The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 8 May 2025

SUPPLEMENTARY INFORMATION PACK

PAGE NUMBERS ARE LISTED ON THE MEETING AGENDA WITHIN THE MAIN BOARD PACK

The Shrewsbury and Telford Hospital NHS Trust

Public Participation Report

(October 2024 – March 2025)

Julia Clarke – Director of Public Participation

Volunteering | Engagement | SaTH Charity

Highlights of Public Participation

COMMUNITY ENGAGEMENT (for full details see slides 6 – 20)

- The SaTH Public Assurance Forum, which provides independent assurance on our engagement activities met on the 14 October 2024 and 13 January 2025 the highlights of this meeting are outlined in slides 6-7. Professor Trevor Purt (NED) co-chaired this meeting with Joy Jones (Montgomery Health Forum)
- The Public Participation Team continues to engage with the public through a regular series of virtual and face-to-face meetings, health lectures and newsletter updates. Our community members (5189) and organisations (469) continue to increase.
- Over the past six months, the Public Participation team have supported 56 HTP events with the public. We have attended 42 face to face meetings and events, and 14 online events. (There has been a pause in March/April 2025 due to local elections, in line with Cabinet Office guidelines).
- The community engagement team continue to reach out to our communities and have made links with our Gypsy and traveller community across Shropshire, Telford & Wrekin.

Highlights of Public Participation

NHS
The Shrewsbury and Telford Hospital
NHS Trust

VOLUNTEERS (for details see slides 21 - 28)

- We have 251 active volunteers within the Trust who have provided 13,883 hours of their time over the last six months. These are across 30+ clinical and non-clinical roles.
- Following a successful bid application the Trust are working with Helpforce (a national charity) to deliver a 6-month volunteer project which should help to reduce hospital readmission through safe and timely discharge and follow up community support.
- Our Volunteer to Career (VtC) programme has successfully delivered two new cohorts of volunteers within Radiotherapy and midwifery. Cohort 5 is due to begin in June within Midwifery. We have also launched our VtC Veteran and families programme, which will join cohort 5 in June but provide participants with the chance to look a range of clinical and non-clinical roles within the NHS

Highlights of Public Participation

The Shrewsbury and Telford Hospital NHS Trust

SATH CHARITY (for full details see slides 28 - 38)

- Income for 2024/5 is around £556k (total to be confirmed). This represents almost 56% increase on £357k income in 2022/3. The 6 months October 2024 – March 2025 was £209,142 compared to £319,462 in the same period last year. Expenditure for the same period was £147,179 compared to £116,195 in 2023
- SaTH Charity had **164** requests for support from SaTH Charity, **56** of which were for the staff Small Things/Big Difference Fund.
- Our supporters continue to fundraise for SaTH Charity, with some events highlighted in this report.
- A 5 year Charity Strategy(2025-2030) has been developed and approved by the Charity's Trustees and provide a clear direction of travel for the charity moving forward
- SaTH Charity Policy has been reviewed and amended and was approved by the Charity's Corporate Trustee's in March 2025

COMMUNITY ENGAGEMENT

COMMUNITY ENGAGEMENT
Public Assurance Forum 15 October 2024

The Shrewsbury and Telford Hospital NHS Trust

- The Public Assurance Forum (PAF) was established in 2021 to bring a public and community perspective to processes, decision making and wider engagement work at The Shrewsbury and Telford Hospital NHS Trust. The Forum provides constructive challenge and scrutiny of decisions from a patient and public perspective. They also share information back into their own organisations
- PAF has a wide range of community and statutory sector organisations as members as well as representation from SaTH's Divisional Leadership Team. All papers are available on the Trust website Public Assurance Forum – SaTH
- The Public Assurance Forum (PAF) met on 14th October 2024, key items that were discussed at the Forum included:
  - An update on the RSH modular wards from the Assistant Chief Executive
  - Presentation on the 2024/5 Operational Plan from the Director of Finance
  - Updates from partner organisations and Divisions
  - Presentation from the Director of Nursing on nurse staffing levels
  - Digital Transformation update with reference to the patient portal
  - Presentation on latest HTP developments and latest ongoing community engagement
  - Presentation from Director of Strategy and Partnership on key developments
  - Presentation on the Emergency Preparedness and Resilience core standards position at SaTH
  - Public Participation action plan update and review of draft Public Participation Board report

COMMUNITY ENGAGEMENT
Public Assurance Forum 13 January 2025

The Shrewsbury and Telford Hospital NHS Trust

- The Public Assurance Forum (PAF) met on 13th January 2025, key items that were discussed at the Forum included:

  - Updates from partner organisations
  - Updates provided by the Divisions on service development and any public engagement
  - Presentation on latest HTP developments (including the proposed presentation for the 'About Health' public update). The HTP Programme Board Engagement report for quarter 3 was discussed.
  - Digital Transformation update, including an update on the A&E waiting time webpage. After discussion with the group, a more detailed update will be provided at April's meeting
  - Presentation from Associate Director of Strategy and Partnership on key developments
  - Public Participation action plan update (including Plan on a Page for Charity, Community Engagement and Volunteers) was discussed

Community Engagement

The Shrewsbury and Telford Hospital NHS Trust

- The Community Engagement team hold a series of community events 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 newsletter update –** An email update to our 5000+ members and organisations
  - **Monthly Hospital Update (previously Community Cascade)** – this is a public session delivered once a month by the Director of Public Participation and focuses on current hospital news, public participation update and provides a Q&A opportunity. The presentations are available on our website
  - **About Health Events**– There is an ongoing series of one hour Teams health events delivered by health professionals for staff and the public on topics including the menopause, HTP, chaplaincy and other requested topics. The sessions are recorded and available on the website, with an opportunity for Q&As.
- The Hospitals Transformation Programme remains the main theme of feedback received by the Community Engagement team and we continue to work closely with HTP colleagues to support ongoing engagement.

Community Members

Total at 31/03/25 **5189**

Joined Oct - March **194**

Organisations

Total at 31/03/25 **469**

Joined Oct - March **40**

Community Events

Held Oct - March **12**

Attended Oct - March **60**

Community Engagement

The Shrewsbury and Telford Hospital NHS Trust

The Engagement team have attended a wide range of events across the whole of Shropshire, Telford & Wrekin and mid-Wales over the past 6 months, sharing information about HTP, volunteering and involvement opportunities and gathering feedback about SaTH services.

Events included:

- Wem Health event
- Montgomery Health Day
- Carer's Rights Day events in Telford & Shrewsbury
- Dementia Information Day at Bridgnorth Rugby Club
- Shropshire Rural Support
- Community Connectors (across Shropshire and Telford &Wrekin)
- Welshpool Livestock Market
- Community Open Day (Donnington)

Gypsy Travellers' Outreach, Donnington

Community Engagement - Hospital Events

The Shrewsbury and Telford Hospital NHS Trust

Our Autumn/Winter About Health programme has covered a wide variety of topics including:

- Menopause
- HTP (x2)
- Pastoral Care in our hospitals
- Research & Innovation
- Emergency Planning
- Parking Now and in the future

When the public register for these events they are asked if they want to join the Trust as community members. The Parking event alone brought more than 20 new members who now receive our monthly updates.

Allowing for breaks for Christmas and the pre-election period, the engagement team have also delivered:

- 4 x online Hospital Update meetings
- 2 x Young People's Academy and 1 x People's Academy

Our Menopause About Health event remains our most popular session and was attended by ~100 people

Our Pastoral Care About Health event had >20 people attend and created a new volunteer for the team

Quarterly updates about research opportunities at the Trust are now included in #GetInvolved

We shared information about onsite parking to >20 members of the public with potential to follow up in 12 months

Social Inclusion - Gypsy and Traveller Outreach

The Shrewsbury and Telford Hospital NHS Trust

One of our areas of focus this year is increasing engagement with the Gypsy Traveller communities living in Shropshire, Telford & Wrekin and mid-Wales.

We have been working with local Councils and health partners and have visited a number of sites including Lodge Road (Donnington), Lawley and Park Hall (Oswestry). We were joined at the March visit by our EDI Midwife and are looking for further opportunities for joint visits in 2025.

The purpose of our visit was to understand how we can engage and involve with this seldom-heard community. Feedback included:

- Prefer to be given information face to face, although some people we spoke to use Facebook.
- Difficulty in accessing online forms
- Information being provided in a simpler format

We have liaised with the relevant areas regarding this feedback

HTP ENGAGEMENT

Getting involved with HTP

The Shrewsbury and Telford Hospital NHS Trust

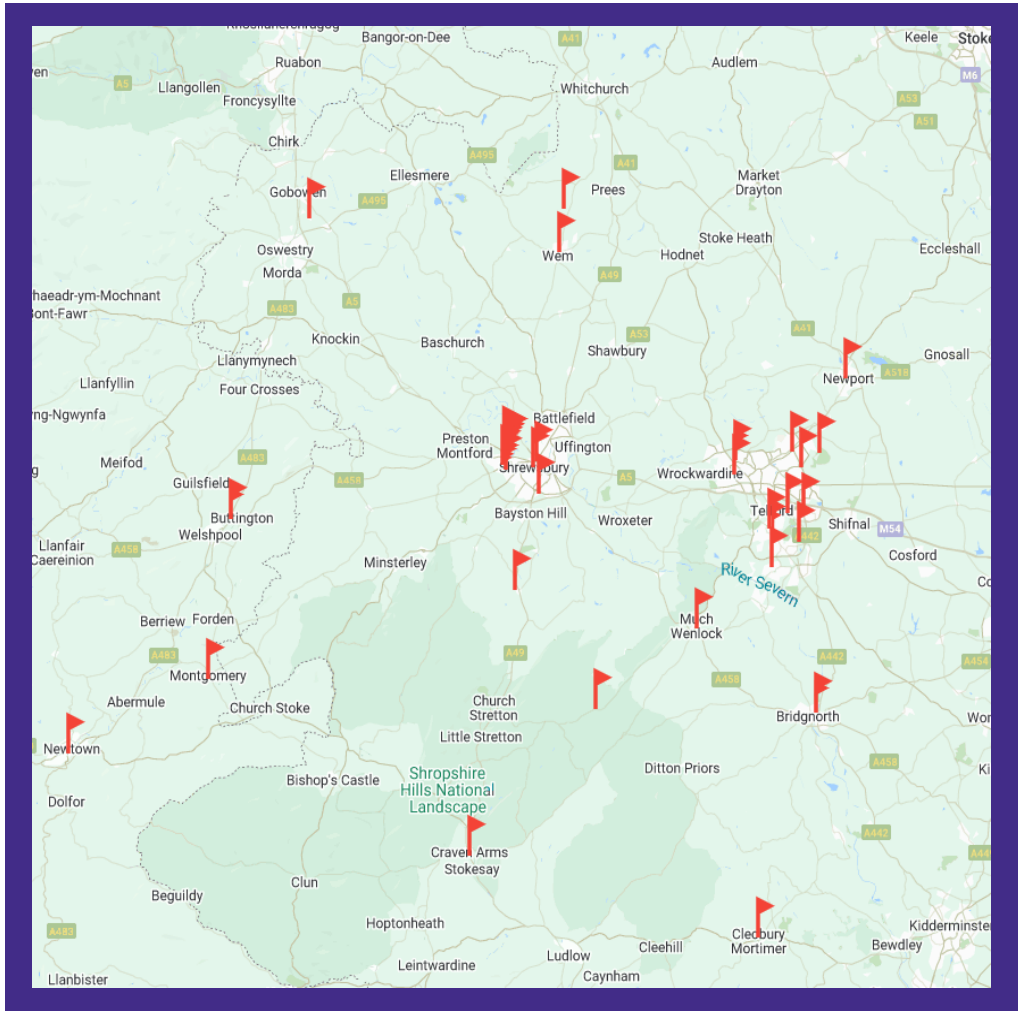
The Public Participation Team has been supporting our Trust to engage with our local communities around the Hospital Transformation Programme (HTP). The team has organised a number of events including:

- **Quarterly focus groups** which are aligned to our clinical workstreams. Workstream focus groups have been planned over the next two years which will inform the plans as they develop towards implementation and will continue until the programme is completed. We hold the focus groups every three months, and members can either attend in person or via MS Teams. Focus groups were held in early March, July and September for Medicine and Emergency Care with Surgery, Anaesthetics, Critical Care and Cancer and another for Women & Children's services
- We are holding a series of specialised focus groups based upon the feedback we received from our quarterly focus group members and local communities. From April-September we have held HTP focus groups for patients with Dementia, Mental Health, Children and Young People, the new RSH Front Entrance and for patient who are deaf with BSL translators. In October focus groups were held for our hard of hearing communities and our Armed Forces Community, as well as two for GP Patient Participation Groups.
- **Presentations, Q&As and action logs** from our focus groups are published in the public domain and can be found here with the Q&As from the focus groups : HTP Focus Groups – SaTH
- **Quarterly *About Health HTP* events** have been delivered using MS Teams in April, July and October and the next About Health event is on the evening of **Tuesday 6th May 2025 at 6.30pm.** All About Health events are recorded and available on the website

HTP Engagement Map

The Shrewsbury and Telford Hospital NHS Trust

- The map displays the **42** events we have attended in the reporting period (October 2024 – March 2025) and discussed HTP with the public.
- Please note that all external engagement from the 10th March has been paused due to being in pre-election
- We have also organised/attended **14** online meetings/events; often these meetings cover large geographical areas across T&W, Shropshire and Powys.
- We held **6** focus groups in this period as well as tours of ED1 in place of the quarterly focus groups scheduled for March, attended by **63** members of the public.
- We hosted **6** drop-ins in community settings across the areas we serve during this period, attended by **180** members of the public.
- **13** presentations were delivered to **205** people.



HTP Engagement

The Shrewsbury and Telford Hospital NHS Trust

In Q3 2024/25 we attended the following events :

Date	Event
01 October 2024	Wem Rural Parish Council
03 October 2024	Hard of Hearing Focus Group
08 October 2024	RSH Volunteers - entrances focus group
11 October 2024	Much Wenlock Drop-in
14 October 2024	Public Assurance Forum
17 October 2024	Armed Forces Focus Group
22 October 2024	Volunteer Coffee and Catch-up
24 October 2024	PPG Focus Group F2F
24 October 2024	PPG Focus Group Online
29 October 2024	About Health HTP
30 October 2024	Young People's Academy
26 November 2024	Telford Town Centre Drop-in
03 December 2024	MEC&SAC Focus Group
05 December 2024	W&C Focus Group
05 December 2024	RSH Residents Drop-in
09 December 2024	Welshpool Livestock Market Drop-in
11 December 2024	Volunteer Coffee and Catch-up

Tom Jones and Aaron Hyslop with Senedd Member for Montgomeryshire, Russell George, at Welshpool Livestock Market

HTP Engagement

In Q4 2024/25 we organised and facilitated the following events:

Date	Event
08 January 2025	Wellington Probus Club
13 January 2025	Public Assurance Forum
28 January 2025	About Health HTP
28 January 2025	Rotary Club of the Severn
29 January 2025	Countywide Community Connectors
14 February 2025	Newport Market Drop-in
20 February 2025	Young People's Academy
25 February 2025	RSH Residents Drop-in
13 March 2025	People's Academy
13 March 2025	Rotary Club of the Wrekin
18 March 2025	MEC&SAC & W&C ED1 Tours

Julia Clarke, Matt Neal and Ed Rysdale with David Morris, President of Rotary Club of the Severn

Upcoming Engagement & Focus groups

The Shrewsbury and Telford Hospital NHS Trust

We are entering an exciting phase for the programme as we design the detailed patient pathways. We are committed to engaging and working closely with our local communities, patients and colleagues to ensure we improve the experience for all the communities we serve.

The next Focus Groups:

- **Communications and engagement for Urgent and Emergency Care (UEC)** on Tuesday 3 June at 10:00am (Hybrid meeting)
- **Wayfinding for new healthcare facilities** on Thursday 5th June at 10:00am (Hybrid meeting)
- Please note all Focus groups can be attend in person or via MS Teams

Our next **HTP About Health event** will be held on MS Teams on 6th May 2025 at 6.30pm (Via Microsoft Teams)

Drop-in sessions or meetings are being planned throughout Shropshire, Telford & Wrekin, and Powys, which will provide the opportunity for members of the public to find out more about the programme; dates now confirmed for:

- Church Stretton Co-op – 2nd May, 10:00-13:00
- Shrewsbury Mayor's Charity Fete, Shrewsbury Quarry – 5th May, 10:00-16:00
- Wellington Market – 9th May, 10:00-14:00
- Ironbridge Co-op – 12th May, 12:00-16:00
- Wem Rural Community Drop-in, Edstaston Village Hall – 21st May, 10:00-12:00
- Oswestry Charity Market (Outdoor Market) – 6th June, 10:00-13:00
- Welshpool Market (town centre) – 16th June, 10:00-14:00
- Ludlow Market (Buttercross) – 23rd June, 10:00-14:00
- Bridgnorth Market – 11th July, 10:00-14:00
- Market Drayton Indoor Market, Wednesday 17 September, 10am-1pm
- Lydham Friday market (Lydham Village Hall), Friday 3 October, 10am-1pm

Focus Group Tours of ED1

The Shrewsbury and Telford Hospital NHS Trust

A special event was held in March in which focus group members were invited to see the first area that has been developed as part of the Hospital Transformation Programme – ED1. ED1 is the first development of our new emergency department at RSH and has our resuscitation area and part of our new Major's. Over 22 members of our focus groups and volunteers attended. Some of the feedback from those who saw the new ED1 is below:

So much consideration has been given to the detail and the needs of patients and staff. A real achievement on the part of everyone involved"

Jenny Horner, Market Drayton Patient Participation Group Chair

The spacious facilities, including larger resuscitation bays and an improved majors area, will create a modern, well-equipped and patient-focused environment for urgent and emergency care. It was great to see firsthand how these changes will make a real difference to the experiences of patients and staff.

Andrea Blayney, Deputy Regional Director, Llais

"

*We were given an informative tour and chat about the new areas, and, **WOW!** It's a huge improvement to our current A&E….much more space, thoughtfully laid out"*

RSH A&E Volunteer

Additional Engagement Routes

The Shrewsbury and Telford Hospital NHS Trust

Event & Date	Subject
Hospitals Update meeting	Monthly Trust News Update including update on HTP
Monthly newsletter email update - sent to our 4900+ community members	Update from Public Participation team including HTP update and details on how to get involved
Three weekly 1:50 HTP Clinical design meetings in ED, acute medicine, critical care, maternity & children's services – Public Assurance Forum member representatives on each group	Detailed design discussions with architects and clinical teams
Quarterly Public Assurance Forum (next one July 2025) with representatives from organisations across health & social care in Shropshire, Telford & Wrekin & Mid-Wales	Presentation from HTP team with Q&As
SaTH website and intranet	Webpages which support public engagement and Latest HTP meetings/feedback Public Participation - SaTH

VOLUNTEERS

Volunteers

The Shrewsbury and Telford Hospital NHS Trust

- We currently have **251** active volunteers at the Trust.
- Our volunteers continue to provide support to “one-off” events including:
  - **Exercise SPRING! –** on 18th March 15 volunteers supported ‘Exercise SPRING!’. In view of the Hospitals Transformation Project (HTP), the Trust handed over part of the new Emergency Department (ED)/ Resus in March 2025. The Trust was required to undertake and demonstrate that we could safely evacuate the new areas of the ED footprint. The live exercise, where volunteers posed as patients and their family members tested the progressive Horizontal Evacuation Strategy for the new ED majors and resus.
  - **William Farr Academy** – once again Volunteers supported both the Medical Work Experience Day and the MMI Day for aspiring medical students.
  - **Volunteer Wrapping Gifts –** volunteers helped the charity by wrapping Christmas present donations for children which were delivered to lots of different areas throughout the hospitals.
- We have held a number of focus group for our volunteers including:
  - **HTP Entrance Support** - A feedback session was held with members of the HTP team and volunteers who are helping with the entrance changes. The session was to feedback some of the actions that have been put in progress after feedback from those volunteers. It was also to say thank you for all their work
  - **‘Autism Awareness’** – an excellent focus group was hosted by one of our new volunteer Wendy Dodman. Wendy spoke about being diagnosed with Autism in later life. Over 20 volunteers attended which was a great turnout.
  - Former volunteer (and previous winner of Volunteer of the Year) Ethan Holmes hosted a focus group to talk about how volunteering propelled his career to become a paramedic.

Oct 24 – Mar 25

Total Active volunteers	251
Total hours	13,883

Volunteer Highlights

- **House of Commons** – Julia Clarke and Hannah Morris were invited to attend an event at the House of Commons, Over 80 leaders from across government, the NHS and voluntary and community sectors attended for the launch of a new report by Helpforce - "Unlocking the Power of Volunteering to support our NHS". With in the report SaTH's Volunteer to Career programme was highlighted as an area of good practice.

- **Volunteer Team –** During the past 6 months there have been changes within the volunteer team. At the end of March we welcomed 3 new members of staff to the team – Volunteer Services Manager (Pete), Volunteer Project Lead (Eve) and a Volunteer Facilitator (Jez)

Volunteer Highlights

- **Volunteer Terry Seston turned 90! –** Terry celebrated his 90th Birthday in January and the volunteer team surprised him with a cake and present for his birthday. The news of Terry turning ninety spread and he was featured on the BBC news website and on Midlands Today News

- **Volunteer Celebration Event** – Volunteers were celebrated as part of the Trust's annual Recognition week in the lead up to the Trust awards. Over 60 volunteers came along to the event, held at the Wroxeter Hotel and were able to meet our new CEO and Chair in Common.

- **Volunteer of the Year** – Peter Hicking won the title of Volunteer of the Year at the Trust Awards. Peter regularly contributes over 1,000 hours of volunteering every year

Volunteer Highlights

Volunteer Claire Ashton – As part of LGBT+ History Month, Volunteer Claire Ashton was interviewed by the BBC about how her experiences in the army as a trans women led to a mental breakdown.

“Claire Ashton felt different to other soldiers in the Royal Artillery. She had joined the army in 1969… At the time it was illegal to be gay in the armed forces, something Ms Ashton was not, she was in fact transgender.

"They thought I was gay, but trans hadn't crossed their radar all those years ago" She faced constant speculation and inappropriate questioning, and the pressure of hiding her identity became so overbearing that she had a mental breakdown while on deployment in Germany in 1972 and was medically discharged by the army.

In 2023, Ms Ashton was chosen by Fighting With Pride to carry the charity's flag during the Festival of Remembrance at the Royal Albert Hall in front of the King and Queen.

"There wasn't a prouder veteran that day," said Ms Ashton.

https://www.bbc.co.uk/news/articles/c4gwegv2z54o

'The Army's gay ban led to my mental breakdown'

Claire Ashton became a police officer after leaving the army

Rob Trigg
BBC political reporter, Shropshire

24 February 2025

Volunteer Discharge Project

The Shrewsbury and Telford Hospital NHS Trust

Following a successful bid proposal to the ICB the Shrewsbury and Telford Hospital NHS Trust and Helpforce are working together to deliver a 6 month volunteer project which should help to reduce hospital readmission through safe and timely discharge and follow up community support. This project starts in April 2025

This proposal sets out the resources needed to expand the existing SaTH volunteering services to support the Trust's discharge services to:

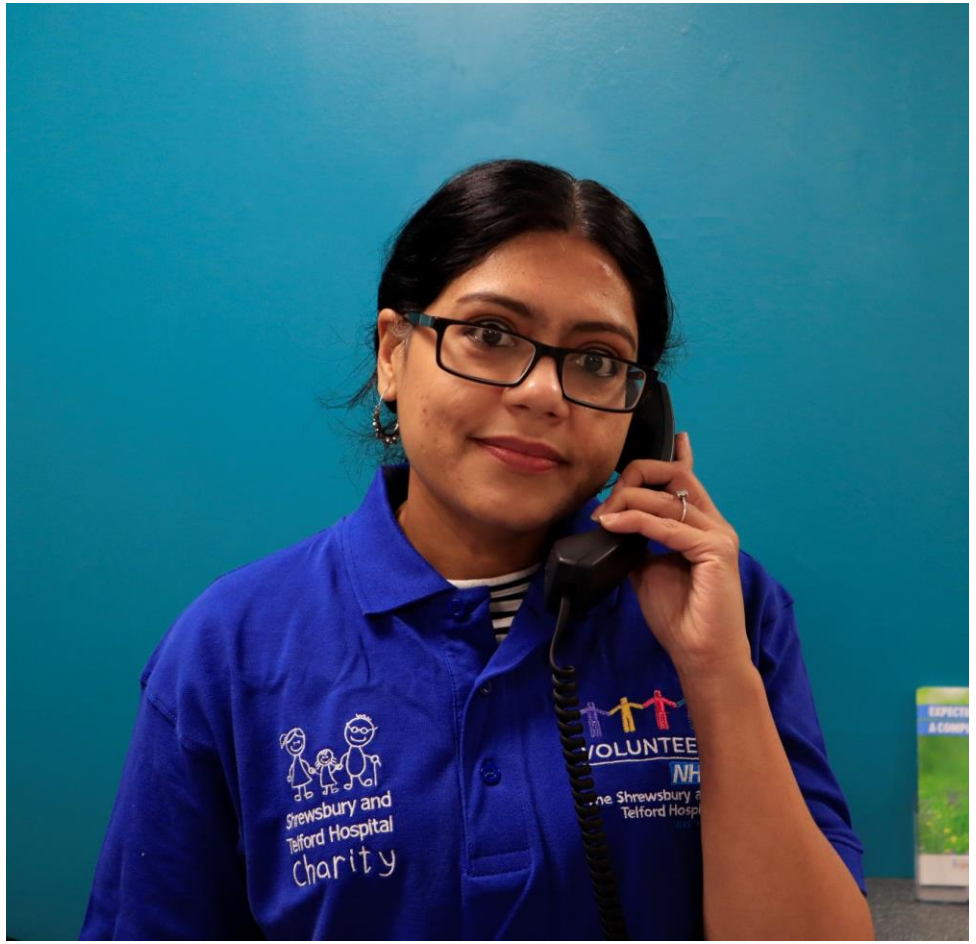
- Speed up the discharge of patients from hospital to their home
- Provide transport and ensure they have support to settle in when arriving back at home
- Identify and support any additional support needs that may arise in the first few days being back at home
- Reduce the risk of the patient being readmitted to hospital.

PROJECT: Discharge Volunteer Roles

The Shrewsbury and Telford Hospital NHS Trust

The volunteer roles required can be split into three main areas:

- **Discharge Volunteers**: these are based in the hospital to support the discharge flow i.e. collecting prescriptions, helping to transport patients from wards to the discharge lounge.
- **Volunteer drivers**: this would be to transport home for suitable patients using a Trust car and support on the day of discharge i.e. ensure that they are safe, well, and warm i.e. have food and drink, and a safe environment at home (e.g. the lighting, water and heating are all fully functional). Could also reduce SaTH reliance on private taxi hire.
- **Settling in volunteers**: wherever possible, working with the Discharge team, a volunteer will meet the patient in hospital just prior to discharge and make telephone calls to ensure patients are comfortable and integrated back into their homes and communities following a stay in hospital. They will call the patient on the next day or within 48 hours if at the weekend and provide support and advice for patients and referrals to other local relevant organisations (where appropriate). These volunteers provide extra support (up to) one week following discharge from hospital, helping to spot problems early on, and prevent readmission to hospital.



DISCHARGE PROJECT: Outcomes

The Shrewsbury and Telford Hospital NHS Trust

Initially the service will run Mon-Fri 9am-5pm.

Once the service has been embedded we would expect:

- Minimum of 50 new discharge calls per month and followed up calls for a maximum of three days post discharge – potentially 200 calls per month
- The service growing incrementally and becoming like business as usual so that next year additional voluntary sector support may not be required
- Regular meetings with stakeholders to highlight positive and/ or constructive feedback for improvement
- A full independent post-project evaluation by Helpforce capturing key indicators

Volunteer to Career (VtC)

Volunteer to Career
a Helpforce programme
Volunteering for your future

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Volunteer to Career
The aim of the clinically-led VtC programme is to provide volunteers with career support and interventions including career conversations, mentoring, guidance on career pathways, employability support and mock interviews and skills. Alongside this the volunteers also get the chance to volunteer for 50+ hours within the designated clinical area.

Cohort 3 (Radiotherapy) and Cohort 4 – Midwifery

Over the past the 6 months we have run a VtC cohort in radiotherapy (RSH) and within midwifery (PRH).

- We have closed the end of the 'formal support' for Cohort 4 and 5 and in December and March we celebrate their success in a celebration evening.

- Our volunteers within Radiotherapy contributed over **461 hours of volunteering** and our maternity volunteers have contributed over **893 hours**

Cohort 5 – Midwifery and Veteran & Families

- In partnership with the national charity Helpforce we are offering the opportunity to extend our Volunteer to Career programme to Veterans and their families. This will be a bespoke cohort and participants will have the chance to look at different roles in the NHS
- In March we held a 'Find out more' session on MS Teams for potential volunteers to find out more about the Volunteer to Career

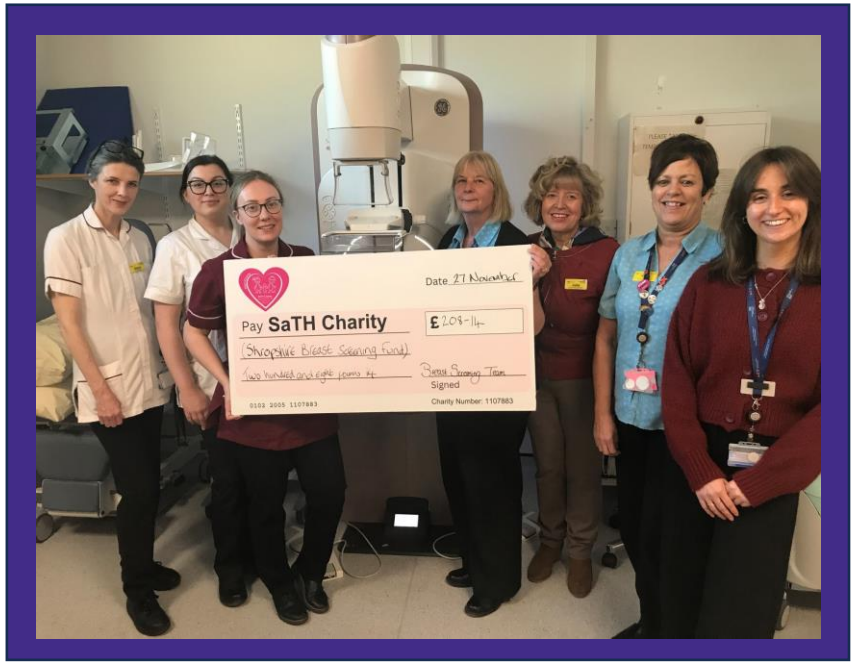
NHS
The Shrewsbury and Telford Hospital
NHS Trust

SaTH CHARITY

SaTH Charity Highlights

The Shrewsbury and Telford Hospital NHS Trust

- SaTH Charity annual accounts 2023/24 were published on the Charity Commission website in January 2025 and saw a 39% increase in income from £359k to £497k.
- The income for 2024-2025 is around £556k (to be confirmed) which is almost 56% on income of £357k in 2022/3, when fundraising support was increased from 0.2wte (currently1.6wte).
- Income for the 6 months October 2024 – March 2025 was £211,146 compared to £273,822 in the same period last year. Expenditure for the same period was £139,659 compared to £131,995 in 2023
- **During this period SaTH Charity had:**
  - **1296** monetary donation entries registered on the charity database, this is more than usual and the increase was down to the successful charity abseil and Lake Vyrwny half marathon that took place during this period.
  - **35** donations were 'In Memory' donations from funeral services
  - **1082** members of staff are now playing the staff lottery
  - There were **164** requests for support from SaTH Charity, **56** of which were for the staff Small Things/Big Difference Fund (mainly funded by the staff lottery).



