The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 11 August 2022

SUPPLEMENTARY INFORMATION PACK

Containing additional information for agenda items

The Shrewsbury and Telford Hospital NHS Trust

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	26.05.2021	Janette Pritchard	Update
4.0	10.06.2021	Janette Pritchard, Joanne Yale, Rebecca Hawkins, Kath Titley	Update
4.1	11.06.2021	Kara Blackwell	Review and Update
5.0	05.07.2021	Janette Pritchard	Updated following publication of V1.6
5.1	01.09.2021	Janette Pritchard	Review and update
5.2	02.12.2021	Janette Pritchard	Review and update
6.0	06.01.2022	Janette Pritchard	Updated following publication of V1.8
6.1	11.05.22	Janette Pritchard , Kath Titley	Ambers reviewed
6.2	29.06.22	Janette Pritchard	Review and update following lates guidance changes

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
5.2	09.12.2021	IPC Operational Group	Janette Pritchard
6.0	11.01.2022	IPC Operational Group	Janette Pritchard

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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					
Systems and processes are in place to ensure:					
1.1	A respiratory season/winter plan is in place:	Draft plan in place			Amber
1.1a	That includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs prevalence, and care services	The Trust undertake Radi/POCT which are run from the lab	The Trust do not have a POCT so this does not take place in emergency care	Rapid test takes place in the lab Discussions are taking place to see if there is an opportunity to have POCT in ED	Amber
1.1b	To enable appropriate segregation of cases depending on the pathogen.	~~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~~ decision was made in the first week of June to remove curtains and screens based on a change in national guidance, and will be reviewed as scheduled on 11 July	Green
1.1c	Plan for and manage increasing case numbers where they occur	As above			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.1d	A multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	Draft plan in place (put draft in)			Green
1.2	Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Covid-secure risk assessments are supported by the H&S Team. See SaTH Intranet - New Ways of Working for supporting information and records of risk assessments received and approved by the H&S Team.	The H&S Team map risk assessments received to ESR cost codes to ensure 100% coverage of workplaces. This exercise reveals a very small number of areas not addressed, some of which are likely to be included within other risk assessments. Most now require review and updating to current guidance, given recent changes.	Templates and supporting information are published at SaTH Intranet - New Ways of Working and review dates are monitored by the H&S Team, and reports on current status monitored by the HSSF Committee. These include 2m or 1m+ social distancing measures according to local environmental constraints	Amber
1.3	Organisational/employers risk assessments in the context of managing seasonal respiratory infectious agents are:				
1.3a	Based on the measures as prioritized in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concer4n in the	Hierarchy of control, ventilation, space/ capacity (social distancing at 1m+) are addressed. Where a concern regarding ventilation			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	local area	is observed, support from Estates is available with H&S Team input. At time of writing, ventilation is not evaluated on a room-by-room basis. Prevalence and variants are not addressed in the covid-secure risk assessments but are taken into account in decision making at various Trust forums including Silver meetings, IPCOG, IPCAC etc.			
1.3b	Applied in order and include elimination; substitution, engineering, administration and PPE/RPE	Included in advice to managers completing local covid-secure risk assessments where appropriate.			Green
1.3c	Communicated to staff.	The Trust has adopted a model of local risk assessments, and managers are expected to communicate the outcome of the risk assessments to their own staff supported by posters, Communications Team updates, messages from Directors, etc. Risk assessments are published at SaTH Intranet - New Ways of Working in order to make them easily accessaible to staff.			Green
1.4	Safe systems of working; including managing the risk associated with infections agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Safe systems of work are contained in guidance within IPC policy documents and covid-secure guidance. These are approved via the appropriate governance committee/ meetings at Trust level. These are accessible via SaTH Intranet - Coronavirus Homepage.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.5	If the organisation has adopted practices that differ from those recommenced/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems	Practices are broadly in line with UK HSA, HSE and covid-secure guidance. Local variations with respect to RPE use have been adopted by way of learning from the Cambridge studies - Efficacy of FFP3 respirators for prevention of SARS-CoV-2 infection in healthcare workers (nih.gov). This is incorporated into IPC policy documents and supporting information including PPE posters.			Green
1.6	Risk assessments are carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents.	The H&S Team support managers with local covid-secure risk assessments and matters arising from those.			Green
1.7	If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	See 1.5, above – this is incorporated into IPC policy and reflected in PPE posters in recognition of inability to achieve 2m social distancing in most inpatient settings.			Green
1.8	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				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  SOP for Managing COVID Contacts whe	
1.9	The Trust Chief Executive, the medical director or the chief nurse has oversight of daily sitrep in relation to COVID 19, other seasonal respiratory infections, and hospital onset cases	"nosocomial" sitrep is signed off by either CE/MD/DoN			Green
1.10	There are check and challenge opportunities by the executive/senior leadership teams of IPC practice 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
1.11	Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	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-		~~Mediscreens and clear plastic curtains are in place on all ward areas to provide a physical barrier between patients.~~ decision was made	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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 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		in the first week of June to remove curtains and screens based on a change in national guidance, and will be reviewed as scheduled on 11 July	
1.12	The application of IPC practices is monitored e.g.				
1.12a	Hand hygiene	Training has taken place for all medical/nursing staff on PPE usage and Hand Hygiene. X:\StaffComplianceReports\Statutory & Mandatory Training Report			Green
1.12b	PPE donning and doffing training	All patient facing clinical and non-clinical staff have been trained to follow UKHSA 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
1.12c	Cleaning and decontamination	The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		monthly triangulated QWW at both ED sites in order to ensure there is timely identification and escalation of any issues			
1.13	The IPC 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(Latest board paper requested from Trust Board EA.			Green
1.14	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
1.15	The trust is not reliant on a particular mask type and ensure that a range of predominantly UK make FFP3 masks are available to users as required	The H&S Team runs RPE fit testing sessions via a core of 3 WTE staff plus 2 WTE Ashfield fit testers at Jan 22. The H&S Team Manager sets a priority order for a total of 10 FFP3s in fit testing practice which aims to fit as many staff as possible to a UK Make FFP3. In current fit testing data it is notable that there is a reliance on Alpha Solway (Globus) products, however this is considered tolerable as these are UK Make products. Fit testing results are published at SaTH Intranet - FFP3 Mask Fit Testing by the Corporate Education and H&S Teams			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		on a regular basis, usually weekly and shared with Incident Command Centre, IPC, Procurement and Communications colleagues via email.			
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	The Trust has a plan in place for the implementation of the national standards of healthcare cleanliness and this plan is monitored at board level.	Implementation reported via IPCOG and IPCAC which feeds through to Quality and Safety Committee. Paper being provided to IPCAC for February meeting on progress for implementation for 1 April 2022 • The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways. • The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. • Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. This is monitored via IPCAC			Green
2.2	The organisation has systems and processes in place to identify and communicate changes in the	The Trust have a space utilisation group which is responsible to communicate changes			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	functionality of areas/rooms				
2.3	Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily detergent and water/tristel (dependant on pathway) 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 UKHSA guidance) and cleaning records are completed.			Green
2.4	Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	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
2.5	Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance	The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways. 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 facilities managers now form part of a monthly triangulated QWW at both ED sites in order to ensure there is timely identification and escalation of any issues			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
2.6	If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Currently no alternative is used			Green
2.7	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Facilities SOP follows recommended contact time of 5 minutes.			Green
2.8	A minimum of twice daily cleaning of: • Patient isolation rooms • Cohort areas • Donning and doffing areas • 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails • Where there may be higher environmental contamination rates including: • toilets/commodes particularly if patients have diarrhoea.	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily detergent and water/tristel (dependant on pathway) 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 UKHSA 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. The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			
2.9	A terminal/deep clean of inpatient rooms is carried out: • Following resolutions of symptoms and removal of precautions • When vacated following discharge or transfer (this includes removal and • disposal/or laundering of all curtains and bed screens) • Following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	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
2.10	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. • Compliance with regular cleaning	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	regimes is monitored including that of reusable patient care equipment				
2.11	As part of the Hierarchy of controls assessment; ventilation systems particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.	• 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
2.12	The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer.	Annual audit undertaken by AE. This took place in Nov 2021 The estates department & ventilation group reviewed the report in February & reported no significant failings			Green
2.13	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	Ventilation monitored by wards x 4 daily. This involved ensure windows are open for at least 10 minutes		Current risk assessments refer to the need to increase ventilation by opening windows/ doors where possible. Operational capacity is addressed with	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				reference to room occupancy, and social distancing measures e.g. in waiting rooms which limit throughput of people in a given time period. Co2 monitors are currently being fitted on some wards by estates (June 22)	
2.14	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• 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
2.15	Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group	Wherever the situation arise ventilation safety group is made aware & discussion takes place			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
2.16	When considering screens/partitions in reception/waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place	~~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~~ decision was made in the first week of June to remove curtains and screens based on a change in national guidance, and will be reviewed as scheduled on 11 July	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 and Stewardship, including choice,	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. E-Script program still	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 stocked must be requested through a	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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.	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.	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	Previous antimicrobial history is considered	• During medicines reconciliation by pharmacy on admission previous antibiotic courses are noted but no policy currently in place for formalised review. • Multiple antibiotic courses whilst in hospital are queried by the pharmacy medicines management	No data on whether prescribers review previous antibiotic treatment in all cases. Capacity and flow mean that pharmacy do not see all patients within 24hours of		Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		team.	admission.		
3.3	The use of antimicrobials is managed and monitored: • To reduce inappropriate prescribing • To ensure patients with infections are treated promptly with correct antibiotic	• Medicines management pharmacy team review antibiotics prescribed on drug chart and query off guideline usage, long courses, intravenous to oral switch etc. • Interventions recorded in escript pharmacy program. • Wards have specific stock lists of antibiotics appropriate to their area. In addition all areas have either a sepsis box/drawer or trolley stocked with antibiotics required for the prompt treatment of sepsis.	Availability of electronic prescribing will assist in ability to monitor and query antimicrobial prescribing. Feedback at time if any issues identified in prescribing, followed up by ward pharmacy teams.	• See section 3.1	Green
3.4	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Monthly reports on antimicrobial spend sent out to care groups. • Monthly snapshot audit of antimicrobial prescribing undertaken by medicines management team. • Quarterly reporting to IPCOG and IPCAG.	Only generalised reports available currently due to lack of electronic prescribing.	• See section 3.1	Green
3.5	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	The Trust has a policy and procedure in place for sharps/ splash incidents including a post-exposure protocol administered with Occupational Health service support. IPC policies addressing specific pathogens are in place.			Green
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further					

