The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 16 January 2025

Agenda item		016/25		
Report Title		Dispatches Programme Exception report – Data 30 December 2024- 5 January 2025		
Executive Lead		John Jones, Executive Medical Director Paula Gardner, Interim Chief Nursing Officer		
Report Author		Donna Hadley, Divisional Director of Nursing MEC Emma Harber, Deputy Divisional Deputy Director Nursing ED Sara Bailey, Deputy Chief Nurse		
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		UECTAC 21 November 2024 Executive oversight – weekly, moved to fortnightly January 2025 to review quality dashboard and exception report.		
Executive summary:		• As previously reported to Board in September 2024, on Monday 24 June 2024 Channel 4 Dispatches programme showed footage of Shrewsbury Emergency Department filmed by an undercover reporter employed as a health care assistant. • Immediate actions were taken to address the specific concerns that arose from the programme, and increase oversight on the floor of the ED. • A scheduled programme of weekly in reach support has been in place and includes documentation, nutrition, falls, fluid balance, dementia, patient experience, safety/privacy and dignity, care comfort rounds and infection prevention and control. • Monitoring of improvements is provided both by senior presence in departments, objectively by a targeted weekly internal and peer audits from which an exception report is produced. The audit findings and impact of the quality in reach support are detailed in the main body of the report. • Additional quality assurances actions have entailed a CQC Mock Inspection 17 December 2024 and scheduled insight visits from the ICB. • From January 2025, given the majority of reported green rated metrics, improvement actions have moved to phase 1 of the step-down approach as approved by UECTAC 21 November 2024. Includes: ➢ reducing to 3x weekly internal audits, 1 peer audit ➢ IPC in reach support x2 weekly ➢ reduced ICB quality visits with focus areas ➢ fortnightly exception reporting to Executives. ➢ Monitoring will continue for 2 months. • Phase 2 of step-down approach will be moving to monthly audits as part of business as usual with no additional in reach support. This is anticipated to be enacted by March 2025.		
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 continuous programme of improvement and oversight.		
Appendices:		Dispatches Enhanced Metrics – Exception Report		

Title:	Dispatches Enhanced Metrics – Exception Report
Report to:	Executive Team
Report from:	Data period 30th December -5th January 2025
Department:	RSH & PRH Emergency Department
Date:	8th January 2025

Introduction

The ED Daily Quality audit results are collated via Gather© which is a database utilised for a range of ward-based audits. Each question is scored against values for compliance. Any audit questions that are not answered based on non-relevance to the patient or process are excluded from the scoring (represented with a N/A). The questions are based on the themes identified for the NMQ metrics (please note less themes being monitored for this report) and fed into a dashboard that enables triangulation of data taken from other audits such as the IPC Quality Ward Walk and Deteriorating patient audit. Individual questions are tagged against each theme to enable a score to be totalled. The expectation is for a daily audit per site to be completed, on occasions this may be more. The questions included within the ED Daily Quality audit have been selected by the ED Team and are taken from the NMQ standard set of questions developed by the Quality Matrons within Corporate Nursing. The questions are developed by Subject specialists to oversee compliance for clinical standards as per existing quality metrics audits. The Matrons receive an instant notification once an audit has been completed. For some questions we have broadened the number of patients to be captured per audit, such as fluid balance (up to 5 patients per audit).

One peer audit per week per site is captured within this audit.
Both ED Matrons reviewing the notifications provided by Gather live during the week.

Acknowledgement to the trust and ED's functioning in Escalation level 4. Many days where there were over 100 patients in the department. Critical incident declared on Friday 3rd January 2025.

Please Note: There has been an identified technical error affecting Gather's ability to extract the raw data accurately into the dashboards. This has been identified, discussed and escalated during the meeting today and the relevant teams are working hard to rectify the error. Dashboards not currently attached to the bottom of the report and can be sent separately once the error is rectified.

