NHS

The Queen Elizabeth Hospital King's Lynn

NHS Foundation Trust

QUALITY ACCOUNT

2020/21

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WELCOME

Welcome to the 2020/21 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 2020/21 to share with our patients, our local community, our partners, staff and wider external stakeholders.

The Trust is on a journey of improvement and can evidence strong progress in many areas. This report is intended to be read alongside the Trust's 2020/21 Annual Report and Accounts and/or also as a standalone document. It summarises how QEH has:

- Made demonstrable improvements following its 2020 Care Quality Commission (CQC) inspection and is now aspiring to be a continuously improving organisation
- Further strengthened the governance arrangements of the Trust Board, Sub-committees and Divisional arrangements, including how the Trust involves Governors in Board Sub-Committees
- Performed against the quality priorities for 2020/21
- Listened to and responded to feedback from patients and their families that we receive via complaints, concerns, patient surveys and following incidents
- Monitored the effectiveness of service by participation in Research and Clinical Audits
- Developed quality priorities for 2021/22, following extensive engagement with our patients, Governors, partners and staff

Even as the Trust has responded to the COVID-19 pandemic, 2020/21 has been a year of further significant progress.

The Trust's Integrated Quality Improvement Programme (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.

The Trust has made strong progress against its IQIP with a high-calibre, experienced Board now in place to take QEH forward. The Trust had an unannounced CQC core services inspection in September 2020. The subsequent report, published in December 2020, resulted in none of the Trust's core services being rated 'inadequate' compared to 19 areas that had been 'inadequate' in the Trust's 2019 inspection. All of the Trust's core services inspected (Medicine, Surgery, Urgent and Emergency Care, Maternity, Diagnostic Imaging and End of Life Care) are now rated as 'Good' for caring - marking a further significant improvement. The Trust has three 'Must Do' and 33 'Should Do' actions from its 2020 inspection (compared to 206 in total in 2019, marking an 82% reduction in 'must' and 'should do' actions). The General Medical Council conditions have been removed and the Trust is no longer under enhanced monitoring.

In addition, five Section 29A CQC Conditions have been closed, 5 Section 31 Conditions for Maternity Services have been removed and a further 10 Section 31 Conditions spanning Maternity, Urgent and Emergency Care and Diagnostic Imaging were lifted in March 2021.

QEH had no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, compared to one the previous year. The Trust continues to do all it can to reduce hospital-acquired infections and QEH's rating moved from 'amber' to 'green' in-year for infection prevention and control by the regulator NHS Improvement/England.

Modernising the hospital (both the estate and digital infrastructure) has been a priority in 2020/21, with much progress made. In another important strategic development, the Trust successfully purchased the private BMI Sandringham Hospital, with the facility being operational within four weeks of the transaction, providing a new 26-bed elective treatment centre for QEH.

The QEH marked its 40th birthday with a Royal visit from the Duke and Duchess of Cambridge, which was a day to remember. The deterioration of QEH's ageing building - designed to last 30 years - remains a real cause for concern for the Trust Board and as such the Trust submitted a compelling case for a new hospital as part of the NHS response to the Comprehensive Spending Review in Autumn 2020 and has started developing a Strategic Outline Case to strengthen its case even further. The allocation of £20.6m national capital funding for short-term safety improvements to the estate was welcomed at the end of 2020/21. However, this must be balanced with the need to find a longer-term solution to addressing the challenges with the hospital's estate on a sustainable basis with a new hospital or substantial rebuild. The patients and the local communities we serve in West Norfolk, North East Cambridgeshire and South Lincolnshire deserve nothing less.

The digital maturity of QEH has improved over the last year. The Trust has a digital work plan which balances getting the fundamentals right (including ensuring compliance with the statutory requirements for Cyber Security by Summer 2021) with progressing digital transformation, supported by clinical engagement via the Trust's Chief Clinical Information Officer and Chief Nurse Information Officer. More virtual outpatient clinics were introduced during the pandemic and we are on-track to introduce Electronic Prescribing and Single Sign On in April 2021 (followed by a new Radiology Information System in August 2021). The Trust is actively engaged and working closely with system partners in the development of a case to bring an Electronic Patient Record to Norfolk and Waveney.

Two important strategic developments were on the cusp of completion at the end of 2020/21, including the new Maternity Bereavement Suite, which has been made possible thanks to £185K of charitable funds after being named the Lynn News Charity of the Year, and a new Cancer Wellbeing and Support Centre, also charity-funded. There has been good progress with the new School of Nursing for King's Lynn and West Norfolk, a partnership venture with the College of West Anglia and the Borough Council of King's Lynn and West Norfolk, with the first intake of Nursing Associates due early 2022.

Engagement

Recognising how challenging this period has been for staff, the Trust introduced a much strengthened and nationally-recognised staff engagement programme. The National Staff Survey results for 2020 have improved across all ten themes for the second year running, providing important external evidence that staff morale, culture and experience is improving. The Trust's results were the twelfth most improved in the country for 2020 and the most improved in the region for the second consecutive year, with response rates the highest since 2017.

The Trust's Medical Engagement Survey results, published in early 2021, show that medical engagement has improved significantly - with QEH one of the most improved Trusts in the East of England. The Trust has launched clear behavioural standards - called 'The QEH Way' - so that there is absolute clarity regarding the standards expected of staff.

A Trust-wide culture transformation programme has launched to bring values to life across the organisation, with a strong focus on kindness, wellness and fairness. This work is a top priority going into 2021/22.

We will continue to build on the opportunities which have been created by the pandemic including flexible and home working, physical and psychological health and wellbeing, staff benefits, greater collaboration with voluntary and other care sectors and the development of a range of staff networks including Black, Asian and Minority Ethnic (BAME) and Lesbian, Gay, Bisexual and Transgender (LGBT) Networks.

With more than double the number of 'speak up' referrals in 2020/21 compared to the previous year, this is a sign that QEH is creating a 'speak up' culture. We will continue to encourage staff to speak up with concerns and feedback, and our team of 19 Freedom to Speak Up Champions who represent staff across the Trust are instrumental in taking this work forward alongside the Freedom to Speak Up Guardian and the Trust's Head of Organisational Culture.

The Trust's inaugural Leadership Summit, attended by a range of nationally-recognised speakers from inside and outside the NHS, was held in March 2021 and was a big success with attendance from over 490 staff, Governors and partners.

An external stakeholder perception survey carried out in summer 2020 returned some of the best feedback the auditor has received from such reviews, demonstrating much-improved stakeholder and partner relationships and more active participation in wider system work across Norfolk and Waveney.

With regard to wider performance, we have seen the impact of COVID-19 on our ability to deliver planned care with a deterioration in 18-week Referral to Treatment and diagnostics performance and a significant increase in the number of patients who are waiting over 52 weeks for treatment.

COVID-19 cases have reduced dramatically since February 2021 and so our attention is now focused on the recovery and restoration of services, including our elective programme. We now have a clear focus on recovery of all of our elective services in line with the nationally agreed performance standards.

Although we have seen pressures across emergency care pathways, there have been improvements made in relation to performance against the national emergency access standard and improvements in ambulance handover times. As the Trust has been running two Emergency Departments during the pandemic which has demonstrated that when QEH has an appropriate department size it can more consistently deliver timely emergency patient care.

The Trust achieved five out of the seven service Cancer targets but did not achieve the 62-day wait target. This will be a clear focus in the year to come.

Thanks to the efforts of staff across the Trust, QEH achieved its financial plan for the second year running and was one of very few trusts nationally to continue its Cost Improvement Programme in 2020/21 - achieving £4.5m savings in-year.

Healthy Lives

The Trust has implemented a comprehensive programme including health and wellbeing for staff, with dedicated posts in place to support staff including 18 Mental Health First Aiders, a clinical psychologist and PTSD specialist posts and a new menopause awareness and manager training programme.

Over 30,000 patients and healthcare staff (including QEH staff) have received their COVID-19 vaccination at QEH's hub and the Downham Market centre since the end of December 2020 and QEH has completed 100% staff risk assessments - the best in region. At 100%, QEH had the best flu vaccination rates in the East of England and in the country.

The Trust's excellent reputation for research and innovation continues to grow. QEH recruited 2,511 participants into research trials in 2020/21 - marking another record-breaking year - and QEH was ranked 27 of 507 Trusts nationally for COVID-19-related research, leading on vaccine trials for the Eastern region.

Whilst it is important to recognise the Trust's progress in so many areas we know where we need to focus our efforts to see further progress and ensure sustained year-on-year improvements to patient and staff experience. There remains much more work to do to deliver consistently safe and compassionate care to our patients and their families and to ensure more timely good quality responses and learning from complaints. Other areas of improvement in 2021/22 include reducing sickness absence and improving appraisal and mandatory training rates.

Central to the delivery of QEH's strategy is the Trust playing a lead and active role in the emerging Norfolk and Waveney Integrated Care System and developing Provider Collaborative, which will see closer relationships being forged between QEH, James Paget University Hospitals (JPUH) and Norfolk and Norwich University Hospitals (NNUH).

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

Strategic Objective one: To consistently provide safe and compassionate care for our patients and their families.

Our 2021/22 priorities include:

- Moving out of 'special measures' and to become rated CQC 'Good'
- Focus on patient experience, including complaints. Consistently ensuring timely and quality responses to patients and their families and sharing learning
- Reducing patient harms and improving learning from incidents
- Improving in all areas of the National Inpatient Survey
- Delivering the agreed improvements to Maternity care in line with the independent review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust
- Ensuring patients receive timely access to care and treatment

Strategic Objective two: Modernising the QEH to support the delivery of optimal care.

Our 2021/22 priorities include:

- Completing a Strategic Outline Case for a new hospital and continue lobbying our compelling case to ensure QEH is one of the further eight new hospitals to be built by 2030
- Significantly improving the Trust's digital maturity, including the implementation and embedding of the new Radiology Information System (RIS) and Electronic Prescribing and Medicines Administration (EPMA) system
- E-Observations and positive engagement with system partners in the work to bring an Electronic Patient Record to Norfolk and Waveney
- To open the new Maternity Bereavement Suite and progress the plans for a new West Norfolk Eye Centre

Full details of our quality milestones and deliverables we have agreed for 2021/22 are available in the Trust's Year 2 Corporate Strategy, which is available on the QEH website.

A big thanks goes to our 4,000-plus Team QEH staff (3,282 whole time equivalents), alongside volunteers, Governors, members, our local community and our partners for their support throughout the year. We look forward to working with you all in the year to come as we move into the next chapter of our journey of improvement and continue to work together, committed to ensuring our patients and their families consistently receive the safe and high quality care they deserve.

Professor Steve Barnett
Chairman
11 June 2021

Caroline Shaw CBE
Chief Executive
11 June 2021


TECMAN
ADVANCED HEALTHCARE PRODUCTS
TECMAN
ADVANCED HEALTHCARE PRODUCTS

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 commissioned where required.

Non-Executive Director-led Board committees have been operational throughout the year, all of which report directly to the Trust Board:

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

These run alongside the:

- Audit Committee
- Nomination and Remuneration Committee (Executive Director Appointments)
- Charitable Fund Committee

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 Group
- Investment and Innovation Executive Group (renamed the Investment and Capital Planning Executive Group in March 2021)
- People Executive Group

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

Throughout 2020/21the 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 and strengthened for 2020/21 with the introduction of 'plot the dots' (Statistical Control Process) methodology. This will be further developed in 2021/22.

The Trust has an Integrated Quality Improvement Plan (IQIP) (as described on page 14) in place, covering strategic priorities, licence conditions reporting and CQC 'must do'/'should do' actions. Progress on the delivery of the IQIP is reported internally to Quality Committee, the Trust Board and externally to the Oversight and Assurance Group and the 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, and a Conditions and Notices Group, set up to oversee and provide assurance to the Trust Board that sustainable improvements have been introduced to support delivery of the IQIP
- A much improved understanding of organisational risk and visibility of high level risks at The Trust Board by the development of a Board Assurance Framework
- Introduction of our new five-year Corporate Strategy with quarterly reporting of progress against corporate strategy key performance indicators
- A revised approach to governance arrangements for the Project Management Office (PMO). The Better Hospital Team has been introduced to support the evolution of the PMO's focus from mere compliance towards creating a culture of continuous improvement, including oversight of the PMO's annual plan and progress against it by the Senior Leadership Team
- Introduction of a comprehensive suite of programmes to transform culture, including a Trust-wide Culture Transformation Programme (with external support) to bring values to life across the Trust, internal culture and organisational development work with a range of corporate and clinical teams, introduction of 'The QEH Way' (new behavioural standards) and 'Ways we listen' relaunched across the organisation
- To support the Trust's 'Speak Up' agenda the Trust has in place an independent Freedom to Speak Up Guardian and has now recruited 19 new Freedom to Speak Up Champions from across the organisation
- Leadership training for Band 5/6 and 7s restarted in October 2020, having been paused during the COVID-19 pandemic, and is being delivered remotely
- Development of a comprehensive maternity action plan to improve safety and outcomes for mothers and babies and strengthen our culture within the service. It incorporates the Trust's response to, and recommendations from, the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust
- A new Urgent and Emergency Care Improvement Programme
- Implementation of the Trust's Clinical Audit Recovery Plan
- A clinical review programme - This consists of a suite of planned inspections undertaken as part of a programme of assurance, and shared learning, which supports the Trust's preparation for its forthcoming Care Quality Commission's (CQC) inspection. The purpose of these visits is to review areas of good and innovative practice, to monitor the embedding of completed improvement actions and identify any areas of concern or where improvement is required. The measurement and improvement of care quality is of paramount importance and a framework based upon the CQC Fundamentals of Care and Key Lines of Enquiry (KLOE) have been devised and used as the framework for these clinical reviews. The clinical review assessment team comprises of a cross section of clinical and non-clinical Trust staff and often includes key stakeholders such as Healthwatch, Clinical Commissioning Groups (CCGs) and NHSE/I colleagues. The aim of the review is to capture areas of good and excellent practice and innovation that staff should feel proud of and in turn are encouraged to tell their 'improvement story'. Any immediate risks identified are acted on and areas for improvements addressed through ward/department action plans. Key themes of findings from all the areas are collated and shared along with any safety concerns and aligned to the Trust Integrated Quality Improvement Plan. Unfortunately due to COVID-19 the 2020/21 Clinical Review Programme was suspended, however whilst we begin to recover, the programme has been re-established which will allow us as a Trust to challenge ourselves, and to test whether improvements we have taken forward over the past 12 months are being sustained and embedded in practice.

CARE QUALITY COMMISSION

The Trust is required to register with the Care Quality Commission (CQC) with the current overall registration status as 'Inadequate' following an inspection in 2019. We remain in Quality Special Measures following the CQC's 2019 inspection.

In 2019 the Trust was formally rated:

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

The latest inspection report details the actions that 'must' be taken to comply with our legal obligations and actions that 'should' be taken to comply with a minor breach that did not justify regulatory action to prevent us failing to comply with legal requirements in the future.

The Trust is fully compliant with the registration requirements of the CQC. However, as a consequence of the findings of the CQC inspections we are subject to the following Notices and Conditions.

QEH has the following conditions on registration:

- Section 31 Urgent and Emergency/Gynaecology (18 March 2019)
- Section 29A Medicine (19 March 2019)
- Section 31 Diagnostic and Screening Procedures (21 May 2019)
- Section 29A Diagnostic and Screening Procedures (23 May 2019)
- Section 29A Maternity (17 May 2018)
- Section 31 Maternity and Midwifery Services (19 July 2018)

It was hoped that the Trust would be re-inspected and re-rated as part of a full on-site inspection during 2020. However, the impact of the COVID-19 pandemic initially suspended all CQC inspections, replacing on-site inspections with an interim Emergency Support Framework. Whilst a full inspection could not be carried out during this time the Trust underwent an unannounced inspection in September 2020 which focused on six core services and resulted in an amended rating for these services.

The Core Services inspected in September 2020 and re-rated were:-

- Medicine
- Urgent and Emergency Care
- Surgery
- Maternity Services
- Diagnostic Imaging
- End of Life Care

Whilst six core services were re-rated following the September 2020 CQC inspection, the Trust's overall rating cannot be changed until the CQC carries out a full on-site inspection to include the domain of well-led. It is anticipated this will be anytime from spring 2021, when it is hoped the CQC will restart their inspection regime post COVID-19.

The CQC published its inspection findings in December 2020 and highlighted the significant improvement and progress the Trust has made over the past 12-months. This provides further external validation of the Trust's improvement programme and its commitment to ensure patients consistently receive safe and effective care.

Inspection highlights:

- None of the Trust's core services inspected are now rated 'inadequate' compared to 19 areas in the same services rated 'inadequate' in the Trust's 2019 inspection.
- All of the Trust's core services inspected (Medicine, Surgery, Urgent and Emergency Care, Maternity, Diagnostic Imaging and End of Life Care) are now rated as 'Good' for caring - marking a further significant improvement.
- The Trust has 3 'Must Do' and 33 'Should Do' actions from its 2020 inspection, the majority of which already feature in the Trust's Integrated Quality Improvement Plan, compared to 206 in total in 2019 and marking an 82% reduction in 'must' and 'should do' actions

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

2020 CQC INSPECTION RATINGS FOR QEH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020	Good ↑ December 2020	Requires Improvement →← December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
Medical Care (including Older People's Care)	Good ↑↑ December 2020	Requires Improvement ↑ December 2020	Good ↑ December 2020	Requires Improvement July 2019	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
Surgery	Good ↑ December 2020	Good July 2019	Good July 2019	Requires Improvement July 2019	Requires Improvement ↓ December 2020	Requires Improvement →← December 2020
Critical Care	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015
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 ↑ December 2020	Requires Improvement ↑ December 2020	Good →← December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
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 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020	Good ↑ December 2020	Requires Improvement →← December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020

In addition to the significant improvement recognised by the CQC, the Trust received formal notification from the CQC on 6 January 2021 that its application to lift 5, Section 31 Conditions for Maternity Services had been approved. This is a significant decision by the CQC and extremely positive for the organisation. This development sends a message of confidence in the organisation and its leadership regarding these improvements and provides a further level of assurance through external validation.

Following publication of the December report, the Trust received confirmation from the CQC in January that it was closing 5 of its 29A conditions, which span the core services of Medicine and Diagnostic Imaging. Whilst improvement was noted against the remaining 29A conditions, they were not reviewed in full during the September inspection but will, instead, form part of the Trust's next on-site inspection in 2021.

In February 2021 the Trust submitted a formal application to the CQC to request the lifting of a further 11 of the remaining 17 Section 31 conditions, spanning the core services of Maternity, Urgent and Emergency Care and Diagnostic Imaging. This application was accompanied by detailed evidence of improvement and compliance. The Trust received verbal notification on the 17th March 2021 that the request had been approved and that 10 of the 11 Section 31 conditions were removed which is extremely positive news for the organisation. The Trust expects to receive formal notification of the removal of these conditions in early April 2021.

In April 2019 the General Medical Council (GMC) raised specific concerns about the standards of training in obstetrics and gynaecology and imposed three conditions across the whole Trust. A comprehensive improvement plan aligned to the IQIP was agreed with Health Education England (HEE) and we have had monthly monitoring returns and bi-monthly visits from the GMC and HEE to meet with trainers and trainees to monitor our progress since then. The huge amount of work through 2019/20 resulted in the conditions being lifted in April 2020 which was a great achievement. Since the lifting of these conditions the Trust has continued to strengthen training opportunities for medical trainees. These improvements have in turn been recognised by the GMC and reflected in their decision in December 2020 to also remove the Trust from enhanced monitoring.

INTEGRATED QUALITY IMPROVEMENT PLAN

The Trust Integrated Quality Improvement Programme (IQIP) has two main areas of focus:

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

Our 2019/2020 IQIP covers eight strategic priorities and includes the findings and recommendations within both the 2018 and 2019 CQC reports. This high-level plan is supported by "Plans on a Page" developed with key milestones and outcome measures. Staff have been involved in detailing the actions required to deliver the necessary improvements.

We have established a robust governance structure which supports the monitoring and delivery of the IQIP. This includes a monthly Quality Forum chaired by our Chief Executive and an Oversight and Assurance Group the membership of which are key stakeholders and regulatory bodies. In addition, we report compliance and progress against our Section 31 Notices to the CQC on a monthly basis.

To provide assurance of progress and evidence that improvements have been effectively completed, we established an IQIP Evidence Assurance Group chaired by the Chief Nurse and, more recently, the Medical Director. This group, which includes a patient representative, undertakes a review of action evidence and, where there is sufficient evidence and assurance of improvement, the action is closed and moved to business as usual. The September 2020 CQC inspection has provided further external assurance and validation of the robustness of these arrangements and organisational insight into its progress and improvement priorities for the year ahead.

Following publication of the 2020 CQC Inspection Report the Trust has taken the opportunity to review and refresh its IQIP, closing the 2019/2020 IQIP and developing a new 2021/2020 IQIP. The Trust completed 178 of the 206 actions (86%) at the point of closure, incorporating the remaining 28 outstanding actions from the 2019/20 IQIP with the 36 Must and Should Do actions detailed in the latest CQC inspection report. The new 2021/22 IQIP was launched in March 2021 and is aligned to the Trust's Corporate Strategic Objectives, giving us clear direction for our ongoing improvement journey.

1. PATIENT SAFETY

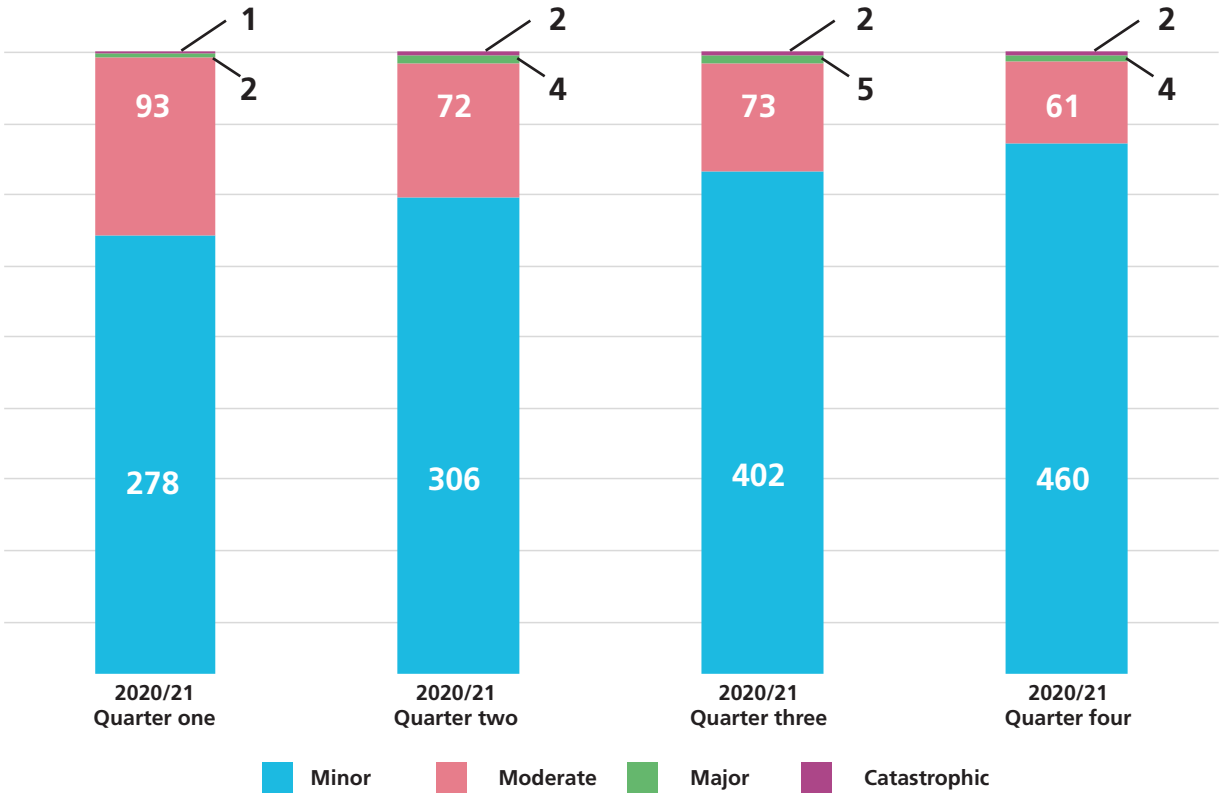
Incident reporting and Never Events

The total patient safety incident reporting rate for 2020/21 was 7,631, a figure which excludes the numbers of pressure ulcers reported on admission. This is an 8% increase in reporting from the financial year 2019/2020 and includes noted decreases in moderate harm incidents. These are both positive indicators of an open culture where staff can raise their safety concerns. Safety incidents resulting in severe harm or death also reduced to 22 incidents, a 25% decrease from the previous year. A wide variation in monthly patient safety incident reporting occurred within the financial year with incident reporting rates per month ranging from 408 in April 2020 to 784 in November 2020. The variation is thought to have occurred due to the Trust's ongoing response to the Covid-19 pandemic.

