George Eliot Hospital NHS Trust

Quality Report

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Date of inspection visit: 30 April and 1 May 2014
Date of publication: 17 July 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

George Eliot Hospital NHS Trust provides a range of hospital and community-based services to 300,000 people in North Warwickshire, South West Leicestershire and North Coventry, employing around 1,917 staff. The hub of the trust is the George Eliot Hospital, a 352-bed district general hospital, based on the outskirts of Nuneaton.

The trust has six locations registered with the Care Quality Commission, including the George Eliot Hospital. The other locations are the Camphill GP Led Health Centre, Satis House, Leicester Road (APMS Practice), The Chaucers (APMS Practice) and the Leicester Urgent Care Centre.

During this inspection we inspected the George Eliot Hospital. This hospital is an acute hospital providing accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people' services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

We carried out this comprehensive inspection because George Eliot Hospital NHS Trust had been flagged as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was one of 11 trusts placed into special measures in July 2013, after Sir Bruce Keogh's review into hospitals with higher than average mortality rates. There were concerns about the role of the leadership team in driving improvements in the quality of care and treatment, the pace of quality improvement, the number of unnecessary bed moves for patients, the level of clinical staff out of hours and at the weekend, the quality of medical handovers, the use of nationally recognised pathways of care, the need to improve incident reporting, and the need to reduce the prevalence of pressure ulcers and to clarify the grading of pressure ulcers.

The announced inspection took place between 30 April and 1 May 2014, with an unannounced visit on 10 May between 4pm and 8pm.

Overall, we rated this trust as 'good'. The trust was good for providing effective, caring and responsive services and was well led. The safety of some services 'requires improvement'.

We rated medical, critical care, maternity, children and young people's services, end of life care and outpatient services as 'good', and A&E and surgery services as 'requires improvement'.

Key findings related to the following:

- We recognised that the trust had worked hard and had made significant progress since entering special measures in July 2013. Ten urgent priority actions had been identified within 55 recommendations for the trust, to improve the quality of their services. As of April 2014, all 10 key Keogh actions identified had been delivered with work ongoing with regards to Board development and the implementation of an electronic incident reporting system.
- Special measures status was designed to provide intensive support to challenged trusts: The trust was partnered with University Hospitals Birmingham NHS Foundation Trust. The relationship was described as supportive and flexible, and had developed depending on the needs of the George Eliot Hospital NHS Trust. The trust had benefited from support to develop governance processes, and support to the leadership, in particular, around challenged services. Both trusts described the relationship as extremely positive.
- The trust had a clear vision and a five-year strategy was in development to adapt and change services, and develop sustainable quality care. There were comprehensive governance processes to monitor quality, performance and patient experience. The leadership team were proactive in taking action on identified risks, and open and transparent about challenges and successes. They had made credible and significant progress against their action plan under special measures, and there had been an impact on reducing mortality, developing the quality of care, the progress of seven-day services, and the use of recognised pathways of care. The monitoring and approach to deliver harm free care was reducing avoidable harms, such as falls and pressure ulcers.

Summary of findings

- Overall, we found that staff were caring and compassionate, and treated patients with dignity and respect. Patient's experiences of care was good, and the NHS Friends and Family Test rating was higher than the national average for inpatient wards and for A&E.
- The trust had identified significant risks around managing patient flow, staffing levels and discharge planning. The number of patient bed moves had significantly reduced, with a change in the model of care and consultant responsibilities, and staffing levels had been reviewed and more staff had been recruited. The management of patient discharge remained a challenge, but was being managed through early discharge planning and co-ordination by the discharge team.
- The hospital had worked to improve emergency care, and had introduced the modified early warning system tool, care pathways and care bundles, to escalate and standardise care for patients who were acutely ill. In March 2014, the trust mortality rates were within the expected range.
- In December 2013, the trust had opened a new acute medical admissions unit and an ambulatory care unit. The A&E department had been reconfigured during 2013 to improve the flow of emergency patients through the hospital, and speed their assessment, treatment and discharge. The trust was seventh in a list of top 10 NHS trusts in the country for seeing A&E patients within four hours, in the 20-week period up to 23 March 2014, and the ambulatory care unit was successful in avoiding patient admissions.
- Seven-day working was developing across all services, and was significantly developed for emergency care. Staff worked in multidisciplinary teams to co-ordinate care around the patient, although clinical support, for example, in therapy, pathology and radiology services, were not as well developed across seven days.
- Nursing staffing levels were assessed using the national Safer Nursing Care Tool and minimum staffing levels had been set. Additional nurses had been recruited, and wards and patient areas were staffed appropriately. There had also been a change in the skill mix of nursing staff on night shifts. There was still a reliance on agency staff, particularly in A&E and the operating department, but where possible, the same staff were being used. Shifts were being monitored using a rating system, where green was staffing levels as required, and red was a safety concern. The trust had a system to escalate concerns when staffing levels fell below the minimum. They reported that there had not been any 'red flags' in the last 2,013 shifts in the last eight weeks leading up to the CQC inspection.
- Medical staffing levels had increased, but there was still concern in A&E, general medicine and paediatrics. Locum staff were being used, but this was costly. Overall, the trust spend on agency and locum staff was 15% of the total staffing budget The trust had a financial imperative to reduce the number of agency and locum posts to substantive posts in the coming year.
- Staff followed good infection prevention and control practices, except in A&E, where poor practices were observed. The hospital was clean and well maintained, and infection control rates in the hospital were in an acceptable range.
- The number of pressure ulcers, falls and catheter related infections was higher than the England average. The hospital monitored harm-free care in all patient areas and had taken action that was reducing these avoidable harms.
- Incidents were reported, but staff did not always receive feedback and the lessons learnt were not widely shared. The trust was investing in a new electronic incident reporting system.
- Pharmacy services and medicines management were not receiving adequate attention. Pharmacy needed to increase its joint working and responsibility for prescribing, administration and medicines management. Medicines were not always being safely stored and managed. This was particularly evident in the A&E department and the operating department. In both departments there were concerns relating to the storage and stock control of medicines, including controlled drugs, where legal requirements not been met. The trust was taking action to improve this.
- Radiology services had been without appropriate leadership for two years. The service had antiquated procedures and these were not responding well to increasing service demands and there were long waiting times for services. The trust needed a new CT scanner and there were currently delays for urgent CTs due to the capacity of the single scanner. The service had unfilled consultant posts and difficulties in recruiting. There was external remote reporting but this was not monitored effectively. The governance

