NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NHS
North East Lincolnshire
Clinical Commissioning Group

Report of the findings and actions from whistleblower concerns raised on 4th January 2020

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Contents

SECTION A – The Investigation

1. Abstract

1.1 This report will provide a summary of the investigation findings into the concerns raised by a whistleblower about the care provided in the Emergency Department at Diana Princess of Wales Hospital Grimsby (the Trust) on the 4th of January 2020.

1.2 The report will also describe the actions taken by the Trust and by Commissioners in terms of both immediate actions to address concerns raised and longer-term transformational actions.

1.3 Finally, the report will set out the agreed governance arrangements between the Trust and the Clinical Commissioning Group in order to provide assurances that the concerns are addressed.

2. Executive Summary

2.1 Throughout this report the whistleblower will be referred to as X and any references to staff who have contributed to the investigation to share their experiences will be anonymised.

2.2 A clinician (X) was working for Core Care Links (CCL) in the Urgent Treatment Centre (UTC) on the evening of the 4th of January 2020 and as part of this shift was passing through and liaising and communicating regularly with staff of the Emergency Department (ED) at Diana Princess of Wales Hospital (DPoW).

2.3 The shift was no busier than a lot of shifts in terms of the activity in the department, especially during the winter just after a bank holiday week and was not exceptional in respect of the performance in ED for timeliness of seeing patients when considered in the context of the Trust's average performance overtime. Analysis of the attendances to the ED through a retrospective audit found the cases attending to be seen and assessed in the right time. What was found to be exceptional about this shift was that most attendances were majors rather than minors, in terms of their triage outcome, which infers that the acuity of the attendances was high. System calls between the Trust, commissioners and other providers had taken place that day to assist with managing the flow of patients and the Urgent Treatment Centre (UTC) was operating alongside the ED to provide care to patients not requiring emergency care.

2.4 Following the shift X emailed concerns about the ED at DPoW, to the Chief Clinical Officer (CCO) of North East Lincolnshire Clinical Commissioning Group (NELCCG) and the Chief Executive Officer (CEO) for Northern Lincolnshire and Goole NHS Trust (NLaG). A copy of the email is attached at Appendix 1.

2.5 Agreement was reached between the CCO and CEO that the CCG lead an investigation in line with the NELCCG Whistleblowing Policy (which can be accessed by following this link: https://www.northeastlincolnshireccg.nhs.uk/publications-1/ and the NELCCG Freedom to Speak Up (whistle blowing) policy which is found under the policy subheading), working very closely with senior representatives from NLaG.

2.6 The investigation took much longer than expected and significant delays were caused due to Covid-19 wave 1 restrictions in accessing staff for the purpose of interviewing.

2.7 However, the learning from this investigation highlights a number of areas where the Trust, commissioners and system partners can address the issues. Some of these have already been addressed by the Trust and some more complex pieces of work are still in planning or in delivery – Section 2 will describe in more detail.

2.8 The key learning from this investigation highlights the significant challenges which arise at times of surge in activity which combine to present a negative impact on the workload and wellbeing of staff and the experience of patients and their families who access the service.

In summary the key learning can be summarised as follows; provision of a suitable environment to deliver the service; adequate communication to meet demands at times of increased activity or acuity; system-wide support and services to manage flow of patients to the right place in accordance with their needs.

3. Contextual Information

3.1 X was interviewed for the investigation and shared that ED staff had shared with X that they have tried to voice concerns themselves, similar to those X had articulated, but they reported that they have not been listened to and felt that they are “told off” or blocked by managers external to the ED when they try to raise concerns.

3.2 Separately to the whistleblower, after the whistleblowing information was published in the media, 2 DPoW staff members (who did not wish to be identified) approached a NELCCG officer and reported that staff feel that they are not able to speak out and raise concerns about the ED.