NHSI/E recommends that Trusts reports safety incidents via the National Reporting and Learning System (NRLS) monthly, as a minimum, which we continue to do. The Trust is continuing its 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
2020/21	7,631	22
2019/20	7,007	29
2018/19	7,710	32
2017/18	6,474	29

Patient safety incident reporting harm outcome



There are a number of work programmes and new functions which were identified and implemented during 2020/21. Key areas of achievement include:

- Significant assurance from a Serious Incident Audit carried out by the Trust's internal auditors
- Launch of new Root Cause Analysis (RCA) training to support staff undertaking serious incident investigations
- Establishment of a robust and transparent process of approval of serious incident investigations at executive level
- A review and refresh of the Trust's Incident Reporting Policy which staff can access on the Trust intranet
- Improvements in data quality and oversight of patient safety information via the monthly Patient Safety Activity Report and Quarterly Patient Safety Trends Report which are presented at the Quality Committee
- The approval of funding to facilitate the implementation of patient safety culture SCORE measurements within the Trust
- Development and implementation of a Trust Datix incident reporting form to support incident reporters
- Two successful virtual patient safety learning events with the content made available for all staff via the Patient Safety intranet page. Each event was launched with a patient story and included presentations on key Trust patient safety learning topics including:
  - » Management of patients who present with agitation and/or delirium
  - » Care of people with dementia
  - » Mental Capacity Act (MCA) practical application and case studies
  - » Learning from COVID-19
  - » Learning from deaths
  - » Recognition and Management of the deteriorating patient
  - » End of life care progress so far
- Restructure of the corporate risk and safety structure to create a new Patient Safety Directorate.
- Establishment of the management of incident action plans via the Datix Learning and Improvement module along with a process of approval of incident action plans by the Evidence Assurance Group (EAG)
- Development and implementation of new processes to support incident investigations and learning across the local health system.
- The Trust identified the Deputy Medical Director and Head of Patient Safety and Clinical Effectiveness to act as designated Patient Safety Specialists, as required by NHS England and Improvement (NHSE), to ensure the implementation of the Patient Safety Strategy within the Trust. These colleagues will be fully trained to provide expert patient safety knowledge and leadership to the Trust ensuring the successful rollout of patient safety strategy, patient safety partners, a new national NHS patient safety incident management system (PSIMS), Patient Safety Incident Response Framework (PSIRF), National Patient Safety Alerts and creating strong local, regional and national patient safety networks.

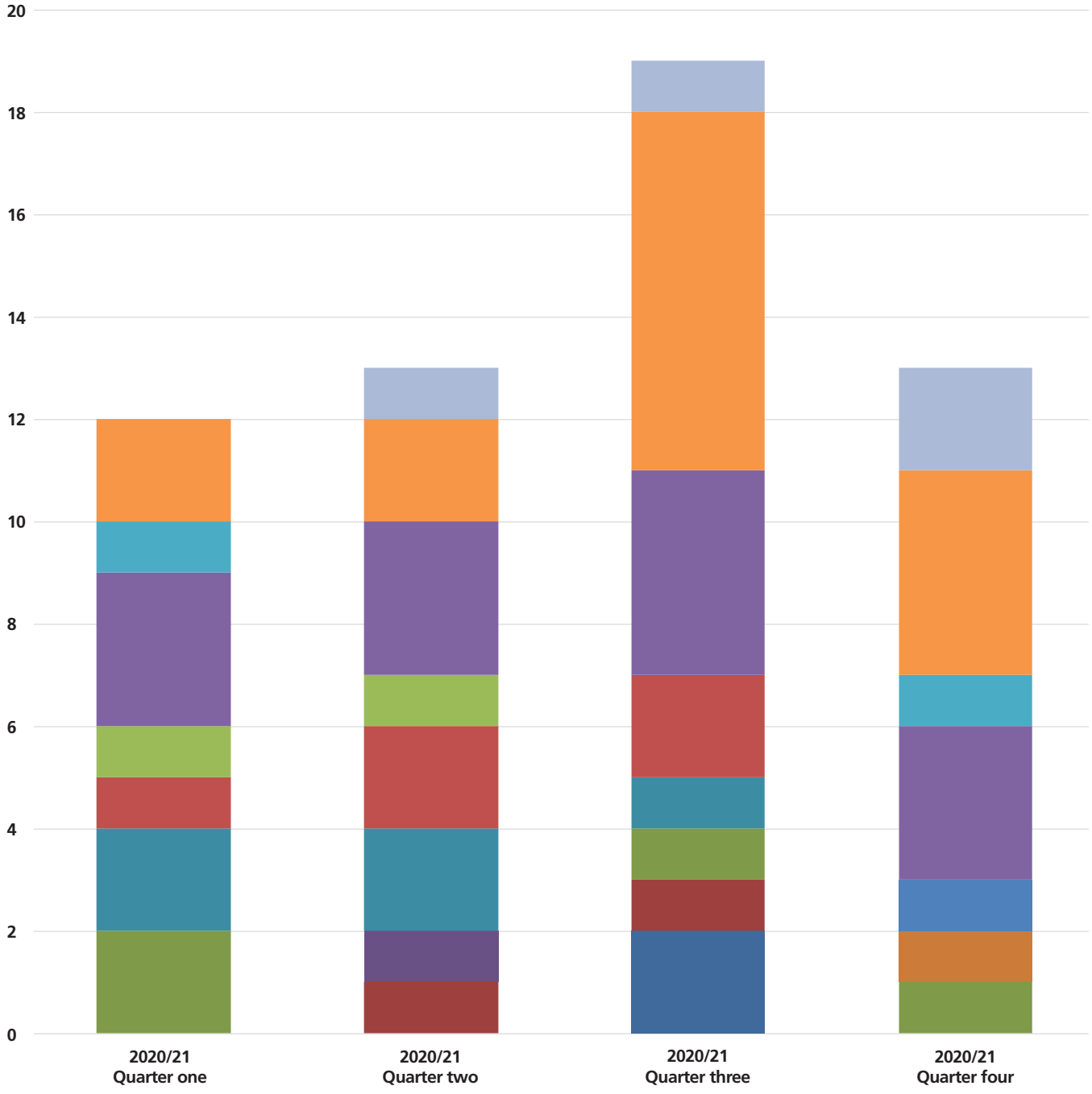
1.1 Serious Incidents reported in year

Throughout 2020/21 we have continued to develop processes for identification of themes from incidents. Key areas of focus for patient safety are:

- Identification of specialities with safety culture development requirements
- The consequences of silo-working within teams and across the patient pathways
- The adherence to policies, protocols and operating procedures
- Poor documentation, either poor or absent recording of care planning or completion of risk assessments e.g. falls risk assessments
- Individual clinical knowledge gaps which may impact on the ability to interpret findings
- Timeliness and appropriate action in response to patients' clinical presentation
- Lack of adherence to audit processes for safety assurance
- Human factor errors

	Clinical Support Services	Medicine	Surgery	Women & Children's	Non-clinical	Total
2020/21 Quarter one	2	4	5	1	0	12
2020/21 Quarter two	3	9	1	4	0	17
2020/21 Quarter three	0	12	1	2	0	15
2020/21 Quarter four	0	8	3	1	1	13
Total	5	33	10	8	1	57

Categories of Serious Incidents declared in 2020/21

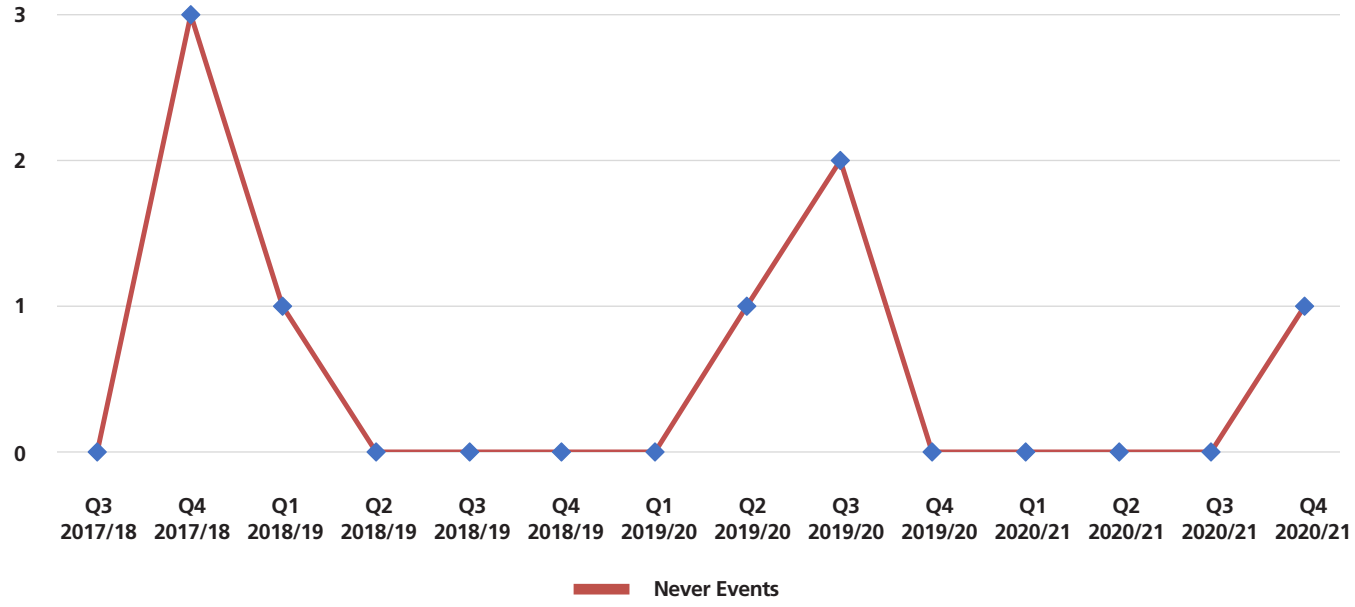


- Abuse/alleged abuse of adult patient by staff
- Abuse/alleged abuse of child patient by third party
- Apparent/actual/suspected self-inflicted harm meeting SI criteria
- Blood product/transfusion incident meeting SI criteria
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results)
- HCA/Infection control incident meeting SI criteria
- Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)
- Maternity/Obstetric incident meeting SI criteria: mother only
- Pressure ulcer meeting SI criteria
- Slips/trips/falls meeting SI criteria
- Surgical/invasive procedure incident meeting SI criteria
- Treatment delay meeting SI criteria
- VTE meeting SI criteria

1.2 Never Events

The Trust declared one Never Event during 2020/21 which occurred within the Ophthalmology service. The incident involved a patient receiving an intravitreal (IVT) injection intended for a different patient during a macular and intravitreal injection (IVT) outpatient clinic.

Never Events from 2017/18 onwards



1.3 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 Act2008 (regulated activities regulations: Regulation 20. This applies to any reported patient safety incident that has resulted in, or potentially resulted in, catastrophic, severe, or moderate 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 other relevant person. This is known as initial discussion (phase one).

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

The Trust has made improvements to ensure that Duty of Candour conversations occur within 10 working days of the identification of an incident. Compliance has increased from 77% in 2019/20 to 95% in 2020/21. This improvement work has been supported through the embedding of the Trust's Openness and Candour Policy and Procedure, and staff Duty of Candour intranet resource page which support the Trust's move towards a more open and transparent culture.

Duty of Candour is a metric monitored through the Performance Review Processes. Although improvements have been made to Duty of Candour compliance further monitoring and support is required to achieve acceptable standards of 100%.

Month (Financial Year 2020/21)	+/- Incidents in month	Phase one completed	Phase one count (completed with 10 working days)	Phase one % (completed with 10 working days)
April	13	13	11	85%
May	20	20	19	95%
June	9	9	9	100%
2020/21 Quarter one	42	42	39	93%
July	12	12	10	83%
August	8	8	8	100%
September	17	17	17	100%
2020/21 Quarter two	37	37	35	95%
October	15	15	15	100%
November	18	18	16	89%
December	13	13	13	100%
2020/21 Quarter three	46	46	44	96%
January	17	17	16	94%
February	12	12	12	100%
March	29	28	28	97%
2020/21 Quarter four	58	57	56	97%
Overall compliance	183	182	174	95%

2. PATIENT EXPERIENCE

2.1 Patients Advice and Liaison Service

The Trust Patient Advice and Liaison Service (PALS) is a confidential point of contact for patients or relatives who may have concerns or questions about their current or previous treatment. The Team also receives general feedback, suggestions and compliments which are shared throughout the Trust. The Complaints Team and the PALS Department work alongside one another with the Complaints Manager overseeing both departments. The role of the Complaints Team is to ensure that formal complaints are appropriately investigated and that a response is provided in a timely manner. The Team is continually seeking to improve the service it provides by setting high standards, such as ensuring that all telephone calls and emails are acknowledged on the same working day

The Department promotes its service with strong visibility on the Trust's website, regular ward visits as well as occupying an accessible location in the hospital main entrance. The Trust also has on-screen advertising via televisions that are positioned outside the PALS Department and in other public areas around the hospital.

We continue to promote the work of both the PALS Team and that of the Complaints Team. This includes the Complaints Team attending education and training to discuss patient experience and share anonymously some of the themes of complaints and concerns raised by families and patients to enhance understanding of why patients and families may be unhappy with the care and treatment provided at QEH.

The 'subject codes' used to categorise issues raised were reviewed and amended in 2020/21 to ensure the appropriate logging of information. During the year, more subject codes have been added to limit the use of 'general information', which results in more meaningful data being captured and enabling improvements to be appropriately targeted. In 2020/21 4,994 PALS contacts (excluding compliments) were logged. The top themes are identified in the table below:

PALS by sub-subject (primary)	Number
General information	1,038
Poor communication	363
Messages to loved ones - passed to the ward	307
Enquiry	301
Update on patient condition/wellbeing	285
Access to health records	170
Inpatient enquiry	170
COVID-19 swab query - public	166
Lack of information	156

PALS by sub-subject (primary)	Number
Directions in the Trust	137
Discharge arrangements	123
Complaints procedure	108
Clinical care	103
Travel expenses	99
Concern	87
Loss of personal items	87
Loss of jewellery/valuables	82
Staff attitude	68

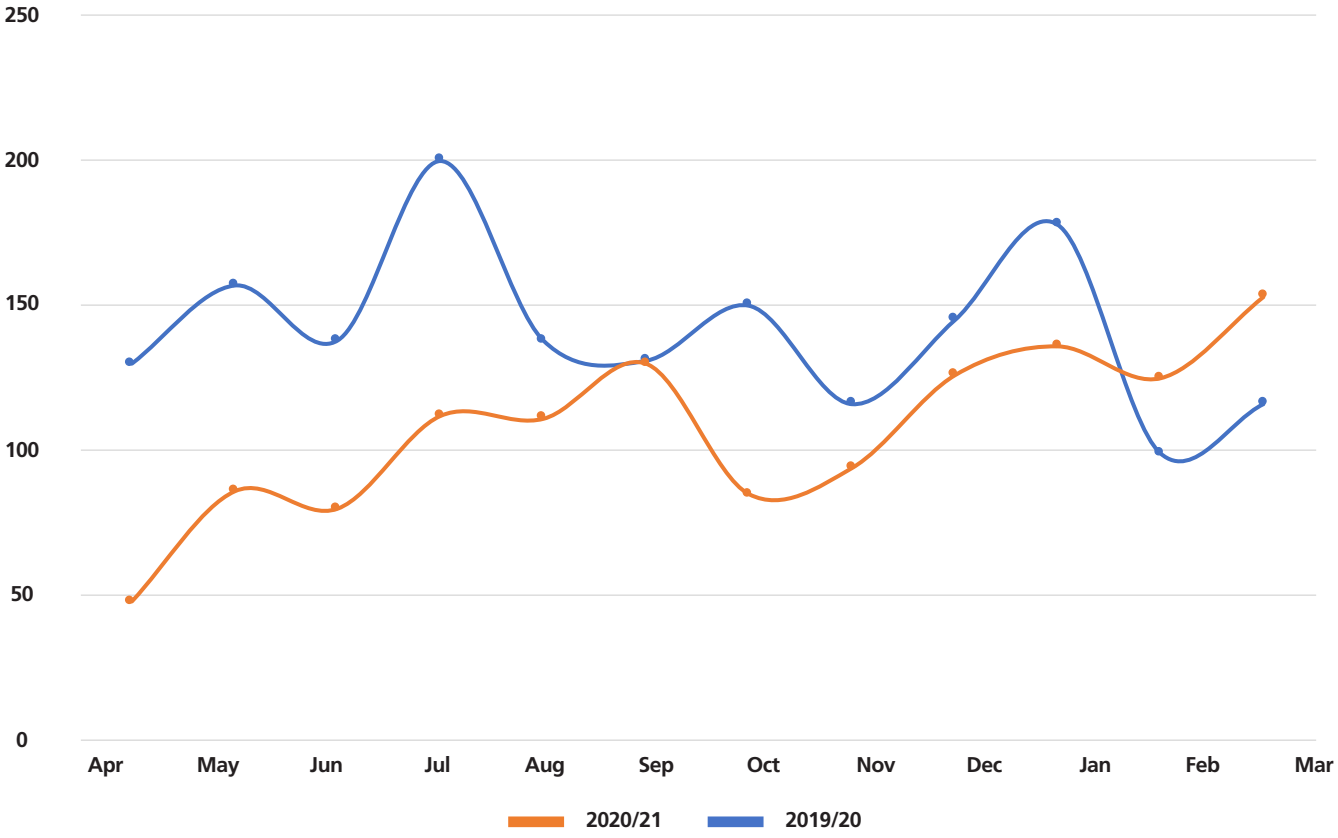
There were some new themes recorded this year which is likely to be attributable to the impact of the COVID-19 pandemic. Visiting of patients was suspended (with nationally recognised exceptions) in the two peak waves of the pandemic resulting in the implementation of 'Virtual Visiting' facilitated by the use of digital technology. Wards were issued with mobile devices which were used to enable patients to contact those that could not visit. Despite these measures there was an increase in concerns raised by 'lack of update on the patient's condition' and 'lack of information in general'. In response to this a COVID-19 Patient Advice Line was launched on January 25th 2021 to serve as a contact for loved ones and family members to get information and updates when visiting was suspended nationally. There was also a facility whereby relatives and loved ones could send a message to the PALS Office which was then delivered, in a printed format, directly to the patient.

The Trust responded further to the communication difficulties found during the COVID-19 Pandemic by appointing eight whole-time equivalent Family Liaison Officers to facilitate audio or video calls between patients and their families, thus taking time pressures off ward staff. In addition, they ensure that all patients know how to charge their own phones and ensure that they are able to access the Wi-Fi service. This is a new staff cohort and we are continuing to evaluate the service but initial feedback from patients is positive.

The high numbers of issues raised in relation to 'directions in the Trust' is likely a result of the necessity to move patients between care areas to meet the clinical demands as part of the COVID-19 Pandemic operational response.

2.2 Compliments

Along with feedback and concerns which are shared with the wards and departments, the divisional leadership teams, matrons and heads of nursing & midwifery the PALS team log any compliments which are shared with them, either made in person, by email or by way of a card sent directly to the ward. When a compliment holds identifiable information, such as an address, the Chief Executive sends a personal thank you. In 2019/2020, 1,705 compliments were recorded and In 2020/21 the number fell to 1m286 with two noticeable peaks during national lockdown periods due to the COVID-19 pandemic.



2.3 Formal complaints

During the year 204 formal complaints were received which was a reduction of 47% on the 388 received in 2019/2020. The reason for this is unclear but is likely to be related to the decrease in planned care activity during the COVID-19 pandemic. It may be possible to corroborate this if the figures return to those similar to 2019/20 in the coming year

Local Resolution Meetings (LRMs) are offered as soon as a complaint is received to encourage complainants to discuss issues raised in the complaint with the senior staff involved in the patient's care. 10 LRMs have been held this year as due to the COVID-19 Pandemic the LRM's were put on hold but in were reintroduced in early 2021.

Organisational learning is vital to improve patient and relatives experience by identifying themes from concerns or complaints and developing an action plan for divisional or Trust wide learning. Currently the complaint investigator updates the 'learning experience action plan' (LEAP). The outcomes from the action plan are shared with each of the Divisional Governance Leads, Divisional Leadership Teams, and Matrons and in clinical service line meetings to ensure that learning from complaints is cascaded throughout the organization. It has been identified that as a Trust we can develop this further to mirror the Patient Safety Model which we intend to do in 2021/22

Complaints by method	Numbers
Email	157
Letter	45
Telephone	7
Complaint form	4
Social media	2
Window enquiry	1
Ward visit	1
Via PALS	3

2.3 Formal complaints *[continued]*

Close relationships are maintained with the Legal Services and Patient Safety Teams. The Complaints Team has the opportunity to raise concerns that may be serious in nature with the bi-weekly Serious Incident Review Panel to seek agreement as to whether a safety risk exists. The teams work closely to give additional support to staff, patients and families during a serious incident investigation and providing support at local resolution meetings. The relevant data is shared with the Patient and Carer Experience Forum and is additionally summarised and included in the quarterly report produced for the Quality Committee.

The Complaints Team continues to use the codes established by the Hospital and Community Health Services Complaints Collection (HSCIC). This allows for much more robust information to be collected. The use of codes is recorded in a quarterly report submitted to HSCIC. The top themes are listed below which continue to highlight that staff attitude and communication, both with the patient and family members, continue to feature as one of the key reasons for complaint, an issue that is being addressed through the Trust's work in relation to values and behaviours

Complaints by sub-subject	Number
Communication with relatives/carers	74
Communication with patient	44
Delay or failure in treatment or procedure	24
Attitude of nursing staff/midwives	23
Care needs not adequately met	20
Attitude of medical staff	19
Delay or failure to undertake scan/X-ray etc	18
Incorrect/no information given	17
Failure to act in a professional manner	17
Failure to provide adequate care (including overall level of care provided)	15

The average response rate to complaints has been variable, and somewhat disappointing. In 2020/21 an average percentage rate of 25% of complaints were responded to within the set time frame. Early in 2020 the World Health Organisation declared a pandemic of COVID-19. The Trust had to respond to a very difficult and challenging clinical environment with staffing challenges that impacted on the ability to prioritise complaint investigations. However, the trends in improvement appear related to the wave intervals between the COVID-19 pandemic.

Formal complaint response rates

2020/21	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clinical complaints	10	15	19	19	28	10	19	21	13	22	15	16
Response rates (%)	82%	83%	100%	95%	100%	68%	69%	47%	70%	86%	44%	71%
Non-clinical complaints	1	0	1	2	0	1	1	2	0	0	0	0

Improvements for 2020/21 include:

- Further development and implementation of key priorities linked to year 2 of the Corporate Strategy to facilitate improvements in the care delivered to patients' and their families.
- A continued approach to reviewing and improving the complaints process within the Trust and engaging with staff to ensure a Trust-wide understanding and awareness of the changes within the Complaints Policy to help improve patient experience.
- To meet the target for 2021/22 of responding to 90% of complaints within 30-working days.
- The development and delivery of master classes. The purpose of these is to firstly focus on customer service and promote the positive impact on the patient experience. The second master class will facilitate internal training for staff on all aspects of the complaint process, how to investigate and respond to complaints and guidance on writing a complaint response.
- Patient stories and quarterly newsletters will be shared as part of the launch of the new processes

2.4 Parliamentary and Health Service Ombudsman (PHSO)

There are times when, despite the Trust's 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 review of their complaint. During 2020/21, two complaints were referred to the PHSO.

- Three are currently under PHSO investigation and awaiting an outcome
- Two are at preliminary referral stage and we are awaiting a decision on whether the PHSO will proceed to investigation stage
- One complaint was not upheld by the PHSO

2.5 "Getting it Right" Programme (for our patients and each other)

This programme was delivered throughout 2020 to improve patient experience following a theme of complaints relating to reported unacceptable behaviours of some staff, towards each other and to patients and visitors, along with evidence of poor care delivery.

It focused on the importance of compassion and professionalism in care delivery to patients from all members of staff to impact positively on both patient and relatives experience and patient safety. It also identified and highlighted the negative impact of poor staff attitude.

The staff session was designed for multi-disciplinary attendance and provided an opportunity to discuss 'why we come to work' and to reconnect with both the Trust's values and behaviours and individual personal motives. Within the session the patients' voice is shared through the use of complaints and patient experience data and staff are encouraged to explore what they perceive to be barriers to providing compassionate care.

The session was designed to promote both poignant reflection and discussion and staff who attended were encouraged to share their own stories. Areas that were covered included privacy and dignity, compassion, "what good looks like," as well as discussing empathy and civility within and between teams.

It was launched in March 2020 and 44 sessions were held with 389 staff attending from a range of clinical areas. Each session lasted approximately two hours and staff were asked to sign and take away a pledge as they left, stating how they planned to make a difference. It has been well evaluated but is very much an iterative process using feedback to inform content and delivery methods in the future.

2.6 Listening to patients

Patient and public involvement is an integral part of how hospitals plan and improve their services so listening to patients, their carers and the public and acting on what they tell us is vital. The QEH has identified three key strategies to improve patient experience and introduce service improvements based on what patients and the public tell us.

These include:

- Improving the patient experience as measured by the 'Friends and Family' Test
- Using learning from compliments, complaints, national surveys and feedback to enhance the quality of the services we offer our patients
- Ensure the environment is appropriate for clinical care and a positive patient experience

2.7 Measuring and reporting patient experience

The Trust seeks to capture patient and carer experience by:

- Promoting the 'Friends and Family' Test to receive anonymous, but timely feedback
- Hosting events for patients and the public
- Seeking invitations to attend meetings and events of organisations in the community
- Listening to patients' stories at Board meetings
- Participating in National Patient Surveys
- Patient and public representation on key Trust committees
- Undertaking simulated Care Quality Commission visits which include talking patients and carers (if they are present during the visit). The reports from these visits and any resulting action plans, are considered by the Trust Patient Experience Committee, the Trust Patient and Carer Experience Forum and by the Service Line Quality and Business Boards covering the wards or departments visited
- Annual PLACE (Patient Led Assessments of the Care Environment) inspections. This was not undertaken in 2020 due to the COVID-19 Pandemic.
- Reading and responding to patients' and carers' feedback posted on the NHS Website and Care Opinion websites, Facebook and Twitter
- Inviting Healthwatch Norfolk to attend the hospital on a monthly basis to meet with patients and discuss their experiences. An interim report on the results of all observational studies was started in November 2020 but this had to be stopped due to the impact of the COVID-19 Pandemic. It is hoped to this will be repeated when it is safe to do so

2.8 Hosting events

The Council of Governors and the Patient Experience Team host events in conjunction with local statutory, community and voluntary sector partners. These events are open to all and provide information and advice about different long-term medical conditions. Unfortunately, due to the COVID-19 pandemic it was not possible to host any events in 2020 - 2021. An event for the visually impaired was planned but could not go ahead due to restrictions. Contact was maintained with the Trust's group for visually impaired people and it was advised that there was strong support for a virtual event in 2021.

