The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 11 November 2021

SUPPLEMENTARY INFORMATION PACK

Infection Prevention and Control Board Assurance Framework

RAG Key:

Action Complete	Action in Progress	Action off Track

Version Number	Date Reviewed	Reviewed by	Change made
3.1	23.02.2021	Janette Pritchard, Kara Blackwell	Full Review and update
3.2	09.03.2021	Janette Pritchard	Full review and update
3.3	04.04.2021	Kara Blackwell	Update
3.4	26.05.21	Janette Pritchard	Update
4.0	10.06.21	Janette Pritchard, Joanne Yale, Rebecca Hawkins, Kath Titley	Update
4.1	11.06.21	Kara Blackwell	Review and Update
5.0	05.07.21	Janette Pritchard	Updated following publication of V1.6
5.1	01.09.21	Janette Pritchard	Review and update

Version	Date Presented	Committee	Presented by
5.0	04.08.2021	IPC Operational Group	Kara Blackwell
5.1	08.09.2021	IPC Operational Group	Janette Pritchard

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users					
Key lines of enquiry		**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
Systems and processes are in place to ensure:					
1.1	Local risk assessments are based on the measures as prioritized in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff	https://intranet.sath.nhs.uk/health/Ward_and_Department_Risk_Assessments.asp	Current risk assessment templates require a review to explicitly refer to the hierarchy of controls published in PHE guidance.	The current risk assessments do address potential control measures at all levels of the hierarchy. This explicit reference to the hierarchy in the PHE guidance can be reviewed as each local risk assessment approaches its review date.	Amber
1.2	The documented risk assessment includes: • A review of the effectiveness of the ventilation in the area • Operational capacity • Prevalence of infection/variants of concern in the local area		Current risk assessments do not explicitly evaluate ventilation.	Current risk assessments refer to the need to increase ventilation by opening windows/ doors where possible. Operational capacity	Amber

				is addressed with reference to room occupancy, and social distancing measures e.g. in waiting rooms which limit throughput of people in a given time period. Recommendation to Gold Command on 16 July 2021 to step up to RPE for all care of covid-positive patients was accepted, not yet reflected in local risk assessments - to be amended on review dates.	
1.3	Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways	The Emergency department have a SOP for admissions, which covers a process to risk assess all patients as they arrive in ED.  Navigator flow chart for PRH.docx  Navigator flow chart for RSH.docx  SOP Management of potential Coronavirus			Green

1.4	When an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given	This provision has been included in the most recent version of the COVID 19 Policy which has been communicated with the Trust via communications and is available on the Intranet for staff to access (link to policy at end of document)			Green
1.5	there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	All patients are screened on admission to the Trust as per national guidance – patients that are identified as high risk of COVID cohorted on designated wards. Patients who are confirmed as positive are isolated in side rooms. See link for policy at bottom of document	It has been identified that the trust has a lack of side rooms that will be addressed by the Hospital Transformation Plan	Patients who have been identified as positive COVID 19 will only be moved if they are being transferred to one of the COVID high risk wards. Where possible any one identified as a contact of a COVID positive case will also not be moved, with the exception of when the hospital is full and there is no admitting capacity. An SOP has been created to guide executives on the least risk options	Green

				SOP for Managing COVID Contacts whe	
1.6	that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	Patient placement is based on PHE high/medium/low risk pathways. Patients who fall into the high risk pathway are either isolated or cohorted appropriately. Patients who fall into the medium risk pathway are COVID swabbed as per guidelines and placed according to pathway. Low risk patients are mainly elective surgical who have ring-fenced wards/beds. WM will sign off domestic cleaning schedule and WM/Matron monitor and ward environmental cleaning and sign off of completion		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
1.7	Resources are in place to enable compliance and monitoring of IPC Practice including; • staff adherence to hand hygiene • Patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	The IPC Team perform regular Quality Ward Walks on all wards in the Trust. If a ward has been identified as an outbreak ward, then a weekly enhanced Quality Ward walk will be completed. This observes adherence to Hand Hygiene, social and physical distancing and adherence to wearing surgical facemasks in both clinical and non-clinical settings. All areas (clinical and non-clinical) are required to provide Health and Safety risk assessments of their areas including maximum capacity to facilitate distancing. (see 1.1 for link to	2 metre distancing of patients in most ward areas is not achievable. A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients	Green

	• monitoring of staff compliance with wearing appropriate PPE, within the clinical setting	document) The Ward Managers and Matrons are responsible for monitoring compliance with staff wearing appropriate PPE with support from the IPC Team. This is formally audited on the Gather platform (audit platform) in the Trust			
1.8	That the role of PPE guardians/safety champions to embed and encourage best practice has been considered	Heads of Nursing have suggested that IPC link nurses for all areas have it added to responsibilities and quick guide produced for them on actions they can take to support good practice The IPC Team have produced a quick guide for Link Nurses on actions they can take to support good practice  IPC link nurse quick guide to PPE v2.pdf			Green
1.9	That twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace	Workforce has implemented lateral flow testing and the reporting mechanism. Following the closure of the staff absence line on 30.06.2021 workforce have communicated new process for accessing PCR test and reporting to manager to all staff. Workforce continue to inform IPC and Occupational Health of any positive results (for investigation and contact tracing) and also monitor positive lateral flow test results without a reported PCR test	This is a new process. Concerns have been raised by the IPC team of the timeliness of staff positive results	Process communicated has emphasised the need for timely reporting to enable investigation of potential outbreaks	Green

1.10	Additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	Due to high background infection rates and outbreaks within the Trust additional targeted testing is taking place within the Trust and will be reviewed as levels decrease.	No guidance published on what a 'high nosocomial rate' is	IPC team provide reports to the IPCOG and IPCAC on findings of investigations relating to nosocomial cases for shared learning	Green
1.11	training in IPC standard infection control and transmission-based precautions are provided to all staff	Staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all clinical areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education:			Green
1.12	IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	All staff are asked to complete Infection Prevention Training at Induction – Level 1 for Non-Clinical – Level 2 for Clinical. Clinical Staff Complete Refresh this Annually			Green
1.13	All staff (clinical and non–clinical) are trained in: • Putting on and removing PPE • What PPE they should wear for each setting and context	All patient facing clinical and non-clinical staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education see above			Green
1.14	All staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per	There is good and reliable stock of PPE within the Trust and this is monitored by procurement.			Green

	national guidance	There is a mask etiquette poster at all mask stations in the Trust which provide guidance on how to don and doff a mask for non-clinical staff and visitors. PPE posters are available in all clinical areas providing a visual guidance on PPE selection			
1.15	there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	 Covid Aware Patient Hygiene.docx  leaflettemplateA5covid copy.pdf			Green
1.16	PC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The National IPC guidance is checked daily and the IPC team receive the daily Gov.uk guidance. • It is also discussed on the Trust COVID call held once per week per week (recommenced July 2021) chaired by the COO/MD. • All changes for escalation throughout the Trust are also reported through to the Covid 19 Incident Control Room • There is a weekly message sent out to staff from a member of the executive team, which communicates any changes. The IPC team are visiting the clinical areas in the Trust daily.			Green
1.17	changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	See 1.12			Green
1.18	risks are reflected in risk registers and the	Risks relating to COVID have been		Business case being	Green

	board assurance framework where appropriate	placed on the Trust Risk Register and are updated monthly as a minimum. The Trust has a COVID risk 1771 on the BAF. BAF risk 1771 was last reviewed by the Trust Board on 5th May 2021 Risk Register No 826, relates to the provision of cleaning 7 days a week and the delivery of additional cleaning services in-relation to extended hours of working.	Pre business case submitted outlining service gaps and cost to address them.	developed for substantive 7 day IPC Nurse service provision Following discussion with the new DoN, business case for 7 day IPC Nurse service currently not being progressed as mitigating actions include: -Consultant microbiology oncall 24/7 for advice -Daily IPC Site reviews (Mon-Fri) -All IPC policies accessible on the Trust Intranet Use of Contractor hours including a Rapid Response Team funded from Covid monies	
1.19	robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	This is normal practice in the Trust. There are policies in place for non-COVID infections that are in date. http://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_relat			Green

		ed_information.asp			
1.20	the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep.	"nosocomial" sitrep is signed off by either CE/MD/DoN			Green
1.21	This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	BAF is reviewed at IPCOG & IPCAC and was included monthly in the IPC Report to Board. This is now reported Quarterly to Board  NHSE&I Visit IPC Board Paper March 2(			Green
1.22	The Trust Board has oversight of ongoing outbreaks and action plans	Reported monthly to IPCOG & IPCAC. This is now reported Quarterly to Board *See evidence in 1.21*			Green
1.23	there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Regular Confirm and Challenge meetings for Divisions are held which are attended by a member of the executive team			Green
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
Systems and processes are in place to ensure:					
2.1	Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	The Trust has designated areas for COVID patients, and training has taken place for all medical/nursing staff on PPE usage and Hand Hygiene. X:\StaffComplianceReports\Statutory & Mandatory Training Report			Green

2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• All Cleanliness technicians are trained to complete all levels of cleaning required to all risk category wards. • All staff that are able to wear an FFP3 mask can now do so. • Training of the use of PPE has been cascaded to all staff from the Cleanliness Supervisors and Cleanliness Managers on each site. • Staff are assigned to their own wards and departments, therefore current COVID-19 isolation and cohort areas have their own Cleanliness Technician for the duration of their 6 hour shifts, with additional support on each cohort ward of 3 hours. • Evening Cleaning on all wards has been implemented as from May 2020 and this consists of all touch points, floors, toilets and bathrooms, replenishment and the emptying of waste bags. • A&E on both sites are now covered for cleaning 24/7	Agency cleaning staff are also being used alongside substantive members of staff under full recruitment for the extended 24/7 cleaning service has taken place. Business case for additional funding has been submitted, and is awaiting approval. Reduced capability for cleaning from 10pm – 6am Nursing teams under pressure balancing patient care and cleaning the environment	Temporary Rapid Response Team and some contractor support is helping to address the gaps in service. Funding for this additional cleaning support has been extended until the end of March 22 Supportive Peer Review Feedback Aug Full business case has been approved internally but now needs to go to ICS for approval.	Amber
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	The Trust uses Tristel to decontaminate areas as per guidelines. The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas			Green

		which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			
2.4	Assurance processes are in place for monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk	Terminal cleans are signed off by the Ward Manager and Cleanliness Technician on the Ward cleaning checklist once complete and the Cleanliness team also maintain their own terminal clean records  Operational Cleaning Policy.pdf Actions and mitigations are discussed during COVID outbreak meetings with support of senior nursing team and external partners			Green
2.5	Cleaning and decontamination is carried out with neutral detergent, followed by a chlorine based disinfectant in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	Environmental cleaning is carried out with detergent/chlorine mix (Tristel Fuse). Contingency plan to use detergent clean followed by sodium hypochlorite (Milton) 1,000ppm in case of Tristel Fuse shortage			Green

2.6	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/ disinfectant solutions/ products as per national guidance	Facilities SOP follows recommended contact time of 5 minutes.			Green
2.7	A minimum of twice daily cleaning of: • Areas that have higher environmental contamination rates as set out in the PHE and other national guidance • Frequently touched surfaces e.g. door handles, patient call bells, over bed tables and bed rails • Electronic equipment e.g. mobile phones, desk phones, tablets, desktops and keyboards • Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily tristel cleaning of all areas and more frequent cleaning of touch points. Ward Staff are also cleaning lockers, tables and contact points twice daily (as per PHE guidance) and cleaning records are completed. Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits. Facilities decontaminate these areas twice daily.			Green
2.8	Reusable non-invasive care equipment is decontaminated • Between each use • After blood and/or body fluid contamination • At regular predefined intervals as part of an equipment cleaning protocol • Before inspection, servicing or repair equipment	Decontamination of all non-invasive care equipment is detailed in the Cleaning, Disinfection and Sterilization policy which is available on the Intranet https://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_related_information.asp			Green

2.9	Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen is handled as per Trust Policy/National guidance. http://intranet/Facilities_Department/Policies_and_Procedures.asp			Green
2.10	Single use items are used where possible and according to Single Use Policy	Single use items are used as per policy.			Green
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance (link below) and the appropriate precautions are taken https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control	Power Air Purified Respirator units with helmet head-tops are decontaminated according below SOP. Hood Usage and Decontamination SOP A process for decontaminating reusable tight-fitting Respiratory Protective Equipment (half mask or full face respirators with P3 filters) V2 - Usage and Decontamination of F The Trust is not currently re-using any FFP3 respirators beyond a single task or session. The Trust is using single use eyewear/visors and not reusable.		New versions of reusable respirator document https://intranet.sath.nhs.uk/coronavirus/ppevideos.asp	Green
2.12	cleaning standards and frequencies are monitored in non-clinical areas with actions	The C4C monitoring programme includes the auditing of non-clinical			Green

	in place to resolve issues in maintaining a clean environment	areas			
2.13	Where possible ventilation is maximised by opening windows where possible to assist the dilution of air	• Increased air-changes via mechanical ventilation to ensure air dilution. • Areas have been encouraged to open windows where possible • Non circulating portable air conditioning units may be considered • Matrons were emailed in October with PHE paper & requested implementation : Simple summary of ventilation actions to mitigate the risk of COVID-19, 1 October 2020 • Ventilation assurance is provided at COVID outbreak meetings			Green
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Systems and process are in place to ensure:					
3.1	arrangements for antimicrobial stewardship are maintained	• Antibiotic Policy in place. • Antibiotic prescriptions are reviewed by a pharmacist wherever possible. • E-Script pharmacy program used to record antibiotic prescriptions, data entered by pharmacy staff and occasionally doctors when undertaking discharge summaries. • Prescriptions are screened to ensure compliance with Trust	Antibiotic policy in place. Pharmacy medicines management under increasing pressure, not all antibiotic prescriptions are able to be reviewed daily or seen at start of course meaning possible delay in querying prescribing.	Pharmacy seeks to prioritise undertaking a full Medicines Reconciliation as soon as possible after admission and to see all patients at discharge. Restriction of stock antibiotics on wards to guide prescribing. Antibiotics not	Amber

