LAP assessment report

The Queen Elizabeth Hospital

LAP Assessment Report ID : LAP-02381

Inspection visit date(s): 17 & 18 March 2026

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The Queen Elizabeth Hospital

Location findings

Ratings for this location

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

Overall location summary

The Queen Elizabeth Hospital Kings Lynn provides a range of NHS hospital services.

Date of assessment: On the 17 and 18 March 2026 we carried out an assessment of surgery.

The rating of surgery has been combined with the ratings of the other services from the last inspections. See our previous reports to get a full picture of all the other services at The Queen Elizabeth Hospital Kings Lynn.

The rating of The Queen Elizabeth Hospital Kings Lynn remains requires improvement.

Safe

Rating Requires improvement

The overall rating of safe at The Queen Elizabeth Hospital Kings Lynn has remained requires improvement.

The Queen Elizabeth Hospital

Location findings

We rated safe as requires improvement for surgery.

Effective

Rating Good

The overall rating of effective at The Queen Elizabeth Hospital Kings Lynn has remained good.

we rated effective as good for surgery.

Caring

Rating Good

The overall rating of caring at The Queen Elizabeth Hospital Kings Lynn has remained good.

We rated caring as requires improvement for surgery.

Responsive

Rating Requires improvement

The overall rating of responsive at The Queen Elizabeth Hospital Kings Lynn has remained reguires improvement.

We rated responsive as good for surgery.

Well-led

Rating Requires improvement

The overall rating of well-led at The Queen Elizabeth Hospital Kings Lynn has remained requires improvement.

We rated well-led as requires improvement for surgery.

Surgery

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

Our view of the service

On the 17 and 18 March 2026 we carried out an assessment of surgical care. This was a responsive assessment due to an emerging safety risk for people receiving care at the Queen Elizabeth Hospital King's Lynn. We inspected all quality statements under the safe, effective, caring, responsive and well-led key questions.

During our inspection we spoke to staff, patients and families using the service. We observed how patients were being cared for and reviewed treatment records of patients.

The service demonstrated some positive practices, including good adherence to safety procedures within the operating theatre teams. However, there were concerns incidents were not always reported and staff did not consistently complete patient risk assessments. Environmental and equipment risks, such as obstructed fire exits and incorrect oxygen storage, contributed to concerns.

Staff delivered treatment in line with legislation, evidence-based standards, and patients' individual needs. However, effectiveness was hampered by shortcomings in assessments and documentation.

Compliance to World Health Organisation (WHO) standards was observed in theatres.

Staff mostly showed kindness, compassion, and respect. Patients generally felt informed and supported. Staff provided emotional support, used private spaces for sensitive conversations, and made effective adjustments for people with learning disabilities and additional needs. Frontline teams aimed to respond promptly to immediate needs. High acuity pressures sometimes caused delays.

The service engaged with partners, implemented improvement initiatives and utilised an accreditation framework to drive improvement.

During our assessment, we found concerns which resulted in a breach of regulation. The service breached legal regulations relating to safe care and treatment, and to premises and equipment. Patients' care and treatment was not always delivered in a way that met their needs because of incomplete assessments. Access to ward areas was unrestricted.

In instances where CQC has begun a process of regulatory action, we may publish this information on our website after any representations and/or appeals have been concluded, if the action has been taken forward.

People's experience of the service

Overall, people's experiences of using surgical services at The Queen Elizabeth Hospital Kings Lynn presented a generally positive picture regarding interactions with staff and involvement in their care. Patients described feeling well-cared for by a team they perceived as kind, compassionate, and respectful. This positive feedback extended to feeling included in the planning of their care. Information was accessible, catering to people with different communication needs. Patients we spoke to told us they could access their call bell and use it to alert staff. Staff did not always respond promptly to people's needs. We observed delays in staff responding to patient call bells.

Safe

Rating Requires improvement

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also checked people's liberty was

protected where this was in their best interests and in line with legislation.

At our last assessment we rated this key question good. At this assessment the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.The service was in breach of legal regulations in relation to the safe care and treatment and premises and equipment.

Learning culture

Score

3. Evidence shows a good standard of care

The service listened to concerns about safety and investigated and reported safety events.

From December 2025 to March 2026, 332 incidents had been raised for the surgery division and 313 had been reviewed and 19 required further information prior to review at the surgery divisional incident huddle as per the trust policy. Leaders told us these huddles happened 4 times a week to ensure timely review of incidents.

Identified incident themes included the management of diabetes on surgical wards and we saw actions in place to share learning.

We reviewed the last 2 investigations related to patient safety within the surgery division and found these followed a structured approach and highlighted where lessons were learnt.

Leaders told us they take a multidisciplinary approach to reviewing incidents and develop action plans to prevent reoccurrence and share learning with staff. Staff we spoke to were able to give examples of recently reported incidents and how learning had been implemented. For example, a staff member told us of the development of the rib fracture pathway.

Staff and leaders we spoke to told us they completed daily safety huddles to raise awareness of reported incidents and immediate actions to be taken to reduce risk. Additionally debriefs were

carried out following a patient fall to ensure learning is shared and actions put in place.

Some of the areas we visited had noticeboards which provided examples of how the department had learned from incidents. Displays provided guidance on ways staff could reduce the risk of incidents.