3.3 The weekend was not an extraordinarily busy weekend in terms of the activity presenting to the ED, however the acuity in the presentations was high and it was the first weekend of the New Year, and externally to the Trust the health and care system was busy. The UTC was operating alongside ED and did not have large volumes of patients attending, alongside the fact that the acuity attending ED was high and therefore the UTC was not able to relieve pressure from the ED. System

support was in place in the form of GP Out-of-Hours and the usual community response services like Community Urgent Care Team were in place.

3.4 At times of increased activity, the CCG provides a system co-ordination and escalation role to ensure that across the system the response to the activity surge is maximised and any risks to patient care and service delivery is managed to the best of the system's ability. This is achieved through regular calls with all relevant senior leads from services to manage a changing demand for services and increasing pressures. These calls enable services to respond by increasing their staffing or extending hours or by agreeing to escalate outside of the local system for further support where this is required. This operates both in and out of hours with a commissioner on-call every day to facilitate this and this was in place on the weekend of January 4th, 2020.

The Commissioner on-call records show that additional capacity for GP OOH and for "focus" social work had been put in place on Friday 3rd January to cover the weekend, anticipating it to be a busy weekend. The records also show that whilst no calls were made to the commissioner On-Call that weekend to escalate concerns, NLaG did seek ambulance diverts to other hospitals that day which were declined by East Midlands Ambulance Service (EMAS) due to the levels of activity they were experiencing. However, EMAS did agree to a partial divert between the ED's in Grimsby and Scunthorpe for short periods of time to help manage the activity.

4. Analysis and findings of the investigation.

Analysis against each of the **lines of enquiry (in bold print**) taken from within the terms of reference for the investigation will follow to ensure each is considered and learning extracted.

4.1 Care rounds and affording basic care including appropriate food and nutrition, privacy and dignity and patient comfort.

i. A review of the patient records from that weekend discerned that the majority of patients who were in the department for four or more hours or were cared for within majors received regular care rounds – which included vital sign monitoring and nutrition and hydration care delivery.
ii. The overwhelming finding from staff sharing their experiences was that all of them thought that patient privacy, dignity and comfort was compromised due to the amount of activity in the department resulting in patients being placed on trollies or chairs in corridors.
iii. Staff described providing care to patients in the corridors and the waiting room – providing the care because they felt they needed to ensure the patient to be safe but feeling worried because they were unable to maintain patients' privacy and dignity whilst doing this.

4.2 Timeliness of appropriate care in Majors dept.

i. The records review work showed slight delays for some patients, specifically in the administration of STAT medication doses (A STAT dose is medication which must be given urgently, as soon as possible, usually within the hour it was prescribed). There were a few occasions (4/38) where patients did not receive their STAT doses within the hour they were prescribed.
ii. Analysis of whether the plan of care was carried out in a timely manner was limited by incomplete record keeping, the time of the decision regarding the plan of care was not always recorded in the patients record (12/38).

4.3 Safe staffing based on activity and complexity in the dept.

i. Review of the staffing determined that the 4th of January day shift was a very well-resourced shift with experienced Consultant and Middle Grades undertaking the EPIC (Emergency Physician in Charge) role over the 24 hours period on the shop floor.
ii. The day shift's actual staffing met the planned staffing levels, which included planned increase of two registered nurses and three health care assistants.
iii. The night shift of the 4th of January actual staffing was slightly below the planned staffing levels. The three additional healthcare assistant roles were not resourced. However, instead an additional flow co-ordinator was resourced to the shift.
iv. The experience and feedback from staff in the interviews clearly articulated that they feel, at times of surge, that staffing and the environment in which they work is challenging. This may also be influenced by the level of acuity at any one time so whilst the numbers of patients might remain static, the level of acuity and patient need could vary and require more nursing or carer time to meet their needs.
v. The 06:00 DPoW situation report evidences an extremely busy ED with long waits throughout the night. The report also includes evidence that extra resource was identified. This included additional in reach medical staff, a request for additional GP's and additional nurses.

