George Eliot NHS Hospital

Quality Report

George Eliot Hospital
College Street
Nuneaton
Warwickshire
CV10 7DJ
Tel:024 7635 1351
Website: www.geh.nhs.uk

Date of inspection visit: 2 December 2019
Date of publication: 16/01/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services responsive?	
Are services well-led?	

Overall summary

George Eliot Hospital NHS Trust was opened in 1984 and provides a range of hospital and community-based services to more than 300,000 people across Nuneaton and Bedworth, North Warwickshire, South West Leicestershire and North Coventry.

We carried out this unannounced inspection on Monday 2 December 2019 as part of our winter pressure resilience programme. The decision to inspect was based on intelligence we held about the department and was associated to a potential increase in risk. During our inspection we spoke with 16 members of staff, six patients and three relatives. We looked at 10 sets of patient records. We also spoke with the leaders of the department, the trust medical director, director of nursing and director of operations.

The emergency department (ED) provides a 24-hour, seven day a week service. From June 2017 to July 2018 there were 81,661 attendances (an increase of 6% from the previous year). Of these, 19,000 were children of 17 years and under who were treated in a dedicated children's assessment unit. 6,724 adult patients arrived by ambulance (7% increase from the previous year). Between September 2018 October 2019, attendances to the emergency department had increased to 103,006 patients.

The ED consists of a major treatment area with 10 cubicles and a side room, a minor treatment area with six assessment/treatment rooms, and a resuscitation room with three trolley bays. A rapid assessment and treatment

Summary of findings

area had recently been built and consisted of four curtained trolley bays. The department had a seven-bed clinical decision unit and a seated observation area for a further seven patients.

We last inspected the emergency department in November 2018 and rated them as 'Requires Improvement'.

Our key findings were as follows:

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Staff did not always complete equipment checklists and limited space meant patients were cared for in non-clinical areas. Staff did not always complete risk assessments for each patient swiftly. However, staff used systems and processes to identify and act upon patients at risk of deterioration.

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to meet the demands of the service.

There were not enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The department had a high vacancy rate and was heavily reliant on temporary doctors. There had been little improvement in medical staffing since our last inspection.

Patients could not always access the service when they needed it. Although there had been some improvement in patient flow since our last inspection it was not enough to prevent patients being cared for in a corridor daily.

The vision for the department was poorly developed and there remained no agreed strategy.

There had been limited progress in governance processes since our last inspection in part because of the limited capacity within the medical workforce.

Whilst there was a system in place to support the improvement of quality of services, further work was required to ensure action plans were robustly implemented.

There had been some improvement within the culture of the senior leadership team; however, there remained a lack of common purpose and shared values within the clinical teams responsible for the day-to-day delivery of care.

We have told the provider they need to make improvements in a range of areas including:

The provider must ensure patients are assessed and identified risks are acted upon in a timely way to reduce the potential for avoidable harm. Whilst there had been some improvements in the completion of documentation, staff did not always complete risk assessments for each patient swiftly.

Patient flow must be coordinated across the whole emergency care pathway to ensure patients receive care and treatment in a timely way. This should include, but is not limited to, addressing the challenges in both the stroke and mental health pathways.

The provider must ensure there are sufficient numbers of staff with the right skills deployed at all times to ensure the department remains safe.

The provider must address the cultural challenges in the department and ensure there is a cohesive and multi-disciplinary approach to the management of patients in the department.

The provide must ensure governance processes are sufficiently robust. Actions from action plans and other improvement initiatives should be verified to ensure they have been effectively implemented and where appropriate, change audits undertaken to demonstrate sufficient improvements have been made.

The provider should ensure equipment is checked and records of such checks are maintained.

The provider should ensure there is a robust and sustainable strategy for the emergency care service provided from George Eliot Hospital.

On the basis of this inspection findings, and due to the need to significantly improve the quality of health care services provided, we have issued the trust with a s29A warning notice. We will monitor the trust's progress closely to ensure all patients receive safe, high quality care.

Summary of findings

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Requires improvement 	The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always complete equipment checklists and limited space meant patients were cared for in non-clinical areas. Whilst there had been some improvements in the completion of documentation, staff did not always complete risk assessments for each patient swiftly. However, staff used systems and processes to identify and act upon patients at risk of deterioration. The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to meet the demands of the service. There were not enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The department had a high vacancy rate and was heavily reliant on temporary doctors. There had been little improvement in medical staffing since our last inspection. Patients could not always access the service when they needed it. Although there had been some improvement in patient flow since our last inspection it was not enough to prevent patients being cared for in a corridor daily. The vision for the department was poorly developed and there remained no agreed strategy. There had been limited progress in governance processes since our last inspection in part because of the limited capacity within the medical workforce. Whilst there was a system in place to support the improvement of quality of services, further work was required to ensure action plans were robustly implemented.

