The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
AGENDA

Date: 8 July 2021
Time: 1300hrs
Venue: Via MS Teams (link in meeting invitation)
Chair: Catriona McMahon

Time	Item no.	Item	Paper Verbal	Page	Lead	Action
Procedural Items						
1300hrs	166/21	Welcome, introductions, and apologies	Verbal	-	Chair	For noting
	167/21	Staff Story – Nurses from Overseas	Verbal / Video	3	Director of Nursing	For discussion
	168/21	Quorum	Verbal	-	Chair	For noting
	169/21	Declarations of conflicts of interest	Verbal	-	Chair	For noting
	170/21	Minutes of the previous meetings held on 6 May 2021, and 10 June 2021	Enc.	6 19	Chair	For approval
	171/21	Action log	Enc.	32	Chair	For approval
	172/21	Matters arising from the previous minutes (not covered elsewhere on the agenda or action log)	Verbal	-	Chair	For discussion
Strategic Matters						
1345hrs	173/21	Report from the Chair	Verbal	-	Chair	For noting
	174/21	Report from the Chief Executive	Verbal	-	Chief Executive	For noting
	175/21	Hospitals Transformation Programme Report	Enc.	33	Deputy CEO	For noting
Quality and Performance Matters						
1430hrs	176/21	Integrated Performance Report	Enc.	38	Chief Executive	For assurance
Assurance Framework						
1530hrs	177/21	Data Security and Protection Toolkit (DSPT submission)	Enc.	92	*Senior Information Risk Owner / Director of Governance	For assurance
	178/21	Clinical Negligence Scheme for Trusts (CNST) maternity declaration, and action plan	Enc.	94	Director of Nursing	For approval
	179/21	The Ockenden Report - Progress Report	Enc.	136	Director of Nursing	For assurance

	180/21	Ockenden Report Assurance Committee Monthly Report	Enc.	169	Committee Chair	For assurance
	181/21	Finance & Performance Assurance Committee Monthly Report	Enc.	172	Committee Chair	For assurance
	182/21	Quality & Safety Assurance Committee Monthly Report	Enc.	174	Committee Chair	For assurance
Procedural Items						
1630hrs	183/21	Any other business – to be agreed by the Chair	Verbal	-	Chair	For discussion
	184/21	Date and Time of Next Meeting 13:00 on **Thursday 5th August 2021**	Verbal	-	Chair	For information
Stakeholder Engagement						
1645hrs	184/21	Questions received from the public	Verbal	-	Chair	For information
Close of meeting						

* Non-voting

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
July 2021

Agenda item	167/21			
Report	Staff Story – Nurses from Overseas			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 1 and 4	
	For decision / approval		**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
Executive summary:	This story was shared as part of an international nurse recruitment presentation at the Cultural Diversity Event for Shropshire, Telford and Wrekin Integrated Care System, which took place on 21st May 2021. The whole presentation took the form of three short films in which our international nurses talked about their journey from their home countries, arrival in the UK, completion of OSCE exams and their transition to the clinical environments across SaTH, as well as their experience of nursing in a pandemic. The presentation was narrated by Sister Jamie Henry, a SaTH Philippine Nurse who has also been through OSCE (Objective Structured Clinical Exam), and is a Professional Development Nurse with the International Recruitment Project. Consent was given by the nurses interviewed, to share their stories within the Trust and externally to support reflection, learning and training. The Board are invited to watch the film in which the nurses' stories are shared.			
Appendices	Appendix 1: International Nurse Recruitment project – nurses' stories.			

1.0 Introduction

1.1 This presentation captures the nurses' experiences of travelling to the UK, preparing for and taking OSCE, transitioning to the clinical areas at both Princess Royal and Royal Shrewsbury Hospital, as well as nursing in a global pandemic.

1.2 The nurses have shared their accounts of their experiences to provide feedback and reinforce the positive impact the Trust has had on their career development.

1.3 This story is presented as a short film.

2.0 Background

2.1 The film captures the experiences of eight nurses who have all joined the Trust over the last five years. One of the nurses, from the Philippines, joined the Trust in a previous international recruitment drive. The rest – one from Nigeria and six from India have all come to the Trust, either through the Health Education England Global Learners Programme or the OSCE ready pipeline, in the last twelve months. These two programmes combined have put a total of 205 nurses in to clinical areas across SaTH.

2.2 All nurses featured in the presentation have taken OSCE and passed, enabling them to obtain a UK PIN number and practice on the Nursing and Midwifery Register. The narrator was also a nurse from the Philippines, who joined SaTH 5 years ago and is now a Professional Development Nurse supporting the most recent international recruits through OSCE.

2.3 The nurses not only reflect upon their experiences of arriving in the UK and taking OSCE. They also recollect the support and guidance they received from staff in the clinical areas, as well as from members of local communities across the county.

2.4 The nurses talk about their previous clinical backgrounds, their motivations for leaving their home countries and the emotions of leaving their families and loved ones so they can embark on a new career in the NHS.

2.5 The nurses share their aspirations for their future careers, words of wisdom for other international nurses planning to make the same journey and also the pivotal part they have played in nursing patients with COVID back to health.

2.6 The presentation reflects a snapshot of the experiences of the international nurses who have joined the Trust over the last five years. It evokes real emotion as we hear their inspirational stories and the pride they have in their skills as healthcare professionals.

3.0 The use of stories

3.1 These stories value the perspective of the people sharing their experience, providing a tool through which they can share what is important to them, enabling storytellers through empowering them to tell their story in their own words and in their own way.

3.2 The nurses' stories provide an honest and genuine insight into their experience, offering a different perspective and an opportunity to reflect.

4.0 Risks and actions

4.1 Following the nurses' stories being shared the subsequent actions have been taken:

- The films will be used by the Recruitment Team as a resource for future international recruitment events at the Trust.
- A page on the Trust website is being developed to showcase international recruitment and encourage other international health care workers to consider SaTH as a place to work.
- The films will be used by the International Nurse Education Team to further inform the development of pastoral care and support for future cohorts of international recruits.

5.0 Conclusion

5.1 The Board is asked to note this presentation and take assurance of the work being undertaken to embed the value of international nurse recruitment across the Trust to improve patient experience.

Director of Nursing
July 2021

The Shrewsbury and Telford Hospital NHS Trust
Board of Directors' meeting in Public

Thursday 6 May 2021 via MS Teams (and live streamed to a public audience)

MINUTES

Name	Title	Item (if applicable)
MEMBERS		
Dr. C McMahon	Chair	
Mrs T Boughey	Non-Executive Director	
Mr A Bristlin	Non-Executive Director	
Mr D Brown	Non-Executive Director	
Prof C Deadman	Non-Executive Director	
Mrs H Flavell	Director of Nursing	
Dr. J Jones	Acting Medical Director	
Dr. D Lee	Non-Executive Director	Left at 13:58 Re-joined at 15:37
Mr N Lee	Chief Operating Officer	
Prof T Purt	Non-Executive Director	
Mrs H Troalen	Director of Finance	
IN ATTENDANCE (non-voting)		
Ms R Boyode	Acting Workforce Director	
Mrs J Clarke	Director of Corporate Services	
Ms A Milanec	Director of Governance & Communications	
Mr C Preston	Interim Director of Strategy & Planning	
Mr R Steyn	Co-Medical Director	
Ms C West	Improvement Director	
Mrs P Neil	Interim Board Secretary (Minutes)	
GUESTS		
Dr. M Hon	Clinical Director for Obstetrics, Women and Children's Division	Item 115/21
Mrs J McDonnell	Divisional Director of Operations, Women and Children's Division	Item 115/21
Mr N Nisbet	Director of Transformation	Item 101/21
Ms J Payne	Head of Midwifery, Women and Children's Division	Item 115/21
Mr A Tapp	Medical Director, Hospital Transformation Programme	Item 101/21
Ms H Turner	Freedom to Speak Up Guardian	Item 115/21
Mr M Underwood	Medical Director, Women and Children's Division	Item 115/21
Mr M Wright	Programme Director, Maternity Assurance	
APOLOGIES		
Mrs L Barnett	Chief Executive	
Dr. A Rose	Medical Director	

GENERAL BUSINESS		
092/21	**Welcome and apologies** The Chair welcomed all those present and observing members of the public attending the meeting via the live stream. Apologies were noted. The Chair thanked all members of the public who attended the previous Board of Directors' meeting in public on 8 April 2021 and provided feedback. It was brought to the attention of the public that the attending members of the Board would be using the digital chat box to indicate to the Chair when they wished to ask a question. Apologies were noted.	
093/21	**Patient Story** The Board of Directors received the report from the Director of Nursing and the accompanying video, screened live at the meeting and published on the Trust's website.	
094/21	**Quorum** The Chair declared the meeting quorate.	
095/21	**Declarations of conflicts of Interest** No conflicts of interest were declared that were not already declared on the register. The Chair reminded members of the need to highlight any interests which may arise during the course of the meeting.	
096/21	**Minutes of the previous meeting**. The minutes of the meeting held on 8 April 2021 were approved by the Board of Directors as an accurate record.	
097/21	**Action Log** 2020/52 - Waiting List Initiatives [WLI] Review of Policy – The Board of Directors' approved a request for an extension of this item to June 2021.	
098/21	**Matters Arising** The Chair advised that no matters had been raised which were not already covered in the action log or on agenda.	

STRATEGIC MATTERS		
099/21	**Report from the Chair** The Board of Directors received the verbal report from the Chair. Dr. McMahon confirmed that she had been appointed Chair of the Shrewsbury, Telford and Wrekin Integrated Care System (ICS) People Committee from the 1 April 2021. Dr. McMahon impressed upon those attending and observing the meeting that questions from the public afforded an excellent opportunity for the Trust to engage with the public and that therefore, questions about the previous Board of Directors' meetings from the public were welcomed. However, as a result of the increased volume of questions being received, work to improve the process for preparing and delivering the Trust's response was being undertaken and further details would be provided at the next meeting. The Board noted the verbal report from the Chair.	
100/21	**Report from the Chief Executive** The Board of Directors received the verbal report from the Acting Chief Executive, Mr Preston. Mr Preston reported that the Trust had maintained focus on the delivery of maternity and quality improvements whilst also, as the impact of the pandemic on the Trust had reduced, increased the emphasis on the restoration of elective clinical capacity, targeting the areas of highest clinical priority. It was noted that our programmes of work with Alliance colleagues, both University Hospital Birmingham NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust, were progressing and that the additional capacity and expertise was having a the positive impact on the Trust's recovery plans. Mr Preston also advised that the Trust was in the process of resetting and refocusing a number of longer term strategic plans, including the Hospital Transformation Programme. He emphasised that, as delivery of these plans was progressed, looking after our staff and ensuring their wellbeing remained a priority. The Board of Directors noted the verbal report.	
101/21	**Hospital Transformation Programme (HTP) Report** *Mr Nisbet and Mr Tapp joined the meeting.* The Board of Directors received the report from the Director of Strategy and Planning, who introduced Mr Nisbet and Mr Tapp.	

	Mr Preston summarised key highlights from the report and stated that the programme timelines and goals had been 'reset', now that the impact of the pandemic on the Trust was reducing. Mr Preston reported that the finalisation of the HTP Strategic Outline Case was critically dependent on the System Long Term Plan and also confirmed that a bi-monthly report would be submitted to the Board of Directors outlining programme progress. Mr Tapp provided background to the changes in the models of care that were developed as part of the Future Fit consultation and will be delivered through HTP. These will provide a system-wide approach to the delivery of high quality NHS care. The models chosen consolidated the majority of emergency services on the Shrewsbury site, co-located with all the specialties required by patients attending the Emergency Department and supported by a correctly staffed, and sized, ITU together with adequate bed numbers. The approach was consistent with the development of Same Day Emergency Care and community delivered admission avoidance schemes. Both hospitals would have Urgent Treatment Centres and the centre on the PRH site would be enhanced to ensure that patients who did not need admission to hospital, could be seen locally. The majority of planned care services would take place on the Telford site, resolving the systemic risk of unplanned and planned care pathways becoming mixed, with a separation of patient flows. Mr Tapp suggested that one of the impacts of the current model of care had been recruitment failure, causing a subsequent reliance on agency staff. Resourcing both hospitals with the right number of highly skilled staff to provide a wide range of patient services had become increasingly challenging. Prof. Deadman suggested that the positive benefits of the plan for patients should be promoted to stakeholders, highlighting the potential for a centre of excellence and reduced service leakage out of the county. Mr Tapp agreed and confirmed that this would be addressed within the Strategic Outline Case. Dr. McMahon sought assurance that the HTP would incorporate learnings from COVID-19 for example, sufficient single rooms to ensure patient dignity and respect, recognition of local environmental strategies, and the developing national/regional digital agenda. Mr Nisbet confirmed that in order to progress through the national application process, these questions would need to be addressed in the HTP plan and design solution. Mr Preston noted that two of the main causes of the increase between the original costing of £312m (2016 Draft SOC) and the revised costing of £533m (November 2019 Draft SOC), resulted from changes in inflation indices (£134m) and changes to accounting policy (£28m), neither of which were associated with changes to the scope of the programme. The Board of Directors noted the report.	ACTION

	Mr Nisbet and Mr Tapp left the meeting.	
OPERATIONAL REPORTING		
102/21	**Integrated Performance Report [M12]** The Board of Directors received the report from the Interim Director of Strategy and Planning. Mr Preston drew the Board's attention to the executive summary, stating that the report continued to be refined, that the benchmarking process was progressing and there was an increasing focus on forward actions. **Quality** Mrs Flavell confirmed that the Trust had not met the annual reduction in methicillin-susceptible *Staphylococcus aureus* (MSSA) in the financial year 2020/21, with four cases above the target. The Trust had had two methicillin-resistant *Staphylococcus aureus (*MSRA) in 2021, with the most recent being in March 2021. Whilst the Trust had seen a reduction in falls, we remain focused on training and ensuring a review of each fall within 24 hours. It was noted that COVID-19 had impacted the Trust's use of same sex accommodation during 2020/21. Mitigations, supported by the reduction in COVID-19 patients, were in place. Mrs Flavell confirmed, in response to a question from Mr Preston, that a deep dive into the recent rise in the number of pressure ulcers was currently underway. **Operational** Mr Lee confirmed that COVID-19 levels had reduced significantly in March 2021, together with a reduction in patient numbers in Critical Care and a reduction in the mutual aid staffing with partners. Maintaining infection control standards and the management of pathways (Red – known, or high risk of being COVID-19 positive, Amber - COVID status unknown, and Green - confirmed COVID negative elective patients) remains critical, despite the reduction in numbers. Significant backlogs remained with prioritisation being clinically lead, with focus on the highest priority patients. Activity in A&E increased in March 2021 and improvement work on patient flow had been undertaken. The Emergency Department continued to focus on their quality metrics, including benchmarking against other organisations. **Workforce** Ms Boyode wished those Trust staff members, whose families were in India, well and acknowledged the enormous contribution they were making to the Trust during the pandemic.	

Ms Boyode highlighted from the report, safety culture, health and wellbeing, quality of care and staff morale as the key areas of focus. Staff needed to believe they could deliver quality care to all patients, she said. The Trust's focus was currently on the skill set required to deliver the right care, including support from military personnel, retirees, volunteers, and temporary agency staff to support this work.

Quality of care emerged as an important issue in the recent staff survey, Ms Boyode reported. The Trust remained below the target for mandatory training (90%) which was currently at 85%. Executives were being encouraged to ensure that all staff were given the time to complete training, recognising competing challenges from annual leave, sickness demands and any impact from the supernumerary status of new staff.

Mr Brown endorsed the healthy upward trend in the number of Whole Time Equivalent (WTE) staff. Ms Boyode confirmed that a report would be coming to a future Board of Directors' meeting that will include a forecast the reduction of agency staff as a result of an improvement in sickness absence, recruitment and retention.

International nurse recruitment would be subject to the outcome of the COVID-19 issues emerging in India.

Finance
Ms Troalen reported that the draft month 12 position showing a surplus of £4.2m for the YE 2020/21. The full year accounts would be subject to the external audit process.

A significant shift in the value of the Trust estate, the reevaluation of which is undertaken every 5 years, was included in the accounts for 2020/21, reflecting positively on the I&E position. This will be stripped out of the performance position, resulting in the Trust reporting a deficit of £3.8m. A provision of £6m for carrying forward staff annual leave for YE 2021/22 and beyond, had been included. The capital position for YE 2020/21 was £43m.

Ms Troalen explained that External Financing Limit (EFL) was the amount of cash that the Trust was expecting to hold at the end of the year. Whilst the Trust was holding more cash than expected due to COVID-19, Ms Troalen advised that it was not an outlier when benchmarked against other Trusts.

Mr Bristlin mentioned that Mr Drury, Mrs Clarke and the Estates Team, were instrumental in making sure the capital expenditure for YE 2020/21 was committed.

Transformation
Mr Preston reported that the overall performance status of the programme was similar to April 2021 and that delivery was continuing to progress well. Ambitions and plans for Phase 2 of the programme (2021/22) are now being developed.

The Board of Directors took assurance from the report.

103/21	**Public Participation Report** The Board of Directors received the report from the Director of Corporate Services. Mrs Clarke reported that the Department of Community Engagement Volunteers and the Trust's Charity had been merged to form the Public Participation team, which was being managed by Hannah Roy. A Social Inclusion Facilitator had been appointed by the Trust to manage the community engagement work being undertaken with hard to reach groups. A number of health lectures had been successfully held. Work was underway to restore the 500 Trust volunteers recently paused during COVID-19, following guidance from NHS England, and it was noted that the Trust now had 88 young volunteers providing 352 hours / 10 WTE of ward support to staff and patients by meeting and greeting, supporting discharge, deliveries to patients on wards. Income and donations in-kind into the Trust's Charity had been maintained notwithstanding COVID-19. The NHS Charities Together stage two bid of £222.7k for 9 organisations across Shrewsbury, Telford and Wrekin, plus the stage 3 bid of £143k for improvements to the outdoor environment, had both been successful. The Board of Directors took assurance from the report.	
104/21	**Estates & MES Quarterly Report** The Board of Directors received the report from the Director of Corporate Services. Mrs Clarke reported on the highlights from the newly formatted report. Mr Brown commented on the percentage of high level reactive maintenance jobs delivered in 2020/21 (due to backlog) and their relationship to the aged estates, enquiring into the role that this information would play in discussions regarding the investment for the HTP. Mr Preston confirmed that this work is being incorporated into the development of the SOC. It was noted that the Trust had managed circa 10,000 planned and reactive maintenance jobs in the last three months. Mr Bristlin praised the MES Team for their efforts. The Board of Directors noted the report.	
ASSURANCE FRAMEWORK		
105/21	**The Ockenden Report – Action Plan** *Mr Underwood, Dr. Hon, Ms McDonnell joined the meeting.*	

	The Board of Directors received the report from the Director of Nursing, and were asked to take assurance from the report. Mr Underwood, in response to a question about the rate of C Sections and inductions of labour undertaken at the Trust, confirmed that the Trust's C Section rates were in line with a national increase of 3-4% across the UK and were probably a reflection of patient choice. Dr. Hon suggested that, whilst the induction rate was in line with a national trend, there may also be a data quality problem - confusion between the coding of the terms 'induction' and 'augmentation'. Mrs Flavell highlighted key issues from the report including the update on the Ockenden Report actions for April 2021. She confirmed that a Maternity Transformation Assurance Committee, chaired by her, had been convened for oversight of the delivery and evidencing of Ockenden Report and Maternity Transformation Plan actions. As of April 2021, 15 actions had progressed from 'not yet delivered' to 'delivered but not yet evidenced', 45 actions were on track, and 4 were off track. Three of the four off-track actions related to actions that required input / action by the region / system as a whole. In response to a question from Prof. Deadman, Ms Troalen confirmed that the organisation was working with the System to ensure there the Trust would not experience non-delivery of the required actions due to lack of funding and the System triple lock financial process., It was noted that the Trust is required to deliver efficiencies, as well as develop robust cases to support the prioritisation of quality, safety, and investment. Mr Wright confirmed that implementation of Ockenden Report actions was progressing at pace. Dr. Hon confirmed that the timeframe for delivery of the Ockenden Report Action Plan was realistic, and Mr Wright confirmed that that the Board of Directors would be advised if progress or delivery of any of the actions, was seriously behind plan. Dr. Hon, in response to a question from Mr Preston, confirmed that whilst work was being undertaken to ensure the Trust appropriately engaged with the community, it would take some time before evidence of that embedded relationship could be provided. Mrs Clarke extended an invitation for Dr. Hon to attend one of the regular community engagement meetings held by the Trust. The Board of Directors took assurance from the report.	
106/21	**Board Assurance Framework** The Board of Directors received the report from the Director of Governance and Communications. Ms Milanec reported on the work being undertaken to update the document for 2021/22 and sought approval to close 2020/21 using the existing 2020/21 BAF, as at 31 March 2021 (year-end - YE) and as recommended by the ARAC; approval of the new risk descriptors (1-9) for the BAF YE 2021/22, as agreed at the Board of Directors'	

	seminar, including allowance for recent developments; and approval of the draft BAF risk descriptors (10-11) for the BAF 1021/22 not previously seen by ARAC and the Board of Directors' Seminar. The Board of Directors approved the first two elements of the proposal. However, with regard to the draft descriptors 10 - 11 for the BAF YE 2021/22, it was agreed that these would be further discussed at a future Board Seminar.	
107/21	**Risk Management Report** The Board of Directors received the report from the Director of Governance and Communications and were asked to take assurance from the report. Ms Milanec confirmed that all risks at the Trust with a residual risk value of 15 and above (the net risk remaining after mitigations had been factored in) would be submitted to the Board of Directors' meetings quarterly, together with the BAF. Focus over the next few months would be on reviewing the older risks and mitigations. Consideration would be given to convening an Operational Risk Management Committee responsible for oversight of operational risks. Dr. McMahon suggested that the Risk Management Report submitted to future Board of Directors' meetings included significantly deteriorating risks regardless of their rating. Ms Milanec confirmed that as at 31 March 2021 the Trust had 460 risks logged onto the register. Dr. McMahon suggested that thought be given to how the Trust might develop a risk management culture. Ms Milanec and Ms Boyode agreed that a collaborative approach would be worthwhile. Mr Bristlin suggested that an assurance pathway for risk management should be identified to ensure a robust audit trail to the Board of Directors. The Board took assurance from the report.	
REGULATORY AND STATUTORY REPORTING		
108/21	**Report from the Responsible Officer** The Board of Directors received the report from the Acting Medical Director. Dr. Jones reminded the Board of Directors that the Responsible Officers (RO) role was statutory and responsible for monitoring the performance of doctors by undertaking annual appraisals, culminating in 5-yearly revalidation of doctors not in training. .	

	Dr. Jones summarised the key components of the report including the appraisal process; the impact of COVID-19 in the Trust; the rescheduling of 2020/21 revalidations as detailed by the GMC; and the management of missed appraisals and the fit-to-practice process. Dr. Jones confirmed that the next submission to the GMC was due in September 2021. In response to a question from Mr Preston about the inclusion of performance measures in appraisal, Dr. Jones and Mr Steyn pointed out that the framework for medical appraisal linked to revalidation was not intended for performance management. Performance management should be included, instead, within the job planning process. The Board of Directors took assurance from the report.	
109/21	**Learning From Deaths Report** The Board of Directors received the report from the Acting Medical Director. Dr. Jones highlighted key aspects of the report, in particular the data sets for mortality benchmarked across organisations. It was reported that the Trust's mortality, as measured by the RAMI currently sat at <100 although it had been higher during the COVID-19 outbreaks. The increase in mortality during COVID-19 was being investigated; as a result of COVID-19, all mortalities at the Trust would be investigated internally by a medical examiner who was independent of the patient's care, and who had the authority to refer cases to the Coroner. It was noted that as from May 2021, all COVID-19 related mortalities would be deemed as an SI. A peak in SIs was anticipated nationally after May 2021. Dr. McMahon invited Dr. Jones to consider including a category for learning disability mortalities in the report. The Board of Directors took assurance from the report.	
110/21	**Freedom To Speak Up Guardian's Report** *Ms Turner joined the meeting.* The Board of Directors received the report from the Freedom To Speak Up Guardian (FTSUG), Ms Turner. Ms Turner confirmed there had been a 200% increase in FTSU contacts reported in 2020/21 against a national increase of 34%. The increase suggested the emergence of a positive and confident response by staff within the Trust to speaking up, but she cautioned	

	that it was too early to be sure; the situation would be closely monitored. Ms Turner highlighted key aspects of the Quarter 4 report and End of Year position, stating that nurses, in line with the national average, were the group who spoke up the most, with a focus on safe staffing numbers. Junior Doctors, deemed the hardest group to reach nationally, were also speaking up more, and in Quarter 4, a significant rise in Midwives speaking up, had been noted. Dr. McMahon suggested that the increase in reporting could be due to a general increase in unhappiness, as distinct from an increase in confidence to speak up, and she asked the FTSUG what they were hearing to suggest it may be the latter and not the former. Ms Turner reported there had been a number of positive signals including receipt of positive feedback by the FTSU team, and soft intelligence on the ground. Mr Lee suggested, by way of an example to support an increase in incident reporting overall, that it be viewed as positive in order to encourage reporting as part of an open and honest culture. Mrs Boughey asked what more the Board of Directors' could do to support the FTSU Guardian. Ms Turner confirmed that a Business Case for additional staff and a database had been submitted to finance for approval and the outcome was pending. The Board of Directors took assurance from the report. *Ms Turner left the meeting.*	
BOARD GOVERNANCE		
111/21	**Standing Financial Instructions Annual Review** The Board of Directors received the report from the Director of Finance, Ms Troalen. Ms Troalen summarised the SFI annual review, emphasising changes following the previous review, and the work that was required to improve the SFI process. In response to a question from Mr Preston, Ms Troalen suggested that mention in the document of the current financial position with the system was being considered for future iterations. Ms Troalen confirmed that a further revision would be undertaken in 6 months with an extensive review in 12 months. The Board of Directors approved the revisions to the SFIs.	
112/21	**Quality & Safety Assurance Committee Report** The Board of Directors received the report from the Committee Chair, Dr. Lee.	

	Dr. Lee highlighted the Trust's dependency on IT systems to deliver assurances required, with particular reference to Badgernet and the new A&E system. The Board of Directors took assurance from the report.	
113/21	**Finance & Performance Assurance Committee Report** The Board of Directors received the report from Mr Brown on behalf of the Committee Chair, Prof. Deadman. Mr Brown highlighted a reduction in sickness levels and staff turnover rates; delivery of the key capital schemes on time and within budget; and appointment to the Trust of the Authorised Competent Person responsible for overseeing a range of regulatory appointments. The Board of Directors took assurance from the report.	
114/21	**Audit & Risk Assurance Committee Report** The Board of Directors received the report from the Committee Chair, Prof. Purt. Prof. Purt suggested a need to consider a review of the waiver process in light of 46 waivers (£7m) requested recently. Ms Troalen suggested that whilst a number of the tender waivers were due to the speed with which the vaccination programme had been implemented, an investigation was currently underway with procurement. The Board of Directors took assurance from the report.	
115/21	**Ockenden Report Assurance Committee Report** The Board of Directors received the report from the Committee Chair, Dr. McMahon. Dr. McMahon confirmed that the second multi-stakeholder ORAC meeting had been held on 22 April 2021. It was noted that it had been live streamed to the public, attended by the Trust's Alliance partners, and had been chaired by Jane Garvey, one of two co-chairs. Three items were covered at the meeting, IEA Theme 1 (enhancing safety), LAFL Theme 2 (maternal deaths) & 4 (neonatal services) and common themes were identified, including the importance of audit capacity, implementation of Badgernet etc. The dates for future meetings in public were confirmed. The Board of Directors took assurance from the report.	

	Mr Underwood, Dr. Hon, Mr Wright, and Ms McDonnell left the meeting.	
116/21	**Any other Business** There was no further business.	
117/21	**Date of next Board of Directors' meeting in public:** 13:00 on Thursday 10 June 2021. Via MS Teams	

STAKEHOLDER ENGAGEMENT

It was noted that the number of questions from members of the public, was continuing to increase on a monthly basis, which were gratefully received, with the Board seeking to respond to all questions relating to the Board agendas.

Ms Milanec highlighted that the themes arising from the questions asked were consistent and mainly referred to quality and safety of care, HTP, and maternity matters.

The Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospital NHS Trust
Board of Directors' meeting in PUBLIC

Thursday 10 June 2021 via MS Teams (and live streamed to a public audience)

MINUTES

Name	Title
MEMBERS	
Dr C McMahon	Chair
Mrs L Barnett	Chief Executive
Mrs T Boughey	Non-Executive Director
Mr A Bristlin	Non-Executive Director
Mr D Brown	Non-Executive Director
Prof C Deadman	Non-Executive Director
Mrs H Flavell	Director of Nursing
Dr J Jones	Acting Medical Director
Dr D Lee	Non-Executive Director
Mr N Lee	Chief Operating Officer
Prof T Purt	Non-Executive Director
Mrs H Troalen	Director of Finance
IN ATTENDANCE	
Ms R Boyode	Acting Workforce Director
Mrs J Clarke	Director of Corporate Services
Ms A Milanec	Director of Governance & Communications
Mr C Preston	Interim Director of Strategy & Planning
Mr R Steyn	Co-Medical Director
Ms C West	Improvement Director
Mr M Wright	Programme Director, Maternity Assurance
Mr M Underwood	Medical Director, Women & Children (Item 132/21)
Ms B Barnes	Board Secretariat (Minutes)
APOLOGIES	
Dr A Rose	Medical Director

No.	ITEMS	ACTION
PROCEDURAL		
119/21	**Welcome and Apologies** The Chair welcomed all those present, and observing members of the public attending the meeting via the live stream. Apologies were noted.	

120/21	**Patient Story** The Director of Nursing introduced the patient story, presenting a video in which a patient spoke about the issues he experienced due to a lack of guidance and available assistance for the free disabled parking process when visiting our hospital sites at the weekend. The Board of Directors noted the patient story and was pleased to learn from the video account that he had received a timely initial response when he had highlighted his issues to the Trust, and that his ongoing feedback had been sought on the resolutions proposed. This had resulted in the speedy introduction of guidance posters for patients in numerous locations across the Trust. The Board of Directors asked that Mrs Flavell express recognition and compliments to the Patient Experience Team for such positive and speedy engagement and implementation, which it was noted, would result in an improved experience for patients who attend our hospitals going forward. The Chair requested the inclusion of a staff story on the agenda of the next Board of Directors' meeting, and suggested the rotation going forward of a staff story at every third meeting, with patient stories presented at each of the meetings between.	**ACTION**
121/21	**Quorum** The Chair declared the meeting quorate.	
122/21	**Declarations of Conflicts of Interest** No conflicts of interest were declared that were not already declared on the register. The Chair reminded the Board of Directors of the need to highlight any interests which may arise during the meeting.	
123/21	**Minutes of the previous meeting** The Chair advised that, due to unforeseen Board secretariat resource issues, the minutes of the meeting held on 6 May 2021 were not yet ready for approval. A draft version had been circulated with the meeting papers for information, and the Chair asked that the Board of Directors review and forward any amendments by email to Ms Milanec following the meeting. The Chair invited the Board of Directors to raise any materially urgent comments or errors in the minutes that should be highlighted at this stage. In this regard, Dr McMahon requested a correction to the second sentence of Item 099/21, Report from the Chair. It was noted this	**ACTION**

	should read that Dr McMahon had been appointed as Vice Chair (not Chair) of the Shrewsbury, Telford and Wrekin Integrated Care System (ICS) from 1 April 2021. The Board of Directors noted that the final draft version of the minutes would be presented at the July meeting for approval.	
124/21	**Action Log** The Board of Directors reviewed the action log, and noted the request to further extend the deadline against Action 52/20, Waiting List Initiatives (WLI). The Acting Medical Director clarified that, due to the Covid-19 pandemic, the process has been delayed around one remaining action relating to additional clinical activity. It was agreed that this would be reported to the Audit and Risk Assurance Committee, for subsequent noting by the Board of Directors. The Board of Directors noted that there were no further actions due for review at this meeting.	
125/21	**Matters Arising** No other matters were raised which were not already covered in the action log or agenda	
STRATEGIC MATTERS		
126/21	**Report from the Chair** The Board of Directors received the report from the Chair. Dr McMahon highlighted that the report focused on the introduction of a formalised process for the management of questions from members of the public. The Board of Directors noted the details contained in the report, and acknowledged that answers provided to questions from the public would also be used to inform the way the Trust engages with its communities going forward.	
127/21	**Report from the Chief Executive** The Board of Directors received a verbal report from the Chief Executive. Mrs Barnett highlighted the following key points: • The current low number of Covid patients in Trust hospitals; • Acknowleding the current long waiting times as a result of the challenges of the pandemic, she advised that colleagues across the	

	Trust are working intensively, in conjunction with system partners, to restore services; and • The Trust remained highly committed to delivering its Getting to Good and Maternity Transformation Plans. Mrs Barnett clarified that reports against subsequent agenda items provided detailed information relating to the above matters. The Board of Directors noted the verbal report.	
128/21	**Risk Management Strategy and Policy** The Board of Directors received the report from the Director of Governance and Communications, and were asked to approve the strategy and policy documents, which set out a short/medium term strategy and methodology for the management and mitigation of risks within the organisation. Ms Milanec reported that, following feedback from members of the Audit and Risk Assurance Committee at their meeting of the previous day, the following amendments had been been proposed: • Unclear risk appetite wording would be deleted from page 8 of the strategy as appropriate • Reference to risk appetite to be added to page 48 of the policy. In response to a request from Committee members, Ms Milanec undertook to also provide clarification of the different types of risk registers in the documents. Dr Lee suggested that there should be more explicit reference to infection prevention and control within policy listings. Ms Milanec thanked Mr Lee for this suggestion, and confirmed that this would be considered. Following the recommendation of the Audit and Risk Assurance Committee, the Board of Directors approved the Risk Management Strategy and Risk Management Policy, subject to the above noted amendments.	**ACTION**
OPERATIONAL REPORTING		
129/21	**Integrated Performance Report** The Board of Directors received the report from the Chief Executive, Mrs Barnett who referred to her executive colleagues in order to provide more detailed information for the Board. **Quality Summary** Mrs Flavell highlighted that infection prevention and control indicators were delivered in accordance with plan for both MRSA and C.difficile,	

	however the number of infections reported for MSSA and e.Coli exceeded the improvement plan trajectory. She provided assurance to the Board of Directors that all infections were thoroughly investigated and action plans developed. It was noted that there were 25 Serious Incidents (SIs) open at the end of April 2021, across all four divisions of the Trust, with 9 reported in month. Mrs Flavell provided assurance to the Board of Directors that all SIs were comprehesively investigated within defined timelines, and none are overdue against deadline. There was a continued increase in the volume of falls in April, at a level higher than the improvement trajectory. Mrs Flavell confirmed that the number of falls remained a key area of focus for improvement. Venous thromboembolism (VTE) performance showed a sustained improvement, however, it was slightly below target in April. Dr Jones reported that further improvements were being introduced, to strengthen delivery of patient care and risk mitigation. Mr Bristlin observed, with regard to one of the maternity indicators, that the Trust was considerably higher than the end of year 6% target for 'smoking rate at delivery'. He therefore suggested that it would be beneficial to consider reporting against a trajectory rather than a specific target. Prof Mr Deadman and Mr Brown endorsed Mr Bristlin's observations and expressed the view that trajectories should be included, which will help inform porgress gaianst relevant plans. In response to a query from Mr Brown on the Trust's complaints process and volumes, Mrs Flavell advised that a review of the complaints' process had been completed, and a deep dive undertaken by the Quality and Safety Assurance Committee (QSAC). The Trust was working closely with the Patient and Carer Experience (PACE) panel, and Mrs Flavell was pleased to advise that the Trust's Patient Experience Lead was proactive and innovative in her approach. The Board of Directors noted that QSAC would be the primary forum for assurance relating to complaints going forward. **Covid-19 and Operating** The Chief Operating Officer highlighted the continued emphasis on separate infection control pathways, and noted that recently published national infection control guidance strongly reaffirms the importance of maintaining this approach. Mr Lee provided assurance to the Board of Directors that the Trust continued to make progress in the restoration of services and the reduction of the current waiting list levels, although longer waiting times were expected to continue throughout 21/22. He reported on proposals to expand capacity to support increased activity that will help to address clinically urgent care and help manage the length of waiting times for our patients.	

The Board of Directors noted that the Trust continued to monitor activity against the levels set in the national planning guidance thresholds. Dr McMahon queried whether reporting against phased targets could be introduced, rather than using static national targets for recovery plans. Mr Lee responded that he has been in discussion with the Trust's Head of Performance in this regard, and additional information had been requested for submission to the Finance and Performance Assurance Committee to consider this matter.

Prof Purt requested clarity on the total emergency admissions figure from A&E, and Mr Lee confirmed that the figure is not the same as the conversion rate. Prof Purt suggested that the conversion rate is probably therefore a more valuable source of information in determining whether there are increased levels of acuity or risk averse decision making at the front door. Mr Lee reported that the Shropshire system has a major programme of work underway looking at solutions for emergency admission avoidance.

Dr McMahon added that it would be useful to consider which reporting aspects should act as a trigger and which are for information.

Workforce

Ms Boyode was pleased to report that sickness levels continued to remain low. She highlighted, however, that many instances of staff sickness absence were mental health related; the Board of Directors was assured to note the extensive support options offered to colleagues by the Trust in this regard.

Ms Boyode added that restoration and recovery of services was also creating pressure for colleagues. She reported that the Trust was working closely with agencies on staffing requirements.

Prof Purt suggested that whilst acknowledging there is no national target for temporary/agency staffing, it would be helpful to include a local target. He also observed that the percentages shown for vacancies required greater clarity than the chart in the report currently represents.

Mr Brown queried the reason for a reduction in temporary staffing numbers and Ms Boyode clarified that this was a result of the Corporate Nursing team focusing extensively on better utilisation of workforce.

Ms Boyode highlighted the key requirement to focus on flexibility for our colleagues in the interests of staff retention, particularly in Nursing and Midwifery, where feedback has shown there was an identified need for greater flexibility to assist colleagues in balancing the demands of work and home life.

In response to a query from Dr McMahon, Ms Boyode clarified that improvements to rostering would be a key retention solution, by providing colleagues with greater notice to work. Discussion also took

	place on the impactfulness of bank work and whether colleagues had flexibility to either work or not work bank shifts. Mrs Boyode commented that she would welcome the opportunity to discuss the current position and proposals for improved flexibility at a future meeting. Mrs Barnett highlighted that there was an opportunity to share good practice across the organisation with regard to flexibility, noting that some areas were operating more flexibly than others. She also referred to the additional communication channels that were available to colleagues, which were encouraging feedback and esclation of issues. Ms Boyode reported that the Trust's mandatory training completion rate was still below target and that Workforce were working with the Divisions to carry out a deep dive in this regard. She also advised that it has been identified that other Trusts benefit from a dedicated business unit to coordinate training on behalf of the clinicians. In light of the challenges on the capacity of clinical staff it was proposed that this approach be introduced in the Trust, and it was noted that a business case was being prepared in this regard. **Finance** Mrs Troalen highlighted that the Trust is operating within a temporary financial regime for the first six months of the 2021/22 financial year (H1). A H1 deficit plan for the Trust of £3.998m had been agreed with system partners and NHSE/I. Mrs Troalen further confirmed that the capital budget was separate to revenue, and that the Trust was operating within a 12 month budget for capital. In response to a query from Dr McMahon, Mrs Troalen confirmed that all of the capital budget has been allocated. Mrs Troalen provided an assessment of the Trust's efficiency programme readiness. She highlighted that efficiency plans had been disrupted over the last 12 months due to the pandemic, however an efficiency programme had been stood up over the last 8 weeks. Finance had engaged with each Division to set out why efficiency was important, and the Divisions were keen and willing to be part of the programme. Mrs Troalen reported that there were over 100 efficiency programmes currently in the pipeline. The Trust had very recently welcomed a seconded NHSE/I Head of Efficiency, who would lead on ensuring appropriate focus on key programmes, in addition to the introduction of a multi-year programme. Mrs Troalen reported that she would be presenting a formal request in this regard to the Finance and Performance Assurance Committee before submission to the Board of Directors in July. Prof Deadman asked if there were any plans to re-name the current Cost Improvement Programme, to something more engaging, in the interest of involvement and understanding from staff in the Trust's efficiency journey. Mrs Troalen acknowledged this point and invited the	

	Board of Directors to contact her direct with any suggestions on a new title for the programme. **Transformation** Mr Preston drew the attention of the Board of Directors to the progress made in embedding quality improvement across the Trust, alongside the challenges of managing the pandemic and delivery of the vaccination programme. He highlighted that specifically the refresh of the Maternity Transformation Plan to incorporated the Ockenden report actions; estate improvements; culture work; and the Hospitals Transformation Programme. Phase 2 of the Getting to Good (G2G) programme would commence in July 2021, building upon the foundations of the work completed to date. Discussion took place on how the relationships with our improvement partners, University Hospital Birmingham (UHB) and Sherwood Forest Hospitals Foundation Trust (SF) were having a positive impact on the Trust's improvement journey. Mrs Barnett confirmed that the Trust was working closely with both partners, and Mr Steyn added that working relationships were very positive through two way sharing of experiences and a supportive approach from our partners. Dr McMahon requested that an acronym guide be included in future reports. Discussion took place on a view put forward by Prof Purt that improvements could be made to the format of the IPR in terms of a more defined link with the Board Assurance Committees. As Mr Preston highlighted this was more complex than it might appear it was agreed that this would be discussed further outside of the meeting. The Board of Directors noted the Integrated Performance Report.	**ACTION**
130/21	**Annual Report from the Director of Infection Prevention and Control (DIPC)** The Board of Directors received the report covering the period 1 April 2020 to 31 March 2021, presented by the Director of Nursing/DIPC. Mrs Flavell reported on recent positive feedback from the national team, and acknowledgement that the Trust's Infection Prevention and Control (IPC) management was now much more robust than previously. She also advised that a review visit is scheduled to take place by regional colleagues in July 2021. Mrs Flavell was also pleased to report on the forthcoming introduction of ICNET software, an automated IPC surveillance system.	

