FOLLOW UP TO EXTERNAL REVIEW

CULTURE AND RELATIONSHIPS - EMERGENCY DEPARTMENT UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST (UHPT)

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Executive Summary

An external review was undertaken in December 2020 focusing on culture and relationships as key enablers for sustained performance improvement in the UHPT Emergency Department (ED). This included relationships within the department itself (between and across staff groups), between ED and wider Trust leadership teams, and with other clinical specialties. The report was received by the Trust in January 2021 with the findings and recommendations accepted in full. The more recent planned follow up review demonstrates that the Board has taken decisive action to strengthen systems, processes, capacity, and capability such that there is a clearer line of sight to progress made against the original recommendations, and more recent Care Quality Commission (CQC) inspections.

Progress to date to date

Improvements have been made in a number of areas including relationships, clinical engagement, joint understanding and ownership of the issues, and a sense of acceptance that everyone is working hard to deliver sustainable solutions to long-standing challenges. Kind and compassionate care was witnessed; the introduction of Acute Physician shifts into ED has been positively received; supervision and training for junior doctors is reported as remaining good; several patient flow initiatives including some Same Day Emergency Care (SDEC) pathways have been successfully implemented; a revised escalation framework is being tested; and key new appointments have been made.

Ongoing actions

There is a detailed plan in place which captures the majority of the ongoing and further improvement actions required to deliver sustainable improvements. This includes the need for continued Organisational Development (OD) interventions to support cultural change; focused action to improve recruitment, retention, and staff wellbeing; specific support for wider nurse leadership and professional practice improvements in ED; streamlining of site-management and flow-coordination arrangements; a further refinement of escalation procedures; and joint action with partners to better manage demand for admission and expedite hospital discharges. Delivery of these priorities, together with a more targeted approach to developing a new model of care for acute medicine, requires increased pace and sustained attention.

Further considerations

Since the initial review, further pressures on bed occupancy due to increases in delayed transfers of care and workforce constraints (in both health and social care) means that at any one time the available inpatient bed-base is reduced. Whilst not inconsistent with the national picture, the ongoing local challenges with recruitment, retention and flow through the hospital and wider health and care system are likely to be masking the impact that the improvements should be delivering for patients and staff in the Emergency Department. Furthermore, the sustained consequences of the pandemic and the continued need for social distancing and segregation of COVID patients has brought into sharper relief the space and infrastructure constraints on the Derriford site which, until the new build is complete, will continue to be a barrier to some of the planned pathway improvements.

Whilst relationships are better and efforts are being made to tackle the challenges, the day-to-day pressure of ambulance handover delays, numbers of patients waiting assessment in the department, and long waits for admission, transfer, and discharge, create an environment which continues to directly impact on staff wellbeing and quality of care.

- There is an urgent need to prioritise the actions required to improve flow focusing on those areas of highest impact internally and in the wider health and care system.
- Strengthened ED triage is needed to better manage undifferentiated risk and improve patient pathways and experience.
- Targeted wellbeing support for ED staff needs to be extended in parallel with a more innovative approach to recruitment, retention, and transformational role redesign to stabilise and grow the workforce.

Until such time as whole-system flow is resolved, the positive improvements that have been hard earned will remain fragile. Moving forward, greater emphasis needs to be placed on the wider system actions to close the demand and capacity gap and ensure patient care is delivered in the most appropriate setting according to need. This wider ownership of the challenges and the requirement for urgent and sustained action with partners needs to be firmly reinforced with a clear mechanism for jointly holding each other to account for delivery.

1. INTRODUCTION

As part of the original remit for the high-level review of the cultural and relationship challenges that may be impacting on the delivery of high-quality safe care within the Emergency Department (ED) at Derriford Hospital (January 2021), it was agreed that the reviewers would revisit the Trust within 6 – 12 months to provide an independent assessment of progress for the Board.

The focus of the initial review was on culture and relationships in ED as key enablers for sustained performance improvement. The review also considered relationships:

- Within the ED - between and across the various staff groups
- Between the ED and the Care Group Leadership Team
- Between the ED and the Executive Team
- Between the ED and other key specialties (specifically Acute Medicine, Emergency Surgery, Trauma and Orthopaedics (T&O) and Site/flow management teams)

There were a number of key issues that were outside the scope of the review including:

- Direct assessment of the quality of patient care in ED
- Direct assessment of clinical safety in ED
- Consideration of the quality of education and training in ED

Relationships with external stakeholders were not specifically included in the terms of reference. However, the wider health and care system within which the ED operates has a significant impact on the functioning of the department. It is in this context that the need for strategic support from partners to deliver sustainable improvements was acknowledged in the original review and is again reflected in the progress update.

The original Terms of Reference **(Annex 1)** and the recommendations from the initial review formed the basis for the follow-up discussions with staff and the analysis contained within this progress update **(Annex 2)**.

2. RECENT CONTEXT

Since the original review, there have been two CQC unannounced inspection visits to the Emergency Department in March and September 2021. The March report, response from the Trust and the resultant action plan were made available as part of the document review to inform this progress update. At the time of writing this report, the outcome of the September unannounced inspection has not been published.

Constraints in domiciliary care, together with reduced access to beds in community hospitals and care homes, are having significant impact on the numbers of delayed transfers of care. From an historical low base of circa 4%, there has been an increase to 11% between the two review periods. This is equivalent to an additional 80-100 beds unavailable at any one time placing significant additional demand on inpatient capacity resulting in an adverse impact on patient flow. The consequences for flow are over and above those which were present at the time of the first review and are likely to be masking the impact of the improvements the Trust has made in its internal systems and processes. It is also important to acknowledge the tragic events in Keyham (August 2021) and the significant impact on the staff of the ED. Whilst the timing of the follow-up interviews was clearly difficult and may have affected the numbers of staff engaging with the process, the reviewers have no reason to believe that this impacted on the validity of the feedback received.