Summary of findings

arrangements in radiology were a concern and risk management, incident reporting and audit were underdeveloped; infection control standards were not being met. The trust was now working to identify leadership support for this service.

- Staff told us that special measures had been difficult, but wanted us to be aware of the positive changes. They felt that the culture was open and transparent, and staff were encouraged to learn and innovative. Learning across the trust, however, was not shared effectively. Some staff groups, such as cleaners, and administrative and clerical staff, said they were still under pressure and wanted their concerns to be heard. There were also particular services where there were leadership concerns, such as in theatres and maternity, and morale was low in radiology. This could affect patient care if they remained unresolved. The Trust had engaged with staff in these areas and was taking taking action to strengthen leadership arrangements and to build effective team working and resilience in these services.
- Complaints management was improving in response to patient feedback about delays, and defensive and jargonistic replies. A new format was being introduced to standardised responses and ensure information was being communicated in a way that patients could understand. There were still excessive delays however, with only 20% of complaints in February 2014 being responded to within 25 days.

We saw several areas of outstanding practice including:

- The ambulatory care unit (ACU), opened in December 2013, had had a positive impact on preventing patient admissions. The ACU was helping to meet the needs of patients in the community who required medical intervention without the need to be admitted to the hospital.
- There were physician associates, who were staff trained to support medical staff with assessment, investigation and diagnosis. One physician associates was trained to complete comprehensive assessments for frail elderly patients.
- The trust had developed initiatives to encourage people living with dementia to eat. They used coloured plates and adapted cutlery, and warmed plates to keep food warm.
- The trust had a carer's passport, which was a scheme where named relatives could offer their help by coming into the ward and providing care for their loved one, such as help to eat meals or personal care. The hospital offered the named relative free parking or 10% off meals purchased at the hospital.
- Discharge booklets were introduced in all medical wards. These were kept by every patient's bed, and were completed by members of the multidisciplinary team (including intermediate care and social services) to record specific outcomes leading towards safe patient discharge.
- A nurse-led early discharge support team was provided for patients with chronic obstructive pulmonary disease. This included home visits and physiotherapist input. The team worked closely with the respiratory ward to ensure longer term management. A discharge bundle had been introduced, which included follow-up within 72 hours.
- The Oasis Project identified patients during their pre-operative assessment who may be anxious about surgery. The project comprised of a team of volunteer therapists who had a professional relaxation qualification. Therapists would talk through any anxieties at the pre-operative assessment, to provide reassurance to the patient, and also note any issues for the patient's admission for surgery.
- The trust had produced a leaflet for relatives and friends inviting them to contact the critical care outreach team directly if they had concerns about their relative.
- The hospital had made significant strides in the recognition and management of sepsis and the delivery of the 'Sepsis Six' care bundle. They had a critical care outreach nurse seconded as a Sepsis Nurse who monitored compliance and had introduced a sepsis recognition tool, sepsis boxes for the wards and stickers to improve fluid balance completion.
- Picture screens were used in the intensive therapy unit (ITU), which depicted, for example, pictures of a soothing flower blossom scene. Staff and relatives commented that these were calming and relaxing, and gave the patients lovely visual images.
- A special service called Providing Information and Positive Parenting Support (PIPPs) was available, providing information and positive parenting support to vulnerable and teenage mums. Midwives developed