	Dr Lee added that the pandemic has clearly brought IPC into sharp focus, and he acknowledged the positive contribution that the above investment will deliver for the Trust. The Board of Directors noted the IPC Annual Report.	
131/21	**Safe Nurse Staffing Bi-Annual Report** The Board of Directors received the report presented by the Director of Nursing. Dr Lee referred to Item 2.4 of the report stating that during January 2021, the divisions met the national requirement overall of a ratio of 1:8 colleagues maximum. He suggested that the wording be amended, based on his understanding that the ratio should not exceed 1:8. Dr Lee also proposed the inclusion of a trackable actions summary to enable the Board of Directors to seek greater assurance around safe staffing where necessary. Mrs Flavell responded that this information would be included going forward, initially through submission to the Quality and Safety Assurance Committee. Mr Bristlin referred to Item 5.3 of the report, which implied that the level of Care Hours per Patient Day (CHPPD) on Ward 7 had an impact on falls and other issues as detailed. Mrs Flavell provided assurance that staffing meetings were underway to ensure improvements were delivered. The Board of Directors took assurance from the report, subject to the points made above.	**ACTION**
ASSURANCE FRAMEWORK		
132/21	**The Ockenden Progress Report** The Board of Directors received the report, presented by Mrs Flavell, Mr Underwood and Mr Wright, providing an update to the Trust's Ockenden Report Action Plan and other related matters. Mrs Flavell reiterated the Trust's very positive relationship with Sherwood Forest Hospitals NHS Foundation Trust (SF), reporting that they have recently completed a clinical immersion visit and a maternity safeguarding peer review. She advised that the Trust was also being supported by an NHSE/I adviser. Mr Underwood added that SF were highly complimentary following observations on their immersion visit, and he informed the Board of Directors that he and colleagues would be visiting SF in coming weeks. The Board of Directors asked that their thanks be relayed to maternity colleagues with regard to their contribution to the partnership work with SF.	

	Dr McMahon added that the External Expert Advisory Panel (EEAP) had also made recognition of the work Mr Underwood and his teams were undertaking. Prof Deadman queried how the programme expenditure was being managed, and made the point that finances should be seen as a solution to improving patient experience, not an issue in terms of available funding. Mr Bristlin additionally highlighted the governance around the financial elements of the programme, in particular through the Maternity Transformation Assurance Committee. In response to a query from Mr Preston, Mrs Flavell provided assurance on progress against due dates within the Action Plan. Mr Wright added that, whilst not in a position to guarantee delivery dates, the Trust would be transparent on the reasons for any slippage, should this occur. The Board of Directors noted and took assurance from the report *Mr Underwood left the meeting.*	
133/21	**Guardian of Safe Working Report** The Board of Directors received the report presented by the Acting Medical Director. Dr Jones drew attention of the Board of Directors to Item 2.31 of the report with regard to an ongoing issue regarding the weekend cover in Surgery Division. He provided assurance that a strategy to address the concerns highlighted in the report, had been presented to the Guardian of Safe Working Hours. Ms Boyode added, in response to a query from Dr McMahon, that a good relationship exists with the GoSW and there was a great deal of transparency at union meetings with regard to Junior doctor voices and issues. Dr Lee observed that there some cases where locums have significantly exceeded 48 hours per week, and he asked what action the Trust takes in this regard. Dr Jones responded that he will conduct further investigation on this matter and report back to the Quality and Safety Assurance Committee. The Board of Directors noted the report.	**ACTION**
134/21	**Review of our Disciplinary Process** The Board of Directors received the report presented by the Workforce Director, which provided an update on the Trust's response to letters from Baroness Dido Harding (Chair of NHS Improvement) in 2019 and Prerana Issar (NHS Chief People Officer) in 2020, providing guidance	

	relating to the management and oversight of disciplinary investigations and procedures for NHS Trusts. It was noted that a correction was required to Item 2.24 of the report, removing reference to the Workforce Committee, as investigations and outcomes were now reported to the Board of Directors quarterly. Mrs Boughey queried how the Trust was linking with the Diversity and Inclusion Lead to ensure decision making was as free from bias as it possibly could be. Ms Boyode responded that this fed into the Trust's cultural leadership programme and there is strong recognition of the need to ensure there is fair representation through processes and level of equaility on panels. Dr Jones also advised that there was a very significant impact when an individual was put through a formal investigation process, and early decision making was critical. Ms Boyode responded that there is a powerful link with how lessons are learned and ensuring people have an opportunity to feel safe to share concerns and speak up when things have not gone right. In response to a query from Mr Steyn with regard to whether different staff groups were being treated in a fair manner, Ms Boyode confirmed that the Trust's aim is was ensure a fair and compassionate culture across the organisation. Dr McMahon observed that there was no reference in the report to the Trust supporting colleagues to return to work and reintegration into the workplace. Ms Boyode acknowledged this and agreed to consider further. Ms Boyode acknowledged a point made by Mrs Boughey urging caution around the extent of secondments for returning colleagues, highlighting that this should not necessarily be the default option. The Board of Directors noted for assurance the current position within the Trust, the improvements already made and the further improvements that were taking place.	
BOARD GOVERNANCE		
135/21	**Quality and Safety Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Committee Chair. Dr Lee reported the Committee's growing concern with regard to the delayed introduction of information technology across the Trust. He stressed the need to ensure that the Trust was highly functional in this regard as these systems would generate the information that will provide the quality of assurance the organisation aspires to.	

136/21	**Finance & Performance Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Committee Chair. Prof Deadman informed the Board of Directors of the Committee's intention to hold focused sessions on digital developments, and workforce issues. Findings would be reported back to the Board of Directors in future meetings. It was further noted that the Trust's Digital Roadmap would be presented at the next Board of Directors' meeting.	
137/21	**Audit & Risk Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Committee Chair. Prof Purt highlighted that, following the recent cyber security review, risks and issues need to be incorporated in the work referred to in the previous items.	
138/21	**Ockenden Report Assurance Committee Monthly Report** The Board of Directors received and noted the report, presented by the Committee Co-Chair, covering the third live streamed meeting of the committee which had been held on 27 May. Dr McMahon highlighted that a significant level of thanks was provided from the Committee to the teams involved in providing updates at the meeting. Noting that the Committee reviewed all of the questions that had been submitted by members of the public, together with the Trust's responses, from the meeting in March, Dr McMahon observed that no questions had been received for the Committee in April. She took the opportunity to encourage women, families and members of the public to get in touch with any questions that they may have.	
139/21	**Ockenden Report Assurance Committee Terms of Reference** The Board of Directors received and approved the final draft of the Committee Terms of Reference	
PROCEDURAL ITEMS		
140/21	**Any Other Business**	

	The Chief Operating Officer drew the attention of the Board of Directors to a number of capital business cases with regard to capacity, as referenced in the earlier Finance and Performance Assurance Committee Monthly Report. Mr Lee requested the Board of Director's ongoing support for these cases; Prof Deadman endorsed this request.	
141/21	**Date and Time of Next Meeting** **The next meeting of the Board of Directors was scheduled for Thursday 8 July 2021, commencing at 1300hrs. The meeting would be live streamed to the public.**	
STAKEHOLDER ENGAGEMENT		
	Response to questions from the public The Chair referred to the introduction of a formalised process for the management of questions from members of the public, as covered in her earlier report. Dr McMahon informed the Board of Directors that analysis of the questions would be included in the quarterly Public Engagement report presented by the Director of Corporate Services. Ms Milanec highlighted that key recurring themes for comments and questions recently had been the Hospitals Transformation Programme (HTP), and patient safety. She confirmed that analysis of these will also be included in the above quarterly report. The Director of Corporate Services informed colleagues and observing members of the public joining the meeting via live stream that Mr Preston, Director of Strategy and Planning, would be attending the Trust's Community Cascade Group virtual meeting on 30 June 2021, and the whole two hour meeting would be dedicated to the HTP. Members of the public were invited to register on the Trust website through Eventbrite. Mrs Clarke also confirmed that all Community Cascade Group sessions are recorded and published on the Trust's website so that they could be accessed at a later time.	
	The meeting was declared closed.	

Board of Directors **Action Log - Public Meeting**

Date of meeting	Agenda item	Item	Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer	Action
	2020						
08/12/2020	2020/52	Waiting List Initiatives [WLI] Review of Policy	Review the Waiting List Initiatives [WLI] policy and previous reviews. Further request for the action to be carried forward to May to allow for the work relating to this matter to be completed. Item to be taken to ARAC on 21 July 2021	MD	~~11/02/2021~~ ~~06/05/2021~~ ~~21/07/2021~~	**07/01/21** - AR & RB to table a paper at BoD on 11/02/21 on the use of Waiting List Initiatives [WLI] with particular reference to Covid-19.	Open
2021							
							Open
			All other actions complete and closed, or moved to the board planner for planned action.				Open
							Open
							Open

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 July 2021

Agenda item	175/21			
Report	Hospitals Transformation Programme Report			
Executive Lead	Interim Deputy Chief Executive			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF risks 1, 2, 3, 4, 5, 6, 7, 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		970, 1083, 1930, 2027, 2065	
	For noting	√		
	For information			
	For consent			
Presented to:	N/A			
Dependent upon (if applicable)**:**				
Executive summary:	This report outlines the progress and next steps associated with the Hospitals Transformation Programme (HTP). The Board of Directors' is requested to **NOTE** the content of this paper.			
Appendices	N/A			

1. Introduction

This paper describes the progress that has been made during the month of May and into June to support the delivery of the Hospitals Transformation Programme, both by the Trust and by our external system partners.

Following discussion at the Board meeting in early May, more detail on the change in financial assumptions between the 2016 and 2019 draft Strategic Outline Cases (SOCs) is included at Appendix 1.

2. Development of the Hospitals Transformation Programme (HTP)

2.1. Acute transformation

- At the end of May, NHSEI approved the request to engage an external consultancy to work with the Trust to finalise the Strategic Outline Case (SOC). PA Consulting commenced working with the Trust at the start of June, have now undertaken a gap analysis and are finalising a detailed delivery plan for the finalisation of the SOC, working closely with the programme teams. Due to the delayed approval, the draft SOC is now scheduled to be finalised at the end of August and to run through internal and system governance processes in September.
- A series of internal workshops have taken place to explore the clinical and operational feasibility of accelerating the delivery of key elements of the acute transformation. The costs and benefits of those elements are currently being assessed and, where appropriate, will be incorporated into the options considered as part of the Strategic Outline Case.
- Work has also continued on reviewing the key assumptions of and, where necessary, refreshing the core components of the draft SOC.

2.2. Local care transformation

- Local Care transformation is being led by the Shropshire Community Health NHS Trust and is focused on delivering care closer to home through best practice pathways and ways of working. The programme will put in place sustainable service capacity, based on demand analysis, and ensure that services are delivered from an estate that is fit for purpose.
- A programme board has been established to drive the delivery of this work, involving relevant partners across the local health and social care system, with oversight through Shropshire and Telford & Wrekin Place Boards.
- Key targeted benefits include better population health management, improved integration of care pathways, reduced inequalities and better value for money.
- The output of the local care transformation work will also inform acute hospital capacity requirements.

2.3. System planning and assumptions

- Work has commenced on the development of a high level system plan, underpinned by core assumptions relating to activity growth, inflation, efficiency improvement, local care transformation and other planned service changes.
- The first draft of the assumptions is due to be agreed in early July and will be used to inform the development of the SOC. The system plan will be further developed over the summer months and is expected to be finalised by the end of September.

3. Key risks

The following key risks (if unmitigated) are likely to result in a delay to overall programme timescales and may increase the cost of finalising the SOC:

- Critical path activities are not delivered in the required timescales e.g. system assumptions, local care transformation assumptions
- Core health system assumptions change materially from the previous version of the SOC e.g. system activity projections, impact of local care transformation
- National assumptions change materially e.g. the number of single rooms that need to be incorporated into the hospital design
- Affordability gap cannot be resolved e.g. insufficient capital funding is available to deliver the models of care that were consulted upon
- Insufficient capacity and capability to complete the economic analysis
- Unavailability of key staff e.g. many staff have carried forward large holiday entitlements from the previous year

4. Recommendation

The Board of Directors' is requested to **NOTE** the content of this paper.

Financial analysis of the change in assumptions between the 2016 and 2019 draft Strategic Outline Cases (SOCs)

1. Background

1.1. The changes to local health and care services envisaged as part of the Future Fit consultation are an essential part of improving the health and wellbeing, and meeting the future needs, of the communities across Shropshire, Telford and Wrekin.

1.2. HTP was established to deliver these crucial changes, with key objectives focusing on safer care and better outcomes for patients, bringing our services and care closer to people's homes, and increasing preventative activities to keep people well.

1.3. Other benefits include streamlining the care and services people receive, reducing cancellations of planned care, and reducing the amount of time people stay in hospital, which should all contribute to an improvement in patient experience.

1.4. The cost of the programme at Pre-Consultation Business Case (PCBC) stage in 2016 was £312m. In March 2018, the Department of Health and Social Care formally allocated £312 million of funding to the programme.

1.5. In the updated 2019 SOC, the funding requirements had increased to £533m, predominantly due to increases in published government inflation rates and changes to technical classifications. Further details of these changes are provided in the narrative below.

2. Key changes to the capital costs of the Hospitals Transformation Programme

2.1. Inflationary impact (£134m)

In preparing capital business cases of this nature, the Trust is required to utilise the appropriate government published indices for inflation.

In 2016, when the first draft SOC was developed, the PUBSEC index was showing deflation in future years. However, in developing the draft SOC at that time it was agreed that the deflationary element would not be included (given the uncertainty in the construction market) and that price levels would be assumed to remain at 2016 levels.

In 2019, when the updated version of the SOC was developed, the PUBSEC index projected significant inflation in future years. Applying those indices to the original build cost meant that £134m was added to the build cost. This was verified by our technical advisors (Rider Hunt) in October 2019.

The change in value due to inflation is illustrated in the chart below:

	2016	2017	2018	2019	2020	2021	2022	2023
PUBSEC index	214	210	208	208				
2016 SOC (£m)	312	→	→	312				

	2016	2017	2018	2019	2020	2021	2022	2023
PUBSEC index	214	227	252	260	271	283	304	
2019 SOC (£m)	312	→	→	379	→	→	446	

	Index when draft SOC developed
	Projected index value at estimated time of build (for 2016 SOC value assumed to remain at 2016 index level i.e. reduction in index not incorporated)

2.2. National design changes (£24m)

A number of new nationally mandated changes to service specifications impacted on the design solution, including:

- Transitional care capacity in maternity
- Diagnostic capacity
- Space standards in Paediatrics

2.3. Changes in accounting rules (£28m)

In the 2016 SOC, the Trust had included alternative funding arrangements for a number of development areas, including the multi-storey car park and a new Energy Centre. A change in the accounting rules means that a number of these options now need to be recognised as part of the capital cost of the programme.

2.4. Responding to stakeholder feedback on the 2016 draft SOC (£35m)

The Trust received feedback on the 2016 draft SOC about the need to address a number of space utilisation issues on the site once the development was completed. As a result, the scope of the programme was expanded to convert the disused ward block into office accommodation and to demolish the Copthorne Building, which was no longer required as part of the design solution.

2.5. Summary

The overall cost of the programme increased from £312m in the draft 2016 SOC to £533m in the draft 2019 SOC. The key variances are summarised in the table below.

Description	Cost of the programme (£m)
2016 draft SOC	**312**
Inflationary impact	134
National design changes	24
Changes in accounting rules	28
Responding to stakeholder feedback	35
2019 draft SOC	**533**

Board of Directors' Meeting
8 July 2021

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	176/21			
Report	Integrated Performance Report			
Executive Lead	Louise Barnett, Chief Executive			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1,2,3,4,5,7,8 and 9	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR1, CRR2, CRR3, CRR4, CRR5, CRR6, CRR9, CRR10, CRR11, CRR12, CRR13, CRR15, CRR17, CRR19, CRR21, CRR22, CRR23, CRR27	
	For noting			
	For information			
	For consent			
Presented to:	Senior Leadership Committee - Operational - 24.06.2021, Finance & Performance Assurance Committee – 29.06.2021, Quality & Safety Assurance Committee - 30.06.2021			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	This report provides the Board of Directors with an overview of the performance of the Trust to the end of May 21. Key performance measures are analysed over time to understand the variation taking place and the level of assurance that can be inferred from the data. Where performance is below expected levels an exception report has been included that describes the key issues, actions and mitigations being taken to improve the performance. The indicators for inclusion in future reports are currently being finalised following the Board Seminar held in May 21. Planned year-end positions have been included in the overall dashboard and planned monthly performance trajectories have been included on a number of the SPC charts. The Board of Directors is requested to **NOTE** the content of this report.			
Appendices	n/a			

Integrated Performance Report

Purpose

This report provides the Board of Directors with an overview of the performance of the Trust. It reports the key performance measures determined by the board using analysis over time to demonstrate the type of variation taking place and the level of assurance that can be taken in relation to the delivery of performance targets. Where performance is below expected levels an exception report is provided. This outlines the key issues, actions and mitigations being progressed to improve the performance. The end of year targets are provisional and will be confirmed when the operational plan is formally approved.

The report is aligned to the Trusts functional domains and includes an overarching executive summary together with domain executive summaries for: Quality, Workforce, Operational Performance, Finance and Transformation.

Contents

1. Executive Summary
Louise Barnett, Chief Executive

- Ensuring that we deliver high quality care to our patients is our highest priority. We are currently finalising the implementation plan for our quality strategy and have set ambitious but achievable targets to improve key quality indicators during the remainder of 21/22.
- We have seen a reduction in falls and pressure ulcers this month and are ensuring that the learning from these improvements is embedded across all of our specialties. During May, we received a regulation 28 notice from the Coroner linked to the falls training for our staff and the safe transfer for patients. It is critical that we learn rapidly from serious incidents to sustainably improve the care that we provide for our patients. The issues identified are being actively addressed with our staff and our transfer processes have been revised.
- During May and into June we have continued to focus on restoring elective services and implementing our recovery plans. We have secured support for a number of additional initiatives to increase our capacity during the first half of the year, which will enable us to deliver more elective activity. The initiatives include continuing use of the Vanguard theatre, use of insourcing for weekend surgery on site, use of the independent sector, and additional outpatient clinics.
- Whilst our elective performance in May 21 exceeded the 75% national threshold, we recognise that many patients are waiting over a year to commence treatment. We are prioritising our patients by clinical need and scheduling patients according to their clinical priority. This does mean that long waits will continue throughout 21/22. Steps are being taken, with primary care partners, to ensure patients are fully informed.
- We have been able to establish a second green pathway for elective surgery on the RSH site with the allocation of further beds, and in June we will re-commence elective orthopaedic surgery on the PRH site.
- During May 21, the number of Covid-19 patients in our general adult and critical care units has remained low. We continue to work with partners to support the vaccination programme, actively encouraging the take up of first and second doses.
- A&E attendances in May 21 increased, exceeding pre-covid levels and higher than the winter of 19/20. The higher number of attendances has adversely impacted ambulance handover times, 4 hour access targets and 12 hour breaches. We remain focused on our transformation work which aims to improve patient flow and experience.
- Our contracted staffing levels continue to increase and the number of vacant posts has fallen to around 7% of the establishment. This growth in our permanent workforce supports the ongoing development of our staff and our cultural change programme, whilst also reducing the reliance on temporary staffing. We are also continuing to work with staff to improve their well-being and were pleased to provide 700 staff with awards for their contributions during the Covid-19 pandemic.
- The integrated care system (ICS) has received approval this month for the development of a community diagnostic hub. This is an important transformation which aims to improve accessibility to diagnostic services for our population.
- The Trust's adjusted financial position was a deficit of £(0.821)m, in line with the second month of the agreed plan for the first half of the financial year (H1).

2. Overall Dashboard

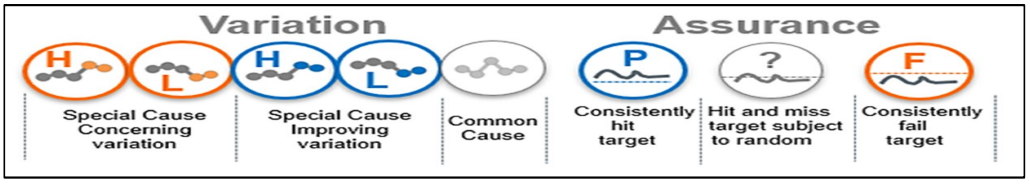
Quality - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	SaTH Year End Plan
Mortality									
HSMR	Mar 21	86.6	100.0	100			No		100
RAMI	Mar 21	81.1	100.0	100			No		100
Infection									
HCAI - MSSA	May 21	2		<2.3			No	6	28
HCAI - MRSA	May 21	1	0	0			Yes	1	0
HCAI - c.Difficile	May 21	1		<2.5			No	2	30
HCAI - E-coli	May 21	3		<3.16			No	10	38
HCAI - Pseudomonas Aeruginosa	May 21	0		0			No	1	3
HCAI - Klebsiella	May 21	2		<1			Yes	2	13
Patient harm									
Pressure Ulcers - Category 2 and above	May 21	10		<13			No	24	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	May 21	0.49		tbc				0.6	tbc
VTE	Apr 21	94.4%	95.0%	95.0%			Yes		95.0%
Falls - per 1000 Bed Days	May 21	4.22	6.60	<4.5			No	4.95	4.50
Falls - total	May 21	86		<89			No	199	1074
Falls - with Harm per 1000 Bed Days	May 21	0.10	0.19	<0.17			No	0.13	0.17
Never Events	May 21	0	0	0			No	0	0
Coroners Regulation 28s	May 21	1		0			Yes	1	0
SIs	May 21	4		<5			No	13	57
Mixed Sex Breaches	May 21	32	0	0			Yes	52	tbc
Patient Experience									
Complaints	May 21	67		<56			Yes	118	672
Complaints Responded within agreed time	Mar 21	61%	85%	85%			Yes		85%
Friends and Family Test	May 21	98%	80%	80%			No	98.2%	80%
Compliments	May 21	43 letters of Thanks yous received						114	tbc
Maternity									
Caesarean Sections	May 21	26.3%	25.5%	25.5%			Yes	25.6%	25.5%
Smoking rate at Delivery	May 21	11.9%	6.0%	6.0%			Yes	14.0%	6.0%
One to One Care In Labour	May 21	99.6%	100.0%	100.0%			Yes	98.5%	100.0%
Delivery Suite Acuity	May 21	67.0%	85.0%	85.0%			Yes		85.0%

Workforce - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
WTE Employed**Contracted	May 21	5794		6173			Yes	5794	tbc
Total temporary staff -FTE	May 21	553					Yes	553	tbc
Staff turnover rate (excludes junior doctors)	May 21	1.30%	0.8%	0.75%			Yes	1.14%	0.8%
Sickness absence rate Excluding Covid Related	May 21	4.40%		4.00%			Yes	4.26%	4%
Appraisal Rate	May 21	84%	90%	90.0%			Yes		90%
Appraisal Rate (Medical Staff)	May 21	88%	90%	90.0%			Yes		90%
Vacancies	May 21	7% (411)	<10%	<10%			No	411	<10%
Statutory and Mandatory Training	May 21	86%	90%	90.0%			Yes		90%

Operational - KPI	Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Elective Care									
RTT Waiting list -total size	May 21	33763 (English 30564)					Yes		26209 English
18 week RTT % compliance -incomplete pathways	May 21	56.6% (English Only)	92%				Yes		40% English
52 week breaches	May 21	3275 (2925 English only)	0				Yes		4156 English
Cancer									
Cancer 2 week wait	Apr-21	84.2%	93%	93%			Yes	84.3%	93%
Cancer 62 day compliance	Apr-21	79.0%	85%	85%			Yes	74.7%	85%
Diagnostics									
Diagnostic % compliance 6 week waits	May 21	76.3%	99%				Yes		tbc
DM01 Patients who have breached the standard	May 21	1807	0	1254			Yes	3799	tbc
Emergency Department									
ED - 4 Hour performance	May 21	73.0%	95.0%	68.20%			Yes	74.2%	78%
ED - Ambulance handover > 60mins	May 21	356	0				Yes	602	tbc
ED 4 Hour Performance - Minors	May 21	95.8%	95%	95%			No	96.2%	95%
ED 4 Hour Performance - Majors	May 21	52.0%	95%				Yes	54.2%	tbc
ED time to initial assessment (mins)	May 21	25	15	15			Yes	24	15mins
12 hour ED trolley waits	May 21	1	0	0			Yes	13	tbc
Total Emergency Admissions from A&E	May 21	2977					Yes	5897	29744
Hospital Occupancy and activity									
Bed Occupancy -G&A	May 21	83.0%	92%	92%			Yes		92%
ED activity (total excluding planned returns)	May 21	13369		12286			Yes	25363	118403
ED activity (type 1 excluding planned returns)	May 21	11217		10278			Yes	21432	tbc
Total Non Elective Activity	May 21	5114		5572			Yes	10038	62349
Outpatients Elective Total activity	May 21	52383		54823			Yes	319291	558021
Total Elective IPDC activity	May 21	5187		5515			Yes	10175	58789
Diagnostic Activity Total	May 21	16843		16500			No	33386	tbc

Finance - KPI	Latest month	Latest Value	National Standard for month	Plan for year	Perfomance	Assurance	Exception	Year to Date	Year End Planned Trajectory
Cash	May-21	13.462m		22.354m			Yes	13.462m	1.700m
Efficiency	May-21	0.196m		2.400m(H1)			Yes	0.311m	2.400m(H1)
Income and Expenditure	May-21	(0.468m)		(3.998m) (H1)			Yes	(0.821m)	(3.998m)(H1)
Cumulative Capital Expenditure	May-21	0.219m		34.142m			Yes	0.271m	34.142m

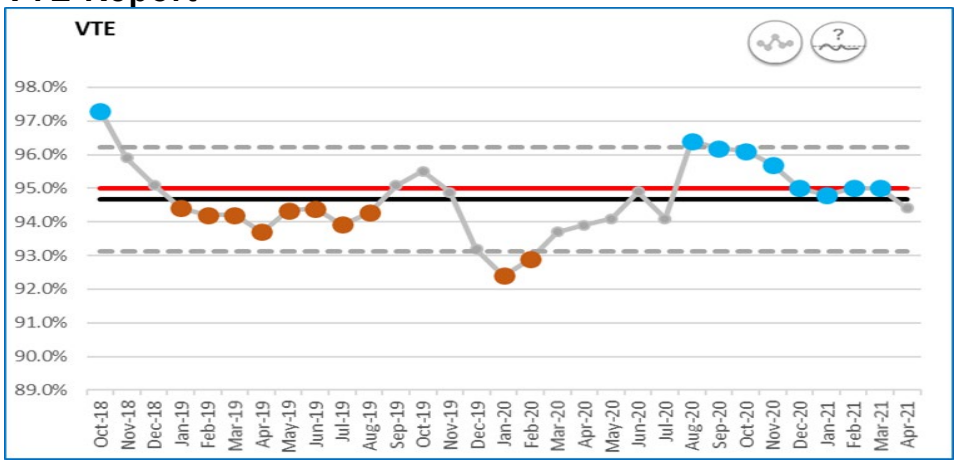
SPC Variation Icons



3. Quality Summary
Hayley Flavell, Director of Nursing
Richard Steyn and John Jones, Acting Co-Medical Directors

- Both mortality indicators are showing performance better than the reference level.
- There were four serious incidents reported this month and zero never events. This report also includes the 18 open SIs at the end of May split by Division. All 18 are within the 60 day timeframe set for closure. 2 SIs were closed during the month.
- Improvement is noted in falls, with all three indicators showing an improved position.
- We have received a regulation 28 notice from the Coroner in relation to the training of our staff in the safe transfer of patients so as to prevent falls.
- There were 10 pressure ulcers at grade 2 or above this month, a continuation of the improvement noted last month
- The infection prevention and control indicators delivered in accordance with the improvement plan with the exception of MRSA and Klebsiella.
- A deterioration is seen in the number of mixed sex breaches.
- Acknowledgement of complaints on receipt is continuing to perform well. The response time to resolve complaints continues to be a concern, with performance well below the target set.
- VTE performance remains slightly below target this month. Actions to ensure patients are not transferred to inpatient wards without completed assessments are due to be delivered by 10th June 2021 to secure further improvement in patient care and risk mitigation.
- Maternity indicators are included in this report to provide an overview of the performance within the service. These indicators form a small proportion of the overall maternity dashboard which is being used to review the service performance. The national measure for reduction in smoking in pregnancy for 21/22 is to reduce to no more than 6% of women smoking at delivery. This has been included in the dashboard to reflect the importance of this for health promotion of the mother and unborn child.
- Patient experience in relation to FFT, cleanliness and catering scores are all showing sustained good performance.

VTE Report

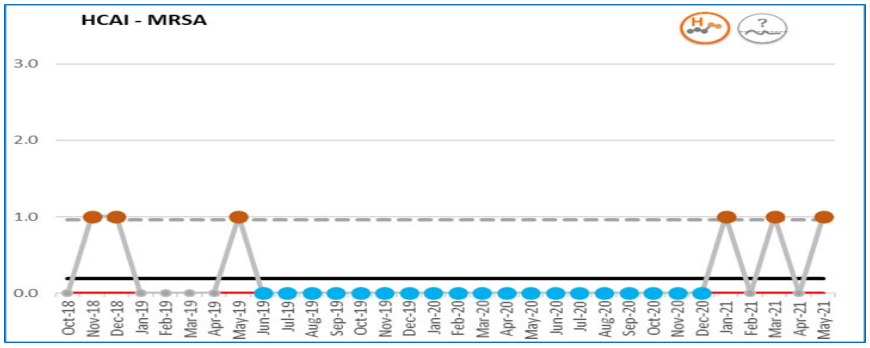


April 2021 actual performance
94.4%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
Delivery continues to be close to target and planned performance

Background	What the Chart tells us	Issues	Actions	Mitigations
This is clinically important in order to protect inpatients from harm.	August to December 2020 the 95% performance target had been achieved. January was just below at 94.8%, February achieved 95% but March and April are slightly below 94.4% and 94.5% respectively.	Assessments not being completed prior to transfer from the assessment areas.	Implementation on 10.6.2021 of a block on the transfer from assessment areas to wards if VTE assessment is not complete. Expected that this will result in improved performance from this date.	Daily report sent to all Clinical Directors to highlight performance.

Hospital Acquired Infections

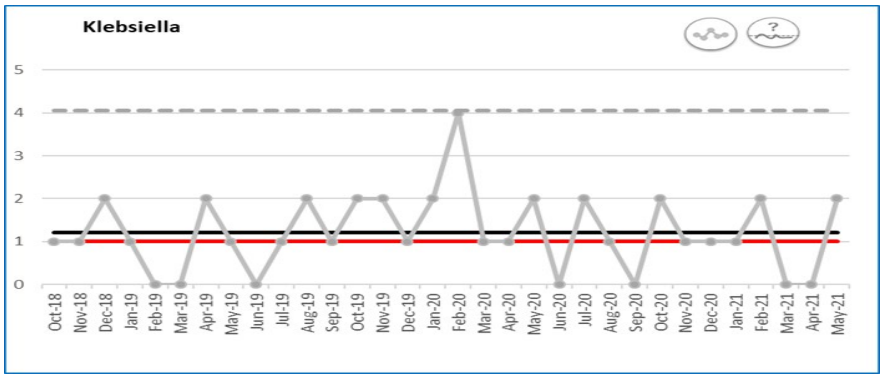
MRSA



May 2021 actual performance
1
Variance Type
Special Cause Deterioration
Local Standard
0
Target / Plan Achievement
0 infections for 21/22

Background	What the Chart tells us	Issues	Actions	Mitigations
The Target for all Acute Trusts is Zero cases of MRSA bacteraemia	There was one pre-48 hour MRSA bacteraemia reported in the Trust in May 21.	On Post Infection Review, this case was considered to be a contaminant, therefore has been attributed to the Trust.	Education for staff. Competencies for junior doctors to be in place consistently.	Monitored through IPC Ops.

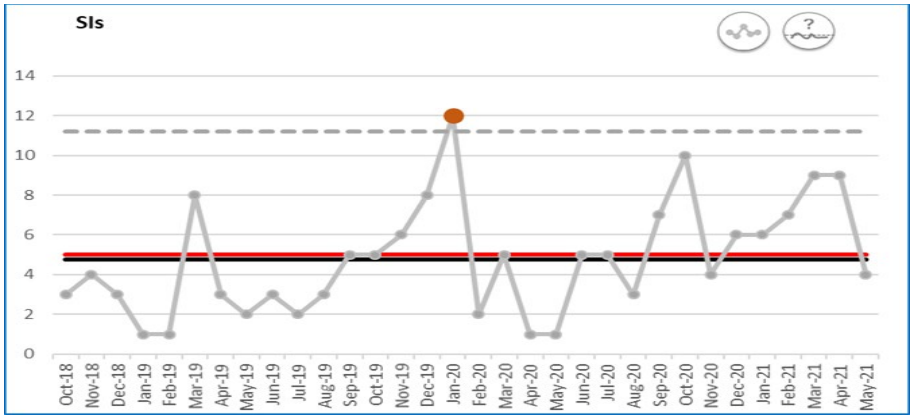
Klebsiella



May 2021 actual performance
2
Variance Type
Common Cause Variation
Local Standard
1
Target/ Plan achievement
Sustain or improve on 2020/21

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Klebsiella is a mandatory requirement	There were 2 cases of post 48 hour Klebsiella in May 2021	In one case the source was considered to be pyelonephritis therefore was not device related. The second case is currently being reviewed to establish the source.	If the 2nd Case is deemed to be device related an RCA will be completed. Other ongoing actions are outlined in the other reported HCAIs.	Cases are monitored through IPC Ops Group at Trust and Divisional Level.

Serious Incidents



May 2021 actual performance
4
Variance Type
Special Cause Concern
Local Standard
5
Target/ Plan achievement
10% reduction on 20/21 (No more than 57 cases) pro-rata =<5per month

SI theme	Number Reported
Fall from bed/bed rails resulting in death	1
Fall resulting in Head Injury	1
Infection Control C-Diff on death certification	1
Maternity obstetrics affecting baby	1
Total	4

N.B. all SIs are fully investigated to determine the cause and any necessary actions to prevent re-occurrence. The board will be updated on progress in due course.

Background	What the Chart tells us	Issues	Actions	Mitigations
The number of SIs reported continues to show Common Cause Variation.	Following a peak in reporting during October, reporting has remained above the mean for five months. May has seen a drop to 4 reported. There are no reportable patterns emerging.	Over the coming months COVID 19 related incidents such as delayed diagnosis due access issues/outbreaks and COVID related deaths may continue to see reporting figures increase	Monitor reviews. Maintain investigation reporting within national framework deadlines for timely learning Embed learning from incidents	Weekly Rapid Review of incidents. Early identification of themes. Standardised investigation processes.

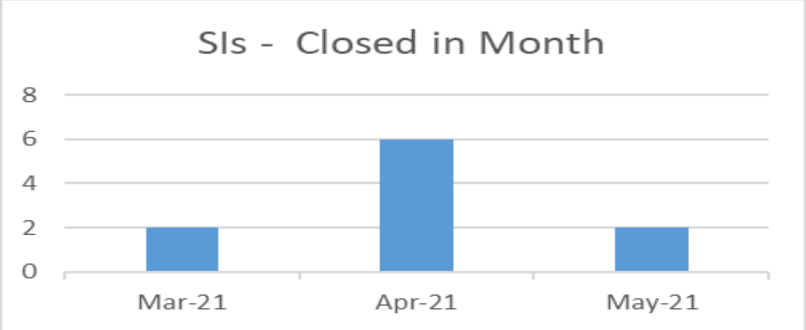
				Early implementation of actions

Serious Incidents – Total Open at Month End

SI – Total Open at Month End per Division	Number Reported
Medical and Emergency Care	8
Surgical, Anaesthetics and Cancer	8
Women's and Children's	2
Total	**18**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open Serious Incidents	Number of open SIs	18 open SIs all within 60 day framework	Monitoring of progress of investigation	Weekly review of progress

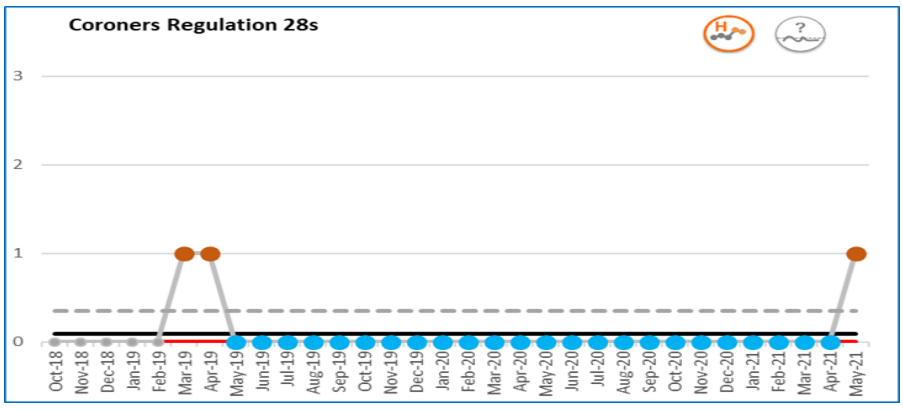
Serious Incidents – Closed in Month



May 2021 actual performance
2
Variance Type
Internal Target
5
Target/ Plan achievement

Background	What the Chart tells us	Issues	Actions	Mitigations
Serious incidents have a 60 day life cycle. The number of SIs closed in month will vary dependent on the number reported	There were 2 SIs closed in month with a 100% completion within the 60 day target	All SIs to be completed within 60 day timeframe	Monitor reviews Maintain investigation reporting within national framework deadlines for timely learning Embed learning from incidents	Weekly review of progress of investigations

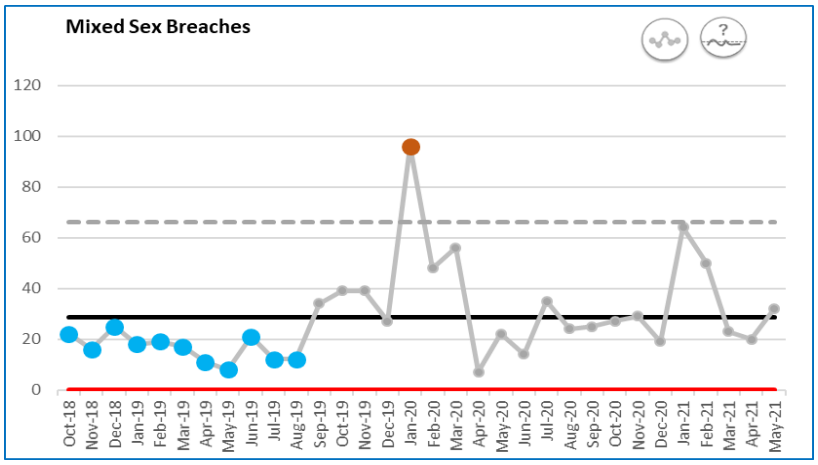
Coroner Regulation 28 Notices



May 2021 actual performance
1
Variance Type
Special Cause deterioration
Local Standard
0
Target/ Plan achievement
Standard not achieved this month after a prolonged period of achievement.

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure	There has been one Regulation 28 reported in May	Training of portering staff in safe transfer of patients to minimise risk of falls	Nursing staff to always assist with transfer of patients from chair to wheelchair etc., not for porters to do alone.	New Trust Transfer Policy.

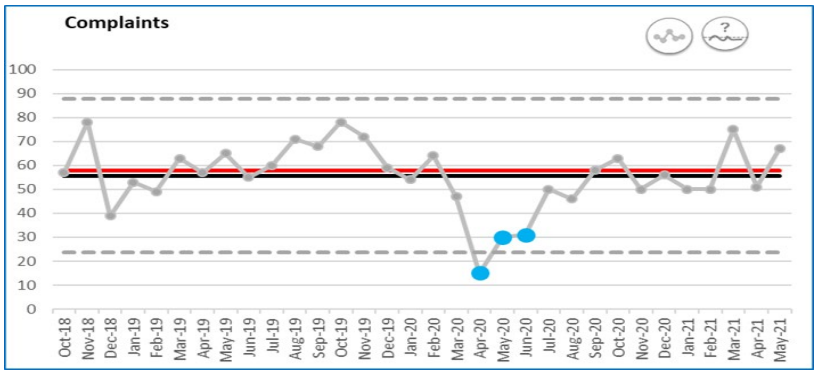
Mixed Sex Breaches Exception Report



May 2021 actual performance
32 Primary mixed sex breaches
Variance Type
Common Cause variation
National Target
0
Target/ Plan achievement
Continuing to breach this target. Majority of breaches relate to delays leaving ITU/HDU when fit to return to the ward.

