The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 13 November 2025

SUPPLEMENTARY INFORMATION PACK

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

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Public Participation Report

(April 2025 – September 2025)

Julia Clarke – Director of Public Participation

Volunteering | Engagement | SaTH Charity

Highlights of Public Participation

The Shrewsbury and Telford Hospital NHS Trust

COMMUNITY ENGAGEMENT (for full details see slides 8 – 25)

- The SaTH Public Assurance Forum, which provides independent assurance on our engagement activities met on the 14 April 2025 and 21 July 2025 the highlights of this meeting are outlined in slides 6-7. Professor Trevor Purt (NED) co-chaired this meeting with Joy Jones (Montgomery Health Forum)
- The Public Participation Team continues to engage with the public through a regular series of virtual and face-to-face meetings, health lectures and newsletter updates. Our community members (5337) and organisations (472) continue to increase.
- The community engagement team continue to reach out to our communities and are measuring the impact of their engagement activities
- Over the past six months, the Public Participation team have supported 31 HTP events with the public (either face to face or online).
- The community engagement are currently developing their 5-year strategy and are engaging with members of the public

Highlights of Public Participation

The Shrewsbury and Telford Hospital NHS Trust

VOLUNTEERS (for details see slides 26 - 34)

- We have 214 active volunteers within the Trust who have provided 12,542 hours of their time over the last six months. These are across 30+ clinical and non-clinical roles.
- During the last six months we have had changes within the volunteer team – a new Volunteer Service Manager and Volunteer Facilitator. Since June our average processing time for new volunteers was, on average, only 3.2 weeks
- We have developed and implemented a number of new roles including a volunteer appointment reminder service, a digital volunteer role (supporting patients to use health app technology), and a volunteer driver scheme. In addition, our volunteers have supported one off events, including Exercise Jupiter, and a vertical evacuation event at SERII.
- The RSH patient transport buggy has been launched following support from SaTH Charity and the League of Friends
- Following 6 months funding from the ICB the Trust has launched a volunteer driver service, which has supported over 462 patients since June.
- The Volunteer service is currently developing their 5-year strategy and are engaging with volunteers and members of the public

Highlights of Public Participation

The Shrewsbury and Telford Hospital NHS Trust

SATH CHARITY (for full details see slides 35 - 46)

- Income for the 6 months March – August 2025* was £113,462 compared to £349,982 in the same period last year**. Expenditure for the same period was £188,101 compared to £178,986 in 2024. *(*September income was not available at the time of reporting. **in May and August 2024 we received 3 legacies totalling £212,489 which is why the income is significantly higher)*
- SaTH Charity had **189** requests for support from SaTH Charity, **71** of which were for the staff Small Things/Big Difference Fund funded through the Staff Lottery.
- Our supporters continue to fundraise for SaTH Charity, with some events highlighted in this report.
- SaTH Charity 5 Year Strategy document is now live for staff and the public to view: SaTH Charity Strategy 2025 - 2030 by The Shrewsbury and Telford Hospital NHS Trust – Issuu

Developing our 5-year strategy

The Shrewsbury and Telford Hospital NHS Trust

Recently SaTH Charity's five-year strategy was approved by the Corporate Trustee

The other areas of the Public Participation department – Community Engagement and Volunteers are now in the process of developing their 5-year strategies.

As part of the process, both teams have met to discuss their vision and what they would like to achieve over the next five years. Included in these discussions have been, members of the public participation team, the Associate Director of Strategy and Partnership and colleagues from the ICB. Drafts are being shared with Shropshire Community Trust

Following these meetings draft objectives have been developed. The next steps include:

- Survey to community members and a survey to current volunteers in November
- Volunteer Focus group in December
- Focus group in December for community members/public
- Updates and feedback from Senior Leadership Team (SLC) and Public Assurance Forum members
- Final version of both strategies to SLC/PAF in April 2026
- Trust Board in May 2026

Community Engagement Strategy

The Shrewsbury and Telford Hospital NHS Trust

The 5 draft objectives for the strategy are:

- **OBJECTIVE 1: MORE JOINED-UP WORKING**
  Work together with system partners, VCSE and other stakeholders to identify the synergies in organisational priorities to streamline engagement and maximise capacity

- **OBJECTIVE 2: FOCUS ON PREVENTION NOT TREATMENT**
  Work to support the reduction of health inequalities across the communities we serve. There are complex reasons why people and services don't always match up and understanding this and what people want can help reduce this gap

- **OBJECTIVE 3: TRANSFORMING CARE**
  Ensure early involvement in transformational programmes at SaTH and system-wide to build in engagement – better design involving local people can lead to improved access, experience and outcomes –those who rely on our services should have a say in the decisions we make

- **OBJECTIVE 4: COMMUNICATION AND FEEDBACK**
  Increase opportunities to provide feedback to our communities on the difference their involvement has made, to establish relationships based on trust and transparency and to empower local communities and build a culture of involvement

- **OBJECTIVE 5: FOUNDATION TRUST**
  Move towards the national objective of all Trusts achieving Foundation Trust status by 2035, with the first wave in 2026

Volunteers Strategy

The Shrewsbury and Telford Hospital NHS Trust

The 5 draft objectives for the volunteer strategy are:

- **OBJECTIVE 1 – ENHANCE RECRUITMENT OFFER**
  Offer a thriving and inclusive volunteer programme providing meaningful and rewarding opportunities for volunteers and an individualised and supportive experience which align with patient and clinical priorities

- **OBJECTIVE 2 – IMPROVE OUR VOLUNTEER EXPERIENCE**
  Develop models of volunteering that maximises the quality of the volunteering experience and lead to improved retention

- **OBJECTIVE 3 – MORE TWO-WAY COMMUNICATION AND FEEDBACK**
  Provide more opportunities for our volunteers to share their ideas and feedback to them on outcomes

- **OBJECTIVE 4. BUILD TRANSFORMATIONAL VOLUNTEERING PARTNERSHIPS**
  Develop strong strategic partnership links at national and local level to bring the greatest benefit to the patients and become a national beacon for innovative volunteer schemes

- **OBJECTIVE 5: USE INFORMATION SYSTEMS TO MEASURE PERFOMANCE AND ENSURE INCLUSIVITY**
  Expand our volunteer management systems to manage and share our data to better capture the impact of volunteering in order to increase the recognition of its value and visibility

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COMMUNITY ENGAGEMENT

COMMUNITY ENGAGEMENT
Public Assurance Forum 14 April 2025

The Shrewsbury and Telford Hospital NHS Trust

- The Public Assurance Forum (PAF) was established in 2021 to bring a public and community perspective to processes, decision making and wider engagement work at The Shrewsbury and Telford Hospital NHS Trust. The Forum provides constructive challenge and scrutiny of decisions from a patient and public perspective. They also share information back into their own organisations
- PAF has a wide range of community and statutory sector organisations as members as well as representation from SaTH's Divisional Leadership Team. All papers are available on the Trust website Public Assurance Forum – SaTH
- The Public Assurance Forum (PAF) met on 14 April 2025, key items that were discussed at the Forum included:
  - Updates from partner organisations and Divisions
  - An update presentation on service changes – Cardio-Respiratory and Maxillofacial
  - Digital Transformation update with reference to the patient portal
  - Presentation on latest HTP developments and latest ongoing community engagement (including Presentation on latest HTP developments (including the HTP Programme Board Engagement report for quarter and proposed HTP About Health presentation).
  - Presentation from Associate Director of Strategy and Partnership on key developments
  - The Director of Public Participation provided an update on the new SaTH Charity five year strategy
  - Public Participation action plan update and review of draft Public Participation Board report

COMMUNITY ENGAGEMENT
Public Assurance Forum 21st July 2025

The Shrewsbury and Telford Hospital NHS Trust

- The Public Assurance Forum (PAF) met on 21st July 2025, key items that were discussed at the Forum included:

  - Updates from partner organisations
  - Updates provided by the Divisions on service development and any public engagement
  - Presentation on latest HTP developments (including the proposed presentation for the 'About Health' public update). The HTP Programme Board Engagement report for quarter 1 was discussed.
  - Chief Communications Officer provided an update and received feedback about the proposed Group Model Digital Transformation update, including an update on the A&E waiting time webpage. After discussion with the group, a more detailed update will be provided at April's meeting
  - Presentation from Associate Director of Strategy and Partnership on key developments
  - Public Participation action plan update (including Plan on a Page for Charity, Community Engagement and Volunteers) was discussed

Community Engagement

The Shrewsbury and Telford Hospital NHS Trust

- The Community Engagement team hold a series of community events where the public across Shropshire, Telford & Wrekin and Powys are invited to join us virtually to find out more about their hospitals, which includes:
  - **Monthly newsletter update –** An email update to our 5000+ members and 400+ organisations
  - **Monthly Hospital Update (previously Community Cascade)** – this is a public session delivered once a month by the Director of Public Participation and focuses on current hospital news, public participation update and provides a Q&A opportunity. The presentations are available on our website
  - **About Health Events**– There is an ongoing series of one hour Teams health events delivered by health professionals for staff and the public on topics including the menopause, HTP, chaplaincy and other requested topics. The sessions are recorded and available on the website, with an opportunity for Q&As.
- The Hospitals Transformation Programme remains the main theme of feedback received by the Community Engagement team and we continue to work closely with HTP colleagues to support ongoing engagement.

Core20PLUS Engagement in Quarter 1 & 2

The Shrewsbury and Telford Hospital NHS Trust

Dementia **Diabetes** **Respiratory** **Cardiovascular**

	National Events		About Health		Community Group Visits		Community Events			
April	All engagement paused during pre-election period									
May	Dementia Action Week 19 - 25 May 2025	Type 2 Diabetes Prevention Week 26/05 - 01/06	**HTP**	**Operational Update**	Deaf Awareness Week Independent Living Centre, Telford 07/05/25	Memory Café Ludlow Library 13/05/25 14:00 - 16:00				20/05/25 Dementia, See & Hear Day
June	Diabetes Awareness Week 09 - 15 June	Learning Disability Week 16 – 22 June	**24/06/25 Dementia - Karen B**		Dementia Friendship Group, Albrighton 20/06/25 13:30 - 16:00	The Green Room (Caxton Surgery group) Hope Church, Town Walls, Oswestry 05/06/25 13:30 - 15:00	13/06/25 Severn Pumpers Conference, STFC	Diabetes Awareness Stand Telford Town Centre 11/06/25 13:00 - 16:00	14/06/25 AF Day Shrewsbury	29/06/25 AF Day Telford
July	Alcohol Awareness Week 09 - 13 July		**HTP**		Butterfly Café LoF Bridgnorth Hospital 04/07/25 14:00 - 16:00		Shropshire Autism Hub 28/07/25 13:30 - 15:30			
August			**19/08/25 Diabetes: Your Questions Answered - Anna Green**				Pods Families Picnic in the Park Charlton School Monday 10/08/25 10:00 - 16:00			
September	Know Your Numbers Week 08 - 14 September	Launch of Winter Vaccination Campaign			Befrienders Session Mayfair Centre, Church Stretton 08/09/25		Telford Patients First	Shropshire Patient Group		

#GETINVOLVED Community Engagement

Dementia | Diabetes | Respiratory | Cardiovascular

All priority areas benefit from sharing 4 key messages:

- Drink in moderation
- Eat a balanced diet
- Exercise more
- Don't Smoke

We are visiting community groups where evidence shows an increased risk of these conditions, and sharing information/signposting to local services

Dementia

We are working with the dementia team and audiology to share **All About Me** forms in community settings and encourage people to have their hearing checked

Diabetes

We are working with hospital and community teams to encourage people with diabetes to take up annual health checks with particular emphasis on foot checks

Respiratory

We are working with system partners to see if winter vaccination outreach can be taken to community settings for vulnerable groups (addiction, autism, gypsy/traveller communities)

Cardiovascular

We promote Public Health Blood Pressure checks and share details of smoking cessation services

Dementia | Diabetes | Respiratory | Cardiovascular

Hospital Events

We hold monthly **Hospital Update** sessions on the last Wednesday of each month (apart from December!) Attendance at these events is generally around 20 members of the public. The presentation is shared on the #GetInvolved page of our website after the event.

Our regular **About Health** events, which are 60-minute sessions looking at particular topics of interest. These are recorded and the videos shared online after the event.
This year we have covered:

- Hospitals Transformation Programme (x2)
  - Operational Update
- See the person, not just the Dementia
- Diabetes: Your questions answered

Impact of Engagement

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About Health – Diabetes: Your questions answered

Dr Anna Green joined us in August to give a talk about Diabetes as part of our thematic engagement.
During the event, the audience were invited to ask questions and guide the information being shared. A recording of the event is available to view here: https://bit.ly/2508Diabetes As well as an explanation of how diabetes affects the body, Dr Green spoke about the impact of different foods, treatments and complications for people living with diabetes (Type 1 and Type 2)

Visit to CoCo Befrienders

We were invited to the monthly meeting of the CoCo Befrienders at the Mayfair Centre in Church Stretton this month. There were more than 30 befrienders at the meeting, and we covered key messages relating to Dementia, Diabetes, Blood Pressure and Seasonal Vaccinations during her talk.

Questions were raised about the Hospitals Transformation Programme we were able to share the latest HTP leaflet and signpost to the About Health event in November.

Severn Pumpers Diabetes Conference

We attended this event and had an information stand so we could discuss with colleagues the work of the public participation team and how we could support getting key health messages out to our local communities.

We also received some generic information leaflet to share with some of our communities on Continuous Glucose Monitoring (CGM) – aimed at older people using insulin to manage their diabetes and may not be aware of this.

Impact of Engagement

The Shrewsbury and Telford Hospital NHS Trust

Visit to Shropshire Autism Hub

Visited the Shropshire Autism Hub in July, to talk about the importance of people with diabetes having their annual health checks, and service users taking up their appointments for the winter vaccination programme.

Made aware of the challenges for people with autism when given “text heavy” information leaflets, but also their reluctance to accept “Easy Read” information as an alternative. One way of mitigating this might be to simply remove the Easy Read badge from that information. Shared this learning with Diabetes UK who are currently producing an Easy Read version of their pocket guide to diabetes, and received the following response:

Revised quick guides. We are currently working with NHS Leicester and their LD team who are testing it with focus groups. Your point is extremely valid, and we will ensure it’s not badged as Easy Read.

Dementia Information Day

The Dementia Information Day organised by Radfield Home Care was combined with the existing See & Hear Exhibition organised by Sight Loss Shropshire and and Community Resource to create a one-stop event at Theatre Severn.

We shared a table with the Dementia team, and handing out All About Me forms to families during the day!

We signposted people to local activities using Live Well Telford, The Shropshire Together Community and Family Directory and infoengine (*Powys*).

Our knowledge of local groups and activities continues to grow through the Community Connectors networks across the county.

We now take the All About Me forms out when visiting our local communities for carers or individuals who may be living with dementia

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HTP ENGAGEMENT

Getting involved with HTP

The Shrewsbury and Telford Hospital NHS Trust

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

- **Quarterly focus groups** which are aligned to our clinical workstreams. Workstream focus groups have been planned over the next two years which will inform the plans as they develop towards implementation and will continue until the programme is completed. We hold the focus groups every three months, and members can either attend in person or via MS Teams. Focus groups were held in early April, June and September
- We are holding a series of specialised focus groups based upon the feedback we received from our quarterly focus group members and local communities. From April-September we have held HTP focus groups Communication for Urgent and Emergency Care and Signage and Wayfinding,
- **Presentations, Q&As and action logs** from our focus groups are published in the public domain and can be found here with the Q&As from the focus groups : HTP Focus Groups – SaTH
- **Quarterly *About Health HTP* events** have been delivered using MS Teams in April, July and October and the next About Health event is on the evening of **Tuesday 4th November 2025 at 6.30pm.** All About Health events are recorded and available on the website

HTP Engagement Map

The Shrewsbury and Telford Hospital NHS Trust

- The map displays the **31** events we have organised or attended in the reporting period (1 April 2025 – 30 September 2025) and discussed HTP with the public.
  - We hosted **14** drop-ins in community settings across the areas we serve during this period, attended by **313** members of the public.
  - **5** presentations were delivered to **173** people attending community groups, meetings, or conferences.
  - We have also organised/attended **9** online meetings/events, attended by **128** people; often these meetings cover large geographical areas across T&W, Shropshire and Powys.
  - We held **3** focus groups in this period, attended by **34** members of the public.

Please note that all external engagement was paused for 6 weeks prior to the Shropshire Council elections held on 1st May 2025

HTP Engagement

The Shrewsbury and Telford Hospital NHS Trust

In Q1 2025/26 we attended the following events :

Date	Event
14 April 2025	Public Assurance Forum
02 May 2025	Church Stretton Co-op Drop-in
06 May 2025	About Health: HTP
08 May 2025	Wellington U3A Presentation
09 May 2025	Wellington Market Drop-in
12 May 2025	Ironbridge Co-op Drop-in
21 May 2025	Edstaston Village Hall Drop-in
03 June 2025	RSH Neighbours Drop-in
03 June 2025	Communications for UEC Focus Group
05 June 2025	Signage and Wayfinding Focus Group
06 June 2025	Oswestry Market Drop-in
10 June 2025	SALC HTP update
13 June 2025	Shrewsbury Library Drop-in
16 June 2025	Welshpool Market Drop-in
23 June 2025	Ludlow Market Drop-in
25 June 2025	Community Connectors Southeast meeting

Rachel Webster and Aaron Hyslop with a Ludlow Town Councillor, at Ludlow Buttercross

HTP Engagement

In Q2 2025/26 we organised and facilitated the following events:

Date	Event
06 July 2025	Ellesmere Regatta information stand
11 July 2025	Bridgnorth Market Drop-in
21 July 2025	Public Assurance Forum
24 July 2025	Brookside Community Centre Drop-in
29 July 2025	About Health: HTP
30 July 2025	Hospital Update
07 August 2025	Oswestry & Cambrian Rotary Presentation
13 August 2025	Lingen Davies all staff presentation
27 August 2025	Hospital Update
04 September 2025	HTP Focus Group
04 September 2025	JHOSC HTP update
17 September 2025	Market Drayton Market Drop-in
24 September 2025	Hospital Update
25 September 2025	Trust AGM information stand
26 September 2025	Nursing, Midwifery, AHP Conference Presentation
26 September 2025	Rotary Club of Wellington Presentation

Aaron Hyslop at Bridgnorth Market

Upcoming Engagement

The Shrewsbury and Telford Hospital NHS Trust

With building work well underway at RSH, we remain committed to engaging and working closely with our local communities, patients and colleagues to ensure we improve the experience for all the communities we serve.

Upcoming engagement:

- **Rotary Club of Ironbridge**, presentation on 23rd October
- **Hospital Update,** MS Teams on 29th October, 11:00-12:00
- **Public Assurance Forum**, MS Teams on 3rd November
- **About Health HTP**, MS Teams on 4th November, 18:30-19:30
- **Hospital Update**, MS Teams on 26th November, 11:00-12:00
- **HTP Focus Group**, Hybrid – William Farr House or MS Teams, on 2nd December, 10:00-12:00
- **HTP Focus Group – Critical Care Sky Garden with Shrewsbury Severn Rotary Club**, Hybrid – William Farr House or MS Teams on 5th December, 11:00-13:00

Transforming PRH Hub

The Transforming PRH Hub was recently opened near the entrance of PRH, providing a space for the charities that are supporting developments at PRH to share information about their activities, as well as a place to share information about HTP.

HTP informational leaflets are always available from the hub, the HTP Engagement Facilitator is based in the Hub one day a week, and the wider HTP team is based in the hub the first Monday of every month.

MP Shaun Davies, Matt Neal, Sara Biffen, Jo Williams, and Jon Sargeant at opening of Transforming PRH Hub

HTP Engagement – You said, We did

Feedback	Action
Following feedback from public members at our June focus group we developed a HTP Naming and Colour Survey – The survey received 1617 responses from the public, staff and volunteers, the results were conclusive on naming convention but very close for the colour palette.	The naming of the areas in the new build at RSH came back as “Hills”. However considering the closeness of the colour palette results, the two options were taken back to the focus group for a final decision in September. Focus group members unanimously agreed on ‘option 3’ which was inspired by local nature and has been taken forward as the colour palette for the new building.
Brookside Community Centre – Healthwatch Telford & Wrekin contacted SaTH after their own engagement event in Brookside where they noted continuing concern about the plans.	Held HTP Drop-in, in conjunction with Healthwatch T&W who helped to promote and attended on the day, in Brookside Community Centre. The information provided did offer reassurance to local residents and future plans for PRH, particularly the Cancer Treatment Centre, were appreciated.
Design Council Slices – These information boards have been discussed at the September public focus groups and generally been considered a good idea. Suppliers were met on site to provide a quote for board design and installation in ED1 and ED2.	Suppliers have worked with HTP team to provide indicative designs that meet Design Council specifications. These were presented to the September focus group to gauge opinions and determine next steps to obtain suitable boards.

HTP Engagement – You said, We did

Feedback	Action
Nursing, Midwifery, AHP Conference: • Request during presentation, from a ShropCom colleague, to share information obtained from Dementia focus group as colleague was working in community hospitals on improving environment for those living with Dementia. • SaTH colleague in endoscopy department suggested leaving HTP leaflets in waiting areas for patients.	• Dementia Focus Group Q&As and presentation shared with colleague, as well as contact details for the SaTH Dementia Nurse Specialist. • Colleague supplied with leaflets for both PRH and RSH endoscopy and more will be provided, as required.
Wellington Rotary Club – A Rotarian in attendance was also a founder member of Telford Visual Impairment Group which HTP are presenting to on 02/10/25 and requested presenters to speak slowly and clearly as some members did not hear well, also requested printed copy of presentation notes to be in 20-point Arial.	Presenters informed and presentation notes formatted in 20-point Arial, using style template that will be suitable for screen readers. This will be distributed afterwards for members unable to attend and made available on trust website in HTML for maximum accessibility.
Joint Health Overview and Scrutiny Committee - Healthwatch T&W shared feedback that members of the public had sometimes been confused by the engagement offer, as to whether events were presentations or open-ended drop-ins.	Engagement portion of the SaTH website, content in presentations, and social media updated to more clearly list upcoming events as either presentations or drop-ins.

Additional Engagement Routes

Event & Date	Subject
Hospitals Update meeting	Monthly Trust News Update including update on HTP
Monthly newsletter email update - sent to our 4900+ community members	Update from Public Participation team including HTP update and details on how to get involved
Quarterly Public Assurance Forum (next one November 2025) with representatives from organisations across health & social care in Shropshire, Telford & Wrekin & Mid-Wales	Presentation from HTP team with Q&As
SaTH website and intranet	Webpages which support public engagement and Latest HTP meetings/feedback Public Participation – SaTH
Quarterly About Health online updates (next one July 202	One hour MS Teams online presentation for public from HTP team with Q&As

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VOLUNTEERS

Volunteers

The Shrewsbury and Telford Hospital NHS Trust

- We currently have **214** active volunteers at the Trust.
- **Volunteer Team –** During the past 6 months there have been changes within the volunteer team. We have a new Volunteer Service Manager (Eve Simmonds-Jones) and Jeremy Gardner (Volunteer Facilitator). We are also currently recruiting for a Band 5 to fill a vacant position.
- **Volunteer Coffee and Catch Up – Evening Sessions.** It was lovely to see so many volunteers attending our evening sessions of our monthly 'Coffee and Catch up'. We plan to hold 6 monthly evening sessions to give volunteers with commitments during the day the opportunity to attend, in place of one of our monthly morning sessions.
- Our session at RSH was attended by the Director of Public Participation, Julia Clarke, and our session at the PRH was attended by Hannah Morris, Head of Public Participation. Volunteers enjoyed the opportunity to have a valuable update on the services and developments within the hospital, along with being able to ask any questions they might have, and chat to other volunteers.
- **Our processing time for new volunteers from June to September was, on average, 3.2 weeks** which includes all recruitment checks (references, DBS, Occupational Health clearance) and mandatory training. Any delays were due to volunteers not completing their training or providing references, rather than internal processes.

April 25 – Sept 25

Total Active volunteers	214
Total hours	12542

Volunteer Highlights

The Shrewsbury and Telford Hospital NHS Trust

National Coverage

In collaboration with the National Charity Helpforce, we have been able to highlight the amazing work of our volunteers has gained local and national media attention with the inspirational stories of Alisha-Mai Stevens, Claire Ashton and Robert Turner.

- 17-year-old **Alisha-Mai Stevens** volunteers on the Discharge Lounge at the Princess Royal Hospital and has shared her desire to give something back after seeing the care and support her mother receives with her ongoing battle with cancer. Alisha's story has been featured on the BBC, Radio Shropshire and also the Shropshire Star. Telford teen volunteer inspired by mum's cancer treatment - BBC News
- **Claire Ashton** has also had the national spotlight shining on the work she does with our new Volunteer Driver Service, Patient Transport Buggy Service and our Equity, Diversity, and Inclusion Panel. Claire's story has been featured nationally by Helpforce and also included in a write up in the Shropshire Star. Shropshire hospital helpers from teenage to retirement age back mass mobilisation of NHS volunteers | Shropshire Star
- Another volunteer receiving recognition is **Robert Turner**, who was our original Volunteer Driver at the Princess Royal Site and played a key part in its success. Robert's story has also been featured in nationally with Helpforce. Helpforce | 75 year old Robert urges others to volunteer their...

Volunteer, Alisha-Mai

Volunteer Highlights

The Shrewsbury and Telford Hospital NHS Trust

Exercise Jupiter

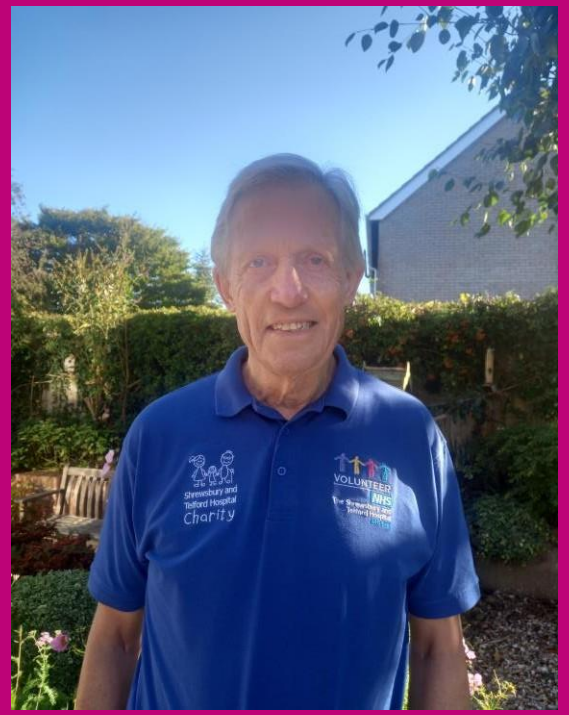
With the help and support of our volunteers, we carried out 'Exercise Jupiter', a simulated Mass Casualty/Hazmat exercise which was been planned in conjunction with the RAF and supports The Shrewsbury & Telford Hospitals (SaTH) Trust's obligations as a 'Category 1' Responder under the Civil Contingencies Act (2004) and supports the requirements of NHSE Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

Initial Operational Response (IOR) Training

In September, we held two IOR training sessions to ensure that all volunteers who volunteer in a 'Meet and Greet' role are aware of what to do in the event of a CBRN / HAZMAT self-presenting casualty attending at the hospital.

Appointment Reminder Service Update

Our new Volunteer Appointment Reminder Service had a successful trial in September and is now ready for the next phase and we are excited to start building the service and supporting more of our patients to attend their appointments, or to officially cancel them to release capacity for other patients waiting.



Meet and Greet Volunteer, Edward

Volunteer Highlights

- **Duke of Edinburgh Award** – Following a meeting with the DofE charity we are now applying to become an Approved Activity Provider for volunteering. This will support more young people access volunteering opportunities at SaTH as part of their award!

- **The new Digital volunteer role has been launched –** Some of our volunteers are started a new role at SaTH, following training from our Digital team. Our digital volunteers have been trained on the NHS app and are supporting patients within clinics to now in accessing their NHS information and appointments digitally.

- **Vertical Evacuation event at SERII, RSH** – 7 volunteers supported a training event at SERII, which was showing staff how to safely evacuation the building in an emergency

- **In April we recognised 1000 hours of committed volunteering by John and Judi Anderson.** In 2024 John and Judi undertook over 1000 hours of volunteering between them. Well known faces they are often seen staffing the meet and greet information desk at the PRH, but they also volunteer in other areas such as the discharge lounge and as patient companions.

Volunteer Highlights - Patient Transport Buggy Service, RSH

- Following joint funding by SaTH Charity and the League of Friends we have been able to purchase a volunteer buggy. The buggy is to support patients with mobility issues to get to outpatient clinics from the treatment centre
- The first group of volunteer drivers have now completed their theory and practical training.
- The new service officially launched on Tuesday 7th October.
- Volunteers will be transporting patients on the designated route between the Treatment Centre Entrance and the Outpatient Clinics.
- New 'Bus Stop' seats have been installed at the Clinics and temporary 'Bus Stop' signage is now in place.

Discharge Support Volunteer Project

The Shrewsbury and Telford Hospital NHS Trust

Following 6 months of funding from the ICB, SaTH developed a new volunteer driver service which launched at the beginning of June at the Royal Shrewsbury Hospital and Princess Royal Hospital.

Our service provides:

- Transport to patients who qualify for non-emergency hospital transport. These patients are often referred to as '1PC'.
- We also support patients who do not qualify for hospital transport but are either unable to get home by themselves or face long waits for friends or family to collect them.
- A delivery service for medications, equipment and discharge letters to allow patients to get home quicker and arrive in time to meet healthcare staff affiliated with commencing care packages.
- Whilst the service prioritises patients being discharged, when volunteers are available, we support patients from outpatients, A&E and the clinics.
- A 'settling in service'. This involves checking that patients have water, electricity and heating, along with a working mobile phone or landline before leaving the patient in their home.
- This service is available to adult patients (over 18), who can get in and out of a vehicle unaided.

Insight: Volunteer Driver activity from June – September 2025

The Shrewsbury and Telford Hospital NHS Trust

462
Journeys made by volunteer drivers since June

90.5%
Patients were collected in 30 minutes or less post-discharge

71.3%
Were patient transport journeys

28.7%
Journeys were delivering medication, letters and equipment

- Our volunteer drivers continue to offer amazing support to our patients, and we now have 14 operational drivers with 4 drivers going through recruitment process.
- In addition to successful trial for discharged patients we have extended the service to support Outpatient, Maternity and Renal patients.
- We are also trialling a daily delivery of letters, medication and personal belongings to allow patients to leave hospital quicker following discharge.

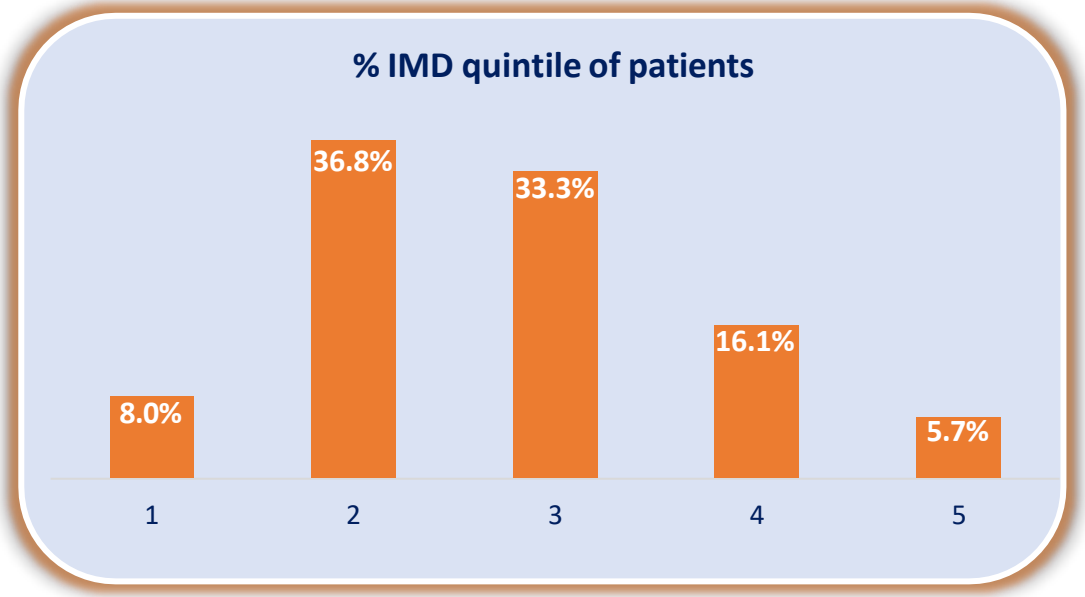
CASE STUDY: Positive patient experience

Our volunteer driver took an elderly patient home at lunchtime patient at lunchtime, and on arriving home was met with a very happy wife who became emotional when she explained that her husband had periodically spent time in hospital and how pleased she was to have him home so early this time, as he had arrived home at midnight the last time he was discharged. She went on to say that their daughter is unwell, she is unable to drive herself, and on the previous occasion, she had spent all day waiting and wondering where he was, so to have him home in time for lunch was a huge relief for her.

Impact: Health inequalities and deprivation

The Shrewsbury and Telford Hospital NHS Trust

- For all patient journeys, we recorded the postcode of the patient's destination address.
- We looked at the whether patients within areas of high deprivation were more likely to utilise our service.
- We compared our data with the Index of Multiple Deprivation (IMD)[1] quintile 1 is the most deprived and 5 is the least deprived.
- **44.8% of patients** who utilised our service were in the **1st and 2nd quintiles for deprivation.**



CASE STUDY: Supporting vulnerable patients who face health inequalities

A 38-year-old patient with no fixed abode had been in hospital for 4 weeks and was being discharged to hostel accommodation. The patient was not eligible for patient transport however he had no money to spare for a taxi and was unable to use public transport due to being on crutches and having multiple bags with him which due to his health condition was unable to carry. In addition, the only accommodation available to him at that time was an upstairs room. Our volunteer driver was able to take this patient to his new accommodation as soon as he was ready to discharge and carried the patient's bags to allow him to navigate the staircase with his crutches without having to struggle with his belongings. Our volunteer helped the patient to access his accommodation and delivered his belongings along with ensuring that everything was in working order and that the patient was safe, comfortable and able to focus on his recovery.

SATH CHARITY

SaTH Charity Highlights

- Income for the 6 months April-September 2025 was £217,683 compared to £349,982 in the same period last year. *I*n May and August 2024 we received 3 legacies totalling £212,489 which is why the income is significantly higher for that period

  Expenditure for the same period was £342,919 compared to £178,986 in 2024/25.

