The Shrewsbury and Telford Hospital NHS Trust

Hospitals Transformation Programme

SRO Update November 2025

Integrated Care System
Shropshire, Telford and Wrekin

Clinical and Operational

Clinical and Operational update

- The clinical and operational delivery of the Hospitals Transformation Programme remains on schedule to implement the clinical model by 2028. A significant amount of work is ongoing to review clinical pathways and associated key milestones, ensuring that the programme continues to be closely monitored and achieves its intended outcomes as construction advances.

- Workforce Planning Masterclasses are being provided to managers to support the transformation with the new HTP clinical model. To date, 70 managers have participated, with further sessions scheduled. Change Agent training is also progressing, with 33 individuals trained, two more sessions planned for November, and additional sessions forthcoming.

- A total of 119 Change Agents have been designated across Divisions and Corporate areas, with monthly divisional meetings arranged to foster ongoing engagement. People and OD Business Partners and management teams have been invited to participate in these monthly catch-ups. These Change Agents will play a vital role in facilitating local engagement, identifying issues affecting staff, and relaying feedback to the Workforce Transformation Lead.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

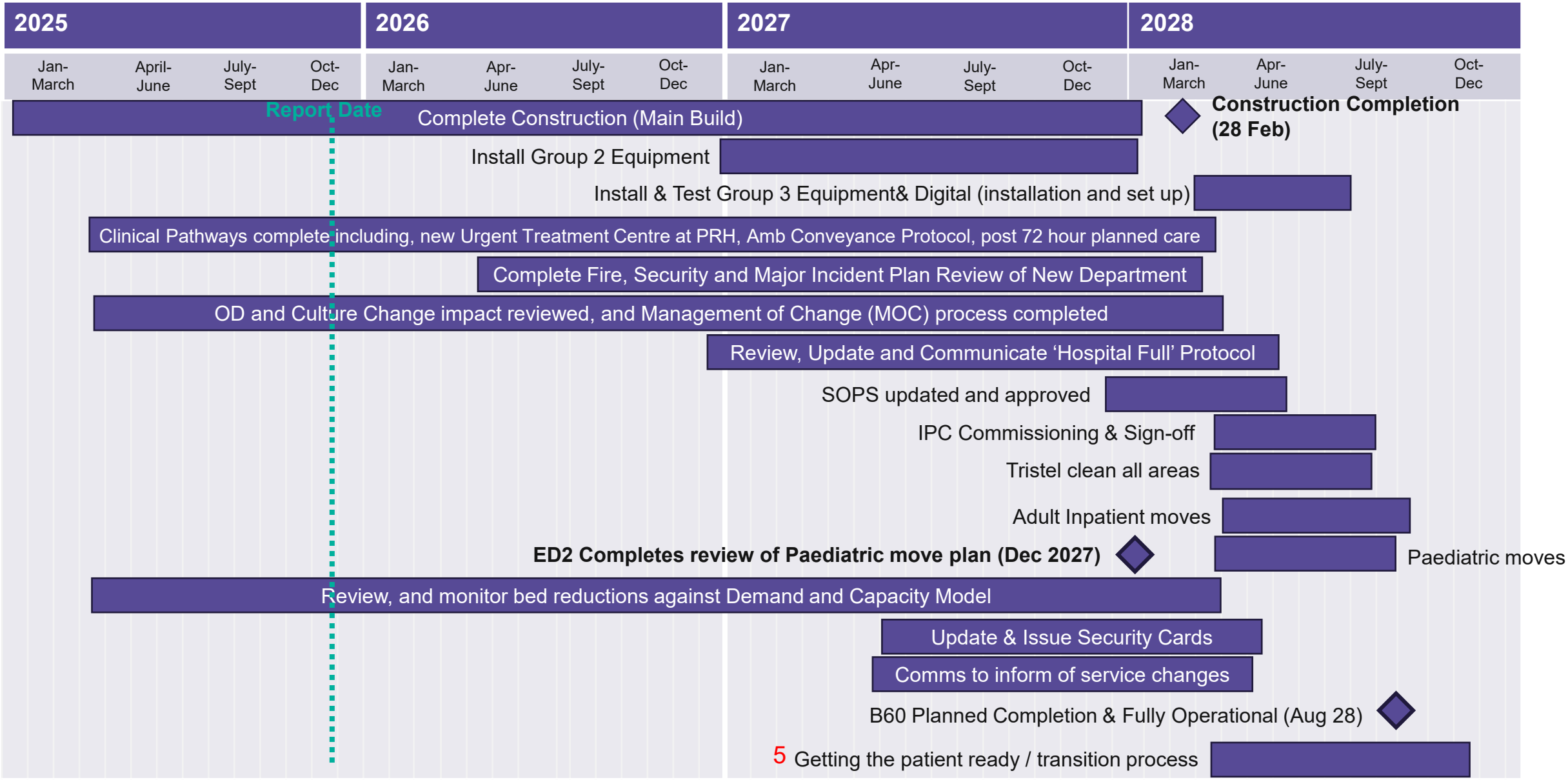
Construction and Estates

Integrated Care System
Shropshire, Telford and Wrekin

B60 Critical Path Overview

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital
NHS Trust



ED2 Critical Path Overview

Integrated Care System
Shropshire, Telford and Wrekin

NHS
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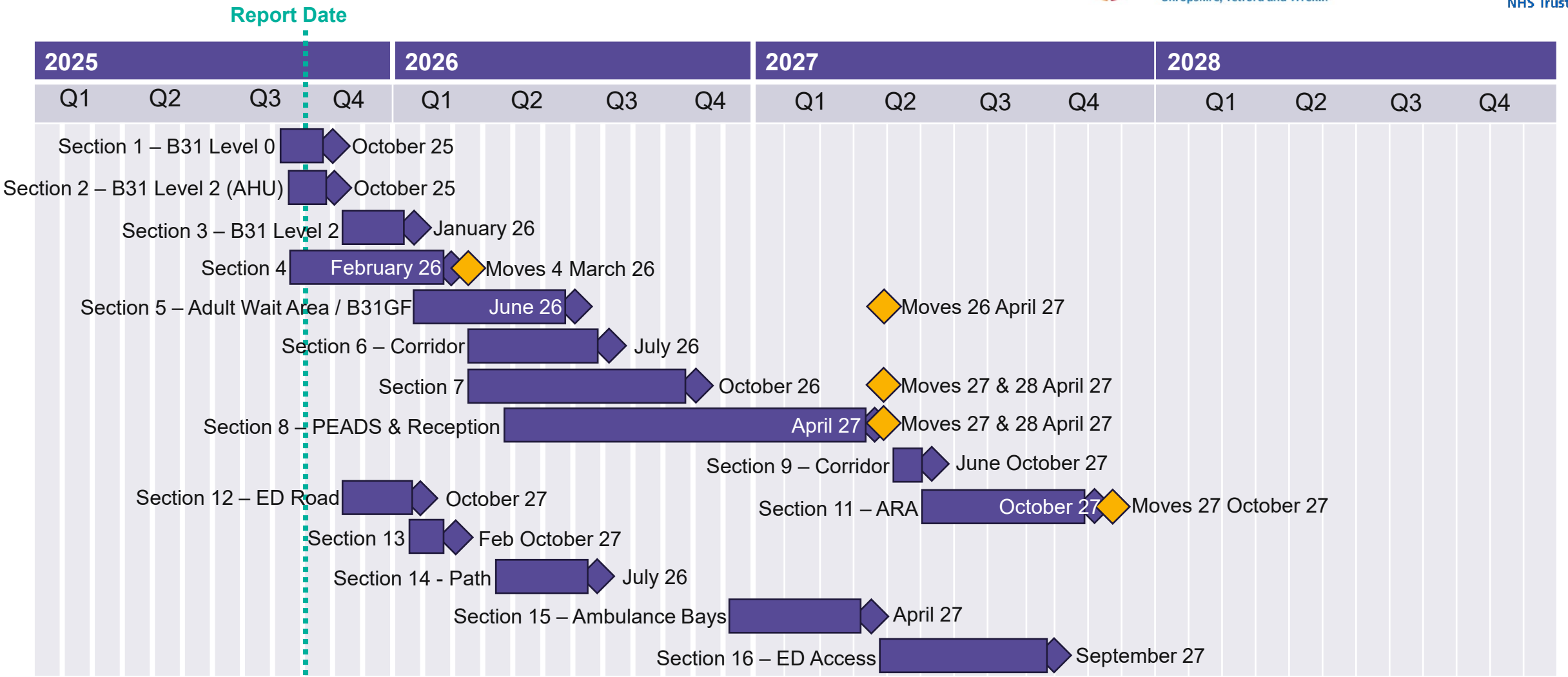
NHS Trust



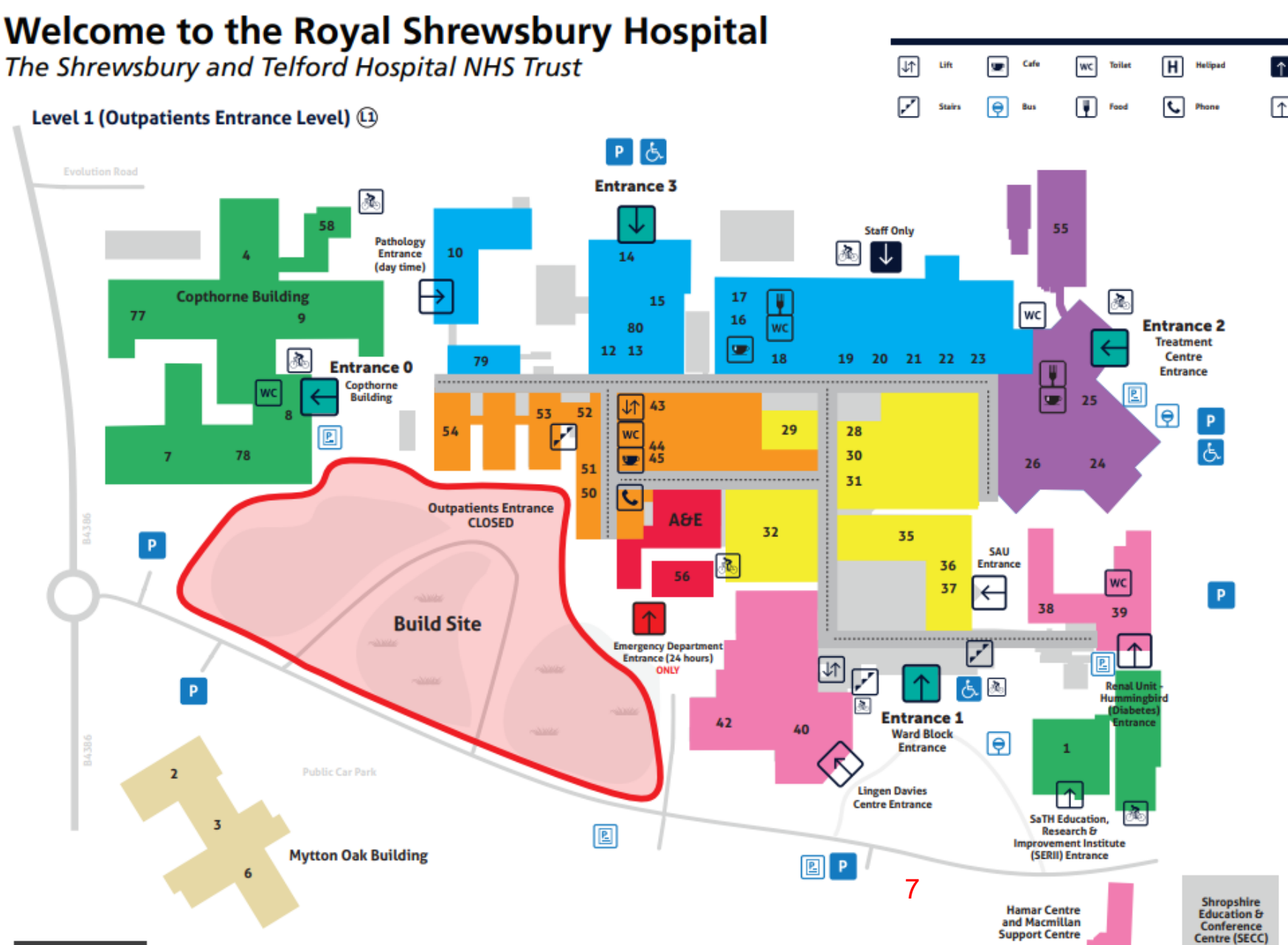
Construction area

Integrated Care System

NHS The Shrewsbury and

Welcome to the Royal Shrewsbury Hospital

The Shrewsbury and Telford Hospital NHS Trust



Construction Progress

Next Steps on Main Build Site

Next steps and site changes to RSH

December 2025 – Reinforced concrete frame to complete, topping out ceremony planned for 17th December. External cladding, installation of windows, internal partitions and steel frame continue. Copthorne car park extension (former modular site) completed and handed over to Trust. Surveys undertaken on proposed site for SDEC relocation. Motorbike shelter to be relocated, ready for start of a second Vacuum Insulated Evaporator (VIE) works.

January 2026 – External cladding, windows, internal partitions and steel frame continue to be installed. Water connection for Building 60 (former modular site) to be partially installed. Concrete pad and duct works to commence for second vacuum insulated evaporator (VIE).

February 2026 – B60 external cladding, windows, internal partitions and steel frame continue to be installed. Second vacuum insulated evaporator (VIE) continue.

Comms and Engagement

Recent and upcoming engagement activity

- HTP Focus Group – 2 December
- Sky Garden focus group – 5 December
- Women and Children's drop-in – 6 December
- Opening of Community Skills Centre – 11 December
- Topping out Ceremony – 17 December
- Wellington Library drop-in (TBC) – 8 January
- Newport Library drop-in – 13 January
- Public Assurance Forum – 19 January
- Whitchurch Library drop-in – 23 January
- About Health event – 27 January
- Oswestry Library drop-in – 28 January

Communications Update

- Proactive engagement with communities and stakeholders – preparing for Winter engagement with drop-ins being held across libraires in Shropshire, Telford and Wrekin and mid Wales. Press release to be issued January 2026.
- Quarterly focus groups held in December; this included a focus group for Sky Gardens in partnership with Shrewsbury Severn Rotary club – with 33 in attendance (mix of staff and public)
- Collaboration continues with the Workforce Lead to support the work of Change Agents and to develop a broader internal campaign “HTP Together”. The campaign will be a phased approach, aligned to different milestones within the workforce and operational programme. Outlined as follows
  - Jan 2026-March 2026 – Launch of HTP Together: General awareness building
  - March 2026-Feb 2027- HTP and Me: Focusing on HR/Change element of HTP
  - Feb 2027-Feb 2028 – HTP Ready: Focusing on getting ready to operationalise building and clinical model

Supporting with a number of upcoming milestones including final Topping Out ceremony – to take place on Wednesday 17 December. Expected coverage to include radio, local media outlets, and regional media outlets.

Recent coverage

- **New sky gardens set to improve patient experience through local partnership – SaTH**

Communications Update – social value

Community Skills Centre official opening held Thursday 11 December.

Delivered by VINCI Building – part of the joint venture with Integrated Health Projects (IHP) – in partnership with Shropshire Council, Enable Shropshire, SBC Training and other local organisations, the centre aims to create real opportunities for people who are currently unemployed or looking to develop new skills to support a career change. The first cohort of job seekers have undertaken a 6-week programme with the hope of gaining employment with IHP or one of their subcontractors after the Christmas period.

The space will also be available to be used by local educators and organisations in the region to **upskill those interested in a career in construction** and is bookable via the IHP team

IHP have also been busy **fundraising for SaTH Charity** – this includes a sponsored hike up Snowdon and a 24-hour cycling challenge. So far, they **have raised over £8,000.**
IHP also kindly gifted Christmas treats to our Chaplaincy Team. The Chaplains will deliver the presents to patients over the Christmas period.

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Thank you

Integrated Care System
Shropshire, Telford and Wrekin

The Shrewsbury and Telford Hospital NHS Trust

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

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.1.0	Continue to review current SATH internal governance structure to support oversight and assurance	Anna Milanec	Already started	31/03/2026	SaTH internal governance structure reviewed in line committee workplans.	**On track**
SaTH 4.1.9	Review level 2 finance governance reporting structure - execs to approve changes	Anna Milanec / Debbie Bryce	01/02/2025	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 on 3 September 2025 at the Financial Recovery Group (FRG) and approved at Finance Assurance Committee on 30 September 2025. **Action Complete**	**Complete & Evidence**
SaTH 4.1.11	Review level 2 Workforce governance reporting structure . - execs to approve changes	Anna Milanec / Debbie Bryce	02/04/2025	31/03/2026	This is rolling 12-month task to monitor for 2025/26. Strategic People Group Terms of Reference approved by PODAC 01 July 2025.	**On track**
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	Action complete for 2024/25 as monthly Integrated performance reports for 2024/25 submitted to each of the public board meetings 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 elements of the system performance and accountability framework developed and implemented						
SaTH 4.2.6	Carry out Board skills audit to include new board members.	Anna Milanec	01/09/2025	28/02/2026	SaTH Board skills audit has been undertaken 31 October 2025.	**Complete & Evidence**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH 4.2.7	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: SaTH and SCHT working towards a new shared leadership 'Group model'.	Deborah Bryce Anna Milanec	01/09/2025	31/03/2026 (pending confirmation of appointment of group members)	Group Transition Committee (a joint committee with ShropCom) established August 2025 with first meeting held in July to review terms of reference. Agenda, Minutes and complete meeting packs submitted. Existing Terms of Reference Template being utilised.	**On track**
SaTH 4.2.8	Pilot the Group People and OD Committee as the initial joint committee to unify workforce strategy, culture, and talent development.	Deborah Bryce	01/09/2025	31/01/2026	The first Group People and OD committee in common meeting was held on 24 November 2025, with a further meeting scheduled on 26 January 2026. November minutes submitted.	**Complete & Evidence**
SaTH 4.2.9	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 and 5.1.4).	Anna Milanec	01/09/2025	31/3/2026	Trust Board in common held between SaTH and Shropcom 23/09/2025. Group Transition Committee in place with Terms of Reference approved by the Board in public 11 September 2025 (in private: August 2025). Meeting papers submitted.	**On track**
SaTH 4.2.10	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 and Non-Executive Directors	Group Chair /Group CEO	01/09/2025	31/3/2026	In progress. Remuneration Committees to consider process and timeline.	**On track**
SaTH 4.2.11	Continue with joint Board Development sessions (SaTH/ShropCom) to build cohesion to greater facilitate close working together. Deliverable: Ongoing programme of	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 26 February 2026.	**On track**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
	joint Board Development sessions between SaTH and Shropcom, with documented outcomes demonstrating increased cohesion and strengthened collaborative working					
SaTH 4.2.12	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.	Jenny Fullard	01/05/2025	31/1/2026	Joint plan is in place and remains on track. An engagement event was held on 19 November 2025 at the AFC Telford football group for c.130 staff across both organisations. Further engagement activity is being planned for 2026.	**On track**
An agreed SATH and all STW provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning.						
SaTH 4.3.4	Approve new Risk Management Policy by SATH Board	Anna Milanec	01/01/2025	28/02/2026	The Risk Management Policy and Risk Management Strategy have been reviewed. Both were considered and agreed at Audit & Risk Assurance Committee on 24 November, prior to 15 January 2026 Board.	**On track**
SaTH 4.3.5	Review timing of each organisation's risk management strategy review	Anna Milanec	01/04/2025	31/01/2026	The same action for 2024/05 was closed. This new action is to show the continued improvement. *See 4.3.4 above.* Policy review is generally every three years; however, there may be earlier consideration as the Group Model progresses in 2026/27.	On track

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
SaTH elements of the PMO designed, implemented and functioning.						
SaTH 4.4.3	Continue to drive the delivery of a system PMO with all partners	Adam Winstanley	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. **Action Complete** Evidence submitted in preparation for the Evidence Review Panel meeting with the ICB/NHSE on 14 January 2026 for this action to be closed.	**Complete & Evidence**

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 2.
Summary of the progress against delivery of the SaTH Workforce and Leadership Improvement Plan 2025/26.

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**
2.1.1	Identify baseline and outturn forecast.	SB	01/12/2025	31/03/2026	Baseline and outturn forecast complete.	**Complete & Evidence**
2.1.2	Review known changes, service changes needed, and business cases approved from 2025/26.	BPs	01/01/2025	31/03/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.3	Outline any assumptions in terms of workforce metrics, turnover absence levels.	SB	01/12/2025	31/03/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.4	Populate Workforce Planning Template.	CM	01/02/2025	31/03/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.5	Calculate the % Change by Staff Group.	CM	01/02/2025	31/03/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.6	Challenge / Sense Check Data.	CM	01/03/2025	28/02/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.7	Review Data with Stakeholders (Divisional teams etc.).	SB	01/03/2025	28/02/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.8	Populate Master Template and Triangulate with Finance and Operations.	SB	01/03/2025	28/02/2026	In progress as part of operational plan timeline. First submission is now drafted ready for review and triangulation with activity and finance.	**On Track**
2.1.9	Final Sign Off - Board and NHSE.	RB	01/03/2025	31/03/2026	In progress as part of operational plan timeline.	**On Track**
2.1.10	Set up and deliver workshops with People and OD team and Divisional reps to identify the priority areas needed that support	SK	01/05/2025	31/03/2026	Discussion on progress at Finance committee / and Board Bimonthly HTP workforce report	**On track**

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**
	delivery of our workforce plan in line with HTP.					
2.1.11	Develop set of actions and milestones that links in with the workforce plan that supports each priority area with time frames and action owners.	SK	01/05/2025	31/03/2026	Bi-monthly 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 of the plan.	SB	02/12/2025	31/03/2026	In progress as part of operational plan timeline.	**On Track**
2.1.13	Capture risks to delivery of the 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	31/03/2026	In progress as part of operational plan timeline.	**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	31/03/2026	In progress as part of operational plan timeline.	**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	31/03/2026	System workforce group in place and KPI dashboard will continue and be updated once plan is finalised.	**On Track**
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. Increase from 2.4% to 30% with continued progress to improve compliance with West Midlands rates.	**On Track**
STW 2.1.26	E-Rostering implementation – medical workforce Phase 1.	Laura Carlyon	01/08/2025	31/03/2026	Progress made but full roll out of medical workforce is going to take minimum of 12 months. Key focus is on the resident doctor rosters as this is required for the newly introduced exception reporting due to go live	**On Track**

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**
					from 4th February.	
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	Conversation to be had with leads on fragile services and actions to be developed. Update provided from Chief Operating Officer – further discussion needed to agree specific actions.	**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**	**Progress**	**RAG Status**
2.2.3	Monitor delivery of strategy via our Strategic People Group. Monthly highlight reports used to demonstrate progress against milestones outline within the priority areas within our Board approved strategy. Ongoing monitoring.	SB	01/10/2024	31/03/2026	Strategy monitored at Strategic People Group.	**On Track**
2.2.5	A set of metrics are outlined with target KPI's that support improvement in workforce retention, unavailability and staff engagement.	SB	01/10/2024	31/01/2026	Will be part of operational plan submission.	**On Track**
2.2.6	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	31/03/2026	Will be part of operational plan submission.	**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**	**Progress**	**RAG Status**
2.2.7	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**
2.2.8	Deliver our cultural and leadership Programmes. Deliverables: 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	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 the Strategic People Group/ PODAC - Quarterly People Pulse Preparation for Group Communication & OD Engagement plans	**On Track**
2.2.9	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.	SB	01/04/2025	31/3/2026	Medical e-rostering continues to roll out having had meetings with Sherwood Forest NHS Trust who are supporting SaTH with our project. Manager self-service progressing in line with agreed project plan. Case being developed for introduction of 'Activity Manager' module to support e-rostering roll out.	**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**
5.1.8	Establish and operationalise an MSK provider collaborative between RJAH, SCHT, and SaTH to deliver integrated musculoskeletal services through shared governance, aligned pathways, and coordinated workforce planning. Deliverable: MSK provider collaborative (RJAH, SCHT, SATH).	TC/SL	New Task	31/01/2026	MSK provider collaborative in place	**Complete & Evidence**
5.1.9	Develop and implement collaborative acute provider arrangements with out-of-area partners (e.g. SaTH with UHNM and RJAH with ROH) to ensure integrated service delivery and patient care continuity across organisational boundaries. Deliverable: Acute provider arrangements without of area. providers e.g. SaTH and UHNM, RJAH and ROH.	TC/SL	New Task	31/01/2026	Acute provider contract arrangements with out of area. providers with SaTH and UHNM, RJAH and ROH.	**Complete & Evidence**

Metric 5.3: Demonstrate collaborative decision-making through the co-development and co-delivery of an System Integrated Improvement Plan that supports delivery of all the RSP exit criteria 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.						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
5.3.3	Ensure robust monitoring and oversight of delivery of all SaTH elements of SIIP via appropriate governance and operational structures (includes ward to board)	CEO SaTH	In progress	31/03/2026	Monthly progress reports submitted to the relevant assurance committees and the Trust Board. The 11th December Board meeting demonstrated the refreshed governance and operational structure from	**On track**

Metric 5.3: Demonstrate collaborative decision-making through the co-development and co-delivery of an System Integrated Improvement Plan that supports delivery of all the RSP exit criteria 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.						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
					board to ward which was presented and approved at the 11th December 2025 Board meeting.	
SaTH 5.3.4	Lead on system wide UEC workstream of SIIP	CEO, SaTH	Sept 2024	March 2026	CEO leads on the systemwide UEC workstream with monthly meetings taking place. Minutes of meetings available.	**On track**
SaTH 5.3.5	Deliver SaTH specific actions following the external assessments of collaborative decision making	CEO, SaTH	In progress	March 2026	UEC workstream with monthly meetings taking place monitoring actions with minutes of meetings available.	**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**
SaTH 5.4.1	Proactively participate in and contribute to System CEO OD Programme	CEO, SaTH	01/11/2024	31/3/2026	Two CEO OD Programme events have taken place.	**On track**
SaTH 5.4.2	Ensure Executive participation in the Executive Directors Development programme including initiating dialogue on shared expectations and collaborative leadership through STG.	CEO, SaTH	29/01/2025	31/3/2026	The Executive Directors Development Programme has initiated dialogue on shared expectations and collaborative leadership. Positive assurances include high engagement levels and actionable outcomes from facilitated sessions.	**On track**
5.4.4	Continued improvement of the workforce dashboard measures for SaTH and ShropCom.	EW/ SB	January 2025	31/3/2026	Annual Cultural dashboard ¼ People Pulse/ NSS IPR	**On track**
SaTH 5.4.5	Analyse pulse survey results and lead on development and delivery of associated action plan	DoHR & OD, SaTH	01/01/2025	31/3/2026	PODAC reports October 2025 Pulse survey results analysed and reported to Strategic People Group and PODAC. Inform strategy milestones to deliver our vision.	**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**

