Acknowledgements

The Enquiry panel is grateful for the engagement and candor of the staff that we met with and who participated in the enquiry. It is essential to the integrity of this enquiry that the identity of individuals has been kept confidential.

The scope of enquiry, under the Terms of Reference, is wide ranging and we are grateful to Alice Casey and Ruth Walker for assisting us with open access to staff across the organisation who have provided us with the information and evidence we have requested.

We are grateful to the RCN and UNISON for their time and engagement, their flexibility and the use of their facilities and in supporting their members during our interviews.

Finally, we would like to single out Jeanette Thomas-French for her support and assistance to the panel, ensuring that documents have been available, meetings arranged and notes produced.
1. Introduction

P1 Cardiff & Vale University Health Board (CVUHB) commissioned an independent enquiry in order to investigate the concerns raised by Royal College of Nursing (RCN) members under “Frontline First, Raising Matters of Concern”. In her letter dated 15th October 2014, Tina Donnelly, Director RCN Wales, described the concerns that had been raised using the following themes:

- Bullying and harassment
- Poor practices of care causing patient harm
- Targets being the priority instead of patient focus
- Staffing levels are poor and inadequate

P2 CVUHB responded by outlining its intention to commission a formal Organisation Health and Culture Review and invited Tina Donnelly to join an Executive Steering Group, reporting to the Health Board, which would have oversight of the findings and subsequent action plans. The RCN declined to join the steering group advising that as the concerns had been raised by RCN members, and as the steering group reported to the Health Board, there may be a potential conflict of interest with ongoing support for RCN members.

P3 On 13 November 2014, the RCN and UNISON submitted a collective grievance under dignity at work and whistle blowing policies. This letter appears to have crossed with a CVUHB letter of the same date, proposing an investigation/enquiry and that included an outline terms of reference. This was followed up with a letter (dated 27th November 2014) to the RCN and UNISON, confirming CVUHB’s intention to proceed with the investigation/enquiry, and provided a modified terms of reference that included the issues raised within the collective grievance.

P4 In his letter to the RCN dated 18 December 2014, the Chief Executive CVUHB, confirmed the independence of the enquiry panel, clarified that the terms of reference ensured the scope of enquiry would include all current members of staff, past members of staff or any other emergency service employee who wished to be interviewed and that the findings would be shared.

P5 On 16 January 2014, the RCN confirmed that its members had reached a consensus to withdraw from the collective grievance. UNISON also confirmed on 29 January
2015 that its members had also decided to withdraw from the grievance. The terms of reference for the enquiry were revised and agreed between CVUHB, the RCN and UNISON.

P6 The panel was commissioned in late December 2014 and commenced on site on 7 January 2015.

2. The Enquiry Panel

P7 The panel members included:

- Fiona Smith, an independent Healthcare Consultant who has worked as a senior NHS manager, with over 30 years NHS experience and who is a qualified RGN specialising in A&E nursing
- Debbie Lymn, an independent Consultant who has worked as a senior HR manager with over 15 years NHS experience
- Professor Fiona Patterson, an Organisational Psychologist with over 20 years experience of assessing organisational culture and development.

P8 Independence of the panel from the organization is guaranteed. None of the members have previously worked in Wales or with any of the Executive Board and in fact with each other.

3. Terms of Reference

P9 The purpose of the enquiry is:

To investigate / review:

1. The organisation of care within the Emergency Service to ascertain whether the provision of care is being compromised due to the prevailing organisational culture within the Emergency Unit and/or Assessment Unit.
2. To establish whether patient care arrangements have resulted in harm to any patient.
3. To establish whether the prevailing organisational culture has resulted in harm to any employee.
4. In particular to review:
The general care of patients in the Emergency and Assessment Units areas. This will include the appropriateness of that care and the location of care.

Whether targets are prioritised instead of patient-focused care

General staffing arrangements.

Sickness absence levels and sickness control arrangements.

Employee turnover and any information ascertained from Exit interviews.

The general culture within the Emergency and Assessment Units and whether bullying, harassment or inappropriate behaviour or treatment by/of middle managers or any employee takes place, and identify the perpetrators.

Any other relevant issue

4. Approach to the enquiry

P10 This independent enquiry is not part of any disciplinary process.

P11 The Health Board has been given the opportunity to comment on the factual accuracy of the report.

P12 We started our investigation on 7 January 2015 and submitted a report to the chief operating officer to be checked for factual accuracy on 1 April 2015.

