The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 10 July 2025

SUPPLEMENTARY INFORMATION PACK

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

FIRST 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 (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

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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

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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

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Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	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

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Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20	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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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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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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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	Delivered, Not Yet Evidenced	On Track	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. This action was agreed as 'Delivered, Not Yet Evidenced' and back 'On Track' at Jun-25's MNTAC with a new assurance deadline of Dec-25 following of confirmation of NHSE's greenlight for the MNISA to start working with families.	10/06/25	31/12/25		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	Delivered, Not Yet Evidenced	On Track	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. This action was agreed as 'Delivered, Not Yet Evidenced' and back 'On Track' at Jun-25's MNTAC with a new assurance deadline of Dec-25 following of confirmation of NHSE's greenlight for the MNISA to start working with families.	10/06/25	31/12/25		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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APPENDIX ONE

FIRST 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 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.

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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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The Shrewsbury and Telford Hospital NHS Trust

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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	On Track	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. This action was agreed as back 'On track' at Jun-25's MNTAC after confirmation of the appointment of a new endocrinologist to support the clinic was received.	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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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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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PROGRESS AS AT 10.06.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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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NHS
The Shrewsbury and Telford Hospital NHS Trust

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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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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
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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The Shrewsbury and Telford Hospital NHS Trust

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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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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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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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PROGRESS AS AT 10.06.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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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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 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 10.06.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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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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

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PROGRESS AS AT 10.06.25

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The Shrewsbury and Telford Hospital NHS Trust

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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

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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	0	3	22
Total	52	0	4	48
Percentage		0%	8%	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	3	0	0	22	0
Total	52	0	4	0	0	48	0
Percentage		0%	8%	0%	0%	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	3	0	0	62	1
IEA	92	0	6	0	0	80	6
Total	158	0	9	0	0	142	7
Percentage		0%	6%	0%	0%	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	8	7	102
Total	210	9	11	190
Percentage		4.3%	5.2%	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	4	0	0	88	1

Counts

IEA	117	0	9	0	0	102	6
Total	210	0	13	0	0	190	7
Percentage		0.0%	6.2%	0.0%	0.0%	90.5%	3.3%

The Shrewsbury and Telford Hospital NHS Trust

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where
	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

PROGRESS AS AT 10.06.2025
Action Plan Status Report

The Shrewsbury and Telford Hospital NHS Trust

Neonatal External Mortality Review

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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	Off Track (see exception report)	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. A new audit presented through Governance in April still did not show sufficiant compliance. This action was reviewed and agreed as 'Off track' while it is jointly reviewed at the Quality and Safety Workstream of the LMNS so blockers and items requiring support can be identified. 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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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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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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Neonatal External Mortality Review

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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.	Evidenced and Assured	Completed	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. This action was agreed as 'Evidenced and Assured' at Jun-25's MNTAC 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: Ongoing compliance with PMRT and incidents reporting including monitoring of actions Monthly Quality and Safety updates to LMNS and network Clinical gems, 3 minutes brief, learning from excellence examples	Short Term (0-6 months)	30/09/2024	08/10/2024	31/05/2025	10/06/2025	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

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 10.06.2025
Action Plan Status Report

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
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. Guidance from the reviewers was received in May-25 and this action will now be brought to the Quality and safety Workstream of the LMNS for joint review and setting timeframes for implementation. 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	On Track	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 were presented 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	31/01/2026		Ned Hobbs	J.Atkinson	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).	Delivered, Not Yet Evidenced	On Track	The team has continued to engage with the Network and to provide exception reports ensuring care continues to be delivered within pathway. The team will conduct a review of transfer cases and discuss the findings with the network to ensure transfers are happening appropriately. Those exception reports are regularly discussed at netwrok and LMNS meetings. This action was agreed as 'Delivered, Not yet Evidenced' at Jun-25 MNTAC. Evidence Requirements for Delivery: Network exception reports - quarterly overview Evidence Requirements for Assurance: Review of Transfer cases Evidence of discussion with ODN	No Timeline Allocated	TBC	10/06/2025	31/10/2025		Dr John Jones	Mr Andrew Sizer	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.

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
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.	Delivered, Not Yet Evidenced	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. This action was agreed as 'Delivered, Not Yet Evidenced' at Jun-25's MNTAC. Evidence Requirements for Delivery: Forward audit plan in place Quality Improvement plan in place Monthly dashboard with review of trends and themes 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	10/06/2025	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

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 10.06.2025
Action Plan Status Report

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
NEMR24	This report should be shared with the trust board, which should have oversight of any action plan developed to address the recommendations.	Evidenced and Assured	Completed	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 and as 'Evidenced and Assured' at Jun-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 - IMNR Nov-24/Jan/Mar/May-25)	Medium Term (6-12 months)	31/12/2024	14/01/25	31/05/25	10/06/25	Dr John Jones	J.Atkinson	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	17	10	8
Total	35	17	10	8
Percentage		48.6%	28.6%	22.9%

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	2	23	0	2	8	0
Total	35	2	23	0	2	8	0
Percentage		5.7%	65.7%	0.0%	5.7%	22.9%	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, where
	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

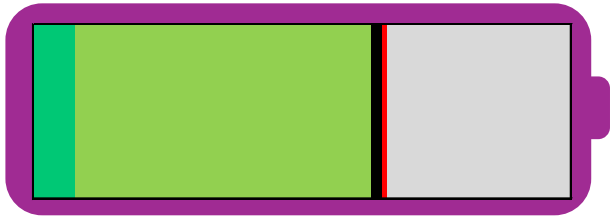
Name	Title and Role	Project Role
Paula Gardner	Executive Director of Nursing	Overall MNTP Executive Sponsor
John Jones	Executive Medical Director	Overall MNTP Executive co-sponsor
Andrew Sizer	Medical Director, Women & Children's Division	Senior Responsible Officer, MNTP and Accountable Action Owner
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

Appendix Three - Maternity and Neonatal Transformation Plan Phase 2 batteries – Post Jun-25 MNTAC

Overall Delivery

79% (190) Not Yet Delivered
13% (32) Delivered, Not Yet Evidenced
8% (20) Evidence & Assured

Overall Progress



8% (20) Complete
55% (133) On Track
2% (6) Descoped
1% (2) Off track
34% (81) Not Started

	Delivery Battery	Progress Battery
Black Maternal Health Plan	67% (6) | 11% (1) | 22% (2)	22% (2) | 33% (3) | 45% (4)
Maternity Community Service Review	100% (37)	32% (12) | 68% (25)
LMNS Equity & Equality	87% (26) | 10% (3) | 3% (1)	3% (1) | 40% (12) | 57% (17)
LMNS 3 Year Delivery Plan	61% (19) | 21% (5) | 18% (4)	18% (4) | 50% (15) | 32% (9)
Cultural Improvement Plan	92% (34) | 5% (2) | 3% (1)	3% (1) | 49% (18) | 48% (18)
CQC Neonates Action Plan	10% (1) | 70% (7) | 20% (2)	20% (2) | 70% (7) | 10% (1)
Neonatal External Mortality Review	49% (17) | 29% (10) | 22% (8)	22% (8) | 66% (23) | 6% (2) | 6% (2)
Neonatal Unit Implementation Plan	98% (46) | 2% (1)	2% (1) | 83% (39) | 4% (2) | 11% (5)
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

LMNS Programme Board June 2025

Agenda item				
Report Title		CNST MIS Year 7 - Progress Updates – June 2025		
Executive Lead		Paula Gardner - Interim Chief Nursing Officer		
Report Author		Jacqui Bolton – Interim Head of Midwifery Cecile Pollitt – MNTP Assistant Project Manager		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Commitee Neonatal Governance Committee Quality safety Assurance Committee LMNS Programme Board Maternity Safety Champions		
Executive summary:		This paper evidences progress against Year 7 of the CNST Maternity Incentive Scheme as of June 2025. The service is currently on track to achieve 9 of the 10 Safety Actions. A risk to the delivery of Safety Action 7 has been identified, more details can be found on section 3.7.2 of this report. Compliance will be evidenced throughout the reporting period with full compliance planned for February 2026 at which time a presentation will be provided to Trust Board for sign off.		
Recommendations for the Committee:		1. Review and discuss this paper and its appendices, and advise the Head of Midwifery of any further detail required. 2. Take assurance of progress toward the delivery of Year 7 of the CNST Maternity Incentive Scheme. 3. Provide assurance for items in section 6.1.2 in the Board's minutes		
Appendices:		• Safety Champions Locally Agreed Dashboard (SA9) • Triangulation of the Scorecard (SA9) • Perinatal Quad Meeting Minutes (SA9)		

2. Introduction

2.1. The Scheme

2.1.1. SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

2.1.2. The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

2.2. Year 7 Guidance

2.2.1. Year 7 guidance was published on 2 April 2025, with version 1.0 and references a relevant time period of either 1 December 2024 until 30 November 2025 or 2 April 2025 until 30 November 2025 for delivery of the scheme, dependant on the Safety Action.

2.2.2. This also includes a self-declaration deadline of noon on 3 March 2026.

2.2.3. This new guidance includes updates for safety actions 1,3,4,7 and 9 from Year 6 requirements.

2.3. This report

2.3.1. The purpose of this paper is to provide the Committee with:

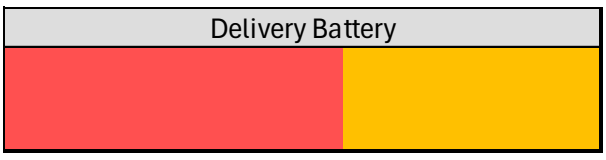
- Details of the standards within year 7 of the scheme that must be evidenced between now and the reporting deadline.
- An update on progress.
- Any risks to the delivery of the scheme under the new safety actions technical guidance.

3. Overall Progress Status

3.1. Delivery

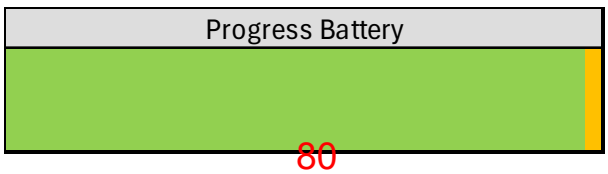
3.1.1. The below chart shows a CNST completion rate as of June 1 2025 (including compliance with the standards and accrual of supporting evidence) of:

- 43% “Delivered Not Yet Evidenced” - Amber
- 57% “Not Yet Delivered” - Red



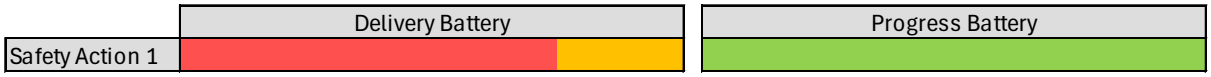
3.2. Progress

3.2.1. The delivery battery should be viewed in conjunction with the below progress battery which evidences the overall status of progress which is 97% “On Track”, with 1 item (3% - section 3.7.2) at Risk.



4. Safety Actions Status

4.1. Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"



4.1.1. **Progress status: On Track**

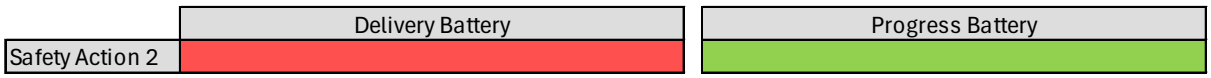
4.1.2. Changes in the guidance from previous year:

- The minimum requirement for MDT PMRT reviews to be completed within 6 months was increased from 60% to 75%. The service achieved 100% compliance in Year 6 and this remains the target for Year 7.
- A new requirement for 50% of deaths reviewed to have an external member present on the panel has been introduced.
- The service has continued to produce a quarterly report that presents the position against all elements of this safety action.

4.1.3. The latest quarterly report included our Q4 position for 2024/25 went through Governance in April 2025 and was then received at Trust Board in May 2025.

4.1.4. All elements of this action will moved to "Delivered, Not yet Evidenced" once full compliance can be demonstrated through a closure report in December 2025, once that closure report is received, they will be moved to "Evidenced and Assured".

4.2. Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"



4.2.1. **Progress Status: On Track**

4.2.2. Changes in the guidance from previous year:

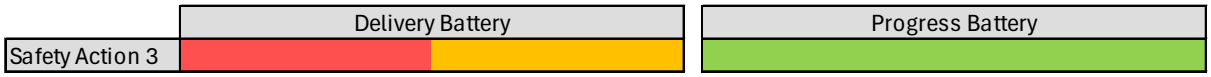
- The requirement for MSDS data quality of 10 out of 11 CQIM metrics was removed
- A new requirement for July 2025 MSDS data to contain valid birthweight information for 80% of babies was added.

4.2.3. NHS Digital, who oversee this Safety Action, will confirm whether SaTH have uploaded all required data points to the Maternity Services Data Set at the required standard of data quality; this will be confirmed in October 2025 based on the data submitted in the month of July 2025 (which is the month against which the standard is tested).

4.2.4. This safety action does not appear to be at risk based on the information known to date however this will not be known until the July data is published in October 2025.

4.2.5. All elements of this action will moved to "Delivered, Not yet Evidenced" when full compliance can be demonstrated through the MSDS Scorecard published in October 2025, once that scorecard is provided to Board, they will be moved to "Evidenced and Assured".

4.3. Safety Action 3: “Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?”



4.3.1. **Progress Status: On Track**

4.3.2. Changes in the guidance from previous year:

- Transitional Care pathways requirements were adjusted to babies between 34+0 and 35+6 to align with BAPM standards
- Trusts that complied with the requirement to start a QI initiative as part of Year 6 need to demonstrate progress against that initiative.

4.3.3. Standard a)Transitional Care guideline has been updated and is going through the appropriate governance processes. It is expected to come into practice in October 2025 while staffing is being adjusted to meet the new requirements.

4.3.4. The BoD via the delegated authority of QSAC has continued to receive a quarterly ATAIN report that includes details of all term admissions, including avoidable admissions. The latest quarterly report, covering Q4 of 2024/25 was presented at Maternity Governance and QSAC in April 2025.

4.3.5. The BoD via the delegated authority of QSAC has continued to receive a quarterly report on transitional care activity. The latest quarterly report, covering Q4 of 2024/25 was presented at Maternity Governance and QSAC in May 2025.

