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

QUALITY ACCOUNT

2021/22

EXCELLENCE STARTS HERE

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NHS

WELCOME

Welcome to the 2021/22 Quality Account for The Queen Elizabeth Hospital (QEH) King's Lynn NHS Foundation Trust.

This Quality Account is prepared in line with the NHS Foundation Trust Annual Reporting Manual 2021/22 to share with our patients, our local community, our partners, staff and wider external stakeholders.

This year, the Trust has continued to make strong progress and can evidence significant improvements in many areas. This report is intended to be read alongside the Trust's 2021/22 Annual Report and Accounts and/or as a standalone document. It summarises how QEH has:

- Received improved ratings from the Care Quality Commission (CQC) following an unannounced inspection in December 2021 and Well-Led inspection in January 2022.
- Become one of the first Trusts in the country to be lifted out of segment four of the System Oversight Framework (previously known as 'special measures'), meaning we no longer require 'mandated intensive support' from our regulator.
- Relentlessly focused on four main priorities, along with the wider system, in response to the challenges QEH and the wider NHS have faced:
  - Addressing the waiting lists that have built up for elective care
  - The ongoing COVID-19 vaccination programme
  - Providing timely urgent and emergency care, and
  - Staff health and wellbeing

These priorities followed extensive engagement with our patients, Governors, partners and staff.

Quality

Over the last year we have continued to provide safe and compassionate care to our patients as we have responded to the COVID-19 pandemic and have faced sustained pressures on our urgent and emergency care services.

The CQC inspected three core services during their unannounced visit in December 2021 - Medicine, Urgent and Emergency Care (including the Emergency Department) and Critical Care. All three services were rated 'Good' overall.

The CQC returned in January 2022 to complete a Well-Led inspection, which resulted in a 'Good' rating. QEH is now CQC 'Good' in three domains - Caring, Well-Led and Effective.

The CQC also recognised the work of our Critical Care team who were rated 'Outstanding' for being Well-Led. Their outstanding practice was recognised in a number of areas, including patient safety, workforce developments and research and innovation projects.

In its report, the CQC noted how 'staff took time to interact with patients and those close to them in a respectful and considerate way' and that 'patients said staff treated them well and with kindness.'

Inspections are also an opportunity to learn, as the findings inform the next chapter of our improvement journey. There are four 'must dos' and nine 'should dos' in our 2022 report (compared to 206 'must' and 'should dos' and condition and warning notices after our 2019 inspection).

The Trust's Integrated Quality Improvement Plan (IQIP) is how we drive the improvements required and it has two main areas of focus:

- Ensuring we provide safe, effective care for our patients and a positive working environment for our staff; and
- Ensuring it is delivered in accordance with all regulatory requirements

We have sustained a clear focus on our continuous improvement journey and delivery of our Integrated Quality Improvement Plan, against which we can evidence further considerable progress for our patients, their families and staff. We have a much-strengthened Quality Improvement training programme for staff, and we have dedicated improvement programmes (including culture work) in place in maternity, radiology, ophthalmology, urgent and emergency care and elective recovery.

The delivery of the Trust's maternity improvement programme is underpinned by the recommendations for action from the interim Ockenden report. This was published in December 2020 following the review of maternity services at Shrewsbury and Telford Hospital NHS Trust (Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust). When the interim report was published, an immediate gap analysis of our maternity services was undertaken. We benchmarked the 12 urgent clinical priorities that were identified from the immediate and essential actions (IEAs), along with wider emergent findings to identify all areas of improvement that were required at the QEH.

This had to be undertaken at pace, as an immediate response was requested by NHS England and NHS Improvement (NHSE/I) from all Trusts providing maternity services within 10 days of the publication of the report. QEH submitted the initial response and completed the required assessment and assurance template by 15 February 2021.

One of the actions from the NHSE/I East of England Team was for Trust Boards to receive outcomes of learning from maternity serious incidents. Therefore, within QEH, it was agreed that a quarterly Maternity Serious Incident Report would be presented at Board level to ensure compliance with the recommended perinatal surveillance model and quarter three (Q3) recommendation as set out in the Ockenden Report, which is now embedded in business as usual.

To ensure Trust-wide oversight of the evidence gathered against action plans to demonstrate compliance and the work which is underway, the Women and Children's Division present completed action evidence at the Trust-wide Evidence Assurance Group (EAG) for agreement and sign-off. This approach was used as an exemplar across the East of England, and we have supported other Trusts within the system to adopt a similar local assurance framework.

The final Ockenden report was published in March 2022, which includes a review of 1,486 cases, with a further 15 themes identified for immediate and essential action (although some of them significantly overlap the actions from the interim report). NHSE/I has been clear it will not be adopting the same approach applied to the initial seven immediate and essential actions when the interim report was published in December 2020. Instead, a decision has been made to adopt a measured approach until the

publication of the Kirkup review into East Kent Hospitals University NHS Foundation Trust Maternity Services as similar findings to that of the Ockenden review are anticipated. NHSE/I is also aware of the huge pressure on maternity units currently, as assurance visits are being undertaken to ascertain whether learning from the interim Ockenden Report has been embedded. However, whilst we await further guidance from NHSE/I, we have reviewed the 15 themes and identified our priorities for focused work, which is already underway.

During 2021/22, QEH had one case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, compared to none the previous year. The Trust also recorded 29 cases of hospital-acquired Clostridium difficile (CD), compared to 21 the year before. Even with the revised ceiling set for CD (< 40) compared to the previous financial year (< 44), which may have accounted for the rise in the cases of hospital-acquired CD, in addition to the challenges COVID-19 continues to place on the Trust, we remain resolute in our commitment to continuing to do all we can to reduce hospital-acquired infections.

We were one of the first hospitals in the country to complete a Duty of Candour exercise for patients who contracted COVID-19 in our care. It involved contacting all patients or their next of kin to apologise for this and answer any questions. Following this four-to-five-month exercise, we published a 'Learning from COVID' report, demonstrating our commitment to openness and transparency.

We have made significant improvements to the timeliness of responding to complaints and learning from complaints. However, we have more to do, including improving the quality of complaint responses and ensuring local resolution of complaints wherever possible.

We introduced a team of Family Liaison Officers (FLOs) in response to feedback from patients and their families about how we could improve communication during the period of restricted visiting as part of our commitment to reducing the spread of COVID-19. Due to its success, this model has now been rolled-out across Norfolk and Waveney and the positive impact of FLOs was referenced in our CQC report, which was published early 2022.

Our digital maturity has significantly improved over the last year with almost £6m invested in Electronic Prescribing, Single Sign On and a new Radiology Information System, all of which are major steps in the digitisation of our hospital. In addition, the Board has approved £4m capital investment in an electronic observations system to bring improvements in patient care. Implementation of a system-wide Electronic Patient Record is being boosted with support from NHSE/I's Transformation Team, who will provide funding and support for the next stage of the Trust's digitalisation journey.

Modernising our estate and digital infrastructure continues to be a priority, and much progress has been made this year. It was a pleasure to welcome The Rt Hon. Matt Hancock, Secretary of State for Health and Social Care at the time, to QEH in June 2021, and he played a part in making a case for our new hospital. In September 2021 we submitted two expressions of interests (EOIs) to the Department of Health and Social Care to become one of the further eight new hospital schemes - one for a single-phase new build and one for a multi-phase build, part new build and part refurbishment. We submitted two EOIs to give us the very best chance of securing the funding we so badly need.

As one of the 'best buy' RAAC (Reinforced Autoclaved Aerated Concrete) hospitals, our hospital's structural framework is at the end of life. Our deadline for eradicating RAAC, based on national expert opinion, is 2030. The only sustainable long-term solution is a new

hospital. There is some evidence to suggest that the poor condition of our current building, and prominence of props, adversely impacts on the experience of patients and staff and the operational running of our hospital.

Therefore, we continue to focus on completing our Strategic Outline Case for a new hospital and its development remains on track for June 2022. In March 2022, the Board approved our Estates Strategy, which sets out an overall site 'masterplan' and ambition for the site. Any investments and decisions we make now are both cognisant and consistent with our preferred new hospital schemes and linked to our long-term vision for the site; so that in the long term, these investments will not be money wasted.

There is a lot of work in progress as we continue to modernise our existing hospital. In 2021/22, QEH attracted more than £38m of capital funding from RAAC, digital investment and other capital monies. This will be spent modernising our hospital through a series of service improvements and installing steel and timber support props where needed, to maximise safety and reduce the risk of plank failures in the roof of the buildings.

This is more capital than we have received in a single year. We have one of the highest capital to turnover ratios in the country, demonstrating both the urgent need for capital investment in our hospital and the confidence in our ability to deliver on the funding timescales required.

We also launched our new five-year clinical strategy, which focuses on six clinical priorities to ensure that we deliver high-quality services and the best possible patient experience that our population needs and deserves. The strategy underpins the vital work taking place to support our ambition to become the best rural District General Hospital for patient and staff experience.

Engagement

Three years ago, we introduced our Staff Engagement Programme to demonstrate our absolute commitment to listening, valuing, and acting on staff feedback. It is key to our vision to be the best rural District General Hospital for patient and staff experience and recognises how challenging the period has continued to be for staff.

We continue to listen to staff and in 2021/22, we chose to invest in all the significant areas raised by staff - extending free staff car parking, providing a Midnight Café, offering half-price gym memberships, and offering annual leave carry over and pay, as well as improving rest areas and refurbishing changing rooms.

One third of our staff attended Values into Action workshops as part of our work to bring our values to life across QEH - with a continued focus on creating a culture where kindness, wellness and fairness are at the heart of all we do. We threaded our values through our appraisal, induction and recruitment processes over the last year and commenced a Leading with Values programme.

The Trust has held two Leadership Summits this financial year, attracting a range of nationally recognised speakers from within and external to the NHS. They were a huge success with hundreds of staff, Governors and system partners attending.

However, despite all this work and focus, our 2021 National Staff Survey results were disappointing. Nationally, there has been a decline in many key areas, which is not surprising given the operating environment and extended impact of the pandemic. However, we must listen to our staff and act, and it is clear we need to take a different approach and look at depth as well as breadth in the year ahead if we are to make the improvements and impact we are striving for.

It is clear from feedback in our recent CQC inspection report and from the staff survey results that we need to invest more in supporting our local leadership teams at the QEH. In response, we are launching a new leadership programme as well as taking a bottom-up approach in developing action plans for each of our divisions and corporate areas based on local results, as well as launching a series of listening events, led by local leaders. As we make our case for a new hospital, we are also mindful of staff feedback about the impact our poor physical estate has on them, their morale and wellbeing.

This year our staff networks - which include LGBTQ+ and Allies, BAME and allies, Armed Forces Network and the Supporting International Nurses Group - have gone from strength to strength ensuring our staff have a voice. In addition, we received the Bronze Rainbow Badge Award for our support in creating a safe and inclusive workspace for LGBTQ+ patients and colleagues.

We have appointed a new Equality, Diversity and Inclusion Lead, which is evidence of our commitment to accelerate our work to create a culture with inclusion and fairness at its centre. We are currently the only Trust in the region with a full-time post.

We have further strengthened the Freedom to Speak Up support we offer and have invested to increase resilience, knowing we have much more to do in this area to truly create a speak up culture where staff feel comfortable speaking up without experiencing detriment. Therefore, our support for Speak Up within the Trust has increased from 30 hours to 120 hours per month and we now have three Guardians in place; one Lead Guardian (staff), one Assistant Guardian (staff) and an Independent Guardian who are supported by a community of 22 Freedom to Speak Up Champions consisting of staff, volunteers and Governors. As detailed later in this report, we continue to see fewer direct to CQC referrals, and the CQC spoke positively about the Speak Up culture we are creating at QEH, whilst recognising we have more work to do with local managers in supporting this hugely important agenda.

We are a very active partner in Norfolk and Waveney and Lincolnshire and Cambridgeshire, and contribute significantly to further improvements to both health and care and wider developments that matter to the local communities we serve. This includes the King's Lynn Town Deal Board, which focusses on improving the local area for those who live, work and visit here.

QEH's Clinical Services Strategy is aligned to the Norfolk and Waveney Clinical Strategy and will form the basis of the Norfolk and Waveney Acute Clinical Strategy which will be developed in 2022. QEH continues to contribute fulsomely to ongoing discussions with Norfolk and Norwich and James Paget Hospitals regarding further opportunities for Norfolk and Waveney's three acute hospitals to work more closely together to improve access and outcomes for our patients, the experience of our staff and value of the Norfolk pound, including via the committees in common.

We also continue to work with both hospitals and wider system partners on the transformation of the Urology and Dermatology services and we have implemented a number of aligned policies across our hospitals to ensure a consistent approach to our practice, which is a welcome step forward. As an anchor organisation in West Norfolk, we are equally prioritising and driving the agenda on the delivery of Place-Based Care recognising the critical role we play in improving health outcomes and reducing health inequalities.

Healthy Lives

We have delivered around 200,000 COVID-19 vaccinations at our QEH and Downham Market vaccination centres since December 2020. This has played a fundamental role in keeping our patients, their families, and our staff safe.

QEH remains one of the most research-active Trusts in the country compared to similar-sized hospitals and we punch well above our weight in this important area. More than 1,000 participants were recruited to National Institute for Health Research (NIHR) portfolio studies in 2021/22, which was a 33% increase compared to 2019/20. QEH has also been actively involved in COVID-related research and was the first NHS Trust to start a UK-wide adaptive trial called Helping to Alleviate the Longer-term consequences of COVID-19 (HEAL). In addition, we received the Health Service Journal (HSJ) patient safety innovation of the year in 2021 for inventing the Safer Injection for Regional Anaesthesia (SAFIRA) device (see page 46 for more information).

We have transitioned from a focus on compliance to creating a culture of continuous improvement with several hundreds of staff attending Quality Improvement training as we seek to improve capability and capacity across the organisation. Our staff ideas scheme (called Room for Improvement) continues to go from strength to strength, with more than 120 ideas submitted which are further improving patient and staff experience. We have introduced Quality Improvement cafés and wider forums, including our patient safety learning events to share learning and good practice across the organisation.

We have a comprehensive health and wellbeing programme in place for staff, which has expanded this financial year to include 20 Mental Health First Aiders, two Clinical Psychologists and a Post-traumatic Stress Disorder specialist to support staff.

We have a national reputation for the work we are doing to support staff going through the menopause. We have been awarded independent Menopause Friendly Accreditation, recognising us as an inclusive employer that builds awareness and understanding around menopause and takes staff health and wellbeing seriously.

While it is important to recognise the progress we have made in so many areas, we know where we need to focus our efforts in the coming months. It is about building on the strong foundations we have made and tackling the areas where we know we must improve for patients and staff.

At the Board meeting in April 2022, our Year Three priorities for 2022/23's Corporate Strategy were approved. Our strategy is our 'compass' and our focus in 2022/23 remains very much on further improving quality, engagement and healthy lives. Every member of our staff, regardless of their job or band, has a role to play in helping us deliver the strategy and priorities for our patients and local community.

Central to the delivery of the strategy is QEH playing a lead and active role in the emerging Norfolk and Waveney Integrated Care System. How the Trust, working with system partners, will recover and move forward from the pandemic is also key, and as such the strategy has been developed with the NHS's priorities and recently updated operational planning guidance in mind.

Looking ahead, we know where we need to focus our efforts to build on our recent improvements. These are described in full in our strategy and our Year Three quality priorities for 2022/23, which include:

Strategic Objective 1:

To consistently provide safe and compassionate care for our patients and their families.

- Consistently sharing learning from complaints, near misses, never events, incidents, mortality and learning from deaths by:
  - Further improving phase three Duty of Candour in relation to sharing learning from Serious Incident investigations with evidence of thematic reviews both intra and inter-divisionally
  - Improving the closure of actions in relation to Serious Incidents incrementally with evidence of a quarterly reduction
- Reducing the number of falls and those resulting in serious harm incrementally with evidence of a quarterly reduction
- Improving our capability for implementing the introduction of The Liberty Protection Safeguards. This will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements
- Delivering year-on-year improvements to patient experience measures (measured via surveys and complaints) with demonstrable evidence of changes in practice

Strategic Objective 2:

Modernising the QEH to support the delivery of optimal care.

- Launching an integrated three-year Digital and Data Strategy
- The management and delivery of cyber security risk and assurance through a business as usual annual workplan approach, which will be monitored by the Digital and Information Forum
- Further improving the Trust's digital maturity by implementing patient observation management systems, chemo prescribing and wristband replacement
- Working both internally and with partners on the preparation for a system-wide Electronic Patient Record
- Further modernising our estate by:
  - Getting added to the New Hospital Programme and moving from Strategic Outline Case to Outline Business Case stage for a new build
  - Securing the required quantum of capital funding for a three-year programme to maximise safety and compliance of the Trust's current estate
  - Increasing car parking capacity via a deck or multi-storey solution to ease pressure
  - Aiming to improve energy efficiency and in turn reduce the carbon footprint for all estates improvement projects
- Completing a Full Business Case for the Diagnostic and Assessment Centre
- Full engagement with wider Integrated Care System estates developments, including maximising the opportunities at North Cambridgeshire Hospital, developing an on-site Elective Hub, and progressing the Primary Care Hubs and Community Diagnostic Centre developments

Full details of our quality milestones and deliverables we have agreed for 2022/23 are available in the Trust's Year Three Corporate Strategy, which is available on the QEH website.

Finally, we would like to thank our 4,000 plus team of staff, volunteers and Governors, as well as our members, local communities, and partners for their support throughout the year. The progress we have made shows what we as Team QEH can achieve together. We look forward to working with you over the next 12 months as we continue our improvement journey. We are an organisation very much on the up and it is an exciting time to be part of Team QEH.

Professor Steve Barnett
Trust Chairman

Caroline Shaw CBE
Chief Executive

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HOW THE TRUST MONITORS QUALITY

The Trust's Senior Leadership Team, Board and key Non-Executive Director-led Board-level committees meet on a regular, programmed basis to scrutinise and oversee our work, with additional oversight arrangements established where required.

Non-Executive Director-led Board committees have been operational throughout the year, and all report directly to the Trust Board. They are:

- Quality Committee
- Finance and Activity Committee
- People Committee
- Education, Research and Innovation Committee

These run alongside the:

- Audit Committee
- Nomination and Remuneration Committees

A number of Executive-led groups report into the Senior Leadership Team, these being:

- Assurance and Risk Executive Group
- Clinical Governance Executive Group
- Operational Management Executive Group
- Investment and Capital Planning Executive Group
- People Executive Group

The Governance Structure for these committees and groups can be seen in Appendix 1.

Throughout 2021/22 the Trust has put in place a range of systems to provide assurance to the Board in respect of our compliance with quality standards. This includes systems to support the Board's assurance and decision-making by providing comprehensive information. The Integrated Performance Report is a key report which has been reviewed during the year to refine and further strengthen the Trust's use of 'plot the dots' (Statistical Process Control) methodology, reflecting best practice and advice from the national NHSE/I lead.

The Trust has had an Integrated Quality Improvement Plan (IQIP) (as described on page 15) in place, covering strategic priorities, licence conditions reporting and CQC 'must do'/'should do' actions. Progress on the delivery of the IQIP has been reported internally to the Quality Committee and the Trust Board, and externally to the Oversight and Assurance Group and CQC.

The Quality Committee has monitored the delivery of our quality and safety priorities. There have also been a number of other programmes underway to support further improvement. These include:

- Embedding of a robust Evidence Assurance Group, which has received external recognition, set up to oversee and provide assurance to the Trust Board that sustainable improvements have been introduced to support delivery of the IQIP
- Further embedding the Trust's approach to understanding organisational risk and the Board's visibility of high-level risks with the ongoing development of the Trust's Board Assurance Framework and Significant Risk Register processes
- Delivery of Year Two of the Trust's five-year Corporate Strategy, with quarterly reporting of progress against key strategic objectives and performance indicators
- The Better Hospital Team, which is the Trust's Project Management Office (PMO), supported the shift in focus from compliance towards creating a culture of continuous improvement, with oversight of the PMO's annual plan and progress by the Senior Leadership Team
- Delivery of key Quality Improvement training programmes to support the development of our improvement culture and the skills and capacity for quality improvement within teams across the Trust. This included a successful Celebrating Team QEH Week, which focused on Quality Improvement in November 2021
- Introduction of a comprehensive suite of programmes to improve our culture, including a Trust-wide culture transformation programme (with external support) to bring values to life across the Trust and internal culture and organisational development work with a range of corporate and clinical teams. Our new behavioural standards, known as 'The QEH Way' were also introduced, while 'Ways we Listen' was relaunched across the organisation
- To support the Trust's Speak Up agenda, we strengthened Freedom To Speak Up (FTSU) Guardian arrangements for QEH, which has seen support for Speak Up increase from 30-hours a month to over 120 hours, with Lead, Assistant and Independent FTSU Guardian resource. The Trust also has 22 Freedom to Speak Up Champions across the organisation, spanning staff, volunteers and Governors, all working together to encourage and enable staff to speak up and create a speak up culture
- Ongoing delivery of our comprehensive Maternity Improvement Plan to improve safety and outcomes for mothers and babies and strengthen our culture within the service. This plan also incorporates the Trust's response to and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust
- Development of comprehensive improvement plans for Radiology, Ophthalmology, Urgent and Emergency Care and Elective Recovery. Each has dedicated PMO support and governance arrangements to monitor and oversee progress
- Ongoing delivery of the Trust's Clinical Audit Recovery Plan, with progress scrutinised through the Audit Committee and Quality Committee. Real progress has been made to the Trust's clinical audit systems and processes. The backlog of outstanding audits from April 2019 to March 2022 (93/943) has reduced by approximately 5% when compared to the total number of the Trust's registered clinical audits (53/992) as at the time of writing the report
- We have improved the quality of our Serious Incident investigations as recognised by the CCG, clearing the backlog of outstanding investigations to meet the 60-day compliance standard. New root cause analysis training has supported staff to undertake serious incident investigations
- Three successful patient safety learning events have been held which have spanned key areas of patient safety and learning, attended by staff from across QEH and many external stakeholders
- Maximising the use of technology including implementing a new Radiology Information System, Electronic Prescribing and Medicines Administration, Single Sign On and advancing plans for the introduction of the Patient Observation Management System. QEH continues to support the development for a single digital care record (Electronic Patient Record), which is being led by the ICS

CARE QUALITY COMMISSION

The Trust is required to register with the Care Quality Commission (CQC) with the current overall registration status as 'Requires Improvement' following an inspection in 2022.

Overall	**Requires Improvement**
Safe	**Requires Improvement**
Effective	**Good**
Caring	**Good**
Responsive	**Requires Improvement**
Well-led	**Good**

The Trust underwent an unannounced core service and Well-Led CQC inspection in December 2021 and January 2022. This latest CQC Inspection report recognises the significant progress the Trust has made over the past year and since being placed in special measures in 2018. During 2021/22 the CQC has removed 18 of the 22, section 31 conditions from the Trust's Certificate of Registration and all 16 of the remaining 29A warning notice conditions spanning the services of Maternity, Diagnostic Imaging and Medicine.

The CQC published its inspection findings in February 2022 which details the significant improvement in the core services inspected (Medicine, Urgent and Emergency Care and Critical Care), all of which were rated 'Good' alongside the Trust's rating for 'Well-Led. The Trust also secured its first rating of 'Outstanding' for Well-Led for Critical Care.

The Trust is now rated 'Good' for Effective, Caring and Well-Led and its overall rating has improved from 'Inadequate' to 'Requires Improvement'. The Trust's rating of 'Requires Improvement' recognises that only three core services were inspected during the latest inspection due to the ongoing COVID-19 pandemic, and therefore reflects what was technically possible for this inspection.

This is a fantastic achievement and a reflection of everyone's commitment and hard work to improve care for our patients and experience for our staff. It also provides further external validation of our improvement programme and commitment to ensure our patients consistently receive safe and compassionate care. In turn, the report confirms the CQC's recommendation to remove the Trust from the Recovery Support Programme (previously special measures).

The Trust has received a total of four 'must do' and nine 'should do' actions with no additional section or warning notice conditions. This is in stark contrast to the 2019 report, where the Trust was issued 206 'must' and 'should do' actions and 43 section and warning notice conditions.

In its latest inspection report of February 2022, the CQC highlights significant improvement in the culture of the organisation and the care of patients. Staff were described as engaged and keen to speak with the inspectors to share their stories of improvement.

Fiona Allinson, the CQC's Deputy Chief Inspector of Hospitals, paid tribute to the work of Team QEH and the impressive improvements that were observed by the inspectors during their visit.

She said: "I am pleased to see significant improvements have been made right across the Trust in the care given to patients resulting in a number of its services being rated Good. More importantly there's been a significant increase in the quality of care being given to people in Norfolk using these services. The COVID-19 pandemic brought a number of additional challenges to the NHS, so staff are to be commended for the progress made at this particularly difficult time.

"The leadership team clearly understood the priorities and issues facing the Trust and were focused on making continual and sustained improvements, which is why the rating for how 'Well-Led the Trust is moves from 'Inadequate' to 'Good'."

The report also stated that:

- "Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs."
- "Staff felt respected, supported and valued."
- "There was a strong focus on quality improvement to improve patients' care and outcomes."
- "The Trust is committed to improving services by learning when things went well and when they went wrong."
- "Communication, inclusion and partnership working were some of the biggest improvements within the Trust."

The latest CQC report reflects how the organisation's leadership has strengthened and matured over the past two years in conjunction with robust governance and assurance processes, supporting long-term improvement.

2019 CQC INSPECTION RATINGS FOR QEH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Inadequate →← July 2019	Inadequate ↓ July 2019	Requires Improvement ↓ July 2019	Requires Improvement →← July 2019	Inadequate →← July 2019	Inadequate →← July 2019
Medical Care (including Older People's Care)	Inadequate →← July 2019	Inadequate ↓ July 2019	Requires Improvement →← July 2019	Requires Improvement →← July 2019	Inadequate →← July 2019	Inadequate →← July 2019
Surgery	Requires Improvement →← July 2019	Good ↑ July 2019	Good →← July 2019	Requires Improvement →← July 2019	Good ↑ July 2019	Requires Improvement →← July 2019
Critical Care	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015
Maternity	Requires Improvement ↑ July 2019	Good ↑ July 2019	Good →← July 2019	Good ↑↑ July 2019	Requires Improvement ↑ July 2019	Requires Improvement ↑ July 2019
Gynaecology	Requires Improvement July 2019	Good July 2019	Good July 2019	Requires Improvement July 2019	Requires Improvement July 2019	Requires Improvement July 2019
Services for Children and Young People	Good →← July 2019	Good →← July 2019	Good →← July 2019	Good →← July 2019	Requires Improvement ↓ July 2019	Good →← July 2019
End of Life Care	Requires Improvement →← July 2019	Inadequate →← July 2019	Good →← July 2019	Inadequate ↓ July 2019	Inadequate ↓ July 2019	Inadequate ↓ July 2019
Outpatients	Good ↑ July 2019	Not Rated	Good →← July 2019	Requires Improvement →← July 2019	Requires Improvement →← July 2019	Requires Improvement →← July 2019
Diagnostic Imaging	Inadequate ↓ July 2019	Not Rated	Good →← July 2019	Requires Improvement →← July 2019	Inadequate ↓ July 2019	Inadequate ↓ July 2019
Overall Trust 2019	Inadequate →← July 2019	Inadequate ↓ July 2019	Requires Improvement ↓ July 2019	Requires Improvement →← July 2019	Inadequate →← July 2019	Inadequate →← July 2019

2022 CQC INSPECTION RATINGS FOR QEH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Good ↑ February 2022	Good ↑ February 2022	Not Rated	Requires Improvement →← February 2022	Good ↑ February 2022	Good ↑ February 2022
Medical Care (including Older People's Care)	Requires Improvement ↓ February 2022	Good ↑ February 2022	Good →← February 2022	Good ↑ February 2022	Good ↑ February 2022	Good ↑ February 2022
Surgery	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Good →← February 2022	Good →← February 2022	Good →← February 2022	Good →← February 2022	Outstanding ↑ February 2022	Good →← February 2022
Maternity	Requires Improvement December 2020	Good July 2019	Good July 2019	Good July 2019	Requires Improvement December 2020	Requires Improvement December 2020
Gynaecology	Requires Improvement July 2019	Good July 2019	Good July 2019	Requires Improvement July 2019	Requires Improvement July 2019	Requires Improvement July 2019
Services for Children and Young People	Good July 2019	Good July 2019	Good July 2019	Good July 2019	Requires Improvement July 2019	Good July 2019
End of Life Care	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients	Good July 2019	Not Rated	Good July 2019	Requires Improvement July 2019	Requires Improvement July 2019	Requires Improvement July 2019
Diagnostic Imaging	Requires Improvement December 2020	Not Rated	Good July 2019	Requires Improvement July 2019	Requires Improvement December 2020	Requires Improvement December 2020
Overall Trust 2022	Requires Improvement ↑ February 2022	Good ↑↑ February 2022	Good ↑ February 2022	Requires Improvement →← July 2019	Good ↑↑ February 2022	Requires Improvement ↑ February 2022

INTEGRATED QUALITY IMPROVEMENT PLAN

The Trust's Integrated Quality Improvement Plan (IQIP) reflects our pledge to deliver high quality, patient-centred, integrated care for the community we serve. It has been produced with input from staff and stakeholders and responds to recommendations from our regulators and the CQC. The IQIP outlines our longer-term ambitions to be recognised for the care we provide and the way we help staff to continually develop throughout their careers so that they are proud to say they work for QEH.