P13 Fiona Smith and Debbie Lymn have written this report and Professor Fiona Patterson has quality assured it to ensure:

- The suitability of the methodology used
- Whether the volume and depth of evidence the panel obtained is adequate
- Whether the evidence used to support the findings is relevant and sufficiently robust
- Whether the findings are clear and unambiguous
- Whether the recommendations address the findings
- Whether the recommendations are clear and unambiguous
- Whether the report demonstrates objectivity and balance
- Whether the report fully addresses the lines of enquiry as set out in the Terms of Reference
4.1 Methodology

P14 The panel adopted a mixed methods approach to gather evidence and opinion as part of their enquiry as follows:
- One to one meetings (n=7)
- Focus groups (n=32)
- Staff Survey (n=87)
- Review of various documents
- Observational visits to the Cardiff and Vale Emergency Services Departments

P15 The investigation was undertaken in private. The interviews were voluntary. By adopting this approach, we were able to gain detailed testimony from key individuals who were prepared to talk to the panel.

P16 Others, who felt less confident in talking to the panel in a one to one situation, participated in dialogue either through focus groups or in complete anonymity through the staff survey.

P17 Hard documentation was used to broaden the panels understanding and evidence base and to triangulate information provided through the face-to-face discussions.

P18 This methodology ensured the panel gave every member of staff in the Emergency Services, clinical and non-clinical, the opportunity to participate.

P19 In total the enquiry panel received input from over 120 individuals.

4.1.1 Individual meetings

P20 We met with the Chief Operating Officer, the Chief Nurse, Clinical Board Director and the Clinical Board Nurse, who has been in post for six month. The Head of Operations and Delivery, declined to meet with us as they felt that they were too new in post to be able to contribute.

P21 We met with the Emergency Services senior management team as a group and as individuals on a one to one basis, on more than one occasion.
P22 In total we met with 56 other individuals.

P23 First we conducted interviews with 12 Union members who made the allegations through the RCN and UNISON, in order to clarify the points raised in the Frontline First letter.

P24 From our initial analysis of the allegations and after the initial interviews had been conducted we requested further interviews with specific named individuals.

P25 In addition, during the course of the review a number of other individuals requested to meet with us.

P26 We met with five former members of staff, other Health Board employees who have direct contact with Emergency Services in the course of their duties, and representatives from the Welsh Ambulance Service Trust, Health Inspectorate Wales, and the RCN and UNISON.

P27 Staff were written to explaining the purpose of our Enquiry and that the findings and recommendations of the report would be published by the Health Board in some form. Guidance to the interviewees and the Terms of Reference for the enquiry were made clear to staff.

P28 Individuals were assured that notes of meetings and statements submitted as part of the review would not be shared outside of the Enquiry and that the report would not include attributable information.

P29 We offered interviewees the opportunity to confirm the accuracy of the interview transcripts or to add to them.

4.1.2 Focus Groups

P30 Seven focus groups were arranged to cover each staff cohort within the Emergency Service as follows:

- AU Staff
- EU team leaders/managers (band 7 and above)
- EU nursing staff (qualified and unqualified)
• Directorate Admin staff
• MEAU and Barry
• Consultants
• ENPs/ANPs

P31 20 individuals were invited to each focus group and were chosen at random. Where there were 20 individuals or less in the identified staff cohort then all individuals were invited. Where the staff cohort had more than 20 staff, names were arranged in alphabetical order and a sample selected on an every second or every fourth name basis, depending on the size of the cohort. This selection methodology was agreed with the RCN and UNISON.

P32 Reassurance was given that any comments made by individuals as part of the focus group would not be directly attributed to them, but summarised as part of overall feedback.

P33 In total 32 individuals attended the focus groups.

4.1.3 Staff Survey

P34 A strictly confidential survey was developed by the organisational psychologist member of the enquiry panel. The survey was created to capture the organisational culture within Emergency Services and asked employees questions about their job and working environment and their perceptions of the organisational culture within the department.

P35 Approximately 340 staff were invited to complete the questionnaire and this included staff who had been met with either as individuals or through focus groups.

P36 The survey was administered online, and was open for completion between the 5th and the 22nd February 2015.

P37 All survey items were subject to a robust and scientific review/selection process prior to inclusion in the survey and were linked to previously validated surveys. Some items were adapted from the previously validated National NHS Staff Survey 2014 and a
number of items were taken from other existing employee satisfaction surveys that have been supported by research and validation evidence.

P38 Given that there were some concerns raised by staff regarding the possibility for ‘gaming’ survey responses, it was ensured that various approaches to significantly reduce this risk were explored. Specifically, we ensured that the software utilised for administration of the survey prevented multiple users from responding to the survey using the same computer. This ensured that there could be only one submission per computer, which reduced the likely incidence of any one person responding multiple times.

P39 87 responses were received.

4.1.4 Documentary Evidence

P40 During the course of the enquiry, the panel reviewed over of 250 pieces of documentary evidence.