4.3.6. Standard b) Progress updates against the QI project started as part of Year 6 of the scheme will be presented to the appropriate governance meetings and provided to the LMNS.

4.3.7. Each element of this action will moved to “Delivered, Not yet Evidenced” when compliance can be demonstrated, once all reports have been presented through the required governance channels, they will be moved to “Evidenced and Assured”.

4.4. Safety Action 4: “Can you demonstrate an effective system of clinical workforce planning to the required standard?”

4.4.1. **Progress Status: On Track**

4.4.2. Changes in the guidance from previous year:

- Compliance against Consultant Attendance requirements can now be evidence through an audit of any 3-month period from February-November 2025.
- Non compliance against BAPM requirement for medical and/or nursing workforce requirements now also need to be monitored via a risk register.

4.4.3. Standard a). A closure paper demonstrating compliance against all Obstetric Workforce requirements will be presented in December 2025 once all the items within the standard have been audited.

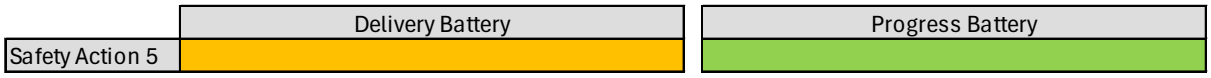
4.4.4. Standard b) A paper evidencing compliance against the ACSA Standard 1.7.2.1 will be presented before the end of the reporting period, with 3-months rotas for Obstetric Anaesthetists provided as part of the evidence.

4.4.5. Standard c) Evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce was provided in previous years of the scheme. A new paper will be presented before the end of the reporting period to reaffirm that position.

4.4.6. Standard d) Work continues to achieve compliance with BAPM standards for the Neonatal Nursing Workforce (70% QIS not yet compliant) and a paper with an updated action plan will be presented before the end of the reporting period.

4.4.7. Each element of this action will moved to "Delivered, Not yet Evidenced" when compliance can be demonstrated, once all reports have been presented through the required governance channels, they will be moved to "Evidenced and Assured".

4.5. Safety Action 5: "Can you demonstrate an effective system of midwifery workforce planning to the required standard?"



4.5.1. **Progress status: On Track**

4.5.2. Standard a) The Midwifery establishment is compliant with the BirthRate+ assessment completed in November 2022. Work is ongoing to schedule a new assessment to comply with the requirement for the assessment to have been completed in the last 3 years, which will become overdue in November 2025.

4.5.3. Standards b-e) The BoD has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended, with the last report being present to the Board in May 2025. This paper demonstrates compliances with all standards.

4.5.4. Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) of safety action 5; this meeting is chaired by the Director of Nursing (DoN). The latest bi-annual staffing paper, covering Q3 & Q4 of 2024/25 was presented to Board in May 2025.

4.5.5. Each element of this action will moved to "Delivered, Not yet Evidenced" when compliance can be demonstrated, and to "Evidenced and Assured" when all reports have been presented at the required governance channels throughout the reporting period.

4.6. Safety Action 6: "Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?"

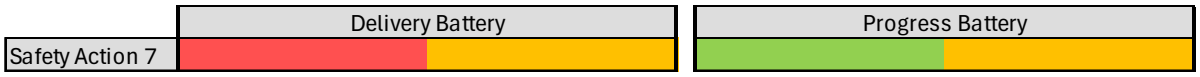
4.6.1. **Progress status: On Track**

4.6.2. This action has been delivered as per the requirements of the previous years of the scheme. Compliance is being benchmarked against the recently published version 3.2, and will continue to be evidenced within the SBLCB implementation tool. Quarterly meetings with System Partners (ICB) monitor ongoing compliance and agreed Stretch Targets for the 6 elements.

4.6.3. Additionally, the BoD via the delegated authority of QSAC has continued to receive a quarterly SBL report demonstrating progress against all indicators and stretch targets. The latest quarterly report, covering Q4 of 2024/25 was presented at Maternity Governance and QSAC in May 2025.

4.6.4. This action is "Delivered, Not yet Evidenced" and will move to "Evidenced and Assured" at the end of the reporting period once evidence that all quarterly meetings with the system have been attended has been collated.

4.7. Safety Action 7: "Listen to women, parents and families using maternity and neonatal services and coproduce services with users."



4.7.1. **Progress Status: At Risk**

4.7.2. Changes in the guidance from previous year:

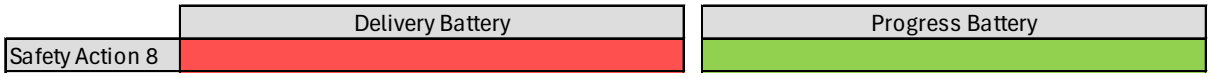
- An escalation process has been introduced allowing Trusts where the LMNS commissioned MNVP Infrastructure isn't sufficient to still comply with the safety Action as long as the issue is escalated via the PQSM.
- Where the infrastructure is in place, there is an explicit requirement for MNVP to be a quorate member of all listed Maternity and Neonatal safety and governance meetings.
- **Identified Risk:** The MNVP structure, as it is currently set up, does not allow us to have the lead as a quorate member of all required meetings outlined in the guidance as there is no cover in case of the lead's absence which who present a risk to our processes. This has been discussed with the LMNS and ICB and we are awaiting guidance from NHSE. Other ICBs and LMNSs are encountering similar concerns

4.7.3. The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike; the MNVP have recently recruited a new employed lead who will enhance the current offer and afford the capacity to extend the reach to the wider community. Evidence of this engagement will be collated throughout the reporting period.

4.7.4. The CQC maternity survey 2024 has a coproduced action plan which was presented at Maternity Governance, and LMNS Board in February 2025 and Safety Champions in May 2025 ; where progress updates will be provided.

4.7.5. The maternity and neonatal safety champions regularly seek feedback from staff in local areas as part of the scheduled walkabouts which are undertaken bi-monthly. These walkabouts are managed in conjunction with the 15 Steps walkabouts and subsequent action plans are monitored via safety champions, MNVP Hub meetings, and maternity governance meetings.

4.8. Safety Action 8: "Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?"



4.8.1. **Progress Status: On Track**

4.8.2. The Trust has been fortunate to participate in the NHSE Pilot of version 2 of the Core Competency Framework (CCF) therefore our local training plan reflects the ask within the technical guidance to be aligned to the CCF.

4.8.3. The education team are working collaboratively with the management team to ensure all staff continue to be released to attend planned sessions to achieve this standard.

4.9. Safety Action 9: "Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?"

4.9.1. **Progress Status: On Track**

4.9.2. This safety action is in keeping with the previous year of the scheme which are now embedded into business-as-usual processes The Trust have fully embedded the Perinatal Quality Surveillance Model (PQSM) and inline with the technical guidance, a non-executive director (NED) is working with the Board Safety Champion.

4.9.3. A Safety Intelligence Dashboard review is be carried out by the safety champions and an updated dashboard presented for each quarter. This is also shared and discussed at governance, safety, Board and LMNS meetings.

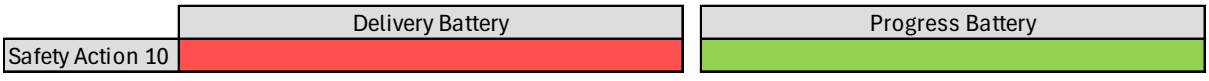
4.9.4. Evidence of ongoing staff engagement sessions and progress with action and progress made provided through publication of the 'You said, We listened' posters.

4.9.5. The Trusts Claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal Trust Board Level Safety Champion at Board meeting quarterly (twice per reporting period). The latest Trust Claims Scorecard and Triangulation, covering Q4 2024/25 was presented to Trust board in May. Evidence in the Trust Board minutes that Board Safety Champions are meeting with the Perinatal Leadership Team bi-monthly and that any support required of the Trust Board has been identified.

4.9.6. Evidence in the Trust Board (or appropriately delegated committee) that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support considered and implemented is included in the Maternity and Neonatal Integrated Report, presented to Board of Directors, bi-monthly.

4.9.7. Evidence for this action will be collated throughout the reporting period.

4.10. Safety Action 10: "Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?"



4.10.1. **Progress Status: On Track.**

4.10.2. This safety action relates principally to the work of the divisional governance team, supported by the legal team.

4.10.3. As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action will not be evidenced as delivered/complete until the end of the reporting period.

4.10.4. Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.

5. Papers provided with this update

5.1.1. The following papers, linked to CNST Safety Actions, were presented to this Board this month as part of its regular governance process:

- Integrated Maternity and Neonatal Report (SA9)

5.1.2. Additionally, the following documents linked to CNST Safety Actions have been provided as an appendix for this Board to receive:

- Safety Champions Locally Agreed Dashboard (SA9)
- Triangulation of the Scorecard (SA9)
- Perinatal Quad Meeting Minutes (SA9)

6. Actions requested of this Board

6.1.1. Review and discuss this paper and advise the Head of Midwifery of any further detail required.

6.1.2. Provide assurance, in the Trust Board minutes, of the following:

- The Board received an update on the Cultural Improvement plan in the Integrated Maternity and Neonatal Report and any support requested has been discussed
- The Board has received and reviewed the quarterly Triangulation of the Claim's scorecard
- The Board has received assurance from the Perinatal Quad Meeting minutes that the Perinatal Leadership team and the Board Safety Champions have met in May-25

6.1.3. Take assurance of progress toward the delivery of Year 7 of the CNST Maternity Incentive Scheme.

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

Maternity Safety Support Programme	Yes

QUARTER 1 - 2025				April	May	June	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths	0	0		**April** : There were no stillbirths reportedin April There were 3 neonatal deaths in April 2025: Baby born at 38+5, admitted on day 5 with abnormal movements, died day 9. PMRT led by BCH. Baby born at 22+4, planned palliative care. Baby born at 23+4, transferred to tertiary unit, died day 6. **May:** There were no stillbirths, late fetal losses or neonatal deaths in May.
			Late fetal losses >22 wks	0	0		
			Neonatal Deaths	3	0		
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI		1	1		**April:** There was one referral to MNSI in April 2025. This has since been rejected by MNSI. **May:** There was one referral to MNSI in May 2025, which has since been accepted for review on the request of the parents.
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**		0	0		April : None May: None
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**		0	1		April : None May: One PSII was comissioned in May 2025. This is the MNSI review mentioned above.
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken		1	1		**April : HIE** Term baby, history of reduced fetal movements with poor CTG and APH, required resuscitation at birth, high oxygen requirement, ventilated, initial PPHN, lactic acidosis, required treatment for hypotension (volume and inotropes), developed possible seizures at around 3 hours of age - transferred to NICU, UHNM for therapeutic cooling. **May:** A baby on the neonatal unit was diagnosed with Klebsiella pneumoniae.
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken		16	17		**April :** Severe - 1, Unexpected admison to NNU significant Mecc showing signs of seizure activity plant to transfer to Stoke, Death - 3 - 1 IUD ,2 Neonatal Death (2 following transfer to Level 3 unit, Breech preterm 23+4) **Moderate - 12** **1 HIE (retrospective datix added MNSI investigating other trust requiring input from Sath)** 3 PPH over 1500mls 1 Neonatal admitted <27weeks exception to pathway 23w 1 Late fetal loss 22+4 1 Birth trauma following MOH 2350L 2 Shoulder dystocia Same patient - following moderates 1 Low Cord PH <7.05 following Cat2 Section poor cord gases PPH 1545mls 1 Passive cooling - 1 Apgar score <7 at 5 mins **May:** Severe - 4 - one was an inverted uterus, one was an MOH, one was a perineal tear, and one was a baby with suspected HIE (MNSI case above) Death - 1 - A re-opened PMRT from 2022 graded as a D - care issues that likely impacted the outcome. **Moderate - 12** 4 3rd and 4th degree tears 5 PPH > 1500ml 1 transfer to ITU 2 transfer of an unstable patient - both for the same patient - one will be rejected
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%		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? 90-100% of attendance in each relevant staff group at: • Fetal Monitoring Training • Multi-professional Maternity Emergencies Training • Neonatal Life Support Training Programme development for 2025 -2026 training year in progress. PROMPT Train the Trainers 23rd June 2025.
			Obstetricians – Fetal Monitoring	90.47%	100%		
			Midwives – PROMPT	98.84%	98.50%		
			Midwives – NLS	97.68%	98.13%		
			Midwives – Fetal Monitoring	97.48%	97.96%		
			Other Drs – PROMPT	100%	100%		
			Other Drs – Fetal Monitoring	100%	100%		
			Neonatal Nurses – NLS	100%	100%		
			Anaesthetists – PROMPT	97.00%	94.74%		
			WSAs/MSW – PROMPT	93.67%	98.73%		
3e	**STAFFING**	Minimum safe staffing in maternity services to include Obstetric cover on the Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Maty Del Suite positive acuity	97%	96%		
			Maty 1:1 care in labour	100%	100%		
			Fill rates Delivery Suite RM	D 104% N 94%	D 80% N 99%		
			Fill rates Postnatal RM	D 95% N96%	D 93% N 90%		
			Fill rates Antenatal RM				
			Obstetric Cover on D Suite	100%	100%		
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements (*To note feedback one month behind)*					No posts/comments made for the month of April. An improvement project is currently in progress to use QR codes on patient lockers and ward areas, to allow people to access the FFT in digital format to improve the response rates.
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*		NA	NA		
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		1	0		April: 1 baby referred to MNSI - awaiting decision. NHS-R referral to be made if criteria met.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust		0	0		To note - there are have been no Regulation 28 since May 2021
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10		Compliant	Compliant		

9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	0	0		
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	3	7		To note percentage of delay in relation to numeber of Category 2 caesarean sections N=60 = 11% delay for May compared to 47 Category 2 in April with 3 delays (6%)
11.	**Supernumerary Status of the Coordinator**	**Neonates**	88.3%	93.0%		There were 62 shifts in May and 1 shift did not contain any data therefore the data is based on 61 shifts. Of those 61 shifts; • The NIC was supernumerary 93% of the time (57 shifts) • The NIC was PARTLY supernumerary for 3% of the time (2 shifts) • The NIC was NOT supernumerary for 3% of the time
12.	**Delay in Neonatal Antibiotics**	Number of babies that had delayed antibiotics (Not within the golden hour)	10	14		• 41 babies were started on antibiotics in total for the month of May • 27 received their antibiotics within the golden hour which 65% From those that breached the golden hour: • 5 were due to difficult access • 1 was due to a prescription issue • 1 was due to staff issue • 6 had no rationale given
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)*