		Antibiotic Policy and Stewardship, including choice, course length, and review periods. • Overall antibiotic usage is average see Fingertips Portal. High usage of WHO access group antibiotics due to longstanding antibiotic policy decisions which are reviewed regularly. • Monthly internal snapshot audits undertaken and fed back to care groups. • Antimicrobial Management Group (AMG) should meet every 2 months membership includes representatives from microbiology, pharmacy, nursing and clinicians from each care group.	E-Script program still in use and antibiotics are entered and recorded when seen by pharmacy staff and doctors undertaking discharge summaries, no electronic prescribing so some antibiotic prescriptions may be missed. All reviewed antibiotic prescriptions are checked against the antibiotic policy, where not in line they are queried with the medical team, course lengths and route are also queried. Regular AMG meetings have been difficult to hold and often not quorate due to lack of clinical representation.	stocked must be requested through a pharmacist and be reviewed against antibiotic policy/microbiologist recommendations. See Trust board sign off for Wave 3 of NHSE/I funding for EPMA system. This is a 2-3 year plan. Business case submitted on 15th September 2020 and approved by Trust however delayed until at least 2023 due to requirements from NHSE/I. Continue to seek engagement from clinicians to attend AMG from care groups.	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	IPC continue to report organisms, such as MSSA, Ecoli, Pseudomonas, Klebseilla and MRSA to PHE. This information also goes to the Quality and Safety Assurance Committee monthly			Green

		chaired by a Non-Executive Director.			
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion					
Systems and process are in place to ensure:					
4.1	National guidance on visiting patients in a care setting is implemented https://www.england.nhs.uk/coronavirus/publication/visitor-guidance/	The Trust has adopted the national guidance and this is on the Trust public facing internet website.		End of life Care visiting line with national guidance. Visiting restrictions have been revised in Maternity, Neonatal unit, and paediatrics in line with national guidance. Managers are aware that there are times when discretion can be used when it is in the patients best interests and they may deteriorate without this contact. Another exception to this is when a young person is admitted to an adult ward, they can have a guardian present in line with paediatric guidance.	Green

4.2	Areas where suspected or confirmed COVID 19 patients are being treated have appropriate signage and have restricted access	All areas have appropriate signage based on PHE pathways			Green
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	The Trust has a designated COVID 19 page on the intranet where all information is easily accessible. http://intranet.sath.nhs.uk/coronavirus/default.asp Easy read versions available: Testing for the COVID v0.7 - Inpatie Mixed Sex Bay COVID v0.1.docx COVID v0.1 - Visitor Guidance.docx Testing for the COVID v0.3 - Pre-Op			Green
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	All infection status information is included in any transfer information including COVID status. COVID 19 cases and contacts are flagged on the trust PAS and PSAG boards			Green
4.5	there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Posters have been produced & are displayed in patient environment			Green

		 leafletemplateA5cov id copy.pdf  Covid Aware Patient Hygiene.docx			
4.6	Implementation of the supporting excellence in infection prevention and control behaviour implementation Toolkit has been considered https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf	Use of toolkit raised with Trust silver command, currently being reviewed to identify appropriate lead for this.			Green
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
Systems and process are in place to ensure:					
5.1	screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	See Section 1: Emergency Department SOP (1.3).			Green
5.2	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases, to minimise the risk of cross-infection as per national guidance	See Section 1: Emergency Department SOP (1.3).			Green
5.3	staff are aware of agreed template for triage questions to ask	The triage/navigator form asks the 3 key questions related to covid to allow appropriate immediate identification of the appropriate pathway for that patient			Green
5.4	triage is undertaken by clinical staff who are trained and competent in the clinical	Initial Assessment, Navigator and pit stop nurses are trained in Manchester			Green

	case definition and patient is allocated appropriate pathway as soon as possible	triage ED also have Manchester triage train the trainer ED senior staff in both depts			
5.5	face coverings are used by all outpatients and visitors	Outpatients & visitors wear face coverings COVID19 Mask Posters.pdf			Green
5.6	Individuals who are clinically extremely vulnerable from COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	Individuals who are clinically extremely vulnerable are prioritised for isolation as per Trust COVID policy (link below)	The Trust has a low number of side rooms, therefore in areas where a large number of patients are clinically extremely vulnerable they may need to be cohorted together (Oncology, Haematology and Renal)	Renal Ward has moved to an area with more side rooms. Oncology and Haematology have reduced their bed base to ensure 2 metre distancing is in place	Green
5.7	Clear advice on the use of facemasks is provided to patients, and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs	Patients are encouraged and supported to wear facemasks whether at their bedside or moving around the ward/hospital covid.pdf 1.4 Patient Wearing Masks - Flow Diagram			Green
5.8	monitoring of inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their	Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients notes			Green

	(physical or mental) care needs				
5.9	Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens e.g. to protect reception staff	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients when 2 metre distancing cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients	Green
5.10	Isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative	• Patient is isolated or cohorted appropriately • Contact tracing is commenced upon positive result ○ This is done by IPC team who look back 48 hours following a positive result of bay contacts via the SQL			Green
5.11	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	The Trust policy advises actions to take when this happens. Please refer to Section 6.2 of Trust COVID policy (link at bottom of document).			Green
5.12	there is evidence of compliance with routine patient testing protocols in line with Infection prevention and control and testing document: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/key-actions-boards-and-systems-on-infection-prevention-control-testing-23-december-2020.pdf	Dashboard in place showing compliance with admission, Day 3, Day 5 & day 13 swabs. Discharge testing is completed by ward 48 hours prior to discharge Offsite screening pathway in place for elective patient screening			Green
5.13	Patients that attend for routine	Where possible routine appointments			Green

	appointments who display symptoms of COVID-19 are managed appropriately	are being carried out over the telephone, when a patient must attend in person, information regarding COVID symptoms are included in their appointment letter.			
6.	**Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**				
Systems and process are in place to ensure:					
6.1	patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Patients are admitted on a low, medium and high risk pathway and staff cross over of these pathways is kept to a minimum			Green
6.2	All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	All staff should have received training on hand hygiene, PPE usage relevant to their roles. Further training is provided as required.	There are some members of staff who have not accessed this training or have not recorded their compliance.	Ward managers, Matrons are to ensure that staff have completed the required training. All managers have been contacted by the IPC team to ensure their staff have completed the training and that the details of staff who have completed training has been provided to the education department to	Amber

			The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training report.	ensure records are correct Corporate Education Department Manager is reviewing data for accuracy and to feedback to Divisions in relation to compliance. Local records being held by departments of staff trained, DivisionalCare Leads ensuring managers send this information to Corporate Education	
6.3	all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it.	All staff should have been trained in the use of and donning and doffing of PPE. There are posters available for this and all staff should have access to the Trust intranet which also has this information accessible. http://intranet.sath.nhs.uk/coronavirus/ppevideos.asp Matrons audit PPE usage as part of their monthly audits	As above	As above Donning and doffing training has been provided by IPC Team and videos are available on the Trust intranet	Amber

6.4	A record of staff training is maintained	Any training that staff attend is recorded by the Trust Corporate Education team, and this information is reported to all Ward Managers (link as above)	The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training report due to delays in local training data being provided to Education Department for updating centrally.	Corporate Education Department Manager to review and scrutinise data for accuracy. Local records being held by departments of staff trained, Divisional Leads ensuring managers send this information to Corporate Education	Green
6.5	adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	IPC Team undertake PPE audits as part of QWW for wards Matrons undertake audits on this via gather			Green
6.6	hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care	The Trust policy advises actions (see link at bottom of document)			Green

	• staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas				
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	Bi monthly hand hygiene audits are undertaken on all wards & departments X:\HighImpactInterventions IPC Team undertake Quality Ward Walks which includes standard IPC precautions Y:\InfectionControl\Quality Walks\April 20- March_21\Quality Walks by year May 20 - March_21.xls IPC Nurses visit wards daily & observe practice & educate This is also monitored on the Matrons audit			Green
6.8	the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is	Hand dryers have been removed and replaced with paper towel dispensers			Green

	located close to the sink but beyond the risk of splash contamination as per national guidance				
6.9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	All toilets have posters with hand hygiene guidance			Green
6.10	Staff understand the requirements for uniform laundering where this is not provided on site	All staff change into their uniform at work Uniforms should be transported home in a disposable plastic bag, which can then be washed separately from other linen in a half load then iron or tumble dry for at least thirty minutes. http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065			Green
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	If staff are symptomatic, they are to contact their manager and access a test via the government route keeping their manager informed of any updates at all times Staff who need to self-isolate due to contact with a positive case report to their manager who will record this on Health roster and this is monitored by workforce			Green
6.12	a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Every positive COVID result is reviewed daily and all cases are assigned a category based on PHE guidance. System wide groups monitor and discuss community situation with regards to prevalence and also have a			Green

		dashboard that reflects the local data			
6.13	positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	All patients who are positive on day 8 or after will trigger an RCA Two or more cases linked by time and place trigger an outbreak & are investigated with the involvement of NHSEI and PHE.			Green
6.14	robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	See link to current policy at end of document			Green
7. Provide or secure adequate isolation facilities					
Systems and process are in place to ensure:					
7.1	restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	See 6.1			Green
7.2	areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	All wards have appropriate signage to differentiate pathways			Green
7.3	Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Any patients who are tested positive are isolated in side rooms. Patient placement is based on PHE high/medium/low risk pathways. Patients who fall into the high risk pathway are either isolated or cohorted appropriately. Patients who fall into the medium risk pathway are COVID		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green

		swabbed as per guidelines and placed according to pathway. Low risk patients are mainly elective surgical who have ring-fenced wards/beds.			
7.4	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	The Trust follows national guidance (section 4.4.3).			Green
7.5	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	All patients with alert/resistant organisms are managed as per normal Trust policy. The Trust also have an isolation risk assessment tool that is available to all staff http://intranet.sath.nhs.uk/Library_Intranet/documents/infection_control/Ward_guidance_folder/isolation on admission tools poster.pdf			Green
8. Secure adequate access to laboratory support as appropriate					
Systems and process are in place to ensure:					
8.1	Testing is undertaken by competent and trained individuals	• The laboratory at SaTH is UKAS accredited • All staff are HCPC registered • Quality assurance training and competence assessments are all in place.			Green
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patient testing is in place in accordance with National and PHE guidance for all admissions, inpatients at day 3, 5-7 &			Green

		13, and for patients who are discharged to a care setting. In addition to this any patients with new symptoms are tested immediately. If staff are symptomatic, they are to contact their manager and access a test via the government route keeping their manager informed of any updates at all times			
8.3	regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Reported daily on PLACERS data return			Green
8.4	regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Cases are reported electronically twice daily via SGSS and there is a daily sitrep (PLACERS) for all positive reported cases			Green
8.5	Screening for other potential infections takes place	All screening for other organisms usually monitored continue to be performed in the as per guidelines			Green
8.6	that all emergency patients are tested for COVID-19 on admission.	Patient testing is in place in accordance with National and PHE guidance for all admissions, inpatients at day 3, 5-7 & 13, and for patients who are discharged to a care setting. In addition to this any patients with new symptoms are tested immediately.			Green
8.7	that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	Wards are aware of the requirement to swab for new onset of symptoms, and the request forms have the option to select new onset symptoms. See link to current Trust policy at bottom of			Green

		document			
8.8	that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	SQL report set up to inform Ward Managers when days 3, 5 & 13 COVID screens are due, and dashboard in place to show compliance by ward area			Green
8.9	that sites with high nosocomial rates should consider testing COVID negative patients daily.	Currently low activity and no outbreaks. To be reviewed at outbreak meetings. Trigger would be when outbreaks and need to isolate contacts impair hospital flow and block beds	Depending on lab capacity and staffing, we may not be able to test all negative patients daily	Test all contacts daily during high activity to ensure timely isolation/cohorting. Consider testing wards on alternate days if transmission high and unable to test all. Or test high risk wards only	Green
8.10	that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	All wards are aware of the requirement to test as per policy (see link at bottom of document)			Green
8.11	that ~~those~~ patients being discharged to a care facility within their 14 day isolation period ~~should~~ are discharged to a designated care setting (link below), where they should complete their remaining isolation. https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-designated-settings	following PHE and regional guidance on discharging patients who have tested positive for Covid 19 to the community. All patients will be given appropriate advice when they are discharged. Many patients will no longer be infectious by this time. Patients who are being discharged to nursing homes are only discharged if they are no longer infectious unless the nursing home is able to isolate patients with Covid and			Green

		has agreed to take the patient			
8.12	that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	All elective surgery patients are tested 3 days prior to admission & are ask to comply with self-isolation. Unless paediatric as per guidance via NICE. Trust have reviewed the process for COVID screening for elective lower GI scopes, in line with other Trusts in the region SaTH no longer screen these cases to facilitate restoration of services.			Green
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections					
Systems and process are in place to ensure:					
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this. This is also reported to Trust IPCOG committee, via Divisional reports and IPC team QWW reports.			Green
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	The National IPC guidance is checked daily and the IPC team receive the daily Gov.uk guidance. • It is also discussed on the Trust COVID weekly silver command Call chaired by the COO/MD. • All changes for escalation throughout the Trust are also reported through to the Covid 19			Green

		Incident Control Room • There is a weekly message sent out to staff from a member of the executive team which communicates any changes. • The IPC team are visiting the clinical areas in the Trust daily.			
9.3	All clinical waste related and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All clinical waste and linen/laundry is handled, stored, managed & disposed of as per national guidance. See section 7.9 & 7.10 of SaTH COVID Policy linked at bottom of document. Management, storage and disposal of linen in also reference in Linen Policy CS02 https://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_related_information.asp			Green
9.4	PPE stock is appropriately stored and accessible to staff who require it	The stock of PPE is continually monitored and the Trust send a daily PPE submission to the Regional West Midlands COVID. Procurement are available from 7.30am until 11pm Monday to Friday. Saturday and Sunday 7.30am until 1pm from 11.30pm-7.30am daily there is a stores and procurement person on call to allow staff to contact if required. SaTH are also part of the LHRP PPE Task and Finish group.			Green
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					

Appropriate systems and process are in place to ensure:					
10.1	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical ~~and psychological~~ wellbeing is supported	Staff are risk assessed by managers and appropriate mitigation taken including remote working / working away from high risk areas. Staff in at risk groups have been prioritised for remote working. A range of support activities have been put in place for staff during this time including: • Comprehensive FAQs for staff • Staff App – Regularly updated with guidance • Team Prevent – Managers Advice Line (Occupational Health) • Employee Assistance Programme • HR Advice and Support - Extended Hours Support for COVID-19 • SaTH Trained Listeners - Hotline Coaching hotline • A free wellbeing support helpline • Peer-to-Peer Listening • Coaching and listening ear support lines available • Redeployment Coaching Support • Wellbeing Hubs • Headspace - Free subscription • Trust Coaches • Freedom to Speak Up Guardians • Accommodation for Staff in Critical Service Roles	**Risk Category Total % Assessed** BAME 55+ 100% White Over 60 85% Male 85% Health Risk 100% Pregnancy 100%	On-going work to complete the rest of the assessments	Amber