Staff we spoke to told us they would raise safety incidents and were encouraged to do so by senior leaders. However, a Royal College of Surgeon report from 2025 raised concerns about staff's ability to discuss issues in a non-confrontational way, which impacted learning culture.

Staff we spoke to understood their responsibility for duty of candour. Duty of candour is a legal requirement for all health and social care providers to act in an open and transparent way with people receiving care. This means that when something goes wrong that causes, or could cause, significant harm, the provider must inform the person (or their family), explain what happened, offer an apology, and outline next steps. There was an up to date openness and candour policy in place. There had been 7 incidents that required duty of candour in the last 3 months, 100% of these had been completed in line with the trust policy.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. They did not always manage or monitor people's safety. They did not always make sure there was continuity of care, including when people moved between different services.

During our inspection we found gaps in documentation in patient records and patient risk assessments not completed appropriately. Following the inspection, we requested copies of documentation audits for the surgical wards. The results of these audits showed report scores ranging from 70.2% to 91.8%. Leaders told us improvement was needed in this area and we were shown ongoing actions to improve documentation standards.

During our onsite visit, we found 6 out of 10 patient Malnutrition Universal Screening Tool (MUST) risk assessments were not completed. MUST is widely used five step method in healthcare to identify adults at risk of malnutrition, undernutrition or obesity. Following the inspection we requested 3 months of MUST compliance audit data. Reported compliance for the four surgical wards was below 90%. Leaders informed us they had action plans in place to address this concern.

The trust had a discharge checklist to support safe and effective discharges. We did not observe this being used during our inspection. Audit data showed this checklist was not completed at the required time for any patient in the last 3 months. As such, we were not assured that care needs were effectively communicated at discharge. Leaders told us this was an ongoing issue, and a review of the document was due to take place to improve completion rates. The target for implementation of the new document was quarter 1.

The trust used National Early Warning Score 2 (NEWS2) as a standardised system to detect early signs of clinical deterioration in adult patients, and we observed this being used during our inspection. For example, a patient had a high score, indicating potential clinical deterioration, the senior nurse on the ward reviewed the patient and escalated the concern to the appropriate clinician. This was in line with the trust policy. Following the inspection we requested 3 months of NEWS2 audit data. Reported compliance for the four surgical wards was above 90%.

The trust assessed patients for the risk of venous thrombosis on admission and reassessed them at 72 hours. Appropriate interventions to reduce risk were implemented. Trust audit data for the last 18 months showed the service was meeting the trust target.

During our inspection we did observe staff assisting patients to mobilise with the use of appropriate equipment. Staff kept ward areas clutter free, therefore reducing risk of inpatient falls. We requested audit data to ensure patients had an accurate falls risk assessment completed on admission. The trust advised that significant work is ongoing to improve completion rates of these assessments.

Safeguarding

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always work well with people and healthcare partners to understand what being safe meant to them and how to achieve that.

The trust provided staff with safeguarding level 3 training that was specific to their role. Nursing staff training compliance for safeguarding adults was 62% and for safeguarding children was 67%. Medical staff training compliance for safeguarding adults was 49% and for safeguarding children was 55%. The trust target was 80%. Leaders told us the reason for poor compliance was because training expectations had changed in December 2024, but we were not shown an action plan to improve compliance.

We reviewed the last 3 referrals made to the safeguarding lead and these showed staff were identifying vulnerable people and taking action to keep them safe.

There was an up to date safeguarding vulnerable adults' policy. Staff we spoke to understood safeguarding and told us if they were concerned about someone's welfare, they would escalate this to their manager. Staff were able to identify categories of abuse, but they were not able to share a recent example.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

During our inspection patients told us that staff explained treatment options to them and their relatives and gave them time to ask questions before making a decision. Patients told us explanations were given to them in a way that they could understand.

Staff communicated with patients so that they could understand their care and treatment. This included finding effective ways to communicate with patients with communication difficulties. For example, staff had access to translation services for patients whose first language was not English.

During our inspection we saw documentation of conversations with patients and their relatives around resuscitation status. The trust provided audit data for the completion of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms for the last 3 months. ReSPECT forms document conversations between individuals and healthcare professionals and record preferences for emergency care. The audit data showed good compliance in completion of these forms.

During our inspection we saw the implementation of Martha's Rule. Martha's Rule gives patients, families, and carers the right to urgently request an independent clinical review if they feel a patient's condition is worsening and not being taken seriously.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

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

Access to the surgical wards was not restricted and was uncontrolled. We observed a lack of professional curiosity to challenge visitors posing a risk to both staff and patient safety and welfare.

There was clear signage for emergency exits on wards identifying escape routes. However, on some wards, there were found to be obstructed by equipment. This was highlighted to staff who rectified this during the inspection.

During our inspection we observed oxygen cylinders being stored incorrectly and this posed a safety risk. This was escalated to staff during our visit. Areas where medical gases were stored were not clearly identified.

Equipment, including special or adaptive, was available and used to deliver care and treatment that was suitable for the intended purpose. Equipment was clean and ready for use and up to date electrical testing was displayed where required. We reviewed 15 items across surgical care wards and found all were labelled and tested in line with health and safety executive (HSE) guidelines.

