NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Our learning from the COVID-19 pandemic

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1 Background

Throughout the COVID-19 pandemic our staff have endeavoured to provide compassionate and thoughtful care in the most challenging of circumstances.

The scale of the challenge facing the NHS during the pandemic has been unprecedented. The leadership and management of the impact of COVID-19 on health and social care systems required people to work at pace in response to a rapidly changing environment. The impact was felt by patients who used our services, their families and staff. The NHS, including The Queen Elizabeth Hospital (QEH), rapidly redeployed staff, changed estate configurations, reduced non-COVID-19 face-to-face appointments and redesigned patient pathways. Despite all of this, at times during the pandemic, the NHS and QEH also saw unprecedented levels of admissions and cared for some of the 'sickest' people we have ever seen.

The Trust extends its condolences to those who lost loved ones and those who contracted COVID-19 while in our care during the COVID-19 pandemic. We recognise that it has been a very difficult time for relatives and friends of those who died, many of whom were sadly denied the opportunity to visit their loved ones due to the tightened visiting restrictions in place to maximise safety, and some never got to say their final goodbyes when those closest to them were approaching their end of life. This report summarises how our understanding of the virus has deepened over the last 18-months and details how our learning from the pandemic will enable the Trust to further improve the experience of our future patients and their families.

2 Summary of cases

Between 1 March 2020 and 28 February 2021, 1,761 patients tested positive for COVID-19 at our hospital. 389 of these patients regrettably either definitely or probably contracted the virus while in our care, and sadly 151 of these patients died at QEH. The remaining patients were discharged from our care.

3 Duty of Candour exercise

The Trust takes openness and transparency with patients and their families very seriously.

A part of our commitment to candour, QEH's Quality Committee and Board of Directors took the decision to contact every patient who contracted COVID-19 in our care, or the next-of-kin for those patients who sadly died, to ensure that they were aware that their loved one is believed to have caught COVID-19 in hospital and to ensure that they know we are very sorry for this. This Duty of Candour exercise - which has been nationally-recognised by NHS England and Improvement and the Secretary of State for Health and Social Care - was also our opportunity to explain to our patients and their families the actions we are taking and our learning from the pandemic.

We committed to sharing the results of this exercise with our patients, commissioners, and staff and with the public via our website upon completion and this report is the product of this work.

A clinical team led the Duty of Candour exercise. Each case was reviewed, and then personal contact was made with all patients who had probably or definitely acquired the virus in our care. For those who had died, the next-of-kin was contacted in the same way.

A dedicated team initially undertook a thorough data checking process with input from our Infection Prevention Control and Information Teams. We sent recorded delivery letters to all of these patients or their next-of-kin, explaining that we thought that they had definitely or probably acquired COVID-19 in our care, and said sorry for this. We then made a follow-up phone call within 48-hours of receipt of the letter. A dedicated phone line for direct communication was also put in place, to maximise support.

We made several options available to meet the individual needs of patients and their families, including bereavement support, clinical psychology referral, or offers to meet the clinical team to help understand what had happened in their case (Local Resolution Meetings). During the telephone contacts, these interventions or other offers of support were made by the clinical staff, based on the feedback received.

4 COVID-19 learning for our clinical teams

There has been much learning since the first wave of the pandemic. This learning has been continuous, and has informed how we provide our care, and in particular it has shaped our response to the second wave of the pandemic.

Personal Protective Equipment (PPE):

In the early stages of wave one, PPE usage was implemented according to the national guidance. However, as COVID-19 became more common across the UK, guidance on PPE usage changed. While PPE was often in low supply, it never ran out at QEH. However, it did lead to anxiety for many staff members and patients. Additional training and support was required to ensure that all staff understood what PPE they needed and how best to use it. A change in mindset was also noticed from an emphasis on protecting self to protecting others, and the impact on others.