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a close relationship with women, and offered additional support, continuity of care and co-ordinated multi-agency case conferences, involving social services.
- Multidisciplinary networks in paediatrics were being developed to deliver care closer to children's homes.
- The AMBER care bundle is a simple approach used in hospitals when doctors are uncertain whether a patient may recover, or are concerned that a patient may be in the final stages of life (months or days), and the package supports advanced care planning. Trained team members act as champions, to drive high quality care at the end of life. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes, and putting plans in place should the person die.
- The end of life care team had rolled out end of life care standards to ward areas using a strategy called 'transform'. Staff were trained to ensure that patients in the hospital had a good experience of end of life care.
- The Patient Advice and Liaison Service (PALS) responded to 95% of patient concerns on the same day.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients; for example, details of the patient's current medication.

However, there were also areas of poor practice, where the trust needs to make improvements.

Importantly, the trust MUST ensure:

- Medicines are managed at all times in line with legal requirements.
- There is effective leadership and governance arrangements in the A&E, operating department,maternity and radiology.

In addition the trust SHOULD ensure:

- Safety standards in the A&E department are improved to be in line with current national guidance.
- Children did not have long waiting times in the Rose Goodwin observation unit in A&E.
- Care pathways and care bundles continue to be embedded into everyday practice and monitored.
- The trust needs to continue to reduce the avoidable harms of pressure ulcers, falls, and catheter urinary tract infections.
- People living with dementia continue to have consistent care and support in all areas of the trust.
- The Five Steps to Safer Surgery checklist is audited to ensure appropriate and consistent use.
- Patients being 'checked in' for theatre have their privacy and dignity maintained.
- Staffing levels continue to improve (especially in A&E and surgery), and patient care is appropriately delivered by trained, experienced and skilled staff.
- The use of linen drapes in theatres is avoided.
- That all staff use the incident reporting system to report incidents, and that learning from incidents is cascaded and shared.
- Do Not Attempt Cardio Pulmonary Resuscitation orders are appropriately completed so that there is timely documentation of the decision by the appropriate person, and this decision is reviewed if there is a change in a patient's condition, and mental capacity is assessed.
- Radiology services improve so that patients do not experience delays and long waiting times.
- Continue to develop services across seven days.
- Medical staff communicate with patients in a way that they can understand.
- Complaints are responded to within 25 days and responses address all concerns and are written in a way patients and the public can understand.

Staff engagement continues and develops and staff at all levels feel involved and listened to.

Professor Sir Mike Richards

Chief Inspector of Hospitals

16 July 2014

Summary of findings

Background to George Eliot Hospital NHS Trust

George Eliot Hospital NHS Trust provides a range of hospital and community-based services to 300,000 people in North Warwickshire, South West Leicestershire and North Coventry, employing around 1,917 staff. The hub of the trust is the George Eliot Hospital, a 352-bed district general hospital, based on the outskirts of Nuneaton.

The trust has six locations registered with the Care Quality Commission, including the George Eliot Hospital. The other locations are Camphill GP Led Health Centre, Satis House, Leicester Road (APMS Practice), The Chaucers (PMS Practice) and the Leicester Urgent Care Centre.

The trust board had not changed significantly in the last 18 months. The chief executive had been in post since 2011. The medical director was new and was appointed in April 2014; prior to this, he had been a clinical director in the trust.

In 2013, the trust was identified nationally as having high mortality rates, and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the medical director for NHS England) as part of the Keogh Mortality Review in May that year. After that review, in July 2013, the trust entered special measures. This was because there were concerns about the role of the leadership team in driving improvements in the quality of care and treatment, the pace of quality improvement, the number of unnecessary bed moves for patients, the level of clinical staff out of hours and at the weekend, the quality of medical handovers, the use of nationally recognised pathways of care, the need to improve incident reporting, and the need to reduce the prevalence of pressure ulcers and to clarify the grading of pressure ulcers.

The trust had been in the process of seeking a strategic partner to secure the long-term sustainability of its services and finances. The trust had started the procurement process in 2013, but in March 2014, the NHS Trust Development Authority (TDA) confirmed that that the process would not continue, and that the trust was in a position to develop its own clinical service strategy and sustainable financial future.

The inspection team inspected the following core services at the George Eliot Hospital:

- Accident and Emergency
- Medical care (including older people's care)
- Surgery
- Intensive / Critical care
- Maternity and Family Planning
- Children and young people's care
- End of life care
- Outpatients

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant in cardiac radiology and clinical management

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 31 included CQC inspectors and analysts and a variety of specialists: A junior doctor and a consultant from emergency medicine; a medical consultant; consultant gynaecologist and obstetrician; surgical doctor; paramedic; midwife; surgical nurse; medical nurse; board level nurse; a critical care nurse; student nurse; dementia care nurse and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG); NHS Trust Development Authority; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); the Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Warwickshire County Council; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event in Bedworth on 29 April 2914, when people shared their views and experiences of the George Eliot Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit on 30 April and 1 May 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We also spoke with the members of the patient's forum and one of the support groups. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections from 4pm to 8pm on Saturday 10 May 2014. We looked at how the hospital ran at the weekends, the levels and type of staff available, and how they cared for patients.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the George Eliot Hospital.