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	4 primary breaches	3 Medical and 1 H&N
ITU / HDU (RSH)	23 primary breaches	6 Medical and 17 Surgical
CCU (RSH)	1 primary breaches	3 Secondary breaches
CCU (PRH)	4 Primary breaches	6 secondary breaches

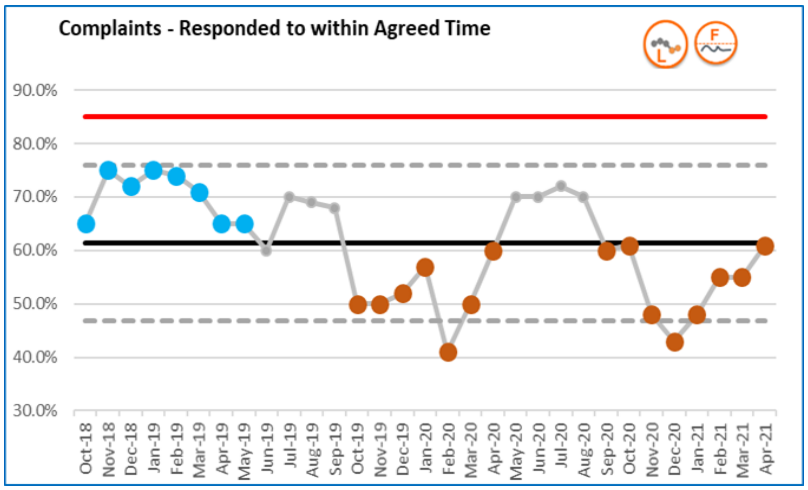
Complaints



May 2021 actual performance
67
Variance Type
Common cause variation
SaTH internal target
<56
Target/ Plan achievement
>10% reduction on 19/20 total complaints

Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a valuable source of learning to the organisation.	Numbers remain within expected variation.	There has been a recent increase in complaints related to Ward 26	This has been escalated to the Matron, and themes are being reviewed	As per actions

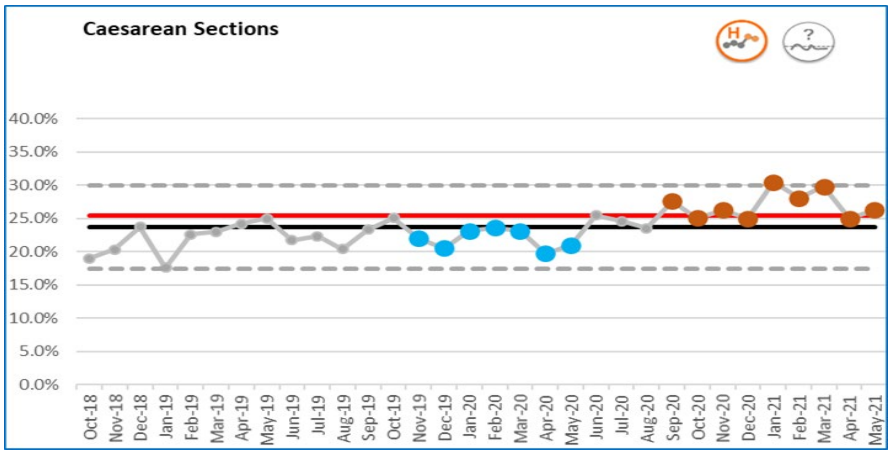
Complaints – Responded within Agreed Time



April 2021 actual performance	
61%	
Variance Type	
Special cause Concern	
National benchmark	**SaTH internal target**
85% compliant with time agreed with complainer	85% responded to within 30 days of receipt
Target/ Plan achievement	
Target is not likely to be achieved with current processes	

Background	What the Chart tells us	Issues	Actions	Mitigations
It is important that patients raising concerns have these investigated and the outcomes responded to in a timely manner as well as the Trust learning from these complaints	The response rates continue to show some improvement but are still low	Divisions continue to struggle to manage competing priorities in responding to complaints in a timely manner. Approval process at divisional level is providing extra assurance but adding to timescales for responding	Training provided New process being piloted in some specialities, with specific email address and tracking of progress within the speciality Regular meetings with divisional managers to review outstanding cases.	Complainants are kept updated as to delays. KPO to assist with review and improvement of supporting processes.

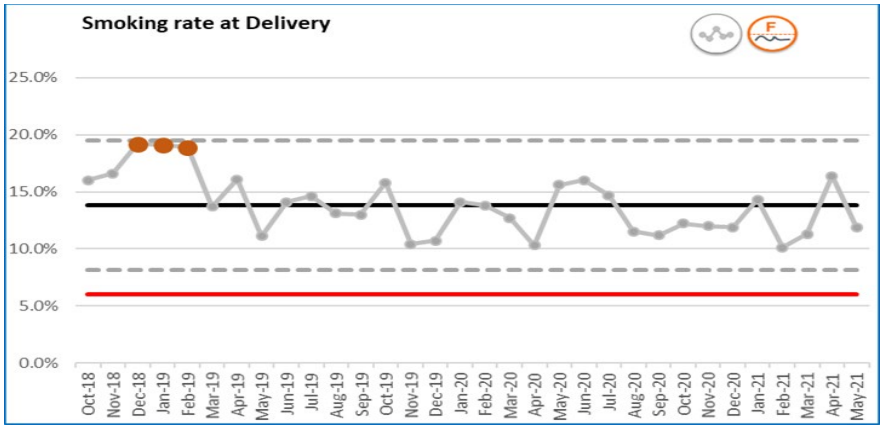
Caesarean Section



May 2021 actual performance
26.3%
Variance Type
Special Cause
National Standard
25.5% (NMPA 2019)
Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
Treatment and care should take into account women's needs and preferences (NICE 2019). This includes the decision as to whether to have a caesarean section or not. NICE guidance is in plan which identifies certain factors which if present, would result in the recommendation of a CS being made. In addition women are supported to choose a CS in the absence of clinical factors, both situations requiring appropriate counselling. Services monitor the rate of CS, including emergency and planned CS, and use this as an indicator of quality and safety of care. Other parameters are also used to triangulate that data to give a full picture of care	Statistically the chart shows a change in the rate of C-section from the summer of 2020. However the decision to undertake a C-section is individual patient dependant and variation around the national standard is to be expected month on month.	No specific issues related to this data	None required	

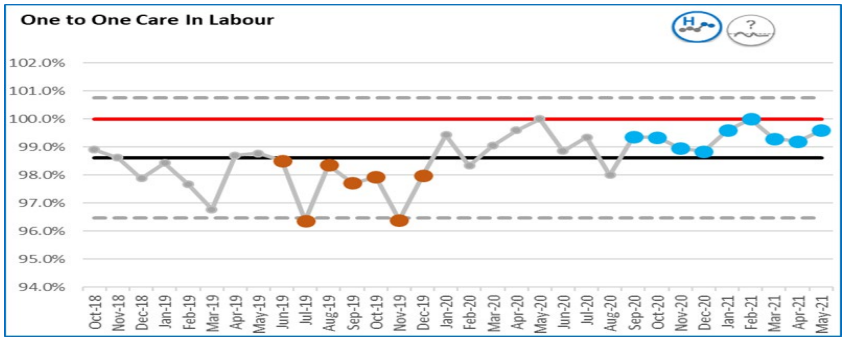
Smoking Rate at Delivery



May 2021 actual performance
11.9%
Variance Type
Normal Variation
National Target
6% March 2022
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
The National SATOD government target for smoking at time of delivery has been set to 6% by 2022. Currently there are two different smoking cessation referral pathways and services. Shropshire is a public health funded stop smoking service whereas Telford and Wrekin has been funded by the CCG / LMNS and is run by the Public health Midwife within the maternity team.	There has been a decrease in SATOD rates from the previous month. Rates are consistent with same period the previous year.	SATOD remains above national average and above government target of 6%. Transition to new integrated Public Health maternity service delayed until late 2021.	Positive change and development is in progress to encourage a family approach to lifestyle change within the county. Family approach and equitable service across Shropshire should reduce SATOD rates in the future Evaluate and review new service once started to ensure local demographic needs are being met and that the service easily accessible in deprived areas.	See actions

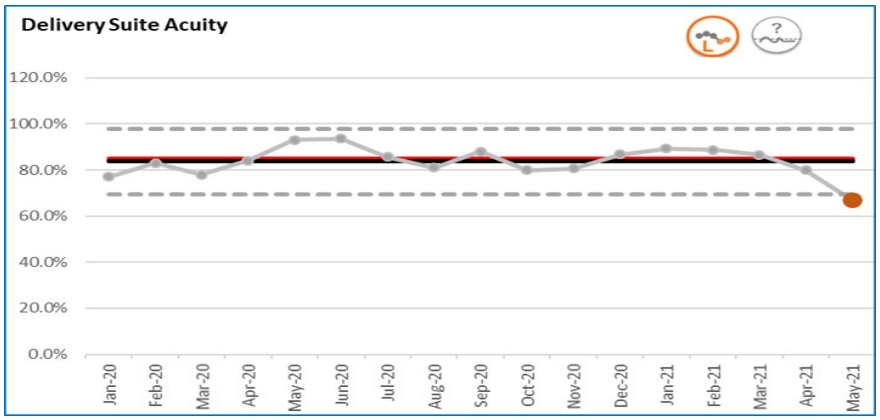
One to One Care in Labour



May 2021 actual performance
99.6%
Variance Type
Special Cause Improvement
National Standard
100% (Better Births)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
Midwifery safe staffing should include plans to ensure women in labour are provided with 1:1 care, including a period of 2 hours after the birth of their baby. The provision of 1:1 care is part of the NCST standard safety action number 5 which requires a rate of 100% 1:1 care in labour.	Consistent above Mean rate since summer 2020	Staffing vacancies high currently, recruitment in progress.	Acuity is managed by DS coordinators and SMT huddles twice daily.	Incentivised Bank shifts in place between 12th June end of July to improve staffing levels until vacancy rate improves

Delivery Suite Acuity



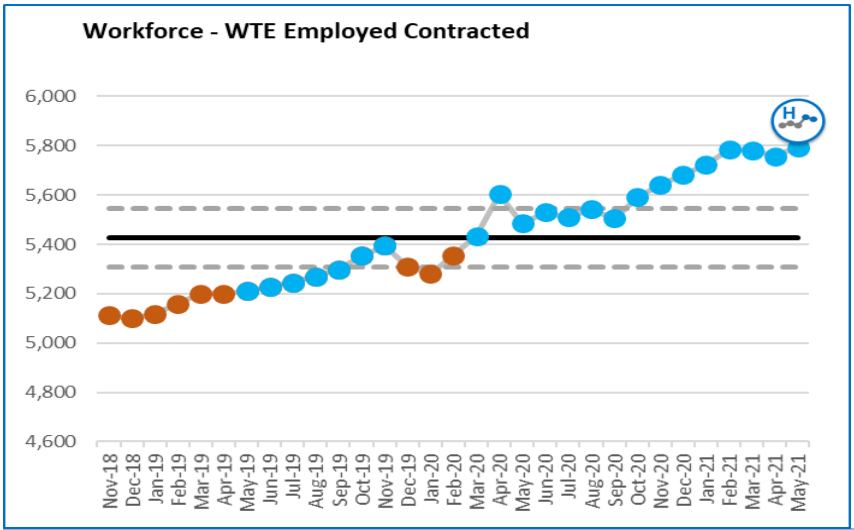
May 2021 actual performance
67%
Variance Type
Special cause concern
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
In 2015 NICE set out guidance for safe midwifery staffing which included the use of a tool endorsed by NICE to measure and monitor acuity. This has been in place at SaTH since 2018 and is reported monthly in line with the CNST standard safety action number 5.	Acuity has fallen in last 3 months	High Vacancy rate currently. Imbalance in staffing due to amount of secondments in service. Some shifts unfilled in DS area between June and July 21.	Staffing review in progress. Recruitment plan being actioned. Escalation used appropriately when required to maintain safe acuity within CU areas. Continue to monitor.	Incentivised bank shifts in place for CU areas from June 12th – end of July to support staffing gaps identified. Twice daily SMT huddles in place to monitor safety and staff deployment across unit.

4. Workforce Summary
Rhia Boyode, Director of Workforce

- Covid-19 positive cases have continued to be low during May (rate of 0.60%, 35 FTE) with the majority of cases due to members of household becoming symptomatic.
- Staff absence of 4.45% for May equates to 263 FTE of which 33% (86 FTE) is attributable to mental health reasons. Staff group of additional clinical services has the highest sickness rate at 6.61% (75 FTE).
- 19% (117 FTE) of staff have left due to work life balance over the last 12 months. In May 20% (12 FTE) of those who left gave a reason of work life balance with 11% (6.5 FTE) giving a reason of lack of opportunities / further education or training. 28% (16.5 FTE) of staff who left in May were from the nursing and midwifery staff group; within this 23% (3.7 FTE) left due to work life balance and 18% (2.96 FTE) due to incompatible working relationships.
- Performance remained at 86% for Statutory Training this month, however safeguarding training compliance has continued to improve month on month.
- Consultant vacancies are currently at the lowest rate over the last 12 months and currently sit at 8%, following 20 new appointments year to date.
- Our focus for Organisational Development over the next few months will be on landing and embedding the new behavioural framework. In addition, we have done more to show appreciation for staff through PACT awards, COVID hero awards, long service awards.

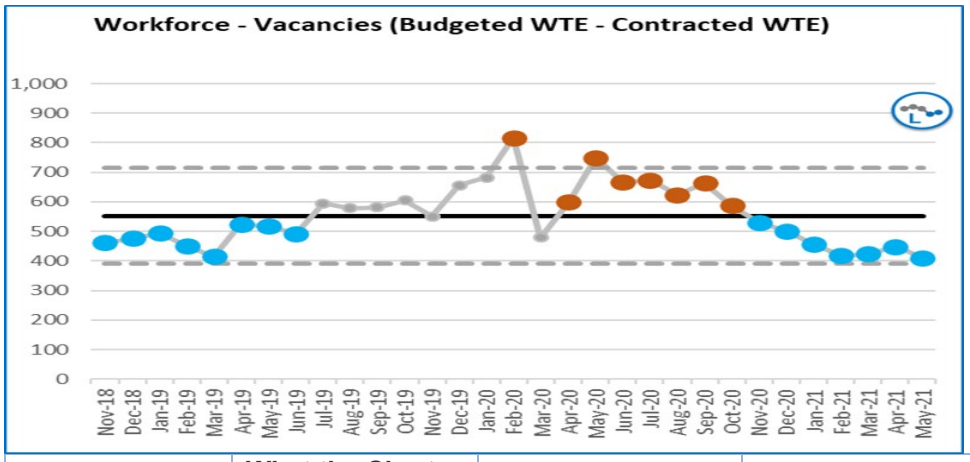
WTE employed



May 2021 actual performance
5794
Variance Type
Special cause Improvement
Local Target
6173
Target / Plan Achievement
Improvement month on month towards the target set

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the WTE contracted staff in post.	WTE numbers show special cause improvement since Apr 20.	Overall WTE numbers have continued to increase, staffing demands continue to present challenges; high patient activity levels and staff absences attributed to covid continues to present challenges to staffing levels.	Recruitment activity continues to increase staffing levels	Utilisation of bank and agency staff to support workforce gaps

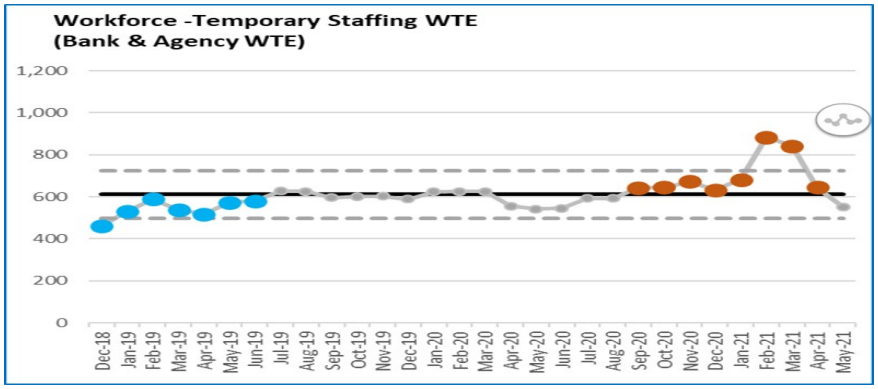
Vacancies



May 2021 actual performance
411=7%
Variance Type
Special Cause Improvement
National Target
<10%
Target / Plan Achievement
Better than target level of performance

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE.	Special cause improvement between Nov 20 and May 21.	Shortfall in gap between contracted WTE and budgeted WTE continues to put pressure on bank and agency usage.	Continue recruitment activities to increase contracted WTE staffing levels and reduce vacancy gap. Initiatives to help retain existing staff.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

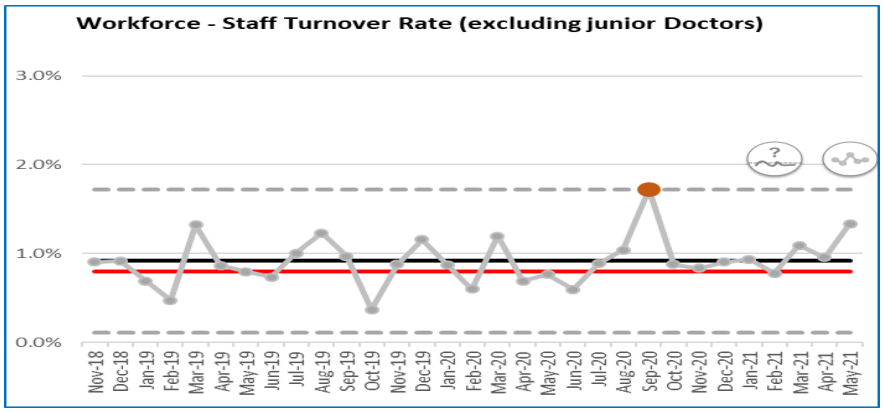
Temporary/ Agency Staffing



May 2021 actual performance
553
Variance Type
Common cause
National Target
N/A
Target / Plan Achievement
TBC

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of agency and bank usage expressed as WTE	Special cause concern over Winter period between Sep 20 and Apr 21. Normal variation in May 21	Staff absences continue to present staffing challenges along with high patient acuity levels and escalation.	Continue to monitor staff absence levels. Monitor roster approvals to help ensure unfilled duties are sent to temporary staffing in timely manner.	Escalated bank rates in ITU. Progress with recruitment activities to increase substantive workforce including international nurses.

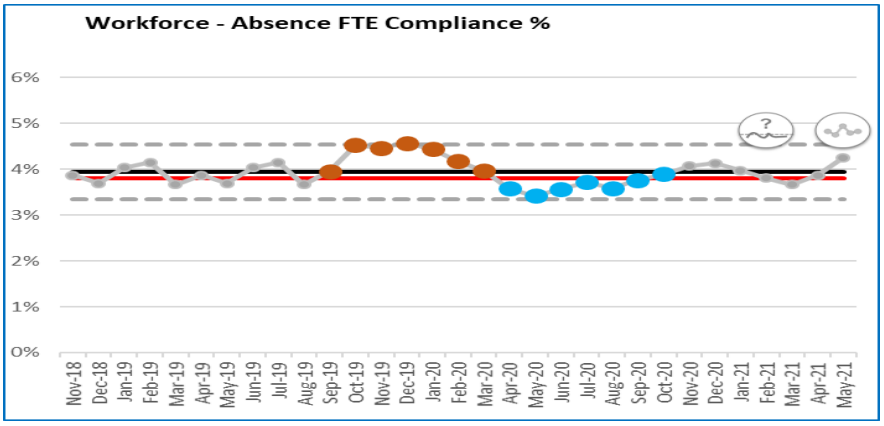
Staff Turnover Rate (excluding Junior Doctors)



May 2021 actual performance
1.3%
Variance Type
Normal Variation
National Target
0.8%
Target / Plan Achievement

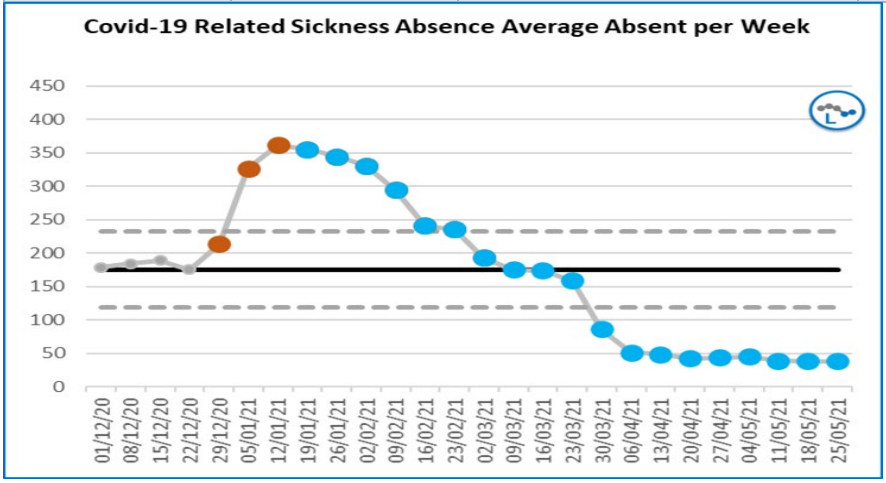
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of the % of staff who have left the organisation	Normal variation continues between Oct 20 and May 21.	19% (117 FTE) of staff have left due to work life balance over the last 12. In May 20% (12 FTE) of those who left gave a reason of work life balance with 11% (6.5 FTE) giving a reason of lack of opportunities/ further education or training. 28% (16.5 FTE) of staff who left in May were from the nursing and midwifery staff group; within this 23% (3.7 FTE) left due to work life balance and 18% (2.96 FTE) due to incompatible working relationships.	Interventions in place to try to identify potential leavers prior to leaving. Opportunity to complete exit questionnaires to help learn lessons from why people are leaving. Review recommendations within the NHS People Plan regarding supporting staff to adopt flexible working practices. Improvement initiatives to improve culture and work-life balance.	Recruitment activity to help ensure minimal workforce gaps Utilisation of temporary workforce to maintain suitable staffing levels

Sickness Absence



May 2021 actual performance
4.4%
Variance Type
Common Cause Variation
National Target
4%
Target / Plan Achievement
Fluctuates around the target each month

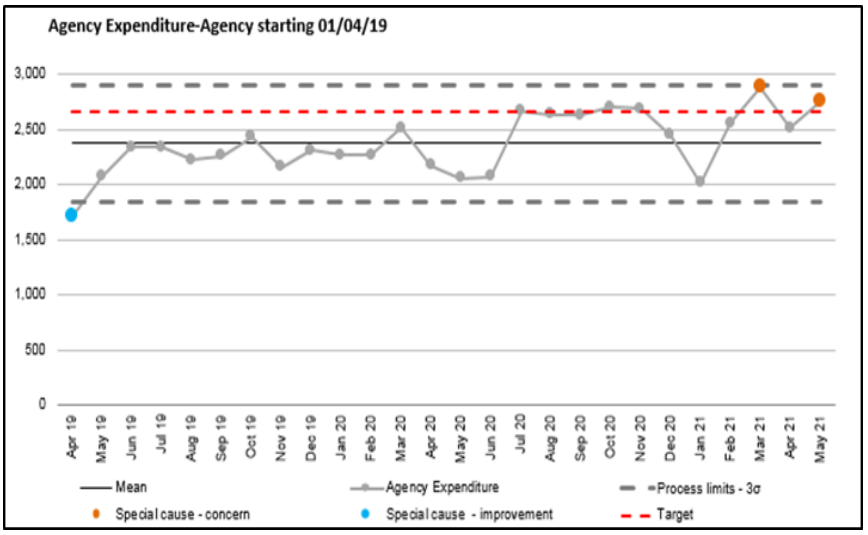
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of FTE calendar days absent Covid-19 related sickness and absence is not included.	Special cause improvement between Mar 20 and Nov 20 with common cause variation through Dec 20 to May 21 reflecting expected seasonal trends.	High levels of absence attributed to mental health reasons. 12 month average of sickness absence 4%. Staff absence of 4.45% for May equates to 263 FTE of which 33% (86 FTE) is attributable to mental health reasons. Staff group of additional clinical services has the highest sickness rate at 6.61% (75 FTE).	Continue to promote health and wellbeing initiatives. HR team supporting with welfare conversations. Introduction of new employee wellbeing and attendance management policy.	Work with temporary staffing departments to ensure gaps can be filled with temporary workforce where necessary.



31St May 2021 actual performance
39
Variance Type
Special Cause improvement
National Target
N/A
Target / Plan Achievement

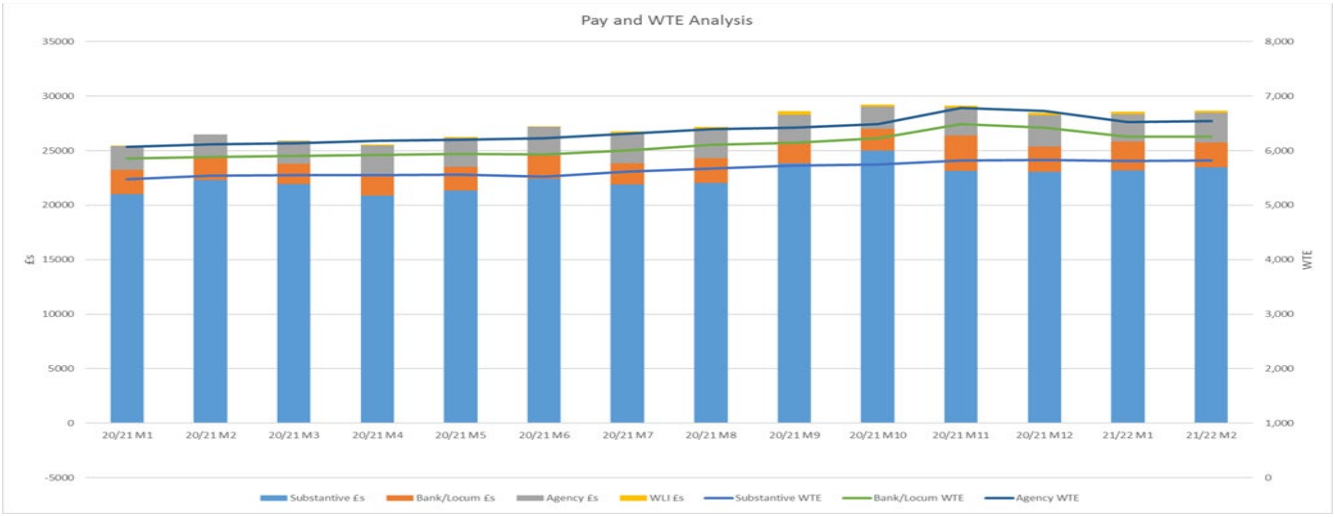
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff Covid sickness absence average per week and is the number of staff absent due to Covid-19 related sickness	Covid-19 related absence shows special cause improvement through February and May.	Covid-19 positive cases have continued to be low during May with majority of cases due to requirement to members of household becoming symptomatic. Covid absence rate of 0.60% (35 FTE) throughout May.	Continue to encourage staff to follow government guidelines on isolation periods. Ensure PPE adherence and encourage social distancing. Continue to monitor numbers of staff undertaking LFT testing and Covid vaccine uptake.	Maintain social distancing; regular and timely staff testing; identification of positive cases and effective contact tracing.

Agency Expenditure

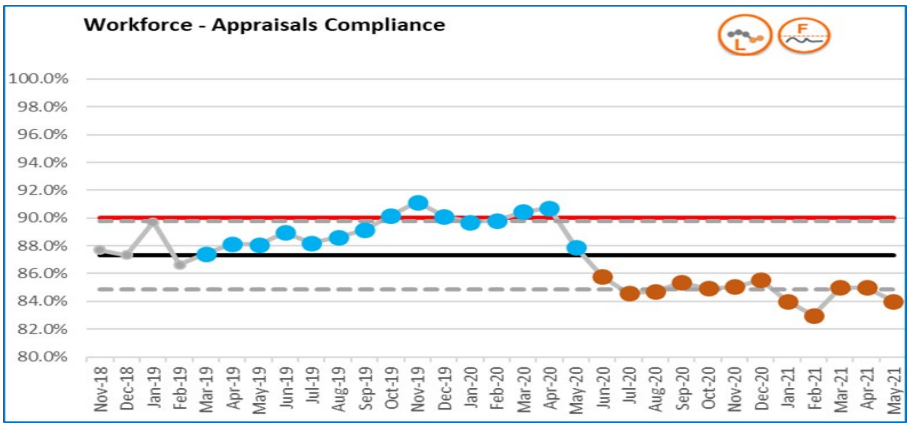


May 2021 actual performance	
Spend year to date £5.276m	
Variance Type	
Special Cause	
SaTH Original Forecast	**SaTH Rolling Forecast**
£2.372m	£5.336m
Target/ Plan achievement	
£0.060m favourable variance	

Background	What the Chart tells us	Issues	Actions	Mitigations
Agency is a constituent element in the Trusts £(3.998)m deficit plan over the H1 period. The H1 agency plan has been set equivalent to Q3 20/21 spend however; this is significantly above the Trusts agency ceiling set by NHSEI of £1.186m per month. There is a strong expectation that the Trust will ensure agency expenditure is reduced and there is a recurrent requirement to substantially reduce agency expenditure.	Agency spend is significantly above the NHSEI ceiling however, year to date agency spend was lower than the Q3 20/21 run rate.	Due to workforce fragility, the Trust is consistently overspent against its agency ceiling. There is an increased requirement for temporary staffing to support the COVID-19 vaccination programme.	Direct engagement groups now set up to focus on agency spend and approval hierarchy; including monthly dashboard review across key nursing metrics Overseas Registered Nursing recruitment in 19/20 and 20/21 (213WTE recruited to date) Increased nursing bank rates in specific high agency areas HCSW, Strands A & B NHSEI agreements to fund focussed substantive nursing recruitment. Recruitment and retention strategy approved key focus on brand and reputation, retention of staff and targeted recruitment campaigns for hard to fill roles. Review of agency procurement strategy with National Procurement team (HTE).	Develop measurable metrics and action plans to understand where we can control agency spend. Build on increased medical bank fill rates since implementation of Locums Nest. Deliver year one of Recruitment and Retention strategy to increase substantive workforce and improve retention levels.



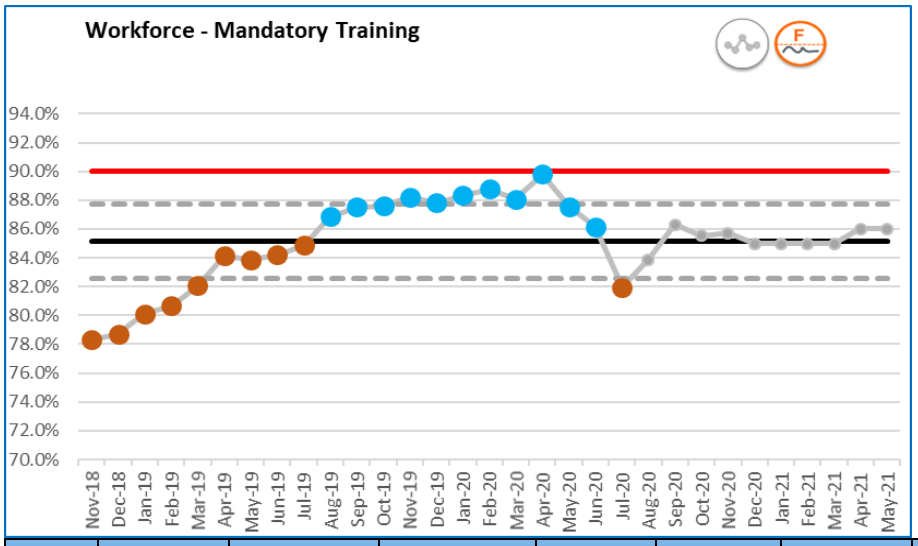
Appraisals



May 2021 actual performance
84%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	The 90% target was achieved January to April 20 then started to drop and has remained below target, it has maintained this month.	CV-19, staffing constraints and service improvement have reduced ability of ward staff to have time to complete.	Focused support is being provided to the managers of any ward that is below target. A substantial review of appraisal will be undertaken once the behaviours and values work is complete to ensure alignment with overall Trust objectives. Corporate Education have sent out reminder emails to all staff who are out of date and due their appraisal.	Appraisal form has had an interim revision to include the new Trust Values and health and well-being and flexible working discussions

Statutory & Mandatory Training

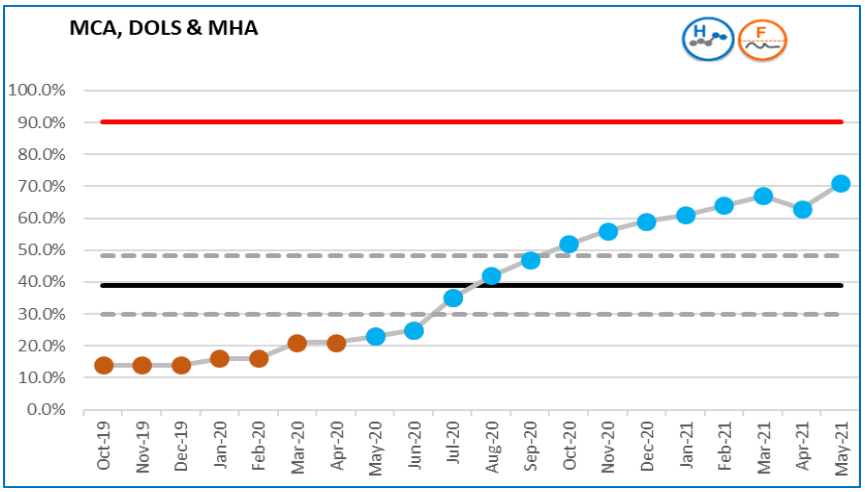


May 2021 actual performance
86%
Variance Type
Common Cause Variation
National Target
90%
Target / Plan Achievement
The target is above the upper process limit and so unlikely to be achieved at present

Fire Safety	Load Moving & Handling	Infection Prevention & Control	Hand Hygiene Competence	Patient Moving & Handling Class	Adult Basic Life Support	Paediatric Basic Life Support	Equality & Diversity	Information Governance	Health & Safety Level 1
86%	93%	82%	89%	88%	76%	74%	91%	80%	88%

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their training.	Maintained 86% for a second month, but still remains below target. Safeguarding training compliance continues to improve month on month.	CV-19 & the Vaccination Programme, staffing constraints and service improvement have reduced ability of wards to release staff for training. Increased Stat/Mand training requirements e.g. Hand Hygiene moving from triennial to annual. Poor IT literacy impacting on e-learning completion. Some data validation issues.	Corp Ed is working with Care Groups to identify and reduce data conflicts. Corp Ed is supporting Ward/Dep managers to prioritise and schedule training completion. Corp Ed requested proxy facility to support remote e-learners effectively. New Learning Management System purchased – implementation started. E-Learning reminder email sent to all staff who are non-compliant.	E-learning and workbooks offered as alternatives to face to face training Requirements made more transparent to divisional teams and staff. Libraries supporting learners to access e-learning Phone support for e-learning.

Trust MCA – DOLS & MHA

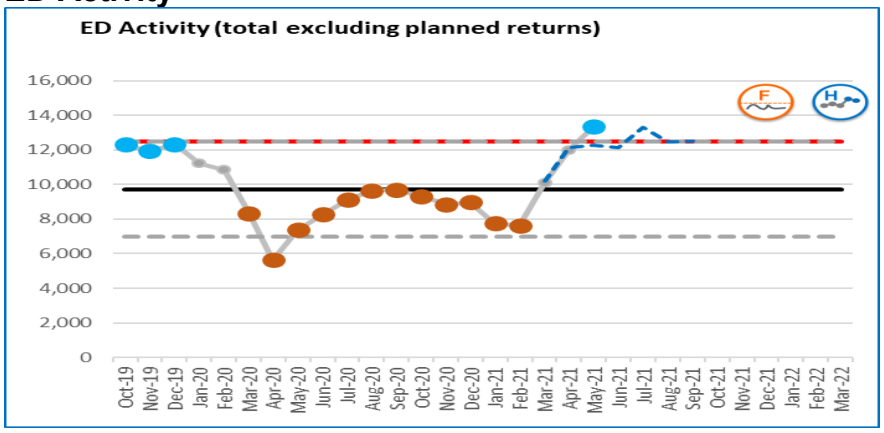


May 2021 actual performance
71%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Remains significantly below target, with target above upper control limits

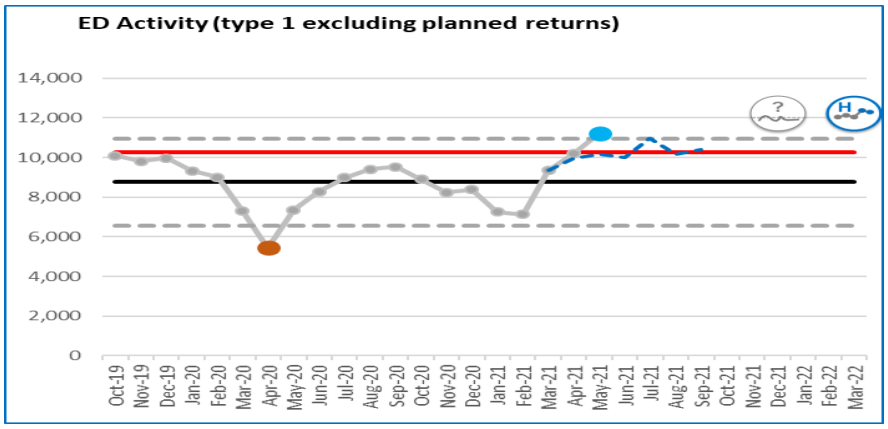
5. Operational Summary
Mr Nigel Lee Chief Operating Officer

- May 2021 has seen a parallel focus on managing the increasing Urgent and Emergency care demand whilst looking to expand the recovery in elective and diagnostics given our high waiting lists. Covid inpatient numbers remain low (single figures and primarily between 1 and 4 inpatients throughout the month) albeit we have cared for Covid patients on critical care. However, in accordance with national Infection Prevention and Control (IPC) guidance, we have retained separate high and medium risk pathways in A&E, assessment areas and wards. And separate low risk (Green) pathways have been maintained for elective surgery together with strict protocols for cleaning and separation between patients in all clinical areas.
- Urgent care demand has risen to pre-Covid levels and beyond, with total activity up to circa 10% vs 19/20 levels; ambulance activity has similarly increased vs May 2019 (up by 9%), but with an increase in the Category 1 and 2 conveyances (usually greater clinical urgency). For A&E activity overall, the level of 'majors' has also risen, especially at the Royal Shrewsbury site. Volumes of patient arrivals at peak periods continue to cause challenges (especially later afternoon and early evening), and the Trust has seen pressure on ambulance handover delays. The peaks in activity also put pressure on certain metrics such as initial assessment within 15 minutes. Joint work continues with West Midlands Ambulance service and our local system partners to promote alternatives to A&E and alternate admission routes. Of note, the activity at the urgent treatment centres alongside both A&Es has risen, with the centre at PRH up 26% above May 19 levels.
- Elective recovery delivery also remains a key priority. The Trust, and local system as a whole, delivered against the national delivery threshold in May (75% vs 19/20 levels), and we expect to deliver against the increasing threshold for June and July 21 (80 and 85% respectively). Plans to expand the elective inpatient capacity have been implemented at the end of May on both sites; this will put additional pressure on emergency care capacity but is vital to reduce waiting lists. Additional internal capacity also began in late May, with insource and outsource activity starting in June; both schemes are funded through the national Elective Recovery Fund and will be vital to begin to see reductions in the waiting lists.
- Diagnostics presents a vital enabler but a key risk; the regional mobile CT scanner leaves SATH at the start of June, and the service will prioritise the urgent and cancer activity (and any routine activity where possible) until new capacity comes on line at start of September 2021. Radiology staffing is also pressured, and is limiting some restoration of services.
- Cancer activity has also returned to above pre-Covid levels, and a number of specialty areas are challenged. The Breast service is steadily returning to a two week wait time below 14 days (albeit is currently at 16 days at start of June). Pressure remains in Urology, Colorectal and Lung services. The Skin service continues to perform well.