The 2021/22 IQIP was aligned to Year Two of our 2020-2025 Corporate Strategy and had two main areas of focus:

1. Ensuring the provision of safe, effective care for our patients and a positive working environment for our staff.
2. Ensuring the care we provide is delivered in accordance with all regulatory requirements.

We have achieved these aims by:

- Continuing to invest and improving leadership development at Board, senior and middle management levels
- Continuing to focus on communication, culture change and improving staff engagement
- Embedding an overarching scheme of clinical and corporate governance and risk management framework
- Focusing on recruitment, retention and workforce utilisation
- Continuing to improve the environment and layout of our Emergency Department
- Closer working with external partners and stakeholders
- Reviewing and improving our medical education programmes

The Trust's 2021/22 IQIP built on the sustained progress and improvements achieved through the 2020/21 IQIP and included a total of 83 actions. These actions were a combination of section and warning notice conditions and 'must do' and 'should do' actions. Of these, 57 (69%) were approved for closure by the end of March 2022, which demonstrates sustained progress throughout the year.

A robust governance and assurance framework was developed to support the monitoring and reporting of progress against the IQIP in 2019 and has continued to provide significant assurance and accuracy of progress to the Trust Board, sub-committees and key external stakeholders ever since. In turn, the success of the IQIP governance framework has started to influence reporting arrangements for broader Trust Quality Improvement Plans. It is important therefore to now apply this tested governance framework to key Trust Quality Improvement Plans to ensure a structured and standardised approach is applied, with clear reporting through to the Trust Board.

The IQIP will therefore evolve and becomes a Compliance Plan, incorporating the remaining 'open' 'must' and 'should do' actions from the 2021/22 IQIP with the 13 new 'must' and 'should do' actions from the latest CQC report.

1. PATIENT SAFETY

1.1 Incident reporting and Never Events

The total patient safety incident reporting rate for 2021/22 was 7,549, a figure which excludes the number of tissue viability incidents reported on admission. This is a 1.09% decrease in reporting from 2020/21.

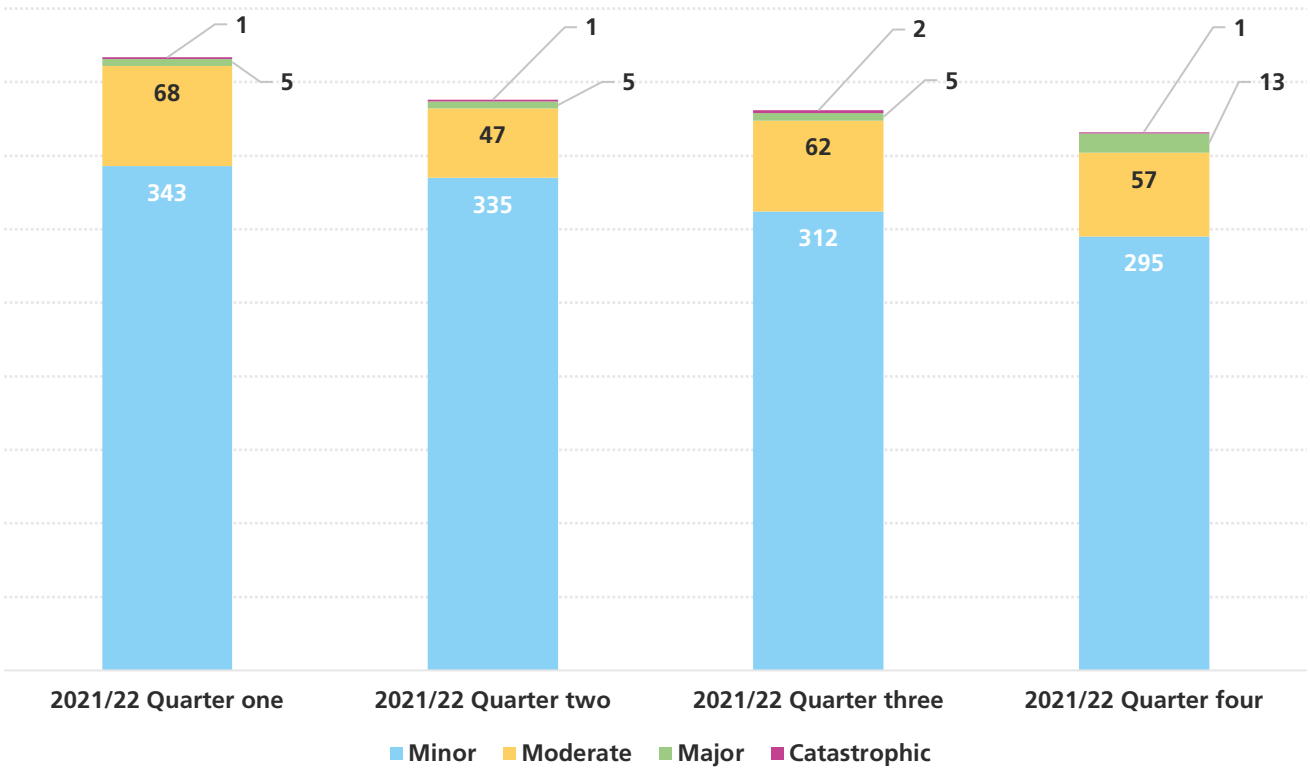
The Trust continues to develop an open safety culture where staff can raise their safety concerns. Safety incidents resulting in severe harm or death (catastrophic) increased by 50% from 22 incidents in 2020/21 to 33 in 2021/22. The increase is in part attributable to the use of escalation areas to increase inpatient bed numbers to address capacity issues. All patient safety incidents that meet the threshold of a moderate harm incident are reviewed by the Trust's Serious Incident Review Panel to ensure any immediate safety actions are carried out, Duty of Candour is initiated, and investigations are undertaken in line with the National Serious Incident Framework where applicable.

A variation in monthly patient safety incident reporting occurred within the financial year with incident reporting rates per month ranging from 533 in April 2021 to 740 in March 2022 with a monthly average of 631 patient safety incidents. The variation is reflective of the Trust's response to the second wave of the COVID-19 pandemic.

NHSE/I recommend that Trusts reports safety incidents through the National Reporting and Learning System (NRLS) monthly, as a minimum, which we continue to do. The Trust is continuing to focus on promoting incident reporting practices as part of the ongoing safety culture development with a range of training and support provided by the corporate Patient Safety Team.

Financial year	Total reported patient safety incidents, excluding pressure ulcers on admission	Safety incidents that resulted in severe harm or death
2021/22	7,549	33
2020/21	7,631	22
2019/20	7,007	29
2018/19	7,710	32

Patient safety incident reporting harm outcome



A number of work programmes and new functions were identified and implemented during 2021/22. Key areas of achievement include:

- Maintained improvement in completing Duty of Candour phase one and two. CQC Must (M.03) - 'The Trust must ensure that Duty of Candour is carried out as soon as reasonably practicable, in line with national guidance'- was approved for closure at Evidence Assurance Group in August 2021.
- Sustained use of the Trust's Evidence Assurance Group (EAG) to provide additional internal oversight, challenge, accountability, and assurance for completed Serious Incident (SI) action plans sign off.
- Improved working across boundaries between clinical divisions and the Patient Safety Team to ensure Serious Incident investigations are on track.
- Divisions were given autonomy to review and ratify all moderate investigation reports and action plans, increasing their capacity to deploy the right resource to serious incident investigations.
- A new process, collaboratively developed by the Anticoagulation and Patient Safety Teams, is to be piloted for identifying, reporting and investigating hospital-acquired thrombosis through the Trust's Datix system.
- Recruitment of a substantive 1.0 WTE Patient Safety Manager.
- Development and roll-out of new investigation templates to support staff with thematic review investigations.
- Successful completion of virtual patient safety learning events with the content made available for all staff through the Patient Safety intranet page. Each event was launched with a patient story and included presentations on key Trust patient safety learning topics including:
  - Learning from serious harm falls
  - Nutrition and hydration - Learning from serious incidents
  - Mouth care - improving care for our patients
  - Getting It Right First Time (GIRFT) - Claims review
  - Learning from hospital discharges - A family's experience, learning from incidents and Quality Improvement, what does a 'good' discharge look like?
  - Documentation: The importance of capturing the essence of care – A journey of improvement
  - Learning from Deaths - Introduction to learning from deaths, learning from deaths' weekend report and action plans from learning from deaths' weekend report

1.2 Serious Incidents reported in year

The Trust declared 61 Serious Incidents within 2021/22 and has continued to develop processes to support the investigation and learning opportunities to reduce future harm and the likelihood of re-occurrence. This number is reflective of all the major and catastrophic harm related incidents, in addition to only the moderate harms that meet the threshold of a Serious Incident investigation following review at the Trust's Serious Incident Review Panel.

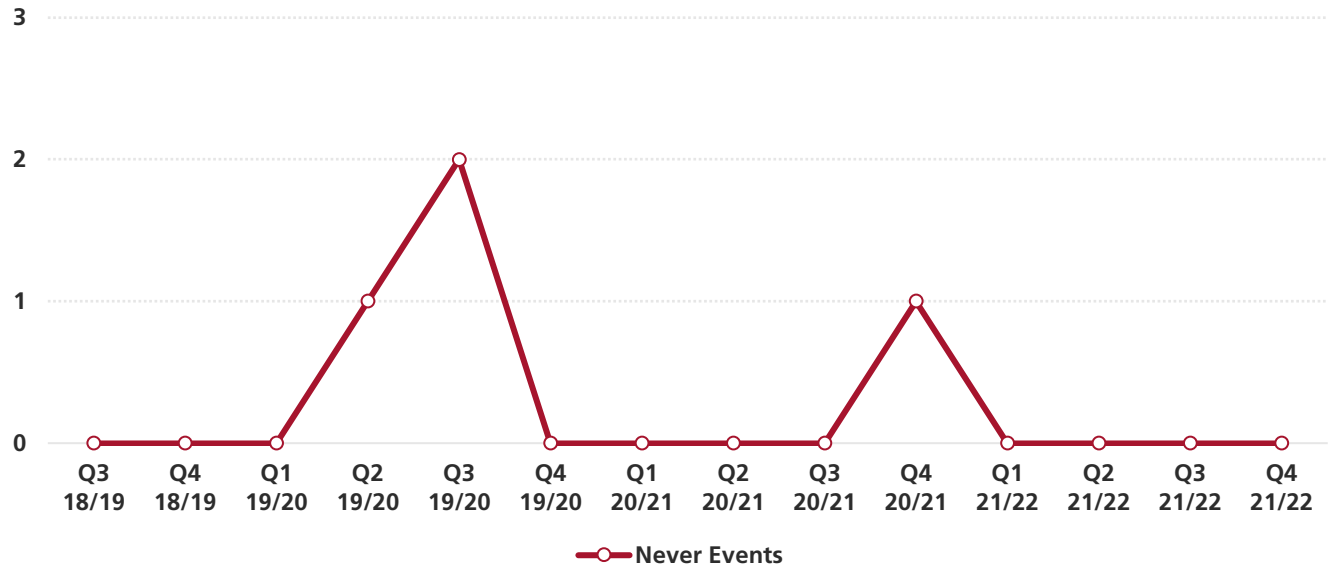
	Clinical Support Services	Medicine	Surgery	Women and Children	Trust-wide	Total
Accident e.g., collision/scald (not slip/trip/fall) meeting SI criteria	0	0	1	0	0	1
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	1	0	0	1	2
Commissioning incident meeting SI criteria	0	3	0	0	0	3
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	3	2	0	1	0	6
Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)	0	0	0	7	0	7
Maternity/Obstetric incident meeting SI criteria: mother and baby (this includes foetus, neonate and infant)	0	0	0	1	0	1
Medication incident meeting SI criteria	0	1	1	0	0	2
Pending review (a category must be select before incident is closed)	0	0	1	0	0	1
Slips/trips/falls meeting SI criteria	0	12	1	0	0	13
Sub-optimal care of the deteriorating patient meeting SI criteria	0	0	1	0	0	1
Treatment delay meeting SI criteria	1	17	5	1	0	24
Total	4	36	10	10	1	61

Serious Incident investigations identify key safety themes and areas of focus for patient safety improvement including:

- Communication between clinicians, wards and teams on the patient pathway, including patients and their families. Contemporaneous records should be kept in line with good medical practice, adherence to Duty of Candour and implementing personalised care plans with meaningful conversations with families, including all the information that they require to make an informed decision about their care.
- Awareness or adherence to Trust's policies, processes and pathways, such as the Trust's Falls Policy, NEWS2 escalation and Maternal Medicine Care pathway for high-risk mothers with pre-existing medical conditions and high levels of medical complexity.
- The safety systems for patients waiting for physical health and mental health beds.

1.3 Never Events

The Trust declared zero Never Events during 2021/22.



1.4 Duty of Candour

The Trust has a responsibility to ensure that the statutory Duty of Candour is undertaken for all notifiable safety incidents in line with The Health and Social Care Act 2008 (regulated activities' regulations: Regulation 20). This applies to any reported patient safety incident that has resulted in, or potentially resulted in moderate, severe, catastrophic harm or prolonged psychological harm caused by the incident.

As soon as practicable, and within 10 working days following the identification of a notifiable safety incident, a lead clinician for the service involved must undertake a statutory Duty of Candour conversation with the patient, next of kin, carer or a relevant legal patient representative. This is known as the initial discussion (phase one).

This initial discussion must be face-to-face, where possible. It must include the facts known at the time of the incident and a sincere verbal apology that the incident occurred while receiving care at the Trust. The conversation must also include an opportunity to receive a written notification (phase two) of the discussion with clear information on how they will be kept informed during any subsequent investigation or inquiry.

The Trust has made sustained improvements to ensure that Duty of Candour conversations occur within 10 working days of the identification of an incident. Compliance has increased from 95% (174 out of 183) in 2020/21 to 98% (205 out of 209) in 2021/22. In 2022/23, we will review and develop our reporting process for timely completion of phase three Duty of Candour compliance to support and ensure timely feedback on the incident investigation outcome to the patient, next of kin, carer or a relevant legal representative.

Duty of Candour is a metric monitored within clinical divisions through Divisional Board Reports and centrally through the Executive Clinical Governance Group and Integrated Performance Review Processes.

Quarter (Financial Year 2021/22)	+/- Incidents in month	Phase one completed	Phase one count (completed with 10 working days)	Phase one % (completed with 10 working days)
Quarter one	47	47	44	94%
Quarter two	53	53	53	100%
Quarter three	49	49	48	98%
Quarter four	60	60	60	100%
Overall compliance	209	209	205	98%

Duty of Candour COVID-19 project

In response to the pandemic, a COVID-19 Duty of Candour Task and Finish group was established to undertake Duty of Candour with patients who had either:

- Hospital-onset probable healthcare-associated (a positive specimen date eight to 14 days after hospital admission) or
- Hospital-onset definite healthcare-associated COVID-19 (a positive specimen date 15 or more days after hospital admission)

while receiving care at the QEH during wave one and two of the pandemic

The group, led by the Deputy Chief Nurse, successfully made 248 contacts with patients, next of kin or a relevant legal representative of the patient to undertake a Duty of Candour conversation, send a Duty of Candour letter and share the next steps for the Trust to learn from this event.

The project received national press coverage because of the significance of its objectives and because QEH was the first Trust in the country to undertake Duty of Candour for this group of patients.

2. PATIENT AND CARER EXPERIENCE

At QEH, we are committed to engaging with our patients, their carers, and the public so that they can contribute fully to further improving the quality of services that we provide. This helps us to make sure that everyone who receives care at our hospital, together with their loved ones, have the best possible experience of our services and hospital environment.

2021/22 has been an exciting year of change for the Patient Experience Team. New roles have been introduced and the structure of the team has been reviewed as our role continues to grow. We have reviewed our policy and processes for managing the feedback we receive from patients and relatives and fully engaged with the Divisions at QEH so that we can work collaboratively to share feedback and learning. We also fully revised the patient experience work plan to align it with the Trust's Year Two corporate priorities while making it more meaningful to the patient experience.

In 2021/22 there was a significant reduction in the number of formal complaints received by the Trust compared to 2020/21; this was believed to have been attributed to the impact of the COVID-19 pandemic on the suspension of some services, the decline in footfall across the Trust relating to visiting restrictions and increased virtual appointments. However as a Trust we were unable to consistently maintain the key performance indicator (KPI) of returning the formal response letter within thirty days; in addition we were not able to tangibly demonstrate the learning from complaints to prevent re-occurrence. This has been fully addressed as part of the precursor to the new patient experience strategy proposed by the Chief Nurse and Deputy Chief Nurse, which has included a significant review, restructure, and revision of all the processes and governance within complaints.

2.1 Patient Experience team

The patient experience team undertook a review of the processes and policy for managing patient and relative feedback, which has been critical, with full engagement of the divisions and collaborative working with patient and their relatives to share their feedback and any learning. Also the patient experience work plan was fully revised so that it is more meaningful to patient experience, measurable and aligned with the Trust's Year Two priorities.

Additional to the fully revised patient experience work plan, the patient experience strategy in development is under scrutiny in a broader context to be widely inclusive and reflective of the patient's voice and their needs from our care delivery service.

Five core objectives were identified:

- Complaints
- Compliments
- Patient experience - Reduction in noise at night
- Patient experience - Improve the discharge experience
- Increase the "patients'" voice

This led to the new proposed governance structure for the Trust's Patient and Carers Forum and the resultant work streams that the Chief Nurse and Deputy Chief Nurse developed. Each work stream has a Chair's Assurance report that is shared at the bimonthly Governors Patient Experience Committee meeting.

The patient experience team has continued to develop the patient experience strategy in collaboration with Healthwatch Norfolk (HWN) who engaged with the public within the Queen Elizabeth Hospital catchment area including West Norfolk, South Lincolnshire, and North East Cambridgeshire and healthcare professionals from within primary, secondary and community care. Feedback was collected through a mixed methods approach - through a survey and focus groups, to reach people from all areas of the community and include feedback from a wider demographic. The survey had a mixture of open and close ended questions and was made available online, in print and easy read formats, while the focus groups were facilitated by HWN and the Associate Director of Patient Experience with younger people.

2.2 Patients' Voice

The patients' voice has been integral to many aspects of the positive changes in patient experience and learning from patients, their families and/or carers' feedback. We have worked with patients and their families to share organisational learning. Several patients and their families have worked with us to share their experiences and contributed through suggestions on how their experience can be improved. One example of this was 'Betty's' family who kindly gave permission for the local resolution meeting (LRM) audio recording to be used to share their difficult experience; it gave voice to their story, which afforded others an opportunity to hear how they felt about the care their mother Betty had received; it was honest and frank but told a powerful story more eloquently than feedback in a patient safety huddle could have done.

The Chief Nurse and Non-medical Education Lead approached the University of East Anglia, and a bespoke leadership program was developed for the band seven Ward/Unit Managers using the LRM audio recording as the main theme with identified objectives. The family agreed that we could share the content of the LRM with other health care professionals to give a wider 'voice' to how 'Betty's' family felt when care was not delivered to the standard we set as a Trust. The objectives were set as part of leadership values for the ward managers.

We have also used this LRM recording in the 'Caring with Kindness' movement because of how extremely powerful hearing directly from a patient and their family is, of what it felt like to have had a poor experience. Other families have also made much welcomed suggestions on how we can improve our services. This work is ongoing.

We have also received feedback from patients and families about their poor patient experience specifically for patients with sensory impairments. This led to collaborative working with the West Norfolk Deaf Association (WNDA) and Vision Norfolk. The WNDA visited the Trust to provide training to support the Family Liaison Officers, housekeepers and ward clerks; this training aimed at raising awareness of the type of care hearing and sensory impaired patients need. They also shared their experience of what it feels like to be sensory impaired and gave insight into the specific needs of patients with a sensory impairment. WNDA and Vision Norfolk have also joined our sensory impairment work stream to provide on-going support.

Another family worked with us in patient experience, which led to making a video explaining the impact of sensory impairment for patients. This was 'Sarah's' story, and she described her father's care and the impact being sensory impaired had on his experience as a patient. We have shared this video as part of experiential learning through various educational platforms including 'Caring with Kindness' to support organisational learning. The feedback from patients and relatives has been instrumental and invaluable in providing a platform to share the impact of poor patient experience.

2.3 Family Liaison Officers

Eight Family Liaison Officers (FLOs) were appointed in March 2021 with a sole purpose of supporting our patients' experience after a business case was developed to support the implementation of the FLO role for a year on a fixed term contract. During this financial year, they continued to support the previous COVID-19 advice line developed in 2021 as part of the surgical division recovery plan, which was designed to support patients and their families. Also the FLOs continued to support patients and their families' virtual visiting, telephone communication and acted as escalation officers if any concerns were escalated to them. Although their role is extremely varied, they have become an invaluable resource to support patients and their relatives. The FLO role has been so successful that a number of regional Trusts have contacted us for information regarding the implementation of the role within the Trust. The operational model has also been shared across the Integrated Care System (ICS) and in the latter part of the financial year, funding was made available to implement the role across the East of England in six NHS Trusts. Also in the QEH, a second business case was developed to make the role substantive and increase the establishment to 10.3 WTE, which would increase the number of FLOs to six on each shift.

FLO contacts - top themes	
Update on patient condition/wellbeing	2,320
Concern - resolved via helpline	1,572
General information	1,569
Messages to loved ones, passed to ward	263
Discharge information	206
Concern - referred to PALS	18
Inpatient enquiry	12
COVID-19 swab query - public	9
COVID-19 test results	7
Poor communication	7

2.4 External facilitated Workshop

On the 26 January 2022 a study day was arranged by the Deputy Chief Nurse and facilitated by Linda Moir, an expert in Human Relations and customer service. Linda Moir headed the London 2012 dream team that delivered outstanding front of house service by 15,000 volunteer Games Makers to 9 million spectators, resulting in one of the most successful Olympic and Paralympic Games in history. Previously, she was Virgin Atlantic's Director of in-Flight Services, responsible for the airline's award winning service and 'making flying fun'. Some of the governors, patient families and/or carers were invited to this day. The plan for the workshop was to use Linda's significant executive, large scale industry expertise and experience to facilitate an exciting mapping exercise. This was believed to be a fairly unique approach in healthcare and was designed to support our ongoing development of the patient experience at the QEH.

At the workshop, we discussed four key clinical access areas and collectively reviewed access. This provided a way to systematically review where there were pitfalls and areas of improvements needed. It was an excellent study day and provided a unique opportunity to share ideas to support improvement plans.

2.5 Caring with Kindness

The Chief Nurse and Deputy Chief Nurse designed an experiential learning event to put patients and their families at the centre of patient experience, highlighting the importance of fundamental care with kindness. Various patient stories on the impact of poor patient care were shared by families to remind healthcare professionals of the importance of providing individualised patient care. Caring with Kindness has become a movement to ensure the standard of care is improved and that patients are put back at the centre of each healthcare provider's focus.

The original program was developed for healthcare professionals at Bands 2, 3 and 4 levels and was run over six weeks for three hours per week, based on themes identified through feedback from patients and their relatives. The first cohort was vibrant and provided really positive feedback; one of the recommendations made was for the caring with kindness programme to be run for 2 days and for all who were directly involved with patient care. So on the 2 March 2022, a refreshed Caring with Kindness program was launched, aimed at registered and unregistered health care professionals.

We have also commissioned AccessAble, a leading provider of access information for disabled people in the UK to provide accessible disability and wheelchair friendly information to patients, their families and/or carers and the public who visit the Trust and need this service. Also there is work underway with Digital services and the Hospital Information System to become fully compliant with the Accessible Information Standards. This piece of work began at the beginning of Q4 2021/22; it has also led to the identification of some variation in the provision of accessible information for some of our patient groups by the Patient Experience disability work stream. Therefore the Chief Nurse has commissioned a clinical audit, which will focus on reviewing the Trust's current accessible information provision to reveal areas that need improvement. The results will be available at the end of Q1 2022/23 and will underpin an improvement work plan.

2.6 Patient stories at Board

We support patients, their families, and/or carers so that they can tell their stories in person at Board meetings, which allows the Board to hear about their experiences first-hand and to learn about the aspects of care that our patients value the most. It also provides an opportunity for patients, their families and/or carers to describe experiences where care could have been improved so that we can act on their feedback.

During the past year, the Board has heard the following stories that have led to action within the Trust:

- A staff member spoke of the poor bereavement experience which their family had at the Trust
- A patient who came to QEH with a leg problem praised the efficiency of our urgent and emergency care services and described all of the staff he interacted with as kind and professional
- A lady who was visiting the Trust as a guest speaker described the positive experience she had when she became unwell and had to access acute care. She praised the teams involved in her care and the diversity of our workforce.
- The Board heard about improvements in our Critical Care Unit, where a ceiling light display has been installed in the quiet room to make the environment better for relatives
- A story was also shared of how a bespoke clinical pathway was developed for a patient using an elastomeric pump so that he could return home for Christmas and continue his intravenous antimicrobial therapy at home rather than at the Trust

Modernising our estate - patient voice

Currently the Associate Director of Patient Experience and Patient Engagement Lead are working with some of the project managers on the major estates' developments. In addition, we are developing a patient panel to support patient experience as utilised across the Integrated Care System.

Next steps:

We have been working with the College of West Anglia (CoWA) students as part of developing the patient experience strategy. As part of the next steps we want to increase this collaborative piece of work and are keen to increase our working relationship with the newly opened School of Nursing (Anglian Ruskin University/CoWA).

2.7 National patient surveys

The Trust participated in five national patient experience surveys and the results were published between April 2021 and March 2022 - the National Urgent and Emergency Care Survey (2020), National Children and Young Person's Survey (2020), National Maternity Survey (2021), Cancer Patient Experience Survey (2020) and the National Inpatient Survey (2020).

	Month sampled	Month published	Response rate	Average national response rate
National Urgent and Emergency Care (2020)	September 2020	September 2021	38%	29%
National Children and Young Person's Survey (2020)	November to December 2020 and January 2021	December 2021	27%	24%
Cancer Patient Experience Survey (2020)	April to June 2020	November 2021	64%	59%
National Inpatient Survey (2020)	November 2020	October 2021	43%	46%
National Maternity Survey (2021)	January to February 2021	February 2022	49%	54%

National Urgent and Emergency Care Survey

The results of the National Urgent and Emergency Care Survey 2020 were published in September 2021 and highlighted one key area for improvement when compared with other organisations:

- Patients advised that their waiting times in ambulances was too long. Therefore an Urgent and Emergency Care Improvement plan was initiated, led by the Trust's Deputy Medical Director to support the delivery of the 15 minute handover key performance indicator in April 2022

There were a number of areas that the Trust out-performed other organisations and they included:

- How important it was to patients to be kept informed about the duration of the wait for treatment
- Access to suitable food and drink
- Discussions with staff about transport arrangements prior to leaving hospital

Comparisons made over time indicated that the Trust had significantly improved in 11 areas and had not shown any significant deterioration. To ensure this is maintained, the team in the Emergency department use feedback from complaints, PALS and the Friends and Family Test to improve the experience of patients.

National Children and Young Person's Survey

The results of the National Children and Young Person's Survey 2020 were published in December 2021. There were areas of improvement and deterioration over time and between Trusts. When compared with other organisations the QEH was poorer in:

- Children and young people understanding what hospital staff said to them. To improve this, patients and families will have treatment plans shared regularly and checking understanding with young patients

There were some positive areas noted from the results:

- Staff introduced themselves
- Parents and carers had better access to hot drinks facilities in the hospital

The areas of change over time relate mainly to patient entertainment as parents reported that there was not enough for their child to do in hospital although the Wi-Fi was good enough for patients to entertain themselves. To address patient entertainment the team will be undertaking a survey to find out what patients would like, there is a plan to increase the availability of play specialists, to increase engagement of nursing staff with patients and to request the support of volunteers.

Cancer Patient Experience Survey

The Cancer Patient Experience Survey 2020 differs from previous years because the survey was run on a voluntary basis due to unprecedented pressures on cancer services in 2020. The survey involved 55 NHS Trusts. As not all NHS Trusts participated in the survey no comparisons to scores nationally was available; however there were changes outlined in the report that related to improvements or deterioration over time.

There were two areas the Trust showed significant improvement:

- Patients had all the information they needed before their operation
- Patients felt length of time for attending clinics and appointments for cancer was appropriate

There was one area the Trust was significantly poorer:

- How well the general practice staff did in supporting patients during treatment

Some of the actions underway to address this to improve patient experience include:

- Greater communication with GPs via the Clinical Commissioning Group
- Virtual education events amongst other actions

National Inpatient Survey

The results of the National Inpatient Survey 2020 were published in October 2021 and highlighted two areas for improvement for the Trust when compared to other organisations:

- Insufficient nurses on duty
- Knowing whom to contact if worried following discharge from hospital

Action plans in place to address these concerns include:

- An extensive overseas recruitment programme
- Growing local talent through the newly established School of Nursing at the College of West Anglia

There are other schemes in place to train and support unregistered existing staff evolving into nursing careers and the mitigation in place is the use of bank and agency nurses to backfill vacant shifts.

Also to ensure that patients remain informed about their care after discharge, a number of actions have been introduced, aimed at improving awareness of medication and who to contact if worried as well as what to do following discharge. These include:

- Providing elective patients with information prior to admission and at the point of discharge, condition specific information leaflets are available on wards.
- Providing discharge letters that contain a summary of discussions about medications with ward staff or in the discharge lounge to all patients with staff.