		Staff are being risk assessed taking into consideration the health, age, ethnicity and gender.			
10.2	that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	Risk assessment process in place with support also available via occupational health (as required). Documents available on intranet and SaTH app.			Green
10.3	Staff required to wear FFP reusable respirators undergo training that is compliant with national guidance (link below) and a record of this training is maintained and held centrally https://www.hse.gov.uk/coronavirus/ppe-face-masks/index.htm	Staff are fit-tested to FFP3s and more recently FFP2s, in accordance with HSE guidance on tight-fitting RPE. The Trust uses both qualitative and quantitative (ambient particle counting) methods. During the course of the fit test staff are trained to don the respirator correctly, and to perform a fit check specific to the valved/ unvalved type of respirator they are fitted to. Reports on numbers fit-tested are submitted to the incident command room twice weekly, and a recent submission is attached for information. http://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp Practice in the fit testing open sessions conforms to HSE guidance on reducing the risk of transmitting coronavirus during the fit test, and this information was also cascaded out to Divisional fit testers for local implementation on 25 March 2020 and 6 April 2020, via email.			Green

		The PHE videos covering donning and doffing of PPE, including FFP3s, have been promoted via the Trust intranet and via sessions held in the Education Centre lecture theatres. Training records relating to those videos are held on ESR, and a report is available on request from Tom George, Corporate Education.			
10.4	staff who carry out fit test training are trained and competent to do so	The majority of RPE fit testers have been trained by a Fit to Fit accredited external trainer. A smaller number were trained in-house by a member of the H&S Team. A list of current, trained fit testers is maintained at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp and this was last updated on 29 March 21. This includes dates of in-house refresher training and competency assessments.			Green
10.5	all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Fit tests are undertaken for every make and model of FFP3/ reusable respirator issued to staff. The H&S Team work closely with Procurement colleagues to coordinate fit testing provision with stock changeovers. A weekly report on fit testing outcomes is escalated to the Incident Command Centre. All staff are requested to be fit tested to two masks as a contingency plan in case of stock shortages			Green

10.6	a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Records of fit tests are recorded on each staff member's ESR record, and a report on current fit test data by individual is produced by Corporate Education weekly and published at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. The original fit test records are scanned for H&S Team files, then returned to the employing ward department to be held on personal files (though there is currently an admin backlog). Staff are not given a copy of the fit test record at the time of the fit test, but are encourage to make a note/ take a photograph of the FFP3 they fit to, and are informed that their name will be published on the intranet within a week for future reference.	A copy of the fit test record is not given to the staff member at the time of the fit test.	Staff are encouraged to access the fit testing report on the intranet to look up their own records.	Green
10.7	those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Records of failed fit tests are managed in the same way as records of successful fit tests, as described above.			Green
10.8	embers of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Staff who cannot wear an FFP3 in stock have access to loose-fitting RPE and, in Critical Care areas, reusable tight-fitting RPE. Staff who cannot wear any of the alternatives to FFP3s are assigned to suitable duties by their own line managers, with HR support.			Green
10.9	a documented record of this discussion should be available for the staff member	If staff cannot be fitted – this is recorded on ESR – these people then become			Green

	and held centrally within the organisation, as part of employment record including Occupational health	hood users			
10.10	following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	If staff still cannot tolerate a hood, they are recalled to be retested if new masks are introduced. Further options are then explored, if staff still cannot be fitted, they are referred to Occupational Health who will keep a record on the member of staffs personal file and their line manager will also receive this information. Please see national supporting document below: supporting-fit-testing-steps-actions-to-be-undertaken-use-of-ffp3-masks.pdf (england.nhs.uk)			Green
10.11	boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Results are published at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. A report on fit testing outcomes is presented on alternate months to the IPC Operational Group and the IPC Assurance Committee, and also to the quarterly Health, Safety, Security and Fire Committee.			Green
10.12	Consistency in staff allocation is maintained, ~~with reductions in the~~ reducing movement of staff ~~between different areas~~ and the cross-over of care pathways between planned/elective care pathways and urgent/emergency care pathways, as per national guidance	**USC** – due to the current vacancies and the staff sickness this can be challenging. This is kept to a minimum where possible. **SC** –there is some movement of staff to cover sickness/gaps in rosters, however this is kept to a minimum. The elective	There is still some movement of staff between areas to ensure safe provision of staffing due to gaps	Matrons are responsible for ensuring daily staffing plans are in place which mitigate the movement of staff between areas but maintain safety	Amber

		ward is protected. **Women's and Children's Services** – Paediatrics and Neonates allocate staff between Covid /Non Covid/symptomatic areas. Gynae – there are only 2 RN's on shift, so can be a challenge where joint RN input is required. Allocation of 1RN/1HCA where possible is the aim with the least interaction as possible. **Maternity** – this area is challenging as there are women on the planned and unplanned pathways in the same areas and staff will be caring both groups of patients. There is a dedicated team running the planned Caesarean Section list		and that these are communicated to the Clinical Site Team out for out of hours. Monthly staffing report provided to Workforce assurance committee Clinical staff are trained in the appropriate donning and doffing techniques to reduce the risk of contaminating oneself Staff are required to complete a Datix report if looking after both COVID positive and negative patients during the same shift	
10.13	All staff adhere to national guidance and are able to maintain 2 metre social and physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas	In line with national guidance staff will be wearing facemasks in all areas of the Trust (both clinical and non-clinical) Staff are only not required to wear a facemask if they are in an office alone.			Green
10.14	health and care settings are COVID-19	Covid-secure guidance, including			Green

	secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	templates for risk assessments, was produced by the H&S Team and is published at https://intranet.sath.nhs.uk/coronavirus/waysofworking.asp. A list of completed and missing risk assessments is maintained at the same page, and updated frequently. Completed covid-secure risk assessments are published at the same page. Some physical inspections of covid-secure areas are undertaken by the H&S Team and reported via the Health, Safety, Security and Fire Committee.			
10.15	staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	The need for facemasks is addressed in covid-secure guidance and risk assessments described above. The Communications Team have produced standard posters published at https://intranet/coronavirus/briefings.asp , including ones addressing the use of surgical masks. Surgical mask stations are present at entrances to buildings and other key areas including the staff restaurants, the PRH Education Centre and SECC and these are equipped with surgical masks, hand gel, clinical waste bins and posters are displayed.			Green
10.16	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	If staff are symptomatic, they are to contact their manager and access a test via the government route keeping their			Green

		manager informed of any updates at all times. Occupational Health also complete a well being check on those staff self-isolating due to a positive result. Staff who need to self-isolate due to contact with a positive case report to their manager who will record this on Health roster and this is monitored by workforce			
10.17	Staff that test positive have adequate information and support to aid their recovery and return to work.	The feedback of results is provided via our system occupational health team. The information on results and advice is provided to staff via qualified occupational health professionals that can provide support and advice to aid recovery. Staff only return to work when fully fit and do so as part of the return to work process. This includes a return to work discussion with their manager and completion of return to work assessment. This details any known risks underlying health conditions any adjustments that need to be made and referral to occupational health if required.			Green

SaTH COVID Policy Link: http://intranet.sath.nhs.uk/coronavirus/ipc.asp

Public Participation Quarter 2 (July-Sept 2021)

Julia Clarke – Director of Public Participation




Partnering
Ambitious
Caring
Trusted

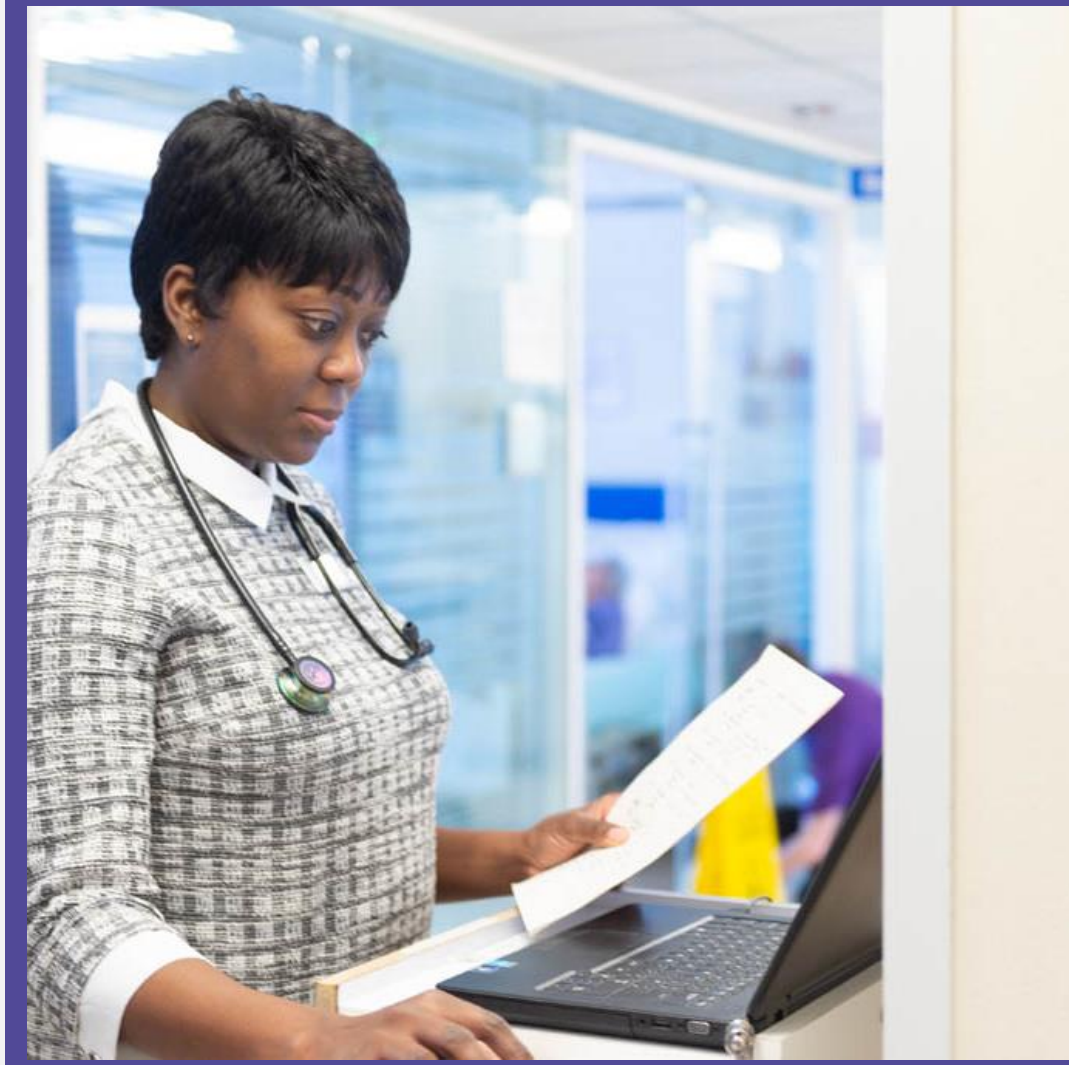
Volunteering | Engagement | SaTH Charity

Our Vision: To provide excellent care for the communities we serve

Highlights of Public Participation – Q2

The Shrewsbury and Telford Hospital NHS Trust

- Public Participation Plan was approved at Trust Board 7 October and we are now developing the Public Assurance Forum with NED lead - David Brown
- Supporting our Divisions with their Section 242 duties to engage the public around service changes
- Continue to hold a range of meetings/lectures including a monthly Community Cascade briefing for members of the public with attendance across Shropshire, Telford & Wrekin and Powys
- Held a virtual Health Lecture on 18th October 2021 on **"The Recovery Trial"**, Sister Mandy Carnahan (Lead Research Nurse)



Highlights of Public Participation – Q2

The Shrewsbury and Telford Hospital NHS Trust

- Our Response Volunteer role has been developed and volunteers are now able to carry out ward-based roles (with some restrictions)
- The Volunteer team have developed two new roles to support patient flow - an A&E support/comfort role and a Pharmacy “runner” role (for urgent medications)
- A new Volunteer management software package has been introduced to support the recruitment and management of volunteers at SaTH
- SaTH Charity continues to support staff through charitable activities including the Rapid Relief Team providing over 1000 wellbeing bags to staff on both sites in September
- Work has commenced on the Captain Tom’s Garden at RSH, funded through NHS Charities Together grant

Public Participation Plan

- Our Public Participation Plan, which outlines how we will work with our communities over the next 5 years, was approved by the Trust Board on 7 October 2021
- The Plan was developed in partnership with our communities. We held a number of engagement events over the past year to hear the views of our local communities and from our staff, including:
  - Virtual Focus Groups (staff and public)
  - An online survey
  - Make a Difference online interactive platform
  - David Brown agreed as lead NED
- **Next steps include:**
  - To meet with stakeholders to develop and implement the Public Assurance Forum
  - Development and prioritised implementation of a 5 year Action Plan

Community Engagement - Meetings

The Shrewsbury and Telford Hospital NHS Trust

- The Engagement team hold a series of community meetings where the public across Shropshire, Telford & Wrekin and Powys are invited to join us virtually to find out more about their hospitals, which includes:
  - **Monthly email update –** An email update to our 3000 community members and organisations
  - **Community Cascade** – this is delivered twice a month following feedback from the public requesting session in the evening
  - **Monthly Community Drop-ins –** informal drop-ins for a community to meet with members of the engagement team
  - **Quarterly Community Meeting**, with the main agenda item being around specific topics – our last meeting had an update on the HTP programme
  - **Health Lectures** – There is an ongoing series of virtual health lectures for staff and the public. The autumn health lecture series is on COVID19.

Engaging with our Local Communities

The Shrewsbury and Telford Hospital NHS Trust

- In September we held our Quarterly Community Meeting. Presentations were given about:
  - The draft Cancer Strategy given by Jessica Greenwood (Lead Cancer Nurse)
  - Non-Emergency Patient Transport, from our new provider E-zex Medical Transport Services
  - Inpatient Cardiology Services (proposed temporary inpatient service change), Donna Moxon (Operations Manager)

- In response to public feedback, the Public Participation Team have organised a series of online Health Lectures this autumn featuring different aspects of hospital services during the COVID19 pandemic. Forthcoming lectures include:
  - **"Living with the Effects of COVID-19"** by Mandy Taylor, (Inpatient Therapy Manager and Head of Inpatient Physiotherapy), 6pm, **Thursday 18 November 2021**.

Engaging our Seldom Heard Communities

The Shrewsbury and Telford Hospital NHS Trust

The Community engagement team have started to attend events in Q2 to promote opportunities to #GetInvolved with SaTH. These events have been a great way to talk to individuals and groups from our Seldom Heard Communities

On Sunday 25th July we attended the Windrush Generation Celebration at the Hadley Learning Community, Telford. The event was attended by over 400 people.