Summary of findings

There had been some improvement within the culture of the senior leadership team however there remained a lack of common purpose and shared values within the clinical teams responsible for the day-to-day delivery of care.

Summary of findings

Contents

George Eliot Hospital

Services we looked at
Urgent and emergency services

Summary of this inspection

Background to George Eliot NHS Hospital

George Eliot Hospital NHS Trust was opened in 1984 and provides a range of hospital and community-based services to more than 300,000 people across Nuneaton and Bedworth, North Warwickshire, South West Leicestershire and North Coventry.

Information from the last Census conducted in 2011, indicated that there are now around 2,800 fewer young people (aged 5 to 15 years) in Nuneaton and Bedworth than there were 10 years ago. The largest percentage increases in population have been seen in the older age categories; over 85-year olds grew by 40% in the last 10 years in Nuneaton and Bedworth. The 'white British' ethnic group accounted for 88.9% of the population of Nuneaton and Bedworth in 2011, a fall from 93.5% in 2001. This was roughly in line with the countrywide trend. The Census indicated that 6.3% of the population was from minority ethnic groups. This was an increase of 43% from 3,977 to 5,705 people in 2011.

The main hospital site is George Eliot Hospital which is based on the outskirts of Nuneaton.

Acute hospital sites at the trust:

George Eliot Hospital, College Street, Nuneaton, Warwickshire, CV10 7DJ

The trust provides a range of elective, non-elective, surgical, medical, women's, children's, diagnostic and therapeutic services (Source: http://www.geh.nhs.uk).

The trust was last inspected by the CQC in November 2018 and was rated as requires improvement overall. We issued the trust three requirement notices in relation to regulations that were not being met, and where they needed to make significant improvements in the healthcare provided.

Facts and data about the trust

There are approximately 286 beds, including eight critical care beds, 12 day case beds and a coronary care unit with 11 beds. There are 14 inpatient wards. There are no children's inpatient beds. The trust has eight operating theatres providing planned and emergency surgical facilities for trauma and orthopaedics, general surgery (including breast and colorectal surgery), urology and gynaecology.

They also offer a wide range of day case procedures, for adults and children aged 2 to 16 years old. The trust also provides a range of community services across Coventry, Warwickshire and Leicestershire. These include, sexual health and community dentistry services for the whole of Warwickshire.

Urgent and emergency services

Details of emergency departments and other urgent and emergency care services

All urgent and emergency care services are located at George Eliot Hospital. Within urgent and emergency care are the following departments and units:

- Emergency Department (ED).
- Urgent Care Centre (UCC) for patients with non-emergency illnesses and injuries.
- Clinical Decisions Unit (CDU) for patients waiting for the results of investigations (seven beds and a seated observation area for a further seven patients).
- Ambulatory Care Unit (ACU) providing urgent day case medical treatment.

The emergency department (ED) provides a 24-hour, seven day a week service. From June 2017 to July 2018 there were 81,661 attendances (an increase of 6% from the previous year). Of these, 19,000 were children of 17 years and under who were treated in a dedicated children's assessment unit. 6,724 adult patients arrived by ambulance (7% increase from the previous year). Between September 2018 October 2019, attendances to the emergency department had increased to 103,006 patients.

The ED consists of a major treatment area with 10 cubicles and a side room, a minor treatment area with six assessment/treatment rooms, and a resuscitation room with three trolley bays. A rapid assessment and treatment area had recently been built and consisted of four curtained trolley bays.

Summary of this inspection

The department had a seven-bed clinical decision unit and a seated observation area for a further seven patients.

We last inspected the emergency department in November 2018 and rated them as 'Requires Improvement'.

We carried out this unannounced inspection on Monday 2 December 2019 as part of our winter pressure resilience programme. The decision to inspect was based on intelligence we held about the department and was associated to a potential increase in risk. During our inspection we spoke with 16 members of staff, six patients and three relatives. We looked at 10 sets of patient records. We also spoke with the leaders of the department, the trust medical director, director of nursing and director of operations.

Our inspection team

Our inspection team included a CQC inspector and two specialist advisors consisting of an emergency care consultant and an experienced emergency care nurse, who was the head of nursing for a large teaching hospital.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection for Midlands region.

How we carried out this inspection

This was a focused unannounced inspection of the emergency department at George Eliot Hospital on 2 December 2019.

We did not inspect the whole core service, therefore there are no ratings associated with this inspection. We did not inspect any other core service or wards at this hospital or any other locations or services provided by George Eliot NHS Hospital Trust. During this inspection, we inspected using our focused inspection methodology. We did not cover all key lines of enquiry; however, because we took enforcement action, we opted to rate the safe, responsive and well-led domains as detailed in the summary section of this report.

Requires improvement

Urgent and emergency services

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Inadequate

Summary of findings

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Staff did not always complete equipment checklists and limited space meant patients were cared for in non-clinical areas. Staff did not always complete risk assessments for each patient swiftly. However, staff used systems and processes to identify and act upon patients at risk of deterioration.