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	Annual refresh of MTFP and 5-year high level financial plan (including triangulation).	SaTH 1.1.2	AW	Commenced	31/01/2026	Annual refresh and triangulation complete in line with annual planning submission. Draft plan submitted 17/12/2025	**On Track**
	Ongoing monitoring of underlying position against MTFP and HTP assumptions.	SaTH 1.1.3	AW	Ongoing	31/03/2026	Ongoing - monthly review of underlying position which is reported to FAC and Board	**On Track**
	SaTH Demand and capacity model aligned to system model - 1 year model (Sept/Oct 24) 3-5 years (March 2026).	SaTH 1.1.4	AW	Ongoing	31/03/2026	Year 2 model	**On Track**
	Cashflow requirements matched to MTFP modelled (March 2026).	SaTH 1.1.5	AW	Ongoing	31/03/2026	Year 2 of 3-5 year financial plan (MTFP) in place.	**On Track**
	2025/26 Annual refresh of Joint Forward Plan (JFP). To maintain strategic alignment, accountability and responsiveness across the system.	STW 1.1.6	Nigel Lee	31/01/2026	31/03/2026		**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**
	Signed off LTFP High Level Model 10 year - SaTH/ICS/NHSE Metric -Alignment with ICS/NHSE financial sustainability requirements.	SaTH 1.1.8	AW	Ongoing	31/03/2026	System Long term plan – rolled over from 2024/25.	**On Track**
	Transformation Recovery plan trajectory based on Strategic transformation Programmes including HTP, LCP and Benchmarking opportunities updated in SaTH and system MTFP model (March 2026).	SaTH 1.1.9	AW	Ongoing	31/03/2026	This is based on Transformation Programmes and rolled over from 2024/25	**On Track**
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	25/26 Efficiency plan PIDs signed off by scheme leads and directors.	SaTH 1.2.1	AW	Ongoing	31/03/2026	Rolled over from 2024/25	**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**
	25/26 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions SaTH.	SaTH 1.2.11	AW	Ongoing	31/03/2026		**On Track**
	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	31/03/2026	£2.3m off plan at month 7. 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 Assurance Committee).	SaTH 1.2.24	Ned Hobbs	Ongoing	31/03/2026		**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	Update SaTH Estates Strategy.	SaTH 1.3.5	LW	Commenced	30/11/2025	This 2024/25 action has been transferred over on to the 2025/26 action plan as the Estates Strategy delivery date slipped from November 2024 due to consultation with modular wards. The Estates Strategy was approved at the Public Trust Board on 11 September 2024. Evidence submitted to the review panel that will take place in January 2026. **Action complete**	**Complete & Evidenced**
	Support system delivery of 25/26 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG.	SaTH 1.3.8	AW	30/04/2025	31/03/2026		**On Track**
Independent review of 'grip & control' - identifying SaTH's gaps (I&I phase 1 work) resulting in a plan to address gaps Follow up re-assessment review of 'grip & control'	Delivery against Phase 1 I&I organisation specific intervention action plans (Enhance vacancy scrutiny panels, temporary staffing controls and de-risking cost efficiency schemes). Monitored weekly and reported to ICS.	SaTH 1.4.2	AW	Commenced	30/11/2025	Evidence submitted to the evidence review panel in January 2026 for the action to be closed **Action complete**	**Complete & Evidenced**
	Follow up review of I&I actions to ensure continued delivery.	SaTH 1.4.4	AW	30/08/2025	30/11/2025	Revised end date from 31/10/2025. Completed and monitored through FRG. Evidence submitted to the evidence review panel in December 2025 for the action to be closed **Action complete**	**Complete & Evidenced**

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**
Independent review of 'grip & control' - identifying SaTH's gaps (I&I phase 1 work) resulting in a plan to address gaps Follow up re-assessment review of 'grip & control'	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	31/12/2025	Completed in 2024-25 and in the process of being refreshed for 2025-26. Internal Audit to review in Q3. **Action complete**	**Complete & Evidenced**
	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 audit report recommendations	SaTH 1.4.8	AW	Ongoing	31/03/2026		**On Track**
	Individual organisational tracking of timely completion of external audit actions (Monthly).	SaTH 1.4.9	AW	Ongoing	31/03/2026		**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**
	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

The Shrewsbury and Telford Hospital NHS Trust

3.1	Deliverable: Deliver SaTH elements/ benefits of the System led UEC Improvement Plan 2025/26					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.1	Deliver SaTH specific workstreams	Ned Hobbs	01/04/2024	31/03/2026	Workstreams are progressing and have been revised as part of the updated UEC plan 2025/26	**On Track**
SaTH 3.1.2	Actively engage with and make a marked contribution to system wide workstreams	Ned Hobbs	01/04/2024	31/03/2026	The deliverable is on track as part of the System-led UEC Improvement Plan 2025/26. Evidence includes meeting minutes and performance reports confirming active engagement and contribution to system-wide workstreams.	**On Track**

SaTH 3.1b	Deliverable: 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	01/10/2024	31/03/2026	November utilisation of UTC reached 20% which is a positive improvement but still short of the 25% target. A Standard Operating Procedure (SOP) has been finalised to improve uptake of return appointments, which should help drive further utilization.	**At Risk**
SaTH 3.1.1.3	Implement further GP direct access speciality pathways across women's and children's services	Zain Siddiqui	12/05/2024	28/02/2026	Pathways are in place for early pregnancy. Further pathways are under development with 111, Shropdoc and WMAS.	**On Track**
SaTH 3.1.1.4	Implement further GP direct access speciality pathways across surgical services	Andrena Weston	02/04/2025	28/02/2026	Referrals to surgery are being taken by SAU from the CCC. I&D pathway in place, Breast patient pathway in place, Pancreatitis pathway in place,	**On Track**

					diverticulitis pathway in place. Evidence submitted to support and awaiting approval at the next Evidence Review Panel meeting on 14 January 2026. A pathway review session took place on 07/11/2025 between Divisional representatives and Health Hero. New pathways are under development for 2025/26.	
SaTH 3.1.1.5	Improve productivity of Minors	Rebecca Race Rebecca Houlston	3/07/2024	31/03/2026	4-hour performance in minors improved further to 88.7% in November 2025.	**On Track**
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) Improved wait to be seen metrics	Rebecca Race	01/07/2025	31/03/2026	Waiting times averaged at 124 minutes in November 2025. It is anticipated that the increased bed base will have a positive impact on ED wait times by increasing available capacity in ED.	**At Risk**
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	The Staff survey submission is now closed, and the results are expected in March 2026.	**On Track**
SaTH 3.1.1.9	Reduction in the number of UTC hand backs	Rebecca Houlston	01/07/2025	31/03/2026	A Standard Operating Procedure (SOP) which will reduce the number of hand backs via return appointments has been finalised.	**On Track**
3.1.1.10	Embedding of Initial Assessment clinical model to achieve 75% performance	Emma Harber	01/07/2025	31/03/2026	Cross site test of change has taken place with improvements shown at both sites following the implementation of escalation action cards to mitigate delays during periods of high demand.	**At Risk**
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 (Superseded by 3.1.5.5) Deliverable: Launch of frailty SDEC PRH.	Tom Phelps	01/07/2025	28/02/2026	The Frailty SDEC at PRH has now launched.	**On Track**

SaTH 3.1.1.12	Improvement in UTC 4 hour performance to >90%	Rebecca Houlston	01/07/2025	31/03/2026	November 2025 performance was 86.1%. Recruitment into UTC continues. Performance is close to the target and trending in the right direction.	**At Risk**
3.1.2b	**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	31/03/2026	The Trust has not improved response times to referrals on AMU and Medical Wards therefore a delivery date has been requested and extended to 31/03/2026. A Cardiology Recovery Plan has been developed to improve response times. This has been submitted as evidence	**At Risk**
SaTH 3.1.2.3	Reconfiguration of bed base on PRH site to expand acute medical beds to align with demand	Susanne Crossley	01/11/2024	31/01/2026	Ward moves are ongoing to support the bed base reconfiguration. The working group continues to meet weekly, and the work remains on track for delivery.	**On Track**
SaTH 3.1.2.4	Recruitment following reconfiguration of Cardiorespiratory to optimise diagnostics.	Nina Moran	31/05/2024	28/02/2026	Cardiorespiratory service has transferred to Clinical Support Services division. Recruitment has continued and is ongoing to a number of different roles.	**On Track**
SaTH 3.1.2.7	Therapies - review stroke pathways - implement business case - follow up action on business case and recruitment from 24/25.	Emma Weaver	01/07/2024	31/01/2026	Demand and Capacity modelling to be completed by 31/01/2026 with a view to task completion.	**At Risk**
SaTH 3.1.2.8	Radiology- Gap analysis against proposed 12hr turnaround - follow-up action on business case and recruitment from 24/25 and show sustained improvement in 2025/26	Helen Williams	01/04/2025	31/01/2026	Radiology 12hr turnaround data shows improvement.	**Completed & Evidenced**
SaTH 3.1.2.9	Radiology: 12hr turnaround draft proposal including procedures and SOP	Helen Williams	01/04/2025	31/01/2026	Data to be presented at the Evidence Provider Review meeting in January 2026 to show sustained improvement.	**Completed & Evidenced**
SaTH 3.1.2.10	Pharmacy - Development of business case for Pharmacy staff in ED - follow up on business case and recruitment from 24/25 and show sustained	Imran Hanif	01/07/2025	31/01/2026	• The plan includes 2.41 WTE Pharmacists (Band 8a), Pharmacy Assistants (Band 6), and	**On Track**

	improvement in 2025/26.				Pharmacy Technicians (Band 4) to support ED operations. • Recruitment activity WAS initiated in 24/25 and continues into 2025/26 to ensure full establishment.	
SaTH 3.1.2.12	Pathology - Recruitment of additional posts to extend out of hours provision'	Adrian Verdee	01/11/2024	28/02/2026	Posts have been recruited to, evidence submitted for consideration	**On Track**
SaTH 3.1.2.15	Increase in patients referred to Medical SDEC of 5%	Liz Slevin	01/07/2025	31/03/2026	Improvements to SDEC performance continue with a November 2025 performance of 41.1% despite a reduction in admission to the bed base to 18.2%. Escalation document being tested to mitigate risk of closure during periods of high demand	**Completed & Evidenced**
SaTH 3.1.2.16	Implementation of back pain pathway	Andrew Evans	01/07/2025	31/03/2026	Work to develop the overnight MRI service (to be launched January 2026) continues	**At Risk**
SaTH 3.1.2.17	Reduction in 14 day / 21-day inpatient length of stay	Alison Vaughan	01/07/2025	31/03/2026	November showed a higher number of NCTR patients in SaTH, an average of 137. 14 day LOS remained stable with increases shown in 21 day LOS.	**At Risk**
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	Planning for the ATA service continues as part of the bed base reconfiguration work which will provide streaming opportunities for orthopaedic patients.	**Completed & Evidenced**
3.1.2.19	Improvement in pre 08:45 Discharge Lounge utilisation.	Alison Vaughan	01/07/2025	31/03/2026	Recruitment to support extended hours for the Discharge Lounge continues. RSH Discharge lounge has been relocated. Extended opening hours are approved.	**On Track**
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	Rebecca Houlston/ Angela Raynor/ Claire Evans	01/08/2024	31/03/2026	Engagement from Surgery, Medicine and ED with the ICCC is ongoing and embedded within the system-led UEC Improvement Plan for 2025/26. The ICCC has been enhanced through multi-agency teamwork, signposting patients to alternative care settings and reducing unnecessary ED attendances. This is a central principle of the improvement programme for 2025/26.	**On Track**

					Integrated Care Coordination Working Group established, chaired by senior leaders, with representation from ED, Surgery, Medicine and system partners. ICCC handled an average of 1,528 cases per month in 2024/25, a 38% increase compared to the previous year. Increased referrals to community pathways, Virtual Ward and Urgent Community Response teams to optimise flow and discharge processes.	
SaTH 3.1.3.2	Engagement with ICCC and development of STW integrated urgent care model	Ned Hobbs	01/10/2024	31/03/2026	• ICCC engagement plan is fully aligned with STW urgent care model objectives. • Pathway redesign deliverables have been defined, covering key areas such as ED streaming, virtual ward referrals, and urgent community response integration.	**On Track**
3.1.4	**Working with system partners to deliver system frailty**					
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Status**
SaTH 3.1.4.1	Continued engagement from surgery, medicine and ED with the Integrated Care Coordination Centre.	Alison Vaughan	01/08/2024	31/03/2026	• ICCC engagement extended to frailty-specific pathways, supporting complex discharge planning and integration with community frailty teams. • Deliverables include improved referral processes to Virtual Ward and Urgent Community Response teams, reducing patients with stays over 14 and 21 days. • Alignment with system-wide frailty strategy ensures consistency across acute and community services.	**On Track**

SaTH 3.1.4.3	Improving the data quality of ECDS to support identification of further alternative opportunities	Rebecca Houlston	01/11/2024	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.	**At Risk**
STW 3.1.4.11	Frailty Clinical advice & guidance line as part of the FAU offer,	Tom Phelps	20/05/2024	28/02/2026	Advice and Guidance line is launched but uptake is low. A relaunch plan will be put in place following the opening of Frailty SDEC at PRH	**On Track**
SaTH 3.1.4.12	Frailty intervention team extended hours	Tom Phelps	12/06/2024	28/02/2026	Frailty SDEC has now been launched at PRH and provides extended service hours	**On Track**
3.1.5	**Deliverable: Working with System partners to deliver system discharge alliance plan to reduce NCTR 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**
3.1.5.4	Review Welsh documentation and link with Powys	Tom Phelps	10/02/2024	31/12/2025	Evidence submitted of Powys documentation post-review with a view to action closure	**Completed & Evidenced**
3.3	**Deliver UEC specific actions as per the Quality Improvement Plan including CQC must/should do's**					
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.	Liz Slevlin	01/05/2024	31/03/2026	The elements of the QIP are monitored through various governance forums and reported through to the Quality Safety Assurance Committee (QSAC) and the Board.	**On Track**
SaTH 3.3.2	To reduce initial assessment time exceeding 15 minutes	Liz Slevin	01/05/2024	31/03/2026	Cross site test of change has taken place with improvements shown at both sites following the implementation of escalation action cards to mitigate delays during periods of high demand	**On Track**
SaTH 3.3.3	Improve Mean ambulance handover time	Susanne Crossly	01/04/2025	31/03/2026	A new process has been drafted to improve ambulance handover time with a clear escalation policy and an immediate offload cut off point. The process will be piloted in January 2026	**On Track**
SaTH 3.3.4	Providing additional core and winter bed capacity (RSH)	Susanne Crossly	01/04/2025	31/03/2026	Wards 38 and 39 have now opened with estates work underway to support the opening of additional MEC capacity on ward 25.	**On Track**

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	Work continues in partnership with Medicine to reduce inappropriate referrals including adjustments to clerking documents and planned work to avoid deconditioning of inpatients	**At Risk**
SaTH 3.4.2	Review and implement assessment area for acute Oncology presentation	Sally Hodson	01/07/2025	31/03/2026	Working group established to support the ongoing improvements. The pilot of the haematology assessment bay continues.	**Completed & Evidenced**

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Metric ID	Deliverable Owner	Improvement Plan	Task ID	Task	Task is linked to RSP exit	Task Owner	Type of change requested	Original End Date	Revised End Date Requested	Case for change	Date change considered by SDM	Decision	
1.1	Adam Winstanley	Finance	SaTH 1.1.2	Annual refresh of MTFP and 5-year high level financial plan (including triangulation)	Yes	Adam Winstanley	New Task		31/01/2026	This is a 5 year high level financial plan and is the second year, therefore rolled over from 2024/25.			
1.1	Adam Winstanley	Finance	SaTH 1.1.3	Ongoing monitoring of underlying position against MTFP and HTP assumptions	Yes	Adam Winstanley	Revise end date	31/03/2025	31/03/2026	Essential to ensure sustainable financial sustainability, early risk detection and strategic alignment ensuring ongoing monthly review of underlying position. This task is repeated on an annual basis for 3 years, therefore a repeat task and a revised end date requested for 2026.			
1.1	Adam Winstanley	Finance	SaTH 1.1.4	SaTH Demand and capacity model aligned to system model - 1 year model (Sept/Oct 24) 3-5 years (Mar 25).	Yes	Adam Winstanley	New Task		31/03/2026	This is a 3 -5 year plan and is the second tear so rolled over from 2024/25. This task is repeated on an annual basis for 3 years. Repeated for 2025/26.			
1.1	Adam Winstanley	Finance	SaTH 1.1.5	Cashflow requirements matched to MTFP modelled. (Mar 25)	Yes	Adam Winstanley	Revise end date	31/03/2025	31/03/2026	This is a 3 -5 year plan and is the second year of MTFP so rolled over from 2024/25. This task is repeated on an annual basis for 3 years. Therefore a revised end date requested.			
1.1	Nigel Lee	Finance	STW 1.1.6	2025/26 Annual refresh of Joint Forward Plan. To maintain strategic alignment, accountability and responsiveness across the system.	Yes	Nigel Lee	New Task		31/03/2026	Transferred over from the STW plan. However the Trust can only be held to account for its contribution to the joint plan.			
1.1	Adam Winstanley	Finance	SaTH 1.1.8	System and NHSE sign off of LTFP	Yes	Adam Winstanley	New Task		31/03/2026	Internal SaTH sign off in 2024/25, system and NHSE slipped into 2025-26. Part of the Transformation recovery programme. Task is repeated on an annual basis for 3 years. Repeated for 2024-26			
1.1	Adam Winstanley	Finance	1.1.9	Transformation Recovery plan trajectory based on Strategic transformation Programmes including HTP, LCP and Benchmarking opportunities updated in SaTH and system MTFP model (Mar 2026).	Yes	Adam Winstanley	New Task		31/03/2026	This is a repeat task based on Transformation Programmes so rolled over from 2024/25 as part of the 2025/26 Transformation Programmes.			
1.2	Adam Winstanley	Finance	SaTH 1.2.1	25/26 Efficiency plan PIDs signed off by scheme leads and directors	Yes	Adam Winstanley	New Task		31/03/2026	This is the second year so rolled over from 2024/25 as part of the 2025/26 efficiency plan.			
1.2	Adam Winstanley	Finance	SaTH 1.2.11	25/26 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions	Yes	Adam Winstanley	Revise end date	01/01/2025	31/03/2026	A repeat task for 2025/26 acuity plan to demonstrate sustained improvements.			
1.2	Adam Winstanley	Finance	SaTH 1.2.23	In year monitoring of financial performance against plan assumptions identifying escalation actions where needed (oversight through OPOG, FRG and Finance Committee	Yes	Adam Winstanley	Revise end date	Ongoing	31/03/2026	Moved from ongoing and applied an end date.			
1.2	Adam Winstanley	Finance	SaTH 1.2.24	Monitor ongoing demand & capacity actuals against plan assumptions identifying escalation actions where needed (oversight through OPOG and Performance Assurance Committee)	Yes	Ned Hobbs	Revise end date	Ongoing	31/03/2026	Moved from ongoing and applied an end date.			
1.3	Adam Winstanley	Finance	SaTH 1.3.5	Update SaTH Estates Strategy	Yes	Inese Robotham	Revise end date	30/11/2024	30/11/2025	This 2024/15 action has been transferred over on to the 2025/26 action plan as the Estates Strategy delivery date slipped from November 2024 due to consultation with modular wards. The Estates Strategy was approved at the Public Trust Board on 11 September 2024. Evidence submitted to the ERP in December 2025. Action completed.			
1.4	Adam Winstanley	Finance	SaTH 1.4.4	Follow up review of I&I actions to ensure continued delivery	Yes	Adam Winstanley	Revise end date	31/10/2025	30/11/2025	Evidence submitted for 2024/25 action to the evidence review panel in December 2025 and awaiting approval. Completed and monitored through FRG.			
1.4	Adam Winstanley	Finance	SaTH 1.4.5	External review of individual organisation assessment against NHSE grip and control checklist & HFMA Financial Sustainability checklist and efficacy of controls.	Yes	Adam Winstanley	New Task		31/12/2025	Completed in 2024-25 and in the process of being refreshed for 2025-26. Internal Audit to review in Q3. Repeated task for 2025-26 to demonstrate sustained improvement. Rolled over as this action is being refreshed for 2025/26.			
4.1	Anna Milanec	Governance	SaTH 4.1.9	Review level 2 finance governance reporting structure - execs to approve changes	Yes	Anna Milanec Debbie Bryce	Revise end date	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 have been drafted for Financial Recovery Group (FRG) and are due for review at FRG on 3 September 2025 followed by the Finance Assurance Committee on 30 September 2025. Trust board meeting 13th November 2025. Evidence submitted to the ERP in December 2026 and awaiting approval. Action completed. Task rolled over for 2025/26.			
4.1	Anna Milanec	Governance	SaTH 4.1.11	Review level 2 Workforce governance reporting structure - Execs to approve changes	Yes	Anna Milanec Debbie Bryce	Revise end date	31/03/2025	31/03/2026	Repeated task for 2025/26. This is a rolling 12 month task to monitor for 2025-26 therefore a request for a revised end date.			
4.1	Anna Milanec	Governance	SaTH 4.1.14	Reporting from collaborative workstreams into SATH governance to commence	Yes	Anna Milanec	Remove task	30/01/2026	n/a	Request to be descoped and cross referenced and replaced with SaTH 4.2.9.			
4.2	Jo Williams	Governance	SaTH 4.2.5	SaTH Board to consider and approve TOR / MOU / appropriate delegations to enable the creation and operation of provider collaborative arrangements	Yes	Anna Milanec	Remove task	31/03/2025	n/a	This now a more substantial piece of work following the development of the group model with Shropcom, for which all documents and frameworks will need to be created. To be descoped and replaced with SaTH 4.2.7 and 4.2.8.			
4.2	Anna Milanec	Governance	SaTH 4.2.6	Carry out Board skills audit to include new board members.	No	Anna Milanec	New Task	28/02/2026	n/a	New task to reflect latest requirements and previous developments.			
4.2	Anna Milanec	Governance	SaTH 4.2.7	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: SaTH and SCHT working towards a new shared leadership 'Group model'.	No	Anna Milanec / Deborah Bryce	New Task		31/03/2026	New task and deliverable to reflect latest requirements and previous developments. This task was added to new plan 2025-26 - for approval. 31st March 2026 end date pending confirmation of group members.			
4.2	Anna Milanec	Governance	SaTH 4.2.8	Pilot the Group People and OD Committee as the initial joint committee to unify workforce strategy, culture, and talent development.	No	Deborah Bryce	New Task		n/a	New task to reflect latest requirements and previous developments.			
4.2	Anna Milanec	Governance	SaTH 4.2.9	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).	No	Anna Milanec	New Task		n/a	New task and deliverable to reflect latest requirements and previous developments.			

4.2	Anna Milanec	Governance	SaTH 4.2.10	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 and Non-Executive Directors.	No	Group Chair / Director of Governance	New Task		n/a	New task and deliverable to reflect latest requirements and previous developments. Added NEDs within the same action.			
4.2	Anna Milanec	Governance	SaTH 4.2.11	Continue with joint Board Development sessions (SaTH/ShropCom) to build cohesion to greater facilitate close working together.	No	Group Chair / Director of Governance	New Task		n/a	New task and deliverable to reflect latest requirements and previous developments.			
4.2	Jo Williams, CEO	Governance	SaTH 4.2.12	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.	No	Jenny Fullard	New Task		n/a	New task and deliverable to reflect latest requirements and previous developments.			
4.3	Anna Milanec	Governance	SaTH 4.3.3	Engage with STW Provider Governance Leads to co-ordinate implementation of risk register accessible to all	Yes	Anna Milanec	Remove task	Started	45838	This was a conscious decision with the STW providers not to progress with the implementation of a risk register accessible to all. Therefore request to remove this task.			
4.3	Anna Milanec	Governance	SaTH 4.3.4	Approve new Risk Management Policy by SATH Board.	No	Anna Milanec	Revise end date	45747	46081	The current Risk Management Policy is still in date, therefore it has only recently been reviewed. The Risk management policy has been to the policy group and ARAC. It is next to go to SaTH Board for approval in February 2026, Therefore a revised end date is requested.			
4.3	Anna Milanec	Governance	SaTH 4.3.5	Review timing of each organisation's risk management strategy review.	Yes	Anna Milanec	Revise end date	45748	46053	The same action for 2024/05 was closed. This repeated action for 2025/26 is to show the continued improvement.			
5.1	CEO, SaTH	leadership	SaTH 5.1.1	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of UEC	Yes	COO, SaTH	Remove task			Agreed by NHSE to be removed, as provider collaborative no longer relevant and these deliverables have been replaced with other deliverables linked to the development of a group model.			
5.1	CEO, SaTH	leadership	SaTH 5.1.2	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of Finance	Yes	DoF, SaTH	Remove task			Agreed by NHSE to be removed, as provider collaborative no longer relevant and these deliverables have been replaced with other deliverables linked to the development of a group model.			
5.1	CEO, SaTH	leadership	Sath 5.1.3	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of Workforce	Yes	DoHR &OD, SaTH	Remove task			Agreed by NHSE to be removed, as provider collaborative no longer relevant and these deliverables have been replaced with other deliverables linked to the development of a group model.			
5.1	CEO, SaTH	leadership	SaTH 5.1.4	Deliver SaTH specific actions following the external assessments of the effectiveness of the Provider Collaborative	Yes	CEO SaTH	Remove task			Agreed by NHSE to be removed, as provider collaborative no longer relevant and these deliverables have been replaced with other deliverables linked to the development of a group model.			
5.1	CEO, SaTH	leadership	SaTH 5.1.5	Agree and approve the scope of the provider collaborative and the necessary arrangements (including delegations) via SATH governance arrangements	Yes	CEO and Dir of Gov SATH	Remove task			Agreed by NHSE to be removed, as provider collaborative no longer relevant and these deliverables have been replaced with other deliverables linked to the development of a group model.			
5.1	TC/ SL	leadership	SaTH 5.1.8	Establish and operationalise an MSK provider collaborative between RJAH, SCHT, and SaTH to deliver integrated musculoskeletal services through shared governance, aligned pathways, and coordinated workforce planning. Deliverable: MSK provider collaborative (RJAH, SCHT, SATH).	Yes	TC/ SL	New Task			New task to reflect MSK Provider Collaborative latest requirements and previous developments.			
5.1	TC/ SL	leadership	SaTH 5.1.9	Develop and implement collaborative acute provider arrangements with out-of-area partners (e.g., SaTH with UHNM and RJAH with ROH) to ensure integrated service delivery and patient care continuity across organisational boundaries. Deliverable: Acute provider arrangements without of area. providers e.g. SaTH and UHNM, RJAH and ROH.	Yes	TC/ SL	New Task			New task to reflect provider collaborative arrangements with out of area partners.			
5.3	CEO, SaTH	leadership	SaTH 5.3.3	Ensure robust monitoring and oversight of delivery of all SaTH elements of SIIP via appropriate governance and operational structures (ward to board).	Yes	CEO, SaTH	Amend Wording	31/03/2026		Wording changed to - Ensure robust monitoring and oversight of delivery of all SaTH elements of SIIP via appropriate governance and operational structures (ward to board). Added ward to board to demonstrate flow of information.			
5.4	CEO, SaTH	leadership	5.4.2	Ensure Executive participation in the Executive Directors Development programme including initiating dialogue on shared expectations and collaborative leadership through STG.	Yes	CEO, SaTH	Amend Wording	31/03/2026		Request for a change of wording to include additional text highlighted in red. Ensure Executive participation in the Executive Directors Development programme 'including initiating dialogue on shared expectations and collaborative leadership through STG.'			
5.4	CEO, SaTH	leadership	SaTH 5.4.4	Continued improvement of the workforce dashboard measures for SaTH and Shropcom.	Yes	DoHR &OD, EW, SB SaTH	Amend Wording	31/03/2025	31/03/2026	Also requesting a revised end date from August 2025 to 31 March 2026. Wording change requested from: Analyse staff survey results and lead on development and delivery of associated action plan to read: Continued improvement of the workforce dashboard measures for SaTH and ShropCom.			
5.4	CEO, SaTH	leadership	SaTH 5.4.5	Analyse pulse survey results and lead on development and delivery of associated action plan	Yes	DoHR &OD, EW SaTH	New Task		31/03/2026	Annual repeat task so put in the plan for 25/26 as a new task.			
3.1.1	Ned Hobbs	UEC	SaTH 3.1.1.1	Was 'Review and recommission UTC provision to increase utilisation' for 25/26 this action now reads - Increase in utilisation of UTC to 25%	Yes	Rebecca Houlston	Amend Wording	01/04/2025	31/03/2026	Also a request for a change in end date. Originally was deliver by 01/04/2025. Task updated to reflect the revised UEC plan 2025/26 and latest requirements of the operational plan and previous developments.			
3.1.1	Zain Siddiqui	UEC	SaTH 3.1.1.3	Implement further GP direct access speciality pathways across women's and children's services	Yes	Zain Siddiqui	Revise end date	01/04/2025	28/02/2026	Revised end date as no update presented at the November 2025 evidence review panel. New pathways are under development for 2025/26 with 111, Health Hero and WMAS. Pathways for 2024/25 are in place for early pregnancy.			
3.1.1	Andrena Weston	UEC	SaTH 3.1.1.4	Implement further GP direct access speciality pathways across surgical services	Yes	Andrena Weston	New Task		28/02/2026	Revised end date as no update presented at the November 2025 evidence review panel. New pathways are under development for 2025/26. Pathways for 2024/25 are in place Referrals to surgery are being taken by SAU from the CCC. I&D pathway in place, Breast patient pathway in place, Pancreatitis pathway in place, diverticulitis pathway in place. Evidence submitted to support. Pathway review session took place on 07/11/2025 between Divisional representatives and Health Hero.			
3.1.1	Rebecca Race / Rebecca Houlston	UEC	SaTH 3.1.1.5	Improve productivity of Minors	Yes	Rebecca Race / Rebecca Houlston	Revise end date	01/01/2025	31/03/2026	New task added.			