ED Activity



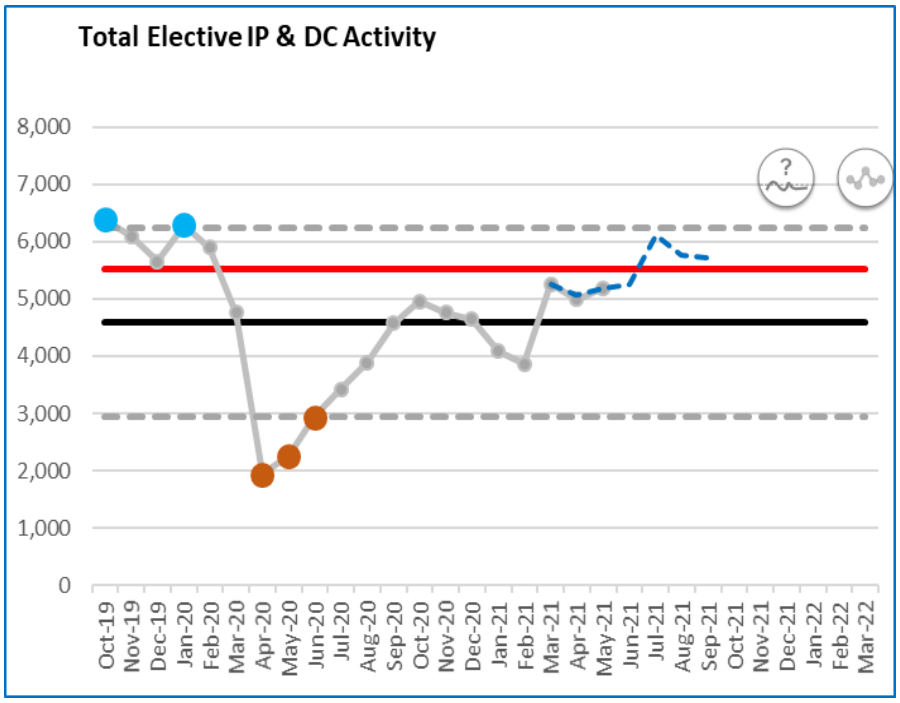
May 2021 actual performance
13369
Variance Type
Special Cause
Local Target
12286 (monthly average)
Target/ Plan achievement
Trajectory Based on H1 plan



May 2021 actual performance
11217
Variance Type
Special Cause
Local Target
10278 per month
Target/ Plan achievement
Trajectory Based on H1 plan

Background	What the Chart tells us	Issues	Actions	Mitigation
The ED activity levels reflect the demand for unscheduled care presenting at the A&E departments. Type 1 activity is the major A&E activity and excludes minor injury unit and urgent care centre activity	The level of activity is higher than the planned trajectory and above the local plan for 21/22.	Activity has returned to pre-covid-19 levels, however segmented pathways need to be retained for infection prevention and control reasons. These reduce capacity and so impact on flow in the department. The activity that has returned to A&E tends to be patients presenting with high acuity. This increased attendance is placing pressure on the system and impacting on time to assessment, 4 hour waits and ambulance handover times.	A&E improvement plan developed and being implemented. SDEC being optimised. Surgical SDEC opened. UCC returned to both acute sites to support signposting of patients to these facilities.	System wide pathway work being managed by UEC group chaired by SaTH COO.

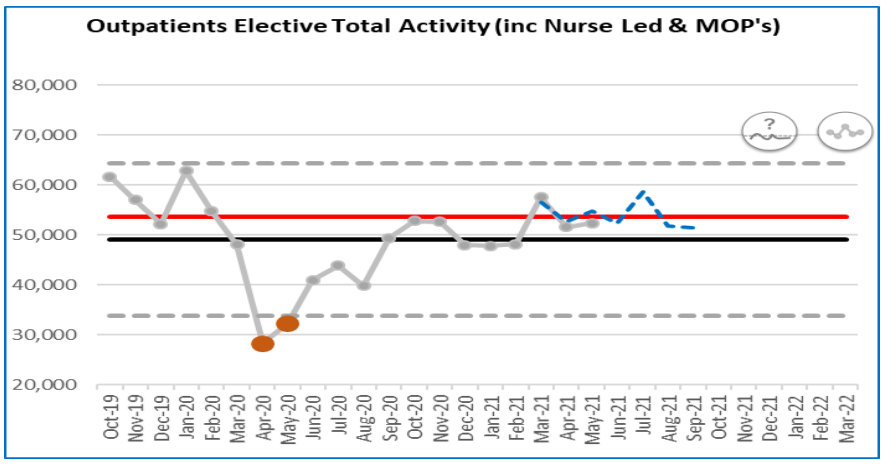
Elective IP & DC Activity v H1 recovery plan



May 2021 actual performance
Total 5187 **DC** 4897 **IP** 290
Variance Type
Common Cause
National Target
National DC & IP 75% **Local** 5515 (monthly average of H1 plan)
Target/ Plan achievement
H1 75% achieved however activity slightly lower than plan. This may well improve with completion of coding for the frozen SUS position.

Background	What the Chart tells us	Issues	Actions	Mitigation
Activity remains below historic levels and below expectation with regard to "Restoration & Recovery." There was a further significant dip in February in relation to the standing down of elective activity and conversion of the low risk pathway (DSU) at RSH to support critical care surge and at PRH to support medical escalation. This is now starting to recover.	Performance is tracking broadly in line with the H1 plan trajectory, however remains lower than 19/20	Lack of inpatient beds on both sites	Ward 21 has opened as elective surgery at RSH, increasing the number of day case beds from 31.5.21 Ward 36 has opened at PRH for elective orthopaedics from 14.6.2021. Insourcing commencing June/July to provide weekend day surgery. Vanguard weekly utilisation to be optimised and monitored.	See actions

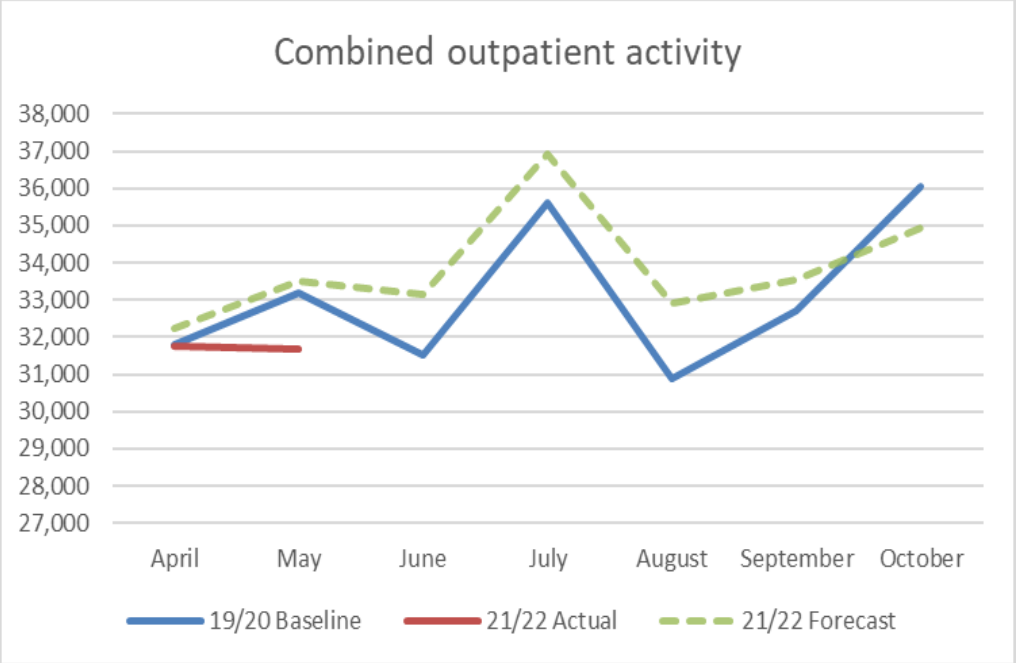
Outpatients Elective Total Activity

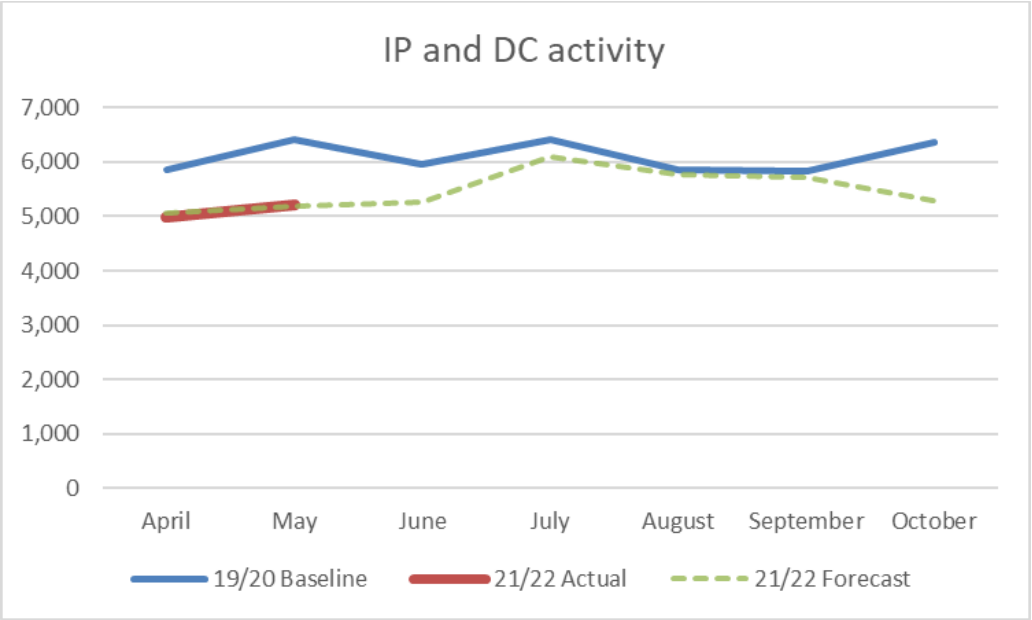


May 2021 actual performance
52383
Variance Type
Common cause
Local Target
54823 (Monthly Average of H1 plan)
Target/ Plan achievement
Below H1 plan

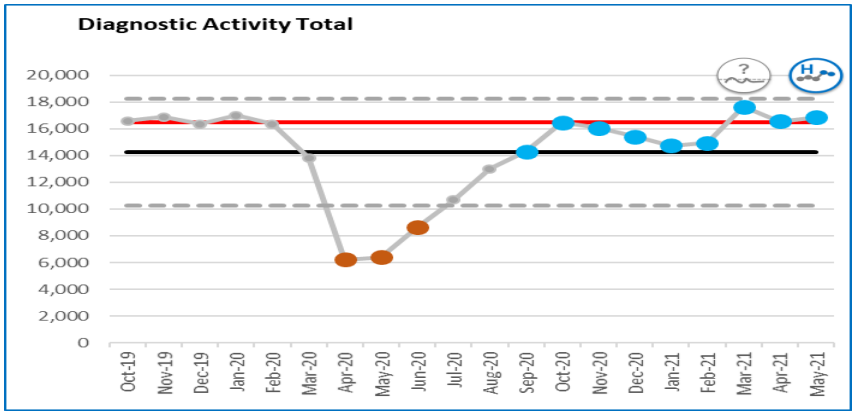
Background	What the Chart tells us	Issues	Actions	Mitigation
The availability of outpatient capacity remains constrained as a result of 2 metre social distancing, and the availability of manpower in some specialities where staff have been redeployed to support emergency and Covid related pressures.	We haven't returned to pre covid levels and are currently delivering below the agreed level in the H1 plan, although remain above the expected recovery threshold for the month.	Lack of available rooms	Bookwise now operationally giving the trust the ability to use rooms and see available rooms. Review the use of virtual appointments where appropriate. PIFU commenced for three specialties during June 2021 enabling patients to self-refer on symptoms and avoid use of time-based reviews.	See actions

From April 21 – September 21 the elective recovery scheme for England is in operation. The activity levels for Outpatients, IPDC are monitored against the % of 19/20 baseline activity to assess the extent of service recovery. The ERF sets out thresholds for expected levels of performance increasing from 70% of the 19/20 baseline in April 21 to reach 85% of the July 19 activity by July 21 and sustain this level in August and September. The threshold for May 21 is 75% of the May 2019 activity. Achievements above these thresholds are incentivised via the ERF scheme providing the other criteria for transformation, improvement and management health inequalities are met. It is noted that the activity plan is applied to all patients, however the ERF is based on English patients and the financial value of activity delivered as opposed to the number of patients treated. The tables and charts below show the actual positions for April and May 2021 and the forecast for June – October 21. The diagnostic recovery plan is shown in the next section of the report.





Diagnostics phase 3 recovery plan

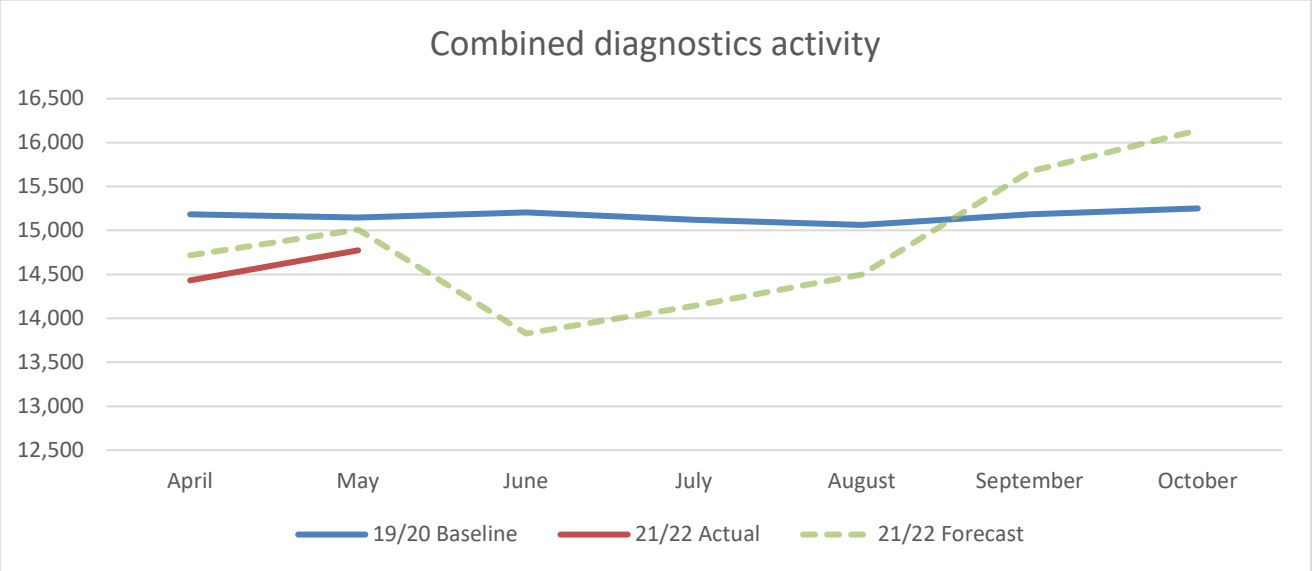


May 2021 actual performance
16843
Variance Type
Special Cause Improvement
Local Target
16500 (based on Apr-19-Feb-20 average)
Target/ Plan achievement
Recovered to target and slightly better than H1 plan

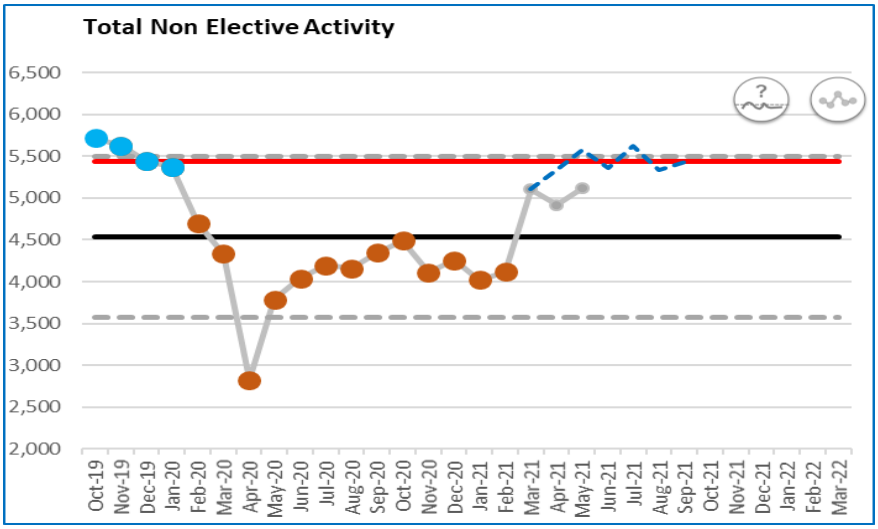
Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic activity is made up of the number of tests/procedures carried out during the month; it contains Imaging, Physiological Measurement and Endoscopy Tests.	Activity continues in line with the 16,500 target and pre-COVID levels.	Due to continued challenges in workforce activity fluctuates with staff availability, particularly school holidays as in May. This is expected to impact on performance throughout the summer period.	Regular review of appointment templates to maximise capacity. D&C model updated and reviewed weekly to identify change and plan interventions. Recruitment campaign to support appointment to the Radiology POD. System working with RJAH to agree consistent A4C bandings.	Staff continue to offer voluntary overtime alongside additional external capacity within the plan.

Imaging Recovery v H1 plan (national target is 70% April, 75% May, 80% June, 85% July onwards of 2019-20 baseline). All three imaging modalities delivered better than the national recovery thresholds for May, although Ultrasound delivered below the intended plan.

Endoscopy recovery v H1 plan (national target is 70% April, 75% May, 80% June, 85% July onwards of 2019-20 baseline). While above the threshold for colonoscopy and gastroscopy, the threshold was not achieved for flexi-sigmoidoscopy and is challenged in recovery to the plan set out for H1.



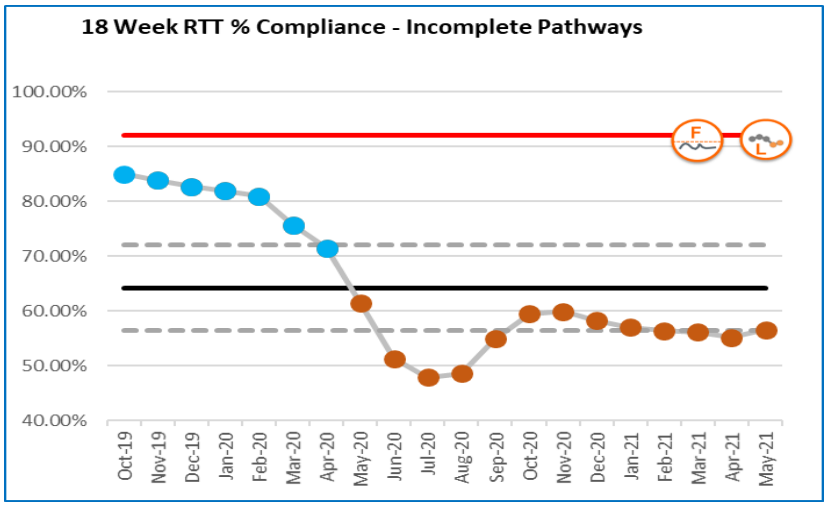
Non-Elective Activity



May 2021 actual performance
5114
Variance Type
Common Cause
Local Target
5572 (Monthly Average of H1 plan)
Target/ Plan achievement
The forecast is for demand to return to 19/20 baseline

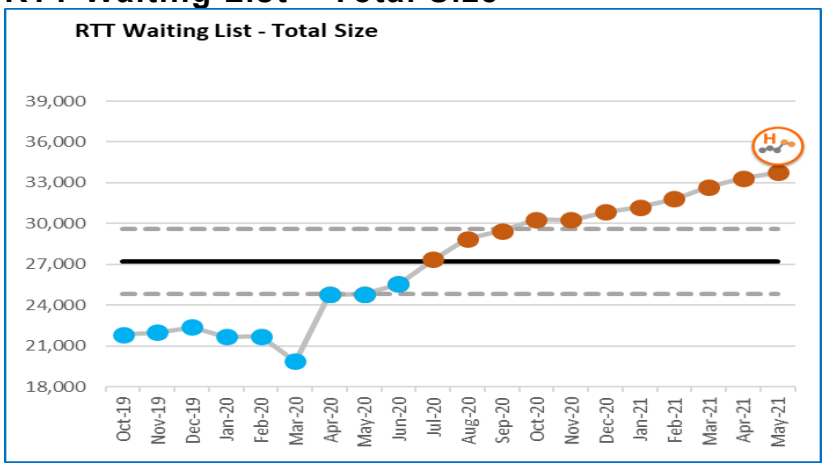
Background	What the Chart tells us	Issues	Actions	Mitigations
Non-elective activity reflects the demand from unscheduled care for admissions to hospital. It represents the greatest demand on beds and increases can result in constraints on elective activity, while reductions impacts negatively on contract income.	The level of activity has not yet returned to the pre-covid levels, despite the rise in A&E attendances and acuity.	Primary care admissions remain lower than in 19/20 Covid-19 inpatients are presently low, however segmentation of beds remains important for infection control.	Increase capacity for elective activity while unscheduled bed occupancy remains low. Monitor impact on H1 plan.	See actions

18 week RTT Exception Report

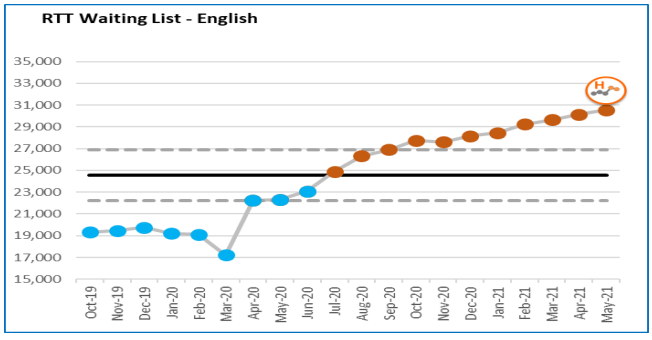


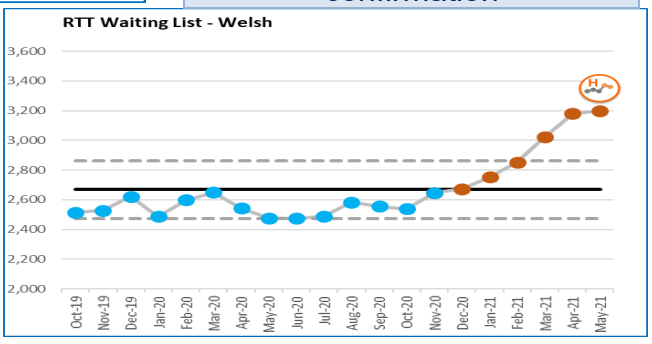
May 2021 actual performance
56.6%
Variance Type
Special Cause
National Target
92%
Target / Plan Achievement
Due to the size of the backlog developed the target will not be achieved. Local plan focuses on clinically prioritised patients.

RTT Waiting List – Total Size



May 2021 actual performance
33763
30564 (English) 3199 (Welsh)
Variance Type
Special Cause
Local Plan
26209 (English) by Mar 2022
Target / Plan Achievement
Overall plan dependant on Welsh ERF scheme confirmation

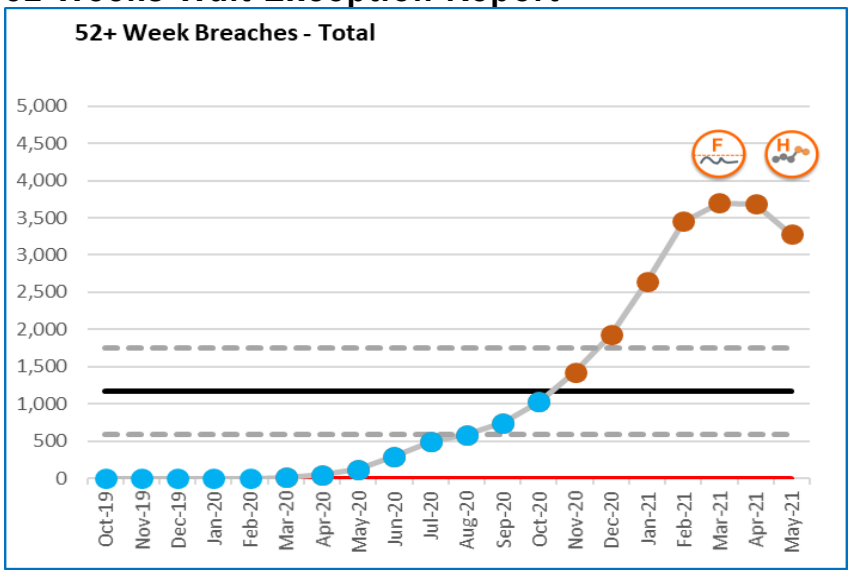




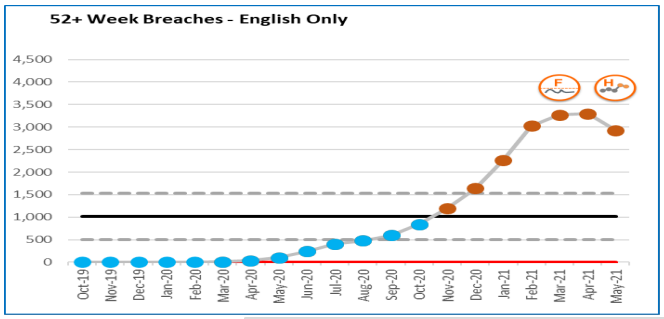
Background	What the Chart tells us	Issues	Actions	Mitigations
Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways. .	Continuation of the increase in the total waiting list size and high proportion of the waiting list being over 18 weeks due to the backlog of elective activity and need to address clinically urgent cases.	Limited OPD capacity (social distancing). Limited operating capacity (theatre staffing & beds to enable segregation). The prioritisation of urgent patients due to the limited available capacity means that high volume	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date to avoid over 104 week waits where possible. Restoration of further OPD face to face capacity. ERF plan and use of Nuffield for suitable patients where possible and outsourcing to Rowley Hall for urology Elective orthopaedics commenced mid-June. RSH elective inpatient bed base expanded from end May.	Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways.

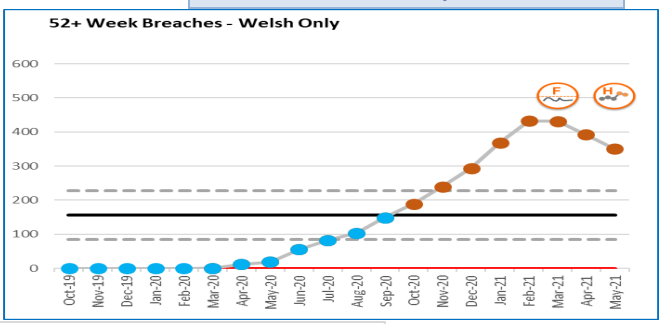
		procedures are not being cleared.	Bookwise operationally to aid room visibility and scheduling. Insourcing by 18weeks planned from end of June to increase surgical weekend working and additional outpatient activity	

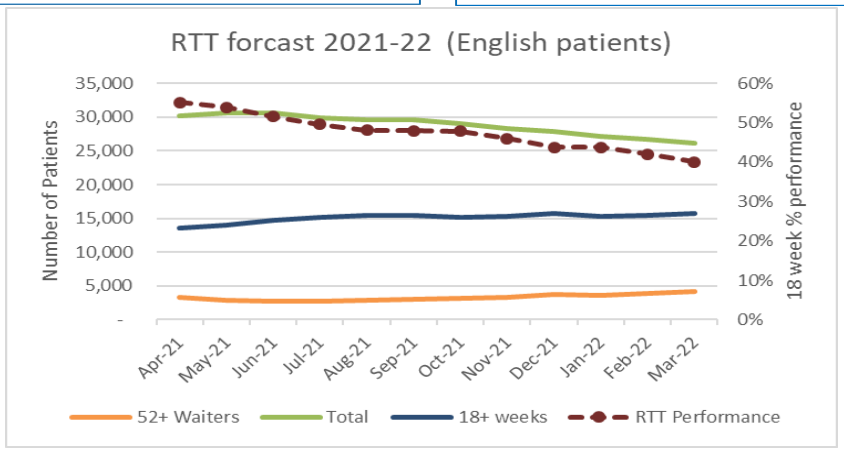
52 Weeks Wait Exception Report



May 2021 actual performance	
3275 2925 (English only) 350 (Welsh patients)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	**4156**
Target / Plan Achievement	
The target will not be delivered in 21/22. Local forecast developed aligned to the H1 plan.	

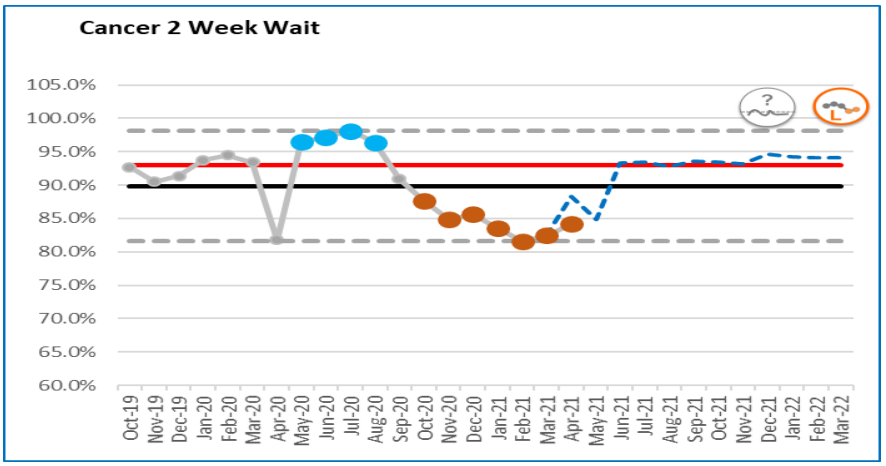






Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It continues to increase because routine patients are not currently being prioritised for treatment.	The reduction seen in over 52 weeks at present is not forecast to be sustained. Total waiting list is forecast to reduce as the most urgent patients are treated. This means that the 18 week performance will continue to decline as the most urgent patients tend to wait in shorter time bands.	Significant number of patients breaching due to the volume on the waiting list and the priority given to the most urgent patients in shorter time bands.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date where possible. Avoidance of over 104 week breaches. ERF plan and use of Nuffield for suitable patients where possible and outsourcing to Rowley Hall for urology.	Clinical prioritisation of patients in terms of PL scores and monitoring patients over 52 and 76 weeks date where possible.

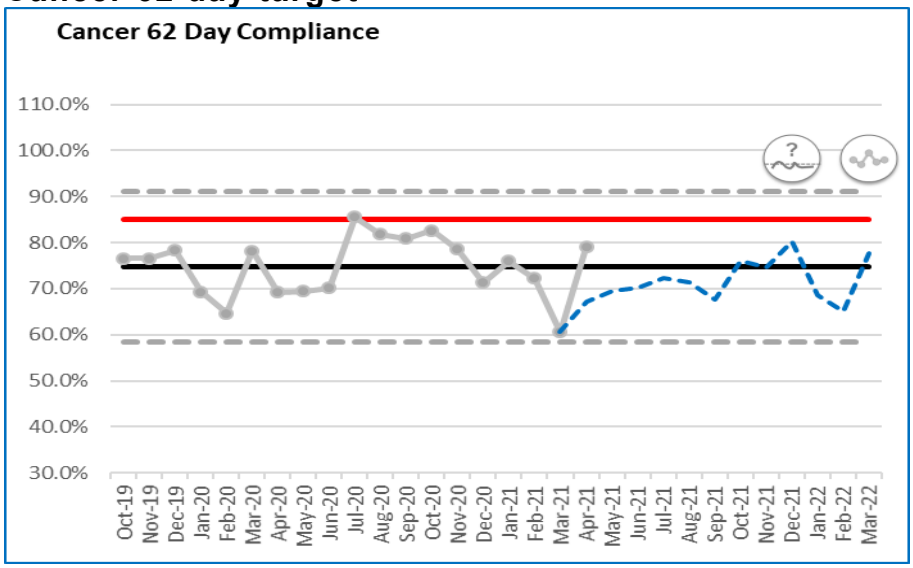
Cancer 2 week waits



April 2021 actual performance
84.2% (May forecast 84.5%)
Variance Type
Special Cause Concern
National Target
93%
Target / Plan Achievement
Measure currently unlikely to meet the target

Background	What the Chart tells us	Issues	Actions	Mitigation
This measure is a key indicator for the organisation's performance against the national Cancer Waiting Times guidance ensuring wherever possible that any patient referred by their GP with suspected cancer has a first appointment within 14 days.	The present system is unlikely to deliver the target. Compliance with this target has fluctuated since April 2019 – attributed to poor performance (capacity) within the breast service. Performance is slightly worse than the recovery trajectory set.	Capacity issues in the Breast specialty has impacted negatively on SaTH's overall 2WW performance.	Extra capacity being added to the Breast 2WW clinics and improvement trajectory in place. Current forecast is that Breast will be back on target in July.	Implementation of revised 2WW Breast Referral Proformas

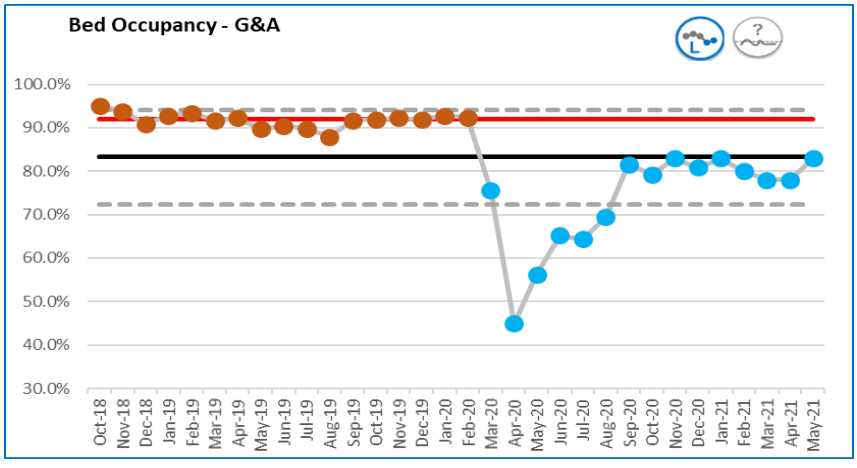
Cancer 62 day target



April 2021 actual performance
79.0% (May forecast 69.57%)
Variance Type
Common Cause
National Target
85%
Target / Plan Achievement
Measure is not capable of meeting the target reliably, however performance is better than planned

Background	What the Chart tells us	Issues	Actions	Mitigations
This measure is a key indicator for the organisation's performance against the national Cancer Waiting Times guidance ensuring wherever possible that any patient referred by their GP with suspected cancer is treated within 62 days of referral.	The present system is unlikely to deliver the target. Compliance with this target has been achieved once since April 2019.	Capacity does not meet demand (diagnostics a significant issues even prior to COVID). Surgical capacity not back to pre covid levels. Losing mobile CT scanner at the end of May. Rise in 2WW referrals.	Weekly review of PTL lists using Somerset Cancer Register – escalations made as per Cancer Escalation Procedure. New pod to house a CT/MRI scanner to be in place by Sep 21.	Pathway Project Managers introduced to review pathways and implement efficiencies to assist compliance with targets Cancer Performance and Assurance Meetings on-going chaired by Deputy COO.

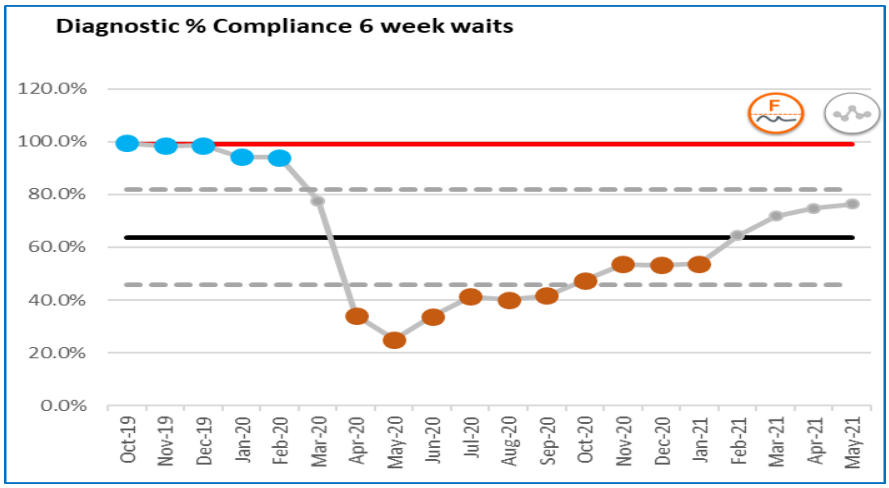
Bed Occupancy



May 2021 actual performance
83%
Variance Type
Special Cause improvement
National Target
92%
Target / Plan Achievement
Occupancy continuing to be lower than pre-covid-19

Background	What the Chart tells us	Issues	Actions	Mitigation
Bed occupancy is an important measure indicating the flow and capacity within the system	Bed occupancy has increased overall, however the majority of the increase represents an increase in emergency non-covid-19 admissions Occupancy levels remain below the pre-covid-19 levels	Segmentation of beds has created smaller bed pools and reduced flexibility. The increase in NEL occupancy has reduced capacity to restore elective activity	Bed base re-allocated to increase green elective capacity. Bed base assessment to be conducted to ensure bed establishment and changes to bed allocation are accurately reported. Winter planning commenced and schemes under-development to continue admission avoidance.	See actions

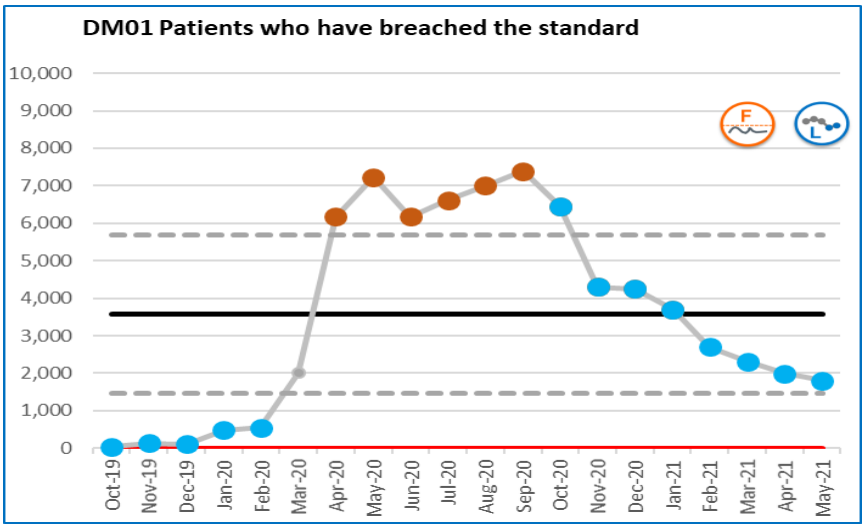
DM01 Diagnostic over 6 week waits



May 2021 actual performance
76.33%
Variance Type
Common Cause
National Target
99%
Target / Plan Achievement
Target will not be delivered with present capacity constraints in some diagnostic services

Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6w of the referral	Performance continues to improve towards compliance as planned.	Staffing levels continue to be a significant challenge in all modalities and the main constraint to quicker service recovery. COVID safe working practices continue to impact on imaging capacity. Loss of mobile CT capacity is expected to adversely affect performance from June.	Staff continuing to offer voluntary additional sessions. However, this must be balanced to preserve well-being and is expected to reduce through the summer period. Revise and resubmit business case for mobile CT when these become available to bridge the gap until pod becomes operational.	Continued prioritisation of appointments in line with Clinical urgency. Appointment team working to fill all available capacity.

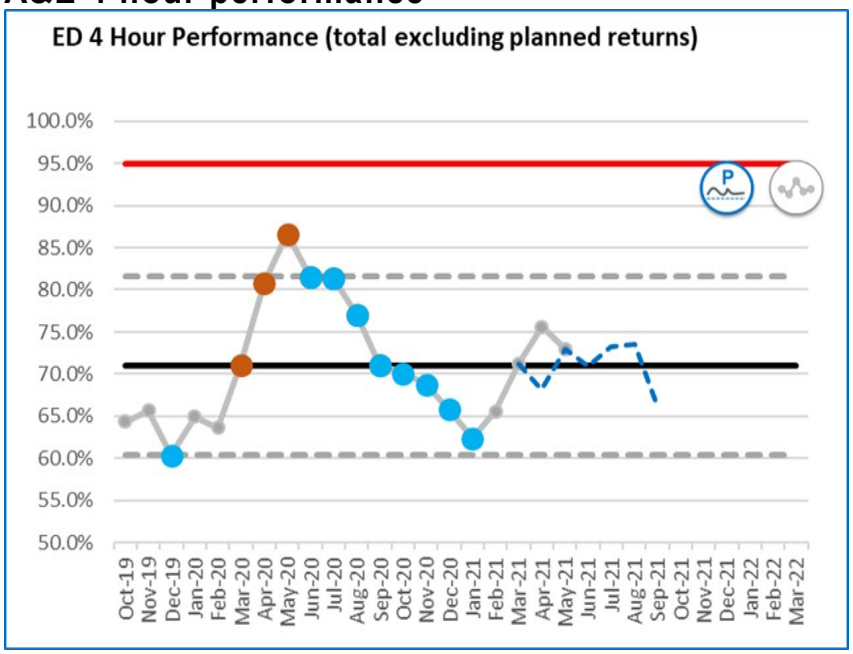
DM01 Patients who have breached the Standard



May 2021 actual performance
1807
Variance Type
Special Cause improvement
National Target
0 - < 6weeks
Target / Plan Achievement
Target will not be delivered with present capacity constraints in some diagnostic services

Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6w of the referral. There must be no more than 1% of patients waiting longer than 6w	The number of patients waiting more than 6 weeks for diagnostic tests continues to improve/decrease, from just over 4,000 in November 2020 to just under 2,000 in May 21.	Removal of mobile CT scanner from the end of May means that this rate of improvement will not be sustained and will potentially impact on DM01 from June assuming other modalities remain consistent.	Approval this month means that recruitment to the Imaging pod has commenced. Continued active management of waiting lists to prioritise clinical urgency and maximise use of available capacity. Clinical prioritisation by D value to be completed by the end of July 21.	All additional capacity is being proactively utilised to support the standard. The business case for mobile CT will be revised and re-submitted

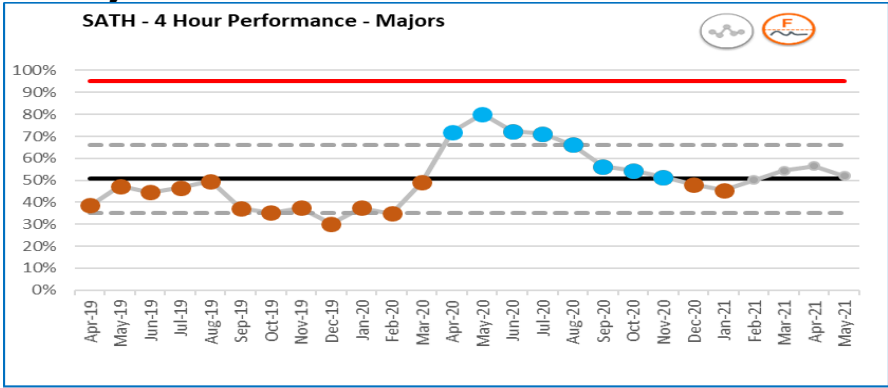
A&E 4 hour performance



May performance
73%
Variance Type
Common cause
National Target
95%
SaTH Local Plan
73%
Target / Plan Achievement
Performance is in line with the improvement trajectory set. However the 95% target cannot be achieved and the Trust is working with system partners towards delivery of 85%

Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department.	ED performance is forecast to continue to be below national target. The A&E improvement plan has been developed which will now be applied to this forecast to demonstrate year-end improvement.	ED attendances have increased and are now higher that pre covid levels which is increasing pressure on the departments Ensuring whole system approach adopted to deliver improvement New UEC measures being introduced during 21/22.	ED performance improvement plan with associated trajectory developed and in process of implementation. Key actions include mapping of workforce against demand, increasing physical capacity for RSH ED via capital build programme, maximising capacity created by SDEC models and supporting flow through from the departments by improving ward management processes.	Daily 'safe today' huddles in place across both departments Demonstrable improvement in the quality of care for patients within ED submitted to CQC.