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to meet the demands of the service.

There were not enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The department had a high vacancy rate and was heavily reliant on temporary doctors. There had been little improvement in medical staffing since our last inspection.

Patients could not always access the service when they needed it. Although there had been some improvement in patient flow since our last inspection it was not enough to prevent patients being cared for in a corridor daily.

The vision for the department was poorly developed and there remained no agreed strategy.

There had been limited progress in governance processes since our last inspection in part because of the limited capacity within the medical workforce.

Whilst there was a system in place to support the improvement of quality of services, further work was required to ensure action plans were robustly implemented.

There had been some improvement within the culture of the senior leadership team; however, there remained a lack of common purpose and shared values within the clinical teams responsible for the day-to-day delivery of care.

Requires improvement

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always complete equipment checklists and limited space meant patients were cared for in non-clinical areas.

The emergency department had one triage room which was located at the main reception area. This was staffed by a registered nurse 24 hours a day, seven days a week. We had previously reported the adult emergency department was not of sufficient size or design to currently treat the increasing number of patients who presented to George Eliot Hospital; this remained the case at this recent inspection. The adult emergency department (ED) consisted of 10 major's cubicles and one major's side room, a minor treatment area with six assessment/treatment rooms and a resuscitation area with three trolley bays. To supplement the space available in the adult ED, an additional four trolley area was used to accommodate patients who were identified as being of lower acuity but still required a trolley and where the corridor was not an appropriate area for patients to wait. This area had initially been intended to operate as a rapid assessment area; however, following a short trial period, the senior management team determined that until challenges in medical staffing had been resolved, rapid assessment could not be effectively carried out.

An urgent care centre was co-located next to the waiting room and was used to see and treat patients who presented with minor ailments and minor physical injuries. We noted that whilst the waiting room was clean and tidy, the positioning of the chairs meant patients faced away from reception staff and the triage nurse. This meant patients who were perhaps showing signs of deterioration such as pallor, or who were showing non-verbal signs of pain such as facial gestures may not be immediately recognised, thus potentially delaying care and treatment. To address this, the service had introduced a new navigator staff role, whose remit was to provide clinical oversight to the waiting room, whilst also assessing all new patients who presented to the department and to navigate them to the most appropriate clinical pathway. We have discussed this pilot role in more detail further on in the report.

A clinical decision unit was co-located in the emergency department and was primarily used for patients who were awaiting results of investigations. This consisted of seven beds and a seated observation area for an additional seven patients. During the inspection, the seven beds were occupied by six medical and one surgical "outlier" patients (outliers is a common phrase used to describe patients who often require input from medical or surgical specialties but due to a lack of capacity, cannot be admitted to the correct specialty ward).

A children's assessment unit was co-located next to the main emergency department but operated as an independent unit, thus separating the children's and adult's emergency care pathways as recommended by national standards. The children's unit consisted of eight cubicles and one triage room. Five cubicles contained trolleys, whilst three contained chairs for those children identified as being of lower acuity. The service was supported by qualified children's nurses, a consultant paediatrician and a junior doctor Monday to Friday between the hours of 8am and 10pm. A consultant paediatrician and junior paediatric trainee doctor remained on site at George Eliot Hospital outside of these hours to support the maternity and special care baby unit, and so were able to provide advice and support to the emergency team out of hours. Children who required admission were transferred to one of three local NHS trusts depending on their presenting complaint. Access to the children's assessment area was by way of doors which were locked; access was controlled by the reception staff who were observed confirming the identity of individuals before access was permitted. We noted the line of sight between the nurses' station and the children's waiting room was restricted because of the design of the partition wall. This meant nursing staff may not have been able to identify or witness a child deteriorating suddenly whilst in the waiting room.

The department had a dedicated ambulance entrance, which was located near to the major treatment and resuscitation areas. Two screens displaying impending ambulance arrivals and the associate clinical complaint

of the patient was viewable to the nurse in charge who was responsible for receiving and assessing all patients who arrived by ambulance. An adjacent imaging department provided X-rays and scans for walking patients and those on trolleys.

We checked a range of specialist equipment, including adult and children's resuscitation equipment. Whilst equipment was clean and organised, a review of equipment checklists showed that daily checks had not been completed for a range of the trolleys located in the emergency department. Clinical waste and specimens were appropriately labelled and segregated. They were stored safely and disposed of according to hospital policy. We had previously reported the design and layout of the emergency department was no longer suitable to meet the growing demands of the service.

During this inspection, we noted the department to be under some operational pressure. We observed six patients being cared for along the main corridor of the emergency department and some patients being in the department for extended periods due to a lack of beds across the hospital. We noted the bed position improved during the inspection resulting in patients being discharged across the hospital, allowing patients in the emergency department to be admitted to inpatient beds. We also noted that three clinical decision trolley spaces had been reallocated back to the ED, to help improve flow through the emergency pathway and to reduce the number of patients required to wait in the corridor.