In September we attended Freshers' events at the local colleges (Shrewsbury Colleges Group and Telford College), talking to young people and promoting opportunities including volunteering.

Telford & Wrekin including Telford Mayor, Cllr Amrik Jhawar and Cllr Paul Watling, Cabinet Member for Cooperative Communities, Engagement and Partnerships (shown right)

Engagement - Section 242 Duties (Cardiology)

- We have supported the Cardiology department to engage with patients and the public around the potential temporary relocation of inpatient services from RSH to PRH
- Whilst no decisions have been made regarding this service change the engagement of our communities was important prior to any decisions being made
- Regarding this potential service changes the Trust engaged with:
  - The Healthwatch's and CHC, members of the HOSC and the Health and Wellbeing Board
  - Local Patient groups
  - National and local Cardiology Patient groups
- Feedback from the stakeholder meeting was positive with patients groups being supportive of this move
- The EQIA is currently being reviewed, with patient and public involvement

Engagement - Section 242 Duties (Cardiology)

The Shrewsbury and Telford Hospital NHS Trust

- **We have supported the Cardiology department to engage with patients and the public around the potential relocation of inpatient services from RSH to PRH. Whilst no decisions have been made regarding this service change the engagement of our communities was important prior to any decisions being made.**
- We held a Stakeholder Event on Thursday 2nd September which had representatives from:
  - Healthwatch (Shropshire, T&W)
  - CHC
  - Members of Health Overview and Scrutiny Committee (HOSC)
  - Members of the Health and Wellbeing Boards (HWBB)
  - Local and National Cardiology patient groups
  - Local Patient groups (e.g Telford Patient First and Shropshire Patient Group)
  - Following the meeting we have sent the presentation slides and the draft EQIA to all who attended to share with their groups and provide any feedback.
- We have a website page which has a recording of the stakeholder presentation, a question and answer sheet and the draft EQIA – this is accessible to all members of the public. There is also an open invitation to attend other meetings on request
- We have written the following:
  - MP's
  - HOSC
  - HWBB
  - We included a copy of the presentation and EQIA

Attendance at other events to discuss the proposal, led by the cardiology team:

- Quarterly Community Meeting – 22nd September 2021
- Powys Services Planning Committee – 21st September 2021
- Montgomeryshire Local Committee – Thursday 14th October 2021
- Telford Patient First - Wednesday 3rd November 2021
- Ludlow Community Connectors – 9th November 2021

Questions from Trust Board

The Shrewsbury and Telford Hospital NHS Trust

We look to identify any trends in questions to the Trust Board so that we can be responsive in planning future engagement events with our local communities.

During Quarter 2 there was one Trust Board Meeting and 3 questions were submitted to the Trust Board.

- **Question 1 -** related to an increase number of Freedom to Speak up concerns raised by Midwives
- **Question 2 –** Process to ensure safety of patients experiencing long ambulance waits
- **Question 3** - Plans relating to HTP progression

These have been published on our website - https://www.sath.nhs.uk/about-us/trust-information/questions/previous-questions-to-the-board/ and the following actions have been taken to share more widely:

- **Freedom to Speak Up**
  - Helen Turner attended Montgomeryshire Local Committee in October to speak about her role as a Freedom to Speak up Guardian and she has been invited to attend our Quarterly Community Meeting in December
- **HTP:**
  - Regularly HTP updates are given at our monthly community update meetings
  - Chris Preston is due to attend our next Quarterly Community Meeting in December to provide an update on HTP

Volunteer Update

- We currently have **192** active volunteers, **52** of whom are young volunteers.
- We currently have **74** pending volunteers, an increase of 26 compared to last quarter, who are going through the application process.
- The Volunteer Team are implementing a new volunteer management tool to improve the recruitment and retention of volunteers.
- We are currently processing return packs received from postponed volunteers to enable their return.
- Approval has been given for the reintroduction of volunteers to ward areas to support staff and patients, subject to vaccination status. Training sessions area underway
- The Volunteer Team have attended recruitment events at the start of September with the local colleges and councils.

Julia Clarke and Bir-Inder ironmonger presenting Peter Hicking with recognition award for his service to Phlebotomy throughout the pandemic

Volunteer Update - Response Volunteer Scheme

The Shrewsbury and Telford Hospital NHS Trust

- Response Volunteers cover both hospital sites on a 9-5pm rota every day of the week. Our response volunteers are providing up to **336 hours each week.**
- The Response Volunteer role has been developed to now provide support on the wards.
- Volunteers can now carry out ward-based tasks to enhance patient wellbeing and experience providing they meet the following criteria:
  - double Covid-19 vaccinated
  - twice weekly lateral flow tests
  - full Occupational Health Clearance
  - no clinically vulnerable volunteers
  - attended non-clinical ward-based training provided by the Volunteers' Team
- Currently **69** volunteers have completed the non-clinical ward-based training. We delivered a further three training sessions during October.

Vicky, Donna and Amelia learning about PPE at the non-clinical ward based training in Telford

Pharmacy Volunteer Role (RSH)

We have launched a new volunteer pharmacy “runner” role at RSH, 5 days a week between 10am-1pm and 3-5pm.

Pharmacy Response Volunteers are able to collect urgent prescriptions from pharmacy and deliver them to wards and departments using the Prescription Tracker System (PTS).

All Response Volunteers have been trained by a member of the Volunteer Team on how to use the PTS and the process involved.

We hope to increase support in Pharmacy over the next few weeks and establish this as a permanent part of the Response Volunteer role.

This role has a direct impact on staff time and patient flow.

A&E Role

The Shrewsbury and Telford Hospital NHS Trust

The Volunteer Team have been working with the A&E teams on both sites to develop and expand a role within the waiting areas to improve patient flow and experience.

Phase one of the new role is based in the waiting areas, a

- reassure patients that they will be seen through the triage system
- Keep the area clean and tidy (wiping chairs etc.)
- Escort patients to different areas i.e. xray
- Providing companionship and reassurance to patients

Phase two will be to expand the service into clinical areas to support patients who are receiving treatment or waiting to be admitted to wards.

The challenge is to recruit the right profile of volunteer to fit this role in a challenging and busy environment.

Volunteer Update – Better Impact

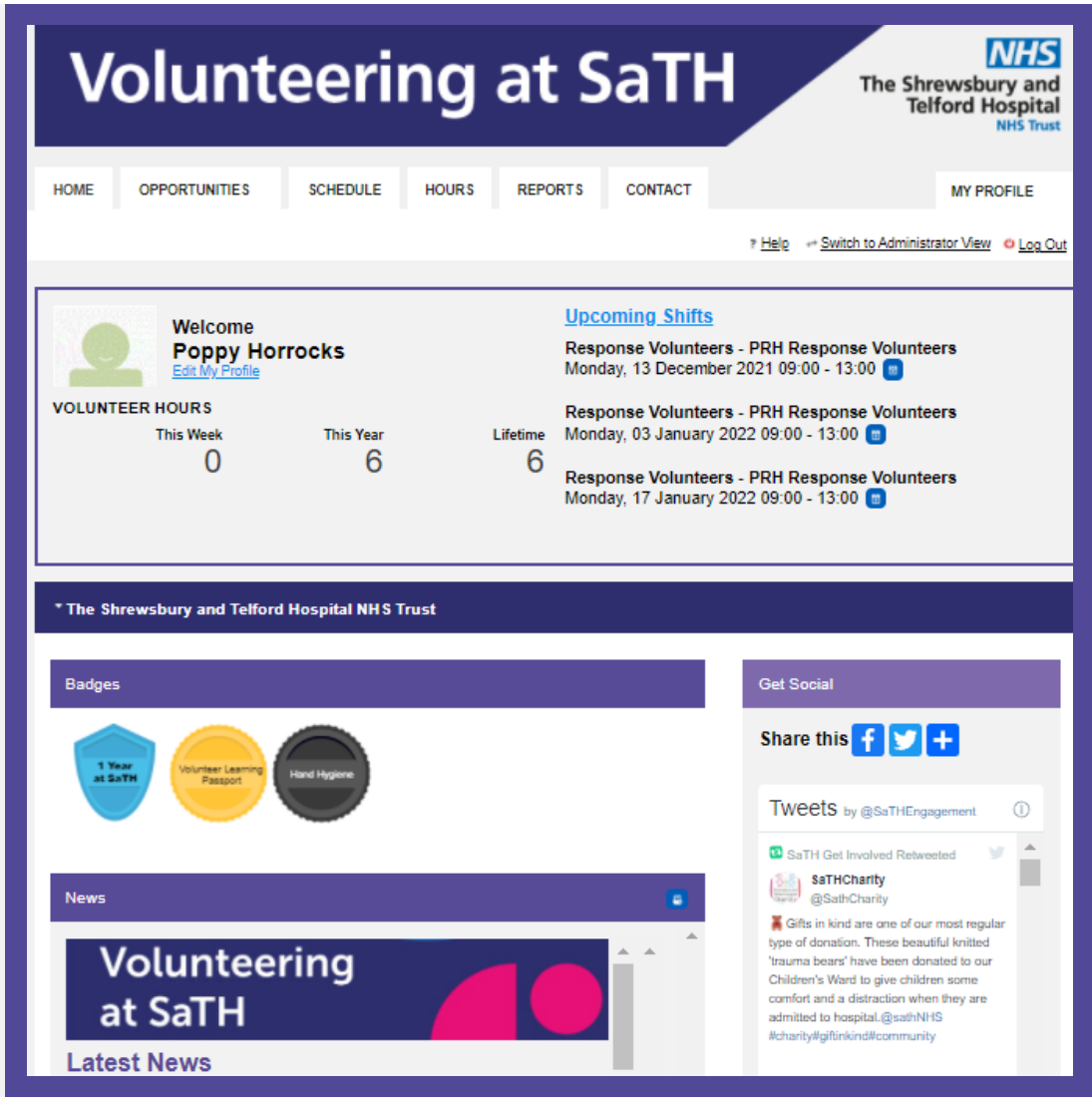
The Shrewsbury and Telford Hospital NHS Trust

The Volunteer Team are very busy transitioning to a new volunteer management system. We are really excited about this new software as it will allow us to grow the volunteer base and our volunteers will be able to access the platform to keep up to date and engaged with the Trust.

The software will:

- improve the recruitment process for staff and volunteers
- enable personalised interaction to help them feel part of the SaTH Volunteer Community.
- create a profile for volunteers where they can:
  - access important news and documents
  - read about and sign up to roles and shifts
  - download/access rotas
  - access training records and sessions

In the first two weeks of launch we have received **31 new volunteer** applications. Feedback from volunteers who have been using the platform has been really positive - they find the system easy to navigate and informative of the process.



SaTH CHARITY – In Brief

- SaTH Charity continues to support staff through charitable activities and providing opportunities for engagement.
- Income for the 3 months of Q2 2021 is £68,702 compared to £213,313 in the same period last year which was heavily supported with grants from NHS Charities Together
- Expenditure for the same period was £63,381 compared to £96,358 in 2020
- In September the Rapid Relief Team and their volunteers were at both sites, giving over 1000 goodie bags to staff
- Captain Tom's garden at RSH has commenced outside the Ward block and is being funded through a successful grant application made to NHS Charities Together. It follows the successful project of Captain Tom's Courtyard at PRH. NHS CT have asked provide us to provide peer support to another trust planning a similar project.

SaTH CHARITY – Update

- We supported NHS Charities Together's Big Tea to celebrate the NHS birthday on 5 July providing free tea, coffee and cake for most staff members. We held a raffle during this week and it raised over £3,200 for SaTH Charity
- SaTH Charity continues to support our staff, an order of 14 picnic benches has been placed. A "new staff room" dome was funded and installed for the W&C team at PRH, this provides much needed space for breaks and lunches.
- A earlier relationship with Reconomy a local recycling company has been further developed from their donation of £15,000 with 2 staff volunteering days at PRH. This improves the environment for patients and staff

SaTH Charity – Update our supporters

The Shrewsbury and Telford Hospital NHS Trust

- There has been an increase in the number of patients and relatives looking to support the Trust with fundraising which is likely due to restrictions being lifted. Some of the highlights of how are communities have been supporting SaTH Charity include:
    - Andrew Walmsley's (community fundraiser) cycle ride for breast cancer, raising £1,202
    - Sarah Brown's (from our Dementia Team) 26 mile walk for dementia
    - The Smokestop restaurant in Ford raised nearly £1,500 at their charity fun day
    - Sue Bennett (Medical Secretary) is running the Loch Ness Marathon
    - Art work donated by artist Rory McCann, based on staff reflections of the support from the public during the pandeoic, has been installed in the Mytton Restaurant at RSH

Forward Plan

- Launch of the NHS Cadet Scheme (online) in partnership with St Johns Ambulance
- To develop and implement the Public Assurance Forum
- Develop an action Plan for the Public Participation Plan
- To continue with the programme of Virtual health Lectures
- Monthly community update meetings
- Launch of the online People's Academy
- Participation in ICS Digital Advisory Group

Dates for your Diary – October - December

The Shrewsbury and Telford Hospital NHS Trust

Date	Time	Event	Booking
Wednesday 10 November	11:00 – 12:00	Monthly Community Cascade	Via Eventbrite
Wednesday 17 November	18:30 – 19:30	Monthly Evening Cascade	Via Eventbrite
Thursday 18 November	18:00 – 19:00	**Health Lecture** Living with the effects of Covid-19	Via Eventbrite
Tuesday 30 November	14:30 – 16:00	Monthly Community Drop-In	Via Eventbrite
Tuesday 30 November	19:00 – 21:00	**The 5th Annual William Farr Memorial Lecture**	Via Eventbrite
Wednesday 08 December	11:00 – 12:00	Monthly Community Cascade	Via Eventbrite
Wednesday 15 December	10:00 – 12:00	Quarterly Community Engagement Meeting	Via Eventbrite
Wednesday 15 December	18:30 – 19:30	Monthly Evening Cascade	Via Eventbrite

Please register for all events online at:

https://sathnhs.eventbrite.co.uk/

Dates for your Diary – January – February

The Shrewsbury and Telford Hospital NHS Trust

Date	Time	Event	Booking
Wednesday 12 January	11:00 – 12:00	Monthly Community Cascade	Via Eventbrite
Wednesday 19 January	18:30 – 19:30	Monthly Evening Cascade	Via Eventbrite
Tuesday 25 January	14:30 – 16:00	Monthly Community Drop-In	Via Eventbrite
Wednesday 09 February	11:00 – 12:00	Monthly Community Cascade	Via Eventbrite
Wednesday 16 February	18:30 – 19:30	Monthly Evening Cascade	Via Eventbrite
Tuesday 22 February	14:30 – 16:00	Monthly Community Drop-In	Via Eventbrite

Please register for all events online at:

https://sathnhs.eventbrite.co.uk/

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	Evidenced and Assured	Completed	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'. A pilot audit of 20 case notes was conducted in May and June. This comrpised a series of questions designed to test compliance with a number of actions from the Ockenden Report. It included questions on whether risk assessment was conducted at booking, and at the onset of labour. The audit found that this was compliant in 100% of cases. MTAC were statisfied at their August 2021 to mark this action as 'Evidenced and Assured', but directed that the audit should be repeated as soon as possible with a higher number of cases, and routinely checked going forward, including when Badgernet is in full use - the system will make this audit very automated.	22/04/21	30/06/21	10/08/21	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	Evidenced and Assured	Completed	Videos and leaflets available plus BabyBuddy app. Key info also provided in handheld notes, which enhanced in partnership with the MVP. The Trust has conducted a review of peer-organisations websites and social media content, and accordingly is working to update its own offering. 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, and minutes from the Birth Options Clinic was sufficient to move this to 'Delivered, Not Yet Evidenced'. A pilot audit of 20 case notes was conducted in May and June. This tested evidence of conversation with healthcare professional to support the decision-making process, written information, documented outcome of the discussions, and number of time a care plan outside of the recommended pathway/national guidance was chosen. Compliance in most cases was around 100%, though only 63% for the provision of written information. This will certainly improve with the introduction of Badgernet, which has mandatory fields to support this and checks to ensure the birthing person has been able to access the information. MTAC approved this action 'evidenced and assured' in their August 2021 meeting, subject to ongoing audit as outlined above.	22/04/21	30/06/21	10/08/21	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	Evidenced and Assured	Completed	This action was accepted as 'Delivered, Not Yet Evidenced' at the July 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. The action was accepted as 'Evidenced and Assured' at the September 21 MTAC meeting, based on the information provided as part of the response to the minimum evidence requirements for IEA 6 (especially 6.1 and 6.2) (which mirrors this LAFL) as set out by NHSE/I. The two dedicated midwives have conducted monthly audits to prove compliance.	13/07/21	31/08/21	10/08/21	Hayley Flavell	Shirley Jones	

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.

