabled the school children learn basic skills of first aid and CPR techniques, to help them step in to support someone else in need.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always detect and control potential risks in the care environment. However, they made sure equipment, facilities and technology supported the delivery of safe care.

The environment did not consistently support safe care. We identified several environmental risks that could affect safety and dignity. In the Neonatal Intensive Care Unit (NICU), the

environment did not fully meet relevant health building standards and national guidance on space between beds. We observed cramped conditions and lack of adequate storage space of equipment, which limited space for staff to deliver care safely and posed an evacuation risk. The service had plans to redevelop these areas and senior leaders told us that expansion and refurbishment plans of NICU will commence in mid-2026.

In outpatient areas, we found that safety controls were not always effective. Safety gates designed to restrict access were not consistently locked, which increased the risk of falls. We highlighted this to senior leaders and staff were reminded to ensure the safety gates were locked however, on day 2 of our assessment we observed a safety gate still being unlocked despite the new extra safety signage.

There were additional risks relating to storage and layout. Equipment, including children's bikes, were stored in corridor areas. This created potential trip hazards and could obstruct evacuation routes in an emergency. Staff we spoke to were not sure if a risk assessment had been carried out where children's equipment were been stored. In the Paediatric Short Stay Unit (PSSU), treatment areas were cramped and we identified potential ligature risks. The PSSU still had limited play facilities, toilet and bathroom facilities. The risk identified at the last assessment of children and young people attending PSSU being exposed to violent and aggression situations in the emergency department (ED), was still present at this assessment. Staff told us they were exploring charity funding to refurbish the PSSU and improve its environment.

In the paediatric intensive care unit (PICU), we observed a broken blind which was reported on 3 May 2026 and a faulty door reported on 12 May 2026. Although staff had identified these issues, they had not been resolved promptly. This meant the faulty blind and door were not being actioned in a timely manner.

Overcrowding and layout issues reduced staff's ability to maintain clean and safe environments to minimise infection risk particularly NICU and Princess Elizabeth Ward. In some areas including rehabilitation bays, limited space and overcrowding, which increased risks related to infection prevention and control and reduced privacy and dignity for patients. Although the risk had been recognised in NICU, with an expansion plan in place, the Trust had also recognised the environmental risks on Princess Elizabeth Ward and plans for refurbishment works were underway at the time of the inspection, with completion planned for November 2026.

Despite these concerns, there were examples of good practice. Access to paediatric areas was controlled through video entry systems, which supported the security of children and young people.

The service provided a range of clinical environments, including cubicles and open bay areas, which supported the monitoring of children and young people. The layout of wards enabled staff to observe patients effectively and respond to their needs. Dedicated treatment spaces were available in some areas, which supported the safe delivery of minor procedures.

Staff had enough suitable equipment to safely care for children and young people. Staff carried out daily safety checks of fridge, specialist and emergency equipment, in line with safety requirements. Data showed that staff achieved between 83% and 100% in the emergency equipment audit.

Equipment was visibly clean, appropriately PAT (portable appliance testing) tested, maintained and within servicing dates. There were systems in place to maintain and service critical equipment such as ventilators. This provided assurance that risks associated with equipment failures were recognised and managed.

Overall, while some areas of the environment supported safe care, risks relating to space, maintenance and layout meant the service did not consistently provide a safe environment for children and young people.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not make sure there were enough qualified, skilled and experienced staff. Not all staff were up to date with their mandatory and role specific training modules. However, staff received effective support and supervision.

The service did not consistently maintain one-to-one nursing care for babies and children who required intensive or advanced critical care. Improvements required in staffing had not been fully achieved since the last assessment and continued to impact the safety and sustainability of the service. Staffing levels within the NICU and PICU had remained below recognised British Association of Perinatal Medicine standards (BAPM) and Paediatric Critical Care Society (PCCS) standards. Both PICU and NICU were not meeting the PICCs nor BAPM standards and not complying particularly with the 1:1 care for intensive care.