4.4 Escalation and operational decision making that supports safe care and supports staff welfare.

i. There is evidence that the capacity of the ED to manage the flow of patients and ambulances was escalated through the chain of command, a request for divert from the Grimsby site to the Scunthorpe site was made by the bronze command and the divert was authorised by the gold command (day shift, late afternoon-early evening on the 4th of January 2020).
ii. Staffing was at the required level on the day and there was no evidence in the command logbook that staffing was escalated as a concern on the day shift on the 4th of January 2020, the operational managers recollection of the shift supports this.
iii. The evening bronze command logs reflects a "very challenging" ED, HALO implemented, and 8 beds were opened on B4 to help improve the flow of admissions into the hospital.

4.5 Explore the length of time patients are in the Department so that we understand the reason for delays in patient care and any "pinch points" in the patient's journey.

i. Two patients left the department without being seen/treated and without informing departmental staff they were leaving, so time in department was unknown for 2/38 records reviewed.
ii. The mean length of time in the department for the remaining 36 patients was 7.3 hours (all lengths of time rounded down to the nearest hour).
iii. The patients waiting the longest period were for admission or transfer to another hospital (10/38 patients were for admission or transfer, with 50% of these admitted from the ED in excess of 10 hours).
iv. It appears the "pinch point" on the shift was the flow of admissions to the wards.
v. It was difficult to analyse the patient's journey, in terms of "pinch points", through ED in any more detail due to the lack of times being recorded for when patients were seen and plans of care were made.

4.6 Safe transfer of patient out of A&E - as determined by the assessment of the patients care at point of transfer out of A&E and to the receiving ward/area.

i. We assessed this line of enquiry through the record review work. The audit of the records showed that all the patients who were admitted had their plan of care documented and appropriately commenced.
ii. The experience of the staff on the wards receiving the patients into their care from ED was not captured through the staff interviews, it is acknowledged that this is a limiting factor for this line of enquiry.

4.7 Outcomes for patients who went through the ED department during that shift.

i. The records review work was utilised to understand this line of enquiry.
ii. 2/38 patients left the department without being seen/treated.
iii. 10/38 patients were admitted to hospital, one of which was transferred to Hull Royal Infirmary.
iv. 3/38 self-discharged against medical advice. It was not recorded in the patient record why the patient was opting to self-discharge against medical advice
v. 23/38 were discharged home.

4.8 Workload and wellbeing of staff.

i. The workload and wellbeing of staff was a key theme in the informal interviews with staff.
ii. Although each of the members of staff could not recollect the exact shift due to length of time which had passed since the shift to point of interview, they readily spoke about examples over the winter period which were similar to the shift described by the whistleblower on the 4th of January. The fact that this shift does not stand out to staff suggests the experiences described by the staff were occurring regularly over the winter period.
iii. None of the staff disagreed with the content of the whistleblowers email.
iv. The experiences shared by staff clearly articulated the negative impact on staff wellbeing of challenging shifts in the winter period.
v. Staff shared experiences of feeling overwhelmed, tearful and exhausted following the challenging shifts.

vi. Professionally registered clinical staff spoke of concern for maintaining their own registration when they were confronted with scenarios, such as a trolley lined corridor and two to a bed space, where they knew they were not able to always maintain dignity and respect.
vii. There was an overwhelming concern for the coming winter of 2020.
viii. Multiple staff shared experiences of where patients were doubled up in single bays – particularly in resus, but the staffing was not always able to be increased to manage them.
ix. Staff described how they felt the department was too small to manage the activity and felt that there is not enough nurses on the floor to support safe patient care when the activity in the department surges.