Areas of Compliance

Metric	Week 49	Week 50	Week 51	Week 52	Week 1
Results against ED Daily Quality Audit					
DQA - Documentation (Clinical Effectiveness)	94.6 (15)	93 (15)	96.8 (15)	93.8 (5)	96.5 (6)
DQA - Nutrition	87.2 (15)	96.8 (15)	92.7 (15)	90.3 (5)	92.3 (6)
DQA - Falls	87.5 (15)	96.9 (15)	95.4 (15)	92.3 (5)	95.2 (6)
DQA – Fluid Balance	73.7 (15)	86.1 (15)	87.1 (15)	91.3 (5)	93.7 (6)
DQA - Dementia	91.3 (15)	100 (15)	100 (15)	97.9 (5)	100 (6)
DQA - Patient Experience	99.3 (15)	99.3 (15)	97.9 (15)	94 (5)	97.9 (6)
DQA - Safety / Privacy / Dignity	98.3 (15)	98.3 (15)	98.3 (15)	100 (5)	100 (6)
DQA - Care Comfort Round	93.3 (15)	93.3 (15)	96.6 (15)	92 (5)	100 (6)
DQA – IPC	94 (15)	97.9 (15)	98.1 (15)	92.6 (5)	99.6 (6)

(Key: figures in brackets total number of audits per week over the two sites, collective result based on calculation of denominator and numerator rather than average scores)

Sustained improvements in compliance – Nutrition, Falls, Documentation, Patient Experience, Privacy and Dignity, Care Comfort Round, IPC.

Audits completed per site during w/c 30/12/2024 to 5/1/2025.

Site	Area	Number
PRH – 3 audits carried out	ARA	1
	Majors	1

	Other- Resus	
	Fit2sit	1
RSH – 3 audits carried out	Fit2sit	1
	Majors	2
	ARA	
	Others	

Areas of Green Compliance against overarching theme *(Data Source: Dashboard / Summary report / Week 1)*

Nutrition –Overall result for both sites green.

Service	Broken down per site:	Documented evidence that the patient has been offered diet and fluids (on ED checklist)?	Data representing	Diabetic patient - is there a plan to ensure blood glucose is controlled? (question split from place from 4/10)	Data representing	BM recorded and if applicable, evidence re-checked at appropriate intervals?	Data representing
	Week 1	100	3/3 patients	N/A	0/3 patients	N/A	0/3 patients
	Week 52	100		100		N/A	
	Week 51	100		100		100	
PRH	Week 50	100	7/7 patients	100	7/7 patients	100	7/7 patients
	Week 49	100	7/7 patients	100	7/7 patients	100	7/7 patients
	Week 48	100	7/7 patients	100	7/7 patients	100	7/7 patients
	Week 1	100	3/3 patients	100	3/3 patients	100	3/3 patients
	Week 52	80		100		N/A	
	Week 51	87.5		80		80	
RSH	Week 50	87.5	7/8 patients	83.3	7/8 patients	83.3	7/8 patients
	Week 49	87.5	7/8 patients	100	8/8 patients	100	8/8 patients
	Week 48	87.5	7/8 patients	80	6/8 patients	57.1	5/8 patients

key *fluctuation in the number of patients due to non-relevance of question for some patients

Falls – Green compliance overall across the two sites during week 1

Service	Broken down per site:	Has a Falls risk Screening tool been completed on Care flow within 6 hours? (split from 7/10/24)	Has the ED fall bundle and plan of care been completed in full?	Are any equipment needs identified, if so are they available, in use or requested (i.e. slide sheets)?	On observing the patient, does the bed rails used for the patient reflect the bed rails/falls assessment?	Has a trolley rail risk assessment been completed?	If yes on observing the patient does the assessment reflect correct use?	If the patient had a fall, has an incident form been submitted
	Week 1	100 3/3 patients	100 3/3 patients	66.7 3/3 patients	100 3/3 patients	**N/a**	**N/a**	**N/a**
	Week 52	1003/3	1003/3	1003/3	1003/3	**N/a**	**N/a**	**N/a**
	Week 51	100(7 / 7)	100(7 / 7)	100(7 / 7)	100(7 / 7)	75(5 / 7)	100(7 / 7)	N/a
	Week 50	100(7 / 7)	100(7 / 7)	100(7 / 7)	100(7 / 7)	100(7 / 7)	100(7 / 7)	100
PRH	Week 49	**100 (7 / 7)**	**100 (7 / 7)**	**100 (7 / 7)**	**100 (7 / 7)**	**100 (7 / 7)**	**100 (7 / 7)**	**N/a**
	Week 48	**100 (7 / 7)**	**100 (5/5)**	**100 (6 / 6)**	**100 (6/6)**	**33.3 (1/3)**	**100**	**85.7 (7/8)**
	Week 1	**33.3** (1/3 patients)	**66.7** (2/3 patients)	**100** (3/3 patients)	**100** (3/3 patients)	**N/a**	**N/a**	**100**
	Week 52	100	100	50	**N/a**	100	100	**N/a**
RSH	Week 51	87.5	83.3	75	100	100	100	N/a