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
support or nursing/ medical care in a timely fashion					
Systems and process are in place to ensure:					
4.1	Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Currently the Trust has started to allow visiting again. Add SOP			Green
4.2	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 patient's 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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
4.3	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment	As above 4.2			Green
4.4	There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing	Posters have been produced & are displayed in patient environment  leaflettemplateA5cov id copy.pdf  Covid Aware Patient Hygiene.docx			Green
4.5	If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Nurse in charge would inform visitor. There are also posters that have been produced & are displayed in patient environment  leaflettemplateA5cov id copy.pdf  Covid Aware Patient Hygiene.docx			Green
4.6	Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	 SOP Compassionate Visit			Green
4.7	Visitors are not present during AGP's on infectious patients unless they are considered essential following a risk assessment e.g. carer/patient/guardian	A conversation with the Health and Safety Team will be required, a risk assessment undertaken and provision of a Hood may be required. During office hours it may be possible to fit test			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		a visitor to an FFP3 depending on timescales and the Health and Safety Team can advise on availability of this service on request.			
4.8	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	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival	All wards have appropriate signage to differentiate pathways			Green
5.2	Infection status of the patient is communicated to the receiving organisation, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred	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
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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
5.4	Screening for COVID 19 is undertaken prior to attendance wherever possible to enable early recognition and clinically assess patients prior to any patient attending a healthcare environment.	The Emergency department have a SOP for admissions, which covers a process to risk assess all patients as they arrive in ED. ED have also introduced an ASK 5 audit to ensure that screening questions are asked during the booking in process and details entered to SEMA.  Navigator flow chart for PRH.docx  Navigator flow chart for RSH.docx  SOP Management of potential Coronavirus Samples from patients in both ED's have rapid tests performed.			Green
5.5	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID 19/other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	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
5.6	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Initial Assessment, Navigator and pit stop nurses are trained in Manchester triage ED also have Manchester triage train the trainer ED senior staff in both depts Screening questions also asked as part of the booking in process and are monitored via an ASK 5 audit. 100%			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		compliance for both sites recorded since early Sept 2021			
5.7	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Dashboard in place showing compliance with admission, Day 3, Day 5-7, day 13 and every 7th day afterwards swabs. Discharge testing is completed by ward 48 hours prior to discharge Offsite screening pathway in place for elective patient screening			Green
5.8	Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	All patients are given a Type IIR mask. Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients notes			Green
5.9	Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	See Section 1: Emergency Department SOP (1.3).			Green
5.10	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	See Section 1: Emergency Department SOP (1.3).			Green
5.11	Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered	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 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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
			Renal)		
5.12	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Medical teams consider this			Green
5.13	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance	~~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~~ decision was made in the first week of June to remove curtains and screens based on a change in national guidance, and will be reviewed as scheduled on 11 July	Green
5.14	Patients, visitors, and staff can maintain 1 metre or greater social & 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~~ Decision was made in the first week of June to remove curtains and screens based on a change	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				in national guidance, and will be reviewed as scheduled on 11 July	
5.15	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
5.16	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
5.17	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Where possible routine appointments are being carried out over the telephone, when a patient must attend in person, information regarding COVID symptoms are included in their appointment letter.			Green
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	Appropriate infection prevention education is provided for staff, patients and visitors	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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		posters in all areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education see above			
6.2	Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning and doffing) PPE safely	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. The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training	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 ensure records are correct Corporate Education Department Manager is reviewing data for accuracy and to feedback to Divisions in relation	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
			report.	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 put it on and remove 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	Adherence to 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
6.5	Gloves are worn when exposure to blood and/or body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's	The Trust has a standard precautions policy for staff to follow Microsoft Word - 608001865_0786.doc (sath.nhs.uk)			Green
6.6	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	Hand dryers have been removed and replaced with paper towel dispensers			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance				
6.7	Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	The Trust policy advises actions (see link at bottom of document). This is addressed in covid-secure risk assessments.			Green
6.8	Staff understand the requirements for uniform laundering where this is not provided on site	All staff are asked change into their uniform at work. There is no provision for uniform to be laundered on site, and scrubs only are sent to an off-site laundary. 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
6.9	All staff understand the symptoms of COVID 19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	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
6.10	To monitor compliance and reporting for	There is a mechanism in place for staff to report their Lateral Flow test results			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	asymptomatic staff testing	and we ask staff to report at lerast twice weekly. This via a web based portal which we monitor and provde daily report to managers.			
6.11	There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/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 dashboard that reflects the local data			Green
6.12	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
7. Provide or secure adequate isolation facilities					
Systems and process are in place to ensure:					
7.1	That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) provided it can be tolerated and is not detrimental to their (physical or mental) care needs.	Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients notes			Green
7.2	Separation in space and /or time is maintained between patients with and without suspected respiratory infection by appointment or clinical scheduling to reduce waiting times in reception areas and avoid mixing or infectious and non-	~~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~~	A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was	~~Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between~~	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	infectious patients	~~Screens have been purchased for outpatient administration areas where unable to maintain social distancing~~.	deemed not possible and created further risk	~~patients~~ decision was made in the first week of June to remove curtains and screens based on a change in national guidance, and will be reviewed as scheduled on 11 July	
7.3	Patients who are known or suspected to be positive with a respiratory pathogen including COVID 19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Any patients who are tested positive are isolated in side rooms. Patient placement is based on previous 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.		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
7.4	Patients are appropriately placed i.e. infectious patients in isolation or cohorts	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
7.5	Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependant on clinical care requirements).	~~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~~ decision was made in the first week of June to remove curtains and screens based on a change in national guidance, and will be reviewed as scheduled on 11 July	Green
7.6	Standard infection control precautions (SIPC's) are used at point of care for patients who have been screening, triaged, and tested and have a negative result	Any patients who are tested positive are isolated in side rooms. Patient placement is based on previous 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.		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
7.7	The principles of SICP's and TBP's continued to be applied when caring for the deceased	See 7.6.3 Seasonal Respiratory Infections (including COVID-19 and Influenza)			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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 testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	Patient testing is in place in (for COVID, Influenza and RSV) 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
8.3	Staff testing protocols are in place	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			Green
8.4	There is 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
8.5	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
8.6	Screening for other potential infections takes place	All screening for other organisms usually monitored continue to be performed in the as per guidelines			Green
8.7	That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate 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
8.8	That those inpatients who go on to develop symptoms of respiratory infection/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 document			Green
8.9	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, 5/7 COVID screens are due, and dashboard in place to show compliance by ward area			Green
8.10	That sites with high nosocomial rates should consider testing COVID negative patients daily.	When outbreaks have been identified, additional testing is implemented. This is done for patients on alternate days.	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
8.11	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
8.12	Those patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting (link below), where they should complete their remaining isolation as per national guidance. 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 has agreed to take the patient			Green
8.13	There is an assessment for the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of a case suspected/confirmed case of COVID 19 within the last 10 days. Instead these patients can take a lateral flow test (LFT)	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. The only other exception is for local anaesthetics and patients that need to backfill due to late cancellations, these can be tested via LFT with agreement of clinician			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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	The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	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	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
9.3	Safe spaces or staff break areas/changing facilities are provided	Welfare arrangements are compromised by space constraints. Mitigations (maximum occupancy posters, staggered breaktimes, provision of external seating areas etc.) are addressed in covid-secure risk assessments.	The Trust has insufficient changing facilities which comply fully with the Workplace (Health, Safety and Welfare) Regulations 1992, as identified via H&S audit.	Issue considered by Health, Safety, Security and Fire Committee January 2022, discussed at Silver and for SLC-O consideration of potential solutions including mobile changing units next.	Amber
9.4	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	of an outbreak	This is also reported to Trust IPCOG committee, via Divisional reports and IPC team QWW reports. The Trust also has a policy for the management of outbreaks which includes the documented recording of an outbreak.			
9.5	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
9.6	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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 seek advice when required from their local IPCT/occupational health department/GP or employer as per their local policy	Staff can seek advice from our occupational hrealth as per Human Resources Policy No. HR65			Green
10.2	Bank, agency and locum staff follow the same deployment advice as permanent staff.	All staff including bank and agency are provided the same advice.			Green
10.3	Staff who are fully vaccinated against COVID 19 and are a close contact of a case of COVID 19 are enabled to return to work without the need to self-isolate (see	Staff need to have had a PCR & completed a risk assessment. This risk assessment is reviewed by the Trust DMG & a decision is made if the member of staff can return to work			Green
10.4	Staff understand and are adequately trained in safe systems of working, including donning and doffing of PPE	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. 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 cascaded out to Divisional fit testers for local implementation on 25 March 2020 and 6 April 2020, via email and is addressed in in-house refresher training sessions. 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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.			
10.5	A fit testing programme is in place for those who may need to wear respiratory protection	An RPE fit testing service is currently available office hours on most weekdays at RSH and PRH. This is staffed by fit testers trained in qualitative and quantitative methods by a Fit2Fit accredited training provider, Fire Safe International of Atcham. Outcomes are recorded on staff ESR records and summary reports published at SaTH Intranet - FFP3 Mask Fit Testing.			Green
10.6	Where there has been a breach in infection control procedures, staff are reviewed by occupational health who will: • Lead on the implementation of systems to monitor for illness and absence • Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID 19 • Encourage staff vaccine uptake	Occupational Health not provide anti-viral treatment and have no facilities to do so. However do implement vaccination programmes, excluding covid-19. Staff will be reviewed by OH if they are referred, or contacted by IPCC to become involved in a breach, for example a TB exposure. Occupational health support delivery of Flu programme each and help encourage vaccine uptake.	Occupational health do not currently provide anti-viral treatment	As part of reviewing future service provision requirements this will be considered in service specification going forward.	Amber
10.7	Staff who have had and recovered from or have received vaccination for a respiratory	All patient facing clinical and non-clinical staff have been trained to follow PHE			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	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			
10.8	A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID 19 • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups • That advice is available to all health and social care staff, including specific advice to those at risk of complications • Bank, agency and locum staff who fall into these categories should follow the same deployment advice as permanent staff • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff	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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• Wellbeing Hubs • Headspace - Free subscription • Trust Coaches • Freedom to Speak Up Guardians • Accommodation for Staff in Critical Service Roles Staff are being risk assessed taking into consideration the health, age, ethnicity and gender. Risk assessment process in place with support also available via occupational health (as required). Documents available on intranet and SaTH app.			
10.9	Vaccination and testing policies are in place as advised by occupational health/public health	Occupational Health have an immunisation policy in line with PHE/DOH.			Green
10.10	Staff required to wear FFP reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records	Staff are fit-tested to FFP3s, 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. This is recorded on the fit test report form which is scanned and held electronically by the H&S Team, and the original hard copy form is			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		returned to the employing department for filing on personal files. The outcome of each fit test is recorded in ESR and a summary report published at SaTH Intranet - FFP3 Mask Fit Testing. 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.			
10.11	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 and remains correct. This includes dates of in-house refresher training and competency assessments.			Green
10.12	all staff required to wear an FFP3 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		fit testing outcomes is escalated to the Incident Command Centre.			
10.13	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	All staff are requested to come forward to be fit tested to two, ideally three FFP3s as a contingency plan in case of stock shortages. Progress is reported to HSSFC, IPCOG, IPCAC and the Incident Command Centre.			Green
10.14	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. Staff are not given a copy of the fit test record at the time of the fit test, but are given a sticker with the makes/ model they do and do not fit to, and encouraged to make a note/ take a photograph of the FFP3 they fit to in order to foster familiarity, 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, but a sticker summarising fits and fails to specific makes and models is provided for immediate reference pending update of records at SaTH Intranet - FFP3 Mask Fit Testing.	Staff are encouraged to access the fit testing report on the intranet to look up their own records. The H&S Team support staff and managers who ask for help to do so.	Green
10.15	those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators	Records of failed fit tests are managed in the same way as records of successful fit tests, as described above.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	and hoods				
10.16	That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	Staff who cannot wear an FFP3 in stock have access to loose-fitting RPE and, in Critical Care areas, reusable tight-fitting RPE. SOPs for decontamination of hoods and reusable respirators are published at SaTH Intranet - PPE.			Green
10.17	Members 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 in line with nationally agreed algorithm	Staff who cannot wear any of the alternatives to FFP3s are assigned to suitable duties by their own line managers, with HR support. 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
10.18	A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including occupational health	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.	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
10.19	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 syst4em 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 to the IPC Operational Group and the IPC Assurance Committee, and also to the quarterly Health, Safety, Security and Fire Committee.			Green
10.20	Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	**Medicine and Emergency Divisions** – due to the current vacancies and the staff sickness this can be challenging. This is kept to a minimum where possible. **Surgery Division** –there is some movement of staff to cover sickness/gaps in rosters, however this is kept to a minimum. The elective ward is protected. **Women's and Children's Division** – 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	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 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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		running the planned Caesarean Section list		Staff are required to complete a Datix report if looking after both COVID positive and negative patients during the same shift	
10.21	Health and care settings are COVID 19 secure workplaces as far as practical, that is, that any workplace risks(s) are mitigated maximally for everyone	Covid-secure guidance, including 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. From time to time physical inspections of covid-secure areas are undertaken by the H&S Team and reported via the Health, Safety, Security and Fire Committee.			Green
10.22	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 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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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			
10.23	Staff who 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