Other Infection Prevention and Control measures:

National guidance on Infection Prevention and Control measures changed during the pandemic as we understood more and more about the virus. Recommendations on testing also changed, and gradually it became easier and quicker to test patients and staff for COVID-19. This is particularly important for some newer variants of COVID-19, some of which are more infectious but can be carried by some people without symptoms. Ideally, we wanted to keep any patient with confirmed or suspected COVID-19 physically separate from other patients to minimise the chance of spread. Unfortunately, QEH has a very limited number of side rooms and therefore regrettably some patients experienced numerous moves to try to minimise this exposure. However, we learnt that this led to a very poor patient experience, and so we gradually changed how we cohort patients. During the pandemic, we evolved how we used these side rooms to best effect. We also undertook building work to physically separate some bays or areas. This included introducing one-way systems, social distancing, introducing multiple screens, increasing the spacing between beds. We also closely followed national guidance on isolating contacts of patients with a positive swab. We brought in regular staff swabbing when lateral flow tests became widely available, and continue to undertake repeated swabs on the day of admission as well as on day three and day six for all patients admitted to our care, whether they have symptoms of COVID-19 or not.

Staff training:

As we learnt more about the virus, we were able to evolve the clinical care provided to patients. Additional training was given to staff to support this new need, for example providing extra training in the use of different forms of oxygen and ventilation, or to

prescribe and administer new drugs as they were identified as effective against this new virus. Many of our staff also worked in circumstances or clinical areas that they had not previously worked in, and so received training for those areas. For example, staff who usually worked in operating theatres were redeployed to the expanded Emergency Department.

Communication:

Patients were cared for by staff who were behind masks and gowns, which made communication much more difficult than usual. That said, skilled, compassionate care remained central to how individuals and teams cared for patients, with many staff members sharing with us how they felt they had not only taken on the role of a clinician, but rather a mum, a dad, a brother, or a sister when family members were not able to be physically present in the hospital – and this emotional burden and responsibility has taken its toll.

However, restrictions to visitors on site also led to significant challenges, with the loss of vital support and understanding that visitors provide to ward staff, leading to patients needing additional support from staff, and multiple queries and concerns from worried relatives and friends unable to visit their loved ones. This led to the provision of virtual visiting, with electronic mobile devices provided to the wards to enable virtual visiting either by phone or video link, outbound calls from the wards to keep family members updated and later the development of the Family Liaison Officer (FLO) role to further enhance communication with families as visiting remains restricted. The introduction of FLOs was in direct response to patient and family feedback about poor communication.

Staff Support:

Significant additional support was also required to support staff who were experiencing extremely high levels of anxiety, additional workload and work that they were not previously used to undertaking. This took the form of staff briefings, clinical psychology support, the training of mental health first aiders, additional rest areas and additional food and drink and accommodation for some staff members working very long hours or who were unable to continue living with vulnerable family members.

5 Learning from the Duty of Candour exercise

During our conversations with patients, their families and loved ones a number of key (and recurring) themes were identified. The majority (over 50%) of patients and their families the Trust made contact with as part of the Duty of Candour exercise reported that they had no concerns or issues and were thankful and appreciative of the care that they received.

Some comments received were:

"Very happy with care – very kind"

"Happy with all care"

"Very grateful for the care received. Wishes to thank everyone involved in caring for him"

"Appreciate the care given to me"

"Understand the pressure you were all under and so appreciative of the care received"

"I was very well treated"

" I cannot thank the nurses enough for the great care received"

"Care received was exemplary and the staff were angels"

"You all did a fantastic job"

"Nothing but praise for QEH's response to COVID-19. Staff went above and beyond to give excellent care. Staff were kind, compassionate, caring and patient"

However, there were some key themes from which the Trust must learn moving forward which impacted adversely on patient and family experience – notably:

- Poor care
- Communication
- Infection Prevention and Control concerns
- Multiple moves
- Lost property

Individuals spoke of not being able to see their loved one and all too often finding it difficult to get through to the ward to know what was going on.