What people who use the trust's services say

- We held a public listening event when we spoke with approximately 60 people. People told us that they had experienced good care at the George Eliot Hospital and were kept informed. However, people also raised concerns about communication especially with doctors, not being involved in decision-making, delays for X-ray and CT scans, the lack of response to complaints, and the care of elderly people including discharge delays and end of life care.
- The results of the Friends and Family Test (FFT) for November 2013 to February 2014 showed that the trust scored well above the England average for all four months on the inpatient wards. The A&E scores also showed that the trust was performing above the England average for all four months. Response rates were consistent across the four month period.
- The CQC adult inpatient survey (2013) included 15 wards at George Eliot Hospital NHS Trust. Response rates varied between wards, from 0% and 103%. The trust had performed within expectations for other trusts for all areas of questioning except for questions identified under the heading of 'doctors'. For three of the questions assigned to 'doctors' the trust was performing worse than the national average in the following areas: doctors answering questions in a way they (patients) could understand; having confidence and trust in doctors treating them; doctors not talking in front of patients as if they were not there.
- The Cancer Patient Experience Survey (CPES) by the Department of Health 2012/13 is designed to monitor national progress on cancer care. 152 acute hospital NHS trusts took part in the 2012/13 survey, which comprised of a number of questions across 13 different cancer groups. Of the 69 questions, for which the trust had a sufficient number of survey respondents on which to base findings, George Eliot Hospital NHS Trust performed better than other trusts nationally for 16 questions, and worse than other trusts for 12 questions.
- The CQC Survey of Women's Experiences of Birth 2013 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth.

Summary of findings

- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. The trust scored higher than national average for cleanliness (98.6%), privacy, dignity and well-being (89.9%), facilities (91.1%) and food and hydration (87.1%).
- The George Eliot Hospital had 93 reviews on the NHS Choices website. It scored four out of five stars overall. There were 27 comments which were rated as five stars, and 13 rated as one star. The highest ratings were for cleanliness, staff co-operation, excellent care, staff were professional, polite and courteous, good A&E, involvement in decisions, and patients being treated with dignity and respect. The lowest ratings were for lack of information, lack of communication between departments, mis-diagnosis, staff being rude and unprofessional, and waiting times.
- During our inspection, patients told us that they were treated with compassion, dignity and respect. They spoke highly of staff, and told us they were given enough information and were kept informed.

Facts and data about this trust

1. Context

- Around 352 beds
- Population around 300,000 (North Warwickshire, South West Leicestershire and North Coventry)
- Staff: 1,917
- Annual turnover(total income) £122,494m (2012-13)
- Surplus (deficit) £300,000 (2012/13)

Note: This is the trust's financial performance for the year 2012/13. The trust has an accumulated deficit of £2.4 million.

- The trust runs an urgent care centre, four GP surgeries and a range of community services, including dentistry.

2. Activity

- Inpatient admissions: 38,138 (2012-13)
- Outpatient attendances: 207,419
- A&E attendances: 65,831
- Births: 2,502 (October 2012-November 2013)
- Deaths in hospital: 697 (2013/14)

3. Bed occupancy

- General and acute: 90.3% (October-December 2013). This is above the England average (87.5%), and above the level (85%) at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital
- Maternity: 90.3% (higher than England average 58.6%)
- Adult critical care: 79.2% (lower than England average 82.9%)
- Neonatal Intensive Care Unit: n/a

4. Intelligent Monitoring

- Safe: Risk = 0, Elevated = 0, Score = 0
- Effective: Risk = 2, Elevated = 1, Score = 4
- Caring: Risk = 0, Elevated = 0, Score = 0
- Responsive: Risk = 0, Elevated = 0, Score = 0
- Well led: Risk = 1, Elevated = 1, Score = 3

Total: Risk = 3, Elevated = 2, Score = 7

Individual risks/elevated risks

- **Elevated risk:** Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators
- **Elevated risk:** TDA - Escalation score
- **Risk:** Composite indicator: In-hospital mortality - Cardiological conditions and procedure
- **Risk:** Composite indicator: In-hospital mortality - Respiratory conditions and procedures
- **Risk**: GMC National Training Survey – trainee's overall satisfaction

5. Safe:

Never events in past year: 2 (December 2012 and January 2014)

Serious incidents (STEIs): 135 (December 2012 and January 2014)

National reporting and learning system (NRLS) March 2013-February 2014:

Summary of findings

- Deaths: 3 (Note: It is one death; the trust incorrectly coded two as deaths)
- Severe: 67
- Moderate: 250
- Abuse: 10 (potential abuse or safeguarding prior to patient admission)
- **Total: 328**