3.1.1	Ned Hobbs	UEC	SaTH 3.1.1.7	Reduction in time patients wait to be seen by an ED clinician to 60 minutes (national target)	Yes	Rebecca Race	New Task		31/03/2026	New task to reflect revised UEC plan and latest requirements and previous developments.			
3.1.1	Ned Hobbs	UEC	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	No	Hannah Walpole	New Task		31/03/2026	New task to reflect revised UEC plan and latest requirements and previous developments.			
3.1.1	Ned Hobbs	UEC	SaTH 3.1.1.9	Reduction in the number of UTC hand backs	No	Rebecca Houlston	New Task		31/03/2026	New task to reflect revised UEC plan and latest requirements and previous developments.			
3.1.1	Ned Hobbs	UEC	SaTH 3.1.1.10	Embedding of Initial Assessment clinical model to achieve 75% performance	No	Emma Harber	New Task		31/03/2026	New task to reflect revised UEC plan and latest requirements and previous developments.			
3.1.1	Tom Phelps	UEC	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	No	Tom Phelps	New Task		28/02/2026	New task to reflect the revised UEC plan. Directly supports improved care delivery, system efficiency and patient outcomes.			
3.1.1	Ned Hobbs	UEC	SaTH 3.1.1.12	Improvement in UTC 4 hour performance to >90%.	Yes	Rebecca Houlston	New Task		No Change	New task added.			
3.1.2	Ned Hobbs	UEC	3.1.2.1	Improve response time to referrals on the AMU and medical wards (currently 24hrsin 24/25) by cardio and respiratory	Yes	Saskia Jones-Perrott	Revise end date	30/04/2025	31/03/2026	Not achieved in 2024/25 so revised end date requested.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.2	Review effectiveness of the Admission and Referral Protocol following relaunch	Yes	Steve McKew	Remove task	24/05/2024	30/04/2025	IPS Workstream has been put on hold until September 2026 therefore this task will not be delivered by March 2026. Request to remove and descope.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.3	Reconfiguration of bed base on PRG site to expand acute medical beds to align with demand	Yes	~~Laura Graham~~ Susanne Crossley	Revise end date	01/07/2025	31/01/2026	Not achieved in 2024/25 so requested a revised end date. Directly supports improved care delivery, system efficiency and patient outcomes.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.4	Recruitment following reconfiguration of Cardiorespiratory to optimise diagnostics.	Yes	~~Tom Phelps~~ Nina Moran	Revise end date	31/03/2025	28/02/2026	Not achieved in 2024/25 so requested a revised end date. Cardiorespiratory service has transferred to Clinical Support Services division and recruitment has continued and is ongoing to a number of different roles.			
3.1.2	Ned Hobbs	UEC	3.1.2.7	Therapies - review stroke pathways - implement business case - follow up action on business case and recruitment from 24/25.	Yes	Emma Weaver	Revise end date	31/12/2024	31/01/2026	Revised end date requested. Wording of the task changed from: Therapies - Review Stroke Pathways considering the opportunities as outlined in the CQC report. To: Therapies - review stroke pathways - implement business case - follow up action on business case and recruitment from 24/25.			
3.1.2	Ned Hobbs	UEC	3.1.2.8	Radiology- Gap analysis against proposed 12hr turnaround - follow-up action on business case and recruitment from 24/25 and show sustained improvement in 2025/26	Yes	Emma Weaver	Revise end date	31/10/2024	31/01/2026	Revised wording of description added in 'follow-up action on business case and recruitment from 24/25'. Picked up in evidence review panel of 24/25 and closed action as Radiology 12hr turnaround data shows improvement. This is a follow up action for 25/26 plan to demonstrate sustainability of the 12 hour turnaround times.			
3.1.2	Helen Williams	UEC	SaTH 3.1.2.9	Radiology: 12hr turnaround draft proposal including procedures and SOP	Yes	Helen Williams	Revise end date	30/11/2024	30/01/2026	Didn't go to panel in November 2025 so extension requested.			
3.1.2	Ned Hobbs	UEC	3.1.2.10	Pharmacy - Development of business case for Pharmacy staff in ED - follow up on business case and recruitment from 24/25 and show sustained improvement in 2025/26	Yes	Imran Hanif	New Task		31/01/2026	Picked up in review of 24/25 closed action following additional evidence submitted. This has been completed = business case approved and Pharmacy staff recruited. Evidence submitted and additional evidence approved on 2/12/2025. New action for 2025/26 for sustained improvement.			
3.1.2	Adrian Vreede	UEC	SaTH 3.1.2.12	Pathology – recruitment to extend out of hours provision	Yes	Adrian Vreede	Revise end date	31/03/2025	28/02/2026	Revised end date requested to provide additional time to complete.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.15	Increase in patients referred to Medical SDEC of 5%	No	Liz Slevin	New Task		n/a	New task to reflect revised UEC plan for 2025/66 and latest requirements and previous developments. Reducing unnecessary admissions and enhancing care delivery.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.16	Implementation of back pain pathway	No	Andrew Evans	New Task		n/a	New task to reflect revised UEC plan for 2025/26 and latest requirements and previous developments. Reducing unnecessary admissions and enhancing care delivery			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.17	Reduction in 14 day /21-day inpatient length of stay	No	Alison Vaughan	New Task		n/a	New task to reflect revised UEC plan for 2025/26 and latest requirements and previous developments. Reducing unnecessary admissions and enhancing care delivery.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.18	Increasing Streaming opportunities to alternative pathways (Direct Access to specialties) by 5%	No	Susanne Crossley	New Task		n/a	New task to reflect revised UEC plan for 2025/26 and latest requirements and previous developments. Reducing unnecessary admissions and enhancing care delivery.			
3.1.2	Ned Hobbs	UEC	SaTH 3.1.2.19	Improvement in pre 08:45 Discharge Lounge utilisation	No	Alison Vaughan	New Task		n/a	New task to reflect revised UEC plan for 2025/26 and latest requirements and previous developments. Reducing unnecessary admissions and enhancing care delivery.			
3.1.3	Ned Hobbs	UEC	SaTH 3.1.3.1	Continued engagement from surgery, medicine and ED with the Integrated Care Coordination Centre	Yes	Alison Vaughan	Amend Wording	31/03/2026	No change	Request to change wording from: Continued engagement from surgery, medicine and ED with the Care Transfer Hub to: Continued engagement from surgery, medicine and ED with the Integrated Care Coordination Centre.			
3.1.3	Ned Hobbs	UEC	SaTH 3.1.3.2	Engagement with ICCC and development of STW integrated urgent care model	No	Ned Hobbs	New Task		31/03/2026	New task requested.			
3.1.4	Ned Hobbs	UEC	SaTH 3.1.4	Now 2025/26: Working with system partners to deliver system frailty. Was: 2024/25 deliverable Working with system partners to deliver the alternatives to ED attendances/ admissions and Care Coordination .	Yes	Ned Hobbs	Amend Wording		n/a	Was STW System task 3.1.5 in 2024/25 plan.			
3.1.4	Ned Hobbs	UEC	3.1.4.2	Be a key stakeholder in the development of the STW integrated urgent care model	Yes	NH/JW	Remove task			Task superseded by another deliverable.			
3.1.4	Ned Hobbs	UEC	SaTH 3.1.4.3	Improving the data quality of ECDS to support identification of further alternative opportunities	Yes	Rebecca Houlston	Revise end date	31/03/2025	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	Tom Phelps	UEC	STW 3.1.4.11	Frailty Clinical advice & guidance line as part of the FAU offer.	No	Tom Phelps	Revise end date	03/01/2025	28/02/2026	New task, strengthens access and coordination and quality of care for frailty patients. In line with NHSE Alignment of UEC Improvement Delivery Plan (System-Level).			
3.1.4	Tom Phelps	UEC	STW 3.1.4.12	Frailty intervention team extended hours.	Yes	Tom Phelps	New Task	28/02/2026		New task requested.			
3.1.5	Tom Phelps	UEC	SaTH 3.1.5.4	Review Welsh documentation and link with Powys	Yes	Tom Phelps	Revise end date	31/03/2024	31/12/2025	Discharge pathway SOP for Powys, post review, date extended. Evidence submitted of Powys documentation to the ERP and awaiting confirmation of closure.			

3.1.5	Ned Hobbs	UEC	SaTH 3.1.5.5	Continued engagement from surgery, medicine and ED with the development of a fully integrated frailty pathway	Yes	Rebecca Houlston Angela Raynor Claire Evans	Remove task	31/03/2026	n/a	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". Implementation of Frailty SDEC is the current priority.			
3.3	Liz Slevin	UEC	SaTH 3.3.1	Deliver QIP in line with agreed timescales	Yes	Liz Slevin	Revise end date	01/04/2025	31/03/2026	Revised end date requested.			
3.3	Liz Slevin	UEC	SaTH 3.3.2	To reduce initial assessment time exceeding 15 minutes.	Yes	Liz Slevin	New Task		31/03/2026	Added action and added to the deliverable. This action is In line with NHSE Alignment of UEC Improvement Delivery Plan (System-Level). Changed task owner. Added action - UEC Delivery Group reporting. Added to the Deliverable: Deliver QIP in line with agreed timescales - Escalation process to mitigate risk of exceeding 15 minutes initial assessment time.			
3.3	Ned Hobbs	UEC	SaTH 3.3.3	Improve Mean ambulance handover time	No	Susanne Crossley	New Task		31/03/2026	Provides system efficiency, patient safety and operational performance			
3.3	Ned Hobbs	UEC	SaTH 3.3.4	Providing additional core and winter bed capacity	No	Susanne Crossley	New Task		31/03/2026	Essential maintaining safe, responsive, and resilient care delivery during periods of peak demand.			
3.4	Ned Hobbs	UEC	n/a	New Deliverable 25/26 - *Delivery of the SaTH UEC Transformation Programme actions for the CSS Transformation Programme*	No	n/a	Amend Wording	n/a	n/a				
3.4	Ned Hobbs	UEC	SaTH 3.4.1	Reduction in inappropriate physiotherapy/occupational therapy inpatient referrals	No	Charlotte Jacks	New Task		31/03/2026	New task to reflect revised operational plan and latest requirements and previous developments. Essential improving quality of care, resource efficiency and patient flow.			
3.4	Ned Hobbs	UEC	SaTH 3.4.2	Review and implement assessment area for acute Oncology presentations	No	Sally Hodson	New Task		31/03/2026	New task to reflect revised operational plan and latest requirements and previous developments. Improve safety, responsiveness and outcomes for cancer patients see acutely			
2.1	SB	Workforce	SaTH 2.1.1	Identify baseline and outturn forecast	Yes	SB	New Task		31/03/2026	Repeated task for 2025/26.			
2.1	BPs	Workforce	SaTH 2.1.2	Review known changes, service changes needed, and business cases approved from 2025/26.	Yes	BPs	New Task		31/03/2026	Repeated task for 2025/26. Wording changed to reflect a date of 2025/26.			
2.1	SB	Workforce	SaTH 2.1.3	Outline any assumptions in terms of workforce metrics, turnover absence levels	Yes	SB	New Task		31/03/2026	Repeated task for 2025/26			
2.1	CM	Workforce	SaTH 2.1.4	Populate Workforce Planning Template	Yes	CM	New Task		31/03/2026	Repeated task for 2025/26.			
2.1	CM	Workforce	SaTH 2.1.5	Calculate the % Change by Staff Group	Yes	CM	New Task		31/03/2026	Repeated task for 2025/26.			
2.1	CM	Workforce	SaTH 2.1.6	Challenge / Sense Check Data	Yes	CM	New Task		28/02/2026	Repeated task for 2025/26.			
2.1	SB	Workforce	SaTH 2.1.7	Review Data with Stakeholders (Divisional teams etc.)	Yes	SB	New Task		28/02/2026	A repeat task. In progress as part of operational plan timeline. First submission now drafted ready for review and triangulation with activity and finance.			
2.1	CM	Workforce	SaTH 2.1.8	Populate Master Template and Triangulate with Finance and Operations	Yes	SB	New Task		28/02/2026	A repeat task so marked as a new task to reflect latest requirements and previous developments.			
2.1	CM	Workforce	SaTH 2.1.9	Final Sign Off - Board and NHSE	Yes	RB	New Task		31/03/2026	A repeat task so marked as a new task to reflect latest requirements and previous developments.			
2.1	SB / EW	Workforce	SaTH 2.1.10	Set up and deliver workshop with People and OD team and Divisional reps to identify the priority areas needed that support delivery of our workforce plan	Yes	SB / EW	New Task		31/03/2026	A repeat task so marked as a new task. Wording amended to include 'in line with HTP' at the end of the description.			
2.1	EW	Workforce	SaTH 2.1.11	Develop set of actions and milestones that support each priority area with time frame and actions owners	Yes	EW	New Task		31/03/2026	A repeat task so marked as a new task. Also a request for rewording from: Develop set of actions and milestones that support each priority area with time frame and actions owners to; Develop set of actions and milestones that support each priority area with time frame and actions owners.			
2.1	SB / EW	Workforce	SaTH 2.1.12	Finalise plan with fully supported narrative describing the impact and benefit of delivery the plan	Yes	SB / EW	New Task		31/03/2026	A repeat task so marked as a new task 2025/2. Also a request for rewording from: Finalise plan with fully supported narrative describing the impact and benefit of delivery the plan to: Finalise plan with fully supported narrative describing the impact and benefit of delivery the plan.			
2.1	SB / EW	Workforce	SaTH 2.1.13	Capture risks to delivery of plan and any mitigations to reduce risk	Yes	SB / EW	New Task		31/03/2026	A repeat task so marked as a new task for 2025/26.			
2.1	SB	Workforce	SaTH 2.1.14	Develop summary project plan showing high level timescale – Gantt chart	Yes	SB	New Task		31/03/2026	A repeat task so marked as a new task for 2025/26.			
2.1	RB	Workforce	SaTH 2.1.15	Gain sign off from each provider and NHS England	Yes	RB	New Task		31/03/2026	A repeat task so marked as a new task for 2025/26. Also a request for a revised end date as this did not go to the evidence review panel in November 2025. Also a request for a wording change from: Gain sign off workforce plan linking in with the operational plan from each provider and NHSE to Gain sign off from each provider and NHS England.			
2.1	SB	Workforce	SaTH 2.1.16	Ensure actions and milestones monitoring is incorporated into fortnightly agenda of workforce planning and assurance group and Agency reduction group. Ongoing monitoring	Yes	SB	Amend Wording	31/03/2026		Slightly reworded to = Ensure actions and milestones monitoring is incorporated into fortnightly agenda of system workforce group. Have clear Terms of Reference agreed at the group.			
2.1	Denise Rotchell	Workforce	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	Yes	Denise Rotchell	New Task		31/03/2026	New task to reflect latest requirements and previous developments.			
2.1	Laura Carlyon	Workforce	STW 2.1.26	E-Rostering implementation – medical workforce Phase 1	Yes	Laura Carlyon	New Task		31/03/2026	New task to reflect latest requirements and previous developments.			
2.1	Ned Hobbs & John Jones	Workforce	STW 2.1.27	Develop fragile services action plan supported by Caroline McIntyre, Head of Workforce Transformation	Yes	Ned Hobbs & John Jones	New Task		31/03/2026	New task to reflect latest requirements and previous developments.			

2.2	SB	Workforce	SaTH 2.2.2	Ensure strategy aligns with STW People Strategy once finalised	Yes	SB	Remove task	31/05/2025		Evidence to be presented to the ERP in December to confirm that the action has been completed. SaTH are requesting to remove task 2.2.2 as the People Strategy aligns with the final STW People Strategy. Based on this evidence, please can this be considered to be removed as 2.2.3 is delivery of the People Strategy.			
2.2	SB	Workforce	SaTH 2.2.5	A set of metrics are outlined with target KPI's that support improvement in workforce retention, unavailability and staff engagement.	Yes	SB	Revise end date	31/01/2025	31/01/2026	Revised end date requested as this did not go to the November 2025 evidence review panel.			
2.2	WM/SF	Workforce	SaTH 2.2.6	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	Yes	WM/SF	New Task		31/03/2026	New task as this will be part of the operational plan submission and reflects the latest requirements and previous developments.			
2.2	TG/ RA/ SF	Workforce	SaTH 2.2.7	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.	Yes	TG/ RA/ SF	New Task		31/03/2026	New task to reflect latest requirements and previous developments+K105.			
2.2	Emma Wilkins	Workforce	SaTH 2.2.8	Deliver our cultural and leadership Programmes. Deliverables 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	Yes	Emma Wilkins	New Task		31/03/2026	New task to reflect latest requirements and previous developments.			
2.2	Laura Carlyon	Workforce	SaTH 2.2.9	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.	Yes	Laura Carlyon	New Task		31/03/2026	New task to reflect latest requirements and previous developments.			
5.1	CEO, SaTH	leadership	SaTH 5.1.1	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of UEC	Yes	COO, SaTH	Remove task			Agreed by NHSE to be removed as superseded by development of group model.			
5.1	CEO, SaTH	leadership	SaTH 5.1.2	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of Finance	Yes	DoF, SaTH	Remove task			Agreed by NHSE to be removed as superseded by development of group model.			
5.1	CEO, SaTH	leadership	Sath 5.1.3	Ensure individual SaTH contribution to delivery of Provider Collaborative elements of Workforce	Yes	DoHR &OD, SaTH	Remove task			Agreed by NHSE to be removed as superseded by development of group model.			
5.1	CEO, SaTH	leadership	SaTH 5.1.4	Deliver SaTH specific actions following the external assessments of the effectiveness of the Provider Collaborative	Yes	CEO SaTH	Remove task			Agreed by NHSE to be removed as superseded by development of group model.			
5.1	CEO, SaTH	leadership	SaTH 5.1.5	Agree and approve the scope of the provider collaborative and the necessary arrangements (including delegations) via SATH governance arrangements	Yes	CEO and Dir of Gov SATH	Remove task			Agreed by NHSE to be removed as superseded by development of group model.			
5.3	CEO, SaTH	Workforce	SaTH 5.4.2	Ensure Executive participation in the Executive Directors Development programme including initiating dialogue on shared expectations and collaborative leadership through STG.	Yes	CEO, SaTH	Amend Wording		31/03/2026	Continued action for 2025/26. Reworded to - Ensure Executive participation in the Executive Directors Development programme including initiating dialogue on shared expectations and collaborative leadership through STG.			

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

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

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FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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4.64	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.	Y	10/12/20	30/04/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	03/02/22	H. Flavell	A. Lawrence	Monday.com
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	03/02/22	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	03/02/22	28/02/22	28/02/22	H. Flavell	A. Lawrence	Monday.com

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

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

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

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Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	31/03/21	30/04/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.98	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/09/21	30/06/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.99	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.	Y	10/12/20	31/10/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/01/21	31/10/21	14/09/21	H. Flavell	A.Sizer	Monday.com
4.100	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.	Y	10/12/20	31/05/24	Delivered, Not Yet Evidenced	On Track	This action was approved as Delivered, Not Yet Evidenced at May-24's MTAC. 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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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	Delivered, Not Yet Evidenced	On Track	External dependent action on NHSEI. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as the MNISA who is in post cannot start working with families until the greenlight from NHSEI has been received. We currently have no information as to when that greenlight is expected. Progressing this action with NHSEI sits with the LMNS. All other evidence requirements for this action have been met and it will be proposed for "Delivered, Not yet Evidenced" as soon as NHSEI enable the MNISA to start their work with families. A new timeline for "Evidenced and Assured" will be proposed at the same time. This action was agreed as 'Delivered, Not Yet Evidenced' and back 'On Track' at Jun-25's MNTAC with a new assurance deadline of Dec-25 following of confirmation of NHSE's greenlight for the MNISA to start working with families.	10/06/25	31/12/25		P. Gardner	P. Gardner	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	TBC	Delivered, Not Yet Evidenced	On Track	External dependent action on NHSEI. Linked to IEA 2.1. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as this action is dependant on IEA 2.1. Until progress can be made with the above action, realistic new timelines cannot be estimated. This action was agreed as 'Delivered, Not Yet Evidenced' and back 'On Track' at Jun-25's MNTAC with a new assurance deadline of Dec-25 following of confirmation of NHSE's greenlight for the MNISA to start working with families.	10/06/25	31/12/25		P. Gardner	P. Gardner	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/05/21	30/04/21	08/06/21	H. Flavell	A. Lawrence	Monday.com
2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	Y	10/12/20	TBC	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/03/24	TBC	11/06/24	H. Flavell	A. Lawrence	Monday.com

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

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

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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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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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

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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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FINAL OCKENDEN REPORT ACTION PLAN

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

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PROGRESS AS AT 11.11.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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

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The Shrewsbury and Telford Hospital NHS Trust

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

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

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Local Actions For Learning Theme 18: Maternal Deaths													
14.50	In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	08/08/23	J. Jones	A. Sizer	Monday.com

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Local Actions For Learning Theme 19: Obstetric Anaesthesia													
14.51	The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/08/23	14/02/23	J. Jones	G. Dashputre	Monday.com
14.52	The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.	Y	30/03/22	28/02/25	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/01/25	31/07/25	14/01/25	H. Flavell	J. Jones	
14.53	The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.	Y	30/03/22	31/07/24	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/08/24	30/12/24	14/01/25	H. Flavell	J. Jones	
14.54	The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/03/24	09/05/23	H. Flavell	J. Jones	Monday.com
14.55	The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.	Y	30/03/22	30/06/24	Evidenced and Assured	Completed	This action was accepted as Evidenced and Assured at Mar-25's MTAC.	09/07/24	31/03/25	11/03/25	P. Gardner	J. Jones	Monday.com

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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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Workforce planning And Sustainability The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.													
1.1	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	Y	30/03/22	31/05/25	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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PROGRESS AS AT 11.11.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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Immediate and Essential Action 6: Learning from Maternal deaths Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.													
6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(Royal Colleges). Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at 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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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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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FINAL OCKENDEN REPORT ACTION PLAN

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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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PROGRESS AS AT 11.11.25

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
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

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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The Shrewsbury and Telford Hospital NHS Trust

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

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Ockenden 1

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	0	1	26
IEA	25	0	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%

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 11.11.2025

APPENDIX TWO

Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital NHS Trust

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NEMR1/I_NEMR2	The service, an LNU, has retained equipment to provide nitric oxide even though changes have been made nationally to focus the provision of nitric oxide within NICUs. The equipment was rarely used and yet associated with anxiety among nursing staff, many of whom were said to lack experience or training in its use. It is therefore recommended that the nitric oxide equipment should be removed from the unit where currently it poses a risk.	Evidenced and Assured	Completed	This action was approved as 'Evidenced and Assured' at Jan-25's MNTAC. Evidence Requirements for Assurance: Letter from the Network Addition to Risk Register Updated Persistent Pulmonary Hypertension of the newborn (PPHN) guideline following nitric oxide removal Engineering services email confirming removal	Immediate (0-3 months)		14/01/2025		14/01/2025	Dr John Jones	CD's	Monday.com
NEMR2/I_NEMR3	The unit should develop a first hour (golden hour) checklist to facilitate delivery and documentation of time critical interventions within the first hour from birth for all infants admitted for intensive care.	Delivered, Not Yet Evidenced	Off Track (see exception report)	An exception report was approved at Jan-25's MNTAC changing the deadline for green to Apr-25 so the audit can be repeated. Initial audit did not show sufficient compliance to ensure the action is fully embedded. A new audit presented through Governance in April still did not show sufficiant compliance. This action was reviewed and agreed as 'Off track' while it is jointly reviewed at the Quality and Safety Workstream of the LMNS so blockers and items requiring support can be identified. Evidence Requirements for Delivery: Golden Hour Guideline - validated at Apr-24 Neonatal Governance Golden Hour Checklist - validated at Apr-24 Neonatal Governance Evidence Requirements for Assurance: Audit of compliance against guideline	Immediate (0-3 months)	30/09/2024	08/10/2024	30/04/2025		Dr John Jones	CD's	Monday.com
NEMR3a/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: a. The unit should collaborate with the ODN to review the number of intensive care days (HRG1) within the unit. The review team observed that for a birth denominator of 4,100, intensive care days appeared to be high, potentially indicating an interventionist approach to neonatal care.	Evidenced and Assured	Completed	This audit has been undertaken further to receipt of the initial letter following the review. This action was accepted as "Delivered, Not yet Evidenced" at Nov-24'MNTAC. Further to this, specific data points were added to the dashboard for ongoing monitoring and form part of the Network monitoring process. This action was accepted as Evidenced and Assured at Mar-25's MNTAC. Evidence Requirements for Delivery: Intensive Care Days Audit - causes Evidence Requirements for Assurance: Surveillance of ITU and HDU care days integrated into Network monitoring processes (Steering Group) Data points added to dashboard for ongoing monitoring	Immediate (0-3 months)	31/12/2024	12/11/2024	28/02/2025	11/03/2025	Dr John Jones	CD's	Monday.com
NEMR3b/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: b. The unit should undertake quarterly audit of all neonatal resuscitations that extend beyond initial inflation breaths, against UK Resuscitation Council Newborn Life Support guidance, with specific focus on timeliness and sequence of interventions, escalations for additional senior help, response, and documentation on advanced resuscitation proforma.	Evidenced and Assured	Completed	Quarterly audit of neonatal resuscitation of all babies requiring more than inflation breaths for 6 months then quarterly for a total of a year completed. Outcome from audit - CD and maternity education team to incorporate neonatal resuscitation education into NLS update teaching. This action was accepted as "Delivered, Not yet Evidenced" at Nov-24'MNTAC and accepted as Evidenced and assured at Mar-25's MNTAC with the integration of the quarterly audit into the Forward Audit Plan. Evidence Requirements for Delivery: Resuscitation Audit Evidence Requirements for Assurance: Listed audits integrated into Forward Audit Plan	Immediate (0-3 months)	30/11/2024	12/11/2024	28/02/2025	11/03/2025	Dr John Jones	CD's	Monday.com
NEMR3c/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: c. The unit should undertake a gap analysis of how its Family Integrated Care provision aligns with national guidelines.	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. An exception report was accepted at Nov-25's MNTAC, amending the Assurance date to Sep-26 to allow for the recruitement of the FICare lead who will be essential to the embedding of this action. 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	30/09/2026		Dr John Jones	CD's	Monday.com