Although doors to sluices or storage rooms were not always locked, cupboards containing hazardous substances were locked securely. This ensured hazardous substances were locked away safely from reach.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Emergency trolleys were easily accessible within the service. We checked the emergency trolleys on the surgical wards and found these were secured with a snap lock, so it was clear if someone had accessed the resuscitation equipment.

The operating theatre department was visibly clean, but we observed the corridors were cluttered with equipment. Staff told us the department lacked space for adequate storage in part due to the aging estate.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. They did not always make sure staff received effective support, supervision and development.

Leaders told us that staff across the surgical division were being supported to attend face to face mandatory training sessions to ensure there is rapid progression to the trust target of 80% compliance. We asked for data for core training modules and this showed inconsistent completion rates. For example, 100% of medical staff had completed level 1 resuscitation training but we were not provided with this data for nursing staff. As such we were not assured that all staff receive appropriate training.

Vacancy rates within medical staffing for the division was 8.2% and when combined with staff sickness rates this equates to 15-20% workforce loss. Leaders told us this created operational risk and rostering is being reviewed. They explained a risk assessment has been drafted and will be discussed at risk and compliance group meeting in April 2026.

Nurse staffing levels were reviewed and planned in a timely manner by ward managers. Staff generally reported good levels of staffing and use of bank staffing where there were shortfalls.

During our inspection we saw there were appropriate staffing levels and skill mix allocated to theatres, recovery, and the surgical wards. The actual staffing levels largely met the planned levels.

The trust used the Safer Nursing Care Tool (SNCT) to calculate the number and grade of nurses and healthcare assistants required to manage the acuity of the patients on the wards. This was reviewed by senior nursing staff to help them make decisions regarding safe staffing across the division and organisation. When staffing issues were escalated managers told us they moved staff to where they were most needed within the division. The trust provided data that showed no safety incidents had been reported in the last 3 months because of staffing levels not meeting the service need.

Regular staffing level reviews were undertaken to ensure staffing levels remain safe. Leaders told us that following a recent review staffing numbers on Elm Ward and the Surgical Assessment Unit (SAU) had been increased.

Physiotherapy and occupational therapy services were provided to the surgical division. The general surgery team provided Monday to Friday support to patients that had surgery and had

complex rehabilitation needs. Patients being stepped down from critical care were reviewed by a weekend therapy team as appropriate. The orthopaedic team provided a Monday to Friday service and aimed to cover a Saturday service with bank staff. These teams worked with the wider multi-disciplinary team (MDT) to support with discharge planning.

Staff appraisal rates for the surgical division were below the trust target of 90% as of February 2026. For medical staff the rate was 82%. For other staff groups the rate was 77.7%.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always assess or manage the risk of infection.

During our inspection we observed a patient mattress that was soiled and contaminated with bodily fluids but was being prepared for use. This posed a significant infection transmission risk. We highlighted this to senior staff who took action to remove the equipment from service. Leaders told us they did not routinely monitor mattress integrity.

The trust provided staff with infection prevention and control training. Nursing staff training compliance was 79%. Medical staff training compliance was 72%. Allied health professionals training was 50%. We did not see an action plan to improve compliance.

The wards we inspected appeared visibly clean. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Cleaning audit data for December 2025 showed that Denver and Elm wards scored 94%, this is below the trust target of 95%. Sandringham and Feltwell wards achieved 98% and 97% respectively. Where the trust target was not met a re-audit was completed within 24 hours and showed action taken to rectify concerns. Audit data for January 2026 showed all surgical wards achieved the trust target. Data for February 2026 showed all surgical wards achieved the target with the exception of Feltwell ward that scored 94% but passed when re-audited.

We observed equipment being cleaned after each patient contact. We observed staff following Infection Prevention and Control (IPC) principles, including the use of personal protective equipment, effective handwashing and being bare below the elbows.

Hand hygiene signage was displayed throughout the wards. All waste and clinical specimens were observed to have been managed appropriately.

Cleaning records for operating theatres were seen and up to date. Where disposable curtains were used these had a recent replacement date displayed.

Leaders told us they had a number of initiatives to promote infection prevention and control. These included an initiative to reduce the use of gloves when not clinically necessary. We saw promotional material and evidence of discussion at relevant meetings; however, staff we spoke to were not aware of the initiative or its impact.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. Medicines and treatments were not stored safely.

The trust provided mandatory training for medication management to staff. Data from January 2026 indicated compliance with this training was a concern with 14 out of 27 staff groups in the surgical division not meeting the target completion rate. Leaders told us mandatory training was discussed within the division at relevant meetings. No medication incidents had been reported for the last quarter, but this does not mitigate the gaps in staff training.

Medication storage rooms on the wards we inspected had security keypads on the doors. The cabinets within the room had locks but these were not used. This posed a security risk and we were not assured medications were being stored securely.

Medication requiring storage in a cooler environment was kept in fridges. Staff on the wards we visited did not monitor the temperatures consistently. Some staff told us they thought the

temperatures were monitored centrally and some told us they monitored them on the wards. We were not assured medications were stored safely.

Controlled drugs (CDs), which were controlled under the Misuse of Drugs legislation (and subsequent amendments) were logged and followed the trust policy. Leaders had identified concerns around CD drug record keeping, expired CD drugs not being returned to pharmacy and discrepancies in oral liquids greater than 5% of total volume, which is outside expected tolerance. A training session was arranged for April 2026.