3. METHODOLOGY

As the progress update was undertaken by the same individuals who undertook the original review, they were familiar with the key issues, individuals, and the department. This meant that the methodology could be simplified as follows:

Phase 1

Documentation Review:

- Update reports to Board
- Papers of UEC Oversight Board
- Performance data

Phase 2

Intelligence gathering:

- Remote Group and 1:1 discussions with staff
- Site Visit and face-to-face meetings

Phase 3

Analysis of findings and submission of Report

General communication was sent to all staff advising them of the follow-up review, inviting them to participate and providing direct contact details for the review team. The same group and individual meetings were scheduled as per the original review and any staff member who had previously requested a meeting was directly contacted and offered the opportunity for a further conversation.

A total of 54 individuals directly participated in the follow-up review process. This reflected the same staff groups as the original review and included:

- Emergency Departmental staff – clinical and non-clinical
- Care Group Leads
- Clinical leaders from other specialties
- Chief Executive and other Executive Directors

The reviewers conducted 5 group meetings and 28 individual meetings. One separate email submission was also received.

Of interest is that:

- less people requested individual meetings following their involvement in the planned group discussions compared with the previous process (anecdotal feedback suggesting greater confidence in expressing views openly amongst colleagues)
- engagement from Junior Doctors and Band 5/6 Nurses was significantly reduced when compared with the original review.

The Junior Doctors position is to some extent understandable given that the fieldwork was undertaken in September and October when the majority had only just commenced their rotation. This was balanced by good engagement from the middle grade Doctors (trainees and non-trainees) who had continuity of experience during the intervening period.

The lack of engagement from the more junior nurses, however, is of concern especially given the previous feedback from this staff group and current relatively high levels of sickness absence and turnover. Several attempts were made during the site visit to engage directly but were frustrated by operational pressures in the department.

4. PROGRESS UPDATE

The original review findings were structured around three key headings which also formed the basis for the follow-up discussions with staff:

- Culture and Relationships
- System Flow
- Governance

As with the previous report, all feedback received is unattributable, confidential and triangulated with at least two other sources before being included in this report.

4.1. General Observations

It is important to acknowledge that the ED at Derriford Hospital remains under considerable, sustained pressure; staff are working extremely hard, in very difficult circumstances, to meet the needs of patients who continue to experience long delays for care and admission; and whilst progress has been made in the last 9 months, there remains a lot to do both internally and with system partners to deliver sustainable improvements in urgent and emergency care in Plymouth.

Our initial report concluded that failure to follow through in any sustainable way on the delivery of the recommendations of previous reviews meant that opportunities had been lost for incremental improvements over the previous 5 years. It also identified clear consensus on the challenges relating to relationships, system flow and governance together with recognition of and commitment to the need for change.

In response, the Board has taken decisive action to strengthen the systems, processes, capacity, and capability such that there is a clearer line of sight to progress against the recommendations of our review and the more recent CQC inspections. This in turn has created momentum for change and a stronger sense of accountability for action that is generating improvements.

This follow-up review has identified a number of positive improvements including:

- Relationships between the Executive Team and ED
- The scale and depth of clinical engagement across the organisation
- A much greater sense of joint understanding of the challenges which is described as 'more people being on the same page'
- A recognition that people are trying very hard and lots of actions are being taken

At the same time however, there have been several factors which have negatively impacted on flow and activity resulting in an overall sense that the pressure within ED is at best no different (described by some staff as being *'even worse than before'*). These include:

- Increased delayed transfers of care (4.4% of total available hospital beds in June increasing to 11.5% in September)
- Rates of ED sickness absence and staff turnover, particularly amongst nurses

A high-level summary of assessed progress against the key recommendations from the original review is included as **Annex 2.**

4.2 Culture and relationships

This element of the review considered the dynamics within the ED itself, between the ED and other departments and with senior and executive management within the Trust. Complex dynamics were identified which, back in December 2020, were clearly contributing to defensive behaviour, the lack of a common narrative underpinning the challenges and little evidence of joint working to achieve any clearly defined and agreed improvement outcomes.

It is a credit to all the people that participated in this follow-up process that they recognised most findings of the original review. As difficult as it was to acknowledge some of the issues described, there was general acceptance that they were a true reflection of the position at the time and have acted as a catalyst for change.

The delays in being able to identify suitable OD support have meant that some of the team-based interventions did not commence until late September 2021 and as such, it is too early to assess the impact. In the meantime, however, the 'listening exercise' has been positively received with the Freedom to Speak Up (FTSU) guardians assisting in the identification of key themes to feed into the ongoing OD programme.

Despite the ongoing operational pressures and challenges, progress has clearly been made in most of the areas identified which is to be commended. Whilst there is acceptance of continuing underlying cultural and behavioural issues needing to be addressed, some staff groups remain focused more on the need for others to change rather than this being a shared responsibility. The differing views about behavioural expectations, even when under extreme pressure, will need to be picked up as part of the ongoing team-based OD programme.

4.2.1 Emergency Department

The original review referred to one of the key strengths and weaknesses of the ED as being the sense of 'family' – positive for those who feel they belong but extremely difficult for those that do not. This was the one finding that some senior staff in the department struggled to recognise which is suggestive of unconscious bias. If this remains unchecked, it could lead to further isolation of those who do not 'fit-in' with little recognition of personal and collective responsibility to actively ensure that everyone is treated equally and made to feel part of the team.

The lack of engagement of the junior doctors and junior nursing staff in this follow-up review has meant that it has been difficult to test this concern further. It is important that this is not lost as part of the ongoing development work with the teams.

During the site visit, kind and compassionate care was witnessed but the poor staffing levels and overcrowding in the department creates an environment where this is difficult to maintain with high self-reported levels of stress amongst the whole ED workforce.

The Consultants reported greater team cohesion and the changes to the former Hot Floor Clinical Director role have been helpful in addressing previous leadership role ambiguity.

The Trust has continued to work closely with Health Education England (HEE) to ensure that the training needs of medical staff are being met. Middle Grade Doctors report that Consultant supervision and support for training and wellbeing remains good but that the pressure of work is having an adverse impact on any sense of real progress in the department. Concern was expressed about the impact this is having on morale, turnover, and sickness absence even amongst long-serving senior staff.

Concerns regarding a truly multi-professional approach to leadership and management of the department remain with some staff reporting that the nursing voice remains silenced and undervalued.