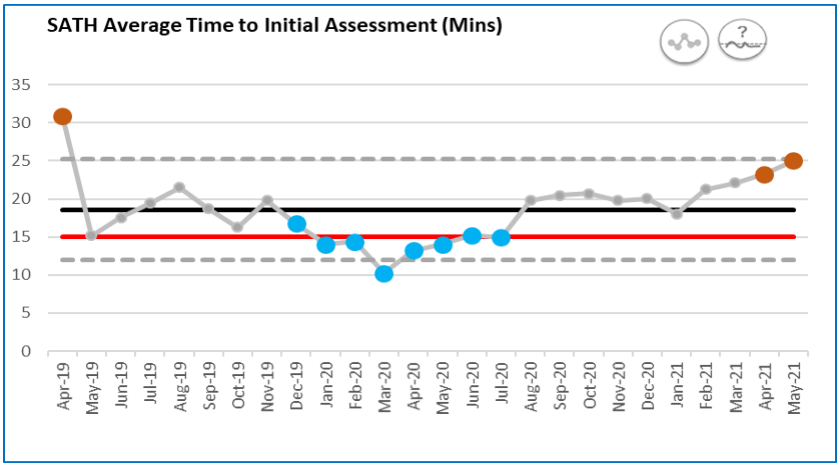
ED Majors Performance



May 2021 actual performance
52.0%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
The target is above the upper process control limit and so will not be achieved

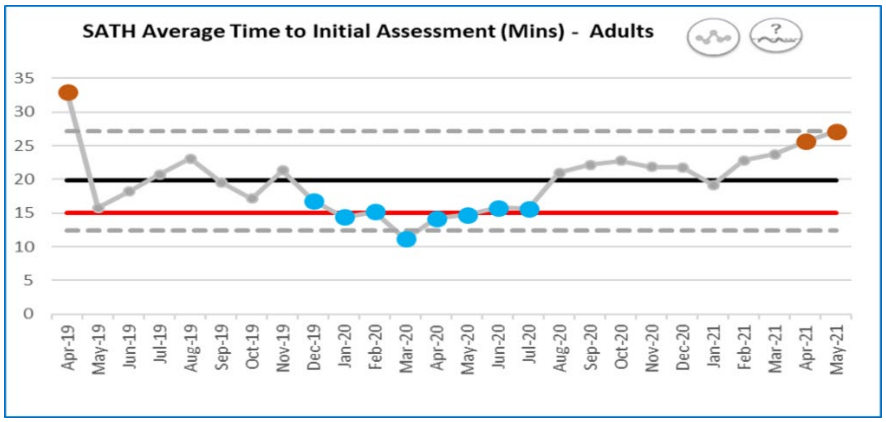
Background	What the Chart tells us	Issues	Actions	Mitigations
4 hour performance for major presentations is dependent on having good flow into and out of ED	Performance has stabilised however the target is well above the upper control limit and so will need the proposed redesign.	Increased in proportion of attendees who are classified as majors. Maintaining red and green IPC pathways.	As per the 4 hour A&E improvement plan and estate redesign as described above	See actions

ED –Time of Initial assessment (mins)



May 2021 actual performance
25 Minutes
Variance Type
Special Cause Deterioration
National Target
15 Minutes
Target / Plan Achievement
Performance remains worse than target

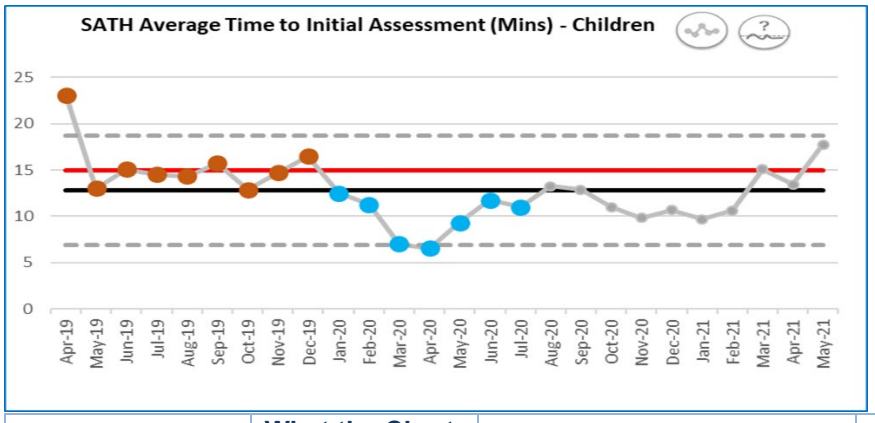
ED Time to Initial Assessment - Adult



May 2021 actual performance
25 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Performance worse than target

Background	What the Chart tells us	Issues	Actions	Mitigations
Time to initial assessment is a patient safety indicator.	Overall time to initial assessment is worse than the target. The performance for adult initial assessment is the key contributor to this	Capacity constraints within the departments especially when patients arrive in close proximity	Continued recruitment into vacant ED posts will allow resilience in planning rota's to support expected peak arrival times and further improve initial assessment times. Think 111 implemented on a phased approach to support patients to pre booking walk in appointments where appropriate which can be staggered Increased senior nurse focus in Q1 21/22 with improvement plan to address this.	Internal escalation processes

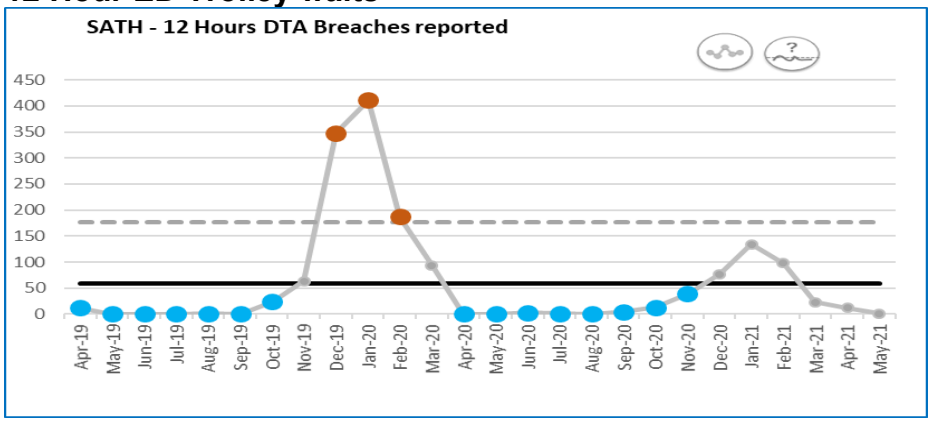
ED Time to Initial Assessment - Children



May 2021 actual performance
18 Minutes
Variance Type
Common Cause
National Target
15 Minutes
Target / Plan Achievement
Until May, the target has been achieved consistently

Background	What the Chart tells us	Issues	Actions	Mitigations
Time to initial assessment is a patient safety indicator.	This target had been delivered for the last 15 months. Deterioration in performance is seen this month.	Delivery challenged due to exponential increase in activity, particularly for minor activity on the PRH site. As previously flagged, there is a fundamental risk to delivery identified due to change in management practice associated with paediatric referral management.	Increased focus from senior nursing on the consistency of achievement for all children and continuing to audit and address reasons for non-achievement.	Escalated to Director of Nursing re process management issue

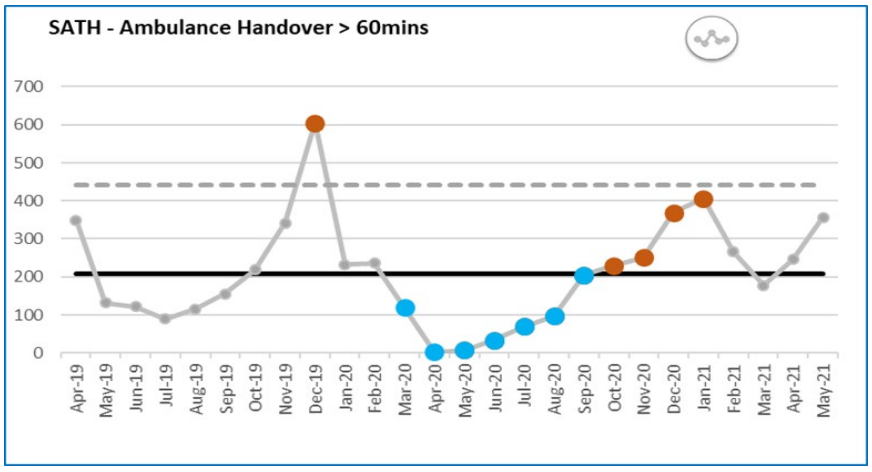
12 Hour ED Trolley waits



May 2021 actual performance
1
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The target was nearly missed this month

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a patient experience and outcome measure.	Performance has improved and is returning towards delivery of the target.	1 patient has breached during the month due to flow out of ED into available ward bed. Performance from the end of May will be affected by closure of discharge lounge and reduction in number of medical beds to facilitate surgical recovery plan.	Continue delivery of ward process improvement plan to facilitate earlier discharge and allow flow from ED's. Ensure SDEC clinical model is fully optimised. Source and establish an alternative discharge lounge .	Patient safety SOP and navigator role in ED for ambulance offload delays.

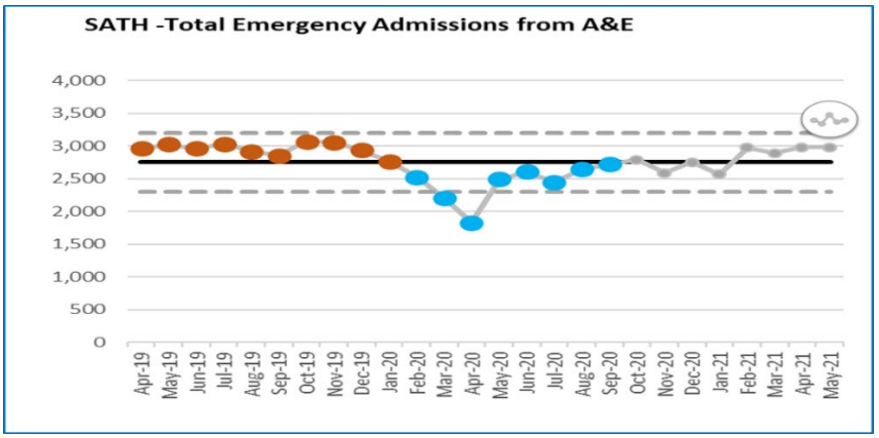
Ambulance handover> 60 Mins



May 2021 actual performance
356
Variance Type
Common Cause
National Target
0
Target / Plan Achievement
The system is not capable of delivering this target consistently

Background	What the Chart tells us	Issues	Actions	Mitigations
Ambulance handover times are an important indicator for patient safety and to support the community response to 999 calls by release of ambulances to respond.	Common cause variation is showing an increase in over 60minute handovers with the present increase in conveyance contributing to the system being unlikely to meet this target	Ambulance offload delays due to lack of capacity HALO role no longer in place. Insufficient physical capacity for offload.	Ambulance navigator role in place with plan to increase initial assessment to SDEC & UTC where appropriate. Senior clinical doctor supports with assessing patients delayed on ambulance where appropriate	Ambulance arrival sop in place Harm review process established

Total Emergency Admissions from A&E



May 2021 actual performance
2977
Variance Type
Common Cause
National Target
N/A
Target / Plan Achievement
N/A

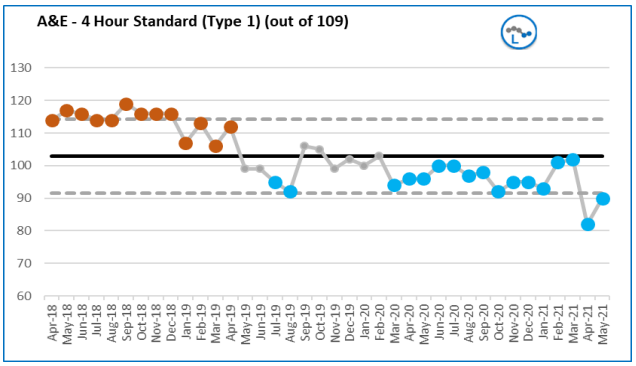
Background	What the Chart tells us	Issues	Actions	Mitigation
The number of emergency admissions is an indicator of system performance and a reflection of the prevalence of serious illness and injuries in the community	The level of emergency admissions via A&E has returned to close to pre-covid-19 levels	Green and red pathways need to be maintained Lack of flow into beds results in patients being held in ED and impacts on ED performance and ambulance hand-over times.	Bed allocations being reset. Additional bed requirements for winter 21/22 identified and bid for modular beds submitted Professional standards and direct access to assessment areas proposed	See actions

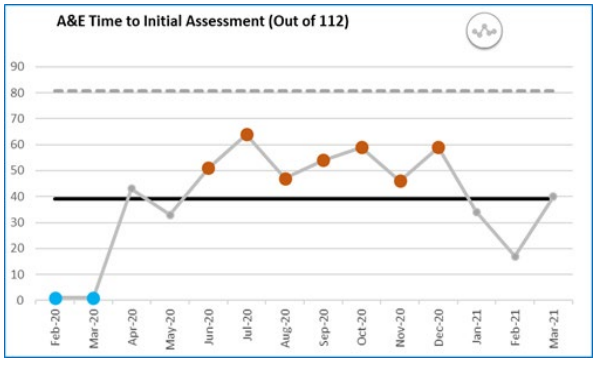
Operational Performance Benchmarking

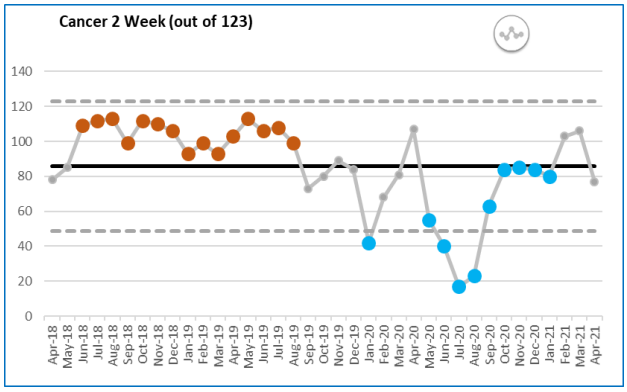
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts. Work is underway to adapt this icon so as to distinguish it from the icon used in other charts, ensuring it is clear this icon refers to relative ranking of the trust rather than performance over time.

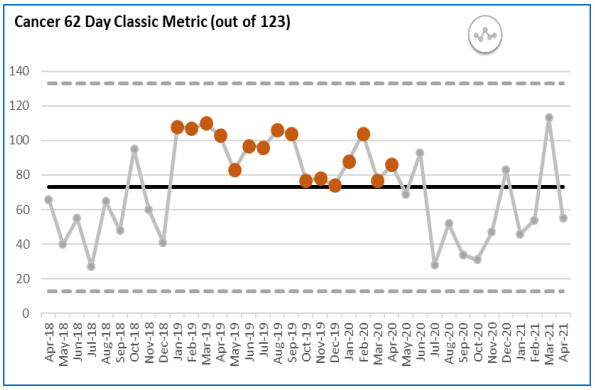
KPI	Latest month	Actual Performance Ranking	Perfomance	Assurance	Lower process limit	Upper process limit
A&E - 4 Hour Standard (Type 1) (out of 109)	May 21	90			92	114
A&E - Time to Initial Assessment (OUT OF 110)	Mar 21	40			-2	81
Cancer 2 Week (out of 123)	Apr 21	77			49	123
Cancer 2 Week Breast Symptomatic (out of 113)	Apr 21	101			31	131
Diagnostic 6 Week Standard (out of 123)	Apr 21	72			33	96
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 122)	Apr 21	8			-6	46
Diagnostic 6 Week Standard - Audiology Assessments (out of 110)	Apr 21	51			6	101
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 102)	Apr 21	98			-4	102
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 91)	Apr 21	30			-28	107
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 123)	Apr 21	92			44	107
Diagnostic 6 Week Standard - Computed Tomography (out of 123)	Apr 21	65			20	117
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)	Apr 21	108			82	120
Diagnostic 6 Week Standard - Colonoscopy (out of 123)	Apr 21	38			-4	81
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)	Apr 21	59			-7	84
Diagnostic 6 Week Standard - Cystoscopy (out of 119)	Apr 21	84			4	98
Diagnostic 6 Week Standard - Gastroscopy (out of 123)	Apr 21	40			3	76
RTT 52 Week Breach (out of 123)	Apr 21	90			57	81
RTT Incomplete 18 Week Standard – (out of 123)	Apr 21	109			39	80
Emergency C-Section (out of 122)	Feb 21	42			-2	29
Elective C-Section (out of 122)	Feb 21	109			-7	95

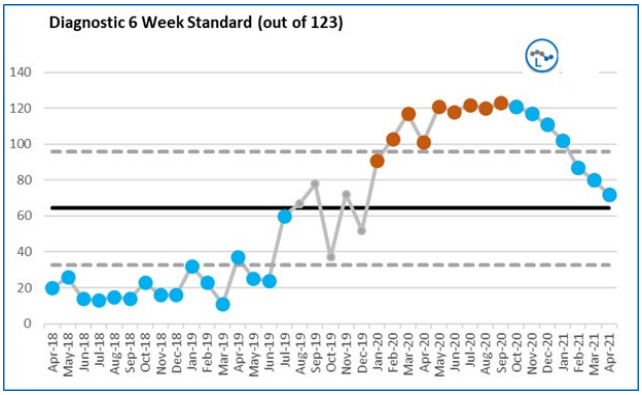
The SPC charts show the relative ranking of the Trust compared to other English trusts over time and so demonstrates the change in relative position compared to previous periods and the variation in the Trust ranking. The lower the ranking the higher is the relative position of the Trust compared to others. It is noted that the Trust has consistently improved its ranked position in relation to A&E 4 hour performance, echocardiography, respiratory sleep studies, but is deteriorating in terms of RTT performance.

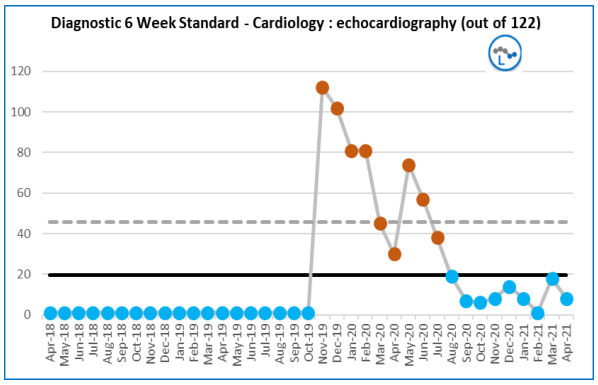


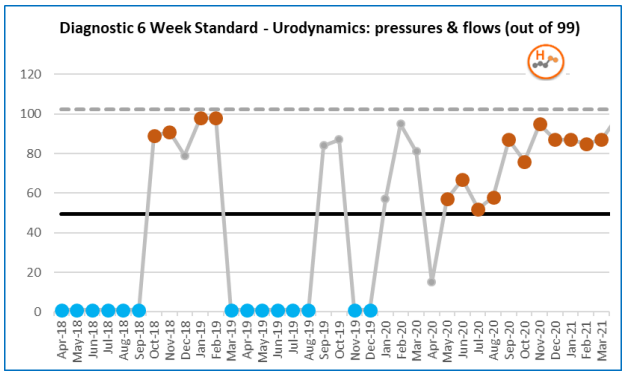


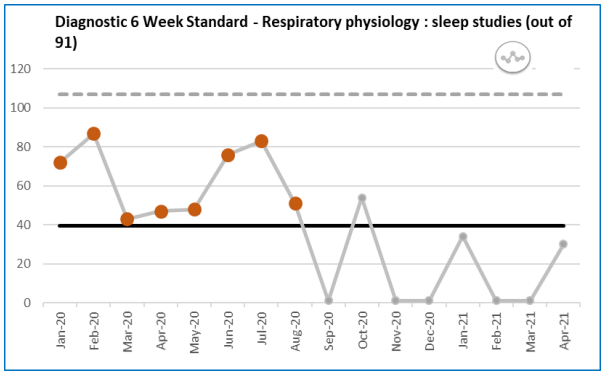


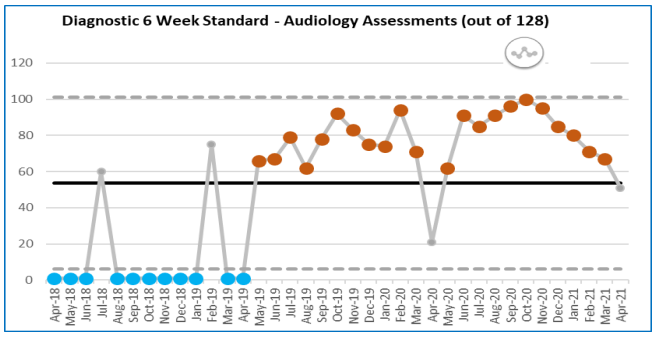


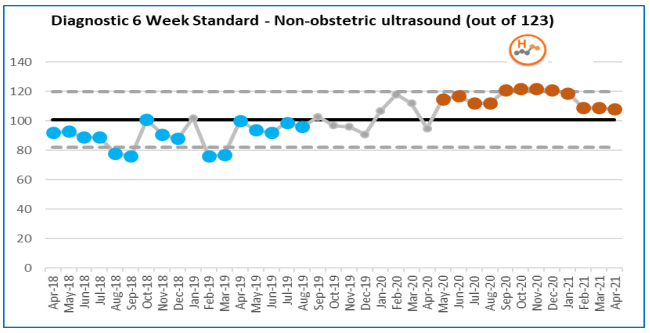

Diagnostic 6 Week Standard (out of 123)

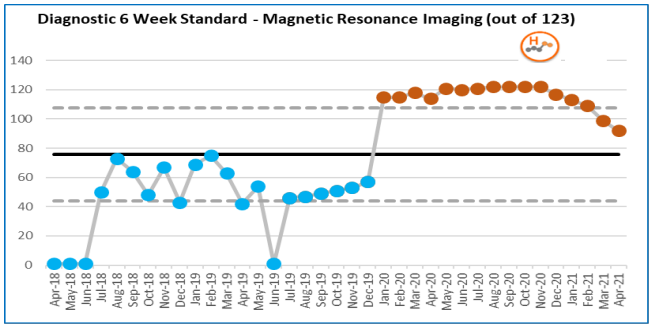

Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 122)

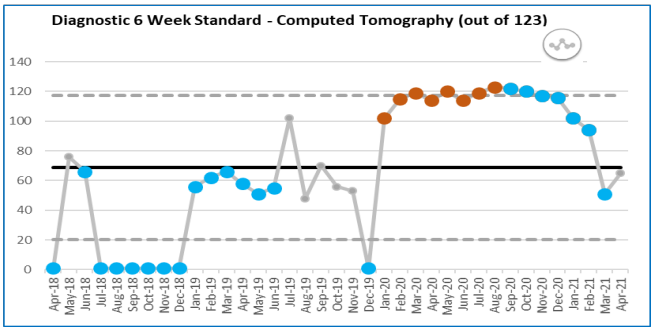

Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 99)

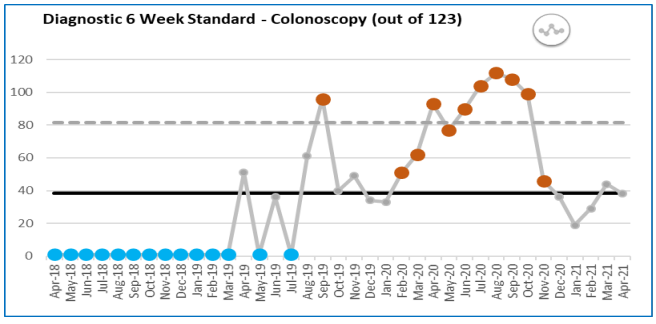

Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 91)

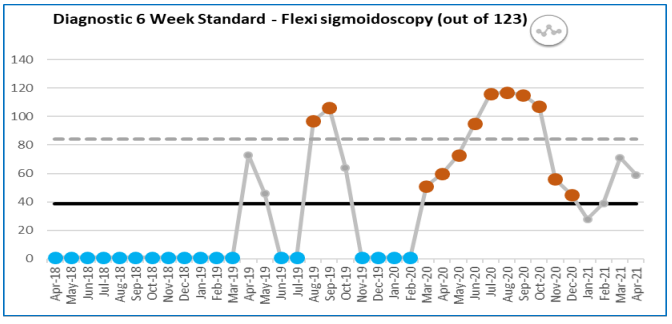

Diagnostic 6 Week Standard - Audiology Assessments (out of 128)

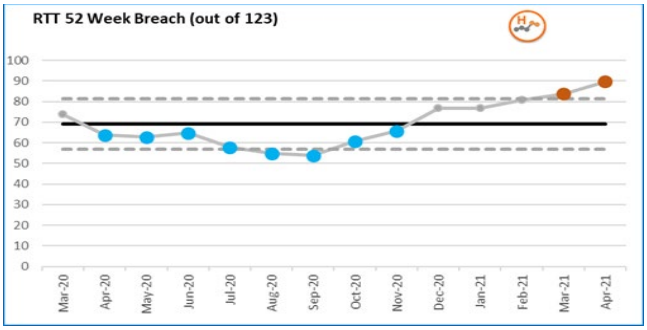

Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 123)

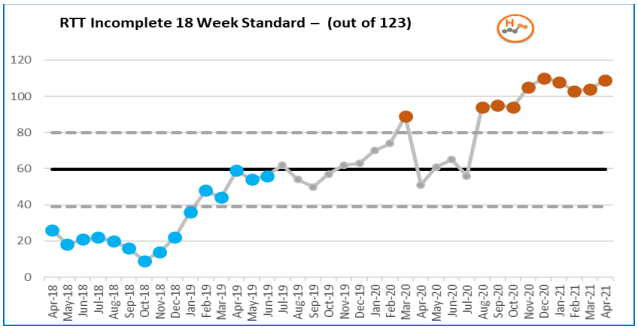

Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 123)


Diagnostic 6 Week Standard - Computed Tomography (out of 123)


Diagnostic 6 Week Standard - Colonoscopy (out of 123)


Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 123)


RTT 52 Week Breach (out of 123)
100
90
80
70
60
50
40
30
20
10
0
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21


RTT Incomplete 18 Week Standard – (out of 123)
120
100
80
60
40
20
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
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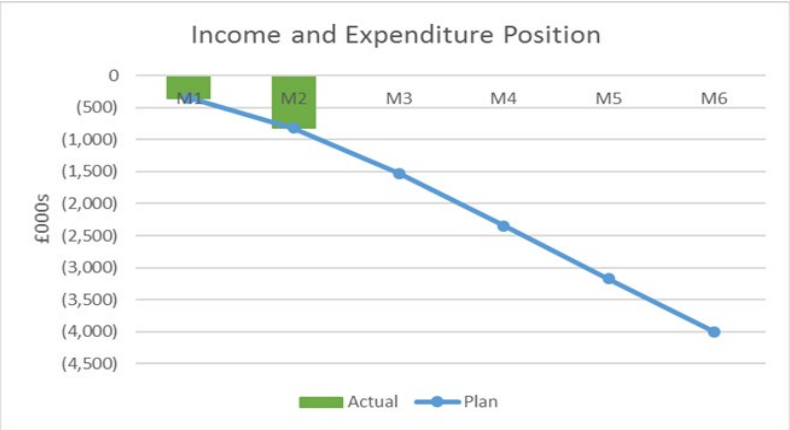
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21

6. Finance Summary
Helen Troalen, Director of Finance

- The Trust continues to operate within a temporary financial regime for the first 6 months (H1) of the 21/22 financial year. Publication of the national guidance for the final 6 months (H2) awaits.
- The Trust agreed a plan for the H1 period which reported a £(3.998)m deficit. However, further discussions have taken place with the system since this submission and an additional £0.779m of funding has been secured due to a change in how the system funding has been allocated. Health systems have the opportunity to resubmit their H1 plans during June and the additional income will be reflected in the revised plan submission.
- The Trust's H1 plan will therefore improve to a deficit of £(3.219)m from month 3 reporting.
- The STW system plan remains the same as previously reported which is equivalent to the system funding received for H1, however to deliver this plan £6m of financial risk must be mitigated over H1.
- The Trust recorded a deficit of £(0.821)m after 2 months of the reporting period which is in line with plan.
- £8.474m of funding to support the ongoing Covid response has been received for H1. The Trusts Covid related spend is £0.886m in month which is £0.704m lower than the previous month. The YTD Covid spend is £2.476m, £1.024m lower than the plan. This position is offsetting overspends against non-Covid related spend.
- Trust expenditure (excluding Covid) is £(1.132)m over plan which is primarily a timing/phasing issue due mainly to activity related expenditure and one-off set-up costs linked to the recently implemented endoscopy maintenance contract.
- This situation is not unexpected given that when Covid activity is low non-Covid activity increases.
- The Trust has included additional funding linked to achievement of the Elective Recovery Fund (ERF) in the YTD position to offset the costs of the Vanguard Theatre. Further ERF income is expected to be received during June to offset additional marginal costs incurred by the Trust which is driving some of the overspend YTD.
- The Trust must, as a minimum, deliver £2.4m of efficiency savings during H1. These savings have been planned to deliver incrementally from month 2. Savings of £0.311m have been delivered YTD against a plan of £0.240m YTD.
- Total capital spend YTD is £0.271m against a planned spend of £1.398m, this is a timing issue and the Trust is still forecasting to deliver the total capital allocation for 21/22 of £31.297m. Included within this is £21.934m of capital allocation agreed within the ICS capital programme and £9.363m of external funding for phase 2 of the RSH A&E capital scheme.
- The Trust held a cash balance at the end of May of £13.462m, which is £8.892m lower than plan due to the timing of cash flows linked to some of the 20/21 national year-end items including annual leave accrual and lost non-clinical income which are now expected to be received in August.
- At the end of May the Trust incurred agency costs of £5.276m inclusive of COVID. This monthly spend is £0.060m favourable to plan.

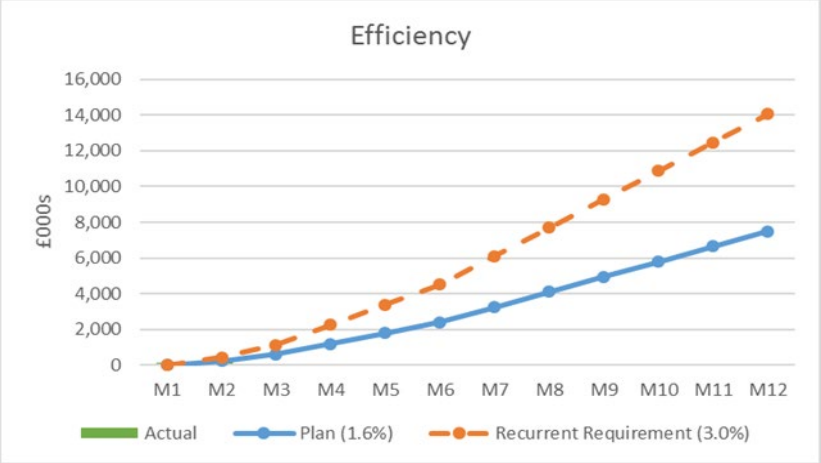
Income and Expenditure Position



April 2021 actual performance	
Income & Expenditure Position year to date (£0.821m)	
Variance Type	
Overspend to date	
National Target	**SaTH Plan 2021/22**
(£0.821m)	(£0.821m)
Target/ Plan achievement	
Balanced position	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust continues to operate within a temporary finance regime for the first 6 months of 21/22 (H1). The STW system has submitted a plan which is compliant with the H1 system funding received but with £6m of unmitigated risk. As part of this the Trust is plan is to deliver a deficit over the H1 period of £(3.998)m. This plan is compliant with the recurrent system sustainability plan.	The Trusts financial position is line with plan in month and year to date.	None to report	Further work will be done ahead of Q2 to report the underlying financial position going forward.	No further action required

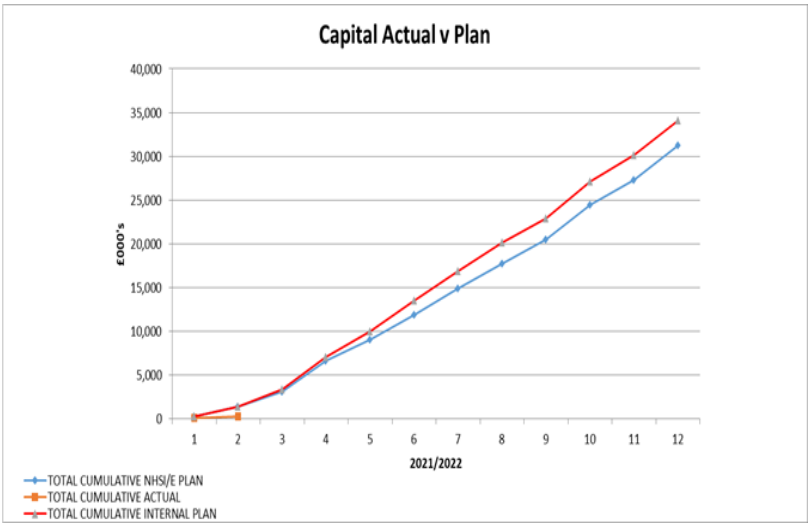
Efficiency



May 2021 actual performance	
Income & Expenditure Position year to date (£0.311m)	
Variance Type	
Over performance to date	
National Target	**SaTH Plan 2021/22**
£0.000m	£0.240m
Target/ Plan achievement	
£0.071m favourable variance	

Background	What the Chart tells us	Issues	Actions	Mitigations
In order to achieve the £(3.998)m deficit plan over the H1 period the Trust is required to deliver £2.400m of efficiency savings. A minimum of 1.6% in year savings are required to deliver the recurrent system sustainability plan, 3% FYE. This would allow the Trust to make new investments in year	The efficiency delivery is phased to commence from May with £2.400m required to deliver H1 plan and 3% FYE to allow investments and deliver underlying sustainability position.	Whist the Trust has delivered an efficiency saving year to date equivalent to £0.311m, there is an accelerated need to identify efficiency savings and to deliver 3% savings recurrently.	Head of Efficiency commenced with the Trust. Efficiency group established in May. Finalise governance arrangements (SROs, PIDs etc.) Agree project priorities and milestones.	Non-recurrent opportunities

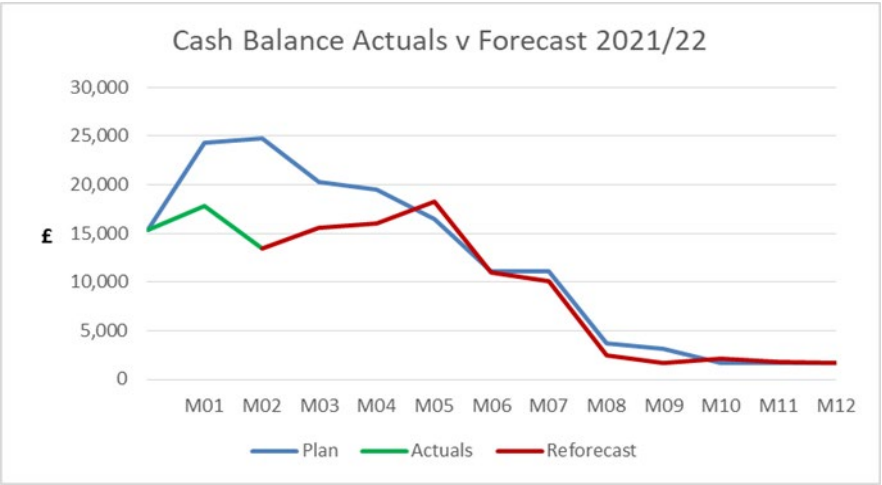
Capital Expenditure



May 2021 actual performance	
Spend year to date is £0.271m	
Variance Type Underspend	
Underspend to date £1.127m	
National Target	**SaTH Plan 2021/22**
N/A	£34.142m
Target/ Plan achievement	
To meet the Trust's Capital Resource Limit (CRL) at year end.	

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust's total Capital Allocation for 21/22 was set at £31.297m. Included within this is £9.363m for Phase 2 of RSH A&E Scheme which is externally funded by PDC. In addition sale proceeds of £2.845m are to be received to fund the Reconfiguration of Endoscopy Services (Althea MSC), bringing the total Capital Programme to £34.142m.	Within the Capital Plan submitted to NHSEI, the Trust forecast spend at Month 2 of £1.398m. Only £0.271m has been expended giving an underspend of £1.127m to Plan. The Internal Plan includes the Endoscopy Reconfiguration in addition to the original NHSEI Plan	No issues of concern.	The detailed Capital Programme was discussed at May Capital Planning Group and it is expected that expenditure will now start to be incurred on the agreed Projects.	No mitigations required.

Cash



May 2021 actual performance	
£13.462m cash in Bank	
Variance Type	
Lower Cash Balance	
SaTH Original Forecast	**SaTH Rolling Forecast**
£24.713m	£22.354m
Target/ Plan achievement	
£8.892m lower Cash Balance than Rolling Forecast	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust developed a Cash flow forecast as part of Going Concern requirement for the Annual Accounts on	The Trust forecast a cash balance which was £8.892m higher than the actual balance held at Month 02.	The Trust received less income than forecast mainly due to timing of receipt of cash relating to income included in 20/21 (Powys income, donated £1.9m now	The difference between forecast and actual is a difference in timing. A rolling monthly forecast is produced to take this timing difference into account. The year-end	See actions

which the plan is based.		forecast as receipt in June and annual leave and loss of clinical income £4.0m now forecast as receipt in August).	forecast remains the same.	

7. Transformation Summary
Chris Preston, Interim Director of Strategy and Planning

- Across the 25 programmes, twenty-one have remained consistent in period and three have improved. One project has seen a worsening performance in month, project 16 - Improving Service Sustainability. In summary, this project has been paused since April due to the change in Medical Director (executive sponsor). The pause has continued in to May with scope being reviewed as Phase 2 of the Getting to Good programme is being developed.
- Overall performance to the end of May shows that 46% of all milestones in the programme are complete which a13% improvement on last month is. A further 34% of milestones are reported as good, or 'on track' for delivery. Only 15% of milestones are showing as having some risk to delivery but with mitigation plans in place and 4% are reported as at risk of non-delivery.
- At the end of May 21, the RAG status for overall delivery of the 25 'Getting to Good' work plans is as follows:

FULL PROJECT STATUS	APRIL	MAY	TREND BETWEEN PERIODS		
GOOD	12	15	IMPROVING	CONSISTENT	WORSENING
REASONABLE	11	7	3	21	1
BELOW REQUIRED	1	2			
COMPLETE	1	1			
TOTAL	25	25			

BRAG RATINGS	PROJECT / MILESTONE:
BLUE	Complete
GREEN	No material performance concerns
AMBER	Material risk(s) of non-delivery of objectives or targets, robust plans in place to mitigate and/or recover
RED	Material risk(s) of non-delivery of objectives or targets, without clear plans to mitigate and/or recover

- In the month of May, 27 milestones were recorded as delivered and 13 milestones were not delivered. Programme and project performance is reviewed at the Getting to Good Committee along with change requests to adjust plans and milestones. The current status for June looks promising with 37 out of 40 milestones expected to be delivered (7 with recovery plans already in place).
- Phase 2 of the Getting to Good (G2G) programme will commence in July 2021, building upon the foundations of the work completed in 20/21, and key aims include:
    - Reviewing and streamlining the plans to ensure that the core focus remains on delivering sustainable quality improvements within our services for our patients and community, including maternity services
    - Increasing the pace of delivery and aligning plans with CQC domains and other strategic priorities
    - Embedding learnings from 20/21 and taking on board feedback from reviews, NHSE/I and the Alliance
- During May, work has taken place to further develop and refine the scope of the programme. The existing programme has been rationalised into nine priority areas

– Leadership, Corporate Governance, Culture, Quality & Safety, Maternity, Operational Effectiveness, Workforce, Finance & Resources and Digital Transformation. Throughout June, detailed plans will be finalised for each area confirming scope, timelines, outcome measures and resource requirements.