An area of the ED had been designated as a "Fit to Sit" area. Fit to sit areas are based on a concept which helps support patient flow and improve departmental performance against the standard set by the Royal College of Emergency Medicine (RCEM), which recommends all patients should commence their treatment within one hour of arrival. However, during the inspection we noted this area was not always used to its optimum capacity. We noted two patients who had been assessed and had received primary treatment; however, they had been relocated to chairs in the corridor whilst they awaited investigation results rather than being moved to the fit to sit area which would have been more appropriate. Where we observed patients being cared for in the main corridor, a nurse had been allocated to meet the ongoing needs of patients. We spoke with three patients who were receiving care whilst being accommodated on the main corridor. Each patient reported nursing staff had been responsive to their needs; however, each patient reported they were not fully aware of their treatment plan or next steps of care.

There was a designated room for seeing patients who required a mental health assessment. This had recently been re-furbished so that it met the Psychiatric Liaison Accreditation Network quality standard requirements. Patients identified as being at high risk of self-harming were allocated a nurse to provide one to one care. Staff reported patients would be located to a cubicle within the majors 2 area to help improve observation of the patient.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. However, staff used systems and processes to identify and act upon patients at risk of deterioration.

National standards require 95% of patients to have had an initial clinical assessment within 15 minutes of arrival to the department by ambulance. Data available to the Commission showed the average time from arrival by ambulance to assessment was zero between the reporting period of October 2018 to September 2019. However, due to the limited capacity of the nurse-in-charge (whose responsibility it was to both co-ordinate the major's department and to also receive all patients who arrived by ambulance), patients often experienced some delay with being assessed. At approximately 16:50 on the day of the inspection, the average time for those patients who arrived by ambulance was thirty minutes for one ambulance trust and 1 minute for another (the discrepancy is likely explained by the numbers of patients conveyed by each ambulance service respectively). The trust was able to clarify the dataset and reported as follows:

- Median time to initial assessment was reported as zero minutes between September 2018 and October 2019, except for:
  - November 2018 (2 minutes).
  - December 2018 (2 minutes).
  - January 2019 (4 minutes).
  - and September 2019 (3 minutes).

The average time to initial assessment ranged from four minutes to 18 minutes during the above period. The

average time for the entire period was nine minutes. This was better than the national recommended standard which states all patients arriving by ambulance should be assessed within 15 minutes of arrival.

We reviewed the process by which patients were initially received in to the department when conveyed by ambulance. The department had previously established a four-trolley rapid assessment area. This area was newly built and commissioned in 2018. Following a short trial, it was recognised that due to limited medical oversight, in part due to sustained medical workforce challenges, the delivery of a rapid assessment and treatment service was not viable. Therefore, all patients conveyed to the ED via ambulance were reviewed and assessed by the nurse in charge who, based on their assessment, would allocate the patient to a specific area within the majors' department. Where a patient was identified as being of low risk or low acuity, the patient was queued along the main ambulance corridor. Patients who presented to the emergency department independently (walk-in) were first required to book in with a receptionist.

The trust had recently commenced a new pilot in which a navigator nurse had been introduced. The role of the navigator was to undertake a rapid assessment of patients to ascertain the most appropriate clinical pathway, be it via the minor see and treat, urgent care, majors or resuscitation pathway. However, due to staffing challenges on the day of the inspection, there was no allocated navigator and so the service reverted to their standard triage pathway. A senior nurse was attempting to fulfill some element of the navigator role; however, other clinical and managerial responsibilities meant this individual could not be present to at the reception area to navigate all patients who self-presented to the ED.

We spent time reviewing the triage process. Staff used a nationally recognised triage system which helped to prioritise patients dependent on their clinical risk indicators. High risk patients were prioritised or fast-tracked to the most appropriate clinical area such as the resuscitation area. During the inspection we observed the triage process; seven patients waited longer than 15 minutes before being assessed. One patient waited 27 minutes before being seen by the triage nurse.

As part of their induction, all reception staff had received training on 'red flag' presenting complaints and the deteriorating patient. Red flags are signs and symptoms that indicate the possible or probable presence of serious medical conditions that can cause irreversible disability or untimely death unless managed promptly.

We reviewed 10 patient records during the inspection. National early warning scores (NEWS2) were used to assess the seriousness of a patient's condition. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, temperature, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. The observations were recorded on an electronic recording system which automatically calculated the early warning score and alerted staff if action needed to be taken.