4.9 Staff being supported to speak out and raise their concerns and potential solutions.

i. Staff felt able to raise their concerns with the shift leads and their departmental manager but felt that the next line of management did not listen to their concerns.
ii. Some staff felt able to raise their concerns, but they were not given the time to do this – when shifts were challenging, breaks were unable to be taken and they were leaving work exhausted.
iii. There were two areas that staff identified in the interviews which they felt were potential solutions to the challenge on safety in the department at times of increased activity. One was improving the environment, to ensure there is space to see and treat patients, and the other was increasing nurse staffing.

5. Conclusion of the Investigation.

5.1 This investigation determined that the following concerns raised by the whistleblower **were upheld:**

i. Length of time patients were in the department. The investigation found that the majority of patients were in the department in excess of 7 hours. 50% of patients who were subject to the retrospective record review with a decision to admit were in the department in excess of 10 hours.
ii. Workload and wellbeing of staff. All the staff interviewed, other than an operational manager, described experiences of feeling overwhelmed and practicing unsafely. Several staff stated they felt exhausted after shifts, unable to do anything and worried about their next shift.

5.2 This investigation determined that the following concerns raised by the whistleblower **were partially upheld:**

i. Care rounds and affording basic care including appropriate food and nutrition, privacy and dignity and patient comfort. Whilst care rounds were afforded some elements like privacy and dignity were not always achieved.
ii. The majority of the patient records reviewed did evidence care rounds and basic care being afforded to the patients. However, all the staff interviews supported the statement that patient privacy and comfort was not always afforded due to the challenging circumstances of the shift (patients on trolleys in the corridors and doubled up on patient bed spaces).

iii. Timeliness of appropriate care in Majors dept, based on the analysis of the activity data. The records evidenced some delays for some patients, but as the records did not always include a time this was difficult to assess. We have partially upheld this concern because we cannot be confident that care was not timely without the evidence to support or challenge this either way.

iv. Safe staffing based on activity and complexity in the department. Although actual staffing levels generally met the planned uplifted staffing levels for the weekend it is clear from the investigation findings in relation to the other key lines of enquiry and the feedback from staff, that the staffing might benefit from a review of working patterns. Several external agencies have since reviewed the ED staffing with a recommendation that staffing levels were correct, but a recommendation to stagger shifts.

v. Escalation and operational decision making that supports safe care and supports staff welfare. The logbook from the 4th and 5th of January clearly outlines that escalations were made concerning the ED department activity and the decisions made to manage it including creating an ambulance divert to assist with the flow within the department and the increased staffing for that weekend.

vi. Staff well-being and feeling supported to speak out and raise their concerns and potential solutions. Staff felt they are able to raise their concerns with their departmental manager and shift lead but did not feel they would be listened to by senior managers. The majority of staff felt the environment as well as nurse staffing, were the areas which primarily need to be addressed to provide a potential solution to safely managing the activity which comes into the ED. Staff identified that more space to see and treat patients is needed. It was recognised by the investigation team that not all staff spoken to, knew the outcome of escalations that they made, in terms of the operational decision making, such as reducing the flow into the Department by enacting a divert.

5.3 This investigation found that none of the concerns raised by the whistleblower **were not upheld.**

5.4 In addition to making a judgement on whether the key lines of enquiry for this investigation were upheld, the following areas of learning were also identified; the importance of clear communication (In record keeping – including times of actions and decisions. In escalation processes – to ensure messages are not misunderstood or distorted as they are passed along, and to ensure a robust two-way process so staff understand what decisions have been made to manage the situation); the importance of a suitable environment to safely and effectively deliver a service; importance of listening, responding and supporting the wellbeing of staff.

Section B. Actions already taken and/or planned.

There are a number of workstreams and projects currently in place within NE Lincolnshire which will support and transform the urgent and emergency healthcare system to better manage the demand and activity. The system recognises the need to work together to address this and is engaged in workstreams, which when combined, should contribute to improve the management of patient flow across the system and when relevant, into the local Emergency Department (ED).

The learning from the whistleblowing investigation further supports the need for the system to collaborate and work to reduce the demand on the local ED and these projects and associated workstreams are owned and overseen by the A and E Delivery Board in Northern Lincolnshire.