Although this was a longstanding issue, the service had an action plan in place to address this such as recruitment, use of temporary staff and safer staffing tool. The service was not consistently able to provide1 to 1 care for high-dependency neonatal patients. During the assessment staff told us there were gaps in medical cover overnight. Following the assessment the trust provided evidence the medical rota was covered overnight. However, the gaps in 1 to 1 care meant staff may not have been able to provide the level of continuous observation, monitoring and timely intervention required to meet patients' acuity and dependency needs. This increased the risk that deterioration, equipment alarms, treatment complications or urgent care needs would not be identified and acted on promptly. This did not provide assurance that staffing levels and skill mix were always sufficient to keep babies, children and young people safe from avoidable harm. However, staff told us there have been recruitment of nurses since the last assessment, which have resulted in a slight improvement in staffing**.**

From February to April 2026, the unfilled shifts rate in the service was 23% for nursing staff. Whilst the other staff achieved an overall 8% unfilled shift rate. However, the figure was high in the month of April 2026 and was 25%. Recent data from April 2025 to March 2026, showed that PICU reported 52% unfilled shifts and whilst NICU reported 26% unfilled shifts.

Leaders calculated the number and skill mix of staff required to meet patient needs. However, staffing levels did not always meet planned levels.

On both days of our assessment during the day shift; NICU were short of nurses and staff were redeployed from PICU to maintain safe staffing. However, PICU had low acuity and was not understaffed on day 1 of our assessment. Staff were also redeployed from NICU to the surgical ward during the assessment to ensure safe staffing. On day 2, we observed 2 babies requiring 1:1, did not have dedicated staff during staff break or preparation of medicines. This left their colleagues to look after the babies and also raised concerns that the nurses in charge, may not

always be supernumerary. On the first night of our assessment NICU was short of 4 nurses and could not maintain 1:1 care in intensive care to safely care for babies. Staff told us 1:1 was achieved in NICU around 90% of the time due to staffing. We observed PICU was short of 4 nurses on day 1 during the day shift but achieved safe staffing due to low acuity. However, this would not be achieved if they admitted more patients and had high acuity.

Managers deployed staff and used bank and agency staff to maintain safe staffing levels on shifts. While this supported the delivery of care, the continued reliance on temporary staff affected team continuity and stability.

The service did not always have enough medical staff to keep babies, children and young people safe. From 20 November 2025 to 20 May 2026, the service reported 10 unfilled shifts for registrars and 9.6 unfilled shifts for senior house officer (junior doctors) for medical staff due to sickness and vacancies. Recent data for medical staff between February and April 2026 showed 18% unfilled shift rates for medical staff. Leaders advised they had mitigation in place such as use of consultant, senior doctors and advanced clinical practitioners to fill the gaps for medical staff. However, on day 2 of our assessment we observed the special care baby unit (SCBU) was short of 2 registrars and 1 registrar on postnatal ward. Consultants and other registrars covering other areas in high dependency unit (HDU) and NICU were expected to offer support in SCBU.

Medical staffing arrangements covering the 24-hour service provision did not consistently support safe care. The service relied on consultants and locum medical staff to maintain clinical cover however there were gaps in rota. Consultants in the NICU worked beyond their planned job roles, which impacted on their wellbeing and family work life balance. This had the potential to affect staff wellbeing and clinical oversight. Staff raised concerns about the sustainability of the medical staffing model, and whether it met recognised national safety standards. However, senior leaders advised the trust was proposing a model that would make them in line with national recommendations.

At the time of the assessment the service had 63% Qualification in Speciality (QIS) trained staff in PICU and 49.5% in NICU. However, this did not meet the national requirement of 70% of staff requiring QIS qualifications in SCBU, HDU and Neonatal Intensive Care Unit (NITU). Senior staff told us 4 nurses were currently on the QIS training in PICU and will qualify in August 2026. The QIS training is 12 months, and senior staff told us it will take 2-3 years to meet the QIS target for NICU with their current workforce and course availability.