NHSR Scorecard Q4 (Jan-March 2025)

Date: June 2025

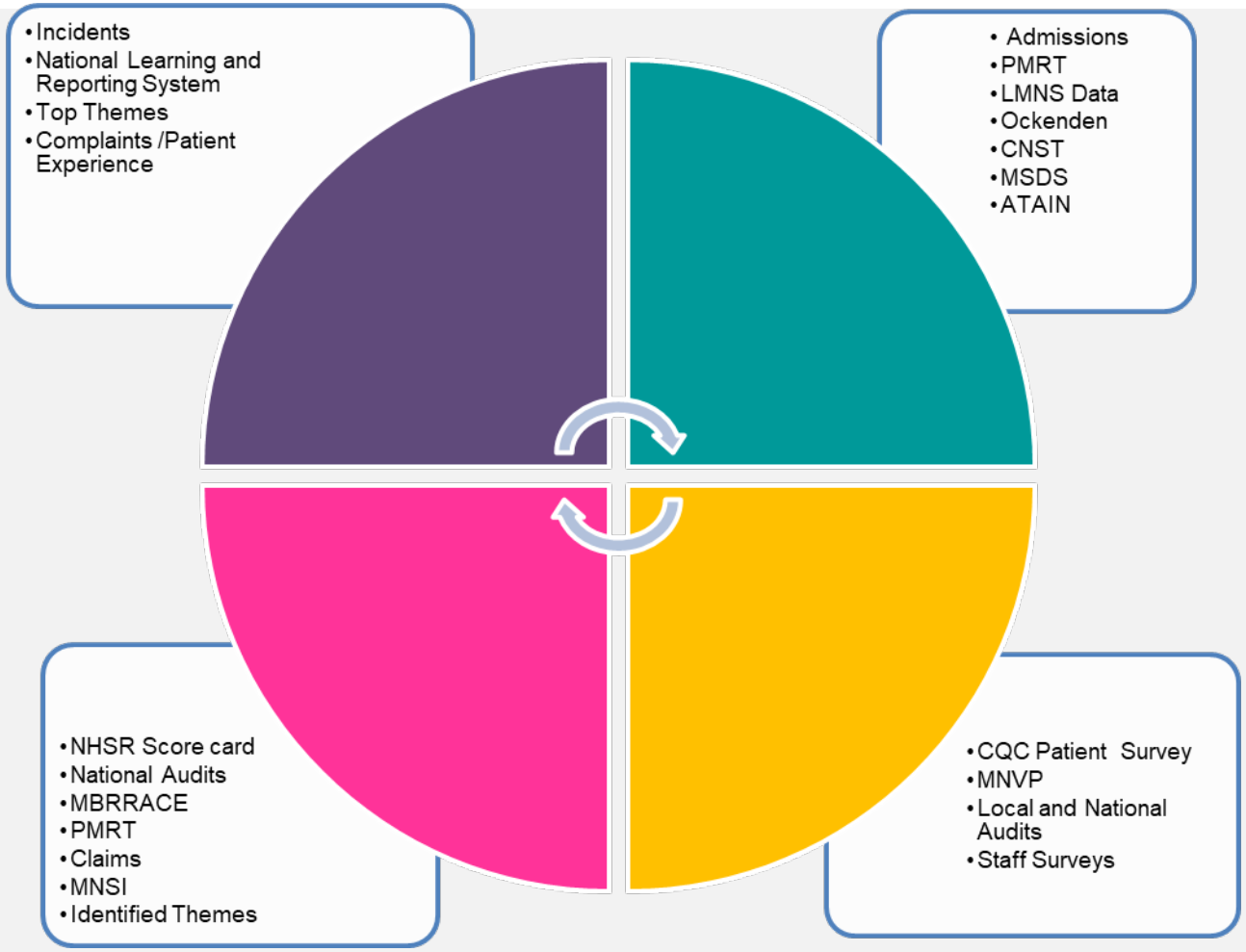
Jacqui Bolton Interim Head of Midwifery

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

The Shrewsbury and Telford Hospital NHS Trust

- 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 Q4

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
Medication	prescribing error

Incidents Top 5 Themes Q4 Maternity

The Shrewsbury and Telford Hospital NHS Trust

Theme	Example
Care/Monitoring	Post Partum Haemorrhage > 1500mls
Discharge of Patients	Self Discharges against medical advice
Diagnosis = Delay/Failure	Booking bloods not checked
Communication between teams	Delayed results/Bleeps/reviews/Miscommunication
Neonatal	Unexpected admission to Neonatal unit (ATAIN)

Incidents & Actions Q4
Maternity and Neonates

The Shrewsbury and Telford Hospital NHS Trust

Maternity

No PSSI's Commissioned

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

Neonates

No PSSI's Commissioned

No After-action Review Commissioned

Duty of Candour Documentation

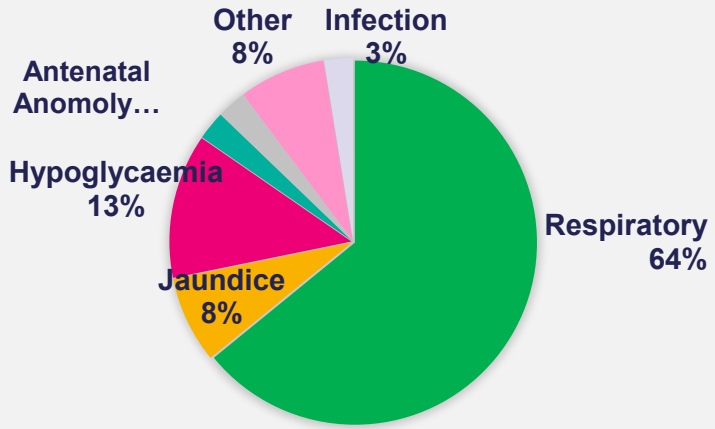
ATAIN

The term admission rate for Q4 (January, February, March 2025) was 4.6 % of all births at >37 weeks, a decrease from the previous Q3 figure of 5.7%.

The year-to-date term admission rate is 5.5%. This rate remains just below the national target of 6%. We have remained below this target for the past 2 months.

A total of 39 term babies were admitted to the NNU in Q4 2024/5 (comparing with 52 in the previous quarter.)

Pie chart below shows - Primary reason for admission in Q4



Quarter 4 (January, February, March)

The numbers of babies admitted each month were:

272 Term births at PRH
January 2025 – 7.4% of all term births at >37 weeks (n = 20)
Avoidable admissions: (n=3)

272 Term births at PRH
February 2025– 2.6% of all term births at >37 weeks (n=7)
Avoidable admissions: (n=1)

291 Term births at PRH
March 2025– 4.1% of all term births at >37 weeks (n=12)
Avoidable admissions: (n=0)

Compliments Complaints FFT MNVP Staff Survey

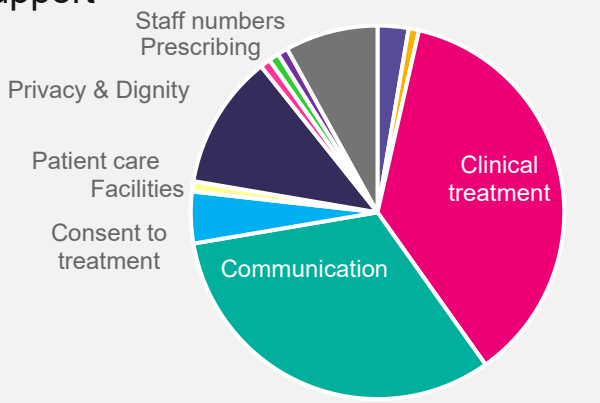
The Shrewsbury and Telford Hospital NHS Trust

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

Q4 Maternity Complaints Subjects



PMRT MBRRACE

The Shrewsbury and Telford Hospital NHS Trust

January – March 2025 (Q4)	number	MBRRACE Reportable
Late Fetal Loss (20-23+6 weeks)	2	Yes – Only cases >22 weeks.
Early Fetal Loss (16-19+6 weeks)	5	No
Early Neonatal death (Live birth >20 weeks or 400g) < 7 completed days post birth	2	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)	0	Babies born after 22 weeks who receive neonatal care and die >28 days after birth.
Termination of Pregnancy (any gestation)	6	Only if resulting in Stillbirth (from 24 weeks gestation) or Neonatal Death (from 20 weeks gestation).
Stillbirths (over 24 weeks)	2	Yes

PMRT Themes

Joint counselling for those with threatened or active preterm labour.

Translation Services and leaflets available in different languages.

QA questions in the perinatal period – Finding opportunities to ask.

Learning

Abdominal pain – All women with abdominal pain to attend triage.

Referral to PNMH for women with moderate/severe depression

Provide an initial supply of Aspirin at booking if needed.

Appropriate referral to preterm prevention if history of cervical trauma

MNSI Publications

The Shrewsbury and Telford Hospital NHS Trust

1 Final report received with 9 Safety Recommendations (Feb 2025)

- It is recommended that when a mother reports an elevated blood pressure taken using a home blood pressure monitoring device she is invited into the unit for review without delay.
- It is recommended that when a multidisciplinary review of abnormal day assessment unit test results takes place, a holistic assessment, reflective of all available clinical and laboratory information informs the time and location of subsequent care, supported by a digital record of the care planning discussion.
- It is recommended that the Trust provides decision making tools to mothers offered antihypertensive medication in pregnancy to ensure that they are informed of the side effects and the risk of hypoglycaemia in the neonate.
- It is recommended that the Trust supports staff to undertake a complete physical examination of a baby where it has been escalated the baby is jittery to enable a full assessment of their wellbeing.
- It is recommended that the Trust supports staff to attend the local blood gas analyser training session to ensure up to date knowledge and accurate use of the equipment.
- It is recommended that the Trust supports the use of available feeding assessment tools to enable parents and staff to monitor the frequency and effectiveness of babies' feeds.
- It is recommended that the Trust ensures all staff providing feeding support to mothers, including 'bank staff', have completed the required infant feeding training before supporting mothers with feeding.
- It is recommended that the Trust updates their local jaundice guidance in line with national guidance to ensure babies who are being treated with phototherapy have their hydration monitored.
- It is recommended that the accuracy and timeliness of documentation is prioritised to ensure patient records are complete and support continuity of care.

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

The Shrewsbury and Telford Hospital NHS Trust

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

The Shrewsbury and Telford Hospital NHS Trust

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 (commenced April 2025)

Reintroduction Team of the Shift

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

Thank you

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting: June 2025

Agenda item		CNST INFORMATION PACK		
Report Title		Minutes of the Quad/Safety Champions Bimonthly Meeting		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Jacqueline Bolton, Interim Head of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community	√	
Effective		Our people	√	
Caring		Our service delivery	√	**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, June 2025 W&C Divisional Committee Meeting, June 2025 Quality and Safety Assurance Committee, June 2025 LMNS/PNQSG march 2025, BoD June 2025.		
Executive summary:		These are the minutes from the quarterly Safety Champions/W&C Quad meeting as per Safety Action 9.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with CNST Safety Action 9.		
Appendices:		None		

The Shrewsbury and Telford Hospital NHS Trust

Perinatal Quad / Board Safety Champions BiMonthly Meeting
28th May 2025
MS Teams
MINUTES

In Attendance	Jacqui Bolton (JB)	Interim Head of Midwifery
	Mei-See Hon (MSH)	Obstetric Clinical Director
	Stephen McKew (SMc)	Deputy Executive Medical Director
	Wendy Nicholson (WN)	Non-Exec Director
	Julie Plant (JP)	Divisional Director of Nursing
	Andrew Sizer (AS)	Divisional Medical Director
	Jay Atkinson (JA)	W&C Director of Operations

	Welcome and apologies
	Welcome and apologies were noted as above. This meeting has been set up to satisfy the ask of Safety Action 9.
	Declarations of Conflicts of Interest
	No declarations made.
	Perinatal Culture and Leadership Development Programme (PCLDP)
	MSH shared that The Perinatal Culture and Leadership Development Programme is currently being integrated into other work streams within the division. This integration aims to avoid duplication of efforts and ensure that the cultural improvement work aligns with existing initiatives. A relaunch of the programme is scheduled for June 25th, during which the team will review the progress made so far, update the cultural plans, and set new directions for the future. This relaunch will involve key stakeholders, including senior leadership, to ensure a comprehensive approach to cultural development. The goal is to create a supportive environment that fosters positive cultural change across the division.
	Understanding Local Culture
	During the meeting, the recent staff survey results were discussed, revealing positive feedback from neonatal services and marginal drops in maternity. The neonatal team received praise for their positive survey results, attributed to recent improvements in leadership and team organisation following an external review. This review helped rally the team and reduce anxiety, leading to a more positive outlook. The Maternity survey results showed only slight declines, which were not statistically significant but still indicated areas needing attention. The discussion highlighted the importance of a ground-up approach to cultural improvement, where staff at all levels are involved in identifying and

	implementing changes. This approach aims to create a supportive environment that fosters positive cultural change and improves staff morale. WN suggested learning from other departments, such as the Emergency Department (ED), which had shown positive staff survey results despite facing significant challenges. This could provide valuable insights into effective strategies for improving staff morale and culture in maternity services. Overall, the discussion highlighted the critical role of staff morale in achieving the division's goals and the need for continuous efforts to support and engage staff in cultural improvement initiatives
	Cultural Score Survey
	The cultural survey results were previously integrated into the original culture improvement plan. This plan was developed to address the findings from the survey and guide the division's efforts in improving the workplace culture. Further updates on the cultural improvement plan and the integration of the survey results will be provided after the workshop scheduled for June 25th. This workshop aims to review the progress made so far, update the cultural plans, and set new directions for future initiatives.
	Safety Champions Dashboard
	JB mentioned that the safety intelligence dashboard continues to be populated with relevant data. The importance of the safety champions meetings was discussed, highlighting the value of feedback from walkabouts and the need for a settled schedule to ensure consistent participation. WN highlighted that engaging staff through these meetings is crucial for transparency and addressing issues promptly. It was noted that the feedback from staff during walkabouts has led to quick escalations and resolutions of concerns, demonstrating the effectiveness of these interactions. MSH requested an updated safety champions poster to reflect the current personnel, as the existing poster contained outdated information. This update is necessary to ensure accurate representation of the safety champions and maintain clear communication with staff.
	AOB
	Celebrating Achievements: WN suggested finding a platform to celebrate the excellent work happening within the Trust. This could be done internally or through a larger conference involving regional and national participants. **Support for Cultural Programme:** JA indicated that after the workshop on June 25th, there might be a need for additional support to drive the cultural programme forward.