- SaTH Charity 5 Year Strategy document is now live for staff and the public to view: SaTH Charity Strategy 2025 - 2030 by The Shrewsbury and Telford Hospital NHS Trust – Issuu

- **During this period SaTH Charity had:**
  - **916** monetary donation entries registered on the charity database.
  - **18** donations were 'In Memory' donations from funeral services.
  - Over **1200** members of staff are now playing the staff lottery, which funds the Small Things Big Difference Fund for staff requests.
  - There were **189** requests for support from SaTH Charity, **71** of which were for the Small Things/Big Difference Fund

SaTH Expenditure

- There were **183** approved requests for charitable funds. Examples of approved funding included:

- **New Stretcher Improves Patient Care for Cardiology Patients £6,098** SaTH Charity recently purchased a fluoroscopy stretcher for Cardiology; by purchasing this stretcher patients will receive quicker treatment, it requires less personnel to operate and therefore a team could be stood up quicker in an emergency.

- **The Opening of the Library Wellbeing Zone at Royal Shrewsbury Hospital - £192** Funded by the Small Things Big Difference Fund which is from the Staff lottery, the Wellbeing Zone offers a much-needed area of calm amidst the busy hospital environment and includes calming activities such as Lego and jigsaw puzzles.

- **3 x Milano chairs £5,670 -** 3 specialist chairs have been purchased by SaTH Charity for use on ward 9 and ward 28 to support patients getting up and moving to support efforts to reduce deconditioning.

SaTH Charity Supporters

The Shrewsbury and Telford Hospital NHS Trust

Donors

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

Fundraisers

Organise events, and other initiatives, such as a sponsorship for a marathon, to raise money and donations. This will be drawn through our links with donation pages such as Just Giving

Donors	
Number of Donations	Total
1	972
2 to 4	75
5 and above	10

Fundraisers	
Number of Fundraising Pages	Total
1	78
2 and above	17

Transforming PRH Hub opens at Princess Royal Hospital

The Shrewsbury and Telford Hospital NHS Trust

SaTH Charity is delighted to announce the opening of a dedicated Transforming PRH Hub, in collaboration with the League of Friends of the Shrewsbury and Telford Hospital and Lingen Davies charities. The Hub officially opened its doors on 5 September at the main entrance of Princess Royal (PRH), with local partners in attendance, including local MP Shaun Davies. The hub will serve as a central information point for patients, visitors and staff to find out more about the work happening to transform PRH and how they can get involved.

Impact Statement:
"Together, we are committed to advancing healthcare services and ensuring that every patient receives the highest standard of care possible. With the support of local people, and our charities, we are planning a multi-million pound investment in PRH, to provide state of the art respiratory and cancer services. This will help us to provide a better experience and help reduce travel and waiting times for some of our most vulnerable patients. We will continue to keep people informed and involved as our work progresses. "The Hub is a significant step forward in our mission to deliver exceptional healthcare and support to the people of Telford and beyond."
Jo Williams, Chief Executive of SaTH

Supporting our Patients (1)

The Shrewsbury and Telford Hospital NHS Trust

Robotic scope for upper GI surgery - £23,179

The charity has purchased a fourth robotic scope to be used for Upper Gastrointestinal Surgery. The Trust has 3 scopes available to use. They are single use and therefore only 3 patients can be operated on using the robot per day as the scopes are sent to decontamination prior to being used again. There is capacity on the list for four patients, however the fourth patient has to be operated on without the robot.

The benefits of robotic surgery are enhanced precision and dexterity, improved visualisation for the surgeon which reduces accidental injury, it is less invasive resulting in less pain, reduced infection risk, less blood loss and faster recovery times.

Impact Statement:
"Whilst robotic surgery is not necessarily quicker it does support quicker recovery times, increased Daycase surgery and shorter length of stays for those that do need to stay in hospital so helps us to be more productive whilst offering a greater patient experience." **Claire Bailey, Operations Manager, Theatres**

Image of the Da Vinci Surgical Robot purchase by the Trust. The new scope will now allow for some Upper GI patients to benefit from this state-of-the-art surgery.

Supporting our Patients (2)

The Shrewsbury and Telford Hospital NHS Trust

New Stretcher Improves Patient Care for Cardiology Patients £6,098

SaTH Charity recently purchased a fluoroscopy stretcher for Cardiology; by purchasing this stretcher patients will receive quicker treatment, it requires less personnel to operate and therefore a team could be stood up quicker in an emergency. The area the stretcher resides is purpose built which means that patients are treated in a more comfortable and less daunting environment.

The stretcher cost £6098 and is made in such a way that the x-ray imaging arm can fit under it, which means patients can be treated nearer the ward for things like temporary pacemakers and Pericardiocentesis which reduces the need for them to go down to the Cath lab.

Impact Statement:
"The purchase of this stretcher will transform care in Cardiology, having a positive impact in many areas including freeing up space on other emergency, reducing staffing costs, increased utilisation of the room. It will also have a positive impact on staff wellbeing as they will be nearer their area and less people would need to be called into the hospital out of hours to undertake these emergency procedures."
Keely Banks, Echocardiography Lead/Clinical Scientist

Fluoroscopy stretcher in Cardiology

Supporting our Staff

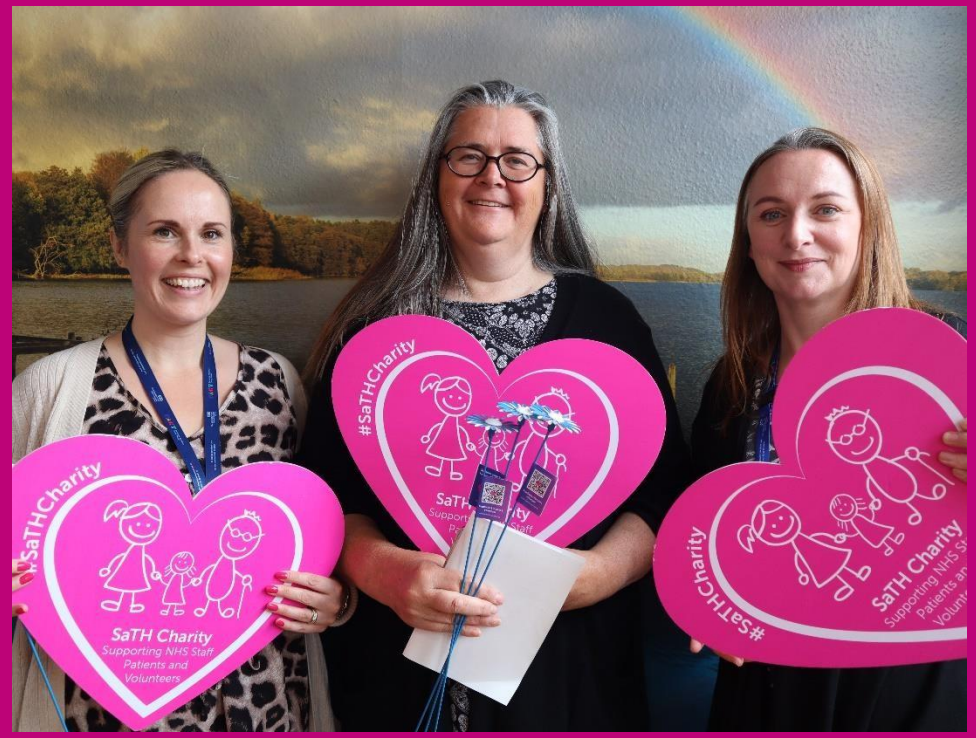
The Shrewsbury and Telford Hospital NHS Trust

SaTH Charity Thank You Daisies

In honour of the NHS birthday on July 5th, SaTH Charity spread some serious sunshine with their annual Thank You nominations! This year, an amazing 270 people received these special daisies at both PRH and RSH — each one came with a card revealing their nomination and who put them forward them.

Staff have been buzzing with excitement, reading their cards and discovering who has taken the time to appreciate them!

Impact Statement:
““Congratulations to all the SaTH Charity Daisy recipients — your nominations were so well deserved. A huge thank you to everyone who took the time to nominate a colleague. These daisies are a beautiful way to say thank you for all the dedication and care you show every day.” Julia Clarke, Director of Public Participation



Staff receiving their nominations and thank you daisies in the Mytton Oak Restaurant.

Celebrating our Fundraisers (1)

The Shrewsbury and Telford Hospital NHS Trust

Tracy Hamer successfully completed the Manchester Marathon on 27 April in 4h 36 mins and raised £3,360 for SaTH Charity to give back to the Neonatal Unit where her grandson Henry was treated in December 2024.

Tracy Hamer's grandson Henry was born on Christmas Day last year and needed the support of the Neonatal Team at Princess Royal Hospital in Telford. He was discharged after eight days and is now a healthy baby boy.

Shrewsbury Half Marathon Raises over £3,000

SaTH Charity secured several places in this year's Shrewsbury Half Marathon, which is took place on Sunday 28 September 2025. Six fundraisers, mainly staff, took on the run on an unseasonally warm day. The runners took on either a half marathon (13.1 miles) or a metric half marathon (8.1 miles).

Impact Statement:

"In a moment of madness we decided to take on Shrewsbury Half Marathon to raise money for a cause close to our hearts - the Children's Ward at The Shrewsbury and Telford Hospital NHS Trust. When our little boy, Tomi, was two weeks old he began having seizures. Tomi stayed on the Children's Ward at Telford for a couple of weeks and the care he received was fantastic. Tomi has made a brilliant recovery and at 18 months old he is now thriving. We will forever be grateful to the staff on the Children's Ward for helping us through such a tough time."

Celebrating our Fundraisers (2)

The Shrewsbury and Telford Hospital NHS Trust

The Swan Fund has celebrated a milestone birthday, turning 10 years old and raising over £100,000 thanks to the generosity of the public.

The fund was created in 2015 with a £500 donation collected at the funeral of Jules Lewis' father Harold who died at the Royal Shrewsbury Hospital (RSH).

The money raised is used to support last hours and days care for patients and their loved ones.

To celebrate the fund's birthday, the team invited the volunteers and knitters to a thank you café at Shropshire Education & Conference Centre to thank them for their ongoing support.

Impact Statement:
"It is so lovely that we have turned the date of my lovely dad's death into the Swan Fund Anniversary, a joyful and hopeful thank you café to celebrate the dedication of volunteers and knitters to our 'one chance' work, dad would have loved that. The day was such a heartwarming morning celebrating our volunteers and knitters."
Jules Lewis, End of Life Care Facilitator/Lead Nurse

Jules Lewis, Julia Clarke and Jules Lock who baked the cake.

Working in Partnership – Football Tournament (1)

The third annual SaTH Charity Football Tournament took place on Sunday 1 June at the Sports Village in Shrewsbury.

The event was a great success with 160 members of NHS staff, from SaTH, students from Keele University and a team from West Midlands Ambulance, taking part and together they raised nearly £4,800 for the Dementia appeal and the Neonatal Unit of SaTH Charity.

Congratulations to the winning team Drongo's United and the runners up SaTHletico Madrid. The winner of the runners up SaTH Charity cup was Fantasy First Responders, made up of West Midlands Ambulance Service.

Impact Statement:
"We are grateful to have been selected as one of the funds to benefit from the money raised by the SaTH Chairty Annual Football Tournament. We know our young patients and their families will benefit from the money raised, we are always striving to improve their experience during their time on the unit." **Jo Demers, Neonatal Matron**

Fantasy First Responders from West Midlands Ambulance and Teresa Boughey presenting the SaTH Charity Runners up Cup

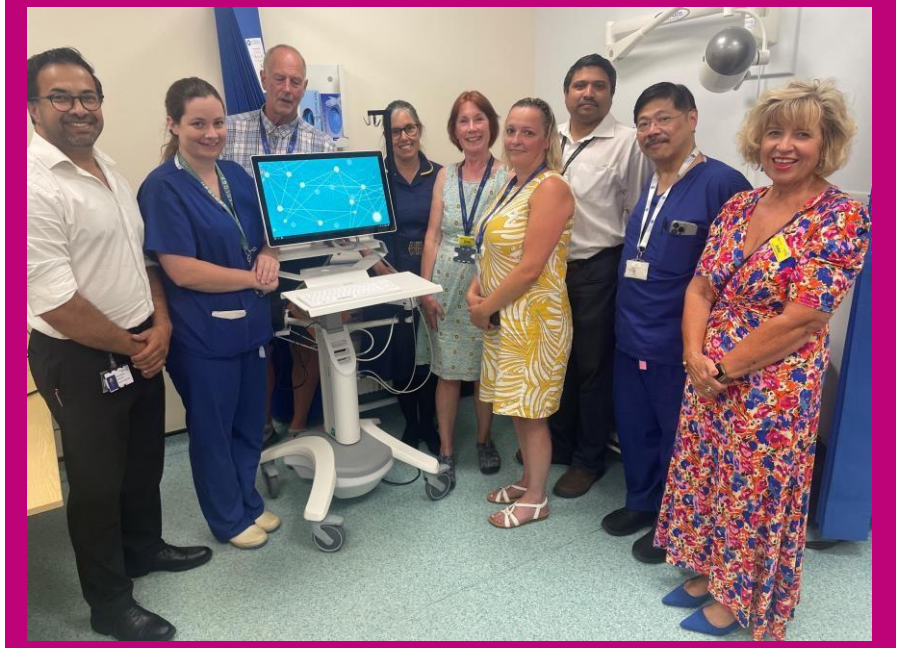
Working in Partnership (2)

The Shrewsbury and Telford Hospital NHS Trust

Charity Partnerships and Staff Dedication Drive Major Advancements in Urology Services at SaTH

The League of Friends of the Shrewsbury and Telford Hospital has generously donated nearly £245,000, playing a crucial role in transforming the care available for urology patients across both hospital sites. The substantial investment, jointly supported by SaTH Charity, has enabled the purchase of vital equipment including a Urodynamics machine, a Percutaneous nephrolithotomy (PCNL) machine, and enhanced capabilities for HoLEP (Holmium laser enucleation of the prostate) procedures. These additions have helped reduce waiting times, improve patient comfort, and allow a greater number of operations to take place locally.

Impact Statement:
"The Urodynamics machines has been installed at the Royal Shrewsbury Hospital, allowing patients to be seen more quickly and closer to home. Urodynamics testing helps assess bladder and urethra function and is key in diagnosing complex urinary symptoms. The presence of this equipment on both hospital sites has significantly reduced waiting lists and improved access to care." **Naing Lynn, Consultant Urologist**



SaTH Charity, the LOF and staff from Urology around the new Urodynamics machine.

Looking Forward

Public Participation- Forward Look

The Shrewsbury and Telford Hospital NHS Trust

- The Public Assurance Forum to meet on 19th January 2026
- Continue to support staff with any future service changes engagement
- Supporting the HTP Engagement programme, including the quarterly focus group for the public and patients.
- Continued attendance at community events to engage with the public
- Continuing to support staff wellbeing through Charity Small Things Big Difference Fund
- Support fundraising for the Hospitals Transformation Programme
- Develop our 5-year strategy for Volunteers and Community Engagement with our staff, volunteers and local communities
- Continue to grow and support our volunteers and the opportunities we provide to them

Dates for your diary

The Shrewsbury and Telford Hospital NHS Trust

Date	Time	Event	Booking
Thursday 13 November	18:30 – 19:30	*About Health* – **Diabetes Footcare**	
Wednesday 26 November 2025	11:00 – 12:00	**Monthly Hospital Update** (formerly Community Cascade)	
Thursday 4 December	18:30 – 19:30	*About Health* – **Patient Portal**	

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

Hospitals Transformation Focus Group

Date	Time	Event	Booking
Tuesday 4 November 2025	18:30 – 19:30	*About Health* – **Hospitals Transformation Programme**	If you are interested in joining a Focus Group please email sath.engagement@nhs.net
Tuesday 2 December 2025	10:00 – 12:00	**HTP Quarterly Focus Group**	
Friday 5 December 2025	10:00 – 12:00	**HTP Critical Care Sky Garden Focus Group**	

The Shrewsbury and Telford Hospital NHS Trust

Appendix 1. Summary of the progress against delivery of the SaTH Governance, Leadership Improvement Plan 2025/26.

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
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~~ 31/10/2025	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 were agreed at 3 September 2025 Financial Recovery Group (FRG) and approved at Finance Assurance Committee on 30 September 2025.	**Complete**
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.	**On track**
SaTH 4.3.4	Approve new Risk Management Policy by SATH Board	Anna Milanec	01/01/2025	28/02/2026	The new Risk Management Policy and Risk Management Strategy remain under review. Both are scheduled for Audit & Risk Assurance Committee on 24 November, prior to January 2026 Board.	**On track**
SaTH 4.4.3	Continue to drive the delivery of a system PMO with all partners	Ned Hobbs	01/11/2024	31/12/2025	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.	**On track**
SaTH 4.4.4	Carry out Board skills audit to include new board members. Deliverable: A comprehensive report summarising the skills, experience, and competencies of all current and newly appointed board members.	Anna Milanec	01/09/2025	28/02/2026	SaTH Board skills audit has been undertaken 31 October 2025.	**Complete**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.4.5	Develop template for joint Committee Terms of Reference between both providers as part of the group model (SaTH and Shropcom). Agree (joint) membership of board committees. Deliverable: A jointly developed Terms of Reference (ToR) template for board committees, including agreed membership from both SaTH and Shropcom as part of the group model.	Deborah Bryce Anna Milanec	01/09/2025	~~31/12/2025~~ 31/03/2026 (pending confirmation of appointment of group members)		**On track**
SaTH 4.4.6	Pilot the Group People and OD Committee as the initial joint committee to unify workforce strategy, culture, and talent development. Deliverable: Successful piloting of the Group People and OD Committee, with documented outcomes demonstrating progress in aligning workforce strategy, culture, and talent development across SaTH and Shropcom.	Deborah Bryce	01/09/2025	31/12/2025	Currently agreeing a committee in common meeting schedule, to start in November 2025.	**On track**
SaTH 4.4.7	Develop an Accountable and Governance Group Framework for setting out shared principles, objectives, and ways of working of the two providers working together (SaTH and Shropcom). (Superseded by 4.1.14 and 4.2.5). Deliverable: A documented Accountable and Governance Group Framework outlining the above.	Anna Milanec	01/09/2025	31/3/2026		**On track**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.4.8	The decision taken by the Boards on 23/9/25 to formally agree to the establishment of the Group, now allows action to be taken to appoint the Joint Leadership Team. Deliverable: Formal Board decision (dated 23/09/25) approving the establishment of the Group, enabling the initiation of the Joint Leadership Team appointment process.	Group Chair /Group CEO	01/09/2025	31/3/2026	In progress. Remuneration Committees to consider process and timeline.	**On track**
SaTH 4.4.9	Continue with joint Board Development sessions (SaTH/ShropCom) to build cohesion to greater facilitate close working together. Deliverable: Ongoing programme of joint Board Development sessions between SaTH and Shropcom, with documented outcomes demonstrating increased cohesion and strengthened collaborative working.	Group Chair / Director of Governance	01/09/2025	31/3/2026	A joint Board of Director development day was held on 23rd October 2025. Next one scheduled during February 2026.	**On track**
SaTH 4.4.10	Unified Communications Strategy: • Create a joint internal and external communications plan to keep stakeholder informed and involve as the group is established. • Ensure consistent messaging to staff, stakeholders, and the public. Deliverable: A unified internal and external communications plan jointly developed by SaTH and Shropcom, outlining key messages, communication channels, stakeholder engagement approaches, and timelines to support the establishment of the Group.	Jenny Fullard	01/05/2025	31/3/2026	Joint internal and external communications plan in place and progressing well.	**On track**

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 2:
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 and Long Term Plan

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

Task ID	Task	Task Owner	Start Date	End Date	Progress	BRAG Status
STW 2.1.23	Temporary Staffing Task & Finish group implement Phase 2 of NHSE Midlands initiative (bank rates) Eliminate off framework and reduce agency usage across the Trust	Denise Rotchell	01/06/2025	31/03/2026	Complete for non-medical areas. Agency rates for medical workforce are being reduced from September 2025.	On Track
STW 2.1.26	E-Rostering implementation – medical workforce Phase 1	Laura Carlyon	01/08/2025	31/12/2026	Progress made but full roll out of medical workforce is going to take minimum of 12 months.	On Track
STW 2.1.27	Develop fragile services action plan supported by Caroline McIntyre, Head of Workforce Transformation	Ned Hobbs & John Jones	01/07/2025	31/03/2026		On Track
2.1.1	Identify baseline and outturn forecast	SB	04/11/2025	30/11/2025		On Track
2.1.2	Review known changes, service changes needed, and business cases approved from 26/27	BPs	01/12/2025	31/12/2025		On Track
2.1.3	Outline any assumptions in terms of workforce metrics, turnover absence levels	SB	01/12/2025	31/12/2025		On Track
2.1.4	Populate Workforce Planning Template	CM	06/01/2026	31/01/2026		On Track
2.1.5	Calculate the % Change by Staff Group	CM	06/01/2026	31/01/2026		On Track
2.1.6	Challenge / Sense Check Data	CM	03/02/2025	28/02/2026		On Track
2.1.7	Review Data with Stakeholders (Divisional teams etc.)	SB	03/02/2025	28/02/2026		On Track
2.1.8	Populate Master Template and Triangulate with Finance and Operations	SB	03/02/2025	28/02/2026		On Track
2.1.9	Final Sign Off - Board and NHSE	RB	03/03/2025	31/03/2025		On Track

2025-26 SIIP Workforce and Leadership Plan for completion by 28 February 2026

Task ID	Task	Task Owner	Start Date	End Date	Progress	BRAG Status
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 in line with HTP	SK	01/05/2025	31/03/2026	Bimonthly HTP workforce report	On track
2.1.11	Develop set of actions and milestones that links in with the workforce plan that supports each priority area with time frame and actions owners	SK	01/05/2025	31/03/2026	Bimonthly HTP workforce report	On Track
2.1.12	Finalise workforce plan linking in with the operational plan with fully supported narrative describing the impact and benefit of delivery the plan	SB	02/12/2025	31/12/2025		On Track
2.1.13	Capture risks to delivery of plan and any mitigations to reduce risk	SB/EW / SK	01/04/2025	31/03/2026	BAF in place Risk Register in place	On Track
2.1.14	Develop summary project plan showing high level timescale – Gantt chart	SB	02/02/2025	31/12/2025		On Track
2.1.15	Gain sign off workforce plan linking in with the operational plan from each provider and NHS England	RB	06/01/2026	31/01/2026		On Track
2.1.16	Ensure actions and milestones monitoring is incorporated into fortnightly agenda of system workforce group. Have clear Terms of Reference agreed at the group.	SB	06/01/2026	31/01/2026		On Track

Metric 2.2: Delivery of SaTH People and OD strategy actions for 2026/27

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
2.2.1	Deliver our cultural and leadership Programmes.	EW	01/04/2025	31/03/2026	- Annual plan in place to deliver leadership development, HWB, OD interventions, Staff Survey, Reward & Recognition, EDI improvement plans. - Reports to Strategic People Group/ PODAC - Quarterly People Pulse - Preparation for Group Communication & OD Engagement plans	On track
2.2.3	Deliver our Workforce Digital Programme including: • Deploy Manager Self-service. • Continuing to support Job Re-design/ Team Job Planning including different approaches to rostering, agile and flexible working. • Further development and roll out of medical electronic rostering and dashboards to provide greater visibility of doctor working hours.	LC	01/04/2025	31/03/2026		On Track
2.2.5	Develop our expansion plans linked in with the Operational Plan to support an increase in e.g. student placements, medical school placements, GP placements etc	WM/SF	01/04/2025	31/03/2025		On Track
2.2.6	Work with Higher Education Institutions to develop innovative education pathways and new clinical roles, creating accessible recruitment and career routes that build a sustainable pipeline of local talent.	TG/ RA/ SF	01/03/2025	31/3/2026	Bimonthly Education Group Reports Education annual report	On track

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 and Shared Services. Deliverables: A framework of provider collaboration in place across the system:- • SaTH and SCHT are working towards a new shared leadership 'Group model'. • MSK provider collaborative (RJAH, SCHT, SATH). • Acute provider arrangements with out of area. providers e.g. SaTH and UHNM, RJAH and ROH.	TC SL	In progress	31/03/2026	Highlight reports 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. Group model work in progress.	On track

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	Continued improvement of the workforce dashboard measures for SaTH and Shropcom	EW/ SB	01/04/2025	31/3/2026	Annual Cultural dashboard ¼ People Pulse/ NSS IPR	On track

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 2025/26

The Shrewsbury and Telford Hospital NHS Trust

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	Task *The tasks you need to complete to produce the deliverables (*	Task ID	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG
SaTH has an agreed medium term 3-5 year financial plan (MTFP) in place that has been signed off by the Board and agreed with the ICS and NHS England Triangulation exercise - financial plan to workforce, activity and performance plans; with evidence of testing and review against the HTP model. To be included with the MTFP for sign off. A further SaTH +5 year high level summary plan is required to align with HTP timescales and underlying financial balance for the system MTFP to include a summary of efficiencies linked to benchmarking opportunities	Ongoing monitoring of underlying position against MTFP and HTP assumptions	SaTH 1.1.3	AW	Ongoing	31/03/2025 31/03/2026		**On Track**
	Annual refresh of MTFP and 5-year high level financial plan (including triangulation)	SaTH 1.1.2	AW	Commenced	~~31/12/2025~~ 31/01/2026		**On Track**
	2025/26 Annual refresh of Joint Forward Plan (JFP)	STW 1.1.6	Nigel Lee	31/01/2026	31/03/2026		**On Track**

SaTH SIIP actions due to be completed by 28 February 2026

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
24/25 and 25/26 financial plans agreed and signed off by SaTH aligned to the ICS plans and NHS England Plans to include a fully developed Financial Improvement Plan (i.e. CIPs) with supporting PIDs linked to the benchmarking opportunities	In year monitoring of financial performance against plan assumptions identifying escalation actions where needed (oversight through OPOG, FRG and Finance Committee	SaTH 1.2.23	AW	Ongoing	Ongoing 31/03/2026	£1.3m off plan at month 6. Risk identified as well as additional mitigations. Closely monitored through Finance Assurance Committee (FAC).	**On Track**
	Monitor ongoing demand & capacity actuals against plan assumptions identifying escalation actions where needed (oversight through OPOG and Performance Committee)	SaTH 1.2.24	Ned Hobbs	Ongoing	Ongoing 31/03/2026		**On Track**
Capital plans for 24/25 and 25/26 signed off by SaTH aligned to system plans and NHS England	Support system delivery of 25/26 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG. Delivery against Phase 1 I&I organisation specific intervention action plans (Enhance vacancy scrutiny panels, temporary staffing controls and	SaTH 1.3.8	AW	30/04/2025	31/03/2026		**On Track**
		SaTH 1.4.2	AW	Commenced	30/11/2025		**On Track**

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
Capital plans for 24/25 and 25/26 signed off by SaTH aligned to system plans and NHS England	de-risking cost efficiency schemes). Monitored weekly and reported to ICS						
	Follow up review of I&I actions to ensure continued delivery	SaTH 1.4.4	AW	30/08/2025	31/10/2025 30/11/2025	Completed and monitored through FRG.	**Complete; Evidence received**
	External review of individual organisation assessment against NHSE grip and control checklist & HFMA Financial Sustainability checklist and efficacy of controls.	SaTH 1.4.5	AW	1/10/2025	Ongoing 31/12/2025	Completed in 2024-25 and in the process of being refreshed for 2025-26. Internal Audit to review in Q3.	**On Track**
	Delivery of individual organisational internal audit report recommendations from prior years and pro-active management in year (Monthly review).	SaTH 1.4.6	AW	Ongoing	31/03/2026		**On Track**
	Individual organisational tracking of timely completion of internal audit actions (Monthly).	SaTH 1.4.7	AW	Ongoing	31/03/2026		**On Track**
	Delivery of individual organisational external	SaTH 1.4.8	AW	Ongoing	31/03/2026		**On Track**

SaTH SIIP actions due to be completed by 28 February 2026

Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Task** *The tasks you need to complete to produce the deliverables (*	**Task ID**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**BRAG**
Capital plans for 24/25 and 25/26 signed off by SaTH aligned to system plans and NHS England	audit report recommendations						
	Individual organisational tracking of timely completion of external audit actions (Monthly).	SaTH 1.4.9	AW	Ongoing	31/03/2026		**On Track**
	Internal Audit findings for all finance related audits to be rated moderate or substantial	SaTH 1.4.10	AW	Ongoing	31/03/2026		**On Track**
	External audit including VFM to be rated moderate or substantial	SaTH 1.4.12	AW	Ongoing	31/03/2026		**On Track**

BRAG Status
Completed and evidenced
On Track
At Risk
Off Track

Appendix 4
Summary of the progress against delivery of the SaTH elements of the System led UEC Improvement Plan 2025/26 plan

The Shrewsbury and Telford Hospital NHS Trust

3.1	**Deliver SaTH elements/ benefits of the System led UEC Improvement Plan 2025/26 plan**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.1	**Delivery of the SaTH UEC Transformation Programme actions for the MEC Transformation Programme**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.1.1	Increase in utilisation of UTC to 25%	Rebecca Houlston	01/07/2025	31/03/2026	September 2025 showed slightly improved performance to 19.3% from 18.4% in August 2025. GP recruitment continues	
SaTH 3.1.1.6	Improvement in UTC 4 hour performance to >90%	Rebecca Houlston	01/07/2025	31/03/2026	September 2025 performance was 87.8%, an improvement from August 2025 which was 81.1%. September performance is the highest since March 2025.	
SaTH 3.1.1.3	Implement further GP direct access speciality pathways across women's and children's services	Zain Siddiqui	05/12/2024	~~01/01/2025~~ 28/02/2026		
SaTH 3.1.1.4	Implement further GP direct access speciality pathways across surgical services	Andrena Weston	05/12/2024	~~05/12/2024~~ 28/02/2026		
SaTH 3.1.1.5	Improve productivity of Minors	Rebecca Race Rebecca Houlston	01/07/2025	31/03/2026	New non-admitted task and finish group to launch in October 2025 which will include minors' performance	

2025/26 SaTH SIIP actions to be completed by 28 February 2026

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.1.7	Reduction in time to be seen by ED clinician to 60 mins (aligned to 4hr/12hr/mean offload metrics – (National Target)	Rebecca Race	01/07/2025	31/03/2026	Zonal working introduced in ED for senior clinicians. Partially aligned – ambulance metric monitored system-wide, but delivery supported through SaTH ED actions. Identify process improvements and staffing adjustments to achieve safe handover within 45 minutes	
SaTH 3.1.1.8	Improvement delivered in staff survey metrics for themes: recommend a family member be treated here, I would want to be treated here	Hannah Walpole	01/07/2025	31/03/2026		
SaTH 3.1.1.9	Reduction in the number of UTC hand backs	Rebecca Houlston	01/07/2025	31/03/2026		
3.1.1.10	Embedding of Initial Assessment clinical model to achieve 80% performance	Emma Harber	01/07/2025	31/03/2026	Initial assessment streaming model continues at both sites, streaming SOP awaiting senior sign off in October 2025	
3.1.1.11	Implementation of Frailty SDEC at PRH improving direct access to Frailty services and reducing 0 day length of stay for Frailty patients	Tom Phelps	01/07/2025	28/02/2026	Frailty SDEC on track to go live at PRH in December 2025	
SaTH 3.1.2	**Delivery of the SaTH UEC Transformation Programme actions for the Capacity and Flow Transformation Programme**					
SaTH 3.1.2.1	Improve response time to referrals on the AMU and Medical Wards currently 24 hours) by cardio and respiratory	Saskia Jones-Perrott	21/05/2024	30/04/2025	Complete	
SaTH 3.1.2.2	Review effectiveness of the admission and referral protocol following relaunch	Steve McKew	24/05/2024	30/05/2025	Complete	
SaTH 3.1.2.3	Reconfiguration of base on PRH site to expand acute medical beds to align with demand	Susanne Crossley	01/11/2024	~~07/01/2025~~ 31/01/2026	Operational and estates plans for ward moves providing additional capacity at both sites remain on track with ward moves planned for December 2025	

2025/26 SaTH SIIP actions to be completed by 28 February 2026

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 3.1.2.4	Recruitment following reconfiguration of Cardiorespiratory to optimise diagnostics	Nina Moran	31/05/2024	~~31/12/2025~~ 28/02/2026	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	Check completed	
SaTH 3.1.2.9	Radiology: 12hr turnaround draft proposal including procedures and SOP	Helen Williams	01/10/2024	~~31/05/2025~~ 30/11/2025	Data to be presented at the evidence provider review meeting 11th November – therefore this action will be closed and delivered.	
SaTH 3.1.2.12	Pathology – recruitment to extend out of hours provision	Adrian Vreed	01/11/2024	~~31/05/2025~~ 28/02/2026		
SaTH 3.1.2.15	Increase in patients referred to Medical SDEC of 5%	Liz Slevin	01/07/2025	31/03/2026		
SaTH 3.1.2.16	Implementation of back pain pathway	Andrew Evans	01/07/2025	31/03/2026		
SaTH 3.1.2.17	Reduction in 14 day / 21-day inpatient length of stay	Alison Vaughan	01/07/2025	31/03/2026	Care Transfer Hub have started management of change to extend operational hours to a 8am-8pm 7 day model to aid a reduction in length of stay for complex patients	
SaTH 3.1.2.18	Increasing Streaming opportunities to alternative pathways (Direct Access to specialties) by 5%	Susanne Crossley	01/07/2025	31/03/2026		
3.1.2.19	Improvement in pre 08:45 Discharge Lounge utilisation	Alison Vaughan	01/07/2025	31/03/2026	Develop pathway milestones to achieve target discharge ratios and early discharge utilisation.	
SaTH 3.1.2.20	Deliver key performance metrics in accordance with the 2025/26 operational plan (4 hour/12 hour/mean ambulance offload)	Ned Hobbs	01/07/2025	31/03/2026	4-hour breach validation work has been ongoing, further piece of work scoped to mitigate breaches between 4 and 5 hours which explores the discharge process within ED	