Further areas of improvement on reflection of the Trust results over time include:

- The need to improve the experience of patients at night. The Trust's Helping U Sleep Healthier (HUSH) project aimed at reducing disturbance at night continues to listen to staff suggestions and patient feedback to make the changes required.

Also through patient and carer engagement, in addition to patient representative organisations, the Trust continues to work collaboratively to address not only concerns raised in this annual survey but to make improvements highlighted as themes through complaints, PALS, Friends and Family Test (FFT) feedback and any other method patients and the public employ to provide feedback.

National Maternity Survey

The results of the National Maternity Survey 2021 were published in February 2022 and highlighted a number of improvements across the service both over time and in comparison to other Trusts. These included:

- How patients felt listened to during antenatal check-ups and had the opportunity to ask questions and how staff knew their medical history
- How birth partners felt they were allowed to be involved to the degree they wanted involvement during labour
- How important signposting to support changes in mental health and physical recovery post-natally was to patients

Improvements in the experience of care were also found in relation to discharge delays and the cleanliness of the hospital.

Areas for improvement when reviewed over time primarily related to staff introducing themselves, choice of locations being offered for where to have their baby or postnatal care and also the availability of advice especially during evenings, nights and weekends (to support feeding their baby and about baby's progress six weeks after birth). An action plan has been introduced to address a number of these concerns; for example the use of digital as well as traditional methods of communication to share details of choice relating to location of birth and postnatal checks; also links to baby feeding advice have been made available to patients. Some of these concerns are attributable to the impact of COVID-19 which led to changing the way services are provided; however learning from the pandemic will allow services to be offered in a variety of ways to improve access to support.

2.8 Working across the Integrated Care System (ICS)

During the COVID-19 pandemic there has been closer working across the ICS to improve the experience of patients and ensure a consistent approach to supporting patients and their families. Hospital visiting has been severely restricted since the onset of the pandemic. The introduction of national guidance to manage hospital visiting has been implemented across the three acute Trusts in Norfolk and Waveney as consistently as realistically possible; however the difference in organisations and estate have meant that some discrepancies have been inevitable.

In June 2021 the three acute Trusts within the system held a virtual Carers Conference co-produced with carers and carer representative organisations across Norfolk and Waveney. The conference featured carers stories; there was a presentation on Carers Passports from NHS England and training from Caring Together and Restitute, two carer representative organisations locally. Carers were keen to continue this work, which was made possible through a funding award from the ICS to co-produce a carers passport recognised at the three acute trusts and to introduce carer awareness raising training.

Also through shared learning across the ICS, it has been possible to work on a wide range of areas to support patients and their families to have a good experience of healthcare. A good example is the roll-out of Family Liaison Officers across the acute trusts within the Norfolk and Waveney locality, after it originated from the QEH and proved to be invaluable to patient experience of care. Working in this way will continue because of the benefits it affords our patient and staff groups across Norfolk and Waveney.

2.9 Examples of the ways the Trust has used feedback to improve the experience of patients and their carers

There are a number of ways we have used feedback to improve the experience of patients and their carers in 2021/22. Some of them have been carried over from the previous financial year:

- We have continued to work closely with forums supporting specific groups of people e.g. carers, people with learning disabilities, non-English speakers and those with visual impairments, to identify the changes that the Trust needs to make to give patients with additional needs the best possible experience when accessing care
- We have continued with the work we began in the previous financial year to streamline zebra crossing points on the Trust site, improving visibility and addressing issues raised by the hospital's group for visually impaired people, which resulted in additional barriers to reduce the time that vulnerable people remain on the road at the front of the hospital
- We created a breastfeeding video so that we can better support breastfeeding mums who are admitted as inpatients
- We have continued to improve our children's play areas
- We have continued to provide young inpatients with chargers for their tablets and mobile phones so that they can stay in touch with family and friends during their admission
- The information booklet given to elective inpatients has been refreshed
- There is improved access for patients with additional needs to our COVID-19 vaccination centre for patients and coordinated bookings for people from the same household
- Patients' partners attending antenatal scans continue to be provided with buzzers so they can be called to the clinic at the patient appointment time to prevent overcrowding and support COVID-19 safety precautions

2.10 Working with the Governors' Council

The Governors' Council and Patient Experience Team host events in conjunction with local statutory, community, voluntary sector partners and the cancer services user group. Healthcare Events which provide information and advice about long-term medical conditions are open to the whole community. Due to the COVID-19 pandemic it was only possible to host one event in 2021 with patients and Governors, to feed into the Trust's Patient Experience Strategy. This was held in East Winch Village Hall.

2.11 Patient groups

In 2021/22 we have established a number of new forums to support the development of patient experience focussing on sensory impairment, carers, disability as well as the established groups to support end of life, learning disabilities and autism, dementia and mental health. These groups meet virtually and include patients, carers, Governors and representative organisations.

Each group meets monthly and provides a Chair's Assurance Report to the Patient and Carer Experience Forum.

2.12 Compliments, complaints, concerns, and comments

The Trust's Patient Advice and Liaison Service (PALS) is a confidential point of contact for patients, relatives or members of the public who may have concerns about their current or previous treatment or service provision. The PALS team also receives general feedback, suggestions and compliments, which are shared across the Trust. The Complaints Team and PALS work together, with the Associate Director of Customer Feedback managing both departments alongside the 'Friends and Family' mechanism.

The PALS team continuously seeks to improve the service it provides; one of the ways is through setting high performance standards, such as ensuring that all telephone calls and emails are acknowledged on the same working day wherever possible. This is measured through a 'rate our service' survey, which is included in all emails and compliment slips.

The PALS department promotes its service in a number of ways including visibility on the home page of the Trust's website; it occupies an accessible office space located near the hospital main entrance. Also there is on-screen advertising through televisions positioned outside the PALS department and in other public areas around the hospital.

All PALS contacts are recorded electronically for case management and reporting purposes.

The PALS department continued to review and amend the subject codes used to categorise issues raised during 2021/22 to ensure that information was appropriately logged. This led to the development of additional categories so that less generic information was retrieved from the data captured, enabling improvements to be appropriately targeted. There have been significant changes incorporated within the department to be able to provide a breakdown of the type of contact recorded to ensure appropriate escalation and to streamline the service provided (i.e. PALS feedback, informal concern, concerns received through the Executive Team and MPs).

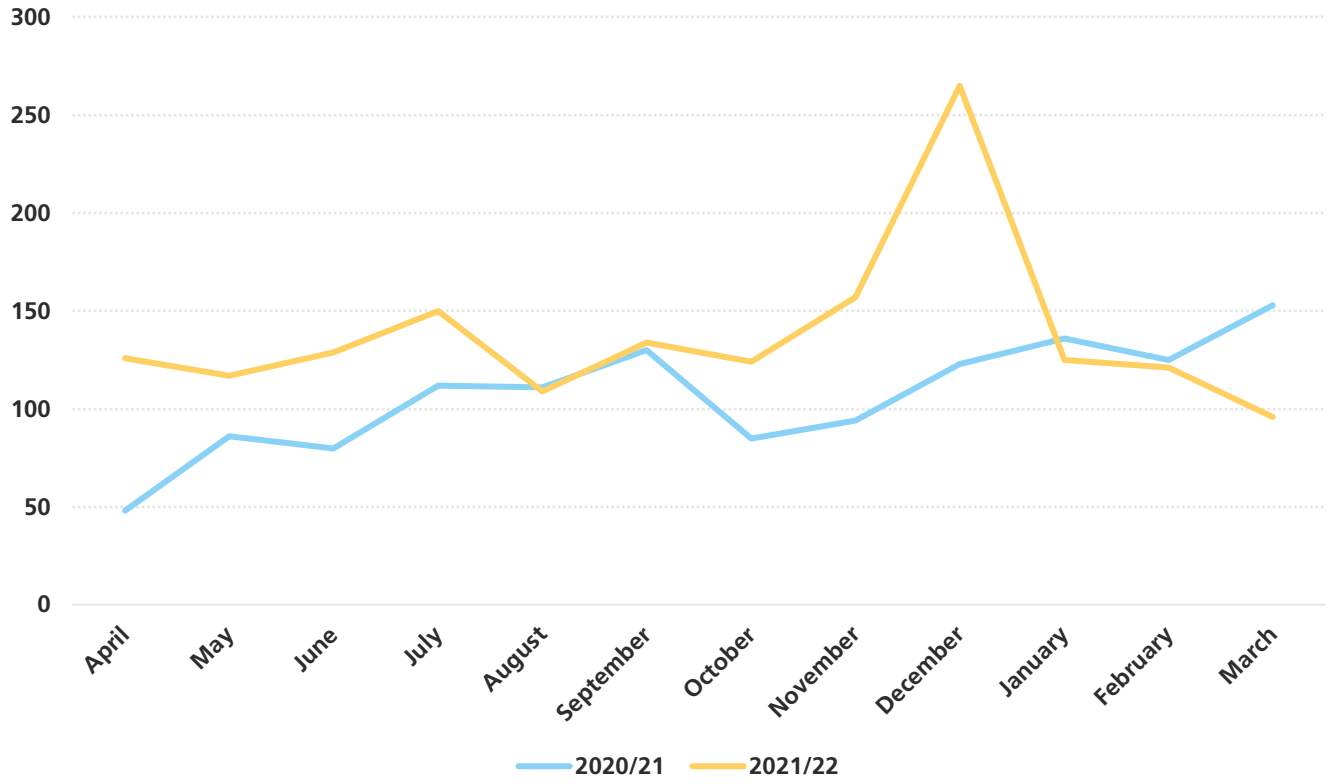
In 2021/22, 5,404 PALS contacts (excluding compliments) were logged. The top themes are outlined in the table below:

PALS by sub-subject (primary)	Number
General information	1,024
Poor communication	414
Clinical care	346
Enquiry	227
Access to health records	203
Lack of information	197
Staff attitude	196
Update on patient condition/wellbeing	186
Discharge arrangements	181
Travel expenses	150

2.13 Compliments

Along with feedback and concerns which are shared across the Trust, the PALS team log any compliments they receive, either in person, by email or when a card or gift is sent directly to the ward. When a compliment contains identifiable information such as an address, the Chief Executive sends a personal thank you. In 2021/22, 1,709 compliments were recorded, compared to 1,286 in 2020/21.

The PALS Department have recently implemented a weekly collection of compliments from inpatient areas to promote the importance of sharing positive experiences. There is a planned review in 2022/23 to explore how the recorded compliments can be used to further extrapolate evidence of good practice and service provision across the Trust. This is in addition to ensuring that all staff have sight of the appreciation that is received from service users.



2.14 Formal complaints

The role of the Complaints Team is to make sure that formal complaints are appropriately investigated and that a response is provided in a timely manner. The Trust received 90 formal complaints in 2021/22, which was a 59% reduction from the 220 received in 2020/21. The reduction in complaints is likely attributed to a number of reasons some of which include:

- The decline of the number of complaints received during the pandemic due to the suspension of some services
- The decline in footfall across the Trust relating to visiting restrictions,
- Increased virtual appointments
- And the revised process that has been implemented for complaints management

Complaints by method	Number
Email	63
Letter	19
Telephone	8

In 2020/21, the Trust had a significant number of overdue formal complaints awaiting response and was unable to achieve responding to 90% of cases within the agreed 30 working day time frame. During 2021/22, the Trust successfully completed a recovery trajectory to manage the backlog of complaints and to improve the complaints management process. In addition, the Trust has consistently achieved 100% compliance with the 30-working day response target for 9 months out of 12.

Complaints received are managed in a timely manner and when possible, complainants are encouraged to use the informal route to arrive at an agreeable resolution. If the complainant agrees to the informal route, appropriate contact is made by a senior member of staff. The Trust aims to resolve issues that are raised quickly and effectively to avoid the need for formal escalation. There has been an increase in the uptake of both face to face and virtual Local Resolution Meetings. The meetings provide complainants an opportunity to voice their concerns to senior staff and to have their concerns addressed.

The main themes from the complaints we received from patients and their families:

Complaints by sub-subject (primary)	Number
Delay or failure in treatment or procedure	9
Communication with relatives/carers	8
Attitude of medical staff	6
Communication with patient	4
Attitude of nursing staff/midwives	4
Delay or failure to undertake scan/x-ray etc	4
Delay or failure in treatment for infection	4
Inappropriate treatment	3
Acquired infection (i.e. not present on admission)	2
Failure to adopt infection control measures	2

The Trust's average complaint response rate has significantly improved. In 2021/22, an average percentage rate of 88% of complaints were responded to within the set time frame when compared to 2020/21, when the average response rate was 25%.

Written complaints rate

2021/22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clinical complaints	15	16	10	9	4	3	5	7	1	6	2	8
Response rates (%)	58	41	95	100	100	100	100	100	100	100	67	100
Non-clinical complaints	1	1	0	0	0	0	0	0	2	0	0	0

Further improvements for 2022/23

Further development and implementation of key priorities linked to Year Three of the Corporate Strategy to facilitate improvements in the care delivered to patients and their families include to:

- Launch a Customer Feedback Service that incorporate all types of feedback and complaints in a unified approach to improve patient experience
- Implement the outcome of a service review of changes to ways of working within the PALS Department to improve accessibility and responsiveness
- Continue to schedule masterclasses for staff to improve focus on customer service and raise awareness about the complaints process, as well as how to investigate and respond to complaints
- Introduce a revised approach to learning from concerns and complaints
- Continue to work with the Patient Safety Team so that we can make sure learning from complaints is shared effectively
- Aim to respond to 100% of complaints within 30 working days

2.15 Parliamentary and Health Service Ombudsman (PHSO)

There are times when, despite our best efforts, we are unable to resolve a complaint at a local level and the complainant remains dissatisfied. When this happens, the complainant may seek guidance from the Parliamentary and Health Service Ombudsman (PSHO) to ask for an independent investigation into their complaint and financial redress.

During 2021/22, 6 complaints were referred to the PHSO.

- 3 cases are currently under PHSO investigation and awaiting an outcome
- 5 cases are at preliminary referral stage, and we are awaiting a decision on whether the PHSO will proceed to investigate
- One complaint was partially upheld by the PHSO

2.16 Measuring and reporting patient experience

The Trust seeks to capture patient and carer experience by continuing to:

- Host events for patients and the public
- Seek invitations to attend meetings and events held by community organisations
- Listen to and learn from patients' stories at Board meetings
- Take part in national patient surveys
- Ensure patients and the public are represented at key Trust committees
- Read and respond to patients' and carers' feedback posted on the NHS and Care Opinion websites, Facebook, and Twitter

2.17 'Friends and Family' Test (FFT)

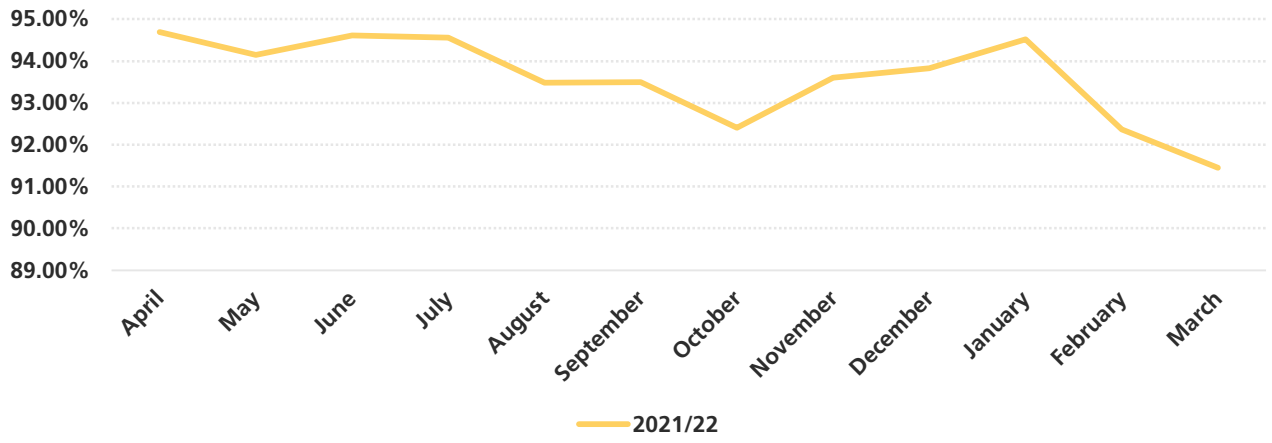
We commissioned a new provider of the 'Friends and Family' Test in conjunction with Norfolk and Norwich University Hospital in March 2021, which uses SMS texting to collect feedback in outpatients and ED. QR code posters are also displayed around the hospital to encourage patients to provide immediate feedback on the service they have received.

We continued to report on the indicative participation rates in 2021/22 as this reflects the representative nature of any themes identified through consideration of the total number of patients treated by the Trust. Also patients were given the opportunity to provide feedback at any point during their period of care (and could provide feedback multiple times if they wished).

The Trust has found that the free-text comments submitted with the FFT responses provides a valuable insight into issues and concerns that are important to patients. The FFT allows us to make changes based on patient feedback far more quickly than when awaiting results from other types of feedback. Feedback is shared with patients, staff and visitors and used in training courses to focus staff on the experiences that our patients have had and how we can improve things further. Working closely with the Patient Experience Team and the Ward Managers, we aim to actively respond to the comments made and in doing so provide a cohesive and reactive response to all concerns raised.

Positive feedback regarding specific wards or named individuals are shared on a regular basis to ensure that evidence of good practice is recognised.

As a snapshot guide, our average FFT satisfaction score from April 2021 to March 2022 was 93.61%.



We are taking the following actions to further improve these scores by:

- Ensuring monthly feedback is available to all senior staff to cascade to colleagues across the Trust
- Regularly collecting and sharing time-sensitive information with wards/areas to ensure an immediate response to rectify issues that require this approach
- Reintroduction of feedback with patients and the public through ward noticeboards, information screens and social media, and to staff through regular internal communications
- Reviewing the negative feedback received in conjunction with other sources of patient feedback (concerns, complaints, patient surveys) to monitor trends and identify actions required

2.18 Chaplaincy

Chaplaincy seeks to offer spiritual and pastoral care to all patients, staff and visitors. The team consists of three staff (2.4 FT equivalent) who along with slowly returning volunteers give patients a listening ear in the midst of their ever changing circumstances.

Stories

To begin the chaplaincy section of the Quality Account, chaplaincy offers you a story - a story of a patient who was not particularly religious but who valued the role of the chaplain with the Trust.

A chaplain was called by the ward to see a patient who had suffered a go-karting accident, which would stop him from engaging in motorsport in the future, a hobby he shared with his son. The patient had some complaints about doctors using jargon and loss of dignity. The chaplain offered compassionate listening and in response, the patient wrote in July 2021 to say: 'The purpose of this letter was not to tell you about me but to thank you for your kindness, both for your presence and your spoken words, during our meeting. Those together helped to lift me further away from a place that was getting ever darker as my period of hospitalisation continued and were appreciated more than you can ever understand'.

Figures

During 2021/22, the team:

- Visited 2,043 patients
- Supported 149 relatives
- Completed 318 bedside Holy Communions
- Conducted 10 adult funerals
- Conducted 42 baby funerals
- Conducted 21 naming and blessing services, or baby baptisms
- Had 649 end of life encounters
- Blessed one wedding

Three times a year, the Chaplaincy hold a bereavement support group which is open to all members of the community. In 2021, 15 people came along to the groups as chaplaincy led them in the journey through the grief process.

Special services

As Chaplaincy was unable to gather together patients and staff in the normal way due to COVID-19, the team recorded weekly services which were broadcast on the Trust's hospital radio station, as well as additional virtual services for YouTube. These included the annual baby loss memorial service, an Easter Sunday service, Christmas carol service, which was supported by staff who sang carols, and a Remembrance Sunday service. For the first time, the team also recorded a service for all those who had lost a loved one in the last year.

On Remembrance Day itself, one of the chaplains led a small service outside the main entrance at 11am, and was joined by many members of staff. The feedback received from patients who overlooked the main entrance was that it was extremely moving to see so many members of staff recognising the importance of the day.

The future

Later on this year the Trust will be opening a new Multi-faith prayer room, which will open up space within the Sacred Space. This will allow us to accommodate patients who (subject to ward approval) want to spend some time in a different environment within the hospital that is peaceful and quiet. This is independent of whether they class themselves as spiritual or religious.

3. STAFF COMMUNICATIONS AND ENGAGEMENT

The Trust's Staff Engagement Programme was refreshed for 2021/22 to deliver a step change in staff engagement and the way people felt about working at QEH. Learning from the 2021/22 programme was used to embed and further strengthen this work, while the impact of initiatives which have taken place has also been measured.

The programme remains front and centre of the Trust's Corporate Strategy, and has been supported by our Staff Engagement and Culture Forum and our BAME (Black, Asian and Minority Ethnic) and Allies, LGBTQ+ and Allies, Armed Forces and Disability Staff Networks.

KINDNESS	IMPROVE	WELLNESS	LISTEN	FAIRNESS	CELEBRATE	INSPIRE
Culture Transformation Programme (values into action for leaders and all staff)	Staff ideas scheme	Looking after our physical financial and mental health	Speak Up - champions and guardian	Equal opportunities for all regardless of ethnicity, sexual orientation, age or gender - including:	Team QEH Awards	Leadership development programme
Bespoke organisational development/culture intervention work	Quality, Service Improvement and Redesign (QSIR) training	Menopause awareness	Schwartz Rounds	Jobs and career opportunities	Long Service Awards (staff and volunteers)	Visible leadership
Daily message boards with inspirational messages	Project Management Office (PMO) angel	Occupational health and staff wellness tender - integrated service	Staff networks	Access to development opportunities	Staff idea of the month	Open door policy
	Personal Development Plan for everyone	Mental health first aiders	CEO and Executive Team briefings	To have your say	Monthly Values awards	Leadership Conference (annual)
	Randomised Coffee Trials	Weight loss	Staff Engagement Forum		Retirements	Managers' induction
	Ideas hubs	Sleep and rest	National Staff Survey		Team QEH success stories and our progress	
			Pulse surveys		Local and Divisional award schemes	
			Feedback pods		National Awards and honours	
			Medical Engagement Survey			
			Culture perception survey			
			Safety culture survey			

After listening to feedback from colleagues, we identified three main areas of focus for 2021/22, which were:

1. **Kindness**
2. **Wellness**
3. **Fairness**

A variety of initiatives have taken place during the year to support this work.

Kindness: Work which has taken place to create a culture of kindness includes:

- Providing practical tools to help staff role model, manage, coach, appraise and lead their teams through our Leading with Values masterclasses and Values into Action workshops
- Continuing to embed the behavioural standards detailed in 'The QEH Way'
- Promoting a culture of saying 'thank you'

Wellness: The Trust has built on the support services available to staff, which includes dedicated Clinical Psychology support. In addition, we have placed a continued focus on wellbeing by:

- Making improvements to staff rest and break areas
- Expanding the emotional and psychological support available to staff by recruiting additional Mental Health First Aiders and providing access to Change Grow Live services on-site
- Receiving accreditation as a 'Menopause Friendly' employer and introducing a new Peri-Menopause and Menopause Policy, Menopause Champions and education and training sessions for managers and staff. A menopause clinic for staff was also launched in March 2022
- Offering health MOT sessions for staff
- Recruiting the Trust's first Wellbeing Guardian
- Introducing a new app to keep our staff informed
- Being a member of the Cavell Nurse' Trust
- Introduction of a financial support and advice service for staff
- Offering gym memberships and our Employee Assistance Programme to staff

Fairness: During the year, we recruited an Equality and Diversity Lead and carried out a programme of work to promote equality.

This included:

- Making changes to interview panels to ensure gender balance and BAME representation on panels for jobs at band seven or above
- Developing our Anti-Racism Strategy

- Launching our "See Me First" campaign, which invites colleagues to sign a personalised pledge to uphold the Trust's values, promote inclusivity and celebrate diversity
- Further strengthening our staff networks
- Running our Diversity Café
- Celebrating the diversity of our workforce by displaying the 65 nationalities which make up Team QEH on our lift doors
- Introducing an Equality, Diversity and Inclusion calendar for 2022
- Launching 'My Reality', which provides guest speakers with a safe space to share stories and challenge stereotypes
- Providing reverse mentoring

3.1 Staff reward and recognition

At QEH, we recognise the importance of valuing and rewarding our staff and the impact this has on overall morale and staff experience.

During 2021/22, we celebrated the achievements of our colleagues at the annual Team QEH Staff Awards. This year, the awards were aligned to the Trust Strategy, with new categories introduced to reflect our diversity.

In addition, the Trust strives to ensure staff feel valued by offering:

- Long Service Awards for staff marking 15, 20, 25, 30, 35 and 40 years of service
- Long Service Awards for volunteers
- Monthly 'living our values' awards
- 'Team of the Week' recognition
- Recognition for retirees
- Appreciation vouchers for food and drink on special days and holidays
- Benefits through The Work Perks
- Staff recognition boards and walls at staff entrances
- Staff appreciation cards

3.2 NHS Staff Survey 2021

The NHS Staff Survey is carried out at the same time each year and offers a snapshot in time of how people feel about their working lives. The results are aggregated and provide a rich source of data which helps us to understand the experience of staff across the NHS.

The survey underwent some significant changes in 2021, with 32 new questions added and 24 removed. It was also aligned to the NHS People Promise, with reporting based around the seven People Promise elements.

In 2021, QEH recorded an increase in the number of staff completing the survey for the third consecutive year, and now sits just 1% below the national median. This is a positive reflection of the improved engagement which is taking place at the Trust.

Each Division or corporate area has a single point of contact who is responsible for progressing actions and encouraging staff to complete the national survey, as well as quarterly Pulse surveys, so that we can continue to make improvements.

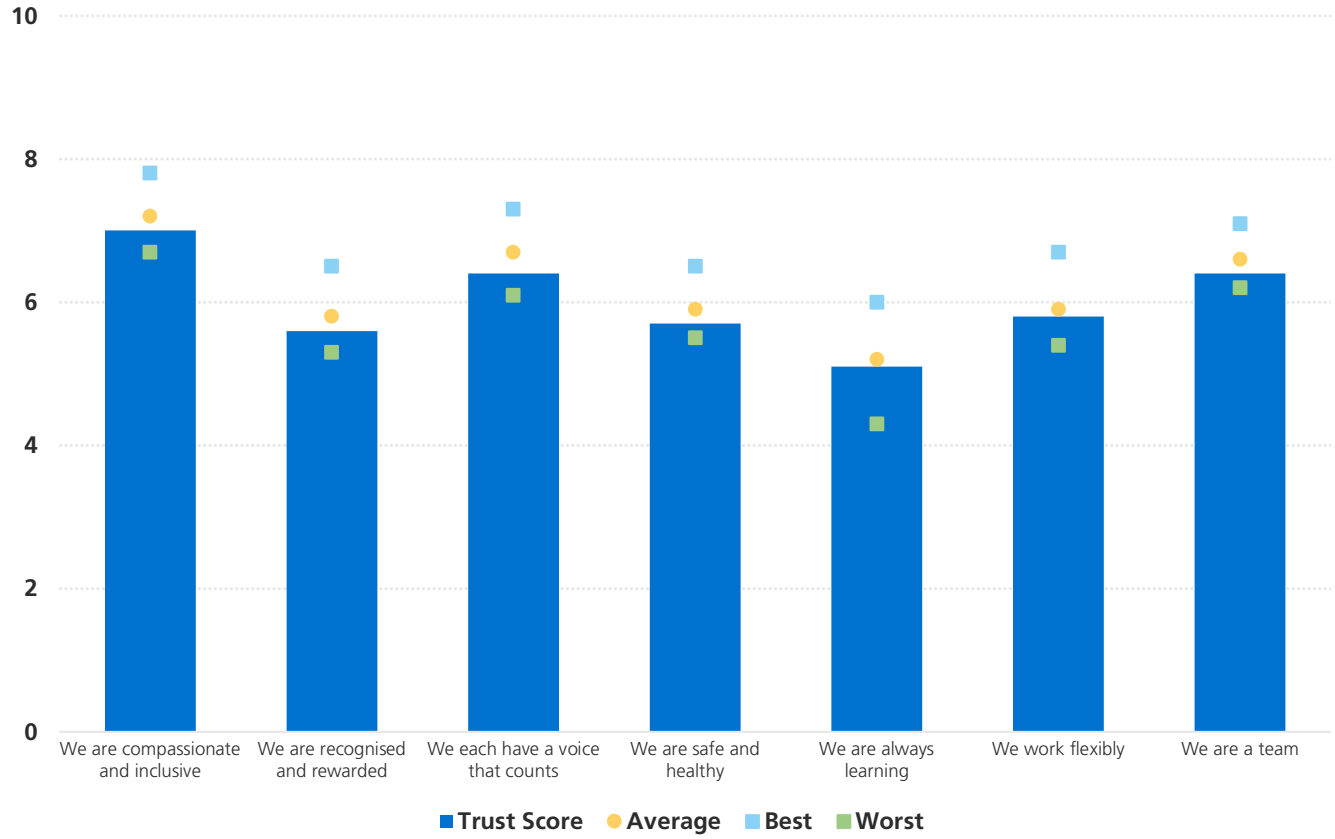
This is supported by a communications and engagement plan which keeps staff updated on actions which have been taken as a result of their feedback using a "you said, we did" format.

