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Dear Zoe

I would firstly like to take this opportunity to thank you and your team again for undertaking an unannounced core service inspection at the Queen Elizabeth Hospital (QEH) last week and for providing written feedback so very quickly. This has allowed us to share your initial findings with our Trust Board and staff. It is clear from speaking with staff over the past week, they were delighted to have had the opportunity to meet with CQC colleagues and talk through some of the improvements they have been involved in over the past 12months, to improve the safety and care of our patients and I think it's fair to say, your visit generated a real 'buzz' across the whole organisation.

Whilst I appreciate this initial feedback does not replace the draft report, it was really heartening to read that you found patients were treated with kindness and compassion and words such as happy, compassionate, caring, engaged and support were used to describe your findings. We are really pleased to have been able to demonstrate this during your visit, reflecting a further positive shift in the culture of the organisation. Whilst we recognise we still have work to do, the delivery of compassionate and safe care remains a priority for us, underpinned by strong and visible leadership.

Having read through the letter, I thought it would be helpful to provide you with a response to the points of concern noted, relating to the core services of Critical Care, Urgent and Emergency Care (UEC) and Medicine, which I have detailed below.

Critical Care
The inspection team noted patients remain within the Critical Care Unit longer than required at times due to the capacity within the Trust. Staff were acutely aware of pressures within the Trust and where appropriate patients were discharged directly home.

I would like to reassure you that we are committed to discharge patients from the Critical Care unit within 4 hours of a decision having been made and this is based on standards set

out in the NHS Critical Care Service Specification and the Guidelines for the Provision of Intensive Care Services. This is monitored by the specialty as part of their quality dashboard and discussed at the monthly departmental meetings. However, as highlighted in your letter, the more recent operational pressures across the Trust and consistently high bed occupancy, has delayed the discharge of some patients from the Critical Care Unit. Whilst this is not ideal, a decision to delay a patient's discharge is always discussed at every Bed Meeting and risk assessed to ensure the safety of patients is not compromised in any way. The organisation is very aware of this issue, which is currently a Moderate risk, with a score of 8 on the Risk Register with clear mitigation in place.

We would also like to reassure you that the data for all patients within Critical Care is recorded and gathered through ICNARC (Intensive Care National Audit and Research Centre), allowing benchmarking with other sites and regular reports are shared with the Critical Care team. These standards are supported by a Standard Operating Procedure for Critical Care which includes the discharge of patients from the Unit.

Concerns were raised following the announcement that the Clinical Director is leaving which will leave the unit with six Consultants and although there is active recruitment, it is difficult to recruit into these roles. Consultants were doing additional hours to cover and ensure patients remained safe. The concern was around sustainability of this staff group. Although during the feedback you confirmed a plan had already been put into place regarding the replacement of the Clinical Director.

Thank you for reflecting in your letter our discussion regarding the replacement arrangements planned for the Clinical Director (CD), but I thought it would be helpful to provide further detail regarding this.

Our Critical Care funded establishment is 8 WTE consultants and we currently have 7 Consultants in post. The on-call rota is 1 in 8, with the 8th slot filled internally through additional payments.

Recruitment for that vacant Consultant post had already been approved, but the team were keen to wait for an excellent candidate currently working as a trainee in our region before adverting this. They know him already, and know that he is interested in applying for this post. His CCT (the certification necessary to be appointed into a substantive consultant role) is due in the next few months and so he is now eligible to apply for posts (but not to start until the CCT is through). The team decided that they would prefer to cover the on-call gaps internally to wait for this candidate.

1 Consultant (who is currently the CD) has also resigned 29/11/21, and his last working day will be 29 March 2022. We have already invited expressions of interest internally for a replacement CD with a view to them taking over in March.

We have also approved recruitment for this post. The job description is currently being finalised with the team, with a view of going to external advert by the end of this month. We do have 1 highly experienced SAS doctor who works for us already, who is suitable and available to fill rota gaps in case there is a gap in a new substantive team member starting as part of our forward planning. He is also keen to apply for a specialist post with us, and we are also aware of 2 other potentially suitable candidates depending on the exact composition of the advertised jobs (as they are both dually accredited and would prefer joint posts - one across Critical Care and Acute Medicine, the other in Critical Care and Emergency Medicine). Finally, as a further level of assurance, several of our Consultant Anaesthetists are also available to support colleagues in Critical Care if gaps arise.