Within the nursing team, examples given of continued lack of professional respect; failures to follow procedures; reluctance to tackle poor practice and behaviour; and overall team dynamics raise concern that this is an area where little progress has yet been made. We are advised that this is to be a priority for the new Head of Nursing and will be supported by specific professional development linked to the ongoing OD programme.

There has been a temporary pause on accepting preceptorship nurses into ED given the lack of capacity to provide the necessary supervision and support. Whilst this demonstrates a positive improvement in recognition of their development requirements, there needs to be an urgent plan to address this to ensure a future pipeline of new staff in a challenged labour market.

The new ED Matrons had only recently taken up post at the time of the initial review and provide important leadership capacity for ED. However, having two posts also creates the potential for inconsistency in approach and decision-making.

The role of the Band 7 Nurses and the introduction of a team-based structure to support supervision and appraisal remains outstanding and is a key enabler to providing more localised professional leadership. These are key roles in the ED and will represent a significant change for some of the individuals who will need development and support to rise to this important challenge. Historical practices cannot be allowed to get in the way of

modernising roles to better meet the demands of the service together with the need for greater supervision and support for junior staff.

The Board has invested in the recommended new post of Head of Nursing and a very experienced individual took up post early October. This creates a real opportunity to revisit the nursing leadership structure to ensure it is fit for purpose going forward; to reinforce standards of care and practice; to drive up professionalism; and to be a strong voice for nursing that will support positive change and development. The individual will need support from the Chief Nurse and wider executive team to positively tackle long-standing behaviours and practices going forward.

4.2.2 ED and other specialities

Whilst ED staff and clinical leaders from other specialties reported some improvement in the relationships between departments, this remains variable.

The development of the 'Internal Professional Standards' agreement is positive, but its sustained application is inconsistent. Communication is reported to be better and responsiveness to requests for assessment have generally improved. However, the responsibility for following-up on any actions determined is regularly passed back to ED staff. 'Ownership' of patients in ED remains largely determined by location rather than clinical need which creates tension and clinical risk when patients are waiting for many hours before a bed becomes available for admission.

The sense that specialities are being constantly asked to assist a struggling ED appears to remain the dominant narrative. This is hugely frustrating for ED staff whose view is that they are only asking specialties to take responsibility for their own patients who are waiting in ED for admission.

The introduction of Acute Physician shifts into ED has been positively received and is making a real difference to those patients who can be assessed and either discharged directly from ED or fast-tracked into alternative pathways. However, the variability of support and

operating hours of the service creates some inconsistency in patient pathways and limits overall system benefits.

A solution for the safe and appropriate care of mental health patients waiting assessment or placement remains outstanding and must be urgently addressed. Prolonged waits in ED and the Clinical Decisions Unit (CDU) creates increasing risks for these individuals and other patients in the vicinity.

4.2.3 ED and Senior / Executive Management

The relationship between senior leaders and clinicians in ED and the Executive Team has significantly improved since December 2020. The process of developing the compact was as important as the outcome itself. Creating the time and space to have an open and honest dialogue regarding respective positions proved to be a catalyst for positive change.

This has resulted in a shift from confrontation towards collaboration; from entrenched positions to a much better sense of everyone being 'in this together'; and a more mature relationship where there is greater recognition of competing priorities and tensions.

The Executive Triumvirate is providing more cohesive and effective leadership of the agenda and whilst the new Medical Director and Chief Operating Officer (COO) have been instrumental in building trust between the teams, there is tacit recognition that such improvements, which are hard earned, can be quickly lost.

The Care Group remains an important part of the overall governance and accountability arrangements. Some changes have been made in recent months which appear to be generating greater ownership of operational challenges but there is more to be done to consolidate the arrangements and ensure that the proposed changes to the configuration of the care groups have no unintended consequences on the management of flow.

The ongoing coaching for key leaders together with the wider OD programme will be critical in ensuring that momentum is maintained, and the improvements sustained going forward.

4.3 System Flow

There has been a significant focus on the development and delivery of multiple interventions to improve flow through the ED and the wider hospital over the past year. There is clear evidence of much wider clinical engagement across specialities and greater distributed ownership of the challenges. This has been instrumental in driving improvements in several areas that would have been previously undeliverable including the development of the HALO corridor and implementation of the full capacity protocol which triggers boarding of patients on wards to better share and manage risk.

Refinement of the escalation policy and introduction of daily Bronze, Silver, and Gold escalation calls have had a positive impact on achieving a more real-time shared understanding of whole-hospital pressure. However, actions remain slow in the early part of the day which continues to build pressure into the early evening.

As the arrangements mature the focus needs to increasingly be on empowering teams at 'Bronze-level' to take quick decisive action to manage, mitigate and de-escalate risk. An effective escalation system should require 'Silver' to be stood up only in times of extreme pressure and 'Gold' for very short periods to provide specific additional senior decision-making support. Prolonged functioning of the 3-tier system risks disempowerment of front-line leaders and normalisation of escalation to executives.

The opportunity to streamline the site management and flow co-ordination arrangements remains outstanding and the system continues to operate on a 'push' rather than 'pull' model. The lack of any systematic approach to twice daily 'Board Rounds' and roll-out of 'Anticipated Date of Discharge' (ADD) means that forward planning is constrained by the inability to reliably predict capacity. In turn, discharge summaries and take-home medications (TTHs) are delayed resulting in bottlenecks in the discharge process. Ambitions for early morning use of the Discharge Lounge and early discharges are frustrated by these process issues, many of which are potentially avoidable.

The national benchmarking data is demonstrating positive improvements in Same Day Emergency Care (SDEC). However, the lack of an overall plan, underpinned by robust

demand and capacity modelling that includes a whole range of alternatives to ED means that sustainable alternatives to admission for primary care and paramedics remain limited. The lack of hot clinics and rapid access to outpatient diagnostics continues to result in greater default to admission. The feedback from ED staff is that whilst there may be improvement in these pathways, it is insufficient to deliver any visible impact on ED attendances and flow. The Operations team are working hard to drive this agenda and it may be opportune to reflect and refocus on those high-volume interventions likely to generate greatest yield.