2.9 Attending events hosted by other organisations

Our Governors and the Patient Experience and Public Involvement Lead attend meetings arranged by other organisations, ensuring that we listen to patients and the public in their space, rather than expecting them to come to us. Key meetings attended include the Cancer Services User Group, Maternity Voices, forums arranged by Healthwatch Cambridgeshire / Peterborough and meetings of GP practice-based Patient Participation Groups. Many of these meetings moved online in 2020/21 but this does not appear to have adversely affected attendance. Some patients have advised that by using technology they do not need to worry about building access, transport or infections especially for those with young babies or those who are immunocompromised.

The Trust also attends the 'Step into Health' meetings held, both in person (when possible) and virtually, to support members of the armed forces to move to employment in health and social care. Regional health and social care meetings across Norfolk and Waveney are held virtually in alternate months, attendance is good as many organisations see the benefits of virtual attendance with no travelling time to share good practice across a wide variety of organisations.

Trust attendance at external meetings gives us insight into the experiences that patients have had of our services. Feedback from these events is reported to the Governors' Patient Experience Committee and the Trust's Patient and Carer Experience Forum. Whilst many of the traditional events are not organised or attended by the Governors they endeavour to keep up with public opinion regarding NHS matters by reading the literature which has been published by HealthWatch Norfolk and other forms of feedback collected both locally and nationally.

2.10 Patient stories at Board

To ensure that the patients' voice is heard at the Board, patients and their carers have been given the opportunity and support to enable them to tell their stories, in person, directly to the Board. This has allowed the Board to hear about their experiences first-hand and to learn from them about the aspects of care that patients value most. It also provides an opportunity for patients and carers to describe experiences where care could have been improved and, in so doing, enable us to act on this feedback. During 2020/21 the Board has heard the following stories that have led to action within the Trust:

- The experience of a patient cared for in A&E and a number of wards, including Oxborough, being treated for COVID-19
- A story from a patient who is also a member of staff cared for on one of our surgical wards detailing the positive experiences he had but also areas of improvement relating to the communication skills of junior doctors and the importance of sleep which was a key theme from results in the National inpatient survey
- A patient and family experience of care on West Newton ward. The story was presented by the patient's daughter.
- A story from a patient who is also a member of staff. The patient contracted COVID-19 and was cared for on our intensive care unit
- A patient and family experience describing the impact of the difficulty in maintaining good communication between the ward and patient families during visiting restrictions.

2.11 National patient surveys

Results of national patient surveys published between April 2020 and March 2021 relating to the experience of patients - National Cancer Survey (2019), National Inpatient Survey (2019)

	Months sampled	Month published	Response rate	Average national response rate
National Cancer Survey 2019	April to June 2019	June 2020	66%	61%
National Inpatient Survey 2019	July 2019	July 2020	49.4%	45%

National Cancer Survey

There were a number of positive improvements reported in the National Cancer Survey. These included two areas in which we were significantly better than other Trusts.

- Patients found it very or quite easy to contact their Clinical Nurse Specialist
- Patients had all the information needed about their surgery before coming for the operation

However, there were three areas in which the Trust was significantly poorer than other Trusts.

- Patients told they could bring a family member or friend when first told they had cancer
  - » During the COVID-19 pandemic whilst hospital visiting restrictions were in place cancer patients were encouraged to bring a friend or family member with them to their diagnostic appointment and to subsequent appointments at the clinician's discretion
  - » The above was highlighted through the Cancer Services User Group, social media, and posters across the hospital, communications to staff and in clinic letters
- Patients having confidence and trust in all doctors treating them
  - » Medical colleagues continue to be encouraged to attend and contribute to the Trust's Patient and Carer Experience Forum
  - » Confidence and trust in all staff was an element of the 'Getting it Right' programme (see section 2.5) for all staff including doctors
- GP being given enough information about patient's condition and treatment
  - » At diagnosis the patient's GP is provided with a copy of the clinic letter
  - » Trust wide improvements to the dictation process have been implemented to prioritise letters to GPs
  - » Consultation and summary records are completed in triplicate for some tumour sites of which one copy is sent to the GP
  - » Patients are advised that a copy of their consultation and summary records will be provided to their GP (in addition to the hard copy they have been handed) but that there may be a delay of approximately 6 working days to clarify the process for patients and enhance their understanding
  - » The Cancer Services Team is working with the CCGs to understand exactly what additional information would be required by GPs to enhance their care of the patient with cancer
  - » The Cancer Services User Group will be supporting the Trust to develop these systems further to benefit patients and GPs and enable all healthcare professionals supporting the patient to have access to relevant information

National Inpatient Survey

Results from the National Inpatient Survey (2019) were published in July 2020 and highlighted areas of focus for improvements at QEH. There were a number of areas for the Trust to address, some of which continue to build on areas of concern to embed solutions whilst others have resulted in the initiation of programmes aimed at changing practice to make improvements for patients.

The main areas of focus include

- Noise at night
- Confidence and trust in teams caring for patients
- Decisions made about a patient's condition or treatment when not enough information was provided to patients about their care
- Patients felt that there was not enough staff in hospital to allow patients to talk to about their worries and fears and receive emotional support
- Members of teams not working well together at times and patients were not satisfied with the way we handled their discharge arrangements

In response, an action plan addressing key areas has been implemented. Measures include:

- A HUSH (Helping U Sleep Healthier) project group has been established incorporating support from patients, carers, clinical staff, project managers, porters and domestic staff to work on ways to reduce disturbance at night and improve patient sleep
- Multi-disciplinary "Board Rounds", cross division meetings, combined with divisional newsletters, a closed social media page and trust-wide weekly information cascade have improved communications and team working
- A discharge transformation project has been set up to reduce discharge delays, make better use of the hospital's discharge lounge and to improve the provision of information to patients
- Nursing teams are supported by divisional heads of nursing in the development of a plan to support the Nurse in Charge to ensure that patients are aware of who is leading the ward and who to contact with any concerns or worries they may have during their time in hospital

Trust score responsiveness to the personal needs of its patients

Indicator	**The Trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period.** **This indicator, based on data from the National Inpatient Survey, forms part of the NHS Outcome Framework**		
	Reporting period	**QEH score**	**England**
The data made available to the Trust by the Information Centre with regard to: The overall patient survey score* 2017/18 calculation methodology changed Results not comparable with previous years (2016/17 amended to show comparison in brackets)	2014/15	76.4	76.9
	2015/16	77.7	77.3
	2016/17	75.9	76.7 (78.0)
	2017/18	75.5	78.4
	2018/19	73.9	76.2
	2019/20	The next publication of the overall Patient Experience scores for the 2019 Adult Inpatient Survey update has been suspended due to COVID-19 work pressures.	

Following their publication, survey results are presented to the relevant clinical and management teams, Executive Directors, members of the Governors' Patient Experience Committee and the Patient and Carer Experience Forum. Action plans are developed and implemented by the relevant divisional team to address any issues raised by the results. These are monitored through the Patient and Carer Experience Forum.

Some examples of how we have used feedback to improve the experience for patients and their carers in 2020/21 are:

- Carers' Cards distributed throughout the Trust to support unpaid carers who provide emotional and personal support to patients, especially those with dementia, delirium and learning disabilities. These are highlighted on posters and offer concessionary car parking and discounted food in the hospital restaurant
- Close working 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 hospital needs to make in order for the experiences of patients with additional needs to be the best possible
- Streamlining 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 in the road at the front of the hospital
- Creation of a video to be shared with teams supporting breastfeeding mums admitted as inpatients to ensure that they can maintain this activity whilst an inpatient
- Improving play in areas where children are cared for. Tired and old toys removed and replaced by donations and 'wish list' items. The main play areas were refurbished with colour and new blind . During the COVID-19 pandemic sanitised toys were brought to the patient bedside to manage the risk of infection
- On the children's ward, young people were provided with chargers for their mobile phones and tablets to ensure that they can maintain contact with their friends and family as well as utilizing social media through the availability of the free guest Wi-Fi system
- Information booklet for elective inpatients incorporates relevant changes made to support patients who are attending the hospital for surgery e.g. raising awareness of veteran support and information that is available from our local voluntary agencies, available through the PALS office for patients on their return home
- Patient-led change in our COVID-19 vaccination centre to improve access for our patients with additional needs and to co-ordinate bookings for people from the same household
- Buzzers provided to patient partners attending antenatal scans (to call them to the clinic at the patient appointment time) to prevent overcrowding in the antenatal clinic and support COVID-19 safety precautions
- Patient waiting times in clinics and A&E have caused concern for patients - all teams involved have been working to improve communication to patients about delays and possibly address clinic delays through appointment redesign e.g. fewer, longer consultant led clinic appointments for Gynaecology)
- Activity boxes to be introduced across the hospital through donations obtained from the local Rotary Club of items to entertain patients during their time on the wards, aiming to reduce anxiety and boredom
- Support for patients with hidden disabilities - SCOPE to donate sunflower lanyards and awareness raising campaign to be established to increase staff awareness of how to support patients with additional needs and to obtain additional support from the Trust's liaison team if required
- To reduce infection control concerns in the hospital early pregnancy unit patients are provided with their own blood pressure cuff to take home and return with at every appointment
- Handwashing reminders along with hand sanitiser and masks at the hospital main entrance front entrance supported through banners and a member of staff offering advice to everybody entering the hospital

Communicating learning locally within wards and departments

- Wards and departments receive a monthly ward poster detailing number of surveys completed, likelihood to recommend and a selection of comments made by patients
- All room for improvement comments are returned to area leads for action and support provided to make changes if required
- A monthly report from our 'Friends and Family' Test Service Provider is made available electronically to senior staff across the Trust
- All NHS website/Patient Opinion comments and the responses we give are distributed to lead staff in the areas concerned
- Improvements are discussed at sessions for clinical staff in mandatory training and through development courses
- Actions taken in response to patient feedback shared across the Trust to other areas experiencing similar problems

2.12 'Friends and Family' Test (FFT)

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.

As a snapshot guide, the FFT satisfaction score across the Trust at the end of February 2021 was 97% (April 2020- February 2021 inclusive). National comparisons were not available for the time period as monthly uploads were not required due to the COVID-19 pandemic.

Inpatient FFT

Indicator		**Patient Friends and Family Test Inpatients**			
The data made available to the Trust by NHS England FFT Data pages	**Reporting Period (annual information not available hence March of each year used as snapshot)**	**QEH score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family. In April 2020 the FFT question changed to rate satisfaction rather than recommendation scores.	March 2015	91	95	100	78
	March 2016	95	96	100	72
	March 2017	96	96	100	82
	March 2018	95	96	100	81
	March 2019	96	96	100	77
	*February 2020	94	96	100	73
	**February 2021	98			

Emergency Department FFT

Indicator		**Patient Friends and Family Test Inpatients**			
The data made available to the Trust by NHS England FFT Data pages	**Reporting Period (annual information not available hence March of each year used as snapshot)**	**QEH score**	**National average**	**Highest score**	**Lowest score**
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family. In April 2020 the FFT question changed to rate satisfaction rather than recommendation scores.	March 2015	92	87	99	58
	March 2016	90	84	99	49
	March 2017	91	87	100	46
	March 2018	90	84	100	64
	March 2019	91	86	100	56
	*February 2020	93	85	99	40
	**February 2021	88			

** The February data is highlighted as March data has been suspended due to COVID-19 and the temporary suspension of data collection.*

*** February data is highlighted as national data reporting will not recommence until April 2021. Also to note that the February 2021 figures relate to a different question asked of patients - satisfaction score rather than likelihood to recommend.*

The QEH is taking the following actions to improve on our scores by:

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust
- Sharing feedback with patients and the public through ward noticeboards, information screens, social media and additionally to staff through regular internal communications
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients
- Monitoring feedback following changes to ensure positive impact and assess sustainability of changes
- Sharing of actions and learning with other areas in the Trust
- Sourcing a new provider of the Friends and Family Test, in conjunction with Norfolk and Norwich University Hospital Trust, started in March 2021. SMS texting to collect feedback commenced for outpatient and A&E
- Enhancing opportunities to provide feedback at any point of the patient journey also enhanced by QR (Quick Response) code posters sited across the hospital allowing patients to provide feedback at a time suitable to them, or immediately, using the free guest Wi-Fi system

2.13 PLACE (Patient-Led Assessment of the Care Environment) Inspection

Due to the COVID-19 Pandemic the annual National PLACE report was not undertaken. When reintroduced it is likely to take place from September 2021 through to November 2021.

3. STAFF ENGAGEMENT

The Trust's Staff Engagement Programme for 2020/21 has delivered a step change in staff engagement and how people feel about working at QEH. The three main areas of focus in 2020/21 were:

1. Culture and learning
2. Reward and recognition
3. Health and wellbeing (covering physical, mental and financial health)

The work in these areas was further accelerated as the Trust responded to COVID-19.

This has been supported by the Trust's Staff Engagement Forum and new staff networks, notably: BAME Network, LGBT+ Network and Armed Forces Network. The programme has received national recognition, especially that of the strengthened approach to supporting staff wellness during the pandemic, which saw dedicated clinical psychologist and PTSD support posts being introduced as well as 18 new mental health first aiders.

The Medical Engagement Survey results are among the best in the region and demonstrate further evidence of positive staff engagement.

The number of "Speak up" referrals at QEH more than doubled over the course of the year which is the sign of a healthy culture. There were 60 cases which is a 140% rise on the 25 referrals in the previous year. This is clear evidence that more staff are feeling comfortable about speaking up recognising that there will be no adverse consequences to them if they do so.

3.1 National Staff Survey 2020

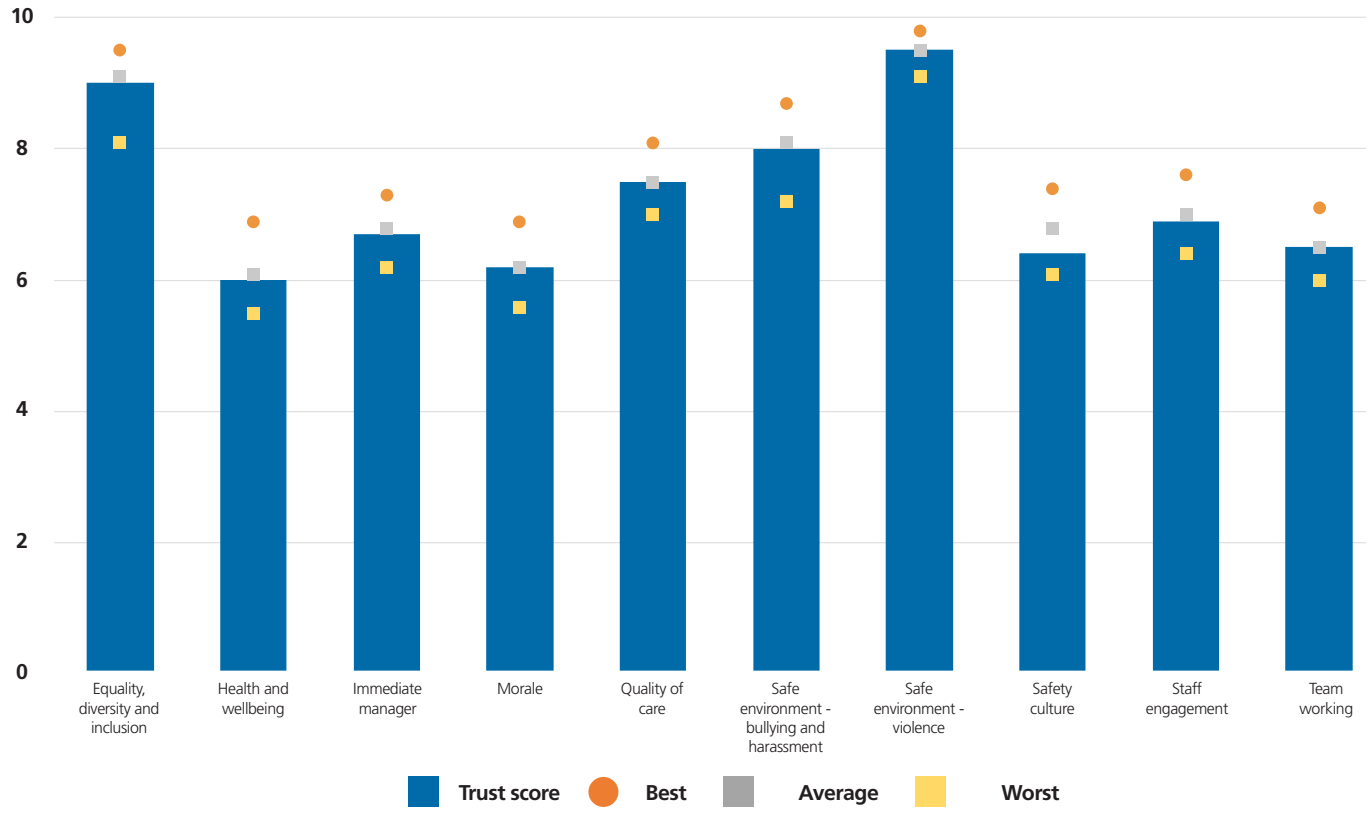
The Trust achieved a response rate of 45% in the 2020 staff survey, which was an increase of 3% on the 2019/20 rate and consistent with the national average response rate.

The results showed an improvement in all 10 themes, including statistically significant improvements in 9 areas and the overall staff engagement score improved to 6.9/10 in 2020 from 6.7/10 in 2019. These results mean that the Trust achieved the 12th most improved national staff survey in the NHS.

The Trust improvedmost in these areas	
"The organisation and managers take positive action on health and well-being and offer flexible working patterns"	Up from 48.9% to 54.4%
"Care of patients/service users is my organisation's top priority"	Up from 68.5% to 76%
"I am satisfied with the quality of care I give to patients/service users	Up from 75.7% to 81.6%

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity and inclusion	8.9	1,346	9.0	1,524	Not significant
Health and wellbeing	5.8	1,352	6.0	1,525	↑
Immediate managers	6.5	1,345	6.7	1,529	↑
Morale	6.0	1,317	6.2	1,520	↑
Quality of care	7.3	1,158	7.5	1,292	↑
Safe environment - bullying and harassment	7.7	1,340	8.0	1,523	↑
Safe environment - violence	9.3	1,341	9.5	1,522	↑
Safety culture	6.2	1,344	6.4	1,528	↑
Staff engagement	6.7	1,352	6.9	1,532	↑
Team working	6.4	1,345	6.5	1,517	↑

National Staff Survey 2020 - score by theme



3.2 Strengthening staff engagement

There has been evidence throughout the year of ongoing work to improve staff engagement following a challenging position in 2019/20. The CQC acknowledged improvements in staff engagement but still states that further work should be undertaken. An improvement in the staff survey response also indicates improved levels of staff engagement along with an improved score for overall staff engagement. However, there remains much to do if we are to create and sustain the right culture at the Trust; one where staff feel valued, supported, listened to and able to develop their true potential.

Based on the initial high-level feedback from the 2020 national Staff Survey and other mechanisms of staff feedback, the 2021/22 Staff Engagement Programme has been refreshed and refocused, with the proposed 7 pillars for the 12-months to come as follows:

KINDESS

Culture Transformation Programme (values into action for leaders and all staff)

Bespoke OD/culture intervention work

Daily message boards with inspirational messages

IMPROVE

Staff ideas scheme

QSIR training

PMO angel

Personal Development Plan for everyone

Randomised Coffee Trials

Ideas hubs

WELLNESS

Looking after our physical, financial and mental health

Menopause awareness

OH & staff wellness tender - integratedd service

Mental Heatlh first aiders

Weight loss

Sleep and rest

LISTEN

Speak Up - champions & guardian

Schwartz Rounds

Staff Networks

CEO & Executive Team Briefings

Staff Engagement Forum

National Staff Survey

Pulse surveys

Feedback pods

Medical Engagement Survey

Culture perception survey

Safety culture survey

FAIRNESS

Equal opportunities for all regardless of ethnicity, sexual orientation, age or gender including:

- Jobs and career opportunities
- Access to development opportunities
- To have your say

CELEBRATE

Team QEH Awards

Long Service Awards (staff and volunteers)

Staff idea of the month

Monthly Values Awards

Retirements

Team QEH success stories and our progress

Local and Divisional Awards schemes

National Awards and honours

INSPIRE

Leadership development programme

Visible leadership

Open door policy

Leadership Conference (annual)

Managers' inductions

3.3 Staff engagement during COVID-19

Throughout the COVID-19 pandemic, staff have been well supported with their physical, emotional and financial health needs.

In addition to the dedicated posts the Trust provided mental health awareness-raising activities to support working towards a culture where it is acceptable to talk about and seek support for personal mental health challenges. A hardship fund was set up to give staff access, with dignity, to financial support needed through the coronavirus outbreak.

Complimentary food bags and beverages were provided to staff working on the frontline through the generosity of the public and local businesses and we provided food and toiletries to our international colleagues arriving in the UK and quarantining ahead of commencing employment.

Staff had around the clock access to "safe spaces" and these calm rooms provide quiet areas where staff can spend a few moments away to process their thoughts, find a sense of calm, reflect and recharge. Coaching sessions for leaders and in-reach support for front line staff were set up to help deal with the pressures faced in their day-to -day work amidst the crisis.

Measures were put in place to support staff members who were isolating, shielding or working from home to regain an effective work-life balance and addressing fears about returning to work. Staff were offered menopause awareness sessions and we undertook training sessions for managers around this subject to ensure that staff going through this life- changing event felt understood and supported. We also signed the "Time to Change Pledge" committing to changing the way we think and act about mental health in the workplace.

3.4 Looking to 2021/22

In 2021/22, we aim to build on these results, with a greater focus on:

- Encouraging people to share feedback and speak up (so that this becomes the
- Improving and educating our workforce on equality, diversity and inclusion
- Continuing our good work to reward, value and recognise staff and doing more to celebrate our successes, focussing on the many positives at both organisational and Divisional/service levels
- Creating a culture of fairness and kindness where staff feel valued and respected
- Cultivating leaders who inspire, support and encourage their staff
- Improving staff engagement at divisional and service level - as well as sustaining the improvements at Trust level

The proposed 3 priority areas for 2021/22 for staff within the overall Corporate Strategy will be:

1. Kindness
2. Wellness
3. Fairness

A set of KPI's have been developed to provide a measurable value that demonstrates how effectively the programme, and associated work, is achieving the two key strategic objectives linked to the Staff Engagement programme.

4. PARTICIPATION IN CLINICAL AUDIT AND CONFIDENTIAL ENQUIRIES

The Clinical Audit Department exists to support, monitor and facilitate all clinical audit activity throughout the Trust. It is a small operational unit working in partnership with the clinical divisions and is organisationally part of the Patient Safety Directorate.

The Trust participates in a number of clinical audits, these include both National and Local clinical audits as clinical audit planned for the year.

Clinical audit data and performance is presented to the Clinical Effectiveness Group on a monthly basis.