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
	Actively engage with system wide UEC work in relation to Acute Flow project, providing workstream updates and trajectories					
3.1.5	**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**
SaTH 3.1.5.1	Improvement in pre 08:45 Discharge Lounge utilisation	Alison Vaughan	01/08/2024	31/03/2026	Develop pathway milestones to achieve target discharge ratios and early discharge utilisation.	
SaTH 3.1.3	**Working with system partners to deliver 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 3.1.3.1	Continued engagement from surgery, medicine and ED with the Integrated Care Coordination Centre	Alison Vaughan	01/08/2024	31/03/2026		
SaTH 3.1.3.2	Engagement with ICCC and development of STW integrated urgent care model	Ned Hobbs	01/10/2024	31/03/2026	Align ICCC engagement plan and define pathway redesign deliverables.	
SaTH 3.1.3.3	Improving the data quality of ECDS to support identification of further alternative opportunities	Rebecca Houlston	01/11/2024	~~31/10/2025~~ 31/03/2026	Access to data has been achieved and is being reviewed with a view to submit and review the opportunities. Further work is being undertaken to review the accuracy of the data.	
3.1.4	**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**
STW 3.1.4.2	Frailty intervention team extended hours	Tom Phelps	12/06/2024	~~02/01/2025~~ 28/02/2026		
STW 3.1.4.11	Frailty Clinical advice & guidance line as part of the FAU offer	Tom Phelps	20/05/2024	~~03/01/2025~~ 28/02/2026		

2025/26 SaTH SIIP actions to be completed by 28 February 2026

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
~~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~~	To be replaced with SaTH 3.1.1.11: Implementation of Frailty SDEC at PRH improving direct access to Frailty services and reducing 0-day length of stay for Frailty patients	
3.3	**2025/26 Acute Flow**					
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 UEC Delivery Group reporting	Liz Slevin	05/01/2024	31/03/2026	The refreshed initial assessment process continues to be embedded cross-site. Follow up of CYP patients who leave ED without being seen remains compliant. Agree governance structure with System PMO for data visibility and evidence milestones.	
SaTH 3.3.2.1	Mean ambulance handover time	Susanne Crossly	01/04/2025	31/03/2026		
SaTH 3.3.2.2	Increasing streamlining of patients to SDEC to increase proportion of non elective admissions managed by zero length of stay	Susanne Crossly	01/04/2025	31/03/2026		
SaTH 3.3.2.3	Maximising the effectiveness of the UTC's to reduce type 1 ED demand	Susanne Crossly	01/04/2025	31/03/2026		
SaTH 3.3.2.4	Providing additional core and winter bed capacity	Susanne Crossly	01/04/2025	31/01/2026	Modular wards progressing	
3.4	**Delivery of the SaTH UEC Transformation Programme actions for the CSS Transformation Programme**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.4.1	Reduction in inappropriate physiotherapy / occupational therapy inpatient referrals	Charlotte Jacks	01/07/2025	31/03/2026		
SaTH 3.4.2	Review and implement assessment area for acute Oncology presentation	Sally Hodson	01/07/2025	31/03/2026		

2025/26 SaTH SIIP actions to be completed by 28 February 2026

BRAG Status
Completed and evidenced
On Track
At Risk
Off Track

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

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

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

PROGRESS AS AT 14.10.2025

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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

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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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FIRST OCKENDEN REPORT ACTION PLAN

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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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FIRST OCKENDEN REPORT ACTION PLAN

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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

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 14.10.2025

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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

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PROGRESS AS AT 14.10.2025

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
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. An exception report was presented at Oct-25's MNTAC changing this action's timeframe for assurance from Sep-25 to Jan-26. This will allow for additional work to be completed to further secure honorary contracts allowing for hands on practice in future rotation, following feedback from the already completed rotation.	14/05/24	31/01/26		P. Gardner	A.Sizer	Monday.com

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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight													
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - Evidenced and assured.	08/03/22	28/06/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/07/21	31/07/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.	Y	10/12/20	30/04/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	10/05/22	30/04/22	30/04/22	H. Flavell	H. Flavell	Monday.com
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	TBC	Evidenced and Assured	Completed	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. This action was agreed as "Evidenced and Assured" at Jul-25's MNTAC.	14/01/25	30/06/25	08/07/25	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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FIRST OCKENDEN REPORT ACTION PLAN

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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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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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

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

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

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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Local Actions For Learning Theme 11: Diabetes Care													
14.32	The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.	Y	30/0322	30/11/23	Delivered, Not Yet Evidenced	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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Local Actions For Learning Theme 13: Consultant Obstetric Ward Rounds and Clinical Review													
14.34	All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017237). These consultant reviews must occur with a clearly documented plan recorded in the maternity records	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	09/08/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.35	All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/10/22	30/04/23	10/01/22	H. Flavell	A. Sizer	Monday.com
14.36	The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR239 to enable all staff to escalate and communicate their concerns.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence & C. McInnes	Monday.com

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

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

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

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

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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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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Local Actions For Learning Theme 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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PROGRESS AS AT 14.10.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Local Actions For Learning Theme 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. An exception report was accepted at Aug-25's MNTAC with a new timeframe for assurance at Jan-27.	13/12/22	31/01/27		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 Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		TBC		J. Jones	P. Gardner	

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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	Delivered, Not Yet Evidenced	On Track	This action was accepted as 'Delivered, Not Yet Evidenced' at Jul-25's MNTAC. An exception report was accepted at Oct-25's MNTAC adjusting this action's tiomeframe for assurance to Feb-27, aligning with the latest assurance date within the plan as this action will only be assured once all other actions within the trust's power have been fully embedded.	08/07/25	28/02/27		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 Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		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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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 Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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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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PROGRESS AS AT 14.10.25

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FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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 Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		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	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. 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. This action was agreed as 'Delivered, Not Yet Evidenced' at Jul-25's MNTAC.	08/07/25	31/10/25		P. Gardner	A.Sizer	Monday.com
8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	09/05/23	H. Flavell	A. Sizer	Monday.com
8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	08/08/23	H. Flavell	A. Sizer	Monday.com

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

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

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Immediate and Essential Action 11: Obstetric Anaesthesia In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.												
11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MNTAC.	08/11/22	28/02/25	11/03/25	P. Gardner	J. Jones	Monday.com
11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/04/23	31/08/23	12/09/23	H. Flavell	J. Jones	Monday.com
11.3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	J. Jones	Monday.com
11.4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies (RCoA) obtaining resources. Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		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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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. An exception report was accepted at Aug-25's MNTAC, where a new timeline for Evidenced and Assured was set for Dec-25.	13/12/22	31/12/25		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. An exception report was accepted at Aug-25's MNTAC, where a new timeline for Evidenced and Assured was set for Dec-25.	13/12/22	31/12/25		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

Colour	Status	Description
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	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.

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

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Immediate and Essential Action 14: Neonatal Care There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.													
14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	28/02/23	13/09/22	J. Jones	H. Flavell	Monday.com
14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	This action has been accepted as 'Descoped' at the Mar-24 MTAC as its delivery sits with the Neonatal Delivery Network. The Trust will continue to work on enabling the rotation of Neonatal staff within other unites through its delivery of LAFL 4.100. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		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 Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		TBC		J. Jones	H. Flavell	Monday.com

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

Colour	Status	Description
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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 15: Supporting Families Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care													
15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com
15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com
15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com

Colour	Status	Description
	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.

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	2	23
Total	52	0	3	49
Percentage		0%	6%	94%

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	2	0	0	23	0
Total	52	0	3	0	0	49	0
Percentage		0%	6%	0%	0%	94%	0%

Counts

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	6	5	81
Total	158	7	8	143
Percentage		4%	5%	91%

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	5	0	0	81	6
Total	158	0	8	0	0	143	7
Percentage		0%	5%	0%	0%	91%	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	6	7	104
Total	210	7	11	192
Percentage		3.33%	5.24%	91.43%

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	7	0	0	104	6
Total	210	0	11	0	0	192	7
Percentage		0.0%	5.2%	0.0%	0.0%	91.4%	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
Jacqui Bolton	Interim Head 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 14.10.2025

APPENDIX TWO

Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR1/I_NEMR2	The service, an LNU, has retained equipment to provide nitric oxide even though changes have been made nationally to focus the provision of nitric oxide within NICUs. The equipment was rarely used and yet associated with anxiety among nursing staff, many of whom were said to lack experience or training in its use. It is therefore recommended that the nitric oxide equipment should be removed from the unit where currently it poses a risk.	Evidenced and Assured	Completed	This action was approved as 'Evidenced and Assured' at Jan-25's MNTAC. Evidence Requirements for Assurance: Letter from the Network Addition to Risk Register Updated Persistent Pulmonary Hypertension of the newborn (PPHN) guideline following nitric oxide removal Engineering services email confirming removal	Immediate (0-3 months)		14/01/2025		14/01/2025	Dr John Jones	CD's	Monday.com
NEMR2/I_NEMR3	The unit should develop a first hour (golden hour) checklist to facilitate delivery and documentation of time critical interventions within the first hour from birth for all infants admitted for intensive care.	Delivered, Not Yet Evidenced	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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APPENDIX TWO

Neonatal External Mortality Review Action Plan

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
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 Jul-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 Jan-26 and Apr-26 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)	31/01/2026		30/04/2026		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).	Evidenced and Assured	Completed	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: Education reports (3 months) demonstrating compliance against training.	Short Term (0-6 months)	31/10/2024	08/10/2024	31/10/2025	12/08/2025	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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PROGRESS AS AT 14.10.2025

APPENDIX TWO

Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital NHS Trust

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
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	Delivered, Not Yet Evidenced	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. This action was accepted as 'Delivered, Not Yet Evidenced' at Sep-25's MNTAC' 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

Colour	Status	Description
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APPENDIX TWO

Neonatal External Mortality Review Action Plan

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
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	Delivered, Not Yet Evidenced	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. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. 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	08/07/2025	30/09/2025		Paula Gardner	Julie Plant	Monday.com

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PROGRESS AS AT 14.10.2025

APPENDIX TWO

Neonatal External Mortality Review Action Plan

The Shrewsbury and Telford Hospital NHS Trust

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
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

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Neonatal External Mortality Review Action Plan

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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.	Evidenced and Assured	Completed	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC with the addition of evidence of evaluation of the four pillars during appraisals. 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) Evidence of evaluation of the four pillars at appraisal	Short Term (0-6 months)	30/09/2024	08/10/2024	31/08/2025	14/10/2025	Dr John Jones	CD's	Monday.com
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.	Evidenced and Assured	Completed	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. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Agile workshop - Actions Review Multidisciplinary training Learning events rolled out and open to all staff Unit meetings in place All members of the team invited to governance meetings Process in place for debrief after acute events Evidence Requirements for Assurance: Meeting and events attendance records Measure of culture shift (survey results, recruitment & retention, reporting culture)	Medium Term (6-12 months)	01/06/2025	08/07/2025	01/09/2025	14/10/2025	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.	Evidenced and Assured	Completed	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Planning in place to deliver recruitment trajectory - funding in place Leadership roles appointed to - email Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	30/09/2024	08/10/2024	31/01/2025	14/10/2025	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.	Evidenced and Assured	Completed	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. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Neonatal Leadership enrolled on SaTH leadership programmes Evidence Requirements for Assurance: Compliance with Leadership Programme Attendance of Clinical directors to quarterly CD meetings Measure of culture shift (staff survey, retention and recruitment)	Medium Term (6-12 months)	31/06/2025	08/07/2025	30/09/2025	14/10/2025	Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com

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PROGRESS AS AT 14.10.2025

APPENDIX TWO

Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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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.	Evidenced and Assured	Completed	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. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Integration of Neonates into MNTP Leadership and Specialist roles recruitment plans Evidence Requirements for Assurance: Staffing papers including recruitment and retention positions. Recruitment and retention measures	Medium Term (6-12 months)	31/06/2024	08/07/2025	30/09/2025	14/10/2025	Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com

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NEMR13	The PMRT process needs further development to become a useful mechanism for learning, including securing neonatal consultant as well as fetal medicine externality, protected time for neonatal nurse participation, and a clear mechanism for sharing learning with respect to the network. A network-wide approach may be needed to make best use of available resources and expertise, given the tension between a neonatal unit functioning with significant workforce gaps alongside a need of more from this same workforce in terms of PMRT attendance.	Delivered, Not Yet Evidenced	At Risk (see exception report)	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. This action was brought to the committee for discussion at Jul-25's MNTAC where it was agree this action should be marked 'At Risk' due to the difficulty in securing externality for PMRTs. New timeframes (Mar-26) were agreed at Aug-25's MNTAC with the added requirement of complying with CNST SA1 Y7 for added assurance. 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 CNST year 7 - Safety action 1 compliance	Short Term (0-6 months)	31/01/2025	11/02/2025	31/03/2026		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.	Delivered, Not Yet Evidenced	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. This action was accepted as 'Delivered, Not Yet Evidenced' at Aug-25's MNTAC with new timeframes for green to jan-27. Evidence Requirements for Delivery: CNST SA4 compliance for Years 4, 5, 6 Refreshed QIS trajectory - Jun-25 Staffinf papers demonstration QIS cover on shifts Evidence Requirements for Assurance: CNST year 7 compliance QIS compliance reached	Short Term (0-6 months)	31/06/2025	12/08/2025	31/01/2027		Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com

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The Shrewsbury and Telford Hospital NHS Trust

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NEMR16	The neonatal service should review its 'golden hour' care practices for preterm infants and sick term infants born within the service, with a focus on implementing evidence-based care practices around resuscitation, stabilisation, surfactant administration and other supportive measures in the first few hours after birth.	Not Yet Delivered	On Track	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. This action was agreed back 'On Track' at Jul-25's MNTAC with new timeframes of Sep-25 for amber and Apr-26 for green. Evidence Requirements for Delivery: Amended guideline and checklist Evidence Requirements for Assurance: Audit of guideline and checklist implementation	Short Term (0-6 months)	30/09/2025		30/04/2026		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).	Evidenced and Assured	Completed	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. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Network exception reports - quarterly overview Evidence Requirements for Assurance: Review of Transfer cases Evidence of discussion with ODN - LMNS agenda and minutes	No Timeline Allocated	TBC	10/06/2025	31/10/2025	14/10/2025	Dr John Jones	Mr Andrew Sizer	Monday.com

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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. An exception report was submitted and accepted at Jul-25'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 Sep-25 for amber and Jan-26 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)	30/09/2025		31/01/2026		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.

APPENDIX TWO

Neonatal External Mortality Review Action Plan

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.

The Shrewsbury and Telford Hospital NHS Trust

Women & Children's Transformation Programmes

Oct-2025 Batteries

Post Assurance Committee

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

The Shrewsbury and Telford Hospital NHS Trust

Maternity and Neonatal Transformation

Phase 2

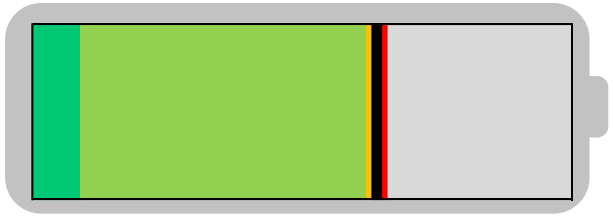
Phase 2 batteries – Post Oct-25 MNTAC

The Shrewsbury and Telford Hospital NHS Trust

Overall Delivery

72% (175) Not Yet Delivered
15% (35) Delivered, Not Yet Evidenced
14% (32) Evidence & Assured

Overall Progress



14% (32) Complete
49% (119) On Track
2% (6) Descoped
1% (2) Off track
1% (1) At Risk
33% (80) Not Started

	Delivery Battery	Progress Battery
Black Maternal Health Plan	56% (5) | 22% (2) | 22% (2)	22% (2) | 33% (3) | 45% (4)
Maternity Community Service Review	100% (37)	32% (12) | 68% (25)
LMNS Equity & Equality	83% (25) | 14% (4) | 3% (1)	3% (1) | 40% (12) | 57% (17)
LMNS 3 Year Delivery Plan	43% (12) | 32% (9) | 25% (7)	25% (7) | 39% (11) | 4% (1) | 32% (9)
Cultural Improvement Plan	92% (34) | 5% (2) | 3% (1)	3% (1) | 49% (18) | 48% (18)
CQC Neonates Action Plan	10% (1) | 40% (4) | 50% (5)	50% (5) | 20% (2) | 20% (2) | 10% (1)
Neonatal External Mortality Review	31% (11) | 26% (9) | 43% (15)	43% (15) | 46% (16) | 3% (1) | 3% (1) | 6% (2)
Neonatal Unit Implementation Plan	96% (45) | 2% (1) | 2% (1)	2% (1) | 83% (39) | 4% (2) | 11% (5)
CQC National Review	25% (1) | 75% (3)	100% (4)
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

Board of Directors' Meeting 13 November 2025

Agenda item		**Appendix 4**		
Report Title		CNST MIS Year 7 - Progress Updates – October 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 Committee Neonatal Governance Committee Divisional Committee Quality & Safety Assurance Committee Maternity & Neonatal Safety Champions LMNS		
Executive summary:		This paper evidences progress against Year 7 of the CNST Maternity Incentive Scheme as of October 2025. The service is currently on track to achieve 9 of the 10 Safety Actions. One risk to delivery remains: - Safety Action 1, linked to PMRT externality requirements detailed in section 3.1.2 of this paper. The previous risk to Safety Action 7 has been deescalated, as detailed in section 3.7.2 of this paper. 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, its appendices and advise the Head of Midwifery of any further detail required. 2. Note receipt of the CNST appendices within the minutes for evidence.		
Appendices:		• PMRT Quarterly and Board reports (SA1) • Maternity MSDS compliance scorecard screenshot (SA2) • CNST Obstetric Anaesthesia workforce closure paper (SA4)		

	• DoM Safe Staffing report (SA5) • MNVP CNST action plan (SA7) • Safety champions locally agreed dashboard (SA9) • Triangulation of the Scorecard (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 guidance for year 7 included 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:

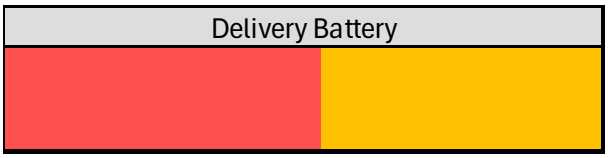
- An update on progress against delivery of Year 7 of the scheme.
- Any risks to the delivery of the scheme under the new safety actions technical guidance.

3. Overall Progress Status

3.1. Delivery

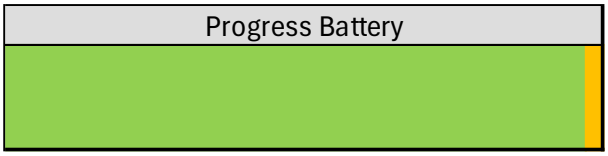
3.1.1. The below chart shows a CNST completion rate as of October 16 2025 (including compliance with the standards and accrual of supporting evidence) of:

- 53% “Delivered Not Yet Evidenced” - Amber
- 47% “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 items (3% - sections 3.1.2) 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?"

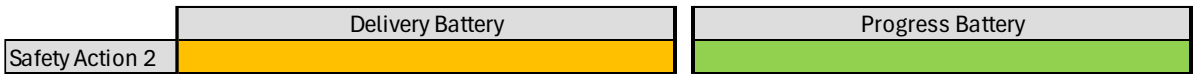
4.1.1. **Progress status: At Risk**

4.1.2. **Identified Risk:** The guidance requires that for 50% of PMRT reviews, an external member of the panel be present. That member needs to be a clinician of the relevant speciality and of sufficient seniority. While this is achieved routinely for obstetric cases, securing externality for neonatal cases or joint cases, where both an external obstetrician and neonatologist need to be present, has proven more difficult. There is an agreement at the network level for member organisations to provide externality in rotation but the process is not yet fully embedded in practice. So far, externality has been achieved for over 50% of PMRT and compliance continues to be closely monitored.

4.1.3. The latest quarterly report including our Q2 position for 2025/2026 is being presented at Governance this month and will be received at Trust Board in November 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 by the Board, 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. 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).

4.2.3. Internal review of the July data indicated full compliance and this action is now Delivered, not yet Evidenced.

4.2.4. Once that scorecard has been received from NHS Digital and provided to Board, it will move 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. 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.

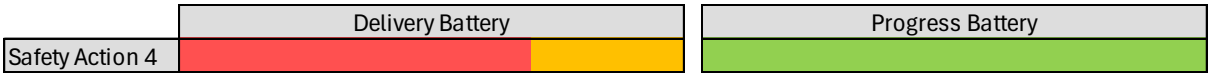
4.3.3. The BoD via the delegated authority of QSAC has continued to receive a quarterly ATAIN report that includes details of all term admissions, including avoidable admissions. The latest quarterly report, covering Q2 of 2025/26 is presented at Maternity Governance, Neonatal Governance and QSAC this month.

4.3.4. The BoD via the delegated authority of QSAC has continued to receive a quarterly report on transitional care activity. The latest quarterly report, covering Q2 of 2025/26 is presented at Maternity Governance, Neonatal Governance and QSAC this month.

4.3.5. Standard b) The QI project initiated in Year 6 of the scheme was made up of two elements: Improved recognition and management of Chorioamnionitis, which has now been delivered, and reducing admission due to respiratory causes by introducing Vapotherm. A decision has been made by the clinical teams to stand down the Vapotherm element due to safety concerns. A new project has been developed and forms part of the papers for maternity and neonatal governance this month and will also be shared with the LMNS and Safety Champions.

4.3.6. Each element of this action will moved to “Delivered, Not yet Evidenced” when compliance can be demonstrated, and the new project has been validated through the appropriate channels. 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. 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.

4.4.3. Standard b) A paper evidencing compliance against the ACSA Standard 1.7.2.1 has been included with September 2025’s update paper, with 1 month’s rotas for Obstetric

Anaesthetists provided as part of the evidence. This item is now Delivered, Not Yet Evidenced and will be fully assured once received at Board on November 2025.

4.4.4. 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.

4.4.5. 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.

4.4.6. 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?"

	Delivery Battery	Progress Battery
Safety Action 5		

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. Contact has been made with Birthrate+ to schedule the new assessment.

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 compliance 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?"

	Delivery Battery	Progress Battery
Safety Action 6		

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 Q1 of 2025/26 was presented at Maternity Governance and QSAC in August 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."

	Delivery Battery	Progress Battery
Safety Action 7		

4.7.1. **Progress Status: On Track**

4.7.2. **Identified Risk - Deescalated:** 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 was formally escalated through the PQSM at the LMNS, ICB and regional levels. An action plan has now been developed and agreed at LMNS Board in October 2025, providing sufficient evidence to comply with the Safety Action which is now Delivered, Not yet Evidenced until the required evidence is presented at Board. The action plan is presented along with this update to Governance meetings this month.

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 has enhanced the previous offer and afforded 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 within the reporting period.

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?"

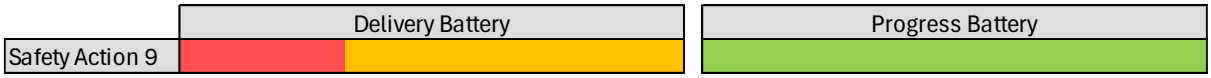
	Delivery Battery	Progress Battery
Safety Action 8		

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. Information regarding the revised Perinatal Quality Oversight Model was published in September and is being reviewed before this action can be considered fully Delivered.

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.

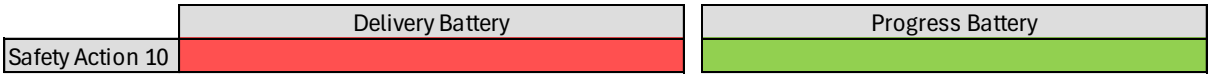
4.9.4. Evidence of ongoing staff engagement sessions and progress with action and progress made provided through publication of the 'You said, We listened' posters.

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 Q1 2024/25 will presented to Trust board in November 2025. 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 provided to the Board of Directors this month:

- PMRT Quarterly and Board reports (SA1)
- Maternity MSDS compliance scorecard screenshot (SA2)
- CNST Obstetric Anaesthesia workforce closure paper (SA4)
- DoM Safe Staffing report (SA5)
- MNVP CNST action plan (SA7)
- Safety champions locally agreed dashboard (SA9)
- Triangulation of the Scorecard (SA9)

6. Actions requested of the Board of Directors

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

6.1.2. Note the receipt of the associated appendices for evidence in the minutes.

PMRT - Perinatal Mortality Reviews Summary Report

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

The Shrewsbury and Telford Hospital NHS Trust

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

1/7/2025 to 30/9/2025

There are no published reviews for The Shrewsbury and Telford Hospital NHS Trust in the period from 1/7/2025 to 30/9/2025

The Shrewsbury and Telford Hospital NHS Trust

PMRT July-September 2025

Agenda item	**Appendix 5b**			
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q2 2025-2026			
Executive Lead	Paula Gardner, Interim Chief Nursing Officer			
Report Author	Silje Almklow			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	**√**	Safe	**√**
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	**√**	Well Led	**√**
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	**√**		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance October 2025 Neonatal Governance meeting October 2025			
Executive summary:	There have been 2 stillbirths, 1 neonatal death, and 1 late fetal loss in quarter 2 for which SaTH will be leading on the PMRT. Compliance with CNST Safety Action 1 is on track, however, this report highlights two cases from Q3 where the PMRT reports were not published within 6 months and highlights two cases where complete externality were not achieved. We are on track for achieving appropriate externality for > 50% of reviews overall, however, the neonatal death reviews in isolation may not meet this target. A higher rate of ethnic minorities has been noted amongst PMRT cases when compared to the ethnicity data of women birthing at SaTH, with Pakistani and Black African women disproportionately affected by perinatal bereavement.			
Appendices	MBRRACE generated Trust Board Report			

1.0 The babies whose care should be reviewed using the PMRT

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

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

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

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

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

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

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

2.0 Deaths reported to MBRRACE

In the time-period from the 1st of July to the 30th of September 2025, there were 2 stillbirths, 1 neonatal death, and 1 late fetal loss at SaTH. Reporting to MBRRACE was completed in line with reporting guidelines.

Late fetal losses

There was 1 late fetal loss at SaTH in Quarter 2 2025/2026. The mother was pregnant with twins and had lost twin 1 at 15+ weeks gestation. She attended with abdominal pain and was found to have an intrauterine death of twin 2 at 22+5 weeks gestation.

Stillbirths

The first stillbirth that occurred in Quarter 2 was an antepartum stillbirth at 32+3 weeks gestation. The mother had recently moved into the area, and the review will be completed as a joint review with the trust that provided most of the antenatal care.

The second stillbirth that occurred in Quarter 2 was an antepartum stillbirth at 40+1 weeks gestation. The mother attended maternity triage at 39+4 weeks gestation with reduced fetal

movements, and the intrauterine death was diagnosed on scan. The mother opted to delay the induction of labour by one day after the diagnosis.

Neonatal deaths

The neonatal death in Quarter 2 was a baby born at 36+4 weeks gestation due to maternal scar pain and threatened preterm labour. She was found diseased at home at 10 days old. A Joint Agency Review (JAR) took place and there were no immediate concerns raised. The PMRT review will be led by SaTH.

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

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

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

Quarter 1 2025-2026	Notified to MBRRACE	Working days to notify	Surveillance information completed	Months to complete surveillance
Stillbirth 99873/1	Yes	0	Yes	< 1
Stillbirth 99880/1	Yes	0	Yes	< 1
Neonatal Death 100072/1	Yes	0	Yes	< 1
Late fetal loss 100115/2	Yes	0	Yes	< 1

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

In Quarter 2, all parents were given the opportunity to ask questions and have their perspectives included in the PMRT review. SATH are 100% compliant with this target for quarter 2.

Quarter 4 2024-2025	Families informed	Date parents contacted	Date of second contact
Stillbirth 99873/1	Yes	15/08/2025	29/08/2025
Stillbirth 99880/1	Yes	21/08/2025	27/08/2025
Neonatal Death 100072/1	Yes	05/09/2025	02/10/2025

Late fetal loss 100115/2	Yes	04/09/2025	02/10/2025

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

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

The technical guidance states that the external panel member "[…] should be from relevant specialities (you may require more than one dependent on the details of the case) and should be senior enough to provide challenge […]". SaTH has interpreted this to mean that we require obstetric externality at consultant level for all cases and neonatal externality at consultant level for all neonatal deaths.

This report provides assurance that 14 of the 16 reportable cases from 2024 had reports published within 6 months. SATH was 87.5% compliant with these targets in 2024 as per the below table.

SaTH PMRT 2024	Case ID	Review status	Cause of delay	Months to start review	Months to publish report
1	91636	Review complete		< 1	< 2
2	91966	Review complete		< 1	< 2
3	92385	Review complete		< 1	< 2
4	92440	Review complete		< 1	< 4
5	92914	Review complete		< 2	< 4
6	92915	Review complete		< 2	< 3
7	93568	Review complete		< 1	< 6
8	93799	Review complete		< 1	< 4
9	94316	Review complete		< 1	< 3
10	95124	Review complete		< 1	< 4
11	95236	Review complete		< 1	< 5
12	95376	Review complete		< 1	< 5
13	95544	Review complete	Coroner's PM	< 1	< 9
14	95933	Review complete		< 1	< 4
15	96092	Review complete	MNSI Case MI-039067	< 1	< 9
16	96096	Review complete		< 1	< 3

Quarter 2 provides assurance that the reportable cases from 2025 are on track for 100% compliance with the review being started within 2 months and publication within 6 months. Externality is sought for 100% of cases though we were unsuccessful in obtaining obstetric externality for one case and neonatal externality for one case published in 2025. The Trust is working with the Midlands Perinatal Network to achieve neonatal externality for neonatal deaths.

Quarter 4 2024/2025	**Date of loss**	**Months to start review**	**PMRT date**	**Report Published**	**Months to publish report**	**External Panel member**
Stillbirth 1: 97390/1	19/02/2025	< 1	14/04/2025	03/07/2025	< 5	No external panel member – joint PMRT with Stoke
Neonatal death 1: 97682/1	09/03/2025	< 1	14/05/2025	14/05/2025	< 3	External obstetrician – Yes External neonatologist - No
Stillbirth 2: 97803/1	15/03/2025	< 1	16/06/2025	08/09/2025	< 6	External obstetrician - Yes
Quarter 1 2025/2026	**Date of loss**	**Months to start review**	**PMRT date**	**Report Published**	**Months to publish report**	**External Panel member**
Neonatal death 1: 98349/1	27/04/2025	< 1	18/08/2025	10/09/2025	< 5	External obstetrician – Yes External neonatologist – N/A – planned palliation
Stillbirth 1: 98949/1	10/06/2025	< 1	17/09/2025	18/09/2025	< 4	External obstetrician - Yes
Quarter 2 2025/2026	**Date of loss**	**Months to start review**	**PMRT date**	**Report Published**	**Months to publish report**	**External Panel member**
Stillbirth 99873/1	17/08/2025	< 1	TBC	TBC		
Stillbirth 99880/1	13/08/2025	< 1	TBC	TBC		
Neonatal Death 100072/1	01/09/2025	< 1	TBC	TBC		
Late fetal loss 100115/2	03/09/2025	< 1	TBC	TBC		

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


PMRT_BoardReport _The Shrewsbury an


PMRT_BoardReport _The Princess Royal


PMRT_BoardReport _The Shrewsbury an


PMRT Quarterly report Oct-Dec 2024


PMRT Quarterly report Jan-Mar 2025


PMRT Quarterly report Apr-Jun 2025

4.0 Quarterly overview

	Quarter 3	Quarter 4	Quarter 1	Quarter 2
Deaths are reported to MBBRACE within 7 working days.	100%	100%	100%	100%
Parents should have their perspectives of care and any questions they have sought.	100%	100%	100%	100%
Reviews started within 2 months.	100%	100%	100%	100%
A minimum of 75% of multi-disciplinary PMRT reviews should be completed and published within six months (increase from 60%).	50%	100%	100%	TBC
For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	100%	33%	100%	TBC

The Trust has reported 9 cases to MBRRACE within the CNST year 7 reporting period. 5 cases have been reviewed and published, all within the 6-month timeframe. 3 of the 5 cases published had appropriate externality, which equates to 60% of cases published to date. Work is ongoing to ensure that the remaining cases that are due to be reviewed will have appropriate externality in attendance.