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	Evidenced and Assured	Completed	A dedicated SBL project midwife in post, progress against Saving Babies' Lives (SBL) v2 is monitored within scope of Maternity Transformation Plan (MTP); and funding for this post has been secured for a second year. The audits and guideline updates conducted and implemented by this colleague were supported and scrutinised by a specialist senior midwife working on behalf of our partners from Sherwood Forest Hospitals NHS Foundation Trust. They were also subject to oversight and scrutiny from MTAC and the Board of Directors in their relation to Safety Action 6 of Year 3 of CNST and found to be complete and robust. Accordingly, MTAC approved this as 'Evidenced and Assured' in their August 21 meeting.	13/07/21	15/07/21	14/09/21	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	Evidenced and Assured	Completed	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'. Subsequently, at their August meeting, MTAC accepted this as 'Evidenced and Assured' based on the results of the pilot case notes audit, which showed 100% compliance in suitable conversations as part of the intrapartum decision-making process (including a documented discussion of risks, benefits and alternatives in 88% of cases). Continuous fetal monitoring was required (in line with guidelines) for 61% of the cases, and in 100% of these, it was documented that that woman had agreed to the recommendations of continuous fetal monitoring.	22/04/21	30/06/21	10/08/21	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~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	A review of the governance team structure is underway. The Trust has also set up two new divisional governance forums with the aim of ensuring timely and thorough conduct of investigations. Despite this ,and whilst improvements are being made, the MTP Group does not feel that 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. An exception report was created and accepted by MTAC on 10/08/2021, but no deadline has been re-assigned to the deliverable, pending a clearer picture on when the review is likely to be completed.		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~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	A review of the 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 corporate Head of Clinical Governance) and new forums have been set up that will help deliver this action. The divisional team is benefitting from the interim leadership of the Trust's Head of Patient Safety, plus the imminent addition of a senior Risk and Governance specialist midwife, to be supported in due course by two further specialist midwives. However, until the above interventions have been carried out and more of the action's sub-tasks have been completed (including the conduct of an assurance exercise and cross-referencing between Datix and MEDWAY), the MTPG cannot yet advise MTAC to approved this action as 'Delivered, Not Yet Evidenced'. As with 4.59, an exception report was created and accepted by MTAC on 10/08/2021, but no deadline has been re-assigned to the deliverable, pending a clearer picture on when the review is likely to be completed.		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	Evidenced and Assured	Completed	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'. This decision was followed up as part of the pilot case-notes audit, which found that, of the 20 sets of notes audited, 8 women had been referred to a consultant. In all cases (100%), this was to the correct Consultant based on the primary condition, the appointment was made within CRT guidelines, and the women did indeed attend the appointment. The highest grade of doctor who saw the women was, in each case, a consultant. Based on this, MTAC approved the action as 'Evidenced and Assured' in their August meeting. The action must be the subject of ongoing audit as described above.	22/04/21	31/05/21	10/08/21	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	Evidenced and Assured	Completed	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. An audit if handover notes proved appropriate inclusion of MDT colleagues, including fro obstetric anaesthesia. 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. Subsequently, thanks to LMNS funding, the requisite SIM equipment has been purchased. The latest PrOMPT courses (including train-the-trainer) have been acquired from MTP funds and will form part of CNST Safety Action 8 for year 4. Accordingly, and subject to the usual ongoing audit requirements, MTAC approved this action as 'evidenced and assured' in their August meeting.	22/04/21	30/06/21	10/08/21	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	This action is in place - 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'. Since the above direction was provided by MTAC, the MTP has not yet been able to secure the evidence required. An exception report has been prepared and was accepted by MTAC on 10/09/2021, agreeing a revised evidence date of 28-Feb-22 based on the point that the case notes audit tool is being revised, and a subsequent audit will be conducted as soon as possible.	22/04/21	28/02/22		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 as the next step for evidencing. Accordingly, a specific section (Question 15, parts a-l) on the case notes audit tool was created. However, the results of the pilot audit were inconclusive. The tool has been amended to increase clarity, and the next audit will be run as soon as possible. Depending on the findings to this part of the audit, MTPG will propose an change to the delivery status for this action at a future meeting. A exception report has been prepared, with a request to extend the evidence date to Feb-22. This was accepted by MTAC at their September meeting.	22/04/21	28/02/22		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 are in place, but the Trust does not yet have a named consultant lead (although consultants are currently offering this care collectively). Funding has been agreed for the rainbow clinic, of which the consultant will be a part. 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. This action has already been the subject of one agreed deadline amendment (from June to July 21 for delivery, and September 21 for evidence). As the action has not yet been delivered, as at mid-September, a further exception report has been prepared and submitted to MTAc at their September 21 meeting, with a request to amend the delivery and evidence dates to February 2022 in line with LAFL 4.66.		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	28/02/22	Not Yet Delivered	On Track	14/09/2021: The Trust has conducted a self-assessment regarding the level to which the pathway has been adopted. This indicates a high-level of compliance. However, it has not been externally validated. Sands (the stillbirth and neonatal death society) have been commissioned to conduct a review of bereavement care at SaTH; the will visit the Trust on 9-10th November. Subject to their advice, SaTH will engage Sands for further development guidance and support. The Trust has in place two specialist bereavement midwives. Consultant-led bereavement care is in place, however as yet there is no named consultant lead. Funding for the rainbow clinic has been approved. Once this is in place, and the consultant lead is named; it is likely MTP will be able to advise MTAC to consider this action 'Delivered, Not Yet Evidenced'. MTAC accepted an exception report to this effect at their August 21 meeting and agreed a revised date for both delivery and evidencing of February 2022.		28/02/22		Hayley Flavell	Shirley Jones	

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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	The escalation policy already in place; it was updated in November 2020 to describe situations where Consultants must be in attendance. A process is in place to assess competencies of all middle grade doctors, not just O&G trainees. At their meeting on 22/04/2021, MTAC accepted status 'Delivered, Not Yet Evidenced' based on the escalation process poster that is displayed on the wards. In order to progress to 'Evidenced and Assured Status', the committee next wish to see the completed guidelines / SOP document, and an audit of adherence to them. This formed part of the pilot case notes audit, but the evidence regarding this section (Q7 c and d and Q8) was inconclusive. Accordingly, the wording of the associated questions within the audit tool has been made more specific and explicit, and the next round of audit will be commenced as soon as possible. In the meantime, the deadline having been missed, an exception report has been prepared and was accepted by MTAC at their September meeting.	22/04/21	28/02/22		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~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	SaTH's 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. MTAC noted at their August 21 meeting that completion of this action is reliant on several external dependencies that are not within SaTH's control to implement. The main one is the establishment of the regional Maternal Medicine Specialist Centres. The original (self-imposed) June deadline having been missed, MTAC were provided with an exception report, which they accepted - including the proposal that the delivery and evidence dates be left blank until a clearer timeline from the regional Clinical Network is available. However, in the meantime, the service must ensure that all relevant guidelines covering care for women with co-morbidities (for example cardiac conditions) should be reviewed, and where necessary, updated. Furthermore, the service should draft guidelines for referral to specialist maternal medicine centres (acknowledging that the guidelines are the prerogative of the Network), that can be finalised once the centres are nearing implementation.				Hayley Flavell	Guy Calcott	

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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. Of note, the Ockenden report does not specify 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). However, the MTP group have not yet been able to secure audit evidence that the appropriate consultant is being nominated for all such cases requiring this level of care. The case notes audit (the tool for which is currently being revised, following the pilot audit and in preparation for the imminent re-audit) should help to evidence this. However, the action having missed its intended (self-imposed) deadline for evidencing, an exception report has been prepared and was accepted by MTAC at their September meeting.	22/04/21	28/02/22		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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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 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	31/03/22	Not Yet Delivered	On Track	Anaesthetists participating in MDT ward rounds and running / participating in MDT emergency obstetrics course simulation centre, approximately 3 x per year. The Lead obstetric anaesthetist is a key facilitator in weekly in situ simulation training and the service has recently recruited a new anaesthetist with deep experience in sim traning design to further support. The training includes obstetricians, anaesthetists of all grades, ODPS & other theatre staff and midwives of all grades (incuding students and co-ordinators). More than 90% of Obstetric anaesthetists completed the online PrOMPT course by April 2021, and there is planned Involvement of anaesthetists in PrOMPT training for the remainder of 2021 and into 2022 – both as facilitators and participants. The service has also identified an obstetric anaesthetic consultant to join the weekly teaching faculty. Once this is is in place, and all of the above points sufficiently evidenced, it is likely MTCA will be in a position to accept this action as 'Delivered, Not Yet Evidenced'. Given the complexity, scale and challenges of fully meeting these actions, MTAC, at their August meeting, accepted the proposal mooted at the July ORAC, that all actions relating to Obstetric Anaesthesia should have the delivery and evidence deadline extended to March 2022. In the meantime, the Trusts interim co-medical directions will meet with the Obstetric Anaesthesia lead and other senior leaders in the Trust's anaesthesia services to ascertain what further support is needed. MTAC stated a requirement for a full progress updated on all of these actions to be provided no later than their December meeting, to ensure that they are on track to meet the revised deadline.		31/03/22		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	31/03/22	Not Yet Delivered	On Track	There is good engagement with anaesthetics department, but this is over-dependent on the contributions of the obstetric anaesthesia lead, and must therefore be broadened. Two consultants have been appointed to take on this role, and evidence of this will be shared in due course. The consultant Anaesthetics Lead for Obstetrics is working closely with Clinical Director for obstetrics to ensure that anaesthetics staff are fully-embedded in the delivery of safe and effective care. The lead is also a principal office in the planned establishment of a high-dependency service for mothers within maternity / neonatal care - this is a multi-disciplinary initiative. Notwithstanding this, MTAC recognised the complexity involved in implementing the actions associated with Obstetrics Anaesthesia, and granted a deadline extension for this action to March 2022, with an update required no later than December 2021.		31/03/22		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	31/03/22	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). The Guidelines review that was started this year is now almost complete, with two final sets to be finished. The audit of this is not yet in place, but will partly covered by the bespoke Ockenden Report Case Notes audit tool, with further resources to be provided as needed. Noting the scale of this task and the associated resources challenges, MTAC agreed a deadline extension to March 2022 for this task, adding a requirement for a formal update no later than December 2021.		31/03/22		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	31/03/22	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: “When to Call a Consultant” has been completed and published on the SaTH intranet document library. Compliance of completed CPD sessions is in progress of being collated and audited by a member of the anaesthetics team. As with all of the actions derived from this section of the report, in the light of the complexity and scale of this action and the associated challenges, MTAC approved a revised delivery and evidence date of 31/03/2022 at their August 21 meeting, but require a formal progress update by their December meeting.		31/03/22		Hayley Flavell	Shirley Jones	Link to SaTH Anaesthetics Document Library