	Closing remarks
	Meeting closed.
	Date of Next Meeting
	Monday, 23rd June 2025

Appendix 1. Summary of the progress against delivery of the SaTH Governance, Leadership Improvement Plan

The Shrewsbury and Telford Hospital NHS Trust

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.0	Continue to review current SATH internal governance structure to support oversight and assurance:	Anna Milanec	Already started	31/03/2026	Complete – Governance diagram in place which supports this. New HTP Assurance Committee established in 2024, along with Performance Assurance Committee and Finance Assurance Committee.	Completed and Evidenced by SaTH
SaTH 4.1.1	Following recent changes, review level 1 finance governance reporting structure (Link with SaTH1.1, SaTH1.2, SaTH1.3)	Debbie Bryce	01/12/2024	28/02/2025	The Finance and Assurance Committee (FAC) was established as a separate committee of the Board in September 2024. FAC terms of reference and associated groups currently under review. FAC effectiveness survey was undertaken in February 2025 and reported to the March FAC meeting.	Completed and Evidenced by SaTH
SaTH 4.1.2	Review level 1 Workforce governance reporting structure (Link with SaTH 2.1 and SaTH 2.2)	Debbie Bryce	01/12/2024	28/02/2025	PODAC terms of reference were reviewed and agreed by PODAC on 02/12/24 and approved by Board on 16/1/25. PODAC effectiveness survey was undertaken in February 2025 and considered on 7 April at the PODAC meeting.	Completed and Evidenced by SaTH
SaTH 4.1.3	Review level 1 UEC / performance governance reporting structure (link to SaTH 3.1 and 3.2)	Debbie Bryce	01/12/2024	28/02/2025	PAC was established as a separate committee of the Board in September 2024. Terms of reference currently under review for PAC and UECTAC. PAC effectiveness survey scheduled for July/Aug 2025 following discussion with the committee chair. UEC reporting into QSAC for quality and safety items was added to QSAC terms of reference which were considered at QSAC on 25 March 2025. UEC reports into PAC for performance elements.	Completed and Evidenced by SaTH
SaTH 4.1.4	Review level 1 HTP Committee governance framework in conjunction with above	Anna Milanec	01/12/2024	28/02/2025	(Anna's action). As a new committee of the Board, the terms of reference were agreed by Board in July 2024. Terms of reference are in date and are next due for review again in July 2025.	Completed and Evidenced by SaTH
SaTH 4.1.5	Review level 1 Quality & Safety Assurance governance framework in conjunction with above	Anna Milanec	01/01/2025	28/02/2025	QOC terms of reference approved by QSAC in February 2025. QSAC terms of reference annual review scheduled for March 2025 meeting. QSAC effectiveness survey undertaken February 2025 and considered at QSAC on 25 March 2025.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.6	Produce level 1 assurance mapping template	Anna Milanec	01/01/2025	28/02/2025	High level mapping template in place and presented to the Board in January 2025 as part of SIIP update.	Completed and Evidenced by SaTH
SaTH 4.1.7	Review, adjust and incorporate any gaps highlighted by assurance map	Anna Milanec	28/02/2025	31/03/2025	UECTAC reporting into QSAC for quality and safety elements has been added to QSAC terms of reference 25 March 2025 – agreed by QSAC and will be scheduled for May public Board approval.	Completed and Evidenced by SaTH
SaTH 4.1.8	SaTH Board to approve changes to internal level 1 governance structure as required	Anna Milanec	28/02/2025	31/03/2025	High level mapping template in place and presented to Board in January 2025 as part of SIIP update.	Completed and Evidenced by SaTH
SaTH 4.1.9	Review level 2 finance governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	~~31/03/2025~~ ~~30/06/2025~~ 31/08/25	Capital Planning Group terms of reference considered and approved by the Finance Assurance Committee on 25 March 2025. Financial Recovery Group (FRG) is in place and is part of the weekly CEO meeting. Terms of reference have been drafted for Financial Recovery Group and are currently under review.	
SaTH 4.1.10	Review level 2 UEC / performance governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	31/03/2025	UECTAC terms of reference were agreed August 2024 and are due for review August 2025. This reports into PAC and QSAC (addition to QSAC terms of reference agreed by QSAC 25 March 2025).	Completed and Evidenced by SaTH
SaTH 4.1.11	Review level 2 Workforce governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	~~31/03/2025~~ ~~02/06/2025~~ 31/08/25	Strategic People Group (SPG) terms of reference reviewed by the corporate governance team in April 2025 and reviewed by the people team at 6 May 2025 SPG meeting, returning at 3 June SPG meeting. Due for approval at the 04 August 2025 PODAC meeting.	
SaTH 4.1.12	Continually review / update as required committee / group TORs, agendas and workstreams to ensure they reflect focus on new / amended requirements	Anna Milanec / Debbie Bryce	Ongoing	31/03/2026	Business as usual work and processes embedded. Schedule of terms of reference reviews/agendas/workstreams in place and included within cycles of business for committees and groups.	Completed and Evidenced by SaTH
SaTH 4.1.13	Review monthly integrated performance reports to Board to ensure continued focus on essential elements	Inese Robotham	01/12/2024	31/03/2026	Once the Operational Plan is approved the KPIs for the main objectives will be aligned with the Operational Plan 2025/26. The KPIs have been drafted in preparation for this.	

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.14	Reporting from collaborative workstreams into SATH governance to commence	Anna Milanec	28/02/2025	30/01/2026		
SaTH 4.2.1	Agreement of SIIP approval and ongoing assurance arrangements within SaTH.	Jo Williams	Ongoing	14/11/2024	SaTH elements of the system performance & accountability framework have been developed and implemented. This was signed off at the Board of Directors meeting held on 14 November 2024 and discussed on 16 January 2025. (Board paper and minutes Evidence SaTH 4.2.1) (Assurance Committee, Key Issues Reports (4A's.)	Completed and Evidenced by SaTH
SaTH 4.2.2	SaTH elements of system performance & accountability framework documented and signed off by SATH board	Jo Williams/ Anna Milanec	01/11/2024	30/01/2025	SaTH elements of system performance & accountability framework was signed off by SATH Board of Directors in February 2025	Completed and Evidenced by SaTH
SaTH 4.2.3	Development of governance arrangements to deliver UEC performance, via a provider collaborative arrangement	Anna Milanec	Already started	31/03/2025	See 4.2.3	Completed and Evidenced by SaTH
SaTH 4.2.4	Review SATH SO's, SFI's, SORD to support the creation and operation of provider collaborative arrangements	Anna Milanec	Already started	31/03/2025	Review of SO's, SFI's and SoRD complete for 2024/25. Reviewed annually and approved by Board. Provisions in place for collaborative arrangements.	Completed and Evidenced by SaTH
SaTH 4.2.5	SaTH Board to consider and approve TOR / MOU / appropriate delegations to enable the creation and operation of provider collaborative arrangements	Anna Milanec	01/12/2024	31/03/2025	Provider collaborative arrangement need to be reviewed	Completed and Evidenced by SaTH
SaTH 4.3.1	SATH Risk Manager, James Webb, appointed the lead liaison role with ICS colleagues.	Anna Milanec	Already started	31/03/2025	Completed on 08/08/2024 – SaTH Risk Manager-liaising with ICS Colleagues'.	Completed and Evidenced by SaTH
SaTH 4.3.2	Engage with governance leads to develop risk management policies that all align with consistent risk language, scoring, risk management reporting procedures.	Anna Milanec	Already started	31/03/2025	Completed analysis of similarities across ShropCom, RJAH, SaTH and ICB Risk Management Policies on 16/01/2025	Completed and Evidenced by SaTH
SaTH 4.3.3	Engage with STW Provider Governance Leads to co-ordinate implementation of risk register accessible to all	Anna Milanec	Started	30/06/2025	Last correspondence was sent by James Webb to Alison Smith, Executive Lead, Governance and Engagement, on 16/01/2025	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.3.4	Approve new Risk Management Policy by SATH Board	Anna Milanec	01/01/2025	~~31/0/2025~~ 31/07/2025	The new Risk Management Policy and Risk Management Strategy is under review	
SaTH 4.3.5	Review timing of each organisation's risk management strategy review	Anna Milanec	01/01/2025	01/04/2025	Completed on 19.03.2025	Completed and Evidenced by SaTH
SaTH 4.4.1	Engage with programme / governance leads to develop and implement proposals.	~~Nigel Lee~~ Ned Hobs	31/12/2024	28/02/2025	System PMO Steering Group established Jan 2025, with SaTH COO as member. Fortnightly meetings held.	Completed and Evidenced by SaTH
SaTH 4.4.2	SaTH elements of system PMO structure & approach documented and signed off by SATH board and ICB	~~Nigel Lee~~ Ned Hobs	01/11/2024	~~28/02/2025~~ 08/05/2025	The STW System PMO proposals and alignment of resources associated were agreed at the STW CEO's meeting. This followed formal approval by SaTH and STW ICB respective Boards in May 2025.	Completed and Evidenced by SaTH
SaTH 4.4.3	Continue to drive the delivery of a system PMO with all partners	~~Nigel Lee~~ Ned Hobs	01/11/2024	31/12/2026	The Trust continues to support the delivery of a system PMO within the STW Integrated Care System, the focus is on maintaining a collaborative approach with all partners, building on existing digital transformation initiatives, and addressing identified challenges.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Summary of the progress against delivery of the SaTH Workforce Delivery Plan, Leadership collaborative decision-making at both system and organisational levels (aligned to the priorities within the Strategic Commissioning Plan and System Culture and Leadership improvement programme

Appendix 2

Metric 2.1: SaTH workforce delivery plans for 2024/25 and 2025/26 aligned to overall system plans and signed off by the Board of Directors

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
2.1.1	Identify baseline and outturn forecast	SB	04/11/2024	30/11/2024	Workforce plan submission (2nd submission to the ICB due 31 January) - **Complete**	Completed and Evidenced by SaTH
2.1.2	Review known changes, service changes needed, and business cases approved from 24/25	BPs	01/12/2024	31/12/2024	2nd submission of the Workforce Plan to the ICB due 31 January 2025 This will include the submission of PODAC reports and IPR reports - **Complete**	Completed and Evidenced by SaTH
2.1.3	Outline any assumptions in terms of workforce metrics, turnover absence levels	SB	01/12/2024	31/12/2024	PODAC reports IPR reports **Complete**	Completed and Evidenced by SaTH
2.1.4	Populate Workforce Planning Template	RW	06/01/2025	31/01/2025	Workforce planning template is fully populated **Submitted as part of final operational plan March submission**	Completed and Evidenced by SaTH
2.1.5	Calculate the % Change by Staff Group	RW	06/01/2025	31/01/2025	Once the workforce plan is finalised for the 2nd submission this will be calculated as part of the template. **Submitted as part of final operational plan March submission**	Completed and Evidenced by SaTH
2.1.6	Challenge / Sense Check Data	RW	03/02/2025	28/02/2025	**Complete**	Completed and Evidenced by SaTH
2.1.7	Review Data with Stakeholders (Divisional teams etc)	SB	03/02/2025	28/02/2025	Divisional planning meetings 3rd and 4th February 2025. **Presented at Senior Leadership Meeting**	Completed and Evidenced by SaTH
2.1.8	Populate Master Template and Triangulate with Finance and Operations	SB	03/02/2025	28/02/2025	**Submitted as part of final operational plan March submission**	Completed and Evidenced by SaTH
2.1.9	Final Sign Off - Board and NHSE	RB	03/03/2025	31/03/2025	Due end March 2025	Completed

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
						and Evidenced by SaTH
2.1.10	Set up and deliver workshop with People and OD team and Divisional reps to identify the priority areas needed that support delivery of our workforce plan	SB/EW	04/11/2024	30/11/2024	Operational Plan Stocktake meeting held 17th December 2024 **Complete**	Completed and Evidenced by SaTH
2.1.11	Develop set of actions and milestones that support each priority area with time frame and actions owners	SB/EW	02/12/2024	31/12/2024	Pro forma developed for divisional planning meetings scheduled 3rd and 4th February 2025. **Complete**	Completed and Evidenced by SaTH
2.1.12	Finalise plan with fully supported narrative describing the impact and benefit of delivery the plan	SB/EW	02/12/2024	31/12/2024	First cut of plan drafted for review.	Completed and Evidenced by SaTH
2.1.1	Capture risks to delivery of plan and any mitigations to reduce risk	SB/EW	02/12/2024	31/12/2024	Risks captured with mitigations aligned to People Strategy. Risk Register, BAF & PODAC Assurance reports	Completed and Evidenced by SaTH
2.1.14	Develop summary project plan showing high level timescale – Gantt chart	SB	02/12/2024	31/12/2024	Draft actions developed timelines drafted **Complete**	Completed and Evidenced by SaTH
2.1.15	Gain sign off from each provider and NHS England	RB	06/01/2025	31/01/2025	Need to gain approval by NHSE will need to extend timeframe to 31 March 2025 for final approval.	Completed and Evidenced by SaTH
2.1.16	Ensure actions and milestones monitoring is incorporated into fortnightly agenda of workforce planning and assurance group and Agency reduction group	SB	06/01/2025	31/01/2025	Due end January 2025. Need to gain approval by NHSE will need to extend timeframe to 31 March 2025 for final approval.	Completed and Evidenced by SaTH

Metric 2.2: Refreshed SaTH People and OD strategy aligned to the system strategy

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
2.2.1	Deliverable Completed -People Strategy has been refreshed and approved by Board this year (2024). Includes how we will deliver strategy and what this will do to improve our key KPIS	EW	01/10/2024	31/01/2025	People Strategy	Completed and Evidenced by SaTH
2.2.2	Monitor delivery of strategy via our Strategic People Group. Monthly highlight reports used to demonstrate progress against milestones outline within the priority areas within our Board approved strategy.	SB/EW	01/10/2024	31/01/2025	PODAC assurance paper Various reports are brought to Strategic People Group for assurance, challenge, decision and discussion all aligned to the People Strategy. Assurance and progress is reported/ escalated to PODAC. **Complete**	Completed and Evidenced by SaTH
2.2.3	Strategy sets out key actions and deliverables that are aligned to the NHS People Plan and are underpinned by the NHS People Promise and NHS Future HR and OD Report.	SB/EW	01/10/2024	31/01/2025	People Strategy **Complete**	Completed and Evidenced by SaTH
2.2.4	A set of metrics are outlined with target KPI's that support improvement in workforce retention, unavailability and staff engagement.	SB/EW	01/10/2024	31/01/2025	People Strategy IPR- monthly Culture Dashboard **Complete**	Completed and Evidenced by SaTH

SaTH Transition Criteria 5 Progress Report for Leadership: Demonstrate collaborative decision-making at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.