Liquid medications did not have opening dates recorded. Trust policy indicated that liquid medications should have an opening date recorded.

Patients told us they received information about prescribed medication and had the opportunity to ask questions about them. Patient records we reviewed showed patients' pain levels were assessed and patients we spoke with told us their pain was managed appropriately. We saw in records that patients had been prescribed and administered pain relief.

Effective

Rating Good

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care.

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

Assessing needs

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always make sure people's care

and treatment were effective because they did not always check and discuss people's health, care, wellbeing and communication needs with them.

We reviewed 10 sets of patient records and were unable to locate up to date risk assessments in 6 of these. We were not assured risk assessments led to effective care plans to ensure patient needs were met.

Staff did not always make sure patients' nutrition needs were assessed and met in line with current guidance. Not all patients on the surgical wards had a Malnutrition Universal Screening Tool (MUST) assessment completed or a care plan to meet their nutritional needs. The menu offered to inpatients included patient choice with a range of diets and textures.

We observed boards at patients' bedsides used to highlight individual patient needs, such as visual impairment, additional communication needs or requiring assistance at mealtimes, these boards were not completed and did not provide staff with information on individual patient needs. Staff we spoke to said the boards would be useful but were rarely completed.

Pre-operative assessments involved detailed patient reviews, which included past medical history and patient preferences. However, patients told us they often had to repeat this information to different staff. For example, one patient told us they had made the service aware of their need for an altered textured diet, but they were regularly offered unsuitable food and drink.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

The trust's intranet contained a comprehensive range of policies and standard operating

procedures which provided guidance for staff that reflected best practice.

Staff gave patients clear information about their care and treatment needed to support both their physical and mental health. Patients told us they felt their expectations and needs were considered during decision making.

Staff we spoke to told us they could access a range of specialists, if required, to meet the needs of patients such as physiotherapists, dietitians and pharmacists. Staff told us these reviews happened in a timely way when requested.

We observed patient theatre lists and saw effective systems in place to promote and protect the safety of patients. The service followed National Safety Standards for invasive procedures and World Health Organisation (WHO) surgical safety checklists. We reviewed clear consent processes and allergy checks as part of the preoperative checklists.

Our observations in theatre highlighted adherence to best practice. For example, we observed staff counting disposable items, including gauze, needles and other instruments as a safety measure to prevent retained surgical items in line with guidance from the Association for Perioperative Practice (AfPP).

The service involved people in surgical treatment planning. Audit data showed 89% overall compliance for the correct completion of consent forms.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service worked well across teams and services to support people.

We saw evidence of good multidisciplinary team (MDT) working. When people were due to move between services, all necessary staff, teams, and services were involved in assessing their needs to maintain continuity of care.

Staff informed us they worked well with other staff. Nursing staff told us medical staff were available for advice and support including overnight and on weekends and there were good working relationships between colleagues.

Theatre teams were observed to work well together for the safety of the patients.

We observed staff sharing appropriate patient information when they moved between departments. Staff told us patient information was shared between staff at shift handover.

Leaders told us about weekly MDT meetings for orthopaedic patients that ensure patient concerns were listened to, discussed and plans taken to address barriers to care. Length of stay for orthopaedic trauma patients has reduced from an average of 22 days to 11 days.

We observed the surgical divisions therapy team, comprising of physiotherapists and occupational therapists, actively supported multidisciplinary care. They provided patient rehabilitation across surgical wards, coordinated discharges and worked to reduce inpatient deconditioning.

We observed staff from the surgical wards meet with senior leaders to discuss patient safety concerns and delays in care in real time and ensure plans were made and enacted to ensure timely reviews. Leaders told us these meetings occurred daily.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

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

Health promotion was part of care provided to patients. Staff worked collaboratively to assess all aspects of general health, and to give advice and support to promote healthy lifestyles.

People's health was assessed at pre-assessment and staff could make referrals relevant to the patients' needs e.g. smoking cessation at any point in the pathway. On discharge patients were signposted and given advice on where and when to seek help.

Patients told us they were given information and advice about their physical health, including the benefits of taking regular exercise, smoking cessation and weight loss.

We observed staff effectively communicating with patients about treatment options and care plans. Staff explained expected recovery timescales post-surgery.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always routinely monitor people's care and treatment to continuously improve it. They did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves.

The trust showed inconsistent performance within clinical audits. While they seemed to perform better within the National Joint Registry (NJR) data, the National Emergency Laparotomy Audit (NELA) data showed 7 metrics below the expectation. The National Hip Fracture Database (NHFD) data also showed inconsistent patterns, in 8 metrics the trust was in the 25% best performing hospitals and in 3 metrics it was in the 25% of worst performing hospitals. These clinical areas could therefore represent areas of improvement for patient experience and outcomes.

The trust had an appropriate Learning from deaths policy, approved in January 2024 and completed Structured Judgement Reviews (SJRs) where appropriate. We reviewed the last three Learning from Deaths reports which identified learning themes. Learning from Death reports are shared with staff at the monthly divisional learning event. Data for February 2026 showed there were 10 SJRs awaiting review. The oldest outstanding SJR was from February 2025, there is a risk in implementing learning being delayed as a result. Leaders told us SJR

groups would meet every two weeks to reduce this backlog.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

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

People told us staff explained care and treatment options in a way they understood and gained verbal consent before carrying out procedures.