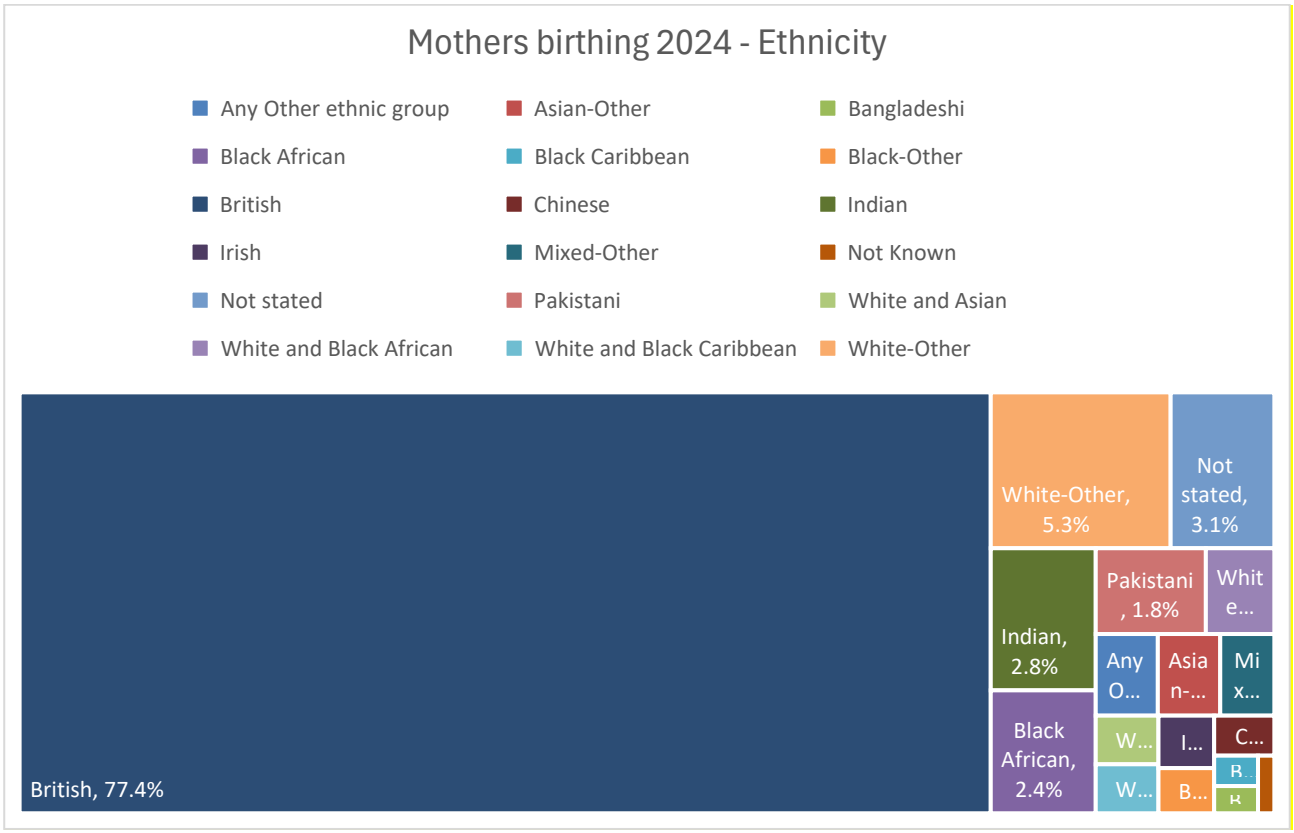
Equality Diversity and Inclusivity

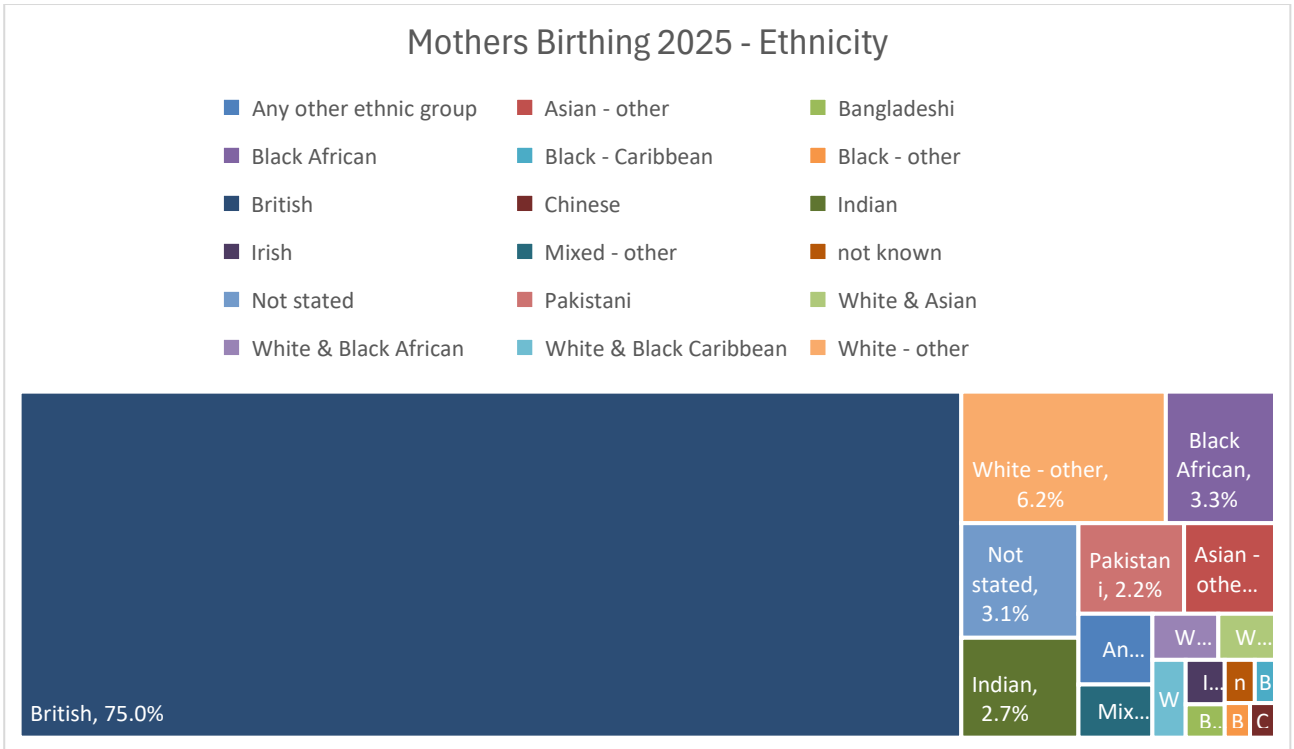
Recent reports have emphasised that the disparities in maternity and neonatal care for Black, Asian, and Minority Ethnic (BAME) families in the UK, as noted in the 2004 report, have seen only slight improvements, twenty years after its publication. Reports show that the inequalities also persist in families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

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

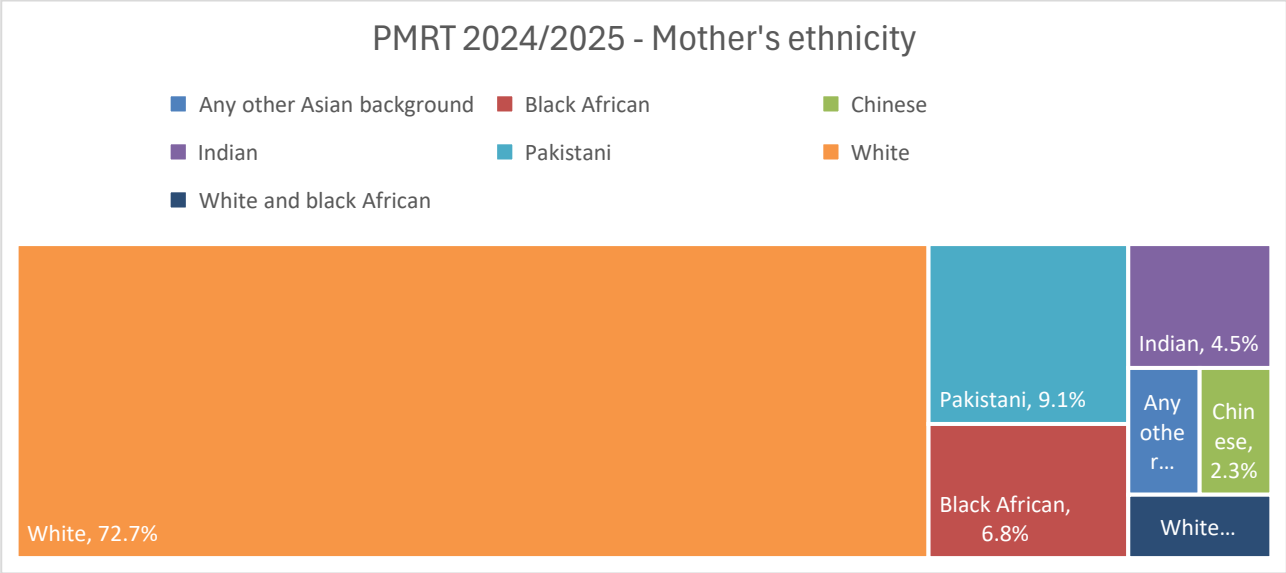
Despite recommendations, these more recent reports show that BAME families continue to face disproportionately poor outcomes in maternity and neonatal care, when compared to white families. Addressing these inequalities is essential, and both national and local initiatives are being implemented to enhance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

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

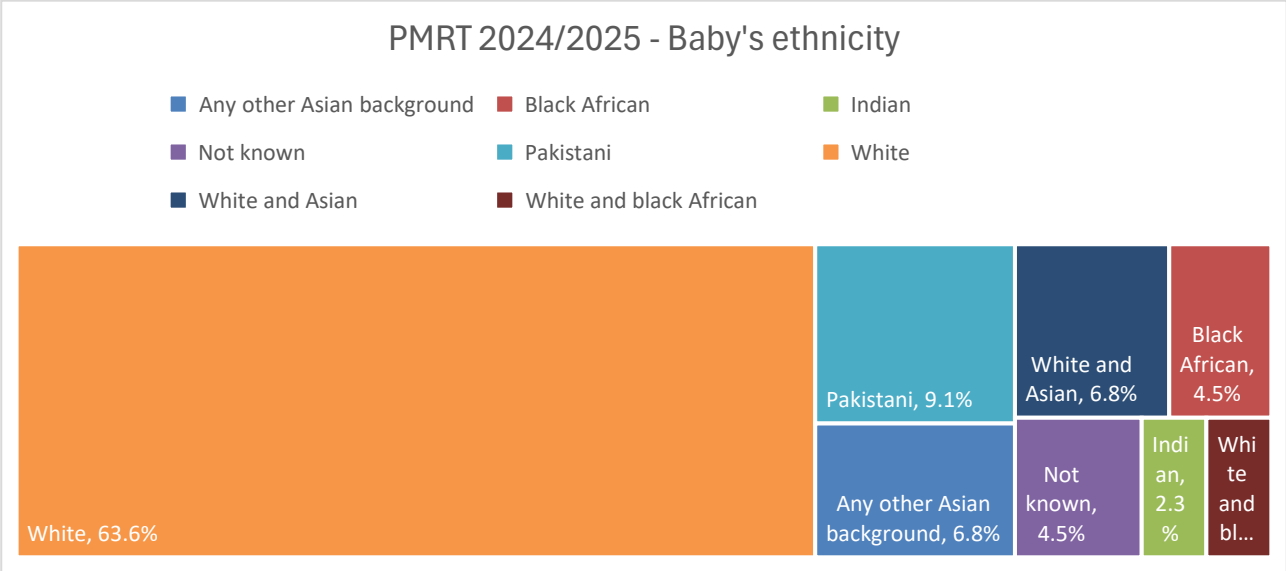




A review of the population accessing our services demonstrate a relatively stable population of white and white British women birthing at SaTH (82.7% in 2024 and 81.2% in 2025). The population of Black African women has increased from 2.4% to 3.3%, whereas the remaining groups remain stable.



* Ethnicity data includes PMRTs led by SaTH and joint PMRTs with other trusts. Numbers include all PMRT's from 2024 and 2025.



* Ethnicity data includes PMRTs led by SaTH and joint PMRTs with other trusts. Numbers include all PMRT's from 2024 and 2025.

A review of ethnicity from PMRT cases in 2024/2025 demonstrates that the rate of white women experiencing perinatal bereavements is lower than the rate of white women birthing at SaTH. The rate of Black African, Pakistani, and Indian women who experience perinatal bereavement is disproportionately higher that the rate of these women who birth at SaTH. The Pakistani population is of particular note with rate a of perinatal bereavement over four times higher that the rate of Pakistani women accessing our services.

5.0 Issues from reviews and completed reports undertaken in Quarter 2

The learning identified from PMRT reviews in Quarter 2 include:

Red cell antibodies
A PMRT case from 2024 highlighted that women with red cell antibodies who are at higher risk of bleeding are not routinely having 72-hour cross matched samples taken.
The guideline is being updated to clarify who is at "higher risk"

Risk of the bereaved mother
A woman presented with a stillbirth and a suspected placental abruption but did not receive close monitoring for signs of deterioration.
A new HDU chart has been developed in line with national MEWS and will be included in the bereavement pack to ensure close monitoring of bereaved mothers for signs of deterioration.

Neonatal alerts for red cell antibodies
All women with significant red call antibodies are highlighted to the monthly fetal medicine meeting for oversight. In a recent case this did not happen, but this had no impact on the outcome. The process is under review to ensure appropriate escalation, review, and care planning.

QA questions in pregnancy
We continue to see women who have not been asked QA questions at the appropriate times during pregnancy. The documentation regularly states that the women were not asked due to partners being present, with no documentation of attempts being made to find an opportunity to ask.

Thermoregulation
Thermoregulation is essential for preterm babies and planning is key to achieve normal temperature.
Turn on the resuscitaire to let it warm.
Use a hat - even if the Neohelp is being used.
Consider completing procedures in a closed incubator if the practitioner is confident.
Review the Thermoregulation SOP.

Taking baby home
Bereaved parents can take their baby home for a few days.
The fetal loss and early neonatal death guideline provides all the relevant information for staff and the family in the appendix.
Please document clearly if the family have been offered the opportunity to take baby home and their choice.

Antenatal Optimisation 22+0-34+6 weeks
STAMPED - antenatal optimisation
S -Steroids
T - Transfer - early recognition and planning is key
A - Antibiotics
M - Magnesium
P - Parents - joint counselling with neonatal and obstetric teams improves understanding
E - Evaluate for tocolysis
D - Delivery plan

Abdominal Pain

Consider tests to rule out preterm labour for women who present with abdominal pain. Urinary tract infections are known to increase the risk of preterm labour and can present as abdominal pain.

6.0 Feedback

To all the midwives
A small poem to show my gratitude and to remember my beautiful daughter

When my world shattered, beyond
Control
You all held my heart, so tender
And true
Angels of mercy, supporting me
Through
My sweet Willow, now a silent
Tear
You whispered hope, calming my
Fear
With a loving touch and spirits
So bright
You guided us through that
Darkest night
You all honoured my baby, a love
So deep
In my brokenness, you helped
Me keep
Previous memories alive, a gentle
Flame
Softly whispering my Willow's
Name
For every kindness, every tear
You dried
I thank you now for being by
My side
Your loving care, my heart will
Hold
Just know you all have a heart
Of gold!

A bereaved mother who lost her daughter, Willow, to stillbirth

7.0 Conclusion

Compliance with CNST Safety Action 1 is on track, however, this report highlights two cases from Q3 where the PMRT reports were not published within 6 months and highlights a challenge in achieving neonatal externality for reviews of neonatal deaths. We are on track for achieving appropriate externality for > 50% of reviews overall, however, the neonatal death reviews in isolation may not meet this target.

Author name and title
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Quality Governance Team
Date 02/10/2025

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

Maternity Safety Support Programme	Yes

QUARTER 2 - 2025					July	August	September	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		0	2	0	**August** 99873/1 - Stillbirth at 32+4 weeks gestation – SaTH to lead on the review with input from the Trust that provided antenatal care until the woman booked at SaTH at 29 weeks. 99880/1 - Stillbirth at 40+1 weeks gestation – SaTH to lead on the review. **September** A Neonatal death at 36+4/40 – SaTH to lead on the review. A late Fetal Loss of a twin at 22+5/40 – SaTH to lead on the review.
			Late fetal losses >22 wks		0	0	1	
			Neonatal Deaths		0	0	1	
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI			1	0	0	**July** 2 final MNSI reports were received in July 2025. MI-039067 - The report has no safety recommendations for SaTH. MI-039028 - This was an external report for a baby at a neighbouring Trust that received therapeutic hypothermia. SaTH provided antenatal care for the woman. The report has no safety recommendations for SaTH. **August** No new referrals or final reports received. **September** No new referrals or final reports received.
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**			0	0	0	
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**			1	0	0	**July** 1 PSII was commissioned for maternity in July 2025. This was a never event - 10x the dose of Insulin. **August** No new learning responses were commissioned in August **September** No new learning responses were commissioned in September
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken			4	2	1	**July** 3 Moderate harm and 1 severe harm incidents were reported in July 2025. Two were for the same patient, a baby that was admitted to the NNU with bilious vomiting and later transferred to a tertiary unit. One was a weight discrepancy which impacted medicine administration, and one was an admission to the NNU with bilirubin levels above transfusion line which were later found to be incorrect. **August** 2 moderate harm incidents were reported in August 2025. One was a missed NIPE - miscommunication between SaTH and a tertiary unit. One was an exravasation injury to the arm, reviewed by tissue viability, DoC completed. **September** 1 Moderate (Staff Incident) Tristel senstivity realction requiring ongoing treatment
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken			10	19	18	**July** 6 moderate harm and 4 severe harm incidents we reported in July 2025. 1 was the never event as mentioned above. 4 were PPH > 1500ml. The remaining were a shoulder dystocia, delayed observations, term admission to NNU, and OASI. August 17 moderate and 2 severe harm incidents were reported in August 2025. 6 3rd and 4th degree tears 7 MOH > 1500ml 1 admission to ITU - linked to a MOH. The remaining were missed screening, a patient fall with fracture, and communication issues. **September** 11 moderate and 7 severe harm incidents were reported in September 2025 1 Birth Trauma #Fracture Left Humerus 2 ATAIN - term admission to NNU Transferred into PNW via CMW on day 3 with jaundice weight loss, bilirubin on gas 469 - DOC to be completed 14 MOH > 1500ml 1 remaining and communication issues.
3d.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Consultant Obstetricians & SAS	PROMPT	100%	91%	92%	**Medical staff compliance and bookings has been escalated. Bookings have subsequently been confirmed up to November 2025 for PROMPT and EFM (Obstetricians) .** **Anaesthetists – 13 staff need to attend during October and November to maintain individual compliance and achieve > 90%.** **2 Anaesthetists bookings remain outstanding, and this has been escalated to the Lead for Anaesthetists training.** *Data sources: Compliance data for Midwives and Support Staff training is from the Trust Staff compliance report 6th October 2025. Compliance data for Medical Staff training is from the Maternity Training Monitors on the shared Y Drive as of 9th October 2025.
				Fetal Monitoring	100.00%	100%	96%	
			Midwives	PROMPT	98.85%	98.48%	98.84%	
				NLS	98.85%	98.86%	98.06%	
				Fetal Monitoring	98.34%	99.59%	99.58%	
			Other Drs	PROMPT	100%	69%	71.4%	
				Fetal Monitoring	94%	100%	100%	
			Neonatal Nurses	NLS	100%	100%	100%	
			Anaesthetists	PROMPT	94.59%	83.33%	87.5%	
			WSAs/MSW	PROMPT	100.00%	98.65%	98.65%	
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		99%	95%	97%	
			Maty 1:1 care in labour		100%	100%	100%	
			Fill rates Delivery Suite RM		D 95% N 90%	D 93% N 87%	D 88% N 85%	
			Fill rates Postnatal RM		D 115% N 110%	D 120% N 112%	D 106% N 98%	
			Fill rates Antenatal RM					
			Obstetric Cover on D Suite		100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements (*To note feedback one month behind)*						**September** I'd like to say a massive thank you to the Antenatal Ward, Delivery Suite & Postnatal Ward for their care. I was extremely nervous about using a hospital to birth my baby due to previous traumas, mostly via ***** Hospital. I haven't birthed in Telford before & this is my 4th baby, admittedly also the press surrounding maternity care. However, I was listened too, cared for, advocated for if I felt uncomfortable myself. I was looked after by ***** on antenatal, she was incredible, my mom was able to sleep over with me throughout my induction process, which eased so much of my anxiety with her living so far & me being a fast labourer. I had two *****s on delivery, they were both incredible, they weren't quite expecting to start their shift & a baby be born in the time she was, no one panicked & I was able to go into the position I felt was best for me. We wasn't rushed off the ward in anyway either to go down to postnatal. Equally on postnatal ward, the care was great, I was left waiting a while, but I understand things get busy & there's more people to look after, the information provided was informative, I was given pain relief quickly when asked. Also a huge thank you to Triage, once I'd left and gone home I unfortunately had to return early hours due to retained placenta, I wasn't worried at all, the doctor who removed the rest was amazing, i do apologise for driving myself in though it was lovely to also meet a member of staff who has the same health condition as my eldest daughter. Also, my consultant, I only met her a couple of times but she advocated for me so much & for me seen by outside services so fast, something I couldn't have done alone. I'm truly so eternally grateful for everything & I would 100%, if I wasn't done having babies, have another at Telford. You're all incredible 🩶

5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*	No walkabout	07.08.2025 RSH MLU	No walkabout	**August Walkabout** • Main issues raised included IT problems (intermittent access to computer systems in both the MLU and GP surgeries), leading to workarounds on paper, which pose risks to safetyand confidentiality. • Capacity concerns were noted, with flexible working sometimes leading to staff pressure and potential fatigue. • Staff reported dealing with a high number of high-risk women, compounding other challenges. • The open door between the MLU and cancer services was highlighted as a potential safety issue. • Problems with requesting blood due to IT access issues were mentioned, which could impact care. • Staff morale was described as low and palpable. • Privacy and dignity issues around breastfeeding facilities were raised. • Parking difficulties may contribute to missed appointments, which then require community team follow-up. • Consultant clinic capacity was affected by cross-covering and induction periods, leading to some clinics being cancelled and emergency slots being used for booked appointments. • The group agreed to document these findings and circulate for feedback, with no immediate actions required except to escalate IT issues and consider
6.	**EXTERNAL**	Requests from an external body (MNSI/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust	0	0	0	**July -** none received **August -** none received **September-** none received
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	0	0	0	**July -** none received **August** - none received- To note - there are have been no Regulation 28 since May 2021 **September**- none received- 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	Compliant	
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	0	0	0	
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	6	3	3	**July N=6 (13%)** 50% of reasons for sections where delay in 1st stage of labour with no maternal or fetal concerns of those 67% due to theatre acuity **August N=3 (7%)** 33% were delays in 1st stage of labour **September N=3 (7.9%)** No common theme for reason for category 2 section 66.6% of reasons for delay were delay in transfer to theatre
11.	**Supernumerary Status of the Coordinator**	**Neonates**	58	57	59	**July** There were 4 shifts that did not have any data therefore the following results are based off 58 out of a possible 62 shifts. Of those 58 shifts: • The NIC was FULLY supernumerary for 82% of the time (48 shifts) • The NIC was PARTIALLY supernumerary for 13.7% of the time (8 shifts) • The NIC was NOT supernumerary for 3.33% of the time (2 shifts) Of those shifts where the NIC was not supernumerary, the acuity was noted to be amber/red for 7/8 shifts. **August** There were 5 shifts that did not have any data therefore the following results are based off 57 out of a possible 62 shifts. Of those 57 shifts: • The NIC was FULLY supernumerary for 63% of the time (36 shifts) • The NIC was PARTIALLY supernumerary for 5% of the time (3 shifts) • The NIC was NOT supernumerary for 31% of the time (18 shifts) Of those shifts where the NIC was not supernumerary, either partially or completely, the acuity was noted to be amber for all shifts. There is a significant drop of 19% in the supernumerary status of the NIC during the month of august and this is mainly due to being over capacity with HDU patients which would require extra nursing staff. **September** There was one day missing information so this is based off 59 shift for the month of September. Of those 59 shifts; • The NIC was supernumerary for 81% of the time • The NIC was NOT supernumerary for 15% of the time • The NIC was partially supernumerary for 3% of the time The total time that the NIC was not fully supernumerary was 18% which is a considerable improvement on last month which was 36%
12.	**Delay in Neonatal Antibiotics**	Number of babies that had delayed antibiotics (Not within the golden hour)	14	14	17	**July** From those that breached the golden hour: **NNU=8** Administration times for antibiotics on the NNU have increased significantly with a larger number being given > 1 hour with an increase from 5% to 28%. The reason given for the delay was 'difficult cannulation' **TC=6** Timings were increased for administration within TC. There was a increase from 5% to 57% of babies receiving antibiotics outside of the hour. The reasons stated for delay was 'decision made whilst stabilising' , 'not stated' AND 'Delay getting Unit number' **August** From those that breached the golden hour **NNU=6** Administration times for antibiotics on the NNU continue to increased with a larger number being given > 1 hour with an increase from 28% to 35% The reason given for the delay was 'cannula resited' 'cuddles on labour ward' and others not stated **TC= 8** Good news for TC, over the hour antibiotics reduced from 57% to 50%. The reasons stated for delay was 'parental issues' , 'not stated' and 'NIC not aware antibiotics had been given. **September** From those that breached the golden hour **NNU=7** Administration times for antibiotics on the NNU continue to increased with a larger number being given > 1 hour with an increase over the last 3 months from 28%, 35% and 41% respectively. The reason given for stabilisation on Labour ward which should give rise to a discussion on when time of decision is taken. Dealing with a sick baby on the unit as well as difficult cannulation and communication issues were amongst issues raised **TC= 10** Good news for TC, a further decrease in over the hour antibiotics reduced from 57% , 50%, 48% over the last 3 months The reasons stated for delay was 'difficult cannulation', 'delay in getting unit number' and mum unwell'.
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 Q1 (April-June 2025)

Date: September 2025

Jacqui Bolton Interim Head of Midwifery

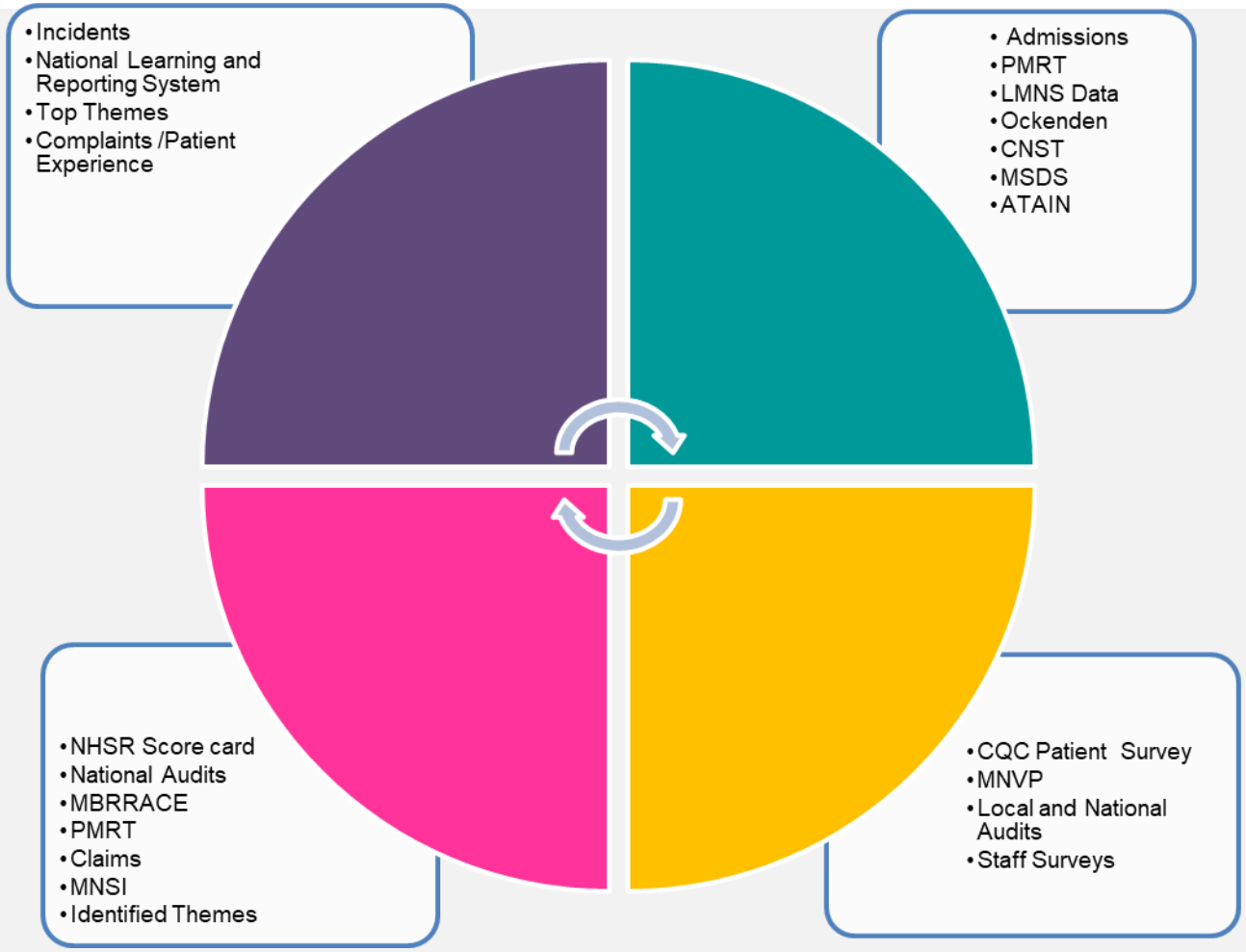
Maternity Incentive Scheme Year 7

Safety Action 9

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

The Shrewsbury and Telford Hospital NHS Trust



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 Q1

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
Pressure ulcer/ skin damage	Extraversion injury

Incidents Top 5 Themes Q1 Maternity

The Shrewsbury and Telford Hospital NHS Trust

Theme	Example
Care/Monitoring	Post Partum Haemorrhage > 1500mls, Shoulder Dystocia, 3rd and 4th Degree tears
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 Q1
Maternity and Neonates

The Shrewsbury and Telford Hospital NHS Trust

Maternity

No PSSI's Commissioned

There were no formal learning responses commissioned for Maternity in Q1

Neonates

No PSSI's Commissioned

No After-action Review Commissioned

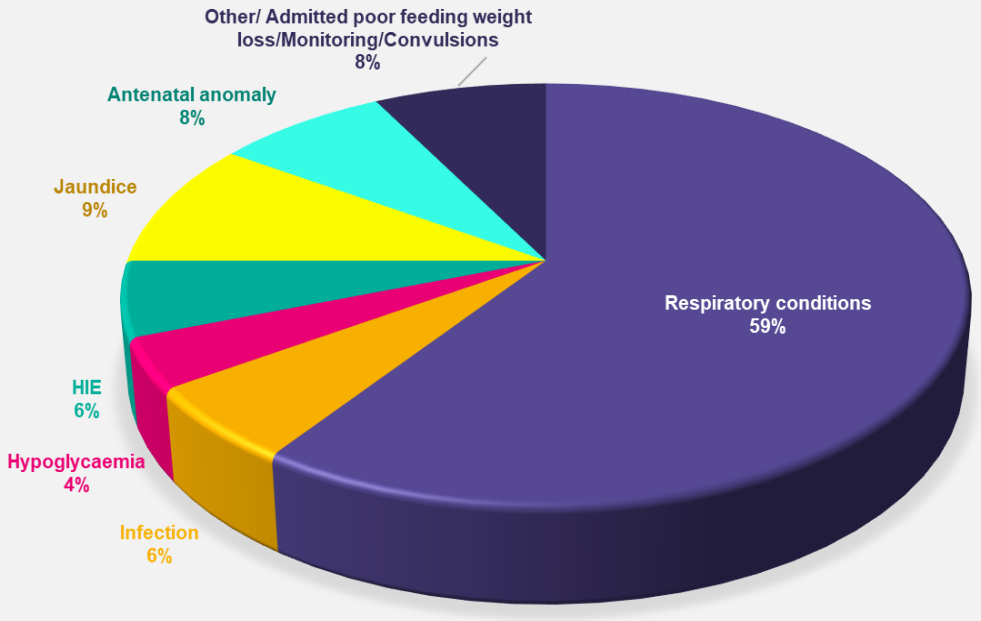
Duty of Candour Documentation

ATAIN

The term admission rate for Q1 (April, May, June 2025) was 5.9 % of all births at >37 weeks, an increase from the previous Q4 figure of 4.6%.

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 4 months.

A total of 53 term babies were admitted to the NNU in Q1 2025/2026 an increase (comparing with 39 in the previous quarter.)



Quarter 1 (April, May, June)

The numbers of babies admitted each month were:

343 Term births at PRH
April 2025 – 5.8% of all term births at >37 weeks (n = 20)
Avoidable admissions: (n=1)

305 Term births at PRH
May 2025– 4.9% of all term births at >37 weeks (n=15)
Avoidable admissions: (n=0)

303 Term births at PRH
June 2025– 5.9% of all term births at >37 weeks (n=18
Avoidable admissions: (n=1)

Compliments Complaints FFT MNVP Staff Survey

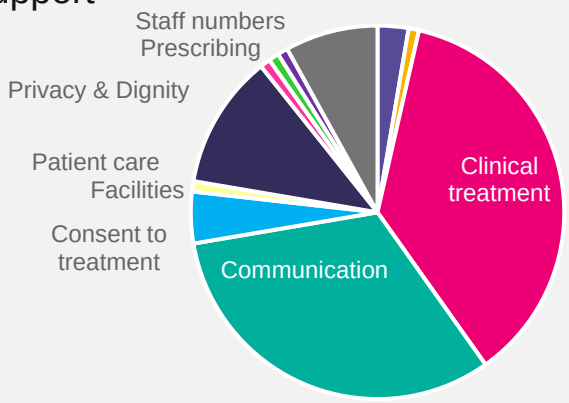
The Shrewsbury and Telford Hospital NHS Trust

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

April – June 2025 (Q1)	number	MBRRACE Reportable
Late Fetal Loss (20-23+6 weeks)	0	Yes – Only cases >22 weeks.
Early Fetal Loss (16-19+6 weeks)	3	No
Early Neonatal death (Live birth >20 weeks or 400g) < 7 completed days post birth	3 (2 born at SaTH died at L3 Unit)	Yes
Late Neonatal Death (Live birth >20 weeks or 400g) 7-28 days post birth	1 (born at SaTH died at BWH)	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)	7	Only if resulting in Stillbirth (from 24 weeks gestation) or Neonatal Death (from 20 weeks gestation).
Stillbirths (over 24 weeks)	1	Yes

PMRT Themes

Risk assessment for women with an intrauterine death – unknown cause of the death = unknown risks. It is essential that women presenting with a stillbirth receive a thorough MDT review, careful monitoring, and rapid escalation of concerns.

Airway management in extremely preterm babies – intubation of extremely preterm babies must be attempted by the most experienced clinician present.

The emergency resuscitation proforma for neonates is being updated to facilitate easy and timely documentation of all medications administered.

MNSI Publications

The Shrewsbury and Telford Hospital NHS Trust

2 safety recommendations were received in 2025 pertaining to MI-037627

It is recommended that the Trust ensures that when a fetal heard rate cannot be heard during a homebirth, the Trust's homebirth escalation of concerns in labour

It is recommended that the Trust and ambulance service work collaboratively to establish a robust process for the timely transfer of neonates to a hospital with the equipment, facilities and clinical expertise needed for ongoing neonatal care and this process is embedded in practice and familiar to all staff who are involved in the care of neonates.

4 safety recommendations were received in 2025 pertaining to MI-037179

The Trust to ensure each woman has a documented review and management plan daily during induction of labour in the Maternity Unit.

The Trust to ensure that when there is unsuccessful escalation, staff are empowered with escalation tools including the use of the emergency call buzzer.

The Trust to ensure that there is an environment in the Trust where a second clinician can be asked to help when there is task overload to ensure adequate fetal monitoring is maintained.

The Trust to ensure the safety of Mothers during labour is maintained with the minimum staffing levels and skill mix.

MNSI have developed a new report format which includes safety prompts in addition to safety recommendations. These will be considered in addition to the Safety Recommendations when action planning.