SaTH Expenditure

The Shrewsbury and Telford Hospital NHS Trust

- There were **136** approved requests for charitable funds. Examples of approved funding included:
- Specimen x-ray window – this request was for an additional x-ray window so both theatre rooms had this capability. The window gives the ability to visualise the specimens and to harvesting more samples preventing 'Insufficient' pathology biopsies. **£15,000**
- Urodynamics Machine – this additional Urodynamics machine at RSH would enable those urology patients who do not require x-ray to be seen in a separate clinic educe the time waiting to an estimated 12 weeks rather than the current 40 weeks. **£13,026**
- Single-use cordless retractor - the lighted retractor is indicated for enhancing visibility to a surgical field through retraction of soft tissue and illumination of the surgical cavity. It is intended for general, plastic, and reconstructive procedures in breast. **£5,461**
- HTP wayfinding signs – this was requested to enhance the signage around the organisation to improve patient experience and access. The method was tested by the HTP and received positive feedback from volunteers who requested this improvement. **£4,894**
- Furniture for professional nurse advocate (PNAs) 'safe space' – furniture was requested to furnish the safe space where staff and the PNAs can talk.

SaTH Charity Supporters

The Shrewsbury and Telford Hospital NHS Trust

SaTH Charity Supporters – we have approximately 1,045 supporters in two categories

1) Donors

Provide financial support to the charity – this could be through a one-off donation, or multiple donations.

2)Fundraisers

Organise events, and other initiatives, such as a sponsorship for a marathon, to raise money and donations.

We are currently working to report more on our supporters and how we can support them (stewardship). This information will be gathered using the Beacon Database which has been collecting this data since August 2022.

Donors	
Number of Donations	Total
1	875
2 to 5	70
5 and above	9

Fundraisers	
Number of Fundraising Pages	Total
1	74
2 and above	17

Thank you supporters!

Thanks to the ongoing relationship with The Works in Shrewsbury, the charity received six boxes filled with donations, purchased by their customers, including nearly 1000 packs of stickers, books and soft toys.

Stickers are very popular with our young patients, they can help a child feel better about visiting the hospital and children will often stop crying to choose their favourite sticker!

We are honoured to have SaTH Charity's Dementia Appeal chosen as one of the charities to benefit from donations made to the Telford's Tree of Life which is organised by the four Rotary Clubs of Telford. The tree could be viewed at Telford Shopping Centre.

The Tree of Life gives loved ones an opportunity to sponsor a name on the tree. These names are displayed on the Tree of Light in Telford Centre, Orbit Wellington and the windows of Tranter Lowe's offices in Oakengates.

Sally Jamieson's Halloween Event

Sally runs a yearly Halloween event to raise awareness of breast cancer as part of the breast cancer awareness month in October. This year she had to change plans due to flooding at the planned venue and instead held an event selling cakes and tombola at a local Co-op.

She was joined by her granddaughter Willow Mitchell, and her two friends Molly Moore and Ella Seeney, selling the jewellery. The sales from the spooky jewellery raised £60 The event raised £1561 in total for the Breast Cancer Fund.

Impact Statement:

"We are so grateful to receive this donation from Willow, Molly and Ella.

"I'm so impressed with their ingenuity and thoughtfulness at creating items for SaTH Charity. We know this money will make a real difference to patients who are receiving treatment for breast cancer.

We are also very grateful to Sally for her ongoing support of SaTH Charity."

Julia Clarke, Director of Public Participation

Willow Mitchell, Molly Moore and Ella Seeney selling jewellery.

Football Tournament support

The Dementia team have received items purchased thanks to all the generous supporters of the second annual SaTH Charity Football Tournament, organised by RSH Porter Mark Rawlings back in May. The tournament raised nearly £5,000 for the Dementia appeal of SaTH Charity and saw Drongo United lift the trophy.

The event was a great success with 140 members of staff from SaTH taking part and hundreds of supporters cheering them on.

The money raised from the day has enabled the dementia team to purchase single-use items such as reminiscence dolls, teddies, other nostalgic items and activities for patients living with dementia.

The next SaTH Charity football tournament is planned for **1st June 2025** and we are looking for staff teams to join this amazing charity event!

Impact Statement:

"We are so grateful to Mark and the players for choosing the dementia care appeal. We use lots of single use items to support our patients like reminiscence dolls and teddies, the money raised will make a real difference to our patients and enable us to provide more support."

Karen Breese, Dementia Care Clinical Specialist

Members of the Dementia Team with items purchased from donations raised by the football tournament

Ward 32 Courtyard Redevelopment

The courtyard on Ward 32 (Trauma and Orthopaedics) at RSH has been redeveloped with the help of SaTH Charity, who purchased the area a new gazebo and two new benches.

The gardening team at RSH has worked closely with the ward staff to create raised beds, filled with sensory plants that can support patients who have memory issues to connect with nature and memories of their gardens. The area will also give patients an opportunity to get outside and to try some reconditioning activities.

Impact Statement:
"The patient's moods were immediately lifted by coming outside, sitting in a green space and feeling the sun on their skin. We can't underestimate the importance of getting patients outside not only for their physical health but their general wellbeing. I look forward to seeing how the garden develops."
- **Jo Williams, Chief Executive of SaTH**

Opening of the courtyard on ward 32.

Working in Partnership

The Shrewsbury and Telford Hospital NHS Trust

Urodynamics Machine £26,000

SaTH Charity and the League of Friends of Shrewsbury and Telford Hospital jointly purchased an additional Urodynamics Machine for the Urology Service. Machine is a specialised piece of equipment used to measure bladder and urethral function during a urodynamics test. The Urology Team has recently raised over £2,000.00 during the SaTH Charity Abseil in 2024 which was put towards the purchase.

Impact Statement:

"An additional Urodynamics machine at RSH would enable those urology patients who do not require x-ray to be seen in a separate clinic. It will also provide this service on both hospital sites – enabling intervention closer to home for some.
A 2nd urodynamics machine would result in reduction of this waiting list by 104 patients. This would reduce the time waiting to an estimated 12 weeks rather than the current 40 weeks.

Example of the type of eurodynamics machine purchased

HTP Wayfinding Signs at RSH

The Shrewsbury and Telford Hospital NHS Trust

After the outpatient entrance was closed to start building work for the Hospitals Transformation Programme, SaTH Charity was asked to fund wayfinding signs to support patients and relatives to navigate to and from the clinics and the Treatment Centre/Ward Block entrances. The additional signage cost £4,995 and has had a positive impact for visitors to the hospital.

Impact Statement:
"Due to the new HTP building at RSH, the old outpatient entrance was closed. As a result, we received feedback from patients and volunteers about how to improve the signage from the alternative entrances. Thanks to the charity the signage is now in place and is helping patients and relatives navigate to the right department."
Rachel Webster, HTP Nursing, Midwifery and AHP lead

Furniture for Professional Advocate Team

The Shrewsbury and Telford Hospital NHS Trust

Thanks to SaTH Charity, the Professional Nurse/Midwifery/AHP Advocate Team now has a comfortable 'safe space' to facilitate Restorative Clinical Supervision (RCS) sessions for our colleagues working at PRH.

SaTH Charity 'Small Things Fund' purchased 2 comfy chairs and a coffee table to furnish the room, make it more inviting. Previous feedback from the team highlighted the difficulties in finding a suitable place to meet with members of staff away from their place of work to talk openly and confidentially.

Impact Statement:
"I can't thank you enough for helping the Professional Nurse/Midwifery/AHP Advocate team create a comfortable 'safe space' to facilitate Restorative Clinical Supervision (RCS) sessions for our colleagues working at PRH. We hope to create the same at RSH in the future."
Karen Sargent, Professional Nurse Advocate

Karen Sargent, Professional Nurse Advocate Lead with the items SaTH Charity purchased.

Looking Forward

Public Participation- Forward Look

- The Public Assurance Forum to meet on 14 April 2025
- Continue to support staff with any future service changes engagement
- Supporting the HTP Engagement programme, including quarterly focus groups for the public and patients.
- Continued attendance at community events to engage with the public
- Continuing to support staff wellbeing through Charity Small Things Big Difference Fund
- 1-7 June is National Volunteer Week and we will be celebrating with our volunteers and staff with a special “Thank you” event on 4th June
- Work with Helpforce to set up the Veterans to Career pilot and the Volunteer Discharge Project.

Dates for your diary

The Shrewsbury and Telford Hospital NHS Trust

Date	Time	Event	Booking
Thursday 22 May	18:30 – 19:30	*About Health* – **Operational Update**	
Wednesday 28 May 2025 Wednesday 25 June 2025	11:00 – 12:00	**Monthly Hospital Update** (formerly Community Cascade)	

About Health events are held on Microsoft Teams and take place 18:30 – 19:30.Further details and booking information can be found on our web pages here: https://bit.ly/SaTHEvents

Hospitals Transformation Focus Group

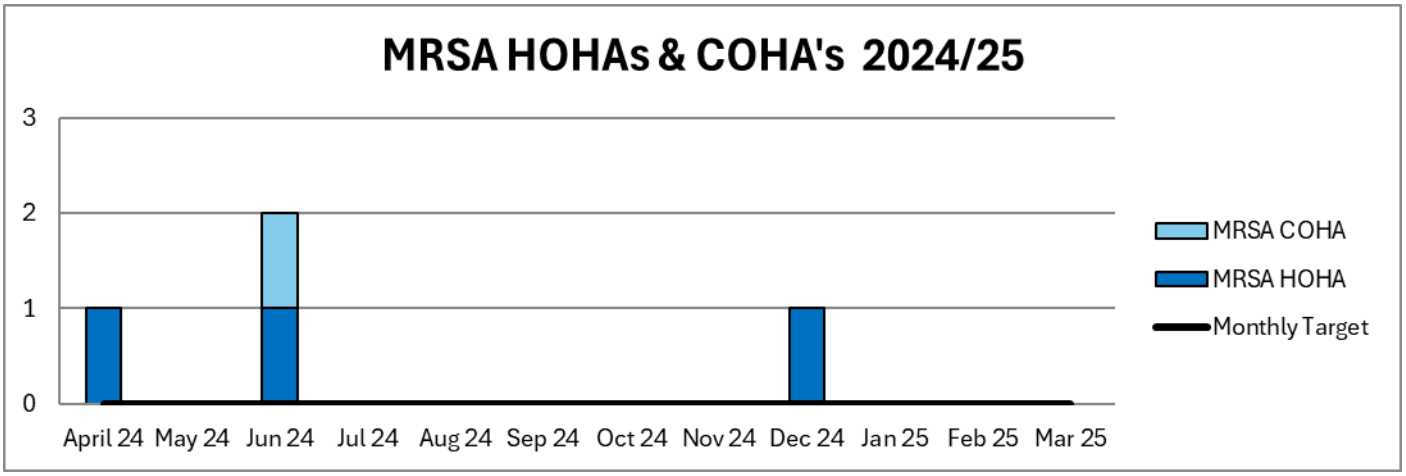
Date	Time	Event	Booking
Tuesday 6 May 2025	18:30 – 19:30	*About Health* – **Hospitals Transformation Programme**	If you are interested in joining a Focus Group please email sath.engagement@nhs.net
Tuesday 03 June 2025	10:00 – 12:00	**Communications and engagement for Urgent and Emergency Care (UEC)**	
Thursday 5 June 2025	10:00 – 12:00	**Wayfinding for new healthcare facilities focus group**	

Appendix 1 HCAI targets 2024/25

	2023/24 Target	2023/24 Actual	2024/25 Target
C. diff	32	97	98
E. coli	90	147	146
Klebsiella	22	38	36
Pseudomonas	18	21	19

Appendix 2 HCAI graphs

Table 1



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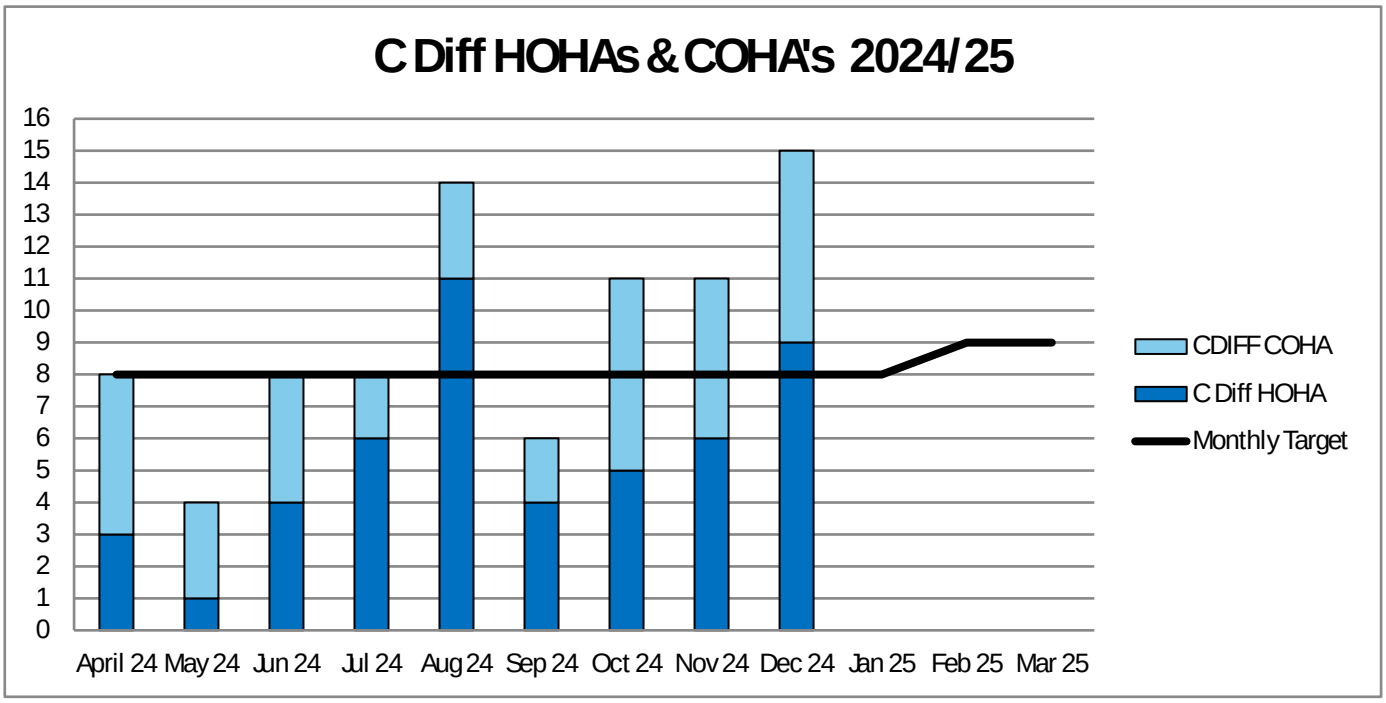

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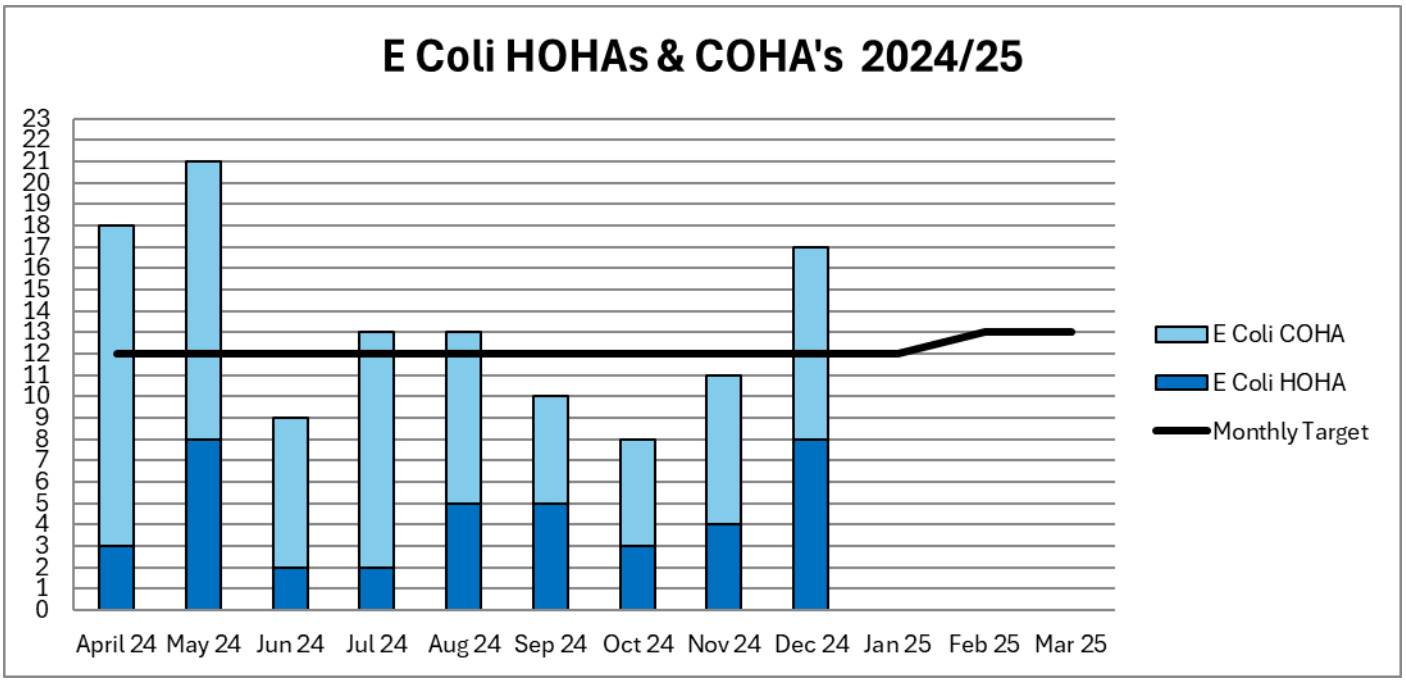

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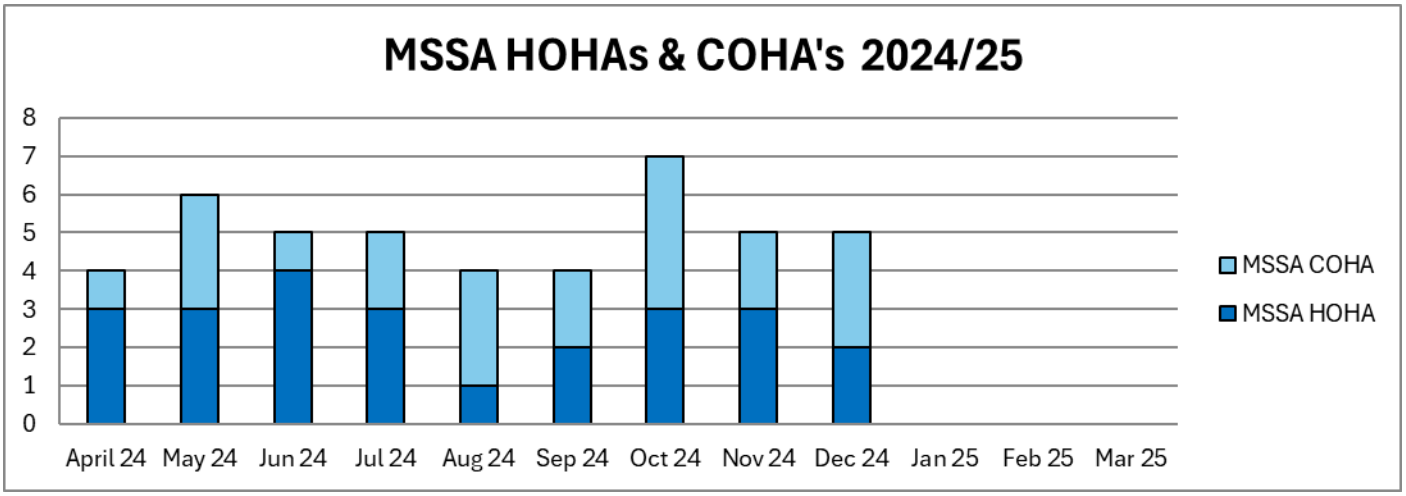

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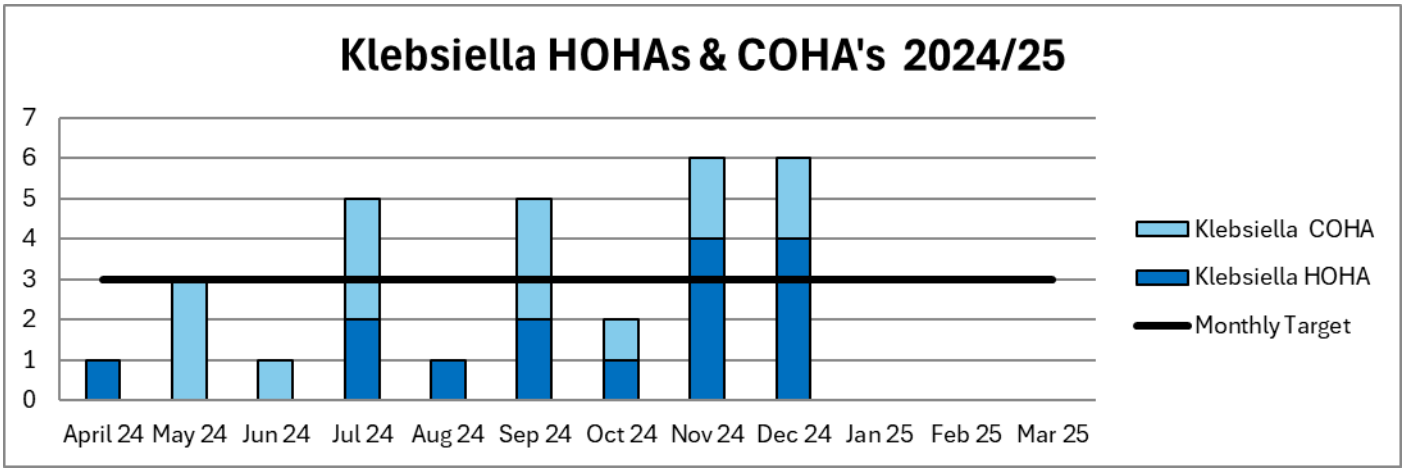

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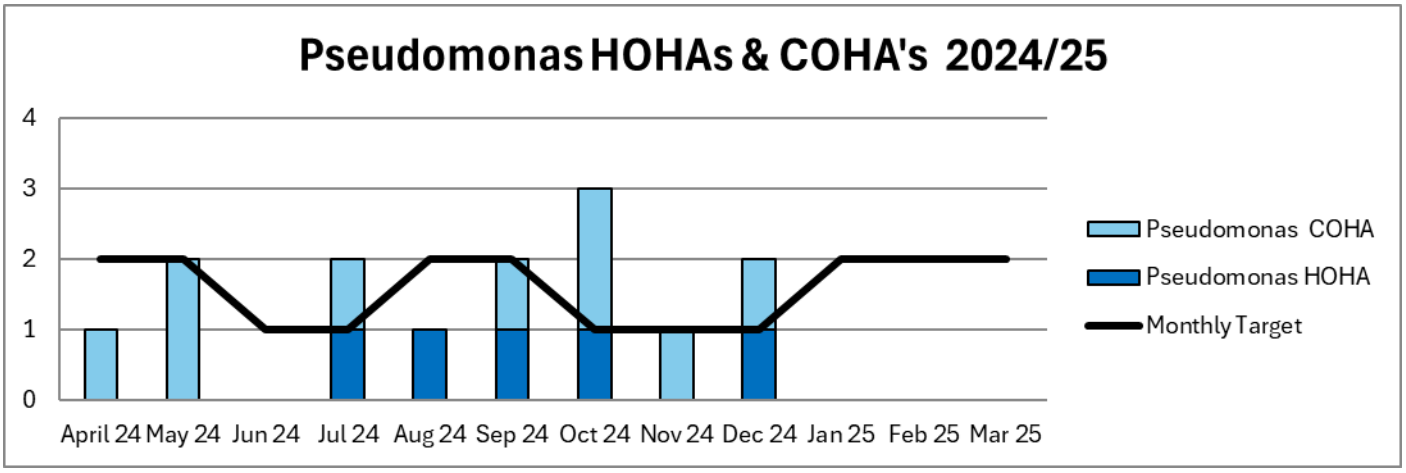


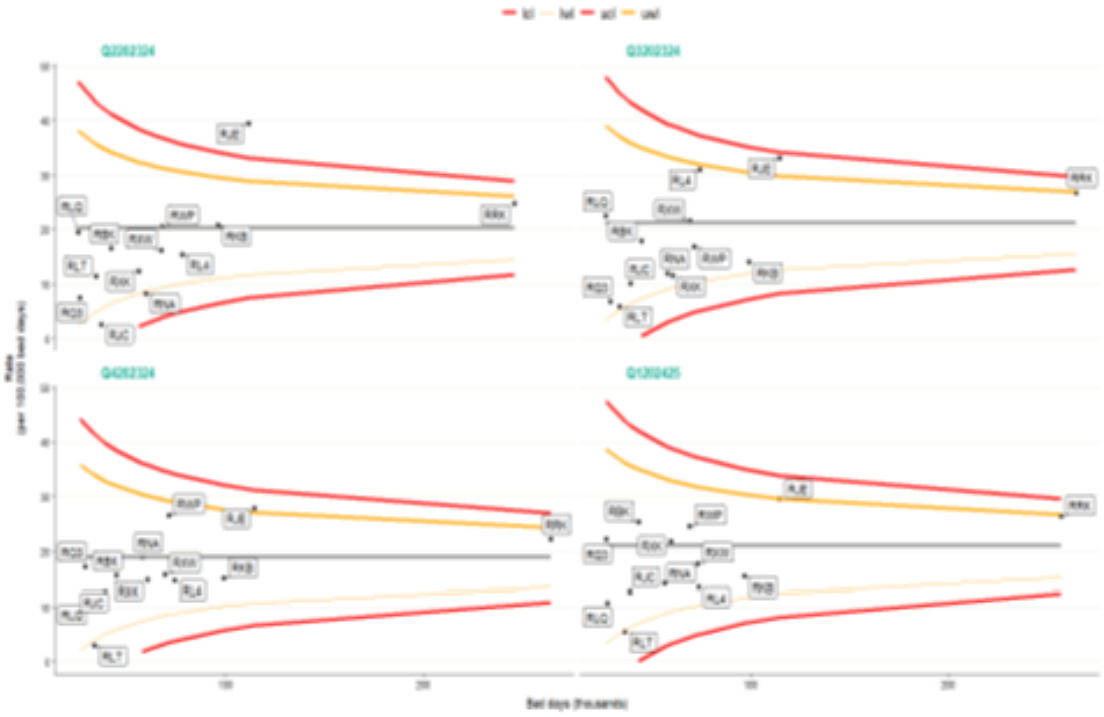
Appendix 3 – Health and Social Care Act 2008 self-assessment tool (November 24)

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance				
Self-Assessment Tool				
Shrewsbury and Telford Hospitals NHS Trust				
Criterion	**Statement of Compliance**	**Compliance Score**	**Score**	**Potential Score**
Criterion 1	Systems 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 that their environment and other users may pose to them.	95%	120	126
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	93%	75	81
Criterion 3	Ensure appropriate antimicrobial use and stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.	79%	19	24
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further health and social care support or nursing/ medical care in a timely fashion.	100%	66	66
Criterion 5	Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	100%	6	6
Criterion 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.	100%	18	18
Criterion 7	Provide or secure adequate isolation facilities.	92%	11	12
Criterion 8	Secure adequate access to laboratory support as appropriate.	100%	15	15
Criterion 9	The service provider should have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	98%	405	408
Criterion 10	The registered provider will have a system or process in place to manage health and care worker health and wellbeing and organisational obligation to manage infection, prevention and control.	100%	48	48
Total Compliance		**97%**	**783**	**804**

Appendix 4: Funnel Plots

- Numbers of bacteraemias are related to the number of beds in the acute trust, but larger trusts also have greater numbers of community related infections.
- SATH appears to have consistently higher numbers of bacteraemias than some other comparable trusts in terms of bed numbers and patient mix.

See below for Funnel Plots No of bacteraemias /100,000 bed days.

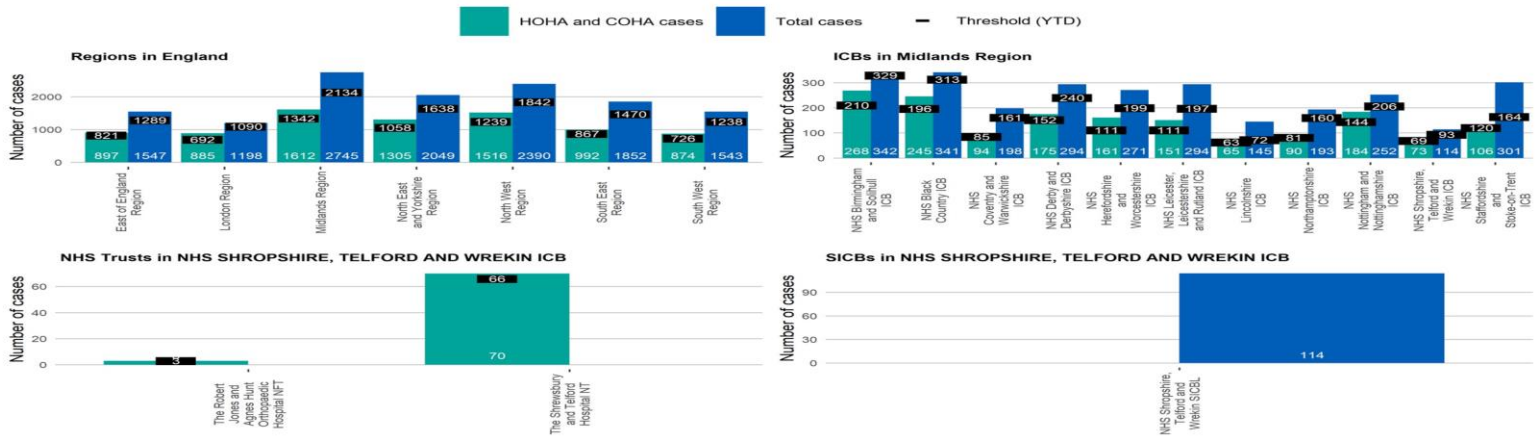


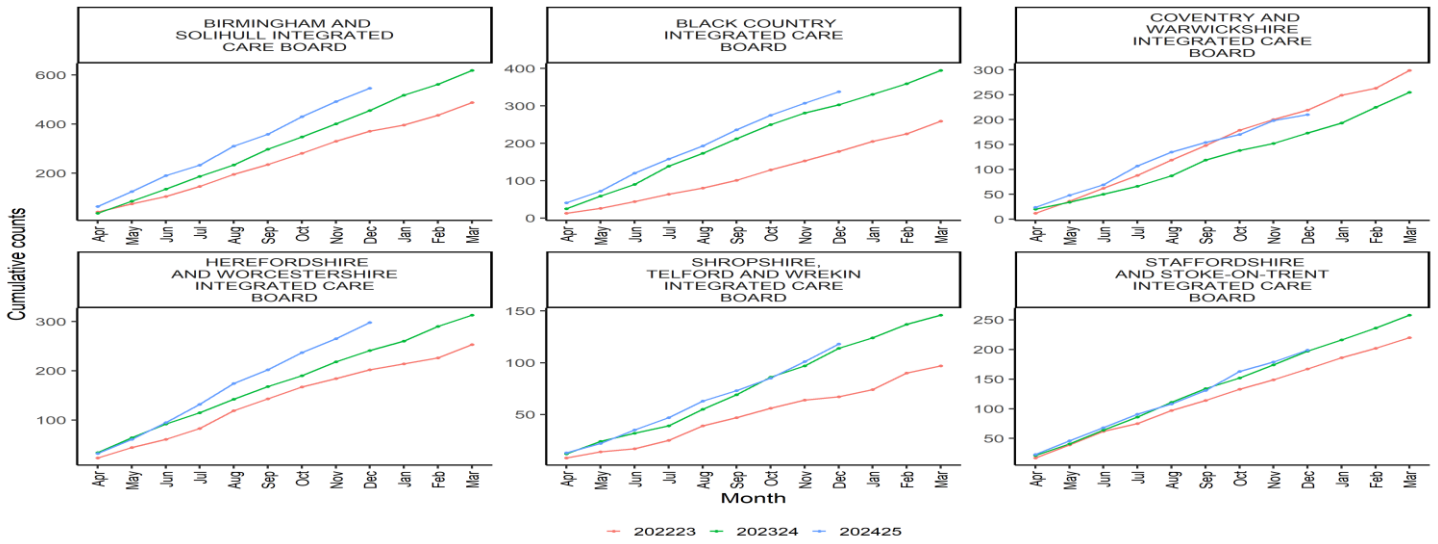
NOTE – SATH is RXW. RWH is RL4

Appendix 5 Comparative data

C. difficile cases (NHS Standard Contract 24/25). Year to date: November 2024

NHS England





Appendix 1

Yes	A fast friendly response with and offer of a chat on the phone. Will always be happy to contact. Thank you.
Yes	I feel my voice has been heard on behalf of my colleagues and we should see improvements. I'm confident that if this issue isn't resolved, my Ward Manager and Matron will be proactive with the steps going forward. Thankyou so so much for all your time, advice and just for listening! You have been a great support and definitely gave me the confidence I needed to raise the concern further
Yes	I found this useful just to be able to speak safely, which gave me the means to be able to reflect and make clearer decisions, based on the situation I found myself in.
Yes	I had experienced 15+ months of bulling from my line manager and nothing had happened to change this by following more informal routes and asking for help within my department – I felt totally unheard and unsupported. By contacting Freedom to Speak Up and finding someone who listened and was then able to point me in the right direct to get help, things have changed. I have a new line manager and support from a union rep and the psychology team to help me get back to working normally. I don't think I could have started this process alone as I was too affected by the bullying behaviour to know where to turn.
Yes	Helpful, plenty of feedback throughout the process and very approachable. I felt I was constantly kept in the loop with what was happening – even after leaving the department (unrelated to my FTSU concern) I was still kept informed. Felt very supported and listened to by Chan throughout.
Yes	I would definitely speak up again as I felt supported and given a safe environment to discuss what happened, how this affected me and how to go about it. I have found the advice very helpful and reassuring in my situation. Helen made me feel at ease and that I haven't troubled anybody or caused any inconvenience by arranging a phone call following my email. Thank you.
Yes	You weren't able to resolve our problem but I was also seen to have taken note what the night shift were saying to me and tried to help because I was out of answers. It is also good to speak up because sometimes just talking a problem through with someone else helps
Yes	Talking to XXXX was reassuring because it felt as I was being heard, and that these issues mattered.
Yes	I would feel comfortable to contact the FTSU team and raise concerns in the future if needed.