Sepsis screening tools were completed in three of the four relevant care records we reviewed. Where patients had been identified as being at moderate or high risk of sepsis, we noted good adherence to local and nationally aligned treatment protocols including the early administration of intravenous fluids, timely administration of antibiotics, strict fluid balance monitoring and the use of oxygen. There was one case in which the sepsis screening protocol was not completed for a patient who had arrived with a low temperature and who had been found having collapsed and unresponsive for approximately 10 minutes. Whilst it was clear from the treatment plan that staff had considered both chest and urinary tract infections, staff had potentially missed the opportunity to instigate more timely treatment by not having completed the sepsis screening bundle. We also noted the patient safety checklist had not been completed past two hours, despite the patient having been in the department for five hours. We further noted the patient had not had a falls risk assessment completed despite having been found in a collapsed state at home. The patient had not had a skin integrity assessment completed; the department standard was that all patients would have such an assessment within two hours of arrival. We fed this back to the trust who acknowledged that whilst improvements had been made in the completion of documentation, more work was required to ensure patients received timely assessments to help staff manage risks to patients.

A second patient had been in the department for approximately 12 hours; however, their ED safety checklist had only been completed for the first three hours. The matron reported that daily documentation checks of patient safety checklists and associated nursing documentation was undertaken, which showed improving compliance. They recognised that further work was required to ensure staff consistently completed the relevant documentation for patients.

Nursing staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to meet the demands of the service.

At the time of the inspection, the trust reported a vacancy rate of 22.98 whole time equivalent nursing staff for the ED. Of this, 15.19 whole time equivalent vacancies were across the band five ED nurse workforce. This was an improving position, in part due to sustained active recruitment and retention strategies. Both band 4 and band 6 nursing workforce were over-established to help offset the band five vacancies. We had previously reported that nurse staffing levels had not been assessed or reviewed with the use of an evidence-based resourcing tool.

At this inspection, a comprehensive five-year review of the nursing workforce had been completed. The trust reported that following a nursing workforce transformation review, the current seven shift pattern used in the ED would be changing to a two-shift pattern on 12/01/2020 to provide a consistent 16 staff on the long day and 14 on the night. Staff on flexible contracts would be accommodated using their hours across the long day or night and supplemented with regular temporary workforce, unused hours and roster balancing. The trust was liaising with national agencies, including NHS Improvement, to quality assure the process and to seek support in developing a validated emergency department acuity tool.

Each shift was managed by an experienced senior band six or band seven nurse. Through the 24-hour period, staffing was assessed through a safety matrix two hourly within ED. The shift co-ordinator used the safety matrix information to determine the most effective allocation of the available workforce to optimise safety within the ED. All staffing issues, shortfalls and staff movement were recorded on the co-ordinator shift handover for record. Any compromise or patient safety issue arising from staffing was reported via the incident management system.

At 8.15am each weekday, nursing huddles took place during which staffing was discussed. Resources between the ED and the admissions unit were reviewed to ensure staff were appropriately deployed to ensure each area had the right skill mix and number of staff. Nurse staffing was discussed three times a day at the site meetings. Shortfalls were escalated, and temporary staff were sourced where appropriate. A matron of the day was available seven days a week with the responsibility for safe staffing and a clinical site manager responsible outside of normal working hours.

Current NHS guidance ('Safe, sustainable and productive staffing in urgent and emergency care', November 2017) states that there should be a minimum of one qualified nurse for every two patients in the resuscitation room. We had previously reported that legacy rota allocations meant the three-trolley resuscitation area was not consistently covered by a substantive nurse. Instead, a nurse working in the major's area was assigned to cover the resuscitation area in the event the department received a pre-alert call, or where a patient required increased observation or resuscitation whilst in the ED. This remained the same at this inspection despite the trust having approved, in 2018, funding for a full-time registered nurse to be assigned to the resuscitation room. The trust reported that this supplementary funding had been used to offset agency costs during periods of peak activity. The trust reported that following our initial feedback, the Director of Nursing was now reviewing the reasons as to why the post had not been substantively recruited too.

Medical staffing

There were not enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The

department had a high vacancy rate and was heavily reliant on temporary doctors. There had been little improvement in medical staffing since our last inspection.

There were not enough consultants to provide the daily 16 hours of consultant presence as recommended by the Royal College of Emergency Medicine (RCEM). During the week there was a consultant in the department for 12 hours a day and for four or five hours a day at weekends. The department directly employed 3.5 consultants in emergency medicine. The part time consultant did not participate in the on-call rota. The department was budgeted for five WTE consultants. The newly appointed clinical lead acknowledged further work was required to ensure there were enough consultants employed to support the department. A range or recruitment strategies had been adopted by the trust to address the shortfall.

The clinical lead reported they were working towards increasing the establishment of consultants to six WTE, if they were to meet RCEM safer staffing recommendations. The executive team were able to describe a range of mitigating strategies they could instigate in the event the consultant workforce reduced further. The clinical lead further reported significant challenges in the recruitment of experienced middle grade doctors to support the ED. As of 8 December 2019, the department had a budgeted establishment of 22 whole time equivalent middle grade doctors, however there were only 1.6 WTE in post.