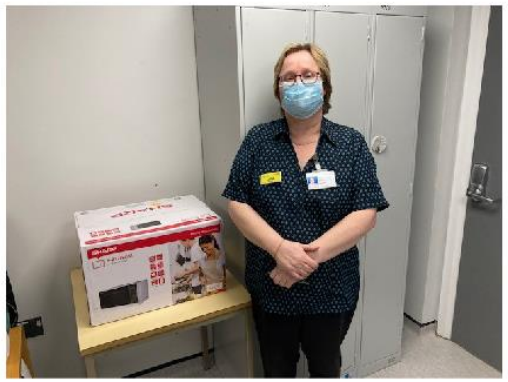
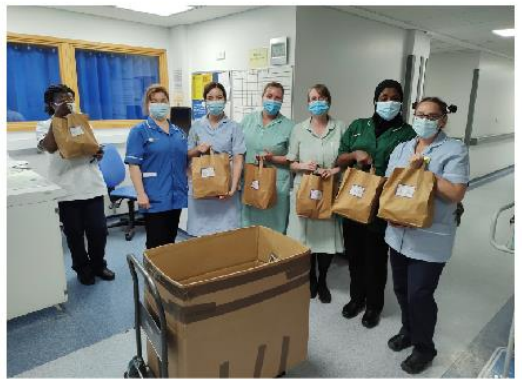
SaTH COVID Policy Link: http://intranet.sath.nhs.uk/coronavirus/ipc.asp

RAG	Total Number
	120
	10
	0

Public Participation Report Quarter 1 (April - June 2022)

The Shrewsbury and Telford Hospital NHS Trust

Julia Clarke – Director of Public Participation


Partnering Ambitious Caring Trusted

Volunteering | Engagement | SaTH Charity

Highlights of Public Participation – Q1

The Shrewsbury and Telford Hospital NHS Trust

- Community membership increased in Q1. We aim to increase our community membership by 10% year on year and are on target to achieve this.

- We have continued our membership recruitment campaign with Town and Parish Councils and councillors (across Shropshire, Telford & Wrekin and Mid-Wales). All the town and parish councils in Telford and mid-Wales are signed up to receive our monthly email updates.

- The team have been supporting our Divisions with their Section 242 duties to engage the public around service changes, in Q1 this included:
  - ENT and Audiology
  - Paediatric Ophthalmology
  - County Breast Screening Unit (Market Drayton and Bridgnorth)

- Our work around social inclusion has involved working with our partners to build links with our rural and BAME communities

Highlights of Public Participation – Q1

The Shrewsbury and Telford Hospital NHS Trust

- 1-7th June was National Volunteers Week and we have been celebrating and showing our appreciation for our volunteers at SaTH

- **NHS CT Funding –** the Volunteer Team have been awarded £86k from NHS Charities Together to develop a 15 month Young Volunteer Project, the project is now underway and new volunteering opportunities and partnerships have been created.

- NHS Charities Together has paired SaTH charity with our local Starbucks. We have collection tins in stores in Shrewsbury.

- As a thank you for our staff, an ice cream van was funded by SaTH Charity at both hospital sites and Shrewsbury Business park.

- The Small Things, Big Difference Fund continues to support staff at work. Funded by the staff lottery and donations that are specifically donated to support staff well being

Public Assurance Forum 4 July 2022 (1)

The Shrewsbury and Telford Hospital NHS Trust

- The Public Assurance Forum met on 4th July 2022, with good member representation from community members and divisional teams. Chair invited contributions from members for future agenda items
- Key Items that were discussed at the Forum included:
  - **Member's Updates**
    - engagement commencing on the T&W Ageing Well strategy
    - CCG consultation on future of T&W HealthWatch
    - membership of sub-partnership groups reporting to TWIPP and SHIPP discussed
  - **Divisional Updates**
    - meeting queried the communication around the suspension of Midwifery Community of Care service. The meeting were advised work was ongoing with Maternity Voices Partnership but community members could contact W& C if any concerns
    - Badgernet was now being offered to all mothers booked since April. This includes detailed advise and information that can be accessed in digital format, but paper-based information and care plans are still available for service users if preferred
    - Mobile breast screening service - it was confirmed that the county mobile unit is going to Bristol for approximately 6-8 weeks in August for a £175k equipment upgrade
    - discussed the ICS Outpatient Transformation programme and that there will be an agreed comms & engagement plan wrapped around the project
    - Noted that the Trust is seeking recent patients to join specialty experience groups. Also looking for Patient Safety partners by September to sit on key safety committees
- **Future Developments**
  - HTP - Forum was pleased to hear of latest position and noted that there need to be clear messages on what is in the SOC and also a clear engagement plan to help prepare for OBC production
  - Surgical expansion at PRH. It was noted that the day surgery expansion plans aligned with HTP but initially would be to help address waiting list delays.

Public Assurance Forum 4 July 2022 (2)

The Shrewsbury and Telford Hospital NHS Trust

- **Ockenden Report -** Forum was pleased to note progress to date and engagement through Maternity Voices Partnership and support being provided to families.
- **Service Changes -** The Forum welcomed the comprehensive update on the service changes in Q1, including:
  - PRH renal dialysis relocation
  - county mobile breast screening in Market Drayton and Bridgnorth in 2022 (temporary)
  - paediatric ophthalmology (temporary)
  - RSH ENT and audiology outpatient clinics (temporary)
- **SaTH Improvement Programme -** Trust Volunteers have recently been on the one day Improvement Fundamentals course. Forum raised question about greater patient/public involvement in improvement work and were pleased to hear that every project includes consideration of patient involvement.
- **Public Participation updates -**
  - Received Public Participation Strategy prioritised Action Plan. The five year plan was presented with annual plans for community engagement, social inclusion, volunteers and SATH Charity showing the plan for the coming year. The Forum complimented the Public Participation team on its work especially with regards to volunteers
  - Draft Quarterly Board report presented

Engaging with our Local Communities

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 members and organisations
  - **Community Cascade** – this is delivered twice a month following feedback from the public requesting an additional session in the evening
  - **Monthly Community drop-ins –** informal drop-ins for a community to meet with members of the engagement team
  - **About Health Events**– There is an ongoing series of virtual health events for staff and the public.