P41 These documents provided additional evidence or were used to triangulate information that had been provided to the panel. Documents fell into the following broad categories:

- Organisational Policies and Procedures
- Local Procedures
- Personal accounts
- Performance information
- Quality and Safety Documents
- HR documentation (including formal and informal personnel documents; files; and job descriptions)
- Correspondence
- Reports and Plans
- Action Plans
- Union Documentation
- Minutes
- Best practice reference material

Triangulation of evidence

P42 To compile this report we have drawn on all of the evidence collated through the various methods. We have included quotes and examples derived from the interviews,
focus groups and the staff survey, so that the reader can themselves hear the staffs’ voice.

P43 During the course of the investigation we heard suggestions that some staff raised concerns for the dubious motives such as avoiding action to address poor performance. If this happens it is regrettable as it makes it harder for staff to raise genuine concerns. In his report “Freedom to Speak Up” Feb 2015, Robert Francis noted “Whilst there may be some cases in which issues are fabricated or raised to forestall some form of justifiable action against the, this cannot be true of them all”. Whatever the motive patient safety concerns that are raised still need to be addressed.

P44 We have not included individual staff’s personal complaints relating to their own circumstances, as these are outside of the Terms of Reference and should be dealt with through internal Health Board processes.

P45 Given the sensitivities surrounding an Enquiry of this nature we have been cognisant of individuals who may have individual agendas which may influence their reflections, and the quotes therefore come from all staff groups to add balance. The quotes used relate only to the themes that arose from the evidence.

P46 The panel have based their analysis and findings in relation to the key lines of enquiry, on the views of all the clinical and non-clinical staff who contributed to the enquiry either through one to one interviews, focus groups or staff survey and triangulated this evidence with relevant documentary evidence wherever available.

5. Background information

P47 Cardiff & Vale University Health Board provide emergency services from three sites:

- The Medical Emergency Assessment Unit at Llandough Hospital. The unit provides secondary services for Vale of Glamorgan and Cardiff residents. It is the first point of contact for all medical admissions to Llandough Hospital and in addition to accepting direct emergency admissions accepts referrals from GPs. It has twelve assessment beds and two higher dependency rooms.

- The Minor Injuries Unit at Barry Hospital. This is a nurse led unit.
The Emergency Unit at University Hospital Wales

The Emergency Unit (EU) at University Hospital Wales (UHW) provides a 24-hour service, seven days per week to the local population. EU attendances are approximately 131,000 patients per year and in line with the rest of the UK, and for similar reasons, the number of attendances has increased year on year. Patients present to the department either by walking into the reception area or by arriving by ambulance. Patient activity in the different areas of the department is as follows:

- Majors (Inc. Ambulatory Care Unit (ACU), Streaming, Resus and Majors) = 58,000 pa
- Minor injuries = 52,000 pa
- Paeds = 30,500 pa

The EU had a major refurbishment in 2014. At this time, the Majors and Resus areas were expanded and the ambulatory care function was combined with minors.

The refurbishment facilitated the removal of “the Corridor”, a corridor area that had been used as an overflow space at times when admission to a hospital bed was delayed causing overcrowding in the EU.

The Emergency floor is now run through separate functional areas that consist of a Streaming, Resuscitation, Majors, Ambulatory Care Unit, Minors, Clinical Decision Unit (CDU), Assessment Unit Lounge, Assessment Unit (AU) and Paediatrics.

6. Findings and Recommendations

The findings are laid out against the key lines of enquiry from the Terms of Reference and recommendations against the findings as follows:

6.1 Key line of enquiry: The organisation of care within the Emergency Service to ascertain whether the provision of care is being compromised due to the prevailing organisational culture within the Emergency Unit and/or Assessment Unit.
A commonly used definition of organisational culture in the research literature is 'the way we do things around here'. Organisational culture directly affects the quality and safety, productivity and performance of service delivery. Consistent with previous research, we organised the evidence obtained to determine the organisational culture of the emergency services using the following themes:

- Leadership and management
- How business is conducted
- How communication is organised
- How employees are treated
- How much freedom is allowed in decision making and developing new ideas
- How committed employees are towards collective objectives.

Overall Finding (OF)

**OF1.** We found evidence that the provision of care is being compromised due to the prevailing organisational culture within the Emergency Unit and/or Assessment Unit.

Supporting findings and recommendations

- **Supporting Findings: Leadership and management**
  - **F1** We found that the ES management team to be a very hard working and committed group of individuals who want to do a good job.
  - **F2** We found that there is confusion amongst the general staff body in the UHW EU particularly about who is ultimately in charge.
  - **F3** We found that there is an authoritarian command and control management approach. Consultants, senior nurses and band 7s have been disempowered and do not consistently take responsibility for managing staff and delivering quality improvements. Additionally the ill-defined management lines has resulted in the deskillling of junior management roles and upwards delegation.