Safety thermometer:

- Pressure ulcers - High but decreasing
- VTE – Low
- Catheter UTIs – High but variable
- Falls – high but variable

6. Effective:

- HSMR: Elevated Risk (Intelligent Monitoring); Within expected limits (March 2014)
- SHMI: No evidence of risk (Intelligent Monitoring)

7. Caring:

- CQC inpatient survey (10 areas): Worse for one area 'doctors' (communication, confidence in treatment); about the same as other trusts for the remaining nine areas
- FFT inpatient: Above the England average
- FFT A&E: Above the England average
- Cancer patient experience survey (69 questions): Above England average for 16 questions; average for 41 questions; below average for 12 questions

8. Responsive:

- A&E 4 hour standard – Variable but improved over the course of the year (2013/14). Target was missed for eight out of 52 weeks the lowest level (was 85% for weeks in April and October 2013).
- A&E left without being seen: better than average.
- Cancelled operations: Similar to expected
- Delayed discharges: Average
- 18 week RTT: 95.6% (Better than the NHS operating standard of 90%)

9. Well led:

- Staff survey (28 questions): Above England average for 7 questions; average for 4 questions; below for 17 questions
- Sickness rate 3.5 %: Below 4.2 % which is the England average
- GMC training survey: The trust was worse than expected in three areas in Anaesthetics and Emergency Medicine, and had one or more areas that were worse than expected in six other specialties. The trust was better than expected for workload in general surgery and workload and regional teaching in obstetrics and gynaecology.

10. CQC inspection history

- Six inspections at the trust since its registration in April 2010.
- The trust was compliant against outcomes relating to care and welfare, meeting patients' nutritional needs, and staffing at the most recent inspection in March 2014.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall, we rated the safety of services in the trust as 'requires improvement'. For specific information, please refer to the report for the George Eliot Hospital. Staffing levels had been reviewed, and safe staffing levels were introduced across the trust. Medical and nursing staffing levels had increased, but there was still a reliance on agency staff in A&E and surgery. We observed good, informative medical and nursing handovers. Infection control was appropriately managed, with practice observed in all areas meeting standards, except in the A&E department. Equipment was well maintained and regularly checked, but standards for medicines management, including controlled drugs, were not met in A&E and in the operating department. Incidents were reported, but many staff said that they did not receive feedback or sharing of lessons learnt, and this had resulted in under-reporting in some areas. There were established safeguarding procedures in place for both adults and children.	**Requires improvement** 
Are services at this trust effective? Overall, we rated the effectiveness of the services in the trust as 'good'. For specific information, please refer to the report for the George Eliot Hospital. Patients were treated according to national evidence-based guidelines, and clinical audit was used to monitor standards of care. There were good outcomes for patients, and mortality rates were now within the expected range. Seven-day services were developing, and were in place for patients in most areas of the hospital, and had significantly developed for emergency care. Staff worked in multidisciplinary teams to co-ordinate care around the patient, but clinical support services, such as therapy services, pathology and radiology, were not as well developed across seven day working. Staff reported that they were supported and encouraged to develop their skills, and this had improved compared to previous years.	**Good** 
Are services at this trust caring? Overall, we rated the caring aspects of services in the trust as 'good'. For specific information, please refer to the reports for the George Eliot Hospital.	**Good** 

Summary of findings

Patients received compassionate care, and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care, and they received good emotional support from staff. Patients who received end of life care were supported to have a good experience of care.

Are services at this trust responsive?

Good

Overall, we rated the responsiveness of services in the trust as 'good'. For specific information, please refer to the reports for the George Eliot Hospital.

There had been a service redesign of the A&E department, the introduction of the acute medical unit (AMU) and ambulatory care unit, and a redesign of children's services, to ensure that these areas were better able to meet the needs of the local population in a safe and responsive way. Support for patients with a learning disability, or for people living with dementia, was available. Translation and interpreter services could be accessed by all staff, and some information leaflets were available in different languages. Most patients in A&E, waiting for surgery or outpatient appointments, received care within national waiting times. Although some areas, for example, in orthopaedics, neurosurgery and oral surgery, had longer waiting times for surgery. The number of unnecessary patient bed moves had decreased and most patients were on the appropriate ward for their medical condition. Some discharges were still delayed, but staff were improving discharge arrangements, and there was a dedicated team working to ensure timely discharge of patients with complex care needs.

Are services at this trust well-led?

Good

The trust leadership was rated as 'good'. The leadership in some services, such as in A&E, surgery, maternity and radiology, required improvement but the progress made by the leadership team was recognised. The Trust had been made significant progress and improvement. The Trust had demonstrated effective action on all areas of concern and actions had also resulted in many examples of outstanding practice.

Since entering special measures, the trust had worked hard to improve, and had made significant progress. The trust's Keogh Mortality Review action plan was completed, and the trust had developed a quality improvement strategy for continuous improvement. New services had been introduced and reorganised, to manage the flow of patients through the hospital and improve the

emergency care of patients. Governance arrangements were good, and quality and performance were monitored for each service, and displayed in ward areas for patients to see. The trust had engaged with the public and staff to improve services.