- Our team have attended a number of events in Q1, either virtually or in person, to listen to the views of our local community including:

  - **Hear Here Senior Club**, Whitchurch
  - **ICS Healthier Minds Festival,** Hadley
  - **Regenerative Agriculture & Rural Communities conference,** Norbury, South Shropshire
  - **Healthwatch Shropshire "Once Chance" event,** Shrewsbury
  - **Armed Forces Outreach**, Shrewsbury
  - **Polish Heritage Day**, Telford
  - **SaTH Information Stand,** Newtown, Powys

Section 242 duties– Service changes

The Shrewsbury and Telford Hospital NHS Trust

- The detail of all service change proposals and engagement can be found at Services Changes and Developments – SaTH These webpages contain information which includes:
  - The proposal presented to our stakeholders and communities
  - Equality Impact assessment
  - Engagement Plan and Report
  - Questions and Answers

Current service changes and development include:

- **Breast Screening Mobile Unit (Market Drayton & Bridgnorth) temporary service change -** The Trust is proposing a temporary service change to the Breast Screen mobile service to Market Drayton and Bridgnorth to help us catch up screening appointments following the pandemic. A patient/public meeting were held about this service change on Tuesday 14th June 2022, 2pm, and Friday 24th June, 6pm via MS Teams. Further information about this temporary service change can be found on the following link: Breast Screening Mobile Unit (Market Drayton & Bridgnorth - Temporary Service Change (June 2022) – SaTH

- **Audiology and ENT (Ear, Nose and Throat) at RSH, temporary service change** - A patient/public meeting was held about this temporary service change on Thursday 19th May 2022, 9.30am, via MS Teams. Further information about this temporary service change can be found on the following link: Audiology and ENT, Royal Shrewsbury Hospital - Temporary Service Change – SaTH

- **Paediatric Ophthalmology service, temporary change –** The Trust has taken the difficult decision to temporarily close the Paediatric Ophthalmology service to new patients. The Trust has put interim arrangements in place to support current and future patients, please see the attached press release Temporary closure of the children's eye-care service - SaTH. A Stakeholder meeting was held on 11th May 2022.

#GetInvolved

People's Academy

- In April we held a virtual People's Academy with 10 people completing the full 4 week course, and 3 more booked in to sessions later in the year to complete.
- We had attendees from outside the Trust area who were looking for work in our hospitals and joined the course to find out more about us.
- Some attendees were supported to come to the People's Academy by their employers as part of their redundancy package

About Health Events

- In April an *About Health* event was delivered by Helen Turner about our Freedom to Speak Up Guardians, and how they support our staff to raise concerns.
- We our currently engaging with our public through an online survey to find our what topics they would like on the Autumn Programme

Social Inclusion

The Shrewsbury and Telford Hospital NHS Trust

- A gap analysis of our seldom heard communities has been undertaken and is now complete. An action plan has been developed and a quarterly update is provided to the SaTH's Public Assurance Forum
- In Q1 our Social Inclusion Facilitator has been linking with our rural communities in Oswestry, Whitchurch and Craven Arms. Feedback from these communities were that online meetings and events will support further involvement and make our hospitals more accessible to people living rurally.
- The Engagement Team attended the Healthier Minds Festival and made links in a number of areas including public health in Shropshire and Telford & Wrekin, The Chinese Arts and Culture Centre, the Sikh Women's group, and ACCI - African Caribbean Community Initiative
- Work is ongoing to connect to BAME communities across the county and mid-Wales. We are working with Imam Adil Saleem in our Chaplaincy team to reach out and increase our engagement

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 1, three **eligible* questions** were submitted to the Trust Board
- **Question 1 –** related to how £7.5m efficiencies saving were achieved and if this was in relation to a reduction of community Audiology services
- **Question 2** - related to querying a high staff turn over of nursing and Allied Health professionals in March 2022
- **Question 3** – there was a decrease in the number of maternity staff that access the Freedom to Speak Up Guardians in Q3 & 4 compared to Q1 & 2 and what the reason for this was?

- All eligible questions submitted to the Trust Board from the public are published on our website - Public Questions Log – SaTH and the following actions have been taken to share more widely:
    - Community Cascade – Our monthly Community Cascade which is delivered twice each month, covers a variety of different topics including Workforce recruitment and retention, Getting to Good and Maternity Transformation
    - About Health Event (Freedom to Speak Up), in April Helen Turner (Freedom to Speak Up Guardian) gave a presentation to the public on the how staff can raise concerns within the Trust

* i.e. relevant to an agenda item and within 10 days of the meeting

Volunteers' Highlights

The Shrewsbury and Telford Hospital NHS Trust

- **We have 302 active volunteers** at the Trust.
- National Volunteer Week (1-7th June) was celebrated with a number of events, including a 'thank you' tea party for our volunteers at both sites, recruitment events, and staff were able to send our volunteers 'Thank You' messages via the intranet
- The Volunteer Team visited Shrewsbury Colleges Group and a recruitment event for the Shropshire Youth Support Trust in May to engage with young people looking to pursue careers in health.
- 2 new, large and external banners have been installed at both sites to promote volunteering to the public.

99 volunteers aged 16-17
34 applications in process

203 volunteers aged 18+
60 applications in process

91 new active volunteers
100 new applications

NHSCT Funding – Youth Volunteer Project

The Shrewsbury and Telford Hospital NHS Trust

- **NHS CT Funding –** The Trust is one of 16 Trusts around the country to be awarded funding to enhance our young volunteer scheme through a project to target young people, aged 16-18, in the area who may experience barriers to volunteering.

- **Severndale Academy - t**he team are working with the Catering team, Estates and League of Friends to develop voluntary roles for the students at Severndale Academy

- **Youth volunteer survey and feedback event -** In April, we issued a survey to volunteers aged 21 and under to understand their motives for volunteering at the hospital, 88.6% of those wo replied stated it was to gain experience and 79% to support applications for university. Feedback from this survey demonstrated how valuable it is to provide a young volunteer scheme to provide experience for students wanting to explore a career in healthcare and ultimately grow our future workforce.

- **Local schools and colleges** – We have dates in the diary for promotional sessions in 5 schools/colleges in the Shropshire and Telford and Wrekin area.

Volunteers' Week 2022

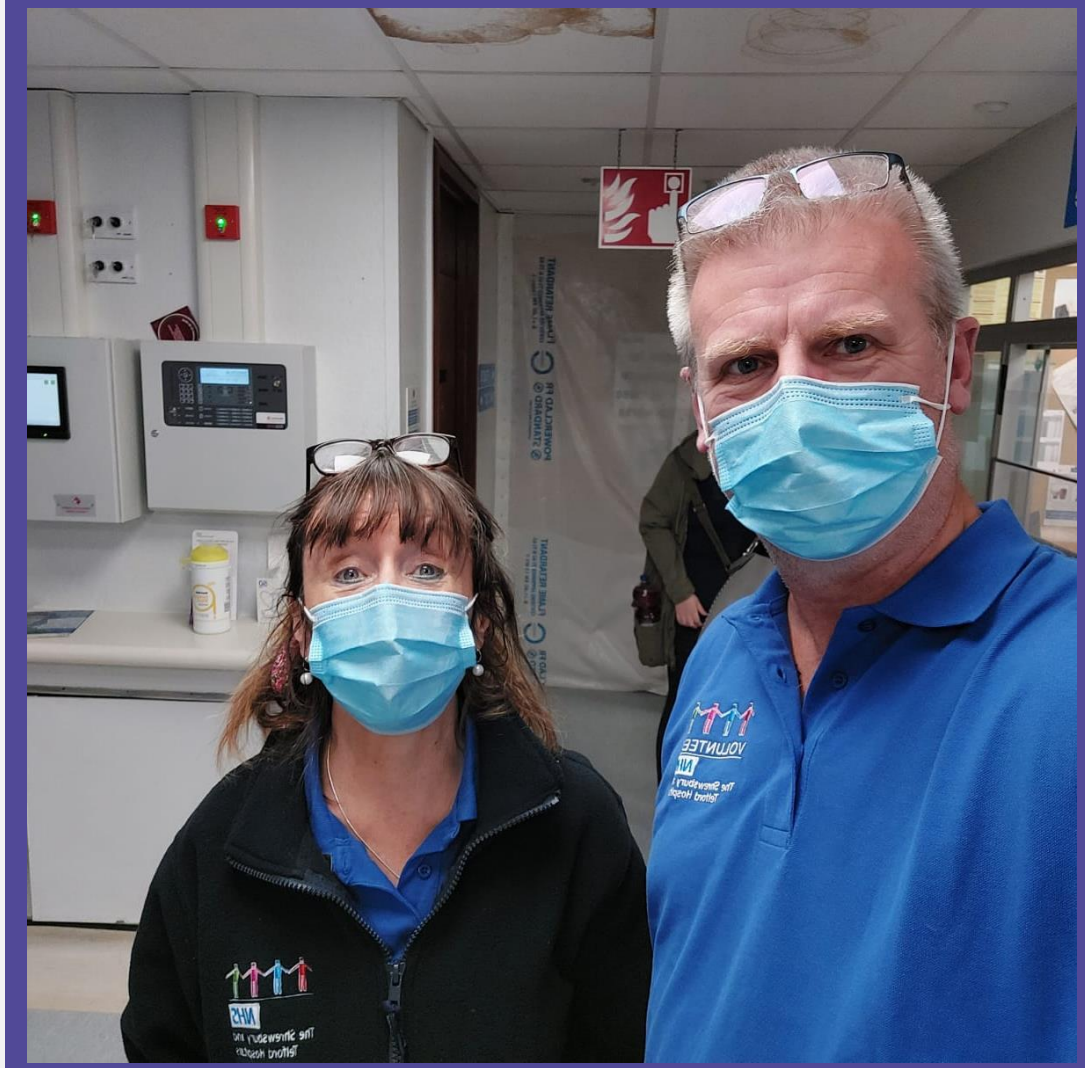
Volunteers' Week is an annual celebration of the contribution millions of people make across the UK through volunteering.