No	*Nothing was done about the Senior Manager whose behaviour was against Trust values, who was a bully. It was reported (also by others) about the way that the Director was treating the staff, but nobody came to check on our wellbeing, and the individual remained with the Trust. The reported resolution was not appropriate, saying it had been discussed a staff side meeting! There should have been support for the staff, nothing was done, the temporary Directors contract just ran out, that is the only reason he left, not because the issue was dealt with. I have lost all faith in the process of the FTSU, which is a shame as at the time I did feel listened to, but I fear that the Guardian's feedback to the senior managers wasn't.*
Yes	Thank you for all your help
Yes	XXXXXXXX was very supportive when I approached her. XXXXX followed through with my concerns and reported back the outcome. Thank you for your support.
Yes	I would speak up again as this resolved my problem. Thank you again for your help.
Yes	*It made me realise the importance of my concern even if senior management were ignoring it.* *Made me realise there are other avenues to go down to raise a concern when you do not feel listened to*
Yes	*Having someone impartial to speak to is helpful, due to rather than going head-on into a situation, thinking how you are dealing with something is the correct way, it helps to get a bit of clarity with advice, that may help a situation being resolved in a better way.* *Also having someone there who is able to contact any relevant teams in an impartial way, before escalation is important.* *Sometimes the advice you get may not be what you are expecting, but that's the importance of impartiality and often results in better resolutions*
Yes	FTSU officers were friendly and open to listening to my concerns. My concern was escalated appropriately and promptly. I was spoken to with respect and without judgement which eliminated my fears around speaking up, in fact I was actively encouraged. Thank you for your time!
No	The response took some time and when it arrived it was neither empathic or insightful it just read like corporate speak or something lifted from a well-rehearsed Press Release. The response showed a lack of insight into the problems HTP is causing both patients and staff which seems to have been grossly underestimated. Eg. Ophthalmologists are struggling to carry out delicate eye surgery where 1mm counts, due to the shaking of their building whilst major works are going on right in front of the Copthorne building!
Yes	Chan was extremely helpful and gave me the time I needed to explain my situation. I took the advice given and things have been taken in the right direction.

Yes	I am very grateful to staff at freedom to speak up to feel listened too and supported. I would recommend freedom to speak up to any of my colleagues who feel that there are concerns where they work . I feel freedom to speak up help enforce the trust ethos of all working together and putting patients first I am grateful for the support
Yes	The support and follow up from XXXX was amazing. I was signposted to the people who could help with my issues, and I really felt like I was being heard in a large organization which is usually very difficult. She was amazing and very caring. I have learnt a lot about what is available to help me in work as a disabled member of staff when I otherwise would have had to search a very long list on the intranet. Chan helped explain what I needed to have in place and what to request.
Yes	Knowing it was confidential and the advisor would give sensible advice. I always believe that HR's first objective is to protect the Trust, whilst FTSU has my best interests at their forefront.
Yes	It has been a hugely relational experience that felt very consultative, almost like coproduction. In this case, there was no safeguarding concern or need for escalation, but my concerns have been taken seriously; positive, supportive action taken and a commitment given to keep the situation under review. Throughout the process, the communication and (gentle) intervention has always been positive, constructive and with the support for the wellbeing and effectiveness of all parties always paramount.
Yes	I felt that I was listened to and what I had to say was taken seriously without feeling guilty for speaking up
Yes	Helps to talk things through with someone who listens in a calm and trusting environment
Yes	Thank you so much for your help, you have done so much in a day and this has been going on for 5 month and I wasn't getting anywhere with it. Wish I called you sooner
Yes	I received a prompt response from the team, they guided me to the best options.
Yes	The freedom to speak guardian is very helpful and supporting. They hear your feelings and thoughts and help accordingly.
Yes	XXXXXX has been extremely helpful in supporting to communicate with my managers, in a beneficial way, the concerns staff members have.
Yes	FTSU gives me to talk things over with someone who is impartial, empathetic and supportive. FTSU is a bridge between management and HR, who is able to offer advice on possible ways of dealing with any issue. I feel like I can trust any FTSU Guardian to have my best interests at heart, when I have needed support.
Yes	My issues have been resolved, many thanks for your help and support.

Yes	XXXXXX responded to my email getting in touch really quickly and arranged a face-to-face meeting to go through my concerns in depth. She was professional and got to grips with the intricacies of my case easily. She was so very kind and supportive throughout the whole process and was able to liaise with HR and other more senior members of staff in the appropriate areas to get things moving having been sat stagnant for months before her help. XXXXX also went out of her way to keep in touch, sometimes out of hours, just to make sure I was OK and that I was happy with the progress being made. I had more contact from the FTSU team than i have had from my line manager during my extended sickness absence.
Yes	The advice you gave me was very helpful, I will definitely use the FTSU again if I need to.
Yes	Yes I would use the FTSU Guardian again as XXXXX has been so helpful and did more in 1 day then what my management team did in 6 months. XXXXX kept me updated through the whole process and was able to get a meeting with HR and the XXXX
Yes	I'm happy to close it now and just escalate to the XX manager if any further occurrences happen. Thank you for all your help.
Maybe	Of the cases I have spoken up about, your advice has been great. However, I do feel that me speaking up has not changed anything. I have been to XXXXXX on several occasions, about my worries/ concerns following your advice. But these concerns and worries have just been swept under the carpet and ignored. The problem being is XXXXX collude together and deny anything that has happened, to their manager. They keep getting away with the way they run the department and nothing is changing, if anything it's getting worse. By no means is this a reflection on you, your advice is great. It's just they don't listen to the issues within the department. This then brings the mentality of (what's the point in speaking up) in not just myself but also my colleagues. Of course this isn't the way it should be, but unfortunately, we all need our jobs and are in fear of the repercussions from XXXX for us speaking up. This includes fabrications of the truth to suit him and complete denial of any problems in the department. I am sorry to have to say these things but I am speaking from my experiences as a XXXX working under XXXX. I now feel I just come to work and have to keep my head down and just do my work as I have a family to feed Please understand that this is not aimed at you, as you have listened to me and my worries and concerns and have given great advice.

No	Well, I'm really struggling to understand the point of this service, because as understanding as the Freedom to Speak people were, it was an exercise in futility. Nothing good came of seeking advice through the correct channels, and I have been bullied out of my job. And it is for that reason that I think things like "Freedom to Speak Up" are ultimately pointless. It's all just a formality. Nothing can be done because nobody really wants to do anything, do they? It's in the best interest of the management if nobody speaks up, and they've got their cover stories figured out to make sure they can remove anyone who does.
Yes	I was getting no response when asking about XXX but FTSU achieved within 8 days what had taken me over 8 months, despite having a grievance upheld.
Maybe	It would depend on what the situation is, I will be honest and say that I wouldn't contact FTSU about issues relating to myself whether its professional or personal.
Yes	Very helpful and knowledgeable
Yes	I found it really useful to be able to speak things out and make sense of what happened. I was signposted to services to help me resolve my issues. In the longer term finding networks to assist me has given me confidence to progress further and be able to support other members of staff facing similar issues and concerns. Representing the trust and making working lives better for all.

Appendix 1: Exception Reports Q4

In Q4 a total of 28 exception reports were raised.

Exception Reports (ER) – Quarter 4	
Total number of exception reports received	28
Number relating to immediate patient safety issues	0
Number relating to hours of working	26
Number relating to pattern of work	1
Number relating to educational opportunities	1
Number relating to service support available to the doctor	0

The table below shows the number of exception reports carried over, raised, closed and outstanding for Q4. Please note this data excludes exception reports related to educational opportunities.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Acute Medicine	0	1	0	1
General Medicine	4	2	4	2
General Practice	0	1	1	0
General Surgery	0	6	5	1
Haematology	0	11	6	5
ENT	0	1	0	1
Trauma & Orthopaedics	0	4	4	0
Urology	4	1	1	4
Total	**8**	**27**	**21**	**14**

The below table provides a breakdown of the number of exception reports divided by medical grades for Q4.

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	12	10	2
FY2	0	9	4	5
CT1-2 / ST1-2	3	3	3	3
CT3+ / ST3+	5	3	4	4
Total	**8**	**27**	**21**	**14**

Appendix 2: Locum Bookings by Department, Grade and Reason

Locum bookings (shifts) by department

Department	Filled by Bank	Filled by Agency	Unfilled
Acute Medicine	324	0	1
Anaesthetics	106	13	0
Breast Surgery	0	64	0
Cardiology (Medical)	90	0	0
Emergency Medicine	439	75	14
Endocrinology and Diabetes	38	0	0
Gastroenterology	38	0	0
General Medicine	1508	0	3
General Surgery	123	25	1
Haematology	26	0	0
Neonatal Medicine	43	1	0
Obstetrics and Gynaecology	77	0	0
Oncology	42	0	11
Ophthalmology	23	0	0
Oral and Maxillofacial Surgery	81	55	0
Orthopaedic and Trauma Surgery	88	8	1
Paediatrics	123	18	0
Renal Medicine	19	0	0
Respiratory Medicine	96	0	0
Stroke Medicine	33	0	0
Urology	47	0	0
ENT	48	63	0
ITU	15	0	0
Grand Total	**3427**	**322**	**31**

Locum bookings (shifts) by grade

Grade	Filled by Bank	Filled by Agency	Unfilled
FY 1	2	0	0
Core Trainee	2533	13	2
StR (ST3-8)	892	309	29
Grand Total	**3427**	**322**	**31**

Locum bookings (shifts) by reason

Reason	Filled by Bank	Filled by Agency	Unfilled
Annual Leave	13	0	0
Compassionate / Special Leave	30	7	0

Covering Shadowing Period	23	1	0
Elective Recovery Fund	45	0	0
EPR Backfill	2	0	0
Escalation area	708	0	0
Exempt from On Calls	91	0	0
Extra Cover	517	33	2
Less Than FT Trainee Gap	20	1	0
Paternity Leave	27	0	1
Pregnancy / Maternity Leave	54	0	0
Sick	593	88	12
Strike	1	0	0
Study Leave	8	2	0
Vacancy	1236	190	16
Winter Pressures	56	0	0
Career Break	3	0	0
Grand Total	**3427**	**322**	**31**

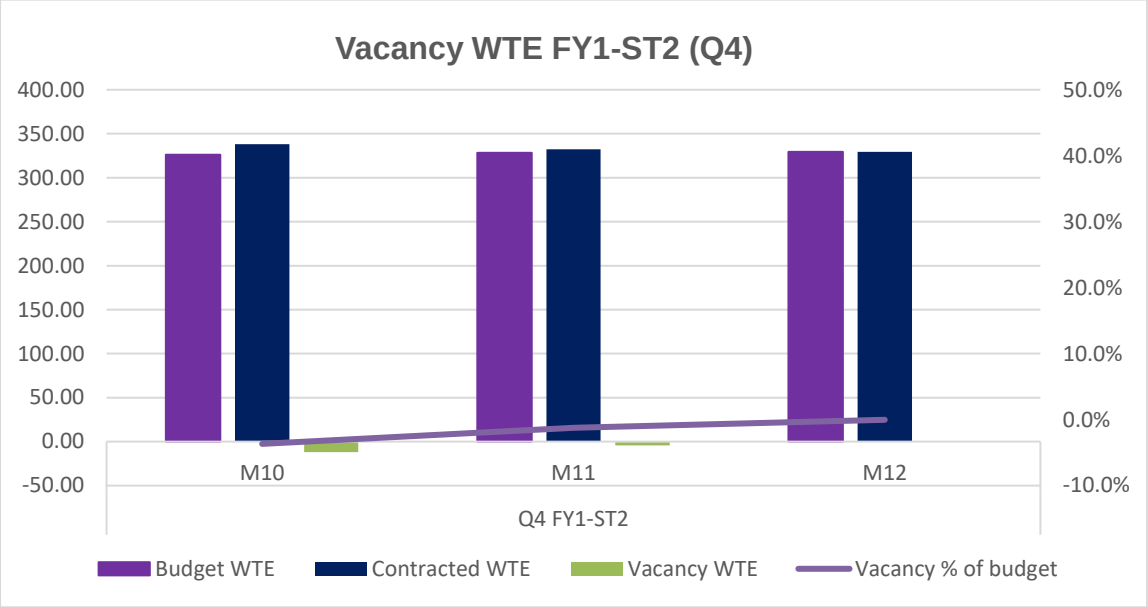
Comments

General Medicine leads with the highest number of bank shifts at 1508, with 3 unfilled shifts. Emergency Medicine follows closely, with 439 shifts filled by bank, 75 shifts filled by agency, and 14 unfilled shifts. Acute Medicine has 324 shifts filled by bank and just 1 unfilled shift. Some specialties, such as Breast Surgery and Oral and Maxillofacial Surgery, have higher agency reliance, with 64 shifts and 55 shifts filled by agency, respectively. Neonatal Medicine and Haematology have relatively few agency shifts, with 1 shift and 0 shifts filled by agency, respectively, and no unfilled shifts. In general, the data shows that most departments rely heavily on bank shifts, with only a few departments depending on agency shifts, and the number of unfilled shifts remains relatively low across all specialties.

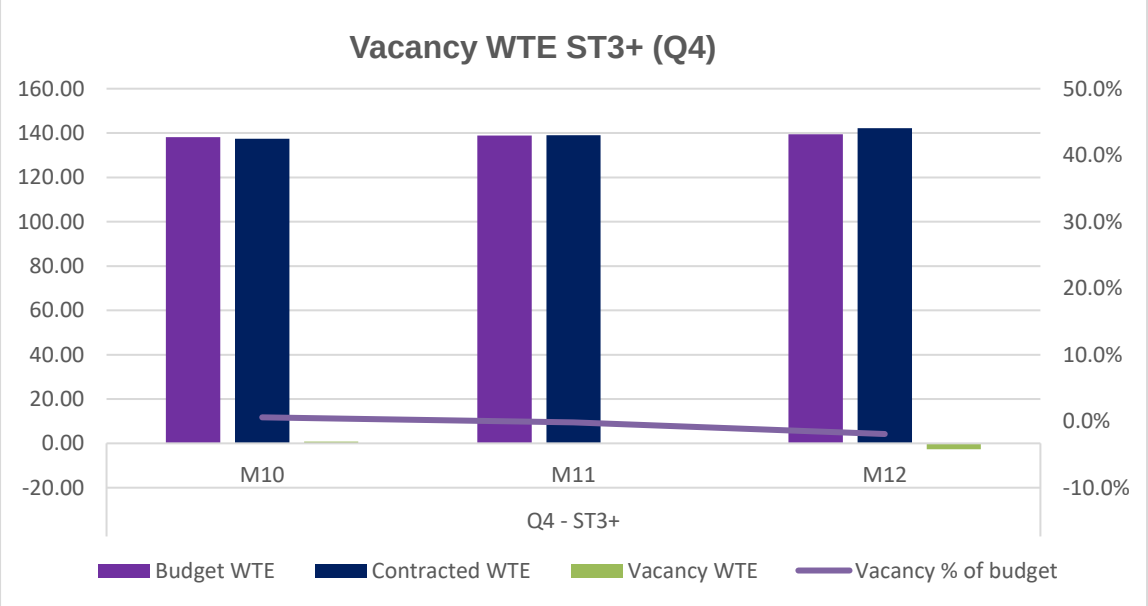
The table on Locum bookings by reason shows the distribution of shifts based on various types of leave and staffing requirements. The Vacancy category accounts for the largest number of shifts, with 1236 shifts filled by bank, 190 shifts filled by agency, and 16 unfilled shifts. Escalation area is the second-largest category, with 708 shifts filled by bank and no unfilled shifts. Sick leave also contributes significantly, with 593 shifts filled by bank, 88 shifts filled by agency, and 12 unfilled shifts.

Appendix 3: Vacancy WTE for Resident and Locally Employed Doctors Q4

	Q4 FY1-ST2		
	M10	**M11**	**M12**
Budget WTE	326.12	328.30	329.47
Contracted WTE	338.09	332.43	329.55
Vacancy WTE	-11.97	-4.13	-0.08
Vacancy % of Budget	-3.7%	-1.3%	0.0%



	Q4 ST3+		
	M10	**M11**	**M12**
Budget WTE	138.17	138.83	139.49
Contracted WTE	137.37	139.06	142.18
Vacancy WTE	0.80	-0.23	-2.69
Vacancy % of Budget	0.6%	-0.2%	-1.9%



Appendix 4: Budgeted, Contracted, Vacancy (WTE) and Vacancy % of Budget M10-M12 (FY1-ST2)

		M10 FY1-ST2				M11 FY1-ST2				M12 FY1-ST2			
Care Gr	Specialty	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of budge	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of budge	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of budge
MEC	A&E	51.00	46.20	4.80	9%	51.00	45.95	5.05	10%	51.00	45.20	5.80	11%
MEC	Acute Medicine	22.80	29.92	-7.12	-31%	22.80	27.12	-4.32	-19%	22.80	16.57	6.23	27%
SAC	Anaesthesia	21.00	13.81	7.19	34%	22.00	12.95	9.05	41%	22.00	12.87	9.13	42%
MEC	Cardiology	6.00	4.93	1.07	18%	6.00	4.93	1.07	18%	6.00	4.00	2.00	33%
MEC	Care of the Older Adult	20.90	18.95	1.95	9%	20.90	18.95	1.95	9%	20.90	19.30	1.60	8%
CSS	Clinical and Medical Oncology	3.00	3.00	0.00	0%	3.00	2.25	0.75	25%	3.00	2.00	1.00	33%
CSS	Clinical Haematology	2.00	3.00	-1.00	-50%	1.00	3.00	-2.00	-200%	1.00	2.00	-1.00	-100%
MEC	Dermatology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
MEC	Diabetes & Endo	9.00	11.00	-2.00	-22%	9.00	11.00	-2.00	-22%	9.00	11.00	-2.00	-22%
SAC	ENT	8.00	9.00	-1.00	-13%	8.00	9.00	-1.00	-13%	8.00	9.00	-1.00	-13%
SAC	Gastroenterology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
MEC	General Medicine	34.00	24.93	9.07	27%	34.00	25.93	8.07	24%	34.00	36.93	-2.93	-9%
SAC	General Surgery	17.00	21.57	-4.57	-27%	17.00	20.50	-3.50	-21%	17.00	21.00	-4.00	-24%
WAC	Gynaecology	13.00	14.00	-1.00	-8%	13.00	13.89	-0.89	-7%	13.00	14.00	-1.00	-8%
SAC	ITU	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
Corporate	Medical Directorate	14.00	26.60	-12.60	-90%	14.00	26.60	-12.60	-90%	14.00	26.20	-12.20	-87%
SAC	MSK Management	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
WAC	Neonatology	4.00	4.00	0.00	0%	4.00	4.00	0.00	0%	4.00	5.17	-1.17	-29%
MEC	Nephrology	14.00	13.93	0.07	1%	14.00	13.93	0.07	1%	14.00	13.93	0.07	1%
MEC	Neurology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
SAC	Ophthalmology	3.00	3.00	0.00	0%	3.00	2.27	0.73	24%	3.00	2.00	1.00	33%
SAC	Oral & Maxillo-Facial Surgery	4.00	6.00	-2.00	-50%	4.00	6.00	-2.00	-50%	4.00	5.00	-1.00	-25%
WAC	Paediatrics	17.00	19.59	-2.59	-15%	17.00	20.33	-3.33	-20%	17.00	20.69	-3.69	-22%
SAC	Palliative Care	0.00	2.00	-2.00	0%	0.00	2.00	-2.00	0%	0.00	2.00	-2.00	0%
CSS	Pathology	4.80	5.00	-0.20	-4%	4.80	5.00	-0.20	-4%	4.80	4.03	0.77	16%
CSS	Radiology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
Reserves	Reserves	11.82	0.00	11.82	100%	13.00	0.00	13.00	100%	14.17	0.00	14.17	100%
MEC	Respiratory	12.00	14.94	-2.94	-25%	12.00	14.11	-2.11	-18%	12.00	13.94	-1.94	-16%
MEC	Stroke Medicine	1.00	4.00	-3.00	-300%	1.00	4.00	-3.00	-300%	1.00	4.00	-3.00	-300%
SAC	T&O	22.80	27.00	-4.20	-18%	23.80	28.00	-4.20	-18%	23.80	28.00	-4.20	-18%
SAC	Urology	4.00	5.72	-1.72	-43%	4.00	4.72	-0.72	-18%	4.00	4.72	-0.72	-18%
SAC	Vascular Surgery	6.00	6.00	0.00	0%	6.00	6.00	0.00	0%	6.00	6.00	0.00	0%
Total		**0.00**	**338.09**	**-11.97**	**-4.98**	**328.30**	**332.43**	**-4.13**	**-5.46**	**329.47**	**329.55**	**-0.08**	**-3.85**

Comments

In Q4, the vacancy WTE for FY1-ST2 showed positive progress. In M10, the budgeted WTE was 326.12, which increased to 328.30 in M11 and reached 329.47 in M12. The contracted WTE was consistently higher than the budget, with 338.09 in M10, 332.43 in M11, and 329.55 in M12. However, the vacancy WTE showed a gap between the budgeted and contracted staff, with -11.97 WTE in M10, -4.13 WTE in M11, and -0.08 WTE in M12. The vacancy percentage of the budget improved over the quarter, starting at -3.7% in M10, improving to -1.3% in M11, and reaching 0.0% in M12, suggesting that by the end of the quarter, the vacancy gap between budget and establishment was almost entirely closed.

In M10, the budgeted WTE for ST3+ was 138.17, which slightly increased to 138.83 in M11 and reached 139.49 in M12. The contracted WTE began at 137.37 in M10, increased to 139.06 in M11, and further grew to 142.18 in M12, surpassing the budgeted WTE in the later months. The vacancy WTE was positive at 0.80 WTE in M10, but turned negative in M11 and M12, reaching -0.23 WTE and -2.69 WTE, respectively. The vacancy percentage of budget started at 0.6% in M10, moved to -0.2% in M11, and finished at -1.9% in M12, indicating that by the end of the quarter, there was an overachievement in filling vacancies, reflecting a maintained improvement in staffing levels.

Appendix 5: Budgeted, Contracted, Vacancy (WTE) and Vacancy % of Budget M10-M12 (ST3-ST8)

		M10 ST3+				M11 ST3+				M12 ST3+			
Care Gr	Specialty	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of budge	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of budge	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of budge
MEC	A&E	4.00	5.40	-1.40	-35%	4.00	4.54	-0.54	-14%	4.00	4.40	-0.40	-10%
MEC	Acute Medicine	12.00	9.16	2.84	24%	12.00	9.37	2.63	22%	12.00	7.27	4.73	39%
SAC	Anaesthesia	9.00	15.81	-6.81	-76%	9.00	16.40	-7.40	-82%	9.00	15.73	-6.73	-75%
MEC	Cardiology	5.00	5.00	0.00	0%	5.00	4.00	1.00	20%	5.00	4.00	1.00	20%
MEC	Care of the Older Adult	6.00	6.18	-0.18	-3%	6.00	5.57	0.43	7%	6.00	5.57	0.43	7%
CSS	Clinical and Medical Oncology	4.00	2.80	1.20	30%	4.00	2.80	1.20	30%	4.00	2.80	1.20	30%
CSS	Clinical Haematology	1.00	0.80	0.20	20%	1.00	0.80	0.20	20%	1.00	0.80	0.20	20%
MEC	Dermatology	0.00	1.00	-1.00	0%	0.00	1.00	-1.00	0%	0.00	1.00	-1.00	0%
MEC	Diabetes & Endo	3.00	3.00	0.00	0%	3.00	4.00	-1.00	-33%	3.00	4.00	-1.00	-33%
SAC	ENT	3.00	3.00	0.00	0%	3.00	3.00	0.00	0%	3.00	3.00	0.00	0%
SAC	Gastroenterology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
MEC	General Medicine	21.00	9.46	11.54	55%	21.00	10.00	11.00	52%	21.00	12.46	8.54	41%
SAC	General Surgery	10.00	10.51	-0.51	-5%	10.00	11.51	-1.51	-15%	10.00	11.51	-1.51	-15%
WAC	Gynaecology	8.00	9.81	-1.81	-23%	8.00	10.81	-2.81	-35%	8.00	10.75	-2.75	-34%
SAC	ITU	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
Corporate	Medical Directorate	7.60	2.20	5.40	71%	7.60	2.20	5.40	71%	7.60	2.20	5.40	71%
SAC	MSK Management	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
WAC	Neonatology	3.00	3.00	0.00	0%	3.00	3.00	0.00	0%	3.00	3.34	-0.34	-11%
MEC	Nephrology	5.00	3.00	2.00	40%	5.00	3.00	2.00	40%	5.00	3.00	2.00	40%
MEC	Neurology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
SAC	Ophthalmology	2.00	1.86	0.14	7%	2.00	3.63	-1.63	-82%	2.00	3.66	-1.66	-83%
SAC	Oral & Maxillo-Facial Surgery	1.00	0.00	1.00	100%	1.00	0.00	1.00	100%	1.00	1.00	0.00	0%
WAC	Paediatrics	6.00	5.38	0.62	10%	6.00	5.38	0.62	10%	6.00	7.80	-1.80	-30%
SAC	Palliative Care	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
CSS	Pathology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
CSS	Radiology	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%	0.00	0.00	0.00	0%
Reserves	Reserves	4.69	0.00	4.69	100%	5.35	0.00	5.35	100%	6.01	0.00	6.01	100%
MEC	Respiratory	7.00	9.00	-2.00	-29%	7.00	8.89	-1.89	-27%	7.00	8.89	-1.89	-27%
MEC	Stroke Medicine	0.00	2.00	-2.00	0%	0.00	1.00	-1.00	0%	0.00	1.00	-1.00	0%
SAC	T&O	7.88	21.00	-13.12	-166%	7.88	20.16	-12.28	-156%	7.88	20.00	-12.12	-154%
SAC	Urology	5.00	4.00	1.00	20%	5.00	4.00	1.00	20%	5.00	4.00	1.00	20%
SAC	Vascular Surgery	3.00	4.00	-1.00	-33%	3.00	4.00	-1.00	-33%	3.00	4.00	-1.00	-33%
Total		**138.17**	**137.37**	**0.80**	**1.07**	**138.83**	**139.06**	**-0.23**	**0.16**	**139.49**	**142.18**	**-2.69**	**-1.18**

Appendix 6: Rostering Dashboard for Safe Working Hours Q4

The below tables summarises the instances identified from the retrospective rostering dashboard. Each breach is a singular count of the number of instances where a rest requirement has not been met. Where this is consecutive days, each day is counted as a breach (e.g. if a doctor worked 10 consecutive days, days 8-10 would be counted as 3 breaches). The number of episodes shows the occurrences by grouping breaches by runs of shifts worked.

Specialty	Sum of No. Episodes	Sum of No. Breaches
Emergency Medicine	3	13
General Surgery	1	4
T&O	7	13
ENT	1	2
Oral & Max Fax	1	1
Grand Total	**13**	**33**

The table below categorises the breaches into the safe working hours listed in Schedule 3 of the 2016 Junior Doctor Contract. A summary of the headings is provided below.

- **No rest of 4 long (48 hours)** - No more than four long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) shall be rostered or worked on consecutive days. Where four long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fourth long shift.
- **No rest after singular or max 4 nights** - Where shifts (excluding non-resident on-call shifts) defined as having 3 hours fall into the period 23:00-06:00 rostered singularly, or consecutively, there must be a minimum 46-hour rest period rostered immediately following the conclusion of the shift(s).
- **More than 7 consecutive days** - A maximum of seven shifts of any length can be rostered or worked on seven consecutive days
- **No rest after 7 consecutive days** - Where seven shifts of any length are rostered or worked on seven consecutive days, there must be a minimum 48-hours' rest rostered immediately following the conclusion of the seventh shift.
- **Over 72 hours** - No more than 72 hours' actual work should be rostered for or undertaken by any doctor, working on any working pattern, in any period of 168 consecutive hours.

Specialty	No rest after 4 long (48 hours)?	No rest after singular or max 4 nights?	More than 7 consecutive days?	No rest after 7 consecutive shifts?	Over 72 hours?
Emergency Medicine	1	0	9	3	0
General Surgery	0	0	1	1	2
T&O	4	0	2	3	4
ENT	0	0	1	1	0
Oral & Max Fax	1	0	0	0	0
Grand Total	**4**	**0**	**10**	**4**	**9**

It is recognised that singular episodes can represent breaches in different categories of safe working hours. As an example, a singular episode could breach rest after 4 long days, more than 7 consecutive days and more than 72 hours worked in one run of shifts, which explains the higher number of breaches recorded vs episodes counted.