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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	31/03/22	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. The QI task requires a significant level of audit against multiple data points; this represents a significant challenge in the light of limited resources. The Trust's QI team have agreed to support the implementation of the methodology, but only once the data set has been secured. Accordingly, and as with all of the actions derived from this section of the report, in the light of the complexity and scale of this action and the associated challenges, MTAC approved a revised delivery and evidence date of 31/03/2022 at their August 21 meeting, but require a formal progress update by their December 2021 meeting.		31/03/22		Hayley Flavell	Shirley Jones	
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	31/03/22	Not Yet Delivered	On Track	Obstetric Anaesthetist expertise is incorporated to regular Datix reviews and these colleagues also provide regular input to 'Human Factors' investigations. The Trust recognises the need for Anaesthetics consultants (other than the obstetrics anaesthesia lead) to dedicate SPA time to Obstetrics in additionin order to progress this action, and this will require audit evidence. It represents a significant challenge to the service in its current format, hence MTAC approved a revised delivery and evidence date of 31/03/2022 at their August 21 meeting, but require a formal progress update by their December meeting.		31/03/22		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	SaTH have proved compliance Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, safety action 8, which governs multi-disciplinary training for emergencies including neonatal resuscitation. A simulation course is held 3 x per year, and In situ simulation training conducted weekly. 90% of obstetric anaesthetists submitted evidence of completion of the online PrOMPT course by April 2021. MTAC accepted this as 'Delivered, Not Yet Evidenced' at their first meeting in April 2021, 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. It was agreed at this time that the demonstrated fulfilment of CNST MIS Safety Action 8 will move this to 'Evidenced and Assured Status', however attendance records had not been secured in time for the September MTAC meeting, and will therefore be shared at the October meeting, at which point it is likely MTPG can advise MTAC to accept the action as 'evidenced and assured'.	22/04/21	31/03/22		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	Evidenced and Assured	Completed	Roll out of combined medical and nursing notes to Neonatal Unit (NNU) was implemented soon after receipt of the Ockenden Report, in Q4 2020/2021. The NNU undertook to ensure information on joint medical and nursing note keeping held on all staff induction. Adherence to the above is monitored via an audit, designed and conducted by one of our consultant neonatologists. MTAC approved this as 'Delivered, Not Yet Evidenced' in April 2021 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. Having been provided with the evidence of subsequent audits proving compliance, MTAC accepted the action as 'Evidenced and Assured' in their September meeting. To further embed the action, NNU will repare a business case for Neonatal Badgernet EPR, which wil align efficiently with the system that was introduced to Materntity Services in August 2021.		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	Evidenced and Assured	Completed	Confirmation was received on 16-Aug-21 from Dr R Kennedy (Associate Medical Director NHSE/I Midlands) that, following his discussion with the ODN Medical Leads (neonatologists) and they are in agreement that compliance with the WM ODN Pathway framework, BAPM Guidance on Good Practice for LNUs and the NHSE Commissioning Guidance for Neonatal Care is sufficient. Additionally, he recommended a local SoP be developed which sets out escalation, triggers for level three unit consultation and referral, compliance with which should form part of the audit schedule. The SOP is in place. Based on this, MTAC accepted this action as 'Evidenced and Assured' in their September meeting, with the proviso that the sudit of adherence to the SOP should form part of the ongoing audit schedule.	14/09/21	30/06/21	14/09/21	Hayley Flavell	Shirley Jones	
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	Evidenced and Assured	Completed	The issue of a split Tier 2 rota due to the size of the paediatric department is being developed actively. The neonatal unit is compliant with BAPM staffing and activity for medical/ANNP staff with a combined rota but the activity and size of paediatrics has led the Deanery to recommend a split Tier 2. SaTH have now recruited a seventh Consultant Neonatologist, with an expected start date of January 2022. Given evidenced compliance with the BAPM guidelines (externally checked and validated by Dr Kennedy, Medical Director NHSE/I Midlands), and assurance that the recruitment of the seventh consultant has been conducted, MTAc accepted this action as 'Evidenced and Assured' in their September meeting.	12/01/21	31/10/21		Hayley Flavell	Janine McDonnell	

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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
4.100	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	Not Yet Delivered	On Track	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. However, the plans stalled as SaTH were not able to reelease consultants for attachments at the same time as maintaining a safe rota: a seventh consultant would be needed for this. Accordingly, the action was moved back to 'Not Yet Delivered' status. SaTH has subsequently recruited a seventh neonatal consultant and reconfirmed agreement from the Neonatal Departments at Stoke and Birmingham Women and Children's Hospitals to accept our neonatal staff (both consultants and Advanced Neonatal Nurse Practitioners) on rotational attachments (2 weeks per year). This has been introduced to consultants' Job Plans. However, this consultant will not be able to start at the Trust until January 2022. MTAc accepted an exception report detailing this at their September meeting, and agreed a deadline extension to February 2022.		30/10/21		Hayley Flavell	Janine McDonnell	SaTH NHS SharePoint

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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	On Track	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	Evidenced and Assured	Completed	MTAC (at July meeting) approved 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. Subsequently, an audit was carried out to check that an external specialist had been a panel member at the relevant meetings was conducted and proved compliance. MTAC therefore accepted the action as 'Evidenced and Assured' at their August meeting.	13/07/21	31/07/21	10/08/21	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	TBC	Not Yet Delivered	Not Started	SaTH have embarked on a review of membership of LMNS with a view to joining a larger LMNS - this includes a review of current structure and work streams to ensure adequate and effective oversight. LMNS and CCG have implemented t the Perinatal Clinical Quality Surveillance Model, which includes SaTH, and have supplied 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. However, the NHSEI minimum evidence requirements for IEAs, published in May 2021, do not allude to this specific action. Given the large number of external dependencies on which the action is contingent, and to avoid arbitrary deadlines, MTAC agreed that the delivery and evidence date should be amended to 'to be confirmed', pending clarity on this process.		TBC		Hayley Flavell	Hayley Flavell	
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	TBC	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. 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. Work to formalise a regional partnership is ongoing. At their August meeting, Match acknowledged that this is a major strategic decision for SaTH and is also dependent on a significant number of external deliverables and partners. In order to avoid arbitrary deadlines, MTAC agreed that the delivery and evidence dates for this should be marked as 'to be confirmed', pending greater clarity. All actions with no assigned date will be reviewed on at least a monthly basis to check whether enough clarity has been obtained to be able to move forward with the action.		TBC		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	Evidenced and Assured	Completed	MTAC accepted this as 'Evidenced and Assured' at their August-21 meeting, based on the evidence provided: CCG Terms of reference and published list of members; showing that the LMNS chair is a member of the CCG's board. Subsequently, SaTH's Maternity and Neonatal Safety Champion now benefits from the addition of the CCG's Senior Quality Lead and Patient Safety Specialist, further strengthening the promotion of the safety agenda between CCG, LMNS and the Trust.	31/01/21	30/06/21	10/08/21	Hayley Flavell	Hayley Flavell	
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	28/02/22	Not Yet Delivered	On Track	SaTH recognise the need to review and strengthen SI reporting process to Trust Board and LMNS - a quarterly report to Trust Board, using peer as example of reporting process, must be part of this. 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 remained 'Not Yet Delivered'. At MTAC's August meeting, the committee still felt this action is not being met sufficiently. At their September report, they agreed a further exception report requesting a delivery and evidence extension to February-22 to give time for the ongoing governance review to be completed and embedded (this action will form a key part of the review). 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		28/02/22		Hayley Flavell	Shirley Jones	

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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 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	TBC	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. This not being within SaTH's control, there is no requirement or benefit in marking the action as 'Off Track', further, MTAC agreed at their August meeting to amend the delivery and evidence dates to 'to be confirmed' pending clarity on a national level as to when and how these roles will be created.		TBC		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	TBC	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'.		TBC		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	SaTH has a Non-Executive Safety Champion in post with oversight of Maternity Services, and an Executive Safety Champion in post – Trust Executive Medical Director (Interim co-Medical Directors currently representing). All of these post-holders are active members of the Maternity and Neonatal Safety Champions Group, and participate on a monthly basis in this group's 'walkabouts' and meetings. The actions was 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.	22/05/2021	30/04/21	08/06/21	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	TBC	Not Yet Delivered	On Track	Action to be discussed with CQC at relationship meeting. It is understood the MVP were not contacted by CQC at their most recent inspection of SaTH. 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'; there is no reason or benefit in marking 'Off Track' as the action is not within our control and there is no escalation route. MTAC agreed at their August meeting that the delivery and assurance dates should be left 'to be confirmed' until greater clarity can be obtained from CQC and other parties.		TBC		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	Delivered, Not Yet Evidenced	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 Identified Obstetric anaesthetic lead with Human Factor specialist interest attends MDT training. MTAC (at July meeting) approved 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. The approved MDT funding bid and MTP training allocation are being implemented - for example, SaTH has 25 places on both Baby Lifeline's Management of the Sick and Deteriorating Woman and Learning From Adverse Events courses in November. SaTH has also invested in enhanced Clinical Practice Educator roles and training backfill for midwives and consultants as well as PA to deliver PROMPT and CTG training. Upon confirmation and evidencing that LMNS are receiving quarterly reports on this activity, the action will be recommended for acceptance as 'Evidenced and Assured'.	13/07/21	30/10/20		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	Evidenced and Assured	Completed	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 must a daily sheet that records the ward round and a Monthly audit of attendance at Ward Rounds has been introduced. SaTH has recruited a number of additional consultants over the summer of 2021, with more recruitment ongoing. 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. Based on evidence of the audit mentioned above, MTAC accepted the action as 'Evidenced and Assured' in their August 21 meeting.	22/04/21	30/06/21	10/08/21	Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
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	Evidenced and Assured	Completed	SaTH have 13 associated proposed business cases comprising investment of up to £5.1m across all Women and Children's specialties with a further £0.3m provided by the LMNS. Included in this request is up to 102 members of staff, of which 55 would be permanent additions. Of this, the Maternity Transformation Programme has been allocated £1.35m of which £190k (14% of the total) has been set aside for training, the bulk of which is multi-disciplinary. Further, the Trust has been awarded £55k of part of the national response, which has been ring-fenced for PrOMPT, fetal monitoring training and instruction, and associated backfill for clinical time. Al of this is being reported regularly to MTAC and has been approved by the Director of Finance. Accordingly, MTAC accepted this as 'Delivered and Evidenced' at their August 21 meeting.	10/08/2021	30/09/21	10/08/21	Hayley Flavell	Hayley Flavell	

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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 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	Delivered, Not Yet Evidenced	On Track	All women with complex pregnancies have a named consultant lead. Appropriate risk assessment documented at each contact A formal auditing process has commenced and will be report to respective local governance meetings. This includes a review of Midwifery led cases for appropriate referral onwards, to be undertaken. Based on this, as well as the evidence already reviewed and accepted for LAFL 4.54, MTAC approved this as 'Delivered, Not Yet Evidenced' at their July meeting.	13/07/21	29/10/21		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	Delivered, Not Yet Evidenced	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. 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. An audit has commenced to test that correct referrals are being made at all times. Connections to the regional maternal medicine specialist centres, which are being rolled out, are being developed in order to achieve holistic solution. Based on this, and the fact the NHSEI minimum evidence requirements were the same as for IEA 4.1 (and similar to LAFL 4.54, which has already been delivered), MTAC approved this as having been 'Delivered, Not Yet Evidenced' at their July 2021 meeting.	13/07/21	29/10/21		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	TBC	Not Yet Delivered	On Track	The location of the regional centres has been divided upon by the clinical network, but the centres have not yet been set up. SaTH will act to formalise connections with specialist maternal medical centres once established This action was one of six that MTAC, at their August 21 meeting, accepted as being outside of the direct control or ability of SaTH to implement - the specialist centres are being established under the oversight of the regional clinical network. Therefore, MTAC agreed that the delivery and evidence dates should be set as 'to be confirmed' pending an update from the network. This is to be monitored closely by divisional clinical and managerial leads, and as soon as the details are known, the action plan must be updated and implemented with urgency. Given that we do not have an clear indication of timeline for this action, there is no benefit in marking it 'off track' hence status has reverted to 'on track'.		TBC		Hayley Flavell	Guy Calcott	
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 accepted as 'Delivered, Not Yet Evidenced' in April 2021. Since then, SaTH has become an early implementer of the Perinatal Mental Health Service, under the leadership of one of the Transformation Midwives. The clinic is now in the course of being set up, with specialist midwives and psychologists recruited. Once this has had time to establish itself, an update will be shared (to include details of how it is integrated regionally); this is likely to be suitable evidence to move the action to 'Evidenced and Assured'.	20/04/21	29/10/21		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.

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 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. Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact 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 specified that 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. This latter evidence was still not available as of the MTAC meeting in September. Accordingly, an exception report was provided. This explained that the evidence collated on this point from the pilot Ockenden Report case notes audit was inconclusive, and that accordingly the tool is in process of being modified preparatory to a second audit as soon as possible. This combines with the implementation of Badgernet in mid-August 21 to give confidence that the evidence will be available in the next few weeks. However, a significant deadline extension (to February 2022 from June 2021) for evidencing this was requested, to ensure the audit data can be analysed and acted upon before reporting back to the committee.	22/04/21	30/06/21	28/02/21	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 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). The audit evidence to support this action's move to 'Evidenced and Assured' status was still not available as of the MTAC meeting in September. Accordingly, an exception report was provided. This explained that the evidence collated on this point from the pilot Ockenden Report case notes audit was inconclusive, and that accordingly the tool is in process of being modified preparatory to a second audit as soon as possible. This combines with the implementation of Badgernet in mid-August 21 to give confidence that the evidence will be available in the next few weeks. However, a significant deadline extension (to February 2022 from June 2021) for evidencing this was requested, to ensure the audit data can be analysed and acted upon before reporting back to the committee.	22/04/21	30/06/21	28/02/21	Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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.

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 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	Evidenced and Assured	Completed	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 was accepted as 'Delivered, Not Yet Evidenced' at the July 2021 MTAC meeting, 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. It was noted that the requirements are closely linked to those of LAFL 4.56, which has also been accepted. MTAC accepted the action as 'Evidenced and Assured' at their September meeting based on the evidence provided as part of the NHSE/I minimum evidence requirements for IEAs. The committee did note, however, that formal response from NHSE/I as to the level to which this evidence supports proven completion of the action is still pending, and this must be factored in upon receipt. Further, ongoing evidence of the CTG training and activities will be expected (as with all of the Ockenden Report actions).	13/07/21	31/08/21	14/09/21	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	Delivered, Not Yet Evidenced	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. The two fetal monitoring midwife leads have now been in post for several months and have provided evidence of a multiple well-attended fetal monitoring training days throughout the spring and summer, 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, MTAC (at their July meeting) accepted this as 'Delivered, Not Yet Evidenced'. Given the evidence deadline is in October, MTP will not ask for acceptance of this action as 'Evidenced and Assured' until the October 21 MTAC meeting, so that more examples of training activities and SI involvement (as appropriate) can be shared with the committee.	13/07/21	30/10/21		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	Evidenced and Assured	Completed	SaTH benefits from the close oversight of the SBL care bundle by a senior project midwife (1.0 WTE) who will remain in the post for at least another 24 months. The Trust declared compliance with all required elements of the Saving Babies Lives v2 Care Bundle for the year three CNST MIS scheme. The evidence for this was robustly tested at MTAC and other governance forums as well as specialist senior midwifes from NHSE/I and our Sherwood Forest Hospitals NHS Foundation Trust partners. MTAC therefore accepted the action as 'Evidenced and Assured' at their August 21 meeting.	13/08/21	15/07/21	13/08/21	Hayley Flavell	Shirley Jones	

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.