This year we had a calendar of events and releases to celebrate the work volunteers do within SaTH:

- Staff could send a 'Thank You' message to a volunteer via the intranet
- Teagan, a young volunteer at PRH, has spoken with Clare Ashworth on Radio Shropshire
- A press release was issued focusing on how volunteers help people and examples of people who have gone successfully apply for study courses or paid work.
- Volunteer 'Thank you' events at both RSH and PRH was a great success, with 75 volunteers receiving thank you bags and certificates, as well as badges for long service
- There was a 'Volunteer taking over' on the SaTH Instagram account for the day

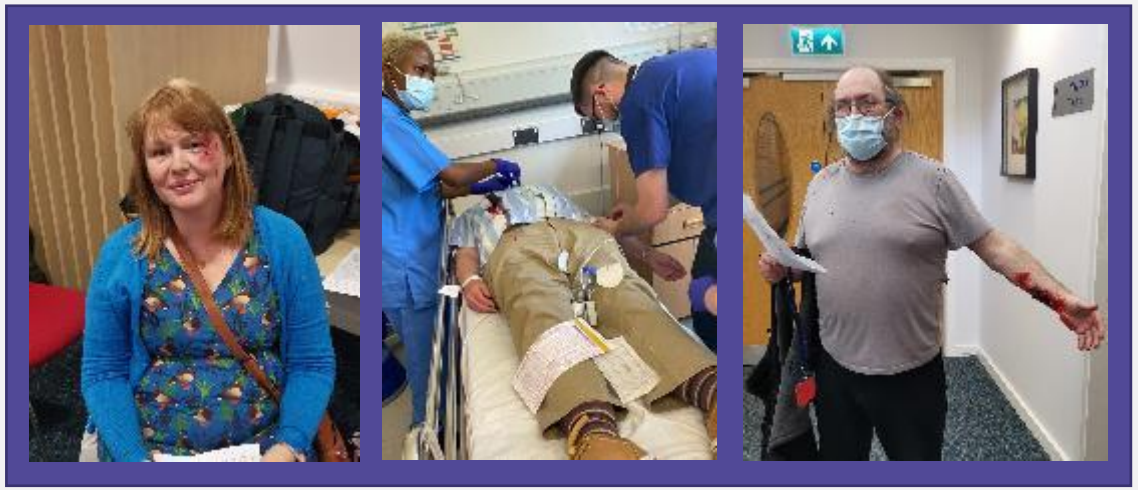
Volunteer Roles

- **Medical Registrar Clinical Simulation-** The volunteer team provided two volunteers to support this event. They acted as relatives of critically ill simulated patients and played a very important role in support of the development of our doctors.
- **Macmillan –** We have successfully allocated a volunteer to support the Macmillan Team, the volunteer will provide appropriate information and signposting services to users of the Information Centre.
- **Audiology –** Audiology has called on the support of the Response Volunteers for the next 3 months to deliver hear aids to the team, while they are undergoing a departmental move
- **Dietetics –** the Volunteer team have been working with Dietetics to develop a volunteer support role to aid the team in restocking and the distribution of goods.
- **Introduction to Improvement training for Volunteers –** the Volunteer Team are working with the Improvement Hub to establish a calendar of training sessions for volunteers to learn about the work they undertake at the Trust.



Exercise Rainbow

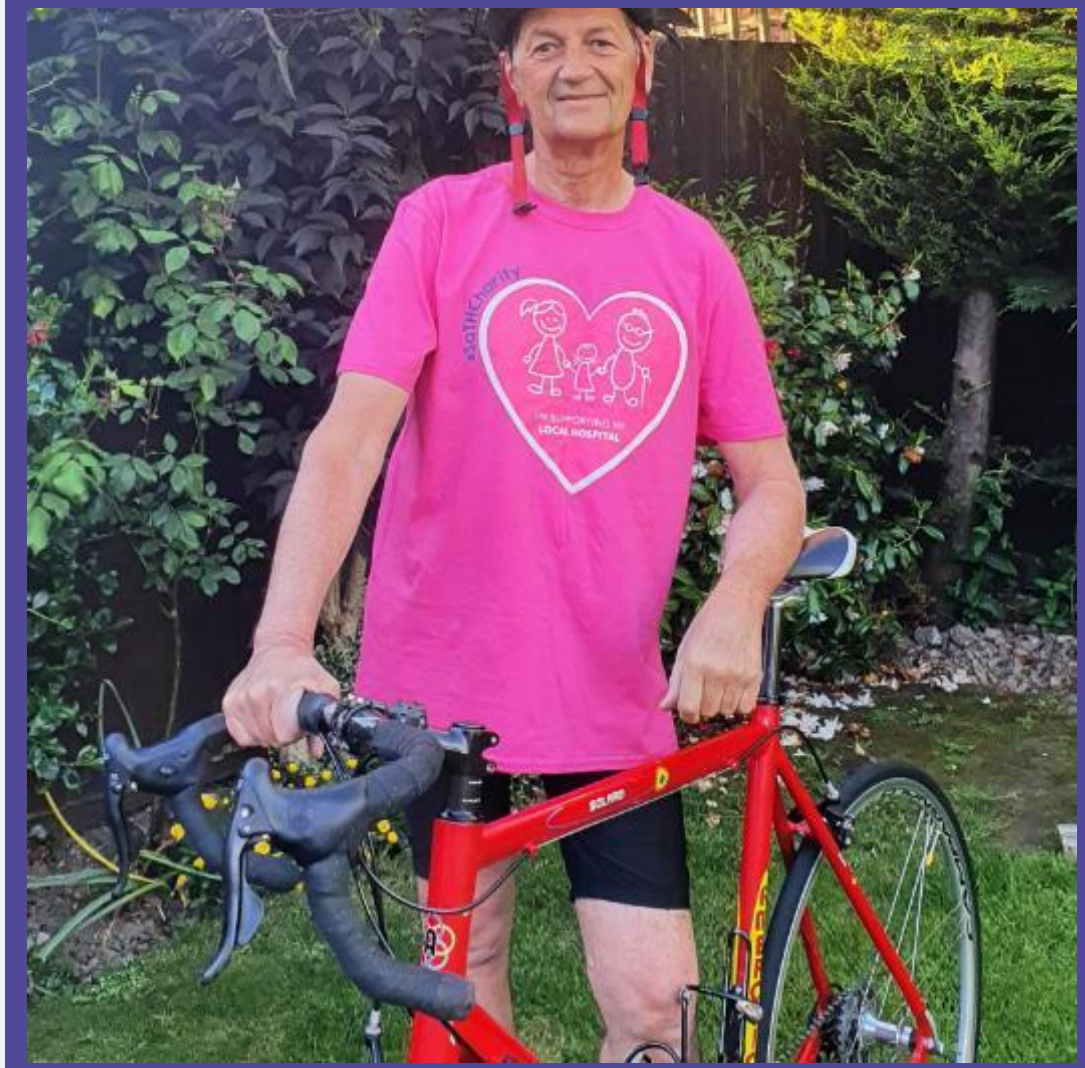
- **Exercise Rainbow -** The Volunteer Team sourced **12** volunteers to support the event and coordinated a further **30** volunteers from external organisations such as TCAT and the Casualties Union.
- The volunteers played casualties throughout the day and thoroughly enjoyed themselves, we received very positive feedback from all involved.



SaTH CHARITY – Highlights

The Shrewsbury and Telford Hospital NHS Trust

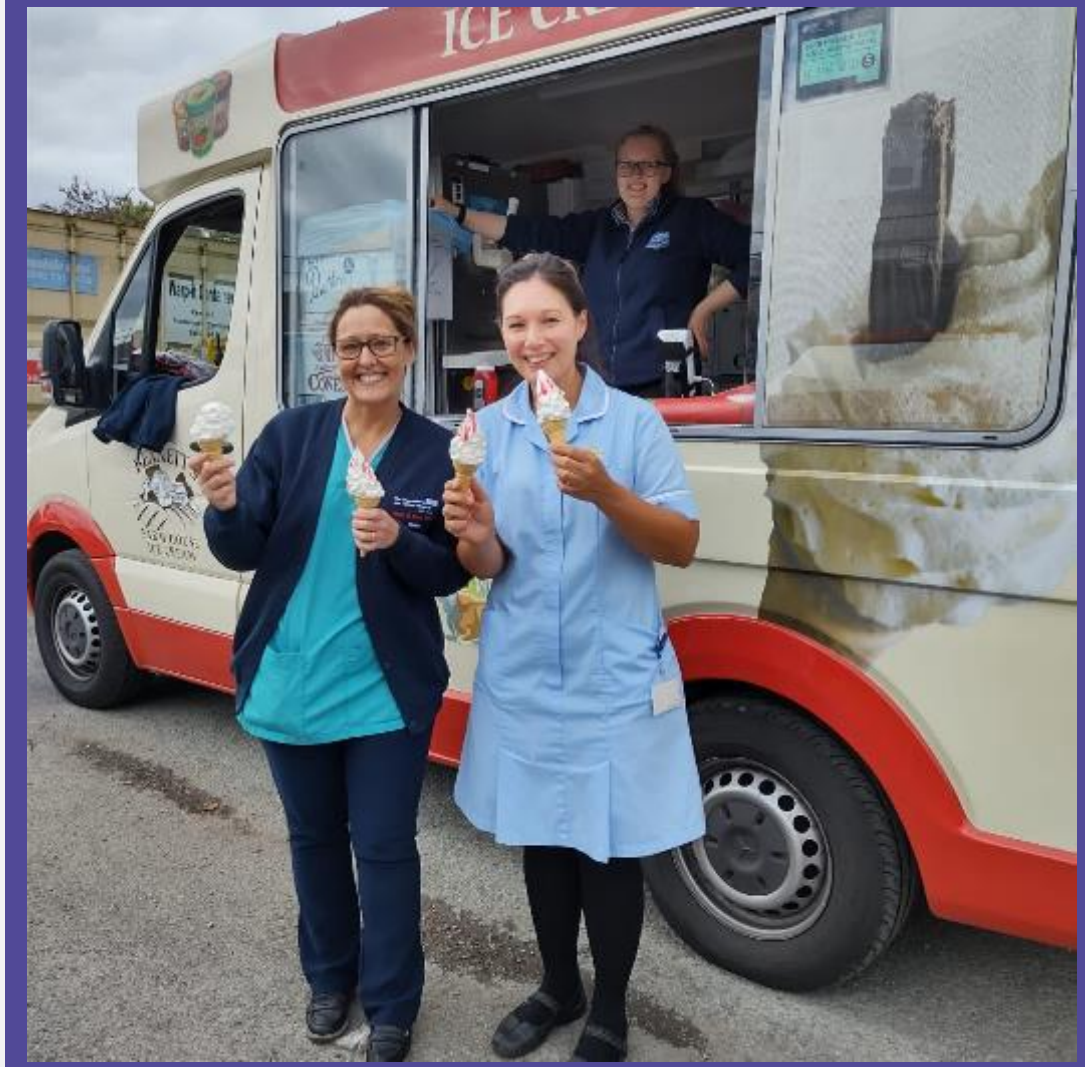
- Income for the 3 months of Q1 2022 is £161,880 compared to £351,273 in the same period last year (£220,000 of the income for 2021 came from a NHS CT stage 2 grant for other charities in the area).
- Expenditure for the same period was £198,545 compared to £161,384 in 2021
- The family of Steven Fisher visited the hospital to say their thanks. The family had raised £12,000 for ITU through several different events including charity walks, a memorial for Steve, and donations from friends, family and colleagues
- NHS CT has paired SaTH charity with our local Starbucks. We have collection tins in stores in Shrewsbury. We also met Lauran and Owen who are members of the Starbucks team and will be raising money during a colour run later in the year
- Ian, a SaTH employee who works in Medical Illustration, completed the Ride London cycling event on 29th May. Ian completed the100-mile event in under 6 hours and raised over £600 for SaTH Charity's Ophthalmology campaign.