	Week 50	87.5(7 / 8)	100(8 / 8)	100(8 / 8)	100(8 / 8)	100(8 / 8)	80(6 / 8)	N/a
	Week 49	100 (8 / 8)	100 (8 / 8)	100 (8 / 8)	100 (8 / 8)	83.3 (6/7)	100 (8 / 8)	N/a
	Week 48	85.7 (6 / 7)	100 (7 / 7)	80 (4/5)	80 (4/5)	66.7 (2/3)	66.7 (2/3)	100

Key *patient numbers will fluctuate dependent on relevance and appropriateness of question

Week 1- *Acknowledge the risk assessments have not been timely due to the increase presentation of patients and additional patients remaining in rapid offload spaces and other undesignated spaces. Risk assessments prioritized per patients and no harm identified whilst waiting for completing. Clinical judgement was applied to maintain safety where non-compliant was noted.*

Privacy and Dignity – Remained within green

Service	Broken down per site:	Curtains in place	Data representing	Curtains closed to maintain privacy if a care intervention is being delivered	Data representing	Patient's drink within reach	Data representing	Patient able to reach the call bell?	Data representing
PRH	Week 1	100	3/3 patients	100	3/3 patients	100	3/3 patients	100	3/3 patients
	Week 52	100	3/3 patients	100	3/3 patients	100	3/3 patients	100	3/3 patients
	Week 51	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients
	Week 50	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients
	Week 49	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients
	Week 48	100	7 / 7 patients	100	7 / 7 patients	100	7 / 7 patients	87.5	6 / 7 patients
RSH	Week 1	100	3/3 patients	100	3/3 patients	100	3/3 patients	100	3/3 patients
	Week 52	100	3/3 patients	100	3/3 patients	100	3/3 patients	100	3/3 patients
	Week 51	100	8 / 8 patients	100	8 / 8 patients	100	8 / 8 patients	100	8 / 8 patients
	Week 50	100	8 / 8 patients	100	8 / 8 patients	100	8 / 8 patients	87.5	7 / 8 patients
	Week 49	100	8 / 8 patients	100	8 / 8 patients	100	8 / 8 patients	87.5	7/8 patients
	Week 48	100	8 / 8 patients	100	8 / 8 patients	100	8 / 8 patients	100	8 / 8 patients

key *fluctuation in the number of patients due to non-relevance of question for some patients

Patient Experience – Remaining within the green rating.

Service	Broken down per site:	Do you know which Nurse or Healthcare is looking after you today?	Are the nurses kind?	Are the Doctors kind?	Do you feel involved in decisions about your care?	Do the health care professionals wash their hands before caring for you?	Are you happy with you care?	If you use your call bell, is it answered promptly?	Have you been offered refreshments?	Has your pain been addressed?	Has your medication been explained to you?
PRH	Week 1	100 3/3	100 3/3	100 3/3	66.7 2/3	100 3/3	100 3/3	66.7 (2/3)	100 3/3	100 3/3	100 3/3
	Week 52	100	100	100	100	100	100	100	100	100	100
	Week 51	100	100	100	66.7	100	83.3	100	83.3	66.7	100
	Week 50	100	100	100	100	100	100	100	100	100	100
	Week 49	100 7/7	100 7/7	100 7/7	100 7/7	100 7/7	100 7/7	100 7/7	100 7/7	100 7/7	100 7/7

	Week 48	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	85.7 7 / 8	100 8 / 8	100 8 / 8	100 8 / 8
	Week 1	100 3/3	100 3/3	100 3/3	100 3/3	100 3/3	100 3/3	100 3/3	100 3/3	100 3/3	100 3/3
	Week 52	100	100	100	66.7	100	100	100	100	100	100
	Week 51	100	100	100	85.7	100	100	100	100	100	83.3
	Week 50	100	100	87.5 7 / 8	87.5 7 / 8	100	87.5 7 / 8	100	100	100	100
	Week 49	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	100 8 / 8	87.5 7/8
RSH	Week 48	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7	100 7 / 7

Key * fluctuations in numbers of patients applicable to the question asked and whether they are appropriate and relevant to this question / theme

Week 1- *Call bell acknowledged an explanation provided to patient that they would return as soon as they had completed the intervention with another patient.*

IPC – Noted compliance within the green RAG rating.