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APPENDIX TWO

Neonatal External Mortality Review Action Plan

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NEMR3d/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: d. The unit should review National Neonatal Audit Programme (NNAP) quality outcome trends, particularly bronchopulmonary dysplasia, brain injury, non-invasive ventilation rates, and create quality improvement projects to address any issues identified.	Delivered, Not Yet Evidenced	On Track	The clinical team have undertaken a review of NNAP data for 2022/23 and is in the process of reviewing the outcome of the 2023 data, evidence to demonstrate this will be presented to MNTAC in December 2023. Further evidence of any amended practice or dissemination of learning will be presented to MNTAC in due course to provide evidence of embedded practice. Evidence Requirements for Delivery: NNAP review undertaken for latest available data through governance processes Evidence Requirements for Assurance: Robust Process in place for receiving and responding to national reports Evidence of QI projects delivered and audited	Immediate (0-3 months)	31/12/2024	10/12/2024	31/08/2025		Dr John Jones	CD's	Monday.com
NEMR4	The unit should develop a training programme on approaches to ventilation that reflect expectations in BAPM's Neonatal Airway Safety Standard, drawing on supporting training materials (for example, including for videolaryngoscopy).	Not Yet Delivered	On Track	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. Current consultant staffing on the unit does not allow for a lead to be appointed until recruitment needs are met, which would be required to develop BAPM compliant training programme. An exception report was submitted to 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 11.11.2025

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NEMR6b/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Governance Lead	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

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

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 11.11.2025

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
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
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. A further exception report was presented at Nov-25's MNTAC amending the timeframes to Mar-26 for amber and Jul-26 for Green as absences within the team has delayed the work required to implement this action. Evidence Requirements for Delivery: Amended guideline and checklist Evidence Requirements for Assurance: Audit of guideline and checklist implementation	Short Term (0-6 months)	31/03/2026		31/07/2026		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

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
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
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. This action was agreed as 'Delivered, Not Yet Evidenced' at Jun-25's MNTAC. An exception report was accepted at Nov-25's MNTAC, amending the Assurance date to Mar-26. 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

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 11.11.2025

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
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. An exception report was accepted at Nov-25's MNTAC, amending the Delivery date to Feb-26 and the Assurance date to Sep-26 to allow for the recruitement of the FICare lead who will be essential to the embedding of this action. 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)	28/02/2026		30/09/2026		Paula Gardner	Julie Plant	Monday.com
NEMR24	This report should be shared with the trust board, which should have oversight of any action plan developed to address the recommendations.	Evidenced and Assured	Completed	The report and the associated action plan will be presented to the Trust Board in November 2024. This will be followed by regular reports on progress of delivery aligned with the assurance processes incorporated into the MNTAC process. This action was agreed as 'Delivered, Not Yet Evidenced' at Jan-25's MNTAC and as 'Evidenced and Assured' at Jun-25's MNTAC. Evidence Requirements for Delivery: Agenda and Minutes from Board BoD Neonatal Review appendix Evidence Requirements for Assurance: Evidence of progress being shared at agreed intervals - IMNR Nov-24/Jan/Mar/May-25)	Medium Term (6-12 months)	31/12/2024	14/01/25	31/05/25	10/06/25	Dr John Jones	J.Atkinson	Monday.com

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

Counts

NEMR

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
Actions	35	11	9	15
Total	35	11	9	15
Percentage		31.4%	25.7%	42.9%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
Action	35	2	16	1	1	15	0
Total	35	2	16	1	1	15	0
Percentage		5.71%	45.71%	2.86%	2.86%	42.86%	0.0%

Glossary and Index to the Neonatal Mortality Review Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

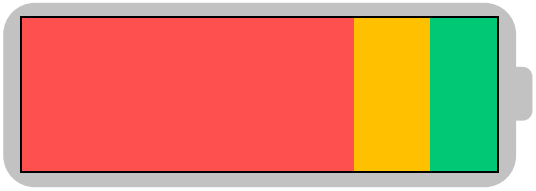
Accountable Executive and Owner Index

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

Phase 2 batteries – Post Nov-25 MNTAC

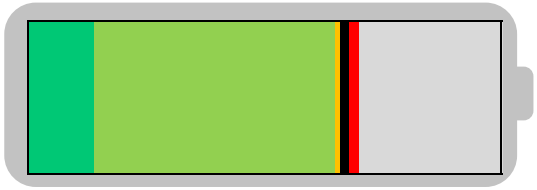
The Shrewsbury and Telford Hospital NHS Trust

Overall Delivery



70% (170) Not Yet Delivered
16% (39) Delivered, Not Yet Evidenced
14% (33) Evidence & Assured

Overall Progress



14% (32) Complete
51% (119) On Track
2% (6) Descoped
2% (4) Off track
1% (1) At Risk
30% (74) 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	77% (23) | 20% (6) | 3% (1)	3% (1) | 40% (12) | 57% (17)
LMNS 3 Year Delivery Plan	36% (10) | 36% (10) | 28% (8)	28% (8) | 57% (16) | 4% (1) | 11% (3)
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	94% (44) | 4% (2) | 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

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VETERAN AWARE

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

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 15th January 2026

Agenda item				
Report Title		CNST MIS Year 7 - Progress Updates – December 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 Board of Directors		
Executive summary:		This paper evidences progress against Year 7 of the CNST Maternity Incentive Scheme as of December 2025. The service has now delivered all of the 10 Safety Actions. The last of the papers linked to CNST evidence have gone through the appriopriate committees in December and to Trust Board and the LMNS in January, after which all Safety Actions will be "Evidenced and assured", ahead of the mandatory presentation to Board and official sign off in February 2026. Final step will be the official submission to the CNST scheme before the Mar-26 deadline.		
Recommendations for the Committee:		1. Review and discuss this paper and its appendices, and advise the Head of Midwifery of any further detail required. 2. Consider section 5.1.2 for inclusion in the minutes, to ensure appropriate evidence of the Board's approval is available as per CNST requirement.		
Appendices:		As detailed in section 4.1.1.		

1. Introduction

1.1. The Scheme

1.1.1. 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.

1.1.2. 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.

1.2. Year 7 Guidance

1.2.1. 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.

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

1.2.3. This guidance for year 7 included updates for safety actions 1,3,4,7 and 9 from Year 6 requirements.

1.3. This report

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

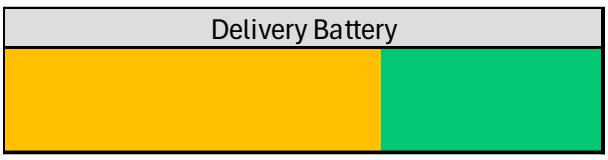
- An update on progress against delivery of Year 7 of the scheme.
- Any risks to the delivery of the scheme under the new safety actions technical guidance.

2. Overall Progress Status

2.1. Delivery

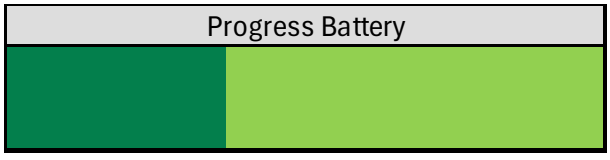
2.1.1. All CNST Safety actions have now been delivered. The below chart shows a CNST completion rate as of December 15th 2025 (including compliance with the standards and accrual of supporting evidence) of:

- 37% “Evidenced and Assured” - Green
- 63% “Delivered Not Yet Evidenced” – Amber



2.2. Progress

2.2.1. The delivery battery should be viewed in conjunction with the below progress battery which evidences the overall status of progress which is 63% “On Track” (light green) and 37% “Completed” (dark green)



3. Safety Actions Status

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

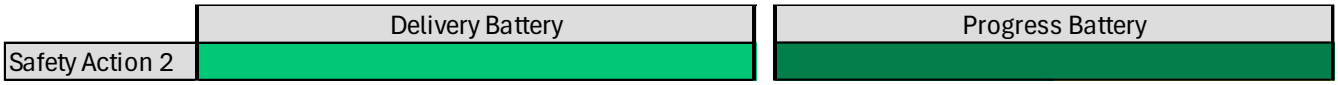
3.1.1. **Progress status: On Track**

3.1.2. **Deescalated Risk:** The guidance requires that for 50% of PMRT reviews, an external member of the panel be present. This was at risk due to difficulty securing appropriate externality for Neonatal PMRTs. The service has now achieved externality for over 50% of the PMRT cases with one PMRT remaining which will not impact overall compliance. Compliance has been achieved.

3.1.3. The latest quarterly report including our Q2 position for 2025/2026 has been presented at Governance was received at Trust Board in November 2025.

3.1.4. A closure report demonstrating compliance against all criteria is provided alongside this update. This Safety Action is now "Delivered, Not yet Evidenced", and will be "Evidenced and Assured" once the closure report is received by the Board, in January 2026.

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

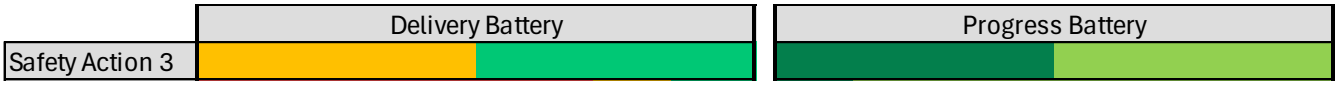


3.2.1. **Progress Status: Complete**

3.2.2. 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 has been 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).

3.2.3. The scorecard has been received from NHS Digital and provided to Board in November 2025, it is now "Evidenced and Assured".

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



3.3.1. **Progress Status: On Track**

3.3.2. Standard a)Transitional Care guideline has been updated and is going through the appropriate governance processes. It is expected to come into practice when staffing allows. Current guideline in practice has not changed and meets the CNST requirements as per the previous years of the programme. This is now "Delivered, Not Yet Evidenced" and will be assured once this update has been provided to Board in January 2026.

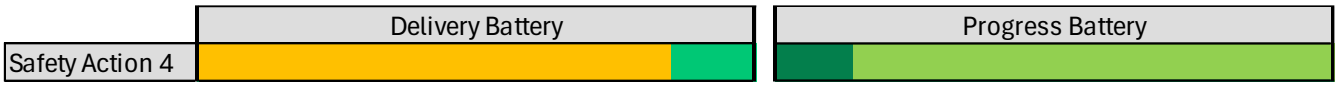
However, following a review by the ODN, an action plan has been co-produced to further improve Transitional Care provision, including NG tube feeding, which the network considers critical to the provision of best and safest care considering the inclusion of late preterm babies within the CNST requirement. This further satisfies evidence requirements for this action. This action plan is provided as an appendix for approval by the Board. Once signed off, this standard will be "Evidenced and Assured".

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 was presented at Maternity Governance, Neonatal Governance and QSAC in November.

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 was presented at Maternity Governance, Neonatal Governance and QSAC in November.

3.3.3. 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 has now gone through all governance processes and been presented to Safety Champions and the LMNS. This standard is now "Evidenced and Assured".

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



3.4.1. **Progress Status: On Track**

3.4.2. Standard a). A closure paper demonstrating compliance against all Obstetric Workforce requirements forms part of the papers going through the appropriates committee in December. This standard has been met and will be "evidenced and Assured" once the paper is provided to Board in January 2026.

3.4.3. 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 has since been presented to Board and this item is "Evidenced and Assured".

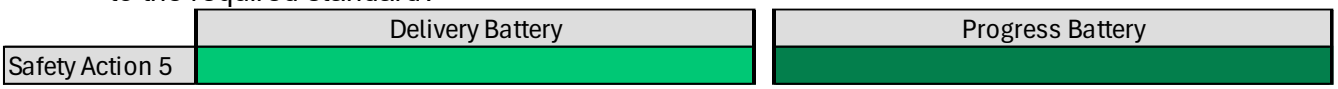
3.4.4. Standard c) Evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce was provided in previous years of the scheme. A new paper reaffirming this position forms part of the papers going through the appropriate committee in December. This standard has been met and will be "evidenced and Assured" once the paper is provided to Board in January 2026.

3.4.5. 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 forms part of the papers going through the appropriate committee in December.

This standard has been met and will be "Evidenced and Assured" once the paper is provided to Board in January 2026 and the action plan included is signed off.

3.4.6. Once all reports have been presented through the required governance channels and Board in January 2026, they will be moved to "Evidenced and Assured".

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



3.5.1. **Progress status: Complete**

3.5.2. Standard a) The Midwifery establishment is compliant with the BirthRate+ assessment completed in November 2022. The new assessment is now underway which will make the service compliant with the requirement. Evidence of this has been collated along with refreshed evidence about midwifery budget aligning to the previous assessment.

3.5.3. Standards b-e) The BoD has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended. This report demonstrates compliance against the standards set out in CNST, with the last report presented at Board in November 2025. This standard has been met and is evidenced and assured

3.5.4. This action is now Evidenced and Assured.

3.6. 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?"

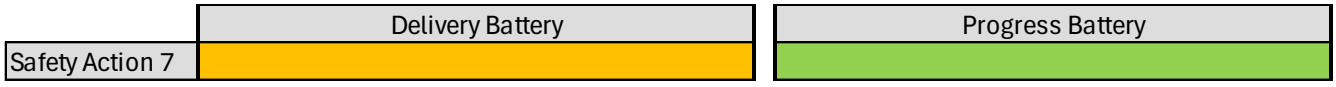
3.6.1. **Progress status: Complete**

3.6.2. This action has been delivered as per the requirements of the previous years of the scheme. Compliance has benchmarked against the recently published version 3.2, and continues 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.

3.6.3. 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 Q2 of 2025/26 was presented at Maternity Governance and QSAC in November 2025, including evidence of the latest quarterly meeting with the ICB.

3.6.4. This action is now "Evidenced and Assured"

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



3.7.1. **Progress Status: On Track**

3.7.2. 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 last of the reports are collated in December. The action plan was presented along with the monthly CNST update to Governance in October 2025 and provided to Board in November 2025.

3.7.3. 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.

3.7.4. 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 ; a paper on progress was provided to the appropriate committees in December 2025.

3.7.5. The results of the 2025 CQC survey have been received and showed positive improvements demonstrating women cared for by our teams felt that they were treated with kindness and compassion and were spoken to in a way they could understand. There were no sections or questions in which the Trust scored worse than most others.

3.7.6. Qualitative data is expected from the CQC after the New Year, once that is received, an action plan will be co-produced in conjunction with the 2024 response.

3.7.7. 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.

3.7.8. This action will be "Evidenced and Assured" once this update has been provided to board in January 2026..

3.8. 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		

3.8.1. **Progress Status: On Track**

3.8.2. 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.

3.8.3. Attendance against elements of training required for CNST has now been compiled, and compliance has been achieved, as evidenced by the SA8 closure paper provided alongside this update.

3.8.4. This action is now "Delivered, Not Yet evidenced" until this update is provided to Board, in January, after which it will be "Evidenced and Assured".

3.9. 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?"

	Delivery Battery	Progress Battery
Safety Action 9		

3.9.1. **Progress Status: On Track**

3.9.2. 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 has been reviewed, it will be discussed with the LMNS for full implementation. Reporting templates have been received and are being considered for use in the next financial year.

3.9.3. A Safety Intelligence Dashboard review is 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.

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

3.9.5. 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 was presented to Trust Board in November 2025.

3.9.6. 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 is requested of Board in section 5.1.2 of this update. Board has been provided evidence of the latest meetings with every CNST update.

3.9.7. Evidence in the Trust Board (or appropriately delegated committee) minutes 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. The last paper (IMNR) covering the reporting period has been provided to Board alongside this update.

3.9.8. The last of the evidence for this Safety Action has been provided to Board with this update, it will be "Evidenced and Assured" following discussion by the Board.

3.10. 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?"

	Delivery Battery	Progress Battery
Safety Action 10		

3.10.1. **Progress Status: On Track.**

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

3.10.3. As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, compliance, now that the reporting period has ended, is demonstrated in the Safety Action 10 closure paper provided with this update.

3.10.4. Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit has been to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme This is included as part of the closure paper.

3.10.5. This action is now "Delivered Not Yet Evidenced" until this update is presented to Board in January 2026, after which it will be "Evidenced and Assured".

4. Papers provided with this update

4.1.1. The following papers, linked to CNST Safety Actions, were provided to Board this month:

- CNST Safety Action 1 Closure report (SA1)
- Transitional Care (TC) action plan (SA3)
- CNST Obstetric Workforce Closure Paper (SA4)
- CNST Neonatal Workforce Closure Paper (SA4)
- CNST Safety Action 8 Closure report (SA8)
- Locally Agreed Dashboard (SA9)
- CNST safety Action 10 Closure paper (SA10)

5. Actions requested of the Board of Directors

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

5.1.2. Include the following in the minutes of this meeting, should the Board agree, in accordance with CNST guidance:

- The Trust Board approves the Transitional Care (TC) action plan (SA3).
- The Trust Board has received the CNST Obstetric Workforce Closure Paper (SA4) indicating compliance against the obstetric Workforce standards within CNST Safety action 4.
- The Board has received the CNST Neonatal Workforce Closure Paper (SA4) showing the service meets the BAPM recommendations for neonatal medical workforce.
- The Board has received the CNST Neonatal Workforce Closure Paper (SA4) showing the service does not meet the BAPM recommendations for neonatal nursing workforce, and agrees the action plan included in that closure paper to meet the QIS standard (70%). The associated risk is monitored through the risk register (Datix risk ID 684).
- The Trust board has received evidence that the Board Safety Champion(s) have met with the Perinatal leadership team in May, June, September and November 2025, meeting the requirement of at least three times within the reporting period.

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:

1/12/2024 to 30/11/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *12*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
11	2	5	4	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
5	2	1	2	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 6)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	1	0	1	2	4
Antepartum stillbirths	*0*	*0*	*1*	*0*	*1*	*2*	*4*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	2	0	0	0	0	2
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	2	1	0	1	2	6
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	2	1	0	1	2	6
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	2	1	0	1	2	6
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	2	1	0	1	2	6
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	2	0	0	0	0	2
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	1	0	0	0	0	1
Neonatal care re-orientated	0	1	0	0	0	0	1

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 6)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	1	0	1	2	4
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	1	0	1	2	4
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	1	0	0	2	3
Limited and targeted post-mortem	0	0	0	0	1	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	2	0	0	0	0	2
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	0	0	0	0	2
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	1	0	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	1	0	1	2	4
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	1	0	1	2	4
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 4)

Role	Total Review sessions	Reviews with at least one
Chair	1	25% (1)
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	10	100% (4)
Community Midwife	1	25% (1)
External	6	100% (4)
Management Team	1	25% (1)
Midwife	48	100% (4)
MNVP Lead	2	50% (2)
Neonatal Nurse	3	50% (2)
Neonatologist	2	25% (1)
Obstetrician	9	100% (4)
Other	1	25% (1)
Risk Manager or Governance Team	12	100% (4)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 2)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	3	100% (2)
Community Midwife	0	0%
External	4	100% (2)
Management Team	0	0%
Midwife	13	100% (2)
MNVP Lead	0	0%
Neonatal Nurse	5	100% (2)
Neonatologist	4	100% (2)
Obstetrician	4	100% (2)
Other	1	50% (1)
Risk Manager or Governance Team	3	100% (2)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 6)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	1	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	1	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	2	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	1	0	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 6)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**4 causes of death out of 4 reviews**
	Fetal vascular malperfusion
	The cause of death was undetermined
	Placental insufficiency
	Asphyxial mode of death
Neonatal deaths	**2 causes of death out of 2 reviews**
	Extreme prematurity at 22w 6 d and Major antepartum haemorrhage
	1a extreme prematurity. 1b ascending genital tract infection. 1c severe early fetal growth restriction, marginal placental separation.
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	1	Review and benchmark the RFM guideline with consideration of alternative management for women with frequent attendances with RFM, and audit the management of recurrent RFM in the third trimester.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	5	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	2	Share learning about the opportunity to take the baby home following a bereavement.
		No action entered
There is no evidence in the notes that this mother was asked about domestic abuse at booking	2	No action entered
		Ongoing piece of work regarding QA questions.
Although indicated this mother was not offered a Kleihauer test	1	Learning to be shared with all staff regarding the need to offer a Kleihauer.
During resuscitation the baby required intubation but there were difficulties with the intubation	1	Airway lead to be identified to lead on training, records of skills and monitor compliance as per BAPM airway framework.
During the resuscitation of the baby surfactant was indicated but was not given	1	No action entered
It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available	1	Revision to checklist to include narrative section to checklist to explain rationale for a 'no' response and the education of all staff regarding this change.
Review felt should have had genetic testing in view of previous Turners fetus and early severe growth restriction in this pregnancy.	1	Letter to be sent to Perinatal Pathologist to consider undertaking genetic testing on fetal tissue.
The discussion regarding Progesterone was not clearly documented in the notes	1	Learning to be shared with the EPAS team regarding the importance of clear documentation of discussion and the rationale for decisions made.
The management of PET was not appropriate following the diagnosis of the antepartum stillbirth.	1	Expedite the tea-trolley teaching sessions on bereavement care. Focus on deteriorating adults.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	1	This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance

Maternity & Neonatal Clinical Governance Meetings December 2025

Agenda item				
Report Title	CNST MIS Safety Action 1 - PMRT			
Executive Lead	Paula Gardner, Executive Director of Nursing			
Report Author	Silje Almklow, Divisional Quality Governance Lead			
	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 Meeting December 2025			
Executive summary:	SaTH is a participant in year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. This paper sets out SaTH's completion status against safety action 1 which must be approved by the Board of Directors.			
Recommendations for the Committee	The Committee is asked to: Receive the report in line with Safety Action 1.			
Appendices	PMRT board report PMRT action tracker			

1.0 Introduction

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.

1.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate that 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.

1.3 The purpose of this paper is to provide the Board of Directors with an update against safety action 1: "**Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?"**

2.0 Required Standards

2.1 Safety action 1 is made up of the following standards which need to be evidenced against:

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

3.0 Minimum Evidence Required for Trust Board

Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical notes 2 & 4 regarding the introduction of the NHS Submit a Perinatal Event Notification (SPEN) system in 2025). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT.

A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

4.0 Qualifying cases

Standards A, B and C are evidenced in the below table. The cases highlighted in green have been completed and published. 100072/1 has been discussed in a PMRT meeting and is awaiting post-mortem results prior to being published.

a) 100% of stillbirths were notified within 7 days and 100% of neonatal deaths were notified within 2 days as per the technical guidance.
b) 100% of parents were informed of the review and given the opportunity to provide feedback and raise questions to be considered as part of the review.
c) 100% of reviews were commenced within 2 months of the death. 100% of published cases were published within 6 months of the death. The remaining cases are within the 6 months' timeframe and are scheduled to be reviewed and published within 6 months. 66% of published cases had the appropriate level of externality*.

* 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.

97390/1 – The review was carried out jointly with a tertiary unit and had consultant attendance from both trusts; however, we could not achieve an external consultant from an independent trust due to last minute sickness.

97682/1 – The review was led by SaTH, and an external obstetric consultant was in attendance. We could not secure an external neonatologist. The lead nurse for child death was in attendance as an external panel member.

MBRRACE Number	Date of loss	Type of event	Working days to notify	Parent's views Verbal	Parent's views Letter	Months to complete surveillance	Date of PMRT meeting	Date PMRT published	MDT	External member present	Months to publish report
97390/1	19/02/2025	SB	0	**24/02/2025**	**11/03/2025**	< 1	14/05/2025	03/07/2025	Yes	Obs - No Neo - N/A	< 5
97682/1	09/03/2025	NND	0	**12/03/2025**	**13/03/2025**	< 1	14/05/2025	14/05/2025	Yes	Obs - Yes Neo - No	< 3
97803/1	15/03/2025	SB	0	**17/03/2025**	**28/03/2025**	< 1	16/06/2025	08/09/2025	Yes	Yes	< 6
98349/1	27/04/2025	NND	0	**09/05/2025**	**14/05/2025**	< 1	18/08/2025	10/09/2025	Yes	Yes	< 5
98949/1	10/06/2025	SB	1	**09/06/2025**	**03/07/2025**	< 1	17/09/2025	18/09/2025	Yes	Yes	< 4
99873/1	17/08/2025	SB	**0**	**15/08/2025**	**29/08/2025**	< 1	Scheduled for 17/12/2025				
99880/1	13/08/2025	SB	**0**	**21/08/2025**	**27/08/2025**	< 1	13/10/2025	24/10/2025	Yes	Yes	< 3
100072/1	01/09/2025	NND	**0**	**05/09/2025**	**02/10/2025**	< 1	19/11/2025		Yes	Yes	
100115/2	03/09/2025	LFL	**0**	**04/09/2025**	**02/10/2025**	< 1	Scheduled for 17/12/2025				
100956/1	30/10/2025	SB	**1**	**31/10/2025**	**09/12/2025**	< 1	Scheduled for Jan 2026				
101160/1	12/11/2025	SB	**2**	**11/11/2025**	**01/12/2025**	< 1	Scheduled for Jan 2026				
101282/2	17/11/2025	SB	**4**	**18/11/2025**	**20/11/2025**	< 1	Scheduled for Feb 2026				

5.0 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.