SaTH CHARITY

The Shrewsbury and Telford Hospital NHS Trust

- Funding has been agreed by Charitable Funds Committee for outside staff domes at both DSUs using funds from NHS CT. Funding has also been agreed for a dome at the Hamar Centre.
- SaTH Charity paid for an Ice Cream Truck to visit RSH, PRH and Shrewsbury business park. Ice creams were also dropped off at Atcham Business Park, Severnfields and Queensway. It was a gesture to thank staff for everything they do.
- SaTH Charity supported Easter at the Trust this year. Chocolates were funded for staff, and links were made between companies wishing to donate eggs and to areas happy to receive them
- The Dementia Team at SaTH have been stocking up on items for their ‘rummage boxes’ with thanks to recent fundraising. Dolls, cats, dogs and playing cards have all been purchased.



SaTH CHARITY

- 5 members of staff applied to run on behalf of SaTH Charity at the TCS London Marathon 2022. Nicky Brierley, a Cardiac Nurse at PRH was chosen to represent SaTH Charity.
- The family of Steven Fisher visited the hospital to say their thanks. The family had raised £12,000 for ITU through several different events including charity walks, a memorial for Steve, and donations from friends, family and colleagues
- Oswestry Golf Club raised over £2000 for the Shropshire Blood Trust Fund.
- Ophthalmology held a very successful cake sale to raise money for their on-going campaign
- A raffle to win a Dewalt Drill, donated by Jewson's in Wellington, raised £215 for the PRH estates team to spend on courtyard decorations to celebrate events throughout the year, including the Platinum Jubilee

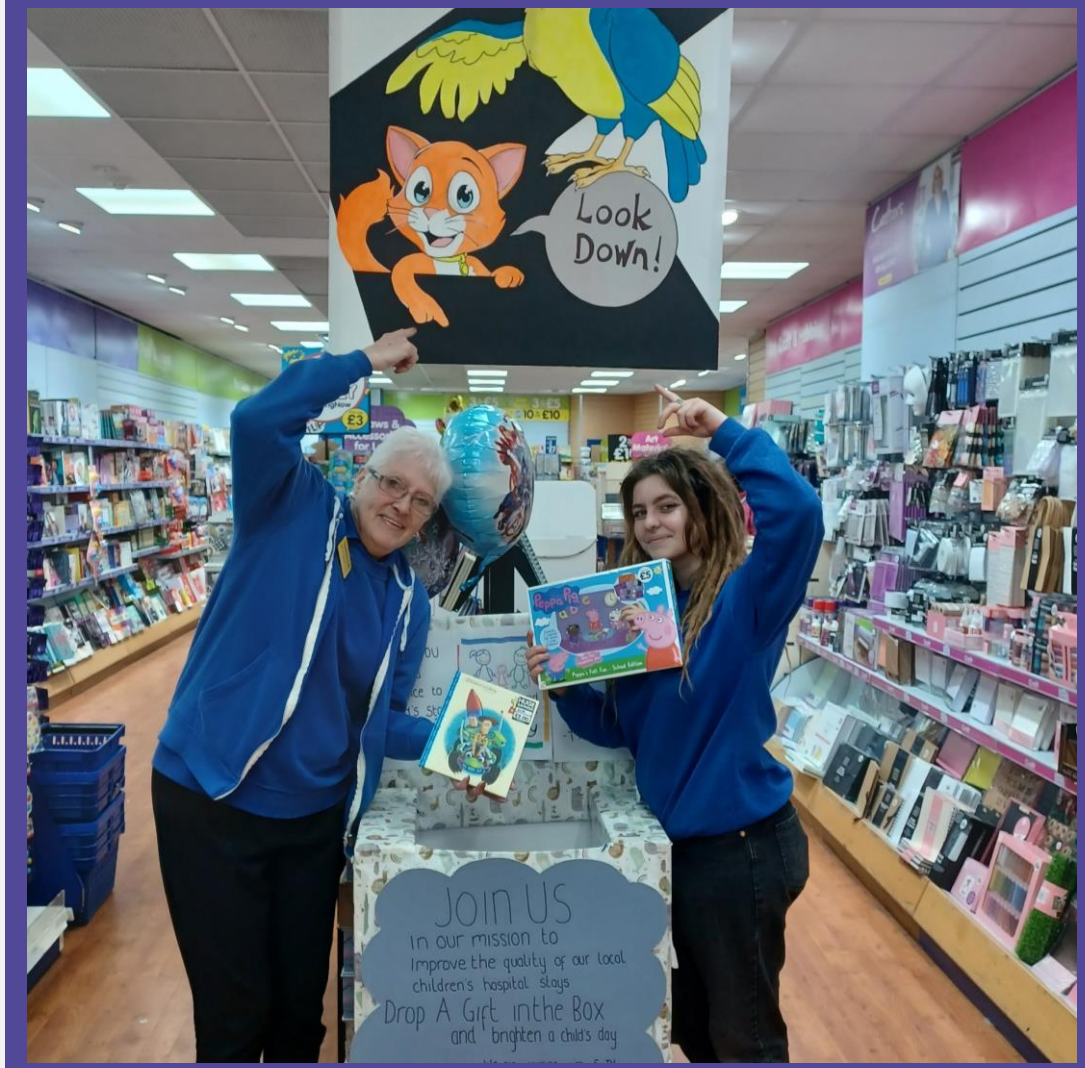
SaTH CHARITY

- Local artists Sue Campion and Richard Edwards have each donated 16 prints to brighten public areas in the Trust. SaTH Charity has paid for them to be framed and are liaising with staff to place them

- The Works (a national chain of book and craft shops) which has a store in Shrewsbury have sent up a drop off point for customers to buy items for the Trust. The items will be split between children's areas.

- 8 radios and headsets were purchased after a donation from Barbara Martin. Barbara donated £220 in memory of her son Paul and wanted the money to go towards radios as they had brought Paul comfort in his days with us

- Donations of 'Kindness snack boxes' were delivered to staff at PRH with thanks to the Ironbridge Lions Club. This is the third donation they have made since the start of the pandemic.



SaTH CHARITY

The Small Things Big Difference fund continues to support our staff with items for staff rooms and other items that makes their life more comfortable at work.

Funded by the staff lottery and donations that are specifically donated to support staff. Over the past three months there have been many items provided to support staff at SaTH, including:

- Microwaves, Fridges, Vacuum Cleaners, lockers
- Plants, Picnic benches
- Radios, TVs Kettles
- We supported Dr Pam Sturgess for another Art Club evening with refreshments.

Bridie Cashmore, Corporate Nursing:

"It was easy to apply and our application to The Small Things Fund was processed very quickly"

Impact Statement

Ward Clerk Jane Waterworth said:

"The staff are very grateful and could not wait to put their names on the locker doors. Thank you very much."

Jubilee Celebrations at SaTH

The Shrewsbury and Telford Hospital NHS Trust

- The Estates team at PRH applied for funding to decorate the hospital for the Queen's Jubilee. A number of items were brought to decorate Captain Tom's Courtyard for staff and patients to enjoy over the Jubilee weekend. Jo, who was staying on the Children's Ward, did the official 'turning on' of the Beacon (made by Estates) in the courtyard.

- SaTH Charity provided funding for biscuits for wards and departments for staff who were working on the Saturday of the jubilee weekend.

Forward Plan

- The Public Assurance Forum to meet on 3rd October 2022
- Supporting staff with any service changes engagement
- A Young People's Academy and a People's Academy to start in Q2
- A number of Young People Volunteer recruitment events are planned in Q2 at local schools and colleges.
- Social media campaign to recruit young volunteers starting in September
- To continue to support staff wellbeing through SaTH Charity
- Attendance at community events to engage with the public

Dates for your diary – June/July 2022

The Shrewsbury and Telford Hospital NHS Trust

Date	Time	Event	Booking
Wednesday 20 July	18:30 – 19:30	Evening Cascade	Via Eventbrite
Tuesday 26 July	14:30 – 16:00	Community Drop-In	Via Eventbrite
Wednesday 10 August	11:00-12:00	Community Cascade	Via Eventbrite
Wednesday 17 August	18:30 – 19:30	Evening Cascade	Via Eventbrite

Please register for all events online at:
https://sathnhs.eventbrite.co.uk/

Events	
Date	Event
Tuesday 5th July	NHS Big Tea – Coffee mornings and activities at both hospital sites
Sunday 17th July	Telford Carnival
Thursday 15 September	About Health Event – Recovery of Hospital Service after COVID

SaTH Charity Development & Action Plan April 2022 March 2023

V1a 27/04/2022

Stakeholder Groups

A. Public
Appealing to the public is important to achieve our core objectives of community engagement and raising funds to support improved clinical outcomes.

B. Local Business and Organisations
SaTH cares for the workers of local businesses many come into contact with us or through a family member. Supporting SaTH Charity makes good business sense.