Generally, it is one question per audit, however with the Hand Hygiene and Bare Below Elbow ten observations of staff members are carried out.

Service	Broken down per site:	Patients in isolation, is the signage correct on the door?	Data representing	Hand Gels clean, working and available at all entrances to bays/rooms and bed spaces?	Data representing	Are Staff PPE compliant See key below for target	Data representing	Staff are compliant with hand hygiene? / 10 staff See key below for target	Are staff bare below elbow? / 10 staff See key below for target
PRH	Week 1	66.7	2/3 audits	100	3/3 audits	100	3/3 audits	70 (13/30)	95
	Week 52	100		100		100		100	100
	Week 51	100		50		100		98.3	
	Week 50	100	7 / 7 audits	100	7 / 7 audits	100	7 / 7 audits	97.1 (68/70)	95.7 (65/70)
	Week 49	100	7 / 7 audits	100	7 / 7 audits	100	7 / 7 audits	98.3 (67/70)	93.3 (64/70)
	Week 48	100	8 / 8	87.5	6 / 7	100	8 / 8	95.7 (76 / 80)	91.4 72 / 80)
RSH	Week 1	100	3/3 audits	100	3/3 audits	66.7	2/3 audits	100	93.3
	Week 52	100		100		100		100	96.7
	Week 51	100		100		100		95.7	
	Week 50	100	8 / 8	100	8 / 8	100	8 / 8	93.8 (73/80)	95 (75/80)
	Week 49	100	8 / 8	100	8 / 8	100	8 / 8	96.3 (76/80)	92.5 (72/80)
	Week 48	100	8 / 8	100	8 / 8	87.5	7 / 8	92.5 (72 / 80)	90 (70 / 80)

(Key for target - RAG for PPE, Hand hygiene and BBE – should be 100% fully compliant)

PRH HH – Medical staff

BBE PRH – Medical staff
BBE RSH- Paramedic, Medical doctor

Week 1- *Continue to reiterate to teams in staff huddle regarding BBE and HH and challenged at the time re hand hygiene. Continue to prioritize weekly ward walks on both sites. IPC support provided whilst on critical incident. Staff huddle for this week is focusing on IPC. Reintroduction of masks throughout the hospitals, posters are printed and laminated in the department*

Reiterating in staff huddle and challenging visiting doctors and WMAS staff at time to remain BBE and follow HH.

Availability of Hand gel is available in the department, but sometimes access to availability of hand gel in overcrowding areas is limited. Liaised with IPC, purchased individual pocket clip hand gels.

To follow up regarding the dedicated workstream for HH within C. Diff working project group.

Care Comfort Round – remains within green

Service	Broken down per site:	ED patient safety checklist updated and initialled and timed on an hourly basis? Or comfort chart 2 hourly if over 12 hours	Data representing	Care/comfort rounds been carried out as identified?	Data representing
PRH	Week 1	66.7	1/3	100	3/3
	Week 52	100		100	
	Week 51				
	Week 50	100	7 / 7	100	7 / 7
	Week 49	100	7 / 7	100	7 / 7
	Week 48	100	7 / 7	100	7 / 7
RSH	Week 1	33.3	1/3	66.7	2/3
	Week 52	100		100	
	Week 51				
	Week 50	87.5	7 / 8	100	8 / 8
	Week 49	87.5	7 / 8	87.5	7 / 8
	Week 48	87.5	7 / 8	87.5	7 / 8

Week 1- Patient *had received the care but there was delay in evidence of care delivered, limited availability of screens due to additional patients in undesignated areas. Care needs of patients were prioritized, no patient harm was noted regarding care comfort round. New screens been ordered but delay in receiving them.*

Dementia – Review of questions by Dementia Lead and ED Matrons took place.