Consultants would gain written consent before any surgical procedure. Staff reviewed consent forms in theatre as part of the checklist.

Staff considered patients' capacity and ability to consent. Patients,' or a person lawfully acting on their behalf, were involved in planning, managing, and reviewing their care and treatment. Staff showed understanding of when and how to assess whether a patient had the capacity to make decisions about their care, and the Mental Capacity Act (MCA) 2005. Audit data from the last 3 months showed 100% of staff questioned across the division were aware of what to do if a patient lacked capacity.

Staff followed the trust policy and procedures when a patient could not give consent. We reviewed the consent policy, which was in date and accessible to staff.

Caring

Rating Requires improvement

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

At our last assessment we did not rate this key question. At this assessment the rating is requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always treat people with kindness, empathy and compassion, or respect their privacy and dignity.

Staff mostly treated people with kindness and respect. However, we observed a patient in a single occupancy room calling for help. Staff spoke loudly and abruptly from outside the room “what do you want?” and did not enter. Personal protective equipment was required and was available to protect staff, but this was not used. The patients’ needs were not identified in a dignified way. Care provision was delayed. There was a lack of empathy. We reported this to the nurse in charge and were assured a professional conversation would take place with the staff concerned to address the concerns.

During the assessment, we spoke with 10 patients who shared their experiences of care. Many commented that staff appeared busy but were trying their best to support them. However, some patients noted that they occasionally had to wait for their needs to be met.

In the 2024 National Inpatient Survey, overall patient experience was rated 7 out of 10. The results were in line with those of similar services across England. Leaders told us of action plans to improve discharge communication, fundamentals of care and ensure there were enough nurses to meet patients needs. Staff we spoke to within the division were not aware of actions to improve survey results.

We observed staff in theatre deliver care in a dignified and respectful way.

We saw staff explaining things to patients in a way they could understand. Staff involved

patients and those close to them in decisions about their care and treatment. Patient's family and carers told us visiting times were flexible.

Staff mostly kept patient records secure. However, we observed occasions where medical records were left unattended. There was a risk of unauthorised access to patients' private medical information.

Treating people as individuals

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences.

Most people we spoke with told us the service took account of their individual needs and preferences. We saw in patient records that people's needs and preferences were reflected in plans for patient care.

We observed that staff treated people as individuals, considering any relevant protected equality characteristics. People's personal, cultural, social, and religious needs were understood.

The service had systems such as translation services to support communication and choice.

Staff were observed providing additional time, supporting a non-verbal patient with a learning disability in a quiet area.

Staff were observed making adjustments to allow a relative to remain with a patient living with dementia while they waited for surgery.

Staff utilised private rooms to discuss sensitive details or for breaking bad news.

The hospital had a chaplaincy service which staff could access to support patients and their relatives.

Independence, choice and control

Score

3. Evidence shows a good standard of care

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

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with during our assessment understood their treatment plans. Patients were involved in decision making about their care.

Staff talked with patients, families and carers in a way they could understand. Staff told us they had access to communication aids and provided printed information where necessary.

We observed appropriate equipment such as walking sticks and walking frames available to help staff promote independence and mobility.

Responding to people's immediate needs

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always listen to and understand people's needs, views and wishes. Staff did not always respond to people's needs in the moment or act to minimise any discomfort, concern or distress.

The service did not ensure patient risk assessments were consistently completed and reflective of patients' current needs. In 6 of 10 reviewed patient records risk assessments were incomplete. This meant that staff did not always have an accurate understanding of an individual's risk, potentially limiting their ability to respond effectively to patient needs.

Staff understood the importance of identifying patient needs, views and wishes and aimed to prioritise this. Staff told us they worked to meet patients' needs but staffing levels sometimes made this difficult.

Patients we spoke to told us they could access their call bell and use it to alert staff. Staff did not always respond promptly to people's needs. We observed delays in staff responding to patient call bells.

We observed 'nurse rounding,' a system whereby staff interact with patients to ensure any immediate needs were met. Trust audit data showed good compliance with 'nurses rounding' across the surgical division.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always care about and promote the wellbeing of their staff. They did not always support or enable staff to deliver person-centred care.

Leaders told us they had systems to support staff wellbeing and these were underpinned by policies and procedures such as the attendance management policy and flexible work policy. However, staff told us managers did not follow these policies consistently.

Theatre staff described uncertainty within the department following the Royal College of Surgeons (RCS) report into general surgery at the trust. Staff told us changes within leadership structure, reporting lines and uncertainty about the future of the service had a negative impact on their wellbeing. We spoke to staff due to start work within the general surgery team who reported they felt apprehensive and anxious. They were unaware of support available to them or of the published action plan to address the RCS findings.

Staff from the Day Surgery Unit (DSU) theatres told us they had raised workplace cultural

concerns and listening groups had been completed as a result. However, they were unaware of changes that had occurred as a result and felt the concerns remained.

Staff told us that following reported incidents of workplace abuse, such as racism and homophobia, managers did not offer support or provide them with investigation feedback. They told us this resulted in them being unlikely to report incidents in the future.