4.1 Clinical Audit

Table 1 - Participation in national audit

In 2020/21, the Trust engaged in 45 out of 75 (59%) of national audits. The National Clinical Audits including their eligible to take part in, and for which data collection was completed during 2020/21, are listed in the table alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

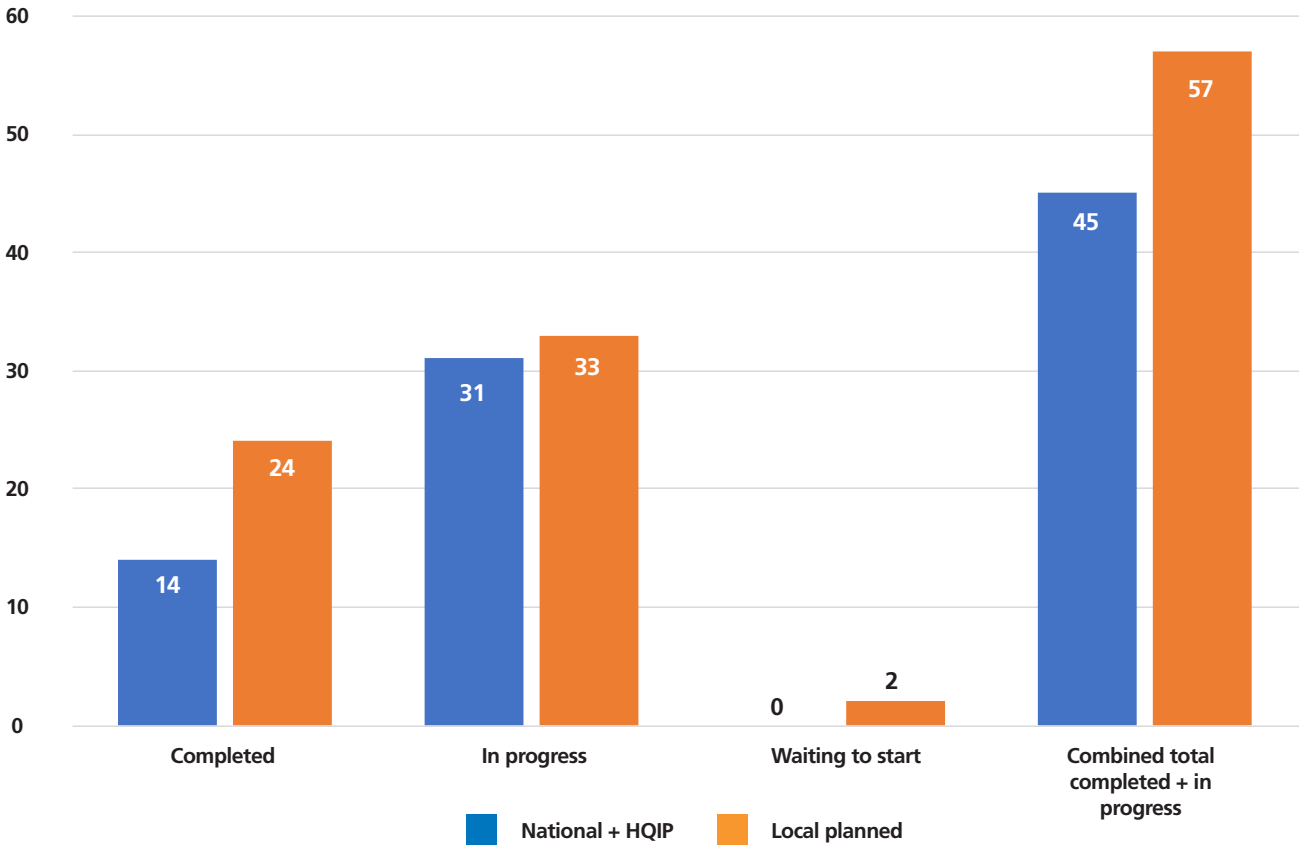
Participation in clinical audits		
Audit title	**Participation**	**% of cases submitted**
Acute		
Society for Acute Medicines Benchmarking Audit (SAMBA)	No	Audit provider withdrew audit plans due to COVID-19 system pressures
UK Renal Registry National Acute Kidney Injury programme	No	Non-participation as service not provided by the Trust
UK Cystic Fribrosis Registry	No	Not designated participant
Anaesthetics		
Perioperative Quality Improvement Programme (PQIP) - researched closed in Aug partial completion, 2018-19 attached and circulated to anaesthetic clinical lead	Yes	100% case submission
National Emergency Laparotomy Audit (NELA)	Yes	Data for 31% of confirmed cases were submitted
Anaesthesia Sprint Audit Practice3 (ASAP3 project) (snapshot for 2month records submitted to NHFD)	No	100% case submission
Trauma Audit Research Network (TARN)	Yes	55% of Trust achieving 96.3% accreditation. Audit submissions close in June 2021
Cardiology		
Myocardial Ischaemia National Audit Project (MINAP)	Yes	66% of available episodes, closing 5 May 2021
National Heart Failure Audit	Yes	74% of available episodes closing 5 May 2021
Cardio-Respiratory		
National Audit of Pulmonary Hypertension	No	Not designated participant
National Lung Cancer Audit (NLCA)	No	No current audit provider. Data submission measures in place as a temporary solution
National Audit of Cardiac Rehabilitation	No	Non-participation as service not provided by the Trust
Clinical Haematology - Anticoagulation		
Root cause Analysis of Hospital Associated Thrombosis	Yes	100% case submission
Serious Hazards of SHOT	Yes	100% case submission
Safety Indicators for patients starting Warfarin Therapy	Yes	100% case submission
Safety Indicators for patients established on Warfrain Therapy	Yes	100% case submission
Clinical Haematology		
National Comparative Audit Of Blood Transfusion Programme - 2020 Audit of the management of perioperative paediatric anaemia	No	Non-participation as service not provided by the Trust

Participation in clinical audits		
Audit title	**Participation**	**% of cases submitted**
Critical Care Unit		
Case Mix Programme (CMP)	Yes	Rolling audit. 2019/2020 data to be submitted in June 2021
Dermatology		
BAD National Audit -safety and Quality indicators on management of hidradenitis suppurativa- missed due to covid situation and staffing 01/04/2020	No	Audit participation should have occurred in 2020/21. However, due to clinical staffing pressures during the COVID pandemic this did not take place
Diabetes		
National pregnancy in Diabetes	Yes	100% case submission
National Diabetic Foot care audit	Yes	100% case submission
National Diabetic Harms	Yes	100% case submission
National Diabetic Inpatient audit (NaDIA)	No	National audit provider withdrew audit due to COVID-19 - Local snapshot performed to ensure continuity
Emergency Department		
Fractured Neck of Femur (RCEM)	Yes	100% case submission
Pain in Children (RCEM)	Yes	100% case submission
Infection Control (RCEM)	Yes	92% of available episodes submitted - 8% exclusions
ENT		
UK Registry of Endocrine and Thyroid Surgery	Yes	70% case submission
Gastroenterology		
Inflammatory Bowel Disease (IBD) registry, Biological Therapies Audit	Yes	Participation at small scale due to complexity of provider database and the data needing to be provided
General Surgery		
Inflammatory Bowel Disease (IBD) registry, Biological Therapies Audit	Yes	Participation at small scale due to complexity of provider database and the data needing to be provided
National Gastro-Intestinal Cancer Audit Programme - National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100% case submission
National Gastro-Intestinal Cancer Audit Programme - National Bowel Cancer Audit (NBoCA)	Yes	100% case submission
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100% case submission
National Oesophago-Gastric Cancer Audit	Yes	100% case submission
Elective Surgery (National PROMs Programme)	Yes	100% case submission. There was a 4 month gap in activity (April 20-July2020) due to COVID-19 pandemic
British Spine Registry	No	Non-participation as service not provided by the Trust
Cleft Registry and Audit Network (CRANE)	No	Non-participation as service not provided by the Trust
National Bariatric Surgery Register	No	Non-participation as service not provided by the Trust
National Vascular Registry (NVR)	No	Non-participation as service not provided by the Trust
Infection Control		
NHS provider interventions with suspected/confirmed carbapenemase producing Gram negative colonisations/ infections	Yes	Providing monthly capture data direct to PHE
Mandatory Surveillance of HCAI	No	Providing monthly capture data direct to PHE

Participation in clinical audits		
Audit title	**Participation**	**% of cases submitted**
Obstetrics & Gynaecology		
Child Health Clinical Outcome Review Programme (Child death review / Maternal Deaths / perinatal Mortality	Yes	100% case submission
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100% case submission
Each Baby Counts (5-year project)	Yes	100% case submission
Ophthalmology		
National Ophthalmology Database Audit	No	Non-participation due to lack of patient system software integration
Paediatrics		
National Neonatal Audit Programme (NNAP)	Yes	100% case submission
National Paediatric Diabetes Audit (NPDA)	Yes	100% case submission
Antenatal and newborn national audit protocol 2019-22	No	Audit provider not collecting data this financial year
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100% case submission
Report for England and Wales Round 3 Cohort 1 (2018-19) Summary Report	Yes	100% case submission
Paediatric Intensive Care Audit (PICANet)	No	The Paediatric Intensive Care Audit Network (PICANet) do not currently receive data from units without level 3 intensive care unit for children
Paediatric Oncology Satisfaction Survey	No	Survey did not commence nationally
Palliative Medicine		
NACEL round three (2020)	No	Has been cancelled due to the impact of COVID-19. NACEL round three will now be completed in 2021
Pharmacy		
Thalidomide Celgene	Yes	100% case submission
Respiratory		
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit programme (NACAP)	Yes	82% of available episodes, closing 1 June 2021
Resuscitation		
Coronary angioplasty (percutaneous coronary interventions)	No	Service not provided in the Trust
Coronary angioplasty (percutaneous coronary interventions) Part of National Cardiac Arrest Audit NCAA	Yes	100% case submission
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	No	Audit not applicable - Ambulance Services only
Rheumatology		
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100% case submission
Neurophysiology		
Neurosurgical National Audit Programme	No	Non-participation as service not provided by the Trust
Stroke		
Sentinel Stroke National Audit Programme (SSNAP) - continuous data submittal	Yes	Rolling audit data collection
Trauma & Orthopaedics		
National Joint Registry (NJR) audit	Yes	100% case submission
National Hip Fracture Database (NHFD)	Yes	100% case submission
Surgical Site Infection Surveillance (SSI)	Yes	Rolling audit. SSI patients for Q1, Q2 and Quarter three submitted to a 100%, Q4 project in progress

Participation in clinical audits		
Audit title	**Participation**	**% of cases submitted**
Trust Wide		
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	No	No current NCEPOD's in place in 20/21 due to COVID-19 pandemic
Prescribing Observatory for Mental Health UK (POMH-UK)	No	Not applicable to the Trust
National Clinical Audit of Anxiety & Depression (NCAAD) - Report added but QEH did not participate	No	Non-participation as service not provided by the Trust
National Clinical Audit of Psychosis (NCAP)	No	Non-participation as service not provided by the Trust
Learning Disabilities Mortality Review Programme(LeDeR)	No	Managed through CCG
Mental Health Clinical Outcome Review Programme	No	Non-participation as service not provided by the Trust
National Audit of Dementia (NAD)	No	Audit postponed in March 2020 due to COVID-19 pandemic
Urology		
National Prostate Cancer Audit (NPCA)	Yes	100% case submission
The British Association of Urological Surgeons (BAUS) - (Renal colic)	Yes	100% case submission
The British Association of Urological Surgeons (BAUS) Cystectomy	No	Non-participation as service not provided by the Trust
The British Association of Urological Surgeons (BAUS) Female Stress Urinary Incontinence	No	Non-participation as no consultant lead for audit
The British Association of Urological Surgeons (BAUS) Cytoreductive. Radical Nephrectomy Audit	No	Non-participation as service not provided by the Trust
RESECT - Quality of TURBT project (Pilot trial study)	Yes	Pilot- data collection survey and case study monitoring

Table 2 - Trust activity against plan for 2020/21



Audit Update Inflammatory Bowl Disease National Audit (IBD)

With clinical and divisional support data has been added to the IBD registry but this is an ongoing process. Data entry has been time-consuming and further clinical support is needed to meet the requirements for data collection and submission. If this were to become available additional data including the individual histories, including the pharmaceutical, surgical intervention and clinic appointments data may be added to support the database. This would allow appointments with the relevant clinicians to have an easy to generate summary of the current history and add richness to the data.

Audit Update Trauma Audit & Research Network (TARN)

Data submission to TARN and department compliance oversight has not effectively occurred within the financial year. Work is underway with the clinical lead of TARN to review the TARN submission process.

	Deadline for TARN reporting	Total outstanding	Completed	Completion compliance
Q1 April - June	Already passed	13	71	80%
Q2 July - September	Already passed	41	42	49%
Q3 October - December	15 April (requested extension)	41	41	50%
Q4 January - March	Awaiting confirmation	28	0	

4.2 Confidential Enquiries

Due to the response of the COVID-19 pandemic no new National Confidential Enquiries were released for participation 2020/21.

4.3 Care Quality Commission (CQC) and Integrated Quality Improvement Programme (IQIP)

The CQC has identified a number of actions for improvements to clinical audit. These are:

- The Trust must ensure that regulatory requirements, recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed effectively
- The Trust must ensure that risks are swiftly identified, mitigated and managed. There must be robust, consistent processes in place to ensure that action plans are enacted following audit, mortality reviews, incidents and complaints. There must be clear process for reviews, analysis and identification of themes and shared learning
- The Trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff

These actions are have been monitored in 2020/21 as part of the Integrated Quality Improvement Plan (IQIP). The IQIP will continue to be managed into 2021/22.

Progress so far has included:

- Establishment of a robust Clinical Effectiveness with Executive oversight
- Developed and enhanced partnership with the divisions with a focus on accountability and oversight
- Increased junior doctor engagement with clinical audit activity
- Review and redesign of clinical audit polices and Standard Operating Procedures
- Establishment an audit index 'gatekeeper'
- Redesign and enhancement of NICE and clinical guidelines index spreadsheets
- The production of standardised report templates to present audit activity at divisional board and speciality level
- Successful implementation of a NICE and clinical guidelines recovery plan

Further development opportunities identified include:

- Recognition that divisions are in different stages of their development. Clinical audit support to be standardised, but flexible in approach to meet division's needs.
- Build consistent and mature clinical audit department processes, whilst having divisional authorisation process of unplanned audits
- Clinical audit presence at staff induction and junior doctor induction
- Implement standardised clinical audit training and support programme

Priorities for 2021/22

- Continue to focus on developing opportunities to share clinical audit learning
- Introduction of a half-yearly benchmarking national audit learning report
- Integrate clinical audit learning into the quality and safety newsletter
- Triangulation of clinical audits with risks and serious incidents
- Launch the clinical audit symposium in May 2021 and invite STP partners
- Joint guidelines review with Acute Service Integration (ASI) partners
- Review of clinical audit teams functions to increase efficiency and sustainability
- Undertake clinical audit team development

5. PARTICIPATION IN CLINICAL RESEARCH

The National Institute for Health Research (NIHR) is the arm of the NHS that is responsible for research. It maintains a portfolio of studies which are peer-reviewed and funded either by themselves or an associated medical charity (e.g. Cancer Research UK) which means that these studies are of high quality. The Research and Development department at the Trust is funded to work solely on these studies.

The number of patients receiving relevant health care services by the Trust during 2020/21 and recruited to clinical research trials was 2,511, an increase on the 924 recruited in 2019/20. The Trust actively recruited to 35 NIHR studies and 7 non-portfolio research studies. Non-portfolio studies are pilot studies, registries and local studies. The Trust participates in these for a variety of reasons including clinician engagement, quality improvement and to a local evidence base. A Trust-sponsored study named COVID-19 Serology in Oncology Staff recruited 436 oncology staff across 3 sites and had a national impact suggesting that staff should have been routinely tested for signs of current or previous coronavirus infection for both the virus antigen and antibody until a vaccine became available.

In 2020 a new suite of portfolio studies emerged as the COVID-19 pandemic started. These were badged "Urgent Public Health Research" and the Department was mandated to work on these by the Chief Medical Officers in the UK. The best known of these clinical trials is the RECOVERY trial aimed at to re-purposing already licensed therapeutics in the fight against COVID-19. The Trust recruited 90 COVID-19 patients to this trial, which found that dexamethasone and tocilizumab helped decrease mortality in those needing oxygen therapy. Another study, to which The Trust recruited 1,260 patients, is the World Health Organisation's Clinical Characterisation Protocol which studies any acute condition with a public health interest in a bid to ensure an effective public health response. This work has helped to define clinically how the COVID-19 virus works and how it interacts with the person infected. The study has provided rapid, coordinated clinical investigation of patients and has enabled the provision of up to date information to the Government and media outlets. One significant finding is the increased risk of severe COVID-19 infection in people from BAME communities.

The Trust has worked on 7 of these Urgent Public Health Studies as well as maintaining patients on pharmaceutical studies which were open prior to the pandemic. We have achieved one national first recruit to a cancer trial, which illustrates how efficiently and flexibly we can work.

The strong team effort throughout the year reflects excellent team working. The RECOVERY trial has allowed us to encourage more clinicians to take part in offering research trials to our patients, and has allowed us to further embed research into all aspects of patient care.

The Trust's excellent reputation for research and innovation continues to grow. The large number of patients recruited to clinical trials marked another record-breaking year and the QEH was ranked 27 of 507 Trusts nationally for COVID-19-related research, leading on vaccine trials for the Eastern region.

6. PARTICIPATION IN NATIONAL CQUINS

The Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care. It covers a wide range of areas intending to drive transformational change within the NHS. It aims to

1. Improve the quality of the NHS services and outcomes for patients
2. Reduce health inequalities
3. Encourage collaboration
4. Improve the working lives of NHS Staff

Each year CQUIN schemes are published with key quality improvement targets that attract funding for providers from commissioners if achieved.

In March 2020, NHS England and Improvement (NHSE/I) published guidance on contracting under COVID-19. This covered contractual arrangements through to 31 July 2020 and set out that NHS commissioners did not need to put in place written, signed contracts with Trusts for that period; instead, block payments would be made to Trusts, at levels set nationally by NHSE/I. The operation of the CQUIN scheme was also suspended for all providers for the same period. In July 2020 NHSE/I published the following updated guidance, "The operation of the 2020/21 CQUIN scheme will remain suspended for all providers for the remainder of the year; an allowance for CQUIN will continue to be included in the block payments made to Trusts, and commissioners should continue to make CQUIN payments to non-NHS providers at the full applicable rate."

7. REDUCING AND ELIMINATING HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

The Trust Strategy for Infection Prevention and Control - with objectives based on the Code of Practice within the Health and Social Care Act 2008 (updated 2015), known as the Hygiene Code - gives us the standards on the prevention and control of infections with related guidance from the Department of Health and is used by the CQC as a measure of standards.

7.1 Management structure for infection prevention and control

There is a structure in place for the prevention and control of infections which is led by the Director of Infection Prevention and Control (DIPC). The structure was reviewed in 2020 to ensure effective management and delivery of IPC.

7.2 Healthcare HCAI data

Trajectory for (Methicillin Resistant Staphylococcus Aureus) MRSA and Clostridium Difficile MRSA bloodstream infections (target = zero)

For the year 2020/21 there has been zero MRSA blood stream infection associated with the Trust. To keep patients safe, MRSA screening continues to take place across the Trust for MRSA (on admission and weekly thereafter, as required)

For Methicillin sensitive Staphylococcus aureus (MSSA) bloodstream infection. No trajectory has been set)

For the year 2020/21 there have been 13 cases of MSSA blood stream infection associated with the Trust.

For Clostridioides Difficile Infection (CDI), the objective is fewer than 44.

During 2020/21, the Trust CDI objective, set by NHSI/E, remained unchanged from 2019/20 at fewer than 44 apportioned cases. The number of cases reported in 2020/21 was 49 with 21 of these cases apportioned to the Trust and 17 of these cases not apportioned to the Trust. Eleven cases remain under review to determine attribution and cause.

Actions taken to reduce healthcare associated CDI are:

- Post Infection Reviews undertaken for each case, process supported by Clinical Commissioning Group (CCG), IPC colleagues, and lessons learned shared across the Trust
- Bespoke education / training provided to affected areas
- Education at Induction / Mandatory Training
- Trust CDI Policy re-launched at ward "huddles"
- Site team educated in isolation room prioritisation
- Antibiotic stewardship management and engagement
- Addressing outbreaks and periods of increased incidence promptly undertaking measures to reduce any further transmission
- Reviewed standards, methods and assurance of cleaning across the Trust
- Domestic staff trained in national cleaning standards
- IPC Team support procurement colleagues to ensure effective and efficient cleaning products are purchased and are in place for use
- 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 daily 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)

Following a review of the 2016 plan for reducing GNBSI's during 2019/20 the NHS re-set 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 2020/21 the Trust reported 43 GNBSIs.

7.3 Challenges this year

COVID-19 - Preparation and planning for the 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 and evolve with many challenges faced at this unprecedented time to ensure the best possible protection for our patients, staff and visitors to the trust.

The IPCT structure, in terms of resourcing of substantive posts and in particular Registered Nurse establishment and leadership, has been a challenge. During wave one the IPC Team were supported, for three months, by five redeployed nurses who supported the Post Infection Review process for the team. Since Wave 1 Interim arrangements have been financially supported in response to the challenges posed by COVID-19. The Executive Team took a proactive decision to employ a dedicated Deputy DIPC to develop and lead the IPCT and service.

It remains a challenge that the IPC Team does not have dedicated access to timely and accurate data systems for IPC data management. Data submission, extraction and processing and production of IPC reports, for both internal and external requirements, has become increasingly challenging with present systems in place. This has proved challenging for both the IPC Team and the Trust to respond to COVID-19 data requirements. Information Services are presently working cohesively and supporting the IPC Team with present challenges and the future recruitment of a dedicated IPC Information Officer.

7.4 Multi-agency visits

A multi-agency infection prevention and control visit on 9 July 2019 identified concerns with the Trust and we remained at escalation level red on the NHS Improvement/England internal infection prevention escalation matrix. A further visit from the multi-agency team occurred on 14 November 2019 and the Trust was rated amber. The Team noted that significant improvement had been made across the hospital and that it was anticipated that the hospital would be able to move to a green rating at the next visit, planned for spring 2020. This was subsequently cancelled due to the COVID-19 pandemic. A CQC visit was made in September after which the Trust received a rating of green (good) for infection prevention and control.

Comments in the Report published in December 2020 include:

- "Across the trust, staff prioritised infection control and prevention"
- "All areas were visibly clean and free from clutter"
- "We saw that infection control and prevention was managed well"

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

8. COVID-19 PANDEMIC

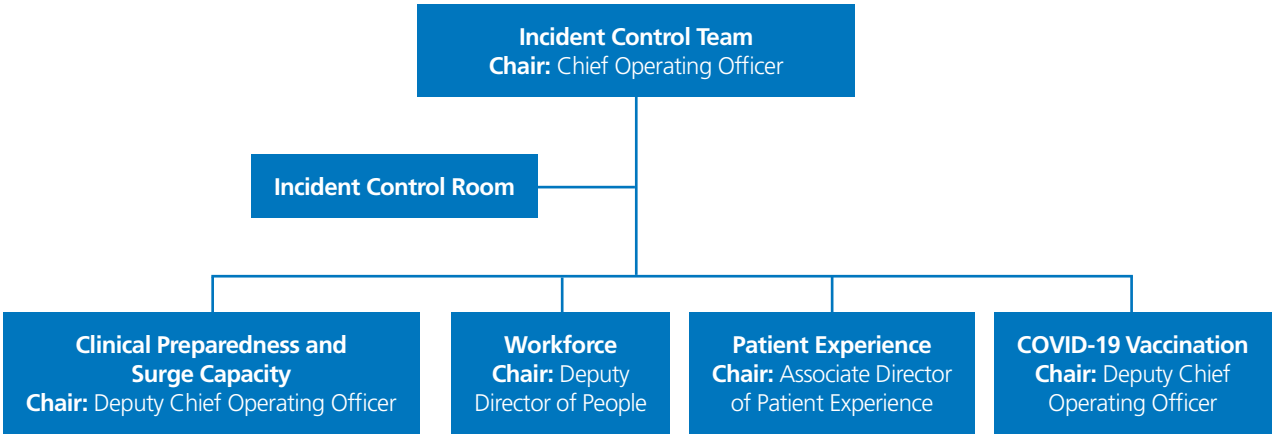
On 30 January 2020, NHS England & Improvement (NHSE/I) declared a Level 4 Incident (the highest level) in response to COVID-19. This is defined as "an incident that requires NHS England National Command and Control to support the NHS response". In this situation, direction from the National team is actioned through the Regional team.

The Trust admitted the first COVID-19 positive patient on 13 March 2020. The peak of wave one was reached on 18 April when there were 90 positive patients in the Trust. In August, the Trust returned to 'near normal' levels of activity. However, in October, at the start of wave two, patients admitted with a positive COVID-19 diagnosis began to increase significantly. The peak of wave 2 was reached on 14 January 2021 at 206 patients.

8.1 COVID-19 Governance Arrangements

In common with other NHS organisations, the Trust put in place robust governance arrangements to manage the COVID-19 pandemic.

The Trust implemented the command and control structure outlined below:



The Incident Control Team (ICT) is led by the Chief Operating Officer and membership comprises the Medical Director, Chief Nurse and Divisional Directors.

The Incident Control Room (ICR) was initially led by the Head of Patient Flow and more recently by the Emergency Planning Manager. The ICR receives instruction from the ICT and is staffed from 8:00 - 20:00, seven days a week.

The Clinical Preparedness and Surge Capacity subgroup is led by the Deputy Chief Operating Officer and membership is drawn from clinical and operational teams across the Trust. The subgroup ensures the Trust is fully prepared to manage the incident.

The Workforce subgroup is led by the HR Director and membership is drawn from clinical, operational and corporate teams across the Trust. The subgroup ensures the Trust has a fully prepared workforce to manage the incident.

The Patient Experience subgroup is led by the Associate Director of Patient Experience and membership is drawn from corporate and operational teams across the Trust. The subgroup ensures the Trust maintains a focus on patient experience during the incident.

The COVID-19 Vaccination subgroup is led by the Deputy Chief Operating Officer. The subgroup ensures the Trust has robust plans in place to deliver the COVID-19 vaccination programme in line with national guidance.

8.2 Workforce

As part of the Trust's response to COVID-19 staffing rotas were developed, reviewed and implemented and individuals were redeployed to work in other areas of the Trust to support the response to the pandemic. All areas developed a business continuity and escalation plan which outlined the resourcing trigger points and a process for utilisation of staff once the trigger points had been hit. This was based on site escalation plans, patient acuity, peaks and staffing levels. A number of processes and policies were amended to ensure the Trust was able to respond to the pandemic and national guidance, to support the required changes in relation to social distancing and ensuring all staff had the correct PPE at all times.

The Trust invested significantly in looking after, listening to and caring for Team QEH and continues to do so with ensuring staff health and wellbeing continues to be at the heart of the recovery phase.

8.3 Infection prevention and control

The COVID-19 pandemic has brought an unprecedented challenge to hospital infection control. High community prevalence, high infectivity, long incubation period and asymptomatic carriage of the virus make provides a unique set of circumstances to prevent spread of the virus in the healthcare environment. Throughout the pandemic, the Trust has implemented and adapted to rapidly changing Infection Prevention and Control guidance from Public Health England.

Healthcare associated COVID-19 - case definition and QEH numbers

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

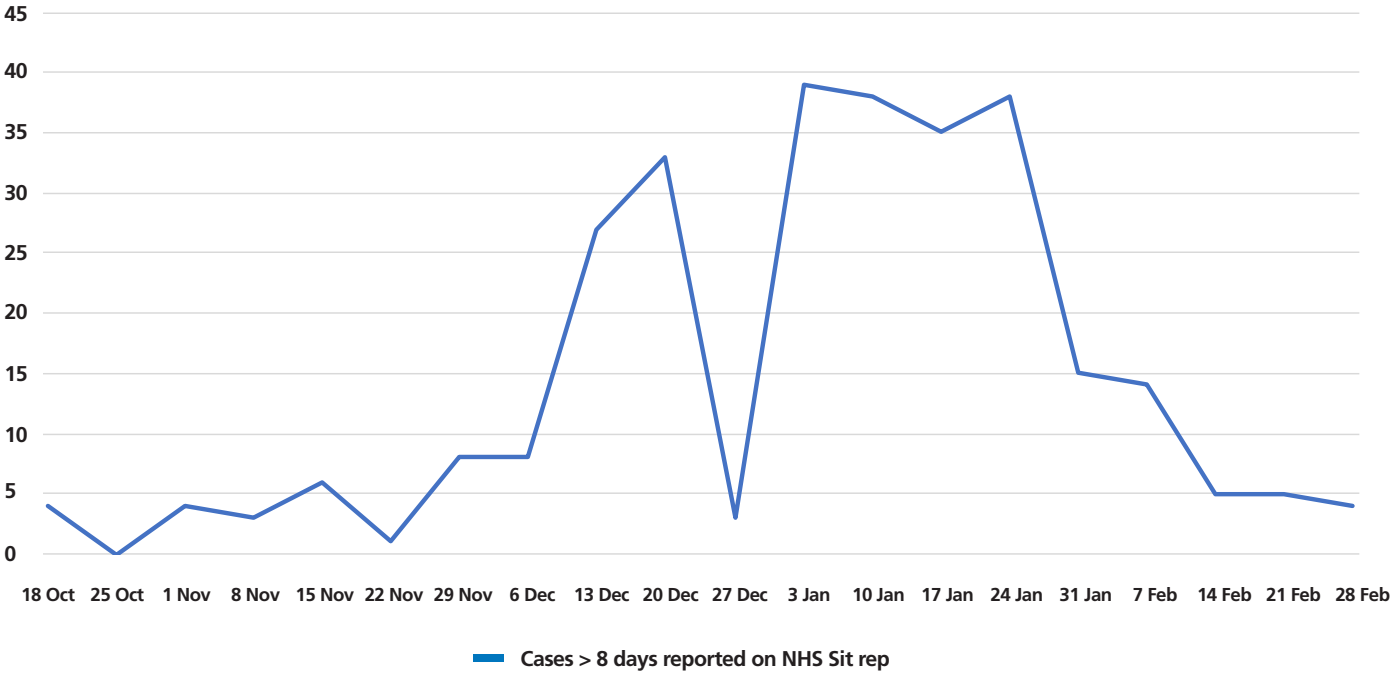
- Definite Healthcare Associated (onset of illness or first positive sample on or after day 8 of admission) and
- Probable Healthcare Associated (onset of illness or first positive sample on or after day 8 of admission)

	Community onset cases (first positive test day 0-7 of admission)	Healthcare onset cases (first positive test ≥ day eight of admission	Total
Wave one (March to May 2020)	362	58*	420
Wave two (October 2020 to March 2021)	839	286**	1132**
Total	1201	344	1552

* The actual number of healthcare onset cases during wave 1 will be lower due to lack of admission screening of all patients at the start of the pandemic

**Numbers reported to NHS England. Note: 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 wave two of the pandemic (Oct 2020-March 2021). An initial peak was seen in December 2020 following a large staff and patient outbreak followed by a second broader peak in January which coincided with the arrival of the novel UK Variant of Concern (VOC-202012/01 lineage B.1.1.7) in West Norfolk.