**Recommendations: Leadership and management**

- **R1** We recommend that the ES management team undertake a structured programme of coaching to develop an effective way of working (both individually and as a team) that builds on the strengths of all working in the team and which articulates a clear and consistent leadership message to staff. This programme should include both individual and team assessments (e.g. MBTI) to improve personal awareness and development,
reflections on personal impact and confidence building. The team must co-develop a coherent and transparent scheme of delegated authority that extends to Consultants, ENPs/ANPs and Band 7s.

- R2 We recommend that the management of rotas and shift swaps is reviewed and that they are delegated to Band 7 nurses in the EU and paediatrics. It is recommended that ENPs and ANPs self roster and manage their own shift swaps. Guidance should be developed with staff to ensure transparency and engagement. The management team and Band 7s will need to develop an understanding of and a mature approach to staff being empowered to self-regulate in relation to the development and management of rotas, with an agreed (efficient and transparent) system for escalation of issues and disagreements.

Supporting findings: How business is conducted

- F4 We found there is a lack of proactive and visible engagement by the other Clinical Boards in delivering the emergency pathway and this results in poor flow and compromises patient care in the EU and AU.
- F5 The senior management team do not engage with the general ES staff and Consultants to collectively develop a vision for ES and there appears to be no clear vision or change management plan to systematically ensure continued development of emergency services and to improve the care provided to patients.

Recommendations: How business is conducted

- R3 We recommend that The Health Board hold all clinical boards accountable for the development of detailed action plans with defined metrics and accountable leads that will deliver an evidenced based breach reduction within agreed timelines and hence deliver an A&E performance improvement trajectory. This wider accountability must be transparent and provide confidence to the ES staff on the shop floor that delivery of the A&E 4 hour target is also owned by the wider organisation.
- R4 We recommend that the Medicine Clinical Board increase their proactive management and support of the ES, reducing the need for Executive level direct management of the EU on a day to day basis.
- R5 We recommend that the ES senior management team supported by the Medicine Clinical Board, develops medium term strategy and supporting business plan, that reflects the changes deriving from the wider organisational strategy.
doing so, they must engage the Consultant body to ensure appropriate debate and the engagement of clinicians in the strategic development of Emergency Services.

Supporting findings: How communications are organised

- **F6** We found that the communication systems within ES do not work effectively. Staff are not proactively engaged and there is no understanding of what is happening strategically or in the wider organisation. ES staff feel that disproportionate pressure is put on them to deliver targets whilst the solution of improved flow sits outside of their domain. Staff do not know what is being done to solve the problem and feel “hopeless” about the situation improving. It is likely that the high staff turnover and stress related absence, is linked to poor staff engagement and morale and this has the potential to compromise patient care.

- **F7** We found that there is a lack of effective involvement and discussion with the wider staff group by the ES management team, with the real potential to lose their valuable contributions which could make a significant difference to patient care and service improvement as well as impact on staff morale.

Recommendations: How communications are organised

- **R6** We recommend that the Health Board review its communications strategy to ensure the cascade system is delivering as intended.

- **R7** We recommend that all staff in Emergency Services is given a Health Board email account as a matter of urgency.

- **R8** We recommend that the ES management team is assisted in developing and implementing a communications plan that is co-designed with ES staff, that delivers structured two way lines of communication and, keeps staff well informed day to day and supports effective staff engagement in wider organisational issues. It should reflect the reality of the technological and social media environment in which the organisation now operates. The communications plan should include the implementation of a system for celebration of success and positive staff contribution. Once implemented, the quality of the outcomes relating to this communication plan should be evaluated.

Supporting findings: How employees are treated

- **F8** We found that amongst the general staff group there is a real sense of team work on a day to day basis.
F9  We found that the ES management team were a tight mutually supporting team who gained strength from the support given to them by the Chief Operating Officer.

F10  We found that the management practices and approach of the ES management team undermine their respect and authority amongst the general staff. Staff do not feel cared for or respected by the ES management team. Staff acknowledge the need for structured and systematic management practice, however the local application of policies such as the WLB, annual leave and special leave lacks flexibility and compassion and this creates bad feeling within the general staff body and demotivates staff.

F11  We found that Rosterpro appeared to be driving staff rotas as opposed to being used as a tool to effectively generate and manage staffing on shifts creating tension between staff and management.

F12  We found that the current refusals to let individuals take annual leave which they have been unable to take due to organisational pressures or sick leave is unfair and potentially a breach of contract. Individuals have a contractual right to the prescribed annual leave, and the intention of leave is to give individuals a break from work. The current situation where individuals have complied with all rules around annual leave and are then left with annual leave they are unable to take is unacceptable. It is the organisations responsibility to ensure shifts are covered and not the responsibility of individuals to forgo their contractual employment rights to provide this cover.

Recommendations: How employees are treated

R9  We recommend that role modeling of the values and behaviours espoused by the Health Board must be the norm and senior leaders must be observant to and challenge inappropriate behaviours of managers and staff in real time. Senior leaders and managers must be prepared to take allegations seriously and fully investigate in a prompt way, regardless of where the allegation comes from.