Below are the quarterly reports that were submitted for the period December 2024 to September 2025. The quarter 3 report will be shared in governance meetings in January 2025.


PMRT Quarterly report Oct-Dec 2024


PMRT Quarterly report Jan-Mar 2025


PMRT Quarterly report Apr-Jun 2025


PMRT Quarterly report Jul-Sep 2025.

Below are the Board reports that were submitted for the period December 2024 to September 2025. The Board report for Quarter 3 will be shared in governance meetings in January 2025.


PMRT_BoardReport _The Shrewsbury an


PMRT_BoardReport _The Princess Royal


PMRT_BoardReport _The Shrewsbury an


PMRT_BoardReport _The Shrewsbury an

From Quarter 2 2025/2026 we also provided a Board Report with Year-to-Date data to provide a better overview of PMRT findings. This will continue to be provided in future.


PMRT_BoardReport _The Shrewsbury an

6.0 Summary

a) All eligible deaths were notified to MBRRACE UK within seven working days.
b) All parents were contacted, informed of the review, and asked for their views of the care they received.
c) 100% of reviews were commenced within 2 months of the death. 100% of published cases were published within 6 months of the death. The remaining cases are within the 6 months' timeframe and are scheduled to be reviewed and published within 6 months. 66% of published cases had the appropriate level of externality*.
d) Quarterly PMRT reports and Board reports were submitted to the Trust Executive Board on an on-going basis for all deaths from 1 December 2024.

7.0 Actions requested of the Board

The Board of Directors is asked to note the content of this paper which evidences delivery of the required standards to achieve safety action 1 of Year 7 of the CNST Maternity Incentive Scheme.

Appendix 1: PMRT action tracker – open actions

Action highlighted are duplicate actions to meet several recommendations.

Action ID	Description	Specialty	Synopsis	Due date	Progress
16344	PMRT RB 94316 - Domestic abuse - improve compliance with QA question	Obstetrics/Maternity	There is no evidence in the notes that this mother was asked about domestic abuse at booking. Further learning to be shared with staff regarding the importance of asking about domestic abuse. Plan to develop and trial the use of coloured pens to write names/mark urine bottles to communicate concerns.	31/12/2024	06/12/2024 - SUA QGT A meeting took place with the safeguarding team 05/11/2024 to discuss how we can best approach the issue of low compliance with the QA Screening during pregnancy. The idea of using coloured pens on urine bottles was deemed not to be feasible. The action has been re-written to reflect this. Domestic abuse raising awareness week took place in November 2024 and learning opportunities were shared with all staff. • 25th November – Addressing people perpetrating domestic abuse • 27th November – Legal options for minoritized women enduring domestic abuse •28th November – Older populations and domestic abuse •29th November – Child to parent abuse – access on the day •3rd December – Supporting women survivors of African and Caribbean heritage •5th December – Strangulation and domestic abuse •6th December – White Ribbon Headline Event •10th December – The Metropolitan Police response to addressing male violence against women and girls Further work to include a review of data regarding compliance with QA question during pregnancy. Action generated to reflect this. 16/01/2025 – unable to progress action. Agreed for RN to take this to PMRT for discussions on a room for 'women only' solution and a provision for males. Agreed to highlight the safety concern on AAA for escalation. Agreed space needs to be factored into newbuild for I/P, O/P and more widely at Telford, Oswestry, Ludlow etc replicating the space required in all areas. 28/01/2024 – agreed to escalate to DOAG as coloured pen option on a poster won't work due to toilets used by males and females. Answer is a separate small room to quickly weigh patient away from spouse/partner. 04/02/2025- Governance team to send out global email to all Community teams for suggestions to improve service. ? WSA to ask question. 08/04/2025: TS to go round Community MLU's to isolate scales into a safe space. Scales to be moved into corridor on WMLU to filter people into safe areas. 20/05/2025 TS Comm Matron – continues to be under review. Efforts underway to try and reclaim maternity office space currently occupied by Shrop Doc.

					20.8.25 - email to Community Matron for current plan regarding space availability
18839	PMRT 97682 - Airway lead to be identified to lead on training, records of skills and monitor compliance as per BAPM airway framework	Neonatology	During resuscitation the baby required intubation but there were difficulties with the intubation	28/02/2026	30.10.25 - To enable job planning to be completed deadline extended to 28/02/2026
18854	PMRT 79515 - Poster to be created to clarify the actions to take if there is entrapment of the aftercoming head. To include pain management and transfer to theatre	Obstetrics/Maternity	This mother's pain was not managed appropriately during labour	30/08/2025	
18859	PMRT 96092 - Red-cell antibodies guideline to be updated with clear guidance on the timing of birth and a recommendation to bring the case to the care planning meeting should there be conflicting guidance	Obstetrics/Maternity	Red cell antibodies not managed according to national or local guidelines during pregnancy	31/10/2025	Guideline updated and awaiting approval at governance meeting.
18860	PMRT 96092 - HDU charts to be included in the bereavement pack	Obstetrics/Maternity	This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines	31/12/2025	15/08/2025 MP-Awaiting new HDU charts to be able to include in bereavement packs
18861	PMRT 96092 - Updated fibrinogen teaching on PROMPT	Obstetrics/Maternity	Although indicated this mother was not offered further postnatal investigations for herself and/or her baby	30/09/2025	Email sent to KH to review action 19.8.25 KH confirmed PPH training on PROMPT where Fibrinogen levels and testing was included was undertaken in 2024, however 2nd PROMPT programme was held 18.8.25 and identified that there are some amendments to be agreed. A PPH simulation to be added and the scenario once we have completed will be added to this action (document attached)

18862	PMRT 96092 - Review the process for bringing neonatal alerts for maternal red cell antibodies to the monthly fetal medicine meeting for oversight and care	Obstetrics/Maternity	The neonatal alert was not discussed in the monthly fetal medicine meeting.	31/10/2025	
18863	PMRT 96092 - Red cell antibody guideline to be updated with a list of women at higher risk of PPH	Obstetrics/Maternity	Unclear guidance regarding crossmatched blood samples for women with red cell antibodies	31/10/2025	List needs to be agreed at labour ward forum by labour ward lead. There is no national list. Currently no labour ward lead in post to forward this action. Recruitment in progress. In mean time can try to see if we can agree a list between consultants separate to labour ward forum and then present to governance meeting as similar quoracy to forum.
18901	PMRT 98349 - Revision to checklist to include narrative section to checklist to explain rationale for a 'no' response and the education of all staff regarding this change.	Obstetrics/Maternity	It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available	30/09/2025	
18902	PMRT 98349 - Letter to be sent to Perinatal Pathologist to consider undertaking genetic testing on fetal tissue.	Obstetrics/Maternity	Review felt should have had genetic testing in view of previous Turners fetus and early severe growth restriction in this pregnancy. and for prenatal genetic counselling referral to BWC if appropriate.	31/10/2025	
18907	PMRT 97803 - Staff survey regarding QA question - how to improve compliance	Obstetrics/Maternity	There is no evidence in the notes that this mother was asked about domestic abuse at booking	30/09/2025	
19320	PMRT 95139 - Review of cervical screening in the ultrasound department	Obstetrics/Maternity	This mother has a history of preterm birth <34 weeks gestation and her antenatal care was not appropriate given this history. The sonographer was asked to complete the cervical length screening at the anomaly scan appointment, but this was not done. A review to be completed to confirm if this was a one off issue or a repeated problem.	31/12/2025	

19324	PMRT 97390 - update guideline with clear guidance re Kleihauer	Obstetrics/Maternity	Fetal DNA suggested that this baby was rhesus negative, however, the mother had a positive Kleihauer at 27+ weeks gestation and was determined that she would need anti-D. This was not given. The guideline states: Anti-D prophylaxis (including RAADP) and Kleihauer is not required for any sensitising events where the fetus is known to be RhD Negative through cffDNA testing. The guidance regarding the positive Kleihauer is unclear - guideline to be updated. Learning to be shared from the updated guideline.	30/11/2025	
19334	PMRT 98371 - Update the IUT guidance in line with regional/national guidance``	Obstetrics/Maternity	This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy which was not managed according to national or local guidelines. The guideline re IUT needs to be clarified to support staff decision making regarding transfers to a tertiary unit.	31/12/2025	

Transitonal Care (TC) status Action Plan

Currently at Shrewsbury and Telford Hospitals (SaTH) we have 4 beds dedicated for Transitional Care (TC) on the post-natal wards. I have attached our current guideline for you to see a full breakdown of our criteria. It is currently staffed by Midwives, and all babies have a formal daily review and plan of care from the Neonatal Medical team and the Neonatal Nursing team support as required. We do accept late pre-terms between 34+0-35+6 as per BAPM standards, however our weight cut off is presently >1.8kgs rather than 1.6kg as per BAPM. We also do not currently provide tube feeding.

We are in the process of setting up a more formal TC which will continue to have 4 beds on the postnatal ward, however it will be staffed by a Neonatal Nurse alongside the Midwifery team. This will enable us to accept babies with lower birth weights of >1.6Kg and additionally, we will provide tube feeding support. This will also have improved Consultant oversight when our 8th Consultant joins us in early 2026. We are also reviewing further TC beds as part of our Hospital Transformation Programme and have 5 rooms allocated on the Neonatal Unit plans; this is an on-going process with no definitive answers to share at present.

Action Plan

The Shrewsbury and Telford Hospital NHS Trust

Objective / Goal	Key actions	Target date	Progress/update	Completed
Establish project Governance and leadership	Identify project leads, steering group and define scope	Jan 2025	Matron oversight, lead Consultant and ANNP in place. Working group in place which includes staff from NNU, maternity services and AHPs. New TC lead will take the lead once established in post. She starts in Dec 2025	
Define service model and clinical criteria	Update admission criteria to meet BAPM standards	June 2025	TC guideline has been updated and approved through the Governance process. It will not be used until TC is fully established to new design.	
Workforce planning	Identify staffing levels, skill mix and training needs	June 2025	5.5 WTE nurses have been recruited to cover 24/7 nursing cover on TC which has been included in the neonatal staffing template. However the current neonatal staffing template continues to have some vacancies which is preventing us from having adequate staffing levels to ensure the release of TC staff and safe staffing levels on NNU. This is being reviewed by the finance team and TC leads to identify where the gaps are.	
Develop clinical guidelines and SOPs	Review current SOP's and identify any changes or new SOP's that are required	Jan 2026	Pathway SOP for TC has been developed Work remains on-going	
Identify physical space and equipment set up	Identify and prepare appropriate bay for TC and identify appropriate equipment including cots,	December 2025	Current TC bay not appropriate as not big enough for staff member to be based in there. Reviewing A and B bay on the post-natal ward to identify the most appropriate space. Working with Maternity team to ensure computer and other equipment required is available for staff members	

Action completed
Action in progress & on track
Action off track
Not yet started

Objective / Goal	Key actions	Target date	Progress/update	Completed
	phototherapy lamps, trolleys for naso-gastric (NG)feeding			
Governance and risk management	Complete risk assessments, safety checks. Consider the use of simulations to aid assessments.	Feb 2026	We conduct quarterly auditing of our current TC practice. This is being used to highlight areas for improvement within both current practice and our redesign. Further risk assessments required when new bay identified	
Training and competency development	Identify training needs including upskilling for Midwifery staff for IV antibiotics administration and tube feeding. Include ward orientation to PNW for NNU staff	Feb 2026	We are working collaboratively with maternity and neonatal staff, AHP's and PEFs to design the new pathways, upskill midwives to support with tube feeding and neonatal antibiotics administration and building relationships between the two teams.	
TC launch and on-going monitoring	Officially open TC with NNU and maternity staff working collaboratively to reach BABPM standards	March 2026		

As evidenced, we do have a functioning TC that accepts babies from 34+0 – 35+6 as per the BAPM standard, however we are working towards improving our provision with the addition of Neonatal Nursing support and further training and upskilling of Maternity staff to enable us to meet more areas of Transitional Care including tube feeding.

Jo Demers (Neonatal Matron) and Consultant Neonatologist Transitional Care Lead Mo Badawy

Princess Royal Hospital, Telford

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting; 19th December 2025

Agenda item				
Report Title		CNST Safety Action 4 : Obstetric Workforce		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Dr Mei-See Hon		
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				
Executive summary:		CNST MIS Year 7, Safety action 4 (Obstetric Workforce) contains four actions regarding 1. The employment of short-term locums 2. The employment long-term locums 3. Compensatory rest after working non-resident obstetric on-call out of hours 4. Compliance of consultant attendance in specific clinical situations. This paper reports on the audit findings evidencing compliance for actions 1 and 4. We did not employ any long term Tier 2 locums and we have 24/7 resident consultants on the Delivery Suite. Therefore actions 2 & 3 are not relevant. An action plan to complete action 4 is included.		
Recommendations for the Board:		The Board is asked to: Take **assurance** from this report and receive it in line with CNST Safety Action 4.		
Appendices:		CNST SA4 Obstetric Workforce, sub action 4 action plan		

1.0 Introduction

- The purpose of this paper is to provide the evidence require to meet the standards CNST Year 7, Safety action 4 which states: “Can you demonstrate an effective system of clinical workforce planning to the required standard?”
- This paper specifically refers SA4 to part a, Obstetric Workforce, which contains 4 sub actions.

2.0 Action 1

NHS Trusts / organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. Currently work in their unit on the tier 2 or 3 rota or
b. Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory ARCP or
c. Hold a RCOG certificate of eligibility to undertake short-term locums

Minimum evidence requirement:

Trusts/organisations should demonstrate their compliance through an audit via Medical Human Resources.

Relevant time period February to August 2025

Evidence: An audit was conducted of shifts that required Tier 2 locums between 1 February 2025 to 1st August 2024. In this time period there were there were 88 shifts that needed covering. All shifts were covered by doctors currently in post and no external locums were used.

(In our Trust the Tier 3 rota consists of consultants not middle grades)

This standard has been met.

3.0 Action 2

Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level Safety champions and LMNS meetings.

Minimum evidence requirement:

Trusts should ensure that they are compliant with the engagement of long-term locums using the monitoring / effectiveness tool contained within the RCOG guidance document.

Relevant time period: six months after February 2025 to 30 November 2025

Evidence: The RCOG document 'Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland & Wales' refers to the employment of long-term locums who are working on the middle grade rota.

In this time period (March – November 2025) we did not employ any long-term middle grade locums therefore the standard has been met.

This standard has been met.

4.0 Action 3

Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.

Minimum evidence requirements:

Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations.

Evidence: This action is not relevant as we do not have any non-resident Obstetric doctors. This SOP details the Roles and Responsibilities of the on call Obstetric consultant:

Roles and responsibilities for t

This standard has been met.

5.0 Action 4

Trusts/organisations should monitor their compliance of consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service

Minimum evidence requirement:
Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS

Relevant time period: three months from February 2025 to 30 November 2025

Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Consultant MUST attend (1st February – 30th April 2025)

	Number of cases	Consultant present	%
Caesarean birth for major placenta praevia / abnormally invasive placenta	2	2	100%
Caesarean birth for women with a BMI >50	14	13	93%
Caesarean birth <28/40	1	1	100%
Premature twins (<30/40)	0	0	100%
4th degree perineal tear	0	0	100%
Unexpected intrapartum stillbirth	0	0	100%
Eclampsia	0	0	100%
Maternal collapse eg septic shock , massive abruption	1	1	100%
Massive obstetric haemorrhage >2000mls where haemorrhage is and the MOH protocol has been instigated	8	8	100%

- One CS for a woman with a BMI of >50 was conducted by the Tier 2 doctor. The consultant had to attend an emergency and deliver a baby in another room.

There are a number of scenarios that it is not possible to identify from a Badgernet report. Therefore these cases have been identified by the Governance team via their reporting systems.

	Number of cases	Consultant present	Compliance
High levels of acuity	0	0	100%
Any return to theatre	2	2	100%
Team brief	0	0	100%
Consultant requested to attend	0	0	100%
Early warning score protocol or sepsis screening where HDU/ITU care is likely.	1	1	100%

- No incidents have been reported where a consultant was not in attendance during high levels of acuity. SaTH have resident consultant cover 24/7 to support this.
- No incidents have been reported where a consultant was not in attendance during a team brief. SaTH have resident consultant cover 24/7 to support this.
- No incidents have been reported where a consultant was asked to attend but did not. SaTH have resident consultant cover 24/7 to support this.
- The remaining incidents had 100% consultant attendance for all qualifying situations.

Consultant must attend UNLESS the most senior doctor present has documented evidence as being signed off as competent (1st February – 30th April 2025)

	Number of cases	Consultant present	Appropriately trained Tier 2 present	Compliance
Any patient with EBL >1.5 litres and ongoing bleeding (earlier if haemodynamically unstable, low body weight / low Hb / other complexities)	16	15	1	100%
Trial of instrumental birth	52	39	9	92.3%
Vaginal twin birth	5	4	0	80%
Caesarean birth at full dilatation	14	14	0	100%
Caesarean birth for women with a BMI >40	25	24	0	98%
Caesarean birth for transverse lie	2	2	0	100%
Caesarean birth <32/40	1	1	0	100%
Vaginal breech birth	4	3	0	75%
3rd degree perineal tear repair	13	11	0	84.6%

- There was 4 trials of instrumental birth where there is no documentation of consultant presence. The Tier 2 doctor has left the Trust so we are unable to confirm if they have gathered written evidence to support independent practice.
- One twin birth where there is no documentation of consultant presence and the Tier 2 doctor has not gathered written evidence to support independent practice. The second twin was breech – this is the same case that is included in the above breech birth data.
- There was 1 Caesarean birth for women with a BMI >40 and 2 third degree tear repairs without consultant attendance. The Tier 2 doctor involved is very experienced and has performed many of these procedures, however has not gathered written evidence to support independent practice.

Discussion

- Overall there were 161 scenarios that required consultant attendance. This was achieved in 151 (93.8%) cases.

- CNST technical guidance states that **"Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent non-attendance"**. All cases have been reviewed by the Clinical Director and an action plan put in place (see Appendix)

- There was significant improvement in consultant attendance for Massive Obstetric Haemorrhage noted for this audit period compared to 2023

    - Consultant must attend >2000mls = 100% vs 96.4% in 2024 and 87.5% in 2023.
    - Consultant may attend >1500mls = 100% vs 97.1% in 2024 and 83.7% in 2023.

- All other case of non-compliance have been reviewed by the Obstetric CD. Where specific concerns have been identified these have been fed back to individuals and their Educational Supervisor.

- Documentation of which staff are present needs to be improved within the Badgernet system.

- Identification of Tier 2 Doctors who do not need direct supervision for procedures that "may require attendance" is difficult and very time consuming.

This standard has been met

6.0 Conclusion

- In conclusion, the compliance rate is good and an improvement on the 2023 and 2024 data.
- The data presented here provides evidence for compliance to all 4 sub parts of Safety Action 4, Obstetric Workforce.
- Quality and completeness of documentation remains challenging.

7.0 Acknowledgements

Many thanks to Lisa Yeaman (Digital Midwife), Silje Almklow (W&C Governance lead) and Jo Kench (Maternity and Neonatal Incident Lead) for all their hard work compiling data for this audit.

Appendix

Action plan for CNST SA4 audit re consultant attendance on the Delivery Suite

Problem identified	Action	Progress
Documentation of who is present needs to be improved.	Present audit findings and need for escalation, consultant attendance and accurate documentation at obstetrics and gynaecology governance feedback meeting.	Planned for 9th January 2026
Tier 2 doctors lacking documented evidence of competence	Discussion at Consultant meeting re importance of confirming competency evidence for trainees when on call Individual doctors and their ES informed re need to gather evidence Trainees to review cases identified and reflect with ES	Planned for 15th December 2025 Email to Educational Supervisor and Trainees 2nd December 2025
Identification of Tier 2 doctors who do not need direct consultant supervision for the procedures that 'may' require attendance is challenging	Work with the College tutor to design a new system of monitoring competencies.	Email to college tutor 10th December 2025
Incomplete documentation of surgical procedures	Present audit findings about accurate documentation at obstetrics and gynaecology governance feedback meeting.	Planned for 9th January 2026

Maternity Governance – December 2025

<table>
<tr><td>Agenda item</td><td colspan="4"></td></tr>
<tr><td>Report Title</td><td colspan="4">CNST Year 7 Compliance – Safety Action 4c/d – Neonatal Workforce</td></tr>
<tr><td>Executive Lead</td><td colspan="4">John Jones – Executive Medical Director</td></tr>
<tr><td>Report Author</td><td colspan="4">Yvonne Humphreys – Centre Manager - Maternity and Neonatal Services
Jo Demers – Matron – Neonatal Services
Cecile Pollitt – MNTP – Assistant Project Manager</td></tr>
<tr><td rowspan="6"></td><td colspan="2">Link to strategic goal:</td><td colspan="2">Link to CQC domain:</td></tr>
<tr><td>Our patients and community</td><td></td><td>Safe</td><td>√</td></tr>
<tr><td>Our people</td><td></td><td>Effective</td><td>√</td></tr>
<tr><td>Our service delivery</td><td>√</td><td>Caring</td><td></td></tr>
<tr><td>Our governance</td><td>√</td><td>Responsive</td><td></td></tr>
<tr><td>Our partners</td><td></td><td>Well Led</td><td>√</td></tr>
<tr><td rowspan="7"></td><td colspan="2">Report recommendations:</td><td colspan="2">Link to BAF / risk:</td></tr>
<tr><td>For assurance</td><td>√</td><td colspan="2">Datix Risk ID 684 – QIS staffing</td></tr>
<tr><td>For decision / approval</td><td></td><td colspan="2">Link to risk register:</td></tr>
<tr><td>For review / discussion</td><td></td><td colspan="2" rowspan="4">Datix Risk ID 684 – QIS staffing</td></tr>
<tr><td>For noting</td><td></td></tr>
<tr><td>For information</td><td></td></tr>
<tr><td>For consent</td><td></td></tr>
<tr><td>Presented to:</td><td colspan="4">Maternity Governance
Neonatal GovernanceDivisional Director of Nursing
W&C Divisional Committee
Quality and Safety Assurance Committee
Maternity and Neonatal Safety Champions
LMNS Perinatal Quality and Safety Group
Board of Directors</td></tr>
<tr><td>Executive summary:</td><td colspan="4">Year 7 of the Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme requires the Trust to demonstrate compliance against BAPM standards for Neonatal medical and nursing workforce or, where compliance is not achieved, that a plan is in place with progress against previous action plans, that this plan has been shared with the LMNS and ODN, and that this is monitored through the risk register.
This paper and its appendices demonstrate that:
- the service is compliant with BAPM requirements for the medical workforce
- the service is not yet compliant with BAPM requirements for the nursing workforce which does not yet meet 70% QIS status
- an action plan is in place to achieve 70% compliance and has been shared with both the LMNS and the ODN
- QIS non-compliant is monitored via the risk register
The service is therefore compliant with CNST Safety Action 4, requirements 4c and 4d.</td></tr>
<tr><td>Appendices</td><td colspan="4">Appendix 1 – Neonatal Nursing Workforce Tool – July 2025
Appendix 2 – Extract of Risk register – QIS compliance risk</td></tr>
</table>

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 Neonatal Workforce:

1.2.1. Requirement 4c – Neonatal Medical Workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

1.2.2. Requirement 4d – Neonatal Nursing Workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal ODN.

2. Compliance

2.1. Requirement 4c – Neonatal Medical Workforce

The BAPM requirements are :

2.1.1.**Tier 1 staffing**: *Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.*

- Tier 1 staffing rotas are fully compliant with this requirement, with all rotas separate from Paediatrics.

2.1.2.**Tier 2 staffing :** *Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.*

- Tier 2 staffing rotas are fully compliant with this requirement, with all rotas separate from Paediatrics.

2.1.3.**Tier 3 staffing:** *A minimum of 7 WTE neonatal paediatricians/neonatal consultants on the on-call rota. Minimum of 1 consultant with a designated lead interest in neonatology. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module.*

- There are currently 7 neonatal consultants/neonatal paediatricians who equally contribute to the neonatal on-call rota and do not cross-cover Paediatrics out of hours/on-call work.
- Two of these consultants have CCT in Neonatal Medicine.

2.2. Requirement 4d – Neonatal Nursing Workforce

2.2.1. Appendix 1 – Neonatal Nursing Workforce Tool – October 2025

The neonatal nursing workforce tool is completed quarterly and was last completed in October 2025 at the time of this paper. It indicated compliance against neonatal nursing standards with the exception of the ratio of QIS nurses on the unit.

BAPM standards require that 70% of nurses be qualified in specialty. As of October 2025, when the tool was completed, the unit had achieved 56% compliance.

The service has continually invested in the training of QIS nurses with recurrent funding allocated. Currently, 9 members of staff need to be trained to achieve the required 70% ratio. The training programme is 15 months long.

Training places have been allocated and it is currently estimated that compliance will be reached by the end of 2027, with the following training schedule:

QIS training	Apr-25	May-25	Nov-25	Dec-25	Jan-26	Feb-26	Nov-26	Dec-26	Feb-27	Dec-27	Feb-28
Total Nurses in training	5	2	4	5	3	4	4	3	4	2	
Nurses starting training			2	1		1	2		2		
Nurses finishing training		3			2		2	1	1	2	2

Progress against this action plan is presented on a monthly basis as part of the Neonatal Staffing report which is shared at LMNS Perinatal Quality Safety groups of which the ODN is a member. Additionally, this Workforce Tool is completed with the ODN on a quarterly basis.

Compliance might also be achieved ahead of this timeline, dependant on the training status of any new starter on the unit as part of the workforce recruitment cycle.

Despite not yet meeting the 70% ratio for overall staffing, the unit has managed to achieve QIS compliance on shifts most months by specialist nurses who are QIS trained filling any short-notice gaps.

2.2.2. Appendix 2 – Extract of Risk register

As required within CNST guidance, the current ratio of QIS nurses has been raised as a risk and is monitored through the risk register.

3. Conclusion

The Committees and Boards are asked to take assurance from this paper and its appendices that:

- the service is compliant with BAPM requirements for the medical workforce
- the service is not yet compliant with BAPM requirements for the nursing workforce which does not yet meet 70% QIS status however:
    - an action plan is in place to achieve 70% compliance and has been shared with both the LMNS and the ODN
    - QIS compliance is monitored via the risk register
- The service is therefore compliant with CNST Safety Action 4, requirements 4c and 4d.