Discussions about developing a 21st century acute medicine service have progressed; however, the detailed model and transformation plan has not yet been delivered. This is a significant gap in the overall unscheduled care improvement plan. A large proportion of medical patients continue to be routed via ED from primary care. This creates a vicious circle of ambulance delays, long waits for access to ED, delayed assessment, and a higher likelihood of admission. The lack of a consistent and reliable direct-to-medicine pathway based on 'assess to admit' contributes significantly to the trolley waits in ED and resultant ambulance handover delays. There is a business case in development which will require further investment in workforce and capacity but in the meantime, the opportunity for phased implementation of an agreed new model must be pursued at pace.

Daily targets for bed turnover are now in place and widely understood but rarely achieved due to a combination of delays in discharge processes and the numbers of delayed transfers of care (up to 11.5% of total available hospital beds at the end of September). This increase (up from 4.4% in June) is potentially masking the impact of any improvements in flow that have been generated by the actions taken by the Trust in recent months. This is extremely difficult to quantify but arguably if they had not been taken, the risks and impact of now operating through a reduced available bed-base would be even greater.

The transfer of the Livewell Southwest contract to the Trust was being finalised at the time of the previous review. This creates significant opportunity to accelerate the streamlining of access to community beds/services and develop a more integrated offer (including pre-hospital reablement and virtual wards) which will facilitate better management of system

flow. At the same time there are several areas within ED itself which contribute to the challenges associated with flow. These include:

- **Geography and space in the department**

Significant efforts have been made to ensure that the available space is utilised to best effect and yet it remains extremely difficult to accommodate the number of patients attending even without the requirement to maintain appropriate social distancing.

The return of Minor Injuries from Nuffield and its co-location with Ambulatory Care is the right thing to do but has added further pressure on the numbers of people needing to be accommodated in the waiting area; space for triage; space for assessment of ambulatory patients; and space for Minors treatment activity. Staffing difficulties in the Cumberland Urgent Treatment Centre (UTC) and primary care pressures are resulting in greater numbers of patients with minor illness and injury self-presenting or being redirected to ED which further compounds the problem.

Whilst this will not be substantively resolved until the new build is completed, urgent consideration needs to be given to the options for better matching the ambulatory and minors capacity to demand (including options for an on-site UTC).

- **Staffing levels**

Despite the proactive decision of the Trust to invest in increasing the medical and nursing establishments within ED, the planned increased staffing ratios are not being achieved due to the inability to recruit to vacant posts which is further exacerbated by the relatively high level of turnover. Whilst it is recognised that there is more to be done to streamline the recruitment process itself, the over-riding factor is the challenging labour market.

Together with high levels of sickness absence, the shift fill rate for Registered Nurses and Support Workers regularly falls below 70% which places significant pressure on the existing workforce and impacts on the quality and efficiency of care they can provide. Strengthened rostering to better balance more experienced nursing staff with newer recruits across shifts would be helpful but this is not going to address the numbers issue. A

more proactive approach to compassionate management of sickness absence is needed so that appropriate early support can be put in place for staff who are under significant pressure. There is a very real risk of a further downward spiral of staff morale resulting in increased sickness absence, attrition and reputational damage which may then impact on future recruitment.

The distribution of staff across the various clinical areas in the ED is also challenging. Understandably, the requirements of Resus and Majors, with the associated patient acuity, pulls heavily on the available resource. However, the physical isolation of Plym Ward and CDU, together with the numbers and case mix of patients, carries risk with the low staff numbers.

- **Shift co-ordination**

There is no system in place for consistent oversight of activity and dynamic deployment of resources across the whole department on a shift-by-shift basis.

The Emergency Physician in charge (EPIC) and a senior experienced Nurse, working together as shift-coordinators, are key roles in the management of risk and activity across the whole ED (from Resus and Majors through Ambulatory Care to Paediatrics, PLYM and CDU). It is essential that these roles remain supernumerary so that they can provide oversight, advice, and dynamic deployment of staff resources to meet changing need.

- **Triage**

During the previous review, with the Senior Triage and Rapid Treatment (START) initiative being operational and ED Minors off-site, the triage process and waits for the ambulatory care stream was not as visible as it is now. The more recent changes and co-location of Minors has brought into sharp relief the difficulties and variability in overall time to triage. At worst this can be several hours which means that there are regularly patients with undifferentiated risk in the waiting area. Reception staff reported having to make decisions (that they are not qualified to make) about escalating concerns to clinical staff regarding deteriorating patients who have not yet been assessed. Furthermore, security issues are reported to be increasing as frustration grows amongst patients waiting.

Effective, timely triage supported by appropriate 'see and treat protocols' and pathways out of ED can significantly increase the turnaround of patients and reduce overall pressure on the department. Real-time information on whole-department activity in a single dashboard supported by a clear escalation protocol would allow the shift coordinator to dynamically deploy staff to reduce the ambulatory care queue at peak times. At the time of the site visit, triage training protocols were being developed and this process now needs to be accelerated.

4.4 Governance

The establishment of the Urgent and Emergency Care (UEC) Oversight Board has been a positive step in ensuring that the arrangements for driving delivery of the improvement actions are hard-wired into the overall governance of the Trust. Chaired by the Chief Executive (CEO) with the membership including a nominated Non-Executive Director (NED), the mechanism for escalation to the Board is firmly established.

The recommendations from the previous external review and recent CQC inspections have been brought together into a consolidated programme of action with systematic tracking and reporting of progress. This represents a significantly strengthened approach to governance and oversight of delivery of the requisite improvements. There are a considerable number of actions being pursued across a multitude of pathways, all of which are relevant and important to overall improvement. Further prioritisation and ordering of interventions will be important going forward so that staff do not become overwhelmed and risk losing focus on those things that will generate maximum benefit.

There has been a streamlining of the general management and accountability arrangements and, together with some changes below executive level, including with the Hot Floor and Care Group, there is much greater clarity of roles and responsibilities. Previously reported tensions and ambiguity did not feature in this most recent review.

Whilst there is more work to be done to reinforce schemes of delegation, accountability, and authority to act, there are an increasing number of examples of more mature,

collaborative approaches to resolution of difficulties. This includes apparent greater confidence that internal escalation will generate appropriate debate and response.