Local & National Audits CQUIM MSDS & Maternity Dashboard

The Shrewsbury and Telford Hospital NHS Trust

Triangulation of Incidents and data analysis of Maternity Dashboard:

Postpartum Haemorrhage >500-<1500mls Audit Quarterly

Postpartum Haemorrhage > 1500mls Audit

VTE Audit Monthly

Decision to Delivery Category 1+ 2 CS

Triage Audit (Triage times and Self Discharges)

Local Guideline/SOP Audit and National Benchmarking

CQC Visit & Maternity Survey

The Shrewsbury and Telford Hospital NHS Trust

CQC Visit October 2023- published May 24

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

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

Litigation NHSR Scorecard

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

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

Themes for the open cases:

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

Themes Claims 2013-2024

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

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

   Consent issues = 3

   Unexpected death = 3

   Perineal tears = 3
5. Inappropriate discharge =2

   Failure to act on abnormal test results = 2

Monitoring Safety

Triangulation

The Shrewsbury and Telford Hospital NHS Trust

Fetal Monitoring and Interpretation

Term Admissions

Test Results (Follow up)

Perineal Tears

Postnatal Bladder Care

Diabetes Service (Including Pre-conception)

Escalation Policy/Process

Communication/Values & Behaviours

Waiting Times

Consent

Improvements

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: August 2025

Agenda item		CNST INFORMATION PACK **– Appendix 8**		
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, September 2025 W&C Divisional Committee Meeting, September 2025 Quality and Safety Assurance Committee, October 2025 LMNS/PNQSG October 2025, BoD November 2025.		
Executive summary:		This is the evidence of meeting held in September from the bi monthly (August meeting moved to September) 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
2nd September 2025
MS Teams
Report of Meeting

In Attendance	Jacqui Bolton (JB)	Interim Head of Midwifery
	Mei-See Hon (MSH)	Obstetric Clinical Director
	John Jones (JJ)	Executive Medical Director
	Wendy Nicholson (WN)	Non-Executive Director
	Andrew Sizer (AS)	Divisional Medical Director
Apologies	Jay Atkinson (JA)	W&C Director of Operations
	Julie Plant (JP)	W&C Divisional Director of Nursing
	Maria Howe (MN)	MNVP Lead

	Welcome and apologies
	Welcome and apologies were noted as above. This meeting has been set up to satisfy the requirement of Safety Action 9 to confirm that the meeting has taken place. Meeting minutes will not be taken for distribution and any actions arising during will be allocated to members to discuss or action at the next meeting.
	Declarations of Conflicts of Interest
	No declarations made.

	Closing remarks
	Meeting closed.
	Date of Next Meeting
	22nd October 2025

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting 13 November 2025

Agenda item		**Appendix 9**		
Report Title		Maternity 6-month staffing report		
Executive Lead		Paula Gardner – Interim Chief Nursing Officer		
Report Author		Jacqui Bolton Interim Head of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		BAF4, BAF3
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	67, 87
Well Led	√	Our partners		
Consultation Communication		n/a		
Executive summary:		The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q1and 2 of 2025 inclusive. The maternity service has faced complex staffing challenges over the last 6 months despite a comprehensive, forward-thinking workforce plan. This is due to an unprecedented amount of staff unavailability which has been further compounded recently by the restrictions introduced for recruitment, and the need for executive and system oversight of all vacancies. Maintaining safe staffing levels has required the service to frequently enact the maternity services escalation policy to ensure patient safety is always maintained as midwifery staffing is complex, with acuity changing rapidly based on individual care needs and patient complexities. Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.		
Appendices:		Appendix 1: Midwifery red flags		

1.0 Introduction

1.1 The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q1 and 2 of 2025 inclusive. This is a requirement of Year Seven of the NHS Resolution Maternity (and perinatal) Incentive Scheme (MIS), and particularly for safety action 5 where the following standards are used:

Table 1

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

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

2.0 Background

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

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

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

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

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

3.0 Current Position

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

Table 2

	Establishment*	In post	Recruited to but not in post	Vacancy
MSWs and Midwives Bands 3 -7**	209.85	208.92	0	-0.93

**Does not include management roles or midwife sonographers*
*** Includes 10wte above BR+ for parental leave cover and additional 5.6wte for Triage above BR+*

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

3.3 Table 3 presents the unavailability position for the last year, with particular attention being drawn to Q1/2 of 2025 to which this report is focused on. Q1/2 saw our lowest number of maternity leave since reporting began which the over establishment allows for. We are seeing significant improvements in long term sickness management in Q4/1 and 2.

Table 3

	Q3 2024	Q4 2025	Q1 2025	Q2 2025
Parental leave	12.85wte	13.29wte	12.92wte	10.42wte
Long term sickness absence	19.33wte	12.02wte	14.03wte	9.69wte
Supernumerary international midwives	0 wte	2 wte	2 wte	2 wte
Total	**32.18wte**	**27.31wte**	**28.95wte**	**22.11wte**

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

3.3 Of the 10wte international midwives eight have successfully progressed to Band 6 in the last few months. Two who were recruited in 2024 are progressing on their preceptorship programme.

3.4 Furthermore, the specialist midwifery workforce continue to provide clinical support Table 4 below presents the current specialist workforce, which makes up 19.8wte.

Table 4

Specialist Role	WTE	Specialist Role	WTE
Fetal Monitoring Midwives	1.4	Public Health Lead Midwife	1.0
Saving Babies Lives Lead	1.0	Perinatal Pelvic Health Midwife	0.6
Digital Midwife	1.0	Lead Education Midwife	1.0
Maternal Mental Health Midwife	0.6	Clinical Practice Educators	3.0
Improving Women's Health Midwife	1.0	Guideline Midwife	1.0
Antenatal Screening Midwife	1.0	EDI Midwife	1.0
Frenulotomy Lead Midwife	0.4	Bereavement Midwives	2.0
BFI Lead Midwife	1.0	Diabetes Lead Midwife	1.0
Infant Feeding Lead	0.6	Multiple Pregnancy Midwife	0.6
Full total			**19.8**

3.5 Moreover, managers work clinically when required covering maternity manager of the day duties providing clinical support, operational flow, maintaining roster oversight receiving sickness updates.

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

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

4.0 Workforce Plan

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

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

4.3 The below table presents the recruitment currently in train as part of the workforce plan, the majority of which recruited has already taken place.

Table 5

Planned Recruitment	WTE	Additional Information
Midwifery Apprentice programme	9.0 over 3 years	3 commenced the programme in September 2023. Further recruitment programme is paused.
International Midwifery Recruitment	2.0 per year	10 recruited in 2023 with 8 progressing to Band 6 posts in 2025. 2 recruited in 2024 progressing on Band 5 Preceptor Programme
Midwifery Support Worker Apprentice programme	3.0	3 WTE commenced on programme.
Apprentice Midwife sonographer	2.0	2 WTE commenced in post as from September 2025

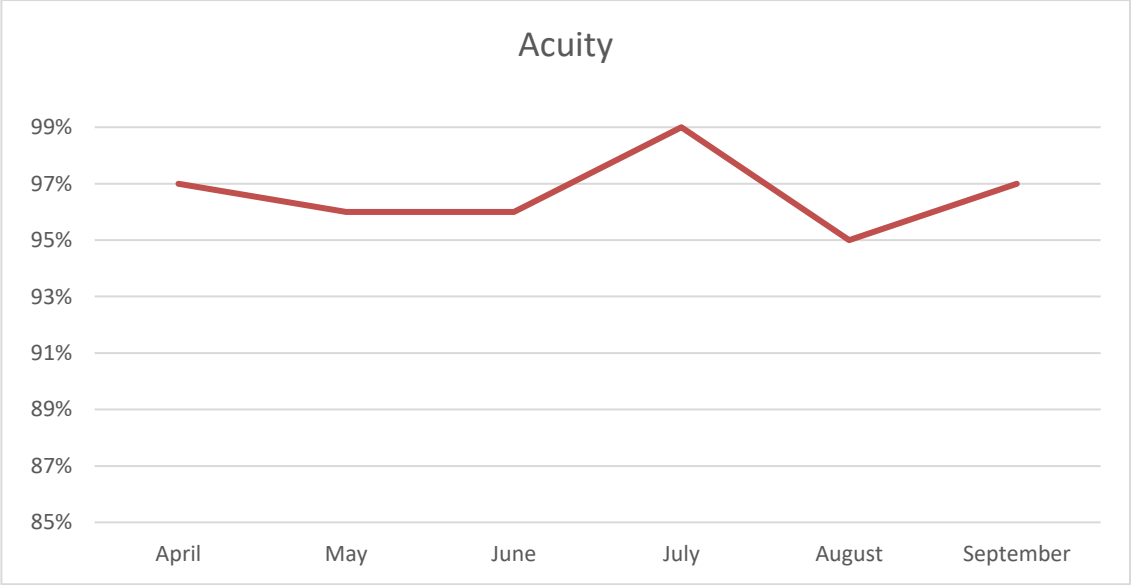
5. Acuity Data

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

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

5.3 The below graph presents the acuity data for Delivery Suite over the last 6 months (April to September 2025) inclusive:

Graph 1



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

5.5 There has been a consistent increase in positive acuity since November 2024, with the service exceeding the national for nine months. This sustained increase is directly related to the workforce plan and robust management of long term sickness reduction.

6.0 Red Flags

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

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

Table 6

Month	Red Flags	One to one Care not met	Co-ordinator not supernumerary	Positive (green) Acuity %	Acuity Amber %	Acuity Red%	Acuity Compliance Rate
April 2025	11	0	0	97%	2%	1%	90%
May 2025	12	0	0	96%	4%	0%	94%
June 2025	7	0	0	96%	4%	0%	90%
July 2025	8	0	0	99%	0.5%	0.5%	91%
August 2025	3	0	0	95%	5%	0%	89%
September 2025	7	0	0	97%	3%	0%	93%

6.3 To meet the required standards of the NHS Resolutions MIS safety action 5, the Midwifery Co-ordinator in charge of labour ward must have supernumerary status and all women in active labour to receive one-to-one midwifery care. Table 6 demonstrates the consistent reporting during this period.

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

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

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

7.0 Retention

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

7.2 This is in-keeping with the service having retained our entire cohort of newly qualified midwives who commenced in post in 2021 and 2022, successfully supporting them all to achieve band 6 midwife competencies. Similarly, in 2024, we recruited 17 wte newly qualified midwives who are progressing to Band 6 in the next few months. We will be in the position to recruit for Band 5 vacancies for those who have qualified in 2025.

8.0 Midwife to Birth Ratio

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

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

Table 7

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

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

Table 8

	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025
Midwife to Birth Ratio	1:23	1:23	1:23	1:23	1:23	1:23

9.0 Medical Staffing

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

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

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

Table 9

Rota Tier	**No of Medical Staff- wte**
Tier 1 (ST1-ST2)	10.8
Tier 2 (ST3-ST7)	13
Tier 3 (Consultant*)	28

*Inclusive of Gynaecology

9.4 In respect of the tier 1 and 2 rota, there have been no rota gaps in the last 6 months. Within the Obstetric tier 3 rota, there are 24 slots.

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

10.0 Midwifery Continuity of Carer

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

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

10.3 As the Trust continues to improve its staffing provision, there will be an expectation from the LMNS, regional and national teams to review our position in terms of restarting MCoC as a model of care.

10.4 In the meantime, we are committed to implementing the building blocks of MCoC in May 2025 we commenced a dedicated homebirth team from within the current establishment.

11.0 Conclusion

11.1 The maternity service has previously faced some complex staffing challenges over This paper provides the staffing status of Q1/2 position which demonstrates a marked improvement.

11.2 Despite the challenges described within this report, the service has seen an

improvement in our overall retention rates for all staff groups which are significantly better than the Trust target.

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

12.0 Actions Requested of the Committee/Board**

12.1 Review and discuss this paper, advising the Interim Head of Midwifery and Interim Chief Nursing Officer of any additional details required.

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

Appendix 1

Maternity red flag events, BirthRate Plus

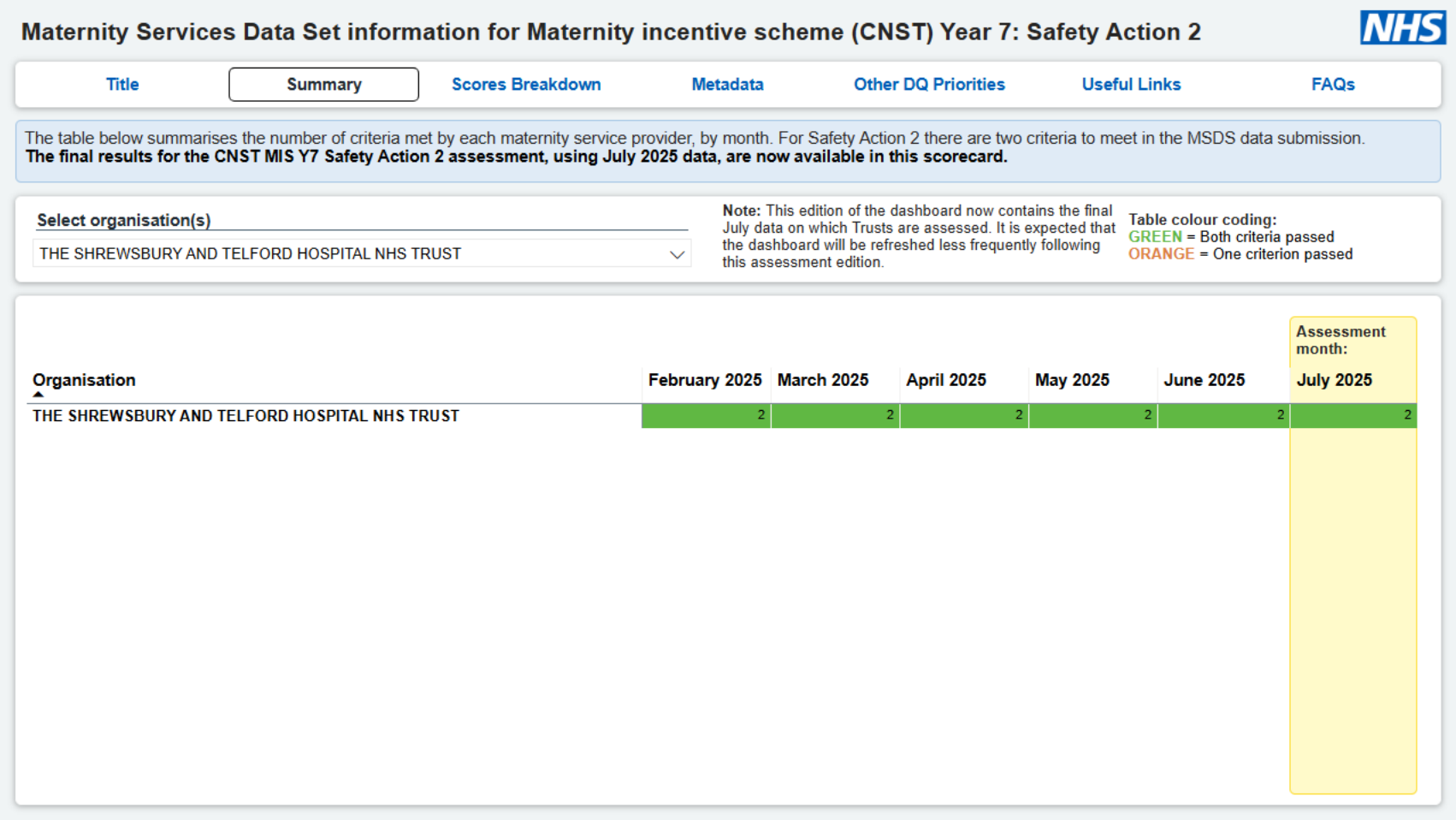
A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

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

MSDS information for Maternity Incentive scheme (CNST) Year 7: Safety Action 2

Microsoft Power BI

The Shrewsbury and Telford Hospital NHS Trust



Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | Summary | Scores Breakdown | Metadata | Other DQ Priorities | Useful Links | FAQs

The table below summarises the number of criteria met by each maternity service provider, by month. For Safety Action 2 there are two criteria to meet in the MSDS data submission.
The final results for the CNST MIS Y7 Safety Action 2 assessment, using July 2025 data, are now available in this scorecard.

Select organisation(s)

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Organisation	February 2025	March 2025	April 2025	May 2025	June 2025	Assessment month: July 2025
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	2	2	2	2	2	2

Trust results for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | Summary | **Scores Breakdown** | Metadata | Other DQ Priorities | Useful Links | FAQs

The tables below contain the detailed results for the selected Trust for the two measures that make up Safety action 2, covering Birthweight and Ethnicity data quality.
The full description and construction for each of the measures is available on the Metadata page in this scorecard.

Select organisation: THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	360	360	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	405	425	95.3	Passed

Pass rate: 90%

September 2025

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	**Appendix 11**			
Report Title	CNST Year 7 Compliance – Safety Action 4b – Anaesthetic Workforce			
Executive Lead	John Jones – Executive Medical Director			
Report Author	Yee Yin Cheng - Consultant Anaesthetist - Clinical Lead Obstetric Anaesthesia Cecile Pollitt – MNTP – Assistant Project Manager			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community		Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	
	Our governance	√	Responsive	
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance Neonatal Governance W&C Divisional Committee Quality and safety Assurance Committee Maternity and Neonatal Safety Champions LMNS Perinatal Quality and Safety Group Board of Directors			
Executive summary:	Year 7 of the Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme requires the following: 4b - *A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)* This paper and its appendices demonstrate compliance with this requirement.			
Appendices	**Appendix 1** - SOP - Staffing Level requirements in Obstetric Anaesthesia, SaTH **Appendix 2** – Obstetric anaesthesia rota , July 2025			

1. Introduction

1.1. CNST Maternity Incentive Scheme

The Maternity incentive Scheme Guidance was released in April 2025.

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

Specifically, within Safety Action 4, the following requirement applies to the obstetric Anaesthesia provision:

4b - A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

Acceptable evidence for this requirement is a representative month of the rota.

2. Compliance

2.1. Appendix 1 – SOP – Staffing Level requirements in Obstetric Anaesthesia

The CNST requirement has been integrated into the Staffing level requirements for Obstetric Anaesthesia under section 2: The Duty Anaesthetist.
"Availability: The duty anaesthetist should be immediately available for the obstetric unit 24/7. The duty anaesthetist should be resident on the hospital site."

The service has a resident obstetric anaesthetist on site 24/7 and an anaesthetic oncall consultant who covers obstetric.

2.2. Appendix 2 - Obstetric anaesthesia rota , July 2025

As required within CNST guidance, the rota for July 2025 has been provided as an appendix to this paper to demonstrate compliance.

3. Conclusion

3.1. The Committees and Board are asked to take assurance from this paper and its appendices that the Trust is compliant with Safety Action 4 – Requirement 4b regarding Obstetric Anaesthesia workforce.

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Standard Operating Procedure (SOP)

SOP Title	Staffing Level requirements in Obstetric Anaesthesia, SaTH		
SOP Number	3403		
Care Group	Scheduled Care		
Version Number	V2		
Effective Date	November 2022	Review Date	November 2025
Author Lead	Dr Gauri Dashputre, Consultant Anaesthetist & Dr Pejhman Rahimi, Speciality Doctor Obstetric Anaesthesia Lorien Branfield, consultant and lead for obstetric anaesthesia		
Approved by	Anaesthetic governance, Anaesthetic operations officers, PRH theatre staff		
Approval date	2 December 2022		
Distribution	Anaesthetic & theatre staff		
Location	Maternity theatres and maternity unit		

Document Control				
Version	Date	Author	Status	Comments
V1	November 2022	Dr Gauri Dashputre & Dr Pejhman Rahimi	NEW	New SOP
V2	April 2023	Dr Gauri Dashputre	Updated	Section 9 – updated following suggestion from the Ockenden review committee

SOP Objectives	To provide a safe and effective anaesthesia service that aims to deliver patient centred care which meets the patient's expectations.
Scope	SOP developed to ensure that obstetric patients received the same standards of anaesthetic care as those recommended for the general surgical population.

Performance Measures	Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out using the auditable standards identified in the audit tool at Appendix *. Results will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

Number	Brief	Responsibility
1	**Provision of Obstetric care** Provision of Obstetric care involves multidisciplinary team input. This SOP covers staffing requirements for anaesthetists and anaesthetic teams working in maternity services.	
2	**The Duty Anaesthetist** • Scope of care: Should extend to any women requiring anaesthetic, medical or surgical attention in the antenatal, perinatal, and postnatal period. • The duty anaesthetist should not undertake elective work during the duty periods. • Grade of anaesthetist: Can be a consultant, an SAS doctor, clinical fellow, or anaesthetic trainee. • Supervision: The duty anaesthetist can practice without direct supervision from a consultant or autonomously practising anaesthetist if they have met the basic training specifications and have achieved the RCoA's Initial Assessment of Competence in Obstetric Anaesthesia or equivalent. • Availability: The duty anaesthetist should be immediately available for the obstetric unit 24/7. The duty anaesthetist should be resident on the hospital site. • Communication with supervisor: The duty anaesthetist as well as staff working on the maternity unit, should be aware of the supervisor's identity, location and how to contact them and should have the means to contact them rapidly. The name of the supervisor should be clearly displayed and visible to all staff. • There should be clear guidance on escalation and involvement from the consultant anaesthetists in daytime and out of hours. (Refer to SOP 3220; When to call a Consultant Anaesthetist to Delivery Suite and/or when to inform a Consultant Anaesthetist) • MDT Handovers and ward round participation: Adequate time for formal multidisciplinary team (MDT) handovers between shifts should be built into the timetable. The duty anaesthetist should participate in MDT delivery suite handover and ward rounds. In the case of the anaesthetist being otherwise engaged with work and unable to attend at the time of the MDT labour ward handover or ward rounds, a briefing from the midwifery and obstetric team should be sought at the earliest opportunity to facilitate a shared mental model of the existing workload/potential patients.	Rota master Duty anaesthetist

3	**The Lead Obstetric Anaesthetist**
	
	• Every obstetric unit should have a designated lead anaesthetist with specific programmed activities allocated to this role.
	• Responsibilities of the lead include ensuring overall delivery of the service by:
	  ○ Ensuring guidelines and protocols are in use and are up to date
	  ○ Monitoring staff training
	  ○ Service risk management
	  ○ Ensuring that national specifications are met
	• Auditing: Ensuring the service is audited against agreed standards, including anaesthetic complication rates, as set out in the RCoA QI Compendium.
		Clinical director of anaesthetics department
		
		Lead obstetric anaesthetist

	• MDT meetings / Governance / Labour ward forums: Ensuring representation of the anaesthetic department at these meetings for service planning, risk management and incident reviews. • Quality Improvement (QI) projects: ensuring the continuity of QI projects aiming to maintain and improve the care in the unit.	

4	**Consultant or other autonomously practising anaesthetist**
	
	• Availability for emergency care: As a basic minimum for any obstetric unit, a consultant or other autonomously practising anaesthetist (Specialist grade) should be allocated to ensure senior cover for the full daytime working week; that is, ensuring that Monday to Friday morning and afternoon sessions, are staffed. This cover is to provide urgent and emergency care, not to undertake elective work.
	• Additional programmed activities should be allocated for:
	  ○ Elective caesarean birth list
	  ○ Antenatal anaesthetic clinics
	  ○ Review of referrals
	  ○ Identification and follow-up of patients with anaesthetic morbidity and arrangement of investigations and further referrals
	  ○ Provision of support system for anaesthetists in training who rotate through the department every three months (or more frequently) with aspects such as initial orientation, training, and supervision into daytime and out of hours.
	• Elective caesarean delivery list: There should be a named consultant or other autonomously practising anaesthetist responsible for every elective caesarean delivery list. This anaesthetist should be immediately available and should have no other concurrent clinical responsibilities.
	• Response time: Consultant or other autonomously practising anaesthetist should be always contactable: on-site attendance on delivery suite or maternity theatres should not extend beyond 30 minutes.
	• Scope of care: Primary responsibility is care of the woman. A separate healthcare professional should be responsible for neonatal resuscitation and the care of the new-born baby.
		Rota master, Clinical Director of anaesthetics department
		
		On-call consultants

5	**Anaesthetic Assistance:** • Standards of care: Women requiring anaesthesia in the peripartum period should have the same standards of perioperative care as for any surgical and medical patient. • Scope of responsibilities: practitioner must be immediately available and should not have any other duties during the time of the anaesthetic intervention. • Training standards and competency: All anaesthetic assistance should comply fully with current national training standards and should demonstrate the relevant competencies to perform the role. • Care of pregnant women: Anaesthetic practitioners should demonstrate additional knowledge and skills specific to the care of pregnant women. • Familiarity with working practices and environment: Anaesthesia assistants should be familiar with the environment and working practices of that unit and work there on a regular basis to maintain that familiarity.	Theatre manager, theatre rota manager, individual theatre practitioners

6	**Postanaesthetic recovery staff** • Standards of care: Women requiring postoperative care should receive the same standards of care as the non-obstetric population. • Familiarity with working practice and environment: Recovery staff should be familiar with the area for recovery of obstetric patients and be experienced in the use of different early warning scoring systems for obstetric patients. • Training requirements: Staff should have been trained to the same standard as for all recovery practitioners working in other areas of general surgical work, should maintain their skills through regular work on the theatre recovery unit and should have undergone a supernumerary preceptorship in this environment before undertaking unsupervised work.	Theatre manager, theatre rota manager, individual recovery practitioners
7	**Other members of the team** • Adult resuscitation team: Team trained in resuscitation of the pregnant patient should be immediately available. • Secretarial support: There should be secretarial support for the department of anaesthesia, including the obstetric anaesthetic service. • Other allied healthcare professionals: Ensure access to other allied healthcare professionals, such as clinical pharmacists, dieticians, outreach nurses and physiotherapists if required.	Operations managers for anaesthetics, theatres, and division
8	**Documentation defining safe staffing levels** Hospital should have approved documentation defining safe staffing levels for anaesthetists and anaesthetic practitioners (this SOP), including contingency arrangements for managing staffing shortfalls. Annual reviews of compliance with these standards should be performed.	Audit lead for obstetric anaesthesia
9	**Staff management** Professional development of the staff should be encouraged, and a pleasant working environment fostered. Provision of Obstetric care is multidisciplinary. To ensure that teams can function effectively, they need to train together and have an appropriate infrastructure and necessary resources in place to deliver a high-quality service. The staff should be supported by the trust to have continual education and training to ensure knowledge, skills and performance is up to date. Staff members should be supported to put into practice principles of clinical governance to ensure high quality care. They should use evidence-based approaches in clinical care with adherence to the guidelines. Learning should be encouraged through experience to improve the practice. Systems should be in place for thorough risk assessments and reporting of incidents and near misses. Any autonomously practising anaesthetist providing cover for the labour ward regularly or on an ad hoc basis must undertake continuing professional development (CPD) in obstetric anaesthesia and must have enough exposure to obstetric patients to maintain appropriate skills. This should primarily be achieved through annual participation in SATH PROMPT courses. Where	Clinical director, lead for obstetric anaesthesia, all anaesthetic consultants Lead for education and training in obstetric anaesthesia Lead for risk management in obstetric anaesthesia Job planning and appraisal systems

	needed, the anaesthetist may also be allocated to supernumerary sessions on the labour ward or in elective caesarean lists while reviewing appropriate CPD during the appraisal Regular audits should be carried out to monitor and improve quality of care against recommended standards. Regular appraisals and job planning should be undertaken to monitor staff performance.	Lead for audit obstetric anaesthesia Lead for audit in obstetric anaesthesia
10	**Reference** RCOA: Guideline for the Provision of Anaesthesia Services for an Obstetric Population 2022. OAA-Anaes.ac.uk: Raising the standards, RCOA quality improvement compendium, 4th edition.	

Appendix 2

The Shrewsbury and Telford Hospital NHS Trust

OBSTETRIC ANAESTHETIC COVER – JULY 2025

	MORNING	AFTERNOON	EVENING	NIGHT
Mon 30th June	**C-Sections -**Dr Dashputre (Cons) **Labour Wd -** Dr Kada (Cons) & Dr Rahimi (Specialist Dr)	**Labour Wd -**Dr Dashputre (Cons) & Dr Rahimi (Specialist Dr)	**Obs on call -** Dr Rahimi (Specialist Dr) & Dr Shivanna (Cons)	**Obs on call -** Dr Fernandes (Specialist Dr) & Dr Shivanna (Cons)
Tues 1st July	**C-Sections -** Dr Elmor (Cons) **Labour Wd -** Dr Rahimi (Specialist Dr) & Dr Irfan (Speciality Dr)	**Labour Wd -** Dr Elmor (Cons) & Dr Rahimi (Specialist Dr)	**Obs on call -** Dr Rahimi (Specialist Dr) & Dr Kada (Cons)	**Obs on call -** Dr Fernandes (Specialist Dr) & Dr Kada (Cons)
Weds 2nd July	**C-Sections -** Dr Cheng (Cons) **Labour Wd -** Dr Punjabi (Speciality Dr)	**Labour Wd -** Dr Cheng (Cons) & Dr Punjabi (Speciality Dr)	**Obs on call -** Dr Punjabi (Speciality Dr) & Dr Dashputre (Cons)	**Obs on call -** Dr Mushtaq (Speciality Dr) & Dr Dashputre (Cons)
Thurs 3rd July	**C-Sections -** Dr Silva (Cons) **Labour Wd -** Dr Irfan (Speciality Dr) & Dr Punjabi (Speciality Dr)	**Labour Wd -** Dr Silva (Cons) Dr Punjabi (Speciality Dr)	**Obs on call -** Dr Punjabi (Speciality Dr) & Dr Elmor (Cons)_	**Obs on call -** Dr Mushtaq (Speciality Dr) & DR Elmor (Cons)
Fri 4th July	**Labour Wd -** Dr Clulow (Cons) Dr Wickramasinghe (Specialist Dr)	**C-Sections -** Dr Stuart-Smith (Cons) **Labour Wd -** Dr Wickramasinghe (Specialist Dr) Dr Chopra (Speciality Dr)	**Obs on call -** Dr Wickramasinghe (Specialist Dr) & Dr Shivanna (Cons)	**Obs on call -** Dr Rahimi (Specialist Dr) & Dr Shivanna (Cons)
Sat 5th July	**Obs on call -** Dr Wickramasinghe (Specialist Dr) & Dr Dashputre (Cons)	**Obs on call -** DR Wickramasinghe (Specialist Dr) & Dr Dashputre (Cons)	**Obs on call -** Dr Wickramasinghe (Specialist Dr) & Dr Dashputre (Cons)	**Obs on call -** Dr Rizvi (Specialist Dr) & Dr Dashputre
Sun 6th July	**Obs on call -** Dr Wickramasinghe (Specialist Dr) & Dr Shivanna (Cons)	**Obs on call -** Dr Wickramasinghe (Specialist Dr) & Dr Shivanna (Cons)	**Obs on call -** Dr Wickramasinghe (Specialist Dr) & Dr Shivanna (Cons)	**Obs on call -** Dr Rizvi (Specialist Dr) & Dr Shivanna (Cons)

Integrated Care System
Shropshire, Telford and Wrekin

Agenda

Date: 13th October 2025

Time: 11:00 to 12:30

Venue: Virtual via Teams

* A=Approval/R=Ratification/D=Discussion/I=Information

	Agenda Item	Enc ref	Lead	Action	Time
1.	**Welcome and apologies**		Chair		11:00
2.	**Review of previous minutes, actions and risk register** • Risk register • Updated Terms of reference Note: No previous minutes or actions for this board due to recent change to governance and separation from PQSG.	 2.2 2.3	Chair	 D R	
3.	**System Updates** • Local context – updates from system/service leads • LMNS board report • Preconception project update • LMNS projects - status report • Three year delivery plan status report	 Verbal 3.1 3.2 3.3 3.4	 All Sue Bull Jane Holloway Jane Holloway/Louise Macleod	 D D D I I	11.10

4.	**Patient/service user voice and feedback**
	• MNVP update
	  ○ 15 steps
	  ○ Delayed ARM survey
	  ○ MOU
	• MNISA update
	• Next steps for responding to feedback
		
		4.1
		4.2
		4.3
		4.4
		4.5
		Verbal
			
			Maria Howe
			
			Liane Powell
			Maria Howe/Liane Powel
				
				D
				D
				D
				A
				D
				I
					11:25

5.	**Equity and Equality**
	• Profiling papers
	  ○ Reproductive age
	  ○ Service users
	• Perinatal equity analysis - summary
	• Next steps towards a single public-facing E&E report and action plan
		
		5.1
		5.2
		5.3
			
			Sue Bull
			
			All
				
				I
				
				D
				
				D
					11:45

6	**CNST Safety Action 7** Action Plan: Volunteer Onboarding & Evidence for CNST Safety Action 7	6.1	Sue Bull	A	12.05
7.	**Diabetes Exemption report** • Support for change	7.1	Guy Calcott	A	12:15
8.	**Any Other Business (AOB)** • Nottingham independent review letters		Chair	D	12:25
	Close				

Date and Time of Next Meeting: TBC

Action Plan: Volunteer Onboarding & Evidence for CNST Safety Action 7

Key Outputs

- All safety/governance groups have at least one trained MNVP volunteer.
- A live evidence folder with everything needed for CNST Safety Action 7
- Documented co-production and feedback loops with service users.

Objective	Actions	Lead / Support	Timeline	Evidence / Output
Map current representation needs	• List all maternity/neonatal safety and governance groups • Identify which currently have service user representation and where gaps exist.	MNVP Lead	**30th September 2025 – completion**	Mapping document showing groups, reps, vacancies
Develop volunteer role profiles	• Draft clear role descriptions for MNVP reps (purpose, time commitment, skills, induction offered). • Include safeguarding, confidentiality and reimbursement details.	MNVP Lead/ LMNS Project officer (project oversight)	**3rd November 2025 - completion**	Approved volunteer role profile
Create a standard reporting template	• Develop a simple form for reps to record key points from meetings (issues raised, actions, feedback needed). • Use a shared drive to upload after each meeting	MNVP Lead/ LMNS Project officer (project oversight)	**3rd November 2025 - completion**	Completed templates from each meeting

Appendix 1

Nursing Establishment Review January/February 2025

1.0 Safer Nursing Care Tool

The Safer Nursing Care Tools (SNCT) calculates clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions.

The tools:

- Provide organisational level metrics to monitor impact on the quality of patient care and outcomes.
- Give a defined measure of patient acuity and dependency.
- Supports benchmarking activity in organisations when used across Trusts.
- Embrace all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE 'Safe, sustainable and productive staffing' resources.
- Include staffing multipliers to support professional judgement.
- Provide accurate data collection methodology.

The levels of acuity within the tool range from Level 0 to Level 3 (Table 1). Level 3 patient acuity is only delivered within ED and Critical Care for adult patients. Not all current versions of the tools (ED and CYP) include all acuity categories, however those that do not are under review by the national team.

Table 1. SNCT levels of acuity -Adult inpatient and Acute Assessment areas

Level	Definition
Level 0	Hospital Inpatient. Needs met by provision of normal ward cares.
Level 1a	Acutely ill patients requiring intervention or those who are **UNSTABLE** with a **GREATER POTENTIAL** to deteriorate.
Level 1b	Patients who are in a **STABLE** condition but are dependent on nursing care to meet most or all of their care needs.
Level 1c	Patients who are in a **STABLE** condition but are requiring additional intervention to mitigate risk and maintain safety
Level 1d	Patients who are in a **STABLE** condition but are requiring additional intervention by 2 or more people to mitigate risk and maintain safety
Level 2	May be managed within clearly identified, designated beds, resources with the required expertise and staffing level **OR** may require transfer to a dedicated Level 2 facility / unit.
Level 3	Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

The review was undertaken across the adult inpatient wards, Emergency Departments and Paediatrics. The data from this census is not reviewed in isolation as data from previous years census is reviewed in the establishment review meetings. No new wards have been opened, from the last census undertake, but a number of wards have opened escalation beds to support flow and reduce risk in the emergency departments. It was noted that the majority of areas where escalation beds were in use the beds were mostly open for the whole-time census data collected. Therefore, the total number of beds in open in an area have been included in calculating census data.