The trusts uniform policy was under review but supported staff with cultural and religious needs by allowing appropriate and respectful adjustments.

The trust had a reward and recognition programme, the QEH Awards, data showed that many individuals and teams from the surgical division were nominated and presented with awards in 2025.

Staff in the theatre department told us they had access to mental health first aiders, however, this service was not known by other staff groups in the division.

Responsive

Rating Good

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we did not rate this key question. At this assessment the rating is good. This meant people's needs were met through good organisation and delivery.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not always make sure people were at the centre of their care and treatment choices and they did not always work in partnership with people, to decide how to respond to any relevant changes in people's needs.

There were mixed views from patients and relatives about their experiences of receiving person centred care. We spoke with 10 patients, 6 patients spoke of being involved in and receiving good standards of care and treatment that met their needs. Whereas 4 patients or their relatives expressed concerns about not being fully involved in making shared decisions and receiving inconsistent information. These concerns were highlighted in the adult inpatient survey 2024 where the trust performed "somewhat worse than expected" or "worse than expected" in 11 questions related to patient experience and involvement in care. The trust provided an action plan to address key themes.

"This is me" patient passports were personalised documents, developed by the Alzheimer's society, that help patients quickly share their needs, preferences and important information with healthcare staff to support person centred care. The trust encouraged their use to support patients. However, during our assessment we observed that these documents had been left blank and patients and their relatives had not been supported in completing them.

Staff mostly ensured patients were given a choice of food and drink to meet their cultural and religious needs.

The service made reasonable adjustments to allow for additional visiting for some patients, for example, those with additional support needs were accompanied by relatives and carers during treatment.

The trust had a learning disability specialist nurse who worked with individuals to create bespoke care plans. The service offered support at outpatients appointments for those patients

attending without carer support.

We were told of an example from the Day Surgery Unit where a neurodivergent patient was supported with an individual nurse with them at every part of their elective surgery pathway.

Care provision, integration and continuity

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. There were some shortfalls in how the service understood the diverse health and care needs of people and their local communities.

Information boards were found on the wards with key information such as dietary requirements, manual handling requirements and mobility status to ensure continuity of care. However, we observed these were not always completed to accurately reflect the patients' needs.

Patients' care and treatment was not always delivered in a way that met their needs because of incomplete assessments. For example, nutritional risk assessments were not completed in 6 of 10 reviewed patient records to identify potential risks and plan necessary mitigations.

Staff told us discharge planning for patients with complex, ongoing needs is coordinated by a dedicated team. This team supported the surgery wards by attending daily board rounds, provided expert advice and supported patient discharge. Referrals can be made to Norfolk First Support (NFS) where required to ensure care continuity, this included access to community-based rehabilitation. Data from the trust showed that 60% of patients referred to NFS were discharged within 24 hours.

Staff told us they referred patients to required specialist services, such as speech and language therapy and occupational therapy when required. Specialist services for diabetes management, tissue viability and stoma care were also available. Staff told us patient reviews happened in a timely manner although this was not audited.

Providing information

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

The service met accessibility information standards and supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs upon request.

Translation services and interpreters were available to support patients whose first language was not English. This included British Sign Language.

Patients were given information leaflets to explain surgical procedures.

Some patients and relatives told us they were not always informed about their discharge arrangements. However, leaders told us about an initiative trialled on Elm Ward to improve the provision of discharge information. Each week an MDT meeting took place and involved patients and their relatives to discuss and formulate discharge plans. This process had reduced the average length of stay for patients from 22 days to 11 days. Staff told us this had reduced the number of complaints received.

Information sharing between teams seemed to be cohesive. We were given examples of multiple ways in which staff shared information throughout the division including daily MDT face to face huddles.

Listening to and involving people

Score

3. Evidence shows a good standard of care

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

Patients we spoke with knew how to give feedback about their experiences of care.

The service enabled people to easily share feedback, ideas and complaints about their care. Staff involved patients in decisions and informed patients of changes made to their care as a result.

The service gathered feedback through various tools, including NHS Friends and Family forms and the hospital's reporting system.

Between December 2025 and February 2026, the surgical division received 47 formal complaints, 36 of which were responded to in the time frame set out by the trust's policy. Appropriate divisional staff investigated complaints and members of the executive team responded to the complainant. Key themes identified were poor communication and delays to treatment. Staff discussed complaints at monthly learning events and specialty governance meetings.

We saw evidence that the division had implemented Martha's Rule. Martha's Rule is a patient safety initiative that gives patients and families the right to request an urgent independent clinical review if they were worried that a patient's condition is getting worse.

Equity in access

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service made sure that people could access the care, support and treatment they needed when they needed it.

Staff were able to order specialist equipment such as air mattresses and bariatric equipment as required. All staff we spoke to knew how to access equipment if needed to support care and

treatment of patients.

The trust had processes in place to identify patients that may require additional support, such as individuals with dementia, autism or a learning disability. These patients were identified by medical and nursing teams who would then inform relevant parties. Staff made reasonable adjustments to support individuals such as pre-arranged visits prior to planned surgery.

The learning disability nurse supported inpatients with a learning disability. The nurse visits patients on the wards supporting with communication, enabling reasonable adjustments and supporting discharge. Access to this service was made by electronic referral.