Looking to 2022/23 we will aim to build upon these results by placing a greater focus on:

- Relationships and team development
- Keeping staff well at work
- Developing a new staff engagement programme for 2022/23
- Continuing to encourage people to speak up without fear of reprise
- Creating a culture of kindness, fairness and wellness

Theme	2021 Trust score	Average score	Best score	Worst score	RAG rating
We are compassionate and inclusive	7.0	7.2	7.8	6.7	▼
We are a team	6.4	6.6	7.1	6.2	▼
We each have a voice that counts	6.4	6.7	7.3	6.1	▼
We work flexibly	5.8	5.9	6.7	5.4	▼
We are safe and healthy	5.7	5.9	6.5	5.5	▼
We are recognised and rewarded	5.6	5.8	6.5	5.3	▼
We are always learning	5.1	5.2	6.0	4.3	▼

NHS Staff Survey 2021 - score by theme



Measure	2021 Trust score	Average score	Best score	Worst score	RAG rating
Morale	5.5	5.7	6.5	5.3	▼
Staff engagement	6.6	6.8	7.4	6.3	▼

NHS Staff Survey response rate

2016	2017	2018	2019	2020	2021
44.90%	45.90%	44.10%	42.40%	44.60%	45.33%

3.3 Looking to 2022/23

In 2022/23, we will aim to build upon these results by placing a greater focus on:

- Relationship & team development
- Keeping staff well at work
- Developing a new staff engagement programme for 2022/23
- Encouraging people to speak up without fear of reprise
- Creating a culture of Kindness, Fairness & Wellness

4. PARTICIPATION IN CLINICAL AUDIT AND CONFIDENTIAL ENQUIRIES

4.1 Clinical Audit

Clinical audit is designed to improve patient care, treatment, and outcomes. Its purpose is to involve all healthcare professionals in a systematic evaluation of delivery of care against evidence-based standards, identify actions to improve the quality of care and deliver better care and outcomes for patients. The resulting recommendations enable local hospitals to drive up standards and enhance patient care and safety.

The Trust participates in national Healthcare Quality Improvement Partnership (HQIP) funded and non-HQIP national audits, local audits, and a few national confidential enquiries. During 2021/22, QEH took part in 59% (54/91) of the registered national audits and six national confidential enquiries.

Table 1 - Participation in national audit

Table one is a list of the national audits the Trust participated in. It outlines the number of cases submitted and percentage submission compliance of registered cases required by the terms of that audit or enquiry where available. It is important to note that some national audits can run for 12 to 14-months; therefore, at the time of producing this report, some audits were in progress, while others had data submitted and were awaiting published reports.

Table one also details the number of registered audits that the Trust did not participate in and the rationale for non-participation

Participation in clinical audits		
Audit title	**Participation**	**Case Ascertainment**
Case Mix Programme - data collected retro for 2020/21, after six months follow up	Yes	398 for Q3, Q4 ongoing; 100% of eligible cases submitted
Chronic Kidney Disease Registry	No	Primary care only
Cleft Registry and Audit Network Database	No	Cleft surgery and services are not provided at QEH
Elective Surgery (National PROMs Programme) on four procedures - varicose vein, hernia repair, hip and knee replacement	Yes	377 questionnaires submitted. 100% post-operative eligible patients
Emergency Medicine QIP - Pain in Children (Care in Emergency Departments	Yes	Five patients per month; 100% of eligible cases
Falls and Fragility Fracture Audit Programme - Fracture Liaison Service Database	Yes	100%
Falls and Fragility Fracture Audit Programme - National Audit of Inpatient Falls	Yes	100% reported falls
Falls and Fragility Fracture Audit Programme - National Hip Fracture (NoF) Database	Yes	100% reported NoF
Inflammatory Bowel Disease Audit	Yes	100% patients - actual submission < 30
Learning Disabilities Mortality Review Programme	Yes	100% of eligible cases
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100% of eligible cases
Mental Health Clinical Outcome Review Programme	No	Not relevant to QEH; for secondary and specialist mental health services - ongoing review of suicidal deaths
National Adult Diabetes Audit - National Diabetes Core Audit	No	Diabetes database not purchased and unable to collate the information

Participation in clinical audits		
Audit title	**Participation**	**Case Ascertainment**
National Adult Diabetes Audit - National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit - National Diabetes Footcare Audit	Yes	100% Diabetic Foot Clinic patients
National Adult Diabetes Audit - National Inpatient Diabetes Audit, including National Diabetes Inpatient Audit - Harms	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme - Paediatric Asthma Secondary Care	Yes	100% of eligible cases
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme - Adult Asthma Secondary Care	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme - Chronic Obstructive Pulmonary Disease Secondary Care	Yes	257/356 - 100% eligible patients; 75% compliance; deadline 13 May 2022
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme - Pulmonary Rehabilitation - Organisational and Clinical Audit	No	Relevant to Primary Care
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Not available at the time of writing
National Audit of Cardiac Rehabilitation	No	Trust not commissioned to provide cardiac rehabilitation
National Audit of Cardiovascular Disease Prevention	No	Relevant to Primary Care
National Audit of Care at the End of Life (NACEL)	Yes	100% consecutive deaths between advised dates - submitted 47
National Audit of Dementia	Yes	Minimum 25 records; (100%) submitted
National Audit of Pulmonary Hypertension	No	Dealt with in tertiary centre. Appropriate patients are referred to Papworth Pulmonary Vascular Department
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100% of eligible cases
National Cardiac Arrest Audit	Yes	Not available at the time of writing
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	No	Trust does not undertake advanced rhythm management
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project (MINAP)	Yes	326/461 cases; 72% compliance; deadline is 25 May 2022
National Cardiac Audit Programme - National Adult Cardiac Surgery Audit	No	Referred to cardiac centres - PAP/NNUH
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	No	Referred to cardiac centres - PAP/NNUH
National Cardiac Audit Programme - National Heart Failure Audit (NHFA)	Yes	461/626 cases; 74% compliance; deadline 8 June 2022
National Cardiac Audit Programme - National Congenital Heart Disease	No	Trust not a congenital heart disease centre
Child Health Clinical Outcome Review Programme (Child Death Review / Maternal Deaths / Perinatal Mortality)	Yes	100% of eligible cases
National Clinical Audit of Psychosis	No	Not relevant to QEH, it is for specialist mental care providers
National Comparative Audit of Blood Transfusion - 2021 Audit of Patient Blood Management and NICE Guidelines	Yes	24 cases; 100% of the sample size required

Participation in clinical audits		
Audit title	**Participation**	**Case Ascertainment**
National Comparative Audit of Blood Transfusion - 2021 Audit of the Perioperative Management of Anaemia in Children undergoing Elective Surgery	No	
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100% new EIA patients referred treated in first year of treatment - 35 pts in 2021/22. Mean performance against the six best practice tariff (BPT) KPI for QEH is 75%; NNUH 63% and JPUH 74%
National Emergency Laparotomy Audit (NELA) - rolling audit	Yes	101/104 cases submitted. 98% of eligible cases were submitted
National Gastro-intestinal Cancer Audit Programme: National Oesophago-gastric Cancer Audit (NOGCA)	Yes	147 cases submitted from Apr 2021 to Jan 2022. Final submitted figure only by Apr 2022. 96% of eligible cases
National Joint Registry (NJR) for 2019/20 and 2020/21	Yes	485 eligible cases submitted for 2019/20 and 170 eligible cases for 2020/21. Achieved 100% compliance for 2019/20 and 2020/21
National Lung Cancer Audit (NLCA)	No	The National Lung Cancer Audit is now being collected through the national COSD data
National Maternity and Perinatal Audit (NMPA) - Rolling	Yes	100% of eligible cases
National Neonatal Audit Programme (NNAP) - Rolling	Yes	100% of eligible cases
National Paediatric Diabetes Audit (NPDA) - Rolling	Yes	100% of eligible cases
National Prostate Cancer Audit (NPCA)	Yes	Not available at the time of writing
National Vascular Registry	No	Vascular Services not provided; referred to Addenbrookes
Neurosurgical National Audit Programme	No	Neurosurgical Services not provided
Out-of-Hospital Cardiac Arrest Outcomes Registry	No	For ambulance services, not acute sectors
Paediatric Intensive Care Audit	No	The Paediatric Intensive Care Audit Network (PICANet) does not currently receive data from units without level three intensive care unit for children
Prescribing Observatory for Mental Health - Prescribing for depression in adult mental health services	No	Not relevant to QEH; for subscribed members only
Prescribing Observatory for Mental Health - Prescribing for substance misuse: alcohol detoxification	No	Not relevant to QEH; for subscribed members only
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100% stroke inpatients - 619 records for 2021/22
Serious Hazards of Transfusion (SHOT)	Yes	100% transfusion cases
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100% patients on selected date of audit
Transurethral Resection and Single instillation Mitomycin C Evaluation in Bladder Cancer Treatment	Yes	43 records, 100% compliance
Trauma Audit and Research Network - (TARN) rolling audit	Yes	203 eligible cases, 175 completed, 28 outstanding, 86% compliance, deadline July 2022

Participation in clinical audits		
Audit title	**Participation**	**Case Ascertainment**
UK Cystic Fibrosis (CF) Registry	No	QEH is not listed as a participant in the CF Audit programme
Urology Audits - Cytoreductive Radical Nephrectomy Audit	No	The audit closed on 31 December 2020. The number of cases submitted was lower than the expected and there will be no national report
Urology Audits - Management of the Lower Ureter in Nephroureterectomy (NU) Audit - British Association of Urological Surgeons (BAUS) Lower NU Audit	No	Not for QEH service provision. Lower NU carried out at NNUH
Surgical Site Infection Surveillance Service (SSISS)	Yes	667 cases submitted as of March 2022, at 81% compliance
Each Baby Counts (Five-year project) - Rolling audit	Yes	100% of eligible patients
Endometrial Cancer 2021/22	Yes	100% of eligible patients
National Smoking Cessation Audit	No	Missed registration window
SSNAP Post-Acute Organisational Audit 2021	No	No data submitted due to a lack of resource to undertake audit
National Emergency Laparotomy Audit (NELA) Frailty Component	Yes	Not available at the time of writing
Royal College of Emergency Medicine (RCEM) QIP 1 Consultant Sign off	No	Cancelled by RCEM. Topic no longer included in QIP
RCEM QIP 2 Cognitive Impairment in Older People	No	Cancelled by RCEM. Topic no longer included in QIP
RCEM QIP 3 Mental Health	No	Cancelled by RCEM. Topic no longer included in QIP
Point Prevalence Study on Antibiotic Prescribing	Yes	100% of eligible patients
Thalidomide PPS audit (Celgene audit). Data collected 14/12/2021 to 14/01/2022	Yes	10 patients identified. 100% of eligible cases
National Gastro-intestinal Cancer Audit Programme: National Bowel Obstruction Cancer Audit (NBOCA)	Yes	153 eligible cases submitted for 2019/20. Achieved 97% compliance. 2020/21 results not available at the time of writing
Breast Cosmetic Implant Registry - National	Yes	Not available at the time of writing
National Hip Fracture Database - 120 days Follow Up discussion	Yes	Not available at the time of writing
National Joint Registry Audit (including Elbow) 2021/22	Yes	Not available at the time of writing. Deadline June 2022.
(SEC1339) National Observational Multicentre Study into the Effect of the Pandemic on the Management of Ureteric Stones	Yes	Phases one and two completed; phase three to commence post-COVID-19 or after September 2021
UK Registry of Endocrine and Thyroid Surgery	Yes	Currently partial compliance - 14/24 cases to submit
NAP7: Perioperative Cardiac Arrest	No	Missed the one-week snapshot window for QEH submission
National Bariatric Surgery Register	No	Bariatric surgery service is not provided at QEH
National Cancer Diagnosis Audit (NCDA)	No	GP audit only. Audit timescale was 2019 to 2021. Now closed

Participation in clinical audits		
Audit title	**Participation**	**Case Ascertainment**
National Head and Neck Cancer Audit (HANA)	No	Service not provided; cancer patients are referred to NNUH
National Ophthalmology Audit (NOD)	No	Cataract Service is provided however Medisoft application software and installation not cost effective at £50,000. Not purchased
Perioperative Quality Improvement Programme (PQIP)	No	Research audit; not mandatory, so is not a requirement
Urology Audits British Association of Urological Surgeons (BAUS) - Renal Colic Audit	No	BAUS closed these audits, as the provider pulled out of the data submission and apologised for this error caused
Urology Audits - BAUS Female Incontinence	No	Service is not provided; moved to NNUH
Sentinel Stroke National Audit Programme (SSNAP) - sprint audit for stroke mimics	No	Missed the window for the data collection
National Transfusion in Surgery Audit (NCABT into surgical PBM)	Yes	126 patients were identified. Only three patients were identified as being transfused (with another excluded) 100% eligible patients
RCEM QIP Infection Prevention & Control	Yes	100% applicable records - 25 patients to date
RCEM QIP Pain in Children	Yes	100% applicable records - 86 patients to date
Post Colonoscopy Colorectal Cancer (PCCRC) Audit	Yes	Data available after April 2022. Part of JAG accreditation requirement

4.2 Learning from National Clinical Audits

National Audit - Bowel Cancer Audit (NBOCA)

At the end of September 2021, the Trust was identified as an outlier as the data submitted for the NBOCA was less than 20%, or the tumour, node, metastasis (TNM) stage was missing in more than 80% of patients included in the analyses for the period of April 2019 to March 2020. QEH had historically been identified as an outlier between 2014 and 2019 because of data quality issues. To resolve this, a huge data reconciliation exercise began in October 2021, which resulted in the submission of missing tumour staging data, pathology results and ASA scores from 2014 to 2020. The national team lead noted that it was the largest data entry seen in the past four years. Following the data reconciliation, in November 2021, the Trust was announced as:

1. First place when benchmarked against regional hospitals in the total and percentage (%) cancers discussed at MDT with a full stage (88%)

L2.3a - Total and % cancers discussed at MDT with a full stage	Trust Average	
NCRAS Eastern	**20,779**	**58%**
Bedfordshire Hospitals (Bedford & Luton)	1,838	75%
Cambridge University Hospitals	2,420	73%
East And North Hertfordshire	909	38%
East Suffolk & North Essex (Colchester & Ipswich)	1,779	36%
James Paget University Hospital	945	71%
Mid & South Essex (Basildon, Broomfield & Southend)	3,641	43%
Norfolk & Norwich University Hospitals	2,997	69%
North West Anglia (Peterborough & Hinchingbrooke)	1,679	65%
Papworth Hospital	309	87%
Princess Alexandra Hospital	532	50%
Queen Elizabeth Hospital King's Lynn	1,095	88%
West Hertfordshire Hospitals	1,510	76%
West Suffolk	1,125	83%

2. Joint first place with Papworth for full staging at diagnosis (87%)

L2.1j - Total and % stageable cancers with a full stage at diagnosis	Trust Average	
NCRAS Eastern	**21,681**	**52%**
Bedfordshire Hospitals (Bedford & Luton)	1,890	73%
Cambridge University Hospitals	2,599	56%
East And North Hertfordshire	986	24%
East Suffolk & North Essex (Colchester & Ipswich)	1,807	32%
James Paget University Hospital	957	69%
Mid & South Essex (Basildon, Broomfield & Southend)	3,758	41%
Norfolk & Norwich University Hospitals	3,134	65%
North West Anglia (Peterborough & Hinchingbrooke)	1,729	65%
Papworth Hospital	309	87%
Princess Alexandra Hospital	690	50%
Queen Elizabeth Hospital King's Lynn	1,145	87%
West Hertfordshire Hospitals	1,529	76%
West Suffolk	1,148	83%

3. Second place for total and percentage (%) cancers discussed at MDT with a performance status (94%)

L2.1j - Total and % cancers discussed at MDT with a performance status	Trust Average	
NCRAS Eastern	**22,022**	**61%**
Bedfordshire Hospitals (Bedford & Luton)	1,958	80%
Cambridge University Hospitals	2,378	72%
East And North Hertfordshire	1,014	42%
East Suffolk & North Essex (Colchester & Ipswich)	2,931	59%
James Paget University Hospital	1,096	82%
Mid & South Essex (Basildon, Broomfield & Southend)	2,957	35%
Norfolk & Norwich University Hospitals	2,664	61%
North West Anglia (Peterborough & Hinchingbrooke)	1,979	77%
Papworth Hospital	353	100%
Princess Alexandra Hospital	898	84%
Queen Elizabeth Hospital King's Lynn	1,181	94%
West Hertfordshire Hospitals	1,411	71%
West Suffolk	1,202	89%

4. Third place for total and % cancers diagnosed with a Clinical Nurse Specialist (CNS) indication code submitted (92%).

L2.1lf - Total and % cancers diagnosed with a CNS indication code submitted	Trust Average	
NCRAS Eastern	**30,997**	**75%**
Bedfordshire Hospitals (Bedford & Luton)	2,192	85%
Cambridge University Hospitals	4,153	90%
East And North Hertfordshire	2,922	72%
East Suffolk & North Essex (Colchester & Ipswich)	3,682	64%
James Paget University Hospital	1,054	76%
Mid & South Essex (Basildon, Broomfield & Southend)	5,696	63%
Norfolk & Norwich University Hospitals	3,628	76%
North West Anglia (Peterborough & Hinchingbrooke)	2,172	81%
Papworth Hospital	354	100%
Princess Alexandra Hospital	1,348	98%
Queen Elizabeth Hospital King's Lynn	1,213	92%
West Hertfordshire Hospitals	1,777	88%
West Suffolk	806	58%

5. First place for total and % cancers diagnosed who had a CNS contact (91%)

L2.1g - Total and % cancers diagnosed who had a CNS contact	Trust Average	
NCRAS Eastern	**21,777**	**53%**
Bedfordshire Hospitals (Bedford & Luton)	2,062	80%
Cambridge University Hospitals	1,322	29%
East And North Hertfordshire	1,248	31%
East Suffolk & North Essex (Colchester & Ipswich)	3,063	54%
James Paget University Hospital	924	67%
Mid & South Essex (Basildon, Broomfield & Southend)	4,110	45%
Norfolk & Norwich University Hospitals	2,637	55%
North West Anglia (Peterborough & Hinchingbrooke)	1,746	65%
Papworth Hospital	189	53%
Princess Alexandra Hospital	907	66%
Queen Elizabeth Hospital King's Lynn	1,195	91%
West Hertfordshire Hospitals	1640	81%
West Suffolk	734	53%

The data collected for both the Cancer Outcomes and Services Dataset (COSD) and NBOCA are very similar, which gives further assurance that the Trust's cancer audit data is currently at the required standard.

In addition, the learning from the data reconciliation exercise has led to a review of the process of data inputting to mitigate against future problems with data migration to the national team. As a result, the Compliance Manager for Cancer Services will support the Clinical Audit Team with data collection and the quality assurance process before submission to ensure case attainment is met monthly.

4.3 National Confidential Enquiries

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) projects improve standards by identifying common poor practice. The work undertaken by the various National Confidential Enquiries involves reviewing patient care nationally. The Trust participated in six relevant national enquiries, as outlined in table two:

Audit title	Stage	Number of patient records required
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Out of Hospital Cardiac Arrest Outcomes (OOHCAO)	A recommendations checklist was completed	92% of the recommendations made were already embedded in normal clinical practice; 7% were not applicable to the Trust
NCEPOD Epilepsy Study	Data upload at 100%	Six patients identified
NCEPOD Alcohol Related Liver Disease	Data upload at 100%	83 patients met the eligibility criteria; 14 were admitted to critical care and five had mortality reviews
NCEPOD Transition Study Patient	Data upload at 100%	Five patients identified
NCEPOD Crohn's Disease	Currently under development	12 patients identified; five patients confirmed for the 2022/23 study
NCEPOD Testicular Distortion	Currently under development	15 patients identified

4.4 Local audits

The Trust registered 235 local audits during 2021/22 and participated in 82% (193/235).

Learning from local clinical audits

Two new local audits were instigated as part of the Trust's wider improvement actions around documentation in response to a CQC 29A section warning notice from a historical inspection: "Records did not provide a full plan of individualised care and did not accurately reflect the needs or wishes of patients. Patient's preferences and individual needs were not considered. There was inconsistent and incomplete record keeping in the Emergency Department. An individualised plan of care was not established for patients at the end of life. Patients requiring end of life care did not always receive appropriate care that met their needs."

Multi-Disciplinary Team (MDT) Documentation Audit

This monthly audit began in October 2020 with support from junior doctors, who sample 10 patient notes from each of our 19 inpatient wards. The questions focus on measuring the condition of paper records, use of personal signatures, documentation of regular assessments, review of care by the responsible clinician and a plan of care aligned to the working diagnosis. The results are reviewed at the monthly Multi-Disciplinary Documentation Forum and Divisional Board meetings with clinical leaders.

The audit has identified several areas of good practice including:

- Clear identification of a management plan from each ward round entry, which includes interventions, change of treatment and discharge planning
- Admission notes documented on the appropriate specialty (Medical/Surgical/Orthopaedic/Pre-assessment) clerking admission proforma
- Clear documentation of diagnosis/ provisional diagnosis at admission or discharge
- Addressograph/ID on each sheet/once if a booklet

The MDT Documentation Audit has supported the development of SMART documentation improvement plans, which are owned by the Divisions of Medicine and Surgery. Noted actions for improvement include:

- Venous thromboembolism (VTE) documentation
- Fluid balance charts
- Clinical entries to have an identifiable signature or stamp
- Dementia assessments
- Documentation of communication of patient condition with patient and relatives
- Assessment of mental/psychological state

Emergency Department Information Systems (EDIS) Audit

The EDIS audit originally started as a pilot study in September 2021 and involved a review of 10 patient electronic records for patients that had been in the Emergency Department (ED) for more than three hours and a decision to admit had been agreed.

The original questions were amended with support from ED MDT in October 2020. The audit is now being undertaken monthly and the results reviewed at the monthly Multi-Disciplinary Documentation Forum. In March 2022, the sample size was increased to 50 patients to optimise the reliability and validity of the data. The following positive improvement actions have resulted from learning from this audit:

- Food and fluids are regularly and routinely offered to patients whilst in ED
- Patients have their pain score documented within twenty minutes of arrival
- Social history is documented
- Allergies are documented
- Clinical frailty score for patients over 65 is recorded

5. RESEARCH AND INNOVATION

QEH remains one of the most research active Trusts in the country compared to similar-sized hospitals.

In 2021/22, we included specific research and innovation milestones in our Corporate Objectives to broaden and diversify participation in research among QEH staff and patients, increase capacity to deliver research and increase visibility of research activities and output. We also published our Clinical Strategy, which includes the aim of becoming a centre of excellence while building research and education into every clinical encounter in our care. We are well on our way to delivering this.

Research activity

We recruited more than 1,000 participants to National Institute for Health Research (NIHR) portfolio studies in 2021/22. This represented a 33% rise in participation rate from 2019/20, which is used as a reference because of the unprecedented level and restricted scope of research activities during the pandemic in 2020/21.

Significant strides have been made over the past year towards recovering non-COVID-19 studies which were suspended during the pandemic. As a result, non-COVID-19 study activities increased from less than 10% in 2020/21 to 70% in 2021/22.

The research team carries a portfolio of 45 active and 38 'follow-up' only studies. In 2021/22, we successfully recruited to 37 of the 45 active studies which covered more than 14 specialties including infectious diseases, cancer, stroke, renal, reproductive health, anaesthesia and pain management, neurology, orthopaedics, diabetes, critical care, surgery, dermatology, radiology and mental health. During the year, we also added new specialties to our research portfolio, including radiology, psychology, dietetics, dementia and speech and language therapy.

In 2021/22, 30 trainee doctors were involved in research in different capacities including identification, recruitment, consent of potential patients and acting as principal investigators. Eight new principal investigators and four associate principal investigators were enrolled and trained to lead clinical studies. In a bid to increase capacity to deliver research among QEH's staff, we also recruited and trained five bank research nurses from our existing staff. In addition, we supported a specialist physiotherapist in pain management by funding his protected time and obtaining regulatory approval to initiate a clinical study to investigate the feasibility of virtual reality in the management of chronic pain. This is the first time that QEH has supported a member of our allied health professional team to become a principal investigator in line with our determination to expand the reach of research across the Trust. QEH also hosted three home-grown NIHR adopted portfolio studies which included another first for the Trust - our first ever locally initiated drug trial: Efficacy of a Streamlined Heart Failure Optimisation Protocol for patients with severely impaired left ventricular systolic function (SHORT trial).

The Trust's excellent reputation for research and innovation continues to receive acclaim, both externally and within the organisation. We were awarded the Health Service Journal (HSJ) Patient Safety Innovation of the Year Award in 2021 for inventing the Safer Injection for Regional Anaesthesia (SAFIRA) device, while the research team also won Clinical Team of the Year at the QEH Staff Awards.

6. REDUCING AND ELIMINATING HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

The Trust's Strategy for Infection Prevention and Control provides standards for the prevention and control of infections. It includes objectives based on the Code of Practice within the Health and Social Care Act 2008 (updated 2015), known as the Hygiene Code, and related guidance from the Department of Health.

6.1 Management structure for infection prevention and control

The Director of Infection Prevention and Control (DIPC) leads the Trust's work on the prevention and control of infection, and is supported by the Infection Control Doctor, Deputy DIPC and the Infection Prevention and Control Team.

6.2 Healthcare HCAI data

NHSE/I sets thresholds for MRSA bloodstream infection (BSI) and C. Difficile. Thresholds for Gram negative blood stream infection (BSI), including E. coli, Klebsiella species and Pseudomonas aeruginosa, were introduced in July 2021.

Oversight of these is provided by the Clinical Commissioning Groups (CCGs). Post infection review (PIR) is undertaken for all cases by the patient's clinical team and should be reviewed by the Infection Prevention and Control Team (IPCT) and CCG IPC lead within 30 days of the specimen date. This timely review allows for learning to be identified so that changes can be made to practice where necessary to improve safety outcomes for future patients.

National surveillance is mandatory for the following organisms and is reported via the Health Care Associated Infection Data Capture System (HCAI DCS):

- Methicillin resistant staphylococcus aureus (MRSA) bacteraemia (BSI)
- Clostridium difficile infection (CDI)
- Gram negative blood stream infections (GNBSI): Escherichia coli (E. Coli) bacteraemia (E. Colib), Methicillin sensitive staphylococcus aureus bacteraemia (MSSAb), Klebsiella spp, Pseudomonas aeruginosa

The ceiling for Methicillin Resistant Staphylococcus Aureus (MRSA) BSI for 2021/22 was zero.

For the year 2021/22 there has been one MRSA bloodstream infection. Whilst this case has been attributed to the Trust, following a post infection review process involving the Infection Control Doctor, the Deputy Director for Infection Prevention Control and Infection Control Lead for the CCG, it was decided that the MRSA was most likely a contaminant. This decision was made on the basis that screening swabs were negative for MRSA, no deep focus of infection was found, repeat blood cultures taken prior to starting effective antibiotics were negative and the patient had made clinical and biochemical improvement prior to starting anti-MRSA antibiotics.

To keep patients safe, MRSA screening continues to take place across the Trust on admission and weekly thereafter, as required.

For Methicillin Sensitive Staphylococcus Aureus (MSSA) BSI, no ceiling had been set for 2021/22. There have been 25 cases of MSSA BSI associated with the Trust.

The ceiling for CDI was fewer than 40. The number of cases reported in 2021/22 was 55, with 29 of these cases attributed to the Trust and 26 not attributed to the Trust. No cases remain under review to determine attribution and cause.

Actions taken to reduce healthcare associated CDI are:

- Post infection reviews are undertaken for each case and managed by the IPC Team, IPC doctor and supported by the CCG. Lessons learned are shared across the Trust
- Bespoke education / training provided to affected areas
- Education at induction / mandatory training
- A Trust CDI policy is in place and up to date with national guidance
- Site team educated in isolation room prioritisation
- Antimicrobial stewardship management and engagement in place
- Addressing outbreaks and periods of increased incidence promptly undertaking measures to reduce any further transmission
- National cleaning standards in place across the Trust and audits undertaken for assurance.
- Domestic and housekeeping staff trained in national cleaning standards
- IPC Team support procurement colleagues to ensure effective and efficient cleaning products are purchased and in place
- Supportive programme of audit including hand hygiene, PPE usage, isolation and environmental cleaning in place
- Practice Development Nurses provide training e.g. aseptic non-touch technique (ANTT)
- Review of individual cases and prompt undertaking of measures to reduce any further transmission
- Attendance at the monthly harm free care meetings to raise awareness (catheter care, nutrition, hydration)
- Safety Thermometer in place across the Trust to monitor catheter-related infections

Gram-negative bloodstream infections (GNBSIs)

The NHS reviewed the 2016 plan for reducing GNBSIs during 2019/20 and reset the long-term plan for a 50% reduction in GNBSIs by 2024/25. Preventing bloodstream infections is anticipated to have a major impact on reducing the rise in antibiotic resistance through reducing the need to prescribe antimicrobials. The IPC Team continues to work with CCG colleagues to identify causes of GNBSI, both those that are community and hospital associated.

During 2021/22, the Trust reported 50 GNBSIs.

6.3 Challenges this year

Preparation and planning for the COVID-19 pandemic began in January 2020. On 11 March 2020 the World Health Organisation declared a pandemic and two days later, on 13 March, the Trust had its first positive case. We continue to work diligently, in line with national guidance, and evolve in response to the many challenges faced by the Trust at this unprecedented time to ensure the best possible protection for our patients, staff and visitors.