It is envisaged that projects and transformational work underway will impact positively upon the issues raised by the whistleblower which were either fully or partially upheld (as discussed in Section 1 of this report).

The section of the report below describes this transformational work and projects being undertaken system-wide but including internal to NLG. It is important here to consider the relevance of this work to the concerns that were upheld or partially upheld by the investigation.

6.0 Developments led internally to NLaG, which will help manage the internal activity and will enhance the support to staff.

6.1 Point Prevalence Study of ED activity.

This study will add to the intelligence known about access to ED by patients. It is a Live survey of all ED attendances on 18th May 2021 and the full report and findings are expected by July 2021. The report should provide a review of all opportunities to improve access to the correct care for patients by signposting to services other than ED, when appropriate, including the new Urgent Treatment Hub (described below) as well as utilisation of direct access to Same Day Emergency Care (also described below).

6.2 Same Day Emergency Care – SDEC.

Same Day Emergency Care (SDEC) is a national initiative. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

There are now SDEC units at both Grimsby and Scunthorpe hospitals for medicine, surgery, gynaecology and frailty. These are based away from the emergency departments. The model became operational in April 2021 and will potentially extend both the operational hours and the model of delivery as 2021 progresses. This approach to delivery of care requires strong collaborative working between acute, community, primary care services as well as ambulance and social care. The benefits of SDEC are that patients can be directly booked into SDEC via the GP or via ambulance services provided by East Midlands Ambulance Service (EMAS), avoiding ED attendance where this is not necessary.

A review of direct access pathways is being undertaken to ensure all opportunities for direct streaming to SDEC are maximised. It is anticipated that a greater number of patients will be seen by SDEC rather than ED. Furthermore, it is expected we will see an improvement to the direct 'pull' of patients from ED, diverting them into SDEC services, thus reducing time spent in the ED department and a reduction in Length of Stay.

6.3 Nurse Leaders in ED - new role of Clinical Co-ordinator.

Following a Chief Nurse review of the ED's an additional Band 7 Clinical Co-ordinator post was introduced 24 hours a day and 7 days per week in both the Grimsby Diana Princess of Wales Hospital (DPoWH) & the Scunthorpe General Hospital (SGH) ED's in July 2020. This had been identified in August 2019, alongside Clinical Educator roles, to enhance the knowledge and skill set of our ED nurses.
The primary focus of this role is to ensure Senior Nursing oversight of all areas of the department. Working alongside the Emergency Physician in Charge, the Clinical Co-ordinator has responsibility for patient safety, understanding current and predicted peaks in activity and ensuring appropriate use of the staff resource available to them to effectively manage this, deploying staff across the department, liaising with the other ED site and senior managers. A critical part of their role is to identify when the departments are reaching critical points with regard activity, acuity and occupancy and enacting timely and appropriate escalation to seek support for general or specific risks to safety and quality. There has also been investment in triage skills, and competency and training for this work started prior to this investigation, but continued over a number of months.

6.4 Nurse Educators in ED – new role

Clinical Educator posts have been introduced in both ED's on an initial 6 month secondment pending establishment review and substantive funding. The role will deliver training and education across all staff groups within the ED's. The role will also support the completion of the RCN Framework and Competencies for ED Nurses at Level 1 & 2 and will work alongside Paediatric colleagues to develop increased education, knowledge and competence in Paediatric care for general trained nurses.

6.5 Matron workforce and education review with ECIST

Over a period of 4 months during 2020 the ED Matrons have worked with ECIST and subject experts to review the workforce and education and training availability in the departments to identify where improvements can be made and make recommendations on additional requirements. This work was completed in February 2021.
A training needs analysis and ED career development programme has been put in place that maps out the training and education that ED nurses will receive, including a focus on new starters and experienced ED nurses and their future development into more senior nursing roles. This programme and the training is aligned to national standards and RCN Frameworks specific to ED nursing.