The roles of the Medical Director and COO in driving professional and managerial performance are better understood and accepted. Relationships with the Medical Director are reported as positive and constructive. Ownership of the performance agenda is firmly with the COO with greater consolidation of the reporting and holding to account arrangements at Board level.

5. CONCLUSIONS

The previous review, jointly commissioned by the Trust and Region, aimed to focus on identification of the cultural and relationship factors that could be getting in the way of developing jointly owned sustainable solutions to improve clinical outcomes, performance and the experience of patients and staff in the department.

The acceptance of the findings and openness to challenge that has been demonstrated by the Board, Executive team and wider staff groups is a real achievement for everyone concerned. The positive shift in relationships has created the conditions for improvement which is evidenced by the positive changes that have been made in structures, systems and processes that would not have seemed possible 12 months ago. However, there is significantly more work to be done to strengthen and embed the 'one-team' ethos in ED so that every member of the team feels that they have a legitimate voice and is valued.

The key appointments of Deputy COO and ED Head of Nursing will bring further capacity and expertise to drive the necessary improvements in flow and professional practice.

The ongoing challenges with recruitment, retention and flow through the hospital and wider health and care system are masking the impact that the improvements should be delivering for patients and staff in the Emergency Department.

Whilst there is recognition that relationships are better and significant efforts are being made to tackle the challenges, the day-to-day pressure of ambulance handover delays,

numbers of patients waiting assessment in the department, and long waits for admission, transfer, and discharge, create an environment which is directly impacting on staff wellbeing and quality of care.

The Trust has invested in the OD agenda; made important changes in leadership and new appointments; put in place the requisite governance arrangements to provide oversight of the improvement agenda; and started to deliver key improvements. There is a risk that the current operational pressures will displace the importance of the ongoing OD work and may also get in the way of tackling some of the poor behaviours and performance issues that continue. This cannot be allowed to happen.

Staff continue to have good ideas about how improvements can be made and amidst all the operational pressures, time needs to be taken to continue to listen and act on their concerns and suggestions as appropriate.

6. RECOMMENDATIONS

The existing combined action plan that brings together the recommendations of the previous review and the CQC inspections contains a multitude of actions, all of which are relevant and essential to drive the necessary improvements in urgent and emergency care.

This follow-up report does not constitute a further review – it has deliberately taken the form of an assessment of progress against the original recommendations. To that effect, **Annex 2** summarises assessed progress and offers up some further relevant issues for consideration in line with the improvement themes.

In the context of all the progress that has already been made there are 4 further key recommendations as follows:

- **Prioritisation and ordering of actions on flow**

With so many action plans and actions, there is a real risk that the capacity and capability to make the necessary transactional and transformational changes is compromised. The development of the SOF4 Improvement plan provides an opportunity to take stock,

prioritise and order the improvement interventions so that there is greater focus in the short-term on the things that will make the most difference to flow.

- **Safer management of undifferentiated risk**

There needs to be a review of triage processes, capacity, and capability with a plan to move quickly and purposefully towards meeting the 15-minute standard. This will facilitate appropriate redirection of patients and more effective management of risk and performance.

- **Wellbeing and development of the workforce**

Whilst this is already a key priority within the UEC improvement plan, there needs to be urgent consideration of further options to strengthen and extend the wellbeing offer to staff. Ongoing clinical psychology support as part of the team OD work may be helpful in assisting with team dynamics and coping strategies while attempts continue to recruit more staff.

At the same time, options for transforming the shape of the workforce needs to be pursued. This includes the potential for new and complimentary roles to support the more traditional models currently in place. In light of the poor levels of engagement of junior nursing staff in this follow-up exercise and ongoing challenges in recruitment, retention, sickness absence and professional standards, urgent consideration need to be given to targeted engagement and improvement actions with this staff group.

- **Out of hospital actions to support UHPT**

Whilst not within the remit of the original review, the recommendations identified the need for greater joint working across the wider health and social care system to deliver better patient outcomes, performance, and value for money.

Relationships are good between partners and there is recognition of respective pressures and challenges. However, the same degree of urgency needs to be applied to the actions in primary care, community services, mental health, and social care necessary to deliver sustainable joint solutions to the increasing demand for care.

The joint priority actions to enhance care at home, provide alternatives to ED, strengthen reablement pathways, and facilitate hospital discharge must be urgently agreed and the necessary resources allocated to drive delivery with scrutiny and oversight by the Western Urgent Care Board.

7. Summary

There has been a clear acceptance by the Board and the staff of the challenges they face and the need for change. A comprehensive action plan is being progressed with appropriate leadership and oversight at the highest level. Relationships have improved, clinical engagement is much better, and key appointments have been made as part of building capacity and capability for change.

Momentum must be maintained in delivering the original recommendations with specific focus on the ongoing team-based organisational development work, nursing culture and leadership in ED, and the development and delivery of the acute medicine model.

Our previous report ended by stating ***"this ED, hospital and community has the potential to provide high quality unscheduled care for patients. It will require teams to openly live the organisational values; a robust plan across the wider unscheduled care system to deliver optimal flow; strong systems of governance to follow through on all agreed actions; and compassionate leadership – supportive, decisive but uncompromising in achieving standards of behaviour and outcomes."***

This very much remains the case with the follow-up exercise identifying that many of the building blocks are in place and progress is being made. However, until such time as whole-system flow is resolved, the positive improvements that have been hard earned will remain fragile.

Culture and relationships will continue to be at the heart of delivery and the ground that has been gained can be quickly lost unless flow improves and the conditions under which care is being delivered (and staff are working) improve. The most substantial risk remains the

ability and will of staff to pull together as a single team in the face of relentless demand and pressure.

Moving forward, greater emphasis needs to be placed on the wider system actions to close the demand and capacity gap and ensure patient care is delivered in the most appropriate setting according to need. This wider ownership of the challenges and the requirement for urgent and sustained action with partners needs to be firmly reinforced with a clear mechanism for jointly holding each other to account for delivery.

External Review of the cultural climate within UHP specifically relevant to the safe and timely delivery of care within the Emergency Department for both patients and the Multidisciplinary Team

With the support of the Board, the Chief Executive (CEO) of University Hospitals Plymouth (UHP) has requested, in partnership with the NHSEI South West Region, to commission an external review of the overall culture and climate within the Emergency Department (ED). Although commission by the CEO, the ToR have been developed between all key members of the wider team within UHP.