Neonatal Nursing Workforce Summary: Princess Royal Telford

INPUT UNIT DETAILS			
Trust	Shrewsbury and Telford Hospital NHS Trust		
Unit	Princess Royal Telford		
Designation	LNU		
Completed by	Jo Demers		
Date completed	15/10/25		
Activity period **Start date:**	01/04/24	**End date:**	31/03/25
	HRG 1 (IC)	**HRG 2 (HD)**	**HRG 3-5 (SC)**
Activity by care level	400	1243	4132
Comissioned cots by care level	3	3	16

DIRECT PATIENT CARE - *DO NOT INCLUDE ANY NON-DIRECT PATIENT CARE WTE*				
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**
Sister / Charge Nurse	7	6.17	5.36	6
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	16.12	11.96	15
Staff Nurse QIS	5 QIS	18.97	18.33	10
Subtotal QIS Nurses		**41.26**	**35.65**	**31**
Staff Nurse NON QIS	5 NON QIS	7.86	7.86	26
Subtotal Non QIS Nurses		**7.86**	**7.86**	**26**
Subtotal - Registered Nurses		**49.12**	**43.51**	**57**
Nursing Associate	4	0.92	1	1
Trainee Nursing Associate	3	1	1	1
Nursery Nurse	4	0	0	0
Healthcare Support Worker	3	5.17	5.2	7
Subtotal - Other direct patient care staff		**6.09**	**6.2**	**8**
TOTAL DIRECT PATIENT CARE		**55.21**	**49.71**	**65**

ADDITIONAL NEONATAL UNIT DATA - *NURSES WORKING ON NEONATAL UNIT ONLY*				
	From	**To**	**WTE**	**Head Count**
New Starters	01/07/2025	30/09/2025	1.8	2
Leavers	01/07/2025	30/09/2025	0.61	1
Net Gain / Loss	01/07/2025	30/09/2025	**1.19**	**1**
Turnover (%)	01/07/2025	30/09/2025	**31%**	**33%**
Current vacancies (WTE)	01/07/2025	30/09/2025	**6.51**	
Current maternity Leave (WTE)	01/07/2025	30/09/2025	2.76	
			WTE	**Hours used**
Sickness in quarter	01/07/2025	30/09/2025	**0.0**	
Bank Usage in quarter	01/07/2025	30/09/2025	**0.0**	3.91
Agency Usage in quarter	01/07/2025	30/09/2025	**0.0**	0

The below table has been autopopulated based on the previous quarter; please kindly check and update this table for the current quarter as required

Check the box to confirm that the data has been reviewed for Q2 ☐

NON DIRECT PATIENT CARE - *DO NOT INCLUDE ANY DIRECT PATIENT CARE WTE*					**COMMENTS**
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	*e.g. no dedicated hours, data not available / not collected*
LEADERSHIP ROLES					
Consultant Nurse	0	0	0	0	
Senior/Lead Nurse	0	0	0	0	
Matron	8a	1	1	1	
Ward Manager	7	1	1	1	
Recruitment & Retention Lead	0	0	0	0	
Other Senior role (please specify)	0	0	0	0	
Subtotal - Leadership roles		**2**	**2**	**2**	
QUALITY ROLES					
Governance Lead Nurse - Band 7	7	0.6	0.6	1	
Practice Development / Education Lead - Band 7	7	1	1	1	
Clinical Educator	6	0.6	0.6	1	Was in post until 31/8/25.Has now left to do ANNP training. Post out to advert shortly.
Infant Feeding Lead	6	0.8	0.92	1	
Family Integrated Care Lead / equivalent	0	0	0	0	
Family Integrated care Nurse / equivalent	6	0.6	0	0	Out to advert shortly
Family Integrated Care Link Nurse	0	0	0	0	
Other Family Care (please specify)	0	0	0	0	
Bereavement Lead	0	0	0	0	
Palliative Care Lead	0	0	0	0	
Professional nurse advocate (PNA)	6	0	0.47	2	
Other (please specify)	6	0.6	0.6	1	Safeguarding specialist nurse
Other (please specify)	0	0	0	0	
Other (please specify)	0	0	0	0	
Subtotal - Quality roles		**4.2**	**4.19**	**7**	
TOTAL NON DIRECT PATIENT CARE		**6.2**	**6.19**	**9**	

TRANSITIONAL CARE NURSING STAFF - Neonatal Nurse staff only					**COMMENTS**
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	*e.g. data not available / not collected*
Transitional Care Lead	7	1	0	0	Appointed but not in post. JointNCOT/TC lead
Transitional Care Neonatal Nurse	6	0	0	0	
Transitional Care Nurse	5	0	0	0	
Transitional Care Nursing Associate	4	0	0	0	
Transitional Care Nursery Nurse	4	0	0	0	
Transitional Care Non-registered	0	0	0	0	
Subtotal - Transitional Care		**1**	**0**	**0**	
OUTREACH NURSING STAFF					
Outreach Lead	0	0	0	0	Appointed but not in post yet
Outreach Registered Nurse - Band 6	6	2	2	3	
Outreach Registered Nurse - Band 5	5	0	0	0	
Outreach Nursery Nurse	4	0	0	0	
Outreach Non-Reg (please specify)	0	0	0	0	
Subtotal - Outreach Nursing staff		**2**	**2**	**3**	
TOTAL NURSING WORKFORCE		**64.41**	**57.9**	**77**	

ENHANCED AND ADVANCED NEONATAL NURSE PRACTITIONER DATA				
	Band	**WTE Budget**	**WTE in post**	**Head Count in post**
Enhanced Neonatal Nurse Practitioner (ENNP)	0	0	0	0
Senior ANNP	8b	6.43	6.29	8
ANNP	8a	2.6	3	3
Trainee ANNP	7	1	1	1

ALLIED HEALTH PROFESSIONALS, PSYCHOLOGISTS & PHARMACISTS - *INCLUDE IN PATIENT WTE ONLY*						
	Band*	**WTE Budget**	**WTE in post**	**Head Count in post**	***Required WTE***	***Variance - in post againsts required WTE***
Dietitian	6	0.4	0.4	1	**0.98**	**-0.08**
	7	0.5	0.5	1		
	0	0	0	0		
Pharmacist	8a	0.2	0.2	1	**0.96**	**-0.76**
	0	0	0	0		
	0	0	0	0		
Physiotherapist	6	0.5	0.5	1	**1.10**	**0.00**
	7	0.6	0.6	1		
	0	0	0	0		
Occupational Therapist	6	0.5	0.5	1	**1.10**	**0.00**
	7	0.6	0.6	1		
	0	0	0	0		
Speech & Language Therapist	6	0.3	0.3	1	**0.99**	**-0.29**
	7	0.4	0.4	1		
	0	0	0	0		
Psychologist	8a	1	0.5	1	**1.10**	**-0.60**
	0	0	0	0		
	0	0	0	0		

**Use multiple rows to capture where multiple bands for each occupation*

Neonatal Nursing Workforce Tool (2020): Princess Royal Telford

Unit details			
Trust	Shrewsbury and Telford Hospital NHS Trust		
Unit	Princess Royal Telford		
Designation	LNU		
Completed by			
Date completed			
Activity period	01/04/24	to 31/03/25	365 days

Activity (HRG 2016)		
	Activity	Commissioned cots
HRG 1 (IC)	400	3
HRG 2 (HD)	1,243	3
HRG 3 - 5 (SC)	4,132	16
Total	**5,775**	**22**

Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	41.26	35.65
Total Non QIS	7.86	7.86
Total Non Reg	6.09	6.20
Total	**55.21**	**49.71**

Activity calculations (HRG 2016)							
	Activity	*For calculations*		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	400	*1.4*	*6.07*	3	36.53%	2	1
HRG 2	1,243	*4.3*	*3.04*	3	113.52%	4	-1
HRG 3	4,132	*14.2*	*1.52*	16	70.75%	14	2
Total	**5,775**			**22**	**71.92%**	**20**	**2**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 57.67, of which 40.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	55.21	49.71	48.78	6.43	0.93
Total reg nurses	49.12	43.51	42.34	6.78	1.17
Total QIS	41.26	35.65	29.64	11.62	6.01
Total non-QIS	7.86	7.86	12.70	-4.84	-4.84
Total non-reg	6.09	6.20	6.44	-0.35	-0.24
Reg nurses as % nursing staff	89.0%	87.5%	86.8%		
QIS as % reg nurses	84.0%	81.9%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependency care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Nathalie Eveson (previously Watson)

Shrewsbury and Telford NHS Trust - Risk Review Management Form

[Please click here to view the Risk Matrix]

Some hints to help you complete the form:

* indicates a mandatory field.
indicates help text that provides guidance on how this field should be completed.
indicates a field where multiple values can be selected.
allows you to spell check.

If you require any support using the Risk Register Module, please contact: James Webb, Head of Risk Management on j.webb19@nhs.net or Holly Burrows, Risk Officer on holly.burrows4@nhs.net.

Risk Details

Title and Reference

Risk Title The risk title should succinctly capture the essence of the risk - for example 'Nursing staff 'Trust wide' unable to access mandatory training'	Compliance of QIS nurses does not meet BAPM requirements
Date Opened (dd/MM/yyyy)	17/04/2023
Has this risk been generated as a **DIRECT** result of COVID-19	No
DATIX Risk ID	684
4Risk Ref If this risk was initially being managed on 4Risk, please input the 4Risk Ref within this field	

Risk Location

Trust	Shrewsbury and Telford Hospital NHS Trust
Site	
Division	Women and Children's
Centre	Neonates
Specialty	Neonatology
Location (exact)	
Other areas this same risk event is relevant to: For example, the main risk record could sit with the Pharmacy Centre, within Clinical Support Services Division, but is a risk that relates to staffing levels within the children's centre and neonates.	

Risk Description

Is the current internal issue of an 'Overcrowded ED' a Cause contributing to this Risk Event?	No
Is the current internal issue of 'Patient Flow Challenges' a Cause contributing to this Risk Event?	No
Cause ***As a result of...*** Example cause: As a result of the inability to release clinical staff for mandatory training due to current staffing levels...	Difficultly in recruiting (Network-wide issue for QIS) Difficulties with releasing trained nurses qualified in speciality to Level 3 Units Restriction of numbers of nurses who can be sent for QIS training A number of staff not having Level 3 exposure/experience
Risk Event Description ***There is a risk that...*** Example risk event: There is a risk that our staff are not receiving compulsory training in resuscitation...	We do not achieve BAPM recommendations for 70% of nurses to be QIS trained Of 45 wte nurses 22 wte are trained in speciality. A further 11 are required to be trained to achieve the BAPM target. With turnover, these numbers are harder to achieve
Consequence ***Which might result in...*** Example consequence: Which might result in: 1. Increase in patient safety incidents 2. Non compliance with core standards	Patient Safety risk Poor rota cover for nurses qualified in service Risk of closure of the unit Loss of activity if unable to keep/accept ITU babies Competency issues - nurses with a lack of skills to care for some babies Compounded by high levels of unavailability
Controls in Place at the point of raising this risk For any further controls introduced since raising this risk on DATIX, please add these to the **Controls Section** accessed to the left of this field	A Programme of training is in place to train 11 further nurses to achieve the required standard 2 cohorts of 3 staff are to be trained per year going forward The Programme is due to deliver by March 2024 Rota Management Twice-daily staffing meetings with oversight of the Senior team

Risk Ownership/Responsibility

Risk Owner	Humphreys, Yvonne - Centre Manager - Maternity and Neonatology
Delegated Risk Owner	
Grant access - Staff (Risk) This will grant access to this record for any DATIX user selected here.	Almklow, Mrs Silje - W &C Quality Governance Officer Barnett, Abi - Assistant Operations Manager, Women and Childrens – Maternity, Neonates and Obstetrics Dacosta, miss Corrine allana - Neonatal ward manager Demers, mrs Jo-Anne - Advanced Neonata Nurse Practitioner Plant, Mrs Julie - Divisional Director of Nursing - Women and Children's Division Siddiqui, Mr Zain - Deputy Director of Operation Women and Children
Does this risk also require engagement from any other external organisations to support with the mitigation of this risk	No

Risk Categorisation

All Risks are now categorised by the Organisations Strategic Goals that it impacts on. This enables the Trust to align the Risk Register to the Organisations Board Assurance Framework (BAF) and overall Trust Strategy (2022/2027) .

Risk Type Please choose from one of the 5 principal risks If in doubt, please click on the ? for further information This **should not** reflect what and/or who this risk impacts on if this risk was to occur.	(●) Workforce Risk ( ) Operational Risk ( ) Clinical Risk ( ) Financial Risk ( ) External Risk
Risk Subtype This section is where you need to select what risk sub type it is. For example, there may be a risk which is a staffing risk (i.e. not enough RGNs on a particular ward) but has a patient safety and/or a financial impact; this would be categorised as a staffing risk and **not** a patient safety and/or financial risk, despite the impacts the risk may have.	Workforce / staffing
If this risk was to occur, which one of the Organisations Strategic Goals would this impact on the successful achievement of? Please choose only 1. This should be the goal that this risk would significantly impact on if it was to occur.	( ) Our Patients & Community: We deliver safe and excellent care, first time, every time ( ) Our Patients & Community: We work closely with our patients and communities to develop new models of care that will transform our services ( ) Our People: Our staff are highly skilled, motivated, engaged and live our values. SATH is recognised as a great place to work. ( ) Our People: Our high performing and continuously improving teams constantly strive to improve the services that we deliver (●) Our Service Delivery: Our services are efficient, effective, sustainable and deliver value for money. ( ) Our Service Delivery: We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure. ( ) Our Governance: We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is planned. ( ) Our Partners: We have outstanding relationships with our partners, working together to deliver best practice integrated care for our communities

Hospital Transformation Programme Workstream

Enables alignment of this risk to a Hospital Transformation Programme Workstream that is currently underway within the Trust. The ED Transformation Programme & Maternity Transformation Programme, do not form part of the HTP programme workstream.

Does this risk also need to be aligned to an active HTP Workstream that is currently underway? Please note this **does not include** any other programme that doesn't currently fall into one of ten HTP workstreams (e.g. ED Transformation	No

Programme/Maternity Transformation Programme do not form part of the HTP workstream).

Risk Effect

If this risk was to occur, could this impact 'Trust Wide'?	No
If this risk was to occur, could it impact on any other Divisions?	No

Risk Rating

Please click here to view the Risk Matrix

Please click here to view the Guide for reviewing a risk record

Please click here to view the Guide for closing a risk

Please click here to view the Guide for creating a PDF of a risk record

Please click here to view the Risk Review Checklist

Initial

This is the **initial** level of risk before any controls are applied

	Consequence (initial)				
Likelihood (initial)	**Negligible(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Severe (5)**
Almost Certain (5)	○	○	○	◉	○
Likely (4)	○	○	○	○	○
Possible (3)	○	○	○	○	○
Unlikely (2)	○	○	○	○	○
Rare (1)	○	○	○	○	○
	Rating (initial): 20			**Risk level (initial):** Extreme (15-25)	

Current

This is the **current** level of risk whilst current controls are in place

Based on **current data** establish how often this risk event is occurring, and then **based on the the established likelihood** agree the level of consequence this risk event is resulting in.

	Consequence (current)				
Likelihood (current)	**Negligible(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Severe (5)**
Almost Certain (5)	○	○	○	○	○
Likely (4)	○	○	○	○	○
Possible (3)	○	○	○	◉	○
Unlikely (2)	○	○	○	○	○
Rare (1)	○	○	○	○	○
	Rating (current): 12			**Risk level (current):** High (8-12)	

Rationale for 'Current Risk Rating' Please explain your rationale for choosing the risks **CURRENT**	[17/08/2023 14:30:27 Nathalie Eveson (previously Watson)] Risk score increased by RMC (20) – not accepted -Risk score to be reduced to 16 and returned to RMC for discussion. [09/08/2023 13:12:38 Nathalie Eveson (previously Watson)] Current risk score increased from 16 to 20 at RMC 26/07/2023 [26/07/2023 09:42:50 Louise Duce] Attendance at deliveries is required

level of likelihood and consequence Example, L = 4 (Likely) Current data supports the fact that this risk event is occurring on a weekly basis C = 2 (Minor) Based on this risk occurring on a weekly basis, this is resulting in minor levels of harm L4XC2 = 8 (A total score of between 8-12) equates to this risk **currently** being a 'high level' risk	Unpredictability of labour Some staff senior have not been to a level 3 unit [26/07/2023 09:38:17 Louise Duce] Unpredictability of delivery of babies Sickness and skill mix, majority junior staff Having not been to level 3 units No honorary contract started as yet [17/07/2023 12:26:47 Nathalie Eveson (previously Watson)] Staffing Compliance Major (4) x Almost certain (5) = (20) Staffing Compliance Major (4) x Likely (4) = (16) Mitigation

Current Trend
Based on the **current risk rating** please update every time the risk is reviewed.

How are we monitoring the risks ongoing performance? Key Performance Indicators (KPI) provide targets for teams to work towards, milestones to gauge progress, and insights that help people across the Trust make better decisions Please click on ? for examples	Monitoring

Target
This is the **accepted** level of risk seeking to be achieved once all controls and actions have been completed

Please click here to view the Risk Appetite Statement

	Consequence (Target)				
Likelihood (Target)	**Negligible(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Severe (5)**
Almost Certain (5)	○	○	○	○	○
Likely (4)	○	○	○	○	○
Possible (3)	○	○	○	○	○
Unlikely (2)	○	◉	○	○	○
Rare (1)	○	○	○	○	○
	Rating (Target): 4		**Risk level (Target):** Moderate (4-6)		

Has this risk affected overall staff wellbeing?	◉ None ○ Yes ○ No ○ Not applicable

Financial Impact

What are the financial implications of this risk?	Minor

Risk Approval

Has this risk been approved by either a member of the leadership team or committee?	Yes
Name of person/committee approving risk	W&C Risk Register Committee
Date risk approved	17/04/2023
Is the current rating of this risk Extreme?	Yes
Date Extreme risk discussed and approved at Divisional/Directorate Committee level	17/04/2023
Date Extreme risk scheduled to be discussed and approved at Risk Management Committee	26/07/2023

Key Dates

Please ensure all dates are populated correctly and updated during each risk review, to avoid this risk being identified as 'overdue'.

Last Review Date Please record when the **last review** of this risk took place. This date does not self populate	22/05/2025
Next Review Date (dd/MM/yyyy) Please record when the risk is due to be reviewed **next** Advised risk review frequency in accordance with the **'current'** rating of risk: **Extreme**: Monthly **High**: Bi-Monthly **Moderate**: Quarterly **Low**: Quarterly	22/07/2025
Last updated	Nathalie Eveson (previously Watson) 23/05/2025 12:03:44

Approval Status

To ensure the risk is being placed into the correct approval status, please click on the below

Please click here to view the Approval Status Guide

Current approval status	Active Risks

Controls

Controls

Please click on EDIT TO add any further controls introduced since raising the risk on DATIX

Please remember to click on 'apply changes' once further controls have been added into this section

Value
17/07/2023: Ward Manager and Educator are working clinically when required
17/07/2023: Liaison discussions with other units regarding Priority Order
17/07/2023: 3 x staff commenced training in June 2023
17/07/2023: LD is reporting on QIS as part of the daily capacity (OPEL) report
17/07/2023: Increase of agency recruitment
14/08/2023: Reduce bed occupancy
14/08/2023: Exemption for incentive for bank staff
14/08/2023: Use of Thornbury agency staff - Critical agency staff are QIS trained
28/09/2023: 24-month rolling training program

Business Continuity Planning (BCP)

Business Continuity Plan (BCP) is a logical sequence of events to be followed in the event of a loss or interruption to a critical function

Please click here to view the Business Continuity Planning Policy

Is there currently a Business Continuity Plan in place to help prevent and/or recover from this area of risk?	
Is their scope for a Business Continuity Plan to be considered?	

Actions

Based on any identified gaps in our controls, please create a separate action for each gap to assist with the mitigation of this risk

Once the action has been completed, consider whether this needs to be added as a control within the controls section

Action ID	Responsibility ('To')	Assigned by ('From')	Module	Description	Due date	Done date	Priority
9893	Tina Kirby	Nathalie Eveson (previously Watson)	Risk Register	Operational Plan	31/10/2023	15/06/2023	Medium
9894	DM2	Nathalie Eveson (previously Watson)	Risk Register	Training of QIS - Network	31/10/2023	28/09/2023	Medium
9895	Mrs Louise Duce	Nathalie Eveson (previously Watson)	Risk Register	plan regarding minimum QIS staff on shift	31/07/2025		Medium
11237	Mrs Louise Duce	Nathalie Eveson	Risk Register	Workforce Toolkit	31/07/2025		Medium

		(previously Watson)					
9892	DM2	Nathalie Eveson (previously Watson)	Risk Register	QIS training programme	31/07/2025		Medium

Action chains

Creating a new action chain will send a reminder to the assigned 'action owners' NHS e-mail address, 5 days before the action is due for completion

No action chains

Risk Review

Risk Review Checklist:

As part of the review, the following fields should always be updated within the record:

1. Is this risk still described accurately? (Cause/Risk Event/Consequence field)

2. Have relevant staff members been given additional access to risk? (Risk Ownership/Responsibility field)

3. Is the risk owner and delegated risk owner still correct?(Risk Ownership/Responsibility field)

4. Has the current risk rating score been justified? (Rationale for 'current risk rating' field)-(update 'current trend' field if required)

5. Are the key dates accurate and updated? Low/Moderate (updated Quarterly) High (updated bi-monthly) Extreme (updated monthly)

6. Do any more controls need to be added? (controls section-left hand pane)

7. Is the approval status at the bottom of the record correct?(select question mark for help)

8. Do any more actions need to be added? There should be a minimum of 1 action to show what is being done to mitigate the risk (actions section-left hand pane)

9. If closing the risk, have all the actions been closed?

10.Place an update in the field below

Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 23/05/2025 11:25:54	Neo Risk Update Meeting 22/05/2025: QIS compliance currently at 53% (an increase in the overall workforce impacting the percentage). Trajectory to be produced- Meeting 03 June. All spaces filled for training - in progress: Sept: 3 x foundation Nov: 2 x QIS Dec: 2 x foundation and 1 x QIS
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 28/01/2025 11:11:03	Neonatal Risk Update Meeting 23/01/2025: Update required from Jo Demers
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 28/11/2024 14:00:56	Neonatal Risk Update Meeting 28/11/2024: Band 6 nursing staff - implemented. Ongoing programme to train 2 nurses every 6 months. Trajectory: to be 75% compliant by December 2025 (subject to number of leavers).
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 24/09/2024 13:34:52	Neonatal Risk Update meeting 26/09/2024: Risk Reviewed
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 31/07/2024 15:01:24	The target of 75% compliance by 2025 will be affected by the current Recruitment Freeze as well as educational requirements to undertake the training.

Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 23/05/2024 13:50:27	Business Manager TK 23/05/2024: Possible plan to recruit additional Band 6 nursing staff - With LD
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 29/04/2024 12:15:16	Neonatal Risk Update meeting 25/04/2024: The target of 75% compliance by 2025 will be affected by the current Recruitment Freeze as well as educational requirements to undertake the training. We continue to send 2 x nurses per year for training, every intake. LD 26 04 2024: 50.3% QIS compliance.
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 22/02/2024 14:16:41	Neonatal Risk Update meeting 22/02/2024: Risk reviewed. No further updates.
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 07/02/2024 11:15:37	Neonatal Risk Update meeting 31/01/2024: 3 x nurses have completed training from June 2023 intake 3 x nurses commenced training in January 2024 2 x secured to commence training in June 2024 - 3rd yet to be allocated Compliance % due in March 2024
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 20/12/2023 13:34:21	Neo Risk Update meeting 20/12/2023: Movement into Quality roles. Therefore, compliance percentage has not increased (53.5%). To benchmark against other level 2 units 2 x newly trained QIS nursed and we continue with the rolling training program.
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 30/11/2023 12:40:40	Neonatal Risk Update Meeting 23/11/2023: 2 x new QIS starters – Sept and Oct. Going out to advert for QIS nurses
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 30/10/2023 13:16:17	W&C Risk Register Committee Meeting 24/10/2023: Risk score reduced to possible = 12
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 28/09/2023 15:45:53	LD 28/09/2023 Neo Risk Update Meeting: Risk fully reviewed and updated. Annual Workforce Toolkit has been undertaken - 55% compliance (target of 70%). To continue with mitigation and actions and to repeat the Workforce Toolkit in 6 months
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 21/08/2023 12:02:23	Neonatal Risk Update meeting 21/08/2023: Dr J Brindley has populated a table to demonstrate the number of QIS trained nurses on shifts. LD informed of the reporting of senior and junior QIS skill set - Daily staffing report and roster. Quarterly compliance is reported and monitored via the dashboard. Work has commenced for staff to gain experience on QIS units. W&C Risk Register Committee Meeting 11/09/2023 JP/LD: Challenged the upgrading of the risk by the Rapid Review group in July by the Divisional COO and Director of Midwifery – remains as previous. Very few non-compliant shifts as mitigated by the use of agency nursing. The only few occasions where the shift has been without the agreed numbers of QIS staff have been mitigated by the use of off-framework agency staff. Approximately 2 shifts were below requirements in August due to late notice sickness calls. 3 further staff have been assigned to undertake the programme in January and June 2024 (regular program for 3 staff each programme).
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 17/08/2023 14:30:56	W&C Risk Register Committee Meeting 14/08/2023: + Mitigation – Reduce bed occupancy, exemption for incentive for bank staff, use of Thornbury agency staff, Critical agency staff are QIS trained. + Cause – Compounded by high levels of unavailability. JP to review incidences of low QIS levels on shifts. Risk score increased by RMC (20) – not accepted -Risk score to be reduced to 16 and returned to RMC for discussion.
Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 09/08/2023 13:12:57	Current risk score increased from 16 to 20 at RMC 26/07/2023 -6 month timeframe

Eveson (previously Watson), Nathalie - CNST Administrator (Operation Lincoln) 17/07/2023 12:29:39	Neo Risk Update Meeting 17/07/2023: Narrative fully reviewed and updated. Controls added. 2 x controls to be removed (twice-daily staffing meetings and programme to be delivered by 2024). Risk score increased: From 15 + 10 to 20 + 16. LD to present at RMC, as this is now scoring as an extreme risk

Documents

This section allows for documents to be uploaded to support the risk being on the register

No documents.

Communication and feedback

Recipients

Message

Message history				
Date/Time	**Sender**	**Recipient**	**Body of Message**	**Attachments**
No messages				

Linked Records

This section enables the user to link the risk to any incidents, risks, complaints and claims recorded on DATIX. Please be aware that some users might not have the required permissions to access the linked records.

No Linked Records.

Risk Reporter and Notifications

	Contact ID	Forenames	Surname	Job Title	Tel 1	Email
▶	170590	Nathalie	Eveson (previously Watson)	CNST Administrator (Operation Lincoln)	5951	nathalie.eveson@nhs.net

Notifications

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job title	Originated from
Kirby, Tina	tina.kirby@nhs.net	24/04/2023 11:51:42	251178		Women's & Children's Business Manager	Level 1 Form
McLean, Dovejah Mrs	dovejah.mclean@nhs.net	24/04/2023 11:51:42	477157		*account closed *Matron - Neonatal	Level 1 Form
Plant, Julie Mrs	julieplant@nhs.net	24/04/2023 11:51:42	495768		Divisional Director of Nursing - Women and Children's Division	Level 1 Form

Corporate Risk Register

This section is ONLY to be completed by the Head of Risk

Is this Risk currently on the Corporate Risk Register
Date Risk added to Corporate Risk Register
Reason for Risk being added to Corporate Risk Register
Date Risk removed from Corporate Risk Register

Getting to Good

This section is ONLY to be completed by a Project Manager

If this risk was to occur, which of the 'Getting to Good' projects could this impact on the successful achievement of?