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 1: Maternity Care													
4.54	A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This W. ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
4.56	The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	31/08/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
4.57	These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	15/07/21	14/09/21	H. Flavell	A. Lawrence	Monday.com

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

PROGRESS AS AT 08.04.25

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.58	Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.	Y	10/12/20	30/04/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	30/06/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
4.59	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	Y	10/12/20	31/12/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	31/03/22	28/02/22	H. Flavell	A. Lawrence	Monday.com
4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	Y	10/12/20	31/12/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	31/03/22	08/03/22	H. Flavell	A. Lawrence	Monday.com
4.61	Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	31/05/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
4.62	There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
4.63	Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
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4.64	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.	Y	10/12/20	30/04/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	03/02/22	H. Flavell	A. Lawrence	Monday.com
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	03/02/22	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	03/02/22	28/02/22	28/02/22	H. Flavell	A. Lawrence	Monday.com

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
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FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
4.73	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.	Y	10/12/20	30/04/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/07/24	13/08/24	H. Flavell	G. Calcott	Monday.com
4.74	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
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FIRST OCKENDEN REPORT ACTION PLAN

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20	31/03/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	31/03/22	10/05/22	H. Flavell	A. Lawrence	Monday.com
4.86	Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.	Y	10/12/20	31/03/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	31/03/22	10/05/22	H. Flavell	G. Dashputre	Monday.com
4.87	Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA. Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.	Y	10/12/20	31/03/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	31/10/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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PROGRESS AS AT 08.04.25

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.88	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.	Y	10/12/20	31/03/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	07/12/21	30/06/23	11/07/23	H. Flavell	A. Lawrence	Monday.com
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	31/01/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	30/09/23	12/09/23	H. Flavell	G. Dashputre	Monday.com
4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20	31/03/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/03/22	31/03/22	10/05/22	H. Flavell	A. Lawrence	Monday.com
4.91	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	31/03/22	10/05/22	H. Flavell	W. Parry-Smith	Monday.com

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Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	31/03/21	30/04/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.98	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/09/21	30/06/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.99	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.	Y	10/12/20	31/10/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/01/21	31/10/21	14/09/21	H. Flavell	A.Sizer	Monday.com
4.100	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.	Y	10/12/20	31/05/24	Delivered, Not Yet Evidenced	On Track	This action was approved as Delivered, Not Yet Evidenced at May-24's MTAC.	14/05/24	31/05/25		P. Gardner	A.Sizer	Monday.com

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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

IMMEDIATE AND ESSENTIAL ACTIONS (IEA): To improve Care and Safety in Maternity Services

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight													
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - Evidenced and assured.	08/03/22	28/06/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	31/07/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.	Y	10/12/20	30/04/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/04/22	30/04/22	H. Flavell	H. Flavell	Monday.com
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	TBC	Delivered, Not Yet Evidenced	On Track	This action was brought back into scope and agreed as 'Delivered, Not Yet Evidenced' at Jan-25's MNTAC with a new deadline for green to Jun-25.	14/01/25	30/06/25		P. Gardner	P. Gardner	Monday.com
1.5	The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	31/01/21	30/06/21	10/08/21	H. Flavell	H. Flavell	Monday.com
1.6	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	31/01/22	28/02/22	03/02/22	H. Flavell	A. Lawrence	Monday.com

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NHS
The Shrewsbury and Telford Hospital NHS Trust

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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	Not Yet Delivered	Off Track (see exception report)	External dependent action on NHSEI. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as the MNISA who is in post cannot start working with families until the greenlight from NHSEI has been received. We currently have no information as to when that greenlight is expected. Progressing this action with NHSEI sits with the LMNS. All other evidence requirements for this action have been met and it will be proposed for "Delivered, Not yet Evidenced" as soon as NHSEI enable the MNISA to start their work with families. A new timeline for "Evidenced and Assured" will be proposed at the same time.		TBC		P. Gardner	P. Gardner	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	TBC	Not Yet Delivered	Off Track (see exception report)	External dependent action on NHSEI. Linked to IEA 2.1. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as this action is dependant on IEA 2.1. Until progress can be made with the above action, realistic new timelines cannot be estimated.		TBC		P. Gardner	P. Gardner	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/05/21	30/04/21	08/06/21	H. Flavell	A. Lawrence	Monday.com
2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	Y	10/12/20	TBC	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/03/24	TBC	11/06/24	H. Flavell	A. Lawrence	Monday.com

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Immediate and Essential Action 3: Staff Training and Working Together													
Staff who work together must train together													
3.1	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	30/10/21	07/12/21	H. Flavell	W. Parry-Smith	Monday.com
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/08/21	30/09/21	10/08/21	H. Flavell	H. Flavell	Monday.com

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Immediate and Essential Action 4: Managing Complex Pregnancies There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.													
4.1	Women with Complex Pregnancies must have a named consultant lead.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	31/10/21	04/11/21	H. Flavell	G. Calcott	Monday.com
4.2	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.	Y	10/12/20	30/04/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/06/23	11/07/23	H. Flavell	G. Calcott	Monday.com
4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	20/04/21	30/08/22	10/05/22	H. Flavell	G. Calcott	Monday.com

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Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com

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Immediate and Essential Action 6: Monitoring fetal Wellbeing													
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.													
6.1	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: * Improving the practice of monitoring fetal wellbeing * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Raising the profile of fetal wellbeing monitoring * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	31/08/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
6.2	The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	30/10/21	04/11/21	H. Flavell	W. Parry-Smith	Monday.com
6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/08/21	15/07/21	13/08/21	H. Flavell	A. Lawrence	Monday.com

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Immediate and Essential Action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.													
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/08/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/08/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com
7.3	Women's choices following a shared and informed decision making process must be respected	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Local Actions For Learning Theme 1: Improving Management of Patient Safety Incidents													
14.1	Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.	Y	30/03/22	30/04/24	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/05/24	31/07/24	09/07/24	H. Flavell	A. Lawrence	Monday.com
14.2	The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/09/23	28/02/25	14/01/25	H. Flavell	A. Lawrence	Monday.com
14.3	All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	11/10/22	H. Flavell	A. Lawrence	Monday.com
14.4	The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
14.5	Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	13/09/22	H. Flavell	A. Lawrence	Monday.com
14.6	All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/03/24	10/01/23	H. Flavell	A. Lawrence	Monday.com
14.7	All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com

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14.8	The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/05/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
14.9	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 2: Patient and Family Involvement													
14.10	The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence	Monday.com
14.11	All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence	Monday.com
14.12	The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.	Y	30/03/22	30/09/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/01/24	13/12/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 3: Support for Staff													
14.13	There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	30/04/23	11/10/22	H. Flavell	A. Lawrence	Monday.com
14.14	The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/03/24	13/12/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 4: Improving Complaints Handling													
14.15	Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	31/01/23	10/01/23	H. Flavell	A. Lawrence	Monday.com
14.16	Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/08/23	13/12/22	H. Flavell	A. Lawrence	Monday.com
14.17	All staff involved in preparing complaint responses must receive training in complaints handling.	Y	30/03/22	30/06/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/12/23	14/12/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 5: Improving Audit Process													
14.18	There must be midwifery and obstetric co-leads for audits.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com
14.19	Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	J. Jones	A. Lawrence & A. Sizer	Monday.com
14.20	Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com
14.21a	Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
14.21b	Matters arising from clinical incidents must contribute to the annual audit plan.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 6: Improving Guidelines Process													
14.22	There must be midwifery and obstetric co-leads for developing guidelines.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com
14.23	A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/01/23	14/02/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 7: Leadership and Oversight													
14.24	The Trust Board must review the progress of the maternity improvement and transformation plan every month.		30/03/22	31/07/2023	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/08/23	31/10/23	14/11/23	H. Flavell	H. Flavell	
14.25	The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment235 Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.		30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	C. McInnes	Monday.com
14.26	The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive		30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	31/01/23	13/12/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 8: Care of Vulnerable and High Risk Women													
14.27	The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	30/04/23	11/10/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 9: Fetal Growth Assessment and Management													
14.28	The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com
14.29	Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 10: Fetal Medicine Care													
14.30	The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/10/23	31/03/24	12/03/24	H. Flavell	A.Sizer	
14.31	Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/10/23	31/03/24	12/03/24	H. Flavell	A.Sizer	

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Local Actions For Learning Theme 11: Diabetes Care													
14.32	The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.	Y	30/0322	30/11/23	Delivered, Not Yet Evidenced	Off Track (see exception report)	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. This action is currently Off Track. Recuitment is underway to fill the vacancy necessary to run the diabetes clinic weekly with internal cover but no firm timeline is currently available. The clinic continues to run in the meantime and a locum is being engaged to provide cover with substantive recuitment is underway.	13/09/22	28/02/25		P. Gardner	J. Atkinson	Monday.com

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Local Actions For Learning Theme 12: Hypertension													
14.33	Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	31/08/23	08/08/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 13: Consultant Obstetric Ward Rounds and Clinical Review													
14.34	All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017237). These consultant reviews must occur with a clearly documented plan recorded in the maternity records	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.35	All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	30/04/23	10/01/22	H. Flavell	A. Sizer	Monday.com
14.36	The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR239 to enable all staff to escalate and communicate their concerns.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence & C. McInnes	Monday.com

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Local Actions For Learning Theme 14: Escalation Of Concerns													
14.37	The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
14.38	The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.	Y	30/03/22	31/10/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/11/23	30/06/24	09/07/24	H. Flavell	A. Lawrence	Monday.com
14.39	The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 15: Multidisciplinary Working													
14.40	The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/08/23		H. Flavell	C. McInnes	Monday.com
14.41	The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
14.42	There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com
14.43	Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/08/23	31/03/24	14/12/23	H. Flavell	A. Lawrence, A.Sizer & C. McInnes	Monday.com
14.44	All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/08/23	11/07/23	H. Flavell	A. Lawrence & C. McInnes	Monday.com

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Local Actions For Learning Theme 16: fetal Assessment and Monitoring													
14.45	Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.46a	The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence, A. Sizer & C. McInnes	Monday.com
14.46b	Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/08/23	13/12/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com

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Local Actions For Learning Theme 17: Specific to Midwifery-Led Units and Out-Of-Hospital Births													
14.47	Midwifery-led units must complete yearly operational risk assessments.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/08/23	13/12/22	H. Flavell	A. Lawrence	Monday.com
14.48	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com
14.49	It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence	Monday.com

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PROGRESS AS AT 08.04.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Local Actions For Learning Theme 18: Maternal Deaths													
14.50	In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	08/08/23	J. Jones	A. Sizer	Monday.com

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Local Actions For Learning Theme 19: Obstetric Anaesthesia													
14.51	The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/08/23	14/02/23	J. Jones	G. Dashputre	Monday.com
14.52	The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.	Y	30/03/22	28/02/25	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/01/25	31/07/25	14/01/25	H. Flavell	J. Jones	
14.53	The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.	Y	30/03/22	31/07/24	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/08/24	30/12/24	14/01/25	H. Flavell	J. Jones	
14.54	The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/03/24	09/05/23	H. Flavell	J. Jones	Monday.com

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14.55	The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.	Y	30/03/22	30/06/24	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MTAC.	09/07/24	31/03/25	11/03/25	P. Gardner	J. Jones	Monday.com

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Local Actions For Learning Theme 20: Neonatal													
14.56	The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
14.57	As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MTAC.	14/11/23	28/02/25	11/03/25	P. Gardner	C. McInnes	Monday.com
14.58	The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	C. McInnes	Monday.com
14.59	The number of neonatal nurses at the Trust who are “qualified-in-specialty” must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.	Y	30/03/22	31/12/22	Delivered, Not Yet Evidenced	On Track	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. A new timeline for Evidenced and Assured was set for Jul-25.	13/12/22	31/07/25		P. Gardner	J. Atkinson	Monday.com

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The Shrewsbury and Telford Hospital NHS Trust

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Local Actions For Learning Theme 21: Postnatal													
14.60	The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/08/23	12/09/23	H. Flavell	A. Sizer	Monday.com
14.61	The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	12/09/23	H. Flavell	A. Sizer	

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Local Actions For Learning Theme 22: Staff Voices													
14.62	The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.	Y	30/11/23	30/11/23	Delivered, Not Yet Evidenced	On Track	A deadline extension to Mar-26 was agreed at the Apr-25 MNTAC. Whilst the service has demonstrated good progress in improving the culture, the committee agreed it was too early in the cultural transformation journer to consider this action fully embedded.	10/10/23	31/03/26		P. Gardner	J. Atkinson	

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Local Actions For Learning Theme 23: Supporting Families After the Review is Published													
14.63	Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	14/02/23	J. Jones	H. Flavell	Monday.com
14.64	There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action is fully dependent on NHSEI, commissioners and Mental Health Trusts. Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Apr-25's MNTAC and no national progress was identified that would allow this action to be brought back into scope.		TBC		J. Jones	P. Gardner	

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

IMMEDIATE AND ESSENTIAL ACTIONS (IEA): To improve Care and Safety in Maternity Services

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Workforce planning And Sustainability The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.													
1.1	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	Y	30/03/22	31/05/25	Not Yet Delivered	On Track	This action was accepted as back into scope at Aug-24's MNTAC. The committee agreed evidence requirements pertaining to how it applies to SaTH. New agreed deadlines are: May-25 for Delivered, Not Yet Evidenced Aug-25 for Evidenced and Assured.		31/08/25		J. Jones	H. Flavell	Monday.com
1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MNTAC.	10/01/23	31/03/25	11/03/25	J. Jones	H. Flavell	Monday.com
1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/23	31/03/24	13/09/23	H. Flavell	C. McInnes	Monday.com
1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies (NHSE, RCOG, RCM and RCPCH) . Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Apr-25's MNTAC and no national progress was identified that would allow this action to be brought back into scope.		TBC		J. Jones	H. Flavell	Monday.com
1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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The Shrewsbury and Telford Hospital NHS Trust

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1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	28/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Y	30/03/22	TBC	Delivered, Not Yet Evidenced	On Track	Action 'rescoped' at the Jan-24 MTAC; as the programme has been approved Nationally. An exception report was presented and accepted at May-24's MTAC setting the new deadline for Evidenced and Assured at May-25. This action is no longer 'At Risk'.	09/01/24	31/05/25		P. Gardner	A. Lawrence	Monday.com
1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/03/24	12/09/23	H. Flavell	A. Lawrence	Monday.com
1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	14/12/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com

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1.11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(RCOG and RCP). Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Apr-25's MNTAC and no national progress was identified that would allow this action to be brought back into scope.		TBC		J. Jones	H. Flavell	Monday.com

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Immediate and Essential Action 2: Safe Staffing All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.													
2.1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	13/09/22	H. Flavell	C. McInnes	Monday.com
2.2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
2.3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/01/23	09/08/22	H. Flavell	A. Lawrence	Monday.com
2.4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/08/23	09/08/22	H. Flavell	A. Lawrence	Monday.com
2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/08/23	09/08/22	H. Flavell	A. Lawrence	Monday.com
2.6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	Y	30/03/22	31/12/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/10/23	31/03/24	12/03/24	H. Flavell	A.Sizer	Monday.com
2.7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	30/04/23	13/12/22	H. Flavell	A. Lawrence	Monday.com

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2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	30/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	11/10/22	H. Flavell	A. Lawrence	Monday.com
2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com

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Immediate and Essential Action 3: Escalation and Accountability Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.													
3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com
3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/01/23	13/09/22	H. Flavell	A. Sizer	Monday.com
3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	A. Sizer	Monday.com
3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	31/01/23	11/10/22	H. Flavell	A. Sizer, C. McInnes, A. Lawrence	Monday.com

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Immediate and Essential Action 4: Clinical Governace - Leadership Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.													
4.1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/06/22	31/01/24	14/11/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com
4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	C. McInnes	Monday.com
4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Y	30/03/22	30/09/24	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/11/24	31/12/24	12/11/24	J. Jones	H. Flavell	Monday.com
4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com
4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 5: Clinical Governance - Incident Investigation and Complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.													
5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/01/23	13/09/22	H. Flavell	A. Sizer, A. Lawrence	Monday.com
5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence, A. Sizer	Monday.com
5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/05/23	31/08/23	09/05/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com
5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent	Y	30/03/22	31/10/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/01/23	31/01/23	10/01/23	H. Flavell	A. Lawrence	Monday.com
5.7	Complaints themes and trends must be monitored by the maternity governance team.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	A. Lawrence	Monday.com

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Immediate and Essential Action 6: Learning from Maternal deaths Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.													
6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(Royal Colleges). Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Apr-25's MNTAC and no national progress was identified that would allow this action to be brought back into scope.		TBC		J. Jones	H. Flavell	Monday.com
6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	J. Jones	H. Flavell	Monday.com
6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/01/23	31/08/23	09/05/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com

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Immediate and Essential Action 7: Multidisciplinary Training Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.													
7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/08/23	31/03/24	13/12/23	H. Flavell	C. McInnes	Monday.com
7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	09/01/24	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com
7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	31/01/23	09/08/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/03/24	13/12/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 8: Complex Antenatal Care Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.													
8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Y	30/03/22	30/04/25	Not Yet Delivered	On Track	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. An exception report was presented and accepted at Mar-25's MNTAC. New timelines for Delivered not yet Evidenced and Evidenced and Assured were set for Apr-25 and Oct-25 respectively.		31/10/25		P. Gardner	A.Sizer	Monday.com
8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	09/05/23	H. Flavell	A. Sizer	Monday.com
8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	08/08/23	H. Flavell	A. Sizer	Monday.com

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Immediate and Essential Action 9: Preterm Birth The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)													
9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	11/04/23	H. Flavell	A. Sizer	Monday.com
9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/01/23	30/04/23	10/01/23	H. Flavell	A. Sizer	Monday.com
9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	30/04/23	11/04/23	H. Flavell	J. Jones	Monday.com
9.4	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019) There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Y	30/03/22	TBC	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	TBC	12/09/23	H. Flavell	A. Sizer	Monday.com

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Immediate and Essential Action 10: Labour and Birth Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units													
10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/23	30/04/23	11/04/23	H. Flavell	A. Lawrence, A. Sizer	Monday.com
10.2	Midwifery-led units must complete yearly operational risk assessments.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	13/09/22	H. Flavell	A. Lawrence	Monday.com
10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com
10.5	Maternity units must have pathways for Induction of labour (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/09/23	12/09/23	H. Flavell	A. Lawrence, A. Sizer	Monday.com
10.6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Sizer	Monday.com

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Immediate and Essential Action 11: Obstetric Anaesthesia In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.												
11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MNTAC.	08/11/22	28/02/25	11/03/25	P. Gardner	J. Jones	Monday.com
11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	12/09/23	H. Flavell	J. Jones	Monday.com
11.3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	J. Jones	Monday.com
11.4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies (RCoA) obtaining resources. Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Apr-25's MNTAC and no national progress was identified that would allow this action to be brought back into scope.		TBC		P. Gardner	J. Jones	Monday.com
11.5	Obstetric anaesthesia staffing guidance to include: The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	08/08/23	H. Flavell	J. Jones	Monday.com

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PROGRESS AS AT 08.04.25

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NHS
The Shrewsbury and Telford Hospital NHS Trust

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11.6	Obstetric anaesthesia staffing guidance to include: The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/10/23	14/11/23	H. Flavell	J. Jones	Monday.com
11.7	Obstetric anaesthesia staffing guidance to include: The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/12/23	14/11/23	H. Flavell	J. Jones	Monday.com
11.8	Obstetric anaesthesia staffing guidance to include: Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/01/23	10/01/23	H. Flavell	J. Jones	Monday.com

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

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 12: Postnatal Care Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.													
12.1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/12/22	31/03/24	13/12/22	H. Flavell	A. Sizer	Monday.com
12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. A new timeline forEvidenced and Assured was set for Jul-25.	13/12/22	31/07/25		P. Gardner	A.Sizer	Monday.com
12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	This action was accepted as back 'on track' at Jul-24's MTAC as funding was allocated to the business case. A new timeline forEvidenced and Assured was set for Jul-25.	13/12/22	31/07/25		P. Gardner	A.Sizer	Monday.com
12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com

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Immediate and Essential Action 13: Bereavement Care Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.													
13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com
13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	31/10/23	14/11/23	H. Flavell	A. Lawrence	Monday.com
13.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com
13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/05/22	30/09/22	15/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 14: Neonatal Care There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.													
14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	28/02/23	13/09/22	J. Jones	H. Flavell	Monday.com
14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	This action has been accepted as 'Descoped' at the Mar-24 MTAC as its delivery sits with the Neonatal Delivery Network. The Trust will continue to work on enabling the rotation of Neonatal staff within other unites through its delivery of LAFL 4.100. This action was reviewed as at Apr-25's MNTAC and no ODN progress was identified that would allow this action to be brought back into scope.		TBC		J. Jones	H. Flavell	Monday.com
14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Following a review of all descoped actions, the committee agreed this action should revert back to 'Not Yet Delivered' at Feb-25's MNTAC. The evidence initially provided showed engagement with the network as to what measures are in place with the service but didn't show the network reporting back to commisionners. This action was reviewed as at Apr-25's MNTAC and no ODN progress was identified that would allow this action to be brought back into scope.		TBC		J. Jones	H. Flavell	Monday.com

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	31/08/23	11/04/23	H. Flavell	A. Sizer	Monday.com
14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Y	30/03/22	30/04/25	Delivered, Not Yet Evidenced	On Track	This action was accepted as "Delivered, Not Yet Evidenced" at Nov-24's MNTAC.	12/11/24	31/07/25		P. Gardner	J.Atkinson, A.Sizer	Monday.com

Colour	Status	Description
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PROGRESS AS AT 08.04.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 15: Supporting Families Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care													
15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com
15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com
15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com

Colour	Status	Description
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Ockenden 1

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	0	1	26
IEA	25	2	1	22
Total	52	2	2	48
Percentage		4%	4%	92%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	27	0	1	0	0	26	0
IEA	25	0	1	0	2	22	0
Total	52	0	2	0	2	48	0
Percentage		0%	4%	0%	4%	92%	0%

Ockenden 2

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	66	1	3	62
IEA	92	8	4	80
Total	158	9	7	142
Percentage		6%	4%	90%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	66	0	2	0	1	62	1
IEA	92	0	6	0	0	80	6
Total	158	0	8	0	1	142	7
Percentage		0%	5%	0%	1%	90%	4%

Combined actions - Delivery status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	93	1	4	88
IEA	117	10	5	102
Total	210	11	9	190
Percentage		5.2%	4.3%	90.5%

Combined actions- Progress status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	93	0	3	0	1	88	1

Counts

IEA	117	0	7	0	2	102	6
Total	210	0	10	0	3	190	7
Percentage		0.0%	4.8%	0.0%	1.4%	90.5%	3.3%

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions,
	On track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that this action is being delivered and sustained.
	Descoped	The work to deliver this action is not within the Trust's control to deliver. It is therefore descoped until such time that Local or National progress is made to enable the Trust to implement and embed this action.

Accountable Executive and Owner Index

Name	Title and Role	Project Role
Paula Gardner	Executive Director of Nursing	Overall MTP Executive Sponsor
John Jones	Executive Medical Director	Overall MTP Executive co-sponsor
Andrew Sizer	Medical Director, Women & Children's Division	Senior Responsible Officer, MTP and Accountable Action Owner
Jay Atkinson	Director of Operations, Women & Children's Division	Accountable Action Owner
Mei-See Hon	Clinical Director, Obstetrics	Co-lead: Clinical Practice and Accountable Action Owner
Guy Calcott	Obstetric Consultant	Co-lead: Clinical Practice
Kim Williams	Interim Director of Midwifery	Lead: Governance and Accountable Action Owner
Julie Plant	Divisional Director of Nursing	Lead: Neonatal Transformation
Emma Wilkins	Deputy Director of Workforce	Lead: People and Culture
Yee Cheng	Consultant Anaesthetist	Lead: Anaesthetics

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Neonatal External Mortality Review

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR1/I_NEMR2	The service, an LNU, has retained equipment to provide nitric oxide even though changes have been made nationally to focus the provision of nitric oxide within NICUs. The equipment was rarely used and yet associated with anxiety among nursing staff, many of whom were said to lack experience or training in its use. It is therefore recommended that the nitric oxide equipment should be removed from the unit where currently it poses a risk.	Evidenced and Assured	Completed	This action was approved as 'Evidenced and Assured' at Jan-25's MNTAC. Evidence Requirements for Assurance: Letter from the Network Addition to Risk Register Updated Persistent Pulmonary Hypertension of the newborn (PPHN) guideline following nitric oxide removal Engineering services email confirming removal	Immediate (0-3 months)		14/01/2025		14/01/2025	Dr John Jones	CD's	Monday.com
NEMR2/I_NEMR3	The unit should develop a first hour (golden hour) checklist to facilitate delivery and documentation of time critical interventions within the first hour from birth for all infants admitted for intensive care.	Delivered, Not Yet Evidenced	On Track	An exception report was approved at Jan-25's MNTAC changing the deadline for green to Apr-25 so the audit can be repeated. Initial audit did not show sufficient compliance to ensure the action is fully embedded. Evidence Requirements for Delivery: Golden Hour Guideline - validated at Apr-24 Neonatal Governance Golden Hour Checklist - validated at Apr-24 Neonatal Governance Evidence Requirements for Assurance: Audit of compliance against guideline	Immediate (0-3 months)	30/09/2024	08/10/2024	30/04/2025		Dr John Jones	CD's	Monday.com
NEMR3a/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: a. The unit should collaborate with the ODN to review the number of intensive care days (HRG1) within the unit. The review team observed that for a birth denominator of 4,100, intensive care days appeared to be high, potentially indicating an interventionist approach to neonatal care.	Evidenced and Assured	Completed	This audit has been undertaken further to receipt of the initial letter following the review. This action was accepted as "Delivered, Not yet Evidenced" at Nov-24'MNTAC. Further to this, specific data points were added to the dashboard for ongoing monitoring and form part of the Network monitoring process. This action was accepted as Evidenced and Assured at Mar-25's MNTAC. Evidence Requirements for Delivery: Intensive Care Days Audit - causes Evidence Requirements for Assurance: Surveillance of ITU and HDU care days integrated into Network monitoring processes (Steering Group) Data points added to dashboard for ongoing monitoring	Immediate (0-3 months)	31/12/2024	12/11/2024	28/02/2025	11/03/2025	Dr John Jones	CD's	Monday.com
NEMR3b/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: b. The unit should undertake quarterly audit of all neonatal resuscitations that extend beyond initial inflation breaths, against UK Resuscitation Council Newborn Life Support guidance, with specific focus on timeliness and sequence of interventions, escalations for additional senior help, response, and documentation on advanced resuscitation proforma.	Evidenced and Assured	Completed	Quarterly audit of neonatal resuscitation of all babies requiring more than inflation breaths for 6 months then quarterly for a total of a year completed. Outcome from audit - CD and maternity education team to incorporate neonatal resuscitation education into NLS update teaching. This action was accepted as "Delivered, Not yet Evidenced" at Nov-24'MNTAC and accepted as Evidenced and assured at Mar-25's MNTAC with the integration of the quarterly audit into the Forward Audit Plan. Evidence Requirements for Delivery: Resuscitation Audit Evidence Requirements for Assurance: Listed audits integrated into Forward Audit Plan	Immediate (0-3 months)	30/11/2024	12/11/2024	28/02/2025	11/03/2025	Dr John Jones	CD's	Monday.com
NEMR3c/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: c. The unit should undertake a gap analysis of how its Family Integrated Care provision aligns with national guidelines.	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. Evidence Requirements for Delivery: Family Integrated Care benchmark, gap analysis and action plan Evidence Requirements for Assurance: Family Integrated Care action plan fully implemented Family Integrated Care action plan audited Listed audits integrated into Forward Audit Plan	Immediate (0-3 months)	30/09/2024	08/10/2024	31/08/2025		Dr John Jones	CD's	Monday.com

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Neonatal External Mortality Review

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NEMR3d/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: d. The unit should review National Neonatal Audit Programme (NNAP) quality outcome trends, particularly bronchopulmonary dysplasia, brain injury, non-invasive ventilation rates, and create quality improvement projects to address any issues identified.	Delivered, Not Yet Evidenced	On Track	The clinical team have undertaken a review of NNAP data for 2022/23 and is in the process of reviewing the outcome of the 2023 data, evidence to demonstrate this will be presented to MNTAC in December 2023. Further evidence of any amended practice or dissemination of learning will be presented to MNTAC in due course to provide evidence of embedded practice. Evidence Requirements for Delivery: NNAP review undertaken for latest available data through governance processes Evidence Requirements for Assurance: Robust Process in place for receiving and responding to national reports Evidence of QI projects delivered and audited	Immediate (0-3 months)	31/12/2024	10/12/2024	31/08/2025		Dr John Jones	CD's	Monday.com
NEMR4	The unit should develop a training programme on approaches to ventilation that reflect expectations in BAPM's Neonatal Airway Safety Standard, drawing on supporting training materials (for example, including for videolaryngoscopy).	Not Yet Delivered	On Track	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. Current consultant staffing on the unit does not allow for a lead to be appointed until recruitment needs are met, which would be required to develop BAPM compliant training programme. An exception report was submitted to Feb-25's MNTAC and accepted, allowing for additional time while recruitment is underway. While a programme has not yet been developed that meets all requirements from the BAPM standard, training on airway safety continues to be delivered on the unit. Delivery and evidence dates were changed to Jul-25 and Oct-25 respectively. Evidence Requirements for Delivery: Training plan in line with BAPM Airway/ventilation standards (including cross speciality simulations) Training plan - competencies in place for members of the team Clinical Processes aligned with training plan Evidence Requirements for Assurance: Audits against standards in the training plan Training compliance from the LMS - 90% across all staff groups Rotas - all shifts have competent member of staff - Medical & Nursing	Short Term (0-6 months)	31/07/2025		31/10/2025		Dr John Jones	CD's	Monday.com
NEMR5/I_NEMR4	All neonatal nursing staff should be given protected time to attend mandatory training, equipment training and simulation sessions as a minimum. Simulation sessions should be regularly timetabled. To avoid nurses being pulled away from clinical duties, the trust could consider allocating one to two days over the year to complete mandatory training and attend multidisciplinary simulation training (like the approach taken in maternity services).	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. Evidence Requirements for Delivery: Training needs analysis Training plan for 2 day mandatory training Rosters and rotas demonstrating allocated time for training Evidence Requirements for Assurance: Compliance against TNA Rotas demonstrating staff being released for training	Short Term (0-6 months)	31/10/2024	08/10/2024	31/10/2025		Dr John Jones	CD's	Monday.com
NEMR6a/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Education Lead	Evidenced and Assured	Completed	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. NEMR6a was agreed as "Evidenced and Assured" at Apr-25's MNTAC. Evidence Requirements for Delivery: Education Lead Job Description Education Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2025	08/04/2025	31/08/2025	08/04/2025	Paula Gardner	Julie Plant	Monday.com

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Neonatal External Mortality Review

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NEMR6b/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Governance Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Governance Lead Job Description Governance Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/08/2025		31/12/2025		Paula Gardner	Julie Plant	Monday.com
NEMR6c/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Family Integrated Care Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Family Integrated Care Lead Job Description Family Integrated Care Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/10/2025		28/02/2026		Paula Gardner	Julie Plant	Monday.com
NEMR6d/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Infant Feeding (BFI) Lead	Evidenced and Assured	Completed	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. NEMR6c was agreed as "Evidenced and Assured" at Apr-25's MNTAC. Evidence Requirements for Delivery: Infant Feeding Lead Job Description Infant Feeding Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2025	08/04/2025	31/08/2025	08/04/2025	Paula Gardner	Julie Plant	Monday.com