The Infection Prevention and Control Team structure remains a challenge in terms of resourcing of substantive posts and in particular registered nurse establishment and leadership. The team is currently led by the Deputy DIPC, although there is funding to recruit a permanent Head of IPC. To date, recruitment to this post has been unsuccessful and options are under review.

In addition, the IPC Team does not have timely and accurate systems for IPC data management. Data submission, extraction and processing and production of IPC reports, for both internal and external requirements, has therefore become increasingly challenging. Information Services now have a dedicated IPC data analyst in post who is establishing databases and platforms to support the IPC service.

6.4 Multi-agency visits

In September 2021, Grant Thornton undertook an internal within the Trust against the Board Assurance Framework for IPC and associated policies. A total of 19 clinical areas were visited and the audit concluded significant assurance with some improvement required (three recommendations and two improvement points).

This was a significant improvement from the 2019 audit, when the Trust received 21 recommendations.

The result is evident that infection prevention procedures are in place and demonstrates the considerable commitment all staff have in working towards protecting patients, staff and visitors from avoidable infection.

7. COVID-19 PANDEMIC

On 30 January 2020, NHS England & Improvement (NHSE/I) declared a level four incident (the highest level) in response to COVID-19. This is defined as "an incident that requires NHS England national command and control to support the NHS response". In this situation, direction from the national team is actioned through the regional team.

The incident was de-escalated to level three on 25 March 2021. However, on 13 December 2021, NHSE/I further declared a level four incident in response to the threat from the Omicron variant of COVID-19, asking all NHS organisations to put in place robust governance arrangements to prepare for and respond to the Omicron threat. In particular, acute Trusts were asked to:

- Ensure the successful ramp up of the vital COVID-19 vaccine programme
- Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation
- Create the maximum possible capacity for urgent and emergency care, maintain priority access for elective care and create capacity to respond to a potential increase in COVID-19 demand

From the end of December 2021, there has been a steady increase in the number of COVID-19 positive inpatients at QEH, peaking in March 2022 with 130 COVID-19 positive inpatients. This compares to a peak in wave one on 18 April 2020 when there were 90 positive patients in the Trust and a peak in wave two on 14 January 2021 at 206 patients.

7.1 COVID-19 Governance arrangements

The Trust, like other NHS organisations, put in place robust governance arrangements to manage the COVID-19 pandemic. These have continued through 2021/22 and will remain in place until the incident level is stood down nationally.

7.2 Workforce

As part of QEH's response to COVID-19, staffing rotas were reviewed and individuals were redeployed to work in other areas of the Trust to support the response to the pandemic. All areas developed business continuity and escalation plans which outline the resourcing trigger points and the process for utilisation of staff once the trigger point has been hit. These were based on site escalation plans, patient acuity, peaks and staffing levels and have remained in place throughout 2021/22.

A number of processes and policies have been amended and implemented to ensure that the Trust has been able to respond to the pandemic and national guidance, and to support social distancing, testing and visiting while ensuring all staff had the correct PPE at all times. The Trust has also invested significantly is looking after, listening to and caring for Team QEH and continues to do so, ensuring staff health and wellbeing remains at the heart of our response to the COVID-19 pandemic.

7.3 Infection prevention and control

The COVID-19 pandemic brought an unprecedented challenge to hospital infection control. High community prevalence, high infectivity and asymptomatic carriage of the virus, and in particular the Omicron variant, provided a unique set of challenges when preventing the spread of the virus in a healthcare environment. Throughout the pandemic, the Trust has responded rapidly to any new infection prevention and control guidance.

Healthcare associated COVID-19 - case definition and QEH numbers

The current national definition of hospital-acquired infection with COVID-19 includes:

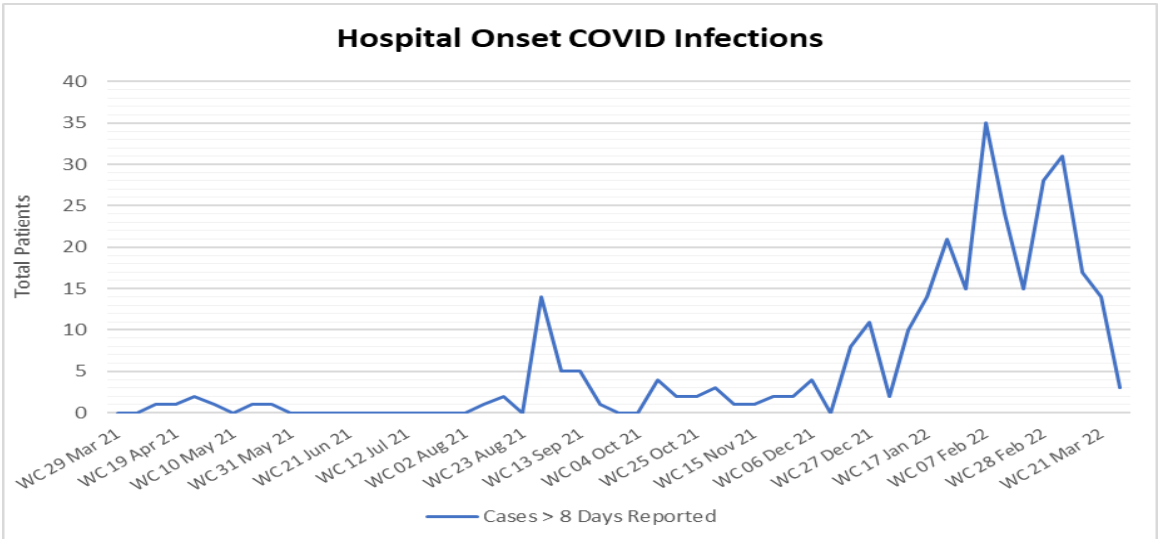
- Definite healthcare-associated (onset of illness or first positive sample on or after day eight of admission) and
- Probable healthcare-associated (onset of illness or first positive sample on or after day eight of admission)

	Community onset cases (First positive test day 0-7 of admission)	Healthcare onset cases (First positive test >= Day 8 of admission)	Total
Wave one (March to May 2020)	362	58*	420
Wave two (October 2020 to March 2021)	839	286**	1,132
April 2021 to April 2022	929	304**	1,233
Totals	2,130	590	2,785

* The actual number of healthcare onset cases during wave one will be lower due to the lack of admission screening of all patients at the start of the pandemic

** Numbers reported to NHS England. Please note that a proportion of these will be community-acquired

The graph below summarises the number of cases of COVID-19 diagnosed more than eight-days following admission to QEH during the pandemic. An initial peak was seen in August/September 2021, followed by a second broader and longer peak at the end of December, which coincided with the arrival of the Omicron variant in West Norfolk.



7.4 Outbreak response

The current criteria for declaring an outbreak of COVID-19 in a healthcare environment is two or more test-confirmed or clinically suspected cases among individuals associated with a specific setting where at least one case (if a patient) has been identified as having illness onset after eight days of admission to the hospital.

During 2021/22 a total of 35 outbreaks have been declared across the Trust.

Summary of learning from outbreaks

Recent months have provided an opportunity for much learning and insights into human factors and behaviours. Both local and system-wide learning include:

- Change mindset from protecting self to protecting others by changing the way people think about risk
- Unify and reinforce knowledge on IPC rules and the infection risk
- Dispel the myths - there's no such thing as 'COVID safe' or an 'in the work bubble'
- Create a speak up culture where it is acceptable to remind and be reminded
- Make it easier for staff by removing infrastructure barriers (where feasible) in key hotspots and reinforce rules for these areas with situational reminders

Patient group

- Poor compliance to mask wearing for inpatients
- Each bed move increases risk for the patient
- Non-concordant patients - increasing challenging behaviours

Environment

- Confirmed contacts from different index cases should not be mixed without risk assessment and agreement by the Infection Prevention and Control Team
- Ageing estate

Other factors

- Poor compliance with swabbing regimes
- Data not always in real time, from data collection systems
- Data reporting reliant on manual transcribing - increase risk with human error

Learning - staff

- Poor compliance with infection prevention and control guidance, such as uniform compliance
- Incorrect usage of PPE, for example within corridors/no patient contact
- COVID fatigue
- Escalating infection prevention and control issues in a timely manner of support enablement of safe holistic care/visiting

7.5 Testing

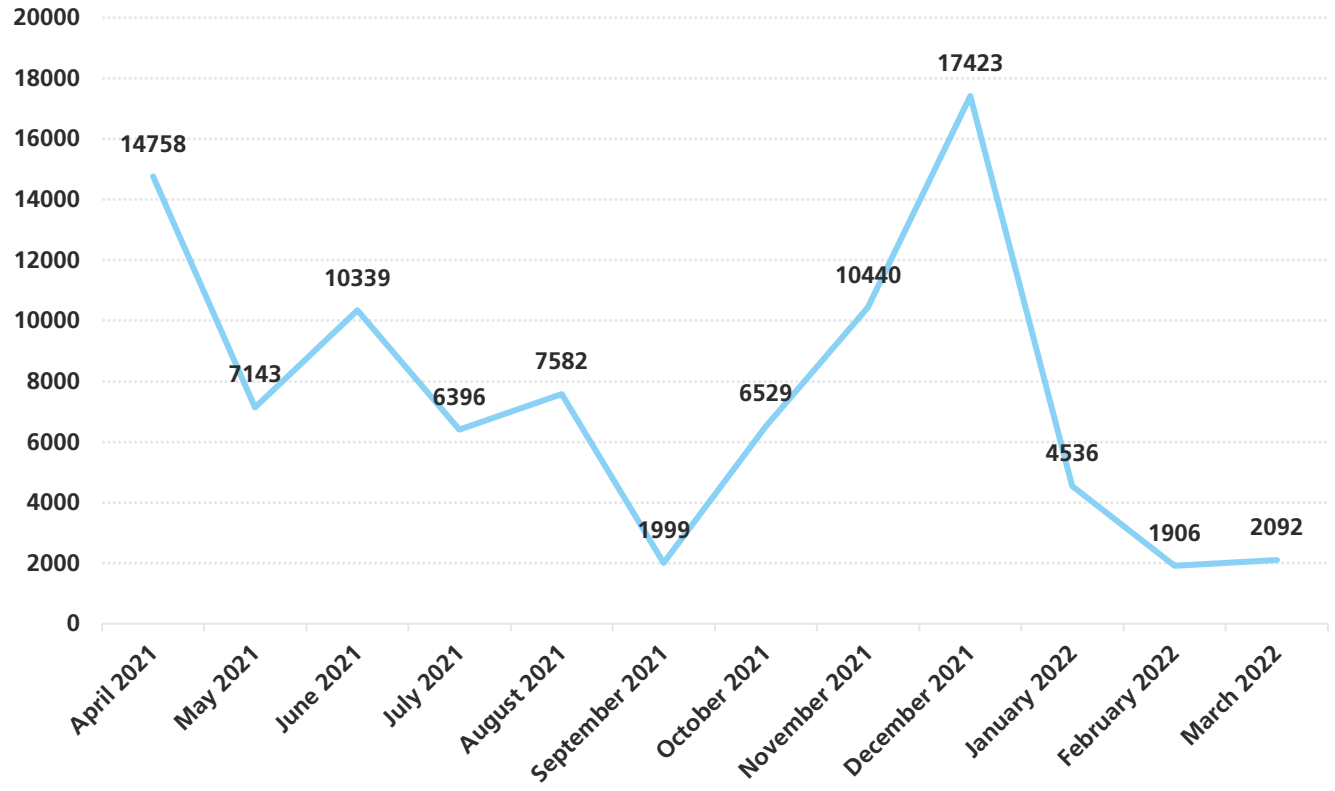
The Eastern Pathology Alliance (EPA) has been pivotal in the local and regional response to the COVID-19 pandemic. The provision of fast and reliable testing for the presence of COVID-19 in both patients and staff is vital both for patients' management and to ensure best infection prevention and control practice. From April 2021 to March 2022, the Trust submitted 60,858 tests for processing; 1,660 of which were positive. Patients being admitted to hospital are screened in line with national guidance.

From December 2020 and throughout 2021/22, the Trust's rapid diagnostic laboratory has provided testing capacity on the QEH site in a significantly reduced time (under four hours) seven days a week. The service has been used to help patient placement, manage patient movement and facilitate rapid discharges of patients requiring social care input.

7.6 COVID-19 vaccination programme

The COVID-19 vaccination programme began on 30 December 2020 and has continued during 2021/22 at both The Inspire Centre at Queen Elizabeth Hospital and in Downham Market.

Our aim was to offer and deliver 100% vaccinations to our staff, other health and social care staff and identified patient groups within the community. This programme has continued to deliver vaccinations to all age groups as defined nationally and has supported 91,170 individuals to receive their vaccination.



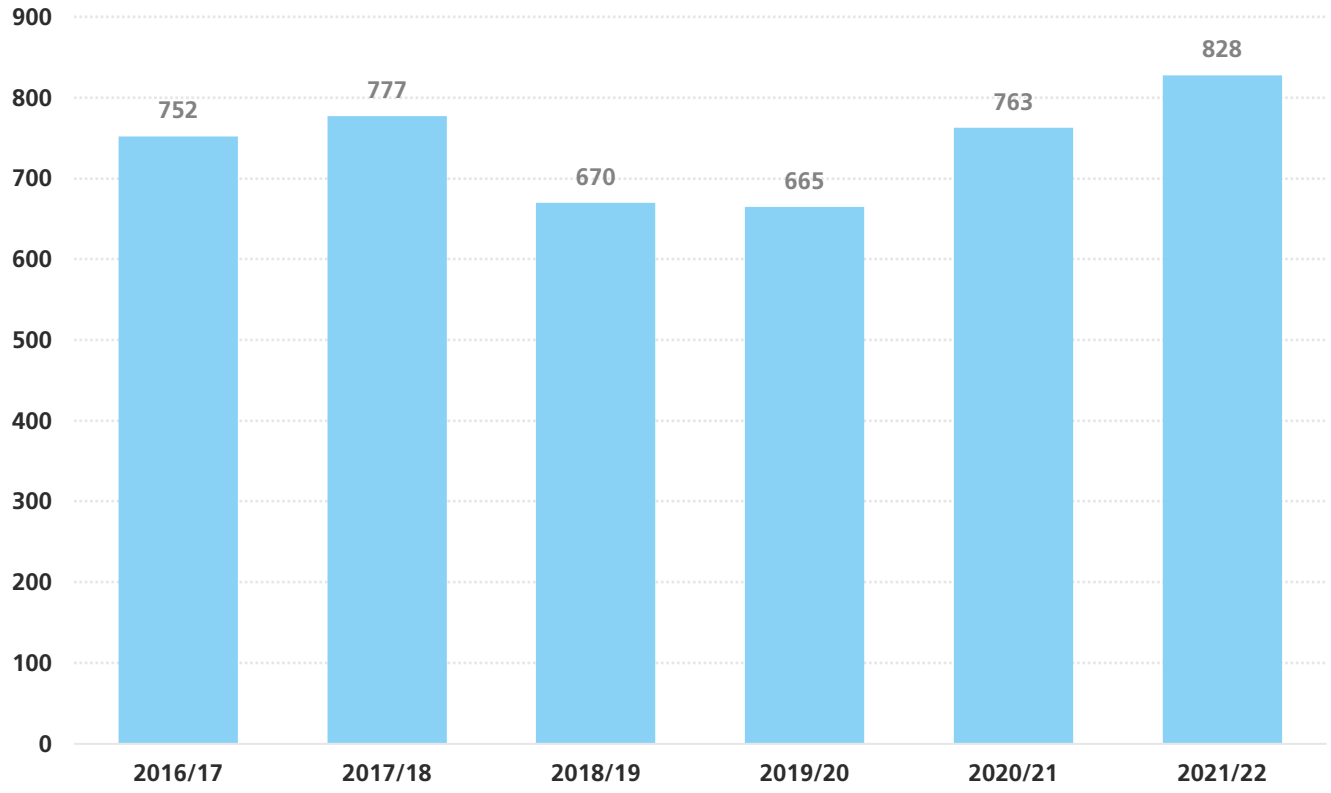
The point of care system used by the Trust is National Immunisation Vaccination System. Booking now takes place through the national booking system.

8. REDUCING THE NUMBER OF PATIENTS EXPERIENCING HARM AS A RESULT OF FALLS IN HOSPITAL

8.1 Falls prevention and management

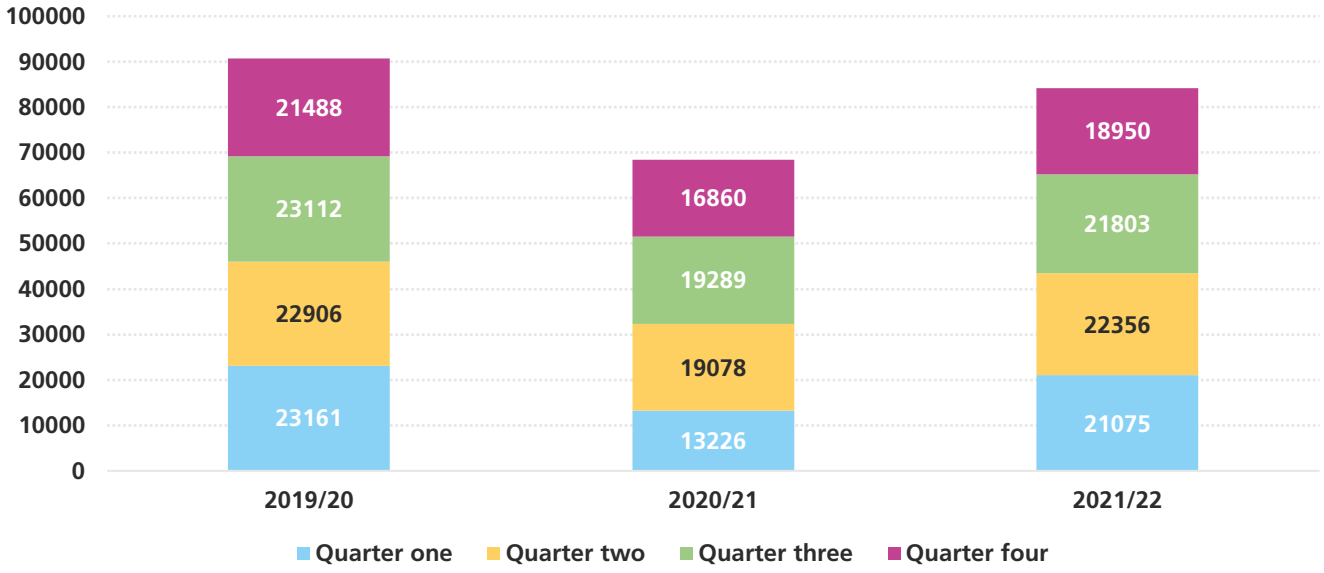
Falls in hospital are the most reported inpatient safety incidents. Falls are caused by a wide variety of factors that may differ between each individual patient and more generally to the unfamiliar hospital environment. Falls prevention requires a multi-disciplinary approach, identification of the potential risk factors for each patient and planned interventions to mitigate these risks. It is the accumulative impact of these often simple actions which reduce the occurrence of falls, prevent avoidable harm, and provide a safe care environment for our patients.

Inpatient falls are the primary cause of hospital-acquired injury and are a major cause of disability and mortality, particularly in older patients. All falls can have an immense impact on the patient, their family, and their experience of inpatient care, even when there is no associated injury. Falls often result in increased length of stay and reduced quality of life and are costly to patients and hospitals alike. In 2021/22, a total of 828 falls were reported at QEH, equating to more than two inpatient falls daily across the Trust



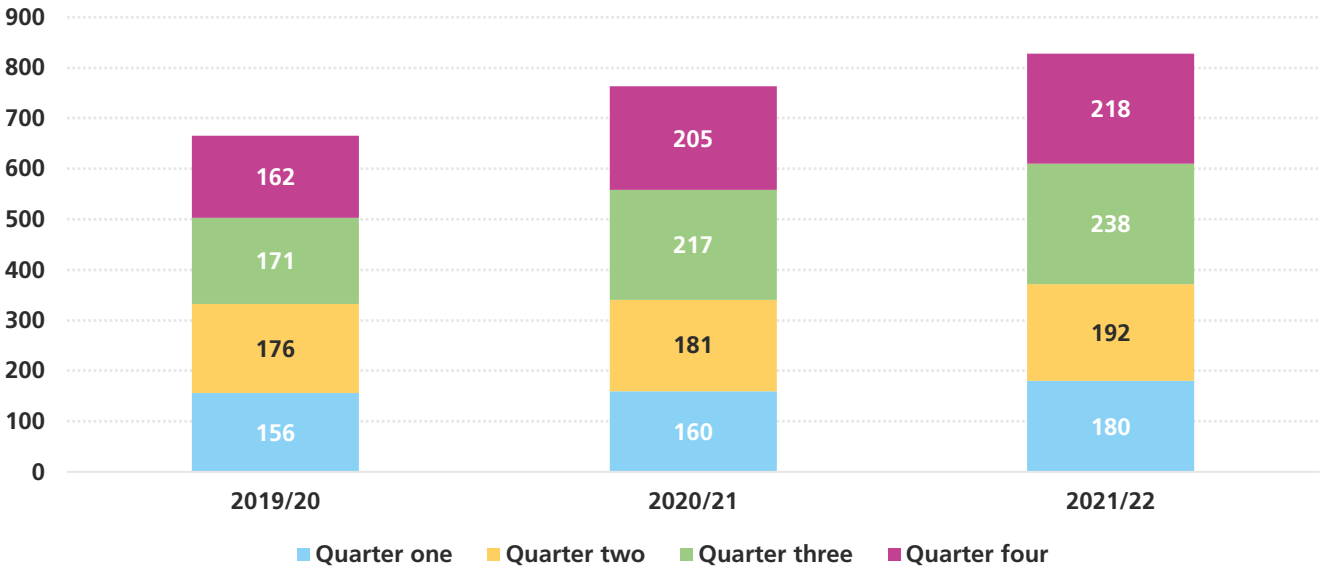
The last two years have seen an increase in the number of falls. This is thought to be because of the adverse factors and associated complications experienced during the COVID-19 pandemic, such as an increase in inpatient admissions, limited staff resources, acuity level of patients, increased number of long stay patients and the use of escalation areas to address capacity issues.

Over the past 12 months, the Trust has remained focused on achieving an agreed performance indicator to reduce the total number of inpatient falls by 15%, a continuation of last year's target, which would equate to 54 falls or less each month. At the start of the financial year, the number of falls per 1000 bed days remained under the Trust target of 4.49 for the first five months before increasing in September 2021 and reaching a peak of 5.74 in December. By the end of 2021/22, the Trust had not achieved its target and reported 65 more falls than during 2020/21.



The increase in the number of falls is minimal in comparison to the significant increase of patient admissions experienced during the year. In 2021/22, a total of 84,184 patients were admitted to the organisation, which is an increase of nearly 16,000 from the previous year. Due to the local demographic and the impact of illness on older people, nearly half (48%) of the patients admitted to hospital were over 65 years of age and were potentially at risk of falls according to NICE guidance.

Therefore, when the number of patient admissions is compared to the number of falls reported, it is reasonable to infer that there is recognition of those individuals at risk of falls and that progress is being made to implement falls prevention strategies across the Trust.



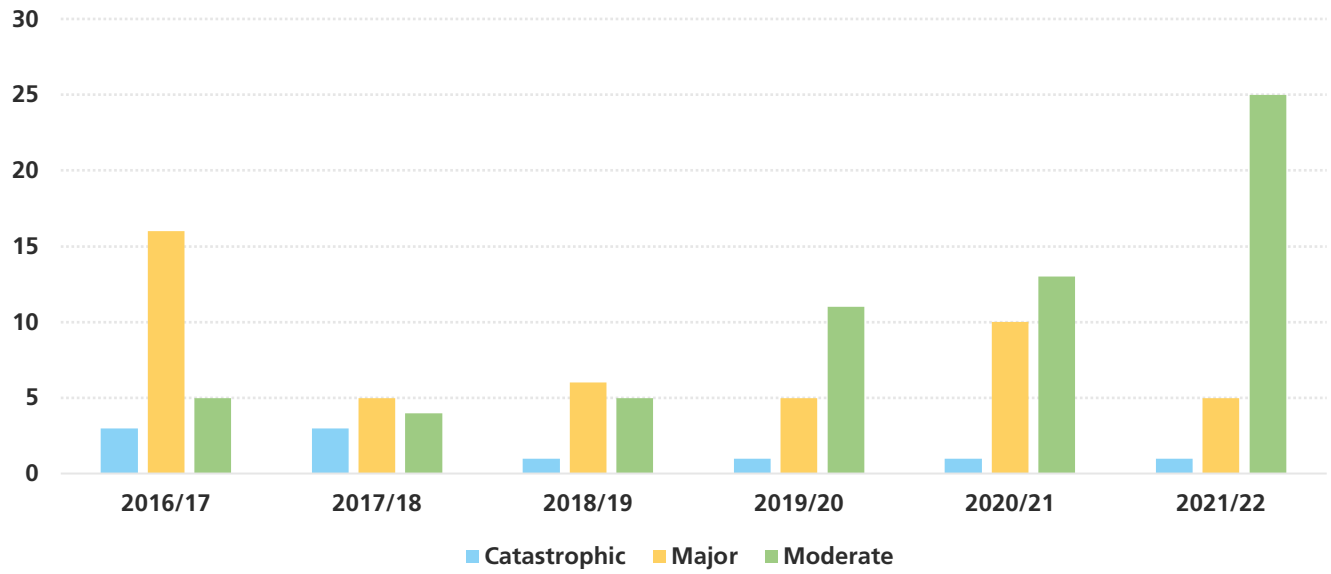
In quarter one and quarter two, there was a modest increase in the number of inpatient falls, with the monthly data on average 15 falls above the intended target.

There was also an increase in the number of inpatient falls in quarters three and four, which is common in the winter months and reflected the increased rate of COVID-19 infections in patients, increased staff absence and higher numbers of medically fit long stay patients awaiting care packages or placements to enable a safe discharge.

8.2 Falls recorded by level of harm sustained

The second key performance indicator outlined by QEH was to reduce the number of harm-related falls. This has been partly achieved with falls categorised as major harm in severity reducing by 50% from 2020/21 to 2021/22. However, there has been a significant increase (48%) in the number of falls resulting in moderate injuries from 2020/21 to 2021/22.

Overall, the total number of falls resulting in injury has increased by approximately 23% from 2020/21 to 2021/22



8.3 Prevention and risk management

The Falls Prevention Coordinator continues to lead on the workstreams which contributed to reducing the falls rate prior to the COVID-19 pandemic. In conjunction with the Patient Safety Team and Divisional Leadership Teams, the Falls Prevention Coordinator has led and supported several quality initiatives which ensure that all elements of falls prevention and management are addressed across the organisation. However, due to the pandemic, some of our falls related initiatives and projects are still ongoing with completion targets delayed.

The workstreams have included continuing the embedding and strengthening of the use of the updated Falls Prevention Care Plan. The care plan covers practical and achievable falls prevention interventions and focuses on a person-centred multi-factorial approach. This has been an ongoing process with the Falls Prevention Coordinator providing teaching and support to new staff when they join the organisation.

Over the past 12 months, the importance of falls prevention and recognition as a shared responsibility has been significantly impacted by the continued development of the services and focus on frailty. Our understanding of caring for older people has increased substantially, not least through the adoption of the frailty concept from the Emergency Department and throughout admission, and with the introduction of new guidelines and strategies. The early identification of frailty, recognition of cognitive impairment from admission and a multidisciplinary team approach with the right knowledge, skills and behaviours have been proven to improve patient experience, patient safety and outcomes.

The awareness of falls prevention has increased, and staff of all professions are becoming more engaged to deliver a robust safety culture across all areas. Clinical areas have undertaken localised reviews of falls data and initiated change to reduce their occurrence of falls. This has included wards identifying most falls that occurred later in the day, which had led to the adjustments of staffing numbers and late shift timings. Other clinical areas have recognised an increased number of falls occurring in the toilets, bathrooms and side rooms, subsequently purchasing appropriate assistive technology for these areas.

The Falls Prevention Coordinator and the Patient Safety Team have worked in collaboration to revise Datix incident reporting for falls, ensuring key information is captured to help undertake incident investigations and facilitate patient safety and improvement initiatives. An incident dashboard has also been developed on Datix for all ward managers to access their falls incidents and identify the corresponding themes or trends at a glance.

Every fall incident report submitted that meets the threshold of moderate harm is reviewed by a senior panel twice weekly to ensure that they have been accurately graded on the Trust's incident reporting system and that the right level of investigation or incident review is accorded. When analysis of the incident reports at the senior panel meetings identifies areas of learning for staff, it is cascaded back through divisional representatives or Trust-wide through the Communications department.

The Trust has introduced the Electronic Prescribing and Medicines Administration (EPMA) software to all clinical areas within the organisation. The software provides immediate medication information, an audit trail for both prescribing and administration, identification of high-risk medications and enables improved protocol prescribing. Although we are in the early stages of using EPMA, it will strengthen the process of polypharmacy medication reviews, optimise the prescribing of falls-inducing medication, and provide links to community services.

"Perfect Ward" (now Tendable) documentation audits have continued to be reviewed monthly to support improvements in quality measures with regards to patients having timely multi-factorial falls risk assessments, bed rails assessment and associated care planning to mitigate the potential risks identified. This has been further supported using ward level safety huddles throughout the shift, which provides a greater level of oversight and identification of risks, thereby enhancing patient safety. A local audit undertaken in all clinical areas has been delayed as a direct consequence of the increased pressures experienced during recent months. However, the data has now been collected and is to be collated and analysed to identify both evidence of good practice and areas of learning.