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 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). Digitalisation of patient records, through the implementation of the Badgernet system (now introduced) will ensure this data is available in digital format. The system can also alert clinicians if a mother has not accessed the information, prompting a discussion as to whether further support is needed. The Communication and Engagement workstream includes MVP and patient representation; our MVP colleagues conducted a comparison of SaTH's online provision with that of other Trusts; this will inform ongoing digital improvements as part of the MTP. MTAC approved this to 'Delivered, Not Yet Evidenced' status based on the evidence referenced for LAFL 4.55, including online and handheld information. However, this action is slightly different from the corresponding LAFL as it emphasises the different points of the pregnancy, and the Trust is developing new leaflets on these specific areas in partnership with the MVP. Therefore, at their September meeting MTAC accepted an exception report explaining that the results on this point from the pilot case notes audit were inconclusive (the tool is being amended accordingly). Further, the digital updates have not been significantly progressed, and finally, SaTH have not yet agreed a method by which we can test service user feedback, via MVP data and with their input and support. For this reason, an evidence deadline extension to February 2022 was accepted.	10/08/21	28/02/22		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	Delivered, Not Yet Evidenced	On Track	Work is on-going as part of the Antenatal Care Pathway sub-project. The Ockenden Report case notes audit and automatic audits from the Badgernet system will help us to ascertain whether the mother and partner / family have received and consumed the information as intended. MTAC decided in their meeting on 22/04/2021 that this should remain 'Not Yet Delivered', as they were not satisfied the Trust has 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. MTAC accepted an exception report with revised delivery date 30/04/21 to 31/07/21 and evidence date from 30/06/21 to 30/09/21. In their August 21 meeting the accepted the action as 'Delivered, Not Yet Evidenced' based on audit data, minutes from the Birth Options clinic, and evidence of greater liaison and co-production with the MVP, including the new 'UX System'. To move the action to 'evidenced and assured', MTAC require proof that women report, via MVP channels, that they feel empowered to make decisions about their care. The evidence deadline has not changed, because it is feasible to have this evidence ready for the next MTAC meeting (October), in which case the missed deadline will only be slightly out of tolerance. By this time, it is also likely the Trust will have received formal feedback as to the level to which the evidence submitted to the NHSE/I minimum evidence portal for IEAs is deemed by that organisation to have met the standard.	10/08/21	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 dedicated PALS officer has been appointed to Maternity Services to offer in-reach and provide real time feedback. MTAC approved this to 'Delivered, Not Yet Evidenced' in their April 21 meeting, 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. To move the action to 'evidenced and assured', MTAC require proof that women report, via MVP channels, that they feel empowered to make decisions about their care. The evidence deadline has not changed, because it is feasible to have this evidence ready for the next MTAC meeting (October), in which case the missed deadline will only be slightly out of tolerance. By this time, it is also likely the Trust will have received formal feedback as to the level to which the evidence submitted to the NHSE/I minimum evidence portal for IEAs is deemed by that organisation to have met the standard.	22/04/2021	28/02/21		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.

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 deadline 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	
Guy Calcott	Obstetric Consultant	Lead: Clinical Quality and Choice Workstream	
Vicki Robinson	W&C HRBP	Acting Lead: People and Culture Workstream	
Shirley Jones	Interim Head of Midwifery	Lead: Risk and Governance Workstream and Maternity Improvement Plan	
William Parry-Smith	Obstetric Consultant	Lead: Learning, Partnerships and Research Workstream	
Mei-See Hon	Clinical Director, Obstetrics	Lead: Communications and Engagement Workstream	

Maternity Transformation Assurance Committee

Exception Reports Greed by MTAC in August (New deadlines to be confirmed)

Date: 10 August 2021

Prepared by:

Tom Baker

Senior Project Manager, Maternity Transformation

Ockenden Requirements Implementation: Exception Report (draft first reviewed by MTAC in July but revised date not assigned)

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. 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 and whilst improvements are being made, the MTP Group does not feel that 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 structure, systems and processes to settle into their role 3) Conduct an audit of recent serious incidents and externally-reportable investigations to ensure that all took place within the mandatory timelines. 4) Oversight to be provided on an interim basis by the Trust's Head of Patient Safety 5) Governance team to be further resourced with a specialist Risk and Governance Midwife and two further specialist midwives.
Recommendation	**What lessons have been learnt from this exception?**
The sub-plan for this particular action centres on the review being conducted. 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. Therefore, this was over-ambitious and is now being reconsidered.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Proposed revised delivery date:**	**To be confirmed**

Ockenden Requirements Implementation: Exception Report

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 the 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 corporate 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. 4) Oversight to be provided on an interim basis by the Trust's Head of Patient Safety 5) Governance team to be further resourced with a specialist Risk and Governance Midwife and two further specialist midwives.

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.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Proposed revised delivery date:**	**To be confirmed**

Ockenden Requirements Implementation: Exception Report

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
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Proposed revised delivery date:**	**To be confirmed**

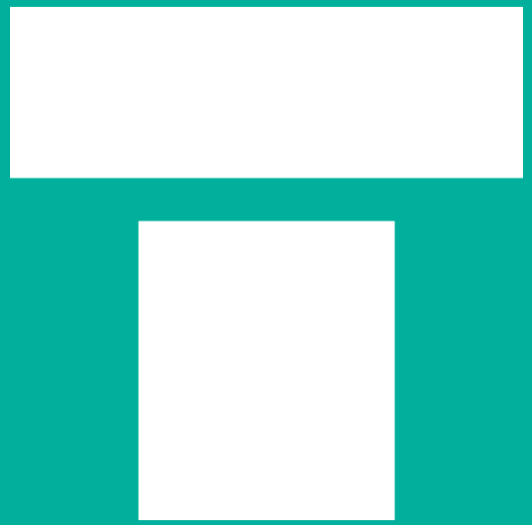
Estates and MES Quarterly Board Report – Jul/Aug/Sep 21

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Helen Troalen
Director of Finance

Will Nabih
Associate Director
Estates & Hospital Site Transformation



Estates Capital Programme Update

The Shrewsbury and Telford Hospital NHS Trust

Works to deliver £19.9M of centrally-funded investment for FY21/22 are underway ;

Major Schemes to be delivered in FY21/22 include:

RSH A&E reconfiguration (£9.3M) – Phase 1 " Majors" Complete & Operational.

RSH 32 Bed Modular Ward (£7.1M) – Start on site 1st Nov 21.

Community Diagnostic Hub (CDH) (£5.7m) – Design in progress

Newport Cottage Hospital X-ray replacement scheme (£500k)

Capital schemes currently underway will be completed in 21/22 including:

RSH MRI- CT RSH (£3.5M) – Now Complete & Operational.

Lingen Davies Clinic Rooms (£285k) - – in progress, completion Q4 FY21/22

There is also £7.8M allocated to address backlog maintenance (£5M) and Endoscopy build projects (£2.8M)

Estates Backlog Maintenance

The Shrewsbury and Telford Hospital NHS Trust

A total of £6M was specifically allocated for backlog schemes for FY20/21.

Due to a combination of the successful delivery of both the targeted maintenance and maintenance eradicated by default as part of the centrally-funded schemes, the impact on the backlog maintenance figures reported annually through the NHS Digital ERIC return is;

Previous submitted ERIC return for **FY 2019/20** backlog maintenance was;

RSH - £40.2M

PRH - £14.6M

(figures net and exclude VAT, consultancy support/fees, builders' prelims, optimism bias and contingencies)

On a cost indices 'like for like' basis the **FY2020/21** figures are;

RSH - £30.6M

PRH - £16.1M

This results in an overall **REDUCTION** of projected backlog maintenance costs of **£8.1M**

The latest refresh of the backlog condition survey carried out by third party specialist surveying consultants in collaboration with the Estates Teams accounts for increased deterioration, factors in additional maintenance items which have been identified since the last ERIC return and has also included a cost indexed annual uplift for inflation of the building costs of 2.5%

ERIC return for FY 2020/21 backlog maintenance is;

RSH - £31.3M

PRH - £16.5M (figures net and exclude VAT, consultancy support/fees, builders' prelims, optimism bias and contingencies)

The investments above are made annually to High and Significant risk backlog to ensure estates and engineering risk is kept to a minimum.

Capital Programme of Works – Update at Q2 21/22

The Shrewsbury and Telford Hospital NHS Trust

Capital Projects Programme of Works	Funding	No of Schemes being handled	FY 21/22 (£000)	FY 22/23 (£000)	Total Value (£000)
Strategic Capital	NHSI/E	1 Live 11 Feasibility	£16,400 £43,800		£16,400 £43,800
System based Projects **CDH / Newport Cottage X-ray**	ICS	2 Live	£6,200		£6,200
Backlog Maintenance **Endoscopy Build**	Trust Backlog Trust Endoscopy	25 Live 2 Live	£5,017 £2,845		£5,017 £2,845
Trust Funded Strategic Schemes (Radiology clinic rooms)	Trust Funds	1 Live 0 Feasibility	£300		£300
Adapt & Adopt / Diagnostic replacement	NHSI/E League of Friends	16 Live 3 Feasibility	£4,500 £4,450		£4,500 £4,450
Additional Funding (modular office at PRH)	Trust	Complete			
Totals		**47 Live** **14 Feasibility**	**£32,262** **£48,250**	**£0** **£0**	**£35,262** **£48,250**

Key Capital Schemes Highlight Report at Q2 FY21/222

The Shrewsbury and Telford Hospital NHS Trust

Key Strategic Schemes				
Project	**Deadline**	**Allocation**	**Status Report**	**Overall Project Stat**
SAU Clinical	**30 April 21**	**£1,740,722**	• Project Completed 30th Apr 21.	Completed
Emergency Care Allocation Schemes (YR 2)				
A&E Refurbishment	**31 March 22**	**£9,300,000**	• Phase 1 Majors – Completed & Operational 23rd Sept 21. • Phase 2 plastering works commenced 04th Oct 21. • Phase 3 Mechanical works due for completion 26th Oct 21. • Clinical Areas due for completion 31st Dec 21. Non Clinical by Mar 22.	
Adopt & Adapt Funding Scheme				
RSH CT & MRI Pod	**CT 9th August, MRI 23rd August 21.**	**£3,469,000 (£740k of total Trust Funded)**	• Completed 03rd Sept 21.	
Trust Capital Funding £1m				
PRH Modular Office Block	**25th June 2021**	**£702,000**	• Project Completed 25th June 21.	Completed

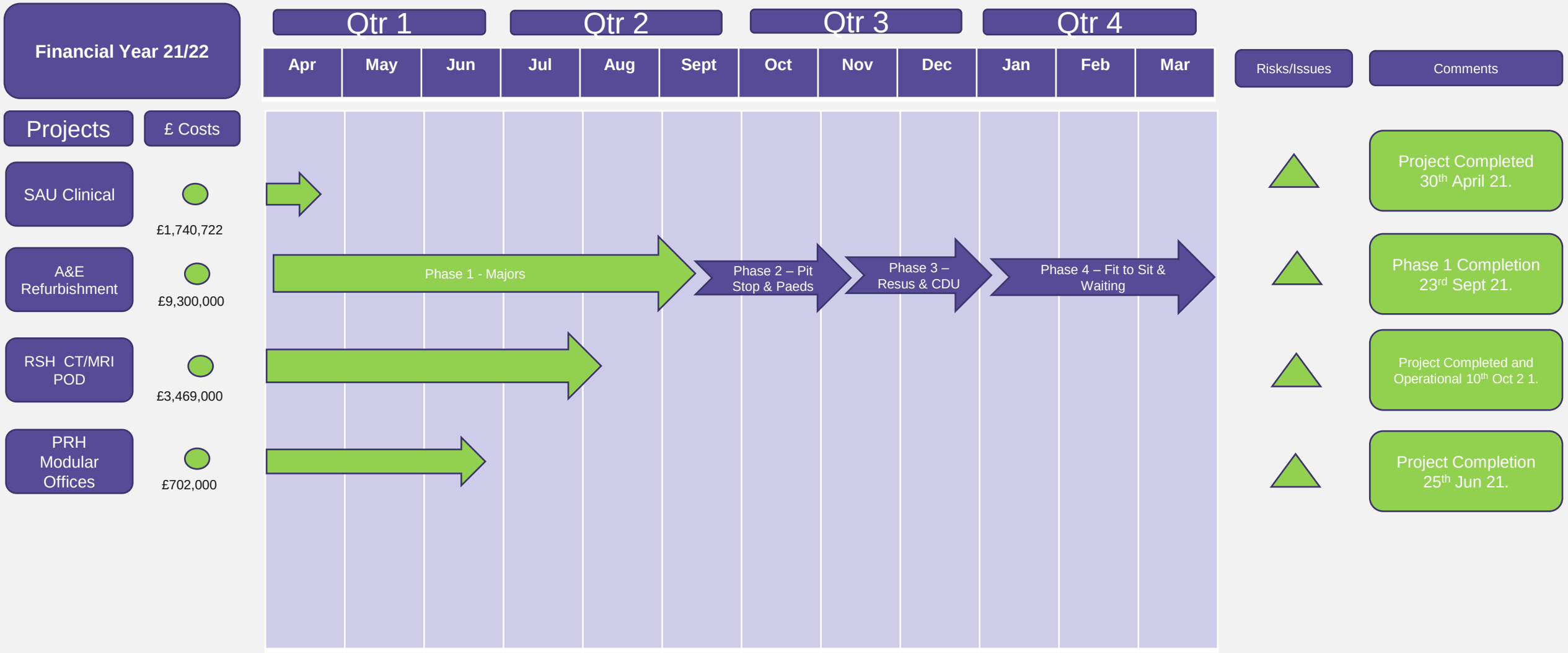
Key Capital Schemes Programme

£ Costs
- On Budget
- Change to Budget

Timescales
- On Time
- Delay to Programme

Risks/Issues
- Low Risk
- Area of Concern

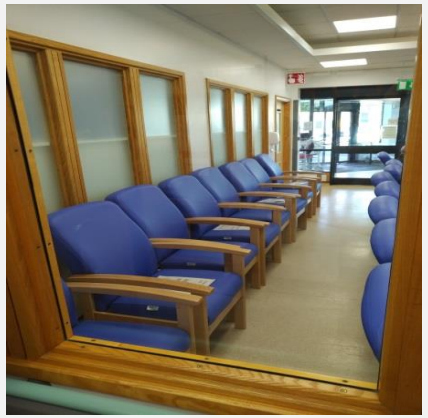
The Shrewsbury and Telford Hospital NHS Trust

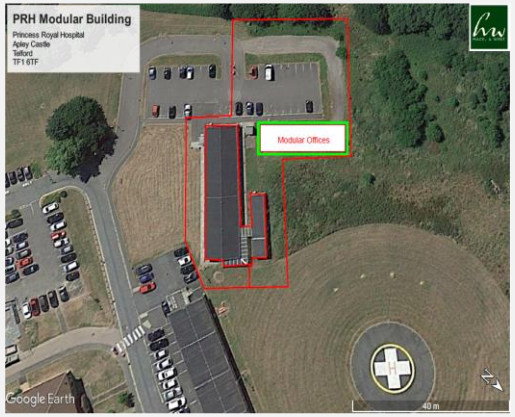


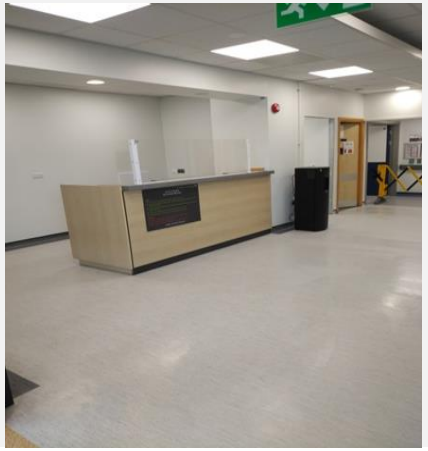
Key Capital Projects Visual Update @ Q2 FY 2021/22