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NEMR6e/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Transitional Care Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Transitional Care Lead Job Description Transitional Care Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/09/2025		31/01/2026		Paula Gardner	Julie Plant	Monday.com
NEMR6f/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Discharge Planning Lead	Not Yet Delivered	Not Started	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. This action is currently on hold while the internal provision is reviewed. Evidence Requirements for Delivery: Discharge Planning Lead Job Description Discharge Planning Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)					Paula Gardner	Julie Plant	Monday.com
NEMR6g/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Safeguarding Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Safeguarding Lead Job Description Safeguarding Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/06/2025		30/09/2025		Paula Gardner	Julie Plant	Monday.com

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NEMR6h/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. IPC Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: IPC Lead Job Description IPC Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	28/02/2026		30/06/2026		Paula Gardner	Julie Plant	Monday.com
NEMR6i/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Breavement Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Bereavement Lead Job Description Bereavement Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2026		31/07/2026		Paula Gardner	Julie Plant	Monday.com
NEMR7	There should be protected time for bereavement quality roles in the neonatal service to work alongside the bereavement midwives.	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including a dedicated bereavement lead post). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. An exception re[ort was presented and accepted at Feb-25's MNTAC adjusting the delivery and evidence timescales to Jan-26 and Apr-26 respectively to adhere to the current trajectory for recruitment. Evidence Requirements for Delivery: Backfill in place to cover for quality roles duties Bereavement lead in post Evidence Requirements for Assurance: Evidence of delivery withing the roles Roster demonstrating protected time - 3 months	Short Term (0-6 months)	31/01/2026		30/04/2026		Paula Gardner	Julie Plant	Monday.com
NEMR8/I_NEMR4	ANNPs should receive 20% protected time to ensure they complete all four pillars of advanced practice and must be able to access their allocated time to update their skills on a NICU.	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. Evidence Requirements for Delivery: Rotas demonstrating planning allows for protected time for four pillars and allocated time on NICUs (3 months) ANNP rotation time allocated and rotations commenced (Ockenden LAFL 4.100 - validated through MNTAC in May-24) Evidence Requirements for Assurance: Audit demonstrating staff are released as required (including for rotation to NICU)	Short Term (0-6 months)	30/09/2024	08/10/2024	31/08/2025		Dr John Jones	CD's	Monday.com

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NEMR9	Team building should be undertaken to reflect on this review and enable the multidisciplinary team to identify actions. This should provide the following opportunities: a. For more junior nursing staff to develop effective working relationships with senior doctors on the unit and collaborate in projects to take the unit forward. b. To ensure debriefs, learning events, meetings, teaching and education aim for a multidisciplinary and multiprofessional theme to reflect the work environment and how care is delivered. c. To encourage psychological safety in ways of working, events, education and training, to ensure a safe space for colleagues to flag any concerns and worries.	Not Yet Delivered	On Track	Further to publication of the final report, a workshop has been held with the specialty clinical teams to discuss this recommendation. A number of actions were identified by the team that will be implemented to ensure this recommendation is delivered. Evidence of delivery will be provided to MNTAC in June 2025 followed by evidence of embedded practice by September 2025 in line with the timescale provided within the report. Evidence Requirements for Delivery: Agile workshop - Actions Review Multidisciplinary training Representation of every tier of staff at Neonatal Workstream Learning events rolled out and open to all staff Unit meetings in place All members of the team invited to governance meetings Learning meetings integrated into preceptorship programme Internal meetings and communication strategy in place (Inc tea trolleys/social events) Process in place for debrief after acute events Civility saves lives and Human Factor Training part of TNA Evidence Requirements for Assurance: Meeting and events attendance records Measure of culture shift (survey results, recruitment & retention, reporting culture) Evidence of process being followed for acute events Civility saves lives and Human Factors training compliance	Medium Term (6-12 months)	01/06/2025		01/09/2025		Executive Triumvirate	Mr Andrew Sizer	Monday.com
NEMR10/I_NEMR4	Neonatal nursing leaders (eg senior sisters) should be given protected time to undertake management and leadership responsibilities.	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. Evidence Requirements for Delivery: Planning in place to deliver recruitment trajectory - funding in place Leadership roles appointed to - email Evidence Requirements for Assurance: Evidence of delivery within the roles - probationary objectives completed Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/09/2024	08/10/2024	31/01/2025		Paula Gardner	Julie Plant	Monday.com
NEMR11	This review highlights the benefits realised with excellence in clinical leadership. The Trust should build on this with specific leadership development investment for medical and nursing leaders within the neonatal unit (eg Neonatal Clinical Lead, Clinical Director, Neonatal Matron). This could be executive coaching or specific leadership development programmes to include topics such as embedding psychological safety in teams, leadership succession planning etc.	Not Yet Delivered	On Track	The division has recently appointed a new clinical leadership team for the specialty. Two new CD's (job share) have commenced in post in September 2024, a new Ward Manager also commenced in post in September and a new Neonatal Matron has been appointed and will take up post in November 2024. Plans are in place to ensure each clinical leaders has an appropriate and bespoke personal development plan in place to equip them with the necessary leadership skills to succeed in their posts. Evidence of compliance with this will be presented to MNTAC in June 2025. Evidence Requirements for Delivery: Neonatal Leadership enrolled on SaTH leadership programmes Evidence Requirements for Assurance: Compliance with Leadership Programme Succession planning in place with development identified through appraisal process Attendance of Clinical directors to quarterly CD meetings MDT feedback for Leadership Team	Medium Term (6-12 months)	31/06/2025		30/09/2025		Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com

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NEMR12	The maternity service has had a new level of stability, following patterns of high turnover across all senior management roles, which has boosted recruitment (section 6.3.4). Trust leaders should facilitate learning from what has worked well in maternity and how this can be translated to neonatal consultant and nursing leadership development on an ongoing basis.	Not Yet Delivered	On Track	The divisional senior team responsible for maternity services in SaTH is also responsible for neonatal services. Consequently, learning from what has worked well in transforming maternity services has informed operational and clinical planning for the neonatal service. Fundamentally, a business case was submitted to the system by the division in March 2023 to seek funding for both clinical and governance roles to bring the service workforce establishment in line with BAPM best practice standards. The funding required has now been provided and recruitment to the identified roles is underway. In addition to this, the Maternity Transformation Programme has been expanded to incorporate delivery of this action plan, adopting the same improvement methodology which has proven to be successful for maternity service transformation. Evidence of compliance with this recommendation will be presented to MNTAC in June 2025. Evidence Requirements for Delivery: Evidence Requirements for Assurance:	Medium Term (6-12 months)	31/06/2024		30/09/2025		Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com

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NEMR13	The PMRT process needs further development to become a useful mechanism for learning, including securing neonatal consultant as well as fetal medicine externality, protected time for neonatal nurse participation, and a clear mechanism for sharing learning with respect to the network. A network-wide approach may be needed to make best use of available resources and expertise, given the tension between a neonatal unit functioning with significant workforce gaps alongside a need of more from this same workforce in terms of PMRT attendance.	Delivered, Not Yet Evidenced	On Track	Actions have been identified by the clinical leadership team to deliver this recommendation. In addition to this, discussions will be held with network colleagues regarding the potential for developing a network wide approach. This action was agreed as 'Delivered, Not Yet Evidenced' at Feb-25's MNTAC. Evidence Requirements for Delivery: PMRT Business Case including PMRT resources PMRT ToRs inc. externality requirement Agendas and Minutes from Quarterly Network Mortality meetings Evidence Requirements for Assurance: Evidence of delivery against PMRT action plans - completed to agreed standards	Short Term (0-6 months)	31/01/2025	11/02/2025	31/03/2025		Dr John Jones	CD's	Monday.com
NEMR14/I_NEMR1	Learning and actions from PMRT and incidents must be clearly documented and there must be a robust mechanism for feedback to the multidisciplinary team.	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. An exception report was accepted at Feb-25's MNTAC moving the evidence date to May-25 while the team continues to embed the PMRT processes and improves delivery of actions plans linked to PMRT. Evidence Requirements for Delivery: ANNP mortality lead in post Monthly PMRT update template and schedule - Q2 through October Governance Quarterly joint mortality meetings (Shared with maternity) Section at governance meetings dedicated to the sharing of learning from PMRT Evidence Requirements for Assurance: Evidence of compliance with process Multiple examples of the monthly PMRT update Evidence of shared learning at meetings	Short Term (0-6 months)	30/09/2024	08/10/2024	31/05/2025		Dr John Jones	CD's	Monday.com
NEMR15	The service should ensure compliance with the medical and nursing standards as listed in BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022.	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards. This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in June 2025 to allow time for recruitment into the new posts identified. Evidence Requirements for Delivery: Benchmark against all standards Action plan for any identified gaps Evidence Requirements for Assurance: Completion of the action plan	Short Term (0-6 months)	31/06/2025		30/09/2025		Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com

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NEMR16	The neonatal service should review its 'golden hour' care practices for preterm infants and sick term infants born within the service, with a focus on implementing evidence-based care practices around resuscitation, stabilisation, surfactant administration and other supportive measures in the first few hours after birth.	Not Yet Delivered	Off Track (see exception report)	A golden hour checklist has been produced and implemented within the department however it only accounted for preterm babies. A review is underway to include sick term babies as per the recommendation. To complete this work, the team requested additional time through an exception report which was accepted at Dec-24's MNTAC. This amended the deadlines to Jan-25 for amber and May-25 for green. This action has been agreed as 'Off Track' at feb-25's MNTAC. With no national guidance available for a golden hour checklist for term babies, the team has contacted the reviewers for more information. A meeting is being organised and new timelines will be proposed once guidance has been received. Evidence Requirements for Delivery: Amended guideline and checklist Evidence Requirements for Assurance: Audit of guideline and checklist implementation	Short Term (0-6 months)	31/01/2025		31/05/2025		Dr John Jones	Mr Andrew Sizer	Monday.com
NEMR17	The trust should expedite consideration of the business case for an electronic patient record to enhance the accurate recording of the clinical journey for babies admitted to the neonatal unit.	Delivered, Not Yet Evidenced	Off Track (see exception report)	A business case for the implementation of an electronic patient record for the neonatal service has been produced and will be presented to the Women & Children's Divisional Committee in October 2024. Further to approval via divisional committee, the case will be submitted to Trust executives for review/ approval. This action was approved as "Delivered, Not Yet Evidenced" at Apr-25's MNTAC with the approval of the business case for Badgernet EPR. Revised timeframes will be presented in May 2025 to enable this action to go back "On Track" Evidence Requirements for Delivery: Approved business case NNU EPR Decision for implementation of NNU EPR Evidence Requirements for Assurance: Implementation of NNU EPR	Medium Term (6-12 months)	31/01/2025	08/04/2025			Ned Hobbs	Carol McInnes	Monday.com
NEMR18	The trust should engage the network in discussions over having a robust 24/7 cot locator service for antenatal and acute postnatal transfers, and for a review to take place into NICU capacity. Consideration could be given to a digital solution that also incorporates maternal bed availability and to learn from exemplar networks with well-developed cot locator services.	Not Yet Delivered	Not Started	Initial discussions with the network regarding the outcome of the review and the associated network wide recommendations to be scheduled. Dates for implementation to be agreed with network colleagues. Evidence Requirements for Delivery: Evidence Requirements for Assurance:	Medium Term (6-12 months)	TBC		TBC		Dr John Jones	Mr Andrew Sizer	Monday.com
NEMR19	The trust should engage the neonatal network in the findings of this review, and specifically: a. Questions raised by the review team over the functioning of the network, with the LNU at times left caring for extremely sick premature babies for longer than it ought to. b. The impact of instances when the NICU appeared reluctant to accept patients for transfer from the LNU (section 6.1.4) on the likelihood or readiness for staff at the LNU to make a referral, and on timely transfer. questions raised during interviews over whether escalation to NICUs happened sufficiently early and 'assertively enough' (section 6.2.2).	Not Yet Delivered	Not Started	Initial discussions with the network regarding the outcome of the review and the associated network wide recommendations to be scheduled. Dates for implementation to be agreed with network colleagues. Evidence Requirements for Delivery: Evidence Requirements for Assurance:	No Timeline Allocated	TBC		TBC		Dr John Jones	Mr Andrew Sizer	Monday.com

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NEMR20	The neonatal team should review the feedback provided on the 18 cases reviewed as an opportunity to consider learning for the whole MDT.	Not Yet Delivered	On Track	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. Evidence will be submitted to MNTAC to demonstrate compliance in December 2024. An exception report was submitted and accepted at Dec-24's MNTAC requesting additional time to conduct a thorough review of the feedback and sharing of the learning from that review thereafter. deadlines were amended to Mar-25 for amber and Jun-25 for green. Evidence Requirements for Delivery: Plan for communication around the action plan and staff involvement in the delivery of the work Plan for the communication of the content of the report itself Review of the 18 cases feedback Evidence Requirements for Assurance: Evidence of communication Evidence of learning from the review being shared appropriately Evidence of attendance to relevant meetings	Short Term (0-6 months)	31/03/2025		30/06/2025		Dr John Jones & Paula Gardner	Mr Andrew Sizer & Julie Plant	Monday.com
NEMR21	The unit should develop a clear programme of quality improvement and audit linked to clinical incidents and PMRT. Audits may include: airway management, golden hour timings, stabilisation, prescribing, documentation. It may be advisable to ask comparable units within a different ODN to share details of their audit programmes and examples of audit proformas, in addition to linking with audits taking place across the ODN.	Not Yet Delivered	On Track	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. To note, additional capacity for clinical audit and quality improvement was incorporated into the aforementioned business case. An exception report was approved at Mar-25's MNTAC changing the delivery and evidence dates to May-25 and Oct-25 respectively. This will allow the processes to go through appropriate governance. Evidence Requirements for Delivery: Audit lead in post Forward audit plan in place Quality Improvement lead in post Quality Improvement plan in place Monthly dashboard with review of trends and themes Share QI plan and practices with other networks Process - what triggers a QI project & how we do QI (Improvement hub) Evidence Requirements for Assurance: Evidence of audits completed according to the Forward Audit Plan Evidence of QI projects delivery	Short Term (0-6 months)	31/05/2025		31/10/2025		Dr John Jones & Paula Gardner	Mr Andrew Sizer & Julie Plant	Monday.com
NEMR22	The trust should consider sharing the conclusions of this review with families (in particular the parents of the babies whose cases were reviewed), and other service users.	Evidenced and Assured	Completed	The Committee agreed this action was fully evidenced and assured following the engagement with the families impacted in the report and the report's presentation at Public Board. Evidence Requirements for Assurance: - Report presented at Public Board and associated minutes - Evidence of meetings with families available due to confidentiality considerations.	Short Term (0-6 months)	31/12/2024	10/12/2024	31/03/2025	10/12/2024	Dr John Jones	Dr John Jones	Monday.com
NEMR23	The service must implement Family Integrated Care and regularly seek out family feedback and involvement in service improvements and redesign. This could be done by using network parent advisory groups, for example.	Not Yet Delivered	On Track	The clinical teams have identified a series of actions to fully deliver this recommendation. To note, a dedicated FIC' post was included within the aforementioned business case which has been approved. This will allow dedicated resource to deliver the required service. Evidence of compliance with this recommendation will be presented to MNTAC in June 2025 in line with the independent review timescale of required delivery within 6-12 months. Evidence Requirements for Delivery: Patient Experience Group - Neonates Nurse Specialist in post MNVP surveys and meetings Local Parent Advisor 'Champion' Benchmark against BAPM PIC standard - Gap Analysis Evidence Requirements for Assurance: Evidence of Nurse Specialist delivering in role Compliance with BAPM OIC standards Evidence of deliverables from PEG meetings and survey findings	Medium Term (6-12 months)	31/03/2025		31/06/2025		Paula Gardner	Julie Plant	Monday.com

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

Neonatal External Mortality Review

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR24	This report should be shared with the trust board, which should have oversight of any action plan developed to address the recommendations.	Delivered, Not Yet Evidenced	On Track	The report and the associated action plan will be presented to the Trust Board in November 2024. This will be followed by regular reports on progress of delivery aligned with the assurance processes incorporated into the MNTAC process. This action was agreed as 'Delivered, Not Yet Evidenced' at Jan-25's MNTAC. Evidence Requirements for Delivery: Agenda and Minutes from Board BoD Neonatal Review appendix Evidence Requirements for Assurance: Evidence of progress being shared at agreed intervals	Medium Term (6-12 months)	31/12/2024	14/01/25	31/05/25		Dr John Jones	Carol McInnes	Monday.com

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

Counts

NEMR

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
Actions	35	19	10	6
Total	35	19	10	6
Percentage		54.3%	28.6%	17.1%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
Action	35	3	24	0	2	6	0
Total	35	3	24	0	2	6	0
Percentage		8.6%	68.6%	0.0%	5.7%	17.1%	0.0%

Glossary and Index to the Neonatal Mortality Review Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions,
	On track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that this action is being delivered and sustained.
	Descoped	The work to deliver this action is not within the Trust's control to deliver. It is therefore descoped until such time that Local or National progress is made to enable the Trust to implement and embed this action.

Accountable Executive and Owner Index

Name	Title and Role	Project Role
Paula Gardner	Executive Director of Nursing	Overall MNTP Executive Sponsor
John Jones	Executive Medical Director	Overall MNTP Executive co-sponsor
Andrew Sizer	Medical Director, Women & Children's Division	Senior Responsible Officer, MNTP and Accountable Action Owner
Jay Atkinson	Director of Operations, Women & Children's Division	Accountable Action Owner
Julie Plant	Divisional Director of Nursing	Accountable Action Owner
Alison Belfitt	Co-Clinical Director - Neonatal	Accountable Action Owner
Jen Brindley	Co-Clinical Director - Neonatal	Accountable Action Owner

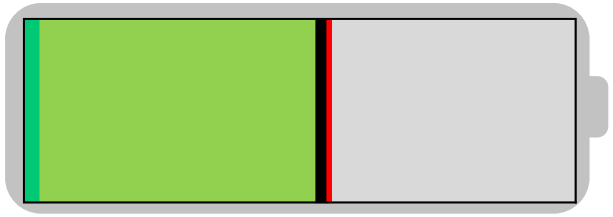
IMNR Appendix Three: Phase 2 batteries – Post Apr-25 MNTAC

The Shrewsbury and Telford Hospital NHS Trust

Overall Delivery

84% (217) Not Yet Delivered
10% (27) Delivered, Not Yet Evidenced
6% (16) Evidence & Assured

Overall Progress



6% (16) Complete
53% (138) On Track
1% (4) Descoped
1% (1) Off track
39% (101) Not Started

	Delivery Battery	Progress Battery
Black Maternal Health Plan	78% (7); 22% (2)	22% (2); 33% (3); 45% (4)
Maternity Community Service Review	100% (37)	32% (12); 68% (25)
LMNS Equity & Equality	94% (28); 3% (1); 3% (1)	3% (1); 37% (11); 60% (18)
LMNS 3 Year Delivery Plan	68% (19); 18% (5); 14% (4)	14% (4); 50% (14); 36% (10)
Cultural Improvement Plan	92% (34); 5% (2); 3% (1)	3% (1); 49% (18); 48% (18)
CQC Neonates Action Plan	20% (2); 60% (6); 20% (2)	20% (2); 70% (7); 10% (1)
Neonatal External Mortality Review	54% (19); 29% (10); 17% (6)	17% (6); 74% (26); 3% (1); 6% (2)
Neonatal Unit Improvement Plan	100% (65)	65% (42); 35% (23)
CQC National Review	50% (2); 50% (2)	75% (3); 25% (1)
Phase 2 Internal Actions	80% (4); 20% (1)	40% (2); 60% (3)

Not Yet Delivered; Delivered, not yet evidenced; Evidenced & Assured

Complete; On Track; At Risk; Descoped; Not Started; Off Track

To note:
1 action within NEMR plan was subdivided. That plan now contains 35 actions

The Shrewsbury and Telford Hospital NHS Trust

Maternity/Neonatal Governance Meeting
PMRT January – March 2025

Agenda item				
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q4			
Executive Lead	Paula Gardner, Interim Chief Nurse			
Report Author	Silje Almklow			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	**√**	Safe	**√**
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	**√**	Well Led	**√**
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	**√**		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance April 2025 Neonatal Governance meeting April 2025			
Executive summary:	There have been 2 stillbirths and 1 neonatal death in quarter 4. External Obstetric Consultants have been present at each PMRT review of care. Compliance with CNST Safety Action 1 is confirmed in this report. A higher rate of ethnic minorities has been noted amongst PMRT cases when compared to the ethnicity data in Shropshire, however, the issues identified in reviews do not disproportionately affect ethnic minorities. The ethnic category of every PMRT in quarter 4 was white British.			
Appendices	MBRRACE generated Trust Board Report			

1.0 The babies whose care should be reviewed using the PMRT

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6.
- All antepartum and intrapartum stillbirths.
- All neonatal deaths from birth at 22+0 to 28 days after birth.
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

Late fetal loss
In this report, a baby born between 22 and 23 weeks of pregnancy, who shows no signs of life regardless of when the baby died, is referred to as a late fetal loss (sometimes referred to as a late miscarriage).

Neonatal death
A neonatal death is a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born. Neonatal deaths of babies born at <22 weeks gestation are not reviewed via the PMRT tool.

Stillbirth
A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks.

2.0 Deaths reported to MBRRACE

In the time-period from the 1st of January 2025 to the 31st of March 2025, there were 2 stillbirths and 1 neonatal death at SaTH. Reporting to MBRRACE was completed in line with reporting guidelines.

Late fetal losses

There were no late fetal losses in January to March 2025 at SaTH.

Stillbirths

The first stillbirth that took place this quarter was an antepartum stillbirth at 33+1 weeks gestation. The mother had joint care in pregnancy between SaTH and a tertiary unit. The mother had a history of PV bleeding during pregnancy. The mother contacted maternity triage with reduced fetal movement and an intrauterine death was confirmed on ultrasound scan.

The second stillbirth this quarter was an intrapartum stillbirth at 25 weeks gestation. The mother had reduced liquor volume, and the baby was growth restricted. A planned scan showed no cardiac activity.

Neonatal deaths

The neonatal death this quarter was a baby born via emergency caesarean section for maternal compromise at 22+5 weeks gestation. Resuscitation was attempted but unsuccessful.

3.0 Safety Action 1 Compliance: **Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 1 December 2024 30 November 2025 to the required standard?**

(Y7 Relaunch) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. (See technical notes 1 to 5).

In Quarter 4, (Jan, Feb, Mar) there were 2 stillbirths and 1 neonatal death that met the criteria for review using PMRT. These cases were reported to MBRRACE within the specified timeframe of 7 working days. SATH is 100% compliant with this target for quarter 4.

Quarter 4	Notified to MBRRACE	Reported to MBBRACE within 7 working days?	Surveillance information completed	Surveillance completed within one calendar month?
Stillbirth 1: 97390/1	20/02/2025	Yes	20/02/2025	Yes
Neonatal death 1: 97682/1	10/03/2025	Yes	10/03/2025	Yes
Stillbirth 2: 97803/1	18/03/2025	Yes	18/03/2025	Yes

(Y7 Relaunch) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards. (See technical notes 6 to 8)

In Quarter 4, all parents were given the opportunity to ask questions and have their perspectives included in the PMRT review. SATH are 100% compliant with this target for quarter 4.

Quarter 4	Families informed	Date parents contacted	Date of second contact
Stillbirth 1: 97390/1	Yes	24/02/2025	11/03/2025
Neonatal death 1: 97682/1	Yes	12/03/2025	13/03/2025
Stillbirth 2: 97803/1	Yes	17/03/2025	28/03/2025

(Y7 Relaunch) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months.

For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT**.** (See technical notes 9 to 18)

Quarter 4 provides assurance that all reportable cases have had reports published within 6 months. SATH are 100% compliant with these targets for quarter 4.

Quarter 3	Date of loss	MDT review date	PMRT date	Report Published	External Panel member
Stillbirth 1: 95933/1	05/11/2024	19/11/2024	15/01/2025	24/02/2025	Yes
Stillbirth 2: 96092/1	16/11/2024	26/11/2024	TBC	TBC	MNSI case – review on hold until the MNSI review is completed.
Stillbirth 3: 96096/1	16/11/2024	26/11/2024	15/01/2025	24/01/2025	Yes
Neonatal death 1: 95544/1	09/10/2024	14/10/2024	19/12/2024	Delay due to coroner's PM outstanding.	Yes
Quarter 4	**Date of loss**	**MDT review date**	**PMRT date**	**Report Published**	**External Panel member**
Stillbirth 1: 97390/1	19/02/2025	04/03/2025	TBC		
Neonatal death 1: 97682/1	09/03/2025	18/03/2025	TBC		
Stillbirth 2: 97803/1	15/03/2025	25/03/2025	TBC		

(Y7 Relaunch) Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)

PMRT_BoardReport_
The Princess Royal Hc

4.0 Quarterly overview

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Deaths are reported to MBBRACE within 7 working days.	100%	100%	100%	100%
Parents should have their perspectives of care and any questions they have sought.	100%	100%	100%	100%
Reviews started within 2 months.	100%	100%	100%	100%
Final reports are published within 6 months.	100%	100%	TBC	TBC

A minimum of 75% of multi-disciplinary PMRT reviews should be completed and published within six months (increase from 60%).	100%	100%	TBC	TBC
For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	100%	100%	TBC	TBC

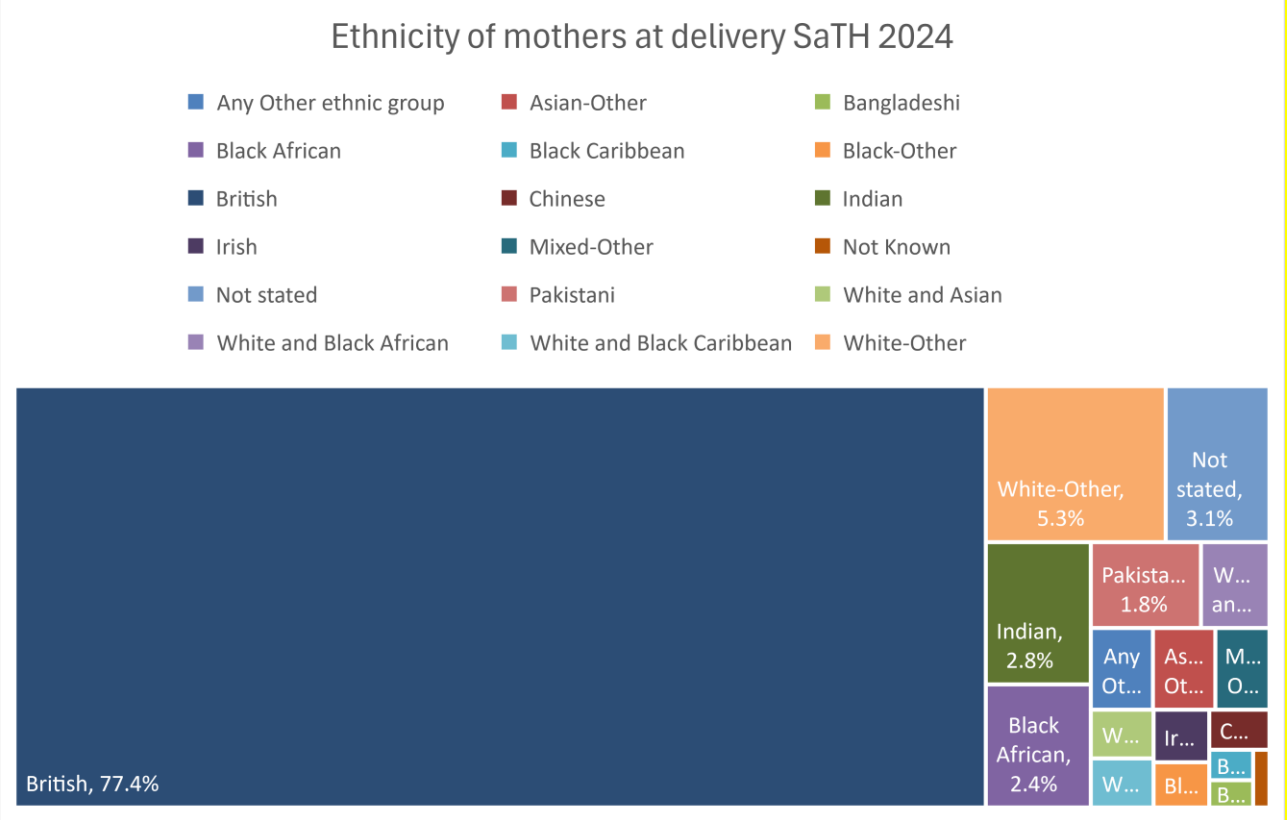
Equality Diversity and Inclusivity

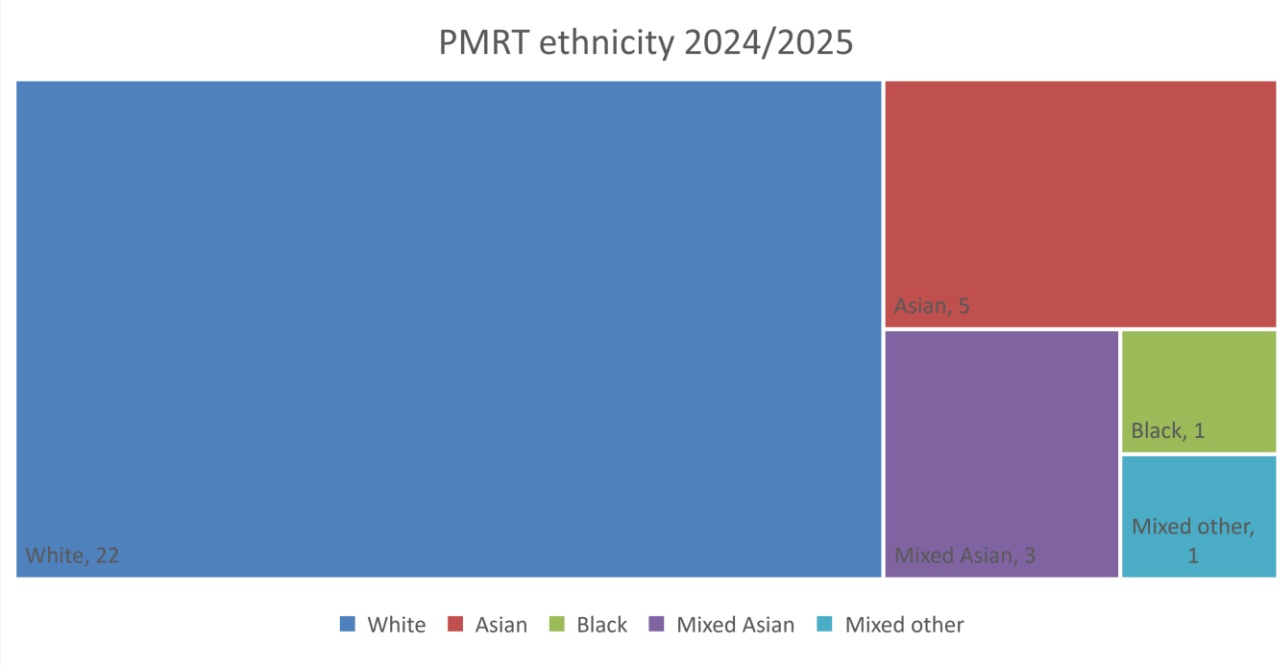
Recent reports have emphasised that the disparities in maternity and neonatal care for Black, Asian, and Minority Ethnic (BAME) families in the UK, as noted in the 2004 report, have seen only slight improvements, twenty years after its publication. Reports show that the inequalities also persist in families from socially deprived areas and women with disabilities:

1. **MBRRACE-UK (November 2021)** reviewed maternal deaths and morbidity from 2017 to 2019, emphasising lessons learned to improve maternity care, noting the marked disparities for BAME communities.
2. **Five X More (May 2022)** focused on the experiences of Black women with maternity services, revealing persistent issues and inequalities in care.
3. **NHS England (2023)** The Three-year delivery plan for maternity and neonatal services, recognises the need to make care safer, more personalised, and more equitable.
4. **NHS Race and Health Observatory (2023)** examined neonatal assessments for BAME newborns, including key measures like the Apgar score, and highlighted gaps in care, particularly regarding conditions like cyanosis and jaundice.
5. **Care Quality Commission (2023)** The "State of Care 2022/23" report addresses the need to tackle health and care inequalities. It highlights the disparities in care and outcomes for families from BAME communities, as well as those affected by disability and poverty.