6.6 Investment in the ED department

NLaG has secured £15m capital to build a new ED at DPOWH and this is now being built at pace. The new ED will be much larger than the existing department and is designed to the most modern standards which will address many of the space and design limitations identified earlier in the report. Having a larger purpose built space will enable staff to care for patients (even at times of surge) in an environment more conducive to allowing the privacy

and dignity to be better maintained and so lead to improved staff morale as they will feel better enabled to do the quality role they want to achieve. The build work is underway. A new ED department is also being built at Scunthorpe general Hospital.

7.0 Developments and initiatives led by system-partners.

The local system is developing a number of new initiatives, systems and services, all of which will contribute to the management of flow. Essentially these initiatives once operational and combined together will shift some of the current demand on the ED into community-based services and ensure patients are seen in the right place for their needs.

7.1 Extended access to Primary Care

This describes an extension of Primary Care hours: this is not new and is in its 3rd year of delivery. It provides an additional 84.5 hrs a week within primary care, accessible for both urgent and non-urgent primary care response across NE Lincolnshire. This is outside of the normal hours and means services are accessible from 18.30hrs to 20.00 on weekdays and on some weekend mornings. However, currently this extra capacity is being used to support the surge in the Covid vaccination programme but will shortly be able to support the management of patients as described above within other projects.

7.2 GP Out Of Hours (GP OOH)

The GP OOH service provides access to routine Primary Care services after the normal Primary Care service hours have ended for the day. The service is operational on evenings and weekends and sees approximately 3,000+ patients per month.
The service was moved from the acute estate in the early phase of the COVID-19 response. This has allowed better utilisation of the acute estate during the pandemic. A patient survey will be undertaken in the 2nd half of 2021 to understand the impact of the move and consider the approach in future. Subject to the outcome of the patient survey the service may continue to be delivered in the community. This approach is consistent with the 111 First approach and the system priorities around diverting patient flow away from ED where clinically appropriate to do so.

7.3 Urgent Treatment Hub

The NEL Urgent Treatment Hub operates a total triage model with face-to-face appointments available when clinically required. It is expected that it will be operational by August 2021 and anticipated to divert approximately 25 ED attendances per day which will assist with the flow of patients through the ED department. This Urgent Treatment Hub has developed from what was formerly known as The Urgent Treatment Centre and was formerly based on the NLG DPOWH site.
A telephone triage model with appointment slots available is being developed. These slots will be directly bookable by 111/SPA. The patient will receive a call back from an appropriate clinician, with the first contact clinician expected to be an Advanced Nurse Practitioner. GP consult by phone or face-to-face will be available if clinically indicated.
The initial phase of the project will involve 25 slots per day however this will be scaled as the demand requires and resources allow. It is expected that once the initial pressure of the COVID-19 vaccination roll-out eases, the system will be able to realign resources to expand the number of slots available.

This is in place of having an Urgent Treatment Centre which many other areas have and is the preferred model of delivery locally in NEL for urgent primary care. This model will

maximise the resources available outside of the acute setting as well as directly influencing the change in patient behaviour to align with the 111/SPA First approach.

7.4 Community Frailty

Across the NEL system, partners have been reviewing collaborative working and joint service delivery to establish a community-based frailty service with specialist geriatrician advice and support across NE Lincolnshire. The model of delivery includes establishing a virtual Multi-Disciplinary Team (MDT) meeting to discuss frail patients who have been identified as requiring support to remain at their usual place of residence. The details of this are being finalised and once agreed will be rolled out in NEL: this is expected to be before the end of 2021.

It is anticipated that this new approach will achieve a reduction in ambulance conveyance and ED attendances by ensuring the right level of support is delivered to those patients who are safe to remain in their own home, supported by the multi-disciplinary team of community providers.

