The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 September 2024

Agenda item		130/24		
Report Title		Dispatches Programme – Action Plan, process and governance		
Executive Lead		John Jones, Executive Medical Director Hayley Flavell, Director of Nursing		
Report Author		Sara Bailey, Deputy Chief Nurse Quality John Jones, Executive Medical Director		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF8
Effective	√	Our people	√	
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance		
Well Led		Our partners	√	
Consultation Communication				
Executive summary:		• On Monday 24th June 2024, a Channel 4 Dispatches programme showed footage of Shrewsbury Emergency Department filmed by an undercover reporter employed as a health care assistant. • The film showed multiple examples of an overcrowded department with images of care provision that fell below acceptable standards. • Immediate actions were taken to address the specific concerns that arose from the programme and to provide increased on the floor oversight. • Monitoring of improvement is provided both by senior presence in departments and objectively by a targeted dashboard viewed weekly by the whole executive team.		
Recommendations for the Board:		The Board is asked to: Note and take assurance that the executive team have acted on the concerns raised by the programme and put in place a continous programme of improvement and oversight		
Appendices:				

1. Introduction

1.1. On Monday 24th June 2024 a Channel 4 “Dispatches” programme was broadcast which contained footage recorded by an undercover reporter who had been working at the Trust as a health care assistant for approximately 2 months

1.2. The footage showed filming of an overcrowded Emergency Department at the Royal Shrewsbury Hospital with patients being cared for in hospital corridors, specifically the X-ray corridor linking the emergency department to the X-ray department.

1.3. There were a number of examples of care provision that fell below expected standards, these included themes relating to: infection prevention and control (IPC), handover, observations, oversight of Fit to Sit areas, length of stay in Fit to Sit areas, pain management, HCA supervision, response to the deteriorating patient, segregations of immunocompromised patients, level of clinical expertise in supervising areas and dignity of patients

1.4. There was language used by staff in the programme that gave the impression of an acceptance of poor standards and hence a cultural concern.

2. Immediate Actions

2.1. IPC interventions that involve both specialist IPC staff attending the ED daily and additional regular walkabouts led by senior staff with reinforcement of roles and responsibilities at daily huddles and handovers.

2.2. Review of sink provision to ensure availability of hand washing facilities for staff managing patients in a corridor.

2.3. Increased health care assistant staff in X-ray corridor when in use

2.4. Consistent staff huddles and handovers to highlight escalation routes for patients in pain recognising time taken to prepare controlled drugs.

2.5. Increase sepsis training to increase current level of compliance from 85 to 90%.

2.6. Identification of new designated areas to isolate immunocompromised patients.

2.7. Additional doctor allocation to the Fit to Sit areas.

2.8. Review of all areas of care concerns highlighted in programme by Executive Medical Director and Director of Nursing to gain assurance of management of personal care needs.

2.9. Visiting of areas by PALS, chaplaincy, and patient experience services

2.10. Additional cleanliness and housekeeper staffing

2.11. Additional volunteer support

2.12. Roles and responsibilities for ad-hoc meal provision identified.

2.13. Further training in use of slide sheets and stock access reviewed.

2.14. Review of oversight of Fit to Sit length of stay.

2.15. Huddles and walkabouts by senior nursing staff to ensure suitability of choice of patients for corridor location and that criteria for corridor care SOP is being followed.

2.16. Audits of observations and dynamic targeting of staff

2.17. Review of ARA space use with WMAS

2.18. Individual and group discussion on use of language and expectations

2.19. Safeguarding review of matters arising from programme

2.20. Programme of support for staff

2.21. Daily increased senior staff presence in departments

3. Action Planning

3.1. An action plan has been developed which is updated weekly.

3.2. A dashboard has been developed which is updated with the daily audit results from key metrics aligned to the action plan.

3.3. The Hospital Full Policy has been revised to alter sequencing of escalation areas to minimise corridor use.

3.4. Monitoring of all assessment areas to measure accumulated wait for each patient.

3.5. Actions aligned with CQC action plan, CQC action plan is monitored through monthly review meetings and existing governance structures.

3.6. Both Emergency Departments are included in the action planning

4. Stakeholder engagement

4.1. Health Watch visits have been undertaken in both Emergency Departments

4.2. ICB led insight visits to both departments, recommendations included in action plan.

4.3. NHSE Infection Prevention and Control Assistant Director of Infection Prevention and Control

4.4. Medical Director and Director of Nursing attendance at Joint Hospital Overview and Scrutiny Committee

4.5. Director of Nursing attendance at Joint Safeguarding Board

4.6. Fortnightly discussions with NHSE at delivery meetings

5. Staff support

5.1. We continue to develop and promote the Trust's health and wellbeing offer as well as the resources already available such as huddles, debriefs, and psychology support. The enhanced offer includes additional chaplaincy and Professional Nurse Advocate support.

6. Monitoring

6.1. Departmental oversight is provided by daily matron audits and weekly audits by quality matrons, cleanliness, and IPC team. These inform a quality dashboard with any red or amber ratings triggering Divisional actions which are reviewed at a weekly Divisional Action Plan review meeting, revision of actions is agreed at these meetings to ensure improvements in compliance where standards are not being achieved, for example further training, tissue viability support. There is additional fluid balance and nutritional in reach support will being in September.

6.2. In addition, the senior nursing team are planning to introduce the short observational framework tool in September, based on the Bradford model, to capture the experiences of people who use our services. This will include observing mood and engagement of people and the quality of staff interactions as well as noting on other aspects of are practice during the observations.

6.3. Executive oversight will be provided by weekly review of quality dashboard and exception report at executive team meetings. Where a metric is below the required standard for two consecutive periods (2 weeks) this will prompt intervention from Executive team in relation to assurance around the actions being delivered to achieve compliance.