C. Staff
Our Trust workforce is a key group that we needs to engage with to help achieve the levels of activity we need. The Charity recognises our staff as a key asset to the Trust and is focussed on supporting their Wellbeing.

D. Existing organisations providing charitable support
We need to ensure that SaTH Charity is not seen as a threat but as a complimentary partner with the charities that support us. Additionally engagement with our ICS partners is an opportunity.

E. Volunteers
Volunteers provide additional capacity to develop and deliver the agreed charitable activities.

Charity Team

The SaTH Charity Team sits within the Public Participation Team and is based within Stretton House at RSH.

The Finance Team are based at The Shrewsbury Business Park under the management of Vicky Hall, Senior Accountant Charitable Funds.

Strategic Aims

To raise funds that provide equipment and workforce training not normally funded through normal NHS channels.

To provide engagement opportunities for local people, business's and organisations

To work alongside the Volunteer Team to encourage support and giving whether its money or time—both are valuable to the Trust.

To develop and implement corporate fundraising priorities which are aligned to the Trust's strategic objectives.

To encourage utilisation of funds to support identified need

To raise awareness of the Trust's activities with our staff, patients, their families and stakeholders to encourage their engagement, to build and develop SaTH and SaTH Charity brand.

To work with and support existing charitable partners which include but not limited to; NHS Charities Together, League of Friends of RSH, Friends of PRH and Lingen Davis.

Desired Outcomes

- To Increase the amount of monies donated, raised or left by legacy to SaTH Charity year on year
- Increase the visibility of SaTH Charity as the Trust's Hospital Charity locally measured by increased income.
- Community Engagement through positive media opportunities to promote SaTH to the population it serves through engagement and fundraising activity— 4 stories a month
- Enhance the reputation of SaTH relating to clinical outcomes, quality, kindness and as a caring organisation

Key Risks / Benefits	L	C	LxC	Mitigation
Funds are not spent to meet the expectation of donors and fundraisers	2	4	8	Expenditure is reviewed to ensure it complies to policy. With more support being made available to achieve effective spend.
SaTH Charity does not comply with charity commission requirements	1	4	4	The Charity Policy was again updated in November 2021 to provide the framework for compliance. Monitoring of activity and actions against the Policy.
Not spending charitable funds in a timely way	4	3	12	Plans are requested from Fund Advisors which are reviewed to ensure planned spend is implemented

Q1 2022 — April – May – June

- Introduce new CRM system
- Commence the development of a supporters database
- Development of positive news and engagement stories 12
- Distribution of support to staff through Small Things Fund equal to income
- Commence gathering information for the Annual report highlighting achievements over the last 12 months
- Engage with NHS CT to align to planned National Campaigns.
- Plan and begin the implementation of events to support the Platinum Jubilee
- Finalise any outstanding fund plans.
- Launch literature for corporates
- Introduce robust overseas aid process for unwanted stock
- Arrange a thank you event for Volunteers—Volunteers week

Q2 2022 — July — August — Sep

- Support staff'wellbeing through supporting the International day of….
- Development of positive news and engagement stories 12
- Continue support of the Queen's Platinum Jubilee
- Implement a review of Fund plans to ensure expenditure is inline with plans
- Create a Charity newsletter to the new database aimed at building support and engagement.
- Submit draft copy of the Annual Report for review
- Support the NHS CT Bg Tea campaign—details to be released later in the year.
- Promote our London Marathon Runner
- Arrange a workshop for Fund Advisors to aid planning, share best practice and ideas.

Q3 2022 — Oct — Nov — Dec

- Christmas Staff Wellbeing options. Engage with OD team alternative ways of thanking and recognising staff. Ensuring event and activity exceeds expectation
- Christmas raffle
- Review activity against individual fund plans.
- Begin discussions on Fund Plans for 2022/2023
- Development of positive news and engagement stories 12
- Engage with local business to seek to be a charity of the year
- Identify potential events that SaTH could be the benefactor of, likely to be a slow burn ie Shrewsbury 10K
- London Marathon.

Q4 2023 — Jan — Feb – March

- Finalise the development of fund plans for 2023-24 highlighting key fundraising activity and planned spend.
- To support staff through the Small Things make a Big Difference Fund. Make sure charity has a strong presence in all areas of the Trust to raise awareness and understanding of the charity.
- Positive News stories 12
- Raise profile of charity through actions on the Public Participation Plan
- Thank you campaign from SaTH Charity
- Arrange a Thank you event or awards event to recognise our supporters

General Notes

Update on Q1 activity:

CRM system is currently will be operational from July .

The supporters database will be held on the CRM, data has been collected to add to the CRM to seek individual feedback to engage with them

The Small Things Fund has seen a large number of requests in Q1 with 20 items approved and purchased.

Annual Report is scheduled and will build on last years submission

The NHS CT Big Tea is being supported. Starbucks are also part of a National campaign.

The Charity and Volunteers supported the review of unwanted stock.

Fund plans are being followed up.

Online request Expenditure Request form delayed

Regular positive news stories have been featured in Trust communications

SaTH Community Engagement Action Plan 2022/2023

PACT Partnering · Ambitious Caring · Trusted

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

NHS The Shrewsbury and Telford Hospital NHS Trust

Identified Stakeholders

- **Individuals from the communities we serve**

Individuals who live in the areas we serve (Shropshire, T&W and Powys) may have an interest in our hospital or a specific service. These individuals may also represent over stakeholders e.g. member of the public, volunteer, staff etc.

- **The wider public**

The wider public may include individuals who do not live within our community and may not receive services from us, but may have an interest in the services we provide e.g. individuals who have an interest in a specific area or condition e.g. maternity.

- **Patients and Carers**

Patients and Carers are individuals who are or have recently (within the last few years) received services from SaTH. Their interest may be specific to a service or may have a wider remit

- **Statutory Bodies**

Including our Healthwatches, Community Health Council, Health and Wellbeing Board, Joint Health Overview and Scrutiny Committee

- **Staff**

Our Trust workforce is a key group that we need to engage with. We would provide support and guidance in engaging with our communities and ensuring they meet their statutory duties

- **Voluntary Organisations**

Voluntary organisations work with a range of individuals, communities and organisations on a range of issues or a particular focus. Voluntary organisations work with Health and Social Care organisations and maybe commissioned to provide services

- **Patient groups**

Patient groups including those with a general remit around health and those groups who are condition or area specific

- **Other Health and Social Care Organisations**

Other Health and social care organisations who we will link with or provide services with including ICS, Shrop Comm, RJAH, primary care, social care etc

Strategic Aims

To contribute to delivery of the Public Participation Plan, namely:

1. INCLUSION: To increase the number and diversity of people involved with SaTH, ensuring that they are provided with meaningful and timely involvement opportunities
2. RESPONSIVE: Build greater public confidence, trust and understanding by listening and being responsive to our local communities
3 DECISION-MAKING: To introduce a public and community perspective to decision making and wider work at SaTH, including, recruitment, strategic planning, training and service development and delivery
4 GET INVOLVED: Ensure our communities feel better informed and able to Get Involved if they choose too. Develop a range of involvement opportunities that are rewarding, meaningful and enable individuals from a diverse range of backgrounds to get involved.
5 COMMUNICATION: SaTH will communicate with our communities directly to ensure they are kept informed and update about what is going on at the hospitals (making use of digital communications)
6 **OUR STAFF:** Enabled our staff to have the skills and confidence to engage with our communities

Desired Outcomes

- Key barriers to engagement identified & mitigation in place
- Regular meetings/networks in place to keep in contact with stakeholders
- Increase in incoming enquires/engagement from stakeholders
- Increase in both group & individual membership

Key Risks / Benefits	L	C	LxC	Mitigation
Fail to deliver the Public Participation Plan, resulting lack of confidence of our communities	3	4	12	A detailed Action Plan and yearly plan on a page will be drawn up and submitted quarterly to the Public Assurance Forum (PAF)
Fail to deliver our statutory duties (S242) to engage with the public	3	4	12	Continue to support our Divisions to ensure they meet their statutory duties. Update PAF on engagement relating to service changes
Staff not having the skills or confidence to engage with our communities	3	3	9	Development of online website with toolkit that is accessible to staff

Q1	Q2	Q3	Q4	General Notes
April—May—June	**Jul-Aug-Sep**	**Oct—Nov—Dec**	**Jan—Feb—March**	
• Develop and share an online survey, asking our communities to prioritise the actions for of Public Participation Action Plan • Identify groups and events to attend for Q1/Q2/Q3 • Online survey to ask our communities what “About Health” Events they are interested in for Autumn 2022 • Contact Town and Parrish Councils in T&W and Powys to promote involvement and membership • Attendance at the STW Involvement and Insight Network • Monthly email update to community members • Increase individual and organisational membership • Work with the divisions to ensure they meet their Section 242 duties	• Develop a social media plan to ensure that opportunities and engagement events are promoted • Contact Town and Parrish Councils in Shropshire, to promote involvement and membership • Relaunch our Young People’s Academy and offer a face to face training day • Put together Autumn/ Winter *About Health* programme and promote to our communities • Develop a video for staff on our Section 242 duties • Monthly email update to community members • Increase individual and organisational membership • Work with the divisions to ensure they meet their Section 242 duties	• Identify stakeholders and opportunities to build links with partners in Health and Social Care • Develop ”hybrid” models for People’s Academy to include face to face and online inclusion • Organise workshops to review our Public Participation webpages to ensure they are relevant and accessible • Monthly email update to community members • Increase individual and organisational membership • Review and update the public participation pages on our website • Work with the divisions to ensure they meet their Section 242 duties	• Develop mechanisms to ensure are “closing the loop” in terms of feedback and comments—documenting feedback at events, FAQ for service changes etc • Develop a You Said, we Did webpage. • Put together Spring/ Summer *About Health* programme and promote to our communities • Plan events and meetings to attend in 2023 to promote involvement and engage with our communities • Monthly email update to community members • Increase individual and organisational membership • Work with the divisions to ensure they meet their Section 242 duties	• **Update on Quarter 1:** • All actions have been completed and are reported to the Public Assurance Forum, Senior Leadership Committee and Trust Board • All actions for this year are linked to the Public Participation Plan • We have supported the Divisions this Quarter with the following service changes/developments: • ENT & Audiology • Mobile County Unit (Market Drayton and Bridgnorth) • Renal Dialysis (PRH)

SaTH Social Inclusion Action Plan Oct 2021 September 2022 V3 02/03/2022

PACT Partnering · Ambitious Caring · Trusted

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

NHS The Shrewsbury and Telford Hospital NHS Trust

Identified Area of Focus

A: Young People:
Methods of Engagement: partnership with VCS youth orgs, Youth parliament, outreach workers

B: LGBT+:
Methods of Engagement: partnership working with LGBT+ representatives and forums. Include SaTH & ICS Pride networks. Attention to engagement with the transgender community.