Urgent and Emergency Care (UEC)
In your letter you raised four points of concern which largely relate to capacity and demand and the flow and management of patients into and out of the Emergency Department.

- *The inspection team noted triage times and the four hour target were not met, although patients were reviewed and safeguards were in place.*
- *The inspection team also noted the 12 hour target was not always being met.*
- *There was a concern regarding the capacity for paediatrics due to the increase in the number of children testing positive for COVID-19.*
- *Flow from the emergency department to the rest of the hospital was a concern, although it was noted the trust was at 100% capacity, with no outliers and no cohorting. The inspection team, again, noted safeguards were in place.*

Thank you for acknowledging the safeguards and mitigation arrangements in place to ensure our patients remain safe and that risk assessments have been completed, particularly the more recent risk relating to paediatrics within the Emergency Department, which was discussed at our Assurance& Risk Executive Group (AREG) on Tues of this week as part of our established governance arrangements.

I would like to reassure you that the Trust has an Urgent and Emergency Care Improvement Plan in place with dedicated improvement manager resource to support the delivery of this. The plan is structured to incorporate improvements across the entire UEC pathway, from pre-arrival through to discharge and comprises of 5 workstreams:

- Pre-arrival
- Front Door
- Wards
- Discharge
- Reporting

The Trust recognises that urgent and emergency care demand has significantly increased since the second wave of the COVID-19 pandemic and that this in line with other Trusts across

the NHS. It is also acknowledged that the size and layout of the Emergency Department does not meet the needs of the service and this has been exacerbated with the increase in demand and the requirement to provide separate areas for patients presenting on 'Amber' and 'Red' pathways. The Trust has experienced a recent increase in presentations to the Paediatric ED, again in line with the national position, and this increase is forecast to continue during the winter period. Therefore, the ED and Paediatric teams are working closely to utilise the space available across the ED and the Paediatric Assessment Unit as effectively and flexibly as possible. The Trust has also developed a plan to utilise recent national funding allocations to expand the ED footprint which will provide increased capacity for the paediatric and adult areas in ED.

Medical Care

The inspection team highlighted two concerns within the Endoscopy Unit which I have detailed below.

- *Within the Endoscopy Unit, noted staff do not use NEWS2 tool although observations are taken. There are plans in place for when the new endoscopy unit is open to use NEWS2.*
- *Young people over the age of 16 are seen within the Endoscopy Unit; however staff have not received safeguarding children training.*

I can confirm that within Endoscopy the NEWS 2 scoring is not used, although I would like to reassure you that all patients' vital signs are routinely monitored and recorded on a standardised observation chart for patients undergoing Endoscopy. This is completed alongside the Leeds Sedation Score and due to the nature of the procedure, patients are under constant observation. The Endoscopy Unit is always staffed with 2 registered Nurses, a Healthcare Assistant at either a Band 2 or 3 level, alongside patient support workers. The Registered staff have all attended BLS and ILS training with support staff having undergone SPEED training to recognise signs of patient deterioration. Staff are however, also trained in the NEWS2 scoring system as part of receiving patient from in-patient wards.

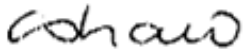
The escalation of a deteriorating patient process is clearly displayed within Recovery area, along with the details of the Critical Care Outreach Team. The Endoscopy Unit also has senior medical cover presence within the department during the Endoscopy lists, who are able respond to any concerns raised by the Recovery team. I would like to reassure you that we have had no serious incidents raised regarding failure to escalate and any adverse events are monitored as part of our JAG accreditation status and presented as part of a routine 6 monthly audit cycle within the Endoscopy Unit.

With regard to the safeguarding children's training, as part of mandatory training, I would like to reassure you that the Endoscopy staff are 100% compliant with their safeguarding training, which includes both children and adults. We would be happy to share any further

evidence or documents with you relating to this, or any other area of your inspection, if you would find this helpful.

Finally, I would like to thank you and your team again for your time, kindness and professionalism. I appreciated leading any inspection must be challenging, but even more so during these unusual times of COVID. However, this early feedback has been hugely beneficial to us as an organisation and allows us to continue to build on all the good work and remain focused on areas of planned improvement.

Yours sincerely



Caroline Shaw CBE
Chief Executive Officer

cc. Steve Barnett - Chair