At the time of our assessment, NICU was not compliant with the BAPM recommendation that all NICU staff appointed after 2010 should have a certificate of completion of training (CCT) in neonatal medicine. Leaders advised that they had 2 consultants who are non-neonatal CCT trained and had been recruited to the non resident rota. Leaders told us they had received some complaints around this which was being addressed as part of a transformation piece. Since the assessment, the trust had completed a programme of work to transform the NICU workforce model. The implementation of the revised model was planned from September 2026. The Trust has undertaking a local review of the 2 consultants who hold a CCT in Paediatrics to review their relevant competencies and experience. Leaders have also confirmed that all future recruitment to relevant NICU consultant posts will be undertaken in accordance with BAPM recommendations.

Workforce data provided by the trust showed an overall vacancy rate of 4.7% during the period reviewed. As of March 2026, the overall vacancy rate was 4.1%, which was below the trust target of 10%. As of March 2026, the medical workforce vacancy rate was 0% and the nursing workforce vacancy rate was 5.5%. This indicated that overall, medical and nursing vacancy rates were below the Trust's target at the time of the assessment. The additional clinical services had a high vacancy rate of 21%. In PICU and other wards in this service, there were vacancies at Band 6 level, with 5 posts unfilled at the time of inspection. In the NICU, staffing levels data showed a shortfall of 28 whole-time equivalent staff. The unit was not meeting the recognised national staffing standards, which increased pressure on staff and affected the viability of safe staffing arrangements. These pressures have led to a high reliance on bank staffing, particularly in nursing, with relatively low agency use, but persistent unfilled shifts remain, most notably in NICU and PICU. This combination of vacancies, turnover, sickness and unfilled shifts presents a safety risk to children and young people. However, since the last assessment the vacancies of nursing staff had reduced by 8%. The service had ongoing recruitment and development initiatives to address the vacancy rates. Leaders had recruited additional staff to strengthen workforce capacity, including 27 whole-time equivalent posts within PICU and other wards in this service. However, due to the shortage of paediatric nurses, senior leaders highlighted that it may take 3 years for the service to comply with the BAPM standards. Staff in the multidisciplinary teams (MDT) told us they did not always feel confident that senior support was available when needed.

The average staff turnover rate for the period 20 November 2025 to 20 May 2026 was 13.4%

however, the service reported a high turnover rate of 22% in March 2026. This was against the trust target of 13%. The high turnover rate for March 2026 mainly related to health care scientist (71%), additional clinical staff (20%) and nursing staff (10.1%). The service had high sickness rates. Data showed that the sickness rates for additional clinical services for the same period was 13% and 10% for estate staff. This was against the trust target of 3.5%. However, the nursing staff had a 4% sickness rate.

Since the last inspection the mandatory training rate had improved however, not all staff were up to date with their mandatory and role specific training modules. At the time of the assessment 85.3% staff had completed their mandatory training against the trust target of 90%. However, staff in children and young people services only met the trust target on 5 out of the 13 training modules. Staff achieved 66% compliance on the resuscitation level 3 paediatric immediate life support (PILS) and European paediatric immediate life support (EPILS), 71% on manual handling and 79.3% on the resuscitation level 2 mandatory trainings.

Staff were expected to complete additional training specific to their role. Data showed the overall compliance for the role specific training was 77.8%. There was low compliance in Oliver McGowan training with 69.7% and blood transfusion training with 76.6%. In the paediatric life support training medical staff achieved 68% compliance, while nursing staff achieved 88% compliance.

Mandatory training compliance had also previously been below target, this issue, alongside ongoing reliance on temporary staffing and workforce pressures, indicated that previous actions to strengthen staffing and competency had not been fully effective.

Managers supported staff to develop through yearly, constructive appraisals of their work to deliver safe care. At the time of the assessment, 90.1% of staff had completed their appraisal. The nurses met the trust appraisal target however, doctors, admin and additional professionals' staff were slightly below the trust target. Following the assessment the trust provided updated compliance for appraisals which had increased to 94.6%.