C: BAME:
Methods of Engagement: make contact with community leaders & representative groups.

D: Gypsy & Travellers:
Methods of Engagement: In person visits to sites with Traveller Officers.

E: Faith groups:
Methods of Engagement: Dialogue with representatives of Faith Groups. Establish relations with Interfaith organisations. Explore engagement opportunities e.g. Bangladeshi Welfare Association.

F: Carers:
Methods of Engagement: Engage with carer's groups and representatives—outreach & publicity. Articles for Carer's newsletters.

G: Substance Abuse:
Methods of Engagement: engage with carer's support groups; re-establish relations with existing support groups; outreach work.

H: Learning Disability:
Methods of Engagement: Engage with support groups & families & 'Experts by Experience'. Through volunteer outreach work.

I: Refugees/asylum seekers:
Methods of Engagement:
Engage local authority services and with refugee support groups

J: Homelessness:
Methods of Engagement; Liaison with VCS homeless organisations, outreach.

K: Armed Forces Veterans: Methods of Engagement:
Liaise with representative organisations, outreach.

L: Disability:
Methods of Engagement: Engage with representative groups and existing forums and Experts by Experience through Section 242 engagement.

Strategic Aims

To contribute to delivery of the Public Participation Plan, namely:

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2. **RESPONSIVE:** Build greater public confidence, trust and understanding by listening and being responsive to our local communities
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4 **GET INVOLVED:** Ensure our communities feel better informed and able to Get Involved if they choose too. Develop a range of involvement opportunities that are rewarding, meaningful and enable individuals from a diverse range of backgrounds to get involved.
5 **COMMUNICATION:** SaTH will communicate with our communities directly to ensure they are kept informed and update about what is going on at the hospitals (making use of digital communications)
6 **OUR STAFF:** Enabled our staff to have the skills and confidence to engage with our communities

Desired Outcomes

- Key barriers to engagement identified & mitigation in place
- Regular meetings/networks in place to keep in contact with stakeholders
- Increase in incoming enquires/engagement from stakeholders
- Increase in both group & individual membership

Key Risks / Benefits	L	C	LxC	Mitigation
Seldon Heard groups unwilling to engage/ engagement sample too small to report on	4	3	12	Wide networking by staff will enable engagement with multiple representative groups
Engagement does not meet needs of stakeholders	2	5	10	Monthly Board Reports to update progress will serve to highlight shortfall, if any
Barriers to engagement such as technology, team resources,	5	2	10	Signposting to community resources and collaborative working within ICS

Q3 — Oct — Nov — Dec

Focus on Rurality and Deprivation in North Shropshire

1. Carry out thorough gap analysis of existing contacts.
2. Meet with identified groups to establish initial contacts.
3. Make contact with identified groups and follow up with phone calls/ meetings. Promote organisational membership.
4. Establish contacts through Community Connectors Meetings.
5. Establish relationships in areas of multiple deprivation
7. Identify potential venues and events for Q1/Q2/Q3

Q4 — Jan — Feb – March

Focus on Rurality and Deprivation in North Shropshire

1. Link to Gap analysis.
2. Identify and establish contact with community groups in target area.
3. Build Community membership: organisations and individuals.
4. Develop KPIs for social inclusion ready for Q1
5. Develop engagement calendar Q1/Q2/Q3.
6. Create 'Grab n' Go' pack for external engagements.
7. Agree generic questions for engagement and outreach.

Q1 — Apr— May — Jun

Focus on Deprivation in Telford

1. Engage with rural & deprived communities from defined list.
2. Meet with minimum of 6 x stakeholder groups and Identify key barriers to participation
3. Meet with interest groups for organisational and individual membership
4. Build Community membership: organisations and individuals.
5. Monitor attendance at People's Academy, Health Lectures and Community Cascade.
6. Develop engagement resources for summer events in Q2
7. Take stand to Public Markets across all areas to engage public and recruit community members.
8. Contact Town and Parish councils

Q2 — Jul-Aug-Sep

Focus on Rurality and Deprivation in South Shropshire and Powys

1. Engage with stakeholders at calendar of summer events
2. Meet with minimum of 6 x stakeholder groups and identify key barriers to participation
3. Build Community membership: organisations and individuals.
4. Revisit gap analysis update action plan
5. Monitor attendance at People's Academy, Health Lectures and Community Cascade.
6. Review and update Gap Analysis.
7. Start building Project Report.
8.

General Notes

General Notes

Additional Points for Consideration:

- Collaborating with departmental colleagues for best use of resources.
- Sharing contacts within Public Participation Department (where appropriate).
- Networking with relevant external organisations.
- Measure volume of signposting to other Departments/Services e.g. PALS, Patient Experience.

Key Performance Indicators

Measure	Month	Quarter
Members	60	225
Organisations	4	12
Meetings held	3	10
Events attended	4	12

KPI's set on capacity of 0.6 WTE

SaTH Volunteer Development & Action Plan April 2022 March 2023

V3 16/06/2022

Stakeholder Groups

A. Volunteers
Volunteers provide additional capacity to support staff, patients and visitors through a combination of tasks that would not otherwise be fulfilled. Improving the patient journey, outcomes and staff wellbeing.

B. Staff
This is a key group that needs to be aware of SaTH Volunteers in order to help and support the Trust to achieve the agreed desired outputs.

C. Public
Engagement with the public is key to ensure the number of Volunteers is maintained to meet the needs of the Trust.

D. Schools, Organisations and Local Business.
Provides candidates for the young Volunteers Scheme. Groups and Organisations support with corporate volunteer days.

E. Other Volunteer Organisations.
Maintain relationships with other volunteer organisations such as LoF, Lingen Davies, British Red Cross, RVS etc.

Volunteer support:

Poppy Horrocks– Volunteer Project Manager
Rachel Higgins– Public Participation Facilitator
Aaron Hyslop- Public Participation Facilitator
Nicky Holland– Public Participation Administrator (Bank)

Strategic Aims

To improve the patient journey and their experience through a vibrant and effective volunteer programme. To ease pressures on staff and support their wellbeing.

To maintain the required number of volunteers to meet the demand from the areas supported by the volunteer service.

Identify new areas within the Trust for support that would receive a positive benefit from a volunteer programme and provide meaningful opportunities.

To reinstate volunteers who have been postponed due to the Covid19 pandemic.

To raise awareness of the Trust's volunteering activities with our patients, their families and stakeholders to encourage their engagement with us.

To provide experience of working in a hospital setting for young volunteers and those experiencing barriers to access volunteering opportunities or those looking for a career in the NHS, for example, the NHS Cadets and Young Volunteer Scheme.

Support our staff to effectively manage and support our volunteers while on placement.

Desired Outcomes

- To maintain the number of active volunteers at around 270 during the year.
- To support up to 60 active young volunteers (aged 16-17) during their volunteering.
- We seek to achieve 100 new successful applications throughout the year
- Ensure active volunteers have meaningful and regular placements.
- Identify 10 additional areas that would benefit from volunteers support and deliver that benefit.
- To provide a minimum of 2 positive news stories a month to support Public Participation

Key Risks	L	C	LxC	Mitigation
Number of volunteers does not meet demand	3	2	6	Actively recruiting volunteers to meet the demand and promoting volunteering at the Trust and encouraging volunteers to do additional shifts.
Exposing volunteers to potential health and safety risks	1	4	4	Accurate role descriptions and risk assessments. Alongside current and up to date training.
Sufficient resources within the Volunteer Team to manage the volunteer programme	2	2	4	Defined roles and processes to ensure all members of the team are capable of supporting the volunteer function. Bank shifts are being utilised.
Having a disproportionate exposure of staff at PRH	3	2	6	Reviewing options for additional office space and ensuring a member of the volunteer team is there once a week.
Volunteers expectations are not met	2	4	8	Quality interviews and open channels of communication between facilitators and volunteers

Q1 — April – May – June

- Identify new areas that would benefit from Response Volunteers Support in light of hospital guidance changes to ensure the role is meaningful
- Establish a calendar of engagement events with local schools and colleges
- Develop a communications plan for volunteering to encourage applications.
- Develop roles in A&E and Discharge through NHSE/I funded project to be ready for handover at end of April.
- Develop a young volunteer project to enhance the Young Volunteer Scheme.
- Review and update website content and social media exposure
- Deliver Volunteers' Week 2022
- Identify areas across both sites that require gardening volunteers

Q2 — July — August — Sep

- Contact local colleges with information on the Young Person's Volunteer Scheme
- Engage with fresher's events at local schools or colleges
- Recruit gardening volunteers to meet any identified need.
- Explore having a greater social media presence i.e. on Twitter, Facebook and Instagram
- Launch social media campaign to attract new volunteers, specifically young volunteers
- To be involved with and promote the Young people's academy to current and prospective volunteers
- Review Better Impact content (files, templates etc.) to ensure it is current.
- Review IPC training in light of hospital guidance changes and update as required

Q3 — Oct — Nov — Dec

- Promote volunteering through the Trust's Peoples Academy
- Ongoing development of Better Impact
- Review postponed volunteers and inform them of current roles
- Consider lead volunteer roles and how they could be developed to support the volunteer programme
- Raise awareness to Trust areas the benefit of having Volunteer support and encourage engagement with placing volunteers.
- Review options of a Staff volunteer management module.

Q4 — Jan — Feb – March

- Volunteer annual survey on the views of our volunteers
- Develop a plan for 2023/24
- Plan for Volunteers' Week 2023

General Notes

Progress against plan Q1

All actions against Q1 have been completed.

Actions have been reported on in SLC report and Quarterly Board report