The department was heavily reliant on locum doctors to support the rota. Whilst staff were complimentary of the locum staff used, some of whom had adopted long-term temporary contracts with the department and so were familiar with staff and working practices, the executive team acknowledged the position was not sustainable long term.

The clinical lead reported their focus was to recruit initially to the consultant body, in order highly experienced clinicians were available to support more junior doctors, and thus improve retention of middle grade doctors. Due to the clinical pathways and clinical services provided at George Eliot Hospital, the department was not recognised as a training centre for emergency medicine specialty trainee doctors, which further impeded the ability of the leadership team to back-fill the middle grade rota.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and flow

Patients could not always access the service when they needed it. Although there had been some improvement in patient flow since our last inspection, it was not enough to prevent patients being cared for in a corridor daily.

At the time of our inspection, the hospital was on operational pressure escalation level (OPEL) 3. This refers to the number of beds available in the hospital and the number of patients needing to be admitted. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL 4; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.

Managers monitored waiting times and but didn't always make sure that patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

From October 2018 to September 2019 performance against this standard showed it was generally shorter than the England average and the sixty minute recommendation. However, the median time began to climb in June 2019 and data was not reported for July 2019.

Managers and staff worked to make sure patients did not stay longer than they needed to but were not always successful.

Requires improvement

Urgent and emergency services

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From November 2018 to October 2019, the trust failed to meet the standard and performed worse than the England average.

From November 2018 to October 2019, the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From November 2018 to October 2019, performance against this metric showed unstable performance and performance worse than the England average.

Over the 12 months from November 2018 to October 2019, 74 patients waited more than 12 hours from the decision to admit until being admitted. Senior clinical staff described a varied response from the site capacity team when managing risk within the emergency department (ED). We observed two site meetings during the inspection, which were led by the allocated site commander. There was representation from a range of professionals including general managers and nurses. The medical director was also present as the executive representative. At the 13:00 meeting, consideration was given to those patients who already had a "decision to admit". This is a phrase used when a clinician has determined a patient requires admission to hospital. The site commander considered the potential beds to become available over the remainder of the day. At the end of the meeting, eight potential beds had been identified; the medical director prompted those present to consider the additional requirements, considering the emergency department was already at full capacity. There were limited actions identified to ensure supply was greater than demand for the full twenty-four-hour period. Critical care had been identified as being at full capacity with no remedial actions to consider any additional requirements from the emergency department throughout the remainder of the day. Pre 12pm inpatient discharges had been reported to be minimal and there had been no robust discussion or action plans identified to try and relocate the surgical and medical outliers occupying the clinical decision unit beds. The site meeting did not consider the risks associated with an overcrowded ED. There were no identified initiatives or actions to help decompress the ED. Staff reported the discharge lounge remained empty at 13:00. Whilst we recognise that there may not always be patients suitable for transfer to the discharge lounge, there had been no discussion as to whether there were any suitable patients within the hospital who could have been moved to enable in-patient beds to be made available. Following the inspection, the trust provided clarity on the discharge lounge in that it was a small area used predominantly to recover patients who were recovering from minor procedures; the area was not a formalised or dedicated discharge facility.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From October 2018 to September 2019, performance against this standard showed it was generally shorter than the England average and the sixty-minute recommendation. However, the median time began to climb in June 2019 and data was not reported for July 2019.

The number of patients leaving the service before being seen for treatments was low.

From October 2018 to September 2019, performance against this metric showed performance was similar or better than the England performance. In July 2019, no data was reported.

We explored the concept of escalation with senior leaders. Whilst staff could describe the processes, it was reported there was little in the way of system response, even when the ED was at a position of being "overwhelmed". A lack of community inpatient provision had been identified as one of the contributory factors to poor flow through the emergency care pathway. Further, clinical pathways had been poorly developed or instigated across the hospital, in part due to legacy leadership decisions which had not been sufficiently challenged previously. Limited capacity in the ambulatory care unit meant insufficient numbers of patients could be appropriately referred instead of receiving care in the emergency department. Rigid referral protocols and again limited capacity in the surgical assessment unit further impeded the ability of the emergency unscheduled care pathway to operate effectively. These were areas the clinical lead and local executive team had recognised these as areas which required improvement and could describe the enabling

strategies and plans which were being instigated to improve the pathways. However, at the time of the inspection, these strategies had not been fully instigated and so we were not able to assess their effectiveness.