- Phase 2 of the G2G programme will form a core part of the Trust's Integrated Plan for 21/22 which is scheduled for review and sign off at the June 2021 Senior Leadership Committee meeting and July Trust Board.

RAG STATUS BY PROJECT

G2G Programme		UHB QIP priority	RAG Status		Status Reason
			Previous Overall	Current Overall	
1.	**Quality Strategy and Plan**	*b. Develop the leadership capacity of SaTH* *c. Clinical improvement plans*			May has seen the delivery of key milestones with clinical engagement continuing as we move into June. Work has been completed with the Performance team to develop the underpinning metrics to support the KPIs that will be used to measure the delivery of the Quality Strategy. A Quality Strategy Dashboard will be developed to provide a baseline and forecast for the delivery of the strategy across the Trust. Implementation of the governance arrangements and Trust-wide communication of the Quality Strategy have been completed, the next step is to formulate and deliver a more grass roots level communications plans and this will form part of the year 2 milestones. Quarter 1 trajectories for improvement have been established and a standard divisional template for QOC has been developed.
2.	**Reducing Mortality and Excess Deaths**	*d. Determine standards for clinical services* *i. Developing a communications and engagement strategy*			The final report of the NICHE1 project has been presented with the recommendations to the Trust Learning from Deaths Group on 13th May. All recommendation have already been addressed. The NICHE2 report was received on 21st April and has been shared with appropriate clinical teams for initial comment. The Wave 1 backlog mortality review is underway and workforce capacity issues are being addressed. The KPO team has been commissioned to support the process mapping and streamlining of the Mortality review process.
3.	**Quality / Regulatory Compliance**	*c. Clinical improvement plans*			Throughout May work has continued on the development of the themed improvement plan and this is now complete. The Governance Structure is complete and will ensure existing committees or groups hold responsibility for the key improvement themes, divisional leads are required to attend these meetings to ensure relevant actions are delivered in their divisions. Further work is needed throughout June to amend the TOR for these groups to reflect the improvement plan, the workforce TOR's have been already updated. An increased focus of the work is on the core service areas of UEC and medicine, including the care of older people at PRH with a view to moving these areas into a 'requires improvement' rating. The CQC have confirmed that they will be lifting 4 conditions following our application in April, further work is now underway to apply for a variation on condition.
4.	**Maternity Transformation**				Progress against the Ockenden actions remains on track - there were no actions due this month, to allow for consolidation. Dr Mei-See Hon has taken over leadership of work stream 5 (Comms and engagement), and in partnership with the PMO and MVP has devised the Comms and engagement plan. A major review of CNST evidence has begun so that our gap analysis is more accurate. Progress has been reported to the Trust Board.

5.	**Increasing Community Engagement**				Our online conversation 'Get Involved' through the Clever Together Platform has been running for the past 4 weeks and closed on the 28th May 2021. The aim of this online conversation is to engage with our local communities about how we can keep them informed and engaged at SaTH, this will support the development of our Public Participation Plan. Throughout May the public participation team have been going out to local community groups and venues to promote individuals getting involved and giving their views through this online platform. Our monthly community update meetings were well attended in May with in an increase in the number of public members joining the evening session. The Public Participation Team were runners-up in a National Award Ceremony run by MES (Membership Engagement Service) for our work on engagement during the pandemic
6.	**Quality Improvement Approach and Methodology**				A new Head of Service Improvement has been appointed and with the completion of appointing into all other posts by the end of May, the team will be in a position to "re-launch" the Improvement Hub by the middle of July. In the meantime, the team is physically moving its location into more central premises at RSH (Former TCI Innovation suite, Mytton Oak Restaurant). The team continues to promote the new 'consultancy approach' and is playing as key role in the hospital flow improvement programme. Following development of four distinct programmes of work using the PDSA approach, significant improvements are being realised. Training has re-commenced to complete the current cohort of Lean for Leaders. A draft three year plan, which brings together all the work so far, has been completed and awaiting further input from the new Head of Service Improvement prior to Executive sign off.
7.	**Leadership, Development and Education**	*b. Develop the leadership capacity of SaTH* *d. Clinical leadership model and managerial development;*			7a. Leadership – All milestones within the Leadership element of this plan are now complete. Throughout May we can confirm that, the Leadership Development programme is in the final sign off stage and is ready to launch in June. The Leadership Masterclasses are in place and the board and executive development programme is agreed. 7b. Organisational Structure – May saw the completion and confirmation of all Job Descriptions for the triumvirate teams, and the divisions will continue to work through phase 2 as business as usual. The development of the organisational change consultation paper and JNCC is complete, and the consultation process was commenced with the outcomes of this consultation implemented. Further work was carried out to support the development of the team through support from MHSEI and 'Do OD' team. 7c. Education – The LMS project team and plan are in place and the medical and clinical support education reviews have been completed. An updated paper was provided to the May Educational Committee.

8.	**Clinical Standards, Skills and Capability**	*c. Clinical improvement plans* *e. Standards for clinical services* *f. Benchmarking clinical outcomes and productivity*			No update provided in month.
9.	**Culture and Behaviours**				May saw the completion of the evidence based review of cultural assessments and the completion of the Trust wide cultural assessment review which resulted in the development of a staff engagement programme. The Behavioural Framework is now in the final sign off stage. The Trust Wide Cultural Improvement plan has commenced and the culture and improvement plan for the Maternity Service Transformation board is complete. In addition, we have embedded Human Factors within existing training to avoid duplication. The Café conversations have taken place, and the Cultural Change Group has been developed. Further progress has been made with the Leadership Development and is due for completion June. An SLC session took place promoting the values and behaviours work. The Executive Board Development programme has also started. This plan will likely move to complete at the end of June.
10.	**Communication and Engagement**	*i. Comms and engagement strategy*			The first four of the milestones are completed; 1 - Monthly Cascade Briefing launched and established, 2 - Review of existing internal communication channels and undertake survey to gather feedback on wider communications, 3 - Undertake a review of the current communications team capacity and skills, resulting in a proposal for the future team structure and vision, 4 - Proposals formally accepted and implementation commenced. Interim Head of Communications (to 30 September at earliest) joined the organisation in May and his views taken on board with regard to team structures, which will form part of an updated delivery plan.
11.	**Recruitment & Retention**				This month we have recruited 39 nurses taking the total offer to 136. We have developed a detailed paper on the current position of the 20/21 international recruitment which will request the use of agencies to recruit from countries other than India. It includes a summary of the current numbers and areas of mitigation summary as follows: • Target is 200 nurses in 21/22 • We have 136 recruited (offers made) 79 of which are from India.

					• For the remaining 64 we are planning to use specific agencies to recruit from other countries, advertise for UK based international nurses and undertake our own direct attraction campaign We have also secured a senior Communications specialist to support the Workforce Directorate who will help support the development of our comms and engagement strategy.
12.	**Urgent and Emergency Care**				Delivery on the three key UEC work streams continues with progress being made in all areas. Work is ongoing in regards to the understanding and preparation for the new UEC measures, and this has been linked for the Trust with the development of a System wide UEC dashboard to provide greater oversight to the Systems UEC delivery group and Board, as well as enabling tracking of outcomes and benefits for the UEC Getting to Good programme as a whole. Medical SDEC continues to develop and embed processes around pull from ED and direct admission from ambulances. Capital works are complete for the provision of the updated SAU. The draft revised FFA electronic process is to be trialled on Ward 22 and 27 from June 21 and the revised pathway zero process has been drafted. The PDSA Ward/Board round changes began on Ward 22 on 17th May with the revised process for organisation for TTO's to be trialled on Ward 22 and 27.
13.	**Restoration & Recovery**				Programme is on target, achieving all its milestones to date. All Demand & Capacity models have been completed and activity gaps identified. SaTH has successfully drawn down Elective Recovery Fund (ERF) and confirmed its insourcing and outsourcing arrangements for additional capacity.
14.	**Digital transformation and Infrastructure**	*h. Developing new models to support the development of integrated health and care* *k. Implementing joint working with partner organisations*			Maternity processes signed off to support BadgerNet Maternity implementation, technical configuration complete and reporting requirements under review to support a phased implementation and subsequent dual reporting from systems. Senior midwifery lead identified. Divisional Digital Roadmap discussions completed. Additional data warehouse support has commenced to align to Digital Programme.
15.	**Physical capacity and estates development**				This overall Year 1 G2G programme for Physical Capacity and Estates development is now complete. All projects have been delivered ahead of time, to budget and handed over to clinical teams to operationalise. The focus will now be on the delivery of the Year 2 plan which centres on A&E redevelopment and sign off of the Estates Strategy.
16.	**Service Sustainability**				Change in Medical Director (executive sponsor) resulted in a pause to this programme in April to re-evaluate the approach and procurement route for this programme. Discussions around

					Phase 2 of G2G have commenced and this programme has been put on hold pending a decision on where this piece of work best sits in the organisation.
17.	**Using Technology to optimise Outpatient efficiency and experience**				Progress is now being made on responding to feedback from specialities on Attend Anywhere and PIFU. Delays to PIFU launch was required while a PAS patch was written and tested, to avoid accidental discharge from PIFU if a patient had a parallel clinic. UAT now complete, pilot go live date now predicted for 8th June.
18.	**System Improvement and integration plan**				The System operational plan and the Trust annual integrated plan 2021-22 have now been produced. The system operational plan is to be formally approved by NHSI/E. The draft Trust annual integrated plan is being presented to Trust Board on the 10th June 21 as a draft for comment, with the final version going to July 21 Trust Board for approval.
19.	**Revise SOC for Hospitals Transformation Programme**				Business case submitted to NHSEI for approval to engage external consultancy to support with SOC. Approval was received at the end of May and PA Consulting have commenced working with the Trust PID developed for the HTP acceleration work and workshops are planned to take place in June to develop the work Resource identified and recruited to undertake financial analysis required to finalise SOC
20.	**System Long Term Plan**				Approach to development of long term plan and financial strategy has been developed and will be submitted (for approval) to the Sustainability Committee in June. Outline system planning and financial assumptions to be agreed by the end of June 21, with more detailed implementation plans to be worked up for approval in September 21.
21.	**Oversight, assurance, roles and accountabilities**	*g. Developing new working models* *j. Clinical quality and risks*			Milestone 1 - Review and optimise the Exec portfolios remains RAG green rather than blue as the CEO has provided the opportunity for executives to provide further details of updates with regard to their portfolios. Board seminars are in place, well embedded and continue on a monthly basis. The board "development" programme is still to be procured.
22.	**Strong Financial Foundations**				The Trust's H1 budget has been finalised. Meetings with Divisional management teams have been held during May to discuss baseline budgets and requirements for 21-22, including

					implications of the Elective Recovery Programme, business cases and development of efficiencies. Development of a revised business case tracker has progressed to ensure all cases, and their Governance status, are tracked and visible to Finance staff and Divisional managers. The Finance Department's Level 1 FFF quality accreditation application was successful and certification was awarded on 17 May. The annual accounts process is almost complete and the only significant outstanding issue relates to a potential prior year change to the Trust's property valuation. The second Deputy Director of Finance has been appointed and will join the Trust in July.
23.	**Performance data and analytics**	*f. Benchmarking clinical outcomes and productivity*			We continue to be working on the build phase of the InPhase performance module with the expectation that this will be populated by the end of June, in line with the project plan. This month the internal audit report on performance data quality was received and provided the Trust with substantial assurance, a significant improvement from previous reports on data quality. Board development session has taken place and comments received from non-Executive directors to support further development of the IPR for 2021-22 business cycle. As a consequence of this feedback some initial changes were included in the May (April data) IPR, and following review of the comments further improvements will be made A strawman of efficiency indicators has been developed and proposed to the Trust's efficiency group as a suitable way of measuring and managing operational efficiency gains. Divisional performance review meetings completed using the performance packs drilled down from the board level KPIs to divisional level. Revised maternity dashboard launched this month and interest has been expressed by partners in developing a system dashboard.
24.	**Risk Management**	*g. Developing new working models* *j. Clinical quality and risks*			Some progress has been made in month: end of year 2020/21 BAF and high level risk register were signed off by the Board in early May, risk descriptors for the 2021/22 BAF (which will more align with Trust objectives) have been signed off by the Board and the new document being mapped for use in committees and the Board moving forward. Risk Strategy and Policy will be presented to Audit and Risk Assurance Committee in June, with June Board approval to follow.

					Team capacity issues are being addressed to increase pace of delivery.
25.	**Programme and Project Management**	*i. Providing assurance to the Committees, and respective Boards, by monitoring delivery of the overall quality improvement plan against a comprehensive framework*			The team continue to support the G2G programme and can demonstrate some significant achievements as we approach the end of year 1. Throughout May we have procured and enrolled a priority cohort of 36 SRO level colleagues onto a year long Prince 2 Training programme delivered by QA using some residual training funds, this will further strengthen the Trusts ability to deliver projects effectively and enhances our Leadership programme. The team have also recruited to the TDP backfill vacancy with an internal secondment; this will add NHS knowledge and experience to the team as well as reducing a significant agency spend. The sequencing of the programme delivery reporting has been agreed, removing some of the time constraints that were impacting the team. The year 2 plan has been redrafted and is awaiting approval and this outlines the key priorities for the PMO over the next 12 months.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 July 2021

Agenda item	177/21			
Report	Data Security and Protection Toolkit (DSPT) Submission			
Executive Lead	SIRO / Director of Governance and Communications			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people	√	Effective	
	Our service delivery	√	Caring	
	Our partners	√	Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	All BAF risks	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	Information Governance Committee, June 2021			
Dependent upon (if applicable)**:**				
Executive summary:	As the Board is aware, an annual submission of the DSPT, (facilitated by NHS Digital) is required, usually by 31 March but this has been deferred for the last two years to 30 September in 2020 and 30 June 2021. Work has been ongoing to create a robust submission, which was made by the deadline. Not all of the required assertions were met, and therefore an improvement action plan also had to be submitted, consisting of five actions relating to five different elements. Since submission, the action plan has been approved by NHS Digital, and the Trust's 'Standards not met' status has changed to 'Standards not fully met (plan agreed)'. The board is asked to note the report, and to take assurance as to a slightly improved position on the previous year.			
	None			

1.0 Data Security and Protection Toolkit background

1.1 The DSPT replaced the former Information Governance Toolkit in April 2018, and with it, brought a more digital / cyber focussed system. It also allows organisations to measure their performance against the 10 National Data Guardian's security standards. Completion is mandatory contractual requirement of the NHSE Standard Conditions Contract.

1.2 Compliance with the toolkit has been difficult for the organisation, and it has not been fully compliant since the introduction of the DSPT in 2018. This is partly due to lack of appropriate resource within both the cyber/digital team and the information governance team. Both are now anticipating a slight increase in WTE resource in the near future.

1.3 The toolkit has developed over the last three years, with further improvements introduced each year.

1.4 Changes introduced by the 2020/21 toolkit saw:

- a more 'business as usual' approach was used for some evidence items.
- Extra evidence items on Backups and Technical requirements
- Technical evidence items move to Mandatory from Non mandatory particularly items covering Cyber Essentials (CE).
- CE+ on site assessment became a non-mandatory requirement for 2020/21.

2.0 Performance

2.1 From 150 evidence texts and 42 assertions to which they relate, an action plan was submitted relating to only 5 of the evidence texts.

2.2 An area of work that requires focus relates to the setting up of a data quality forum, something highlighted in a recent data quality internal audit which provided substantial assurance in May 2021. The foundation work for this is already being undertaken with performance metrics due to be kitemarked by end of September 2021 – thereafter the forum will be established.

2.3 One area that Trusts generally struggle with, is training. The toolkit requires at least 95% of colleagues to have completed their annual Data Security Awareness training within the year. 2020/21 has been particularly difficult due to pandemic pressures, and it has been suggested that the 95% compliance figure is being considered by NHS Digital for future toolkits. This is an area where improvement can be made, and increased resource in the IG team, will support this area of work.

2.4 Three further areas that require improvement relate to, essentially, cyber processes. Funding has been provided to support improvement in one of those areas, with plans to be drawn up for improvement for the others. The IG and Cyber teams work closely together and are inextricably linked to the information and cyber agendas.

Anna Milanec
Director of Governance and Communications
July 2020

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 July 2021

Agenda item	178/21			
Report	Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 1 BAF 2 BAF 3	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion		CRR 16 CRR 18 CRR 19 CRR 23 CRR 27 CRR 31	
	For noting			
	For information			
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon (if applicable)**:**				
Executive summary:	This report provides the background to the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year Three standards, and an update on the Trust's position in relation to achieving them. The Board of Directors is requested to: • Approve the application for reimbursement of MIS incentive scheme funds in section 6 for a B7 Governance and Assurance officer • Approve the affirmatory statements in section 7 • Assign delegated authority to the Chief Executive to sign the CNST MIS year three submission and supporting statements (as per section 8) by midday on Thursday 22nd July 2021.			
Appendices	**Appendix One** – CNST Safety Action Leads and CNST Oversight and Validation Group. **Appendix Two –** CNST Maternity Declaration Position (including summary, action plans and declaration forms)			

1. PURPOSE OF THIS REPORT

This report provides the background to the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year Three standards, and the Trust's preliminary position ahead of the final submission to NHS Resolution by midday on Thursday 22nd July 2021.

2. BACKGROUND

2.1. The Clinical Negligence Scheme for Trusts (CNST)

NHS Resolution (formerly the NHS Litigation Authority est.1995), indemnifies English NHS bodies against claims for clinical negligence through the CNST scheme. The CNST scheme aims to promote effective risk management to minimise harm to patients and the cost of claims. A separate set of CNST standards was developed for maternity services in 2003, because of the disproportionate scale of maternity claims. These have been revised several times since.

NHS provider organisations pay an annual CNST premium; effectively an insurance premium to help cover the costs of litigation. This is in two parts: a general contribution, which covers all clinical services except maternity, and a separate maternity contribution.

For the financial year 2020/21, NHS Resolution is operating a third year of the CNST maternity incentive scheme (MIS) to support the delivery of safer maternity care. In order to fund this, members contribute an additional 10% of their premium to create the CNST maternity incentive fund.

The CNST MIS incentivises 10 Safety Actions. Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution to the MIS fund and will receive a share of any unallocated funds, also. Trusts that do not meet the ten-out-of-ten threshold will not recover their MIS contributions. However, any such trusts are eligible to apply for a small discretionary payment to help them to make progress against actions they have not yet achieved. Such a payment would be at a much lower level to their original 10 per cent contribution.

2.2. Year Three of the CNST scheme

As a result of the Coronavirus pandemic, CNST contributions were not taken in April 2020 as would otherwise have occurred. Year Three of the CNST MIS was re-launched on 1 October 2020, and further/revised guidance was issued to trusts in March 2021. In view of the pandemic, some of the standards have been modified slightly in order to help Trusts to achieve them, although the overall essence of each of the safety actions remains.

2.3. CNST MIS Year Three Eligibility

In order to be eligible for payment under the scheme, trusts are required to submit their completed Board declaration form to NHS Resolution by midday on Thursday 22nd July 2021, and must comply with the following conditions:

- Trusts must meet al ten maternity safety actions in full
- The Board's declaration form must be signed three times and dated by the Trust's chief executive (for, and on behalf of the Board) to confirm that:
    - The Trust Board is satisfied that the evidence provided to demonstrate achievement of the ten safety actions meets the required safety actions' sub

requirements, as set out in the "Maternity incentive scheme – year three – Conditions of the Scheme" document.[1]

- The content of the Board's declaration form has been discussed with the commissioner(s) of the Trust's maternity services
- There are no reports covering either this year (2020/21) or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 15 July 2021.
- The Board must give its permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board's declaration form must be signed by the Trust's Chief Executive. If the form is signed by another Trust member this will not be considered.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (safety action 1 point a, b, c), NHS Digital regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 1-2 and 4-13), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to the Early Notification scheme and HSIB (safety action 10, standard a) and b)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- Trust regional chief midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in year one and year two of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to re-review the maternity incentive scheme submission, and reconfirm if they deem themselves to be compliant. If a Trust reconfirms compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared noncompliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

2.4. Trusts that have not met all ten maternity actions

Trusts that have not achieved all ten actions in full may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 22 July 2021 to NHS Resolution. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the template. Action plans should not be submitted for achieved safety actions.

[1] Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf (resolution.nhs.uk)

2.5. Evidence of Compliance

Trusts are not required to submit their evidence files with the submission. However, this is to be trained securely by the Trust in case it is required to be reviewed by NHS Resolution or regulators at a future point in time.

3. CNST FINANCIAL INFORMATION

3.1. CNST Contributions

The following table summarises the Trust's General and Maternity CNST Contributions for the current financial year:

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)
Contribution assessment for the 2021/22 financial year

	Contribution for 2021/22
Trust	Shrewsbury and Telford Hospital NHS Trust
Membership number:	T650
Contribution:	
General contribution:	£8,045,916
Standard maternity contribution:	£6,795,003
Maternity incentive contribution:	£679,500
Total maternity contribution:	£7,474,503
Total contribution:	**£15,520,419**

As can be seen, the Trust pays a premium of £15.5m to cover clinical negligence claims against it. The Maternity contribution to this is circa. £7.5m. If the Trust is able to meet all Ten Safety Actions in full, it will receive circa. £680k back as the incentive payment.

4. THE LEADERSHIP AND OVERSIGHT OF THE CNST TEN SAFETY ACTIONS

4.1. Senior Responsible Officer (SRO) for the CNST Maternity Incentive Scheme

The SRO for this scheme at the Trust is the Director of Midwifery (DoM). However, due to the sudden and unforeseeable absence of the DoM, remaining colleagues have needed to re-establish and check the evidence baseline more or less from scratch and over recent weeks only. This work has been supported by colleagues from Sherwood Forest Hospital NHS Foundation Trust, NHS England/Improvement and interim colleagues that are supporting the Trust recently.

4.2. Governance and Oversight Arrangements for the CNST MIS Scheme

As a result of the need to work quickly to understand the Trust's position and, also, check and test the required evidence against the compliance standards, a number of extraordinary meetings have needed to take place in addition to pre-scheduled meetings, and over a relatively short space of time. These took place at the following dates and times:

CNST review meeting 1 1000 hrs – 1230 hrs	Friday 14th May 2021
Board Seminar Session CNST was discussed 1145 hrs - 1245 hrs	Thursday 20th May 2021
CNST review meeting 2 0900 hrs to 1130 hrs	Friday 28th May 2021
Maternity Transformation Assurance Committee – 1530 hrs to 1630 hrs	Tuesday 8th June 2021
Board Seminar Session 1200 hrs – 1300 hrs	Thursday 17th June 2021
CNST review meeting 3 1500 hrs – 1630 hrs	Tuesday 29th June 2021

The details of colleagues leading each safety action and those performing the oversight and validation roles are provided in **Appendix One** refers.

The process that has been followed to undertake this work is, as follows:

Each Safety Action lead was required to present to the oversight and validation group and go through the specific elements of the Safety Action they were leading. This included considering each requirement and the available evidence to support it. This evidence was then collated into a central filing area within the Maternity Transformation Programme project management software, to ensure it is secure, contained and accessible.

The validation and oversight team then had the opportunity to question each Safety Action lead and interrogate the evidence. Not only did this take place at the aforementioned meetings, but colleagues also took the opportunity to look at specific elements in more detail outside of these meetings. Discussion then took place with the oversight and validation group to reach a consensus position for each standard.

5. PRELIMINARY POSITION AT MONDAY 4TH JULY 2021

5.1. As of Monday 4th July 2021:

- Three standards are fully Compliant
- A further three standards could become fully compliant subject to the approval of the Board of Directors at today's meeting
- Four standards are non-compliant

5.2. Where a standard is not yet being met fully, these are as a result of technical reporting matters. **They do not represent a risk to the quality of care provided to women, babies and families**. The current position against each of the ten Safety Actions is provided in the following table. Also, this summary provides the number of sub-elements delivered for each standard as a proportion of the total. The full detail for each standard as it stands currently is presented in the draft submission template at **Appendix Two**. (Note: on the submission template, a standards remains marked as 'red' until the standard is met fully).

Safety Action	Final position for submission to NHS-R by 22 July 2021
1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Compliant (8 of 8 met)**

2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	**Not Yet Compliant (1 of 2)** [this could become fully compliant subject to Board, Safety Champion and LMNS approval] – see Section 5.4.1
3. Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	**Compliant (6 of 6 met)**
4. Can you demonstrate an effective system of clinical* workforce planning to the required standard?	**Not Compliant (3 of 4 met)** See section 5.3.1
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?	**Not Compliant (0 of 8 met)** See section 5.3.2
6. Can you demonstrate compliance with all five elements of the SBL care bundle?	**Not Yet Compliant (31 of 33)** [this could become fully compliant subject to Board, Safety Champion and LMNS approval] – see Section 5.4.2.
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	**Compliant (5 of 5 met)**
8. Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	**Not Yet Compliant (12 of 13)** [this could become fully compliant subject to Board, Safety Champion and LMNS approval] – see Section 5.4.3
9. Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	**Not Compliant (17 of 19 met)** See section 5.3.3.
10. Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	**Not Compliant** See section 5.3.4

5.3. **Standards that are not compliant**

For the standards that are not compliant, each is now described along with the reasons for their non-compliance.

5.3.1. Safety Action 4 - Can you demonstrate an effective system of clinical* workforce planning to the required standard?

This is due to a technical reporting/compliance issue. The papers outlining the standards required for each workforce segment were produced in February 2021 for the Maternity Governance Committee and confirmed compliance. A further update confirming on-going compliance was produced for the same committee in April 2021. However, these reports were required to be presented to the Trust Board subsequently, and for it to confirm compliance, also. This stage never happened. The actions required to address this are provided in Action Plan at **Appendix 2** refers**.**

5.3.2. Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Due to unforeseeable staff absences, this work has been delayed and it has not yet been possible to achieve this before the CNST submission deadline. A report covering this topic is due to be presented to the Trust Board in Public in July 2021. The Action Plan at **Appendix 2** refers**.**

5.3.3. Safety Action 9 - Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

There are two of the sub-elements of this standard that have not been met. These are:

5.3.1.1. Sub-element 5 – Was a monthly feedback session for staff undertaken by the Board level Safety Champions in January 2020 and February 2020.

Due to staff absences, it has not been possible to evidence this element, and this 'pre-dates' the current Safety Champions. The Action Plan at **Appendix 2** refers**.**

5.3.1.2. Sub-element 16 – Together with their front-line Safety Champions, has the Board Safety Champion considered the recommendation and requirements of II, III, IV on I by Monday 30th November 2020?

This action relates to whether women were having more adverse outcomes as a consequence of delays and/or not accessing/seeking healthcare in light of the Coronavirus Pandemic. Safety Champions were advised to refer to three pieces of guidance when making this assessment. These are:

i. The United Kingdom Obstetric Surveillance System (UKOSS) report that was published by the BMJ (May 2020)[2]. This report covers the characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in the UK.

[2] https://www.bmj.com/content/369/bmj.m2107

ii. The MBRRACE UK[3] SARS/Covid-19 Report
iii. A letter to all maternity units in the country from the Chief Midwifery Officer for England on 27th June 2020, regarding targeted perinatal support for Black, Asian and Minority Ethnic groups.

With regards to the Trust's position in relation to this requirement, there was an expectation for Safety Champions to review local outcomes in relation to these resources, no later than 30th November 2020. These issues were discussed as described, but on 18th December 2020; however, this took place after the required date.

There is no further action required to address this point. However, having a better system and process for tracking and monitoring the receipt of such reports and any subsequent actions, as with the whole CNST process, will be key to ensuring full compliance going forward. This requires some support resource in order to address it. Action Plan at **Appendix 2** refers**.**

5.3.4. Safety Action 10 – Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification Scheme?

This standard requires trust's to refer cases that meet specific referral criteria to the NHS Resolution Early Notification Scheme (ENS). The ENS investigates the potential eligibility for compensation and includes such actions as supporting families and affected staff, and taking proactive action to reduce legal costs.

Since 1 April 2017, Clinical Negligence Scheme for Trusts (CNST) members have been required to report all maternity incidents of potentially severe brain injury to NHS Resolution within 30 days.

In line with the criteria used by the Each Baby Counts programme of the Royal College of Obstetricians and Gynaecologists, this applied to all babies born at term (≥37 completed weeks of gestation), following labour, that had a potentially severe brain injury diagnosed in the first seven days of life and:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone AND was comatose AND had seizures of any kind.

The standard requirements is, as follows:

5.3.5. Sub-element 4 - Have the Trust Board had sight of the Trust's legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution's Early Notification Team?

From the available evidence thus far, it looks as if the Trust has complied with this requirement, in terms of identifying and reporting incidents that meet the referral criteria. However, these data have not yet been validated independently. Furthermore, these data have not yet been through any formal governance and assurance processes, eventually to the Board of Directors. As such, it is not yet possible to confirm affirmatively that this standard has been met. The Action Plan at **Appendix 2** refers.

[3] https://www.england.nhs.uk/2020/06/nhs-boosts-support-for-pregnant-black-and-ethnic-minority-women/

5.4. CNST Standards that are not yet being met fully

There are some standards that could still become compliant, subject to the Board of Directors agreeing these today. Ideally, these should have been presented to the Board of Directors more systematically throughout the year. However, this did not happen for reasons that are well understood by the Board. Nonetheless, these are possibly recoverable providing the Board of Directors is satisfied to agree and approve them at today's meeting.

Also, it is a requirement of CNST for the Board of Directors to record formally in the meeting minutes that they have approved these statements/commitments.

These are now described for the Board's attention and consideration:

5.4.1. <u>Safety Action Two - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</u>

It is a requirement of this standard that the Board of Directors must confirm that the Trust has, and continues to, submit the required maternity service dataset to a set of given standards to NHS Digital. This is for the purposes of central monitoring and reporting. There are 32 tables of data that make up the MSDS. CNST requires that 25 of these are submitted. SATH is compliant with this element. In addition, CNST requires a locally-funded plan to achieve compliance with any outstanding data tables (to get to the full 32). Providing a plan to achieve this is in place, this standard can considered to be being met. The specific requirement is described below:

"*If this standard is not met fully already, the Board must confirm that a locally-funded plan is in place. Also, the plan must be agreed with the Maternity Safety Champion and Local Maternity and Neonatal System (LMNS)* [note: this is being actioned already].

In response to this:

- The action plan to address the outstanding elements is in place and is attached at **Appendix Two** for reference.
- The plan has been sent to the Maternity Safety Champion and the LMNS for approval. (Note: A verbal update on progress with this will be provided at today's meeting).

If the Board of Directors is satisfied with the action plan, and the Safety Champion and the LMNS have approved it by the time of today's Board meeting, please can it record the following in the minutes:

"*The Board of Directors confirms that a locally-funded plan is in place to meet the Maternity Services Dataset (MSDS v2) requirements, and that this has been agreed by the Maternity Safety Champion and the LMNS".*

Or, alternatively, if the Safety Champion and LMNS have not yet approved the plan by the time of today's meeting:

"*The Board of Directors confirms that a locally-funded plan is in place to meet the Maternity Services Dataset (MSDS v2) requirements, subject to*

final approval and agreement from the Maternity Safety Champion and the LMNS by the required submission date of 22nd July 2020."

If these actions have not been approved by the Safety Champion and the LMNS by the 22nd July, this standard will be non-compliant.

5.4.2 Safety Action Six - Can you demonstrate compliance with all four elements of the Saving Babies' Lives Version 2?

There are two standard statements that the Board of Directors is required to approve for this standard to be compliant fully. These are:

- Sub-element 23 – Has the Board 'minuted' in their meeting records, a written commitment to facilitate local, in person, fetal monitoring training when this is permitted. (Note: this is as a consequence of the Covid-19 pandemic).

If the Board of Directors is satisfied to commit to this, please can it record the following in the minutes of today's meeting:

"*The Board of Directors confirms its commitment to facilitate local, in person, fetal monitoring training when it is permitted".*

- Sub-element 33 (part 1) – Do you have evidence that the Trust Board has specifically confirmed that women at high risk of pre-term births have access to a specialist pre-term birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case, the Board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their clinical network has agreed is acceptable clinical practice.

Response: It is confirmed that this service is available, as described in the standard requirement.

If the Board of Directors is satisfied with this, please can it record the following in the minutes of today's meeting:

"*The Board of Directors confirms that women at high risk of pre-term births have access to a specialist pre-term birth clinic where transvaginal ultrasound to assess cervical length is provided".*

- Sub-element 33 (Part 2) – Do you have evidence that the Trust Board has specifically confirmed that an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.

Response: An audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. This audit is available as evidence in the Maternity Transformation portal: Monday.com

If the Board of Directors is satisfied with this, please can it record the following in the minutes of today's meeting:

"The Board of Directors confirms that an audit has been has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids"

5.4.3. Safety Action Eight – Neonatal Resuscitation Training. Can you evidence that the following staff groups have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019? If the trust has identified any shortfall in reaching the 90% threshold described above, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?

Response: Where the Trust fails to meet the 90% threshold for NLS training for all staff groups, the Board of Directors is required to commit to facilitating multi-professional training sessions once/when this is permitted. The Trust meets the 90% threshold for each of the required staff groups apart from the Neonatal Consultants group. Compliance with this requirement has been achieved by five out of six consultants (83%). The sixth consultant is booked onto the NLS course in August 2021.

If the Board of Directors is satisfied with this plan for the sixth consultant, please can it record the following in the minutes of today's meeting:

"The Board of Directors confirms that there is an action plan in place to facilitate multi-professional training sessions, once/when this is permitted".

6. OPPORTUNITY FOR REIMBURSEMENT OF MIS FUNDS

The CNST MIS year three guidance allows for trusts that do not meet all of the ten safety actions in full to apply for reimbursement of some of the incentive payment, to help address areas of non-compliance. It states:

"If applicable: the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action Plan entry sheet)".

The rationale for the Trust not being compliant is largely as a result of not having sufficiently robust governance and assurance systems and processes in place to monitor, track, assure and report on the required elements. This is a gap. Current staff absences have contributed to this, also. In addition, some sections have relied on individuals to progress work outside of any due diligence, and further support is required in order to do this more thoroughly and more effectively in the future.

As part of the submission to NHS Resolution, an application will be made to seek MIS reimbursement funding of circa. £100k (2 years fixed term – full employment costs) for a Band 7 Governance and Assurance Officer. This will be to establish and coordinate a strategic plan to help address all of the CNST requirements going forward that sets out clearly the required milestones and evidence requirements.

7. AFFIRMATORY STATEMENTS REQUIRED FROM THE BOARD OF DIRECTORS

As described previously in section 5, the Board of Directors is requested to consider if it is prepared to approve and record in the minutes of today's meeting, the following suggested statements. If the statements required for each safety actions are approved, they will become compliant. These are all now provided in the one section for the Board's consideration.

7.3. Safety Action Two (refer to section 5.4.1) - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

"*The Board of Directors confirms that a locally-funded plan is in place to meet the Maternity Services Dataset (MSDS v2) requirements, and that this has been agreed by the Maternity Safety Champion and the LMNS"*.

Or, alternatively, if the Safety Champion and LMNS have not yet approved the plan by the time of today's meeting:

"*The Board of Directors confirms that a locally-funded plan is in place to meet the Maternity Services Dataset (MSDS v2) requirements, subject to final approval and agreement from the Maternity Safety Champion and the LMNS by the required submission date of 22nd July 2020."*

7.4. Safety Action Six (refer to section 5.4.2.) - Can you demonstrate compliance with all four elements of the Saving Babies' Lives Version 2?

7.4.1. Sub-element 23 – Has the Board 'minuted' in their meeting records, a written commitment to facilitate local, in person, fetal monitoring training when this is permitted. (Note: this is as a consequence of the Covid-19 pandemic).

"*The Board of Directors confirms its commitment to facilitate local, in person, fetal monitoring training when it is permitted".*

7.4.2. Sub-element 35 (part 1) – Do you have evidence that the Trust Board has specifically confirmed that women at high risk of pre-term births have access to a specialist pre-term birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case, the Board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their clinical network has agreed is acceptable clinical practice.

"*The Board of Directors confirms that women at high risk of pre-term births have access to a specialist pre-term birth clinic where transvaginal ultrasound to assess cervical length is provided".*

7.4.3. Sub-element 35 (Part 2) – Do you have evidence that the Trust Board has specifically confirmed that an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.

"*The Board of Directors confirms that an audit has been has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids"*

7.5. Safety Action Eight (refer to section 5.4.3) – Neonatal Resuscitation Training. Can you evidence that the following staff groups have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019? If the trust has identified any shortfall in reaching the 90% threshold described above, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?

"*The Board of Directors confirms that there is an action plan in place to facilitate multi-professional training sessions, once/when this is permitted".*

8. PROCESS FOR DECLARATION

There are a number of statements that need to be signed off by the Chief Executive, for and on behalf of the Board of Directors, to accompany the completed electronic submission template to NHS Resolution by midday on Thursday 22nd July. These comprise:

8.3. The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate

8.4. the content of this form has been discussed with the commissioner(s) of the trust's maternity services"

8.5. There are no reports covering either this year (2020/21) or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought o to the MIS team's attention.", and;

8.6. "If applicable: the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action Plan entry sheet)"

8.7. "We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance."

9. SUMMARY AND NEXT STEPS

To summarise the Trust's current position in relation to meeting the CNST MIS year three standards:

9.3. A substantial amount of work has been undertaken by very skilled and dedicated people to meet the equally very challenging and exacting CNST MIS year three standards. It is important that their hard work, dedication and extra efforts to achieve them are both recognised and valued.

9.4. Subject to the Board of Directors' approval, it is possible that six out of ten standards will be complaint by the required submission date of midday 22nd February 2021. Action plans have been devised to address any shortfalls.

9.5. Where a standard is not yet being met fully, this is largely as a result of technical reporting matters and/or a lack of systems and processes to ensure that the correct information is validated, approved and reported accordingly. **They do not represent a risk to the quality of care provided to women, babies and families**.

9.6. As part of the submission, an application will be made to seek MIS reimbursement funding of circa. £100k (2 years fixed term – full employment costs) for a Band 7 Governance and Assurance Officer. This will be to establish and coordinate a strategic plan to help address all of the CNST requirements going forward that sets out clearly the required milestones and evidence requirements.

9.7. Proper to the final submission of the electronic return to NHS Resolution by midday on 22nd July 2021, this report needs to be shared with the Trust's commissioners. The Director of Nursing is progressing this.

There is an opportunity for any Board member to review the available evidence at any point, prior to the submission date of midday on 22nd July 2021.

The Board of Directors must satisfy itself that, in approving the current positon and standards statements, that the work undertaken on behalf of it by the oversight and validation Group meets its requirements, or otherwise.

10. ACTIONS REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to:

10.3. Approve the application for reimbursement of MIS incentive scheme funds in section 6 for a B 7 Governance and Assurance officer

10.4. Approve the affirmatory statements in section 7

10.5. Assign delegated authority to the Chief Executive to sign the CNST MIS year three submission and supporting statements (as per section 8) by midday on Thursday 22nd July 2021.

10.6. Receive this report for information

10.7. Decide if any further information, action and/or assurance is required

Hayley Flavell
Director of Nursing
July 2021

APPENDICES

Appendix One – CNST Safety Action Leads and CNST Oversight and Validation Group.
Appendix Two – CNST Maternity Declaration Position (including summary, action plans and declaration forms)

APPENDIX ONE

CNST SAFETY ACTION LEADS

Safety Action	Lead's Name	Role	Comments
1	Jan Latham / Liz Pearson	Specialist Bereavement Care Midwives	Responsible for PMRT submissions
2	Chris Weston	Information Officer, Women & Children's Division	Responsible for MSDS submissions
3	Sarah Kirk	Advanced Neonatal Nurse Practitioner	Author of ATAIN plan
4	Mei-See Hon	Clinical Director, Obstetrics	Input from anaesthetics and NNU colleagues
5	Nicola Wenlock (Joy Payne in Interim)	Director of Midwifery	Supported by Stephanie Mansell, Interim Deputy Head of Midwifery
6	Lindsey Reid	Transformation Project Midwife and Lead for Saving Babies' Lives	External review and support from Belinda Green, SFH External midwifery consultant
7	Jill Whittaker (Mei-See Hon in interim)	Midwifery Matron	Actively supported by the Maternity Voices Partnership (MVP) development co-ordinator and chair
8	Karen Henderson	Specialist Clinical Education Midwife	
9	Arne Rose (John Jones In interim)	Medical Director and Executive Safety Champion for Maternity Services	John Jones now in place as cover for Arne Rose.
10	Refeth Mirza	Governance Lead, Women and Children's Division	Supported by Liz Pearson

CNST OVERSIGHT AND VALIDATION GROUP

Hayley Flavell	Director of Nursing, Executive Sponsor, Maternity Transformation
Tony Bristlin	Non-Executive Director (NED), Maternity and Neonatal Safety Champion
Zena Young	Executive Director of Nursing and Quality, NHS Shropshire, Telford and Wrekin CCG and LNMS – Senior Responsible Officer (SRO) for Maternity Transformation
Martyn Underwood	Medical Director, Women and Children's Division, SRO for Maternity Transformation (SATH), Consultant Obstetrician and Gynaecologist
Mei-See Hon	Clinical Director, Obstetrics
Guy Calcott	Consultant – Obstetrics and Gynaecology, and Lead for Pre-Term Care
Joy Payne	Interim Director of Midwifery, SATH
Belinda Green	Belinda Green, SFH External midwifery consultant
Shirley Jones	Interim Deputy Head of Midwifery, SATH
Simon Mehigan	Director of Midwifery/Divisional Director of Nursing at the Royal Oldham Hospital NHS Trust, and NHSE/I Improvement Specialist Midwife
Mike Wright	Programme Director, Maternity Assurance

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	Yes
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were your Trust compliant with all 12 criteria in either the December 2020 or the January 2021's submission?	Yes
2	Has the Trust Board confirmed that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	No

Safety action No. 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note standard a), b) and c) of safety action 3 have now been removed.		
Standard D) Commissioner returns on request for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		
1	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	N/A
Standard E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.		
2	Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding	Yes
An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.		