Service	Broken down per site:	Is the patient living with dementia in a bed space where they can be observed?	If no, what action is taken to mitigate the risk? Comments
PRH	Week 1	100 1 patient	
	Week 52	100	
	Week 51	100	
	Week 50	100	
	Week 49	100	
	Week 48	100 (6/6 Patients)	To be populated if answered no
RSH	Week 1	100 1 patient	
	Week 52	100	
	Week 51	100	
	Week 50	100	
	Week 49	100	
	Week 48	50 (1/2 patients)	To be populated if answered no

Questions changed to above on the 27/9/2024 following agreement with Matron, Div DON and Lead Dementia Specialist Nurse. Up until this stage the audit asked if the patient had an 'all about me' If the patient had a diagnosis, and if the patient had been referred to the dementia team. It was agreed that these were not the most suitable questions for the purpose of this audit.

Documentation – Slight increase overall, remains in green

More than one patient's documentation can be reviewed in an audit in order to ensure it is fully completed.

Service	Broken down per site:	Checking of 5 sets of notes with observation completed (5 per audit)	Data representing	Pain relief been administered / 5 patients per audit	Data representing	Documented evidence of escalation / 5 patients per audit	Data representing	Patient safety checklist commenced – 1 patient per audit	Data representing

	Week 1	100	**10/10 patients**	80	**8/10 patients**	70	**7/10 patients**	100	**1/1 patients**
	Week 52	100		100		100		100	
	Week 51	100		100		100		100	
	Week 50	100	35 / 35 patients	100	35 / 35 patients	100	35 / 35 patients	100	35 / 35 patients
	Week 49	100	35 / 35 patients	96.7	34 / 35 patients	100	35 / 35 patients	100	35 / 35 patients
PRH	Week 48	**100**	**35 / 35 patients**	**100**	**35 / 35 patients**	88	**32 / 35 patients**	**100**	**35 / 35 patients**
	Week 1	100	**15/15 patients**	100	**15/15 patients**	90	**14/15 patients**	66.7	**3/3 patients**
	Week 52	100		93.3		80		100	
	Week 51	100		100		100		100	
	Week 50	100	40 / 40 patients	95	37 / 40 patients	92	35 / 40 patients	87.5	31 / 40 patients
	Week 49	100	40 / 40 patients	97.5	38/ 40 patients	65	13/20	75	30/40 patients
RSH	Week 48	**100**	**40 / 40 patients**	**100**	**40 / 40 patients**	**50**	**5 / 10 patients**	87.5	**35 / 40 patients**

key *fluctuation in the number of patients due to non-relevance of question for some patients.

Action log details in progress to track improvements re observation and improvement in documented evidence.

Week 1- *No known harm identified all patients being seen by appropriate clinicians.*
Documentation has increased slightly this week despite having the additional challenge of multiple patients in undesignated spaces who all require simultaneous risk assessments at one single point in time. Verbal clinical discussion taken place. Care needs were prioritized.

Fluid Balance – Overall green rated.

Service	Broken down per site:	Can you identify a patient who requires fluid balance monitoring as per Trust guidance - has a fluid balance chart been commenced (if identified as part of their management plan)? Please note how many out of the 5-pts checked are compliant):	Is the fluid output clearly documented? e.g. urine, type of drain, vomit etc. (Please note how many out of the 5-pts checked are compliant):	Is the fluid balance running total accurate? (Please note how many out of the 5-pts checked are compliant):	Are any outstanding fluids carried forward from a previous fluid balance chart? E.g. IV fluids or NG feed (Please note how many out of the 5-pts checked are compliant):
	Week 1	100	87.5	85.7	No Data
	Week 52	96.6	92.9	86.2	No Data
	Week 51	96.8	90.3	67.7	No Data
	Week 50	90.9	93.8	93.3	92.6
	Week 49	100	100	84.2	100
	Week 48	84.6	76.9	66.7	80
	Week 1	100	87.5	85.7	No Data
	Week 52	96.6	92.9	86.2	No Data
	Week 51				No Data
	Week 50	96.8	90.3	67.7	58.8
RSH	**Week 49**	100	75	58.3	66.7

	Week 48	96	70.8	62.5	41.2

Week 50- *Through the governance process the non-compliance reflects no patient harm incidents were identified as a result of incomplete documentation.*
ED matron validating daily audit results, highlighting where amendments to be made for non-applicable responses. ED matron supporting teams to understand rationale.
Linked in with another organization around fluid management policy and associated risk assessments and forwarded to Deputy Director of Nursing who is reviewing Fluid balance policy.