Leaders had systems in place to manage staffing levels and to measure the severity of a patient's illness across the service. Managers reviewed staffing levels, patient dependency and clinical risks through daily bed management meetings. This supported oversight of staffing pressures and enabled escalation where required. Leaders described reallocating staff and

escalating concerns through operational meetings. However, ongoing vacancies meant that staffing levels were not always sufficient on all shifts to meet patient needs.

Staff told us that bank and agency staff received a local induction and were supported by permanent staff to work safely within the service.

Most staff spoke positively about initiatives to support wellbeing and retention, including a flexible rostering arrangement. These measures supported staff during periods of operational pressure.

Although leaders had systems to manage staffing and had taken action to improve workforce capacity, ongoing vacancies, the reliance on temporary staff and concerns about medical staffing meant the service could not consistently ensure safe and effective staffing.

Infection prevention and control

Score

3. Evidence shows a good standard of care

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

Clinical areas were generally clean and well maintained. Wards had appropriate furnishings to support safe care. Staff completed cleaning tasks regularly. Personal protective equipment (PPE) was available throughout the service, and staff followed infection prevention and control guidance. We observed staff being bare below the elbow and washing their hands and using PPE in line with guidance.

Hand hygiene audit data showed an overall 91% compliance. The infection prevention and control (IPC) and cleaning audit showed an overall 90.1% compliance, indicating generally good standards with some variability in performance across audit periods.

Staff managed sharps safely. *Sharps* (items such as needles or other medical objects that can

cut or pierce the skin) were appropriately handled; containers were secured, not overfilled, and disposed of in line with national guidance.

However, staff told us they tried to maintain equipment and the environment despite the environment constraint to support infection prevention and control.

In neonatal and paediatric areas, staff were aware of the needs to manage risk while supporting family-centred care, which was shown by the awareness of reminding visitors, parents and staff of hand hygiene.

The estate and environment did not always allow for infection risk to be minimised. In the NICU and rehabilitation areas, bed spaces were crowded and storage areas were limited. Equipment and items stored in corridors reduced available space. This affected staff ability to consistently maintain effective infection control practice and increased the risk of cross infection.

Overall, while staff followed infection prevention and control procedures and maintained equipment appropriately, environmental constraints meant the service could not consistently minimise infection risks.

Well-led

Rating Requires improvement

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 requires improvement. The service was in breach of good governance because it did not operate effective systems and processes to maintain clear oversight of the services and mitigate risks to children and young people. The service management and leadership was inconsistent to support the delivery of high-quality, person-centred care.

Although there has been some improvement since the last assessment particularly around the 2025 NHS staff survey and workforce equality, diversity and inclusion, the service was still in breach of regulation 17 (good governance) for concerns around governance.

Services for children & young people

At this assessment the rating has remained requires improvement. This meant the service was not always consistently managed and well-led. However, 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 clear and supportive culture for staff based on transparency, equity, equality and human rights, and engagement. The service had a shared vision and strategy that was based on inclusion and engagement, and staff understood the challenges and the needs of people and their communities. However, some staff were unhappy with proposed changes to the service.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The service's vision was to deliver safe, compassionate and equitable child-centered acute medical care for children in the local area, and expert specialist care for patients from further afield who would benefit from their tertiary services, underpinned by strong clinical expertise, education, and research.

The service's 5-year BOLD strategy, which stood for 'Brilliant people, Outstanding Care, Leaders in Research, Innovation and Education and Diversity, Equality and Inclusion' was nearing its end. At the time of our assessment, leaders had drafted a strategy for 2026 to 2030, following consultation with staff about the care group's vision, priorities and strategic objectives. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, leaders had consulted with senior leaders and discussed the draft strategy at a divisional away day. The strategy included care at the right place and right time, environment, delivering highly specialist service's, support and collaboration for patients.