The invited approach is not part of the NHSI Undertakings process and is a signal of the wider Trust's commitment to work to a more sustainable future for services and staff. The review is focussed within UHP and does not attempt to address with wider community issues which are fundamental to effective system working.

The invited reviewer(s) will have access to all sources of data/information and dialogue with the wider members of the team.

1. Through exploratory conversations with the wider team given an external objective perspective on the overall narrative of the culture, the areas of commonality and key areas of difference across the teams.

2. In reviewing the cultural narrative and the analysis of the data* – identifying the actions already in place or additional actions that require further emphasis, focus and momentum.

3. Observations and recommendations are invited on the overall governance, capacity and capability of the leadership teams involved.

4. Working with the reviewer(s) and NHS England and NHS Improvement South West – identify any further operational actions and observations that need to be addressed to support flow across the hospital and improvements within the department for safer and timely care.

5. Identify any additional actions the wider team need to address to sustainably improve the culture, climate and best practice within the department.

6. The reviewer(s) are invited to make any further additional observations or suggestions for further actions which are considered material for sustained improvement.

* the Trust has extensive access to staff culture and climate data, GIRFT and improvement data to underpin the Board, Executive and wider leadership team understanding of the factors affecting safety, performance and staff health and wellbeing and workforce models.

Annex 2

PROGRESS UPDATE AGAINST RECOMMENDATIONS OF THE REVIEW OF CULTURE AND RELATIONSHIPS - EMERGENCY DEPARTMENT
UNIVERSITY HOSPITAL PLYMOUTH (JANUARY 2021)

1. CULTURE

Recommendation	Progress Update	Further consideration
The Executive Team, Care Group Leaders and ED need to develop and agree a **Compact** which sets out the values, behaviours, and ways of working which will underpin how they take forward this improvement agenda. The **Compact** will need to clearly articulate how people will hold each other to account for behaviours and actions and the consequences of failure on any part. There should be a zero-tolerance to breaches of the compact.	This has been completed with a consensus that the process of developing the compact was as helpful as the compact itself. The ongoing mechanism for holding each other to account for complying with the compact is unclear but does not appear to be an issue thus far.	It would be worthwhile bringing together the key individuals 1 year on from the sign-off of the compact to explore effectiveness and amend as required.
External expertise will need to be commissioned to work with key members of staff to review practice and develop a series of OD interventions to improve culture and working relationships. This will need to include communication, mutual respect and expectations regarding professional behaviours.	The delay in securing external OD capacity has meant that the pace of this work has not been optimal. The 'time to connect' initiative support by a clinical psychologist was appreciated by the staff involved put uptake has been patchy.	There appears to be a growing disengagement of junior nursing staff which needs to be understood and a bespoke OD intervention urgently considered. Ongoing OD work with all teams will be essential over the next 12 months to maintain support and momentum
TRUST RESPONSE: A bespoke OD process started in September 2021 and builds upon the earlier work 'time to connect' initiative, undoubtedly hampered by the ongoing pandemic and operational pressures this development work continues. This work is designed and led by a co-operative team of internal OD experts alongside externally commissioned expertise. In addition, to the wider OD work, the junior nursing workforce benefits form direct engagement from senior nursing professional leadership as a result of the new HoN in place. Additionally, the CNO has already met with Band 5 staff directly, moving to Band 6 staff next week. The aim is to have a weekly drop in CNO clinic with ED nursing staff, which has proved a very successful model used across the wider organization over the past 12 months for preceptees in all areas.		

For the next 12 months, there should be monthly 'listening clinics' for ED staff to be able to come forward in a safe and protected environment to express any concerns and share ideas for further improvements. They should be led by an Executive Director or Freedom to Speak Up Guardian and held outside the department to protect anonymity.	This was undertaken and positively received by those who engaged. Whilst participation should always be voluntary, anecdotally uptake was low amongst junior staff – the reason for this needs to be better understood.	Consideration to be given to testing ongoing need through a pulse survey or other appropriate mechanism.
TRUST RESPONSE: The ED has a number of sources of staff survey data to consider and this has been underway for example, an internal pulse survey, safety surveys and the annual national staff survey. The outcomes, learnings and informing the next stages of staff engagement and development will be considered through the People & Culture sub-committee, Trust Board and through regular regulatory oversight including CQC.		
Careful consideration needs to be given to the mechanism for sharing risk across the organisation so that there is a genuine appreciation of competing priorities and focus on best outcomes for patients. Creating the developmental space for identifying challenges and joint working on solutions between clinical leaders will be critical to success.	Recent agreement to the full-capacity protocol has been very positively received by ED staff but does create difficulties when ward staffing levels are challenged. Middle grade Doctors appreciated the direct dialogue with the MD. Following up on the suggestions made is an important issue of trust and credibility.	Consideration to be given to the best forum for generating further dialogue and action between specialty clinical teams. Suggestions for action need to be followed up and if not pursued, the reason should be communicated back to staff.
TRUST RESPONSE: The established Clinical Advisory Group, medical staffing forums and our clinical engagement and leadership model is now an established feature of clinical engagement within the Trust. The clinical groups work through new pathways, our Covid response and iteratively shape service improvements for example for fracture clinic, full capacity protocol, internal professional standards.		