Despite recommendations, these more recent reports show that BAME families continue to face disproportionately poor outcomes in maternity and neonatal care, when compared to white families. Addressing these inequalities is essential, and both national and local initiatives are being implemented to enhance care quality and outcomes for BAME families. This includes collecting more accurate data, reviewing existing practices, and implementing targeted strategies to enhance support and care during maternity and neonatal periods.

To recognise these disparities, we have included a section in this report aiming to benchmark our local metrics. In future reports, we plan to expand and explore these metrics in more detail, with an additional focus on acknowledging disparities related to social deprivation and disability.





* Ethnicity data includes PMRTs led by SaTH and joint PMRTs with other trusts. Numbers include all PMRT's from 2024 and 2025. Data will become more accurate as time passes and number increase.

A review of ethnicity from PMRT cases in 2024/2025 demonstrates a higher rate of ethnic minorities that is seen in the ethnic makeup of women who birthed at SaTH in 2024. It is important to note, however, that the ethnic category for every PMRT case reported in 2025 (3 internal and 2 external) was White British. We will continue to monitor for signs that ethnic minorities are disproportionately affected by fetal and neonatal losses at SaTH.

5.0 Issues from reviews and completed reports undertaken in Quarter 4

The learning identified from PMRT reviews in Quarter 4 include:

Information leaflets - Accessibility

A recent PMRT review identified that a woman who was non-English speaking did not receive information in a language and format she could access.

Please ensure that all women who are identified as having communication needs have a clear plan documented from booking.

· Interpreter needed - which language

· Leaflets provided in their native language –www.tommys.org provides leaflets in multiple languages.

Triage - abdominal pain

PMRT reviews have identified women who reported abdominal pain and were not advised to attend maternity triage.

The cause of abdominal pain cannot be determined over the phone and all women who report abdominal pain should therefore be asked to attend triage for review.

If a woman attends with abdominal pain without a clear cause, always rule out labour, especially for women who are preterm.

Triage - Taxi provision

If a woman is identified as needing review in triage but reports that she is unable to secure transport, please contact management to arrange hospital taxi.

Cervical Trauma

Please refer to preterm prevention clinic from booking if the woman has a history of cervical trauma, in addition to previous cervical cerclage, trachelectomy, LLETZ > 14mm, multiple LLETZ, LLETZ under GA, or any knife cone biopsy.

Aspirin

Please ensure that all women who are recognised as high-risk for fetal growth restriction and/or pre-eclampsia are provided an initial supply of Aspirin at booking.

Document clearly that Aspirin has been provided on BadgerNet.

Send a letter with information to the GP. Please ensure that this includes details of the midwife/community team and contact details.

Mental Health concerns

Women suffering with moderate to severe anxiety and / or depression should be referred to PMHT, if there are concurrent obstetric issues refer to the Joint Perinatal Mental Health Clinic.

Please follow the high-risk care pathway for women referred to PMHT.

Red-flag symptoms include expressions or acts of self-harm, new and persistent expressions of incompetency as a mother or estrangement from the baby.

Amber-flag symptoms include history of psychotic disorder, family history of bipolar disorder or psychosis.

None of the issues identified from reviews disproportionately affected women from minority ethnic backgrounds.

6.0 Conclusion

Compliance has been met with the CNST safety action 1 requirements, and this report concludes and provides evidence that the National Perinatal Mortality Review Tool is being used to review perinatal deaths to the required standard in Quarter 4.

Author name and title
Silje Almklow
Divisional Quality Governance Lead - Women and Childrens
Quality Governance Team
Date 07/04/2025

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Princess Royal Hospital, The Shrewsbury and Telford Hospital NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2025 to 31/3/2025

There are no published reviews for The Princess Royal Hospital, The Shrewsbury and Telford Hospital NHS Trust in the period from 1/1/2025 to 31/3/2025

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting: April 2025

Agenda item				
Report Title		Maternity 6-month staffing report		
Executive Lead		Paula Gardner – Interim Chief Nursing Officer		
Report Author		Kimberly Williams Interim Director of Midwifery Jacqui Bolton Interim Head of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		BAF4, BAF3
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	67, 87
Well Led	√	Our partners		
Consultation Communication		n/a		
Executive summary:		The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q3 and 4 of 2024/25 inclusive. The maternity service has faced complex staffing challenges over the last 6 months despite a comprehensive, forward-thinking workforce plan. This is due to an unprecedented amount of staff unavailability which has been further compounded recently by the restrictions introduced for recruitment, and the need for executive and system oversight of all vacancies. Maintaining safe staffing levels has required the service to frequently enact the maternity services escalation policy to ensure patient safety is always maintained as midwifery staffing is complex, with acuity changing rapidly based on individual care needs and patient complexities. Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.		
Appendices:		Appendix 1: Midwifery red flags		

1.0 Introduction

1.1 The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q3 and 4 of 2024/25 inclusive. This is a requirement of Year Seven of the NHS Resolution Maternity (and perinatal) Incentive Scheme (MIS), and particularly for safety action 5 where the following standards are used:

Table 1

a	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
b	The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service.
c	All women in active labour receive one to one midwifery care.
d	A six-monthly midwifery staffing report that covers the staffing/safety issues is submitted to the Trust Board.

1.2 The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented.

2.0 Background

2.1 SaTH last undertook a workforce assessment in 2022 using the nationally recognised Birthrate Plus (BR+) workforce tool which recommended a total clinical whole time equivalent workforce (WTE) requirement of 199.80 to be made up of registered midwives (RMs) and midwifery support workers (MSWs).

2.2 Additionally, there is a requirement for the service to have, 21.98wte for specialist roles and midwifery management giving a total requirement of 221.78wte.

2.3 The BR+ workforce assessment does not include any uplift for the rollout of Midwifery Continuity of Carer (MCoC) as the National Midwifery team no longer support the use of BR+ for this workforce model. Instead, they advise using the MCoC toolkit which has been designed by the National team however it is worth noting that this is only currently available in beta mode due to undergoing modifications on the advice of BR+.

2.4 As things currently stand, MCoC is paused at SaTH in line with the National letter of September 2022 which was issued following the publication of the final Ockendon report and recommendations on safer staffing.

2.5 To fully delivery MCoC, a workforce uplift will be required based on the findings nationally therefore this means there is a risk that the 199.80 WTE clinical workforce requirement mentioned above may increase in the future once the toolkit becomes available and the Board are asked to note this is a real possibility.

3.0 Current Position

3.1 The below table presents the current workforce position for clinical midwives and MSWs and includes those recruited to but not yet in post. It does not include any specialist midwives, midwifery management roles, or midwife sonographers. It is also exclusive of any staff on fixed term secondments to support the Maternity Transformation Programme.

Table 2

	Establishment*	In post	Recruited to but not in post	Vacancy
MSWs and Midwives Bands 3 -7**	209.80	211.15	0	+1.35
Telephone Triage	5.6	5.6	0	0
Total	215.40	217.15	0	+1.75

**Does not include management roles or midwife sonographers*
*** Includes 10wte above BR+ for parental leave cover and additional 5.6wte for Triage above BR+*
**** An additional 17wte B5 midwives have been offered positions for autumn start*

3.2 Table 2 presents a stable workforce over-recruited by + 1.75wte, it is important to note that this includes a 10wte increase for unavailability through parental leave above the required recommendation of BR+, in addition to a telephone triage uplift of 5.6wte which again, is outside of BR+ but considered outstanding practice.

3.3 Table 3 presents the unavailability position for the last year, with particular attention being drawn to Q3/4 of 24/25 to which this report is focused on. Q3/4 saw our lowest number of maternity leave since reporting began which is more than the 3wte agreed over establishment allows for. There is also a sustained long term sickness rate which whilst it has improved since Q1/2 of 22/23, remains consistently high.

Table 3

	Q1 2024	Q2 2024	Q3 2024	Q4 2025
Parental leave*	18.69 wte	17.43wte	12.85wte	13.29wte
Long term sickness absence**	15.97wte	15.48wte	19.33wte	12.02wte
Supernumerary international midwives	10wte	1wte	0 wte	2 wte
Total	44.66wte	33.91wte	32.18wte	27.31wte

3.2 Additionally, the service welcomed 10wte international midwives who are counted within the workforce establishment and are now working independently as part of the preceptorship programme.

3.3 The midwifery leadership team are working closely with HR business partners to proactively manage sickness/absence in accordance with Trust policy and guidance, forward planning sickness meetings in advance to ensure timeliness of support and action.

3.4 Furthermore, the specialist midwifery workforce has been reviewed in their entirety to support an increase in staffing for the short term. Table 4 below presents the current specialist workforce, which makes up 21.8wte.

Table 4

Specialist Role	WTE	Specialist Role	WTE
Fetal Monitoring Midwives	1.0	Public Health Lead Midwife	1.0
Continuity of Carer Lead	1.0	Perinatal Pelvic Health Midwife	0.6
Infant Feeding Lead	0.6	Improving Women's Health Midwife	1.0
Saving Babies Lives Lead	1.0	Lead Education Midwife	1.0
Digital Midwife	1.0	Clinical Practice Educators	2.0
Maternal Mental Health Midwife	0.6	Clinical Practice Facilitators	2.0
Transformation Matron	1.0	Guideline Midwife	1.0
Antenatal Screening Midwife	1.0	EDI Midwife	1.0
Professional Midwifery Advocate- Vacancy *	1.0	Multiple Pregnancy Midwife	0.6
Frenulotomy Lead Midwife	0.4	Bereavement Midwives	2.0
BFI Lead Midwife	1.0		
Total	**9.6**	Total	**12.2**
Full total			**21.8**

3.5 Moreover, managers work clinically when required, including providing an on-call regular need to enact the midwifery escalation policy to support safe staffing.

3.6 Daily staffing meetings remain in place to focus on a two-week forward look ahead which provides a further opportunity to identify hot spot areas and action appropriate solutions to maintain safe staffing levels.

3.7 Each month the planned versus actual staffing levels are submitted to the national database and NHS Improvement using the information provided from the Healthroster Allocate rostering system and reported monthly to the workforce meeting.

3.8The service also benefits from a recruitment and retention midwife thanks to initial funding from Health Education England (HEE); this post has been further extended as a commitment to continuing to supporting midwives/MSWs to remain in practice.

4.0 Workforce Plan

4.1 Midwifery has an attrition rate of around 20wte each year in addition to continued long-term unavailability made up from a combination of parental leave and long-term sickness absence. While there is an element of funding available to cover parental leave in the short term, historically, it has always been difficult for providers to recruit to temporary posts especially in the presence of a national midwifery workforce gap.

4.2 This required SaTH to be proactive from a workforce perspective, agreeing with finance to convert some of the funding from recurring temporary positions to 10wte substantive positions that would attract midwives looking for stability and job security.

4.3 The below table presents the planned recruitment currently in train as part of the workforce plan, the majority of which is either already advertised and in the process of being recruited to or about to be advertised and pending executive/system approval as part of the interim financial restrictions.

Table 5

Planned Recruitment	WTE	Additional Info.
Midwifery Apprentice programme	9.0 over 3 years	3 commenced the programme in Sept 23, this has been paused currently in line with the current recruitment freeze.
International Midwifery Recruitment	2 per year	Initial programme recruitment trajectory (10 per year) followed by 2 per year subject to nominal role.
Midwifery Support Worker Apprentice programme	3.0	This has been approved at local/ executive level.

Apprentice Midwife sonographer	2.0	This has been approved at local/executive level, awaiting system approval level.
Breastfeeding support midwife	0.6	This has been paused in line with current recruitment freeze.

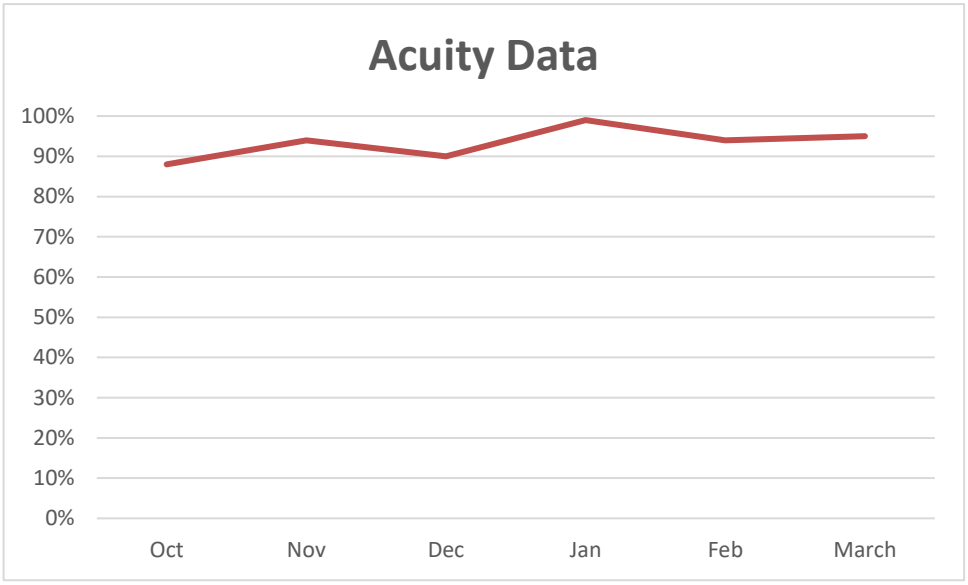
4. Acuity Data

4.1 For this report, acuity is referencing intrapartum activity (the number of women being cared for on the delivery suite) and is measured using the BR+ acuity tool. BR+ defines acuity as "the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency."

4.2 A positive acuity score means that the midwifery staffing is adequate for the level of acuity of the women being cared for on delivery suite at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the delivery suite at the time. In addition, the tool collects data such as red flags which are defined as a "*warning sign that something may be wrong with midwifery staffing.*"

4.3 The below graph presents the acuity data for Delivery Suite over the last 6 months (October 2024 to March 2025) inclusive:

Graph 1



5.4 The agreed standard for positive acuity nationally is 85%, with providers fully established and with minimal unavailability achieving more than that figure. As can be evidenced on the above graph, the reduction in unavailability described within this report is having a positive impact on our overall performance and safer staffing position demonstrating a more stable position.

5.5 There has been an increase in positive acuity over the last 6-months, with the service reaching the national target consecutively for over six months.

6.0 Red Flags

6.1 A midwifery red flag is known as a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service (usually the Delivery Suite Coordinator) should be notified. The midwife in charge should determine whether midwifery staffing is the cause and what action is needed.

6.2 The table below shows the number of red flags in month, followed by the percentage of shifts identified by the tool as red, amber, or green acuity. Any event of the coordinator not being supernumerary, or 1:1 care in labour not being met require immediate escalation as per the escalation of maternity services policy to the manager of the day, or on-call manager out of hours.

Table 6

Month	Red Flags	One to one Care not met	Co-ordinator not supernumerary	Positive (green) Acuity %	Acuity Amber %	Acuity Red%	Acuity Compliance Rate
October 2024	34	0	0	88%	11%	1%	87%
November 2024	20	0	0	94%	6%	0%	89.5%
December 2024	10	0	0	90%	9%	1%	89.78%
January 2025	18	0	0	99%	1%	0%	91.94%
February 2025	15	0	0	94%	5%	1%	90.48%
March 2025	11	0	0	95%	5%	0%	87.63%

6.3 To meet standards b and c of the NHS Resolutions MIS safety action 5, the number of times when 1:1 care in labour has not been met is reported, along with the status of 'coordinator not supernumerary' via the hospitals incident reporting system Datix, in addition to being recorded on the BR+ acuity tool.

6.4 As can be evidenced from table 6 above, the service was able to maintain 1:1 care in labour for all women 100% of the time and there were no occasions whereby the coordinator was not supernumerary as defined within the technical guidance of the NHS Resolutions MIS.

6.5 The maternity service holds twice daily safety huddles during which all red flags are discussed from across the service areas. Where there is a shortfall, midwives will be rotated from one area to another to support any increase in acuity and facilitate safe care.

6.6 The escalation policy is implemented should any area require additional midwifery staffing based on patient numbers and acuity/complexity and all staffing incidents are triangulated at the maternity incident review meeting to identify any impact on patient care.

7.0 Retention

7.1 The midwifery service has a retention lead midwife who oversees recruitment and retention, and this is having a positive impact on our turnover rate which is significantly below the Trust target for all staff groups (except midwifery management due to a whole new structure). Rates are typically between 3-5% against the Trust target of 13.1%.

7.2 This is in-keeping with the service having retained our entire cohort of newly qualified midwives who commenced in post in 2021 and 2022, successfully supporting them all to achieve band 6 midwife competencies. Similarly, in 2024, we had 17 wte newly qualified midwives who commenced employment, last autumn. We currently have 13 who will qualify in September looking for employment with SaTH.

8.0 Midwife to Birth Ratio

8.1 There is no national standard midwife to birth ratio however for years, the midwifery world has worked to the well cited ratio of 28 or 29.5 births to every 1wte.

8.2 The last BR+ assessment which was undertaken in 2022 advised an overall ratio for SaTH of 22.2 births to 1wte which is based on extensive data from BR+ studies and is calculated from a detailed assessment of our workforce planning. The below table shows the WTE broken down by area:

Table 7

Type of care	WTE
Delivery suite births, all hospital care	29.9 births to 1wte
All hospital births, all hospital care	29.4 births to 1wte
Homebirths	33.1 births to 1wte
Community AN & PN Care, all hospital care	96.8 cases to 1wte
All community care including attrition and safeguarding	91.9 cases to 1wte
Overall ratio for all births	**22.2 births to 1wte**

8.3 There is disparity within the community teams with some areas providing a much smaller caseload than others which is not equitable and is impacting on overall morale in the community. For example, Shrewsbury team are supporting caseloads as low as 1:51, with Market Drayton as high as 1:91. This has been highlighted from the community benchmarking assessment which identified variation in shift patterns as a theme and contributory factor. A Quality Improvement project has been registered to review the recommendations from the report. This will also require a full management of change to resolve.

8.4 The below table represents the midwife to birth ratio for all births which is determined by the number of births divided by the number of staff available each month. The figures are also impacted by staff unavailability as detailed earlier within this report.

Table 8

	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Midwife to Birth Ratio	1:23	1:23	1:23	1:23	1:23	1:23

8.5 The figures in table 8 are occasionally above the desired overall ratio of 1.22 and this is due to the unprecedented amount of staff unavailability detailed within table 3.

9.0 Medical Staffing

9.1 The Trust operates a tier 3 rota system for obstetric medical staffing which means there is 24/7 on-site consultant presence as opposed to a consultant being on-call from home.

9.2 One of the many benefits of a tier 3 rota is that there is no delay out of hours when consultant attendance is required as they are already on site and therefore do not have to mobilise into the maternity unit.

9.3 From a rota perspective, the below table shows the number of medical staff supporting each tier of the rota currently and only includes those:

Table 9

Rota Tier	No of Medical Staff- wte
Tier 1 (ST1-ST3)	10.8
Tier 2 (ST4-ST8)	12.7
Tier 3 (Consultant*)	30

*Exclusive of Gynaecology

9.4 In respect of the tier 1 and 2 rota, there have been no rota gaps in the last 6 months. Within the Obstetric tier 3 rota, there are 24 slots – all are now filled/recruited to with for 2 people starting in May.

9.5 Additionally, it is worth noting that the provision of obstetric care is always prioritised given that this is the acute service, however this does mean that there are often gaps within the Gynaecology service as elective care is cancelled to release capacity to support obstetrics. The knock-on effect of this is that the numbers of patients waiting for elective gynaecological procedures continues to increase leading to a sustained reduction in referral to treatment (RTT) performance for this specialty area.

9.6 The specialty has a comprehensive locum induction package that sets out the requirements for all locums to undertake both PROMPT and fetal monitoring training prior to working clinically to reduce the risks to patient safety that are known to be linked to staff unfamiliar to the working environment/multidisciplinary team. This induction package links into the requirements of NHS Resolutions MIS and specifically, the obstetric workforce element of safety action 4.

10.0 Midwifery Continuity of Carer

10.1 MCoC at SaTH remains paused in line with both the recommendations on safe staffing from the Ockenden Report, and the National letter published in September 2022.

10.2 The letter advised that any Trust that was unable to meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care.

10.3 As the Trust continues to improve its staffing provision, there will be an expectation from the LMNS, regional and national teams to review our position in terms of restarting MCoC as a model of care. However, although our vacancy position has improved significantly, we continue to have an extremely high unavailability which must be taken into consideration before any alterations are made to current service provision.

10.4 In the meantime, we are committed to implementing the building blocks of MCoC and are looking at the feasibility of a dedicated homebirth team and elective caesarean section team which would have no impact on current service position as this service is provided from within our current establishment.

11.0 Conclusion

11.1 The maternity service has previously faced some complex staffing challenges over the last 12 months despite a comprehensive, forward-thinking workforce plan. This is due to an unprecedented amount of staff unavailability which has been further compounded recently by the restrictions introduced for recruitment, and the need for executive and system oversight of all vacancies. This paper reflect Q3/4 position which demonstrates a marked improvement.

11.2 Maintaining safe staffing levels has required the service to frequently enact the maternity services escalation policy to ensure patient safety is always maintained as midwifery staffing is complex, with acuity changing rapidly based on individual care needs and patient complexities.

11.3 Despite the challenges described within this report, the service has seen an improvement in our overall retention rates for all staff groups which are significantly better than the Trust target.

11.4 Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are

maintained and safety remains the priority for the service.

12.0 Actions Requested of the Committee/Board**

12.1 Review and discuss this paper, advising the Director of Midwifery of any additional details required.

12.2 Note the content for upwards reporting to the Board via QSAC

Appendix 1

Maternity red flag events, BirthRate Plus

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

Red Flags	Breakdown of Red Flags
RF1	Delayed or cancelled time critical activity
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
RF4	Delay in providing pain relief
RF5	Delay between presentation and triage
RF6	Full clinical examination not carried out when presenting in labour
RF7	Delay between admission for induction and beginning of process
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
RF10	Delay in ARM of more than 8 hours
RF11	Co-ordinator unable to maintain supernumerary status - providing 1:1 care
RF12	Co-ordinator unable to maintain supernumerary status - NOT providing 1:1 care

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
SaTH	Good	Good	Good	Good	Good	Good

Maternity Safety Support Programme	Yes

QUARTER 4 - 2025					January	February	March	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		0	1	1	January : There were no stillbirth reported in Janaury.(There was 1 Neonatal Death Sath patient 22+6) Baby was born at SaTH at 22+6 weeks gestation, was transferred to a tertiary unit for ongoing care, and passed away at 1 day old. The death is recorded as a neonatal death for SaTH, but the tertiary unit will be leading on the PMRT. February : Stillbirth at 33+ weeks gestation. The PMRT review is scheduled for March 2025 1 22+6 (feticide and MTOP for fetal abonormalies**)** **March : 2 cases reported to MBRRACE in March, a stillbirth at 22+ weeks gestation and a Neonatal death at 22+6 weeks. SaTH will be leading the PMRT review which is scheduled to take place in April 2025**
			Late fetal losses >22 wks		0	1	0	
			Neonatal Deaths		1	0	1	
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI			0	0	1	*1 safety action was received in May 2024 - The Trust ensures that mothers with moderate or severe continuous abdominal pain are observed and monitored as part of an ongoing holistic assessment.* October: There were no referrals to MNSI in October 1 final MNSI report was received with 6 safety recommendations: 1. The Trust to ensure that a robust system is in place for women with gestational diabetes to trigger a face-to-face specialist review when there are concerns with engagement and reduced compliance with blood glucose testing, in order to provide ongoing support to mothers, with timely commencement of medication when required. 2. The Trust to provide mothers with accurate personalised information and to ensure their understanding of this, to enable them to make an informed choice regarding mode of birth. 3. The Trust to ensure they have consistent guidance to support clinicians in planning care when there are signs of chronic hypoxia on a cardiotocograph prior to the onset of labour. 4. The Trust to ensure that staff use and understand the checklist for determining if chronic hypoxia or pre-existing fetal injury is present to ensure that there is a consistent assessment of and management of CTG findings. 5. The Trust to review the process of the fresh eyes CTG reviews in labour to ensure they are independent and effective, to optimise the opportunity for recognising fetal heart rate abnormalities. 6. The Trust to ensure that clinicians are supported to follow guidance and commence variable rate insulin infusion when required while caring for women with diabetes in labour. 20-point action plan had been agreed at RALIG – Action submitted on Datix and added to MIRM tracker oversight and monitoring to be presented at November Maternity Governance November: 1 incident was referred to MNSI in November 2024 and was accepted for review. 1 stillbirth at 37 weeks and 6 days self-referred to triage with suspected labour, reduced fetal movements and no FH on USS. She reported that she believed she was in labour and, therefore, meets criteria for MNSI referral. 1 final MNSI report was received in November with 3 safety recommendations: 1. The Trust to ensure that the resources and tools within their local guidance are available for use on the labour ward to support the assessment and calculation of blood loss. 2. The Trust to ensure that the local pathway for the management of massive blood loss in the neonate is embedded into practice to support timely emergency escalation, haematology support and blood product replacement. 3. The Trust to ensure that all actions have been taken to investigate and manage neonatal blood loss prior to consideration and commencement of therapeutic cooling. This will enable clinicians to evaluate that a baby is stable enough to commence treatment with therapeutic cooling. January : No referrals February: No referrals **March: 1 referral, baby required therapeutic hypothermia following a Caeasarean Section - awaiting confirmation from MNSI if this has been accepted (MRI normal)**
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**			0	0	2	January**:** There were no incidents with moderate harm or above in January February: There were no incidents with moderate harm or above in February **March : 1 incident with moderate harm or above in March related to incorrect perscribing and administration of cefotaxime** **1 incident reported as Death - NND pf 22+6 following active resuscitation**
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**			0	1	0	January: There were no formal learning responses commissioned for Maternity in January February: There was 1 learning response commissioned in February 2025 (AAR). Missed opportunities to screen and treat the mother for infection, missed opportunities to diagnose chorioamnionitis and expedite birth. Missed opportunities to monitor the mother appropriately in labour. Presented in RALIG 04.3.25 **March: There were no formal learning responses commissioned for Maternity in March**
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken			0	0	2	January**:** There were no incidents with moderate harm or above in January February: There were no incidents with moderate harm or above in February **March : 1 incident with moderate harm or above in March related to incorrect perscribing and administration of cefotaxime** **1 incident reported as Death - NND pf 22+6 following active resuscitation**
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken			12	12	22	1 IUFD at 18 weeks 1 Preterm 22+6 weeks transferred to Level 3 units and sadly died 1 Bladder injury in emergency section, patienrt had had 3 previous sections. 2 Category 1 Caesaren Section (1 case was also PPH over 1500mls) 2 PPH over 1500mls 1 Hospital Acquired PU Cat 3 - 1 Treatment/surgery problems- patient 5 days postnatal episitomy wound infected 1 MOH 2500mls 1 Diagnosis -diagnosis wrong - Nuliparous patient assessed antenally - Patient diagnosed with severe pre-eclampsia requiring multiple antihypertensive agents at 25 weeks gestation **February**: There were 8 incidents logged as moderate harm, 2 as severe and 2 as death in February both IUD 2 IUFD 33+1 weeks & 16+3 weeks 6 PPH over 1500mls (2 over 2L) 1 Unexpected term admission to NNU 1 Newborn observation issues 1 3rd degree tear . OASI bundle, episiotomy performed for rigid perineum 1 Delay/difficulty in obtaining clinical asisitance (Joint with PRH ED) - appropriate pathway for pregnant woman **March : There were 6 incidents logged as severe, 13 Moderate, 3 Death** 1 IUT 2 Stillbirth 1 HIE 1 birth trauma #skull 1 Bladder injury following Elective Section 1 NND 22+6 1 Baby born by c/s Apgars <7 at 5 mins 1 Delay starting SBR in testing for jaundice 5 PPH over 1500 1 HAPU category 1 1 unexpected reamission for urosepsis/right pylonephritis 2 Missed screening 28 week bloods/ late booker 4 3rd/4th degree tears
3d.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	PROMPT	100%	100%	100%	The Year 7 CNST Maternity Incentive Scheme document has now been released in April 2025. The requirement for the reporting of the 3 elements of Safety Action 8 remain unchanged. Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training? 90% of attendance in each relevant staff group at: •Fetal Monitoring Training •Multi-professional Maternity Emergencies Training •Neonatal Life Support Training The next Training Faculty Meeting is scheduled for 9th April to discuss the training requirements for August 2025 – July 2026.
				Fetal Monitoring	95.65%	100%	100%	
			Midwives	PROMPT	98.35%	98%	98.47%	
				NLS	97.11%	98%	98.46%	
				Fetal Monitoring	97.72%	98%	98.75%	
			Other Drs	PROMPT	100%	100%	100%	
				Fetal Monitoring	100%	100%	100%	
			Neonatal Nurses	NLS	96.00%	100%	96%	
			Anaesthetists	PROMPT	100.00%	100%	100%	
			WSAs/MSW	PROMPT	95.83%	97%	97.44%	
		Minimum safe staffing in maternity	Maty Del Suite positive acuity		99%	94%	95%	
			Maty 1:1 care in labour		100%	100%	100%	
			Fill rates Delivery Suite RM		D- 96% N-84%	D-92% N-87%	D-96% N-84%	

3e	**STAFFING**	services to include Obstetric cover on the Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Fill rates Postnatal RM Fill rates Antenatal RM	D-127% N-99%	D-114% N-98%	D-127% N-115%	NB: the Del Suite positive acuity figure is the 'end of month rate' reported each month on maternity dashboard and not the rolling 13 wk rate.
			Obstetric Cover on D Suite	100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements (*To note feedback one month behind)*					**March:** An improvement project is currently in progress to utilise QR codes on patient lockers and ward areas, to allow people to access the FFT in digital format to improve the response rates. "I Support SaTH" Facebook page. Morning! I just wanted to say thank you to all the staff that have looked after me since Monday! Such a scary couple days at PRH! Firstly, thank you maternity triage for looking after me and reassuring me baby was alright and giving me a dark side room to help with photophobia. Thank you to the antenatal ward for looking after me, especially to the lovely MSW (whose name I'm sorry I can't remember), student and midwife when I lost consciousness a few times. Quite scary when you are been rushed through all the corridors in a trolly to get to safety to get me and baby checked! Thanks to the MRI and radiology team who helped me through my loss of consciousness episodes and to the lovely a+e Dr who came on to check I can't remember her name. Thanks to the labour ward who looked after me when I was so scared I was gonna be rushed to theatre to have my baby. was amazing and explained everything in detail the night staff were amazing and on hand when needed them when I knew they were busy delivering babies! Thanks to medical and obstetric team for fighting on my behalf to get all my tests done as quick as possible! Look forward to be back end of the month to have my baby!
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*	No Walkabout	Antenatal/ Postnatal	No Walkabout		**February alerts:** • Intercom on Postnatal ward has been U/S for a significant amount of time • Some concerns over TTOs and delays • Hearing screeners would like a quiet space for Newborn Hearing Screening • Questions were asked regarding doctor reviews for inductions • Some issues with discharge paperwork and reporting discharges raised from ward clerks • Increased workload on postnatal felt
6.	**EXTERNAL**	Requests from an external body (MNSI/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust	0	0	0		No immediate safety recommendations have been received by the Trust.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	0	0	0		To note - there have been no Regulation 28s since May 2021.
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10	Compliant	Compliant	Compliant		
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	0	0	0		**January:** No delays **February:** No delays March: No delays
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	8	10	5		5 Category 1 caesarean sections in March with no delays 48 Category 2 caesarean section in March with 5 delays - shortest delay 9 minutes and longest delay 25 minutes 60% of the Category 2 delays occured at night Reason for decision for Category 2 caesarean section related to delay in the first stage of labour (80%)
11.	**Supernumerary Status of the Coordinator**	**Neonates**	n/a	n/a	77%		The supernumerary status of the Nurse in Charge for March 2025, the formal collection of data for this commenced on 12th March which meant that there were 20 days worth of data collection (40 shifts to include day and night shifts). Unfortunately, out of those 40 shifts, only 22 shifts (55%) were recorded. The data has shown the following: • The NIC was completely supernumerary 54.55%of the time (12 shifts) • The NIC was supernumerary for part of the shifts for 22.72% of the time (5 shifts) • The NIC was NOT supernumerary at all during the shift for 22.72% of the time (5 shifts) Out of the 10 shifts where the NIC was NOT supernumerary for either part or all of the shift, the acuity was amber for 2 shifts, red for 7 shifts and green for 1 shift.
12.	**Delay in Neonatal Antibiotics**	Number of babies that had delayed antibiotics (Not within the golden hour)	n/a	n/a	n/a		The data collection for the antibiotic Golden hour commenced on 1st April therefore the results will be shared next month.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment							44.3% for Maternity Services published 2023
Proportion of specialty trainees in Obs & Gynae responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours							Reported annually - 87% *(source GMC National Trainees Survey 2022)*