7.5 Think 111 First

A key project which is currently underway is the 'Think 111 First' project. This is a drive for the public to seek advice and guidance via 111 phone or on-line and for the patient to then be signposted to the right place at the right time and be seen by the right professional. This will ensure that only those who require a hospital attendance do attend. This project includes a significant public communications plan and professional education to embed the required changes in public behaviour and professional direction/advice.

This work is already underway and is expected to continue to roll out during 2021, with ongoing monitoring to review the impact. It is anticipated that we will see a change in patient behaviour to patients seeking advice via 111/SPA before visiting the ED. The NEL system is responding by ensuring the right level of non-acute service provision is available in community and is bookable by 111/SPA – including all of the services described in this section.

7.6 Any to Any Booking

Initial work on this project has included creating the ability for 111/SPA to be able to book patients into any part of the health and care system including mental health services, therapies and primary care, and this has required the connecting up of IT systems to make this possible. So when a person contacts 111/SPA, patients are booked into an appointment appropriate for their needs.

The next phase of this work includes 111/SPA being able to re-direct people to a more appropriate service to their need and is reliant on further work during this year to connect IT systems.

Following a successful trial in April 2021, DPOWH is now equipped for Any to Any Booking via 111/NEL SPA. A phased roll out to link other NEL services via Any to Any Booking is now being planned with the priority in NEL being direct booking into the Urgent Treatment Hub and GP OOH service. It is expected that other services will be linked by the end of 2021.

This work will further our ability to redirect patients to the most appropriate service to meet their needs – including signposting away from ED and into the Urgent Treatment Hub or the patient's own GP practice where appropriate.

7.7 2 hours crisis response

This work will appropriately scale the capacity of the Community Urgent Care Team (within Care Plus Group community services) to ensure the service can deliver against the 2 hour crisis response required of it. It will help create capacity for new service arms like OPAT and like Virtual Ward at Home and to be able to respond to urgent needs of patients following notification by, for example, Any to Any Booking or Think 111 First. This will prevent patients attending ED when they can be seen within the community and may require the team to work

with other initiatives like the Community Frailty model. Service redesign is already underway with expected commencement before March 2022.

7.8 Mental Health Street Triage

The NEL mental health provider, Navigo, is working in partnership with Humberside Police to develop a Street Triage service which will not just be for (Mental Health Act) patients who meet the Section 136 criteria,but aiming to reduce the number of S136 detentions.

This is currently being led at Humber level and funding is required to support it. The service would see mental health practitioners join the police officer in situ to support, advise, identify alternative if appropriate, or undertake the mental health assessment with the aim to divert from hospital services. The timeframe for planning purposes is aiming for service delivery from Oct 2021.

7.9 Discharge to Assess – D2A

D2A is a national initiative as part of the wider strategy to improve urgent and emergency care.

When people no longer have a criteria to reside in an acute hospital bed, but may still require care services to support them, they are provided with short term funded support to be discharged to their own home (where appropriate) or to another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

Ensuring patients are discharged as soon as they no longer have a criteria to reside assists with patient flow within the acute setting, reduces length of stay (LOS) and helps to manage the demand for inpatient beds. The D2A arrangements in NE Lincolnshire have been very successful and system partners have worked together during the last 12 months to continually improve the D2A processes and will continue to review and improve how it is delivered.

To summarise, there are many projects underway and planned both internally within the Trust and externally within the surrounding community sector that will positively impact upon the investigation findings included those concerns that were either fully upheld or partially upheld.

The above describes initiatives and services that will ensure patients are seen in the right place at the right time, diverting away from ED where it is appropriate to do so. In addition, the new ED build and environment, alongside new roles and functions will positively impact upon the staff and the patient experience.

Section C. Oversight and sharing of this report.

8.0 Sharing of this Report.

The report will be received and signed off by the Chief Executive Officer (CEO) of the Trust, and Chief Clinical officer (CCO) of the CCG, who both initially received the whistleblowing letter. The report will then be received by the Trust Board or its sub-committees and the CCG Governing Body or its sub-committees.