The Falls Prevention and Management Operational Steering Group has been reintroduced as a virtual meeting to focus on the falls workplan and development of further quality improvement initiatives.

The Trust continues to take part in the National Audit for Inpatient Falls (NAIF) exploring specifically post-fall care for patients aged 65 years and over who sustain a hip fracture whilst in our care, of which there were four incidents in 2021/22. This audit programme aims to facilitate learning and determine areas requiring improvement in care following a fall.

The annualised values over the 12 months to the end of February 2022 are:

- Check for signs of injury before movement from the floor - 100% (NAIF overall 76%)
- Use of the safe handling method to move the patient from the floor - 89% (NAIF 79%)
- Medical assessment within 30 minutes - 56% (NAIF 68%) (patient was assessed immediately by NNP)

8.4 Education and training

Due to continued restrictions on face-to-face training during 2021/22, the falls workbook has remained available to staff through the Trust's electronic staff record (ESR) to facilitate staff accessibility and to streamline recording of training compliance.

The Falls Prevention Coordinator has also developed a comprehensive training session presented virtually once a week to staff of all disciplines. This training focuses on the multi-factorial risk factors of falls, falls prevention interventions, the assessment and provision of special observations and the post-fall care and management.

By the end of March 2022, mandatory training compliance Trust-wide for falls was 69% but efforts are ongoing to achieve the target of 85%.

Following the review of the Trust's Special Observation Policy in May 2021, the Falls Prevention Coordinator has provided 'teach the trainer' sessions to 48 staff including Clinical Nurse Educators. This equips the trained staff to disseminate the learning in their respective clinical areas particularly in the provision of "specialling" to minimise the risk of falls or patient harm and to reinforce the use of distraction techniques using simple activities.

The recent recruitment of the Frailty Nurse Consultant and expansion of the Geriatric Consulting Team has enabled frailty-focused training within the medical profession, particularly within the Medical Division.

8.5 Priorities for improvement in 2022/23

In the next 12 months, we plan to:

- Continue to aim for a reduction of inpatient falls by 15%
- Continue to aim for a reduction of inpatient falls with harm by 15%
- Restructure and expand the Falls Team with the introduction of additional unregistered practitioners
- Reconfigure and refocus the Falls Prevention and Management Operational Steering Group meetings chaired by the Deputy Chief Nurse to ensure accurate representation of the organisation and the needs of our patients
- Utilise data from both local audits and the National Audit of Inpatient Falls (NAIF) to evaluate the effectiveness of the current interventions, identify good practice and learning needs
- Work in partnership with the Frailty Nurse Consultant to provide bespoke training sessions on key learning topics identified.
- Increase the existing infrastructure of the Falls Team to enable further service development
- Link falls prevention initiatives with other workstreams by the Frailty Nurse Consultant and Osteoporosis Nurse
- Work in collaboration with alternative learning forums, including pre-registration learners
- Relaunch of the Trust-wide 'Champion' role, with the possibility of expanding it to include frailty and dementia to engage in the development of falls prevention
- Optimise the application of EPMA to strengthen the completion of medication reviews at ward level, focus on the use of sedatives, hypnotics and anti-psychotics, identification of falls-risk inducing medication and compliance with Trust policy.
- Continue to network with other organisations to learn from those who have had similar experiences and adapt concepts and methods already proven to have worked in other organisations
- Improve and centralise accessibility to useful resources, local and national guidelines and for staff development for falls prevention and management and other associated topics
- Strengthen the organisational safety culture with the consideration of introducing post-fall debriefs and reviewing staff experience and safety within their environment
- Carry out environmental reviews and take part in ward reconfigurations to promote patient and staff safety and enable meaningful activities to take place with patients while including families and carers
- Increase collaborative working with Norfolk and Waveney Integrated Care System

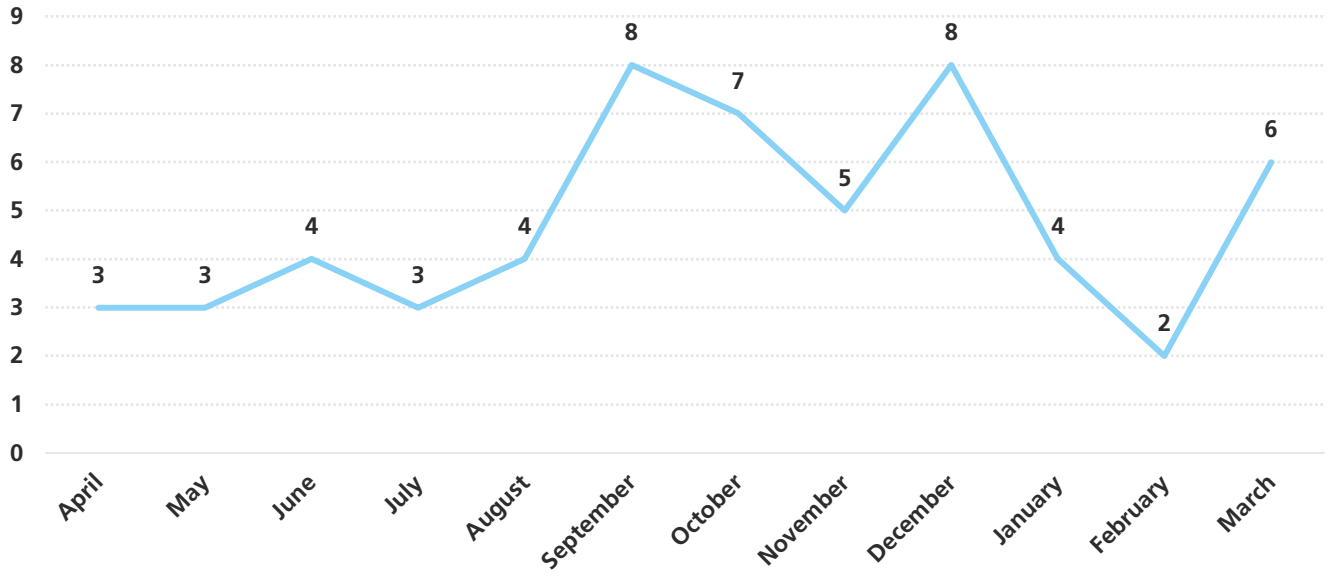
9. REDUCING AVOIDABLE PRESSURE ULCERS

Pressure ulcers remain a concerning, and mainly avoidable, harm associated with healthcare delivery. Despite extensive review and interventions, pressure ulcers remain a challenge for the patients and healthcare professionals involved in their prevention and management. There have been extensive prevention programmes, but evidence continues to suggest that nationally about 1,700 to 2,000 patients a month develop pressure ulcers (NHS Safety Thermometer).

The standardised practice of the Assessment, Skin Inspection, Keep Moving, Incontinence, Nutrition, Surface (ASKINS) bundle continues to keep pressure ulcer prevention at the forefront of our minds and to maintain/improve current standards.

The following table and graph show a comparison of the year-on-year trend in hospital-acquired pressure ulcers (HAPU) for three consecutive years 2019/20, 2020/21 and 2021/22. The totals demonstrate a gradual positive reduction year-on-year of Trust-acquired pressure ulcers.

	HAPU 2019/20	HAPU 2020/21	HAPU 2021/22
April	9	18	3
May	6	8	3
June	7	2	4
July	10	2	3
August	8	4	4
September	6	2	8
October	7	3	7
November	2	5	5
December	5	2	8
January	6	7	4
February	2	4	2
March	1	3	6
Totals	69	60	57



The above graph illustrates 2021/22's monthly hospital-acquired pressure ulcers. It notes a spike in incidents between September and December 2021, with an overall average rate of five per month.

There are many factors that may have contributed towards this spike. It is, however, recognised that the cumulative reduction in education delivered to frontline staff, owing to COVID-19 restrictions, is probably a significant influencing factor. Additionally, we continued to see significant capacity and staffing challenges in the Trust with increased escalation areas required.

Out of the 57 reported incidents, 58% (33/57) were identified to have had associated lapses in care. Analysis of these incidents shows that sacrum/coccyx (28%) and heels (26%) are the most frequent sites for pressure damage. The identified lapses in care were recorded when there was limited, or no written evidence of interventions; they were consistent with themes from previous years with no new trends emerging. The predominant themes were poor documentation to evidence repositioning as per policy and implementation of appropriate pressure relieving equipment.

9.1 Reporting

Following 2018 guidance from NHS Improvement, the Trust continues to conduct investigations into HAPU with a focus on good practice, learning and identifying where lapses in care may exist:

- All category two to four, unstageable and deep tissue injury (including medical device related pressure ulcers) hospital-acquired pressure ulcers are reported via Datix
- The Tissue Viability Nurse (TVN) sees the patient within 48 hours following a reported incident to assess and complete the review using the ASKINS criteria. This is sent to the appropriate Ward Manager/Matron and Divisional Risk and Governance lead. The document is also uploaded to Datix and the incident report is amended in line with TVN validation
- For category three and above, these are discussed at the Moderate Harm/Serious Incident (SI) Panel for a decision to ascertain whether the pressure ulcer incident meets the SI threshold

On review of the 2021/22's incidents and subsequent investigations, the predominant themes for hospital-acquired pressure ulcers remained the same:

- Inaccurate risk assessment leading to inappropriate equipment
- Lack of documented evidence regarding regular repositioning

9.2 Initiatives to further reduce harm as a result of hospital-acquired pressure ulcers

During 2021/22, initiatives that focussed on education and training were further developed to reduce harm through hospital acquired pressure ulcers. These were broken down into:

- Mandatory training
- Simulation based pressure ulcer prevention training
- Unregistered teaching

Adherence to national guidance during the global COVID-19 pandemic led to the Trust reducing all face-to-face teaching where possible to ensure the safety of its staff. This has resulted in the development and implementation of a new e-learning package for pressure ulcer prevention mandatory training. Initial feedback received from staff has been positive in relation to the impact of this training on their clinical practice.

Additional plans for 2022/23 include the introduction of a simulation-based pressure prevention training and some focussed training to support the development of the unregistered workforce

9.3 Leadership

- A project to source and implement a new Trust standard mattress to help reduce HAPU is ongoing
- The first Trust-wide annual clinical prevalence audit for pressure ulcers was completed in October 2021 which provided insight into areas for further improvement. An action plan has been developed in response to its findings with a focus on interactive, targeted education for all ward-based staff informed by the audit results
- Continued visibility on the ward and department areas by the TVNs
- Monthly HAPU data is reported to the Board by the Chief Nurse alongside the monthly Harm Free Care Forum
- The TVN link nurse scheme was relaunched in February 2022 to deliver specific higher-level training and a resource to their ward areas, disseminating information and supporting colleagues in clinical decision-making
- The TVN work plan includes the continuation of education and strengthen the ward-based use of the ASKINS care bundle for prevention of pressure damage. This will continue in conjunction with the '100 days free' campaign
- The TVN team will be increasingly working with other TVNs in the Norfolk and Waveney Integrated Care System
- A review of team composition and organisational working is underway with a proposed plan to increase service provision to further facilitate specialty support and further positively reduce HAPU

10. END OF LIFE CARE

The care provided to patients and their families in the last days, weeks and months of life remain a high priority for the Trust, and we are committed to consistently delivering safe and compassionate care. To help focus on this level of importance, the management of staff working in end of life care has been transferred to the Medicine Division, providing robust governance structure. A strategy for end of life care was launched in July 2020 and reflects the six ambitions of care in the Trust Corporate Strategy.

The CQC and the National Audit for End of Life Care made a number of recommendations for changes in structure and practice in 2020/21, which have been adopted during 2021/22. Over the past 12 months, the team has grown with the addition of a Palliative Care Coordinator and a Lead Nurse, as well as a doctor with an interest in palliative care from the Integrated Care of the Older Person Team who provides two sessions a week with a focus on frailty. The larger team has allowed development of new ways of working including a simplified referral pathway to facilitate access to palliative care advice and a timelier response, closer links with the discharge planning team and hospice teams to facilitate a coordinated discharge plan and the creation of an End of Life Specialist Register. A Clinical Director of Palliative Care was appointed in September 2021.

The team aims to review all patients identified as being in the last weeks of life as well as those who are actively dying, to ensure the best experience for the patient and family at a difficult time. This ranges from symptom control and anticipatory prescribing to facilitating discussions about preferred place of care and reviewing the ReSPECT form so that it reflects the patient's wishes.

The Trust promotes best practice for care in the last days of life using the Individualised Plan of End of Life Care (IPOC), which sets out key priorities and is used across hospitals in Norfolk and Waveney. Monthly audits are undertaken to monitor the consistency of use and the quality of the documentation across all clinical areas, the results of which are reviewed at the End of Life Forum. All deaths occurring within the Trust are also reviewed monthly to identify trends and areas of concern and improvement, the findings of which are presented at the Learning from Deaths Forum.

The use of the purple "tree symbol" to represent end of life is well established across the Trust. A purple tea light on the desk marks the recent death of a patient, subtly promoting quietness and respect by those entering the ward. The "care rounding" documentation associated with the IPOC is produced on lilac paper. Patient property after death is sensitively placed in a purple fabric bag by the Bereavement Support Team for the families to take home. There is also a designated parking space for bereaved relatives who are visiting the hospital to meet the Bereavement Support Team.

Education continues through our End of Life Care Education Lead.

The Trust Chaplaincy Team continues to work closely with the Palliative Care Team, offering spiritual support throughout the hospital to those identified as end of life on the IPOC or identified by other means.

Norfolk Community Health and Care NHS Trust (NCH&C) has been the main contracted provider of specialist palliative care for Norfolk. Although NCH&C continues to hold the contract, QEH has appointed its own team of Specialist Nurses from April 2022 following the recommendation of the exemplar project.

Our plans for 2022/23 include:

- Establish a strong team within the Trust with high visibility on the wards to promote and support teams to provide holistic care at end of life
- Relaunch our End of life Champions on each ward with a view to rolling out best practice across every ward

11. REDUCING AVOIDABLE MORTALITY

11.1 Learning from deaths

The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Index (SHMI) are two standard measures against which hospital mortality outcomes are measured.

HSMR is a ratio of observed to expected deaths of patients based on a subset of diagnoses (56 diagnosis groups that constitutes 80% of all hospital deaths).

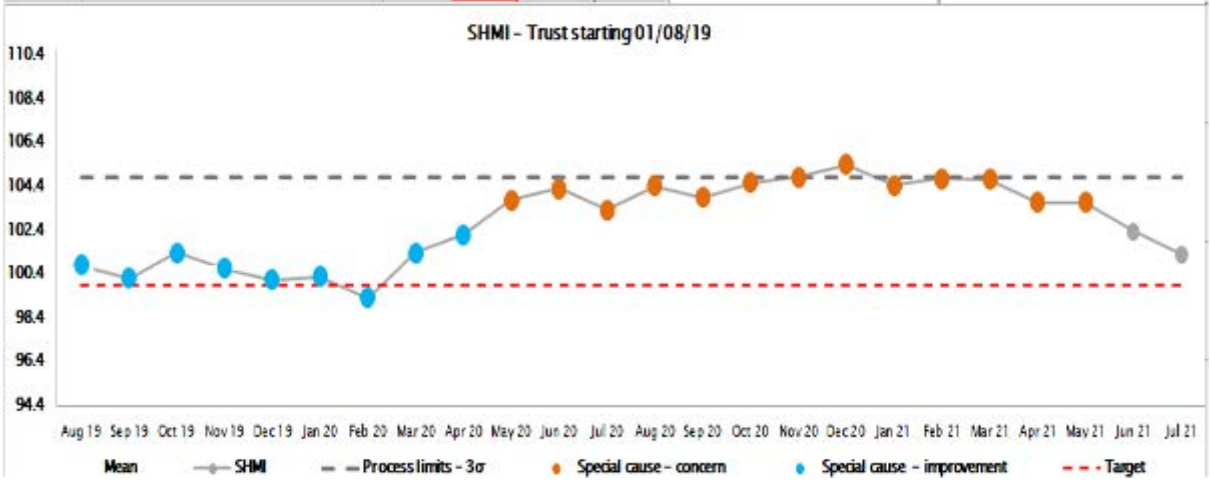
SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. For this reason the SHMI data is reported with at least a five month time lag.

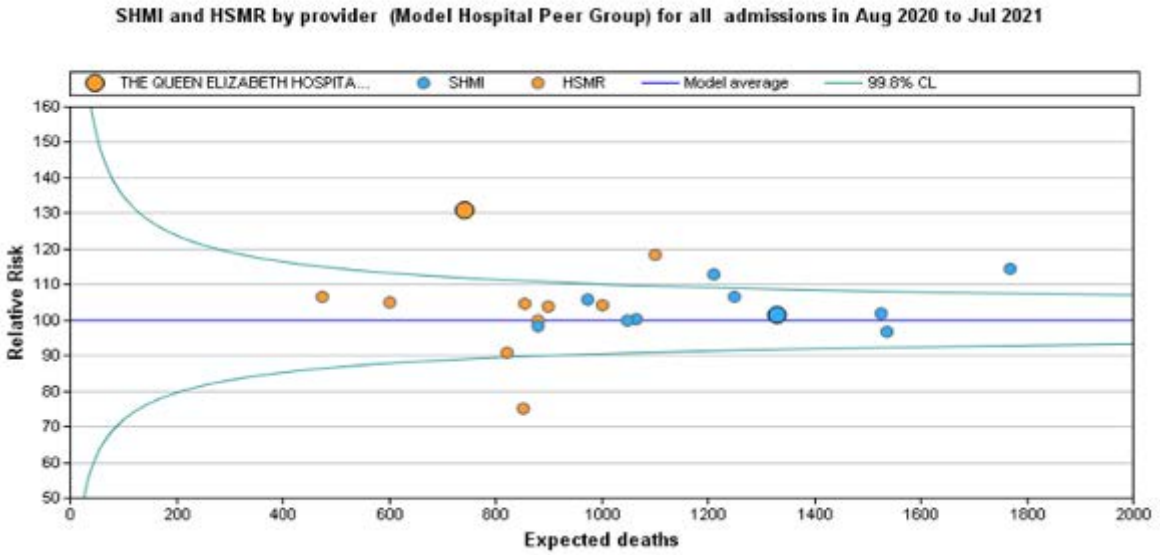
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	HSMR Relative risk	100.00	124.99				

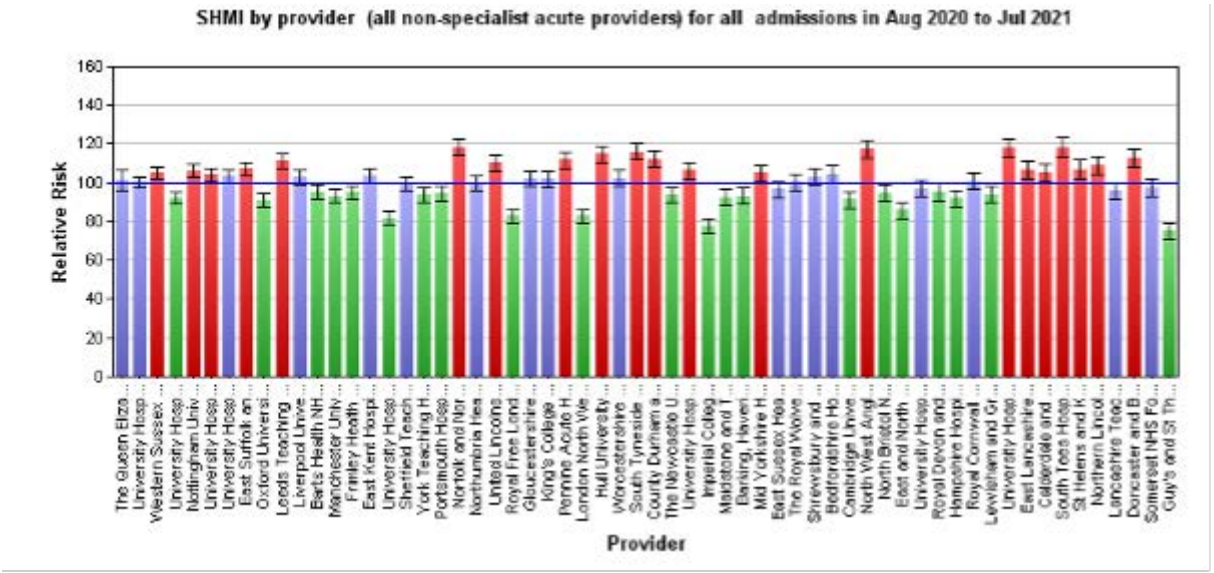
QEH saw a high number of deaths in the second wave of COVID-19 (Jan 2021) and this is still having an impact on our HSMR. For both waves the number of deaths was higher and the number of admissions lower, which adversely affected the HSMR calculation.

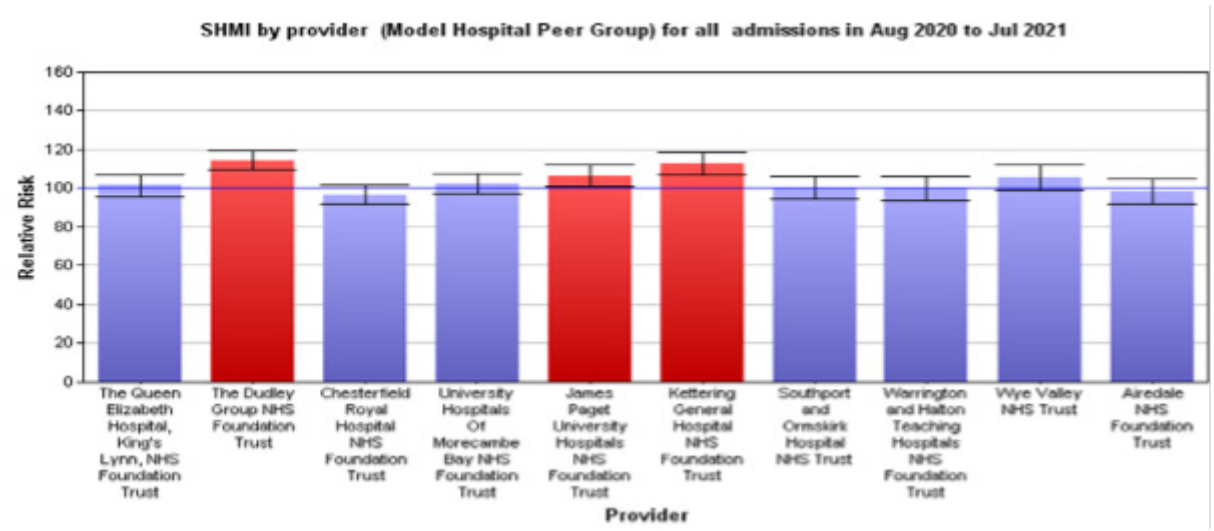
The SHMI has remained stable and within expected parameters as shown in local monitoring below and within national monitoring in the following graphs.

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jul-21	SHMI (Rolling 12 mth position)	100.00	101.37				





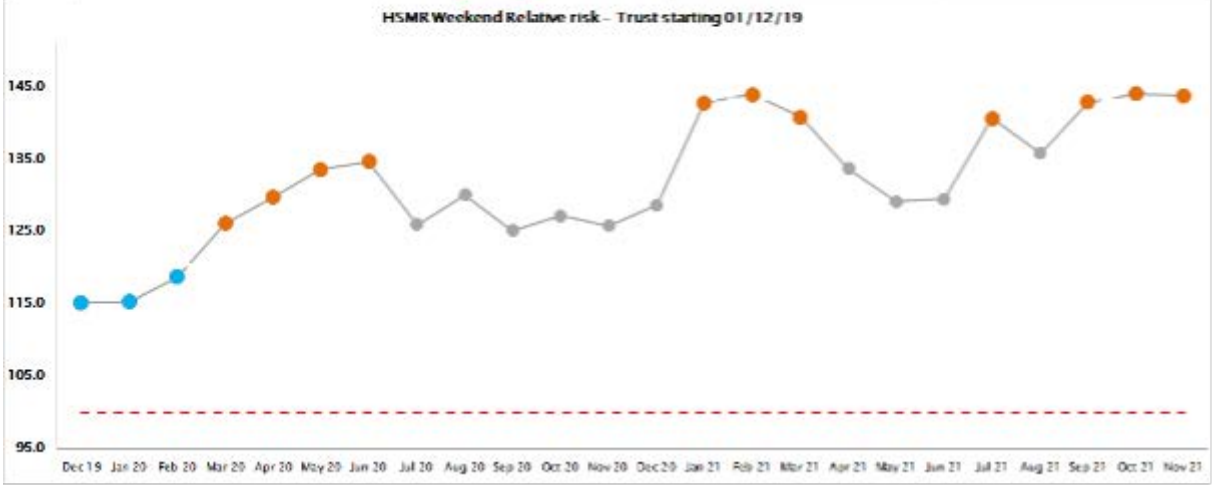




Our weekend mortality, calculated as part of the HSMR, is also adverse to expected (i.e. over the tolerance levels). This has been investigated extensively in previous years so has not been our particular focus in this reporting period. It is, however, monitored on a monthly basis through our Learning From Deaths Forum.

We are aware that our palliative care was and still is very much adverse to that of other Trusts and particularly in COVID-19 related cases. Our focus has been on restoring our HSMR and then we will turn our attention back to the weekend mortality scores.

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-21	HSMR Weekend Relative risk	100.00	143.88				



There were 1,301 deaths recorded in the Learning from Deaths process between January and December 2021. A breakdown of these deaths is provided in the below tables.

Table 1: Number of deaths recorded in the Learning from Deaths process

Time period	Number of deaths
Quarter one	444
Quarter two	239
Quarter three	278
Quarter four	340

Table 2: Breakdown of deaths

Speciality	Number of deaths
Medicine	1,111
Surgery	52
Trauma and Orthopaedics	30
Critical Care	97
Obstetrics and Gynaecology (including still births)	11

Table 3: Structured Judgement Reviews

Our focus for completing Structured Judgement Reviews (SJRs) has changed, and this is now guided by the Medical Examiner who reviews 100% deaths. We have therefore completed less reviews than previous years, but are potentially focused on those cases where learning could occur.

Time period	Number of deaths reviewed	% Of total deaths
Quarter one	161	36%
Quarter two	89	37%
Quarter three	64	23%
Quarter four	60	18%

Table 4: Themes of learning from reviews, incidents and family feedback

Hospital-acquired infections	Primary diagnosis on admission not recorded in notes accurately
Communication with families	Multiple ward moves during hospital stay
Falls assessment and management	End of life and palliative care

Changes continue to be made in the Learning from Deaths Process during 2021/22 to improve our understanding and influence care provided. Much time has been spent comparing the different measures. We continue to engage with NHSE/I and the Better Together Learning from Deaths Group and to receive advice and training in the use of the SJR+ mortality comparator tool to help better analyse our data in order to improve learning.

12. MEDICAL EXAMINER

During 2021/22, the independent Medical Examiner Service has continued to provide scrutiny of all in hospital deaths at QEH. The service reviews all deaths to confirm the cause of death with the attending team and liaise with the bereaved to identify any concerns they may have regarding care during the patient's final illness. The service delivered business as usual throughout the pandemic period.

All referrals to the coroner are reviewed and discussed prior to submission to ensure the referrals are appropriate.

Any concerns identified either through discussion with the bereaved or on case note review are reported through the Structured Judgment Review (SJR) process. The service regularly provides feedback directly to the divisions with comments received from the bereaved. This feedback generally highlights a very positive experience for patients at QEH but where there are concerns these can be identified and reviewed by the divisional team.

During the year, additional recruitment of Medical Examiners and Medical Examiner Officers was undertaken to enable a fully established examiner service in place from May 2022. This consists of four Medical Examiner Officers and eight part time Medical Examiners.

Activity of cases scrutinised

	Month	Total deaths in QEH	Cases reviewed by ME	(%) Of in hospital deaths	Coroner referrals	Structured Judgement Review requested by ME
Quarter one	April	91	91	100	12	14
	May	79	79	100	6	20
	June	85	85	100	17	23
Quarter two	July	102	102	100	15	36
	August	94	94	100	18	31
	September	105	105	100	13	29
Quarter three	October	118	118	100	14	21
	November	111	111	100	12	26
	December	130	130	100	8	24
Quarter four	January	123	125	100	16	28
	February	98	99	100	13	36
	March	116	119	100	9	39

Plans for 2022/23 include:

- Continue to work with the Trust to develop the Learning from Deaths programme
- Working with the local and regional teams to implement the scrutiny process for community deaths
- Working with the national team to develop the Medical Examiner Information Database

13. REDUCING HOSPITAL-ACQUIRED VENOUS THROMBOEMBOLISM (VTE)

As a current exemplar site we are committed to ensuring that we have robust assessment and treatment in place for the prevention of VTE. The roll-out of our electronic prescribing software (EPMA) ensures that all patients are assessed before drugs can be prescribed.

VTE is a condition in which a blood clot forms in a vein, most commonly in the deep veins of the legs or pelvis. Hospitalised patients have a higher risk of developing VTE due to reduced mobility and accompanying illnesses such as infection, inflammation and dehydration, all of which increase the coagulable state of the blood. Each year 25,000 people die from hospital-acquired VTE. However, it is a preventable condition and, hence, there is an expectation that appropriate measures should be taken to avoid VTE in hospitalised patients.