Metric 5.1: Individual SaTH elements of the functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by Integrated Care Board) where open and honest conversations are brokered.

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
5.1.3	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of Workforce	RB	In progress	31/03/2026	Chief People Officer and deputy's roles working across SaTH and SCHT. SaTH continues to support system programmes such as EDI, T Level placements, Workforce information. SRO for ICS TRAIN and REFORM work programmes. ICS report on future People Model received by ICB December 2024.	Completed and Evidenced by SaTH

Metric 5.4: SaTH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
5.4.4	Analyse staff survey results and lead on development and delivery of associated action plan	EW	Jan 2025	Aug 2025	PODAC / Board Reports April-July 2025. Initial Staff survey results received. Shared internally (under embargo) development of plans in progress.	Completed and Evidenced by SaTH
5.4.5	Analyse pulse survey results and lead on development and delivery of associated action plan	EW	Jan 2025	Aug 2025	PODAC reports April 2025 Pulse survey results analysed and reported to Strategic People Group and PODAC. Inform strategy milestones to deliver our vision.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 3. Summary of the progress against delivery of the SaTH Financial Recovery Plan

The Shrewsbury and Telford Hospital NHS Trust

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.1.1	MTFP planning assumptions matched to HTP with differences reconciled and base case modelled and updated in the system MTFP.	JB	Complete	Complete	System MTFP and bridge document to HTP assumptions.	Completed and Evidenced by SaTH
SaTH 1.2.	24/25 Revenue Plan agreed by SaTH, ICS and NHSE and fully identified CIP plan.	AW	Complete	Complete	FPR submission for 2024/25 and CIP updates to FIP showing plans identified.	Completed and Evidenced by SaTH
SaTH 1.1.2	Annual refresh of MTFP and 5-year high level financial plan (including triangulation)	AW	Commenced	Dec-25		
SaTH 1.1.3	Ongoing monitoring of underlying position against MTFP and HTP assumptions	AW	Ongoing	Mar-26		
SaTH 1.1.4	SaTH Demand and capacity model aligned to system model - 1 year model (Sept/Oct 24) 3-5 years (Mar 25).	AW	Sep-24	Mar-25	Completed - SaTH Demand and capacity model aligned to system model - 1 year model (Sept/Oct 24) 3-5 years.	Completed and Evidenced by SaTH
SaTH 1.1.5	Cashflow requirements matched to MTFP modelled. (Mar 25)	AW	Oct-24	Mar-25	Completed - Cashflow requirements matched to MTFP modelled.	Completed and Evidenced by SaTH
SaTH 1.1.6	Triangulation to activity, workforce and performance and updated for 25/26 operational planning guidance. (Dec 24-Jan 25).	KR	Dec-25	~~Jan 25~~ Mar 25	As a consequence of the DWH issues the 2025/26 integrated plan is using the 2024/25 plan as its baseline for all 3 elements of the plan. In addition to this any changes to each of the elements are amended accordingly, therefore the catchment internal plan will triangulate. Triangulation is ongoing and will be completed as part of the final planning submission in March 25. The Operational Activity Plan was signed off at the Board of Directors meeting held on 25 March 2025.	Completed and Evidenced by SaTH
SaTH 1.1.7	Long-Term financial plan model to include full impact of HTP - capital and revenue (complete) - updated to match the system LTFP. (Mar 2025).	SE	Oct-24	~~Mar 25~~ Apr 25	Partially completed - Long-Term financial plan model includes full impact of HTP. System medium term financial plan shared with further discussions at local finance committees in April 25.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.1.8	Signed off LTFP High Level Model 10 year - SaTH/ICS/NHSE	SE	Oct-24	~~Mar 25~~ ~~Apr 25~~ ~~May 25~~ ~~Jun 25~~ Jul 25	To be updated following sign off of FY25/26 financial plan. Additional support from PA Consulting to update the model.	
SaTH 1.1.9	Recovery plan trajectory based on Strategic Transformation Programmes including HTP, LCP and Benchmarking opportunities updated in SaTH and system MTFP model. (Mar 2025)	CMc	Oct-24	~~Mar 25~~ ~~Apr 25~~ ~~May 25~~ Jun 25	Work is underway to develop an overarching recovery plan that incorporates CIP planning and delivery, alongside developing a roadmap for financial sustainability from FY25/26 through to full implementation of HTP that is aligned with LCP and benchmarking opportunities. System MTFP to be shared with local FAC's during May and ICB Boards in June.	Completed and Evidenced by SaTH
SaTH 1.1.10	Triangulation to activity, workforce and performance and updated for 25/26 operational planning guidance	KR	Started	Mar-25	Completed as part of the operational plan submission for FY25/26 which was approved at Board on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.2	25/26 Revenue Plan agreed by SaTH, ICS and NHSE	AW	Commenced	Mar-25	The Revenue Plan was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.3	25/26 Draft efficiency schemes high level	CMc	Commenced	Nov-24	Seven themes identified and shared with FIP. Formal presentation to internal Efficiency and Sustainability Group.	Completed and Evidenced by SaTH
SaTH 1.2.4	25/26 Draft efficiency schemes detail	CMc	Commenced	Jan-25	Draft efficiency schemes presented to Efficiency and Sustainability Group and Financial Recovery Group in January 2025.	Completed and Evidenced by SaTH
SaTH 1.2.5	25/26 Draft efficiency confirm & challenge with FRG	CMc	Commenced	Feb-25	CIP confirm & challenge sessions held with divisional and corporate teams as planned, good engagement in the process from all teams. Two service areas have been identified as requiring additional support from the recovery taskforce and PWC to further develop their plans to address the shortfall in their current planning. Outputs and escalation if required, further to this intervention, will be reported through to the executive led Financial Recovery Group.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.2.6	25/26 Efficiency plan identified	CMc	Commenced	Mar-25	Efficiency plan for 25/26 identified. All evidence is filed on a newly implemented CIP tracker.	Completed and Evidenced by SaTH
SaTH 1.2.7	25/26 Efficiency plan PIDs signed off by scheme leads and directors	CMc	Commenced	~~Mar 25~~ ~~Apr 25~~ May 25	Efficiency planning has been undertaken via a programme management gateway process. Current gateways statuses are as follows: • Opportunity: £0.1m • Plans in Progress: £4.4m • Fully Developed: £4.4m • In Delivery: £32.6m Really good progress has been made in recent weeks with a continued focus to ensure transition trough the gateways to reach 'in delivery' status.	Completed and Evidenced by SaTH
SaTH 1.2.8	25/26 Efficiency plan QIA's developed by clinical leads	CMc	Commenced	~~Mar 25~~ ~~Apr 25~~ May 25	A robust plan is now in place to ensure that PIDS cannot progress through to 'plans in progress' gateway without having a QIA completed by an appropriate clinical lead. Linked to 1.2.7 above.	Completed and Evidenced by SaTH
SaTH 1.2.9	25/26 Efficiency plan QIA's signed off by DoN and MD	CMc	Commenced	~~Mar 25~~ ~~Apr 25~~ May 25	A process has been established to ensure QIA's for PIDS that require DoN and MD sign is undertaken in a timely manner. Linked to 1.2.7 above.	Completed and Evidenced by SaTH
SaTH 1.2.10	25/26 draft operational activity plan based on D&C work	RP	Commenced	Nov-24	Draft activity submission to system in December. 2024	Completed and Evidenced by SaTH
SaTH 1.2.11	25/26 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions	RP	Commenced	~~Jan 25~~ Mar 25	As a consequence of the DWH issues the 2025/26 integrated plan is using the 2024/25 plan as its baseline for all 3 elements of the plan. In addition to this any changes to each of the elements are amended accordingly, therefore the catchment internal plan will triangulate. Triangulation is ongoing and will be completed as part of the final planning submission on March 25.	Completed and Evidenced by SaTH
SaTH	25/26 sign off operational activity plan	Ned	Commenced	Mar-25	The 2025/26 Operational Activity Plan was signed off at	Completed

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
1.2.12		Hobbs			the Board of Directors meeting on 25th March 2025.	and Evidenced by SaTH
SaTH 1.2.13	25/26 sign off workforce plan aligned to activity delivery	SB	Commenced	Mar-25	The 2025/26 Workforce Plan aligned to activity delivery was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.14	25/26 triangulation of finance, activity and workforce	AW / KR	Commenced	Mar-25	Completed as part of the operational plan submission for FY25/26 which was approved at Board on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.15	25/26 draft cost pressures	AW	Commenced	Nov-24	High level cost pressures included within draft planning submission in December 2024. High level financial planning update to Finance Assurance Committee in December. Further discussions are ongoing as part of the 2025/26 planning process.	Completed and Evidenced by SaTH
SaTH 1.2.16	25/26 cost pressures prioritization.	AW	Commenced	Nov-24	High level cost pressures included within draft planning submission in December 2024. High level financial planning update to Finance Assurance Committee in December. Further discussions are ongoing as part of the 2025/26 planning process.	Completed and Evidenced by SaTH
SaTH 1.2.17	25/26 cost pressures internal confirm and challenge.	AW	Commenced	Dec-24	High level cost pressures included within draft planning submission in December 2024. Further discussions are ongoing as part of the 2025/26 planning process with Divisional C&C meetings to take place in February.	Completed and Evidenced by SaTH
SaTH 1.2.18	25/26 cost pressures system confirm and challenge	AW	Jan-25	Jan-25	25/26 cost pressures system confirm and challenge	Completed and Evidenced by SaTH
SaTH 1.2.19	25/26 organisational sign off draft plan submission	AW	Commenced	Feb-25	25/26 organisational sign off draft plan submission	Completed and Evidenced by SaTH
SaTH 1.2.20	25/26 organisational sign off final plan submission	AW	Commenced	Mar-25	25/26 organisational sign off final plan submission and was signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.2.21	25/26 budget setting – pay / non pay completed	AW	Commenced	Jan-25	25/26 budget setting – pay / non pay completed	Completed and Evidenced by SaTH
SaTH	25/26 budget sign off	AW	Commenced	Mar-25	25/26 budget was signed off at the Board of Directors	Completed and

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
1.2.22					meeting on 25th March 2025.	Evidenced by SaTH
SaTH 1.2.23	In year monitoring of financial performance against plan assumptions identifying escalation actions where needed (oversight through OPOG, FRG and Finance Committee)	AW	Ongoing	~~Ongoing~~ Mar-26	PFR's, Finance Assurance Committee, Board and system finance reports.	
SaTH 1.2.24	Monitor ongoing demand & capacity actuals against plan assumptions identifying escalation actions where needed (oversight through OPOG and Performance Committee)	RP	Ongoing	~~Ongoing~~ Mar-26	Data warehouse reporting issues remain. Performance targets continue to be reported.	
SaTH 1.3.1	Sign off 3-Year Capital Plan - SaTH/ICS/NHSE	AW	Commenced	Mar-25	10-year Draft Capital Plan developed. 5-Year Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.2	10-Year first draft capital plan developed. (Complete)	AW	Complete	Mar 25	Complete – System submission of 10-year draft Capital Plan.	Completed and Evidenced by SaTH
SaTH 1.3.3	Capital MTFP update following capital allocations and guidance (Jan 25).	AW	Commenced	Jan-25	5-year capital plan submitted to CPG 5-Year Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.4	24/25 Capital Plan agreed by SaTH/ICS/NHSE (Complete).	AW	Complete	Complete	FPR submission for 2024/25	Completed and Evidenced by SaTH
SaTH 1.3.5	Update SaTH Estates Strategy	LW	Commenced	~~Nov-24~~ ~~May 25~~ ~~Jun 25~~ ~~Jul 25~~ Sept 25	The final draft of the Estate Strategy has been produced to include the configuration of the Modular wards. Following engagement with stakeholders during March and April 25, and in light of ongoing contributions from staff and stakeholders, we are aiming for Public Board sign-off in September 2025.	
SaTH 1.3.6	Sign off of 25/26 capital plan by SaTH/ICS and NHSE (Mar 25).	AW	Commenced	Mar-25	5-Year Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.3.7	Support system delivery of 24/25 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG.	AW	Apr-24	~~Mar-25~~ April 2025	This is on track for delivery. 2024/25 figures will be reported in April 2025.	Completed and Evidenced by SaTH
SaTH 1.3.8	Support system delivery of 25/26 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG.	AW	Apr-25	Mar-26		
SaTH 1.3.9	Capital prioritisation within available resource for 25/26 once funding limits following guidance is confirmed.	AW	Commenced	Mar-25	FY25/26 Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.10	Update the 25/26 Capital plan following the release of national capital guidance and sign-off by individual organisation and system governance and NHSE.	AW	Commenced	Mar-25	FY25/26 Capital Plan signed off at the Board of Directors meeting on 25th March 2025.	Completed and Evidenced by SaTH
SaTH 1.3.11	Submission of agreed 25/26 capital plan into technical planning forms	AW	Jan-25	Mar-25	Submitted to NHSE as part of the planning submission.	Completed and Evidenced by SaTH
SaTH 1.4.1	Phase 1 I&I - External review assessment of Individual organisational self-assessment of NHSE grip and control checklist & HFMA Financial Sustainability checklist.	AW	Complete	Complete	Phase 1 PwC external review assessment report completed.	Completed and Evidenced by SaTH
SaTH 1.4.2	Delivery against Phase 1 I&I organisation specific intervention action plans (Enhance vacancy scrutiny panels, temporary staffing controls and de-risking cost efficiency schemes). Monitored weekly and reported to ICS.	AW	Commenced	Nov-25		
SaTH 1.4.3	Delivery of Phase 2 I&I scope in relation to controls (run-rate improvements) for Workforce, UEC and System PMO (high risk CIPs) - delivery of interventions post PWC Phase 2 completion by March 25.	AW	Commenced	Mar-25	Phase 2 PwC scope completed. Phase 3 PWC scope near to completion	Completed and Evidenced by SaTH
SaTH 1.4.4	Follow up review of I&I actions to ensure continued delivery.	AW	Aug-25	Oct-25		