In line with the Whistleblowing policy, it is important that this report is candidly shared with the whistleblower. This was undertaken on October 26th 2021. The author of the Findings Report and the lead investigator both met with the whistleblower and represented the Trust CEO and the CCG CCO who the whistleblowing email was originally sent to. This approach was taken to avoid the meeting feeling overpowering and that was appreciated by the whistleblower.

The report was very well received and the whistleblower felt the report covered the majority of concerns raised other than the following 2 things:

- Whether the staff get breaks
- Whether the patients now receive an adequate meal

Following the meeting, the whistleblower contacted friends who currently work as nurses in the ED at DPoWH to ask if they feel anything has changed, and the whistleblower subsequently emailed the report author to confirm the following information:

- "The staff are now offered breaks – there is internal department politics about this, but they are at least offered them now. A great step forward".
- "The staff report they are now able to offer patients breakfast, lunch, evening meals which consist of good quality pack-ups or a hot meal".

The whistleblower added that whilst this may seem a minor detail it is huge for the patient experience and for quality of care.

The whistleblower wanted to pass on a "well done" to the Trust, saying that it's the little things that make the biggest difference for the patient and the staff.

The whistleblower felt that some of the above positive changes and improvements in quality of care could've been better captured within Section B of this Findings report and this is acknowledged.

8. 1 Oversight.

The oversight of this report should be with the Trust Board through Speaking Out reporting and the reporting on progress should be shared with commissioners through appropriate quality discussions or meetings. Monitoring of progress should include a revisit of the staff's perceptions and experience in ED once the new build of ED is complete, anticipating that this will address the environment related issues. This revisit will compare their experience as issues and concerns are addressed.

End of Document.

Appendix One: Email from X raising concerns on the 4th of January 21:12

I am writing to you both in sheer desperation for the safety of patients within your A&E department in Grimsby.

I am a XXX within XXX in UTC seeing patients within your department. I worked in A&E myself XXX before leaving to go into primary care. Primary care cannot assist any further in managing that department.

Your issues are your flow through majors, majors and critically ill resus patients, primary care cannot manage these. I have never in my whole career seen patients hanging off trolleys, vomiting down corridors, having ECG's down corridors, patients desperate for the toilet, desperate for a drink. Basic human care is not being given safely or adequately. Your hospital is full – you're A&E department is over-flowing. But no further staff have been provided in A&E. You are concentrating on UTC and minors – this really is not the issue and if you continue to focus in this area someone will die. You are expecting staff to manage treble the amount of patients in majors and resus than they would do normally, without breaks, this is not safe. They cannot provide that care – which is evident. The staff are trying their hardest, working to actual breaking point! They are escalating to site managers – silver / gold command with a response of – we are monitoring it. What do you expect a Sister in charge of A&E to do then? Patients hanging off trolleys, desperate for even a drink! Patients in your dept were offered a single sandwich twice within 15 hours. The staff are desperately trying to find even a spoon so a patient can have a yogurt. Nutrition is paramount in the sick patient – why has the hospital not actioned someone to just go into that department two or three times a day – provide hot meals, adequate nutrition to your patients. Please – you cannot expect A&E nurses already working to treble the capacity to now start doing this also. Why cannot a domestic or someone be drafted in to do this. Provide drinks. It doesn't even need to be a trained member of staff. Why is the hospital not actioning or doing anything to provide basic care to these patients? You are relying on relatives to actually monitor YOUR patient – this is a complete reminder of the Mid Staff's hospital all over again. I've come home from a shift in tears – watching your staff try so hard to just provide care – however your management and escalation policies are failing you.

I am whistleblowing to you both – and I beg you to go into that department at a weekend – when staff are saying its unsafe – for you to see yourselves, exactly how unsafe it is, to hear the responses from your management team to the A&E team, and what you are putting your staff and patients through. This was the worst experience to date in my care