R10  We recommend that the use and application of RosterPro in the ES is reviewed and improved. Any adjustments to the rotas produced by RosterPro by senior nurses must take account of staff rota requests that have been already been “granted” by the system.

R11  We recommend that local HR processes (E.g. work life balance, sickness absence, annual leave, adverse weather) be reviewed by HR with the ES management team to ensure they are tightly aligned to, and in the spirit of,
organisational HR policies. HR must ensure local application does not open the organisation to challenge. Local procedures must be well communicated, and consistently applied with an appropriate level of flexibility considered in partnership with staff, to assist where possible in meeting individual needs.

- **R12** We recommended that the Health Board invests in an Organisational Development programme for Emergency Services to assist the management team and the wider staff group to affect sustained cultural change within ES.

**Supporting finding: How much freedom is allowed in decision making and developing new ideas**

- **F13** We found that through the team structure headed up by Band 7 team leaders, nursing staff are encouraged to take on clinical change projects.
- **F14** We found that there are limited opportunities for decision making outside of a few individuals in the ES management team.

**Recommendations:** As per those for leadership and management

**Supporting finding: How committed employees are towards collective objectives.**

- **F15** We found that there is genuinely a huge commitment by all of the staff that we met and heard from to do their best for the patients in their care and to continue to improve the quality and safety of patient care in ES.

**Recommendation: How committed employees are towards collective objectives**

- **R13** It is recommended that the findings of this report are shared widely with the ES staff so that they can believe that their concerns are heard and recognised. They must be proactively engaged in developing and delivering the action plan to deliver the recommendations as part of the Organisational Development programme to affect cultural change in the ES (see R12).

6.2 **Key line of enquiry: To establish whether patient care arrangements have resulted in harm to any patient.**

**Overall Findings (OF)**

**OF2.** We found no direct evidence that a patient has yet been harmed due to the patient care arrangements.
OF3. We found that the current patient care arrangements lead to patients regularly receiving less than optimum levels of care and experience.

OF4. We found that there is ongoing significant risk of harm to patients based on the current arrangement of care.

Supporting findings

- **F16** We found that the access to the EU and the flow through the EU and AU did not work well. Some patients experienced very long periods waiting to be offloaded from ambulances receiving less than optimum levels of care. Patients in the EU and AU spend long periods in overcrowded and unsuitable environments with associated poor patient experience.

- **F17** We found inconsistencies in the management of patients arriving with a similar clinical need and urgency, when they presents to the AU lounge as opposed to arriving by ambulance. Some of these patients' clinical conditions were unsuitable for the AU lounge and would be managed more safely in the majors' area with a higher nurse: patient ratio and more rapid response ability to any clinical urgency. Due to EU overcrowding there is limited ability for staff to transfer patients from AU/AU lounge to a more clinically appropriate area to sufficiently meet their needs thereby increasing the risk to patients.

- **F18** We found evidence that the long times spent by patients in the AU/AU lounge are not systematically monitored or reported within the organisation and is therefore an unquantified risk.

- **F19** We found that there are no quality assurance checks of the accuracy and effectiveness of ENP and ANP diagnosis and treatment and therefore the quality and safety of their practice is unknown, which is a clinical risk.

- **F20** We found that hospital beds became available too late in the day to facilitate timely admission and there were insufficient discharges in the day to meet the admission demand, leading to overcrowding and the subsequent increase in clinical risk to patients.

- **F21** We found that DTOCs were exceptionally high (for an integrated care organisation) and contributed to the poor flow and delays in admission.

- **F22** We found that shifts were regularly short staffed in EU/AU/Paed and that there were insufficient numbers of staff in certain areas of the unit to provide the necessary care to patients and in a timely way.
• F23 We found that quality governance is inadequate. The ES risk register is incomplete and the risk registers at each level of governance are not aligned and therefore not comprehensive. The risk management cycle is not embedded in ES. There is no systematic process of analysis of incidents and risk. Through a lack of reporting, management at every level of the organisation is unsighted on the themes and trends in risk within ES and the Medical Clinical Board. There is no systematic process for learning from incidents or implementing reviews and improvements as a result of incident reporting. This is discouraging staff from reporting and increasing the overall clinical risk to the organisation.

Recommendations

• R14 It is recommended that the ES management team immediately establish a system of 15 minute meetings every two hours, on the shop floor to undertake an on the spot situational stock take. These should be led by the EU nurse in charge and attended by the most senior ES shop floor doctor, the Senior Controller and the nurses who are in charge of Paeds and AU. They should provide the senior decision makers on the shop floor a helicopter view to ensure resources are deployed to the best effect and to escalate immediate risks appropriately and in real time. They should be designed to give staff the opportunity to stay informed, review events, make and share plans for ensuring well-coordinated patient care.