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 1.4.5	External review of individual organisational assessment against NHSE grip and control checklist & HFMA Financial Sustainability checklist and efficacy of controls.	AW	Complete	Feb 25	Complete - Audit review of HFMA checklist and full review of NRST list reported to Board.	Completed and Evidenced by SaTH
SaTH 1.4.6	Delivery of individual organisational internal audit report recommendations from prior years and pro-active management in year (Monthly review).	AW	Ongoing	Mar-26		
SaTH 1.4.7	Individual organisational tracking of timely completion of internal audit actions (Monthly).	AW	Ongoing	Mar-26		
SaTH 1.4.8	Delivery of individual organisational external audit report recommendations	AW	Ongoing	Mar-26		
SaTH 1.4.9	Individual organisational tracking of timely completion of external audit actions (Monthly)	AW	Ongoing	Mar-26		
SaTH 1.4.10	Internal Audit findings for all finance related audits to be rated moderate or substantial	AW	Ongoing	Mar-26		
SaTH 1.4.12	External audit including VFM to be rated moderate or substantial	AW	Ongoing	Mar-26		

BRAG Status
Completed and evidenced
On Track
At Risk
Off Track

3.1	**Deliver SaTH elements / benefits of the System led UEC Improvement Plan 24/25 and 25/26 plan (to be finalised when national guidance for 25/26 is published)**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.1	Deliver SaTH specific workstreams	Ned Hobbs	01/04/2024	31/03/2026		
SaTH 3.1.2	Actively engage with and make a marked contribution to system wide workstreams	Jo Williams Ned Hobbs	01/04/2024	31/03/2026		
3.1.1	**Lead workstream 1 – 4hr performance plan incorporating GIRFT actions**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.1.1	Review and recommission UTC provision to increase utilisation	Rebecca Houlston	01/10/2024	~~01/04/2025~~ 31/03/2026	UTC provision was transferred to SaTH on the 1st April 2025. Trajectory for 2025/26 developed to increase utilisation of UTC to a position of 25% of all SaTH attendances to be treated as Type 3 by 31/03/2026 following recommissioning of service. Workstream formed to deliver trajectory	
SaTH 3.1.1.2	Implement admission avoidance clinics to reduce demand on ED	Gordon Wood	01/04/2024	30/11/2024	General medicine clinics implemented and running on Mondays and Fridays for internal referrals from ED. Booking process and utilisation provided as evidence	Completed and Evidenced by SaTH
SaTH 3.1.1.3	Implement further GP direct access speciality pathways across Women's and Children's services	Zain Siddiqui	12/05/2024	01/04/2025	Direct access in place for Gynae and EPS via GATU, further pathways are being reviewed as part of a new Direct Access / SDEC Pathways workstream within the Capacity and Flow Programme.	
SaTH 3.1.1.4	Implement GP direct access speciality pathways across surgical services	Andrena Weston	12/05/2024	~~01/04/2025~~ 31/03/2026	Direct access pathways workstream formed. Pathway development for 2025/26 is being scoped with back pain for T&O and skin conditions for Dermatology as potential first steps	

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.1.5	Improve productivity of Minors	Rebecca Race Rebecca Houlston Nat Rose Deb Archer	13/05/2024	~~01/01/2025~~ 31/03/2026	Minors 4-hour performance in April 2025 was at 76.3% (unvalidated position) and remains off track against the operational plan trajectory of 95%. Attendances remained high across both hospital sites. Further recovery planned in May 2025 for roll out in June 2025 at PRH including a stream to minors clinical model.	
SaTH 3.1.1.6	Review ED Medical staffing to ensure it aligns with the hourly demand with both ED departments	Rebecca Race	31/05/2024	31/12/2024	Briefing paper based on demand and capacity analysis completed by Chris Green – Head of Information ECIST, NHS England	Completed and Evidenced by SaTH
3.1.2	**Lead workstream 2 Acute Med & Admission and Referral Protocol (IPS) incorporating GIRFT actions**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.2.1	Improve response time to referrals on the AMU & Medical wards (currently 24 hours) by Cardio and Respiratory	Saskia Jones-Perrott	21/05/2024	30/04/2025	Electronic referral forms implemented and embedded for Cardiology and Respiratory services. Approved at UECTAC	Completed and Evidenced by SaTH
SaTH 3.1.2.2	Review effectiveness of the Admission and Referral Protocol following relaunch	Steve McKew	24/05/2024	30/04/2025	Observational exercise via GIRFT scheduled in June 2025 as part of PRH ED improvement week to monitor adherence to protocol	
SaTH 3.1.2.3	Reconfiguration of bed base on PRH site to expand acute medical beds to align with demand	~~Laura Graham~~ Hannah Walpole	01/11/2024	01/07/2025	Working group established to co-ordinate required moves and estate works to establish additional required capacity	
SaTH 3.1.2.4	Recruitment following reconfiguration of Cardiorespiratory to optimise diagnostics	Tom Phelps	31/05/2024	31/03/2025	Cardiorespiratory service has transferred to Clinical Support Services division and recruitment has continued and is ongoing to a number of different roles.	
SaTH 3.1.2.5	Therapies: Review the use of SPA time and the SOP updating if required	Emma Weaver	01/07/2024	30/11/2024	Staff survey completed on the use of SPA time.	Completed and Evidenced by SaTH

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.2.6	Therapies: Review the impact of the E-job planning trial and agree next steps	Emma Weaver	01/07/2024	30/11/2024	Initial review completed next steps are to undertake a revalidation exercise and arrange a series of 1:1 meetings with staff to sense check if their job plans are where they need to be. To add individual objectives to the system including Trust, Therapy and Care Close to Home objectives.	Completed and Evidenced by SaTH
SaTH 3.1.2.7	Therapies: Review Stroke Pathways considering the opportunities as outlined in the CQC report	Emma Weaver	01/07/2024	31/12/2024	Review of the Stroke pathway has informed the Business Case under consideration by Clinical Support Services division	Completed and Evidenced by SaTH
SaTH 3.1.2.8	Radiology: Gap analysis against proposed 12hr turnaround	Helen Williams	01/10/2024	~~31/10/2024~~ 28/02/2025	Analysis of "request to report" data completed. An exception report was presented and approved at UECTAC held on 23 January 2025.	Completed and Evidenced by SaTH
SaTH 3.1.2.9	Radiology: 12hr turnaround draft proposal including procedures and SOP	Helen Williams	01/10/2024	~~30/11/2024~~ 31/05/2025	Additional onsite observations have been completed by the Improvement Hub which will inform the procedures and SoP.	
SaTH 3.1.2.10	Pharmacy: Development of business case for Pharmacy staff in ED	Imran Hanif	28/10/2024	30/11/2024	Business Case presented to the Innovation and Investment Committee in December 2024.	Completed and Evidenced by SaTH
SaTH 3.1.2.11	Pharmacy - Procurement / Installation / Staff Training / Go live of automated cabinets at PRH emergency dept.	Imran Hanif	21/10/2024	~~31/03/2025~~ 31/06/2025	The RSH ED automated cabinets were in March 2025. A period of staff training is ongoing both face to face and via e-learning prior to hand over. The PRH ED automated cabinets have been installed and go live in May 2025. Staff training commenced.	
SaTH 3.1.2.12	Pathology - Recruitment of additional posts to extend out of hours provision	Adrian Vreede	01/11/2024	31/03/2025	Recruitment of 1 WTE Biomedical Scientists, 6 WTE Medical Laboratory Assistants 1 WTE Associate Practitioner completed Additional recruitment approved at UECTAC May 2025	Completed and Evidenced by SaTH
3.1.3	**Working with system partners to deliver the System Discharge Alliance Plan to reduce No Criteria to Reside, and thus reducing escalation inpatient acute capacity (linking to reduced bed occupancy)**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.3.1	Continued engagement from surgery, medicine and ED with the Care Transfer Hub	Rebecca Houlston Angela Raynor Claire Evans	01/08/2024	31/03/2026		
3.1.4	**Working with system partners to deliver the alternatives to ED attendances / admissions and Care Coordination**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.4.1	Continued engagement from surgery, medicine and ED with the Integrated Care Coordination Centre	Rebecca Houlston Angela Raynor Claire Evans	01/08/2024	31/03/2026		
SaTH 3.1.4.2	Be a key stakeholder in the development of the STW integrated urgent care model	Ned Hobbs Jo Williams	01/10/2024	31/03/2026		
SaTH 3.1.4.3	Improving the data quality of ECDS to support identification of further alternative opportunities	Ned Hobbs	01/11/2024	31/03/2025	Improving the data quality of ECDS is ongoing	
3.1.5	**Working with system partners to deliver system frailty plan**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.5.2	Create and roll out a teaching package for ED and SDEC staff on Clinical Frailty Score	Angela Raynor	09/12/2024	31/03/2025	Training package is now available on LMS for staff to access.	
SaTH 3.1.5.4	Review Welsh documentation and link with Powys	Angela Raynor	10/02/2025	31/03/2025	Documentation has been reviewed, awaiting communication back from Powys.	
SaTH 3.1.5.5	Continued engagement from surgery, medicine and ED with the development of a fully integrated frailty pathway	Rebecca Houlston Angela Raynor Claire Evans	31/05/2024	31/03/2026	Integration of frailty pathway is progressing.	

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
3.2	**SaTH to chair UEC delivery group with effective regular membership from SaTH**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.2.1	SaTH CEO to continue to be SRO for UEC and chair the UEC delivery group	Jo Williams	01/04/2024	N/A		Completed and Evidenced by SaTH
SaTH 3.2.2	Ongoing attendance from key leaders in regard to operational and clinical functions	Ned Hobbs Laurence Ginder	01/04/2024	N/A	Ongoing attendance at key operational functions.	Completed and Evidenced by SaTH
3.3	**Deliver UEC specific actions as per the Quality Improvement Plan including CQC must/should dos and post "Dispatches" actions**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.3.1	Deliver QIP in line with agreed timescales	Donna Hadley	05/01/2024	~~01/04/2025~~ 31/03/2026	Two UEC Section 31 conditions remain relating to 15-minute triage for adults and children and patients left without being seen. There are now 22 specific actions associated with these 2 UEC conditions. Currently 19 actions are "complete" with 14 evidenced and assured and 5 Delivered, not yet evidenced.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting: 10 July 2025

Agenda item		Board Information Pack item		
Report Title		QSAC Chair's Annual Report (2024-25)		
Non-Executive Lead		Sarah Dunnett, Non-Executive Director		
Report Author		Sarah Dunnett, Non-Executive Director		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		BAF13
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	N/A
Well Led	√	Our partners		
Consultation Communication		Quality & Safety Assurance Committee – 27 May 2025		
Executive summary:		1. The terms of reference for the Trust's board assurance committees include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year. 2. This is the Quality & Safety Assurance Committee's annual report for the 2024-25 financial year.		
Recommendations to the Board:		The Board is asked to note the content of the QSAC Chair's annual report.		
Appendices:		-		

1.0 Introduction

1.1 The terms of reference for the Trust's Board assurance committees include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year.

2.0 Purpose

2.1 The purpose of the Quality & Safety Assurance Committee (QSAC) is to seek and obtain evidence of assurance on the effectiveness of the Trust's clinical quality and safety governance structure, systems, and processes and the quality and safety of the services provided to achieve consistently high-quality effective care, ensure continuous improvement and to meet legal and regulatory obligations.

3.0 Committee membership, meetings and terms of reference

3.1 The membership of the Committee was appointed by the Board of Directors and consists of not less than five members, as follows:

Committee Chair: a nominated Non-Executive Director
Two Further nominated Non-Executive Directors
Chief Nursing Officer (lead executive for the committee)
Executive Medical Director.

3.2 From September 2024, the Chair of QSAC changed from Non-Executive Director, Rosi Edwards, to Sarah Dunnett.

3.3 QSAC met 12 times in 2024-2025. The meeting in October 2024 was not quorate as there was one associate non-executive director in attendance, when Trust governance requires a non-executive director. Following the meeting, this was escalated and a request made for associate non-executive directors to be full members of the committee in line with other Trusts. The meeting attendance table is provided below:

Quality & Safety Assurance Committee Attendance 2024/25

			2024-2025											
Name	**Title**	**Role**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Rosi Edwards*	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Sarah Dunnett**	Non-Executive Director	Member	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Brown	Non-Executive Director	Member	✓	✓	✓	✓	✓	x						
Wendy Nicholson***	Non-Executive Director	Member		✓	✓	✓	x	x	✓	✓	x	✓	✓	✓
John Jones	Executive Medical Director	Member	✓	✓	✓	✓	✓	✓	✓	x*	✓	✓	✓	✓
Hayley Flavell	Executive Director of Nursing	Member	✓	✓	✓	x*	x*	✓	✓	✓				
Paula Gardner	Chief Nursing Officer	Member									✓	✓	✓	✓

* Rosi Edwards was QSAC Chair to August 2025 and Sarah Dunnett from September 2025
** Sarah Dunnett was appointed as a full Non-Executive Director from 08 October 2024
*** Wendy Nicholson MBE was appointed as a full Non-Executive Director from 01 January 2025

Note:
x* Denotes deputy in attendance
The October 2024 meeting was not quorate

3.4 During the year there has been regular attendance by observers from the Integrated Care Board.

3.5 Reports are typically presented to QSAC by the authors, who can answer questions raised by the committee.

3.6 All four of, or at least three of the Committee Chair, Committee Secretary, Chief Nursing Officer and Executive Medical Director meet well in advance of each QSAC meeting to agree the agenda, based on the cycle of business and other important matters, as part of a continuing process of focussing the agenda on assurance in support of the Board.