The service's immediate priorities for 2026/2027 included the expansion of the neonatal intensive care unit (NICU), refurbishing pediatric outpatients, Princess Elizabeth and Lion

wards, and improving how critical care data linked with the electronic patient record (EPR) system. Other priorities included strengthening oversight of children cared for outside child health, extending the primary care in-reach service, developing specialties such as neonatology, and improving performance in key services such as endoscopy and allergy services. The priorities also focused on health equity, using data to reduce inequalities for people in the most deprived areas and those with disabilities, mental health needs and long-term conditions. During our assessment, we found plans were in place to deliver some priorities, including the refurbishment of NICU, paediatric outpatients and some paediatric wards.

The child health goal included delivering consistency, high quality and equitable care, financial sustainability, strengthening collaboration and system partnership. It also focused on population health, workforce, research, innovation and digital excellence.

The service vision and strategy were focused on the sustainability of the service and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. Staff we spoke to knew and understood the provider's vision and values and how they were applied in the work of their team. Staff including senior leaders also knew about the service plans and immediate priorities.

The provider's senior leadership team had successfully communicated the provider's vision, values, priorities and strategy to the frontline staff in this service. Multi-disciplinary staff could explain how they were working to deliver high quality care.

Staff we spoke to generally described an improvement in the culture of the service since the last assessment. Staff were proud to work in the service, passionate about their role and generally felt supported, respected and valued. However, a small number of medical staff raised concerns about a poor culture. Concerns were around proposed changes being initiated by leadership without adequate notice or risk assessment on how it will impact staff's wellbeing, workload or the patients and family experience.

However, senior leaders were aware of the medical staff concerns and had commissioned an independent review around the proposed changes. Senior staff acknowledged some elements of the consultation could have been better. Leaders provided evidence to show ongoing engagement and the work being done to address staff concerns and improve the service's

culture and consultation process. This included undertaking listening events and the launch of the Child Health Inter-Team Working Project on 15 May 2026, which will include feedback from staff and staff survey results. The new project aims to enhance staff engagement, improve shared understanding of the teams' experience, promote psychological safety, identify strong practice and translate it into action. The service also had plans to launch the Child Health Excellence Award on 16 June 2026 to celebrate staff and improve outcomes, compassionate care and culture.

The 2025 NHS Staff Survey showed mixed results. The service scored worse than the trust average for work pressure, flexible working and staff thinking about leaving. However, they performed better than the trust average for staff engagement, learning and retention. Results had improved for staff recommending the organisation as a place to work and as a place for friends or relatives to receive care. Overall, the service showed improvement in the 2025 result compared to the 2024 survey on all questions. Leaders had developed an action plan and taken steps to improve culture, including team building, inclusive events, psychologist-led debriefs and a compassionate team programme. Further actions were planned, including leadership engagement events and a culture deep dive. This showed leaders had identified areas for improvement in the service's culture however, there was still some work to do.

The trust and service celebrated staff success and contribution through various ways, such as shout-outs in the staff newsletter and the quarterly and annual Kings Stars Award.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

Leaders had the skills, knowledge, experience and credibility to lead effectively and understood the context in which they delivered care, treatment and support. However, leaders need to take further actions to strengthen senior leader's visibility and accessibility.

The service's leadership team consisted of a clinical director, a general manager and a head of

nursing. They were supported by a deputy clinical director, a governance lead, deputy general managers, senior service managers, 7 matrons, governance managers, lead nurses, lead therapists and a lead pharmacist. There was clear line of reporting from the service leadership team to the trust board. The senior leadership team for the service reported good support and access to the trust board.

Leaders were generally described as accessible and visible in the service and approachable for patients and staff. However, some frontline staff told us some of the trust and service leaders were not always visible, approachable, and accessible. Multi-disciplinary staff described feeling supported by their immediate managers and service managers. Most staff felt confident in the service leadership. However, a small number of staff were not assured the leadership team would take fair action to address their concerns. In the 2025 NHS staff survey, the service performed below the trust average on compassionate leadership and line management. This was not an improvement from the last inspection.

Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good understanding of the priorities, challenges and services they managed. They could explain clearly how the teams were working to provide high quality care. They were aware of the risks within the service and were able to describe the mitigations and action plans in place to address this. This was an improvement since the last assessment.

Leaders were aware of the culture of the service and how it could impact staff and quality of patient care and were working to address this.

We saw evidence of succession planning and development pathways for multidisciplinary staff of all levels. Leadership development opportunities were available, including opportunities for staff such as the band 6 and 7 leadership programme.

Freedom to speak up

Score

3. Evidence shows a good standard of care

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

The 2025 NHS staff survey showed the service performed better than the trust target and 2024 results on staff feeling they could raise concerns and feeling they have a voice that counts. Leaders had developed an action plan to further improve this, this included scheduling a Freedom to Speak Up walkarounds for staff and a listening session in June 2026.

The hospital had a freedom to speak up guardian, and the service had recently appointed a 'Raising concerns ambassador' for the service. The trust had an appropriate and up to date Freedom to Speak Up Policy (which incorporates Whistleblowing) and a Grievance Policy. Between June 2025 and May 2026, 7 concerns were raised to the guardian. This mainly related to changes in staffing, consultant rota arrangements, changes to tongue tie clinic provision and concerns regarding the input of results into systems by non-clinical staff. The key themes also included colleague and workplace relationship issues and the length of competency management processes. Senior leaders advised that these concerns reflected both operational and workforce-related changes during this period.

Patients, parents and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Parents and young people we spoke to knew how to complain or raise concerns. Managers investigated complaints, identified themes and shared feedback with staff. Staff knew how to acknowledge complaints and patients and their families received feedback from managers after the investigation into their complaint. Managers and staff had access to the feedback from patients, parents, carers and staff and used it to make improvements.

Patients, parents and carers were involved in decision-making about changes to the service. They could meet with members of the provider's senior leadership team and King's Young Ambassadors to give feedback. The King's Young Ambassadors programme, and the ambassadors first visit to the paediatric areas took place 19 September 2025. The King's Young Ambassadors is a trust community and education initiative where a group of patient ambassadors aged 9 – 11 years old from a local primary school regularly visit the hospital to take part in health-related education and wellbeing sessions.

The service received 58 complaints between April 2025 and March 2026 which mostly related to

communication, appointments, staff attitude, discharge processes and delays in admission and result. From January to March 2026, the service received 78 contacts from the patient advice and liaison service (PALS), which related to enquiries, concerns and making formal complaints. The top themes were around delays and waiting times, appointments, prescribing and record management.

Majority of the staff we spoke to felt comfortable or confident to speak up. However, not all doctors felt comfortable or confident speaking up or that their concerns would be addressed. A small number of doctors reported pressure from some senior members of staff, to take their names off an ongoing grievance process. Senior leaders told us a number of individuals subsequently withdrew their names from the grievance following independent advice.

Workforce equality, diversity and inclusion

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. Although the service valued diversity in their workforce however they did not always work towards an inclusive and fair culture by improving equality and equity for people who work for them.

The service provided us with trust-wide data on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for the period 31 March 2024 to 31 March 2025. The data available at the time of the inspection was representative of the trust as a whole and was not specific to the service.

Following the assessment the trust was able to provide a more detailed breakdown of the workforce equality information specific to Children and Young People services. This information demonstrated a reduction in bullying and harassment across both WRES and WDES measures, a reduction in reported experiences of discrimination among ethnic minority staff, improved experiences for disabled staff, and comparable perceptions of career progression opportunities between white and ethnic minority staff.

Leaders recognised there was still disparities for ethnic minority and disabled staff. However, believed the direction of travel was positive and reflected sustained leadership focus on inclusive culture and psychological safety. Remaining inequalities continued to be addressed through targeted improvement work.

The provider undertakes equality monitoring of staff within the service to ensure it is diverse in its make-up and representative of the patient group.