Safety action No. 3 continued over the page

3	Do you have evidence of the following • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	Yes
Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.		
4	Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	Yes
5	Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion ?	Yes
6	Has the progress on Covid-19 related requirements been monitored monthly by the board safety champions from January 2021?	Yes

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note that the standards related to the obstetric workforce have been removed.		
1	**Anaesthetic medical workforce** Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	No
2	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	No
3	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	No
4	If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	No
5	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	No
6	If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	No

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	No
2	Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	No
3	Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	No
4	Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	No
5	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **supernumerary labour ward co-ordinator** status in the scheme reporting period? This must include mitigations to cover shortfalls.	No
6	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the **labour ward coordinator** which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	No
7	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **1:1 care in labour** in the scheme reporting period? This must include mitigations to cover shortfalls.	No
8	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with **1:1 care in labour** has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	No
9	Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	No
10	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	No

Safety action No. 6

Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by the Clinical Network.	Yes
3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted this?	Yes
ELEMENT 1 - Reducing smoking in pregnancy		
Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
4	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
5	If the process metric scores are less than 95% for Element 1 **standard A**, has an action plan for achieving >95% been completed?	Yes
Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.		
6	Has **standard b)** been successfully implemented (80% compliance or more)?	Yes
7	If the process metric scores are less than 95% for element 1 **standard b)**, has an action plan for achieving >95% been completed?	Yes

Safety action no. 6 continued over the page

Safety action no. 6 continued from previous page

Standard c) Percentage of women where CO measurement at 36 weeks is recorded.		
8	Has **standard c)** been successfully implemented (80% compliance or more)?	Yes
9	If the process metric scores are less than 95% for element 1 **standard c)**, has an action plan for achieving >95% been completed?	Yes
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		
Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.		
10	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
11	If the process metric scores are less than 95% for element 2 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation:		
12	1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards (or an alternative intervention that has been agreed with the CCG and that the trust's Clinical Network)	Yes
13	2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation (or an alternative intervention that has been agreed with the CCG and that the trust's Clinical Network)	Yes
14	3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Yes
15	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	N/A
16	If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	Yes
17	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	N/A

Safety action no. 6 continued over the page

Safety action no. 6 continued from previous page

18	If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
ELEMENT 3 Raising awareness of reduced fetal movement		
Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.		
19	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
20	If the process metric scores are less than 95% for element 3 **standard a)**, has an action plan for achieving >95% been completed?	Yes
Standard b) Percentage of women who attend with RFM who have a computerised CTG		
21	has **standard b)** been successfully implemented (80% compliance or more)?	Yes
22	If the process metric scores are less than 95% for element 3 **standard b)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 4 Effective fetal monitoring during labour		
Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		
23	Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted?	No
24	Can you evidence that 90% of all staff groups have complete the fetal monitoring competency assessment as outlined in the technical guidance?	Yes
25	If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shortfall in reaching the 90% and commit to addressing those?	N/A
Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment.		

Safety action no. 6 continued over the page

Safety action no. 6 continued from previous page

26	Have training resources been made available to the multi-professional team members?	Yes
27	Can you evidence that 90% of all staff groups have complete the fetal monitoring competency assessment as outlined in the technical guidance?	
28	If the process metric scores are less than 90% for **Element 4 standard b)**, has the trust board identify shortfall in reaching the 90% and commit to addressing those when this is permitted?	Yes
ELEMENT 5 Reducing preterm births		
Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth		
29	Has **standard a)** been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes
30	If the process metric scores are less than 85% for Element 5 **standard a)**, has an action plan for achieving >85% been completed?	Yes
Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
31	Has **standard b)** been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes
32	If the process metric scores are less than 85% for Element 5 **standard b)**, has an action plan for achieving >85% been completed?	N/A
Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
33	Has **standard c)** been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	Yes
34	If the process metric scores are less than 85% for Element 5 **standard c)**, has an action plan for achieving >85% been completed?	N/A

Safety action no. 6 continued over the page

Safety action no. 6 continued from previous page

35	Do you have evidence that the Trust Board has specifically confirmed that: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	No

End of safety action 6.

Safety action No. 7

Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes
2	Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Yes
3	Do you have evidence of service developments resulting from coproduction with service users?	Yes
4	Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?	Yes
5	Do you have evidence that the MVP is prioritising the voice of woman from Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?	Yes

Safety action No. 8

Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, including Covid-19 specific training, including maternal critical care training and mental health & safeguarding concerns training In the current year we have removed the threshold of 90% for this year. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.		
Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:		
1	Obstetric consultants	Yes
2	All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	Yes
3	Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes
4	Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Yes
5	Obstetric anaesthetic consultants	Yes
6	All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota	Yes
7	Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Yes
8	Can you evidence that 90% of all staff groups in line 1-7 above have attended the the multi-professional training outlined in the technical guidance?	Yes

Safety action no. 8 continued over the page

Safety action no. 8 continued from previous page

9	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	N/A
NEONATAL RESUSCITATION TRAINING Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019:		
10	Neonatal Consultants or Paediatric consultants covering neonatal units	Yes
11	Neonatal junior doctors (who attend any deliveries)	Yes
12	Neonatal nurses (Band 5 and above)	Yes
13	Advanced Neonatal Nurse Practitioner (ANNP)	Yes
14	Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes
15	Can you evidence that 90% of all staff groups in line 10-14 above have attended the the neonatal resuscitation training as outlined in the technical guidance?	No
16	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	No

End of safety action no. 8

Safety action No. 9

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	Yes
2	Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	Yes
3	Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	Yes
4	Were monthly feedback sessions for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	No
5	Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	Yes
6	Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	Yes
7	Is the progress with actioning named concerns from staff workarounds visible from no later than 26 February 2021?	Yes
8	Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	Yes
9	Has the Board level safety champion reviewed the continuity of carer action plan in the light of Covid-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	Yes

Safety action 9 continued over the page

Safety action no. 9 continued from previous page

Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed		
10	I) Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020?	Yes
11	II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	Yes
12	III) The MBRRACE-UK SARS-COVID19 report	Yes
13	IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	Yes
14	Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	No
Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas:		
15	• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems	Yes
16	• utilise SCORE safety culture survey results to inform the Trust quality improvement plan	Yes
17	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	Yes

End of safety action 9

Safety action No. 10

Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	Yes
2	Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	Yes
3	For cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	No
4	Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	No

Section A : Maternity safety actions - Shrewsbury and Telford Hospital NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	No	1	1	0
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No	0	3	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	No	0	8	0
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	No	31	2	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	No	13	1	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	No	15	2	0
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	No	2	2	0

NHS Resolution

Section B : Action plan details for Shrewsbury and Telford Hospital NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q2 MSDS	**To be met by**	Q2 2021/22

Work to meet action	*The Trusts' Information Office have devised a plan on how the Trust will achieve compliance for the 7 data tables not already submitted. The plan is aligned to the implementation of the Badgernet for maternity system. The plan is locally funded, and has been shared with the Safety Champions (including the Board-level representative) and LMNS / CCG. Pending approval from these two stakeholders, the Board of Directors will be requested to approve the plan on 8 July 2021.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*The Trust's Information Department under the leadership of Jill Newman, supported by Maternity Information Officer, Chris Weston.*
Lead executive director	*Director of Nursing*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*The full 32 data tables are not yet ready for submission, because some are dependent on te roll-out of the Badgernet System for Maternity, which is scheduled for later this year.*
Rationale	*The action plan submitted to the Board of Directors constitues the final outstanding element of Safety Action 2. It contains a time-bound, realistic plan that can be implemented with existing resources, and ties in with the existing implementation plans for the Badgernet system for Maternity.*
Benefits	*The action plan will ensure that as well as the 25 mandatory data table submissions, that are already being met, the Trust will also be in a position to deliver the remaining 5 that can permissibly be submitted (there are two tables where the current guidance indicates submissions should not be made at this time and information on definitions and time for submission is waited in respect of these).*
Risk assessment	*This safety action helps ensure Trust leadership are provided with the necessary data to form decisisions. The proposed plan is feasible and realistic, and the only forseeable risk is the fact that IT and information capacity is limited and this may impinge on delivery.*

	How?	**Who?**	**When?**
Monitoring	Check compliance with monthly MSDS submissions	Women and Children's Division Information Office	Monthly. Plan to be presented to Board of Directors on 8 July 2021, with target implemention date of September 2021 for most of the data tables, and 2 months from Badgernet go live for MDS 105 and 203.

Action plan 2

Safety action	Q4 Clinical workforce planning	**To be met by**	Q4 2021/22

Work to meet action	*The papers required for the Safety Action, which include an assessment as to whether the required standards are still being met, will be refreshed (check to ansure the data within is still current), and submitted to the Trust Board for formal receipt and action (if required), no later than October 2021.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Clincal Director for Obstetrics, Dr. Mei-See Hon*
Lead executive director	*Director of Nursing*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*Due to a technical oversight, the papers covering Anaesthetic Workforce and Neoneatal Medical and Nursing Workforces were not formally received by the Trust Board in sufficient time to analyse their content prior to CNST declaration (they were received by Maternity Governance Committee in March 2021). Therefore, the Trust cannot declare compliance with this Safety Action.*
Rationale	*This action will ensure that the Trust Board is apprised of the latest staffing status for the workforces in question, and outline any potential gaps, so that they can take informed action to close them. Of note, as of February 2021, all standards were being met.*
Benefits	*Compliance with CNST Safety Action 4 will be achieved.*
Risk assessment	*There are no risks to patient safety as a result of not meeting this standard. However, this means that the Trust has not yet been able to qualify for the MIS year 3 incentive payment.*

	How?	**Who?**	**When?**
Monitoring	Formal papers to be submitted to Trust Board no later than October 2021	Papers to be compiled by CD of Obtetrics and received by Board Secretariat	By October 2021

Action plan 3

Safety action	Q5 Midwifery workforce planning	**To be met by**	Q2 2021/22

Work to meet action	*A full paper is in the process of being written, and will be submitted to the Trust Board in July 2021. This paper will ensure compliance with the CNST MIS Year 3 standards.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Interim Director of Midwifery, Joy Payne*
Lead executive director	*Director of Nursing*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*Due to the sudden and unforseeable absence of the Director of Midwifery, this piece of work was not completed within the requisite time frame.*
Rationale	*The paper will achieve compliance with the requirements of CNST MIS Year 3, and ensure safe midwifery staffing levels are achieved.*
Benefits	*The paper will achieve compliance with the requirements of CNST MIS Year 3, and ensure safe midwifery staffing levels are achieved.*
Risk assessment	*The Trust undertook a Birthrate+ assessment audit in 2017, and midwifery staffing levels were set in accordance with this. The Birthrate+ report that was received in February 2021 shows that only a marginal uplift is required. In addition, daily safety huddles and risk assessments are undertaken to balance the needs of women and babies alongside available staff. Any 'Red Flag' notifications are acted upon in a timely manner.*

	How?	**Who?**	**When?**
Monitoring	Midwifery Staffing paper to be submitted to Trust Board	Interim Director of Midwifery	By July 2021

Action plan 4

Safety action	Q6 SBL care bundle	**To be met by**	Q2 2021/22

Work to meet action	*The requirements of this Safety Action have been carried, under the leadership of the SBL lead midwife, and have been peer-reviewed by a specialist midwife via our partnership with Sherwood Forest Hospitals. Three board-level minuted statements are outstanding: commitment to facilitate local, in-person fetal monitoring training once this is permitted, confirmation that women at high risk of pre-term birth have access to a pre-term clinic with provision of transvaginal ultrasound, and confirmation that an audit has been completed to measure the percentage of singleton live births occuring more than seven days after completion of their first course of antenatal corticosteroids. The Board of Directors has been provided with evidence that the Trust is in a position for them to make such declarations, and subject to their satsifcation with this evidence, they will make the necessary attestations on 8 July 2021. These will be recorded in the minutes of the meeting.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Board Secretariat*
Lead executive director	*Director of Nursing*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*The evidence required by the Board of Directors in order for them to judge whether thay can make the above statements has only recently been finalised.*
Rationale	*The above plan outlines the precise statements required of the Board of Directions, and provised them with the assurance they require in order to do so.*
Benefits	*This action requires the provision of suitable evidence to show the Trust is compliant with all of the requirements of SBL, hence will provide detailed assurance that the Trust is providing the best care for servuce users.*
Risk assessment	*Subject to the Board of Directors agreeing to make the statements listed above, this Safety Action is fully compliant in that the elements of Saving Babies Lives have all been met, and independently tested.*

	How?	**Who?**	**When?**
Monitoring	To be minuted at Board of Directors meeting	Board Secretariat	08-Jul-21

Action plan 5

Safety action	Q8 In-house training	**To be met by**	Q4 2021/22

Work to meet action	*The Trust has only been able to evidence that 83% of its neonatal consultants have completed the NLS module. It must therefore show a plan as to how 90% will be reached. The remaining consultant has been booked onto an NLS course in August 2021, which will attain 100% compliance for this group. All other standards have already been evidenced.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Clincal Director for Noenatal Unit*
Lead executive director	*Director of Nursing*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*The consultant in question had already completed similar course at a more advanced level, but has subseuqnetly booked onto the NLS course to ensure full CNST compliance.*
Rationale	*This action will ensure that the Trust meets or exceeds the 90% completion threshold for all staff groups for all qualifications stipulated in Safety Action 8.*
Benefits	*By having the approved training plan in place, the Trust is compliant with Safety Action 8.*
Risk assessment	*It should be noted that the consultant in question has recently completed the Neonatal Airway Management, BAPM Neonatal Emergency Airway Management and BAPM Stabilisation and Rescusitation of Baby Next to Mother Courses, and had already put plans in place to attend the Advanced Rescusitation of the Newborn Infant (ARNI) course, so is already up-to-date in their knowledge.*

	How?	**Who?**	**When?**
Monitoring	Remaining staff to complete NLS course	NNU consultants	Aug-21

Action plan 6

Safety action	Q9 Safety Champions	**To be met by**	Q2 2022/23

Work to meet action	*The Trust's Maternity and Neonatal Safety Champion Group meet monthly, with a bi-monthly walk-about. The group is active, dedicated and well-organised, making sure that any safety actions raised are dealt with in a timely manner and the results reported back to all stakeholders. However, it is clear that last year there was a failure to ensure that the UKOSS letter was received and acted upon by the group in a suffiently prompt timeframe. This is an example of the weak area of the Trust's approach to CNST this year: all of the compliance failures have been a result of system and process failings. Having a better system and process for tracking and monitoring the receipt of such reports and any subsequent actions, as with the whole CNST process, will be key to ensuring full compliance going forward.* *To help the Trust address all of the shortcomings in the Year 3 MIS submission, as well as any future submissions, we request the below funds in order to employ a governance officer for two years.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*The Executive Safety Champion, supported by the Non-Executive Safety Champion and, in due course, the post-holder referenced above.*
Lead executive director	*John Jones, Interim Medical Director, and Hayley Flavell, Director of Nursing.*
Amount requested from the incentive fund, if required	*£100,000.00*
Reason for not meeting action	*Items 5 and 16 of this action were not met. The former because due to unforseeable staff absence, the meeting minutes from January and February 2020 could not be located, hence there was no evidence that staff feedback sessions had occured in those months. On point 16, the UKOSS report was not discussed by the Trust's Maternity and Neonatal Safety Champion Group until 18th December 2020, thus missing the 30th November deadline. The report was subsequently discussed in more detail and its findings have been actively incorporated into the groups' plans and recommendations to Board and to the Women and Children's Division*
Rationale	*The Maternity and Neonatal Safety Champions Group is now fully embedded, with an agreed formal Terms of Reference and escalation pathway and full multi-disciplinary representation, including direct sponsorship and input from the relevant executives. The support offered by the divisional programme management office, as outlined in the plan, will ensure that key reports and recommendations will be recieved, acted upon, and carefully documented in a timely manner.*
Benefits	*The Maternity and Neonatal Safety Champion group will continue to set out its agenda for the monthly meetings at least one week in advance. During each meeting, effective July 2021, all members will be asked to notify the group if they are aware of new reports or guidance that must be considered by the group in addition to actions based on findings from the walk-abouts. It will be the responsibility of the PMO to ensure these are raised at the next available meeting. This will be measured and checked by the 'AAA' (Alert, Advise, Assure) reports that the group sends to the Trust board, and minutes. This will ensure that national recommendations and findings are discussed and implemented as soon as possible, to ensure our service users receive the best care based on contemporaneous information.*
Risk assessment	*The Trust is confident that with the above support in place, the working processes of the Maternity and Neonatal Safety Champions Group will be further reinforced, and the likelihood of ommissions or delays adequately reduced, so that this Safety Action will be met in full.*

	How?	**Who?**	**When?**
Monitoring	Confirmation that post has been filled, in addition to the existing AAA reports, minutes and Non-Executive Safety Champion reports to the Board of Directors (also to the Ockenden Report Assurance Committee).	Board-level Safety Champions (Executive and Non-Executive).	Mar-22

Action plan 7

Safety action	Q10 EN scheme	**To be met by**	Q3 2021/22

Work to meet action	*The data need to be independently validated, after which they will need to go through the appropriate governance and assurance forums before they can be formally presented to the Trust Board.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Divisional Governance Lead*
Lead executive director	*Director of Nursing*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*It looks as if the Trust has complied with this requirement, in terms of identifying and reporting incidents that meet the referral criteria. However, these data have not yet been validated independently. Furthermore, these data have not yet been through any formal governance and assurance processes, eventually to the Board of Directors. As such, it is not yet possible to confirm affirmatively that this standard has been met.*
Rationale	*The above action plan will ensure that the data has been appropriately tested, which will allow the Board to formally receive them, as per the requirements of Safety Action 10*
Benefits	*This will ensure compliance with the Safety Action.*
Risk assessment	*The above action plan should address the risks.*

	How?	Who?	When?
Monitoring	Data to be validated at appropriate forums and then submitted to the Board of Directors.	Governance Lead for Maternity Services (Refeth Mirza)	Oct-21

Maternity incentive scheme - Board declaration Form

Trust name	**Shrewsbury and Telford Hospital NHS Trust**
Trust code	**T650**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	No	Yes	-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	No	Yes	-	
Q5 Midwifery workforce planning	No	Yes	-	
Q6 SBL care bundle	No	Yes	-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	No	Yes	-	
Q9 Safety Champions	No	Yes	100,000	
Q10 EN scheme	No	Yes	-	
Total safety actions	**3**	**7**		
Total sum requested			**100,000**	

Sign-off process:

Electronic signature

For and on behalf of the board of Shrewsbury and Telford Hospital NHS Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and th

Electronic signature

For and on behalf of the board of Shrewsbury and Telford Hospital NHS Trust

Confirming that:

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature	
For and on behalf of the board of	Shrewsbury and Telford Hospital NHS Trust

Confirming that:

There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature	
For and on behalf of the board of	Shrewsbury and Telford Hospital NHS Trust

Confirming that:

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 July 2021

Agenda item	179/21			
Report	The Ockenden Report – Progress Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1 BAF 2 BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon (if applicable)**:**				
Executive summary:	This report presents an update to the Trust's Ockenden Report Action Plan and other related matters. Progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. There are some challenges in meeting some of the delivery and evidence dates the Trust has set itself to achieve, but these are being managed. Staff absences have compounded some of this work but some of these now appear to be resolving. The Board of Directors is requested to receive and review: • This report, the Ockenden Report Action Plan at **Appendix One** and Draft Exception Reports at **Appendix Two** • Decide if any further information, action and/or assurance is required			
Appendices	**Appendix One:** Ockenden Report Action Plan at 30th May 2021 **Appendix Two:** Ockenden Report Action Plan Draft Exception Reports			

1. PURPOSE OF THIS REPORT

1.1 This report presents an update on all 52 actions in the Trust's Ockenden Report[1] Action Plan since the last meeting of the Board of Directors in Public on 10th June 2021. In addition, updates are provided on other related matters.

2. THE OCKENDEN REPORT (INDEPENDENT MATERNITY REVIEW - IMR)

2.1. The Board of Directors received the first Ockenden Report - Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews, at its meeting in public on 7th January 2021.

2.2. The report sets out the following actions for the Trust to implement:

2.2.1. Twenty-seven Local Actions for Learning (LAFL), which are specific 'Must Do' actions for this Trust, and;
2.2.2. Seven Immediate and Essential Actions (IEA) for all NHS providers of maternity care, which apply to this Trust, also. These seven themes comprise 25 related actions.
2.2.3. In total, there are 52 specific actions for the Trust to implement.

2.3. All of the Ockenden actions (LAFL and IAE's) have been cross-referenced to the Trust's Maternity Transformation Plan, which now includes The Maternity Improvement Plan, as workstream 6.

2.4. The latest version of the first Ockenden Report Action Plan as at 25th June 2021 is presented at **Appendix One** for the Board's consideration (Note: Glossary and Index are at the back of the plan). The latest commentary is provided in blue text.

3. STATUS OF REQUIRED ACTIONS

3.1. The **'Delivery Status'** position of each of the 52 actions as at 25th June 2021 is summarised in the following tables. The first shows the 'current' and 'proposed' position against each. To explain this further, a number of actions have been reviewed by a subset of the Maternity Transformation Assurance Committee (MTAC) to give a preliminary view ahead of the next formal MTAC meeting on 13th July 2021. From this review, it is possible that a number of actions could change their status, subject to them being ratified formally at the next MTAC meeting. In order to ensure full transparency, these are shown in the 'proposed' column to show what the possible movement could look like. However, and as has been discussed previously, these need to be caveated as they will need to go through the full and due testing and validation process first before confirming.

[1] www.gov.uk/official-documents. (2010) Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews.

Delivery Status							
	Total # recommendations	Not yet delivered		Delivered, Not Yet Evidenced		Evidenced and Assured	
		Current	Proposed	Current	Proposed	Current	Proposed
LAFL	27	15	13	12	14	0	0
IEA	25	17	9	7	15	1	1
Total	52	32	22	19	29	1	1

The following table summarises the overall 'Delivery Status' direction of travel, which is positive.

Delivery Status Direction of Travel				
	Not yet delivered	Delivered, Not Yet Evidenced	**Evidenced and Assured**	Trend
LAFL	-2	+2	0	
IEA	-8	+8	0	
Overall	-10	+10	0	

3.2. Using the same approach, the **'Progress Status'** position of each action as at 25 June 2021 is summarised in the following table:

Progress Status											
	Total # recommendations	Not Started		On Track		At Risk		Off Track		**Completed**	
		Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
LAFL	27	0	0	27	23	0	0	0	4	0	0
IEA	25	3	0	21	23	0	0	0	1	1	1
Total	52	3	0	48	48	0	0	0	0	1	1

3.2.1. The following table summarises the overall 'Progress Status' direction of travel, which shows a mixed picture, as follows:

Progress Status Direction of Travel						
	Not Started	On Track	At Risk	Off Track	**Completed**	Trend
LAFL	0	-4	0	+4	0	
IEA	-3	+2	0	+1	0	
Overall	-3	-2	0	+5	0	

3.3. The four actions that were declared in the previous two months as being 'off track' have revised their delivery dates, and these have been approved by the Maternity Transformation Assurance Committee. These are now back on-track.

3.4. Five further actions are now 'off track", having breached their expected 'delivery' and/or 'evidence required' dates. These are four LAFL's and one IEA, as follows:

3.4.1. **LAFL 4.59** - The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.

3.4.2. **LAFL 4.60** - The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.

3.4.3. **LAFL 4.73** - Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.

3.4.4. **LAFL 4.100** - There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

3.4.5. **IEA 1**.4 - An LMS cannot function as one maternity service only.

3.5. The current position for each of these is provided in the narrative written in blue font in the Status Commentary section of the Ockenden Report Action plan at **Appendix One.** In addition, draft exception reports for each are attached at **Appendix Two,** which provide further details. These are still draft as they have yet to be discussed and finalised at the next MTAC meeting on 13th July 2021. However, they are presented to give some sense of where these actions are currently.

3.6. It is suggested that the MTAC should undertake a review of all of the delivery and evidence dates that the Trust set itself in order to ensure that they are fair and appropriate still. The Board is reminded that some of the original dates set by the Trust may have been over-ambitious initially (as these are discretionary to the Trust and are not mandated).

3.7. It is also worth advising the Board that the people leading, coordinating and working on this plan are the same people that have been providing added and extra input and focus to the Clinical Negligence Scheme (CNST) for Maternity Incentive Scheme work and thus, have been spread thinly during May and June. However, this position will improve during July 2021.

3.8. A further 15 actions are requiring to be evidenced by the 30th June 2021. These all require audit evidence to move to the 'evidence and assured' rating. This work has started, however, due to the need for a key staff member to take compassionate leave and, also, amendments that had to be made to the audit tool as a result of the minimum evidence requirements for IEA's published by NHSE/I in May, it has not been possible to complete this work during June 2021. It is most likely that these actions will breach the end of June date but it is hoped that this position can be recovered during July and August 2021.

3.9. In summary, this month presents a mixed picture. However, good progress is being made overall in relation to the number of actions moving to 'delivered but not yet evidenced' status. The reasons for more actions going 'off track' will be reviewed at MTAC. It is anticipated that, whilst there has been an unavoidable delay to undertaking a number of audits, this position will now improve.

4. OTHER MATTERS RELATING TO THE OCKENDEN REPORT ACTIONS

4.1. <u>IEA Return to NHS Midlands on delivery of the Immediate and Essential Actions</u>

4.1.1. The Trust has uploaded all of its current evidence to the national portal within the required timeframe. The position of all NHS providers of maternity care will be

compared and contrasted, and feedback on what this is showing will be presented back to trusts in due course.

4.2. External Expert Advisory Panel (EEAP)

4.2.1. The Trust's Chair has written to the EEAP to agree the next steps in terms of progressing work with the Panel.

4.3. Workforce Plan, Including Birthrate Plus Assessment

4.3.1. The Trust has received the final Birthrate Plus report from the audit that was undertaken in the last quarter of 2020. The Interim Head of Midwifery and Interim Deputy Head of Midwifery have produced a position paper that is being considered currently, ahead of producing a final report. It is anticipated that, once the final report is ready it will be presented to the Board at its July meeting in public.

5. OCKENDEN REPORT ASSURANCE COMMITTEE (ORAC)

The fourth Ockenden Report Assurance Committee took place on Thursday 24th June 2021. The main topic for discussion was the Trust's progress against the Saving Babies' Lives Care (SBL) Bundle (version two). This is a national initiative to reduce the incidence of stillbirths in England. Mrs Lindsey Reid, Lead Midwife for SBL and Mr Guy Calcott, Consultant Obstetrician and Gynaecologist were the main presenters. This was a really positive meeting, with excellent progress being made by the Trust against all of the elements of the care bundle. The Chair will discuss this committee in her report at today's meeting.

6. SUMMARY

Progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. There are some challenges in meeting some of the delivery and evidence dates set by the Trust for itself but these are being managed. Staff absences have compounded some of this work but some of these now appear to be resolving.

7. ACTION REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to receive and review:

- This report, the Ockenden Report Action Plan at **Appendix One** and Draft Exception Reports at **Appendix Two**
- Decide if any further information, action and/or assurance is required

Hayley Flavell
Executive Director of Nursing
June 2021

Appendix One: Ockenden Report Action Plan at 30th June 2021
Appendix Two: Ockenden Report Action Plan – Draft Exception Reports – June 2021

LOCAL ACTIONS FOR LEARNING (LAFL): The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 1: Maternity Care													
4.54	A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Revised risk assessment form introduced (at booking); audit pending. Consider making risk assessment mandatory field in Medway (and Badgernet). Handheld notes include planned place of delivery and risk category (at each appt), but audit needed to confirm this. MTAC agreed on 22/04/2021 that the evidence provided, including booking guideline, risk assessment proforma and Clinical Referral Team process, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	31/01/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Ongoing antenatal care pathway development under way. Videos and leaflets available plus BabyBuddy app. Access to/utilisation of these needs to be determined. Key info also provided in handheld notes. Method to be introduced to confirm mother's understanding / receipt of info. MTAC agreed on 22/04/2021 that the evidence provided, including information videos, virtual ward tours, online antenatal classes, the new Personalised Care and Support Plan (co-produced with the MVP) and Place of Birth Choice leaflet, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.56	The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	This action will be proposed for marking as 'Delivered, Not Yet Evidenced' at the next MTAC, with evidence including proof that a dedicated obstetrician and two specialist midwives are now in substantive posts; all with suitable allocation of time to devote to training and knowledge update of EFM. Job descriptions and person specifications showing the expertise and experience required, and evidence of training provision and continuous professional development were also provided.		31/08/21		Hayley Flavell	Shirley Jones	

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	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.57	These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	A dedicated SBL project midwife in post, progress against Saving Babies' Lives (SBL) v2 is monitored within scope of Maternity Transformation Plan (MTP). The planned peer review, undertaken with Sherwood Forest Hospitals NHS Foundation Trust (SFH), has been conducted, showing >90% of the evidence to demonstrate compliance has been provided and reviewed. Noting that SBL is an ongoing requirement, rather than one-off deliverable, this action will be proposed at next MTAC to be marked as 'Delivered, Not Yet Evidenced' based on the assurance so far carried out. It was the subject of a deep-dive review at the June ORAC meeting.		15/07/21		Hayley Flavell	Shirley Jones	
4.58	Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.	Y	10/12/20	30/04/21	Delivered, Not Yet Evidenced	On Track	FIGO (International Federation of Gynaecology and Obstetrics) guidelines implemented (as opposed to NICE and supported by NHSI/E improvement advisor in 2020) SATH Fetal Monitoring guideline, approved by the Clinical Network, recommends that there should be further internal review given the action for the report. This is being progressed. MTAC agreed on 22/04/2021 that the evidence provided, including an approval record from the Clinical Network of SaTH's fetal monitoring guideline and re-approval by the Quality Operational Committee and QSAC, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	22/04/21	30/06/21		Hayley Flavell	Shirley Jones	SaTH NHS SharePoint
4.59	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	A review of the governance team structure underway, and the Trust has begun recruitment of a dedicated Head of Clinical Governance, initially for a six-month period. The Trust has also set up two new divisional governance forums, NOIR and DOG, with the aim of ensuring timely and thorough conduct of investigations. Despite this, the MTP Group do not feel there is enough evidence in place to recommend MTAC to mark this deliverable as 'Delivered, Not Yet Evidenced', hence it should be marked as 'Off Track', and an Exception Report will be provided to MTAC and the Trust Board shortly.		30/09/21		Hayley Flavell	Shirley Jones	
4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	A review of Governance team structure is underway, actively supported by our SFHNHST partners with a formal Terms of Reference in place. The Trust has taken steps to introduce additional resources (incoming Head of Clinical Governance) and new forums have been set up that will help deliver this action (specifically the Divisional Oversight Group and NOIR). However, the sub-tasks required to deliver it, including the conduct of an assurance exercise and cross-referencing between Datix and MEDWAY has not yet been carried out, hence MTPG will not advise MTAC to mark this as 'Delivered, Not Evidenced'. Therefore the action should be marked as 'Off Track', and an Exception Report will be filed and shared with MTAC and the Trust Board.		30/09/21		Hayley Flavell	Shirley Jones	

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.61	Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	All women with complex pregnancies are seen by an obstetrician, but an audit is required. MTAC agreed on 22/04/2021 that the evidence provided, including the revised risk assessment proforma (used at booking), and the CRT Referral Process, was sufficient to move this to 'Delivered, Not Yet Evidenced', with a formal audit to follow.	22/04/21	31/05/21		Hayley Flavell	Shirley Jones	SaTH NHS SharePoint
4.62	There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Consultant ward rounds at 08:30 and 20:30 in place 7 days per week since September 2019, handover sheets in place, weekly MDT in-situ simulation training in place. Liaison with Anaesthesia department required to ensure inclusion on rounds (see section 'Obstetrics Anaesthesia'). Current simulation training package under review. MTAC agreed on 22/04/2021 that the evidence provided, including examples of obstetric handover sheers, an small audit of the handover run-rate, an example of the safety huddle attendance record, evidence of anaesthetist representatives attending ward rounds, planned purchase of PROMPT sim equipment to be held on wards for in-situ training, and evidence (design and feedback sheets, with attendance records to follow) of regular multi-disciplinary team simulation training was sufficient to move this to 'Delivered, Not Yet Evidenced', with a follow-up check including attendance records to follow.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.63	Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Currently achieved. Need to be able to provide on-going evidence, Retrospective audit of notes and ongoing audit to be conducted. MTAC agreed on 22/04/2021 that the evidence provided (completed obstetric handover sheets) was sufficient to move this to 'Delivered, Not Yet Evidenced', but noted that they would need to see the new handover sheet that is being introduced to add greater control and oversight, and the results of a formal audit, before it can be accepted as 'evidenced and assured'.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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4.64	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.	Y	10/12/20	30/04/21	Delivered, Not Yet Evidenced	On Track	Current guideline regarding use of oxytocin is in line with national guidance, including continuous CTG monitoring. 'Fresh eyes' initiative and regular reviews by obstetricians is in place Guideline to be enhanced beyond required standards, e.g. 4 hourly review by doctor if oxytocin is being used. Standard operating process for documentation of obstetric reviews to be developed. MTAC agreed on 22/04/2021 that the evidence provided (demonstration of use of stickers to show continuous monitoring is carried out, and the preliminary findings of a snap audit of 12 case notes to show continuous monitoring, including during insertion of epidural was being carried out) was sufficient to move this to 'Delivered, Not Yet Evidenced', but outlined a requirement for a full, formal audit (number of cases tbc) as the next step for evidencing	22/04/21	30/06/21		Hayley Flavell	Shirley Jones	SaTH NHS SharePoint
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/07/21	Not Yet Delivered	On Track	Two bereavement midwives in place. Business case submitted for additional 90 hrs of consultant time for delivery of bereavement care. Need to appointment obstetrician to co-lead on bereavement care. At their meeting on 22/04/2021, MTAC found this action has not yet been delivered, because the business case has not yet been approved (though they have seen the document itself). They noted that an appropriate guideline (Fetal Loss and Early Neonatal Death) is in place and appropriately experienced midwives are in place, and that the consultants are providing bereavement care. However, for this service to be consistent and fully optimised, the committee need to see the protected consultant time / appointment - this must also show service user representation in the selection of candidates. An exception report has been provided, and May MTAC agreed delivery date rebaseline from 31/03/21 to 31/07/21; evidence rebaseline from 30/06/2021 to 30/09/2021.		30/09/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Bereavement pathway adopted partially and commitment in place to embed it fully, specifically formal allocation of Consultant time in addition to the two specialist Bereavement Care midwives already in post. The Trust has Implemented the maternity bereavement experience measure. SANDS (Stillbirth and Neonatal Death Society) online training modules mandated for clinical staff, which will need to be evidenced over time. SANDS review has been postponed due to the Coronavirus pandemic, but will be rescheduled. Based on the fact that despite no formal PA allocation, consultant input to Bereavement Care is in place, and well-evidenced care and compliance with HSIB and Early Notification, including family involvement by the midwives, MTPG will recommend next MTAC meeting to mark this as 'Delivered, Not Yet Evidenced'.		31/08/21		Hayley Flavell	Shirley Jones	

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Escalation policy already in place. Updated November 2020 to describe situations where Consultants must be in attendance. Process in place to assess competencies of all middle grade doctors, not just O&G trainees. Compliance with escalation process to be audited. At their meeting on 22/04/2021, MTAC approved status to be 'delivered, not yet evidenced' based on the escalation process poster that is displayed on the wards. The next wish to see the completed guidelines / SOP document, and an audit of adherence.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.73	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	The risk assessment process at booking has been redesigned with early referral for women with pre-existing medical conditions - they are seen in multi-disciplinary clinics. Where there is not a relevant MDT clinic they are seen by an Obstetrician with an interest in maternal medicine for assessment and referral to a local / tertiary Physician. The development of specialist Maternal Medicine Centres is a National priority, led by each Clinical Network. In the West Midlands; the centre is yet to be determined but will not be SaTH. This is not within the control of SaTH to determine timescales. The Service employees a Clinical Referral Team and a Risk Assessment and procedure for the allocation of an appropriate local consultant. Additionally, it is setting the conditions to nominate a Maternal Medicine Centre lead consultant once the Midlands Centre is established. Full engagement with the preparations for this by SaTH with Midlands Perinatal has been evidenced. However, the Trust acknowledges that some of its referral guidelines require an update. Further, the specific criteria for referral to the Maternal Medicine Centres is something the Centres themselves would have to lead on, hence somewhat out of our control at this time. To that end, MTPG advise MTAC to leave this action as 'Not Yet Delivered', and as the target date has been missed, mark it 'Off Track'. An exception report, comprising mitigation plan will be supplied to MTAC and the Trust Board shortly.		30/06/21		Hayley Flavell	Guy Calcott	

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.74	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Complex antenatal and postnatal inpatients are identified at the morning and evening Delivery Suite handovers 7 days a week. This information is recorded on the handover sheets. The on call consultant attends the antenatal ward round daily to conduct a ward round along with the Tier 2 doctor. They also attend the postnatal ward to review any women identified as complex. This will be evidenced by an attendance audit and through auditing the information on the handover sheets. Further clarity to be sought of specifics of this requirement i.e.: what constitutes demonstrated expertise? MTAC approved this as 'Delivered, Not Yet Evidenced' at their meeting of 22/04/2021, noting the revised risk assessment form and CRT referral process (as with LAFL 4.54 and 4.61).	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Anaesthetists participating in some MDT ward rounds MDT emergency obstetrics course run in the SIM centre approx. 3 x per year Lead obstetric anaesthetist key facilitator in weekly in situ simulation training Obstetric anaesthetists to complete online Prompt course by 31/3/21 Include obstetric education section in each Anaesthetic governance meeting Regular obstetric anaesthesia meetings with a learning section Involvement of anaesthetists in PROMPT – both as facilitators and participants.				Hayley Flavell	Shirley Jones	
4.86	Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.	Y	10/12/20	30/09/21	Not Yet Delivered	On Track	Good engagement with anaesthetics department. Consultant Anaesthetic Lead working closely with Clinical Director for obstetrics to ensure that anaesthetics staff are fully-embedded in the delivery of safe and effective care.				Hayley Flavell	Janine McDonnell	
4.87	Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA. Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.	Y	10/12/20	30/09/21	Not Yet Delivered	On Track	Annual audit cycle in regards to Royal College of Anaesthetists (RCoA) Guideline audit currently in place (covers theatre and epidural practice). Trust Guidelines last reviewed in 2016; new review underway. Regular guidelines review to be implemented as standing agenda item of bi-monthly obstetrics anaesthetic meeting. Audit method for compliance with the guidelines to be devised.		30/09/21		Hayley Flavell	Shirley Jones	
4.88	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Middle grade rota is staffed by experienced obstetric anaesthetists only. Continuous Professional Development (CPD) for consultants that cover obstetrics at night but who do not have regular sessions in obstetrics is in place. SOP/Guideline: "W*hen to Call a Consultant*" being developed. Compliance of completed CPD sessions to be collated. 'Cappuccini' audit underway and will be repeated: will demonstrate contactability of anaesthetic consultants.				Hayley Flavell	Shirley Jones	
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Review of effectiveness of application of the ACSA (RCoA) – 189 standards is underway. In place as standing agenda item at the Obstetric Anaesthesia meeting.				Hayley Flavell	Shirley Jones	

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4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Obstetric Anaesthetist expertise is incorporated to regular Datix reviews. Regular input to 'Human Factors' investigations, also. Anaesthetics consultants to dedicate SPA time to Obstetrics in addition to current service lead in order to progress this. Will require audit evidence.				Hayley Flavell	Shirley Jones	
4.91	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Currently working towards compliance with Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, safety action 8. Simulation course held 3 x per year In situ simulation training conducted weekly All obstetric anaesthetists to submit evidence of completion of the online PROMPT course by 31/3/21 MTAC approved this as 'Delivered, Not Yet Evidenced' based on evidence of 89% completion rate of the online PROMPT training by anaesthetists, and feedback notes and course design of MDT training organised by the anaesthetic consultants. Attendance records, plus demonstrated fulfilment of CNST MIS Safety Action 8 will move this to 'Evidenced and Assured Status'. Face-to-face MDT training will resume from 28 April (having been online early during the worst of the pandemic).		30/10/21		Hayley Flavell	Will Parry-Smith	SaTH NHS SharePoint