3.7 QSAC reviewed and agreed its terms of reference at its meeting in March 2025 and these were approved by the Board of Directors in May 2025. An update to the terms of reference was made in 2025 to amend the meeting quorum to require that one Executive Director out of the two Executive Director members and one deputy be present (instead of two executive directors being present). The terms of reference are reviewed annually.
3.8 During the year, there was a review of the frequency the committee receives reports which has allowed time for more in-depth discussions and reviews. This has supported the committee in its effective functioning and ability to:

- seek assurances about adherence to plans and identify where variance occurs
- oversee any allocated risks
- monitor the progress of remedial actions
- seek evidence of the impact of actions taken

3.9 The formation of the Performance Assurance Committee (PAC) in September allowed QSAC to focus on the quality and safety elements of care, while PAC focused on performance delivery. This will be further enhanced with the planned review of governance which will set out reporting channels of sub committees.

4.0 Principal Areas of Review (as per QSAC terms of reference)

4.1 At its meetings QSAC received reports, some in the 4A format (Alert, Assure, Advise, Action), on:

- Safeguarding.

- Infection Prevention and Control.

- Maternity: Maternity Dashboard, Maternity and Neonatal Safety Champions' Report, Maternity Transformation Assurance Committee, Director of Midwifery Safe Staffing Report, birth trauma gap analysis, and Community Midwifery Forward Plan.

- Neonatal MBRRACE update.

- Emergency Care Transformation Assurance Committee.

- Paediatric Care Transformation Assurance Committee.

- Quality Operational Committee reports and its terms of reference.

- QSAC received the Nursing, Midwifery and AHP Key Issues Summary Report for part of the year. It was then agreed for this to transfer to the People & OD Assurance Committee for oversight.

- The Quality Indicators Integrated Performance Report.

- Patient Safety Strategy Update, Patient Safety Incident Response Framework (PSIRF) update and PSIRF Policy.

- The Getting to Good report and the report on progress with the Care Quality Commission action plan, and the CQC Improvement Plan Update.
- Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS): QSAC received detailed papers on CNST, which can be lengthy, in order to agree what should progress to the board.
- The Board Assurance Framework was considered and debated every quarter, prior to Board. Total current risk scores were reviewed, along with gaps in control and assurance for the risks within QSAC's oversight.
- Corporate risk register - quality and safety risks.
- Biannual Nursing and Midwifery Staffing Reports.
- Therapy Improvement Strategy update.
- Health & Safety mid-year progress update.
- Hysteroscopy improvement work.
- QSAC considered the following reports each quarter: PALS, Complaints and Patient Experience; Legal; Learning From Deaths, Medical Examiner and Bereavement; and Palliative and End of Life Care.
- Clinical Audit Annual Report and Audit Plan.
- Quality spot check audit findings and progress.
- Industrial action update.
- Levelling up clinical standards.
- QSAC received the annual reports on Patient and Carer Experience, Safeguarding, and Medication Safety.
- SaTH Annual Quality Account: QSAC received the draft report, and members were able to provide comments and ask questions in advance of the meeting which received it.
- Quality priorities: QSAC considered and agreed the draft quality priorities for the year.
- Approved the terms of reference for Quality Operational Committee
- Agreed that the Safeguarding Adults Policy should go to the Board for approval.
- A quarterly report from the Medical Regulatory Group was also introduced during the year.
- C Difficile deep dive.
- Urgent care deep dive to review progress post Dispatches

4.2 Chair's Reports to the Board

The Committee Chair sent a report to the Board of Directors after each meeting in the 4A format (Alert, Assure, Advise, Action). Actions raised for significant follow up included:- culture and behaviours: QSAC noted a range of examples where cultural issues affected behaviours and hence patient care and asked for these to be drawn together and reported on in the Getting to Good report; QSAC would receive a report on actions so far (May 2024) in response to the Royal College of Physicians' external review, commissioned by SaTH, of Neonatal Mortality for the years 2021 and 2022; and QSAC to consider what areas need in-depth review (Feb 2025).

4.3 Links to the Audit and Risk Assurance Committee (ARAC)

The QSAC Chair sent the ARAC Chair, for information, the following during the year:

- a copy of the Health and Safety Management Annual Report for information in June 2024, due to the potential fit with ARAC's plans for internal audit.

The Chair sent the ARAC Chair a suggestion in September 2024 that it may be helpful to have an audit of the governance of CNST for maternity so that we can be assured that the process is working effectively which was agreed.

The following Internal Audit Reports gave assurance to QSAC and were referenced in the meetings:

- the Mersey Internal Audit Agency (MIAA) Pressure Ulcer Review Action Plan Update which offered substantial assurance
- the MIAA Quality spot check review which provided limited assurance

4.4 QSAC's review of its performance/effectiveness

QSAC reviewed each meeting as a standard agenda item. QSAC also considered the cycle of business as a standard agenda item, looking forward to the next meetings' agendas.

QSAC also carried out an anonymised review of its performance using an electronic questionnaire format provided by the Corporate Governance Team which was issued during February 2025. The results of the survey, compiled by Corporate Governance Team and discussed at QSAC in March 2025, were very positive overall. There were some suggested themes for the committee to consider further to enhance its effectiveness during 2025/26. This included considering the lateness of some papers, ensuring all actions were progressed ahead of the meeting and considering the length of the QSAC agenda which can be very large. How to improve committee effectiveness continues to be a topic of discussion with QSAC members.

5.0 Conclusion

It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2024-2025.

Sarah Dunnett, Chair of QSAC

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 10 July 2025

Agenda item		Board Information Pack item			
Report Title		Finance & Performance Assurance Committee Annual Report 2024-2025			
Executive Lead		Adam Winstanley, Acting Director of Finance			
Report Author		Richard Miner, Non-Executive Director			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe		Our patients and community		BAF 13 (corporate governance)	
Effective		Our people			
Caring		Our service delivery		**Trust Risk Register id:**	
Responsive		Our governance	√		
Well Led	√	Our partners			
Consultation Communication					
Executive summary:		1. All Board Assurance Committees' terms of reference (agreed by committees and approved by the Board) were updated to include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year. 2. This is the Finance & Performance Assurance (and from September 2024 the Finance Assurance) Committee's annual report for 2024/25.			
Recommendations to the Board:		The Board is asked to take assurance from this report as to the required duties and activities of the Committee undertaken during the 2024/25 financial year.			
Appendices:		None			

1.0 Introduction

1.1 The terms of reference for the Trust's Board Assurance Committees were updated to include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the 2024/25 financial year.

1.2 The Finance & Performance Assurance Committee has authority from the Board, as per its terms of reference which are reviewed annually and were approved by the Board on 14 March 2024 and then for the Finance Assurance Committee on 12 September 2024.

1.3 The Committee is an assurance committee of the Board of Directors.

2.0 Purpose

2.1 The Finance & Performance Assurance (and from September 2024, the Finance Assurance) Committee is responsible, on behalf of the Board of Directors, for objective scrutiny and to seek evidence of assurance of the Trust's financial (and, up until August 2024, operational performance), plans, major investment decisions, capital plans, and relevant regulatory compliance.

2.2 The Committee provides the Board with an objective review of those areas set out above on the delivery of the Trust's financial objectives, including identifying any significant risks and associated mitigating actions, making recommendations to Board, where required. And in so doing, be aware of and seek assurance regularly on the impact of the operational decisions of the Trust on its income and cost base.

2.3 The Committee considers processes for the preparation and the content of strategic and operational financial plans and annual revenue, capital and workforce budgets, and tests the key assumptions and risks underpinning such plans.

3.0 Committee membership, terms of reference and meetings

3.1 The membership of the Committee was appointed by the Board of Directors and consists of not less than five members:

- The Committee Chair: a nominated Non-Executive Director;
- Two further nominated Non-Executive Directors;
- Director of Finance (lead executive for the Committee); and
- Chief Operating Officer and since September 2024, Director of Nursing.

3.2 Since May 2024, the Committee has been chaired by Richard Miner, Non-Executive Director.

3.3 As noted above the terms of reference of the Finance & Performance Assurance Committee were last agreed by the Board on 14 March 2024 and the Finance Assurance Committee were agreed by the Board on 12 September 2024.

3.4 The Finance & Performance Assurance and then Finance Assurance Committee met 12 times in 2024-2025 to discharge its responsibilities. See table below.

Finance & Performance Assurance/Finance Assurance Committee Attendee report 2024/2025:

Finance & Performance Assurance Committee Attendee Report 2024-2025

Finance & Performance Assurance Committee - Attendance								
								2025
Name	Title	Role	30-Apr	28-May	25-Jun	30-Jul	27-Aug	
Richard Miner [c]	Non-Executive Director	Member	Y	Y	Y	Y	Y	
Rajinder Dhaliwal	Non-Executive Director	Member						
David Brown	Non-Executive Director	Member	Y	Y	Y	Y	Y	
Simon Crowther	Non-Executive Director	Member	A	Y	Y	Y	A	
Helen Troalen	Executive Finance Director	Member	Y	Y	Y	Y	Y	
Sara Biffen	Acting Chief Operating Officer	Member	Y	Y	Y	Y	Y	
Nigel Lee	Director of Strategy & Partnerships	Attendee	Y	Y	Y	A	Y	
Adam Winstanley	Deputy Director of Finance	Attendee	A	A	Y	Y	Y	
Lisa Mitchell	Senior Governance Support Officer	Admin	Y	Y	Y	Y	Y	
Deborah Bryce	Head of Corporate Governance & Compliance	Guest				Y		

Finance Assurance Committee Attendance Report 2024-2025

Finance Assurance Committee - Attendance									
					2024-2025				
Name	Title	Role	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Richard Miner [c]	Non-Executive Director	Member	Y	Y	Y	Y	A	Y	Y
Sarah Dunnett	Non-Executive Director	Member				Y			
Simon Crowther	Associate Non-Executive Director	Member	Y	Y	Y	A	Y	Y	Y
Helen Troalen	Executive Finance Director	Member	Y	Y	Y	Y	A	A	A
Hayley Flavell	Director of Nursing	Member	Y	Y	A				
Paula Gardner	Interim Chief Nursing Officer	Member				Y	Y	Y	Y
Prof Trevor Purt	Non-Executive Director	Member			Y		Y		
Rosi Edwards	Non-Executive Director	Member					Y	Y	Y
Simon Balderstone	Deputy Director of People & OD	Attendee		Y	Y	Y	Y	Y	Y
Adam Winstanley	Deputy Director of Finance	Attendee	Y	Y	Y	Y	Y	Y	Y
Lisa Mitchell	Senior Governance Support Officer	Admin	Y	Y	Y	Y	Y	Y	Y
Rhia Boyode	Chief People Officer	Attendee					A	A	
Anna Milanec	Director of Governance	Attendee					Y		
Deborah Bryce	Head of Corporate Governance & Compliance	Guest	Y	Y			Y	Y	Y

Meetings were also attended by a representative in NHSE's Improvement Financial Recovery Programme.

At times, it has been a challenge to ensure quoracy and I am grateful to those Non-Executive Directors who have stepped in to ensure we have the numbers to remain quorate.

4.0 Principal Areas of Review

4.1 Business covered during the year:

The Committee considered the following areas of key business during 2024/25:

- Monthly Integrated Performance Report and performance highlights (up to August)
- Monthly finance reports and cash position updates
- Quarterly Board Assurance Framework (particularly around BAF risk 5 – The Trust does not operate within its available resources, leading to financial instability and continued regulatory action)
- Quarterly contract award reports
- Strategy and partnerships updates (up to August)
- 24/25 budget setting, 25/26 Revenue and Capital Budget and 25/26 Trust Operating Plan
- SIIP Transition
- 24/25 Forecast Outturn
- Capital support- and Capital Planning Group Terms of Reference
- Energy Centre Business Case Bidder Selection and Contract Award
- STW ICS Medium Term Planning Update and Operating Plan

- PwC Review of Financial Improvement across the system
- Results of the FAC committee effectiveness survey
- Modular ward update
- RAAC finance update
- Workforce plan and financial impact
- Key issues reports from groups that report into Finance & Performance Committee, e.g. Capital Planning Group and Efficiency & Sustainability Group
- MEC deep dive
- Review of terms of reference and cycle of business

4.2 Reporting to Board

The Committee reports into Board following each meeting via a Key Issues (4A's) report from the chair of the committee, for items of 'alert, assurance, advise and actions'; including any matters of concern or gaps in assurance and significant follow up actions.

4.3 Committee review of its performance/effectiveness

The Committee issued a review of effectiveness survey to its members in February 2025 and considered the results at its meeting in March 2025. The results of the survey indicated a significant number of positive responses. There were also some themes for improvement in overall FAC effectiveness identified which were considered by the Committee and some of which will be revisited by the Chair, as follows:

- Clearly concluding all items on the agenda. An enhanced action log to ensure all follow up points are captured and actioned
- More "deep dives"
- More focus on the regulatory regime
- Exploring greater enforcement of financial limits

Agenda setting pre-meets take place every month and work well in crafting each agenda.

As part of the changes to the original FPAC and its conversion into the FAC, it has given the Committee time to focus far more on the drivers of financial performance and the expected outturn for the year ahead. It follows that it also gives FAC the opportunity to engage in a greater number of "deep dives" of sub-optimal (or even over performing) financial performance and ensure corrective action can be identified and monitored and, in all cases, lessons learned. The Committee is determined to play a key role in driving financial performance for the year ahead and to keep the Board fully informed.