2 SYSTEM FLOW

Recommendation	Progress Update	Further consideration
Consideration should be urgently given to the appointment of a Deputy COO with specific responsibility for system flow. This individual will require a specific skill set and approach which may need to be sourced externally to bring objectivity and experience to the team.	An experienced Deputy COO from outside the organisation has been appointed but at the time of the progress review had not yet taken up post.	At the end of the first 3 months in post, the Deputy COO should be asked to produce a position paper for the Executive Team on the opportunities for further improvements in internal and wider system flow.
There needs to be a rapid review of the synergy between bed management, site management and flow management roles and infrastructure in the hospital with a view to shifting to a single integrated model that is based on high quality, real time data and pulls patients through the system.	There was little evidence of progress in this area at the time of the site visit and it remains an area of opportunity for further improvement. It is understood that a new lead has been appointed for the site team which creates further scope for targeted action.	To be prioritised by the Deputy COO as part of the overall review of flow linked to roll out of twice daily Board rounds, proactive management of Anticipated Date of Discharge and optimising use of the Discharge lounge.
TRUST RESPONSE: External expertise including from the National NHSE/I, Region, National Improvement Team have all had the opportunity to input into opportunities for further improvements in internal and wider system flow. The prioritised areas internally will be part of the Trust's response to CQC. In addition, through the Deputy COO who has direct responsibility for the site team has a developing programme of workstreams to support operational flow and maximise internal opportunities.		
The Escalation protocol needs to be urgently revised to clearly identify triggers and actions across the whole hospital. The Action Card system used for Emergency Planning should be considered as a useful and recognisable approach to ascribing responsibilities and holding individuals to account.	There have been several iterations of the escalation protocol and the introduction of the Bronze, Silver, and Gold calls daily. Due to the prolonged OPEL4 status, this is becoming less of an escalation framework and more like usual practice which creates a risk to normalisation of both the pressures and the management arrangements.	Following the progress review, a full capacity protocol has also been established. This, together with the escalation calls needs to be evaluated after 3 months to ensure that triggers are appropriate and that boarding of patients does not become the new normal.
There needs to be a rapid review of rostering of staff in ED against activity to ensure that skills mix and numbers are optimally allocated. This may require a change in shift patterns to meet peak demand.	This remains a significant challenge with a lack of consistency in numbers and skills-matching within rosters. The issue of a senior nurse shift co-ordinator across the whole ED remains outstanding which is a weakness in the dynamic management of activity to reduce risk.	Rostering rules need to be established and adhered to. The roster co-ordinator needs to be empowered to ensure that standards are met. The Band 7 job plans need to be re-worked to introduce a team-based structure for appraisal and supervision and to establish a shift-co-ordinator role.

TRUST RESPONSE: Heightened difficulties resulting from Covid related absence and shortages of staff will mask the true picture here, but professional leadership lines and clear nursing management responsibility is now in place and already focused on managing shift patterns that are flexible to staff while meeting the needs of the service, improving rostering practices and supporting staff through sickness and facilitating their return to work.		
A specific exercise to map flow through the ED should be undertaken to identify bottlenecks and opportunities for efficiencies.	There is evidence of much work having been undertaken to review internal systems and processes within ED but there remain further opportunities to streamline activity to improve flow.	A prioritisation exercise needs to be undertaken to identify and prioritise implementation of the high impact changes There is an urgent need to implement a reliable Triage service with robust, reliable, alternative pathways out of ED for appropriate patients.
TRUST RESPONSE: A test of change to improve triage was implemented in December 2021. This did have a positive impact however workforce availability and appropriate experience continues to be an issue. UHP is now trying to secure agency staff to ensure consistent workforce in the shorter term. The Trust with the support of the National Improvement team have commissioned Frazer Nash to map demand and capacity to maximise triage capacity. This work is due to start 19th January 2022.		
Working with regional partners and commissioners there needs to be a strengthening of the mental health support to ED and CDU. Consideration should be given to: • The mechanism and timeliness of psychiatric liaison services (Adult and Children and Young People services) • The potential for co-location of Mental Health Crisis Services with ED out of hours	There is little evidence of progress in this area. Whilst the wait for assessment from the mental health team is generally within acceptable timescales, significant risks remain with: • Mental Health patients inappropriately waiting in the general waiting area for assessment • Adults, children and young people with mental health needs waiting in ED/CDU for significant lengths of time for an appropriate placement	There is an urgent need for: • A direct pathway from Primary Care and the ambulance service for acute mental health assessment 24/7 that does not require ED attendance • An alternative place of safety for mental health patients who have been triaged in ED and are either awaiting mental health assessment or placement
There needs to be a high-level mapping exercise to identify those patient groups known to require admission or specialty review but are currently being routed through ED. This includes those from Outpatients, failed discharges or where readmission has already been accepted by the specialty team. These are 'known' patients and a sophisticated flow management system can negate the need for these patients to attend ED unless it specifically adds value to their clinical care.	Whilst there is a significant amount of data to inform decision-making, it has not been possible to identify how this recommendation is being progressed.	This remains an opportunity for decompressing ED linked to the acute medicine work below.

TRUST RESPONSE: The commissioned work with Frazer Nash will support this area of focus in collaboration with ED and the wider Trusts clinical services.		
One of the key strategic priorities for the organisation must be the development of a 21st Century **Acute Medicine** service appropriately led by specialty trained acute physicians and properly resourced to meet demand.	The appointment of 2 locum and 1 substantive Acute Physicians is welcomed and the support to ED is delivering benefits in time to assessment and decision-making. There has also been work undertaken to start to describe the future model for acute medicine with a presentation made to Board. The Review Team was advised that there is a business case in development (which includes funding for Acute Physicians, other key staff and extended capacity) however, there does not yet appear to be a comprehensive acute medicine model and phased implementation plan which addresses need and is owned by all stakeholders. 12 months on from the original review this is a weakness in the overall UEC improvement agenda.	Acute medicine demand remains the biggest driver of inpatient activity via ED and, by default, exit block. This needs to be a priority component of the Strategic Oversight Framework (SOF4) Improvement Plan. Additional expertise and capacity are likely to be needed to supplement what is available within the Trust to accelerate development and delivery.
TRUST RESPONSE: The Trust is concentrating on developing the vision and implementation plan for the acute medical model. Given the current constraints additional external capacity and expertise is being secured through the National Improvement team and will be informed by the Trust clinical strategy. This along with the other improvement future focused actions and opportunities will see delivery throughout 2022.		
Whilst the work is undertaken to revise the Acute Medicine Model for the hospital, an interim solution needs to be identified	The original review identified a number of interim opportunities for modernising practice to support flow. It has been difficult to establish the degree to which this has progressed, and it remains a significant opportunity to address the ED and wider flow challenges.	The demand and capacity modelling for the Acute Assessment Unit (AAU) Medical Admissions Unit (MAU) Acute Frailty, and Medical Short Stay Ward activity needs to be rerun with due consideration given to flexible use of workforce and space. The direct-to-medicine pathways need to be refined alongside the bed management systems to facilitate direct access from Primary Care and Paramedics in line with agreed protocols.