Leaders told us Oliver McGowan training was mandatory for all staff. We were not provided compliance figures for this in the trust's mandatory training data. As such we were not assured staff have received this training.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

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

Staff had a good understanding of patients that used the service and were most likely to experience inequality in their care. Staff completed equality, diversity and human rights training as part of their mandatory training. Compliance for this training module met the trust target with 88.6% of nursing staff and 89.4% of medical staff within the surgical division having completed it. However, only 70% of medical staff on training had completed this training module.

Patients told us their needs and preferences were assessed and understood by staff. They told us they were treated in a non-discriminatory way.

Staff told us they treated people equally and without discrimination. They were able to give examples of how they respected the individual wishes of people with protected characteristics.

All policies we reviewed had an equality impact assessment completed ensuring they did not place vulnerable people or people with protected characteristics at a disadvantage.

Leaders told us they offered outpatient pre-assessment clinics in areas that had beds to patients that had mobility restrictions ensuring clinical assessment and MDT access was equal to those without mobility concerns.

Planning for the future

Score

3. Evidence shows a good standard of care

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

During our assessment we reviewed ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms and Do Not Attempt Resuscitation (DNAR) forms for 4 patients. These had a documented conversation with the patient or their representative around the individual resuscitation status and had clear clinical rationale as to why resuscitation would not be in the patient's best interest.

Patients told us they had been given advice and information on how to manage at home after surgery.

Physiotherapists were involved from the earliest stage to proactively work with patients. This helped achieve the best outcomes. Patients' length of stay was below the national median value.

Well-led

Rating Requires improvement

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

At our last assessment we rated this key question requires improvement. At this assessment the rating remained requires improvement. This meant the service management and leadership were inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. The service did not have a clear shared vision, strategy and culture which was based on transparency, equity, equality and human rights, diversity and inclusion, and engagement.

The trust moved to a group model of working with two local trusts to form the Norfolk and Waveney University Hospitals Group in May 2025 with a shared leadership structure. Staff we spoke to were unaware of this leadership structure and said nothing had changed locally. However, staff from general surgery and the theatre department told us changes within leadership structure, reporting lines and uncertainty about the future of the service had not been effectively communicated and they were unaware of plans for general surgery services in the future.

Staff we spoke to told us there was a positive and supportive culture within their immediate teams. Staff told us they were proud to be part of the team. However, staff told us that they did not always feel listened to, valued or appreciated by senior leaders external to the division.

The NHS Staff Survey 2024 results highlighted division staff did not have confidence that

leaders would act on concerns, they had a poor experience of appraisals that limited their perceived value and there was an increased intention of staff to leave the organisation. Leaders provided us with actions implemented to address these concerns. At the time of our assessment the 2025 survey results had not been published.

The trust had a 10 point strategy developed in 2024 and clearly defined what success will look like. Staff we spoke with understood this strategy and were proud of the actions taken within the surgery division such as reducing the length of stay for patients undergoing elective joint replacements.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. Not all leaders understood the context in which the service delivered care, treatment and support. They did not always embody the culture and values of their workforce and organisation.

There was an established leadership team within the division comprised of a directorate lead, operational lead and nursing lead, who made up the divisional triumvirate. Staff we spoke with told us these leaders were visible and approachable.

Leaders told us they visited clinical areas and supported on the wards when required to identify challenges and potential solutions. Staff told us department leaders were visible but where unaware of who the site leadership teams were. However, the NHS Staff Survey 2024 results for the division scored below the average for burnout and morale. This meant that leaders were not aware of the issues faced by staff.

Staff we spoke to described informal appraisal mechanisms. Division appraisal rates were below the trust target of 90% as of February 2026. For medical staff the rate was 82%. For other staff groups the rate was 77.7%. We are not assured that staff received work appraisal from their immediate managers to support development.

Medical staff told us support was available from peers but not from leaders. The General Medical Council (GMC) trainee doctor survey 2025 showed general surgery was ranked poorly in 11 of 16 indicators. These indicators included “supportive environment” and “clinical supervision”. Medical staff were not aware of actions being taken to address these results.

Leaders were knowledgeable about challenges and priorities for the service and told us they could access appropriate support from the executive board. They explained challenges such as bed capacity and elective surgery backlogs.

Leaders told us they had a number of systems to support staff wellbeing and these were underpinned by policies and procedures such as the attendance management policy and flexible work policy. However, staff told us leaders did not follow these policies consistently with some staff feeling pressured to attend work when unwell.

Freedom to speak up

Score

2. Evidence shows some shortfalls in the standard of care

The evidence showed some shortfalls. People did not always feel they could speak up and that their voice would be heard.

Patients and carers were able to provide feedback in ways that suited their individual needs. Feedback cards were available throughout the areas we visited. NHS Friends and Family data for August to November 2025 showed 85% of respondents from the two non-elective surgery wards reported a positive experience compared to a trust average of 95%. Staff could not tell us of changes being implemented to improve this result.

Staff could access the Freedom to Speak Up (FTSU) Guardian in the trust if they were not able to speak to their manager. Themes for FTSU referrals for the division included human resource processes and staff wellbeing and psychological safety. There had been a reduction in the number of cases with the FTSU Service in 2025 compared to the previous year. Although the number of cases is lower the service had a reduced resource owing to staff turnover. When

adjusted for the 2025 resource, case numbers were on par with previous levels.