As noted above, the Committee considered in some detail BAF Risk 5 in the light of additional governance procedures and whether it was appropriate to reduce or increase the current (20) risk rating. This was then discussed at Board and, so far, no changes have been made to the "20" score.

In recent months, the Chair has attended meetings of the Financial Recovery Group to observe actions being taken and, also, attends the monthly STW ICS Finance Committee.

5.0 Conclusion

5.1 It is considered that the Finance & Performance Assurance (and latterly the Finance Assurance) Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2024-2025.

Report prepared by: Richard Miner, Non-Executive Director and FAC Committee chair. April 2025

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 10 July 2025

Agenda item		Board Information Pack item			
Report Title		Audit and Risk Assurance Committee Annual Report 2024/25			
Executive Lead		Anna Milanec, Director of Governance			
Report Author		Anna Milanec, Director of Governance			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe		Our patients and community		BAF13	
Effective	√	Our people			
Caring		Our service delivery		**Trust Risk Register id:**	
Responsive		Our governance	√		
Well Led	√	Our partners			
Consultation / Communication		Report written in consultation with ARAC Chair.			
Executive summary:		All board assurance committees' terms of reference (ToRs) (agreed by committees and approved by the Board) include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year. Due to committee / board timings, this report has not been through the Audit and Risk Assurance Committee (ARAC) before being presented at Board, but content has been approved by the Committee Chair.			
Recommendations for the Board:		**The Board is asked to take assurance** from this report as to the required duties and activities of the Committee undertaken during the 2024/5 financial year. **The Board is asked to note** that the timing for the annual committee reports 2025/26 being presented to the Board, will be brought forward to the ***May 2026 Board meeting***; this will allow for any anomalies to be presented prior to approval of the annual report and accounts.			
Appendices:		None			

1.0 Introduction

1.1 The terms of reference for the Trust's board assurance committees were updated to include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year.

1.2 This is the report of the Board's Audit and Risk Assurance Committee (ARAC / 'the Committee') for the financial year 2024/25.

2.0 Committee membership and meetings

2.1 ARAC is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA).

2.2 The Committee plays a crucial role in overseeing the integrity of financial reporting, the effectiveness of internal controls, and the independence and performance of the external auditors. Its primary objective is to ensure transparency, accuracy, and compliance with regulatory and statutory requirements.

2.3 External Auditors, Internal Auditors and Counter Fraud attend each meeting.

2.4 The Director of Finance, and Director of Governance / Company Secretary, attend every meeting, and in addition, other executives or senior managers attend meetings as required.

2.5 The Trust's Chair is neither the Chair nor a member of the Committee, as per requirements.

2.6 However, as Committee Chair, Professor Trevor Purt stood down from the Committee for a temporary period as he took up the role of Acting Trust Chair.

2.7 During 2024/5, the Committee met on six occasions, to discharge its responsibilities.

Audit and Risk Assurance Committee Attendance Matrix 2023/24	Committee dates					
Committee Members:	15 Apr 2024	13 May 2024	14 June 2024	2 Sept 2024	25 Nov 2024	17 Feb 2025
Trevor Purt (Chair)	√	√	√	**x**	√	√
Teresa Boughey	√	√	√	√	√	√
David Brown				√		
Richard Miner	√	√	**x**			
Rajinder Dhaliwal (member and interim chair for one meeting)			**x**	√ *	√	√

3.0 **Principal Areas of Review** (as per ARAC terms of reference)

3.1 *Integrated Governance, Risk Management, and Internal Control*

ARAC evaluated the effectiveness of the Trust's internal control systems and risk management processes:

a. The Committee reviewed relevant disclosure statements, particularly the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit Report and Value for Money report, and other appropriate independent assurances.
b. The Board Assurance Framework (BAF) was reviewed by the Committee on a quarterly basis throughout the financial year.
c. Reporting of the Operational Risk Register, and continued oversight of the Corporate Risk register was reported to the Committee.
d. The adequacy and effectiveness of the organisation's financial control systems have been reviewed by the Committee throughout the year through the receipt of regular reports; competition waiver reports, procurement waiver reports, overseas' patients' reports, contract award reports, losses and special payment reports.
e. Annual review of the Trust's Standing Financial Instructions, Scheme of Delegation and Standing Orders takes place.
f. And, in addition, the work of Internal Audit relating to financial control systems and the work of External Audit relating to the financial statements.

3.2 *Internal Audit - MIAA*

Reports were reviewed from management and internal audit regarding significant control issues, with a small number of areas being identified for improvement, as reported to the Board via the four-A's reports after each Committee meeting.

Internal audit reports received during the year were:

Opinion provided	Title of core and risk-based reviews issued
0 **high** assurance opinions:	-
3 **substantial** assurance opinions:	Key Financial Systems. Conflicts of Interest. Freedom to Speak Up
3 **moderate** assurance opinions:	Bank and Agency Divisional Risk Management Technical Review Medical Devices
2 **limited** assurance opinions:	Waiting List Management – Patient Initiated Follow Up (PIFU). National Cost Collection.
Nil **no** assurance opinions	-
0 reviews without an assurance rating	-

The overall Head of Internal Audit Opinion for the 2024/25 provided **Substantial Assurance**, which can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being

applied consistently – which also provides some assurance that the Committee is working effectively within its terms of reference.

3.3. *External Audit - KPMG*

The independence and performance of the external auditors, including their remuneration and scope of work were reviewed by the Committee. Discussions with the auditors on audit findings, accounting treatments, and any significant issues arising during the audit process were held as appropriate between the members and auditors.

External audit assurance was provided during the year through the work relating to the Trust financial statements and annual report. The external auditors' opinion of the veracity of the financial statements and annual report were reflected through their:

- Value for Money Risk Assessment
- ISA 260
- External Auditor's Report

No non-audit services were provided by the Trust's External Auditors during the year, whilst technical updates were provided to the members of ARAC on a regular basis.

The contract for the provision of external audit services was renewed this year, with KPMG once again being awarded the new contract. The lead audit partner, who has served the organisation for five years, will now step down as part of the audit team for the organisation.

3.4 *Other Assurance Functions*

The ARAC Chair also worked with the Chairs of other board assurance committees where particular issues arose, thus being able to seek assurance for areas which are dealt with more closely by other meetings.

The Committee has also added its oversight to non-board assurance committees, the Risk Management Group and Information Governance Committee, and it now also undertakes reviews relating to cyber security and digital.

The Committee also received bi-annual reports from the Trust's Freedom to Speak Up Guardian and the Annual Security Report, and Annual Emergency Preparedness, Resilience and Response Report. The Committee is undertaking further oversight regarding the latter.

3.5 *Anti-Fraud - MIAA*

The aim of all anti-fraud work is to support improved NHS services and to ensure that, through awareness raising and local proactive work, fraud within the NHS is seen as unacceptable, and that the loss to taxpayers is minimal.

Fraud prevention checks continued throughout the year with additional training and awareness materials being used. Several relatively small incidents were reported throughout the year to the Trust's Anti-Fraud specialist, which have been investigated and appropriate actions taken where required.

Anti-fraud covers fraud, bribery and corruption work, and the Government Functional Standard 013 for Counter Fraud is used, on an annual basis, to assess the organisation's compliance with its standards. Work over the last two years has led to compliance having been achieved - after several years of 'near' compliance - with 12 out of 13 sections of the Standards meeting compliance requirements. Full compliance was first achieved in April 2024 and continues to date.

Last month, the Trust was visited by members of the national NHS Counter Fraud Authority team. ARAC Chair, Director of Governance, Director of Finance and Head of Risk Management were interviewed by the team and were advised that the Trust stood out as an exemplar due to the processes and documentation that had been put in place at the organisation for the prevention of fraud and bribery.

This latter point might be reassuring to some extent as NHS bodies may fall under the jurisdiction of the Economic Crime and Transparency Act 2023, which, starting from 1st September 2025, introduces a new offence of 'failure to prevent fraud'. This legislation will hold organisations criminally liable for fraud committed by employees or other associated persons if the organisation lacks reasonable fraud prevention procedures.

3.6. *Financial Reporting*

ARAC reviewed and approved the annual financial statements, ensuring they presented a true and fair view of the Trust's financial position and performance.

The adequacy of disclosures, particularly in relation to significant accounting policies and judgments, were also assessed, focusing on:

a) The wording in the Annual Governance Statement and other disclosures relevant to the Committee's terms of reference
b) Changes in, and compliance with, accounting policies, practices, and estimation techniques.
c) Unadjusted misstatements in the financial statements.
d) Significant judgements in preparation of the financial statements.
e) Significant adjustments resulting from the audit.
f) Letter of representation.
g) Explanations for significant variances.

4.0 Conclusion

4.1 It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2024/25.

Report prepared by Anna Milanec, Director of Governance

On behalf of Professor Trevor Purt, Chair of ARAC

June 2025

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting: 10 July 2025

Agenda item		Board Information Pack Item		
Report Title		PODAC Chair's Annual Report (2024-25)		
Non-Executive Lead		Teresa Boughey, Non-Executive Director		
Report Author		Deborah Bryce, Head of Corporate Governance & Compliance; and Teresa Boughey, Non-Executive Director		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		BAF13
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	N/A
Well Led	√	Our partners		
Consultation Communication		Annual Effectiveness Survey considered at PODAC – April and June 2025		
Executive summary:		1. The terms of reference of the Trust's board assurance committees include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year. 2. This is the People & OD Assurance Committee's annual report for the 2024-25 financial year.		
Recommendations to the Board		The Board is asked to note the content of the PODAC Chair's Annual Report and to take assurance that the Committee has effectively discharged its role and responsibilities during the 2024/25 financial year.		
Appendices:		-		

1.0 Introduction

1.1 The terms of reference of the Trust's Board assurance committees include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year.

2.0 Purpose

2.1 The People & OD Assurance Committee (PODAC) receives assurances that staffing processes are safe, sustainable, and effective and that the NHS People Promises are being delivered.

3.0 Committee membership, meetings and terms of reference

3.1 The membership of the Committee was appointed by the Board of Directors and consists of not less than five members, as follows:

- Committee Chair: a nominated Non-Executive Director
- Two Further nominated Non-Executive Directors
- Chief People Officer (who is a non-voting Director of the Board) - Lead Executive for the Committee
- Director of Strategy and Partnerships

3.2 Teresa Boughey, Non-Executive Director is the chair of PODAC.

3.3 PODAC meets bi-monthly and met six times during 2024-2025. The meeting attendance table is below:

People & OD Assurance Committee Attendance

			2024-2025					
Name	**Title**	**Role**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**	**Feb**
Teresa Boughey (Chair)	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓
Trevor Purt	Non-Executive Director	Member	x	✓	x	x	x	✓
David Brown	Non-Executive Director	Member	✓	✓	✓			
Rosi Edwards	Non-Executive Director					✓	✓	✓
Wendy Nicholson	Associate Non-Executive Director	Member		✓	x	✓	✓	✓
Rhia Boyode	Director of People & OD/ Chief People Officer	Member	✓	x	✓	✓	✓	✓
Sara Biffen	Acting Chief Operating Officer	Member	✓	✓	✓	x		
Nigel Lee	Director of Strategy and Partnerships	Member				✓	✓	✓

3.4 Reports are typically presented to PODAC by the authors, who can answer questions raised by the committee.

3.5 The cycle of business of the committee is kept up to date and is used to plan the agenda for each meeting.

3.6 PODAC reviewed and agreed its terms of reference at its meeting in December 2024 and these were approved by the Board of Directors in January 2025.

4.0 Principal Areas of Review

4.1 At its meetings during 2024/25 PODAC considered the following:

- People & OD Assurance Report (including culture)
- Workforce & Leadership System Integrated Improvement Plan (SIIP) Key Issues Report
- Risk Report People Risks
- Nursing & Midwifery Staffing Report
- Audit recommendations
- Board Assurance Framework – people risks
- Equality, Diversity & Inclusion update reports
- Annual Staff Survey Results
- Education Annual Report
- Operational Workforce Plan
- Vacancy approval – Reform Element
- Workforce financial report
- Workforce productivity
- Clinical Support Workers
- Culture and leadership programme
- Policy updates including: Bullying & Harassment Policy, Equality, Diversity & Inclusion Policy, and Grievance Policy
- Workforce Race Equality Standard (WRES) Annual Report and Workforce Disability Standard (WDES) Annual Report
- Gender Pay Gap and Equalities reports
- Inclusion and Belonging Annual Report
- Employee Relations bi-annual report
- Library assessment update
- Review of Committee Terms of Reference and cycle of business
- Committee effectiveness survey
- Assurance Committee items (items that pass between committees)

4.2 Chair's Reports to the Board

The Committee Chair submitted a report to the Board of Directors after each meeting in the 4A format (Alert, Assure, Advise, Action). Actions raised for significant follow up included:-

- The Employee Relations bi-annual report coming back to PODAC detailing an external review which looked at the Trust's current processes for discrimination cases and recommendations, and how the Trust could make its investigations more robust.
- The cost of recruitment across a range of professions.
- Ensuring discrimination concerns are dealt with robustly and that managers are trained in investigation processes and recognising covert racism.

- Further work to understand why the WRES non-clinical clusters 2,3 and 4 (higher areas) had lower representation to support influencing change.
- Investigating concerns regarding healthy food options for staff.
- The independent report on culture being shared with QSAC to ensure appropriate awareness.
- Chief Nursing Officer taking forward improvement to the safe staffing report.

4.3 PODAC's review of its effectiveness

As part of its commitment to continuous improvement, PODAC includes a standing agenda item at each meeting for members to provide feedback on the effectiveness of the meeting.

The Committee also routinely considers the cycle of business as a standard agenda item, reviewing and planning forthcoming meeting agendas.

In addition, PODAC undertook an anonymised self-assessment of its performance using an electronic questionnaire provided by the Corporate Governance Team, which was issued in February 2025. The survey results, compiled and presented to PODAC in April and June 2025, were very positive overall. There were no 'strongly disagree' or 'disagree' responses. A few comments were raised for consideration to further enhance effectiveness during 2025/26; these were discussed by the Committee, but no additional actions were agreed.

5.0 Conclusion

It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2024-2025.

Teresa Boughey, Chair of PODAC