Staff were positive about the changes and the pace of change, and said that the trust was more open, and there was a clear focus on quality and safety. The trust was in the process of developing a clinical strategy with the aim of ensuring a clinically sustainable future.

Vision and strategy for this trust

- The trust was one of 11 placed into special measures in July 2013, after Sir Bruce Keogh's review into hospitals with higher-than-average mortality rates. Ten key measures were identified as part of a 36-point action plan. In response, the trust leadership and management team had developed a trust quality improvement strategy. As of April 2014, all 10 key Keogh actions identified had been delivered with work ongoing with regards to Board development and the implementation of an electronic incident reporting system. The trust had demonstrated improvements, for example, in seven day working, the pace of quality improvement, understanding and reporting on mortality rates, and minimising patient moves. The outstanding actions that remain were the board development programme, and the implementation of a new electronic incident report system, and work is ongoing to deliver these.
- The trust encompassed its vision in the strapline, 'To ExCEL at Patient Care'. This was an acronym: Effective open communication; eXcellence and safety in all that we do; Challenge but support; Expect respect and dignity; Local healthcare that inspires confidence. Staff throughout the organisation were aware of the trust vision, and the changes that had taken place as part of the quality improvement strategy.
- The trust was developing a five-year clinical strategy to secure a clinically sustainable future. The strategy identified proposals to commissioners and the NHS Trust Development Authority, to continue to provide local general acute care – explicitly including emergency care (A&E); paediatrics and maternity; work closely with other specialist acute providers for specific conditions and care pathways (eg stroke, trauma, cardiac, paediatric care); and providing integrated services, including primary and community care, and working closely with the local social services to bring care closer to people's homes.

Summary of findings

Governance, risk management and quality measurement

- The trust had a structure of three divisions that covered acute medical and clinical support services, elective care, and community and integrated services. The trust had a quality assurance reporting matrix, which included a raft of interwoven committees on quality, risk and patient experience. Despite the seeming complexity of these arrangements, staff told us that there was confidence in the structure to properly identify and address concerns. There were good quality dashboards at corporate, division and ward levels, and quality and safety indicators were displayed on wards for patients to see. These arrangements ensured that responsibilities were clear, quality and performance were integrated and continually reviewed, and problems were detected, understood and addressed. The dashboards did not focus on specific services, however; and though overarching problems were known, the trust could not effectively hone in on specific issues within services. These quality and governance processes were less well established in the operating department, A&E, maternity and radiology.
- The NHS Staff Survey 2013 identified that the trust was trending towards the bottom 20% of trusts for reporting errors and incidents. Staff were reporting incidents and the trust was similar to other trusts for reporting. However, staff told us that they did not always receive feedback and lessons learnt were not widely shared. As a result, there was under reporting in some areas, such as A&E and maternity. The trust was investing in a new electronic reporting system this year.

Leadership of trust

- The trust leadership had been fairly stable in the last 18 months. A new medical director was appointed in April 2014, but had worked at the trust previously. Two new non-executive directors were appointed in 2014.
- In the results of the 2013 NHS Staff Survey the trust scored similar to other trusts for the percentage of staff reporting good communication between senior management and staff. Staff expressed positive support and confidence in the trust leadership team, and said it would be unsettling if this were to change. Staff reported that they knew who the team were, and they were very visible, either in person, or though communications, and that they felt they were approachable, particularly the chief executive. There were concerns about the communication and consistency of approach for some staff in middle management levels.

- The trust was strengthening its board, clinical leadership and ward programmes, to ensure the engagement of clinicians, and develop strategies for improvement. Staff told us that they felt well supported by senior staff, although junior doctors in A&E required consultants to be more accessible. Leadership in the operating department, maternity and radiology was of concern, and the trust had support from staff seconded from University Hospitals Birmingham NHS Foundation Trust and South Warwickshire FoundationTrust to improve the services in these areas; support for radiology was being arranged.

Culture within the trust

- Staff at all levels told us they felt the trust was a more open and positive place to work. Staff said the trust was clearer about challenges, and had a sharpened focus and drive on quality and safety. The pace of change was for the better, and staff reported that they were being asked their opinion and were involved in service changes.
- Staff focus groups were well attended by staff who wanted to express how positive they felt about working in the trust. The consultant focus group was extremely positive and supportive of the trust and leadership team. Staff described the trust as a good, friendly place to work, with good supportive teamwork. There was a sense that they 'owned' the hospital and it 'belonged' to them; they cared about its reputation, their colleagues, and the patients they cared for.
- Staff told us that as a result, being in special measures was 'disappointing', but it had been of great benefit. It was acknowledged that the trust had previously settled into a rhythm of change, which in hindsight was at a slow pace.
- The trust was developing a culture based on the Berwick Report, so that there was a culture of encouraging and supporting continuous improvement and innovation. Many staff believed in the trusts' future direction, and wanted the trust to be recognised as a centre of excellence and research.
- Partner organisations and commissioners said that the trust had been open and transparent, and resilient in response to the intense scrutiny and monitoring that comes with special measures. They considered that the trust leadership team helped the trust to develop its confidence again.