The Shrewsbury and Telford Hospital NHS Trust

NHSR Scorecard Q3 (Oct- Dec 2024)

Date: February 2025

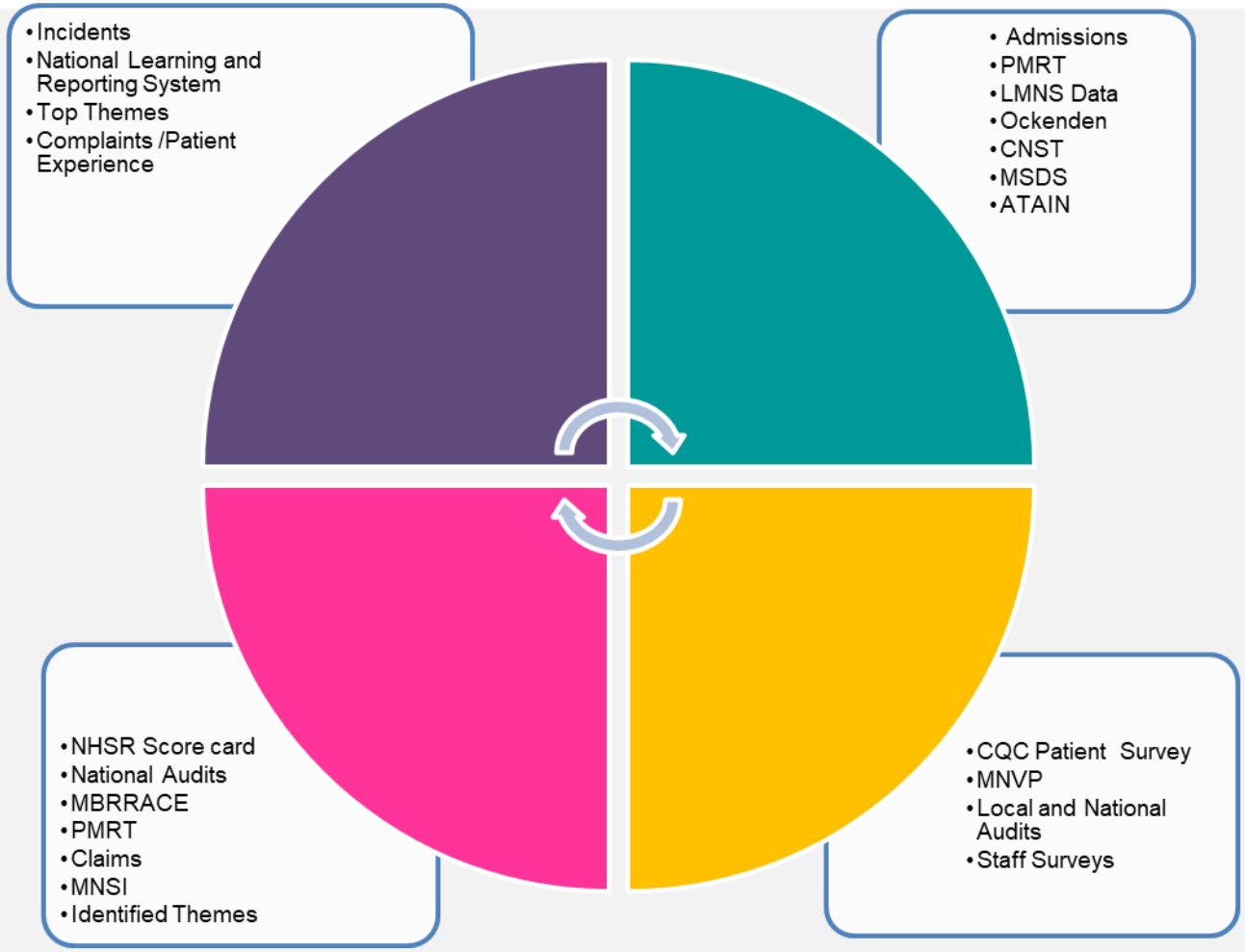
Lauren Taylor Deputy Head of Midwifery and Jacqui Bolton Interim Deputy Head of Midwifery

Maternity Incentive Scheme Year 6 – Safety Action 9

The Shrewsbury and Telford Hospital NHS Trust

Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period).

Evidence Source



Data Collection

- Review of Litigation Claims/NHSR Scorecard
- Themes from Complaints/Compliments/Friends and Family
- Themes from PSII's/PMRT/External reviews (Ockenden, CQC)
- Top Themes from Incidents Reported
- National Reviews of themes/MNSI Safety Recommendations and Publications/MBRRACE/National Reports/CDOP

THEMES

Incidents by Category Neonatal Q3

The Shrewsbury and Telford Hospital NHS Trust

Theme	Example
Neonatal	ATAIN
Staffing Problems	Staffing levels/Acuity
Medical device (Medical equipment & disposables)	Lack/unavailability of device
Communication problem between staff, teams', depts	Staff availability & documentation
Care/Monitoring	Delay /Failure to undertake investigations

Incidents Top 5 Themes Q3 Maternity

The Shrewsbury and Telford Hospital NHS Trust

Theme	Example
Care/Monitoring	Post Partum Haemorrhage > 1500mls
Labour and Birth	Staffing levels/Acuity
Diagnosis = Delay/Failure	Booking bloods not checked
Communication between teams	Delayed results/Bleeps/reviews
Neonatal	Unexpected admission to Neonatal unit (ATAIN)

Incidents & Actions Q3 Maternity and Neonates

The Shrewsbury and Telford Hospital NHS Trust

Maternity

1 PSSI's Commissioned

Neonates

No PSSI's Commissioned

No After-action Review Commissioned

Duty of Candour Documentation

ATAIN

The Shrewsbury and Telford Hospital NHS Trust

ATAIN

The term admission rate for Q3 (October, November, December 2024) was 5.7% of all births at >37 weeks, a decrease from the previous Q2 24/25 figure of 6.9%.

306 Term births at PRH

October 2024 – 6.2% of all term births at >37 weeks (n = 19)

Avoidable admissions: (n=0)

305 Term births at PRH

November 2024 – 5.9% of all term births at >37 weeks (n=18)

Avoidable admissions: (n=2)

302 Term births at PRH

December 2024 – 5.0% of all term births at >37 weeks (n=15)

Avoidable admissions: (n=1)

Themes

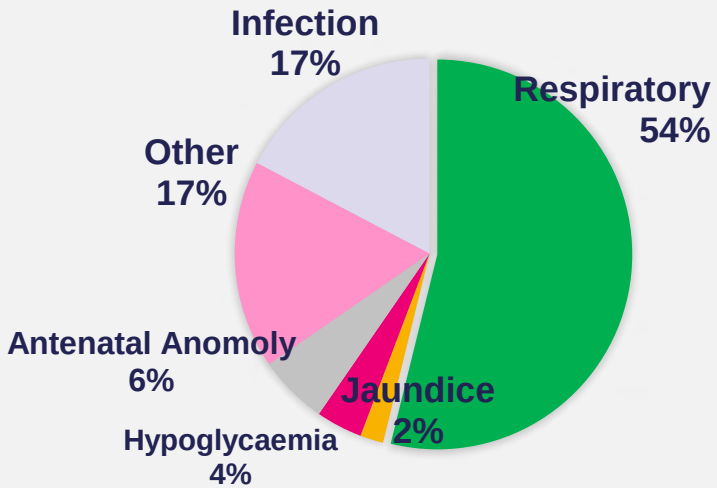
Intensive Oxygen support

Antenatal anomaly

Hypoglycaemia Policy

Jaundice (Capacity and Treatment)

NEWT Observations



Compliments Complaints FFT MNVP Staff Survey

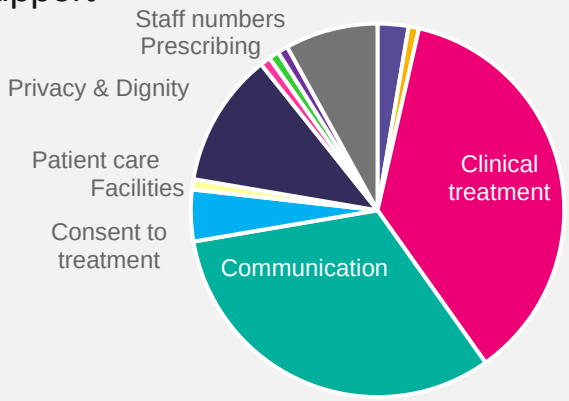
The Shrewsbury and Telford Hospital NHS Trust

Obstetrics / Maternity	Totals
Admission / Discharge	3
Appointment	1
Clinical treatment	41
Communication	36
Consent to treatment	5
Facilities	1
Patient care	13
Prescribing	1
Privacy & Dignity	1
Staff numbers	1
Values & Behaviours (staff)	9
Waiting time	1
Neonates	Totals
Clinical treatment	2
Values & Behaviours	1

Learning

Staff recognition
Guideline and SOP review
Culture & Value Based Workshops
Culture Review
Staff Survey Action Plan
Individual Learning and Development Programmes
Staff Rotations
QI projects - Triage
Refresher Training
MNVP Engagement
UX Workshop
Reflections
PMA support

Q3 Maternity Complaints Subjects



PMRT MBRRACE

The Shrewsbury and Telford Hospital NHS Trust

October – December 2024 (Q3)	number	MBRRACE Reportable
Late Fetal Loss (20-23+6 weeks)	2	Yes – Only cases >22 weeks.
Early Fetal Loss (16-19+6 weeks)	6	No
Early Neonatal death (Live birth >20 weeks or 400g) < 7 completed days post birth	3	Yes
Late Neonatal Death (Live birth >20 weeks or 400g) 7-28 days post birth	0	Yes
Post-Neonatal Deaths (7 days to 1 year post birth)	1	Babies born after 22 weeks who receive neonatal care and die >28 days after birth.
Termination of Pregnancy (any gestation)	5	Only if resulting in Stillbirth (from 24 weeks gestation) or Neonatal Death (from 20 weeks gestation).
Stillbirths (over 24 weeks)	3	Yes

PMRT Themes

Women having late booking for pregnancy.

Translation Services and leaflets available in different languages.

Learning

Bereavement Tea Trolley Training and Simulation Planning – Focusing on care of the mother incorrect partogram use.

Bereavement Champions Team Expanded

Folder to be created to include leaflets for pre/post birth in range of languages.

MNSI Publications

1 Final report received with 3 Safety Recommendations (Nov 2024)

- The Trust to ensure that the resources and tools within their local guidance are available for use on the labour ward to support the assessment and calculation of blood loss.
- The Trust to ensure that the local pathway for the management of massive blood loss in the neonate is embedded into practice to support timely emergency escalation, haematology support and blood product replacement.
- The Trust to ensure that all actions have been taken to investigate and manage neonatal blood loss prior to consideration and commencement of therapeutic cooling. This will enable clinicians to evaluate that a baby is stable enough to commence treatment with therapeutic cooling.

3 draft reports received for factual accuracy; safety recommendations expected

1 referral made to MNSI under the category of intrapartum stillbirth (accepted) - *The mother contacted triage in suspected labour, however on arrival she was diagnosed with a placental abruption and intra uterine death*

Terms of reference amended - MNSI provide Safety recommendations for incidental learning in addition to learning that is directly linked to the outcome

Local & National Audits CQUIM MSDS & Maternity Dashboard

The Shrewsbury and Telford Hospital NHS Trust

Triangulation of Incidents and data analysis of Maternity Dashboard:

Postpartum Haemorrhage >500-<1500mls Audit Quarterly

Postpartum Haemorrhage > 1500mls Audit

VTE Audit Monthly

Decision to Delivery Category 1+ 2 CS

Triage Audit (Triage times and Self Discharges)

Local Guideline/SOP Audit and National Benchmarking

CQC Visit & Maternity Survey

The Shrewsbury and Telford Hospital NHS Trust

CQC Visit October 2023- published May 24

CQC Maternity Survey 2023 (Co-produced with MNVP) Action plan fully implemented

CQC Maternity Survey 2024 (GAP Analysis and Action Plan going through February's Maternity Governance coproduced with the MNVP)

Litigation NHSR Scorecard

We did not have any early notification cases in Q3, the MNSI case did not meet criteria due to the baby being stillborn.

The MNSI report we received also did not meet criteria for NHSR

Themes for the open cases:

1. Delay in escalation of abnormal CTG during second stage – normal MRI
2. Management of feeding and hypoglycaemia in the neonate
3. Gaps in intermittent fetal monitoring in the second stage – normal MRI
4. New case – review ongoing.

Themes Claims 2013-2024

1. Fail/delay in diagnosis = 29
2. Inappropriate treatment = 5
3. Failure to respond to an abnormal FHR = 4

   Failure to monitor 2 stage labour = 4
4. Fail/delay in antenatal screening = 3

   Consent issues = 3

   Unexpected death = 3

   Perineal tears = 3
5. Inappropriate discharge =2

   Failure to act on abnormal test results = 2

Monitoring Safety

Triangulation

The Shrewsbury and Telford Hospital NHS Trust

Fetal Monitoring and Interpretation

Term Admissions

Test Results (Follow up)

Perineal Tears

Postnatal Bladder Care

Diabetes Service (Including Pre-conception)

Escalation Policy/Process

Communication/Values & Behaviours

Waiting Times

Consent

Improvements

Fetal Monitoring Training (Full day, Case Reviews, Workbook and Lead Midwife & Obstetrician)

Intermittent Auscultation Training

ATAIN MDT Meetings (Learning Disseminated)

Professional Development Programmes

Fresh Eyes (Full Holistic Review)

Band 7 Co-ordinator Training

Human Factors Training

Helicopter View Training

Culture Training

Action Planning (Thematic Reviews QI projects)

Staff Engagement Events

Public Engagement (Open Days)

Guideline and SOP review

Re introduction of Antenatal classes (Due to commence April 2025)

Improvements

The Shrewsbury and Telford Hospital NHS Trust

Culture Workshops

Culture Review

Staff Survey Action Plan

Individual Learning and Development Programmes

Staff Rotations

QI projects (Triage, Diabetes Service & Induction of Labour, Postnatal, Community)

Refresher Training

MNVP Engagement

UX Workshop

Reflections

PMA support

Perinatal Pelvic Health Service

OPEL Framework/Manager of the Day/Workforce Plan

Appendix 1 – Staff Survey 2025-26 - Trust Wide and Divisional People Plan schemes

Theme	Analysis	Trust wide schemes 2025/26	Update on Actions 2025-2026
We are compassionate and inclusive.  Comp Culture: Q6a, Q25a, Q25b, Q25c, Q25d Comp. L'ship: Q9f, Q9g, Q9h, Q9i Div & Eq: Q15, Q16a, Q16b, Q21 Inclusion: Q7h, Q7i, Q8b, Q8c	Increased from 7.06 in 2023 to 7.08. Below average for the sector (7.21). Has increased YOY since 2021	To improve our cultural dashboard measures in 2024 staff survey results (annual). Divisional Culture Dashboards will be implemented to support the cultural improvement programmes in all areas. The Culture Group TOR have been updated to ensure alignment with the People Plan. Bi-monthly meetings are held to identify areas for focus. To improve engagement score monitored quarterly via People Pulse (feeding into model hospital data) and yearly by staff survey. Continuing implementation of our EDI 6 High Impact Action Plan. 6 HIA Working group has been formed to support delivery of key milestones. Continue to promote and grow our staff networks. We continue to deliver Civility & Respect sessions across the Trust with open sessions available via LMS and targeted sessions for hot spot areas. The workshop has been updated to include professional challenge to support the addressing of behaviours between colleagues. Continue to deliver Compassionate, Inclusive and Effective Leadership Masterclasses, also shared with ShropCom. Swartz Rounds continue to be carried out and embedded in SaTH. The transition has commenced for this to be owned by the Staff Psychology Team by March 2025, to include ShropCom for the future.	**Surgery, Anaesthetics Critical Care and Cancer (SACC)** <u>Compassionate Leadership</u> Civility, Respect, and Inclusion sessions for areas identified through staff survey. Continue Senior Leadership walkabouts within the division improving visibility and availability for feedback. Agreed divisional framework of compassionate leadership. Communicate across the division to ensure staff understand what they can expect from their leaders. • Listening to Staff • Understanding and supporting issues • Honesty and integrity • Timely response and feeding back. Reinforcing Just Culture in Decision Making Groups related to ER casework. <u>Diversity and Equality</u> Use of WRES and WDES data to identify areas where further support is required. Embed new Appraisal (Talent Conversation) policy to ensure employee led meaningful appraisals, capture career aspirations with PDP for those who want to develop. Develop Career pathway posters for non-clinical staff to be aware of opportunities for development.

		Launched 'Leading a High Performing Team' OD Toolkit for Managers, helping to embed an OD Mindset. Workshops on the toolkit will be delivered as part of FOSATL and STEP Programmes. Launched Stay Conversations toolkit with pilot areas, including internationally educated staff. Signed up to the Sexual Safety Healthcare Organisation Charter. Maintain Disability Confident Leader (Level 3) Status. .	Transparency of recruitment process and using the talent conversation to identify training needs to develop to next level. **Women's and Children (WAC)** *Areas of Focus;* • *Compassionate Culture* • *Compassionate Leadership* Develop Divisional Charter for how staff behave and interact with one another, to include what a Compassionate Culture looks like. Mandate attendance at Civility Respect, Inclusion and Kindness Sessions, target of 90% compliance. Managing Courageous Conversations Sessions rolled out to all managers and leaders. Leaders within the Division continue to make themselves visible and available for feedback by regularly attending huddles and drop-in sessions. Division Leadership Team lead of the development of a model and/or framework for what Compassionate Leadership looks like within the Division. Workforce Plans developed and implemented (where not done so already), with those that are in place annually reviewed and communicated across the division. Career planning and development to form part of 1:1 meeting/supervision/catch ups, which feeds into into Talent Conversations.

			Staff to receive development for roles they aspire to hold in future. Development/ Education on dealing with interviews (internal and external). All areas to hold Team Building sessions once a year. Opportunities made available for staff to attend workshops, training and events in relation to inclusion, equality and diversity, and what this means in the context of the trust. **Clinical Support Services (CSS)** EDI workstream for each Centre following learning from Staff Survey and WRES & WDES data. Continue to embed zero-tolerance approach bullying and harassment. Continue to support Working Without Fear. Continue to roll-out Civility, Respect, and Inclusion sessions for areas identified through staff survey. Behavioural Frameworks following roll out of Civility, Respect, and Kindness. Continue with Facilitated Discussion training Centre plans for supporting individuals through our Leadership Framework. Succession plans for each Centre. Launch divisional induction sessions.

			Continue to embed with our teams our vision, priorities, and objectives as we are onboard Cardiorespiratory and Oncology & Haematology. **Medicine and Emergency Care (MEC)** A clear area for development in MEC is around race and ethnicity inclusion. Within our cultural transformation programmes, we are planning to develop a project to consider the challenges faced by BME colleagues. This can then help us identify solutions and draw on existing resource such as the Galvanise leadership scheme. We have already begun training managers to undertake stay conversations with internationally educated nurses who may constitute a flight risk. **Estates** 97 members of Estates staff attended Civility and Respect Sessions during May, June and October. **Facilities** *Areas of Focus;* • *Compassionate Culture* • *Compassionate Leadership* • *Diversity and Equality* Review and relaunch of the behavioural frameworks to ensure all staff are aware of expected behaviours and live the values within their areas. Civility Respect, Inclusion and Kindness sessions to be made available to attend (this could include bespoke/condensed sessions, or sessions delivered outside of usual office hours).

			Management and Leadership TNA to be re-visited, with time allocated for managers to attend. Opportunities for managers to visit other trusts and areas in the Trust to experience and benchmark culture, leadership and EDI, identify best practice and deliver in their own areas.
We are recognised and rewarded  Q4a, Q4b, Q4c, Q8d, Q9e	Decreased from 5.86 in 2023 to 5.81. Below sector average (5.92). Best result is 6.30, worst is 5.24. The average, best and worst results have all decreased since 2023.	Annual Trust wide recognition plans and celebrating our diversity events/ awareness. We have an annual calendar of events, and we will continue to recognise key dates through the year. We also have a number of other celebration days Annual Recognition Week and the Trust Celebratory Awards 2025 will take place in October and planning is underway. Star Cards are continually used across the organisation. We have introduced digital People Promise cards for managers to use to recognise key dates for the teams i.e. work anniversary, birthday etc.	**SACC** Utilise Away Days, department huddles and team meetings to celebrate success, raise awareness around Star Cards and improve usage. Senior walkabouts to incorporate more personal touch in celebrating success and great work. Using comms to celebrate big achievements e.g. celebrations on Elective Hub and patients going home on day 1. DoN led engagement with HCA's on changes to job evaluation under the Clinical Support Worker project. **Women's and Children (WAC)** Division to look at creating an environment/culture where staff feel proud to be part of Women and Children's and feel safe to be able to celebrate achievements. Digital Screens to be utilised to share celebrations and celebratory messages. Development of an Employee of the Month scheme, which feeds into the Trust wide awards. Work with teams to encourage nominations.

			Increase usage of Star Cards and Thank You Cards. Agenda items on all team meetings encouraging sharing of celebrations and recognising achievements of colleagues (to include F&F feedback). **MEC** We are planning a celebratory event in the Spring to reflect on our transformation programme achievements this year and to set out what our priorities will be over the next year. Medicine and ED Wraps have helped us to recognise staff members and teams. Anecdotally, we know that recognition is an area where there is scope for improvement. Our comms plans reflect staff engagement as a driver of performance as highlighted in the Darzi Report. **CSS** Celebrate success and innovation through divisional recognition scheme. Focus on talent conversations and ensuring appropriate timing to achieve enhance quality and increase compliance. Continue to work celebrate our recognition days. Focus on staff survey advocacy questions with defined next steps to support improvement. One NHS = Unblock barriers to system working through pay and reward inequalities.

			Estates Celebrated Estates and Facilities National Day in June, each member of staff received a letter and pen to thank them for their hard work and contribution. **Facilities** Continue to celebrate Estates and Facilities National Day in June. Encourage teams to nominate for Trust Awards Ceremony. Share regular comms on use of Star Cards. Team meetings to include agenda items of celebration and good practice, work anniversaries etc.
We each have a voice that counts  Auto & Control: Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b Raising Concerns: Q20a, Q20b, Q25e, Q25f	Increased from 6.45 in 2023 to 6.47. Below sector average (6.67). Best result is 7.14, worst result is 5.95. Best, average and worst results have all decreased since 2023.	We have reviewed and updated our timeline for delivery for all elements of a successful staff survey campaign. This considers all elements of a year of listening to ensure colleagues remain engaged and involved in improving the staff experience whilst delivering the actions and on the wider People promise. We continue to support our divisions and corporate areas, and we have developed a new line manager training offer on the Staff Survey via Learning Made Simple (LMS). Divisions / areas have been asked to review their results and discuss with their teams. – briefing packs have been provided by the OD team to help focus on key considerations and actions. A revised and improved Staff Survey Dashboard is being developed, and department level results will be available at the end of March / early April to all managers. This is fully accessible to support priority areas of focus and delivery of local level actions. Engagement Masterclasses have also been produced, and we continue to deliver these. Sessions on Engagement and Staff	**SACC** - Department huddles to finish with feedback session on any hot topics to improve involvement and engagement. Embed Stronger Together within the Division encouraging participation in ideas for cost saving schemes. Successful ideas implementation shared at committee to celebrate success and encourage further engagement. Utilise staff survey dashboard to communicate feedback and agree improvements with teams. Engage with Improvement and OD teams where themes have been identified using Improvement methodology to address concerns, engaging with teams on any changes.

		Survey are delivered as part of the STEP and FOSATL programmes. FTSU, mandating FTSU training, managers handbook, processes and fit for purpose. Supporting a just and learning culture where leaders and managers foster a listening, speaking up culture. Team behaviour conversations continue to take place. We take part in the Quarterly people pulse that goes to all staff aimed at how staff are supported, informed, motivated and anxious they may feel. The number of staff accessing this survey is on the rise with average number of 1200 taking part every quarter. A full plan regarding questions for each month has been developed and will be utilised in line with other strategic plans to deep dive into staff sentiments.	**MEC** Our intention is to demonstrate to staff that their feedback leads to change as it is through the mechanisms of our cultural transformation programmes. We now have a divisional comms lead who is assisting us in enhancing the visibility of our leaders and cultural initiatives. **Women's and Children (WAC)** *Areas of Focus;* • *Autonomy and Control* Behaviour Framework sessions and plans developed for all areas. Sessions undertaken to support the division to develop a shared purpose/narrative. All teams to have received feedback from line managers in relation to the Staff Survey scores and have a role in developing improvement plans. FTSU colleagues to visit wards and share the work they undertake to build trust and confidence. Managers to promote good working practices where staff voice heard, and what changes this has made. Development framework for managers and leaders to support in managing their teams to get the best outcomes.

			CSS Achieve 100% compliance for FTSU Manager Training. Focus on staff survey advocacy questions with defined next steps to support improvement Focus on talent conversations and ensuring appropriate timing to achieve enhance quality and increase compliance. EDI workstream for each Centre following learning from Staff Survey and WRES & WDES data. Continue to embed zero-tolerance approach bullying and harassment and support Working Without Fear Continue to roll-out Civility, Respect, and Inclusion sessions for areas identified through staff survey Behavioural Frameworks following roll out of Civility, Respect, and Kindness. Continue with Facilitated Discussion training Centre plans for supporting individuals through our Leadership Framework. Launch divisional induction sessions. Continue to embed with our teams our vision, priorities, and objectives as we are onboarding Cardiorespiratory and Oncology & Haematology. **Estates** Monthly toolbox talks take place with the teams to gain their views and thoughts on Estate issues and to cascade any Trust wide information.

			Facilities *Areas of Focus;* • *Raising Concerns* Work closely with FTSU to support individuals with an opportunity to raise concerns. FTSU colleagues to visit teams and share the work they undertake to build trust and confidence. Achieve 100% compliance for FTSU Manager Training. Coach and empower managers to support their team members when raising concerns.
We are safe and healthy  H&S Climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g	Remained the same as 2023 at 6.02. Below sector average (6.09). Best result is 6.53, worst result is 5.54. Best result as decreased since 2023.	We have continued to build and provide an excellent health and wellbeing offer to our People and this has expanded further with the launch of our Psychology Hub. We have launched our new Employee Assistant Programme, HELP. We continue to focus on the below areas: Physical Support Psychological Support Financial Support Healthy Lifestyles As a result of staff focus groups relating to our Equality Duty System we are starting to look at what specific support we have for Diabetes, Asthma, COPD, and Obesity. Launched Reasonable Adjustment Guidelines and toolkit for Managers.	**SACC** - Prioritise areas where burnout and mental health absence is high. Seek team support from Psychology service, also identifying any changes that may need to be made to support teams through staff engagement e.g. role clarity. Encourage staff to take breaks and regular leave across the leave year. Workforce plans for every area, look to reform where necessary ensuring JD's are reflective of job requirements. Continue to utilise the psychology team to support: • Care space sessions in identified areas • Psychological Debriefs • Understanding and responding to traumatic incidents

Neg. Experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c Other questions [Not scored]: Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.		Mental Health First Aider and Peer to Peer Listener offer is being reviewed to ensure appropriate support is in place for our colleagues. We continue to engage with staff through: Wellbeing Walks Digital Communications HWB offer delivery to teams at events and training, as well as team huddles and meetings. Hardship and Financial Support to include: School Vouchers Shopping Vouchers Free Breakfast and Discounted Hot Meals. Affinity Finance Courses We continue to support Schwartz rounds. Toolkits include, Bereavement, Reasonable Adjustments, Obesity, Financial and Menopause. We have introduced Digital Wellbeing cards for managers to use within their teams, for example, welcoming back to work after sickness, sending holiday wishes etc. Staff Health clinics have been introduced and are continuing. Launched Wellbeing Conversations training for managers.	Ensure Health and Well-being boards are updated in identified departments to raise awareness of support available. Effectively utilise Health and Wellbeing toolkit and ensure managers are attending wellbeing conversations training especially in identified areas. Embed new Attendance Management Policy, ensuring Managers attend training. Additional support from people advisory with monthly meetings to support and advise managers with specific complex cases providing Divisional oversight and support. Increase number of DSE trained staff to support assessments. H&S support for risk assessments in high areas of MSK absence. Work closely with FTSU to support individuals with an opportunity to raise concerns. Promoting Facilitated Conversations training with managers, identifying areas that will benefit most from the training. **MEC** Within MEC, this area of the People Promise is our weakest area due to burnout and concerns around the effectiveness of our 'working without fear' processes. Our ECTP and MedTP programmes have come together to launch a working without fear/zero tolerance working group. We have shared the Trust guide to implementing reasonable adjustments with our managers as this was an area highlighted in the previous staff survey.

			Women's and Children (WAC) Managers communicate more effectively about what Safe Staffing Levels are and should be within teams/wards, help teams to understand calculations and models so that this can be managed within teams, and any concerns can be raised by staff if template falls outside of this. Managers to regularly meet with their teams to reflect on work, workload and provide feedback. Managers to ensure colleagues are taking rest breaks during the working day. Trust/Division to ensure there are appropriate areas for rest breaks to be taken. Managers to ensure that colleagues are maintaining healthy standards (eg hydration and nutrition) whilst at work. Managers to work with Psychology Services – accessing support as and when appropriate, eg. • Care Space • Tree of Life Sessions • Psychological Debriefs • Reflective Practice (90 mins) • Understanding and Responding to Traumatic Incidents • Identifying Team Values Managers to use Wellbeing Wheel and promote use of H&WB Services available to teams.