Staff reported challenges with ensuring stroke patients were referred to the stroke specialty and transferred to a dedicated stroke assessment bed within four hours of arrival to the hospital. This had been identified as a long-standing challenge for the hospital. We reviewed incidents which had been reported by staff between April 2019 and October 2019 and noted there had been 39 occasions when stroke patients had not been transferred within four hour and a further 13 occasions when patients had not been referred to the stroke team within a timely manner. An action plan had been introduced as a means of improving the access for stroke patients, for assessment on the stroke unit. Whilst it was reported that initial performance had improved, this had not been sustained, in part because the assessment room used on the stroke unit was used to accommodate inpatients during times of escalation, and thus reduced the ability for patients to be transferred to the unit. The stroke team had completed a range of quality improvement initiatives to further evidence the importance of having dedicated assessment areas for the timely assessment of stroke patients, and a detailed report to the quality assurance committee detailed the further work required to ensure a long-term solution was achieved.

The provision of mental health services was also raised as a concern during the inspection and appeared as a theme when we reviewed incident reports for the period of 16 April 2019 through to 30 October 2019. Staff reported patients who required specialist mental health beds could experience significant delays and were therefore required to stay in the emergency period for extended periods until such a bed became available. Staff recognised the ED was not the ideal location for this patient cohort and was an issue we had previously reported on in 2018. We noted on one occasion a young person had spent an extended period on the acute medical unit whilst a specialty bed was sourced. Whilst the trust instigated their local policy regarding the safe management of the patient and could demonstrate they had escalated the matter to regional commissioners, there appeared to remain an on-going problem with the provision of specialist mental health services in the region. The trust was able to provide evidence of on-going system-wide strategies to address the issues; however, we considered there to be limited pace of change regarding this matter. The trust continued to report incidents where mental health patients remained in the department for extended periods of time whilst waiting for specialist beds to be available.

Are urgent and emergency services well-led?

Inadequate

Leadership

Vision and strategy for the service

The vision for the department was poorly developed and there remained no agreed strategy.

At our last inspection in 2018, we reported there was no formal vision for the emergency service at George Eliot hospital. Staff spoke positively about the future of the service and recognised the investment that had been made in terms of developing the urgent care service and creating new clinical spaces to enable improved clinical pathways across the hospital. However, staff could not signpost the inspection team to a formal strategy, nor could they provide us with a long-term plan which was to be used to address longstanding issues within the emergency department (ED) aside from ED improvement plan meetings. These meetings appeared to be orientated towards action plans which addressed issues regarding regulatory compliance and could detail the actions staff were taking to address these. The local Warwickshire North Health and Social Care Delivery Board discussed a range of enabling strategies to help improve access and flow through the emergency care pathway. We were provided with the minutes of the June 2019 meeting in which challenges regarding performance against constitutional access targets, frailty and mental health provision were discussed. There appeared limited outputs and commitments from the wider system to support the acute service. Commentary within the minutes included the requirement for there to be further conversations about specific topics, as compared to the delivery board being used as a driver for change. The effectiveness of the delivery board at the June 2019 meeting may have been hampered by the lack of attendance from key individuals from external parties

including the mental health trust and the local authority. This suggested a lack of grip and ownership of the emergency care pathway by the wider health economy, with responsibility placed with the local team based at George Eliot Hospital.

The newly appointed clinical lead was present at the time of the inspection. They had a clear understanding of the challenges of the department, but also recognised the areas of good practice. There was an acknowledgment of the need to stabilise the team in the first instance, before significant focus could be placed on developing a unit wide vision and strategy. The executive team were also acutely aware of the challenges of sustaining and delivering an emergency care service at George Eliot Hospital which was impeded by the challenges of recruiting enough numbers of experienced doctors. The executive team had developed a range on mitigating strategies in the event medical staffing numbers fell further then than the current establishment as a means of being able to continue to deliver the emergency care service.

There was an appetite among the leadership team to ensure the emergency care service at George Eliot hospital delivered consistently good outcomes for service users, however the team were aware of the challenges they faced in terms of delivering this.

Governance, risk management and quality measurement

There had been limited progress in governance processes since our last inspection in part because of the limited capacity within the medical workforce. Whilst there was a system in place to support the improvement of quality of services, further work was required to ensure action plans were robustly implemented.

Whilst there had been improvements in the development of governance processes within the ED, there was a recognition of the need for further work. All nursing staff had been set standard objectives which included the attendance at governance and morbidity and mortality meetings. There was evidence that this was starting to occur with three nurses reporting their attendance at the most recent mortality review meeting which had assisted their personal development. The ED clinical manager was able to demonstrate improvements across a range of metrics including the completion of documentation however they recognised further work was required. Their approach was to undertake daily audits and to provide real-time feedback to individual nurses to help improve their practice and to ensure compliance with both trust policies and the requirements set by the Nursing and Midwifery council.