Public and staff engagement

- The CQC adult inpatient survey 2013 identified that the trust performed similar to expected in obtaining the views and experiences of patients on the quality of their care. The trust had a patient experience and carers strategy (2013–15) to

develop patient and public engagement, and the strategy covered a variety of methods. This included patient feedback, patient forums and advocates, and using information from comments, concerns and complaints. The trust vision for patient experience was covered in a six step strategy that identified steps to take for reputation, arrival, assessment, care, treatment and discharge. The patient experience group was the driving force in developing and improving patient experience in the trust.

- The trust was monitoring patient experience, and could demonstrate improvement and innovations, such as the Carer Passport, which supported carers who came into hospital to support their relative or friend. Levels of quality and performance of a ward or department were displayed at the entrance to the ward and in the corridors. These displays were visible to staff, patients and visitors, and helped to promote a culture of openness. The displays were called 'Simply Safer' or 'Harm free care' and included information, for example, on patient experience and avoidable harm, such as falls and pressure ulcers. Complaints and concerns were used to improve services, and the board and the patient experience group regularly heard patient stories. The Patient Advice and Liaison Service (PALS) was very responsive, and had resolved 95% of concerns on the same day. Complaints management was improving in response to patient feedback about delays, and defensive and jargonistic replies. A new format was being introduced to standardised responses and to ensure that information was being communicated in a way that patients could understand.
- The hospital had a patients' forum that met monthly, and there was a patients' panel for patients with inflammatory bowel disease (IBD). The patients' forum worked with the trust, and visited the hospital to undertake quality audits and talk to patients. They reported through the members advocate panel, and were able to take issues to patient-experience forums and the patents safety group. The IBD panel was a support group for patients, and was involved in raising money to support the service. They all spoke highly of the trust and the support they received, particularly from the specialist nurses. Patients' representatives were also going to be included in the end of life steering group.
- The NHS Staff Survey (2012) identified that the trust was in the bottom 20% of trusts nationally for staff engagement. There was a difference between the survey results, and the enthusiasm, motivation and commitment of staff that we observed during our inspection, and which was communicated

in focus groups and staff drop-in sessions. Staff reiterated that the trust had changed and was in a better position than in previous years. They identified that the pace of change over the last year had been rapid since the Keogh Review. Some staff groups, such as cleaners, and administrative and clerical staff, said that they were still under pressure and wanted their concerns to be heard. There were also particular services where there were leadership concerns, such as in theatres and maternity, and where morale was low, such as in radiology. This could affect patient care if they remained unresolved. The Trust had engaged with staff in these areas and was taking taking action to strengthen leadership arrangements to build resilience in these services.

Innovation, improvement and sustainability

- In the NHS Staff Survey 2013, the trust was in the bottom 20% of trusts for staff who contributed to improvements at work, with work pressures, motivation and satisfaction either worse or tending towards worse than expected. Staff told us that much of this had changed, and in some areas, staff were encouraged to learn and improve (for example, in medical care, surgery, critical care, children's services and end of life care). This was not apparent in all areas, and some staff demonstrated a reluctance to change. There were many examples of well managed service changes and innovative changes to patient care. However, this enthusiasm was not always harnessed so that there could be systematic learning and development across the trust, and so that lessons learnt could be effectively shared to ensure consistent and widespread improvement.
- Staff in focus groups told us that work pressures were reducing with the increase in staffing levels but pressures were still there for staff working in smaller departments who had very little flexibility when colleagues were on sick or annual leave.
- The trust had predicted a financial deficit of £12m in 2014/15, much of which was based on quality improvements and increased staffing levels. The trust was still planning to invest in quality and safety measures, some of which were required by commissioners, and some of which had been identified as necessary to maintain standards. Further cost improvement programmes (CIPs) were yet to be agreed with commissioners, but would constitute approximately 4% of the total budget per year. The trust quality impact assessment process guarded against risks to patient care in this environment, and CIPs would not be signed off if there were any 'red flags' for clinical risk or potential achievement. The trust had identified efficiency and productivity savings, which included a reduction

in the use of agency and locum staff and replacing these with substantive posts, but this alone would not resolve the deficit. The trust was in discussion with commissioners and the NHS Trust Development Authority to develop their five year clinical services strategy and financial sustainability plan.

