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Our reference: RCX
Caroline Shaw CBE
Chief Executive
The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
Gayton Road
Kings Lynn
PE30 4ET

24 September 2020

CQC Reference Number: INS2-9224100943

Dear Caroline,

Re: CQC inspection of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Following your feedback meeting with Justine Eardley and Beth Malster on 23 September 2020. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Louise Notley and Frankie Swords at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on 23 September 2020 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

Trust wide:

- Infection control and prevention practices were maintained, including frequent handwashing in all staff disciplines.

- Staff were generally positive about their roles and were proud of their accomplishments. Colleagues were praised for their support and teamwork through perceived very difficult times.

Within Surgery:

- Patient risk assessments were completed, and patients were escalated according to clinical needs.
- There was evidence of shared learning from incidents and changes to practice as a result of the learning. This was particularly evident within SERU.
- Staff were particularly positive about the nursing leadership within the division.

Within End of Life Care:

- There had been a perceived trust wide focus on providing a quality end of life care service in response to Covid 19. This had helped the embedding of the Respect forms and internal processes to support patients and their families in the last days/ hours of their lives.
- The team worked collaboratively with stakeholders to provide care for dying patients and their families.
- Staff showed compassion when they reflected on how they had cared for patients in the last days of their lives. They learnt from their experiences and used this to plan care for new patients. For example, staff reported changes to the preparation required for families when completing video calls as a result of feedback from initial calls made.
- Patients and their families were involved with decision making.

Within Diagnostic Imaging:

- Actions had been taken to improve the safety and management of patients undergoing computerised tomography (CT) with contrast media. Patient group directives had been reviewed and there was a robust process in place to ensure their safe usage.
- There was a robust process for reviewing and updating policies and guidelines within the division.
- Staff were very supportive of each other and spoke positively of the ‘team’.

At the time of the feedback meeting we also raised the following:

Within Surgery:

- Venous thromboembolism (VTE) assessments were not consistently completed on Gayton and Elm wards. This issue was particularly noted in medical patients being cared for on the ward. In addition, it was not clearly recorded whether VTE assessments completed at pre admission assessments were reviewed/ reassessed on admission to hospital.
- Some surgeons felt that they were not fully supported by “middle managers” although senior leadership was praised. They were also “unhappy” with the number of cancelled procedures as a result of increased activity within the trust.

- We observed anesthetic medication prepared for administration (150 mls Propofol in three syringes) unattended in one anesthetic room. The anesthetic staff reported that they had briefly left the room.

Within End of Life Care:

- There were variances in the quality of the end of life records, particularly the completion of mental capacity assessments in response to Respect forms.
- Some staff felt that they had not been consulted in changes to ward activity, and that they had not been provided with adequate training to manage different patient groups. They also felt unsupported when they escalated concerns to the bed management team about risks of accepting patients, particularly out of hours.

Within Diagnostic Imaging:

- Staff were not always fully engaged with changes within the department, and some staff reported that that they felt unsupported as a result of gaps or changes to leadership.
- There were challenges with the recruitment of substantive staff.
- We observed two occasions when personal protective equipment (PPE) was worn within the control rooms (staff perceived non clinical area).

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS England and NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
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If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Justine Eardley

Inspection Manager (Interim)

cc. Mark Heath CQC

NHS England

NHS Improvement