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Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Roll out of combined medical and nursing notes to Neonatal Unit (NNU) planned for Q4 2020/2021. A structured 'daily notes guidance' exists already in the Neonatal Handbook Adopt combined records approach in NNU by 31/01/2021. Implement a system and problem-based recording of daily notes for babies receiving intensive and high-dependency care Ensure information on joint medical and nursing note keeping held on all staff induction Check adherence to above through audit Prepare a business case for Neonatal Badgernet EPR and explore the feasibility of using the existing summary record for daily entries in the interim. MTAC approved this as 'Delivered, Not Yet Evidenced' having seen proof of the combined notes format having been adopted (by the deadline set out above). They also saw examples of the SaTH Exutero Exception monthly log for the previous quarter. Next items to check will include plans for the Badgernet rollout referenced above.		30/04/21		Hayley Flavell	Shirley Jones	SaTH NHS SharePoint
4.98	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.	Y	10/12/20	31/07/21	Not Yet Delivered	On Track	Policy for escalation already in place with audits taking place every three months by a senior Neonatologist. Adherence to exception reporting and escalation policy in line with service specification and Network requirements – to be monitored on monthly basis Recording and filing of discussions with NICUs outside of the exceptions to be implemented Review and revise the existing SOP for escalation by tier 2 staff/senior nurses to on call consultant Both MTAC and the nominated Neonatal Consultant supporting this project declared this action 'Not Yet Delivered' in their review on 22/04/2021. As reported at ORAC on the same day, there are some discrepancies with this requirement and current national guidance. SaTH will seek the advice of the External Expert Advisory Panel on how best to proceed. Given the initial due date has passed, a project exception report has been filed. May MTAC approved revised delivery date from 31/03/21 to 31/07/21 and evidence date from 30/04/21 to 30/09/21		30/09/21		Hayley Flavell	Shirley Jones	

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APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 25 Jun 2021)

NHS
The Shrewsbury and Telford Hospital
NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.99	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.	Y	10/12/20	31/10/21	Not Yet Delivered	On Track	1. Business case completed and approved for additional senior clinicians to offer increased clinical presence on neonatal unit - meeting the dedicated 24 hour on-site tier 2 presence. 2. Recruitment to commence in Feb 2021 for anticipated start date of October 2021	12/01/21	31/10/21		Hayley Flavell	Janine McDonnell	
4.100	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Plans underway to enable observation of other NICUs Develop Job Plans to enable neonatal consultants to spend 2 weeks/year at the Network NICUs. MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen of firm plans for such placements to take place at Royal Stoke Hospital, New Cross Hospital and Birmingham Women's Hospital. Regrettably, the Women and Children's Division has not been able to advance this as the business cases for an additional (neonatal) consultant has not yet been approved. Accordingly, attachments cannot be put in place without putting the onsite rota at risk. Therefore, MTPG advise MTAC to revert the status of this action to 'Not Yet Delivered' and mark it 'Off Track'; consequently an Exception Report is required and will be supplied to MTAC and the Trust Board shortly.		30/10/21		Hayley Flavell	Janine McDonnell	SaTH NHS SharePoint

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	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight													
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Y	10/12/20	31/10/21	Not Yet Delivered	Not Started	Review at LMNS Board in order to consider what data is required and in what format Work being scoped with NHSEI to develop national maternity dashboard with SaTH as a key stakeholder				Hayley Flavell	Shirley Jones	
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Not Yet Delivered	On Track	Full embedded status depends on joining with a larger LMNS to support this process. However, MTPG advise MTAC to mark this as 'Delivered, Not Yet Evidenced' based on compliance with the minimum evidence requirements published for this action by NHSEI in May, which proves that all cases which fulfil PMRT criteria are currently reviewed with external panel member present (typically an obstetrician from Walsall NHS Trust); an audit having been carried out to assure this and proof given that the presence of the external person is clearly set out in the relevant guidelines.		31/07/21		Hayley Flavell	Shirley Jones	
1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	Review underway into levels of accountability and responsibility for maternity services held by this LMNS Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate and effective oversight. LMNS and CCG have shared copious evidence of plans to implement the Perinatal Clinical Quality Surveillance Model, plus minutes and organograms showing the formal receipt of information pertaining to maternity issue including SIs, Continuity of Carer roll-out and MVP co-production. Accordingly, MTPG feel MTAC would be justified in marking this as 'Delivered, Not Yet Evidenced', but this is a difficult judgment as the NHSEI minimum evidence requirements for IEAs, published in May 2021, do not allude to this specific action.				Hayley Flavell	Hayley Flavell	
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	SATH currently a single trust LNMS. Issue raised with NHSI/E regional office. Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate effective oversight. This is still underway as of June, and no progress can be reported. The deadline having passed, this must be noted as 'Off Track' and an Exception Report is needed. MTPG will liaise with executive leadership on this and supply the report to MTAC as soon as practicable.				Hayley Flavell	Hayley Flavell	
1.5	The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	This is in place but is not yet evidenced	31/01/2021			Hayley Flavell	Hayley Flavell	

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1.6	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.	Y	10/12/20	31/07/21	Not Yet Delivered	On Track	Review and strengthen SI reporting process to Trust Board and LMNS. Discussions commenced on how best to do this. Quarterly report to Trust Board using peer as example of reporting process to be developed MTAC reviewed progress against this at their meeting on 22/04/2021, and decided there is not enough evidence of transparency (in terms of publishing), so this remains 'Not Yet Delivered'. An exception report has been filed, but the revised due date is tbc. Next steps are for the Trust to consult with SFHNHST to learn from how they report safety matters in the public domain, with a view to adopting best practice. The May MTAC accepted the exception report and agreed revised delivery date from 30/04/21 to 31/07/21 and evidence date from 30/06/21 to 30/09/21.		30/09/21		Hayley Flavell	Shirley Jones	

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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	These roles are being developed, defined and recruited to nationally. It is understood that this process in underway. The NHSEI minimum evidence requirements for IEAs, published in May 2021, made clear that as no progress has ben announced on the national initiative, Trusts are not expected to demonstrate any evidence of progress on this action. MTPG therefore advise MTAC to re-baseline the delivery date until October or November at the earliest. This not being within SaTH's control, there is no requirement or benefit in marking the action as 'Off Track'.				Hayley Flavell	Hayley Flavell	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Once in post, methodology for this is to be developed. The NHSEI minimum evidence requirements for IEAs, published in May 2021, made clear that as no progress has ben announced on the national initiative, Trusts are not expected to demonstrate any evidence of progress on this action. MTPG therefore advise MTAC to re-baseline the delivery date until October or November at the earliest. This not being within SaTH's control, there is no requirement or benefit in marking the action as 'Off Track'.				Hayley Flavell	Hayley Flavell	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Non-Executive Safety Champion in post with oversight of Maternity Services Executive Safety Champion in post – Trust Executive Medical Director (Interim co-Medical Director currently representing). Approved to 'Delivered, Not Yet Evidenced' by MTAC on 22-May-21 and ORAC on 27-May-21 and to 'Evidenced and Assured' by MTAC on 8-Jun-21 based on CNST Safety Action 9 evidence and full compliance with the minimum evidence requirements set out in the NHSEI guidance for this criterion as published on 5 May 2021. In response to MTAC direction that the Trust must engage more with MVP partners, the MTP has co-produced with MVP the 'User Experience' input and feedback system which governs the project management delivery for Workstream 5 (Comms and Engagement). As of June, we have received more than 50 such items of feedback, and are actively planning and working to deliver them. The NED has stated his intent to work more closely with MVP going forward.		30/04/21		Hayley Flavell	Shirley Jones	SaTH NHS SharePoint - Maternity Safety Champions workspace
2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Action to be discussed with CQC at relationship meeting. SaTH enjoys an extremely positive and productive relationship with our much-valued MVP partners, who offer support, challenge and co-production. Highlights include the recently introduced 'UX' ('User Experience) card system to gather direct, actionable user feedback, and which has met with significant praise in local media and from the British Intrapartum Care Society. Notwithstanding this, the action is that CQC inspections must test this, and this aspect it outside our control. The action must therefore remain 'Not Yet Delivered'; MTPG propose a rebaselined delivery date of Oct/Nov, but there is no reason or benefit in marking 'Off Track' as the action is not within our control and there is no escalation route.				Hayley Flavell	Shirley Jones	

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Immediate and Essential Action 3: Staff Training and Working Together													
Staff who work together must train together													
3.1	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	MDT Practical Obstetric Multi-Professional Training (PROMPT) training in place and occurring monthly (doctors and midwives) Weekly MDT simulation exercises take place on delivery suite with ad hoc sessions on Midwifery Led Unit Twice weekly Cardiotocograph (CTG) learning and feedback sessions on Delivery Suite – MDT delivered by CTG midwife and/or consultant Weekly risk management meetings in place, which are MDT, with Lead Obstetrician, Clinical Director, midwifery managers and maternity risk manager in attendance Identified Obstetric anaesthetic lead with Human Factor specialist interest attends MDT training. MTPG advise MTAC to mark this as 'Delivered, Not Yet Evidenced' based on the (peer-reviewed) evidence supplied for Safety Action 8 of CNST and the minimum evidence requirements for IEAs published by NHSEI in May 2021, which comprises PROMPT attendance records and training content. MTP and MDT funding bid largely approved; this includes enhanced Clinical Practice Educator roles and training backfill for midwives and consultants as well as PA to deliver PROMPT and CTG training. A training budget of £190k has been approved at risk to support Workstream 4's plans, and the booking of the initial tranche (with Baby Lifeline), is underway. Further evidence of out-of-hours, in-situ MDT skills drills will be needed to get to 'green' status.				Hayley Flavell	Will Parry-Smith	
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	There is a twice-daily ward round on the delivery suite with the delivery suite midwifery coordinator, duty anaesthetist and obstetric consultant in attendance. These occur at 08:30 and 20:30.If there is a change of consultant, there is an additional ward round at 17:00. 7-day working of consultant in place within maternity services; 7-day rota in place to ensure obstetric consultant cover meeting Consultant to sign a daily sheet that records the ward round Monthly audit of attendance at Ward Rounds to be introduced. Recruit 6 x additional consultant obstetricians to offer 24/7 cover by Summer 2021 Achieve compliance with CNST Maternity Improvement Scheme (MIS) safety action 4. Multidisciplinary Simulation (SIM) training and PROMPT courses already take place. MTAC approved this action to 'Delivered, Not Yet Evidenced' on 22/04/2021, based on the same evidence as discussed for 4.62, as well as information provided on ongoing recruitment of locum consultant obstetricians, with some substantive roles also planned. It was noted that CNST MIS Safety Action 4 has been reduced in scope for Year 3 (as of March 2021), so this benchmark is less applicable now.		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	SaTH still needs identify which funding streams need to be ring-fenced including money from Health Education England (HEE) for students. However, the MTP has put forward a budget proposal for this FY totalling circa £1.9, much of which has been approved at risk, less the capital elements. The DoF has indicated her willingness to attest to a ring-fenced budget, once she has seen evidence of funding received and spent, and that external funding has been spent on training staff can attend in work time, as well as the relevant budget statements. This is in line with the minimum evidence requirements set out by NHSEI in May 2021. All of the above have been collated but not yet tested; nonetheless the MTPG feel comfortable to advise MTAC that this action can be marked as 'Delivered, Not Yet Evidenced'.				Hayley Flavell	Hayley Flavell	

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Immediate and Essential Action 4: Managing Complex Pregnancies There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.													
4.1	Women with Complex Pregnancies must have a named consultant lead.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	All women with complex pregnancies have a named consultant lead Appropriate risk assessment documented at each contact Implement a formal auditing process and report to respective local governance meetings Review of Midwifery led cases for appropriate referral onwards, to be undertaken.				Hayley Flavell	Guy Calcott	
4.2	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Antenatal risk assessments to continually reassess care pathway incorporated and being further developed, including integration with Badgernet Fetal monitoring a priority, with specific leads in place to champion awareness Individual pathways incorporating pre-existing morbidities created Connections to be developed in order to achieve holistic solution. Process already in place including specialist antenatal clinics for diabetes and endocrine, haematology, cardiac disease, rheumatology, respiratory, gastro, neurology and mental health. Review of women with additional needs at monthly multidisciplinary meetings. This may include specific medical conditions but, also, for individualised birth plans. Business case submitted for additional consultant hours to staff an "Urgent" Antenatal clinic to see women developing complex obstetric conditions. Validate and document that these requirements are being fulfilled.				Hayley Flavell	Guy Calcott	
4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Exploration of specialist centres under way. Network identified, but connections yet to be put in place (see Local Action for Learning 4.73) Formalise connections with specialist maternal medical centres once established, and ensure clarity on referral process (which will be led by the centres). Obstetric Clinical Director engaged in discussions with network. This is an on-going discussion regionally and nationally in terms of how SaTH dovetails with these and connects to them. Gain an updated understanding of this across the region – regional leads are taking this forward. SaTH has determined that we do not wish to be a maternal medicine centre but we are currently awaiting further guidance. Full engagement with the preparations for this by SaTH with Midlands Perinatal has been evidenced. However, the Trust acknowledges that some of its referral guidelines require an update. Further, the specific criteria for referral to the Maternal Medicine Centres is something the Centres themselves would have to lead on, hence somewhat out of our control at this time. To that end, MTPG advise MTAC to leave this action as 'Not Yet Delivered', and as the target date has been missed, mark it 'Off Track'. An exception report, comprising mitigation plan will be supplied to MTAC and the Trust Board shortly.				Hayley Flavell	Guy Calcott	

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4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	Obstetric Clinical Director engaged with network on this topic. Perinatal mental health guidelines and referral pathways have been shared as evidence, and this was agreed by the Trust Board in April 2021 as having been delivered				Hayley Flavell	Guy Calcott	

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Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	For Intrapartum care high risk women will have risk re-assessed hourly throughout labour with "fresh eyes" review. A separate risk assessment tool is being developed for women receiving low risk care in all birth settings to clearly document a regular review of risk status. Audit required to confirm ongoing assessment and reassessment, including during labour, is being observed Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact Manual audit underway as stop-gap; weekly feedback Formalised audit to be implemented Rapid Implementation of Badgernet EPR system to allow data extraction and analysis. MTAC were satisfied to approve this to 'Delivered, Not Yet Evidenced' on 22/04/2021 based on the evidence provided for LAFL 4.54. They require to see evidence of risk assessment being made a mandatory field in Badgernet, and audit evidence to show that Place of Birth choice is reviewed at each appointment, in order to progress this to the next delivery stage.		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Place of birth revalidated at each contact as part of ongoing risk assessment Mother's choices based on a shared and informed decision-making process respected This is to be checked within the scope of the audit mentioned at LEA 5.1 MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen for elements of LAFL 4.54 and 4.55 (specifically, the monthly review clinic, from which minutes were provided, and the birthplace choices leaflet and online information)		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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Immediate and Essential Action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.													
6.1	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: * Improving the practice of monitoring fetal wellbeing * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Raising the profile of fetal wellbeing monitoring * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Lead obstetrician in place with allocated time and job description – 1 SPA per week incorporating PROMPT, Fetal monitoring (0.5) & education and training. Two midwife champions have now been substantively appointed as CTG champions. This action will be proposed for marking as 'Delivered, Not Yet Evidenced' at the next MTAC, with evidence including proof that a dedicated obstetrician and two specialist midwives are now in substantive posts; all with suitable allocation of time to devote to training and knowledge update of EFM. Job descriptions and person specifications showing the expertise and experience required, and evidence of training provision and continuous professional development were also provided.		31/08/21		Hayley Flavell	Shirley Jones	
6.2	The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Twice weekly training and review MDT meetings in place reviewing practice and identifying learning. Lead Midwife attends weekly risk meetings to ascertain if CTG is a key or incidental finding in any incident. K2 training for midwives and obstetricians in place Incidents reviewed for contributory / causative factors to inform required actions. Audit compliance with new guideline. The two fetal monitoring midwife leads have only been in place for a matter of weeks, however have provided evidence of a multiple well-attended fetal monitoring training days throughout May and June, and plans for more to follow soon. Examples of fetal monitoring champion input to relevant SIs, as provided by the nominated consultant lead, are also available. Based on this, the MTPG advise MTAC to mark this action as 'Delivered, Not Yet Evidenced'.				Hayley Flavell	Will Parry-Smith	
6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Named project midwife responsible for Saving Babies Lives in place - 1.0 WTE secondment As with LAFL 4.57, the planned peer review, undertaken with Sherwood Forest Hospitals NHS Foundation Trust (SFH), has been conducted, showing >90% of the evidence to demonstrate compliance has been provided and reviewed. Noting that SBL is an ongoing requirement, rather than one-off deliverable, this action will be proposed at next MTAC to be marked as 'Delivered, Not Yet Evidenced' based on the assurance so far carried out. It was the subject of a deep-dive review at the June ORAC meeting. Evidence to support this is compliant with the NHSEI minimum evidence requirements for IEAs as published in May 2021, as well as those of CNST Safety Action 6.		15/07/21		Hayley Flavell	Shirley Jones	

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Immediate and Essential Action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.													
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Patient information leaflets available on the Internet (SaTH Homepage), including recently developed leaflet of choice for place of birth co-produced with the MVP. Also includes link to national PIL on Caesarean section (Tommy's) and Birth after previous caesarean section (RCOG). Work on-going as part Antenatal Care Pathway sub-project; videos, leaflet and Baby Buddy app available. Developing links for women to watch videos on relevant pregnancy topics such as IOL to assist in digesting information. Women requesting a caesarean section are referred to a consultant-led birth options clinic, where this is explored and management is individualised according to their choice. Patient feedback notice boards in place on inpatient areas (translation service available). Through audit, need to confirm that the mother and partner / family have received and consumed the information as intended. Digitalisation of patient record through the implementation of the Badgernet system. The Communication and Engagement workstream includes MVP and patient representation. Review of other websites required to identify best practice. Link with local LMNS and units that also provide care to women from Shropshire to ensure consistent approach to information. MTAC approved this to 'Delivered, Not Yet Evidenced' status based on the evidence referenced for LAFL 4.55, including online and handheld information. They noted the introduction of new 'business cards' handed to mothers; the cards contain a QR link to BabyBuddy app and other verified information sources. MTAC also noted that, following a study of other Trusts' online information, including on social media platforms, and in partnership with the MVP, the Trust is moving forward with a quote to revamp their online presence to maximise accessibility, the funds coming from the MTP budget.		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Y	10/12/20	31/07/21	Not Yet Delivered	On Track	Work currently on-going as part of Antenatal Care Pathway sub-project Confirm that the mother and partner / family have received and consumed the information as intended A process for auditing this will need to be established. MTAC decided in their meeting on 22/04/2021 that this remains 'Not Yet Delivered', as they are not satisfied we have yet done enough to hear from women whether they feel they have all the information they require. MTAC instructed the MTP to liaise more closely with the MVP, who in turn are recruiting a wider section of volunteers and conducting a postnatal survey. Further, WS5 has been further reinforced with the appointment of the Clinical Director of Maternity Services as lead. Topics to explore have already been identified, and this area will be prioritised for the next phase of the project. An exception report has been filed for the missed deadline, but no revised due date has yet been confirmed. The May MTAC accepted the exception report and agreed revised delivery date from 30/04/21 to 31/07/21 and evidence date from 30/06/21 to 30/09/21.		30/09/21		Hayley Flavell	Guy Calcott	
7.3	Women's choices following a shared and informed decision making process must be respected	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	A mechanism for measuring and auditing this needs to be developed. Dedicated PALS officer to be appointed to Maternity Services to offer in-reach and provide real time feedback. MTAC approved this to 'Delivered, Not Yet Evidenced', having been provided with copious meeting minutes (anonymised) from the Birth Options Clinic, showing multiple instances of individualised care being put in place in order to enable the mother's chosen care pathway and place of birth. Further audits, including a review of the findings of the above-mentioned MVP-led survey will be examined once available.		30/06/21		Hayley Flavell	Guy Calcott	

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

NHS
The Shrewsbury and Telford Hospital NHS Trust

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

Colour	Status	Description
	Not yet delivered	Action is not yet in place; there are outstanding tasks to deliver.
	Delivered, Not Yet Evidenced	Action is in place with all tasks completed, but has not yet been assured/evidenced as delivering the required improvements.
	Evidenced and Assured	Action is in place; with assurance/evidence that the action has been/continues to be addressed.

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadine or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	On track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that this action is being delivered and sustained.

Accountable Executive and Owner Index

Name	Title and Role	Project Role
Hayley Flavell	Executive Director of Nursing	Overall MTP Executive Sponsor
Arne Rose	Executive Medical Director	Executive Sponsor
Guy Calcott	Obstetric Consultant	Co-Lead, Quality and Choice Workstream
Janine McDonnell	W&C Divisional Director	Lead, People and Culture Workstream
Nicola Wenlock	Director of Midwifery	Lead, Risk and Governance Workstream
William Parry-Smith	Obstetric Consultant	Lead, Learning, Partnerships and Research
Mei-See Hon	Clinical Director, Obstetrics	Communications and engagement Workstream

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	4.59	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.				
Action Lead:	Shirley Jones						

Reason for exception and consequences	**Mitigation**
A review of the governance team structure underway, and the Trust has begun recruitment of a dedicated Head of Clinical Governance, initially for a six-month period. The Trust has also set up two new divisional governance forums, NOIR and DOG, with the aim of ensuring timely and thorough conduct of investigations. Despite this, the MTP Group do not feel there is enough evidence in place to recommend MTAC to mark this deliverable as 'Delivered, Not Yet Evidenced', because the partnered Governance Review has not yet been completed.	1) Complete the governance review in partnership with Sherwood Forest Hospitals. 2) Allow time for the new Head of Clinical Governance to settle into their role 3) Conduct an audit of recent investigations to ensure that all took place within the mandatory timelines.
Recommendation	**What lessons have been learnt from this exception?**
The sub-plan for this particular action centred on the review. As this has not yet been completed, the only recommended course of action is to re-baseline the delivery date and continue with the plan. By way of assurance, the partnered review is now fully underway under an agreed, formal Terms of Reference between the two Trusts.	The self-imposed June deadline for this deliverable was selected in a desire to act upon the Ockenden recommendations in as timely a way as possible. It has transpired that not enough time was allowed for full implementation. The Trust acknowledged that there were not enough resources and have taken active steps, i.e. hiring the dedicated Governance Head.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	**To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	4.60	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.				
Action Lead:	Shirley Jones						

Reason for exception and consequences	**Mitigation**
A review of Governance team structure is underway, actively supported by our SFHNHST partners with a formal Terms of Reference in place. The Trust has taken steps to introduce additional resources (incoming Head of Clinical Governance) and new forums have been set up that will help deliver this action (specifically the Divisional Oversight Group and NOIR). However, the sub-tasks required to deliver it, including the conduct of an assurance exercise and cross-referencing between Datix and MEDWAY has not yet been carried out, so MTPG cannot yet advise MTAC to approved this action as having been delivered.	1) The risk meeting structure has been revised, but more time is needed to test as to whether the new set-up is delivering to the standard required. It does comprise multi-disciplinary representation. 2) The Divisional Oversight Group is now established, but the Terms of Reference are to be ratified. 3) The sub-task of conducting an assurance exercise, and cross-referencing between the Datix and Medway systems must be completed.
Recommendation	**What lessons have been learnt from this exception?**
The plan devised to answer this requirement remains valid, however due in part to staff absences, has not yet been fully implemented. The Maternity Transformation Programme Group advise continuing with the agreed action plan, but re-baselining the date.	The self-imposed June deadline for this deliverable was selected in a desire to act upon the Ockenden recommendations in as timely a way as possible. It has transpired that not enough time was allowed for full implementation. The Trust acknowledged that there were not enough resources and have taken active steps, i.e. hiring the dedicated Governance Head.
Recommendation approval (name / date)	**Original due date:** 30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:** **To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	LAFL 4.73	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.				
Action Lead:	Guy Calcott						

Reason for exception and consequences	**Mitigation**
The Service employees a Clinical Referral Team and a Risk Assessment and procedure for the allocation of an appropriate local consultant. Additionally, it is setting the conditions to nominate a Maternal Medicine Centre lead consultant once the Midlands Centre is established. Full engagement with the preparations for this by SaTH with Midlands Perinatal has been evidenced. However, the Trust acknowledges that some of its referral guidelines require an update. Further, the specific criteria for referral to the Maternal Medicine Centres is something the Centres themselves would have to lead on, hence somewhat out of our control at this time. In summary, the reason for the exception is due to a lack of clarity on specialist centres referral guidance, and lack of capacity at SaTH to update the relevant guidelines within the timeline at which delivery was initially aimed.	1) The risk assessment process at booking has been redesigned with early referral for women with pre-existing medical conditions - they are seen in multi-disciplinary clinics. Where there is not a relevant MDT clinic they are seen by an Obstetrician with an interest in maternal medicine for assessment and referral to a local / tertiary Physician. 2) The development of specialist Maternal Medicine Centres is a National priority, led by each Clinical Network. In the West Midlands; the centre is yet to be determined but will not be SaTH. This is not within the control of SaTH to determine timescales. 3) SaTH is moving ahead with the appointment of a consultant to lead on liaison with the Centre(s) and the necessary guidelines update.
Recommendation	**What lessons have been learnt from this exception?**
The MTPG recommend a date re-baselined sufficiently far into the future to allow for the completion of the establishment of the Maternal Medicine Specialist Centre(s) for the Midlands and the associated referral pathway. In the interim, appointment of the liaison lead and update of associated guidelines is progressing, and SaTH is in constant liaison with the Midlands Perinatal Network; the MTPG are assured that the establishment of the Centres is proceeding positively.	This deliverable is one of a number of Ockenden Report requirements that depend in part or in full upon external deliverables (in this case the establishment of the Specialist Centres). Although the self-imposed June deadline was selected in a genuine effort for timely delivery, the MTPG accept they should not have set deadlines where so much uncertainty over ability to deliver within that timeframe existing – for expectation management, it would have been better to have left the deadline blank.
Recommendation approval (name / date)	**Original due date:** 30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:** **To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	LAFL 4.100	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.				
Action Lead:	Janine McDonnell						

Reason for exception and consequences	**Mitigation**
MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen of firm plans for such placements to take place at Royal Stoke Hospital, New Cross Hospital and Birmingham Women's Hospital. Regrettably, the Women and Children's Division has not been able to advance this as the business cases for an additional (neonatal) consultant has not yet been approved. Accordingly, attachments cannot be put in place without putting the onsite rota at risk, currently. Therefore, it is suggested that MTAC reverts the status of this action to 'Not Yet Delivered' and mark it 'Off Track'.	1) In the absence of formal attachments, consultants, ANNPs and all other neonatal staff will continue to make best efforts with continuous professional development and maintenance of contemporaneous knowledge and standards. 2) A number of courses in neonatal care have been included in the Workstream 4 training plan – these include the BLL new-born examination module, neonatal life support (NLS) training etc. The budget for this has been approved and booking of the courses is underway. 3) Notwithstanding this, there is no alternative to meeting the requirements of Ockenden action 4.100 (and indeed 4.99) fully without the recruitment of the consultant as described.

Recommendation	**What lessons have been learnt from this exception?**
It is strongly recommended that the Trust explore alternative funding streams, and if this is not possible, work with divisional leadership and central finance to find other staffing costs that can be economised against, in order to free up funds to recruit to this vital post.	Financial and budgeting considerations are at the core to long-term, sustainable implementation of many of the Ockenden actions. As a programme, division and indeed a Trust, we may not have communicated and shared the ramifications of not investing in some proposals effectively enough. This is being partly resolved through the formation of the MTP working group and closer liaison with our colleagues in central finance.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	**To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	IEA 1.4	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	An LMS cannot function as one maternity service only.				
Action Lead:	Hayley Flavell						

Reason for exception and consequences	**Mitigation**
Although work is underway to set up a formal partnership with another Trust, this is not yet in place, and must therefore be marked as 'Off Track' as the target date has passed.	1) To mitigate against any shortfalls that may result from being a single-service LMNS, SaTH is benefitting from its strategic partnership with Sherwood Forest Hospitals NHS Trust 2) Work to formalise a regional partnership is ongoing
Recommendation	**What lessons have been learnt from this exception?**
This is a major strategic decision for SaTH and is also dependent on a significant number of external deliverables and partners. Therefore, MTPG recommend the delivery date be rebaselined to much later in the year.	The target date initially selected for this deliverable was intended to ensure timely compliance with the recommendation. However, given the complexities and strategic importance of the decision, the time allowed was to short.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	

Key to Titles

Title	Description
Date of Report:	Date report written: when exception is predicted or as soon as possible once it has occurred
Ockenden ID:	The paragraph reference to the Ockenden Review document
Delivery Status:	Whether the recommendations is not yet delivered, delivered (not yet evidenced), or evidenced and assured
Progress Status:	Whether the work to deliver the recommendation is not started, on track, at risk, off track, or complete at the time of exception report
Executive Lead:	The executive sponsor, who is accountable for the delivery of the recommendation
Action Lead:	The owner of the actions required to deliver the recommendation
Requirement:	The verbatim recommendation extracted from the Ockenden Review
Reason for exception and consequences:	A description of the cause of why the delivery of the recommendation is in exception, whether than is time, cost, quality or scope
Mitigation:	The possible courses of action to bring delivery of the recommendation out of exception
Recommendation:	Of these course of action, the one deemed most effective in the opinion of the executive and action leads
What lessons have been learnt from this exception?	What have we learned from this exception, and how can we draw upon this to avoid it happening again?
Recommendation approval (name / date):	Records the name of the board member(s) who approved the exception plan
Original due date:	The original deadline set for completion / evidencing of the recommendation
Proposed revised delivery date:	The agreed new deadline per the exception plan (if granting more time is the approved recommendation).

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
08 July 2021

Agenda item	180/21			
Report	Ockenden Report Assurance Committee 24th June 2021 – Co-Chairs' Summary Highlight Report			
Executive Lead	Director of Governance & Communications			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people	√	Effective	
	Our service delivery	√	Caring	
	Our partners	√	Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 4	
	For decision / approval		**Link to risk register:**	
	For review / discussion		970, 1083, 1930, 2027, 2065	
	For noting			
	For information			
	For consent			
Presented to:	N/A			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	1. The fourth meeting of the Ockenden Report Assurance Committee was held on 24th June 2021 and was livestreamed in public. This brief report provides a summary of key points/issues that the Co-Chairs wish to draw to the attention of the Board of Directors. 2. **Recommendation** The Board of Directors is asked to: • Note the contents of the report			
Appendices	None.			

Ockenden Report Assurance Committee

24th June 2021

Co-Chairs' Summary Highlight Report

1. The fourth meeting of the Ockenden Report Assurance Committee was held on 24th June 2021 and was live-streamed in public. This brief report provides a summary of the key themes discussed and highlights any particular matters which the Co-Chairs feel should be drawn to the attention of the Board of Directors.

2. Again, on this occasion, Ms Jane Garvey chaired the meeting. In addition to the usual members and attendees, the meeting was joined by Ms Lindsey Reid (Lead Midwife, Saving Babies Lives) and Mr Guy Calcott (Consultant Obstetrician & Gynaecologist at SATH) who gave a very detailed presentation on the Saving Babies Lives (SBL) Care Bundle 2. They were supported by Ms Belinda Green (Independent Specialist Midwife, Sherwood Forest NHS FT). It was pleasing that Maternity Voices Partnership (MVP) was once again able to join the meeting.

3. The meeting focussed almost entirely on the Saving Babies Lives Care Bundle 2 and the detailed presentation given by Ms Lindsey Reid and Dr Guy Calcott. Saving Babies Lives Bundle 2 is an Ockenden Report Local Action for Learning (4.57) requiring compliance with the recommendations of SBL Care Bundle 2 and subsequent guidelines. The meeting was reminded that in November 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030. To support this, the SBL Care Bundle 1 was introduced, with the primary aim of reducing the number of stillbirths. This national ambition was extended in 2017 to include reducing the rate of preterm births from 8% to 6% with the date to achieve the entire ambition brought forward to 2025. This resulted in the SBL Care Bundle 2 and the addition of the fifth element – reducing preterm births. The other four elements being – reducing smoking in pregnancy; risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction; raising awareness of reduced fetal movement: effective fetal monitoring during labour. All five elements accounting for 45 standards in total.

4. For Element 1 - reducing smoking in pregnancy - it was pleasing to hear that partial CO (Carbon monoxide) testing resumed in March 2021 in line with Covid-19 guidelines and that stop smoking support is moving towards a single service provision across the country. Despite this we heard that the achievement of this standard remains challenging for the service with the current percentage of pregnant women who smoke in this area (11.8% in Shropshire, 15.2% in Telford & Wrekin) being significantly higher than the national average of 10%. For Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR) it was pleasing to hear about the Trust's compliance with serial growth scans since 2018, the existence and expansion of the midwife sonography team, and the consequent performance of the service in performing

better than the national average for key performance metrics. For Element 3 – Raising Awareness of Reduced Fetal Movement – we heard about the need for effective communication and information, and the role that MVP (Maternity Voices Partnership) had played in supporting the service to promote the importance of this message. For Element 4 – Fetal Monitoring – we heard about the detailed arrangements that the service has in place and the plans for a mandatory training day this year. Finally, we heard from Dr Guy Calcott in relation to Element 5 – Reducing Pre-Term Births – and the current performance of the service, the service improvements that are being made and the proposed service expansion.

5. To conclude the SBL presentation, we heard from Ms Belinda Green, Independent Midwife from Sherwood Forest NHS FT, who has been working closely with the service, and who confirmed that she had been impressed with the progress that had been made in implementing the SBL Care Bundle and with the midwives on the "ground floor" who were passionate about what they did and were making a difference. She went on to highlight the outstanding need to put in place a very clear leadership and governance structure for the service; an issue that the Trust Board is familiar with and has been rehearsed previously.

6. In reviewing the effectiveness of the meeting, it was agreed that the Committee should take up the offer of MVP and hear about their work with the maternity services at its meeting in September and also from Powys CHC in relation to the findings from its current survey being conducted on social media. It was agreed that the focus for the meeting on the 22 July should be on the outstanding LAFL – Obstetric Anaesthesia (4.85 – 4.91). The meeting scheduled for 26 August would be cancelled and the work of the Committee would resume at its meeting on 23rd September.

Dr Catriona McMahon & Ms Jane Garvey
Co-Chairs, Ockenden Report Assurance Committee
28th June, 2021.

The Shrewsbury and Telford Hospital NHS Trust

Finance and Performance Assurance Committee Key Issues Report

Report Date: 29th June 2021		**Report of:** Finance and Performance Assurance Committee
Date of last meeting: 29th June 2021		**Membership Numbers:** The meeting was quorate.
1	**Agenda**	The Committee considered an agenda which included the following: • Efficiency Programme Report • RSH ED Reconfiguration Briefing Paper • Post Project Review: Endoscopy Demand and Capacity Business Case • 2021/22 Financial Plan – Q2-Q4 Budget • Integrated Performance Report (Operational, Finance and Workforce sections) Month 02 • Finance Report Month 02 • Recovery Programme Update • Good Corporate Citizen Annual Report • Contract Award Summary • Committee Effectiveness • BAF • COVID-19 Update
2a	**Alert**	The Committee wished to alert members of the Board that: • The Recovery Plan is in place until the end of September 2021 (awaiting publication of national guidance for H2). Uncertainty re the impact on the emergency pathway and maintaining elective zones beyond this. • Improving position with regard to Endoscopy performance, but will be unable to achieve pre-COVD levels due to adherence to IPC guidance. • The Committee considered the Q2 internal budget (deficit of £2.082m) based on the revised H1 plan and **recommended approval of this to the Board of Directors.** • There are a considerable number of overdue follow up outpatient appointments. Inpatient activity and diagnostic performance is below plan. RTT performance is being impacted by the necessary prioritisation of the most clinically urgent patients.
2b	**Assurance**	The Committee wish to assure members of the Board that: • the first indication that the Trust's Efficiency and Sustainability Programme is in place was provided through a report to the Committee which included details of the framework to deliver 1% for H1, governance structures, processes and reporting arrangements.

		• a post project review of Endoscopy Demand and Capacity Business Case (approved 2017) highlighted that benefits of the investment in the expansion of the workforce were being delivered until the onset of the pandemic. • the Trust's sustainability programme continues with robust achievements during 2020/21 highlighted in the Good Corporate Citizen Annual Report.		
2c	**Advise**	The Committee wish to advise members of the Board that: • The Trust's Efficiency and Sustainability Programme will be broader than waste reduction and will focus on all areas of efficiency and sustainability. • an update on the reconfiguration of RSH ED following an allocation of capital funding was provided and included the creation of dedicated Children and Young Peoples zone, fully functioning Clinical Decisions Unit, designated ambulance pitstop and an increase in the number of majors cubicles. The Committee now wished to see these backed up with improvements in flow and discharges. • The Trust's month 2 financial position (deficit of £0.821m) is in line with the plan. Discussions to take place in July with NHSE/I with regard to SaTH's underlying cost base which has been recently reassessed internally. • an overview of the operational, workforce and financial performance of the Trust was received by the Committee as part of the Integrated Performance Report Month 02. Urgent care demand has increased to pre-COVID levels. Improvements noted in a number of workforce areas but still seeing high levels of agency expenditure, which may be driven by COVID-19 sickness rates and the vaccination programme staff requirement. • The Trust achieved its Recovery Plan activity threshold for May (75%). • There are currently very few COVID-19 cases. • Details of two revenue contracts (over £50k) awarded during May 2021 were shared with the Committee. • The BAF was not presented to the Committee although it was an agenda item.		
3	**Actions to be considered by the Board**	• Committee Summary to be noted. • **Consideration and approval of:** • 2021/22 Q2 budget		
4	**Report compiled by**	*David Brown* *Acting Chair*	**Minutes available from**	*Amanda Young* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Quality & Safety Assurance Committee Key Issues Report

Report Date: 30th June 2021		**Report of:** Quality & Safety Assurance Committee
Date of last meeting: 30th June 2-21		The Committee was quorate according to the Terms of Reference
1	**Agenda**	The Committee considered an agenda which included the following: • Board Assurance Framework • CQC/ Section 31 and 29a Update • Maternity Champion Report • Maternity Dashboard • Midwifery Staffing • Developing Workforce Safeguards • Staff Health Immunisation • Safeguarding Key Summary Report • Quality Indicators Integrated Performance Report • Getting to Good highlights • Incident Management Report • Legal Report • Incident Overview Report • QSAC Forward Plan The Committee considered reports from the following • Quality Operational Committee Report • Emergency Department Quality Operational Committee • Maternity Transformation Assurance Committee • Maternity Quality Operational Committee • Infection Prevention and Control Assurance Committee • Nursing Midwifery and AHP Workforce Committee
2a	**Alert**	1. The response to complaints is not meeting the organisation's desired standards. There is a backlog of complaints that require a response. QSAC has requested a report and action plan at the July meeting 2. There is a backlog of unacknowledged DATIX issues. Failure to acknowledge, review and act is not consistent with SATH's aspirations to demonstrate a safety culture 3. The CQC restrictions on SATH's ability to admit Children and Young People with mental health issues are entirely correct but there is consequent pressure on the Trust and the wider system to manage cases. This requires a system response 4. Resignations of consultants within the Head and Neck service will place pressure on the Trust's ability to deliver the current service. It is likely that the solution lies within a networked solution rather than expecting to recruit to the current service model 5. As previously raised, there are concerns about the lack of management information with respect to the work force, specifically linked to the number of nursing vacancies 6. The committee is seeking further assurance with respect to the Medical, AHP and non-clinical workforce. There is

		increasing information with respect to the nursing and midwifery workforce being presented 7. As A&E activity increases, there are challenges in maintaining the agreed targets for triaging children being brought to the departments 8. Increased unscheduled work is placing challenges with respect to ambulance transfers, bed availability and waiting times. 9. Patient flow is not helped by a failure to meet response times therapists to visit patients on wards after referrals
2b	**Assurance**	1. The Maternity Dashboard was presented in its new format. Whilst this is still a non-final version, QSAC members viewed its publication favourably and found it helpful in testing and gaining assurance 2. The committee reviewed the Quality Account document (acting on behalf of the Board). This was carefully reviewed and interrogated but represented a fine piece of work
2c	**Advise**	1. There is strong support for formalizing the extension of cleaning to a 7-day service. This is currently in place using funds awarded to support the Trust's COVID-19 response 2. There is growing confidence in the performance of the executive team and the next level clinical leaders in supporting the assurance function delivered by QSAC
2d	**Review of Risks**	The sub committee awaits the new Assurance Framework for consideration at the June 2021 meeting. In the meantime, the committee considered and confirmed the following risks

For Quality & Safety Assurance Committee the strategic risks that the committee was asked to consider are:

- ☐ BAF 1Poor standards of safety and quality of patient care across theTrust results in incidents of avoidable harm and /or poor clinical outcomes
- ☐ BAF 2The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience
- ☐ BAF 3 The Trust is unable to attract, develop and / or retain its workforce to deliver outstanding services
- ☐ BAF 4 A shortage of workforce capacity and capability leads to deterioration of staff experience, morale
- ☐ and well-being
- ☐ BAF 6 Some parts of the Trust's estates infrastructure, buildings and environment may not be fit for purpose
- ☐ BAF 8 The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards

The QSAC agreed

- Some further training was required to enable the committee to suggest alterations in the numerical risk status
- There needs to be clarity as to how progress to target risk through the actions identified can be tracked at committee level. Executive members are asked to develop proposals
- BAF 3 Aspects of this risk sit with QSAC, Finance and Performance and the Trust Board. The expression of this risk may need to be finessed and there should be careful assessment as to how the risk is considered by Board Committees to ensure comprehensive assurance processes
- BAF 4 Should reference the Diversity Strategy within the actions /mitigations
- BAF 6 is a Finance and Performance Risk
- BAF 8 Should be considered by QSAC with the addition of a specific reference to CQ

3	**Actions to be considered by the Board**	• Report to be noted		
4	**Report compiled by**	*Dr David Lee*	**Minutes available from**	*PA to Director of Nursing*