			CSS Continue to support hotspot sickness absence areas Undertake NHS Health & Wellbeing Toolkit assessment. Focus on annual leave and maintaining targets defined within rostering periods to support our colleagues H&W and maximise service delivery. Ensuring all managers are appropriately equipped to support individuals suffering from stress. Harmonising on-call systems to maintain effective working practices whilst supporting work-life balance Reduction in net hours to support our colleagues' wellbeing. **Estates** Psychological group sessions continued with Medical Engineering teams across both sites. **Facilities** *Areas of Focus;* • *Health and Safety Climate* • *Negative Experiences* Train/Coach managers to effectively utilise the H&WB Toolkit, including the wellbeing wheel. Continue with Health and Wellbeing events previously organised for Cleanliness team which involved sessions with Physio to raise awareness of the fast trac provision and to talk about MSK in general.

			Sessions with Psychology support team attended to talk mental health topics and the service available. Ensure managers are well supported by the PAT in dealing with employee wellbeing cases. Managers to ensure that staff are maintaining healthy standards (eg hydration and nutrition), identifying where there are issues, and supporting staff to gain the appropriate support (eg financial wellbeing information).
We are always learning  Development: Q24a, Q24b, Q24c, Q24d, Q24e Appraisals: Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.	Increased from 5.41 in 2023 to 5.48. Below average for the sector (5.64). Best result is 6.09, worst result is 4.76	Flagship Programme: Development of talent management approach Updated talent conversation documentation and process, ensuring it meets the needs of colleagues at all levels of the organisation. Continue with talent conversations briefings Career conversation Masterclasses Develop and launch training Links between talent conversations and pay progression Review talent portal agreement Review and evaluation Career pathways to address under- representation**:** Education exposure increased (advisors shadow other roles) Career pathway guide development Building Improvement and change capabilities across the Trust Embedding digitally enabled solutions**:** Building Capability document written We continue to Champion policies and practices that achieve measurable improvements and embed restorative just culture.	**SACC** Continue to support leadership development through internal programmes. Managers to protect time to allow staff to attend training sessions when planned, working with the Education team to identify times of the year that are better suited for some specialities to attend training due to demand and capacity. Ensure appraisal objectives are meaningful and are set in line with divisional priorities. Support managers with understanding budget management and contributing to cost improvement projects under the financial recovery programme. **MEC** This People Promise area was the strongest within our 2024/25 staff survey results. Staff were positive about how their talent conversation had helped them develop. We aim to continue this along with the increase in our appraisal compliance rate since the Summer.

		We continue the Promotion of Employee Self Service, Embedding of Manager Self Service Utilisation of leaver data; exit questionnaire data; turnover data to identify key trends. We have a suite of Leadership Development and continue our Strive Towards Excellence Programme (STEP) and Galvanise programmes and hold monthly masterclasses. FOSATL re-launched. We have also been working with the ICS on the High Potential Scheme, a uniquely tailored two-year career development opportunity aimed at band 8a-8d to help 'accelerate your progress'. We are working on the benefits of our Learning Management System 'Learning Made Simple' and seen great improvements in our Mandatory Target %. Development plans drawn up for upskilling Managers and supervisory levels in HR related practices and procedures Competency Framework devised for use with new apprenticeships to aid learning and reaching required standard Review of job descriptions to ensure fit for purpose for roles and for recruitment purposes.	Our longer-term aim is to develop career pathways for staff within nursing and operations. Continuing to signpost staff towards the Trust leadership development programmes can also help us to develop leadership competencies within the division. **Women's and Children (WAC)** *Areas of Focus;* • *Development* • *Appraisals* TNA for managers and development required – to be discussed at Appraisals and throughout the year. Managers to protect time (where possible) to allow for colleagues to attend non mandatory learning. Internal Leadership Opportunities made available to staff through Talent Conversations process eg; SaTH 1 – 4 STEP Programme Galvanise FOSATL External Leadership Programmes identified and attended where appropriate. Attendance on courses relating to Appreciative Enquiry. Appraisal Training to be attended by all colleagues responsible for either line management or undertaking Appraisals.

			Managers set objectives in line with the Division vision and purpose. Change the narrative in relation to appraisals – to a benefit, rather than a chore. **CSS** Continue with our 'grow our own' models of working and expand system/network opportunities for integrated approaches. Centre plans for supporting individuals through our Leadership Framework. Succession plans for each Centre. Achieve 100% compliance for FTSU Manager Training. Focus on staff survey advocacy questions with defined next steps to support improvement. Focus on talent conversations and ensuring appropriate timing to achieve enhance quality and increase compliance. EDI workstream for each Centre following learning from Staff Survey and WRES & WDES data. **Estates** 4 managers attended SaTH and STEP programme and this will continue to be encouraged for existing and new line managers. **Facilities** *Areas of Focus;*

			• *Development* • *Appraisals* TNA of managers, and support for managers to access appropriate development and training. Learning and development programme being created to ensure consistent approach to learning offer across all services. All colleagues who undertake appraisals to access appraisal training, to improve quality of the appraisals.
We work flexibly  Support for work-life balance: Q6b, Q6c, Q6d Flexible working: Q4d	Increased from 6.17 in 2023 to 6.26. Above sector average (6.24). Best result is 6.86, worst is 5.60. Increased YOY since 2021.	Flagship Programme (inc legacy mentors/ retirement) We are delivering training resources for managers. This will be run centrally but can also be commissioned for targeted areas where intelligence (e.g. staff side feedback, staff survey results) indicates take up is low. Promote flexible retirement options, including changes to pensions allowances, through a flexible retirement guide. Encouraging more flexibility in agile working. Updating the Home Working Policy to provide clearer guidance and more support for those working from home. Exploring the Legacy Mentor role which offers a flexible retirement opportunity whilst also supporting newly qualified staff into teams Explore conversations with system partners to see what steps can be taken to improve flexible working opportunities across the system.	**SACC** Identify areas where line managers need to attend flexible working masterclasses to encourage more flexible working. Celebrate and share stories from areas where flexible working has been successful, triangulating with retention and sickness information to encourage other areas. Review of Flexible working arrangements in place to determine if still required and allow for others to be considered. **MEC** We continue to support flexible working requests where operationally viable. We seek to balance flexible working with the need for leaders to be visible. **Women's and Children (WAC)** Health, Wellbeing and WLB will be included in the supervision/1:1 agenda's.

		Improvements to our rostering capabilities. Supporting clinical teams with Team-Based rostering approach to facilitate flexible working options.	Line managers to attend relevant training on managing flexible working requests. Managers will promote the Flexible working policy and process all requests in line with policy. Existing Flexible Working arrangements to be reviewed annually. **CSS** Review our flexible working including reviewing current arrangements, training, sharing learning and promotion, and supporting our teams to review. **Estates** Flexible working and flexible retirement applications continue to be received and supported where possible. **Facilities** Flexible working increased due to redesigning service to aid retention and recruitment.
We are a team  Team working: Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a	Decreased from 6.63 in 2023 to 6.61. Below sector average (6.74). Best result is 7.12, worst result is 6.26.	Inclusive recruitment panels and practice: Defining inclusive recruitment panels at SaTH, exploration of Cultural Ambassador programme for recruitment, review of 6 high impact actions, contacting other Trusts/ICS for advice on implementation Stay / Exit interview process and data review and collation. On-boarding for all**:** Placing the candidate experience at the centre. Review of current onboarding processes for different staff groups (including international recruitment and Bank staff), defining roles and responsibilities for onboarding process (from both the recruitment teams and local	**SACC** Team meeting agendas to identify and discuss areas of learning and improvement in a safe environment. Learning from areas that have shown huge success on improving there 'we are a team' score and sharing stories. Using meetings with Centre Managers/Matrons to focus on how to improve working relationships between teams.

Line Management: Q9a, Q9b, Q9c, Q9d		department induction perspective), agreeing what good onboarding looks like. Affina Team Journey is taking place with a number of teams and we have 5 more team coaches in the Trust. SOAR analysis undertaken to identify areas for expansion	**Women's and Children (WAC)** *Areas of Focus;* • *Line Management* Management and Leadership Development (see development). Develop Communities of Practice, in which representatives meet regularly to discuss issues in their areas, and how areas/services can help one another. Communities of Practice set up eg • Engagement with Staff Survey • Managing People Cases • Managing Appraisals • Objective Setting Team Meetings – set standing items across the division (eg H&WB check in, areas for improvement). **MEC** We will shortly finalise the Medicine behaviour framework (developed via focus group) and are in the process of agreeing a pledge approach to sharing the Emergency Care behaviour framework. We have commenced a process of training managers in undertaking stay conversations with our initial focus being on HCAs and internationally educated nurses approaching two years' service. There is certainly scope for developing our onboarding processes and linking this to our vision for Medicine & Emergency Care.

			We are planning on putting in place further civility, respect and professional challenge sessions for ED staff in the Spring. **CSS** Focus on staff survey advocacy questions with defined next steps to support improvement. Launch divisional induction sessions. Celebrate success and innovation through divisional recognition scheme. Continue to embed with our teams our vision, priorities, and objectives as we are onboarding Cardiorespiratory and Oncology & Haematology. **Facilities** *Areas of Focus;* • *Team Work* • *Line Management* Introduced further regular team huddles/briefs with standardised agenda's. CRIK Sessions. Coaching and Mentoring made available to managers where needed. DISC Profiling of managers. Access to 360 Feedback for managers to inform strengths and areas for development.

Staff Engagement  Motivation: Q2a, Q2b, Q2c Involvement; Q3c, Q3d, Q3f Advocacy: Q25a, Q25c, Q25d	Remains the same as 2023 at 6.59. Below sector average (6.84). Best result is 7.39, worst result is 5.98.	Talent workshops held across the Trust to engage managers and staff in a new process Listening events taking place across Divisions Promotion of Engagement as a key driver for positive patient outcomes**.** Utilising the Advocacy, Involvement and Motivation themes to inform and guide managers to improve staff experience. This is via Masterclasses.	**SACC** Listening events engaging teams following staff survey results, also updating on actions taken from last year's results. Use Improvement Huddles to share successful improvement projects. **Women's and Children (WAC)** *Areas of Focus;* • *Motivation* • *Involvement* • *Advocacy* More use of 'storytelling/start with why' to share objectives of the strategic intentions across the division. Ongoing review and development of Division Culture. Investment in the Leadership Team Development (use of external partners to facilitate). Projects and work activities all define the connection to the overall divisional plan and detail the desired impact. Development of career pathways withing the division workforce plan. Create multiple channels for staff to feedback and make suggestions on improvements (eg standing items on team agenda's and supervision documents).

			MEC We are currently developing a divisional communication strategy and have already put in place wraps to update staff on events within the division. Our comms approach will enable us to share our vision and ensure that front line staff within MEC are aware of the work being undertaken to culturally transform the division. **CSS** Focus on staff survey advocacy questions with defined next steps to support improvement Continue with our 'grow our own' models of working and expand system/network opportunities for integrated approaches. Centre plans for supporting individuals through our Leadership Framework. Succession plans for each Centre. Utilisation of our culture dashboard at Centre-level. **Estates** Monthly toolbox talks take place to ensure staff engagement with updates on operational matters and Trust wide comms are discussed. **Facilities** *Areas of Focus;* • *Advocacy* Roles and responsibilities outlines created across all services for all supervisory staff and above to gain clarity on expectations.

			Social events such as SaTH football challenge to looked at, as a wider team building initiatives.
Morale  Thinking about leaving: Q26a, Q26b, Q26c Work pressure: Q3g, Q3h, Q3i Stressors: Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a	Increased from 5.79 in 2023 to 5.84. Below sector average (5.93). Best result is 6.38, worst result is 5.13.	Quarterly People pulse to monitor progress of staff morale and mood. Leadership development as outlined above with programmes from band 3 to 9. Continue with talent platform and talent conversations Health and wellbeing offer and sleep school. Recognition schemes such as Values Awards, Staff Survey Incentives Involvement in Schwartz rounds NHS Birthday and professional recognition days celebrated	**SACC** Learn from Stay Conversations trial with HCA's to embed Stay Conversation framework in other identified areas. Deep dive into areas with high attrition, triangulated with high sickness and ER issues. Departments and staff groups to understand reasons and devise actions to learn and improve. Continue with Civility Respect and Inclusion, and behaviours framework sessions where appropriate. **MEC** Our approach to enhancing morale centre on leadership and culture. We will promote the Trust leadership programmes and clearly communicate to staff how we are endeavouring to improve the culture of the division. This will include sharing our 2025/26 People Plan. **Women's and Children (WAC)** Managers having 'career and development' conversations throughout the year. Increase use of Stay Conversations. Robust Talent Conversation processes. Exit Interviews – promotion.

			CSS Celebrate success and innovation through divisional recognition scheme. Focus on talent conversations and ensuring appropriate timing to achieve enhance quality and increase compliance. Continue to work celebrate our recognition days Focus on staff survey advocacy questions with defined next steps to support improvement. Maximise digital solutions to enable reform Working through barriers to enable transient system working. Reduction in premium spent to deliver sustainable services. **Estates** Celebrated 3rd National Day in June. **Facilities** *Areas of Focus;* • *Stressors* Encourage nominations for Trust Awards following the success of Catering Team (sustainability/green award & Non Clinical Leadership). Increase stay conversations. Clear communication and clarity of roles.

Culture Dashboard Priority Areas 2024 Survey Results

Dashboard Area	Compassion	Compassion	Compassion	Compassion
Question	Q8c The people I work with are polite and treat each other with respect.	Q8d The people I work with show appreciation to one another.	Q9d My immediate manager takes a positive interest in my health and well-being.	Q9f My immediate manager works together with me to come to an understanding of problems.
1	Accident and Emergency Services	Accident and Emergency Services	Paediatric Services	Paediatric Services
2	Cleanliness Services	Oncology Services	Maternity Services	Maternity Services
3	Theatre Services	Cleanliness Services	Accident and Emergency Services	Surgical Services
4	Surgical Services	Portering Services	Catering Services	Accident and Emergency Services
5	Portering Services	Pharmacy Services	Surgical Services	Catering Services
6	Pharmacy Services	Surgical Services	Cleanliness Services	Portering Services
7	Oncology Services	Catering Services	Portering Services	Cleanliness Services
8	Catering Services	Pathology Services	Radiology & Imaging Services	Neonatal Services
9	Pathology Services	Theatre Services	Neonatal Services	Patient Access Support Services
10	Inpatient Therapy	Obstetrics and Gynaecology Services	Patient Scheduling Services	Care of the Older Person Services

Dashboard Area	Goals & Performance	Goals & Performance	Goals & Performance	Goals & Performance
Question	Q6 a I feel that my role makes a difference to patients / service users.	Q21a Care of patients / service users is my organisation's top priority.	Q21c I would recommend my organisation as a place to work.	Q21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.
1	Catering Services	Inpatient Therapy	Inpatient Therapy	Inpatient Therapy
2	Patient Access Support Services	Portering Services	Pathology Services	Pharmacy Services
3	Patient Scheduling Services	Pharmacy Services	Patient Scheduling Services	Radiology & Imaging Services
4	Patient Safety Services	Radiology & Imaging Services	Theatre Services	Patient Scheduling Services
5	Accident and Emergency Services	Pathology Services	Pharmacy Services	Critical Care Services
6	Cleanliness Services	Cardiology Services	Patient Access Support Services	Portering Services
7	IT Services	Catering Services	Care Closer to Home Centre	Care Closer to Home Centre
8	Pharmacy Services	Patient Scheduling Services	Care of the Older Person Services	Pathology Services
9	Financial Accounts	Care of the Older Person Services	Patient Safety Services	Patient Safety Services
10	People Advisory Service	Head & Neck Services	Maternity Services	Theatre Services

Dashboard Area	Health & Wellbeing	Health & Wellbeing	Health & Wellbeing	Health & Wellbeing
Question	Q6b My organisation is committed to helping me balance my work and home life.	Q6d I can approach my immediate manager to talk openly about flexible working.	Q11a My organisation takes positive action on health and well-being.	11 c. During the last 12 months I have felt unwell as a result of work related stress.
1	Pathology Services	Accident and Emergency Services	Maternity Services	Maternity Services
2	Maternity Services	Paediatric Services	Accident and Emergency Services	Accident and Emergency Services
3	Inpatient Therapy	Portering Services	Trauma & Orthopaedic Services	Pathology Services
4	Accident and Emergency Services	Maternity Services	Cardiology Services	General Internal Medicine Services
5	Portering Services	Surgical Services	Pathology Services	Pharmacy Services
6	Paediatric Services	Patient Scheduling Services	Patient Scheduling Services	Patient Scheduling Services
7	Theatre Services	General Internal Medicine Services	Oncology Services	Care of the Older Person Services
8	Pharmacy Services	Pathology Services	Portering Services	Acute Admissions Services
9	Oncology Services	Care of the Older Person Services	Paediatric Services	Cardiology Services
10	Neonatal Services	Catering Services	Obstetrics and Gynaecology Services	Surgical Services

Dashboard Area	Learning & Innovation	Learning & Innovation	Learning & Innovation	Learning & Innovation
Question	Q24b There are opportunities for me to develop my career in this organisation.	Q24d I feel supported to develop my potential.	Q24e I am able to access the right learning and development opportunities when I need to.	Q25b My organisation acts on concerns raised by patients / service users.
1	Maternity Services	Maternity Services	Inpatient Therapy	Inpatient Therapy
2	Radiology & Imaging Services	Catering Services	Maternity Services	Portering Services
3	Inpatient Therapy	Cleanliness Services	Pharmacy Services	Pharmacy Services
4	Portering Services	Portering Services	Patient Scheduling Services	Patient Scheduling Services
5	Catering Services	Patient Scheduling Services	Portering Services	Pathology Services
6	Patient Scheduling Services	Radiology & Imaging Services	Catering Services	Radiology & Imaging Services
7	Ophthalmology Services	Paediatric Services	Cleanliness Services	Cleanliness Services
8	Cleanliness Services	Pathology Services	Pathology Services	Theatre Services
9	Obstetrics and Gynaecology Services	Inpatient Therapy	Theatre Services	Patient Access Support Services
10	Patient Access Support Services	Patient Access Support Services	Medicine Management Services	Medical Engineering Services

Dashboard Area	Teamwork	Teamwork	Teamwork	Teamwork
Question	Q7a The team I work in has a set of shared objectives.	Q7e I enjoy working with the colleagues in my team.	Q7g In my team disagreements are dealt with constructively.	Q16b In the last 12 months I have personally experienced discrimination at work from a manager / team leader or other colleagues.
1	Cleanliness Services	Catering Services	Accident and Emergency Services	Accident and Emergency Services
2	Surgical Services	Surgical Services	Pathology Services	Cardiology Services
3	Catering Services	Accident and Emergency Services	Portering Services	Pathology Services
4	Portering Services	Oncology Services	Cleanliness Services	Theatre Services
5	Accident and Emergency Services	Portering Services	Catering Services	Critical Care Services
6	Patient Scheduling Services	Cardiology Services	Oncology Services	Renal Medicine Services
7	Oncology Services	Pathology Services	Surgical Services	Care of the Older Person Services
8	Radiology & Imaging Services	Cleanliness Services	Patient Scheduling Services	Corporate Nursing Service
9	Maternity Services	Theatre Services	Neonatal Services	Surgical Services
10	Pharmacy Services	Patient Scheduling Services	Pharmacy Services	Estates Services

Dashboard Area	Vision & Values	Vision & Values	Vision & Values	Vision & Values
Question	Q3f I am able to make improvements happen in my area of work.	Q8a Teams within this organisation work well together to achieve their objectives.	Q8b The people I work with are understanding and kind to one another.	Q25e I feel safe to speak up about anything that concerns me in this organisation.
1	Surgical Services	Patient Scheduling Services	Cleanliness Services	Pathology Services
2	Maternity Services	Pharmacy Services	Accident and Emergency Services	Patient Scheduling Services
3	Paediatric Services	Portering Services	Portering Services	Portering Services
4	Accident and Emergency Services	Accident and Emergency Services	Pharmacy Services	Patient Access Support Services
5	Patient Scheduling Services	Pathology Services	Surgical Services	Maternity Services
6	Portering Services	Oncology Services	Theatre Services	Inpatient Therapy
7	Respiratory Medicine Services	Corporate Nursing Service	Oncology Services	Surgical Services
8	General Internal Medicine Services	Estates Services	Catering Services	Cardiology Services
9	Radiology & Imaging Services	Radiology & Imaging Services	Maternity Services	Care of the Older Person Services
10	Catering Services	Maternity Services	Pathology Services	Estates Services

Dashboard Area	FTSU			
Question	Q21e I feel safe to speak up about anything that concerns me in this organisation.	Q17a I would feel secure raising concerns about unsafe clinical practice.	Q17b I am confident that my organisation would address my concern.	Q21f If I spoke up about something that concerned me I am confident my organisation would address my concern.
1	Pathology Services	Cleanliness Services	Inpatient Therapy	Inpatient Therapy
2	Patient Scheduling Services	Patient Scheduling Services	Portering Services	Pathology Services
3	Portering Services	Portering Services	Care Closer to Home Centre	Patient Scheduling Services
4	Patient Access Support Services	Surgical Services	Cardiology Services	Portering Services
5	Maternity Services	Estates Services	Estates Services	Critical Care Services
6	Inpatient Therapy	Patient Access Support Services	Pharmacy Services	Pharmacy Services
7	Surgical Services	Maternity Services	Accident and Emergency Services	Radiology & Imaging Services
8	Cardiology Services	Catering Services	Surgical Services	Care of the Older Person Services
9	Care of the Older Person Services	Radiology & Imaging Services	Care of the Older Person Services	Theatre Services
10	Estates Services	IT Services	Maternity Services	Care Closer to Home Centre

SaTH Staff Survey Annual Timeline 2024-25

The Shrewsbury and Telford Hospital NHS Trust

Initial Results

January/February

Share results with SLCs along with A Year of Listening (YOL) and Our Way Forward templates.

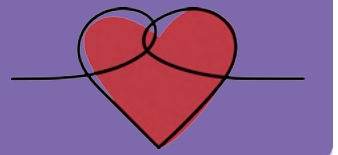
Reiterate embargo rules and the comparator data is only vs IQVIA trusts

Work on results/excel spreadsheet of results with WF assurance/BI teams

Divisional Action planning and focus groups

Quarterly people pulse promotion
Engagement Masterclasses in Feb on LMS

Detailed Reports



February

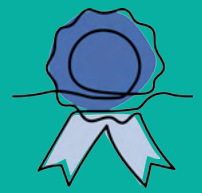
Plan full comms launch as coordination centre results arrive

Continue to work on results/excel spreadsheet of results with WF assurance/BI teams. They need to be ready for embargo lift. Department results shared internally.

Divisional action planning and focus groups continue

Share quarterly people pulse results

Workshops #ImprovingTogether



March

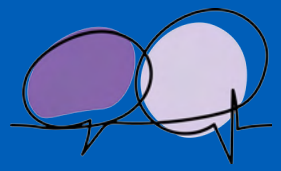
Embargo is lifted.
Chief People Officer briefing with media.
Chief People Officer briefings at Trust and Division level.

All pre documents need to be available for use. Sharing posters, improvement plans etc

BI Dashboard and Action planning e-learning/YOL developed and shared.

Divisional action planning and focus groups continue

Action Planning & Focus Groups



March/ April

Teams are sharing results and action planning.

Divisions need to submit action plans and present at PODAC

April PODAC takes place. Board paper submissions discussed and collated where relevant.
+
Free text comments arrive. They need theming and sending to SLCs for action.

April is quarterly People Pulse engagement survey. Promote this as very useful to double check versus proposed actions

Action Plans Signed off

May

Submit Board report

Deliver staff survey workshops/engagement support etc

Have a voice that counts/YOL in Comms case studies

Quarterly engagement People Pulse results to share

Board Assurance

June

Staff survey results are presented at June Board

Triangulated text comments got to June PODAC

Continue to Deliver staff survey workshops/engagement support etc

Start to work on the ESR structure for approval for this year's data cut

Have a voice that counts/YOL in Comms case studies

Agree response rate incentives for this year

Continuous Improvement Loop

SaTH Staff Survey Annual Timeline 2024-25

The Shrewsbury and Telford Hospital NHS Trust

Board and Local assurance

June/July

Plan this year comms activity

Get teams involved from now until September to be case studies for comms for staff survey

Check in on action plan mobilisation with Divisions

Plan all of the wording for the template letters for CEO sign off.

Planning Time - ongoing

July /August

End of July – ESR hierarchy is agreed

Agree comms plan and present at PODAC. Divisions to update on progress

Complete all of the wording for the staff survey intro letter templates to be submitted.

July – Final people pulse quarterly survey. Results in August.

Staff Survey Roadshows to take place

We listen and act together

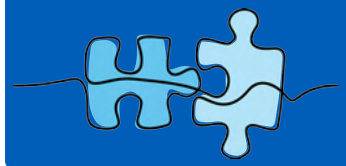
September

Data cut is taken and upload happens by 2nd week onto the portal

Comms plan begins for the year of listening.

Plan staff survey promotions with the Divisions

Staff Survey Launched



October /November

Fieldwork has to have begun by 1st Monday in October and ends last Friday in November.

Execute promotional tour within Divisions

Any further updates from Divisions are presented at PODAC

Reflection

December

Initial results are received in the Trust mid December

Prep the briefings and heat maps for the SLC launches after Xmas.

Continuous Improvement

Continuous Engagement and Feedback

Results and plans are put into culture Dashboard and reviewed at culture committee, PODAC and OPOG

LMS training is available to understand results

Feedback is gained at EDI network meeting to review WRES and WDES feedback

Continuous Improvement Loop

Appendix 4 - Summary of the key actions for 2025-2026 from the **Update on Actions 2025-2026**Appendix 1 Trust and Divisional Schemes and Actions 2025-26 1 document [1]:

Trust-Wide Actions

- **Compassionate and Inclusive Culture**:
    - Implement divisional culture dashboards to support cultural improvement.
    - Continue delivering Civility & Respect sessions and Compassionate Leadership Masterclasses.
    - Promote and grow staff networks.
    - Transition Schwartz Rounds to be owned by the Staff Psychology Team by March 2025.
    - Launch Stay Conversations toolkit and Sexual Safety Healthcare Organisation Charter.
    - Achieve Disability Confident Leader (Level 3) Status.
- **Recognition and Reward**:
    - Annual Trust-wide recognition plans and celebration events.
    - Continue using Star Cards and introduce digital People Promise cards.
    - Plan for Annual Recognition Week and Trust Celebratory Awards in October 2025.
- **Staff Engagement**:
    - Develop a new line manager training offer on the Staff Survey.
    - Implement a revised Staff Survey Dashboard.
    - Deliver Engagement Masterclasses and support a just and learning culture.
- **Health and Wellbeing**:
    - Expand health and wellbeing offers with the launch of the Psychology Hub and Employee Assistant Programme (HELP).
    - Focus on physical, psychological, and financial support, and healthy lifestyles.
    - Introduce Reasonable Adjustment Guidelines and toolkit for managers.
    - Continue with Schwartz rounds and Wellbeing Conversations training for managers.

- **Learning and Development**:
    - Develop a talent management approach and update talent conversation documentation.
    - Continue with talent conversations briefings and career conversation Masterclasses.
    - Develop career pathways and build improvement and change capabilities across the Trust.
    - Promote Employee Self Service and Manager Self Service.
- **Flexible Working**:
    - Deliver training resources for managers on flexible working.
    - Promote flexible retirement options and update the Home Working Policy.
    - Explore Legacy Mentor roles and improve rostering capabilities.
- **Teamwork**:
    - Define inclusive recruitment panels and review onboarding processes.
    - Undertake Affina Team Journey and SOAR analysis to identify areas for expansion.
- **Staff Engagement and Morale**:
    - Hold talent workshops and listening events.
    - Promote engagement as a key driver for positive patient outcomes.
    - Monitor staff morale and mood through Quarterly People Pulse.
    - Continue with leadership development programmes and recognition schemes.

Divisional Actions

Surgery, Anaesthetics, Critical Care, and Cancer (SACC)

- **Compassionate Leadership**: Conduct Civility, Respect, and Inclusion sessions, and continue Senior Leadership walkabouts.
- **Listening to Staff**: Emphasize honesty, integrity, timely response, and feedback.
- **Diversity and Equality**: Use WRES and WDES data to identify areas needing support and embed the new Appraisal (Talent Conversation) policy.

- **Recognition and Reward**: Utilize away days, department huddles, and team meetings to celebrate success.
- **Staff Engagement**: Use department huddles for feedback sessions and embed Stronger Together within the division.
- **Health and Wellbeing**: Prioritize areas with high burnout and mental health absence, and encourage staff to take breaks and regular leave.
- **Learning and Development**: Support leadership development and ensure appraisal objectives are meaningful.
- **Flexible Working**: Identify areas where line managers need to attend flexible working masterclasses.
- **Teamwork**: Use team meeting agendas to discuss areas of learning and improvement.

Women's and Children's (WAC)

- **Compassionate Culture**: Develop a divisional charter and mandate attendance at Civility, Respect, Inclusion, and Kindness sessions.
- **Recognition and Reward**: Create an environment where staff feel proud and safe to celebrate achievements.
- **Staff Engagement**: Develop a shared purpose and narrative, and ensure all teams receive feedback from line managers.
- **Health and Wellbeing**: Communicate safe staffing levels and ensure colleagues take rest breaks.
- **Learning and Development**: Provide internal leadership opportunities and ensure appraisal training for all responsible colleagues.
- **Flexible Working**: Include health, wellbeing, and work-life balance in supervision agendas.
- **Teamwork**: Develop communities of practice and set standing items for team meetings.
- **Staff Engagement and Morale**: Use storytelling to share objectives and create multiple channels for staff feedback.

Clinical Support Services (CSS)

- **EDI Workstream**: Follow learning from Staff Survey and WRES & WDES data.
- **Zero-Tolerance Approach**: Continue to embed zero-tolerance approach to bullying and harassment.

- **Recognition and Reward**: Celebrate success through divisional recognition schemes.
- **Staff Engagement**: Achieve 100% compliance for FTSU Manager Training and focus on talent conversations.
- **Health and Wellbeing**: Support hotspot sickness absence areas and undertake NHS Health & Wellbeing Toolkit assessment.
- **Learning and Development**: Continue with 'grow our own' models and expand system/network opportunities.
- **Flexible Working**: Review current arrangements and promote flexible working.
- **Teamwork**: Launch divisional induction sessions and celebrate success and innovation.

Medicine and Emergency Care (MEC)

- **Race and Ethnicity Inclusion**: Develop a project to consider challenges faced by BME colleagues.
- **Stay Conversations**: Train managers to undertake stay conversations with internationally educated nurses.
- **Recognition and Reward**: Plan a celebratory event in the Spring and use comms to reflect staff engagement.
- **Staff Engagement**: Demonstrate that feedback leads to change and enhance visibility of leaders.
- **Health and Wellbeing**: Focus on burnout and concerns around 'working without fear' processes.
- **Learning and Development**: Develop career pathways and signpost staff towards leadership development programmes.
- **Flexible Working**: Support flexible working requests where operationally viable.
- **Teamwork**: Finalize behaviour frameworks and train managers in stay conversations.
- **Staff Engagement and Morale**: Promote Trust leadership programmes and share the 2025/26 People Plan.

Estates and Facilities

- **Recognition and Reward**: Celebrate Estates and Facilities National Day and encourage nominations for Trust Awards.

- **Staff Engagement**: Monthly toolbox talks to gain views and thoughts on Estate issues.
- **Health and Wellbeing**: Continue psychological group sessions and train managers to utilize the H&WB Toolkit.
- **Learning and Development**: Encourage managers to attend leadership programmes and support for managers to access appropriate development and training.
- **Flexible Working**: Support flexible working and flexible retirement applications.
- **Teamwork**: Introduce regular team huddles and coaching and mentoring for managers.

These actions reflect a comprehensive approach to improving leadership, staff engagement, diversity, recognition, health and wellbeing, learning and development, flexible working, and teamwork across the Trust and its divisions [1].

References

[1] Appendix 1 Trust and Divisional Schemes and Actions 2025-26 1