Amber metrics identified over the week and mitigation in place

Overall themes amber: No overall amber theme for Week 1

Red Themes –No overall red theme this week (from ED daily audits), please note breakdown included per area.

Observation carried on Time

These results are an extract from the audits carried out by ED's own team such as B6, NIC, Matron (Up to 10 per day), these are patients who are triggering over 5 or 3:1 and reported on the dashboard for the monthly Metrics meetings and DPG.

Service	Broken down per site:	Were the next set of observations (following the NEWS2 trigger) completed in the desired frequency (as per Vitals guidance)
PRH	Week 1	No data available
	Week 52	21.1(19 audits)
	Week 51	82.2 (45 audits)
	Week 50	82.2 (45 audits)
	Week 49	65 (20 audits)
	Week 48	55.6 (27 audits)
RSH	Week 1	57.4 (47)
	Week 52	47 (36 audits)
	Week 51	63 (54 audits)
	Week 50	63 (54 audits)
	Week 49	67.4 (43 audits)
	Week 48	71.4 (56 audits)

Week 1- *Clinical priority given to those patients with high early warning score, treated in ARA/ Resus/ on back of the ambulance.*
Continued focus on timeliness of observation and escalation of deteriorating patients. No patient harm was identified, clinician review has taken place.
The breakdown per area being provided and reviewed to add appropriate context (for e.g.- resus patient continued monitoring with clinicians for oversight and intervention timely.

Following DPG further discussions to be held with Quality matron as questions received from DPG group.
Deteriorating patients are on continuous cardiac monitoring with staff patient ratio in resus (1:1/1:2) and in majors (1:5).

Red metrics (including training) identified over the week w/c 30/12/2024 along with updates to Action Plans from previous months on Gather

Standard	Action
Late Observation	• Matron and NIC oversight of live vital pacs board enabling prompt review of late observations and supporting real time actions. • Flag to operational team of patients who remains on vital pacs *(unknown origin).* Individual cases raised via IT; local log held to support individual scrutiny. • Supporting embedded practices of appropriate use of off ward facility of vitals within teams.

	• Supporting embedding practice to review the vital pacs to identify the triggered patients requiring observation. • Still requiring consultant (all specialties) guidance regarding scheduling of observation and documenting in care plan to support nursing teams. This will feed into patient deteriorating group.

Actions / Commentary relating to Weekly ED Dashboard- 30/12/2024 – 05/01/2025

1. During this reporting period it is noted that both departments were operating at unprecedented demand, with additional escalation areas fully open. (Level 4). Additional spaces created to support Rapid offload requests and overcrowded departments.
2. Critical incident declared on Friday 3rd January 2025. Hospital full enacted, next patient spaces in use.
3. Audits carried out during this period were in designated ED spaces.
4. During the period of Christmas and New Year week additional corporate support was provided to both departments.
5. Corporate support scheduled roster to continue for January, roster reviewed regularly.
6. Additional Quality matron support provided over the New Year weekend in line with critical incident being declared.
7. Despite unprecedented demand overall matrix remained green in all elements of audit for both sites. Acknowledge the hard work from teams involved during this challenging period.
8. Ongoing support with bi-weekly ED dashboard / 3 times weekly audits progressing with corporate support and Clinical Information Officer pulling together from Gather©.
9. IPC support continuing 2 times weekly, continuation of 1x QWW per site and 1 other scheduled visit. Additionality for teams to contact IPC for additional support and guidance. QWW uploaded on gather feeding into ED IPC Action plan.
10. Mask wearing introduced in clinical areas in response to an increased prevalence of IPC cases.
11. Visiting restrictions introduced in clinical areas with some exceptions (clinical condition, EOL, paediatrics).
12. Corporate support schedule reviewed and continuation of 1 peer audit per week per site.
13. Additional support from chaplaincy and patient experience team over the Christmas and New Year period.
14. Key agenda items on divisional committee requiring support.
15. Ongoing routine Deputy Medical Director QWW in place with dates identified.