The service promoted a positive culture by encouraging staff to speak up supported by up to date policies. However, staff feedback in relation to feeling confident in speaking up was mixed. Some staff felt confident raising concerns with managers whilst others did not always feel concerns were listened to. Staff we spoke to told us they were less likely to report concerns as they did not feel leaders would take action.

Staff told us they had raised workplace cultural concerns and listening groups had been completed as a result. However, they were unaware of changes that had occurred as a result and felt concerns remained.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

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

Leaders supported work towards an inclusive and fair culture by improving equality and equity for staff. Staff came from a variety of ethnic backgrounds.

Staff could apply to work flexibly. For example, flexible working agreements to accommodate personal circumstances such as caring responsibilities and health issues. Managers approved reasonable adjustments for staff members to help them effectively carry out their role.

Staff mostly said they felt like part of a family and were recognised for their contribution by both their managers and their peers.

Staff had access to multiple networks including;

- Race, Ethnicity and Culture Hertitage Network

- Disability Network
- LGBTQ+ Network.

Governance, management and sustainability

Score

1. Evidence shows significant shortfalls in the standard of care

The evidence showed significant shortfalls. The service did not have clear responsibilities, roles, systems of accountability and good governance. They did not act on the best information about risk, performance and outcomes, or share this securely with others when appropriate.

There was a lack of effective governance for the service. We reviewed the divisional risk register and although all risks had recent updates, we found that not all risks identified during our inspection such as, poor MUST assessment, poor safeguarding training compliance and poor medication management training compliance were not recorded on the service risk register. This did not provide the leadership with effective assurance and risk oversight. We are not assured these issues are being addressed at leadership level.

Leaders told us that staff meetings had been standardised within the past 3 months. We reviewed a sample of meeting minutes from teams within the surgical service and found most showed discussion of patient feedback, incidents, and learning but there was no standardised approach. These meetings were not held consistently. This meant information was not always received or escalated to all staff in a timely manner from board to ward and vice versa.

Specialities within the surgical division held regular governance meetings. At these meetings, learning from mortality reviews, incidents and complaints were presented and discussed. Actions were identified for some areas; however, it was not clear from the minutes of the meetings we reviewed, what action had been taken or was to be taken to share the specific learning to the wider service from incidents and complaints.

Learning from incidents, audits and complaints was not consistently shared, and many staff were unaware of the top risks facing the division. Staff wellbeing concerns were also not addressed, even though they contributed to risk and performance pressures. These issues showed ineffective governance, poor oversight of risks, and a lack of reliable systems to ensure accountability or improvement.

Following the independent review by the Royal College of Surgeons (RCS), general surgery at the trust was operating with governance oversight and clinical leadership from the team at the neighbouring trust which was part of the Norfolk and Waveney University Hospitals Group (NWUHG). Leaders shared with us standard operating procedures and details of how the general surgery team could communicate with the oversight team. Staff from the general surgery team told us that the department structure was unclear and there was an uncertainty around roles and responsibilities. We were not assured all staff were aware of these processes.

Staff of all levels within the division told us the uncertainty around the future structure of the general surgery team was exacerbated by poor communication from leaders.

Partnerships and communities

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. They share information and learning with partners and collaborate for improvement.

Staff and leaders engaged with people, communities, and partners to develop and improve patient experience. They used these networks to identify new or innovative ideas that led to better outcomes for people. For example, the adaptation of clinical environments to meet the needs of patients with neurodiversity.

Staff told us they worked with Norfolk First Support (NFS) where required to ensure safe and timely discharge from the hospital.

We saw hospital volunteers actively supporting patients and visitors. They created a welcoming and reassuring presence. Volunteers were approachable, friendly, and easy to recognise, which helped patients feel comfortable asking for assistance. Their contribution added value to the patient experience by providing practical help and emotional support in busy environments.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The evidence showed a good standard. The service focused on continuous learning, innovation and improvement across the organisation and local system. They encouraged creative ways of delivering equality of experience, outcome and quality of life for people.

Staff were encouraged to complete quality improvement (QI) training and 200 members of staff from the surgical division were trained in QI. The majority of the staff trained were medical or nursing staff but there was inclusion of other staff groups. QI initiatives included the introduction of adaptive cutlery for patients and adjustable orthopaedic chairs to improve patient comfort.

Quality Improvement Projects (QIPs) are structured initiatives that aim to improve patient care, safety and service efficiency. The service had 8 projects registered with the Quality Improvement team since October 2025 and as a result these had not been embedded in practice. These projects included;

- Improving monitoring in patients receiving Total Paternal Nutrition (TPN)
- Improving patient handover from the operating department to the critical care unit to align with National Institute of Clinical Excellence (NICE) guidance
- Improve the safe prescribing of antibiotics commonly used within general surgery
- Develop ultrasound guided vascular access to improve clinical skills
- Improve the prescribing of intravenous fluids for patients nil-by-mouth awaiting

surgery

- Improving the standard of ReSPECT form completion
- Improving the consent process for patients receiving infusion therapy
- Improving the monitoring of frail patients lying and standing blood pressures

The trust is part of a national research project into the treatment of anaemia following emergency surgery. There have been over 160 participants meaning it is one of the national leads in the project.