Leaders considered equality, diversity and inclusion in workforce planning and recruitment. They worked to ensure staff and leaders were representative of the population of people using the service. The 2025 NHS staff survey showed that the service performed better than the trust average and the 2024 scores on inclusion, diversity and equality questions.

Leaders ensured there were effective and proactive ways to engage with and involve staff with protected equality characteristics. The trust supported various staff equality networks and staff we spoke to were aware of the available staff networks. This included:

- Women's network
- Inter Faith and Belief Network
- Race Ethnicity and Cultural Heritage (REACH) Network
- King's Able – staff disability network
- King's and Queers – LGBTQ+ Network

There were also equality and diversity champions within the hospital e.g. LGBTQ+.

Staff received training on equality, diversity and inclusion as part of their mandatory training.

Staff were able to apply to work flexibly e.g. flexible working agreements to account for personal circumstances such as caring responsibilities and health issues. Managers put reasonable adjustments in place for staff members to help them carry out their role.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. Although, the service had clear responsibilities, roles, systems of accountability and good governance, they were still on an improvement journey. Effective governance processes were not fully embedded and leaders were still working on the action plans from the previous assessment.

Although there has been some improvement in governance since the last assessment improvements had not been fully embedded. Leaders were working on the CQC action plan from the last assessment and did not always operate effective governance processes, throughout the service. We found repeated breaches from the last assessment including staffing, incidents, risk assessments and patient records. We found new breach in relation to mandatory training.

At the time of the assessment, the neonatal governance post was vacant but had been recruited to and the appointed staff was due to resume post in July 2026.

Multidisciplinary staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The service held regular service and cross-site governance meetings, which fed into the children and young people oversite group (CYPOG) and trust board report. This included the cross-site child health quality governance and committee and the child health infection prevention and control meetings. Other governance meetings also included audit and safeguarding meetings, the Patient Safety Incident Response Framework (PSIRF) panels and the safety, harm, incidents and learning discussion (SHILD).

The service also attended various external governance meetings within the integrated care system, partner NHS trusts, local authorities, regional paediatric networks and shared performance with the integrated care board.

The service held regular child death cross site reviews and multidisciplinary perinatal mortality

review tool (PMRT) meetings and used the meetings and tools to review care and deaths that occurred within the service to drive improvement.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as risks, performance, guidelines, feedback, learning from incidents and complaints, was shared and discussed. The internal and external governance meetings were well attended by leaders and multidisciplinary staff.

The trust board minutes reviewed showed that children and young people's health items were part of the governance meeting papers and included topics such as performance on national audits, staffing, research, innovation and priorities.

Staff had implemented recommendations from reviews of deaths, incidents and complaints. This included the update of the vancomycin antibiotics guideline and using the correct cancer alert for suspected malignancy and escalation to the relevant paediatric team. The service has a dedicated service incident newsletter that updates staff on themes from reported incidents. This newsletter also had a dedicated study section of recent incidents and highlights the areas of learning and improvement such as a need for timely feedback of clinical result.

Staff now undertook or participated in local clinical audits. This was an ongoing area of improvement from the last assessment as there are still areas of low compliance and recommendations have not been fully actioned. The audits enabled the leaders to monitor performance, identify areas of improvement and act on the results when needed.

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

The service collated and submitted data to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) as required. The trust board papers showed that the service neonatal death rates were lower (better) than comparator trusts in the 2024 MBRRACE-UK perinatal mortality report and they ranked the third lowest nationally and lowest in London.

Hospital data showed that the service had a positive outlier status in the National Clinical Audit for Epilepsies in children and young people under the audit measure for epilepsy specialist nurse. However, the service was an outlier in the 2025 National Paediatric Diabetes Audit. The

recent trust data for 2025-26 audit year showed improvement in performance and the trust were not anticipating being an outlier in the next audit result.

The trust board papers showed that outcomes for children who had a liver transplant were mixed. One-year survival for paediatric liver transplant patients was better than expected.