The limited medical workforce meant there were gaps in the completion of clinical audits. Further, the sparse substantive medical workforce meant responsibility for specific areas rested with one or two individuals. This presented a risk for the department in that audit programmes and risk management strategies could not be fully embedded because of this reliance on individuals to deliver. We noted shortfalls in the process by which the department could demonstrate they adhered to and applied national best practice standards. For example, we asked the local team to provide us with a copy of the protocol for procedural sedation. Neither medical or nursing staff could provide such a protocol, despite this being an area of gold standard practice set by the Royal College of Emergency Medicine. One doctor was able to locate a checklist which they reported was used as part of junior doctor teaching sessions, but confirmed this was not a checklist ordinarily used in day to day practice. We were also left confused as to who in the department undertook procedural sedation activities as we received conflicting answers from different doctors and nurses. The lack of robust governance processes meant that whilst the department could evidence some compliance with national best practice standards, other elements were left wanting.

The leadership team were aware of the risks and areas for improvement in the department and we could see these were discussed at governance meetings. There lacked some attention to detail with regards to the completion of identified actions. For example, we reported in 2018 the requirement for the local major haemorrhage protocol to be introduced. We noted a flow chart dating back to 2014 was on display in the major's department. We raised this with the trust who confirmed the protocol had been updated in October 2018, and was available electronically, and that the flowchart, whilst dated 2013/2014 remained the correct flowchart. The trust reported they would act to ensure the date of the flowchart had been updated so staff were aware it was the latest version. We had also previously reported challenges with staff referring patients to specialty teams in a timely way.

A review of incidents both during and after the inspection identified a continued theme with stroke patients not being referred to the stroke specialty in a timely way. Whilst there was a trust wide action plan to address this, there was limited evidence to suggest there had been sustained improvements in what were long standing issues.

Culture within the service

There had been some improvement within the culture of the senior leadership team however there remained a lack of common purpose and shared values within the clinical teams responsible for the day-to-day delivery of care.

We had previously reported that on a day-to-day basis, there was little joint working between senior medical and nursing staff. Each team had a separate staff base and there was little communication between the two. Although senior doctors and nurses discussed patients at the thrice daily "board rounds" (patient handover sessions) we saw very few discussions at other times. At this most recent inspection, we still considered there to be a lack of cohesive operational working between the consultant in charge of the department on the day of the inspection, and the nurse in charge. There lacked any form of command and control management, even when the department was bordering on a state of being overwhelmed. We observed the responsible consultant spending most of their time in the minor's area, whilst an experienced middle grade doctor was left to oversee the major's area. Whilst we were not concerned with the competence of the middle grade doctor, we considered there had been little progress within the culture of the department in terms of developing the working relationship between those responsible for the daily management of the department. This was an area recognised as in need of improvement by both the clinical lead and the executive team. The team were able to discuss the strategies and approaches they intended to take but could not provide evidence of such action having been taken at the time of the inspection.

Clinical and non-clinical staff told us that, overall, they enjoyed working in the service and felt supported by the leadership team. They were able to express any concerns they may have had but felt they were given little opportunity to make changes in the department. Some staff reported they had not yet met the new clinical lead but were aware of their appointment. There was some concern the new lead would not have enough time to address and sustainably bring about change to the challenges of the department because they had only been appointed on a part time basis.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure patients are assessed and identified risks are acted upon in a timely way to reduce the potential for avoidable harm. Regulation 12 (1)(2)(a)(b): Safe care and treatment.

Patient flow must be coordinated across the whole emergency care pathway to ensure patients receive care and treatment in a timely way. This should include, but is not limited to addressing the challenges in both the stroke and mental health pathways. Regulation 12 (1)(2)(i): Safe care and treatment.

The provider must ensure there are sufficient numbers of staff with the right skills deployed at all times to ensure the department remains safe. Regulation 18(1): Staffing.

The provider must address the cultural challenges in the department and ensure there is a cohesive and multi-disciplinary approach to the management of patients in the department. Regulation 17(1)(2)(e)(f): Good governance.

The provide must ensure governance processes are sufficiently robust. Actions from action plans and other improvement initiatives should be verified to ensure they have been effectively implemented and where appropriate, change audits undertaken to demonstrate sufficient improvements have been made. Regulation 17 (1)(2)(a)(b): Good governance.

Action the provider SHOULD take to improve

The provider should ensure equipment is checked and records of such checks are maintained. Regulation 12(1)(2)(e): Safe care and treatment.

The provider should ensure there is a robust and sustainable strategy to drive improvements in thefor the emergency care service provided from George Eliot Hospital. Regulation 17(1)(2)(e)(f): Good governance.

The provider should ensure all relevant patient risk assessments are documented in a timely manner. Regulation 17(1)(2)(c): Good governance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care · The trust has not taken enough action to mitigate the risks associated with the high levels of vacancies across the medical workforce. · The trust has not taken enough action to address flow challenges across the emergency care pathway in order patients can access care and treatment in a timely way, and in a way which demonstrated the privacy and dignity of patients was always respected. · There remained ineffective governance systems to monitor quality, safety and risk within the urgent care division.