Overview of ratings

Our ratings for George Eliot Hospital were:

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity & Family planning	Good	Good	Good	Good	Requires improvement	Good
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	☆ Outstanding	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Our ratings for George Eliot Hospital NHS Trust were:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency, and Outpatients.
2. Well-led overall was rated as 'good' because the trust leadership had made significant progress and improvement. The trust had demonstrated effective action on all areas of concern and actions had also resulted in many examples of outstanding practice

Outstanding practice and areas for improvement

Outstanding practice

- The ambulatory care unit (ACU) opened in December 2013 and had a positive impact on preventing patient admissions. It was helping to meet the needs of patients in the community who required medical intervention without the need for admission to hospital.
- There were physician associates, who were staff trained to support medical staff with assessment, investigation and diagnosis. One physician associates was trained to complete comprehensive assessments for frail elderly patients.
- The trust had developed initiatives to encourage people living with dementia to eat. They used coloured plates and adapted cutlery, and warmed plates to keep food warm.
- The trust had a 'carer's passport', which was a scheme whereby named relatives could offer their help by coming onto the ward and providing care for their loved one, such as help with eating meals or personal care. The hospital offered named relatives free parking or 10% off meals bought at the hospital.
- Discharge booklets were introduced in all medical wards. These were kept by every patient's bed and were completed by members of the multidisciplinary team (including intermediate care and social services) to record specific outcomes leading towards safe patient discharge.
- A nurse-led early discharge support team was provided for patients with chronic obstructive pulmonary disease. This included home visits and physiotherapy input. The team worked closely with the respiratory ward to ensure longer term management. A discharge bundle had been introduced that included follow-up within 72 hours.
- The Oasis Project identified patients during their pre-operative assessment who may be anxious about surgery. The project consisted of a team of volunteer therapists who had a professional qualification in relaxation. Therapists would talk through any anxieties at that time to provide reassurance to the patient and would make a note in the patient's file to prompt action for when they were admitted for surgery
- The trust had produced a leaflet for relatives and friends inviting them to contact the critical care outreach team directly if they had concerns about their relative.
- The hospital had made significant strides in the recognition and management of sepsis and the delivery of the 'Sepsis Six' care bundle. They had a critical care outreach nurse seconded as a Sepsis Nurse who monitored compliance and had introduced a sepsis recognition tool, sepsis boxes for the wards and stickers to improve fluid balance completion.
- Picture screens were used on the intensive therapy unit (ITU) that depicted, for example, a soothing flower blossom scene. Staff and relatives commented that these were calming and relaxing and gave the patients lovely visual images.
- A special service called 'Providing information and positive parenting support' (PIPPs) was available to give information and positive parenting support to teenage mothers and others who were vulnerable. Midwives developed close relationships with the women and offered additional support, continuity of care and coordinated multi-agency cases conferences involving social services.
- Multidisciplinary networks in children's and young people's services were being developed to deliver care closer to their homes.
- The hospital used the AMBER care bundle, which is a national approach to support advanced care planning when doctors are uncertain whether a patient may recover or be in the final stages of life (months or days). Trained team members acted as champions to drive high-quality care at these times. They encouraged staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about everyone's wishes and putting plans in place should the person die.
- The end of life care team had rolled out care standards to ward areas using a strategy called 'Transform'. Staff were trained to ensure that patients in the hospital had a good experience of end of life care.
- The Patient Advice and Liaison Service (PALS) responded to 95% of patient concerns on the same day.

Outstanding practice and areas for improvement

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of the patient's current medication.

Areas for improvement

Action the trust MUST take to improve
To ensure:

- Medicines are managed at all times in line with legal requirements.
- There is effective leadership and governance arrangements in the A&E, operating department, maternity and radiology.

Action the hospital SHOULD take to improve:
To ensure:

- Safety standards in the A&E department are improved to be in line with current national guidance.
- Parents and Children have information if they have to have long waiting times in the Rose Goodwin observation unit in A&E.
- Care pathways and care bundles continue to be embedded into everyday practice and monitored.
- The trust needs to continue to reduce the avoidable harms of pressure ulcers, falls, and catheter urinary tract infections.
- People living with dementia continue to have consistent care and support in all areas of the trust.
- The Five Steps to Safer Surgery checklist is audited to ensure appropriate and consistent use.
- Patients being 'checked in' for theatre have their privacy and dignity maintained.
- Staffing levels continue to improve (especially in A&E and surgery), and patient care is appropriately delivered by trained, experienced and skilled staff.
- The use of linen drapes in theatres is avoided.
- That all staff use the incident reporting system to report incidents, and that learning from incidents is cascaded and shared.
- Do Not Attempt Cardio Pulmonary Resuscitation orders are appropriately completed so that there is timely documentation of the decision by the appropriate person, and this decision is reviewed if there is a change in a patient's condition, and mental capacity is assessed.
- Radiology services improve so that patients do not experience delays and long waiting times.
- Continue to develop services across seven days.
- Medical staff communicate with patients in a way that they can understand.
- Complaints are responded to within 25 days and responses address all concerns and are written in a way patients and the public can understand.
- Staff engagement continues and develops and staff at all levels feel involved and listened to.