Data was collected for adult inpatient wards and paediatric wards over a 30-day period. A Professional Judgement Framework within the SNCT was also used by the ward managers and matrons to inform their professional judgement used as part of the triangulation for the staffing reviews.

The emergency departments data collection is completed over a 12-day period and records acuity twice a day providing data on the 24 hours period.

Table 2 - Summary of SNCT recommended WTE for January/February 2025 Census Period

	Recommended WTE inc 1c/1d			Recommended WTE exc 1c/1d			
Ward	Reg	Unreg	Total	Reg	Unreg	Total	1c/1d
TAMU	19.23	10.36	29.59	18.9	10.18	29.08	0.52
SAMU	25.27	13.61	38.87	24.91	13.42	38.33	0.54
SAMA	19.42	12.95	32.37	19.21	12.81	32.02	0.35
AOTU	26.22	17.48	43.71	26.22	17.48	43.71	0
Ward 4	24.95	20.41	45.36	24.28	19.8617.66	44.14	1.21
Ward 6/CCU	23.11	9.9	33.01	23.04	9.87	32.92	0.1
Ward 7	26.92	21.15	48.08	26.45	20.79	47.24	0.84
Ward 8	13.86	5.94	19.8	13.86	5.94	19.8	23.3
Ward 9	18.51	15.15	33.66	18.39	15.05	33.44	0.22
Ward 10	25.29	16.86	42.16	25.29	16.86	42.16	-
Ward 11	26.07	21.33	47.41	25.69	21.02	46.7	0.7
Ward 14	8.17	4.14	12.56	8.17	4.14	12.56	-
Ward 15	25.01	20.46	45.47	25.01	20.46	45.47	-
Ward 16	17.05	11.37	28.87	17.05	11.37	28.87	-
Ward 17	28.95	15.59	44.54	29.91	15.03	42.94	1.6
Ward 22SS	21.18	13.45	33.63	20.05	13.36	33.41	0.22
Ward 23OH	24.96	13.44	38.40	24.96	13.44	38.40	-
Ward 24	30.95	16.67	47.62	30.89	16.63	47.52	0.1
Ward 25	32.36	21.57	53.94	32.17	21.45	53.62	0.32
Ward 26	34.13	22.75	56.88	32.81	21.87	54.68	2.20
Ward 27	33.37	27.30	60.67	31.51	25.78	57.29	3.39
Ward 28	28.39	23.23	51.62	28.22	23.09	51.30	0.32
SAU	41.07	22.12	63.19	41.07	22.12	63.19	-
Ward 35	14.62	9.74	24.36	16.62	9.74	24.36	-
Ward 37	29.69	19.8	49.49	29.69	19.8	49.49	-
Ward 19	n/a	n/a	n/a	44.1	22.4	66.5	n/a

SNCT guidance requires a review of data from a minimum of two census periods before making changes to establishments/budgets. Where data is significantly different further census may be required. With multiple changes in ward function, and a number of wards moves the SNCT has limitations if subsequent census periods do not analyse the same ward functions/locations. When applying methodology for safer staffing reviews, the SNCT evidence-based tools should always be considered alongside outcomes and professional judgement.

For the purpose of the bi-annual staffing reviews, a benchmark of RN: HCA ratio of 65:35 has been utilised within the SNCT for adult inpatient wards. It should be noted that the gold standard would be a mix of 70% RN to 30% HCA. Evidence suggests that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths

et al 2016, RCN 2021). However, where a ward has a usual higher dependency rather than acuity need, it is accepted the ratio may need change. Current acuity/dependency scoring across medicine and surgery show a higher dependency (1b) of patients in January/February 2025 in line with censuses completed in 2024, and as such templates currently reflect a ratio with higher levels of HCA. As recommended by the Clinical Workforce lead in the Safer Staffing Faculty in NHSE, any recommended changes in establishments which results in a ratio of less than 65:35 ratio of RN:HCA will require a Quality Impact Assessment (QIA).

2.0 SNCT Results January/February 2025

2.1 Adult Inpatient Wards SNCT %

The overall average percentage data for all adult wards for the last four SNCT periods completed in 2024/2025 is shown below. The main acuity of patients is stable requiring ward care (Level 0) or stable and dependent (Level 1B), with 44.55% and 45.45% respectively in January/February 2025.

Table 3 – average acuity by census (%)

	Empty Beds	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2025	2.74	44.55	5.59	45.45	0.51	0.01	1.14	0
Sept/Oct 2024	2.72	43.6	6.52	45.83	0.87	0.82	1.31	0
Jun/Jul 2024	1.93	43.65	5.96	44.97	1.4	1.18	1.61	0
Jan/Feb 2024	1.69	43.95	8.44	44.62	0.56	0.04	1.69	0.00

2.2 Surgery, Anaesthetics and Cancer Wards SNCT Establishment Review January/February 2025

Data collected for the surgical areas (Chart 1) shows the highest proportion of patients recorded was 1b category (stable dependent patients). Comparison to the June 2024 census shows that there had been a decrease in Level 1b patients and an increase in Level 0 and slight increase in 1a patients. The number of patients requiring 1:1 care (1c) has decreased slightly since June but is higher than January which we previously noted was an outlier month in relation to ECS requirements.

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Chart 1 -SAC Average acuity by census period.

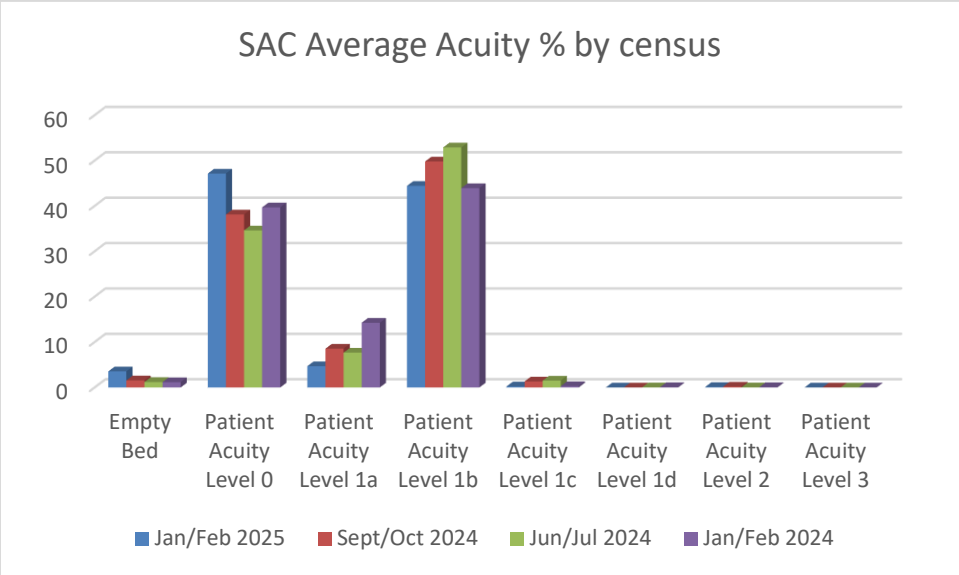


Table 4 - SAC Average acuity by census period.

SAC	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2025	3.53	47.12	4.69	44.41	0.22	0	0.1	0
Sept/Oct 2024	1.56	38.1	8.55	49.78	1.33	0	0.19	0
Jun/Jul 2024	1.2	34.6	7.66	52.87	1.51	0.01	0.01	0
Jan/Feb 2024	1.17	39.68	14.25	43.92	0.28	0.06	0.06	0

In February 2025, escalation beds were open or 'plus one' patient was in operation during the census period, meaning wards regularly had 1-2 additional patients. As this was not consistent over the period of review the additional patients were not captured in the census and included in the calculations for staffing. Staffing has been considered and ward 37 could have up to 4 extra patients so staff levels would be considered on a daily basis in response to the increase in patient numbers. It was also noted that assessment areas were holding patients for long periods whilst awaiting ward beds. The SNCT tool cannot be used to assess staffing in assessment areas where patients are in trollies or chairs, but it is noted wards have needed to care for 'in patients' in these areas whilst also functioning as an assessment space.

Ward 5 was included in the SNCT census from January and February 2025. It is noted though, the ward has not fully returned to normal elective orthopaedic activity which has meant the ward have to support day case activity at times. Estates work is required in this area before orthopaedic activity can return to normal. As activity has been reduced, staff have been redeployed to the Telford Elective Surgery Hub to cover staffing gaps due to vacancies and increases in day case activity. Ward 5 acuity is lower than expected if the ward had been operating normally and this has also reflected in the higher number of empty beds reported. This has affected SAC division overall average acuity score with the highest number of empty beds reported across the last 4 census periods. This is not in line with other areas in this division, as additional patients rather than empty beds have been the norm.

The acute assessment areas on the Trauma and Orthopaedic ward at RSH (Ward 32 AOTU), funded through the SDEC business case is in operation. However, this is currently on Ward 32

rather than the original allocated space on Ward 31 and so not all the funded establishment is being used.

It is noted Ward 4 Trauma and Orthopaedics assessment area is regularly being used for inpatient care with additional patients placed in this area whilst waiting admission. This area has additional staff at night and is covered by the Trauma nurse in the day. It is noted the recommended SNCT WTE is above the staffing template for ward 4, however the assessment staff have been caring for the additional in patients. These staff would not normally be included in fill rate reporting.

Ward 8 patient acuity has increased with several outliers (orthopaedic and medical) placed on the ward. There has also been a reduction in complex head and neck cases admitted to the ward and discussions are ongoing regards further plans for this type of surgery. No final decisions have been made in relation to service changes. This has meant over the last year there has been a change in acuity as there are fewer complex patients with tracheostomies. Some variation in SNCT recommended staffing levels is noted with this change in ward function, however no recommended changes are proposed at this time. The budgeted staffing is above recommended SNCT but is noted the ward is now admitting several patients daily for surgery via their treatment room and waiting area due to lack of surgical admission suite. The ward staff are being utilised to admit and prepare patients for surgery in addition to normal ward work. Also, regular ward attenders utilise the treatment room to decompress the emergency departments. This has meant the ward are having to flexibly use staff to support these additional patients which workload is not included in the SNCT audit.

No recommendations for change were made on Ward 25 this time, however it is noted that the ward will be moving into a new modular build this year which will see an overall increase in beds as the ward will nurse patients over two 28 bedded areas rather than 38 beds on ward 25. Templates for these areas have been reviewed and agreed outside the establishment review process.

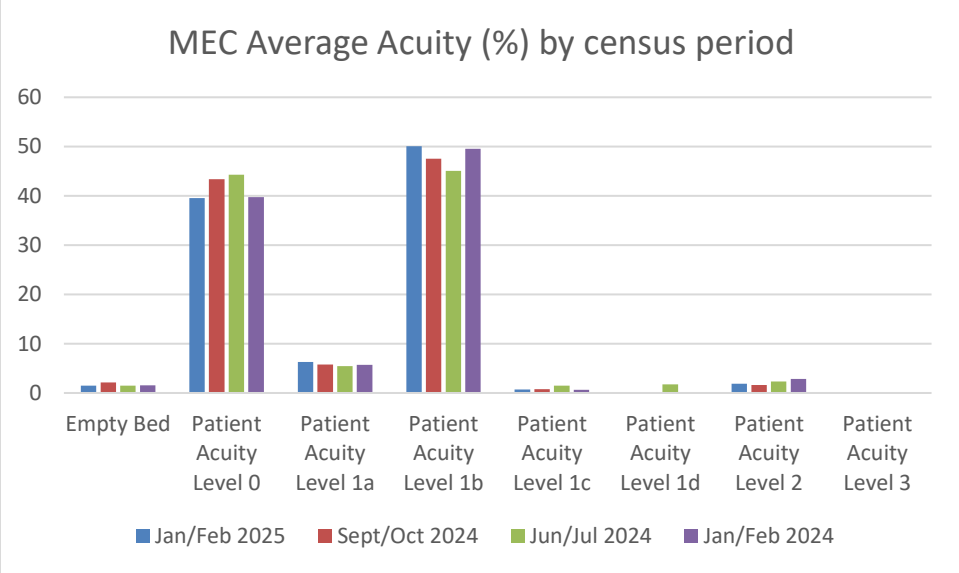
Reductions agreed for Ward 37 were enacted in March 2025, after this census period. However, it was noted that during the census period additional patients have been place on this ward. When the template changes were in place, concerns were raised by the Divisional Director of Nursing for SAC as up to 4 additional patients could be on the ward at any one time. In response to concerns and reviewing risks, where additional patients have been placed on this ward, the Chief Nurse has agreed an additional staff member could be added to the template. This has been reviewed daily and on-going monitoring of the situation and consideration if any permanent changes need to be made.

The Surgical Assessment Unit current budget reflects the clinic/assessment as well as the ward area. Currently the SNCT recommended WTE is greater than budget for inpatient beds however it was felt by the Divisional Director of Nursing the greater risks is in the assessment area due to significant increase in activity in the day and particularly at night. An exercise to map staffing against activity, analyse acuity and case mix will be completed in 2025 to ensure the staffing provision meets the peaks in demand and area is safely staffed. There has been an increase in numbers of patients waiting for long periods in treatment rooms and seats and trollied bays, alongside an increase in planned returns and night-time activity. Work is progressing to develop the dashboard data for these areas, however anecdotally staff report up to 20 patients can be in the waiting area as staff come onto night shifts. The department co-ordinator flexes between the ward and assessment area, to support and deliver patient care, however their role also sees them manage and triage calls regards admissions from ED and from GP’s. Some pathway work is also needed in this area as several patients could be seen in ‘hot clinics’ thus reducing some of the peaks in patient numbers and pressures in the area.

2.3 Medicine and Emergency Care Wards SNCT Establishment Review January/February 2025

Data collected for the medical ward areas show the highest proportion of patients fall into the level 0 (stable - normal ward care) and 1b categories (stable dependent patients). Seasonally, there are higher numbers of dependent patients across the winter months. It is noted the number of patients requiring a level 2 high dependency bed was at its greatest over the last year.

Chart 2 -MEC Average acuity by census period.



MEC 2024	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2025	1.46	39.57	6.31	50.04	0.73	0.02	1.85	0
Sept/Oct 2024	2.13	43.41	5.76	47.56	0.76	0.03	1.64	0.01
Jun/Jul 2024	1.47	44.3	5.44	45.04	1.48	1.76	2.36	0
Jan/Feb 2024	1.57	39.73	5.69	49.54	0.66	0.04	2.84	0

Table 5 – MEC acuity by census period

During the last biannual review, it was agreed to increase staffing on Ward 7 due to change in acuity and dependency on the ward following an operational change in ward function from Cardiology to General Medicine. Ward 7 continues to have the highest SNCT recommended WTE for similar wards at PRH. The increase in staffing was agreed as staff had reported that night shifts were particularly challenging. The impact of changes will not be noted as new roster templates were not enacted until March.

The staffing template for Ward 17 was decreased by 1 Health Care Assistant for both days and nights following the last establishment review. Although budget changes were not enacted on rosters until March 2025, it is noted that the recommended WTE remains in line with the new budget, with the gap reducing. The Respiratory Consultant Team based at the Princess Royal Hospital had raised concerns regards the reduction in template and a meeting was arranged with the Divisional Director of Nursing, Matron and Deputy Chief Nurse to discuss these concerns. Since the staffing changes were enacted no significant changes in the quality of care on the ward has been observed over the last 4 months.

Ward 15/16 SNCT although operating as a unit are separated across a corridor with ward 16 being the Hyper Acute Stroke Unit whereas Ward 15 focuses on caring for patients with rehabilitation needs. The wards have different staffing requirements with ward 16 admitting level 2 patients with acute illness into the thrombolysis room. This area is in addition to wards beds and is not included in census. The staffing for this area reflects the need to be responsive with treatment and care of a patient with an acute ischemic stroke, admitting patients direct to the wards following initial assessment in the emergency department. The healthcare assistant template was reduced by 1 on days at the last establishment review, with changes enacted after this census was completed. No changes were required to ward 15 template and the SNCT recommended WTE remains consistently in line with budget.

Ward 10 Short Stay has seen a change in patient profile with a shift in dependency of patients requiring longer lengths of stays and requiring increase support from staff with care. This change has notably impacted on the outputs of this census with the recommended SNCT increasing from the previous two census periods. Decisions at the last establishment review saw the ward template reduce by 1 Health Care Assistant on a day shift with the changes enacted after this census. Efforts are being made to admit appropriate patients to maintain the wards intended function. If this is not addressed an increase in staffing template may need to be considered if the current patient profile persists.

The recommended SNCT for AMU at the Princess Royal Hospital is similar to previous census periods. The ward bed base remains the same but the number of additional patients in the area has increased with up to 5 new admissions waiting on the corridor for beds on 12 days of the census. Furthermore, the Acute Medical Assessment area (AMA) was used as escalation capacity on 29 occasions during the census, with the areas bedded overnight. As well as this the Same Day Emergency Care (SDEC) assessment space which is in the ‘footprint’ of the AMU was also used as escalation capacity, affecting flow and function of the departments. The SNCT recommended staffing levels would not reflect the staffing requirements for the additional patients, so analysis had to consider the impact on staff workload and departmental pressures. The need to consider these factors in staffing decisions was required, even if not reflected in SNCT data and no changes were recommended.

Ward 35 is situated in the Copthorne building at the Royal Shrewsbury Hospital, separate from the main hospital. Staff must travel through an underground tunnel to access the main hospital, which present logistical and safety challenges. The original staffing template was set above SNCT recommendations due to fire regulations and evacuation complexities, the requirement to transport patients through the underground tunnel which required two staff to escort, the number of ward attenders for renal biopsies and renal line insertions, and renal nurse support for peritoneal dialysis across site, meaning ward nurses can be away from the ward for extended periods of time. At the last establishment review recommendations were made and agreed in line with updated fire officer recommendations, and current patient acuity. These were enacted in March 2025 which was after this census data was collected for analysis, so no further changes for this area are recommend at this time.

The Ward 28 escalation capacity has now been formally incorporated into the wards bed base. Staffing has aligned on a substantive basis to support these additional beds. The latest census shows variation in acuity and dependency compared to previous periods. This is attributed to the opening of the Frailty Assessment Unity on the ward in Summer 2024, which has increased the number of patients discharged on a Level ‘0’ pathway, resulting in a lower overall dependency profile. Staffing for the assessment area was realigned from the ward with the closing of beds to open the assessment area, adjusting staffing to reflect the new clinical configuration. The recommended SNCT WTE for this review is in line with budget, so no changes are proposed.

Following the last establishment review, the staffing template for Ward 27 was increased due to consistently higher SNCT recommendations than funded establishment and professional judgement supporting the need for additional staffing based on higher number of dependant patients, and requirements for cohorting and enhanced care support. The current SNCT recommendation is now more in line with actual budget, indicating improved alignment between staffing requirements and funding. No further recommendations were made following this review as it was felt the impact of the changes needs a period of assessment is required to evaluate impact of recent changes before further review.

Ward 9, similar to Ward 28 opened a Frailty Assessment Unit in the summer of 2024 with conversion of a bedded bay into an assessment area with trollies and seats. Staffing for the assessment area was realigned from the ward with the closing of beds to accommodate the new configuration. A recommended uplift from a Band 5 to Band 6 on day shifts reflected the increased responsibilities of the nurse co-ordinating the care in the FAU. The FAU's functioning has been significantly impacted by regular use of FAU spaces as escalation beds, disrupting FAU normal working and patient flow. While no changes were recommended at this time there is a need to consider a Band 6 role at night as the area is beginning to accept direct referrals at night. The situation will be monitored and reviewed if these continue. Current SNCT is aligned to ward budget and no other immediate staffing or quality concerns were highlighted at the review meeting.

Ward 6/CCU is staffed for 23 beds which includes Level 2 beds. It was noted in the professional judgement conversations that capacity is not utilised fully which does allow some flex in staffing to support the emergency department. No recommendations have been made for changes in the staffing template at this time; however, it is requested an operational review of level 2 beds requirements is undertaken for 2025/26.

Ward 11 SNCT audit recommendation remains above the budget for this area, indicating a potential need for additional staffing. However, the ward manager reported improvements, particularly due to reduced vacancies, despite ongoing challenges with high sickness. The ward continues to care for a high number of dependent patients requiring cohorting to maintain safety. Keeping patients within eyesight can be challenging given dependency levels and additional patients. It was noted the ward annex is consistently in operation with an additional ward patient. Also, on 26 days out of the 30 in the census period, there was one further patient and on occasion two further patients being cared for on the ward. It is recognised that the ward operates with 29 beds as normal, so the annex is included in this census, but the further additional patients were not included in the data collection. No recommendations were made for ward 11 but the impact of the additional patients on staffing will need to be monitored.

Following the last establishment review, the staffing template for Ward 24 was reduced by 1 Healthcare Assistant on both day and night. These changes were enacted after this census was completed, so the impact is not reflected in current SNCT data. Despite the budget reduction, the recommended SNCT continues to be below the budget, indicating no immediate concerns from a tool perspective The ward is budgeted for 6 level 2 beds and support patients requiring enhanced respiratory support. From a nursing perspective it was felt that no changes to registered nurse staffing levels are required, as the is expected to operate with a higher level of registered staff. No further recommendations were made following this review. A period of assessment is required to evaluate impact of recent changes before further changes considered.

No changes were recommended for ward 26 at this establishment review. The recommended SNCT staffing is slightly above the financial budget, indicating a minor variance. The ward reports that day shift are staffed with 5 registered nurses and 1 nursing associate on a full long day with a further nurse associate planned for a 7.5-hour shift. The last few hours of the day can be particularly staff on full long days and one staff member on a 7.5 hour shift they feel the

last few hours of the day can be challenging especially when sickness levels are high and vacancies impact coverage. The last census showed a slight increase in dependant patients (level 1b) from the previous census, with multiple patients requiring cohorting to maintain staffing. Again, when numbers reduce on late shifts it is felt the numbers of patients that require within 'eyesight' supervision can stretch staffing. Ongoing recruitment is helping to reduce vacancies, and the impact of sickness and dependency levels will continue to be monitored.

The staffing for Acute Floor at the Royal Shrewsbury Hospital is stratified into Acute Medical Unit (AMU), Acute Medical Assessment (AMA) and Medical Same Day Emergency Care (SDEC). SDEC snow operates under a separate budget code and is no longer part of the combined roster. AMU and AMA remain on a combined roster, but are physically separate areas, so census data is collected for each area. At the last establishment review, AMU staffing was reduced by 1 HCA which was moved to AMA (reflecting a change that had been enacted locally), and a skill mix change was agreed for a Band 5 to Band 6 to reflect the AMU co-ordinators broader responsibilities, which include managing flow across AMU, AMA and Ward 22SS, resulting in less senior oversight and support available to support the care of AMU patients. No further changes have been made at the most recent establishment review meeting and the SNCT staffing recommendations are slightly below budget and is consistent with previous audits.

At the last establishment review it was agreed AMA template would be increase by 1 HCA. Concerns regard AMA template was discussed at the meeting as it was noted Mondays and Tuesdays had 1 less RN on duty to other days, although activity was the same day to day. Further review of the budget and roster template noted a variance against budget with not enough shifts on the roster version. This has now been resolved and up to date budget has been shared with the e-roster team to upload. No further recommendations have been made at this establishment review. The most recent establishment review sees the staffing for the bedded area of AMA stratified from assessment trollies, seated area and roles that do not directly involve delivering patient care i.e. Triage Nurse for GP referrals. The SNCT recommended staffing for the bedded area is in line with financial template.

It was noted that operationally the seated area in AMA has seen significant numbers of patients seated for long periods of time while waiting for hospital admission and the assessment trollies have been utilised for patients waiting for beds (escalation capacity). This has caused poor flow in the area and staff have reported feeling pressured and stressed. Now the template has been clarified the nursing team are happier as the gaps in staffing on a Monday and Tuesday have been resolved. However, ongoing work with the Transformational lead for Urgent and Emergency Care will focus on the assessment space and how best the capacity is utilised. This area in AMA isn't included in the census as it is trolley spaces and seats not inpatient beds. The other bays house inpatient beds and an enhanced care area, a Level 1 care area, for the monitoring of sicker patients.

At the last establishment review the template for Ward 22 short stay was reduced by 1 HCA during the day. These changes were enacted in March 25, after the census so are not reflected in current SNCT data. The recommended SNCT remains slightly below budget, indicating no immediate concerns from a tool perspective. This area operates a discharge area for the acute floor, which supports flow in daytime hours. It is not included in the SNCT, as does not involve inpatient beds so any recommendations would need to consider staffing in addition for this area. Since staffing changes enacted in March, the ward has reported an increase in patient falls. The ward has 6 bays with limited visibility, which may contribute to safety challenges, especially with reduced staffing. Staffing levels have also been impacted by lower fill rates due to high sickness, so situation will be monitored particularly in regards of falls and staffing pressures if high levels of sickness continue. No further recommendation was made for the ward at this time.

2.4 Women and Children (Ward 14 Gynae and Ward19 Paediatrics Establishment Review January/February 2025

Chart 3 – Ward 14 Average acuity by census period.

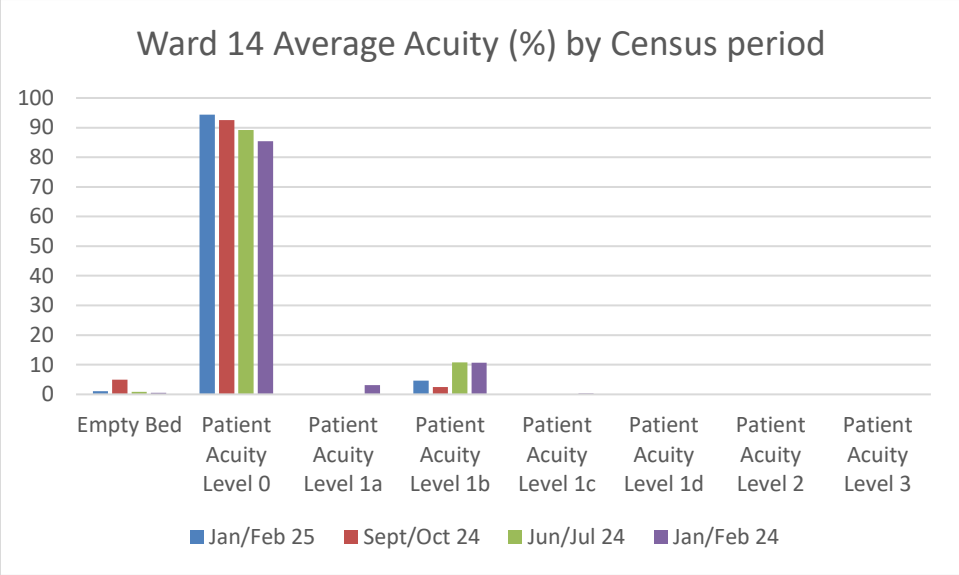


Table 6 – ward 14 acuity by census period

Ward 14	Empty Bed	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 1d	Patient Acuity Level 2	Patient Acuity Level 3
Jan/Feb 2025	1.1	94.4	0	4.6	0	0	0	0
Sept/Oct 2024	5	92.5	0	2.5	0	0	0	0
Jun/Jul 2024	0.83	89.17	0	10.83	0	0	0	0
Jan/Feb 2024	0.51	85.42	3.13	10.68	0.26	0	0	0

It is recognised by the Shelford group who developed the audit tool, there are limitations in relation to the outputs of the tool for smaller wards. The templates for Ward 14 are planned above the SNCT recommendations as there is a need to plan for a minimum of 2 registered nurses on duty. This is a justified and proactive approach to ensure patient safety and standards are met in smaller wards where SNCT may underrepresent actual needs. To further note, the co-ordinator role, although budgeted under ward 14, also supports Gynaecology Acute. The previous establishment review recommended the removal of the additional band 6 from the budget and the roster template for HCA was aligned to budget, with 1 Long day and 1 short shift planned rather than 2 long days. No new recommendations were made at the recent establishment meeting, however, opening of GATU on Sundays is still under review, which may require template adjustments.

Paediatrics

Chart 4 – Ward 19 - Average acuity by census period.

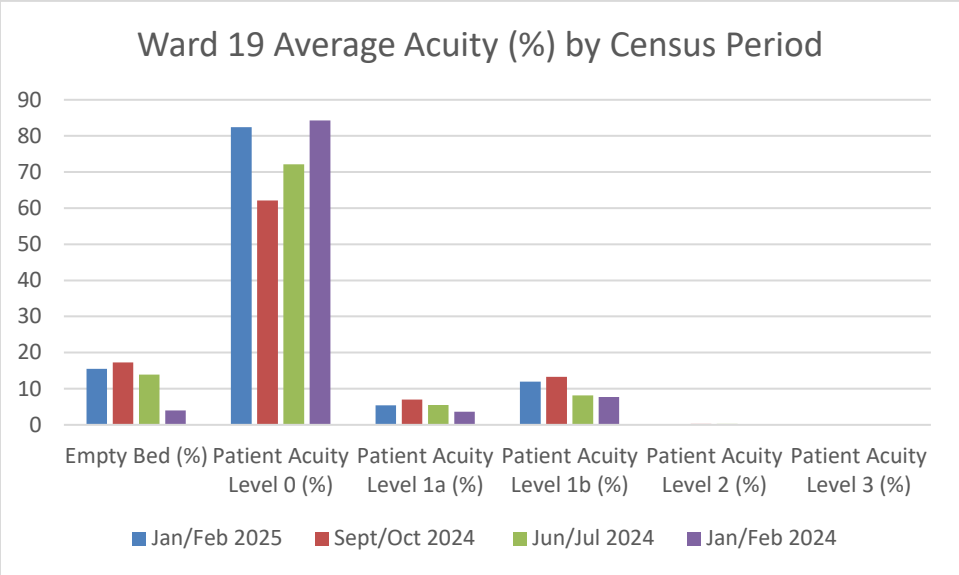


Table 7 – Ward 19 acuity by census period

Ward 19	Empty Bed (%)	Patient Acuity Level 0 (%)	Patient Acuity Level 1a (%)	Patient Acuity Level 1b (%)	Patient Acuity Level 2 (%)	Patient Acuity Level 3 (%)
Jan/Feb 2025	15.5	82.4	5.4	12.0	0.2	0
Sept/Oct 2024	17.27	62.12	6.97	13.33	0.3	0
Jun/Jul 2024	13.93	72.12	5.45	8.18	0.3	0
Jan/Feb 2024	3.98	84.3	3.6	7.7	0.2	0.1

Through 2024, the department has operated on a reduced bed base due to vacancies and recruitment challenges. This led to frequent agency use to maintain safe staffing. A robust workforce plan has led to a significant increase in substantive employment of Registered Children's Nurses, and it is expected by September 2025, there will be no registered nurse vacancies in this area.

At the last establishment meeting, it was agreed to implement a seasonal staffing model as analysis work done by the team noted a consistent variation over several years of activity between summer and winter months and as it was thought efficiencies could be made by aligning a summer and winter template with seasonal variations in activity. The recommended SNCT was above the current budget and template in the Children's Assessment area was changed to a seasonal, as there were significantly more acute admissions over the winter months meaning patient care and experience would benefit from additional staff support. The Summer template was enacted from 11th May 2025, and the current audit reflects the previous (pre-seasonal) budget which did not align at the time the adults were completed to the new staffing model. Financially the budgets for paediatric services have been stratified to clarify staffing needs across:

- Ward 19
- Paediatric Oncology and Haematology Unit
- Children's Assessment Unit
- Paediatric day case
- Paediatric Day Surgery (which is undertaken in the Elective Hub)

With improved recruitment and revised templates, agency staffing ceased from the end of March 2025.

The most recent SNCT audit recommends a WTE staffing level below the combined Ward 19 budget. It is anticipated SNCT recommendations will vary in future audits with variation of beds in operation which should reflect the staffing requirements. At the latest establishment review the Paediatric team highlighted the operational demands beyond ward based care which included the a ward-based paediatric nurse attending all paediatric resus calls in the Emergency Department at the Princess Royal Hospital - This can result in the nurse being off the ward for extended periods, specialist transfers with nurses escorting patients to children's hospitals when specialist care is required, escorting paediatric patients to MRI if they require sedation – again resulting in staff being off ward for extended periods. These off-ward responsibilities are not captured in SNCT data, yet they can impact real-time staff availability. Current templates when reviewing recommended SNCT do have some buffer capacity which would support should support these duties.

It is essential also to consider the defined staffing levels for children and young person services as clearly articulated in the Royal College of Nursing guidance, as it provides an indicative baseline for day and night for nurse-to-patient ratios, which are as follows:

- Level 3 critical care = 1:1
- Level 2 critical care = 1:2
- Level 1 critical care = 1:3
- Ward care = 1:4 if the children are over 2 years old
- Ward care = 1:3 if the child is under 2 years old.

In addition, RCN guidance recommends an uplift of 25%. National Quality Board Guidance (NQB) further recommends uplifts may require adjustment as paediatric wards tend to attract a younger workforce and have a higher level of parenting leave. The average percentage leave required should be reflected in uplift and workforce plans. Guidance also advocates for establishments setting to include time for interhospital transfers of paediatric patients, support outreach of registered children's nurses into areas, such as emergency departments, and consider the impact nursing children and adolescents in a ward area with mental health has on staffing. (Royal College Nursing, 2013; National Quality Board, 2018). Although uplift has not been changed and remains at 24% in line with all clinical ward areas, it has been agreed that fixed term posts can be offered to cover any maternity leave.

2.5 Emergency Department Establishment Review February 2025

Chart 6 - ED Average acuity by census period.