Our target is to screen 97.24% of all inpatient admissions for VTE risk and prescribe appropriate treatments to prevent hospital-acquired VTE and its associated morbidity and mortality.

VTE risk assessments are undertaken for non-elective patients by a junior doctor clerking the patient, or by the pre-assessment clinic team for elective patients. The assessment and treatment plan are verified within 24 hours of admission by the named consultant. Patients deemed to be at increased risk of hospital-acquired thrombosis should be considered for VTE prophylactic treatment, which typically involves receiving a daily injection of a blood thinning agent (anti-coagulant) and the use of thrombo-embolus deterrent (TED) stockings to improve the flow of blood back from the deep veins. However, prophylactic treatment with blood thinners can sometimes increase the risk of bleeding in some patients and, not uncommonly, circulation in the feet can worsen when tight TED stockings are worn. All patients, therefore, need to undergo a three-stage process to assess their risk of clots, their risk of complications from prophylaxis and then the prescription of the appropriate prophylaxis.

In instances where patients are diagnosed with hospital-acquired thrombosis a root cause analysis is undertaken to confirm whether this could have been prevented.

13.1 VTE monitoring

After patients are discharged, all sets of case notes are checked and coded to determine whether the VTE assessment has been completed and documented. These figures are nationally reported and used in the Trust Integrated Performance Report which is presented to the Quality Committee.

A more detailed review of the case notes of all inpatients is also undertaken on a monthly basis. This audit examines whether:

- The documented VTE risk assessment was completed appropriately (for example, if the patient is low risk, the assessment should indicate that there is no need for thromboprophylaxis);
- The risk assessment was reviewed by a consultant;
- The prophylaxis was then prescribed, if indicated; and
- The prophylaxis was then administered appropriately

13.2 Analysis

We have continued to remain above the national target of 97.24% for VTE assessment since June 2020. During this reporting period hospitals generally have worked differently due to COVID-19 which has meant that many more patients are seen and treated in an ambulatory care setting. We agreed that our Same Day Emergency Care Ward (SDEC) admissions would be cohorted to be excluded from assessment as patients are not immobilised for long periods of time. A full VTE assessment will be completed for any admission from SDEC.

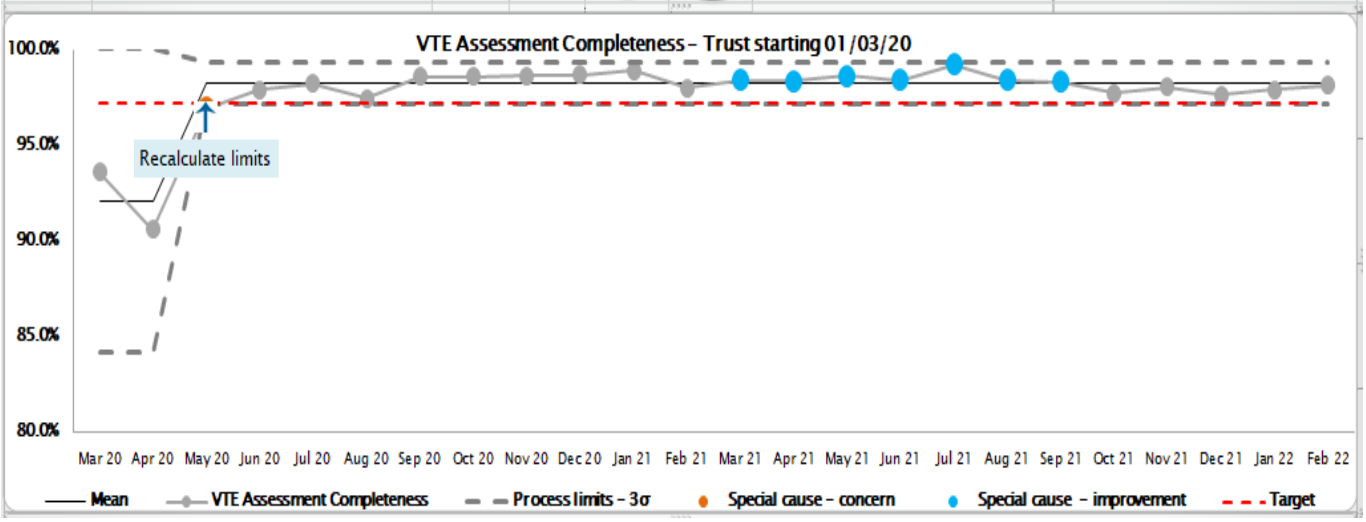
To ensure compliance with the target we:

- Undertake regular awareness sessions at induction for junior doctors
- Ensure mandatory e-learning compliance
- Ensure junior doctors complete monthly medical documentation audits
- Rolled out a 'forcing function' within electronic prescribing from April 2021 which ensures screening for VTE is not overlooked
- Updated Trust guidance on VTE prevention and management in line with NICE guidance. New pathways for standardised management of deep vein thrombosis (DVT) and pulmonary embolism (PE) have been ratified for use and are available to staff
- Standardised guidance on the use of newer generation of anticoagulants (known as DOACs, or directly acting anti coagulants) to help minimise variations in practice
- Present patient case studies on hospital-acquired thrombosis at learning events

We believe these actions are key achievements for the Trust in ensuring its patients are well cared for and safe following their admission.

The table opposite shows our national reporting for the period:

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Feb-22	VTE Assessment Completeness	97.2%	98.2%			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target



14. INFORMATION GOVERNANCE

Information Governance (IG) is the practical application of the laws and principles that relate to the use of information, especially personal information. The legal framework governing the use of personal confidential data in healthcare is complex. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, and the Human Rights Act. It protects the rights of the individuals to whom personal information relates. These are referred to as data 'subjects', i.e. patients. It does not prevent the use of that information, provided those rights are respected.

The Data Security and Protection Toolkit (DSPT) is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy.

The DSPT Assessment Report status for 2020/21 was 'Approaching Standards' and an improvement plan was developed for those assertions not met. Action has taken place during 2021/22, with an update provided in the table below:

Assertions	Assertion description	Status as at June 2021	Status as at March 2022
3.2.1	Have at least 95% of all staff completed their annual data security awareness training in the period 1 April 2020 to 30 June 2021?	Standard not met	Standard met
4.2.3	Logs are retained for a sufficient period, reviewed regularly and can be searched to identify malicious activity	Standard not met	Standard met
4.3.1	All system administrators have signed an agreement which holds them accountable to the highest standards of use	Standard not met	Work ongoing
6.2.10	Does the organisation maintain a list of approved applications, and are users prevented from installing any application that is unsigned or has an invalid signature?	Standard not met	Work ongoing

Assertions	Assertion description	Status as at June 2021	Status as at March 2022
7.1.2	Do you have well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise?	Standard not met	Work ongoing
7.3.6	Are your backups kept separate from your network ('offline'), or in a cloud service designed for this purpose?	Standard not met	Work ongoing
8.1.3	Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the Senior Information Risk Owner (SIRO)	Standard not met	Work ongoing
8.2.1	List any unsupported software prioritised according to business risk, with remediation plan against each item	Standard not met	Work ongoing
8.2.2	The SIRO confirms that the risks of using unsupported systems are being managed	Standard not met	Work ongoing
8.4.2	All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support	Standard not met	Work ongoing
9.3.6	The organisation is protecting its data in transit (including email) using well-configured TLS v1.2 or better	Standard not met	Work ongoing
9.6.1	All devices in your organisation have technical controls that manage the installation of software on the device	Standard not met	Standard met
9.6.4	Only approved software can be installed and run, and unnecessary software is removed	Standard not met	Standard met
9.6.10	You have a plan for protecting devices that are natively unable to connect to the internet, and the risk has been assessed, documented, accepted and signed off by the SIRO	Standard not met	Standard met
9.7.6	Do all of your desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to block unapproved connections by default?	Standard not met	Standard met

15. READMISSION RATES

This indicator measures the percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital.

Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.

Indicator	Readmission rates Percentage of patients readmitted to hospital within 28-days of being discharged				
	Reporting period	Trust score	National average	Highest score	Lowest score
Percentage of patients aged (i) 0 to 15;	2015/16	11.70%	N/A	N/A	N/A
	2016/17	10.86%	N/A	N/A	N/A
	2017/18	10.63%	8.90%	N/A	N/A
	2018/19	11.77%	9.60%	N/A	N/A
	2019/20	10.89%	9.60%	N/A	N/A
	2020/21	9.25%	9.88%	N/A	N/A
	2021/22	11.10%	10.50%	N/A	N/A
and (ii) 16 or over	2015/16	7.90%	N/A	N/A	N/A
	2016/17	8.59%	N/A	N/A	N/A
	2017/18	9.24%	8.30%	N/A	N/A
	2018/19	8.98%	8.70%	N/A	N/A
	2019/20	8.66%	9.00%	N/A	N/A
	2020/21	9.50%	8.38%	N/A	N/A
	2021/22	9.09%	9.28%	N/A	N/A

Data is provided from both NHS England and Dr Foster sources. We are working with system partners across health and social care to ensure safe discharge for patients following elective and non-elective admission.

16. PROGRESS AGAINST PRIORITIES FOR 2021/22

Strategic Objective	Action	Outcome measure
To consistently provide safe and compassionate care for our patients and their families	Aspiration to be a continually improving organisation	• Publication of CQC inspection report in February 2022 confirming significant improvement, with ratings of 'Good' for Well-Led, Caring and Effectiveness and an improved overall Trust rating of 'Requires Improvement' • Only four 'must do' and nine 'should do' actions detailed in the February 2022 CQC inspection report compared to 206 in the 2019 report • Recommendation by CQC for the Trust to be removed from the RSP (previously special measures) from SOF 4 to SOF 3 • Removal of all 16 remaining section 29A warning notice conditions spanning Maternity, Medicine and Diagnostic Imaging. • Sustained progress against the 2021/22 Integrated Quality Improvement Plan (IQIP), with 66% of all actions approved for closure by Evidence Assurance Group.
	Further strengthen our Better Hospital Team	• Recommenced QSIR training scheme and continued the Quality Improvement (QI) fundamentals courses, supported by lunch and learn sessions and a QI week • Additional project management resource has been recruited and the team has also undertaken additional project management qualifications and completed an NSHE business case foundation masterclass
	Focus on patient experience, including complaints	• The Trust saw fewer formal complaints raised in comparison to numbers received in 2020/21 supported by an increase in the uptake of local resolution meetings. • Successful implementation of Family Liaison Officers (FLOs) within the Trust, attracting regional and national recognition. • The Trust has focused on a restructure of governance for the patient and carer experience, which has resulted in an increase in the forums containing patients, carers, Governors, specialist healthcare workers and external organisations. The forums include sensory impairment, carers, disabilities, learning disabilities and autism, dementia and mental health. • The Trust has seen an increase in Duty of Candour compliance from 95% (174/183) in 2020/21 to 98% (205/209) in 2021/22, with evidence of improved involvement of patients/ relatives in the investigation

Strategic Objective	Action	Outcome measure
To consistently provide safe and compassionate care for our patients and their families *[cont.]*	Reducing patient harms	• Falls - The Trust has developed a KPI-led work plan that collaboratively crosses boundaries and pathways of care to provide a more holistic response to falls prevention and management using robust data analytics. We have also reviewed the workforce requirements corporately to strengthen proactive falls management and developed a renewed strategy • Pressure ulcers - There has been continued sustained improvement during 2021/22 for hospital-acquired pressure ulcers with a noted reduction when comparing to the previous year's data. The Tissue Viability Team has been strengthened corporately to facilitate further planned developments
	Improving learning from incidents	• The Trust has held patient safety learning events, which have been well attended including by external stakeholders. • Full roll-out of the Clinical Prioritisation Programme and robust implementation of Clinical Harm Reviews. • In quarter four, the Trust maintained its compliance of 100% (60/60) for Duty of Candour phase one and phase two (50/50), with evidence of sustained improved involvement of patients/ relatives in the investigation. • The CCG remain satisfied with the quality of all investigation reports submitted following QEH Executive sign-off and continue to close serious incident reports following review
	We will ensure that our patients more consistently receive timely access to care and treatment	• While the number of planned care patients on the waiting list has remained constant, clinical teams have worked creatively to ensure that the number of longer waiting patients has been reduced. Those clinically urgent or on a cancer pathway have also received timely treatment. At the end of March 2022 there were no patients waiting over 104 weeks for treatment, other than four who expressly chose to wait in accordance with the national planning guidance. • The Trust successfully bid for Elective Recovery Fund Plus funding to assist with the delivery of the elective programme throughout 2021/22. • Delivery of Primary Care Streaming within ED to support patient flow. • Delivery of the Virtual Ward model to support patient flow throughout the organisation

Strategic Objective	Action	Outcome measure
To consistently provide safe and compassionate care for our patients and their families *[cont.]*	Improvements in all areas in national inpatient surveys	• There have been five national inpatient surveys throughout the year, including the Maternity Survey which was published during quarter four. Overall, predominant improvements were seen in all of the surveys. There were however some areas noted which required further actions. These have informed local action plans monitored through the Divisional structures and the revised Patient Experience and Carers Forum • The development of a Standard Operating Procedure with clear visibility on inpatient survey governance, timings and publication dates has taken place in Q4 to facilitate effective and efficient management in addition to increasing visibility Trust-wide. This is being developed in conjunction with our Communications Team
	Delivery of agreed improvements to maternity care in line with the independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust	• Continued delivery of the required improvements to maternity care in line with the independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust including agreement to increase the Midwifery establishment • The Trust is recognised within the region as an exemplar for our Ockenden response. All actions have been delivered in line with the agreed time frames or are on track for delivery as part of the overarching Maternity Improvement Plan
Modernising our hospital (estate, digital infrastructure and medical equipment) to support the delivery of optimal care	Completion of our Strategic Outline Case for a new hospital	• Submission of two compelling 'expression of interest' proposals for a new hospital to the DHSC in September 2021. Following this, work has been focussed on the completion of the Trust's Strategic Outline Case • Feedback received from NHSE/I has now been reflected in the SOC and the final version will be presented at the New Hospital Programme Board meeting in May for approval. The Trust approval process will be followed throughout May via the Use of Resources Executive Group, Hospital Management Board, Finance and Activity, and a range of external meetings, including the committees in common and CCG Governing Body, with final presentation to Trust Board for approval in June 2022 • Continued proactive work to mitigate the risks associated with Reinforced Autoclaved Aerated Concrete (RAAC) planks. We are also working with other RAAC plank hospitals in the region to make a strong case for emergency capital funding so that we can mitigate the risks associated with the structural integrity issue

Strategic Objective	Action	Outcome measure
Modernising our hospital (estate, digital infrastructure and medical equipment) to support the delivery of optimal care *[cont.]*	To submit a business case for national capital funding	• RAAC year one business case benefits delivered including completion of the Emerson Outpatient Unit and planned refurbishment works on Brancaster and West Dereham Wards • New state of the art Endoscopy Unit in development and planned for completion by June 2022 • New 'West Norfolk Eye Unit' in development and planned for completion by April 2022 and operational by May 2022 • Development of a clear plan for RAAC years two to four and robust engagement with NHSE/I to agree next steps
	Diagnostic Assessment Centre	• The Trust has worked collaboratively with Norfolk and Norwich University Hospital (NNUH) and James Paget University Hospital (JPUH) to draw up a compelling case for the development of Diagnostic Assessment Centres, supported by £69m national capital funding. The Outline Business Case has been approved with the Full Business Case due for completion by August 2022
	Estates and Facilities workplan	• The Estates and Facilities workplan was published in September 2021 and performance is monitored quarterly
	To significantly improve the Trust's Digital maturity/ maximising the use of technology	• Electronic Prescribing Medicines Administration has been rolled out to all inpatient ward areas and ED. Plans to complete roll out across the Trust by June 2022 • New RIS/PACs solution implemented and rolled out • Electronic-Observations (patient outcome monitoring system) business case approved for implementation • Continued engagement with the Integrated Care System in relation to development of a system wide Electronic Patient Record • Cyber and Information Governance – cyber risks and vulnerabilities reduced. Compliance against Data Security Protection Toolkit (DSPT) framework progressing
	Launching the Digital workplan	• The Digital workplan was published in quarter one and performance is being monitored quarterly
	To open our new Maternity Bereavement Suite	• Work began on the Maternity Bereavement Suite (The Butterfly Suite) in September 2021 and planning has commenced for The Butterfly Garden. Service user involvement has been key to the two developments, which are due for completion by the end of May and should be operational in June 2022

Strategic Objective	Action	Outcome measure
Strengthening staff engagement to create an open culture with trust at the centre	Strengthening staff engagement to create an open culture with trust at the centre	**Our culture:** • One third of staff have attended Values into Action workshops, with plans for the next phase of this Trust-wide work underway • Introduction of a new blended approach to Freedom to Speak Up, with Guardian support time increasing from 30 to 120 hours per month • Transition to the new Trust Values (Kindness, Wellness, Fairness) will take place in April 2022 • 'See Me First' campaign launched, with over 150 staff signatures to date, as part of the Trust's commitment to inclusion and anti-racism • Third Leadership Summit being held on 15 March 2022 with a focus on teamwork, resilience and inclusion • Culture intervention work underway within Maternity / Radiology and Sterile Services • Equality, Diversity and Inclusion calendar launched **Staff engagement:** • At 45.3%, the Trust's response rate to National Staff Survey improved for the third successive year • The Trust is actively participating in the national quarterly staff pulse surveys. • The annual staff awards took place in March 2022 • The first QEH celebration week was held in November 2021, focusing on wellness, staff networks, appreciation and recognition/celebrating success
	To improve compliance with mandatory training and appraisals	• Mandatory training compliance rates are below the Trust target. This is another key area of focus for all teams within the Trust and the following actions have been undertaken to improve compliance: › A redesign of the intranet site and development of electronic FAQs and 'How to' guides have been completed including video guides and electronic assessments are now in place. › A new mandatory training facilitator is now in post to support delivery of face-to-face training and reduce backlogs (fire and conflict resolution). • Appraisal compliance rates are below the Trust target. This is a key area of focus for all teams within the Trust and clear performance trajectories are in place for all service areas

Strategic Objective	Action	Outcome measure
Strengthening staff engagement to create an open culture with trust at the centre *[cont.]*	To reduce sickness absence to < 4.5%, excluding COVID-19 related sickness	• Sickness absence rates remain high. This is a key priority for the Trust. Robust and specific departmental and service trajectories have been developed and will be monitored. • Additional support for staff is in place, including an improved Occupational Health service offering
Working with patients and system partners to improve patient pathways and ensure future financial and clinical sustainability	Further improve relationships with external stakeholders and partners	• Clear actions progressed including the development of the Trust's role in Place Based Care and Acute Provider Collaboration, as well as clear stakeholder engagement with wider partners including Healthwatch, Integrated Care Board and local council
	Working with system partners to develop a Provider Collaborative	• The Norfolk and Waveney Hospitals Group Committees (N&WHGC) have met regularly throughout the year. Detailed discussions continue to take place around the key cross-system programmes of work focusing on delivery of improvements within Urgent and Emergency Care, Elective Care and financial recovery • Underpinning the work of the N&WHGC is the development of an acute Clinical Strategy for Norfolk and Waveney, which will be a key workstream to support us in moving forward with greater collaboration and integration • Detailed updates are being provided to the three Boards of Directors and the Councils of Governors. The Governors Forum continues to meet and is providing an opportunity for Governor representatives from each of the three acute hospitals within Norfolk and Waveney to discuss and agree effective communication and engagement with Governors in relation to acute provider collaboration
	To lead on the delivery of Place Based Care	• Work continues at a local level in relation to the development of Place Based Care with agreed priorities for focus of workforce, systems integration and health inequalities • Work is now underway to align key projects and deliverables to these priorities for the benefit of our local population • The positive work which is being done within West Norfolk in relation to health inequalities and population health management will be threaded through the developing Place Based Care priorities to ensure that we are aspiring to meet the needs of our local population • The Norfolk and Waveney Health and Wellbeing Partnerships and Place Boards are starting to develop, with clear governance and priorities expected in quarter one of 2022/23

Strategic Objective	Action	Outcome measure
Working with patients and system partners to improve patient pathways and ensure future financial and clinical sustainability *[cont.]*	To open the West Norfolk School of Nursing to our intake of Nursing Associates in quarter four of 2021/22	• The School of Nursing Studies is now operational. A formal opening is planned for May 2022. • The first Trainee Nursing Associates (TNAs) cohort from QEH commenced in December 2021, initially at Anglia Ruskin University (ARU) but with a plan to transfer to the School of Nursing Studies following NMC/ARU validation. • The next cohort of TNAs is being actively recruited for the September 2022 intake with the aim of increasing numbers to 30
	To achieve a robust financial plan with our system partners that supports sustainability of services and to balance our books and achieve a 3% savings programme	• The Trust delivered against its financial plan for 2021/22 including delivery of a robust Cost Improvement Programme in year and a significant capital programme
Supporting our patients to improve health and clinical outcomes	Delivery of a responsive and flexible response to the flu and COVID-19 vaccination programmes	• The Trust has continued to ensure effective delivery of vaccinations with a total of 62.8% of staff receiving their flu vaccination and 86.4% of staff receiving their first / second and booster COVID-19 vaccinations by 31 March 2022
	Working with system partners to ensure that population health management techniques are used to address health inequalities	• Establishment of the Norfolk and Waveney Health Inequalities Oversight Group (HIOG) with the aim of aligning the current disparate workstreams in relation to Health Inequalities and agreeing collective action. • Local Health Inequalities Working Group is in place within West Norfolk and a framework has been developed for delivery which focuses on known health inequalities within the locality. This uses Protect NoW as the platform to enable clear risk stratification of patients to support delivery of the key priorities. Clear focus on reducing unwarranted variations in care - aligned to health inequalities. • Leading system wide programme to ensure patients on admitted waiting list receive care in order of clinical priority and undergo regular review

Strategic Objective	Action	Outcome measure
Supporting our patients to improve health and clinical outcomes *[cont.]*	To be a smoke-free site	• Approval received in March 2022 from the Board of Directors for QEH to deliver a local project covering key areas of work in relation to smoking cessation, recognising that smoking is a key driver of health inequalities across the Trust's catchment area. In addition, QEH will participate in collaboration across the N&W Hospitals Group to align smoking cessation activities and share knowledge and expertise. • The project will deliver the Trust's existing commitment to become a smoke free site alongside the new national requirement to deliver the national NHS Prevention Plan with regard to smoking cessation across healthcare systems by the end of 2023. • Funding is being sought for a Project Manager for 12-months to deliver the QEH smoke free site project and new smoking treatment pathways for inpatients and maternity in collaboration with JPUH and NNUH To focus on mortality and learning from deaths
	To focus on mortality and learning from deaths	• The Trust has redesigned and relaunched its End of Life Services which has resulted in significant improvements to palliative care service provision for our patients. • Robust governance and oversight are in place to support the delivery of Structured Judgement Reviews, including an established Learning from Deaths Forum
	Further improving the care of older people	• Monthly Virtual Dementia Hub meetings established to keep staff updated and support a focus on innovation and increased awareness across the teams • Increased education sessions within ward huddles, grand round (medicine) and departmental teaching have been received positively and remain ongoing • Cycle eight of the Cognitive Screening and Management QIP, which focuses on the transition from acute to primary care and ensuring that patients identified with cognitive impairment have that information communicated to their GP, is ongoing • Development and roll out of a new function for GP notification of cognitive impairment assessment and screening results on the discharge letter has been created and educational work is ongoing to ensure compliance • Frailty Nurse Consultant in post supporting frailty in-reach to the Acute Assessment Areas

Strategic Objective	Action	Outcome measure
Supporting our patients to improve health and clinical outcomes *[cont.]*	Embedding Research delivery within the organisation	• The Trust has recruited over 1100 participants to NIHR portfolio studies and carries a portfolio of 45 active and 38 'follow-up' only studies • 14 specialties have been recruited to, including critical care, radiology, cancer, neurology, stroke, psychology, infectious diseases, renal, reproductive health, orthopaedic, dermatology, mental health, surgery, anaesthesia/pain management and clinical support services • The Trust successfully hosted a multi-stakeholder webinar on International Clinical Trials Day (20 May 2021)
	To further improve access for cancer patients and families via the Cancer Wellbeing and Support Centre	• Using the Cancer Wellbeing and Support Centre (which opened in April 2021), the Trust has promoted healthy living advice to reduce people's risk of getting cancer and offered tailored advice to cancer patients to support their recovery and reduce the chance of their cancer returning • Holistic supportive services continue to be offered and delivered within the Cancer Wellbeing and Support Centre. These include psychological support, welfare and benefits advise, HOPE self-management programme, Moving forward with HOPE, Mindful Compassion, Look Good Feel Better, a wig referral clinic and complimentary therapies. Monthly patient support groups are offered, including generic, head and neck and Eastern European support group • As part of the Personalised Care Programme, the Trust has recruited and established the Cancer Care Patient Navigator Team. The team will support with the delivery of the holistic needs assessment (HNA), which aims to identify individuals emotional, physical, social and spiritual concerns and ensure signposting for appropriate support and advice
Maximising opportunities for our staff to achieve their true potential so that we deliver outstanding care	Recruitment of a Wellbeing Guardian	• Further strengthened our nationally recognised health and wellbeing programme by: › Continuation of our dedicated posts including Clinical Psychology and Mental Health First Aiders to increase support available to staff. › Ensuring that a Board-level Wellbeing Guardian and Wellbeing Champions are in place. › Implementing a health and wellbeing passport for all staff • Non-Executive Director Sue Hayter recruited as Wellbeing Guardian, successfully passed through stages one and two of the implementation phases

Strategic Objective	Action	Outcome measure
Maximising opportunities for our staff to achieve their true potential so that we deliver outstanding care *[cont.]*	Increasing the visibility of Quality, Service and Redesign (QSIR) training and to increase the number of staff trained and supported to lead improvement projects at local level	• Increased visibility of QSIR through the mobile Quality Bus, which visits clinical and corporate areas to raise awareness. This is supported with social media posts (Facebook & Twitter) and through the intranet and has provided a firm foundation to continue increasing the number of staff trained to lead improvement projects at a local level. • Five members of staff will undertake QSIR College in summer 2022 to develop a sustainable QSIR faculty. • Further promotion of QSIR is supported by Lunch and Learn, Room for Improvement, QI Café and QI Fundamentals, with plans in place to deliver monthly QI drop-ins and quarterly QI 'pop up drop-in' sessions held in various locations. • These improvements have enabled us to surpass our 2022/23 target ahead of schedule (61 staff trained against a target of 60
	Working with NNUH on a joint QI faculty	• A number of exploratory meetings with NNUH have been held to develop a shared QI faculty delivering QSIR, QSIR Virtual and QI Café
	Introducing a new Staff Wellbeing Service that is fit for the future	• Plan to deliver an integrated Staff Health and Wellbeing Service. • Model will offer a service which covers three principle functions of ensuring staff are fit to undertake the role they are employed to do both physically and psychologically, generative interventions to prevent ill health and remedial interventions where ill health has occurred. • ICS collaboration to develop a service level agreement for the transactional aspect of the Occupational Health service, with wrap around staff support services provided directly by QEH employees. New model to be in place by end of 2022. • Cavell & Lind providing additional management support while the new model is developed
	To become a national leader in the NHS for menopause awareness	• Successfully achieved Menopause Accreditation with Henpicked • Menopause clinic launching April 2022

17. QUALITY PRIORITIES FOR 2022/23

During 2022/23, we will be focussing on delivering our Corporate Strategy which includes a number of indicators to support delivery of our quality priorities. These include:

Strategic Objective 1

To consistently provide safe and compassionate care for our patients and their families.

To progress on our journey towards CQC 'Good' by:

- Consistently sharing learning from complaints, near misses, never events, incidents, mortality and learning from deaths by:
  - Further improving phase three Duty of Candour in relation to sharing learning from Serious Incident investigations with evidence of thematic review both intra and inter-divisionally
  - Improving the closure of actions in relation to Serious Incidents incrementally, with evidence of a quarterly reduction
- Reducing the number of falls and those resulting in serious harm incrementally, with evidence of a quarterly reduction
- Improving our capability for implementing the introduction of The Liberty Protection Safeguards - This will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements
- Delivering year-on-year improvements to patient experience measures (measured via surveys and complaints) with demonstrable evidence of changes in practice

Strategic Objective 2

Modernising the QEH (estate, digital infrastructure and medical equipment) to support the delivery of optimal care.