This means more children were alive one year after their transplant than would usually be expected when compared with national data. However, the National Hospital-Level Mortality Outcomes audit showed that 5-year term adjusted survival was lower (worse) than expected. This meant that, after taking account of factors such as how seriously ill children were and the complexity of their conditions, fewer children were alive 5 years after their transplant than expected.

The service risk registers included 18 open risks related to the service at the time of the assessment. This included a pseudomonas aeruginosa contamination of the water system in the neonatal intensive care units. The risk register also included risks on mandatory training and violence and aggression on the Paediatric Short Stay Unit. The register included the risk title, description, date opened, risk cause and rating, next review date and controls. The risk register was maintained through an electronic system, which recorded the date on which individual risks were last reviewed. We noted the risk register was also reviewed at various governance meetings. Although the risk included majority of the risks we identified during the assessment, which provided assurance that leaders and staff were aware of the risks and had mitigations in place. Majority of the staff we spoke to could not tell us what the top risks in the service and their ward areas were. Senior staff told is the top risks were staffing, space constraint and infection prevention and control. Not all staff concerns and risks we identified matched those on the risk register. This included high use of locums in NICU. However, following the assessment the trust provided evidence that this was a known risk to the service and had been regularly discussed and monitored through divisional governance arrangements since February 2026. The trust has now added the risk to the formal risk register.

We observed patient identifiable information displayed openly on the ward boards including children’s names within some clinical areas. This did not consistently support the confidentiality and privacy of children and young people. Staff told us the ward boards could be adapted to meet the needs of individual clinical areas. This included the option to use pseudonyms instead of children’s names and to arrange the information displayed on the

boards according to each ward's preference. However, this was not used consistently across the areas we visited.

The service had plans to cope with emergencies and unexpected events and had a business continuity plan, which included major incident plans such as fire and power failure.

Regulation 17: Good governance

Service

Services for children & young people

Regulated activities

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

How the regulation was not being met

- The service did not always ensure incidents were investigated and action plans were completed in a timely manner in line with trust guidance.
- The service did not always ensure patient confidentiality was not always maintained.
- The service did not always ensure governance process were effective and fully embedded.

Regulation 12: Safe care and treatment

Service

Services for children & young people

Regulated activities

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

How the regulation was not being met

- The service did not always ensure records and risk assessments were completed in line with trust guidance.

Regulation 18: Staffing

Service

Services for children & young people

Regulated activities

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

How the regulation was not being met

- The service did not always ensure staff were up to date with their mandatory and role specific training modules.
- The service did not always ensure there were enough multidisciplinary staff on shifts to make children and young people safe. The service did not ensure staff provided 1:1 care for all ICU neonatal babies and paediatric children.

Regulation 15: Premises and equipment

Service

Services for children & young people

Regulated activities

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

How the regulation was not being met

- Ensure all premises and equipment used by the service provider is fit for use.

Regulation 12: Safe care and treatment

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Patient wristbands were not consistently applied. However, we note significant improvement between visits in May and June 2026.
- Corridor care was not always delivered safely and was used when this was not appropriate due to patients' background or presentation. However, we note significant improvement between visits in May and June 2026.
- Chemicals and products that posed a risk to patient safety were not always stored securely.
- Infection prevention and control standards were not always maintained in relation to cleaning and staff hygiene practices. However, we note significant improvement between visits in May and June 2026.

- Patients who had been referred to specialist teams were not receiving venous thromboembolism (VTE) risk assessments and prophylaxis in a timely manner.
- Patients did not always receive their medicines as prescribed due to medicines not being available to ED staff in a timely manner.
- Patient Group Directions (PGDs) were not accessible, and the service did not keep up-to-date records of staff authorised to use them.

Regulation 15: Premises and equipment

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Equipment for delivering care was not always safe to use.

Regulation 18: Staffing

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- There was no dedicated pharmacy service for the ED (pharmacists were instead shared with other care groups).
- Mandatory training provided to staff was not always completed.
- The paediatric ED did not employ or have regular access to a play specialist.