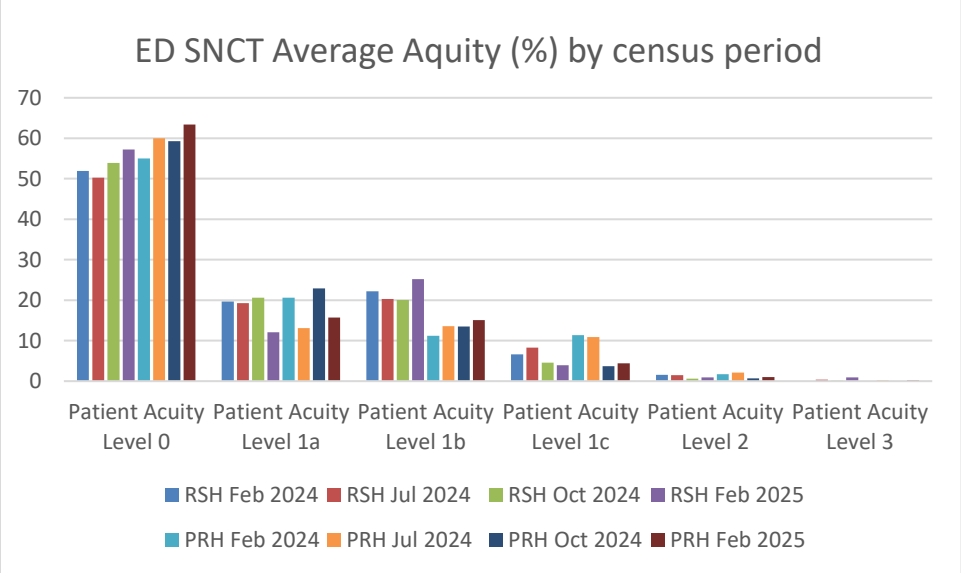


Table 8 – ED acuity by census period

	Patient Acuity Level 0	Patient Acuity Level 1a	Patient Acuity Level 1b	Patient Acuity Level 1c	Patient Acuity Level 2	Patient Acuity Level 3
RSH Feb 2024	51.9	19.7	22.2	6.6	1.6	0
RSH Jul 2024	50.3	19.3	20.3	8.3	1.5	0.4
RSH Oct 2024	53.9	20.6	20.1	4.6	0.6	0.1
RSH Feb 2025	57.2	12.1	25.2	3.9	0.9	0.9
PRH Feb 2024	55	20.6	11.2	11.4	1.7	0
PRH Jul 2024	60	13.1	13.6	10.9	2.1	0.2
PRH Oct 2024	59.3	22.9	13.5	3.7	0.7	0
PRH Feb 2025	63.4	15.7	15.1	4.4	1.0	0.2

The current SNCT tool for ED expects that patients will have been admitted or discharged within 12 hours so there is no current provision in the tool for patients in the department for greater than 12 hours. The SNCT ED tool is currently under review by the national team given the need to consider patients who are in the ED department more than 12 hours as this is occurring nationally. Conversation with regional Safer Staffing Fellows highlights the same issues with capturing the workload associated with 12 hours plus patients and no current national guidance is currently given as to how this workload is captured/equated.

The outputs of the SNCT tool show that without taking professional judgement into consideration the current budgets are well more than the SNCT recommendations but do not reflect the workload in the department and challenges with delivering care.

Layering on the additional work of patients waiting in the emergency department for admission it is recognised that 30-40 patients waiting for admission are held in the emergency departments. The departments can often site at 200% occupancy which disables the ED from working effectively.

Key quality metrics for ED are reported below target i.e. triage within 15 minutes, ambulance handover. During a previous census period the acuity of the additional patients was analysed, and it was noted the patients required a higher level of nursing support than the patients having ED care where the majority are stable. The environment is challenging to care for the additional patients and still operate normally. Cohorting of confused and risk of falls patients has been difficult with an increased requirements and request for staff to support patients requiring 1:1.

This was not undertaken in the current census on the advice of the National Clinical Lead for Workforce.

Waiting rooms can have high number of patients that need observations. At PRH, a nursing during peak times in the department will work differently and will deploy a nurse from fit to sit to the waiting room to ensure patients have timely observations and care. Additional patients can be managed on corridors and support is sought regularly from wards to provide nurse and HCA to when corridor care is being delivered. The navigator will review patients on ambulances and treatments may be initiated for patients waiting outside the emergency departments with staff from the ambulance receiving areas supporting the care of patients in the ambulances waiting to be admitted. This is an additional pull on the staff member duties taking them outside the ED department for significant periods of time.

Professional judgement considerations in relation to the environment particularly at RSH, which includes small, isolated areas and the corridor care at both sites need to be included, which impact on the quality challenges.

No changes to the templates are recommended at this time however it is recognised that the department will need to adapt and work differently.

Appendix 1 SNCT data collected Jan/Feb 2025

Jan/Feb 2025

Dependency Level Summary / SNCT element

Specialty/ Ward	Beds as per SNCT audit	SitRep occupancy Rate %	Empty Bed %	0 %	1a %	1b %	1c %	1d %	2 %	3 %	Proposed SNCT FTE (excluding 1c/1d)	Budget (inc Band 7, RN, NA and HCA)	correct or over/under established based on stratified budgets (excludes WM)	Ratio (percentage of RN to non RN day and night) - Budget	Recommendations or comments
Emergency Care															
AMU PRH	17	98.10%	0.0%	66.9%	4.9%	27.1%	1.1%	0.0%	0.0%	0.0%	29.08	36.42	6.34	57%	No change
AMU RSH	20	95.00%	1.5%	40.0%	4.0%	53.0%	1.0%	0.0%	0.5%	0.0%	38.3	41.59	2.29	73%	No change
SAU (W33/W34)	38	93.90%	0.4%	71.2%	8.1%	20.3%	0.0%	0.0%	0.0%	0.0%	63.19	54.73	-10.46	65%	No change
AMA (18 beds only)	18	NA	2.2%	51.1%	12.2%	33.3%	0.6%	0.0%	0.6%	0.0%	32.02	31.04	-1.98	76%	No change
A&E RSH				57.2%	12.1%	25.2%	3.9%		0.9%	0.9%	60.1	150.73	89.63	70%	No change
A&E PRH				63,4%	15.7%	15.1%	4.4%		1.0%	0.2%	76.2	148.77	71.57	84%	No change
Medical															
Ward 6 CCU	23	98.60%	0.3%	19.1%	56.7%	16.0%	0.1%	0.0%	7.9%	0.0%	32.92	30.01	-3.91	73%	No change - review required CCU capacity
Ward 7 - Endo/Gen Med (PRH)	28	93.30%	0.8%	23.8%	1.0%	73.8%	0.4%	0.3%	0.0%	0.0%	47.24	41.59	-6.65	56%	No change
Ward 9 Frail and Complexe	22	97.10%	0.7%	43.1%	0.1%	55.9%	0.0%	0.1%	0.0%	0.0%	33.44	33.83	-0.61	57%	No change
Ward 11 Nephrology (PRH)	29	97.80%	0.0%	33.1%	0.6%	65.6%	0.8%	0.0%	0.0%	0.0%	46.7	42.59	-5.11	56%	No change
Ward 10 Short Stay	28	94.40%	0.8%	44.8%	0.0%	54.4%	0.0%	0.0%	0.0%	0.0%	42.16	39.01	-4.15	60%	No change
Ward 15	25	98.40%	0.0%	11.5%	0.1%	88.4%	0.0%	0.0%	0.0%	0.0%	45.47	45.66	-0.81	50%	No change
Ward 16	17		7.7%	25.3%	0.6%	58.2%	0.0%	0.0%	8.2%	0.0%	28.87	33.83	3.96	62%	
Ward 17 Respiratory	28	98.80%	2.5%	38.6%	4.4%	47.0%	1.9%	0.0%	5.7%	0.0%	42.94	49.35	5.41	58%	No change
Medical Escaltion	17	97.30%	4.3%	43.9%	1.3%	50.3%	0.1%	0.0%	0.0%	0.0%	25.02	42.96	16.94	62%	Escaltion area, budget initially set for 25 beds, currently 17 beds. SNCT calculations based on 17 beds. Potential move to ward 36 with 26 beds so no recommmended changes in view of increase in bed base
Ward 22 Short Stay	26	100.00%	1.1%	58.8%	113.5%	26.5%	0.2%	0.0%	0.0%	0.0%	33.413	36.42	2.01	64%	No change
Ward 24 Respiratory	31	97.80%	1.5%	39.4%	4.6%	44.4%	0.1%	0.0%	10.1%	0.0%	47.52	57.11	8.59	64%	No change
Ward 27 Gen Med	39	99.10%	0.6%	44.2%	2.7%	49.8%	2.7%	0.0%	0.0%	0.0%	57.29	55.53	-2.76	57%	No change
Ward 28 Medicine & Frailty (RSH)	32	100.00%	0.3%	40.3%	0.3%	57.6%	0.3%	0.0%	1.2%	0.0%	51.2	51.94	-0.26	55%	No change
Ward 26 Endo / Medicine	37	100.00%	0.0%	46.0%	1.1%	51.1%	1.9%	0.0%	0.0%	0.0%	54.68	53.62	-2.06	57%	No change
Ward 35 Renal	16	89.60%	8.5%	37.7%	10.4%	43.4%	0.0%	0.0%	0.0%	0.0%	24.36	37.42	12.06	50%	No change
Surgery															
Ward 25G Colorectal & Gastroenterology (RSH)	38	100.90%	0.1%	55.0%	0.8%	43.9%	0.0%	0.0%	0.0%	0.0%	53.62	58.11	3.49	55%	No change
Ward 37 Surgery	34	98.00%	1.2%	47.3%	3.7%	47.9%	0.0%	0.0%	0.0%	0.0%	49.49	54.43	3.94	60%	No change
Ward 8 H&N	14	97.50%	0.9%	42.9%	16.7%	39.4%	0.0%	0.0%	0.0%	0.0%	20.81	24.3	2.49	68%	No change
Muscoloskeletal															
Ward 4 Trauma and Orthopaedic	26	95.20%	1.5%	21.7%	0.1%	75.2%	1.5%	0.0%	0.0%	0.0%	44.8	40.01	-5.79	54%	No change
Ward 5 Elective Orthopaedic	16	45.24%	43.9%	42.6%	0.0%	13.4%	0.0%	0.0%	0.0%	0.0%	15.8	20	3.20	60%	Ward not operating fully as elective orthopaedics due to IPC works required - no changes recommened.
Ward 32 Acute Orthopaedic Trauma Unit	24	98.60%	1.3%	8.3%	2.5%	87.9%	0.0%	0.0%	0.0%	0.0%	43.71	41.59	-3.12	56%	No change
Oncology															
Ward 23OC Oncology & Haematology	30	95.60%	0.4%	63.6%	8.8%	27.1%	0.0%	0.1%	0.0%	0.0%	38.4	44.18	4.78	65%	No budget changes, template for 30 beds
Womens & Childrens															
Ward 14 Gynaecology	12	82.10%	1.1%	94.3%	0.0%	4.6%	0.0%	0.0%	0.0%	0.0%	12.56	19.52	5.96	68%	1HCA long day change to 1 HCA Early (in budget) but not correct on roster
Ward 19	33	75.30%	13.4%	71.2%	4.7%	10.5%	NA	NA	0.3%	0.0%	66.5	73.34	4.84	74%	Seasonal template (adjustments in bank and substantive)
Total													199.827		

Appendix 2: Developing Workforce Safeguards Gap Analysis and Action Plan

The Shrewsbury and Telford Hospital NHS Trust

	Developing Workforce Safeguards Gap analysis action plan
Executive Sponsors	Paula Gardner - Chief Nurse
Responsible Officers	Stephanie Young - Lead Nurse for workforce
Corporate Nursing Review	30.06.2022
Report signed by (Executive Lead)	Paul Gardner - Chief Nurse

Developing Workforce Safeguards Action Plan

ID	Recommendation	Site	Compliance	Actions required	Deadline	Status	Lead	
	Recommendations 1 & 2 1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safer staffing governance. 2. Trusts must ensure the 3 components are used in their safer staffing processes (evidence based tools, professional judgement and patient outcomes).	Trust	Partially compliant	Review SOP to confirm process and annual calendar for training, data collection and inter-rater reliability checks being organised for completeness in regards to the bi-annual staffing process.	31.07.2022	Delivered	Tracie Black, Lead Nurse for Workforce	
				Training on acuity and dependency for all band 7 Ward Managers and 2 other seniors for each ward area.	30.06.2022	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				Ensure yearly renewal of safer Nursing Care Tool licence	31/10/2021	Delivered	Tracie Black, Lead Nurse for Workforce	
				Training programme for SCNT and inter-rater reliability competency assessments. Champions to be identified from each division to support roll out of training. Training records to be added to LMS	31/12/2022	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Explore options to add SNCT record of competency and training to LMS	31.12.2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop guidance on best practice for deployment of staff	31/07/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	Escalation process developed which includes BOA (nursing)
				Safer staffing policy to be updated with plans for non ward areas establishment reviews	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Development of SOP for escalation processes for safe staffing including response for red flag events	31/07/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	Escaltion process developed which included BOA (nursing)
				Review of SOP for SCNT process and ratification at Workforce Steering Group	31/12/2022	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Updates to SOP for SCNT process	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Explore possibility of Training and competence assessment records being added to LMS	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				New Action- LMS proposal required at next Education Meeting	31/05/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Review governance process regards monthly reporting of safe staffing.	31/01/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Arrange suite of operational meetings to review agency, vacacnies, recruitment and retention, education, rosters and KPI's.	30.09.2023	Delivered	Kara Blackwell	
				AHP teams to attend monthly operational meetings to discuss vacacnies, recruitment, retention, education, rosters and KPI's	31.03.2024	In progress	Kara Blackwell	Attendance not fully embded, menbership of meetings clear in TOR.
				Arrange for roster review deep dives to be organised quarterly and outputs/learning to be presented at workforce steering group and feed in to bi-annual staffing review	30.09.2023	Delivered ongoing monitoring	Kara Blackwell	
				Develop safe staffing paper to include non ward areas in monthly safe staffing paper and ensure relevant data available in relation to area of review.	30/06/2023	Delivered ongoing monitoring	Stephanie Young, Lead Nurse for Workforce	
	Recommendations 3, 4 & 5 Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement.	Trust	Partially Complaint	Director of Governance and Communications to add statement to future annual governance statement	31/01/2022	Delivered	Anna Mianec, Director of Governance and Communications	10/07/2025 Statement not identified as from Chief Nurse/Medical Director. Action required in next years report to comply with DWS recommendations.
				Biannual staffing reviews will have a statement from the Medical Director and Director of Nursing regarding assurances in relation to safer staffing.	31/07/2021	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				Review governance process regards monthly reporting of safe staffing.	31/01/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop safe staffing paper to include non ward areas in monthly safe staffing paper and ensure relevant data available in relation to area of review.	30/06/2023	Delivered ongoing monitoring	Stephanie Young, Lead Nurse for Workforce	
	Recommendation 6 As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement that to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Trust	Partially complaint	Additional training with senior staff on acuity and dependency.	31/03/2022	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				A further full biannual staffing review to take place in June and July 2021.	31/07/2021	Delivered	Hayley Flavell, Director of Nursing	
				A nursing 5 year workforce plan to be fully completed and agreed.	31.07.2022	Delivered ongoing monitoring	Caroline McIntyre, Head of Workforce Transformation	
				A full organisational wide process for vacancy oversight from Ward level upwards	31.07.2022	Delivered and ongoing monitoring	Caroline McIntyre, Head of Workforce Transformation	
				Development of a local Safer Staffing Policy which includes establishment setting and will note the requirement to have QIAs for all changes to staffing establishments – signed off by the Director of Nursing.	01.07.2022	Delivered	Tracie Black, Lead Nurse for Workforce	
				Matrons to receive an inter-rater reliability assessment as part of their induction	30/03/2022	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				Review monthly staffing paper once dashboard on Gather system to ensure greater triangulation and explicit reference to Care Hours Per Patient Day (CHPPD)	30/11/2021	Delivered	Tracie Black, Lead Nurse for Workforce	
				Commence an inaugural Safer Nursing Care Tool assessment on the Emergency Departments once the new tool is released and licence obtained.	31/03/2022	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				SOP development to ensure correct application of SCNT and training in place.	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				SOP development to ensure correct application of SCNT and training in place and expectations of establishment review meetings (including attendance)	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop safe staffing policy to ensure there is clear governance procedures in place for new templates or template reviews outside of bi-annual establishment reviews.	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop roster policy including key KPI's	31/12/2022	Delivered	Steve Minyeko, People Systems Manager	
				Review process for submission of model hospital data	31/05/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop SOP for process of checking and submitting monthly data for safe staffing.	30/08/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop programme plan for review of maternity ward establishments, non ward establishments, and nursing groups.	31/05/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Corporate review of CNS job plans	31/10/2023	in progress	Stephanie Young, Lead Nurse for Workforce	Project plan in development.
				Implementation of SCNT in ED and Paediatrics	31/01/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Non-medical workforce plan development and linked to strategy	31/12/2023	in progress	Simon Balderstone, Transformational Lead for Workforce	Steering Group agreed extension to deadline in view of timeframe for Chief AHP recruitment and funding not not yet agreed for post.
	Recommendation 7 Trust must have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The Board should discuss the workforce plan in a public meeting.	Trust	Partially Compliant ↔	Require a full Workforce Plan for the next 5 years to be agreed by the Executive Team which is able to identify the future domestic and international pipelines annually over the 5 years.	31/07/2022	Delivered and ongoing monitoring	Caroline McIntyre, Head of Workforce Transformation & HTP Team	
				Workforce plan will be presented at a Public Board.	31/07/2022	Delivered and ongoing monitoring	Caroline McIntyre, Head of Workforce Transformation & HTP Team	
				Full plan to be agreed and signed by Chief Executive once ready.	31/06/2022	Delivered and ongoing monitoring	Caroline McIntyre, Head of Workforce Transformation & HTP Team	
				Non-medical workforce plan development and linked to strategy	31/12/2023	in progress	Simon Balderstone, Transformational Lead for Workforce	Steering Group agreed extension to deadline in view of timeframe for Chief AHP recruitment and funding not not yet agreed for post.
	Recommendation 8 The Trust must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.	Trust	Partially compliant	Triangulation and CHPPD in monthly staffing report that goes to the monthly Nursing and AHP meeting, where a AAA report feeds into the Quality Safety Assurance Committee that then feeds to the board.	30/11/2021	Delivered	Tracie Black, Lead Nurse for Workforce	
				Review process for submission of model hospital data	31/05/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Develop SOP that identifies process for checking and reporting monthly data on safe staffing	30/08/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Review current data available to develop dashbaord to be presented at workforce steering group.	31.03.2024	Not yet started	TBC	
				Review governance process regards monthly reporting of safe staffing.	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
	Recommendation 9 An assessment of re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgement and outcome.	Trust	Fully compliant	Completion of SOP as stipulated in actions from recommendations 1 & 2.	01.07.2022	Delivered	Tracie Black, Lead Nurse for Workforce	
				Biannual staffing to continue.	31/01/2022	Delivered and ongoing monitoring	Hayley Flavell, Director of Nursing	
				Safer staffing policy to be updated with all actions required in relation to responsibilities for safe staffing	31/03/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
	Recommendation 10 There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Trust	Fully Compliant ↔	Deputy Chief Nurse for People and Professional Standards is the Safer staffing lead for the Trust and oversees the full use of the Safer Nursing Care Tool ensuring no manipulation of the multipliers.	31/07/2021	Delivered and ongoing monitoring	Hayley Flavell, Director of Nursing	
	Recommendation 11 & 12 As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill mix changes, must have a full quality impact assessment (QIA) review.	Trust	Partially complaint	Development of a safer staffing policy which will include the agreed QIA process as previously mention in actions form recommendation number 6.	01.07.2022	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				Embed process for QIA oversight and review	31.03.2023	In progress	Kara Blackwell	Process for QIA for servbice chnages and skill mix changes. Review of QIA's should be undertaken as part of establilshmsnt reviews. Action required to ensure review is embed in establishment review process.
	Recommendation 13 Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Trust	Partially compliant	Monthly report to Deputy Chief Nurse for oversight of any red flag events linked to staffing which needs to be added to the monthly staffing report.	31/07/2021	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				Review of Agency approval process.	31/10/2021	Delivered	Tracie Black, Lead Nurse for Workforce	
				Further training and utilisation of the Safecare module for all inpatient ward areas to support professional judgement, risk assessments and escalation.	31/12/2021	Delivered and ongoing monitoring	Tracie Black, Lead Nurse for Workforce	
				Review option for turn on of 'Red Flag with safecare	31/12/2022	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Safecare Turn on (including use fo red flags) and SOP to support completion	31/07/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	Safecare used a staffing meetings, process in place for red flag escaltion and review. Assurance regards review monitored at monthly metrics meetings and reported via Safe Staffing report..
				Embed use of Safecare in Daily Staffing Meeting to support decision making	31/07/2023	In progress	Stephanie Young, Lead Nurse for Workforce	Safecare used a staffing meetings, process in place for red flag escaltion and review. SOP for Staffing meeting identifies responsibilities of chair in realtion to Safecare.
				Review Datix reporting in relation to Staffing issues and enhance categorisation of events to clearly identify red flags	31/05/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Agree new catergories for reportingof red flagswith specialist areas	30/08/2023	In progress	Stephanie Young, Lead Nurse for Workforce	Met with W&C Div DON Feb 25. Updates required to Safecare to add addtiaonal redflags.
				Develop on line training programme and competency assessment for acuity scoring and use of deployment tool	30/09/2023	In progress	Stephanie Young, Lead Nurse for Workforce	Development of training videos in progress with medical illustraion and being finalised.
	Recommendation 14 Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Trust	Delivered	Phased staffing plan and associated risk assessment in place for inpatient wards in relation to Covid-19 but due a review in preparation for Winter 2021.	30/12/2021	Delivered	Tracie Black, Lead Nurse for Workforce	
				Need set escalation plan for raising staffing concerns which should be added to the safer Staffing policy.	31.05.2022	Delivered and ongoing monitoring	Simon Balderstone	
				Review Datix reporting in relation to Staffing issues and enhance categorisation of events to clearly identify red flags	30/06/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Agree new catergories for reportingof red flagswith specialist areas	30/08/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	
				Development of SOP for escalation processes for safe staffing including response for red flag events	31/07/2023	Delivered	Stephanie Young, Lead Nurse for Workforce	

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APPENDIX B

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
Domain 1 - Governance				
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control				
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising				
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
Domain 9 - Business Continuity				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning

APPENDIX C

The Shrewsbury and Telford Hospital NHS Trust

Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743 261000

28 October 2025

Dear Sir/Madam

Re: Emergency Preparedness, Resilience and Response (EPRR) annual assurance process 2025/2026.

In accordance with the letter dated 7th July 2025, please find below the Trust proposed self-assessment in relation to The Shrewsbury and Telford Hospitals Trust (SaTH) assurance against the EPRR Core Standards for 2025/2026.

SaTH are reporting a status of Substantial Compliance in relation to the EPRR core standards 2025/2026, with a self-assessment against this year's standards indicating that the Trust is Fully Compliant with 57 out of the 62 Core Standards applicable to Acute Trusts giving a score of 91.9%. The Trust is reporting partial compliance for 5 out of the 62 Core Standards and have put in place an action plan to address these through the EPRR Work Programme.

Following the Confirm and Challenge Meeting on 20.10.2025, it was agreed that 2 of the standards (CS22, CS33) would be noted fully compliant with observational comments for improvement, and that Core Standard 36 remained challenged by NHSE and Shropshire and Telford ICB. The Trust has confirmed that this Standard would be noted as fully compliant and additional evidence has been uploaded to NHS Futures to supplement this.

The Trust provided 64 pieces of evidence in support of this self-assessment which have been reviewed by Shropshire and Telford & Wrekin ICB and NHSE. Where any improvements have been suggested and identified, these will be addressed and monitored through the EPRR Work Programme.

We hope this letter and evidence uploaded to the NHS Futures Platform provides the level of detail required against the letter from NHS England. However, should you require further detail please don't hesitate to contact us.

Yours faithfully

Ned Hobs
Chief Operating Officer
Shrewsbury and Telford Hospitals NHS Trust

cc: Ash Canavan, Deputy Director of EPRR NHS England – Midlands
Ian Bett, Gareth Wright, Felicity Govas - NHS Shropshire, Telford and Wrekin

The Shrewsbury and Telford Hospital NHS Trust

Annual Security Report

2024-25

Foreword

The Shrewsbury and Telford Hospital NHS Trust is committed to ensuring as safe environment for staff and patients as possible so that the highest possible standard of care can be delivered; to this end security remains a key priority within the development and delivery of health services. All of those working within the Trust have a responsibility to assist in preventing security related incidents or losses. This approach underpins and directly links to the Trust's values and objectives.

The designated Board level Director responsible for security management matters is the Chief Operating Officer (COO). This position was held by Sara Biffen until 17 October 2025 and the arrival of the current COO, Ned Hobbs.

Day to day line management responsibility for the Trust Security Manager is undertaken by Susanne Crossley, Deputy Chief Operating Officer responsible for Urgent & Emergency Care.

Jon Simpson is the Trust Security Manager, who ensures that the Trust complies with all NHS security guidance and requirements and oversees the implementation of security management across the Trust.

This annual security report looks at security governance arrangements and incidents for the past year. It also reviews continuing efforts to keep staff and patients as safe as possible as well as securing Trust property and assets.

Ned Hobbs — June 2025

Chief Operating Officer

1 Governance, Risk & Assurance

A sound Governance framework is essential in ensuring a consistent approach to security.

1.1 *Security Arrangement Provision*

In accordance with the provisions of the NHSE Violence Prevention & Reduction Standard (VPRS) (2024), Nice Guidance (NG) 10 (short-term management in mental health, health and community settings 2015), The Mental Health Units (Use of Force) Act (2018), Emergency Preparedness & Resilience Response Standard No 21 (Lock Down), The Terrorism (Protection of Premises) Act (2025) and the Health & Safety at Work Act (1974), Providers are required to have in place and maintain security management arrangements in their organisations[1].

1.2 *Policy*

The Trust has the following security policies in place with scheduled review dates.

- SY01 Security Management Policy
- SY02 Violence & Aggression Management & Reduction Policy
- SY03 CCTV Operating Policy
- SY04 Lock Down Policy
- SY05 Counter Terrorism Procedures
- SY07 Patient Search

In accordance with those schedules SY05 was reviewed and republished during the reporting period, using national guidance and local protocols.

1.3 *Security Risks*

Security risks are managed in accordance with the Risk Policy and entered on to the Datix risk management system where they can be regularly reviewed. There were three security risks scoring more than 15. One concerned contracted/uniformed security staffing numbers/establishment at the 2 main sites[2] which has since been closed (s2.8 refers), the inconsistent use of door access control systems (particularly swipe card access) across all areas of the Trust, especially in-patient wards[3] (s2.12 refers) and security concerns regarding the Admin Hub building at the PRH[4].

1.4 *Security Risk Assessment*

When the Trust Violence & Aggression Prevention & Reduction policy is presented to Health Safety Security & Fire (HSSF) Committee and Policy Approval Group (PAG) for approval (following scheduled review or otherwise) submitted documents include an evidence based self-assessment set against the NHSE VPRS (2024)[5].

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[1] The following sites are provided with varying levels of support: Princess Royal Hospital (Telford), Hollinswood House (Telford), Sterilisation & Decontamination Services Unit (Queensway Business Park Telford), Royal Shrewsbury Hospital, Severn Fields Health Village (Shrewsbury), Medical Records Facility (Atcham Business Park Shrewsbury), NHS William Farr House site (Shrewsbury), Corporate Services at Douglas Court Shrewsbury Business Park (Shrewsbury), x4 Midwife Led Unit at Bridgenorth, Ludlow and Whitchurch Community hospitals and RJAH.

[2] Datix Risk Register id 789.

[3] Datix Risk Register id 312. 4-digit keypad pin code locks are on some entrances, but these systems are always subject to very easy compromise/misuse and counter compromise action is time consuming and very disruptive. Use is awkward and clumsy when linked with or part of a patient or other manual handling task especially if doors do not open or close with electrical assistance, so doors get left open which has led to absconded/missing patient incidents. In the event of a known or immediate external threat all ward doors have the option to be secured manually and good physical security is provided to ward areas until an incident is over/stood down. This functionality is checked and tested every 3 months by security teams records held by the Security Manager.

[4] Datix Risk Register id 1039.

[5] Next scheduled policy review June 2026. Both the policy and VPRS self-assessment are subject to regular informal annual review by the Security Manager.

Through the year security needs/risk assessment advice/support was given to Estates Capital and other Project Management Offices (PMO) as well as Centres and departments[6]. Some (but not all) examples of the (often extensive) support provided, and the locations involved included:

- Hospital Transformation Program (HTP) including A&E refurbishment/extension, 5 floor new build and associated outdoor spaces (access control, CCTV, intruder/staff duress and new-born security alarms, counter terrorism, and general crime prevention measures)[7].

- PRH Elective Theatre Hub (access control, CCTV).

- NHS William Farr House site (inherited/legacy access control and out of hours building security, future CCTV, manned security, and emergency procedures (inc Lock Down).

- 2 story modular ward building at RSH (access control, CCTV, alarm systems and emergency site security support).

- PRH main kitchens and dining room (access control).

- PRH W&C Centre Neo-Natal Unit (NNU) (access control).

- PRH Wrekin Maternity Unit (MLU) (access control).

Areas of Special Interest. Regular and scheduled security risk assessment is undertaken on the following key areas of security:

- Lock Down; every month security team supervisors undertake audit and functionality tests of the emergency Lock Down plan for each of our Emergency Departments (ED). This ensures that paper copies of Lock Down plans are in the place staff expect them to be should they need them, are the correct version and the instructions, systems and facilities referred to in each plan are correctly functioning. After the ED check security supervisors then complete a site wide check of the emergency Lock Down arrangements for each Ward and/or publicly accessible department/entrance at both main sites. Any service or maintenance issues identified are addressed and the check also gives security staff the opportunity to liaise with clinical staff and highlight the procedure and mechanism for securing departments which are not regularly locked and secured because of operational constraints. Records on all these audits are retained by the Trust Security Manager[8].

[6] Auditing of departments for completion of self-assessed security risk assessments (Appendix D to SY01 Security Management policy SaTH Intranet - Security Management in the Trust and local lock down plans is included in the H&S element of the Exemplar Ward program.

[7] A Building Research Establishment Environmental Assessment Method (BREEAM) assessment uses recognised measures of performance, set against established benchmarks, to evaluate a building's specification, design, construction. This includes a Security Needs Analysis (SNA) which has been completed and approved. The build is also being registered for 'Secured by Design' (SBD) accreditation. SBD is the official UK police security initiative that works to improve the security of buildings and their immediate surroundings to provide safe places to work and visit. Both initiatives will assist the Trust with meeting a new statutory obligation. The Terrorism (Protection of Premises) Act 2025 places a legal duty on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures. If the new build application proved successful further effort could be considered to register other Trust premises that have already had incorporated similar security design proposals and features e.g. Hollinswood House.

[8] Names of those clinical staff able to join these security huddles/on the spot briefings are noted and indicate well over 700 staff pa are receiving direct Lock Down briefing and training in relation to their immediate workspace.

- Infant/Newborn Security (s2.13 refers); every 3 months to prevent the undue removal of a baby from the hospital the Baby Tagging security systems are tested to ensure system operability and staff knowledge/reactions. Results of each test, undertaken by the Security and post-natal Ward Managers are fed back to senior Women & Children's leadership/management. Records on all these audits are retained by the Trust Security Manager. The benefit of this assessment process has been noted in previous CQC Inspection[9].

HSSF Committee. A quarterly security report is presented to HSSF Committee which is attended by staff side Chairs/representatives, Union representatives and has Centre management representation. The report provides insight on progress with managing violence and aggression by service users (clinical as well as intentional/inexcusable aggression) including reports on sanction and redress and support to staff affected. In the fourth quarter, the annual security report is presented which gives feedback and a full account of all security management work in the reporting year[10].

Risk Management Committee. The Trust Security Manager joins monthly Risk Group meetings ensuring security management oversight and advice is available for all matters discussed or raised.

Joint Safeguarding Mental Health & Learning Disabilities Operational Group. The Trust Security Manager joins Joint Safeguarding Mental Health & Learning Disabilities Operational Group meetings. Chaired by a Deputy Chief Nurse. This ensures opportunity is given to discuss and focus on any security incidents issues or interventions with service users that have cause for additional interest, concern or general trend analysis as well as provide assurance and accountability on security team performance and training.

1.5 *Release of Information/Freedom of Information (FOI), Complaints & Challenges*

Release of Information

31 releases of CCTV / Body Camera video footage were made in the reporting period.

- 17 to police for preventing/detecting crime / apprehension/prosecution of offenders.
- 7 for internal investigation/fact find on site safety (H&S (5), HTP (1), Facilities (1)).
- 5 for internal investigation/fact find regarding staff disciplinary matters (Centre Management (1) Deputy Chief Nurse/NMC (4)).
- 2 following external/third party request (motor vehicle insurance claim 2).

Complaints

5 formal complaints made to the Trust by patients included/made mention of hospital security teams. A review of the circumstances for each complaint was completed and a response submitted in accordance with the Trust Complaints process.

[9] "Staff followed the baby abduction policy and undertook baby abduction drills. All babies were electronically tagged, and labels and tags were checked daily. Tags were removed as part of the discharge process. All staff were trained and aware of the baby tagging process". Source: CQC Inspection Report (Evidence Appendix) published 8 April 2020 page 392.
[10] No report submission for 2024-25 Q1 Q2 Q3 due to Security Manager long term absence.

Security Incident Reporting & Safe Environment for Staff & Patients

2 Security incident reporting remains key to the maintenance of a pro-security culture. A key principle is that staff working at the Trust and patients and visitors using the Trust, have the right to do so in an environment where all feel safe and secure.

2.1 Comparative figures for 2024-25 are shown in Table 1[11].

Table 1 - Security Incident Reporting

ALL SECURITY INCIDENTS	2022/23	2023/24	2024/25
First quarter: Apr, May, Jun	294	333	461
Second quarter: Jul, Aug, Sep	296	262	360
Third quarter: Oct, Nov, Dec	235	399	604
Fourth quarter: Jan, Feb, Mar	272	609	521
Running Total	**1097**	**1603**	**1946**

2.2 Of the 1946 incidents 1235 occurred at the RSH, 683 at PRH. Most incidents concern aggressive service users. The sharp rises in incident numbers reflects high demand for security support on ever busier main sites but also well embedded awareness amongst work force on how and when to get support if matters escalate or risk is foreseen (s2.7 & s2.8 refer). 28 incidents were on other sites, 25 incidents of these were at Hollinswood House, Telford.