8.4 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 of COVID-19 among individuals associated with a specific setting where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital.

The low threshold of two cases posed a challenged with the COVID-19 numbers involved in relation to determining the source of the outbreak i.e. staff/patient base. During wave two, a total of 18 outbreaks were declared across the trust.)

COVID-19 multi-disciplinary team meetings

Daily (Monday to Friday) multi-disciplinary team meetings (MDT), involving nursing, medical, AHP, estates and facilities teams alongside external partners (CCG & NHSE/I) formed the Incident Management Team for COVID-19 outbreaks. The MDT's reduced in line with COVID-19 outbreak reduction and recently incorporated a fortnightly learning event where themes and trends were discussed and active and reflective learning was shared. Meetings were stopped in early March 2021 and will only recommence should further outbreak situations occur.

Summary of Learning from outbreaks

- Occurrences of hospital acquired cases of COVID-19 with the addition impact of outbreaks can have far-reaching consequences. Urgent action was required to improve compliance with IPC guidelines
- Change mindset from protecting SELF to protecting OTHERS by changing the way people think about risk. Shift thinking from my personal risk to my potential impact on others
- Unify and reinforce knowledge on IPC rules and the infection risk. Educate why those rules matter in all situations and provide situational reminders
- Dispel the myths - there's no such thing as 'COVID-19 safe' or a 'in the work bubble'
- Make it easier for staff by removing infrastructure barriers (where feasible) in key hotspots and reinforce rules for these areas with situational reminders
- Collaborative working, engaging relevant partners will provide an opportunity to reflect and learn more widely for future development and management of systems and processes to support outbreak situations including a pandemic

8.5 Testing

The Eastern Pathology Alliance (EPA) Network has been instrumental in the local and regional response to the COVID-19 pandemic. The provision of fast and reliable testing for the presence of the SARS-CoV-2 virus in both patients and staff is critical both for patient management and to ensure best Infection Prevention and Control practice. As of week ending 21st February 2021, the QEH had submitted 47,782 swabs for processing through EPA since the start of the pandemic. Of these, 2,920 (6%) have tested positive. Patients being admitted to hospital are screened in line with Public Health England Guidance.

From December 2020 the QEH rapid diagnostic testing (RDT) laboratory has provided testing capacity on the QEH site in a significantly reduced time (under four hours) seven days a week. This service has been utilised to help patient placement, managing patient movement and facilitating rapid discharges of patients requiring social care input. So far the QEH rapid diagnostic lab has processed approximately 1,200 samples with 289 samples testing positive

Also from April 2021 novel technology (LAMP) will replace Lateral Flow for asymptomatic staff SARS-CoV-2 testing which is a critical infection control measure. This exciting technology is nationally approved and validated and holds many advantages over current methods such as LAMP uses saliva instead of nasal swabs, once weekly instead of twice and positives do not require confirmatory PCR. The LAMP programme is commissioned by DHSC, and EPA is delivering this staff testing programme in collaboration with Earlham Institute.

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

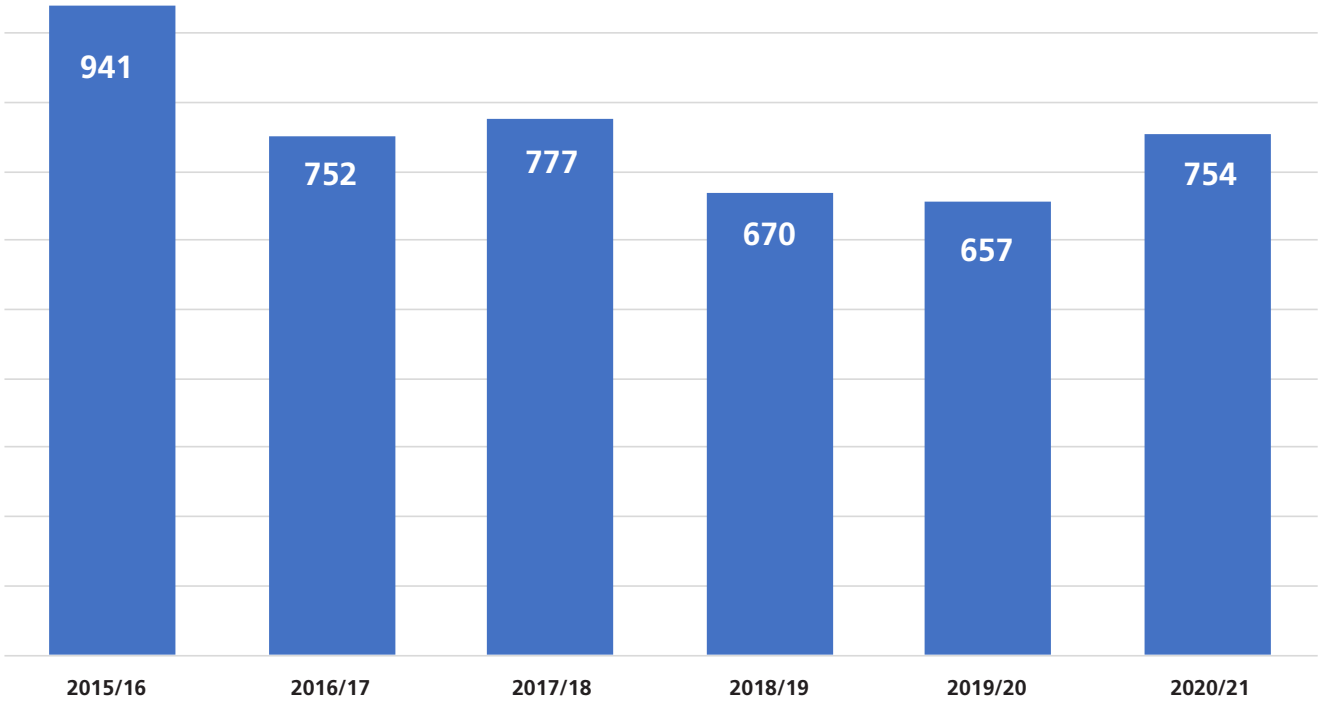
Falls are the most commonly reported incident in hospital and there are more than 100 separate risk factors and reasons that can influence the likelihood of someone falling. Over the past 12-months, the Trust has continued to monitor performance against an agreed benchmark which was set in 2015, committing to a target of fewer than five falls per 1,000 bed days in all adult inpatients.

The focus for falls prevention and management is to minimise patient falls with harm and drive improvements in safety and quality whilst always striving for a positive patient experience. A safe care environment where patients are protected from avoidable harm is actively promoted and managed.

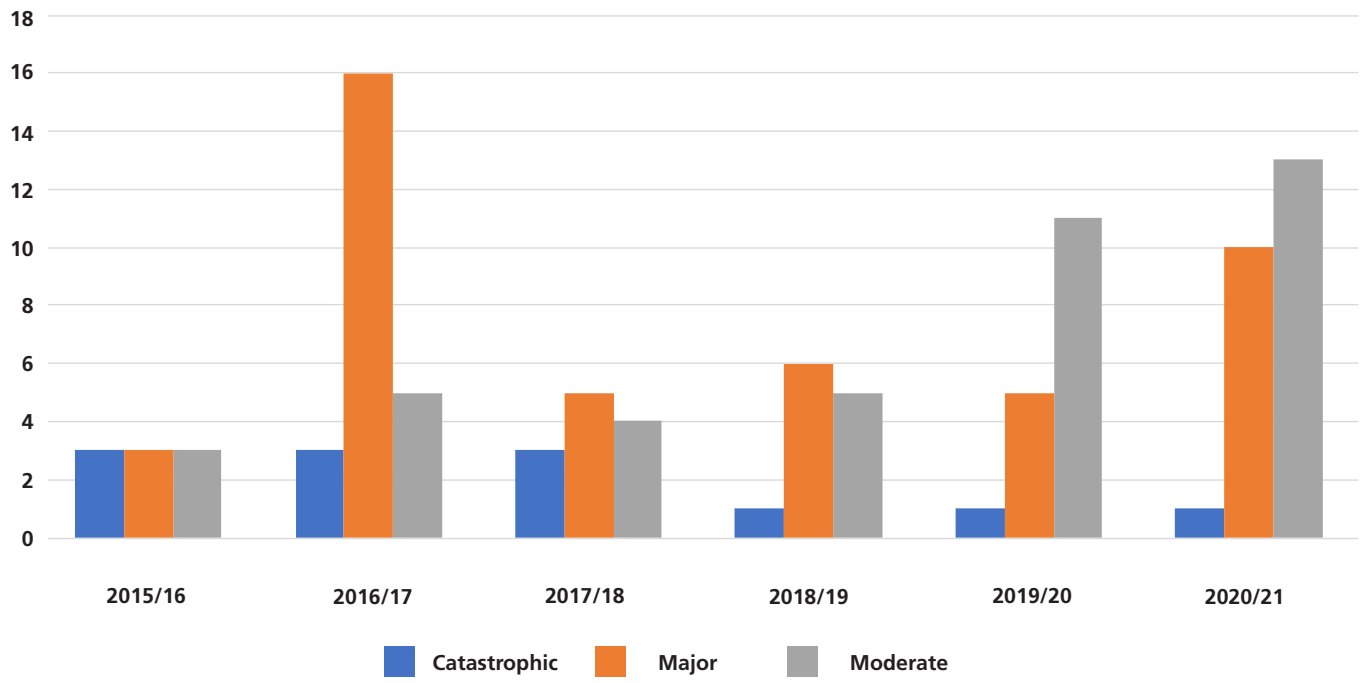
The Trust started to see a reduction in the total numbers of falls between 2018/19 and 2019/20 which is thought to be due to interventions that increased staff awareness of falls prevention. Subsequently, this led to improvements in the implementation of the Trust Falls Prevention Strategy as well as recognition of factors that influence ward systems and activities before the COVID-19 pandemic in March 2020.

The number of inpatient falls has significantly reduced during quarter one (2020/21) thought to be largely due to a reduction of inpatient admissions and activity. The trajectory of falls was noted to significantly increase during quarter two (2020/21) resulting in harm which has continued into quarter three and four. This is thought to be due to cumulative factors before and during the second wave of COVID-19 pandemic where the Trust had seen an increase in inpatient admissions, challenging staff resourcing and the use of escalation areas. Restrictions within the workplace also constrained face-to-face in-house training impacting on mandatory training as well as staff induction programmes. This reduced the ability to provide falls prevention and management education.

Trust-wide falls 2015-21



Falls recorded by severity



The falls quality priority for 2020/21 was to reduce adult inpatient falls by 15% which was, unfortunately, not achieved. Instead of reducing the number of inpatient falls, there have been more incidents reported this year and the harm resulting from falls is much higher in comparison to last year the reasons for which seem to be largely COVID-19 related.

9.1 Prevention and Risk Management

The Falls Prevention Co-ordinator continues to lead on the workstreams which have contributed to reducing the overall fall rate over the past five years. In conjunction and collaboration with the Lead Nurse for Older People, the Falls Prevention Co-ordinator has led a number of quality initiatives which ensure that all elements of falls prevention and management are addressed across the Organisation

The workstreams have included continuation of embedding and strengthening the use of the updated Falls Prevention Care Plan launched in 2018. This plan covers practicable and achievable falls prevention strategies commonly excluded in previous patient falls prevention care plans focusing a person centred multi-factorial approach, strengthened by learning from incidents.

"Perfect ward" audits have been reviewed to support improvements in quality measures with regard to patients having appropriate and timely multi-factorial falls risk assessments and associated care planning, maximising opportunities for harm-free care in the organisation. This has been further supported by the use of ward level "safety huddles" occurring throughout the day and affording a greater level of oversight and identification of risks thereby enhancing patient safety.

A falls quality audit was undertaken in November 2020 to evaluate the Trust's quality performance which included detailed analysis of each individual patient's falls risk, reviewing interventions implemented to eliminate, reduce or manage the specific individual falls risks. The aim of this audit was to provide assurance against the "Perfect Ward" initiative to benchmark and support improvements in patient care across the Trust. This was done by reviewing processes and policies in place to prevent and manage in-patient falls.

Research into, and trials of, new equipment has been undertaken to discover whether patients could benefit from use of assistive technology; the 'falls alarms monitoring system'.

The Trust continues to explore the use of Hi/Lo beds. These may not reduce the numerical risk of a fall but can help reduce the risk of injury if a fall occurs. This is particularly useful to manage patients who are highly confused and agitated who often have poor insight into their own physical limitations and personal safety.

The Trust continues to take part in, and fully comply with, the National Audit for Inpatient Falls (NAIF) exploring specifically post-fall care for patients aged 65 and over who sustain a hip fracture whilst in our care. This audit programme aims to facilitate learning and determine areas requiring improvement in care following a fall and have produced some pleasing results for the Trust. The annualised values over the 12 months to the end of November 2020 indicate:

- Check for signs of injury before movement from the floor - 86 % (NAIF overall 71%)
- Use of a safe handling method to move patient from the floor - 86% (NAIF overall 78%)
- Medical assessment within 30 minutes - 100% (NAIF overall 71%)

The Trust policy on Falls Prevention and Management in adult patients was reviewed in January 2021 (ratified in February 2021) in line with national guidance and changes in hospital practice. This includes a falls prevention flowchart and is available on the Trust staff intranet site.

9.2 Education/training

The falls training programme has been reviewed, refreshed and relaunched to include information contributing to falls. These include the combination of intrinsic, extrinsic and behavioural factors, consequences of patients falling, prevention approaches, the use of equipment and the roles and responsibilities of staff. The training also focuses on the achievement of the three high-impact interventions within the national Commissioning for Quality and Innovation (CQUIN 2019-2020) to help staff bridge the theory-practice gap and have a better understanding for the rationale behind the interventions and their impact on patient care and safety.

Due to a restriction on face-to-face training in 2020/21, a falls workbook was made available in November 2020 and was moved to the Trust's electronic staff record (ESR) recently to facilitate staff accessibility and to streamline recording of training compliance. As of February 2021, mandatory training compliance Trust wide was 74.90% but efforts are ongoing to increase this to the target figure of 85%. The Trust is currently investigating the provision of a medical staff training package offering an extensive content appropriate for the specific clinical training needs of that group of staff.

Following review of the Trust "Special Observation Policy" in May 2020, the Team has continued to deliver sessions to staff on providing 'specialling' to patients to prevent falls or patient harm and reinforce the use of distraction techniques using products such as 'Trip Tree' boxes.

9.3 Priorities for improvement in 2021/22

In the next 12 months it is planned to deliver the following work streams:

- Reduction in inpatient falls (continuation of last year's target which is a 15% reduction)
- Multidisciplinary (MDT) falls prevention meetings chaired by Deputy Chief Nurse
- Introduction of "Bay watch" on the wards. "Bay watch" is a safety initiative designed to ensure uninterrupted monitoring of vulnerable patients in a dedicated area on the ward 24-hours a day
- A strengthening of process for Polypharmacy reviews at ward level with focus on the use of sedatives, hypnotics and anti-psychotics.
- Delivery of micro-teaching sessions to staff on high impact actions to reduce falls
- Utilise data from Local audit and the National Audit of Inpatient Falls (NAIF) to evaluate the effectiveness of the current interventions; identify good practices and learning to adjust practice in light of the lessons learnt from the audit
- A relaunch of the "Champion" role Trust-wide with the possibility of expanding it to include frailty and dementia as "Older Persons Ambassadors" to engage in the design of falls prevention as well as encourage specialist interest; ensuring that implementation would be practicable
- Strengthen falls prevention as a shared responsibility by engaging all staff to consistently deliver a robust safety culture across all areas
- Continue to network with other organisations to share ideas and learn from those who experience similar challenges and adapt concepts and methods already proven to have worked in other organisations

10. REDUCING AVOIDABLE PRESSURE ULCERS

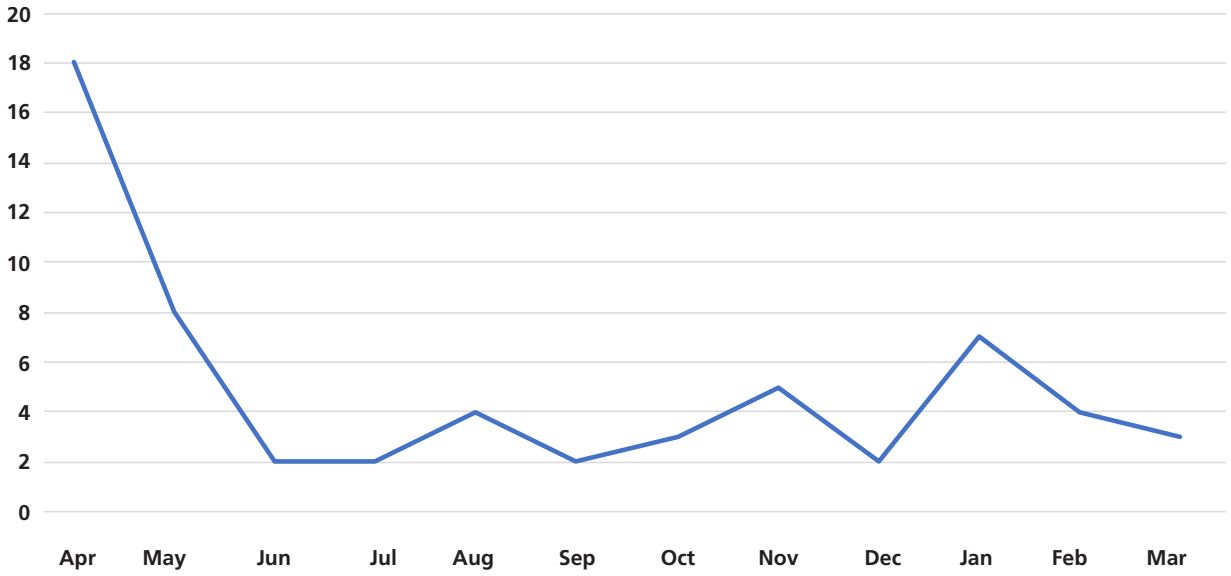
Pressure ulcers remain a concerning, and largely avoidable, harm associated with healthcare delivery. NHS Improvement reported that 24,674 patients developed a new pressure ulcer between April 2015 and March 2016 and treating pressure damage costs the NHS more than £3.8million every day. Finding ways to improve the prevention of pressure damage is, therefore, a priority for policy-makers, managers and practitioners alike" (NHS Improvement, 2018).

Pressure ulcers remain a challenge for the patients and healthcare professionals involved in their prevention and management. Despite extensive prevention programmes, evidence suggests 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. An ASKINS checklist is completed for all hospital acquired pressure ulcers (HAPU) and results are discussed face-to-face with the ward manager or Nurse in Charge (NIC) at the time of completion and sent to each ward manager and matron electronically, The data helps us to identify where specific training should be focused.

The following tables show a comparison of hospital acquired pressure ulcers (HAPU) in the Trust between 2019/20 and 2020/21.

	HAPU 2019/20	HAPU 2020/21
April	4	18
May	3	8
June	5	2
July	2	2
August	6	4
September	4	2
October	5	3
November	5	5
December	9	2
January	3	7
February	8	4
March	4	3
Totals	58	60

HAPU 2020/21



The table shows a sharp rise in HAPU during April 2020 at the start of the COVID-19 global pandemic which is in line with the national trend. The remainder of the year showed peaks and troughs in incident numbers which, generally, correlate with the national COVID-19 situation at the time. Of these 60 incidents, 47% (28) were patients who had tested positive to COVID-19 with over half of these managed in a critical care setting.10.1 Reporting

Overall, we have seen an increase in incidents year on year by 3% (2 incidents). This increase is largely attributable to a rise in HAPU within the critical care unit which accounts for 35% of the total incidents (21 out of 60). Of these 21 incidents, 13 occurred in patients who had been laid prone for the treatment of Acute Respiratory Distress Syndrome (ARDS) secondary to COVID-19 infections. The critical condition of these patients, many of whom were receiving medicines to raise low blood pressure, coupled with a much reduced ability to reposition whilst laid prone creates ideal conditions for the development of pressure damage.

There is also emerging evidence to suggest that COVID-19 can cause a restriction in blood supply to tissues, causing a shortage of oxygen that is needed to keep tissue alive which is almost identical in presentation to pressure damage. On reflection and critical analysis of the published evidence, the Tissue Viability team hypothesise that some of the reported hospital acquired pressure ulcers were, in fact, related to "COVID-19 skin". Data from the Zoe COVID-19 symptom study app, looking at reported symptoms of those in the UK, suggests that some people who suffered with COVID-19 saw changes to the skin. The rashes are usually itchy and may make it difficult to sleep. It is not clear what causes these changes but could be linked to the immune response to the virus.

10.1 Reporting

In line with NHS Improvement guidance (2018), the Trust continues to conduct investigations into HAPU with a focus on good practice, identifying where lapses in care may exist and learning from them.

All category two to four, unstageable and deep tissue injuries (including medical device-related pressure ulcers)and hospital-acquired pressure ulcers are reported via Datix.

The TVN (Tissue Viability Nurse) 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 to the Risk and Governance team. The document is also uploaded to Datix and the incident report is amended in line with TVN validation.

Pressure ulcers graded as category three and above are discussed at the Serious Incident Review Panel (SIRP) for a decision if the pressure ulcer incident meets the SI threshold.

On examination of the year's incidents and subsequent investigations, the general themes for hospital-acquired pressure ulcers remain the same as 2019/20:

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

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

Education and training

- Mandatory training
- Induction
- Ward-focused training
- Teaching specifically for Health Care Assistants

Under the conditions of the global pandemic, the Trust has focused on reducing all face- to -face teaching, where possible, to ensure the safety of its staff. As a result of this, a new eLearning package has been developed on pressure ulcer prevention to meet the mandatory training requirement of all clinical staff.

10.3 Leadership

- Evaluation of prevention equipment. A total bed management review was implemented for all bed frames, dynamic and specialist mattresses in July 2020 in conjunction with extensive teaching and retraining around how to use the equipment to effectively manage and reduce incidence of pressure damage
- Sourcing and usage of a new trust standard mattress to meet the needs of the patient and help towards reducing HAPU
- Daily ward presence of TVNs and Matrons
- Monthly HAPU data is reported to the Board by the Chief Nurse as well as to the monthly Harm Free Care Forum
- Extensive work plan that aims to continue and strengthen the ward-based use of the ASKINS care bundle for prevention of pressure damage, with events planned throughout the year to keep pressure ulcers a key safety issue with front line staff in conjunction with the relaunch of '100 days free' to further reduce the incidents of facility acquired pressure ulcers

11. 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 with the objective to the consistent delivery of 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 from divisional level to the Corporate Nursing Team to ensure that defined focus is applied with support from the Medical Director and the Chief Nurse who is the Executive Lead. 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 which have either been adopted or are part of the Trust end of life care project which will continue into 2021/22. The CQC acknowledged some progress in end of life care following inspection during September 2020 which demonstrated improvements in the caring, well led and safe domains.

End of Life Care is based on the Individual Plan of Care (IPOC) which sets out key priorities. The Trust has worked with partner agencies in Norfolk and Waveney to develop a standardised plan for care delivery which has been launched in the Trust and monthly audits are undertaken to monitor the consistency of use across all clinical areas the results of which are reviewed at the Recognise and Respond Forum. Education continues via our Education Lead for End of Life Care and will be developed further throughout 2021/22.

In March 2020, the Norfolk and Waveney Sustainability and Transformation Plan (STP) launched a new process called the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to help base care and treatment on the patient's preferences, enabling early conversations with patients, if they so choose, on future treatments including but not exclusively ,Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. We continue to work with Norfolk and Waveney partner agencies to ensure a safe and effective implementation of version three of the ReSPECT document.

Norfolk Community Health and Care NHS Trust is the main contracted provider of integrated specialist palliative care across West Norfolk. This includes support from a named Palliative Care Consultant, Specialist, Palliative Care Nurses and access to a 24/7 telephone advice line. However, we have welcomed the support from the Norfolk and Waveney CCG in partnership with Norfolk Community Health and Care NHS Trust to review the opportunities to improve the daily provision of palliative care for our patients and in 2020/21 we have actively sought to recruit extra senior palliative care staff with support from NHSE/I.