• R15 It is recommended that a triage system is used to assess patients arriving in the AU lounge to systematically assess the priority of the patients’ clinical need. An escalation protocol by which high clinical priority AU lounge patients can be moved into the majors’ area of the EU must be established and monitored for effectiveness and reduction in clinical risk.

• R16 It is recommended that the waiting times and length of stay for patients in AU and AU lounge should become part of the regularly performance reporting dataset to ensure risk is understood and necessary improvements quantified and delivered.

• R17 It is recommended that systematic development and training of the ENPs and ANPs is led and implemented by the ES Consultants. This should include undertaking regular Consultant led clinical audits of their practice to ensure they are safe and effective and to inform further development needs.

• R18 We recommend that the job responsibilities of the Lead Nurse role should be developed to become more focused on active quality leadership, proactively undertaking improvement and learning from incident reporting.
• R19  We recommend that the Lead Nurse and Clinical Director should immediately review and improve the risk register. They should lead the development of clinical audit processes that is linked to the risks identified, with the overall aim of reducing risk through quality improvements that are evidenced based.

• R20  We recommend that the introduction of a clinical governance facilitator role supported by a Consultant lead for clinical governance. These roles would be responsible for developing a quality indicator dashboard for reporting, implementing and monitoring a system of early warning indicators and escalation of risk. They would also develop a system that includes staff participation in quality monitoring and improvement that is based on risk assessment. They would ensure action plans are have ownership, deliver outcomes and are followed up to ensure changes have happened.

• R21  We recommend that the ES Quality & Safety Committee should have standing agenda items that include: progress with staff recruitment; review of the quality dashboard, analysis of themes and trends in incident reporting; review of action plan progress and periodic reviews of previous changes to ensure sustainable change has resulted and the clinical audit programme.

• R22  We recommend that a list of the top three learning priorities should be identified from a quarterly review of incidents, complaints and claims. Regular staff training and development programmes should address these themes. Key quality indicators should be monitored at the ES quality and safety committee to ensure continued improvement and sustained change.

• R23  We recommend that training should be provided to staff so that they understand escalation processes and how to effectively report harm/errors.

• R24  We recommend that the Health Board formally reviews its wider quality governance framework, perhaps commissioning a review to provide assurance to the Health Board that its members are fully sighted of the organisation’s quality performance and the robustness of the assurances they receive.

Recommendation 4 in section 6.1 above will address findings 16, 20 and 21

Recommendations in relation to finding 22 will be dealt with in section 6.4.3 under general staffing.

6.3 Key line of enquiry: To establish whether the prevailing organisational culture has resulted in harm to any employee
Overall Finding (OF)
OF5. We found that the prevailing organisational culture has resulted in harm to employees.

Supporting Findings
- F24 We found that the demands being made on staff in the ES are unreasonable especially in relation to the way care is organised (see OF1, section 6.1), staffing levels (see OF8, section 6.4.3) and bullying and harassment (see OF10, section 6.4.6) and has an impact on staff morale and health.
- F25 We found that staff at all levels experience emotional distress on a regular basis and that at times of extreme pressure they will forgo caring for themselves (for example missing breaks and working exceptionally long hours) to ensure patient care is not compromised.

Recommendations
- The recommendations in section 6.4.3 on general staffing and section 6.4.6 on bullying and harassment will address finding 24
- Recommendations in section 6.4.3 general staffing will address finding 25.

6.4 Key line of enquiry: In particular to review:

6.4.1 The general care of patients in the Emergency and Assessment Units areas. This will include the appropriateness of that care and the location of care.

Overall finding (OF)
OF6. We found that care of patients is not always delivered in the most appropriate way or in the most appropriate location based on a patient's clinical need.

Supporting findings
- F26 We found that although the EU has recently been renovated to a good level, bays in resuscitation and majors remain closed and consequently patients remain in ambulances for longer than appropriate or are moved too quickly into less acute areas of the ES.
• F 27  We found that the position and maintenance of the mental health room within the EU increased risk to this vulnerable group of patients.

Recommendation

• R25  It is recommended that the Lead Nurse with the senior nurses and the Band 7s develops and implements “Intentional Rounding” in all care areas within ES to ensure fundamental aspects of care are delivered reliably, alongside individualised care. This is a system that involves nurses carrying out regular checks with individual patients at set intervals to ensure patients’ needs are being met, for example, whether they are comfortable, require pain relief, need assistance with the toilet or a drink or food.

• R26  We recommend that the ES Clinical Director commissions a mental health expert to undertake a risk assessment of the management of mental health patients and the mental health room to determine what improvement can be made and that subsequent actions are prioritised to mitigate risk to this vulnerable patient group and monitored through the ES quality and safety committee.

6.4.2 Whether targets are prioritised instead of patient-focused care

Overall Finding (OF)

OF7. We found that there is a high probability that at times of surge in activity; targets are prioritised instead of patient-focused care.