Maternity & Maty/Neonatal Governance.
Date of meeting: 19th December 2025

Agenda item	Education and Training Report			
Report	**Maternity Incentive Scheme Year 7 Safety Action 8 Closure Report**			
Executive Lead	**Director of Nursing**			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	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:	Divisional committee			
Dependent upon (if applicable)**:**				
Executive summary:	This report provides the final figures for Safety Action 8 of Maternity Incentive Scheme Year 7. A Local Training Plan was developed to meet the requirements of the Core Competency Framework (NHSR 2023) and whilst SATH continues to implement all six core modules of the Core Competency Framework, this will not be measured in Safety Action 8 (NHSR MIS Year 7 V1 1st April 2025) A minimum of 90% compliance for each relevant staff group is required for the following training as part of the Maternity Incentive Scheme reporting for Year 7. • Fetal Monitoring and Surveillance (in the antenatal and intrapartum period) • Multi-professional Maternity Emergencies Training • Neonatal Resuscitation Training **Compliance of 90% has been achieved for all 3 standards along with the requirement for Insitu Simulation and Neonatal Resuscitation Training standards.** The report refers to the LMS training compliance figures from the SATH Staff Compliance Report 5th December 2025. Where data is not available on the LMS for Obstetric Medical Staff and Anaesthetists working in Maternity a local spreadsheet has been compiled and saved on the SATH Shared Y drive. Compliance data for			

	Neonatal Unit Staff has been provided by the Neonatal Education Team and Clinical Director for Neonates. Where figures are not available on the LMS they will be held separately on the Trust shared drive.
Appendices	Appendix 1 – Simulation Reports
Author	Karen Henderson – Clinical Education Midwife

1.0 Introduction

CNST Maternity Incentive Scheme Safety Action 8

The NHSR Maternity Incentive Scheme Year 7 guidance document was published on 1st April 2025 and set out the requirements for Safety Action 8.

A minimum of 90% compliance for each relevant staff group is currently required for the following training as part of the Maternity Incentive Scheme reporting for Year 7.

- Fetal Monitoring and Surveillance (in the antenatal and intrapartum period)
- Multi-professional Maternity Emergencies Training (PROMPT)
- Neonatal Resuscitation Training

2.0 Core Competency Framework

The Local 3 year Training Plan was developed in line with the 4 key principles of the Core Competency Framework Version 2 (NHSE 2023)

1. Service user involvement in developing and delivering training.
2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This includes reinforcing learning from what went well.
3. Promote learning as a multidisciplinary team.
4. Promote shared learning across a Local Maternity and Neonatal System.

The Local Training plan was first implemented in August 2021 (CNST Year 4, CCF Version 1). This Training Plan was then further developed using the' How to Guide' (*NHS England*) to meet the additional requirements of the second iteration of the CCF released on 31st May 2023.

The Local Training Plan was presented at the Maternity Training Faculty meeting in April 2023. The training plan was presented and approved at Divisional Committee on 26th June 2023.

The 3 Year Local Training Plan Schedule.

Year 1 August 2023 -July 2024
Year 2 August 2024 – July 2025
Year 3 August 2025 – July 2026

SATH continues to implement all 6 Core Modules of the Core Competency Framework however compliance with all modules is not being measured in MIS Safety Action 8 this year.

2.1 Maternity Incentive Scheme Year 7 Compliance Figures.

2.1.1 Fetal Monitoring and SurveillanceTraining compliance as of 5th December 2025

Designation	Compliance % December
Midwives	99.16%
Obstetric Consultants	100%
Other Doctors	100%

2.1.2 Multi-professional Maternity Emergencies Training (PROMPT) as of 5th December 2025

Designation	Compliance % December 2025
Midwives	99.62%
Obstetric Consultants	100%
Other Doctors	100%
Obstetric Anaesthetists	97.5%
MSWs / WSAs	97.26%

2.1.3 Neonatal Resuscitation Training Compliance data as of 5th December 2025

Designation	Compliance % December 2025
Neonatal or Paediatric Consultants covering Neonatal Units	100%
Neonatal Junior Doctors	100%
Advanced Neonatal Nurse Practitioner (ANNP)	100%
Neonatal Nurses Band 5 & above who attend deliveries	100%
Midwives	99.23%

2.2 Neonatal Resuscitation Training Standards MIS Year 7 V1 1.4.2025

2.2.1 **In house Neonatal Resuscitation Training annual updates** have been delivered by Registered Resuscitation Council trained NLS instructors in line with the requirements of the MIS Year 7.

2.2.2 **Neonatal Staff Training**

A minimum of 90% of paediatric/neonatal staff ***who attend neonatal resuscitations unsupervised*** *should have been trained and assessed in line with:*

The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024)

*All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.*
No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required.

Confirmation received from Clinical Director for Neonates that current training for Neonatal Staff fufils the BAPM standards in line with Safety Action 8 MIS Year 7 V1 (Email communication 2nd June 2025) .

2.3 Maternity Incentive Year 7 Insitu Simulation Requirement Standards

2.3.1 At least one emergency scenario should be conducted in any clinical area as part of each emergency training day (MIS Year 7 V1 1.4.2025)

This standard has been achieved in the MIS Year 7 reporting period with at least one simulation during the PROMPT Training Day being delivered in the clinical area since the training was moved back to the the Women and Children's Centre Walker Training Suite in May 2023. However this standard is not being measured in Year 7 of the MIS but will continue to be the ambition for local PROMPT training.

2.3.2 At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, Theatre, a ward. This should not be a simulation suite (MIS Year 7 V1 1.4.2025)

This standard has been achieved within the reporting period of Year 7 with recorded attendance from Obstetrics, Midwives and Support staff, Anaesthetics and Theatre Team and Neonatal team.

Simulation report and Summary of Learning presented to Maternity Governance on 17th October 2025.

2.4 Records of compliance

Maternity training compliance is recorded on the Trusts LMS with a monthly report for Women and included in the Staff Compliance report held on the Corporate X Drive.

Where compliance data for Obstetric Medical staff and Anaesthetists is not available on the Staff Compliance report, local records have been compiled and held on the Department Shared Y drive as evidence of compliance.

Compliance data for Neonatal Unit Staff are provided by the Neonatal Education Team and Clinical Director. Where figures are not available on the LMS they will be held separately on the Trust shared drive.

2.4.1 Temporary Staffing

Bank staff who do not have a substantive contract are not included within the Women and Children's figures on the LMS. Ward Managers are responsible for ensuring that bank staff working within their Clinical Areas are up to date with training.

Long Term Locum Medical Staff working in Maternity and Neonates have been included in the figures reported.

2.4.2 Long Term Sickness and Maternity Leave

The MIS year 7 has recognised that any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in the MIS declaration while they are absent from work, and for one month after their return.

Staff have been be prioritised to attend PROMPT, Fetal Monitoring Training and Neonatal Resuscitation Training as soon as possible on their return to work.

2.5 Conclusion

The training standards and compliance required for the Maternity Incentive Scheme Year 7 Safety Action 8 (V1 1st April 2025) have been achieved during the reporting period.

Karen Henderson
Lead Midwife for Education.

Appendix 1.0 Multi-professional Simulation Reports 6th October 2025

Obstetric Emergencies- Simulation in Clinical Areas

SUMMARY REPORT :DATE 6TH OCTOBER 2025

Date and time:	6th October 2025 10:15 hrs
Scenario:	**S:** Hattie is being transferred to theatre for a trial of instrumental delivery due to delay in 2nd stage of labour. **B:** P0, 39+4, IOL for GDM on metformin, epidural in situ and working well, fully +1, pushing for 2 hours but no progress. **A:** Observations prior to transfer to theatre – BP 115/78, pulse 95bpm, temp 37.2, RR 17. CTG – no evidence of hypoxia. Contracting 3:10, on oxytocin 4.8mls/hour. OA position on VE. **R:** The patient has just been transferred to theatre, please continue care.
Details of any adaptions to scenario:	Clinical course: Following completion of theatre sign in, the epidural is topped up effectively. The expectation is that legs are elevated into lithotomy position and the neonatal team are called. The Obstetrician should perform a vaginal examination, and a ROA position will be identified. Neville Barnes Forceps will be applied and locked and following 2 tractions there is no descent. With the CTG in place a fetal bradycardia will be heard. A decision should be made to revert to Category 1 C/S. At CS there is an impacted fetal head requiring vaginal push up and tocolysis. The baby is born in poor condition: pale, floppy and not breathing. The scenario continues with the Neonatal team leading the resuscitation of the baby (See separate SBAR)
Faculty present	Sue Rutter - Consultant Obstetrician Chris Clulow - Consultant Anaesthetist Karen Henderson - Education Team Jade Whitaker – Education Team Naomi Parry - Education Team Emma Douglas – Theatre Team

Attendees/ participants	
Names and designation:	**Obstetric team** Doors Charlesworth – Consultant Joy EddyEffiom – Registrar Emmanuel Newton – SHO **Midwifery Team** Georgia Walker – Midwife Jenny Abbott – Coordinator Danica Price - Midwife **Theatre Team** Sr S Bebbington – Scrub Nurse SN S. Mathews – Scrub Nurse SN S. Danso – Circulator SN Roby – Recovery Nurse **Anaesthetic Team** Aruna Wickramasinghe - Speciality Registrar Manpreet Badh - Anaesthetic trainee (CT3) Irtiqa Punjabi - Speciality Registrar

Organisational Learning
Good Practice Points • Early recognition and declaration of an obstetric emergency • Appropriate clinical management of impacted fetal head • Demonstration of effective clinical leadership and good teamworking throughout scenario • Good communication between Obstetricians and Anaesthetists regarding the need for tocolysis and escalation to Category 1 CS • Appropriate adjustments made to positioning of woman to allow for vaginal push up • Good communication with scribe. Good scribing notes on whiteboard

- Good recording and declaration of estimated blood loss (which was measured)

Key Learning to share with teams?

Neonatal Team: Feedback included within Neonatal simulation summary as below:

- **Handover to neonatal team** – we discussed importance of neonatal team being present for the pre-brief/checklist prior to procedures in theatre when possible, to ensure that they have up to date information about the pregnancy, labour and risk factors for the baby. We also discussed this as an opportunity to ensure the right team are present – for example does the tier 2 or Consultant need to be called?
- **Team's roles and theatre hats -** is there a possibility to have different coloured disposable hats for different roles? E.g. pink for neonatal team, blue for obstetrics/midwifery, green for ODP etc. We discussed that it what challenging to know each person's role – knowing this would help to make communication more efficient and effective. We discussed writing name and role on hats as a temporary measure.
- **Room Layout** - current room layout is particularly challenging for neonatal team – resuscitaire is in the corner with lots of other equipment nearby, especially when equipment such as cell salvage machine is in use. This means there are lots of obstacles, including wires across the floor, which the cot and neonatal crash trolley need to be moved over. Limited options for resolution in current space, but we discussed highlighting this to the HTP team regarding new building.
- **Whiteboard for documentation of neonatal resuscitation plus new scribe sheet** – currently this is too far away from the resuscitaire – we discussed moving this to the opposite wall (to the left of the resuscitaire).
- **Airway equipment** – highlighted that whilst there is airway equipment in the drawers of the resuscitaire, there is no CO2 detector or ET fixation equipment – these are kept in the resus trolley in theatre 9 and in a box on top of the resus trolley by room 8 on labour ward.
- **"Reset"** – this word is used by obstetric/midwifery/anaesthetic team in times when environment is too noisy and needs to be brought to quieter level – this could be used by the neonatal team too.
- **Theatre 10 access** – many of neonatal team do not have access to the room between theatre 9 and 10 – needs to be resolved ASAP with estates.

Additional Learning:

- **Theatre team roles** - Presence of recovery nurse in theatre – discussed importance of attendance with other theatre staff to ensure sufficient staff present for all tasks and improved communication for recovery management.
- **Allocation of tasks –** discussed the importance of allocation of tasks to ensure everyone is aware of their role within an obstetric emergency. Discussed positioning of staff within theatre to aid completion of tasks such as scribing. Identified challenges to room layout and presence of obstacles such as equipment. Although there are limited options within the current space some adjustments can be made in terms of positioning of scribing boards as highlighted in the Neonatal summary. Issue to be highlighted to HTP Team and suggested future simulation to test clinical spaces within new building.

- **The importance of non-clinical/human factors on team working, safety and efficiency** Stressed the importance of clear and calm leadership, role allocation and appropriate task allocation, considering how we communicate in emergencies.

*See Live drills database for action tracker

Faculty learning

What went well:

- Scenario ran as planned with good engagement from all teams.
- Good use of Mentimeter for feedback. Excellent feedback and learning noted.
- Good to use theatre setting which enabled identification of room practicalities along with clinical management and human factors.

What could we have done differently:

Inclusion of Neonatal team within pre brief – to ensure that staff within the simulation are aware that the Neonatal team have left theatre after the team brief and need to be recalled for purpose of the simulation

Use of equipment and sharps – ensure staff fully aware what equipment can be opened. Avoid opening of sharps within the simulation.

Use of Reset – Faculty may also use reset when needed during in situ simulations

Faculty debrief – highlighted it would have been beneficial for all members of the simulation faculty on the day to meet after the simulation to debrief and consider future planning

MDT Simulation (CNST) Neonatal Summary

6TH OCTOBER 2025

Date and time:	6/10/2025 AM
Scenario:	S – Term baby, in theatre initially for trial of instrumental delivery – this was unsuccessful due to head position and baby developed fetal bradycardia – therefore transition to cat 1 c.section. B – Gestational diabetes, on metformin, no infection risk factors, no CTG concerns prior to being in theatre. A – At birth, baby is floppy with HR <60, pale and no respiratory effort. R – Tier 1 bleeped to attend trial of instrumental delivery in theatre, expected to escalate to tier 2 once becomes cat 1 and with fetal bradycardia.
Details of any adaptions to scenario:	Scenario proceeds with NLS. First attempt at inflation breaths did not achieve chest wall movement, but this is obtained with two person technique. HR did not respond and still less than 60 after 30 seconds of ventilation breaths – CPR required. HR improved after chest compressions, but baby then gasping and requires ongoing respiratory support. Baby was intubated at around 8 minutes of age. Cord blood gas showed pH <7.
Faculty present	A.Belfitt (Consultant) M.Badawy (Consultant) J.Stock (Sim Fellow)
Attendees/ participants	R.Delap (Tier 2) E. Oluchuwu (Tier 1) Natasha Peplow (NIC NNU)

Organisational Learning

Good Practice Points

- Good communication between neonatal and midwifery team – e.g. neonatal team sought clarification regarding history on arrival, also listened to suggestions from team.
- Timely escalation – asked for Tier 2 when decision made for cat 1 c.section and fetal bradycardia
- NLS performed as per algorithm
- Recognised quickly the significance of the cord gases and that baby may require therapeutic hypothermia.

Key Learning to share with teams?

- **Handover to neonatal team** – we discussed importance of neonatal team being present for the pre-brief/checklist prior to procedures in theatre when possible to ensure that they have up to date information about the pregnancy, labour and risk factors for the baby. We also discussed this as an opportunity to ensure the right team are present – for example does the tier 2 or Consultant need to be called?
- **Teams roles and theatre hats -** is there a possibility to have different coloured disposable hats for different roles? E.g. pink for neonatal team, blue for obstetrics/midwifery, green for ODP etc. We discussed that it what challenging to know each person's role – knowing this would help to make communication more efficient and effective. We discussed writing name and role on hats as a temporary measure.
- **Room Layout** - current room layout is particularly challenging for neonatal team – resuscitaire is in the corner with lots of other equipment nearby, especially when equipment such as cell salvage machine is in use. This means there are lots of obstacles, including wires across the floor, which the cot and neonatal crash trolley need to be moved over. Limited options for resolution in current space, but we discussed highlighting this to the HTP team regarding new building.
- **Whiteboard for documentation of neonatal resuscitation plus new scribe sheet** – currently this is too far away from the resuscitaire – we discussed moving this to the opposite wall (to the left of the resuscitaire).
- **Airway equipment** – highlighted that whilst there is airway equipment in the drawers of the resuscitaire, there is no CO2 detector or ET fixation equipment – these are kept in the resus trolley in theatre 9 and in a box on top of the resus trolley by room 8 on labour ward.
- **"Reset"** – this word is used by obstetric/midwifery/anaesthetic team in times when environment is too noisy and needs to be brought to quieter level – this could be used by the neonatal team too.
- **Theatre 10 access** – many of neonatal team do not have access to the room between theatre 9 and 10 – needs to be resolved ASAP with estates.

Faculty learning

What went well:

- Scenario ran as planned and identified important human factors elements as well as practicalities in the room.

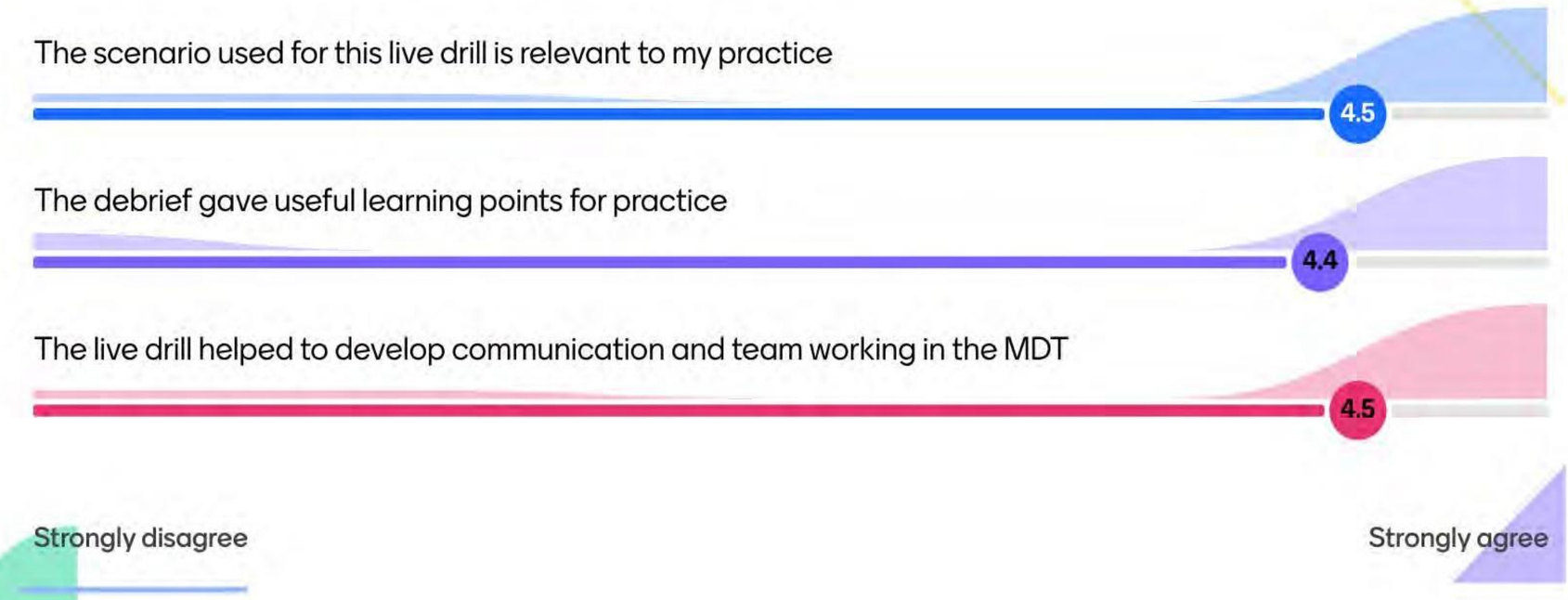
What could we have done differently:

- Although it was good to include neonatal team in the pre-brief, we could have then made it clearer that the team were no longer there for the purpose of the simulation – i.e. would need to be bleeped to attend when needed.

Mentimeter

Live Drills in the Clinical Area

Live Drills



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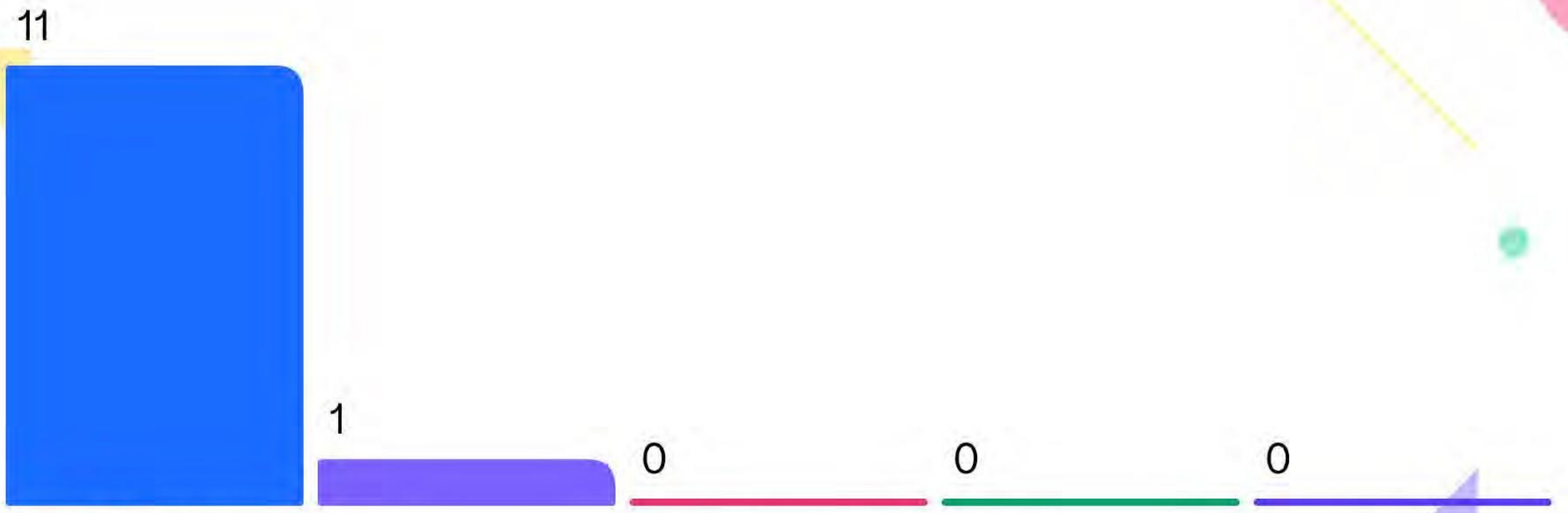
Mentimeter

This live drill was helpful for my learning and practice



12

Mentimeter

Any other comments about the live drill?

Nice	No	No	Good
Good	Really helpful to run the drill in situ - very realistic & relevant scenario, great for learning from an early trainee point of view!	Nil	N/a

1 7

Mentimeter

Any other comments about the live drill?

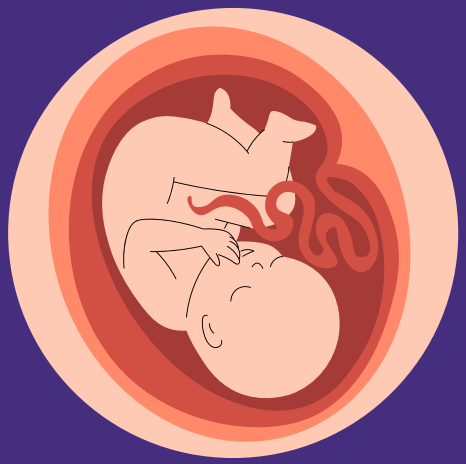
It was an excellent learning opportunity , how to act quickly in an emergency situation.

Very helpful

Really excellent and realistic! Thank you!

Thank you! Really highlighted the mdt and how to work in that.

1 7



Learning from Simulation

6th October 2025

Scenario

A patient is transferred to theatre for a trial of instrumental delivery. Unable to deliver by forceps and a fetal bradycardia is identified - decision for cat 1 CS and identification of impacted fetal head. Managed with tocolysis and vaginal push up. Baby born in poor condition and NLS carried out by neonatal team.

Areas of great practice

- Involvement of all disciplines including: Theatres, Obstetric, Midwifery and Neonatal teams.
- Early recognition and declaration of the emergency
- Effective clinical leadership and teamworking throughout
- Adjustments of positioning made to allow for vaginal push up during CS
- 'Teach or treat' used during the simulation

Points for Learning

- Any person in any team can use the term 'reset' if the noise level is too high or communication is becoming challenging
- An encouragement to write your name and role on your hat, this helps to identify people and allocate roles effectively, especially when we have new team members
- Call the neonatal team in good time so they can receive a full handover and prepare before the birth.

Neonatal simulation
Summary of Learning
6th October 2025

Scenario

Joint simulation with midwifery, obstetric, anaesthetic and theatre team.

Term baby, low risk pregnancy. Initial trial of instrumental delivery but developed prolonged fetal bradycardia and transition to category 1 c.section. Born in poor condition requiring CPR and intubation.

Good points

- Good **communication between neonatal and midwifery team** including listening to team suggestions
- **Timely escalation** and asking for help
- Recognised quickly the **significance of the cord gases** and that baby may require therapeutic hypothermia.

Learning points

Please check you can access Theatre 10 with your ID card! If not please discuss with ID badge office urgently.

Aim for neonatal team to be present at theatre pre-brief/checklist for effective handover

It is difficult to know who is who in theatre! Try writing name and role on scrub cap if you have time (possibility of different hat colours to be discussed!)

Beware challenging room layout in theatre 10. Crash trolley is in theatre 9. Scribe poster to be moved closer to resuscitaire.

Co2 detectors and ET fixation are currently not kept in resuscitaire - found in or on top of neonatal crash trolleys (theatre 9 and LW room 8)

"Reset" - word used by anaesthetic/obstetric team to ask for noise level to be reduced in busy situations - can be used by neonatal team too.