The Trust Chaplaincy Team continues to provide bereavement support to families and friends of patients who have died. This is in the form of small support groups which meets weekly at QEH for a six-week duration. It is open to all and offers non-religious peer support for those who are grieving. The Chaplaincy Team has been invaluable in supporting families and patients to connect with each other, particularly as visiting restrictions due to the COVID-19 pandemic have been a feature of most of the last 12 months. To expand the modes of support for our staff who have encountered significant challenges in caring for patients with COVID-19, the Team has provided, and will continue to provide, 'Listening Ear' time to our ward teams and any other members of staff who need it.

The lilac tree symbol is associated with End of Life care at the QEH and is recognised by multidisciplinary teams across the hospital. We continue to use purple candles and tea light holders to mark that a patient has died and to subtly promote 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.

Our plans for 2021/2022

- Development of an End of Life Specialist Register. This will enable the Palliative Care Team to identify proactively patients admitted to the hospital and to assess them if a visit is required. Patients identified as requiring End of life/palliative care including patients being cared for in the community will be added to this Register
- Work to develop and refine operational processes within the Team. This will clarify and further refine the operational processes within the team to include a standard operating procedure, terms of reference and a governance structure
- Plans for the Palliative Care Team to attend ward 'whiteboard meetings'
- Further work to identify gaps in education and training in end of life care and development of a training programme to address them

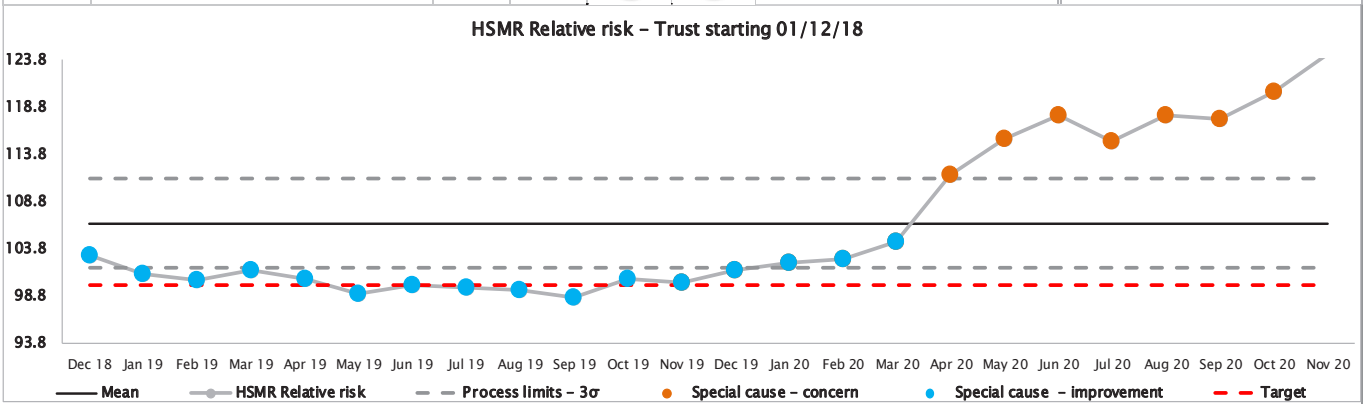
12. REDUCING AVOIDABLE MORTALITY

12.1 Learning from Deaths

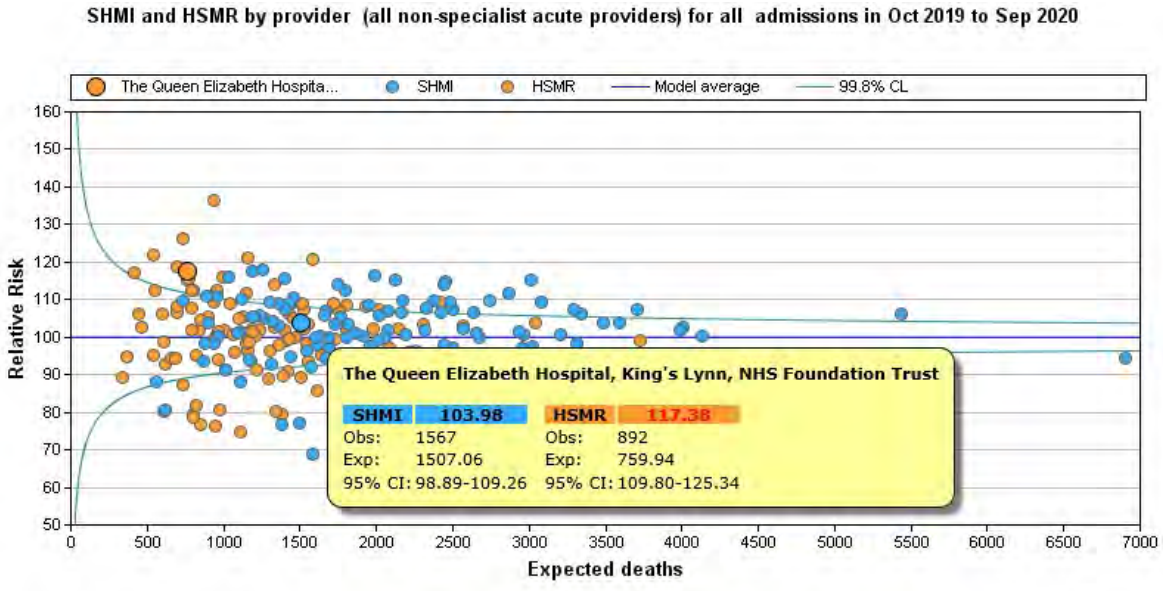
The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Index (SHMI) are two standard measures against which hospital mortality outcomes are measured. HSMR is a ratio of observed to expected deaths of patients based on a subset of diagnoses (56 diagnosis groups that constitutes 80% of all hospital deaths).

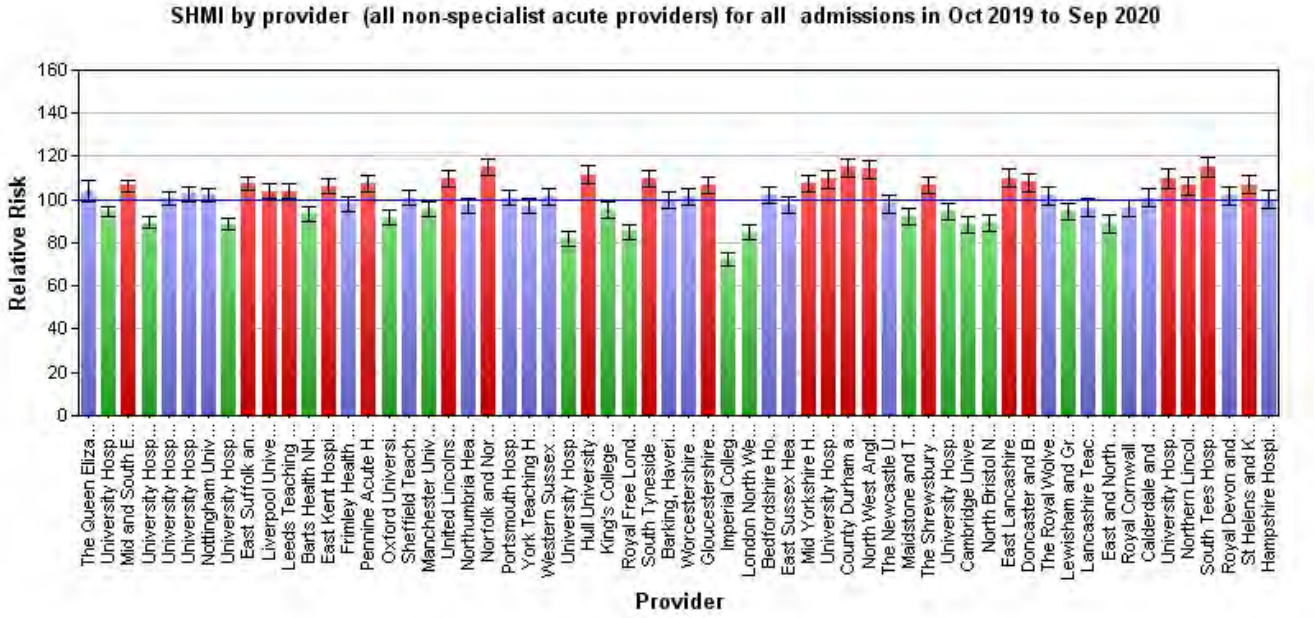
The SHMI is the ratio between the actual number of patient who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. For this reason the SHMI data is reported with at least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

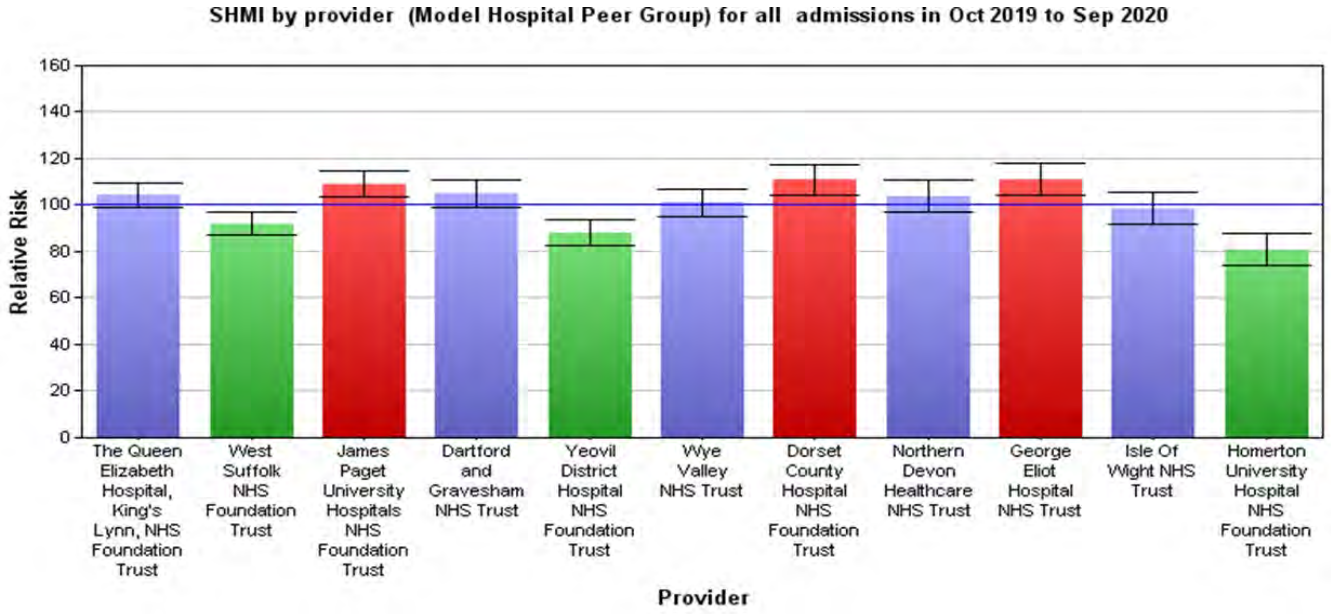
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-20	HSMR Relative risk	100.00	124.46	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target



The QEH has seen a higher number of deaths during the pandemic. For both waves the number of deaths was higher and the number of admissions lower which has had a massive impact on our HSMR. During this time the SHMI has remained stable and within expected parameters. This is indicated in the table below and shows data to September 2020



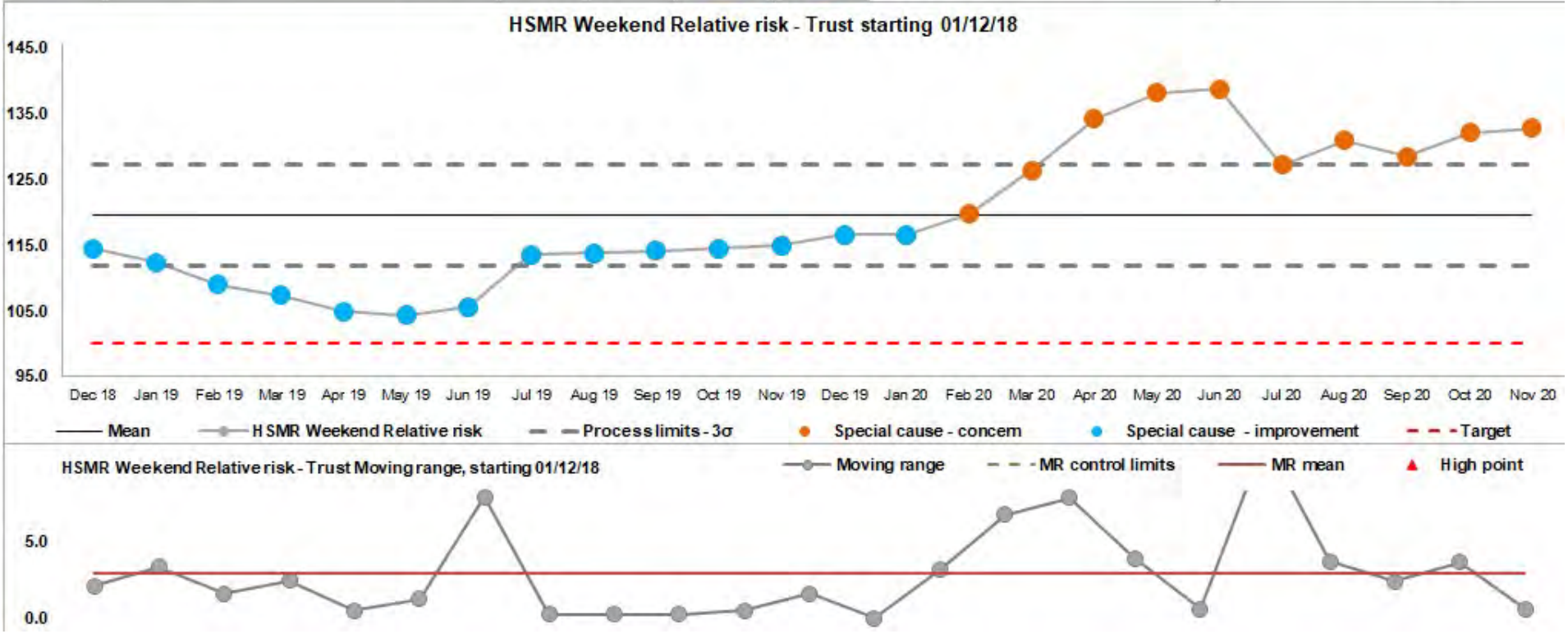




The HSMR (calculated on death in month where the admission date was a Saturday or Sunday) at the Trust continued to remain a source of concern. Following a number of internal investigations which were inconclusive the Trust asked for assistance from NHSE/I in helping us to understand better the reasons for this variance. No lapses in clinical care were identified but there was evidence to show that our palliative care recording was very much adverse to that of other trusts. Actions to address this are being developed and implemented by the newly expanded Palliative Care Team in line with the Integrated Quality Improvement Plan

Weekend HSMR (Rolling 12-month HSMR December 18 to November 20)

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Nov-20	HSMR Weekend Relative risk	100.00	132.81	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target



There were 1,241 deaths recorded in the Learning from Deaths process between January and December 2020. Breakdown of these deaths is provided in below tables.

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

Time period	Number of deaths
Quarter one	321
Quarter two	352
Quarter three	239
Quarter four	329

Table 2: Breakdown of deaths

Speciality	Number of deaths
Medicine	1,079
Surgery	55
Trauma & Orthopaedics	23
Critical Care	81
Obstetrics & Gynaecology	3

Of these 1,241 deaths 608 deaths (49%) were subject to a Structured Judgement Review (SJR) to identify and act upon learning.

Table 3: Structured Judgement Reviews

The object of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or challenges in the care process.

Speciality	Number of deaths reviewed (% of total deaths)
Medicine	540 (50%)
Surgery	39 (71%)
Trauma & Orthopaedics	3 (13%)
Critical Care	25 (31%)
Obstetrics & Gynaecology	3 (100%)

Themes identified from these reviews are set out in Table 4.

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

Hospital Acquired Infections	Communication with families
End of Life and Palliative Care Decisions	Multiple Ward moves during hospital stay
Documentation of clinical care	Access to community and social care facilities out of hours
Primary diagnosis on admission not recorded in notes accurately	Falls assessment and management

Table 5: Avoidability scores on reviews

Avoidability score	Numbers meeting criteria for score
1 Definitely avoidable	0
2 Strong evidence of avoidability	0
3 Probably avoidable > 50:50	0
4 Possibly avoidable but not very likely < 50:50	7
5 Slight evidence of avoidability	12
6 Definitely not avoidable	589

There were several changes made to the Learning from Deaths Process in 2020/2021 to help improve the learning and dissemination of learning from deaths. In addition to renewing the policy and terms of reference, several structural changes to the Forum were made in line with the Trusts' management structure. The Medical Examiners' office saw an expansion of its staff to help support not only the bereavement process for families but also improve on the screening of deaths (100% screening of deaths), timely issue of death certificates (average of 1.5 days), appropriate coroners' referrals, and increased request for clinician review of deaths through SJR to identify learning from these reviews. The Forum also ensured that there was triangulation of learning by including incidents, patient complaints (and compliments) and reviews from learning difficulties forums, all of which improved the learning process.

We will continue to promote shared learning across the health and social care economy and to collaborate in any investigations where required.

13. MEDICAL EXAMINER (ME)

During 2020, the independent Medical Examiner Service has become fully embedded as part of normal process at QEH. The Service has a dedicated office space and the appointment of medical examiner officers has improved the day to day operations of the office. Since June 2020, the service has delivered independent scrutiny of all in-hospital deaths at QEH.

All referrals to the Coroner are reviewed and discussed prior to submission and, increasingly, the service is able to contact families of the deceased to discuss the cause of death and any concerns they may have about care delivered at the Trust. Concerns identified are reported through the Structured Judgement Review (SJR) process. Where themes are identified, they are escalated to the relevant Trust team to request assurance that these are investigated and managed appropriately. The Service regularly sends feedback to divisional teams showing compliments, as well as concerns, from families about the quality of our care and services.

Activity data below shows the number of cases scrutinised, referrals to the Coroner and number of concerns raised by the ME service (requests for structured judgement review).

Activity of cases scrutinised

	Month	Total deaths in QEH	Cases reviewed by ME	%	Coroner referrals	Structured Judgement Review requested by ME
Quarter one	April	173	88	51	9	0
	May	119	94	79	9	2
	June	78	78	100	10	9
Quarter two	July	83	83	100	6	5
	August	101	101	100	16	12
	September	73	73	100	9	7
Quarter three	October	83	83	100	14	15
	November	105	105	100	5	19
	December	143	143	100	6	36
Quarter four	January	227	227	100	15	62
	February	137	137	100	8	32
	March	103	103	100	9	16

Plans for 2021/22 include:

- Working with regional and national partners to develop a model for the Medical Examiner Service to include the scrutiny of community deaths
- Work with the Trust to develop further the Learning from Deaths programme
- Fully embed the processes in readiness for the time when this becomes a statutory requirement
- Develop service resilience to ensure we can meet all patient group requirements, particularly where cultural or faith requirements need prompt release of the deceased into the care of their family

14. REDUCING HOSPITAL-ACQUIRED VENOUS THROMBOEMBOLISM (VTE)

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, hypercoagulable state due to accompanying illness such as infection, inflammation, dehydration and post-operative period all of which increase the coagulable state of the blood. Each year 25,000 people die from hospital-acquired VTE. It is a preventable condition and, hence, there is an expectation that appropriate measures are taken to avoid VTE in hospitalised patients.

There is a target of 97.24% that all inpatient admissions are screened for VTE risk and that appropriate treatments are prescribed 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 is 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 patient receiving a daily injection of blood thinning agent (anti-coagulant)and usually the use 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, worsen the circulation of feet when tight TED stockings are worn. All patients, therefore, need to undergo a 3-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

14.1 VTE monitoring

After discharge of the patient every set of case notes is checked and coded to determine whether the VTE assessment has been completed and documented in the notes. 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), whether the risk assessment was reviewed by a consultant, whether the prophylaxis was then prescribed, if indicated, and whether the prophylaxis was then administered appropriately.

14.2 Analysis

Previously, the Trust was meeting the VTE assessment target and we compared favourably to other trusts but since September 2019 compliance started to fall bringing the annual score in 2019/20 below the national target for the first time in six years. More detailed analysis confirmed that practice had become inconsistent between different teams and clinical areas, with some continuing to achieve 100% every month.

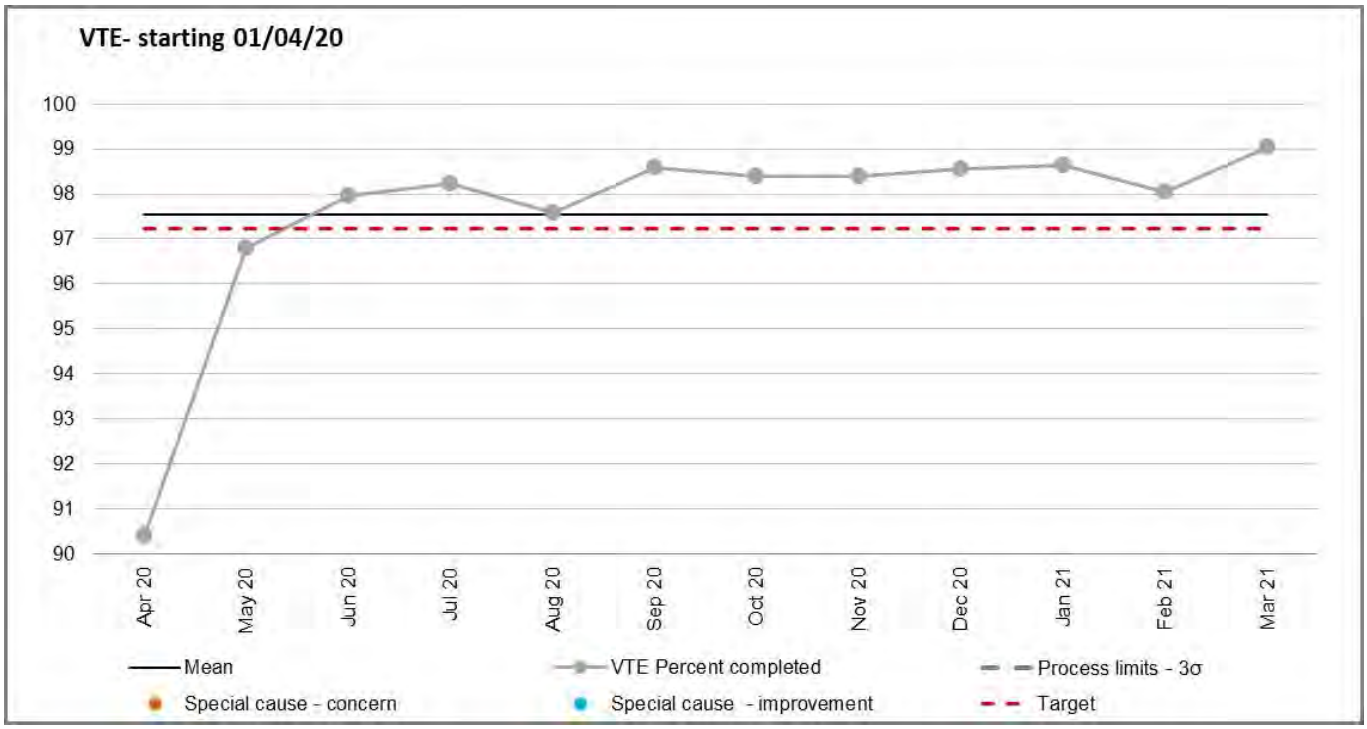
In a bid to ensure the target for assessments is met, a multidisciplinary action plan was developed to improve performance. This included a trajectory to achieve the target agreed for the end of April 2020. Measures introduced to improve the number of assessments undertaken to reach the target include:

- Regular awareness sessions at induction of junior doctors
- Mandatory E-learning compliance
- Monthly medical documentation audit done by junior doctors
- Patient case studies on hospital-acquired thrombosis presented at learning events
- A 'forcing function' within electronic prescribing that will ensure screening for VTE is not overlooked has been developed and will be rolled out from April 2021
- Trust guidance on VTE prevention and management has been updated in line with NICE guidance and 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 use of newer generation of anticoagulants (DOAC-Directly acting Anti Coagulants) to help minimise variations in practice

These actions have contributed to safe practice whilst assessing patients for screening risk and are ongoing to ensure that improved performance is sustained.

Since the measures were implemented there has been a marked improvement in the number of VTE assessments undertaken with the biggest improvement from April to May 2020. Since June 2020 the number of VTE assessments has consistently been above the target of 97.24% with the largest number 99% in March 2021.

This sustained performance has been a landmark achievement in the Trust's quest for quality improvement and provide safe, effective and affordable care for its patients.



15. 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 health care 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 doesn't 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.

All organisations that have access to NHS patient data and systems must use the DSPT to provide assurance that they are practising good data security and that personal information is handled correctly. The DSPT also provides organisations with a way to report security incidents and data breaches.

The DSPT is an annual assessment and as data security standards evolve, the requirements of the Toolkit are reviewed and updated to ensure they are aligned with current best practice. Organisations with access to NHS patient data must therefore review and submit their DSPT assessment in each financial year before the 31 March deadline.

However, NHSX recognises that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response and has therefore taken the decision to push back the final deadline for DSPT submissions for 2020/21 to 30 June 2021.