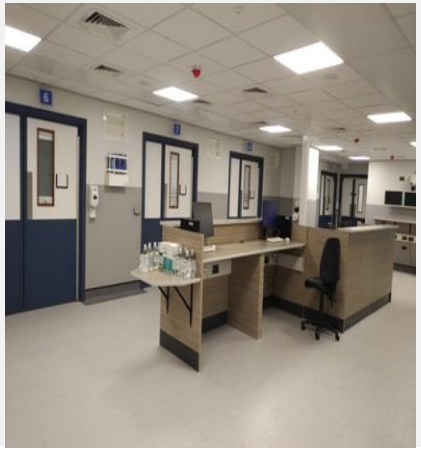
The Shrewsbury and Telford Hospital NHS Trust

Emergency Care Allocation Schemes- YR1	Emergency Care Allocation Schemes - YR2	Adapt and Adopt Funding	Trust Capital Funding	Trust Capital Funding
SAU Clinical	A&E Refurbishment	RSH CT MRI POD	PRH Modular Offices	RSH 32 Bed Modular Ward



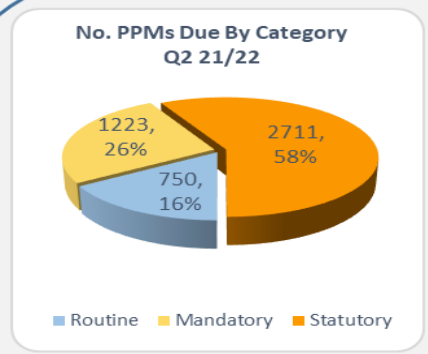


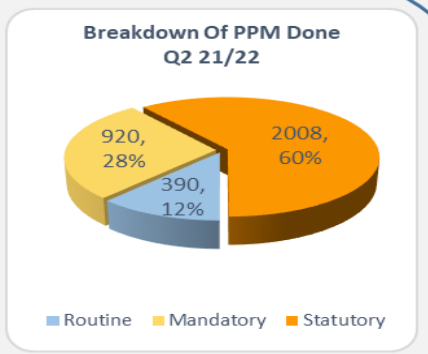


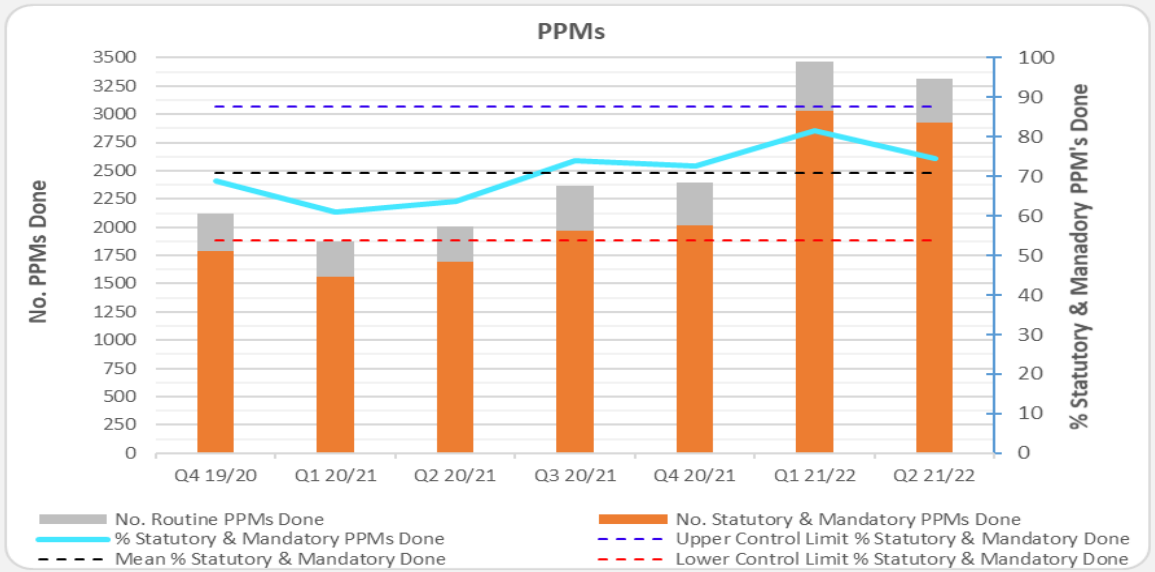


Estates Operations PPM and Reactive Compliance Key Metrics @ Q2 FY21/22

The Shrewsbury and Telford Hospital NHS Trust







Q1 = Apr-Jun Q2 = Jul-Sep Q3 = Oct-Dec Q4 = Jan-Mar

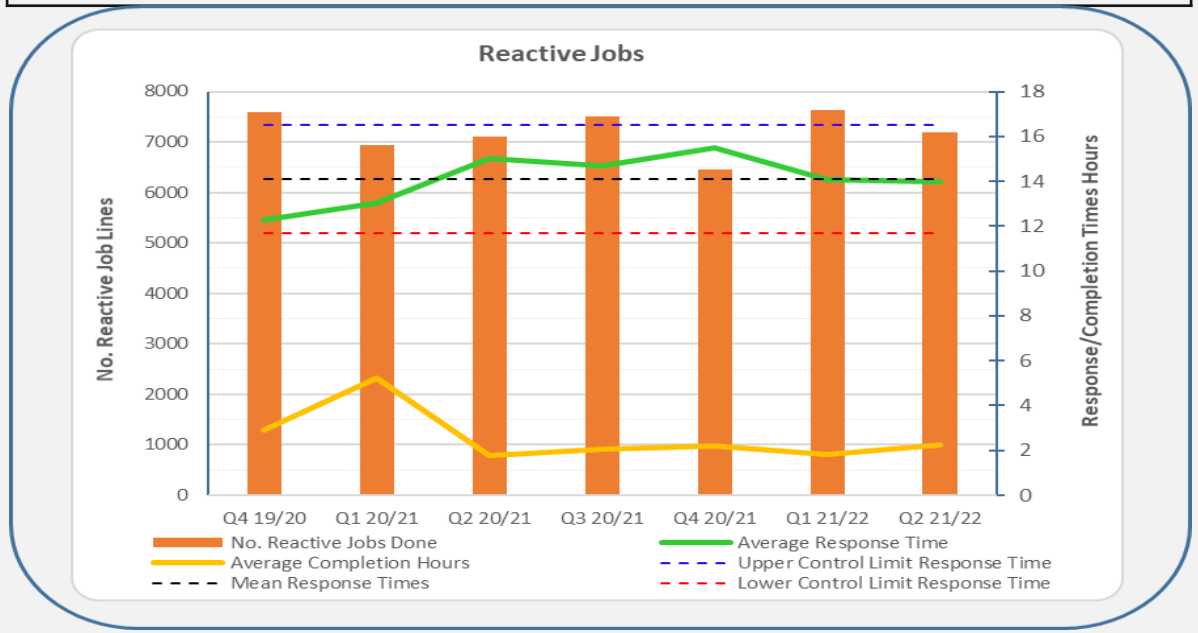
PPMs

- 3,318 PPMs completed.
- 74.4% of Statutory and Mandatory on time. Reduction in performance as a result of Covid period, backlog underway.
- MICAD reporting continues to be refined to provide more accurate data and following appointment of new co-ordinating AP roles.

Reactive Jobs

- 7,297 reactive job lines assigned, 7,185 completed 98.5%.
- Average response time 14 hours.
- Average completion time 2.3 hours.

Note: as reactive increases there will be an impact on PPM and vice-versa



Estates Compliance Key Metrics – Q2 FY21/22

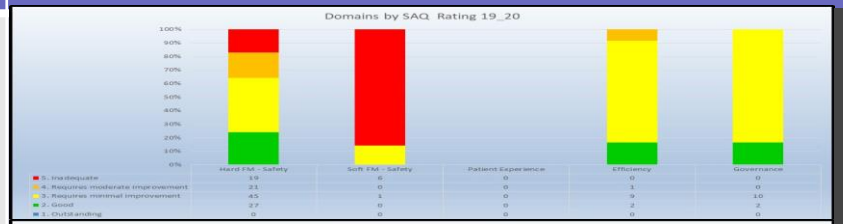
The Shrewsbury and

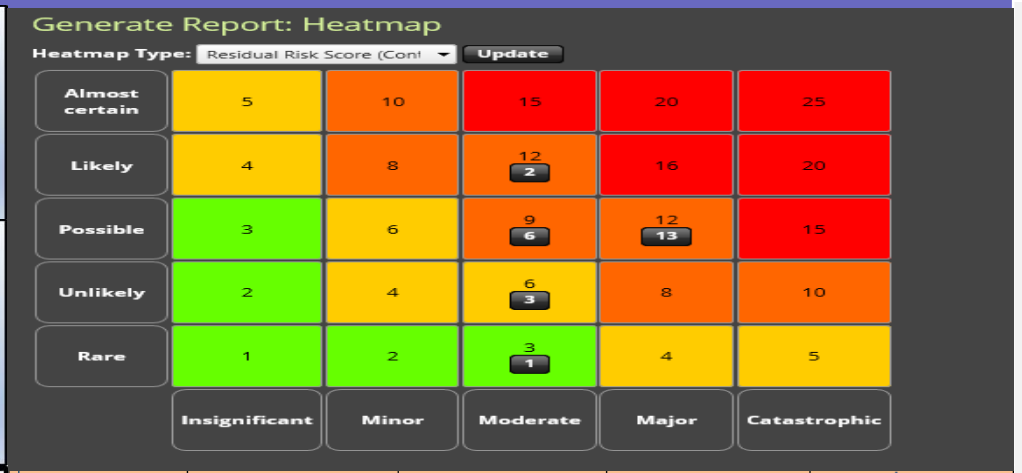
Area	Update

Premises Assurance Model- Compliance
Current PAM compliance for 20_21 = 75.6%
Compliance for 2019_2020 was 21.6%
Target for year end 2021 = 90%

Most "Yellow" is a result of policy and roles & responsibilities still not approved or actions owned by Facilities (Soft Safety)

Risks
25 open (21 Amber, 3 Yellow, 1 Green)

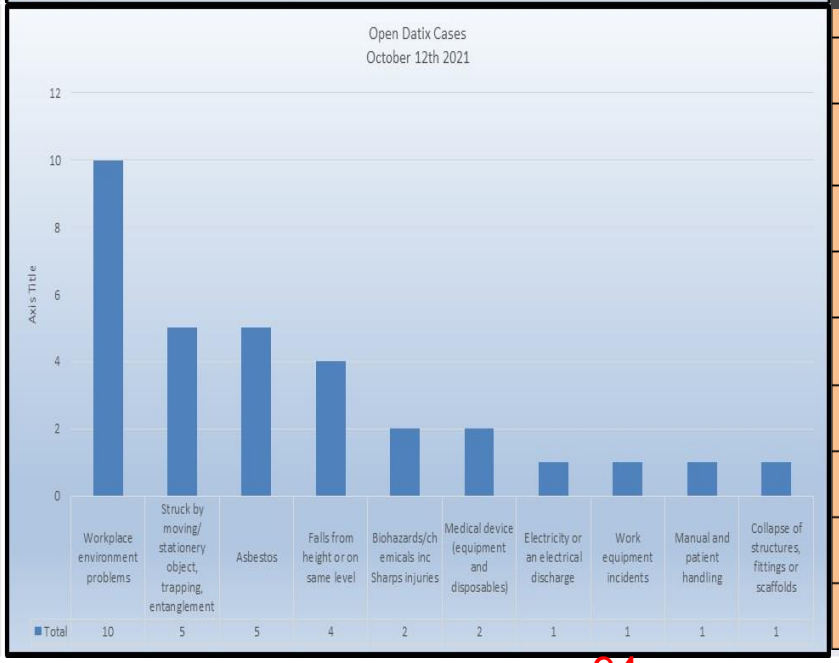




Policies – 9 documented
4 draft to issue to PAG in October (Electric, Lifts, PSSR, BCP & Pest Control)
4 under review/updates to be submitted to HSSF in December (Decontamination, Medical Gases and Heating & Ventilation & BCP)

Compliance Roles & Responsibilities
Current 84% compliant
Recruitment ongoing for Electrical, Fire, Lifts, Med Gas and Ventilation

Datix
32 open cases
5 "awaiting approval" by H&S team
18 reviewed and ready to move to "awaiting approval" stage
9 under investigation
Main issue: Workplace Environment (Equipment failure & heating issues)



Discipline	AE	Co-ordinating (Lead) AP	(Deputy) AP	Chair / Estates RP
Decontamination	Jim Tinsdeal	Dave Lewis (Phil Probert)	Stuart Conroy	Dave Lewis
Electrical Safety (LV/HV)	Nick Lane & Malcolm Partridge	Vacancy-1 (Dave Chan-HV & LV)	Steve Darlington Michael Williams	Dave Chan
Water Safety	Mike Koumi (Hydrop)	Shona Baugh	Martyn Henefer (Subject to Training)	Chris Hood
Medical Gases	Steve Goddard	Michael Williams	Vacancy-1	Dave Lewis
Specialist Ventilation	Ray Hughes	Derek Jones	Vacancy-2	Chris Hood
Fire	Darren Kirk	Vacancy-1	Stuart Leece	Will Nabih
Asbestos	Paul Bayliss (Tetratech)	Shona Baugh	Shona Baugh	Will Nabih
Lifts	Andrew Hicks Horsley TDS Ltd	Vacancy-1	Vacancy-2 Steve Darlington	Dave Chan
Pressure Systems	Anthony Fernandez	Andrew Baxter	Derek Jones	Dave Chan

Medical Engineering Services - Key Metrics @ Q2 2021/22

The Shrewsbury and Telford Hospital NHS Trust

Area	Update
MES	• Undertook commissioning of **952** brand new Medical Devices in Q1 • Planning and delivery underway of **£1.8M** FY21/22 device replacement programme with planned capital and revenue schemes • High risk PPM compliance **3.4%** below target (Being managed and addressed with risk register entry if not rectified by Q3) • There are over **33,000** assets being managed, an increase of approximately 952 this quarter. MES handled **6,062** jobs in Q2 • MES supporting Trustwide Bed/ Mattresses management project • Full Re-certification of Quality Management System ISO:9001 (2015) achieved in September 2021