Some spoke very negatively of the number of moves they had while in our care, often moving from ward to ward and on occasions there were multiple moves for an individual patient, which was of concern and is unacceptable practice. This links to the Infection Prevention and Control issues identified above, and the requirement for more side rooms. Currently, only 10% of our patients are able to be cared for in side rooms and restraints with the hospital's physical environment posed a very significant challenge to the delivery of optimum care. As a result, unfortunately, there were many moves for some individual patients as the organisation coped with the changing numbers and acuity of patients. Individuals told us:

"Unhappy with the multiple moves"

"Feel very let down with the hospital and with the multiple moves – people don't seem to care"

"Patients were moved too many times"

"Mum was moved too many times"

While the Trust took measures in March 2021 in real-time to respond to patient and family feedback about poor communication through the introduction of a new team of FLOs, for many we recognise this service came too late. That said, this service has been well-received and supports our ward staff to ensure patients have contact with their family and loved ones through FaceTime®, Zoom, or a phone call. The team support a wide-range of non-clinical tasks and are contributing positively to the culture and responsiveness to patients and families we wish to create at QEH. This innovative new role has attracted interest from across the NHS as other Trusts seek to replicate the arrangements now in place at QEH, which are leading to an improved patient and relative experience.

6 Recommendations

We do not underestimate the extent of the work that still lies ahead for our team and the ongoing challenges for our community. We are also continuing to provide care for patients with COVID-19, and are aware of the very real possibility of further COVID-19 outbreaks and additional waves of the pandemic, which would of course increase further the challenge we are facing as we continue to roll-out the vaccination programme and address the considerable backlogs that have regrettably built up for

our elective patients over the last 18-months and which we are now prioritising.

However, there are clear recommendations and learnings from our Duty of Candour exercise - notably:

1. Communication must be further strengthened between patients, their loved ones and those delivering care
2. The management of Infection Prevention and Control needs to be everybody's business – with PPE, distancing, and other safety requirements still necessary to prevent the spread of the virus
3. The Trust has more work to do to ensure patients receive care on the ward that best meets their individual needs first time more often – preventing multiple and unnecessary ward moves which too often results in a poor patient experience and leads to a breakdown in communication between the hospital, patients and their families
4. Tablets and smartphones were invested in and facilitated virtual visiting for patients in our care and continued use of these has presented opportunities for families some distance away to talk with their loved ones

Receiving safe and good care should be a fundamental part of anyone's stay or visit at QEH. In addition to the changes the Trust has already made, including some of those described above, QEH is working in partnership with Healthwatch Norfolk to create a Patient Experience Strategy which it will develop with the local community in the months to come so that this learning can be incorporated into our work plan and influence how we do things for the better as part of our continuous improvement journey.

The environment also needs careful consideration to ensure access to side rooms is a priority in any future ward reconfiguration work, as we continue to invest in the much-needed modernisation of our hospital.

7 Conclusion

While all organisations have the capacity to adapt, learn quickly and demonstrate agility in dealing with complexity, they can be equally good at forgetting good practice. As we look back over the last 18-months, while there are occasions we have fallen short or not been able to deliver the care we would have wished for all of our patients and their families, there is lots of good practice that should not be forgotten.

One of the biggest lessons we've learned from COVID-19 is that when the community is working together and indeed when 'Team QEH' pulls together, we are capable of doing amazing things.

Throughout the pandemic, we have digitised our hospital at pace and embraced the use of technology. Service delivery has changed rapidly, staff have worked differently and more flexibly, and have gone above and beyond to care for our patients and to maximise safety. Decision-making has been speeded up and doing what is right for our patients, their families and staff has always guided our decision-making, even in the most difficult of circumstances.

However, the human element of this has been expressed through words such as loneliness, isolation, solitude, fear, courage, commitment, and comradery, and we recognise that throughout everything, nothing can replace the gentle touch of a human, or the kind words offered to an individual in their time of need. Our learning from COVID-19 is even richer having completed the Duty of Candour exercise over a

four-month period between April and July 2021. This learning will stay with us for our lifetimes, and at QEH we are absolutely determined to reflect and learn, and to make and embed the necessary changes in memory of all those who have had their lives changed forever. Our patients, their families and our staff deserve nothing less.

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