TRUST RESPONSE: The Frazer Nash work will establish through demand and commissioned capacity the scale of opportunity to maximise direct access pathways for medical care.		
Pending the establishment of the UEC Improvement Plan and programme infrastructure for SDEC, there needs to be a focus on finalising the pathway to facilitate referrals to the direct access chest pain clinic. Any other pathways currently in development should be completed and implemented within the next 4 weeks.	The SDEC benchmark data indicates that there have been tangible improvements in several areas but there is more opportunity to be gained It is taking far too long to refine pathways (many months rather than weeks)	In line with the acute medicine model 'hot-slots' need to be established in key medicine sub-specialties with pathways from AAU and ED as an interim measure pending direct access from primary care. Pace is a key issue!
TRUST RESPONSE: This work is in progress with slots available in surgery and medicine. Maximising the established pathways has been undermined by both bed availability across the Trust, managing specific Covid requirement and workforce capacity.		
The 4-hour target remains a valid indicator for *Minors* and performance should be actively managed to achieve compliance.	Minors has returned to the main ED from the Nuffield Hospital site since the initial review. Anecdotally, patients are being directed or self-presenting to Minors due to capacity constraints in Primary Care and the Cumberland UTC. This means that the demand for minor illness and minor injuries support is escalating with significant waits for treatment.	An urgent decision needs to be made about the ability to staff the Cumberland UTC with agreed hours of opening communicated and maintained.
TRUST RESPONSE: This has now been actioned and agreed with the System Urgent Care Board, with no short notice closures since.		

3. GOVERNANCE

Recommendation	Progress Update	Further consideration
Internal ED Management Systems	The Reviewers were advised that an induction programme has been developed for new staff, but we were unable to test whether this was workingin practice and is having the required impact. There has been a temporary pause on preceptorship nurses being appointed to ED due to the capacity to manage their induction and development needs. The management pillars have been reviewed and whilst on paper there is greater inclusivity, comments from staffare that Consultant opinion and leadership remains dominant and oftenuncontested.	The management team needs to test directly with new starters who have joined the ED in the last 6 months whether they have had the benefit ofthe programme. Whilst this is understood, it is potentially reputationally damaging for the department as well as having an adverse impact on the pipeline of futurestaff. The Head of Nursing needs to urgently reassess and determine how this is addressed. The Nursing voice remains a real challenge in the ED. A lot of expectation is being placed on the new Head of Nursing to start to redress the balance but there will need to be support from the wider management team for this to be effective.
TRUST RESPONSE: Stabilising and strengthening the nursing workforce in ED is a long-term strategy and is dependent on an integrated plan which encompasses more than just numbers of staff and will take time and planning to deliver. Delivering a strategy that is resilient, responsive and future proof is dependent on taking an approach that defines the numbers and types of staff and the skills, knowledge and competencies required to meet patients' specialist needs within the ED using an evidenced based model. In addition, the successful deployment requires the leadership capacity to define and deliver it within a clinical environment that can function in a positively charged culture. It is important to note that the delivery of this complex workforce strategy is dependent on these foundations being in place before any major milestones are achieved. The work on these foundations, including the strengthening of nursing leadership, the development of a more positive and professional culture and a qualified understanding of what the workforce should really look like are in progress and will support the delivery of the long-term workforce plan.		
Developing and delivering the Improvement Plan	The establishment of the Urgent Care Oversight Board has ensured that there isan appropriate vehicle for development and scrutiny of delivery of the overall improvement plan. Chaired by the CEO with membership including a nominated NED, the appropriate delegation is in place to facilitate decision-making and a line ofsight to the Board. Clinical engagement in the process of developing and delivering the improvement plan is much greater than previously observed.	It is likely that the Urgent Care Oversight Board will need to remain in place as a core part of the overall Trust governance framework for at least the next 12-18 months. The overall plan will need to be refreshed to take account of more recent CQC inspections and consideration given to prioritisation of actions. The linkages with the Western Urgent Care Board and the Devon System Urgent Care Board need to be reconsidered in the context of the requirement to enhance system actions

		to support flow improvements.
Capacity and Capability to deliver	The role of the Chief Operating Officer asthe single Executive lead for unscheduledcare has been reinforced within the organisation. The new appointment has been received positively and has provided an opportunity to strengthen relationships and accountabilities.	With the recent appointment of the Deputy COO, changes to the Care Group leadership teams and the proposal for changes to the Medicine Care Group structures, it is timely to take stock of the options to ensure that time is released for the COO to be increasingly strategic and outward-facing and there are no unintended consequences that could cut across flexible use of workforce and capacity across Medicine and ED.
	The removal of the Hot Floor Clinical Director role and reinforcement of the responsibilities of the Service Line Director (SLD) and Care Group Director has been helpful in addressing some of the ambiguity of leadership and decision-making.	As the new Clinical Director for Integrated Unscheduled Care role develops, it will be important that accountabilities are clearly aligned with those of the relevant SLDs to ensure role clarity.
	Whilst the review recommendation wasfor the appointment of a single Head ofNursing across ED and Acute Medicine, the recent appointment of an experienced Head of Nursing for ED is considered a positive move in providingmore senior clinical and professional nursing leadership to the department.	Consideration now needs to be given to the linkages with acute medicine with a view to creating increasing flexibility of care and workforce. The roles and responsibilities of the two ED matrons also need to be reviewed in the context of the Head of Nursing appointment. Specific consideration should be given to whether 2 Matron roles is sustainable and if one of the posts should be refocused to address priorities in enhanced professionalism and clinical practice.
	Whilst some programme management arrangements have been put in place to support the development and delivery ofthe UEC improvement agenda, the scale of the challenge (including the number ofactions being pursued in response to various reviews) raises the question about longer-term sustainability. The Trust is working hard to make the distinction between 'business as usual' activity that needs to be managed through the Programme Management unit (PMU).	External support has been secured as part of the SOF4 response. Consideration needs to be given to consolidation of the various actions / plans and establishing the ongoing support arrangements from April 2022 with greater delegation within the general management function.