16. 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 The percentage of patients readmitted to hospital within 28-days of being discharged				
	Reporting period	**QEHKL Score**	**National average**	**Highest score**	**Lowest score**
Percentage of patients aged	2014/15	10.48%	8.40%	N/A	N/A
(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
and	2014/15	8.02%	8.00%	N/A	N/A
(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	9.09%	9.28%	N/A	N/A

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

17. PROGRESS AGAINST PRIORITIES FOR 2020/21

	Strategic Objective	Action	Outcome measure
1	To consistently provide safe and compassionate care for our patients and their families	**Reducing complaints, specifically in relation to staff manner and attitude by 50%**	Quarterly target = 4 Quarter four performance = 18 The number of complaints in relation to staff manner and attitude is above target for Quarter Four. These are broken down into the following two sub-themes: • 13 complaints relate to staff attitude; and • 5 complaints relate to staff manner while delivering care. The themes of staff attitude have been shared with Medical, Nursing and AHP staff with a focus on ensuring kindness and compassion in conversations with our patients. The Associate Medical Director for Professional Practice was appointed in February 2021 and is meeting with medical staff where attitude has been raised, Heads of Nursing and AHPs are meeting with nursing, AHP staff.
		Improving learning from incidents to share learning when we get things wrong for our patients by:	
		• The timely investigation of and closure of serious incidents in line with the NHS serious Incident Framework	The average number of working days to submit a Significant Investigation (SI) and for closure by the Clinical Commissioning Group (CCG) for Quarter three is as follows: • Quarter one = 103 • Quarter two = 92 • Quarter three = 85 • Quarter four = 107 There has been an increase in the number of working days to complete and ratify serious incident investigations. SI investigation delays are now monitored monthly at the Quality Committee. The CCG continue to ratify and close submitted SI investigations within 20 working days, with performance in Quarter four averaging 19 working days.
		• Increase in reporting of all patient safety incidents in line with the best Trusts in our peer group	NHSI/E have communicated that the Official Statistics publishing schedule from the NRLS is changing with reports now being published once a year rather than every six months. The next publication is due in September 2021. The total patient safety incident reporting rates for 2020/21 was 7,640 excluding the number of pressure ulcers reported on admission. This is a 9% increase in reporting from the financial year 2019/2020 and includes noted decreases in moderate harm incidents. These are both positive indicators of an open culture where staff can raise their safety concerns. Safety incidents resulting in severe harm or death also reduced to 22 incidents, a 25% decrease from the previous year.

	Strategic Objective	Action	Outcome measure
			A wide variation in monthly patient safety incident reporting occurred within the financial year with incident reporting rates per month ranging from 408 in April 2020 to 786 in August 2020. The variation is thought to have occurred due to the Trusts ongoing response to the pandemic. NHSI/E recommends that the Trusts reports safety incidents via the National Reporting and Learning System (NRLS) monthly as a minimum which we continue to do. The Trust is continuing its focus to promote 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. The number of incidents reported used to be benchmarked nationally across other similar trusts for comparison. For 2021/22, the Trust will use the Model Hospital list of similar 'peer' trusts and will benchmark ourselves against these trusts quarterly to increase context and understanding of the progress made against this KPI.
		Further improving End of Life care by:	
		• Fast-tracking patients to their preferred place of care	The Palliative Team are in daily conversation with the Discharge Team regarding all their patients. The main reason for delay is that there is lack of provision outside of the Hospital to provide care, and it is increasingly difficult to place patients in their PPOC. This delay means some deteriorating patients may RIP prior to completion of discharge. With the hospital being on the border of 3 CCGs, this makes the discharge journey even more difficult, with different criteria, paperwork and availability in each area. We have improved our communication and integrated working over the last four weeks; and now have the discharge team linked into our Palliative Team daily huddle, where we discuss patients. There is also representation from the Palliative Team at the LOS weekly meetings.
		• Documenting ReSPECT	Improvements to the ReSPECT process are currently being reviewed and monitored, led by the Lead Resuscitation Officer and the Clinical Lead for deteriorating patients, and overseen by the Recognise and Respond Forum (R&R). The R&R will oversee the planned relaunch of training and strategy around ReSPECT version 3. A key deliverable of this will be a focus on the quality of ReSPECT forms which are completed, to ensure 100% completion (especially around the Mental Capacity Act) by regular monthly audits of all ward areas.
		• Compliance with the overall completion of the RESPECT form	Quarter four target = 100% Quarter four compliance = 66% Quarter four target = 75% Quarter four performance = 41.7%
		• Ensuring that 75% of patients with an expected death to have a completed individualised plan of care in place	The Palliative Care team have focussed on taking action to ensure they are aware of all admitted patients who are near end of life. The actions they have taken are: • to receive a daily list following all ward rounds of any new patients identified as being at end of life • conducting a daily review of all ward white boards

	Strategic Objective	Action	Outcome measure
			• created a specialist register so that they are notified if any patient who is nearing end of life is re-admitted • receiving notifications or all fast-track patients • to work with an education lead to increase knowledge of the services and support available to patients nearing end of life within all nurses All patients who the team are made aware of will be visited and assessed by a member of the multi-disciplinary team and will be support with an individualised plan of care (IPOC). The March mortality data has been reviewed, and identified that 70% of deaths were 'expected', and of these 62% had an IPOC in place and 41% had a documented review by the palliative care team in the record (baseline when this work started was 8%, and the national comparison is 36%).
		• Delivering a 50% reduction in unexpected hospital cardiac arrests	Quarter four target = 8 Quarter four performance = 4 The number of Cardiac arrests are now being reported a month in arrears to allow time to fully process coding data in order to reduce retrospective validation of figures. In February there were four cardiac arrests, within expected limits, with the expected upper threshold not being breached since August 2019. All cardiac arrests are subject to reviews for learning. This process enables us to scrutinise whether any of these might have been avoidable – for example by earlier escalation to prevent deterioration in an unstable patient, or by earlier recognition and discussion of end of life wishes with the patient. Findings are shared with the clinical teams and reported to the Learning from Deaths Forum The Recognise and Respond Forum (R&R) manage this metric, tracking its progress and initiating any changes required to prevent inpatient cardiac arrests. As part of this regular monitoring and review, the R&R is overseeing a planned relaunch of training, strategy and full compliance with version 3 of the ReSPECT form
		Further reducing patient harms, including:	
		• 50% reduction in incidents associated with the prescribing and administration of anticoagulants	Quarter four target = 10 Quarter four performance = 21 The Hospital Thrombosis Committee review all reported incidents of Hospital Acquired Thrombosis, monitoring any bleeding or Thrombotic complications. The number of incidents decreased by 25% and are expected to reduce further due to increased scrutiny at the Hospital Thrombosis Committee. In the committee, there are ongoing discussions about the prescribing and administration processes and about how to make improvements.
		• 50% reduction in the number of incidents of harm associated with the administration and prescribing of insulin	Quarter four target = 3 Quarter four performance = 8 The steering group, chaired by the Deputy Medical Director, to drive improvements in this measure, continues to meet fortnightly.

	Strategic Objective	Action	Outcome measure
			There is an increased number of incidents being recorded but from these incidents there is a reduced level of harm with patients involved. An e-Learning package to support staff has been rolled out on ESR to raise awareness of risks. The system is tracking compliance with this training, and the group are targeting 100% compliance by December 2021. The Diabetes Link Nurse training is ongoing with the next study day on 19 May 2021. Part of the role of these link nurses will be to enable awareness of risk strategy throughout other staff. The steering group consider that there is good progress on delivering their strategy, and this will continue as work progresses further.
		• A reduction of pressure ulcers with lapses in care by 15%	Quarter four target = 5 Quarter four performance = 8 The Quarter Four target of 15 % reduction in pressure ulcers with lapses in care was not achieved. The Trust has seen an increase in the number of pressure ulcers during January 2021- the peak of the Wave 2 COVID-19 pandemic which was a similar trend seen during the peak in Wave 1. The reported number of pressure ulcers decreased during February 2021 and March 2021. The increase in January 2021 is in line with the national trend and there is also emerging evidence to suggest that COVID-19 can cause a restriction in blood supply to tissues, causing a shortage of oxygen that is needed to keep tissue alive which is almost identical in presentation to pressure damage. The Tissue Viability team continue to support areas where lapses in care were identified and will be delivering joint educational refresher training with external Clinical Nurse Advisors on moisture associated skin damage which is a precursor to pressure ulcer. This is planned in May 2021.
		• A reduction in the total number of falls by 15%	Quarter four target = 142 Quarter four performance = 205 Although the number of falls is over target, the Trust's 'falls rate per 1,000 bed days' remains below the national average rate of 6.63 and the 'consequence of fall, moderate and above' also remains below the national average rate of 0.90 at 0.38. Quarter Four demonstrates a reduction in the number of falls compared to Quarter Three but has not achieved the target of 15% reduction. January 2021 was the peak of Wave 2 COVID-19 pandemic when the Trust reported 85 incidents relating to falls. At the end of March 2021, the number of falls is starting to decrease. The Chief Nurse met the Heads of Nursing and Matrons on 18 February 2021 to clarify the expectations in the prevention and management of falls. A deep dive presentation on falls management on 2 March 2021 identified several actions that are being monitored via the nursing and AHP falls task and finish group. In addition, 11 staff will be attending the National Falls summit during April 2021 to learn and implement best practice in falls management. The Trust's 'falls rate per 1,000 bed days' remains below the national average rate of 6.63 and the 'consequence of fall, moderate and above' also remains below the national average rate of 0.90 at 0.38.

	Strategic Objective	Action	Outcome measure
		Reducing avoidable delays for patients:	
		• Reduce ambulance handover delays > one hour to 0	Quarter four target = 145 Quarter four performance = 201
		• No patients to be waiting > six hours in ED for emergency admission	Quarter four target = 173 Quarter four performance = 250 There has been a reduction in the number of delays to ambulance handovers and numbers of patients waiting in ED with performance in March 2021 at the lowest level of delay since July 2020. Many of the patients who were delayed in Quarter Four were due to issues with patient flow associated with a reduction in COVID patients and the movement or Red wards back to Amber as wards were decanted and deep cleaned. Work to deliver SAFER and 7/7 cover will assist patient flow throughout the hospital and is expected to decongest ED by allowing for faster interventions and improved admission rates.
		• Achieve the national DToC standard of 3.5%	Quarter four target = 3.5% Quarter four performance = 0% Quarter Two 2021/22, however work is ongoing to ensure this is accurately monitored internally to support reviews of stranded and super stranded patients. We continue to monitor all metrics relating to patient discharge including length of stay / stranded patients and reasons for delays with completion of daily point prevalence. This supports the internal transformation work which is underway and enables visibility of delays to facilitate required escalation as needed.
		• No patients to breach 52 weeks (18-week RTT)	Quarter four target = 0 Quarter four performance = 1,412 The Trust is working across the Integrated Care System (ICS) on delivering a new planned care improvement programme. This work will ensure a consistent approach to addressing waiting list backlogs across all providers to meet improvement trajectories. Due to operational pressures, many elective procedures were cancelled to enable resources to be prioritised at those in greatest clinical need. Work on a recovery plan for all services across the Trust will target all services achieving a minimum of 85% of the activity they delivered in 2019/20 by July 2021. As part of this recovery, Day Surgery is planned to reopen 17 May 2021. All patients waiting to be seen continue to be managed in line with the Trust's Patient Access Policy. Work is underway across the Integrated Care System to look at management of patient pathways across Providers led by the Elective Recovery Cell in order to ensure that we are managing our longest waiting patients collectively in line with the agreed clinical prioritisation requirements.

	Strategic Objective	Action	Outcome measure
		Reducing mortality by:	
		• Implementation of SAFER	A senior all patient review is in place but being redesigned in line with emergency care pathways to decongest the emergency department. This will enable the creation of a blended assessment unit, and with the addition of a specialist bed modelling tool will assist with admissions and patient flow. A review process is underway for all stranded and super stranded patients throughout the Trust, supported by the Discharge Services Team.
		• Delivery of 7/7 Consultant care	Work is progressing to deliver 7/7 consultant cover and is currently aiming to achieve over 90% compliance. Consultant models of care are being created to ensure job plans are aligned to services provided by the Trust and will ensure the highest possible compliance with 7/7 and SAFER. This work has been supported by a redesign of junior doctor rotas during the pandemic, with plans to maintain the positive aspects of this co-designed rota.
		• Delivery of Electronic-Observations (E-Obs)	The e-Observations Board have completed work on agreeing a list of functional specification requirements. Work has commenced to ascertain the requirements for medical device integration with an e-Observations solution and an assessment of mobile devices required for the implementation in all clinical areas. NNUH is in the process of introducing E-Obs through one provider (Web-V) and JPUH in introducing E-Obs with another (TPP). Both are being considered for implementation within the Trust, with a business case expected to be approved by QEH Summer 2021.
		• Documentation audit	Good progress has been made with auditing the quality of documentation within the Health records. With stable processes established in medicine, plans to expand further into other sub-specialties are in place. Key findings from the audits completed highlight four areas requiring significant improvements: • Mental Capacity Assessment • Dementia Screening • Dating and timing of entry; and • Signature/stamp readily identifiable From April 2021, findings from audits will be presented to Divisional teams. They will then be expected to provide assurance, through an action plan, on improving the quality of documentation. The nursing documentation audit process was delayed due to amendments required in the contents of audit. This has now been agreed and is expected to provide continuous reports through Perfect Ward audits. In addition, further regular deep dive audit plans are in place for 5 critical areas in nursing documentation. This will be reported through the Multidisciplinary Documentation Forum from June 2021. Review and rationalisation processes are underway in the printed documents in healthcare records. Once completed it is expected that full detailed review of these documents will be undertaken in readiness for implementing electronic patient records.

	Strategic Objective	Action	Outcome measure
		• Delivery of NEWs	**Training** Online training for the National Early Warning Score (NEWS2) continues to be delivered online by the Royal College of Physicians. The training is monitored through the Electronic Staff Record (ESR) system and monthly reports of attendance are generated. As of 28th February 2021, 62.4% of staff required to complete NEWS2 training have completed their online training (total of 1,615 staff members). The deteriorating patient leads are working with mandatory training to focus on appropriate staff that need to complete the NEWS2 training – currently some staff are mandated in the target data but actually do not need to complete the training as NEWS2 has little relevance to their role. This is pulling the overall compliance data down. The next part of this exercise is to map to ESR, meaning the NEWS2 training package will be included on the individual's training section to highlight that it needs to be completed. Ultimately this should result in higher, and more appropriate training compliance. **Delivery** New audit questions integrated into perfect ward have been developed and should be live by May 2021.
5	Supporting our patients to improve health and clinical outcomes	**Help our patients to stop smoking.** Targeting stop smoking programmes for those most in need, implementing the STP tobacco control strategies, including becoming a smoke free site. We will develop additional stop smoking support for people admitted to hospital All NHS Trusts in Norfolk have committed to being smoke free, having a named champion at Board level, a named staff lead and have signed the NHS Smoke Free pledge	All patients are screened for smoking on admission to hospital and given written advice on smoking cessation on discharge from hospital. Further developments are being considered on: • ensuring all identified smokers are considered for nicotine replacement therapy during their stay • offering all staff who smoke support and help to quit; and • discharge processes to ensure that all patients can be directed to stop smoking support A Board level champion is in place for the implementation of the NHS Smoke-Free pledge. Plans to implement a smoke-free environment have been delayed in view of COVID-19.
		Promote healthy ageing. In partnership, promoting a positive view of ageing, encouraging continued activity, healthy eating, encouraging a health approach to alcohol, volunteering and physical activity	All patients are screened for alcohol consumption on admission to hospital and given written advice on healthy levels on discharge from hospital. We are also working closely with system partners to encourage exercise, healthy eating and volunteering. The Trust is in the process of implementing specific menopause training for staff.
		Improve cancer screening rates. Increasing cervical and breast cancer screening across the whole of Norfolk and Waveney, and reduce inequalities in cancer screening uptake in hard to reach groups	Breast and cervical screening have both restarted following the pandemic, with 100% patients in the screening backlog now seen and screened. The Trust will be participating in work in partnership across the ICS looking at health inequalities. Patients will be reviewed with an initial health inequalities impact assessment. The purpose of this work is to determine which groups are having difficult accessing screening and researching what are the obstacles that they are facing. When complete, these findings will be used to drive improvement plans to reduce inequalities and improve overall cancer screening rates.

Strategic Objective	Action	Outcome measure
	Helping cancer survivors to reduce their risk of recurrence. Reducing the risks of getting cancer by promoting healthy living and offering cancer patients tailored advice on healthy lifestyles to support their recovery and reduce the risk of their cancer coming back.	To help patients reduce the risk of recurrence, the Breast Cancer CNS Team conduct a support clinic and specifically discuss this with patients post treatment. Helping patients living with and beyond their cancer diagnosis, is key to personalised care. All patients are offered a holistic needs assessments (HNA) at diagnosis and this is reviewed at key points throughout their treatment. Patients can also initiate these themselves by requesting a HNA at any point. Following an HNA, a patient can be sign posted to appropriate services such as benefits advice, referral to clinical psychology or a referral for gentle exercise. The new Cancer Wellbeing and Support Centre is on track to open April 2021. The team are currently developing a work programme to support patients directly from the hub. Due to COVID restrictions this implementation will be phased. Services being considered are anxiety management, menopause support, counselling, general nutritional advice, physical activity with initial assessment and gentle exercise, support services, Look Good Feel Better and the HOPE programme. These services will deliver improvements in patient experience and outcomes following cancer.
	Support mental health and well-being. Collaborative working to develop and embed mental health prevention and well-being.	Collaborative work between NSFT and QEH continues to ensure better patient outcomes. Both Trusts are supporting an improvement plan that will look to enhance awareness and importance of mental health and wellbeing with staff. There is a key focus on education to help prevention and improve wellbeing, with a goal to deliver enhanced care for those patients who will benefit from increased support and intervention.
	Improve self-care for people with diabetes. Working collaboratively with partners, we will support patients with diabetes by enabling diagnosis, self-care and optimised management through the implementation of the system's diabetes strategy.	The Trust continues to support work with ICS partners to improve self-care for people with diabetes through the system's diabetes strategy.
	Improve quality of care for pregnant women. Focusing on the delivery of agreed improvements to the maternity care pathway, including 35% of women being booked onto defined Continuity of Carer pathway by March 2020, and ensuring that we meet the Clinical Negligence Scheme for Trusts (CNST) requirements from 2020/21 onwards.	The Division has launched our Women & Children 5 Year Strategy 2021-2026, setting out the vision and aims for the services including maternity, aligned with the Trust's strategy of Quality, Engagement and Healthy Lives. The Trust has a Maternity Improvement Plan in place, to address the recommendations of multiple local, external and national reviews. 50% of the actions are currently complete, although this plan is anticipated to continually evolve in response to ongoing recommendations to improve safety and outcomes for mothers and babies and strengthen our culture within the service. Actions following the Ockenden Report have been included in the Maternity Improvement Plan to ensure all Immediate and Essential Actions (IEA) are complete. The Trust is also on track to fully implement the Saving Babies Lives Care Bundle, with just some guideline adjustments requiring ratification at this time. The Maternity Bereavement Suite project is also progressing well, to support our families at this most difficult time. There is a strong service user voice to ensure there is real co-production of this new facility. Following a public vote with over 2500 responses, the suite was named The Butterfly Suite.

	Strategic Objective	Action	Outcome measure
			In order to implement the Continuity of Carer pathway, the Trust needs to consult with staff. A staff consultation paper has been prepared and will be discussed with trade unions on 30 April. Following these discussions and a 45-day consultation, the Trust is aiming to commence this pathway across three teams by the end July 2021. This will enable 35% of women to be booked into this pathway after this time. As at end March 2021, eight out of the ten safety actions had no identified concerns to suggest the Trust would not achieve the Clinical Negligence Scheme for Trusts (CNST) by the end July 2021. The following action is being taken in the remaining areas to: • mitigate staffing levels in regard to minimising risk of red flags for maternity • develop guidelines to support compliance with the care and treatment element of Saving Babies Lives' and • improve the accuracy or recording on Badgernet to provide supporting evidence to demonstrate compliance with all five elements of Saving Babies Lives'
		Provide alternatives to emergency admission for patients with chronic lung conditions. Working with partners, we will deliver a 25% reduction in volumes of Emergency Department attends and non-elective admissions where asthma and Chronic Obstructive Pulmonary Disease (COPD) is the primary diagnosis by delivery of appropriate pathways of care in the community.	Quarter four target = 287 Quarter four performance = 216
		Improve our patients access to the very best stroke services. For patients suffering from a stroke, ensure that 90% of those patients who are admitted to the stroke unit have this done within four hours by 2021.	Quarter four target = 90% Quarter four performance = 24.56% QEH is implementing the National Stroke Strategy. The implications caused by COVID are holding up progress. Despite this, overall stroke performance remains SSNAP A-rated, with excellent performance in Therapy related metrics and Thrombolysis. However, direct admission to the stroke unit within 4-hours has proved extremely challenging. A recovery and restoration plan is in place to ensure performance improves.
		Improve access to research and clinical trials for our patients. Achieving a 10% increase in patient recruitment into research trials.	Year one target = 755 738 patients were recruited to clinical trials in quarter four, bringing the total number to 2,086 YTD. This is a 176% increase from 2019/20.

18. QUALITY PRIORITIES FOR 2021/22

As we move to 2021/22 we will be focussing on the delivery of our Corporate Strategy within which we have agreed a number of indicators to support delivery of our quality priorities. These are set out below:

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

- Moving out of CQC 'special measures' and be rated as CQC 'Good'
- Focus on patient experience, including complaints. Consistently providing timely, high quality responses to patients and their families and sharing learning
- Reducing patient harm and learning from incidents
- Improving in all areas of the National Patient Survey
- Delivering the agreed improvements to maternity care in line with the independent review of maternity services at the Shrewsbury and Telford NHS Trust
- Ensuring patients receive timely access to care and treatment

To further strengthen our Better Hospital Team (Project Management Team) to support quality improvements across the Trust, specifically responding to the 'must' and 'should do' actions in our 2020 CQC Inspection Report

- To move the focus of the Better Hospital Team from compliance to improvement

Improvement priorities for 2021/22 will include:

- Urgent and Emergency Care (front door/site management, ward processes, discharge)
- Planned care restoration (post-COVD pandemic) and improvement
- Delivery of the Integrated Quality Improvement Programme (IQIP) - including: End of Life care and DNACPR
- Modernisation of HR functions (including mandatory training and appraisals)
- Maternity review and action plan
- Continuation of Cost Improvement Programme - led by the Director of Finance
- Oversight of the HIP/RAAC and Estates Strategy work progress and governance, including completion of a strategic outline case for a new hospital

To focus on patient experience, including complaints. Consistently ensuring timely and quality responses to patients and their families and share learning when we fall short

- To reduce the number of re-opened complaints by 10% on a baseline figure at March 2021
- To record 10% fewer complaints per 1,000 bed-days
- To respond to complaints in a timely manner, in line with national reporting requirements
- To embed learning via the Divisional learning cycle (Patient Experience Team reporting)

Reducing patient harm

- To reduce 'lapses of care' (MRSA/CDiff) by 10% on a baseline figure at March 2021
- A reduction in falls by 15% (continuation of year one target - 15% reduction from year one)
- Reduction in avoidable pressure ulcers of 10% on baseline figure at March 2021

Improving learning from incidents

- Sharing learning when we get things wrong by the timely investigation and closure of serious incidents in line with the NHS Serious Incident Framework
- Timely closure of action plans following a serious incident
- Increase in reporting of all patient safety incidents (aligned with annual National Reporting and Learning System (NRLS) reporting). To be aligned with the annual staff survey response relating to a 'reduction in errors, near misses or incidents which when reported my organisation takes action to ensure they do not happen again.'

We will ensure our patients more consistently receive timely access to care and treatment

- Adherence to monitoring of the national standards (to be confirmed in light of COVID-19 recovery and the agreed national deliverables, when published.)
- Monitoring the delivery of the 4-hour emergency access standard of :
  - » No ambulance handovers at > 60 minutes
  - » 0 patients in ED for more than 12 hours
  - » Reduction in the number of patients waiting in the Emergency Department > 12 hours for a mental health bed (end of March 2021 baseline to be used)
- Cancer services: no patients waiting over 104 days for treatment
- An Incremental reduction in 52-week waiting time breaches
- Incremental reduction in the backlog of patients waiting > 6 weeks for diagnostic tests

Improvements in all areas of the National Inpatient Survey

- Improvement on feedback from National Inpatient Survey published in July 2020

Recovery and restoration of planned care post COVID-19

- Adherence to the agreed national delivery requirements for COVID-19 recovery for planned care (aligned to delivery of the agreed Better Hospital Team priority).