Supporting findings

• F28  We found that there are unreasonable levels of scrutiny over staffs’ management of the waiting patients and that there is pressure exerted to see patients out of clinical need order.

• F29  We found that there is at times significant pressure exerted on staff by managers to move patients in order to offload ambulance patients.

• F30  We found that overall the substantive staff resisted the pressure they felt from managers to move patients inappropriately.

• F31  We found that there is a risk that junior, less experienced or temporary staff may not feel able to resist this pressure.

• F32  We found that senior controllers exert pressure on staff to move patients when it is not in the best interest of the patients or safe to do so.
Recommendations

- R27 We recommend that a system of real-time feedback to the ES management team is developed in support of recommendation 14, in order to provide status updates and escalation of issues. The intention must be to develop the trust and confidence of managers in the shop floor team’s ability to balance their clinical judgment against the need to deliver 4 hour A&E performance.

- R28 We recommend that during times of significant pressure and overcrowding in EU/AU/AU lounge/Paeds, that the senior ES management team and representatives from the Medical Clinical Board attend the 15 minute on the spot situational stock take meetings (recommendation 14) and that if necessary these are increased to hourly.

- R29 We recommend that a facilitated session between the senior controllers and Band 7 and 6+ nurses is arranged to agree in advance a process by which they can effectively challenge each other about moving patients in a robust but appropriate way at times of pressure.

- R30 In conjunction with recommendation 14, we recommend that during times of significant pressure and overcrowding, the nurse in charge, supported by the most senior shop floor doctor, acts as ultimate decision maker about patient moves in order that the Health Board signals that quality of care takes precedence over achieving targets.

6.4.3 General staffing arrangements.

Overall findings (OF)

OF8. We found that all areas of the Emergency Services at UHW are significantly understaffed for medical and nursing staff, in terms of budgeted whole time equivalents, staff in post and consequently staff on shift.

OF9. We found that the skill mix, especially in relation to paediatrics, was insufficient to meet the need of this population.

Supporting finding

- F33 We found that benchmarking of nursing establishment was inadequate in that it did not take into account patient factors, environmental factors and staffing factors (as outlined in the “Safe staffing for nursing in A&E departments”, NICE safe staffing guideline draft Feb 2015).
- F34 We found that the general cover arrangements on a shift basis resulted in staff being moved to meet immediate need without consideration of skill mix and the counterproductive impact of doing this, for example moving ENPs to cover other areas of the Unit resulting in longer waits for patients in minors.

Recommendations
- R31 It is recommended that immediate priority is given to increasing the nursing establishment in Emergency Services at UHW, utilising the NICE guidelines, to provide adequate skill mix and capacity to ensure all patients receive their care in a timely way. The panel has provided the Health Board with a recommendation for the daily staffing numbers for each clinical area within UHW ES.
- R32 It is recommended that The Health Board should move to substantively recruit to all Consultant posts (including those currently filled by locums) and increase the numbers of middle grades especially on night duty.
- R33 It is recommended that recognising the difficulty in recruitment of Consultant and middle grade doctors, the Health Board may wish to consider establishing appointing GPs to deliver a front end GP led minor ailments care function to work alongside ANPs and ENPs. This will free EU medical staffing resource to more acute areas in the rest of the unit and reduce overall wait to assessment by a clinician thereby reducing clinical risk.

6.4.4 Sickness absence levels and sickness control arrangements.

Findings
- F33 There is a high sickness absence rate.
- F34 We found there is no overall theme for sickness absence, however stress related sickness absence is high.
- F35 We found that there is unreported work related stress.
- F36 We found that sickness absence management lacks empathy and compassion and may further alienate staff.

Recommendations
Recommendations 1, and 27 to 33 will contribute to a reduction in the sickness absence rate
In addition to these:
- R34 We recommend that the organisation reviews, and considers changing the emphasis of, the Sickness Absence Team's approach to be more supportive with the
involvement of clinical input whilst retaining close communication with staff during the early stage of sickness absence.

- **R35** We recommend that given the significant levels of stress related absence identified in the directorate, that this is investigated further by occupational health and systems/support are put in place to address any findings.

### 6.4.5 Employee turnover and any information ascertained from exit interviews.

**Findings**

- **F37** We found that nursing turnover in MEAU and paediatrics are exceptionally high.
- **F38** As seen in section 6.4.3 we found that paediatric staff shortages are a significant risk to the service.
- **F39** We found that exit interviews are not conducted systematically or rigorously and this leaves the ES management team without information that would assist them in being able make any changes or adjustments that would help them to retain and recruit staff.