- Launching an integrated three-year Digital and Data Strategy
- Managing cyber security risk and assurance through a business as usual annual workplan approach which will be monitored by the Digital and Information Forum
- Further improving the Trust's digital maturity by implementing patient observation management systems, chemo prescribing and wristband replacement
- Working both internally and with partners on the preparation for a system-wide Electronic Patient Record
- Further modernising our estate by:
  - Getting added to the New Hospital Programme and moving from Strategic Outline Case to Outline Business Case stage for a new build
  - Securing the required capital funding for a three-year programme to maximise safety and compliance of the Trust's current estate
  - Increasing car parking capacity via a deck or multi-storey solution to ease pressure
  - Aiming to improve energy efficiency and reduce the carbon footprint of all estates improvement projects
- Completing a Full Business Case for the Diagnostic and Assessment Centre
- Fully engaging with wider Integrated Care System estates developments, including maximising the opportunities at North Cambridgeshire Hospital, developing an on-site Elective Hub and progressing the Primary Care Hubs and Community Diagnostic Centre developments

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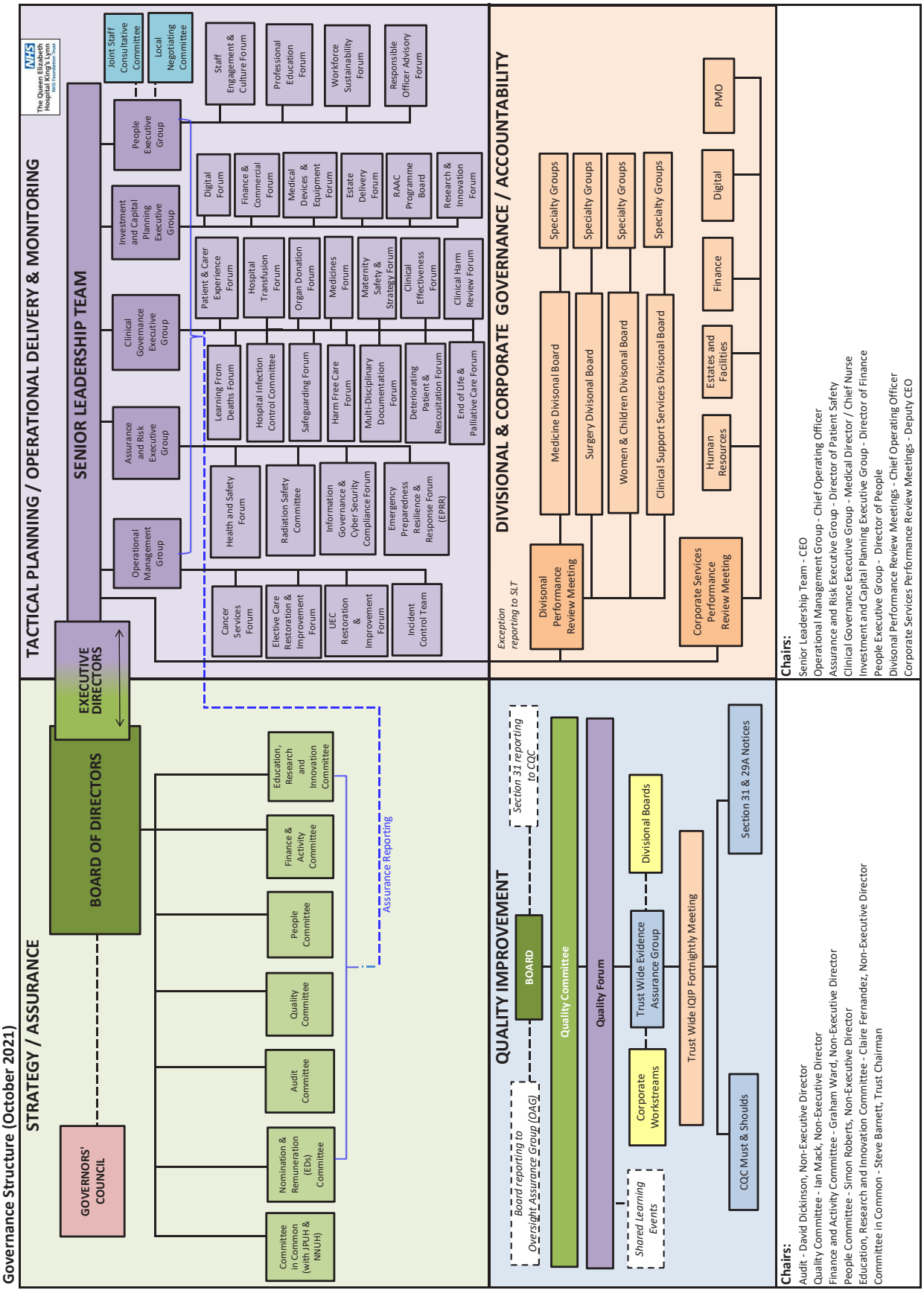
APPENDIX ONE: GOVERNANCE STRUCTURE



APPENDIX TWO:

The Trust Governors' Statement for the Quality Account 2021/22

The Governors of the Queen Elizabeth Hospital, King's Lynn are pleased to contribute their views to the Quality Account 2021/22.

The Governors appreciate that this year has continued to be a particularly demanding one, not only for the hospital but also for many of the stakeholders who work alongside our staff and patients. Once again, we extend our thanks and appreciation to every member of Team QEH for their hard work and dedication as they have continued to respond to the many challenges they face daily.

The CQC inspections in late 2021 and early 2022 recognised the progress that has been made since the regulator visited in 2019 and the Governors are pleased and proud with the decision to move the hospital out of special measures.

It is pleasing to note that we have a full complement of Governors representing the geographical area from which the hospital draws its patients.

Throughout the year the hospital has benefitted from experienced substantive leadership. In March 2022 our experienced Chairman, Professor Steve Barnett moved on to North West Anglia NHS Foundation Trust. As his successor, the Governors were pleased to appoint Graham Ward as Acting Chair.

The members of our Trust continue to be a source of information and advice both to the Board and to the Governors' Council. Their opinions and shared experience continue to be of value.

Governors have recognised that the impact of the pandemic has been well-managed and that the vaccination centre has been extremely successful. Vaccination rates continue to be very high and many patients comment on the excellence of their treatment.

Governors continue to be impressed by the much improved internal and stakeholder communications and the weekly bulletins which are widely shared.

The Governors continue to be concerned about the deteriorating estate but are mindful of the considerable effort that is being expended to ensure the safety of patients and staff and have high expectations that our expression of interest in the new hospital and compelling case that we have submitted will be successful.

The Trust's financial performance continues to meet expectations despite the many demands and challenges of the year. The Governors note that the capital investment achieved in year has exceeded any previous investments in the Queen Elizabeth Hospital, King's Lynn.

Positive Governor observations for 2021/22

- The CQC report recognised improvements in the areas inspected and the lifting of special measures and the Governors applaud the critical care leadership which was recognised as outstanding
- The National Staff Survey showed that staff would recommend the QEH as a good hospital for treatment
- The publishing of QEH's learning from COVID-19 Duty of Candour exercise
- Communication with stakeholders is very good
- Topics are presented with minimum use of acronyms and medical jargon which is essential for members of the public
- The pandemic has continued to be well managed and vaccination rates are high
- The National Cancer Survey showed improved cancer care with the QEH being in the top five Trusts for information given prior to cancer treatment and support, ease of contact and understanding of named clinical nurse specialists
- The National Maternity Survey showed improvement
- The Trust continues to work with the armed forces with positive outcomes, particularly for veterans
- The HUSH project has the ambition to ensure that patients have the opportunity for a good nights' sleep
- The improved complaints procedure is ensuring that complaints are dealt with within the target time frame and more to the satisfaction of patients and their families
- The Leadership Summits have been outstanding with inspirational speakers
- Excellent work continues in education, research and development and a significant number of patients have been enrolled in research programmes
- Financial understanding and the grip on our finances continues to improve
- The Leadership Team has excelled in attracting capital funding
- The Emerson Unit is proving popular with patients and improved parking will enhance patient experience
- The Endoscopy Suite is an exciting improvement and Governors look forward to its opening in June 2022
- The opening of the West Norfolk Ophthalmology Unit in the Emerson Unit will be a positive move in reducing waiting times for patients
- The Executive Team continues to work hard to attract a new hospital to be built on the site
- The Estates Team recognises that car parking is a problem and is seeking a solution for the near future
- The QEH continues to work more collaboratively within the Norfolk and Waveney ICS and is developing good relationships with the Cambridge and Peterborough and Lincolnshire ICSs
- The Trust is playing a significant part in the development of Place Based Care
- The introduction of GP screening at the front door of the Emergency Department

Areas for improvement identified by Governors as we look to 2022/23

- Roll-out of the digital and data strategy and the positive impact it should have for both patients and staff
- Governors' understanding of the Integrated Care Systems, the development of Place Based Care and the Provider Collaborative and the effectiveness of the recovery programme across the system
- Training to improve Governor skills sets and understanding

Areas for improvement identified by Governors as we look to 2022/23 *[cont.]*

- The significant waiting list for elective surgery
- Staff recruitment and retention
- Staff sickness
- Staff confidence in recommending the QEH as a good place to work
- Delays in the availability of diagnostic services and the impact on patient confidence
- Demands on the Emergency Department and the associated estates challenges and ambulance handover delays
- Delayed discharges resulting in poor patient experience and the impact on the availability of beds
- New MRI scanners
- Whilst improvements have been made to End of Life Care there are still improvements to be made
- Car parking
- Development of a Clinical Strategy to underpin the system development
- Slow progress in developing the Integrated Care System
- The website should be urgently updated and out of date information removed
- The lifting of the no visitor rule
- Embedding learning from incidents and training to improve the patient experience
- Middle management training and leadership skills
- Better engagement with GP practices, primary care and healthcare professionals across West Norfolk, Cambridgeshire/ Fenland and South East Lincolnshire
- Governors continue to be concerned about the number of falls
- Staffing in Maternity

APPENDIX THREE:

Statement from Healthwatch Norfolk

Healthwatch Norfolk is pleased to have the opportunity to comment on the Queen Elizabeth Hospital, King's Lynn, Quality Report for 2021-22.

Firstly, we would like to congratulate the Trust on moving out of segment four of the System Oversight Framework (previously known as special measures) and achieving improved CQC ratings following an unannounced inspection in December 2021 and well-led inspection in January 2022. The significantly reduced number of four 'must do' actions and nine 'should dos' in 2022 compared to 206 must do and should do actions and 43 section and warning notices after the 2019 CQC inspection, reflects all the work that the Trust has undertaken during the past 12 months. We fully recognise these achievements have been successfully completed at the same time as having to address the continuing challenges posed by COVID-19. The charts on pages 13 and 14 are a particularly effective visual example of the improved ratings across a number of areas.

The document itself is quite lengthy and not overly 'patient friendly' in terms of the amount of text and statistics but it is recognised that some of the content is as stipulated by NHS Quality Accounts regulations. At the time of this review there is nothing in the document itself that states whether it is available in different formats (other languages, easy read, Braille etc). It is disappointing that we also mentioned this in our statement on the Quality Report for 2020-21. There is a detailed welcome statement from the Trust Chair and Chief Executive summarising the contents of the report.

With regard to patient safety, we note the 50% increase in safety incidents resulting in severe harm or death (catastrophic) and that this increase is partly attributable to the use of escalation areas. We therefore trust that the number will decrease as the impact of COVID-19 measures subsides. We commend the Trust on its Duty of Candour work in response to the pandemic and the number of contacts made with patients, next of kin or a relevant legal representative of the patient.

We were pleased to collaborate with the Trust to develop the patient experience strategy to help make it more meaningful and we fully endorse how powerful the sharing of an experience directly from the patient and/or their family can be as described in paragraph 2.2 on page 21. The introduction of Family Liaison Officers (FLO) is welcomed, and we congratulate the Trust that this initiative has now been rolled out across Norfolk and Waveney. In addition to the details provided of the themes highlighted during FLO contact it would be useful know how the impact of this role has been measured. The ways in which the Trust has used feedback from a variety of sources to improve the experience of patients and their carers demonstrates very practical examples of improvements for patients. It is also good to note that the backlog of complaints has been cleared and improvements made to the complaints management process. The work on clarifying issues raised to PALS should also assist the Trust to use patient feedback in a meaningful way. There has clearly been a great deal of work undertaken to ensure patient experience is fully embedded in a variety of ways and we look forward to learning how the Trust utilises more feedback as the pandemic subsides and more opportunities for patient engagement can resume.

We fully acknowledge the work by the Trust to support is workforce and its decision to invest in all the significant areas raised by staff together with other actions to help to ensure staff feel valued and listened to. We are aware of the challenges both regionally and nationally to recruit and retain staff and note the new staff engagement plan proposed for 2022/23.

The document lists the considerable number of national clinical audits involving the Trust and its actions as a result of the data submitted for the National Audit - Bowel Cancer Audit (NBOCA). It would be useful to know if participation in any of the other audits listed resulted in any actions or learning specific to the Trust.

It is disappointing that the Trust did not meet its target for 2021/22 to reduce the number of inpatient falls by 15% but we recognise the challenges in terms of the significant increase in patient admissions and those potentially at risk of falls according to NICE guidance. The document details a number of actions taken in accordance with the falls prevention care plan including adjustment of staffing numbers later in the day and the use of assistive technology in toilets bathrooms and side rooms. In addition, we note the plans for improvement in this area in 2022/23 and look forward to noting the results next year.

The gradual positive reduction year on year of Trust acquired pressure ulcers is good to see albeit there was a spike between September and December amidst the ongoing challenge of capacity and staffing.

The work on end-of-life care is clearly documented including the relaunch of end-of-life champions on each ward.

Progress against the priorities for 2021-22 is clearly identified and as mentioned above, it is clear there has been a great deal of work undertaken during the year to strengthen and improve services for patient as well as a number of initiatives to provide further support to staff.

The number of falls is clearly a concern, and we look forward to a positive impact of the work proposed for 2022/23 combined with a reduction in patient numbers due to the pandemic. We are pleased to note the statement that those patients deemed to be clinically urgent or on a cancer pathway have received timely treatment. However there appears to be no specific data on waiting lists for elective care.

We also congratulate the Trust on being an exemplar for its response to the Ockenden report which received a great deal of public attention. The response by the Trust should hopefully give some reassurance to members of the public looking to use maternity services at the Trust.

The strategic quality priorities for 2022/23 are summarised well towards the end of the report.

Statement from Healthwatch Norfolk *[cont.]*

Overall, we are pleased to note the significant amount of work undertaken to improve experiences for patients and carers whilst also working hard on staff communications and engagement.

Going forward we look forward to working with and supporting the Trust in its bid for a new hospital and work to mitigate risks associated with the current building structure in the meantime. More generally we will continue to work with the Trust to ensure feedback from patients, families and carers is used proactively particularly against a background of new working relationships as the Integrated Care System is launched across Norfolk.

Alex Stewart

Chief Executive

APPENDIX FOUR:

Statement from Norfolk and Waveney Clinical Commissioning Group

NHS Norfolk and Waveney Clinical Commissioning Group (CCG) supports The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) in the publication of its Quality Account for 2021-22. Having reviewed the report we are satisfied that it incorporates the mandated elements required, based on information available.

The CCG recognises the challenges experienced by the Trust over the last contractual year and the significant pressures that the workforce has faced in managing the COVID-19 pandemic and an increased demand on services. The CCG commends the Trust for your continued delivery of services, and we thank your staff for their commitment during such unprecedented times in caring for those using your services.

The CCG congratulates the Trust for its improved ratings received from the Care Quality Commission (CQC) following the unannounced inspection in December 2021 and Well-Led inspection in January 2022, and for being lifted out of segment four of the System Oversight Framework previously known as 'special measures'.

The organisation's clear focus on their continuous improvement journey and delivery of the Integrated Quality Improvement Plan has been evident and the Trust continues to be committed to delivering safe, effective care for patients and their families alongside providing a positive working environment for staff. The Trust-wide oversight of evidence gathered against action plans to demonstrate compliance and the adoption of this approach across the East of England as exemplar is commendable.

The CCG praises the Trust for completing an extensive Duty of Candour exercise for patients who contracted COVID-19 whilst in their care, and the publication of the 'Learning from COVID' report which validates the ongoing commitment to openness and transparency.

The CCG supports the continued delivery of the Trust's maternity improvement programme in providing personalised and safe care to women, babies and their families, underpinned by the recommendations for action from the interim Ockenden report published in December 2020 and the themes identified for action within the final Ockenden report published in March 2022.

The CCG notes and supports the Trust's Quality Priorities for 2022/23 with the continued focus on further improving quality, engagement, and healthy lives, to ensure the Trust's Corporate Strategy and priorities for patients and the local population are delivered, working actively within the emerging Norfolk and Waveney Integrated Care System.

The CCG recognises the challenges ahead and values the ongoing commitment from all staff within the Trust to improve the experience of patients and their families by learning from both national and local improvement reports, independent enquiries and CQC recommendations. We recognise the importance of collaborative partnership working and the positive impact that this can have on quality, and we look forward to working with you during 2022/23.

NHS Norfolk and Waveney Clinical Commissioning Group commends the QEH for this Quality Account and believes the report provides an opportunity to share with patients, families, and carers the ongoing work of the organisation in maintaining and developing quality. On behalf of NHS Norfolk and Waveney CCG, I would like to thank you for your continued hard work and look forward to working with you during 2022/23.

Karen Watts

Associate Director of Nursing and Quality
NHS Norfolk and Waveney Clinical Commissioning Group

APPENDIX FIVE:

Statement of Directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Account for each financial year.

Guidance has been issued to NHS Foundation Trust Board of Directors on the form and content of the annual quality account (which incorporate the legal requirements) and on the arrangements that NHS Foundation Board of Directors should put in place to support data quality for the preparation for the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting 2021/22 supporting guidance Detailed requirements for quality reports 2021/22
- The content of the Quality Account is not inconsistent with internal and external source of information including:
  - » Board minutes and papers for the period April 2021 - March 2022
  - » Papers relating to quality reported to the Board over the period April 2021 - March 2022
  - » Feedback from Governors dated June 2022
  - » Feedback from Healthwatch Norfolk dated June 2022
  - » Feedback from Commissioners dated June 2022
  - » The Trusts complaint's report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009 due for publication summer 2022
  - » National inpatient survey results published in October 2021
  - » National staff survey results published in March 2022
  - » CQC inspection report dated July 2019 and February 2022
- The Quality Account present a balanced picture of the NHS Foundation Trusts' performance over the period covered
- The performance information in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and the controls over the collection are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance in the Quality Account is robust and reliable, conforms to specified date quality standards and prescribed definitions is subject to appropriate scrutiny and review
- The Quality Account have been prepared in accordance with the NHSE/ Improvements Annual Reporting Manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the quality report

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Accounts

By order of the Board

Professor Steve Barnett
Trust Chairman

Date: 16 June 2022

Caroline Shaw CBE
Chief Executive

Date: 16 June 2022

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GLOSSARY

A

Accountability - the requirement for organisations to report and explain their performance.

Acute - describes a disease of rapid onset, severe symptoms and brief duration. The majority of hospital services provided by QEH are for acute illnesses.

Admission - the point at which a person enters hospital as a patient.

Agency staff - staff working at QEH but employed by a private recruitment agency.

B

Bank staff - staff who are available for short-term or flexible work to help manage vacancies more effectively.

Best practice - a way of working that is officially accepted as being the best to use.

C

Caldicott Guardian - a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian.

Capital expenditure - the money allocated for buildings, equipment or land, also known as fixed assets.

Care Quality Commission (CQC) - the independent regulator of health and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations.

Clinical Commissioning Groups (CCGs) - the NHS organisations responsible for planning and funding the majority of healthcare.

Clinical outcomes - the end result of a medical intervention, such as survival or improved health.

Clostridium difficile (C. diff) - a healthcare-associated intestinal infection that mostly affects elderly patients with other underlying diseases.

Commissioning - the process of identifying the needs of local people and funding services to meet those needs. Commissioning is carried out at a number of different levels in the NHS, but the majority of services patients receive are commissioned by the Clinical Commissioning Group for their local area.

Community care - long-term care for people who are mentally ill, elderly, or disabled which is provided in the patient's own home, in a residential or care home rather than in hospitals.

Commissioning for Quality and Innovation (CQUIN) - a system of reward payments made by commissioners to hospitals to encourage better experience, involvement and outcomes for patients.

COVID-19 (Coronavirus) - an infectious disease caused by the SARS-CoV-2 virus. Most people infected with the virus experience mild to moderate respiratory illness and recover without special treatment. However, others – and especially older people or those with underlying conditions - can become seriously ill and require medical attention. Anyone can get sick with COVID-19 and become seriously ill or die at any age.

D

Dementia - describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer's Disease or a series of strokes.

Discharge to Assess - enabling patients to be assessed for their longer-term health and social care needs at home or in the community, rather than waiting for this to happen in hospital.

E

Early Warning Score (EWS) - a categorisation that uses data taken from routine patient observation to calculate a score indicating potential severity of illness and to act as a prompt to nursing staff to request a medical review at specific trigger points. (PEWS is a specific type of early warning score designed to assess children.)

Elective care - care that is planned. This is usually where the patient is referred by their GP or other healthcare professional. Appointments, treatments and admissions to hospital will be confirmed in advance.

Elective surgery - an operation that is planned in advance and for which the patient will be given a date to be admitted to hospital.

Emergency Department (ED) (also known as Accident and Emergency) - the department specialising in the care of patients with life-threatening or life-changing needs, which require immediate, specialist care.

Equality, Diversity and Inclusion (EDI) - equality is about creating a fairer society where everyone can fully take part. It means giving people an equal opportunity to have their individual needs considered and met, in recognition that society comprises different people with different needs at different times. Diversity is the positive recognition of difference.

End of Life care - ensuring that the care people receive at the end of life is compassionate, appropriate, and gives people choices regarding where they die and how they are cared for. This care is co-ordinated across health and social care services.

Electronic-Observations (E-Obs) - a digital system for recording the vital signs of a patient (such as blood pressure, temperature and heart rate). Often using a mobile device to collect and store patient observations, creating a set of information that can assist in making clinical judgments. This can help indicate signs of deterioration, for example sepsis and acute kidney injury.

F

Financial control total - the maximum amount of deficit or surplus that an NHS organisation is required to achieve. This amount is set by NHS Improvement and agreed with each organisation, or as part of the wider health and care community.

First attendance - the first or only time a patient attends hospital after being referred by their GP or health professional.

Follow-up attendances - the second and subsequent times patients attend hospital for assessment, diagnosis or treatment as an outpatient.

Foundation Trust - see 'NHS Foundation Trust'.

'Friends and Family' Test (FFT) - the national patient satisfaction programme which gives every patient the opportunity to feedback on the quality of their care.

Full-Time Equivalent (FTE) - the measurement and calculation of total staff numbers, using a standard working day. Also known as Whole Time Equivalent (WTE).

G

Getting It Right First Time (GIRFT) - a programme which aims to improve care in hospitals and reduce cost by reducing unwanted variations in services and practices

Gram-negative bloodstream infections (GNBSIs) - infections which are caused by bacteria into the bloodstream and can cause serious complications or death. They include Escherichia coli (E. Coli), Klebsiella and Pseudomonas aeruginosa.

H

Health Scrutiny Committee/Overview and Scrutiny Committee - a function of local councils in England. The committee has the responsibility to review policies, decisions and services in their own council and in other organisations, including the NHS, which may impact on local residents.

Healthcare Assistant (HCA) - staff who work under the guidance of a qualified healthcare professional, usually a nurse. Sometimes staff working in HCA roles are known as nursing assistants, nursing auxiliaries or auxiliary nurses.

Healthwatch Norfolk/Peterborough/Lincolnshire - the local service affiliated to Healthwatch England, the national consumer champion in health and care. It has statutory powers to ensure the voices of patients and service users are heard by those who commission, deliver and regulate health and care services.

Hospital Standardised Mortality Rates (HSMR) - an indicator of healthcare quality that measures if the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Factors such as age and severity of illness are taken into account.

I

Information Governance - the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information to ensure an organisation's regulatory, legal, risk, environmental and operational requirements.

Inpatient - a patient who is admitted to hospital for a period of treatment or to undergo an operation. Inpatients are those that stay in hospital for 24 hours or more.

Integrated Care System (ICS) - new developments in NHS care which bring together commissioners and healthcare providers to plan and deliver care without organisational and financial boundaries. QEH is part of the Norfolk and Waveney Integrated Care System. ICSs were previously known as Sustainability and Transformation Partnerships.

Integrated discharge - planning and managing a patient's discharge from hospital across all services and all part of the hospital.

Intervention - any measure to improve health or alter the course of disease.

L

Locum staff - nurses and doctors employed by the NHS on a temporary, fixed-term basis.

M

Methicillin Resistant Staphylococcus Aureus (MRSA) - is a type of bacteria that is resistant to a number of commonly used antibiotics. It lives on the skin and is mostly harmless unless it gets deeper into the body, for example, if it gets into a wound or where the skin is broken.

Model Hospital - a digital information service designed to help NHS providers improve their productivity and efficiency by comparing and benchmarking performance against peers/other centres.

N

National emergency access standard - a national standard for all Emergency Departments/Accident and Emergency Departments. The standard measures the number of patients seen, admitted or discharged within four-hours; hospitals are expected to achieve 95%. It is often known as the 'four-hour' standard.

National Patient Survey - ensures patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS Trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. There are inpatient, maternity and outpatient surveys.

Never Events - serious, but largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NHS England/Improvement - the organisation responsible for overseeing NHS Trusts, as well as independent providers that provide NHS-funded care. It has recently merged with NHS England and is often referred to as NHS England/Improvement (NHSE/I).

NHS Trust - a statutory, self-governing NHS organisation providing healthcare services. NHS Trusts - and NHS Foundation Trusts - provide the majority of hospital, mental health and ambulance services. Their income is derived from service agreements and contracts with clinical commissioning groups or, for some highly specialist services, NHS England. They have freedom to decide staff numbers and rates of pay and some powers to invest and borrow money.

Non-elective care - is provided when the patient is assessed as needing treatment or hospital admission urgently or in an emergency.

Non-Executive Director - a member of the Trust's Board of Directors who is not part of the Executive Team. A Non-Executive Director typically does not engage in the day-to-day management, but is involved in policy making and planning exercises. In the NHS Non-Executive Director appointments in the NHS are managed by NHS Improvement. Non-Executive Directors have voting rights on the Board.

O

On-the-day cancellation - refers to a planned operation that is cancelled on the day the patient was due to arrive (at hospital), after the patient has arrived in hospital or on the day of the operation if the patient is already in hospital.

Overview and Scrutiny Committee - see Health Scrutiny Committee.

P

Palliative care - services for people living with a terminal illness where a cure is no longer possible. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs.

Parliamentary Health Service Ombudsman (PHSO) - the Ombudsman makes final decisions on complaints that have not been resolved by the NHS in England, UK government departments and other public organisations.

Pathway of care - the planned and most efficient way to provide care from referral to diagnosis, treatment and follow-up. Pathways are in place for most common diseases and conditions and use evidence-based practice to determine the best way for patients to be seen and treated.

Patient Administration System (PAS) - computerised system to record non-medical patient details such as name and address as well as appointments/visits to the hospital.

Patient Advice and Liaison Service (PALS) - provides information, advice and support to help patients, families and their carers. Patient experience - the experience a patient has in our hospitals, whether as an inpatient or an outpatient. This includes not only the care received

Patient experience - the planned and most efficient way to provide care from referral to diagnosis, treatment and follow-up. Pathways are in place for most common diseases and conditions and use evidence-based practice to determine the best way for patients to be seen and treated.

Patient flow - the different elements that make up a patient's progress through the hospital system from referral through to diagnosis, treatment and discharge. This includes all of the staff, departments and organisations who are involved in providing the end-to-end care.

Provider Sustainability Fund (PSF) - national bonus monies allocated to Trusts by quarter based on performance versus plan, including financial plan and emergency access performance. Previously called Sustainability and Transformation Fund.

Public Sector Equality Duty - the public sector's legal duty to eliminate discrimination, advance equal opportunities, foster good relations, and publish data on progress.

Q

Quality Account - every NHS Trust is required to publish a Quality Account, setting out how it continues to improve the quality of services it provides. It covers three key areas: patient safety, clinical effectiveness and patient experience.

Quality assurance - the maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production.

Quality Governance Framework - a set of standards for Trusts to continuously monitor themselves against.

R

RAAC (Reinforced Autoclaved Aerated Concrete) - a form of lightweight concrete sometimes referred to as panels. It was used primarily in roof planks of some public buildings built between the mid-1960s and mid-1990s, including QEH.

Radiology - a science that uses images to diagnose and in some cases treat diseases. It is a general term which covers X-ray, CT and MRI scans.

Re-admissions - the number of patients re-admitted as an emergency within either seven or 28 days of being discharged following previous treatment.

Resilience - the ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver organisationally agreed critical activities.

Respiratory - the specialty which deals with illnesses and conditions affecting breathing.

Referral to Treatment (RTT) - national maximum waiting times set out in the NHS Constitution from the point a patient is referred to hospital by their GP.

S

Safety culture - the attitude, beliefs, perceptions and values that employees share in relation to safety in the workplace. Safety culture is part of organisational culture; a positive safety culture is a key part of improving the quality of care.

Staff engagement - encouraging staff to be committed to their organisation's goals and values, motivated to contribute to organisational success, and enhance their own sense of job satisfaction.

Single Oversight Framework (SOF) - sets out how our regulator NHS Improvement oversee NHS Trusts and NHS Foundation Trusts, helping to determine the level of support they need based on a range of performance measures.

T

Tertiary care - there are three levels of healthcare in the NHS: primary care (the first point of contact for patients including GPs, dentists, pharmacists and opticians); secondary care (specialist services, often provided by a hospital, that patients are referred to from primary care); and tertiary care which is further specialised treatment and care provided by professionals with specific expertise in a given field, for example neurosurgery, cardiac surgery and cancer management.

Tertiary referrals - referrals for specialist care from consultant to consultant. These can be within the same hospital/service or between different hospitals and services.

V

VTE - Venous Thromboembolism is a condition in which a blood clot forms, most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis or DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism).

W

Waiting times - the period that a patient may wait before being seen at a routine appointment or for admission to hospital. The standards and maximum waiting periods are set nationally under the NHS Constitution.

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