Delivery of agreed improvements to maternity care in line with the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust

- Achieve compliance with the 12 clinical priorities outlined in the Independent Review
- Expansion of the midwifery staffing establishment in (to meet the requirements of Birthrate Plus) in line with the approved January 2021 business case approved in January 2021
- Continuity of Carer (CoC) features within the NHS Long Term Plan (LTP), which states that the majority (51%) of women should receive continuity of the person caring for them during pregnancy, birth and postnatally. At QEH our aim is to roll this same standard of care to all women (where ever possible) and ensure that we meet these KPIs for all families within our care

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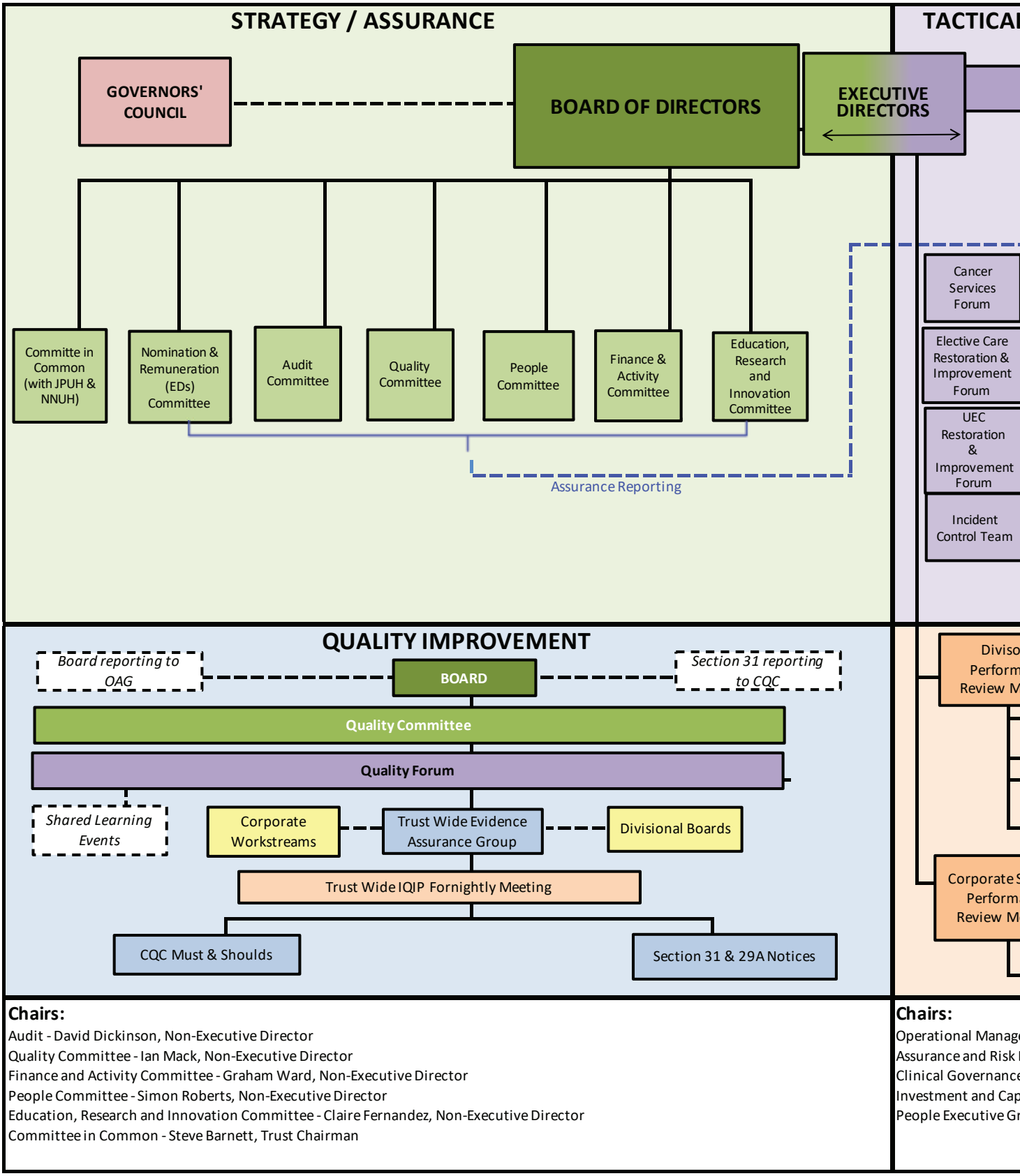
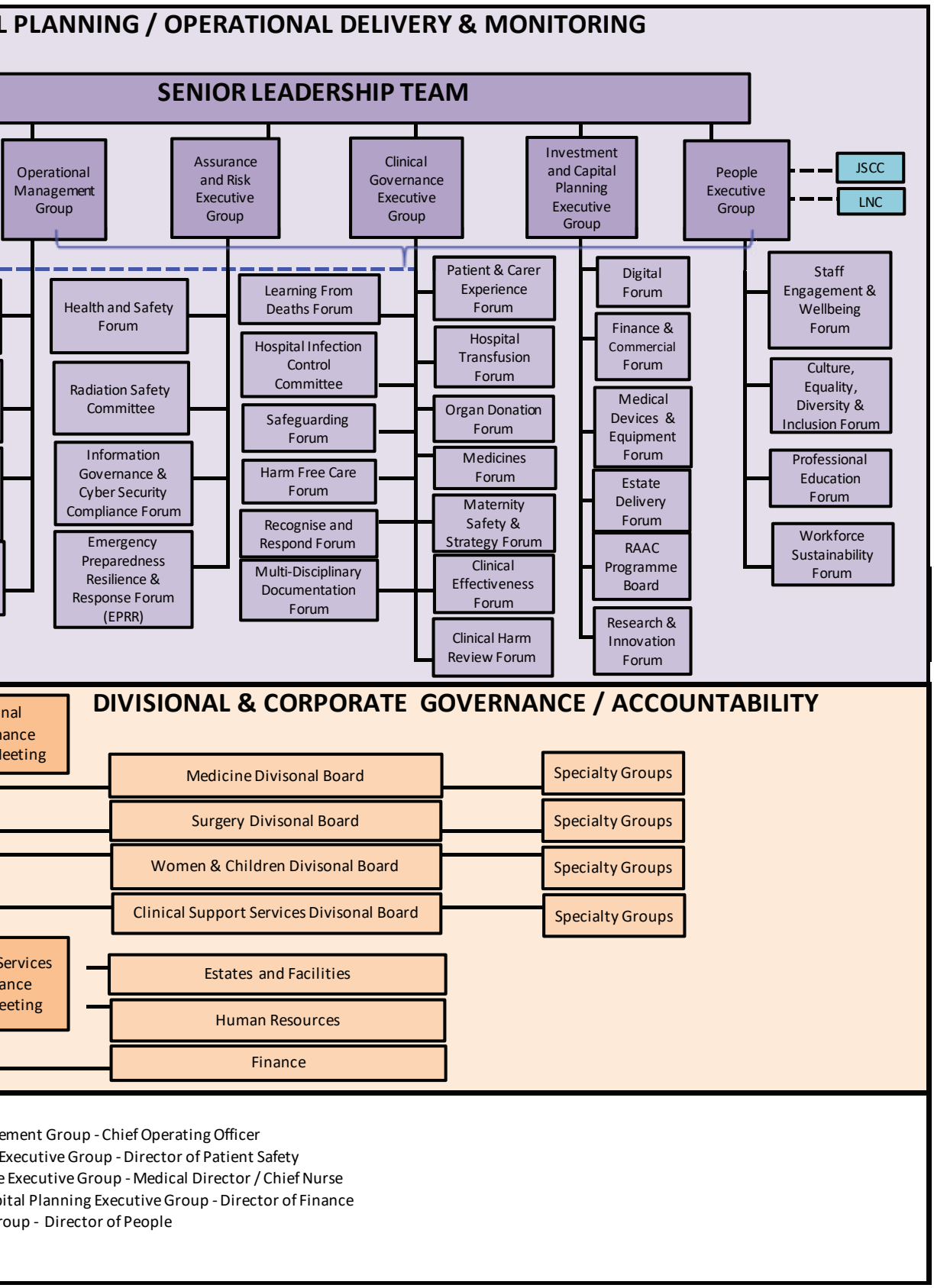
APPENDIX ONE GOVERNANCE STRUCTURE





ement Group - Chief Operating Officer
Executive Group - Director of Patient Safety
e Executive Group - Medical Director / Chief Nurse
ital Planning Executive Group - Director of Finance
roup - Director of People

APPENDIX TWO

Statement from Trust Governors

The following represents a composite of the views expressed by the Trust's Governors on the Quality Account for 2020/21.

Governors appreciate that this report has been compiled during the period in which the Trust is recovering from the COVID-19 pandemic, which has changed the way the hospital is set up and operates, in some cases for the better. It is recognised that it has been a hugely challenging year for staff, who have responded admirably to what has been a year like no other for the NHS and the Queen Elizabeth Hospital (QEH). Our thanks and appreciation are extended to every member of Team QEH for how they have responded to COVID-19 and for their dedication and commitment to delivering safe and compassionate care to our patients and their families.

The Governors have recognised that progress has been made since the 2019 Care Quality Commission inspection, as recognised in the 2020 CQC Inspection Report, which demonstrated that patient care and staff experience is improving.

The Governors, without exception, recognised that the pandemic has been well-managed as has the set-up of the vaccination centre at such short notice. High levels of vaccination rates are considered to be impressive.

Most Governors commented on the much-improved internal and stakeholder communications and that the strengthened staff engagement was making a positive difference. The work the Trust is doing to improve culture at the Trust is gathering traction and starting to make a positive difference to behaviours and teamwork.

The Governors also described their concern about the deteriorating estate but recognised the business case for the new hospital submitted in 2020 is compelling and that the lobbying and campaigning to bring a new hospital to King's Lynn and West Norfolk is gathering momentum.

The purchase of the BMI Sandringham Hospital is recognised as a significant strategic development for the Trust and one which has enabled the development of an elective treatment centre with additional beds.

However, concerns have been raised regarding how the Trust will address the backlog of elective activity that has built up during COVID. Further improvements are needed to consistently respond to complaints in a timely manner.

Some Governors expressed interest in continuing to be meaningfully engaged and involved in Trust services and development and welcomed the improvements in communications with Governors and Public Members.

Finally, a theme that was evident from a number of Governors was the need to improve communication with GPs and primary care, as the Trust focuses on leading Place-Based Care developments in West Norfolk.

Positive Governor Observations about progress in 2020/21

- Progress has been made in moving the Trust from special measures towards Good
- It is evident that much hard work and effort has been made to address the improvements required by the last CQC reports. Thanks are due to all members of staff who have a determination to lift the hospital out of special measures
- Communication to all stakeholders is excellent. In the main, topics are discussed in plain language with minimum use of acronyms or medical jargon which is helpful for members of the public
- Governors recognise the excellent work that has been achieved in Research and Development
- Times are changing and the new organisational structure will need full medical engagement, so the improvement in medical engagement is welcome
- The pandemic has been well managed and vaccination rates are high
- The business case for a new hospital is robust and gaining traction
- A newly appointed Staff Governor confirmed that the Trust has made great progress with instilling the Trust values and behaviours amongst staff
- The Leadership Summit in March 2021 and the workshops which have been run in conjunction with A Kind Life have put the Trust firmly on a journey of culture improvement, which will benefit staff and patients
- A new staff Governor comments that greater staff involvement ensures that they feel valued, consulted and involved
- Patient experience within Cancer Services appears greatly improved as regards access to information and specialist nurses and will be further enhanced with the opening of the Cancer Wellness and Support Centre
- The huge challenge of the pandemic, the flexibility to make the changes in service and the high level of communication with the staff during the pandemic is all very impressive
- Governors acknowledged that changing a culture is difficult to achieve but have confidence that the current approach should be successful
- The information which now passes from the hospital senior management team on a regular basis to the Council of Governors, Members and the community was a huge comfort during the pandemic
- The Leadership Summit organised in March 2021 was outstanding with interesting speakers and lots to take away for consideration
- Vaccination centre - very well run, everyone played their part. Security managed parking and the smooth running of appointments politely and were aware of people who needed help
- Purchase of the private BMI Sandringham Hospital and its opening within four weeks was very impressive
- Impressed that senior management see a significant increase in the number of 'speak up' referrals in 2020/21 compared to the previous year, as positive
- The Staff Engagement Programme to improve culture is important and will contribute to better staff and patient experience
- The Executive team has continued to identify themes from incidents, analyse causes and ensure that learning is embedded.
- Duty of Candour: Governors applaud the Trust's decision to contact all patients and the families of deceased patients who may have acquired COVID-19 while in the care of the QEH

- Governors welcome the move to online mandatory training in the expectation that this will enable staff to remain compliant
- The Trust now has an effective, substantive Board which demonstrates high quality leadership

Areas for improvement identified by Governors as we look to 2021/22

- The Governors acknowledge that the Trust has a significant waiting list for elective surgery, as is the case across the wider NHS
- The Governors are aware of the problems in Radiology and are hopeful that the action plans are successful
- The Governors are aware that the hospital needs new MRI Scanners
- Increased communication with the public regarding the ICS and the Provider Collaborative
- Governors hope to see a reduction in complaints citing poor communication and poor staff attitude
- Governors would like to see more examples of best practice with dementia patients
- Continue to employ best practice, as developed during the pandemic, for example, the appropriate use of video/phone calls in lieu of face-to-face outpatient appointments
- Progressing the site development plan with a fully integrated estates strategy with the ambition to achieve a new build hospital
- Using the Governors' skill sets to add input into quality decision making, rather than just to rubber stamp decisions already made
- Progressing the ongoing digitisation of the hospital
- Embedding learning from incidents to improve the patient experience
- Governors seek to have better engagement with General Practitioners, Primary Care and Healthcare Professionals across West Norfolk, South Lincolnshire and North Cambridgeshire
- Ensure complaints are dealt with in a timely manner
- Better visitor experience required as restrictions ease
- Discharge arrangements, particularly around transport and medication require continued vigilance
- Whilst improvements have been made to End of Life Care, there is work still to be done

The Governors acknowledge the Quality priorities for 2021/22

We look forward to continuing our support for the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in becoming the best rural District General Hospital for patient and staff experience

APPENDIX THREE

Healthwatch Norfolk Statement

Healthwatch Norfolk is pleased to have the opportunity to comment on the Queen Elizabeth Hospital, King's Lynn Quality Report for 2020-2021

This year's document is designed to be standalone but additionally to be read alongside other publications including the Annual Report and the Corporate Strategy. Whilst it does not include comprehensive coverage, in the main it provides sufficient information for patients and members of the public to appreciate the considerable amount of progress made at the Trust in spite of the challenges posed by Covid and to understand the work which still needs to be done together the Trust's plans to further build upon the advances already achieved.

Whilst there is a great deal of focus on the steps being taken to navigate the Trust out of special measures it is very encouraging to note that although this is a key objective, there has been and is the overriding aim of going beyond this to create a sustained high quality hospital service for the population served by the Trust. It is clear that all of the improvements and objectives noted in the report are driven by this longer-term ambition rather than just being mechanisms to bring the Trust out of special measures – important as this is.

The narrative is written in clear language and is accessible for the lay reader. However, there are many technical terms and acronyms which are not always explained and also a number of charts which are very difficult to read.

There is an index and a logical structure to the report and there is an informative Executive/CEO summary at the beginning.

From this we note that whilst the Trust achieved six out of eight Cancer service targets, the 62-day wait is still not met. As we observed last year this has been a challenge for a number of year's now and whilst the report states that this will be a clear focus for the year to come, we look forward to seeing more evidence of specific actions to redress the situation.

Three introductory sections follow the summary: - Monitoring of Quality, Care Quality Commission and Integrated Quality Improvement Plan. These are not included in the index but as they are topics of particular interest to the public, it would be useful if the are given more prominence as an integral part of the report structure rather than just being inserted before the main sections.

In the summary there is some mention of waiting lists for diagnostic tests and elective surgery and no mention at all of outpatients waits. Although these are areas where there are no clear answers at the moment, they are topics of particular interest for patients and therefore more coverage would be beneficial both in the comments about 2020-2021 and in the plans for 2021-2022.

It is not specified whether the draft document is available in different formats e.g., electronic, hard copy, Braille, other languages.

The Trust's Integrated Quality Improvement Programme (IQIP) has driven the impressive amount of progress in 2020-2021. This together a well-defined governance structure gives confidence that the Trust's operations are closely monitored and assurance and risk are clearly visible throughout the organisation. A refreshed IQIP was launched in March 2021 aligned to the Trust's corporate objectives which demonstrates the clear focus on the longer-term objectives as well as addressing the immediate CQC requirements.

The section dealing with Care Quality Commission registration reports significant improvement with 13 actions outstanding from the 2020 inspection compared to 206 in total in 2019. None of the core services are rated as inadequate compared to 19 in 2019. This has been achieved during a period of extreme pressure due to the Covid pandemic compounded latterly by problems caused by the ageing fabric of the building. Healthwatch is delighted to add its congratulations for the level of achievement against such obstacles. Details are provided about each of CQC conditions on registration but these use section references which will mean nothing to the layman. Given that, in the main this is good news, a little more explanation would be useful.

The sections covering Patient Safety, Patient Experience and Staff Engagement provide more details about progress in each of the areas as well as honest details of where performance has not lived up to expectations. It is to the Trust's credit and indicative of a more focussed strategic management style that it is able to recognise where things have not gone as well as it would have wanted.

It is noteworthy that patient safety incident reporting in 2020/2021 increased by 8% from the 2019/2020 figure indicative of welcome improvements in a culture where staff feel that they can raise safety concerns.

In last year's comments we noted that the CQC had raised concerns about the Trust's ability to investigate and learn from safety incidents. We are very encouraged to see that, in 2020/2021 a comprehensive range of initiatives were implemented to ensure that learning from incidents becomes embedded in the culture and operation of the hospital. In fact, the theme of governance and robust processes to identify, learn from and act upon outcomes runs through the whole of the Trust's planning. This provided great confidence about its ability to create a sustainable high quality service.

We welcome the creation of the new Patient Safety Directorate which reinforces the focus on achieving and maintaining the best levels of safety for the hospital's patients. Significant improvements were made in responses under Duty of Candour where the rate for responding within 10 days increased from 77% in 2019/2020 to 95% in 2020/2021 with further steps being taken to achieve 100% in future. This is another area where performance had been well below target for a number of years so this latest step change is yet more good news.

Patient Experience is a major part of the Trust's strategic direction and the report dedicates 15 pages covering a wide range of actions and new initiatives to collect and analyse feedback, to identify themes and to act where necessary to bring about improvements. The results are somewhat variable over the year and it is difficult to assess just how much Covid affected patient experience. We look forward to seeing the data as more normal times return.

The Trust lists a number of examples where patient feedback from Friends & Family tests and other sources has led to improvements and it is clear that a huge amount of effort is being dedicated to listening to patients and external organisations with the outcome of these contacts being shared systematically with the Trust's staff at all levels.

A similar level of focus has been placed on staff engagement and it is very encouraging that significant progress has been achieved although as the Trust comments much remains to be done. Staff survey results have improved significantly as has the response rate

at 45% which was consistent with national levels. This is a marked improvement on the rate of 18% seen a few years ago and is recognition of the great amount of attention paid to supporting and motivating staff in a wide variety of ways whilst simultaneously bringing about a marked change in culture and learning.

The progress made in all three areas of Patient Safety, Patient Experience and Staff Engagement is impressive and is a clear sign that the Trust is well on the way to achieving its strategic objectives whilst not underestimating the magnitude of the challenges ahead.

The Trust has participated in 45 national clinical audits and has continued its active participation in clinical research. The CQC had a identified a number of actions for improvements in clinical audit which have been addressed as part of the IQIP with further actions continuing into 2021/2022. The refreshing of the IQIP gives confidence that the progress made to date across all areas will continue at pace in the coming year.

We are encouraged to note that the Trust has a structure and detailed plans in place to reduce and eliminate healthcare associated infections. These are set out in the report together with the results for 2020/2021 showing zero MRSA cases, 13 MSSA, CDiff 49 of which 21 were apportioned to the Trust with 11 under review. This would indicate that progress has been made but there is clearly more to do and the report sets out a full list of actions being taken.

The report notes that, not surprisingly, Coronavirus was a huge challenge in 2020/2021 but it is clear the Trust responded in a structured manner and also mounted a successful vaccination facility.

The Trust reports that falls increased during the year with a rise in falls resulting in major harm and in those with moderate harm. Although any increases are of concern, the effects of COVID on numbers of inpatients and staff resourcing make it impossible to draw any meaningful conclusions from the data. Work is still going ahead in Falls Prevention and Risk Management and we look forward to seeing the hospital getting back on track if and when normality returns.

A somewhat similar picture emerges in respect of Hospital Acquired Pressure Ulcers which increased slightly in 2020-2021. The trajectory across the year is variable with increases coinciding with COVID activity. Once again it would be unfair to attempt to draw conclusions but we draw a lot of reassurance from the programmes in place aimed at improving the figures.

Other sections deal with reducing avoidable mortality, the role of the independent Medical Examiner and reducing hospital acquired Venous Thromboembolism. In each of these areas much work has taken place and is still underway. It is especially encouraging to see that since changes were made sustained performance has been achieved in maintaining the number of VTE assessments above target.

The report includes 10 pages in which achievements against the priorities for 2020/21 are set out. Many of the priorities have been met but any shortfalls are clearly identified together with actions planned to bring them back on track. These action plans dovetail with the Quality Priorities for 2021/2022 which are listed very clearly in the last two pages of the main body of the report.

The Trust has achieved a remarkable amount of progress in a year dominated by the COVID pandemic. These achievements lend a great deal of credibility to its strategic priorities for 2021-2022 and beyond.

Healthwatch is delighted to continue its support in any ways it can to assist the Trust in continuing its journey of improvement.

Alex Stewart
Chief Executive

APPENDIX FOUR

Norfolk and Waveney Clinical Commissioning Group Statement

I am writing to confirm that NHS Norfolk and Waveney Clinical Commissioning Group (CCG) supports the Trust in its publication of a Quality Account 2020-2021. Having reviewed the report, we are satisfied that the Quality Account incorporates the mandated elements required, based on information available.

The CCG recognises the significant challenge the Trust has faced during the COVID-19 pandemic and the challenge of delivering safe care and services at this unprecedented time. The Trust has proactively developed adaptive ways in working to respond dynamically to deliver safe care and we commend the compassion and commitment of all staff during this time to keep patients, carers and staff connected and as safe as possible. We recognise the skill and commitment of the staff, of whom we know have gone above and beyond to deliver care to our communities and we express our gratitude to them.

The Trust has worked in collaboration with system partners and other key stakeholders as part of the emerging Integrated Care System (ICS) to strengthen and enhance integrated working practice, focussing resources where our patients need them most. We thank the Trust for your work in supporting the system wide COVID-19 vaccination programme.

The CCG recognises the challenges experienced by the Trust over the last contractual year and the impact that this has had on the organisation and commends the Trust for their resilience in progressing and performing well against their priorities. The Trust has made sound progress and demonstrable improvements with their Integrated Quality Improvement Programme (IQIP), developed following an initial inspection in 2019 by the CQC. The re-inspection of core services, published in December 2020, highlighted significant improvements and progress over the past 12 months.

Maternity continues to make good progress with services being removed from the national Maternity Safety Improvement Programme, following a number of section notices being removed to reflect that the necessary improvements in care governance and leadership had been made. We are, in addition, delighted to see to see the development of the new Maternity Bereavement Suite.

The CCG welcomed the launch of your End of Life Care strategy in July 2020, outlining your plans to deliver the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Programme to improve care for our local population.

We recognise the work the Trust has undertaken in staff engagement and culture with progress evidenced in the National Staff Survey results for 2020, which has illustrated improvement across all ten themes for the second year running. The CCG supports your priority for 2021/22 to bring your values to life across the organisation, with a strong focus on kindness, wellness and fairness.

The removal of the General Medical Council training conditions and the results from the Medical Engagement Survey, published in early 2021, demonstrates that medical engagement has improved significantly, with the Trust highlighted as one of the most improved Trusts in the East of England.

The CCG notes and supports the Trust's Quality Priorities for 2021/22 and welcomes the opportunity to work collaboratively with you to achieve your two main areas of focus, ensuring you provide safe, effective care for our patients and a positive working environment for staff, and ensuring it is delivered in accordance with all regulatory requirements. The areas of focus are outlined in your two key strategic objectives:

- To consistently provide safe and compassionate care for our patients and their families
- Modernising the QEH to support the delivery of optimal care

The CCG acknowledges the need for modernising the hospital both the estate and digital infrastructure, and is supportive of these requirements. We are pleased to note the acquisition BMI Sandringham Hospital, which provides a new 26-bed elective treatment centre for QEH.

The CCG acknowledges the impact of COVID-19 in the delivery of planned care with the deterioration in 18-week Referral to Treatment and diagnostics performance, with a significant increase in the number of patients who are waiting over 52 weeks for treatment. The CCG supports your approach to the recovery and restoration of services, including your elective programme.

Strengthened governance arrangements of the Trust Board, Sub-Committees and Divisional arrangements, including how the Trust involves Governors in Board Sub-Committees, is evident. We acknowledge the significant work undertaken by the Trust's Patient Safety Director and their team; embedding a culture of learning and continuous improvement. We welcome working with you as a fellow member of the ICS and with NHS England and NHS Improvement as we emerge as a formed ICS.

We would like to thank Trust staff for their strong leadership and hard work, underpinning continuous improvement in the quality of care delivered to the local population, and once again to thank all staff for their hard work and commitment to responding to the needs of their community.

On behalf of NHS Norfolk and Waveney CCG, I would like to personally thank you for the warm welcome we receive, for your transparency and openness, and continued hard work.

We look forward to working with you throughout the 2021/22 contracting year.

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

APPENDIX FIVE

Statement from Norfolk County Council

Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts and would like to stress this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

APPENDIX SIX

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 2020/21 supporting guidance Detailed requirements for quality reports 2020/2 along with updated requirements published by the Department of Health and Social Care in April 2021 setting out amendments to the process for 2020/21 in light of the COVID- 19 pandemic
- 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 2020 - March 2021
  - » Papers relating to quality reported to the Board over the period April 2020 - March 2021
  - » Feedback from Governors dated xxx
  - » Feedback from Healthwatch Norfolk dated xxx
  - » Feedback from Commissioners dated xxxx
  - » Feedback from Norfolk Overview and Scrutiny Committee dated xxxx
  - » The Trusts complaint's report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009 due for publication summer 2021
  - » National inpatient survey results published in July 2020
  - » National staff survey results published in March 2021
  - » CQC inspection report dated July 2019 and December 2020
- 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: XXX

Caroline Shaw CBE
Chief Executive
Date: XXX

GLOSSARY
of clinical and NHS terminology

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 done 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.

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 ahead 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 and diversity - 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. Care is co-ordinated across health and social care services.

E-observations - a digital system for recording 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) - the Getting It Right First Time (GIRFT) programme aims to bring about higher-quality care in hospitals, at lower cost, by reducing unwanted variations in services and practices

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 - the local service affiliated to Healthwatch England, the national consumer champion in health and care. They have statutory powers to ensure the voice of the consumer is strengthened and 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.

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 Improvement - is 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 Improvement/England.

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 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 and 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 care. Pathways are in place for most common diseases and conditions, using 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 - how it feels to be an inpatient or an outpatient. This includes not only the care received, but also aspects such as the hospital facilities and the patient's comfort throughout their visit.

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, and foster good relations, and publish data on progress.

Q

Quality Account - every NHS Trust is required to publish a Quality Account, setting out how we continue to improve the quality of services we provide covering 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 Innovation, Productivity and Prevention (QIPP) - a large-scale programme to drive forward quality improvements in NHS care, at the same time as making healthcare more efficient.

Quality governance framework - a set of standards for Trusts to continuously monitor themselves against.

R

Radiology - is the 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 7 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.

Sustainability and Transformation Partnership (STPs) - joint health and social care partnerships for improving the health of local people through joined-up working and the development of new models for providing services. There are 44 partnerships across England including the one for Nottingham and Nottinghamshire, which includes NUH. Now called Intergrated Care System. See ICS.

Sustainability and Transformation Fund (STF) - a national budget to support the development of NHS services, set up in 2015. It is allocated to hospitals based on their achievement of a number of specific targets. Now called Provider and Sustainability fund. See Provider Sustainability Fund.

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, 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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