**Recommendations**

- **R36** We recommend that the organisation implement a systematic and robust process for understanding the reasons why people leave the organization, or departments to move elsewhere within the organisation. This should be more than a purely “questionnaire” type approach and should include random selection of individuals for more in depth interviews by appropriately trained staff (e.g. the organisational psychologist).
- Recommendation 32 addresses finding 38 and should contribute to reducing paediatric nursing turnover (F37).

### 6.4.6 The general culture within the Emergency and Assessment Units, and whether bullying, harassment or inappropriate behaviour or treatment by/of middle managers or any employee takes place, and identify the perpetrators.
Overall Findings (OF)

OF10. We found that there is clear evidence of a culture of bullying, harassment and inappropriate behaviour and treatment which pervades all levels of staff in the ES at UHW.

OF11. The behaviours are endemic and involve many individuals and this makes it difficult to identify individual perpetrators. However based on the depth of evidence we found that the inappropriate behaviours of [to maintain their right to confidentiality the names of individuals have been removed] are mentioned most commonly. This list is not exhaustive.

Supporting Findings

- F37 The management team have a right to manage poor performance and inappropriate behavior, and the dysfunctional culture that exists is being used by certain individuals to undermine managers including in some instances scapegoating individuals.
- F38 We found that the way in which managers address performance issues is undermining their own effectiveness and credibility with the wider staff group (for example in some instances adopting a rigid and dogmatic approach, lacking in empathy and compassion and perceived as a personal attack by some staff).
- F39 We found that there is a group of staff who do not engage constructively with the management and development of the service, and that they have isolated themselves from the wider staff group. This results in managers isolating the group further and treating them differently.

Recommendations

Recommendations 1, 10 and 13 will contribute to improvements against findings 37 – 50. In addition:

- R37 It is recommended that a series of interventions are undertaken, by an appropriately trained individual to develop a mutual level of trust and openness within the Emergency Services staff group as a whole. This should include a shared understanding of different roles and responsibilities and the development of an agreed set of ground rules including behavioural values to which all staff should be held accountable to enact.
- R38 It is recommended that the organisation takes immediate steps to implement the recommendations of the Francis Independent Review “Freedom to Speak Up”.

6.4.7 Key line of enquiry: Any other relevant issue

6.4.7.1 HR Support

Findings
- F51 We found that HR is not ensuring cases are managed to conclusion promptly.
- F52 We found that there has been a lack of systematic and skilled involvement in ES by HR in order to advise, guide and coach managers how to safely utilise HR policies more appropriately to ensure valid outcomes.
- F53 The panel found that the manager’s ability to manage openly and effectively was hindered by the belief that they should not retain any written evidence/file notes of informal discussions with staff relating to development/performance issues.

Recommendation
- R39 We recommend that HR work closely with Unions and management to ensure regular review and timely management of ER cases in line with relevant policies.
- R40 It is recommended that a HR coaching programme and management development programme be developed to support managers in applying policies fairly and consistently and with compassion.
- R41 It is recommended that a system of regular one to one meetings by managers (of any level within the ES) and their staff is established to ensure ongoing support and developmental guidance is provided to staff. A simple system for confirming discussions which is then agreed and shared with both parties must be put in place. This will allow issues to be addressed at the lowest possible level in the first instance and information regarding these being retained for future reference.

6.4.7.2 Unions

Findings
- F54 We found that Emergency Services is highly unionised.
- F55 We found that the relationship between the ES team and union representatives is not conducive to effective employee relations.
F56  We found a high level of distrust between managers and local representatives and the Director of RCN Wales, which appears to inform the way in which they communicate with each other.

F57  We found that there is evidence of deliberate attempts by union representatives to undermine the management alongside attempts by managers to exclude unions.

Recommendations
R42  We recommend that work is undertaken with Full Time Officers to establish a robust mechanism for engaging with Unions and review and identify the appropriate local representatives to work with the ES.
R43  We recommend that a clearly defined and agreed escalation and de-escalation route is developed in partnership to manage matters raised or issues that remain unresolved ensure local representatives and junior/middle managers work in partnership to address issues locally. By developing this level of trust and confidence supported by robust and timely HR processes the perceived need by staff for union involvement or escalation should reduce.
R44  It is recommended that the Executive undertake discussions to establish a more open and constructive style of engagement with the Director of RCN Wales, which enables both sides to be confident that issues will be managed by both parties in an appropriate way and at the correct level of escalation.

6.4.7.3  Individual staff concerns

Finding:
F58  We found that the recommendations outlined in this report cannot be implemented effectively without addressing the particular needs and behaviours of these individuals.

Recommendation:
- R45  Individual staff management as follows:
  - [the details of the recommendations in relation to named individuals has been removed to maintain their right to confidentiality. The Health Board will manage the recommendations through its internal processes.]
6.4.7.4 The A&E target

Finding

- F58 There is a risk that delivery of the A&E 4-hour target is being manipulated.

Recommendation

- R46 The organisation should investigate further the potential that the A&E 4 hour target is being manipulated.