2.3 There was a total of 509 non-aggression security incidents, a breakdown is herewith:

- Other Security (458)[12] Damage to Property (31)[13]
- Theft/alleged theft of Trust Property (9)[14] and non-Trust Property (11)[15]

2.4 *Intentional/Inexcusable Violence & Aggression*

Figures for reported intentional/inexcusable violence and aggression incidents in 2024-25 are shown in Table 2. Intentional/inexcusable incidents ranged from acts of physical contact (however minor or inconsequential including spitting) to verbally threatening or intimidating behaviour and racial abuse. Intentional/inexcusable incidents are those incidents where the perpetrator *was not* deemed to have any reasonable excuse for their behaviour e.g. an underlying medical condition or illness such as dementia, delirium, or toxic infection. Legally excess alcohol and/or drug misuse are not seen as mitigating circumstances for adverse behaviour, but as aggravating factors.

[11] Source Datix as of 20 May 2025. Numbers may be subject to change due later reporting, audit or other data administration.
[12] Including building/office/non-public areas found insecure, building alarm activations, suspicious behaviour, general concern re service user behaviour, undue interest in staff (harassment), nuisance phone calls, suspect packages or unattended bags and service users suspected to be or seen to be in possession of knives, blades, or other illegal substances/items. 7 searches for bladed items were carried out, all revealed the presence of a knife or bladed item on the patient. In line with our policy security staff have metal detector search wands available for use when searching patients, this equipment allows for more accurate searching of patients with less likelihood of harm to staff or opportunity for later use of the knife or blade. Trespass included unwelcome/unnecessary presence of relatives, rough sleepers and/or intoxicated members of public in hospital grounds, public in staff only areas. Most concerned patients refusing to leave ED after discharge (demanding non entitled transport, medications).
[13] Nearly all concerned damaged to vehicles or buildings/fixings caused by another vehicle.
[14] Nearly all concerned small/low value items. One instance of significant amount of cash being stolen from car park change machine.
[15] Concerning alleged theft of unattended cash/personal items (staff and patient), theft of bicycles, theft from retail outlet at PRH, one instance of intimidation and theft from student nurse at retail outlet at PRH (suspect identified by security teams/positive police intervention).

Table 2 – *Intentional/Inexcusable Violence & Aggression*[16]

INTENTIONAL/INEXCUSABLE VIOLENCE & AGGRESSION	2022/23	2023/24	2024/25
First quarter: Apr, May, Jun	42	29	50
Second quarter: Jul, Aug, Sep	38	52	45
Third quarter: Oct, Nov, Dec	17	56	47
Fourth quarter: Jan, Feb, Mar	18	40	59
Total	**115**	**177**	**201**

Of the reported 201 intentional/inexcusable violence and aggression incidents 116 occurred at the RSH, 77 occurred at PRH and 8 occurred at Hollinswood House. 60 involved physical contact (however minor or inconsequential) of these 45 involved hospital staff.

2.5 *Non-intentional / Clinical Aggression*

These are incidents where an individual is deemed to lack capacity and are not therefore held responsible for their actions due to their medical condition, treatment or other underlying medical issue e.g. dementia, delirium.

Table 3 - *Non-intentional Clinical Violence & Aggression*[17].

CLINICAL VIOLENCE & AGGRESSION	2022/23	2023/24	2024/25
First quarter: Apr, May, Jun	79	109	152
Second quarter: Jul, Aug, Sep	110	118	117
Third quarter: Oct, Nov, Dec	81	154	237
Fourth quarter: Jan, Feb, Mar	93	218	129
Total	**363**	**559**	**635**

Of the reported 635 non-intentional clinical aggression incidents 362 occurred at the RSH, 270 occurred at PRH and 3 occurred at Hollinswood House, Telford. 296 involved physical contact (however minor or inconsequential) of these 264 were on hospital staff.

2.6 *Immediate Response to Violence & Aggression*

In line with our published policy on dealing with violence and aggression an escalated approach is used to deal with all violent and aggressive incidents, namely:

Step 1 - Use by all staff of conflict resolution techniques to diffuse situations (3.2 refers).

Step 2 - Calling for emergency assistance from hospital Security Officers who provide emergency response and support to all staff facing threats of violence and aggression from service users, intentional or not as well as being backed up by an extensive CCTV network. All Security Officers carry body worn camera[18].

Step 3 - Enlisting emergency assistance from the police.

[16] Concerning all staff, patients, visitors, and contractors. Source: Datix wef 20 May 2025.

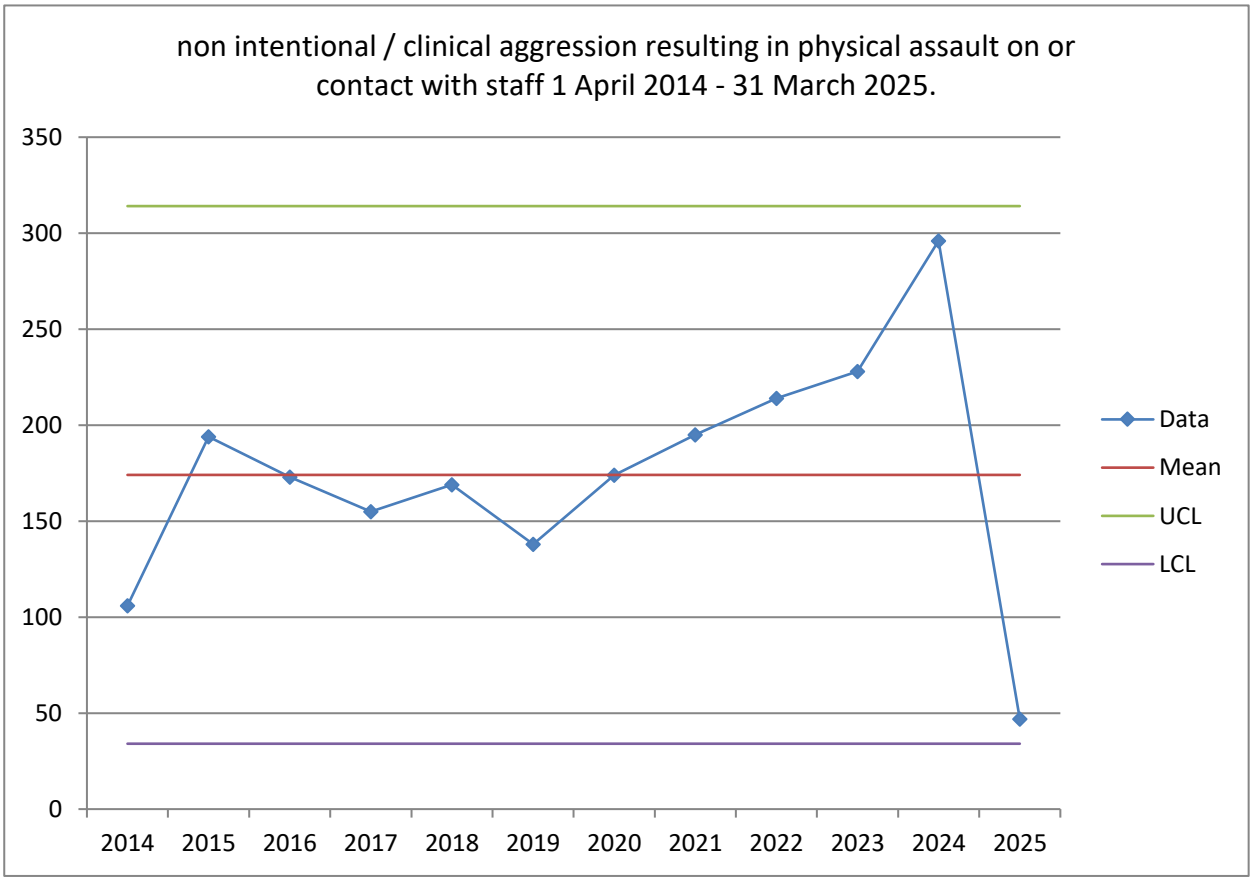
[17] Concerning all staff, patients, visitors, and contractors. Source: Datix wef 20 May 2025.

[18] A statement on how the equipment is used and controlled is included within our published CCTV operating policy. Body Camera are not used when dealing with patients who lack capacity or may be in genuine crisis or ill-health.

2.7 *Violence and Aggression Prevention and Reduction – Assessment of Strategies*

Safe handling and restraint training for security staff (3.1 refers) and use of security staff as the principal resource within the Trust for the safe handling of aggressive service users (2.8 refers) started in 2013-14. Figure 1 shows that the number of incidents of *non-intentional clinical aggression* resulting in physical contact, harm or injury to staff reported each year since remains below the given upper control limit. The noted drop in the second half of 2024 onwards may well reflect recent security staffing increases.

Figure 1: Number of reported non-intentional/clinical aggression resulting in physical assault/contact, harm or injury to staff between 1 April 2014 and 31 March 2024.



Aside from the incidents reported in Tables 2 and 3, there were a further 601 occasions where staff reported concern regarding potential for aggression from a patient[19]. Through appropriate de-escalation and/or intervention including where necessary security team contribution and/or rapid tranquilization, patient behaviour was controlled, and each occasion passed without further escalation, harm or injury demonstrating good incident prevention.

It is recognised the risk of clinically related aggressive behaviour will always be present in an acute hospital, not least due to consistent pressures from an ageing population in Shropshire which is above the national average and increasing levels of dementia and mental health related issues. Figure 1 shows that outcomes to this type of behaviour can be diverted/de- escalated from physical contact and therein physical harm/ injury to staff or even prevented if sufficient resources are in place to address incident numbers/volume (s2.8 refers).

[19] This may be through assessment of patients known to be in-crisis or at risk of self-harm whose behaviour is unpredictable, because of a patient needing a clinical or other intervention, but the patient is known for or will resist the intervention or will become agitated during the intervention and safe holding or restraint may be required for the safety of all concerned. 2023-24 figure was 476 = 26% increase in requests for support.

All reported security incidents from either hospital staff or the security teams are individually reviewed by the Trust Security Manager. This includes liaison with staff affected by more serious incident and/or their line management. The COO acknowledges reported incidents of violence and aggression by writing to all members of staff who may have been physically injured, harmed or significantly affected by an incident, offering support through line management or occupational health/counselling services and advising of the Trust's response to incidents. During the reporting period 52 such letters were sent to staff[20].

Where an assailant's actions were deemed to have been intentional/inexcusable, an entry is made on our electronic violence and aggression register. Linked to a patient's electronic record this allows staff in future to be warned of the potential for adverse behaviour from a patient[21]. A warning letter, signed by the CEO is sent to the perpetrator of the adverse behaviour and copied to the victim and police, advising that non-emergency treatment could be withdrawn if there are any further episodes and support for police action or civil action by the Trust[22]. In the reporting period 23 alerts and warning letters/final warning letters and/or letters of concern were issued. Only 2 of those receiving a warning letter in this period have come to further attention despite further attendances by some, thereby giving some assurance as to the effectiveness of warning letters and the importance of challenging unacceptable behaviour.

The Trust supports all police and Court actions when taken and every effort is made to encourage staff to make complaints to police to allow rightful prosecution of offenders responsible for inexcusable violence and aggression towards staff as well as enable partnership working with police including provision of supporting CCTV, body camera recordings or other documentary evidence (1.5 refers). Examples of reported outcomes reached during the reporting period are herewith:

- web214568: An adult male patient, charged with Assault Occasioning Actual Bodily Harm (AOABH) for assaulting a hospital security officer during a struggle to remove him from the RSH ED Children & Young Person Unit (CYPU) after forcing entry and then locking himself within (this followed an aggressive outburst towards medical and nursing staff elsewhere in the department) was sentenced at Kidderminster Magistrates Court on 6 March 2025 to a 12-month conditional discharge. The Trust responded to the incident at the time in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy which includes written offers of support to affected staff.

- web206075: A male patient, charged with affray for assaulting two hospital security officers and verbally threatening nursing staff whilst at the RSH ED was sentenced at Shrewsbury Crown Court on 26 April 2024 to 4 months imprisonment. He was also given a 12-month Mental Health Treatment Requirement order, a 6-month Drug Rehabilitation Requirement order and a 20-day Rehabilitation Activity order. The Trust responded to the incident at the time in accordance with the provisions of the Trust Violence & Aggression Prevention and Reduction Policy which includes written offers of support to affected staff.

[20] In line with the strategy outlined for dealing with violence and aggression a resulting outcome is that much adverse behaviour is diverted away from medical and nursing staff by the intervention of security staff before the behaviour escalates and so medical and nursing staff can avoid injury or unnecessary involvement; by virtue of their involvement security staff, based on their early involvement become responsible for reporting on the incident with medical/nursing staff being identified as witnesses as opposed to victims. This explains in some way the disparity between numbers of support letters issued to Trust/NHS staff and all reported incidents (Tables 2 and 3 refer).

[21] A recommendation for an alert on a patient's CAREFLOW electronic personal record and the issue of a warning letter is made by the Trust Security Manager. However, prior to this action being undertaken the recommendation must be approved and supported by an ED Consultant; this ensures that patients who may have lacked capacity at the time of the incident and whose circumstances may not have been accurately reflected in the incident reporting process are not unnecessarily sanctioned.

[22] It should be noted that it is not always possible or appropriate to issue a warning regarding unacceptable behaviour because the individual may not have been identified or the circumstances of the individual deem it inappropriate.

At the time of writing there are currently 7 matters being reviewed or progressed by the police relating to assault of hospital staff or other intentional/inexcusable behaviour during the reporting period. These are summarised herewith:

- Datix web242533: Kicks to neck and stomach on PRH ward Staff Nurse by female in-patient.

- Datix web 261935: Racist abuse of RSH security officer by male ED patient.

- Datix web261337: Common assault on RSH ED Staff Nurse who was pushed to the ground by female ED patient.

- Datix web263647: Common assault of RSH security officer who was elbowed in stomach/abdomen and left winded by male ED patient.

- Datix web266622: Assault of RSH Security Officer by female ED patient who spat in the victims' face and eye.

- 9 incidents involving one male patient who made a series of attendances at the RSH ED between February and March 2025. This included assault of a female Nursing Sister who was repeatedly struck on the head by the male and 8 other assaults of security staff, one of whom required 8-week absence from work due to injury.

- A female patient attending RSH & PRH ED between February and March 2025 was responsible for 22 security related Datix. Matters ranged from verbally abusive and insulting words and behaviour towards medical and nursing staff, refusing to leave premises, causing a disturbance or nuisance on NHS premises, public order offences and assault of security officers (one of whom required 6-week absence from work due to injuries sustained) and police officers. Nearly all her attendances were unnecessary, when help or care was offered it was forcibly rejected, resulting in her supervised removal from premises and in most instance arrest. Following a series of appearances at Court relating to incidents at the hospitals as well as elsewhere in the community she is now being held on remand at HMP awaiting due legal process. A Police Criminal Behaviour Order is being developed by police to control her future behaviour, with the Security Manager providing relevant witness testimony and statement in support of the Court application.

Notwithstanding the rises in numbers of reported security incidents involving aggression towards staff, the latest annual NHS Staff Survey suggested the number of Trust staff experiencing physical (Q13a) or non-physical (Q14a) abuse from patients, service users, relatives or other members of the public is still below the national average and very much below NHS Trusts with the worst experiences[23].

The figure in Table 4 below shows that despite increased numbers of incidents over the last 3 years, the number of incidents resulting in moderate or severe harm has not increased at present[24].

[23]NHS Staff Survey Bench Mark report 2024 (Shrewsbury & Telford Hospital NHS Trust) p62-63 NHS Staff Survey 2024 Benchmark Report.
[24] For note, this concerns all staff, patients, visitors, and others (e.g. WMAS) and reflects all categories i.e. patient on patient, patient on other, staff on staff as well as patient on staff. I have not included incidents coded as 'concern re potential aggression' because as the title suggests these are reports which were near/miss incident prevented in the first place.

Table 4 - *Number of incidents resulting in moderate or severe harm v no or low harm.*

	2022-23	2023-24	2024-25
No Harm/Low Harm	423	713	814
Moderate Harm/Severe Harm	25 (24+1)	23 (20+3)	22 (18+4)
Total Incidents	478	736	836

This suggests that current strategies for managing and controlling violence and aggression, in particular consistent use of security teams to provide interventional support, is giving a notable degree of risk mitigation. Of the 24 incidents of intentional/inexcusable physical contact or aggression in both ED departments during the reporting period, 11 directly affected either medical or nursing staff, with the rest of the incidents, affecting or absorbed by security teams. Of these 2 required RIDDOR reporting in accordance with Health & Safety reporting legislation due to time off for injuries incurred[25].

2.8 *Role of Security Officers*

The Trust's staffed security guarding contract is key to being able to implement the provisions of several security policies and numerous other staff and patient safety policies[26]. With any aggression incident security staff are called to help provide reassurance and assistance in seeing the safe closure of the incident or prevent further escalation, as well as providing pre- arranged preventative support to staff to stop a foreseeable incident escalation. Often staff may note a warning alert for aggression on a patient's electronic record, this triggers a request for security staff presence when they attend. All Security Officers carry body camera recording equipment[27]. Security Officers are licensed in accordance with the Private Security Industry Act (PSIA) by the Security Industry Association (SIA)[28] for Door Supervisor duties. They are also trained to make physical interventions by way of safe holding/restraining those service users whose behaviour has escalated to the point that the safety of staff, the service user or others is endangered. To provide security staff with the skills and confidence to do this, specialist training is delivered over a one-week training course to security teams by accredited NHS training staff from the Midlands Partnership Foundation Trust (MPFT) (3.1 refers).

613 safe hold/restraint interventions were undertaken across both sites by security staff during the reporting year. All safe hold and restraints are recorded on Datix making them visible to Centre and Ward Management. Not all 'safe holds/restraints' were undertaken because of actual aggression towards staff. Some were undertaken due to concern about potential aggression due to:

[25]RIDDOR reporting for security staff is completed by their parent/employer company.

[26]The security guarding contract is subject to regular multi quote competitive re-tender process by Shropshire Healthcare Procurement Services (SHPS). The Trust is currently in year 3 of a 4-year contract with MITIE Security Limited, who achieved the highest score across the combined Quality and Price evaluation, achieving a score of 89.11%. They were awarded a 4-year contract to continue providing uniformed emergency security services at the Trusts 2 main operating sites. The MITIE submission evidenced their front-line NHS experience with several large acute hospital Trusts (including SaTH) as well as strategic/national level involvement and engagement in development of healthcare security and forthcoming statutory and regulatory legislation affecting healthcare security. Existing core team locally employed security staff working at both hospital sites were retained and transferred to the new contract under TUPE thereby retaining the invaluable experience. MITIE are a Real Living Wage (RLW) employer, and the contract provides for hourly pay rates to staff that are above the RLW as well as the National Living Wage (NLW) rate, which further encourages retention of staff and knowledge.

[27]A statement on how the equipment is used and controlled is included within our published CCTV operating policy.

[28]Unscheduled assurance visit completed by SIA Inspectorate on 8 March 2024 at the RSH site saw no adverse outcome/findings. Areas of attention included SIA license inspection and validation, right to work checks, confirmation (from the staff) they were in receipt of minim pay rates/National Living wage pay rate and were able to demonstrate a competent understanding of the duties and client expectation. Those staff spoken to by the Inspectorate included core team staff and additional relief staff providing specific ward support.

- Concern by medical/nursing staff about safety for planned invasive procedure where the patients mental or physical state, whilst not aggressive, suggested that harm or injury to the patient or staff would have occurred had an intervention not been undertaken.

- A need to prevent patients in personal crisis from attempting/carrying out self-harm.

- High risk confused and/or agitated patients who had or were attempting to leave the hospital buildings and/or their ward/bed spaces and refusing to return.

2.9 *Other Duties*

Security staff also contribute to a wide range of tasks which are not specifically recorded as security incidents, but occur daily, these include:

- Help with preventing or locating absconded/missing patients or patients in crisis deemed to be vulnerable and/or at high risk of self-harm or may/are intending to take flight (patient safety).

- Fire alarm activations and other fire incident related activity (fire safety incidents).
- Attendance at Air Ambulance arrival/departure (operational task).
- Emergency resuscitation team calls to victims in public areas of the hospitals to ensure resuscitation teams can work without disruption or oversight of victims and ensure safe passage for patient evacuation etc. (medical emergency task).
- Escort of General Office staff carrying out cash transfer and filling/emptying of change machines and collection of valuables from night safes (cash security).

2.10 Past concern that security staff numbers were previously too low and left main sites at risk[29], resulted in development and submission of a Business Case to see an uplift in core team security staff numbers at both sites to 5 on duty at each main site 24/7 365. The rationale for this was based on:

- A 121% rise in reported security incidents between 2020-21 and 2023-24. The overwhelming majority concern aggressive service users who either lack clinical capacity, are in-crisis and require support in best interest or because of Mental Health (MH)/Deprivation of Liberty Safeguard (DOLS) assessment.

- Recognition that security staff are the Trust's primary resource for physical intervention (safe holding/restraint) with service users whose behaviour has escalated to the point that the safety of staff, the service user, or others, is being endangered and aligned to this the Trust had recorded a 91% rise in the number of safe hold/restraint interventions by security teams between 2020-21 and 2023-24[30]. There is a statutory obligation on organisations undertaking regular safe handling and restraint of patients to ensure that there are enough trained staff on duty as dictated by the training needs analysis for the method of restraint used[31]. The MPFT DMI training model requires a minimum of 3 trained staff to complete the most restrictive intervention. When this is required the remainder of a site was left without security provision, this had caused delays in

[29] Datix risk register id 789.
[30] 309 in 2020-21 v 592 2023-24. All security team reports regarding safe hold and/or restraint interventions (however minimal and including use of light hands on to guide individuals away from harm/back to safe place) are made visible to Centre and Ward Management teams. Not all 'safe holds/restraints' were undertaken because of actual aggression towards staff. Some were undertaken due to concern about potential aggression due to concern by medical/nursing staff about safety during a planned invasive procedure where the patients mental or physical state, whilst not aggressive, suggested that harm or injury to the patient or staff would have occurred had an intervention not been undertaken, a need to prevent patients in personal crisis from attempting/carrying out acts of self-harm or high risk confused and/or agitated patients who had or were attempting to leave hospital/ward/bed spaces and refusing to return.
[31] The Mental Health Units (Use of Force) Act (2018).

attendance to urgent calls for support on wards (both sites) and the W&C unit at PRH[32].

- Recognition that after (alleged) unwarranted police involvement in responding to people with mental health needs (MH), the national position adopted by police is they will only attend MH incidents after something has happened e.g. serious injury has occurred[33].

- The Terrorism (Protection of Premises) Act 2025 will place a legal duty on those operating publicly accessible locations (including hospitals) to consider potential threats to safety (principally terrorism related but including other crime and disorder) and relevant mitigation such as dedicated security resources.

- Senior leadership acceptance that the RSH HTP new build program will present more challenging circumstances and environments at the RSH site in terms of staff safety and the safety of in-crisis and chaotic service users. When the new build program is complete the overall RSH building footprint will have increased by a third with 5 levels in the new build, significantly lengthening response times to emergency calls and stretching demand on security staff numbers within the 42-acre site.

- Recognition that at PRH ED, 85% of existing presentations are expected to continue whilst serious trauma will be directed to the RSH site. Most service users requiring security intervention or support can mobilise/are mobile, meaning little change in security demand at PRH where service demand in ED is often higher than RSH[34].

- Violence & Aggression and Musculoskeletal Disorder in the NHS has been the subject of ongoing national scrutiny and inspection programs by the Health & Safety Executive (HSE)[35].

Funding approval for an uplift from 1 July 2024 was subsequently approved and recruitment work by the current contracted security company to recruit and provide additional staff has now been completed resulting in the use of 35 named locally employed contract security staff across both main hospital sites supported by 7 named relief staff who work locally on other MITIE contracts. Within the 5 on duty staff there is a named supervisor. In addition, the contract provides for a dedicated SaTH site security operations manager (Mon-Fri) who moves between each of the main sites as required providing increased oversight, assurance, and accountability for the work of security officers as well as supporting the Trust Security Manager with day-to-day operational security management issues across the main sites.

[32]Datix web238688.
[33]National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk)
[34]K Blackwell BCRG 16 January 24.
[35]HSE 2018-22 Inspection Program Recommendations for Managing Violence & Aggression and Musculoskeletal Disorders in NHS.

2.11 *Closed Circuit Television (CCTV)*

Each main hospital site has a dedicated CCTV camera control room which forms an operating base for Security Officers. Output from security cameras on our main hospital sites is fed back to these camera control rooms[36]. As well as addressing a wide range of security issues and requirements these facilities prove very helpful with the rapid investigation of missing patients, some of whom have either inadvertently or intentionally left the hospital buildings.

Images recorded on all systems are stored and controlled in accordance with our CCTV operating policy.

8 new cameras became operational in the Elective Theatre Hub at the Princess Royal Hospital with replacement of obsolete/failing CCTV camera in the following areas at the Princess Royal Hospital:

- Emergency Department.
- Main hospital street.
- Paediatric Ward.
- Paul Brown Building.
- Mortuary.
- NNU.

CCTV provision has been included within the building schedule for all areas of HTP at the Royal Shrewsbury Hospital. To date this has included the installation of 8 new additional camera within the first phase of the ED refurbishment. 3 new cameras were installed in the Evolution Scanning Unit (Gamma Photography suite).

At the time of writing camera deployment across the sites was:

- PRH 151/ RSH 169.
- Trust Offices at Douglas Court, Shrewsbury Business Park 12.
- Queensway Business Park Telford (Sterile Services & Medical Records facilities) 4.
- Ludlow Community Hospital (MLU) 4.
- William Farr NHS site, Shrewsbury (Therapy Services Building) 4.
- Hollinswood House, Stafford Park, Telford (CDC/Renal Unit) 21.

In addition to HTP plans, further camera additions are planned for the following areas during 2025-26:

- PRH overspill staff car park.
- RSH modular 2 floor sub-acute ward.

[36] Current facility/building at RSH is scheduled for refurbishment as part of HTP program. Contract manager and all shift supervisors are licensed in accordance with the requirements of the Private Security Industry Act for Public Surveillance CCTV Monitoring.

2.12 *Networked Swipe Card Door Access Control*

A security management business case to replace an increasingly unreliable and obsolete swipe card access control system used in several high-risk patient areas[37], several departments requiring high levels of assurance for accreditation and licensing purposes[38] and address concern around poor access control arrangements to and from in-patient areas and both A&E[39] was given £1.2m Capital funding in Sep 2022[40]. Phase 1 of the works, which sees replacement of the existing obsolete system has now commenced and is being overseen by Capital Projects[41]. Phase 2 will see introduction of the system into other in-patient areas and both A&E through forthcoming years.

The new system is being deployed across multiple sites and buildings, including the HTP new build and RSH ED, providing numerous financial and service user efficiencies/advantages.

2.13 *Baby Tagging*

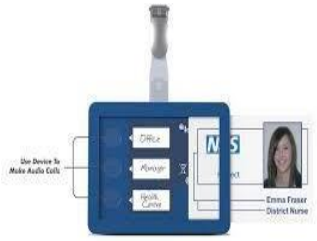
This facility is in operation at the Shropshire Women and Children's Centre at the PRH on the Post-Natal Ward and the Wrekin Midwife Led Unit (MLU) at the PRH. Each new-born can have a tag fitted after delivery. Should the infant then be taken towards a doorway, including a fire exit, the tag will alarm and send doors into Lock Down mode whilst discreetly alerting staff at the nurse base via a PC type console so they can investigate. If doors are physically forced, breached or someone manages to tail-gate out, the system will immediately alarm in a very loud and audible manner. In the Women & Children's Centre should the alarms at the doors fail, a second layer of sensors will activate in the main foyer and each external entrance to the building.

If a tag is forcibly removed or cut off the system automatically goes into alarm. The same occurs if the system detects an inability to communicate with a tag e.g. if the infant were wrapped in coverings or placed in a bag to enable unauthorised removal.

As part of our security management assurance program, testing of the system and staff reactions are carried out every 3 months by Ward and Security Managers with feedback provided to senior management on the outcome from each test. A maintenance and support contract with the supplying company is in place to ensure system continuity and reliability. A 24/7 emergency telephone help line is included within the support element of the contract, so staff have constant access to specialist technical support. Inclusion of similar is being included within the Security Needs Analysis (SNA) for the HTP new build.

[37] In-patient Maternity, MLU & Paediatrics.
[38] RSH Pharmacy, RSH Pathology, Mortuary (both sites), Digital Data Centres (both sites).
[39] 4-digit keypad pin code locks are on some entrances, but these systems are always subject to very easy compromise/misuse and counter compromise action is time consuming and very disruptive. Use is awkward and clumsy when linked with or part of a patient or other manual handling task especially if doors do not open or close with electrical assistance, so doors get left open which has led to absconded/missing patient incidents (Datix Risk Register 312). In the event of a known or immediate external threat all ward doors have the option to be secured manually and good physical security is provided to ward areas until an incident is over/stood down. This functionality is checked and tested every 3 months by security teams records held by security manager.
[40] Capital Planning Group (CPG) meeting minutes 16 Sep 22 (minute 2022.75).
[41] Competitive tender multi-quote completed. Product name is SALTO.

2.14 *Lone Working*



The lone worker device used by the Trust to support workers working alone/off site in the community takes the form an identity badge holder worn around the neck or clipped to a belt/tunic. It includes a panic alarm that can be discreetly activated, which automatically opens a line of communication (via roaming mobile phone signal) to a national Alarm Receiving Centre (ARC), thereby allowing situation assessment and immediate response/escalation, as well as recording of evidence.

In very extreme instances ARC staff can directly provide information from the staff member's device including pre-recorded information on where the staff member is located, to the nearest police control room. The advantage here is that police response is quicker because the information being received by them is from an accredited source as opposed to an anonymous cold call to police from public. This device is not seen as a risk eliminator, rather as a risk reducer designed to work with and complement other safe systems of work. The use of this system was noted during the last CQC Inspection[42]. 138 staff currently have access to a personal use device. There are a few other staff who benefit from access to a shared or pooled device. In total the Trust has 188 devices available for use by staff.

For staff working alone on the main sites (out of hours) upgraded hospital pagers, which allowed sending of a discreet emergency alert to security staff and hospital switchboards, have been in use since 2008. However, notice has since been given by the product and service support provider of a decision to withdraw VHF pagers due to increased costs and lack of components.

In future the device for on-site staff will take the form of a key fob styled device. Provided by the same supplier of the id card holder device it has the same functionality as the id card holder but is more suited to being shared. Testing for signal quality in affected departments has been completed. Work and communication with affected departments to see device switch over will take place during 2025.

[42] Lone worker security devices had been provided for each community midwife". Source: CQC Inspection Report (Evidence Appendix) published 8 April 2020 page 429.

3 Communication, Awareness & Training

3.1 *De-Escalation & Management Intervention (DMI)*

Security staff are the primary trained resource at the Trust for the safe handling and restraint of physically violent or aggressive patients. To provide security staff with the skills and confidence to do this, specialist DMI training is delivered by accredited NHS training staff from the MPFT. The training, which consists of a 5-day foundation course and annual refresher days thereafter, has been accredited by the British Institute for Learning & Development (BILD) and the Institute of Conflict Management. A syllabus ordinarily delivered to NHS Mental Health Professionals (MHP) working at MPFT is followed, but with additional bespoke content aimed at recognising the role of our security staff and the varied and different circumstances and settings experienced in a busy acute hospital environment. In the reporting period 15 security staff undertook whole day annual refresher training whilst 21 new starters completed the initial 5-day foundation course.

As part of a recognised wider training need for key clinical staff to be trained in safe handling and restraint a number of nursing staff received training from MPFT during the reporting period. Having key clinical staff trained in this way allows for due oversight of any safe holding or restrictive intervention activity to the betterment of patients and security staff undertaking such activity. It will also help provide on-hand skills for completion of low level clinical safe holding for patient safety and reduce the need for security team presence at such.

3.2 *Conflict Resolution Training (CRT)*

In the reporting period 2031 employees completed on-line national NHS CRT. In all 4269 staff were identified as in date on 01 April 2025, which equates to 93.89% compliance in terms of staff required to complete training[43]. Aggression from service users can be experienced face to face but also via telephone or social media, whilst on premises or off, and when on duty or off duty. During the pan-demic many staff employed in non-patient facing roles were re-deployed to assist in patient areas. To recognise this and following consultation and recognition of risk in certain exposed staff groups not being trained security and CRT is being extended to reach staff in Estates and Facilities from 1 May 2025[44].

3.4 *Corporate Welcome*

During the reporting period an on-line voice over corporate welcome security information brief was developed for all new staff starting at the Trust from 1 May 2025. This information brief will be administered through the Trust's Learning Made Simple (LMS) on-line portal.

3.5 *The Terrorism (Protection of Premises) Act 2025 & Lock Down awareness*.

This new statutory obligation (also known as known as Martyn's Law) places a legal duty on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures. Under the legislation the Trust will be included in the enhanced category of publicly operated buildings (meaning more that 800+ members of public expected on site per day). Establishment of a regulatory inspection body to oversee arrangements at organisations is underway. It is

[43] Workforce Directorate dated 16 May 2025.
[44] Work Force Partnership Policy Group 7 March 2023, agenda item/paper 1.
Head of Facilities request 29 January 2024.
HSSF C'tee 8 February 2024, paper 12.

expected that security awareness training for NHS staff will be seen as a corner stone of an organisations risk mitigation strategy. As part of the Trust response strategy from 1 July 2025 all staff will be asked to complete a one off 45-minute government on-line security awareness training assessment known as ACT (Action Counters Terrorism), followed by a short 10-minute voice over power point briefing by the Security Manager on local Lock Down arrangements and sign posting to related policies and procedures at the Trust[45]. Thereafter staff will be required to view the local Lock Down arrangement and sign posting presentation for the purposes of timely refresh every 3 years. Both pieces of training will be administered through the Trust's LMS on-line portal.

4 Conclusion

4.1 In addition to maintaining and progressing the activity already covered in this report we will also seek to:

- Continue to provide specialist security risk assessment advice and guidance on security infrastructure and security resources for the HTP and other Capital investments.

- Continue to provide corporate security risk assessment advice, support, guidance to the Trust and all Centres and departments including change of lone worker device support for staff working on main hospital sites.

- Ensure that continued and credible professional uniformed 24/7 emergency security support remains available and at the disposal of all Centres and departments at the Trust including ensuring continued investment in the training of security teams to deal with conflict resolution and support clinical staff with aggressive and/or agitated/confused patients.

- Continue to ensure clear messages are sent to perpetrators of unwelcome and anti-social behaviour to reinforce the Board's robust approach to abuse of staff and patients.

- Continue developing and preparing an organisational response assessments and actions to meet all the requirements of The Terrorism (Protection of Premises) Act 2025.

[45] HSSF 2023.160 dated 8 February 2024.