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

Maternity Safety Support Programme	Yes

QUARTER 3 - 2025					October	November	December	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		1	2		**October** Woman brought in by ambulance following delivery of approximately 34/40 gestation baby at home, un-booked pregnancy, mother not aware she was pregnant. Attended by ambulance crew following birth ongoing joint reviews being held baby very growth restricted. **November** 35+3/40 – twin pregnancy with fetal demise of one twin at 25/40. Delivery by EMCS, for wellbeing of surviving twin. 36/40 – woman attended triage with RFM, but an IUD was sadly diagnosed upon review
			Late fetal losses >22 wks		0	0		
			Neonatal Deaths		0	0		
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI			0	1		**October** No new referrals MI 041750 - Final Report received no safety recommendations, to be presented at RALIG. **November** MI-049260 - EMCS following induction at 41+5/40. The baby required resuscitation at birth, received therapeutic hypothermia, and had a normal MRI. MNSI accepted the case due to family concerns. MRI second opinion from Alderhay awaited, however preliminary report is NAD.
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**			0	0		**October** No new learning responses were commissioned in October **November** No new learning responses were commissioned in November
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**			0	0		**October** No new learning responses were commissioned in October **November** No new learning responses were commissioned in November
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken			1	1		**October** 1 - Moderate reported in October Pressure ulcer / DTI - Images show Deep tissue injury to forehead and nose, device related (CPAP) DOC completed **November** 1 - Moderate Suspected PPHN/HIE baby sent for cooling MNSI referral DOC completed
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken			19	17		**Severe (6)** 6-PPH over 1500ml **Moderates (13)** 3- PPH over 1500ml 5- 3rd and 4th Degree Tears 1- Caesarean section - Category 1 1- Failure to act on adverse symptoms/test images or results 1- Newborn observation issues 1- Transfer to ITU/HDU 1- Unexpected admission to NNU **November** **Severe (5)** Maternal Collaspe 28/40 DCDA twin pregnancy, SROM at 01:00 18/11/25, admitted to AN ward, plan for IUT documented at 13:39 due to NNU capacity. 2 - PPH over 1500ml (2.4L, 1813ml) 1 - Return to theatre **Moderate (12)** 1 - Cat 1 1 - Cord Prolapse 1 - Fall from height 1 - BBA in ambulance 1 - Inadequate information for consent gained 1 - Unexpected admission to NNU (MNSI case) 1 - Postnatal readmission wound infection 3 - PPH over 150ml 1 - Ruprured uterus 1 - 3rd Degree tear
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	96%	100%		The closure report for MIS Year 7 Safety action 8 will be presented at Maternity Governance on 19th December. Over 90% has been achieved for all required staff groups for PROMPT, NLS and Fetal Monitoring training.
				Fetal Monitoring	100.00%	100%		
			Midwives	PROMPT	99.23%	99.62%		
				NLS	99.23%	99.23%		
				Fetal Monitoring	99.58%	99.16%		
			Other Drs	PROMPT	100%	100%		
				Fetal Monitoring	100%	100%		
			Neonatal Nurses	NLS	100%	100%		
			Anaesthetists	PROMPT	90.00%	97.50%		
			WSAs/MSW	PROMPT	98.59%	97.26%		
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		98%	95%		
			Maty 1:1 care in labour		100%	100%		
			Fill rates Delivery Suite RM		D 90% N 78	D 93% N 91%		
			Fill rates Postnatal RM		D 91 N 80	D 107% N 97%		
			Fill rates Antenatal RM					
			Obstetric Cover on D Suite		100%	100%		
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements (*To note feedback one month behind)*						•I didn't know this page existed, so this is VERY belated! But I gave birth on 26th April this year and wanted to say a HUGE thank you to all the team of midwives that looked after me at PRH! But the most special thank you to who was an absolute angel in delivering my little ! Between the mass amount of pain, we did have some laughs!! What a long night we had!! • Just wanted to say a huge thank you to everyone at PRH Maternity triage, antenatal ward, post-natal ward, and delivery suite. I wish I could remember all of your names but you were all very helpful and you eased away my anxieties. Thank you for doing such a good job looking after us. • Our baby was born on the 3rd of December via C Section due to placenta praevia. The team were amazing! Special shoutout to the consultants who made necessary arrangements to make sure my baby and I are safe despite the risks, the surgeons (Dr. *and Dr * - I think. totally forgot the name of the one who did my operation, but he was amazing!), the anaesthesiologist (Dr. * who reassured me and made sure I was ok. She also made me feel seen and listened to) the neonatal doctors and the rest of the team. • Shout out to midwife *at post-natal ward and the very caring HCAs. They took care of me and my baby post c section. If it wasn't for their care, I would not have slept or rested at all. I could not ask for a better team. From the bottom of our hearts, thank you

5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*	Neonatal Unit	No Walkabout		**2nd October 2025** The group received positive feedback from both staff and service users on the walkabout, with staff reporting good working relationships and parents expressing high satisfaction with care and support received. Staff were observed to be open in raising concerns and sharing feedback. The group heard feedback from a range of colleagues (including ANNPs, a medical trainee, a PEF and a data clerk) who expressed feeling well supported and highlighted good interprofessional relationships between nursing and medical staff. A number of parents were complimentary about their Maternity and Neonatal care. The group will share the learning from this to incorporate into future plans for HTP. The group heard that nursing staff retention was much improved with an increase in QIS. The group offered to support with connections for career progression and professional development.
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		**October -** none received **November -** none received
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	0	0		
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10	100%	100%		
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	0	0		**October** - No delays **November -** No delays
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	9	10		**October -** Increase to 16.3% (n=9 delays with 55 Category 2 in October compared to 38 in September m=3 7.9%) . 33% where from ethnic minorites. 1 delay was a multiple pregnany. Most common reason for section was fetal distress with 44%. The most common reason for delay is theatre actuity with 44%. 67% of delays were during the night **November -** 15% (n=10) with 65 Category 2 in November compared to 55 in October. 60% reason for section was fetal distress and 60% is documented 'Theatre acuity'. 80% during the night. 60% of delays were in ethnic minorty groups
11.	**Supernumerary Status of the Coordinator**	**Neonates**	57	56		**October-** There were 5 shift that did not have data therefore this has been calculated on 57 shifts. Of those 57 shifts; The NIC was FULLY supernumerary for 50 shifts (88%) The NIC was NOT supernumerary on 5 shifts (9%) The NIC was PARTIALLY supernumerary for 2 shifts (3%) The total number of times that the nurse was not fully supernumerary was 7 shifts (12%) **November-** The NIC was FULLY supernumerary for 56 shifts (93%) The NIC was NOT supernumerary for 3 shifts (5%) The NIC was PARTIALLY supernumerary for 1 shift (2%) In totay the NIC was not fully supernumerary for 4 shifts (7%)
12.	**Delay in Neonatal Antibiotics**	Number of babies that had delayed antibiotics (Not within the golden hour)	NNU - 4% TC - 42%	NNU- 30% TC - 45%		**<u>October</u>** **NNU-** Administration > 1 hour show a reduction from 41% to 4% Reason for improvement •Greater awareness of the Antibiotic Audit and the need to administer within the hour •Greater documentation so greater accuracy can be audited **TC**- Administration > 1 hour shows a minimal reduction, the last 4 months show figures of 57%, 50%, 48%, 43%. The reasons stated for delay was, delay in getting unit number, 1 person doing x2 screens and busy with sick baby on NNU. **<u>November</u>** **NNU-** October showed a huge reduction in D-A > 1 hour down to 4%, however this is back up to 30%. Although this rise is a negative one when it was felt that timings were improving, it is not up to previous levels of 40-50%. Documentation of reasons for delay: x 2 difficult access. Positive action – Baby given IM Cefotaxime when difficult to cannulate. This meant more timely antibiotics. **TC**- Administration >1 hour shows a minimal reduction, the last 5 months show figures of 57%, 50%, 48%, 43%, 45% The reasons stated for delay was difficult cannulation, prescription and stabilisation on labour ward.
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)*

Maternity & Neonatal Governance Meetings December 2025

The Shrewsbury and Telford Hospital NHS Trust

Agenda item				
Report Title	CNST MIS Safety Action 10 – MNSI and NHS Early Notification Scheme			
Executive Lead	Paula Gardner, Executive Director of Nursing			
Report Author	Silje Almklow, Divisional Quality Governance Lead Sarah Weaver, Acting Head of Legal Services			
	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 and Neonatal Governance Meetings December 2025			
Executive summary:	SaTH is a participant in year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. This paper sets out SaTH's completion status against safety action 10 which must be approved by the Board of Directors.			
Recommendations for the Committee	The Committee is asked to: Receive the report in line with Safety Action 10.			
Appendices	N/A			

1.0 Introduction

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.

1.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate that 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.

1.3 The purpose of this paper is to provide the Board of Directors with an update against safety action 10: "Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?"

2.0 Required Standards

Safety action 10 is made up of the following standards which need to be evidenced against. The Trust's reporting will be cross referenced against the MNSI database and the NHS Resolution database for the number of qualifying incidents recorded for the trust and externally verify that standard a), b) and c) have been met in the relevant reporting period:

a) Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025.
b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025.
c) For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that:
   i. the family have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them; and
   ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

3.0 Minimum Evidence Required for Trust Board

- ✓ Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.
- ✓ Trust Board sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with a SMART plan to address any challenges for the future.
- ✓ Trust Board sight of evidence of compliance with the statutory duty of candour.

All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 12 noon on 3 March 2026.

There is also an external verification process. MNSI will cross-check the National Neonatal Research Database (NNRD) and NHS Resolution will cross-check the NHS Resolution database for qualifying MNSI and EN incidents reportable from 1 December 2024 until 30 November 2025 and will externally verify that standards A and B have been met in the relevant reporting period

In addition, for standard B and C(i) there is a requirement to complete the field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.

4.0 Qualifying cases

Reference	Criteria	Case opened	Outcome	Duty of Candor	ENS referral
MI-040821	HIE/cooling	24/03/2025	Rejected Normal MRI	Yes	Not applicable – normal MRI
MI-041478	HIE/cooling	22/04/2025	Rejected Normal MRI	Yes	Not applicable – normal MRI
MI-041750	HIE/cooling	02/05/2025	Investigation completed – no safety recommendations received	Yes	Not applicable – normal MRI
MI-043484	Early neonatal death	27/06/2025	Rejected – cause of death was a congenital cardiac anomaly with no surgical options.	Yes	Not applicable – congenital condition
MI-049260	HIE/cooling	12/11/2025	Investigation ongoing – MRI normal	Yes	Not applicable – normal MRI

5.0 Summary

5.1 Of the eligible cases, all have been reported to MNSI and none of those cases were eligible for referral to NHS Resolution as required under the scheme.

5.2 Of the 5 cases which did not meet the ENS referral criteria, 3 were rejected by MNSI due to not meeting their criteria following assessment. Two of these cases were HIE/cooling cases where the babies had normal MRI results following therapeutic hypothermia. The third was an early neonatal death due to a severe congenital cardiac anomaly with no surgical options. The remaining 2 cases were accepted by MNSI for investigation due to parental concerns; however, the MRI results were normal and the cases therefore did not meet the ENS referral criteria.

5.3 All the families received information regarding MNSI and NHSR and gave consent for referral to be made, thereby meeting part c, element 1 of the scheme.

5.4 The Trust has complied with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour for each of the cases meeting criteria for reporting.

6.0 Actions requested of the Board

6.1 The Board of Directors is asked to note the content of the paper which evidences delivery of the required standards to achieve safety action 10 of Year 6 of the CNST Maternity Incentive Scheme.

To: Trust Chief Nurses
Trust Directors of Midwifery

cc. ICB Chief Nurses
ICB Directors of Midwifery

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 November 2025

Dear colleagues,

Urgent review of homebirth services following Prevention of Future Deaths report

We are writing to bring to your immediate attention the Prevention of future deaths report issued by the Senior Coroner for Manchester North after the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth. The report raises a number of concerns and we are asking you to urgently review the safety and quality of your homebirth services.

We would like you to consider the following issues which were highlighted in this case:

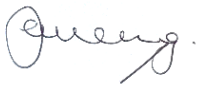
The operational running of your service: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multi-disciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.

Care planning and risk assessment: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.

Governance and oversight: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

Trusts have a continuing responsibility to offer homebirth as a choice for women. Where this review identifies concerns, please take prompt action to address them to ensure your homebirth service remains safe and high quality. While no formal response is required, we expect that the outcome of the review be reported to your Trust board and that you contact your regional NHS England team immediately if you identify any safety concerns requiring urgent attention.

Yours sincerely,



Kate Brintworth
Chief Midwifery Officer for England

Gaynor Armstrong
Regional Chief Midwife, Midlands
NHS England

Birthing outside of guidance

Date: *15 January, 2025*

Content Tags: *Birth choices, Supported decision making, Shared decision making,*

Author: *Angela Foster, Kerry Cunniffe, Helen Woollatt, Sonia Barnfield*

To help women / birthing people have a safe and healthy birth there are national and local healthcare guidelines. However, from time to time, people may choose to give birth outside of these guidelines. Based on findings from MNSI investigations this paper explores how healthcare professionals can support people who choose to give birth outside of guidance and what we can learn.

Identifying the learning theme

Currently there is limited national guidance to help teams support women / birthing people who decide to give birth outside of guidance. On this topic we have made recommendations during our investigations 33 times between September 2018 and December 2023. These were reviewed by a team of investigators and clinical advisors who identified this as a learning theme.
It is important to understand why women / birthing people choose to birth outside of guidance and how healthcare professionals are able to support them so we can improve the outcomes and the experience of mothers / birthing people and babies.

Reasons why birth takes place outside of guidance

We identified multiple reasons during our investigations that influenced a mother's / birthing person's choice to plan their birth outside of guidance. These included:

- previous birth trauma
- fear of medicalised birth
- loss of a sense of control
- birth anxiety

In the investigations we reviewed, the mothers / birthing people were focused on aiming for a positive birth experience with safe care for them and their baby. We found the two most common themes in our investigations for birthing outside of guidance were:

1. **Delaying or declining an induction of labour when it was recommended**
2. **Requests for vaginal birth at home after a previous caesarean birth.**

What we found

In multiple investigations there was no local guidance to support staff facilitating conversations and birth plans when a mother / birthing person was choosing a pathway of care that was outside of national or local guidance. This meant that information about the risks and benefits of their choices was not shared. Decisions were made without all the information needed to make an informed choice.

Individualised care plans were not always in place for mothers / birthing people who had chosen to birth outside of guidance or if they were in place, there was not enough detail to provide staff with a clear understanding of the expectations of the care plan. This led to families and clinical teams being unclear, in advance of birth, as to what the plan of care was and when a decision to escalate or deviate from the plan would be required.

Issues arose when there was no clear understanding of acceptable limits of care; for example, when deviation occurred from the expected pathway, or an emergency occurred, and the wellbeing of the mother / birthing person or baby was in immediate risk. Agreement before birth can assist clinicians and mothers / birthing people in having a joint understanding of when the original plan needs to be changed quickly.

Mothers / birthing people often did not fully understand the risks associated with their chosen birth plan and there was no clear evidence of supported or shared decision making. This meant that sometimes mothers / birthing people did not recognise that their choices were outside of guidance and posed a potential increased risk to the wellbeing of them or their baby.

Case study 1:

A mother declined induction of labour when it was offered due to multiple medical complications and further surveillance was offered. She planned to have a home birth outside of guidance. Following spontaneous rupture of the membranes and meconium being identified the mother was not transferred into hospital. The baby was born requiring resuscitation and required therapeutic cooling.

The investigation found there was no guidance to support the development of a detailed plan for the mother's home birth, taking into consideration her individualised risks.

Case study 2:

After counselling, a mother chose to plan for a vaginal birth at home after a previous caesarean birth, which was outside local and national guidance. She was not initially offered the choice of using the midwifery led unit, as this was not an option included in local guidelines. This led to the mother transferring her care to an alternative trust.

A detailed birth plan which included acceptable limits of care was not made. When the mother was in labour, and events deviated from the expected, including fetal heart rate abnormalities and a prolonged second stage of labour, the mother was not recommended to transfer her care into hospital. This meant that she birthed at home with midwifery support, the baby was born requiring resuscitation and died several days later.

What can maternity providers do?

Maternity providers can discuss and explore with their teams what support is available when someone decides to give birth outside of guidance. These 'safety prompts' will help facilitate those conversations.

Safety prompts

1. Do you have a guideline or process to support staff and mothers / birthing people when care choices are outside of national or local guidance?
2. Is there any training available for staff in how to navigate conversations in order to facilitate supported decision making?
3. Can women / birthing people benefit from birth choice clinics that are multi-professional and use supported decision-making principles?
4. When a woman / birthing person requests a birth plan that deviates from national or local guidance, is this agreed in advance of birth? Do discussions include contingencies so there are clear parameters for acceptable care pathways when the situation changes, or an emergency occurs?
5. Are there resources (leaflets/videos/infographics) available that include up to date information, that are easily accessible and clear, to assist mothers / birthing people in supported decision-making when seeking care outside of national or local guidance?
6. Have you considered exploring with families their reasons for choosing to birth outside of guidance to enable learning?

Further reading

NHS England (2019) Shared Decision-Making: Summary Guide. NHS England » Shared decision-making

This document explains what shared decision making is and how it supports individuals to make decisions that are right for them. It is a collaborative process through which a health professional supports a patient to reach a decision about their treatment.

NHS England (2023) Three year delivery plan for maternity and neonatal services. NHS England » Three year delivery plan for maternity and neonatal services

This document supports shared decision making. It states that: “Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages and uses terminology in line with the re-birth report and is co-produced. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected”.

Birthrights - your human rights during pregnancy and maternity care

Royal College of Midwives (2022). RCM Professional Briefing: Caring for those women seeking choices that fall outside guidance care_outside_guidance.pdf (rcm.org.uk)

Royal College of Midwives (2022). Informed decision making. Available at informed-decision-making_0604.pdf (rcm.org.uk)

Addendum

We recognise that there are differing terminologies used that may be preferred by women/birthing people. Where MNSI has used the term “Supported decision making” we were trying to convey that this involves informed decision making, plus supporting a woman’s / birthing person’s choice and the need to make plans to further support those choices.

Informed decision making is the preferred term agreed within the “Personalised care and support planning guidance.” A link to this document has been added to the reading list.

https://www.england.nhs.uk/wp-content/uploads/2021/03/B0423-personalised-care-and-support-planning-guidance-for-lms.pdf

We appreciate birthing outside of guidance may also be referred to as “birthing off pathway” or “birth choices.”

The original document was published on 15 January, 2025. This version includes an addendum and was published on 14 February, 2025.

MNSI Briefing Birth outside of guidance

Briefing: Birthing outside of guidance
140225_Briefing_Birth_Outside_of_Guidance__v2_Addendum_MASTER_editable.pdf

6 Safety PROMPTS

Do you have guidance or processes to support staff and mothers/birthing people when care choices are outside of national or local guidance	Yes	Guideline in place Women seeking birth that falls outside of guidance https://intranet.sath.nhs.uk/document_library/ViewPDFDocument.asp?DocumentID=17315
Is there any training available for staff in how to navigate conversations in order to facilitate supported decision	Partially	Maternity Day 5 Personalised Care Support Plans. BadgerNet Birth Choices
Can women /birthing people benefit from birth choices clinics that are multi professional and use supported decision-making principles?	Partially	Consultant Midwife Clinic for birth outside of guidance. Referral for Consultant ANC for Consultation Discussion. In the absence of Consultant MW in post current process is for SLT to review and coordinate plans
When a woman /birthing person requests a birth plan that deviates from national or local guidance, is this agreed in advance of birth? Do discussions include contingencies so	Yes	Referral made by communtiy midwife or homebirth team to Care Planning. Updated care plan and birth plan added to BadgerNet
Are there resources (leaflets/videos/inforgraphics) available that include up to date information, that are easily accessible and clear, to assist mothers/birthing people in supported decision making when seeking care outside of national or local guidance?	No	Limited National Resources available around birth outside of guidance. Birthrights website pages. Relies on local information and data. Utilise Natioanl organisations only BirthRights
Have you considered exploring with families their reason for choosing birth outside of guidance to enable learning?	Partially	Part of role with Consultant Midwife pending recruitment to be priority for action

NHSE Urgent review of homebirth services following Prevention of Future Deaths report 2025-833 Homebirth services letter - Midlands.pdf		
	Trust:	Shrewsbury and Telford Hospitals NHS Trust
	ICB/System:	NHS Shropshire, Telford & Wrekin
	Completed By:	Jacqui Bolton (Interim HOM)
	Approved By:	

The operational running of the homebirth services			Actions
Midwifery care available 24 hours a day	Yes	Allocated Homebirth Team this is supported by community on call system overnight. Daily staffing meetings take place for all inpatient and communtiy services by managers and matrons identify any sickness absence gaps reallocation of staff if necessary to support planned homebirths.	
Staff properly equipped, trained and prepared and skilled for providing birth and neonatal care in a home setting	Partially	All MLU, Homebirth and community midwives who participate in the on call service attendance at 4 yearly Resuscitation Council NLS in additional to local annual update is mandatory. PROMPT MDT mandatory. Education Lead and Interim HoM reviewing community PROMPT for midwives attending homebirths	Training and additional communtiy PROMPT being reviewed
Senior MDT support available at all times	Yes	MDT - Consultant on site 24/7. 2 Band 7 Delivery Suite co-ordinators on each shift to provide support. Daytime allocation of Manager of the Day. W&C Divisional on call overnight additionally SLT Interim HoM and Deputy support	

Sufficient rest periods	Yes	Allocation of Homebirth Team model is shift based on MLU. Community midwives on call if on call work short shift (7.5hrs) to ensure rest period before on call commences at 20:00 compensatory rest period as per Trust Policy if called out and working the next day	
Transfer and extraction processes are clear and planned for each birth	Partially	Care Planning meeting monthly. BadgerNet updated with Birth Plan. Access to the WMAS response times for Category 1 this information is provided as part of homebirth assessment to include full transfer times	Review existing SOP details of transfer and extraction
Care planning and risk assessment			
Systematic assessment of complexity and risk	Yes	Monthly MDT care planning meeting. Udpates to plans added to BadgerNet to ensure all updates are published	Extend the invite to co-ordinators and communtiy teams
How the MDT ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended)	Yes	Monthly MDT care planning meeting. Updates to plans added to BadgerNet to ensure all updates are published	
How the MDT continues to maitain good communication at all stages of care with women and between teams including ambulance services	Partially	We receive WMAS response times and this is shared with homebirth and community on call. Consider information sharing with WMAS for care plans. Planned staffing for outside of guidance for 3 midwives to attend. Communication back into DS coordinator. BadgerNet ability to view active record (if not using offline)	Contact WMAS Maternity Lead and if there is a Regional decision on communicating outside of guidance birth plans with WMAS

How dynamic risk assessment is managed and respor	Partially	Risk assessment at each antenatal contact. Management plans updated	Audit evidence required as management plan updates not yet consistent
Governance and risk assessment			
How governance is structured to ensure robust oversight of homebirth services by the whole organisation	No	Homebirth Team provided update on the service to the Safey Champtions meeting in November.	Providing updates to Safety Champtions and Materntiy Governance on outcomes
Executive board has appropirate oversight	No	As above	Report for Maternity Governance as part of cycle of business for Safety Champtions, QSAC and LMNS/PQSG
Audit programme that covers outcomes and clinical operations guidance and leads to continual	Partially	Initial review of outcomes from October 2024-2025 has been undertaken.	Forward audit plan
Comprehensive homebirth guidance including SOP for all stages and aspects of care	Partially	SOP in place	Review SOP to ensure meets all stages and aspects of care including staffing

Appendix 1: Exception Reports Q2

In Q2 a total of 43 exception reports were raised.

Exception Reports (ER) – Quarter 2	
Total number of exception reports received	**43**
Number relating to immediate patient safety issues	2
Number relating to hours of working	38
Number relating to pattern of work	1
Number relating to educational opportunities	0
Number relating to service support available to the doctor	2

The table below shows the number of exception reports carried over, raised, closed and outstanding for Q2. Please note this data excludes exception reports related to educational opportunities.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
T&O	2	2	0	1
Gastro	0	2	0	0
General Medicine	0	5	2	3
General Surgery	1	21	15	6
Haematology	0	1	1	0
Oncology	0	1	0	1
Obs & Gynae	0	6	4	4
Ophthalmology	0	3	0	0
Urology	0	1	0	1
Total	**3**	**43**	**22**	**16**

The table below provides a breakdown of the number of exception reports divided by medical grades for Q1.

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	1	21	9	9
FY2	0	11	10	1
CT1-2 / ST1-2	0	1	0	1
CT3+ / ST3-5	0	8	3	4
ST6-8	2	2		1
Total	**3**	**43**	**22**	**16**

Appendix 2: Locum Bookings by Department, Grade and Reason

Locum bookings (shifts) by department

Department	Filled by Bank	Filled by Agency	Unfilled
Acute Medicine	225	0	1
Anaesthetics	48	0	0
Breast Surgery	0	50	0
Cardiology (Medical)	28	0	0
Emergency Medicine	539	166	27
Endocrinology and Diabetes	59	0	1
Gastroenterology	53	0	0
General Medicine	1365	0	7
General Surgery	237	19	0
Neonatal Medicine	29	0	0
Obstetrics and Gynaecology	39	0	0
Oncology	48	0	0
Ophthalmology	19	0	0
Oral and Maxillofacial Surgery	187	0	0
Orthopaedic and Trauma Surgery	123	17	0
Paediatrics	81	0	0
Renal Medicine	78	0	0
Respiratory Medicine	7	0	2
Stroke Medicine	38	0	1
Urology	40	0	0
ENT	50	59	0
ITU	41	0	0
Dermatology	2	0	0
Grand Total	**3336**	**311**	**39**

Locum bookings (shifts) by grade

Grade	Filled by Bank	Filled by Agency	Unfilled
FY 1	5	0	1
Core Trainee	2350	0	16
StR (ST3-8)	981	311	22
Grand Total	**3336**	**311**	**39**

Locum bookings (shifts) by reason

Reason	Filled by Bank	Filled by Agency	Unfilled
Annual Leave	1	0	0
Compassionate / Special Leave	13	16	0
Covering Shadowing Period	25	0	0
Escalation area	662	0	1
Exempt from On Calls	47	0	0
Extra Cover	444	49	8
Less Than FT Trainee Gap	82	0	0
Paternity Leave	24	0	0
Pregnancy / Maternity Leave	24	0	0
Sick	475	79	11
Strike	352	6	0
Study Leave	16	2	0
Vacancy	1051	159	17
Waiting List Initiative	58	0	0
Essential cover for short term sickness	40	0	0
Additional Agreed Activity	0	0	2
Cover above establishment	9	0	0
Essential cover during shadowing period	8	0	0
Special leave	4	0	0
Annual/Study/Professional Leave	1	0	0
Grand Total	**3336**	**311**	**39**

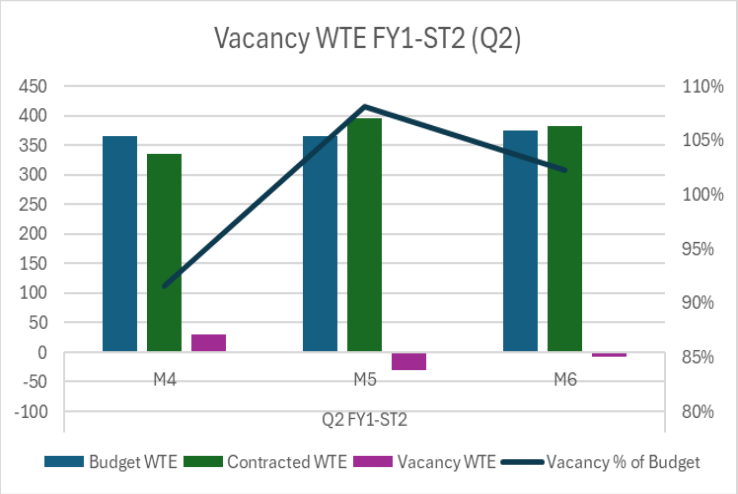
Comments

A total of 3,336 shifts were filled by bank staff and 311 by agency, with only 39 shifts remaining unfilled. The highest locum demand was in General Medicine (1,365 bank shifts), Emergency Medicine (589 bank and 166 agency shifts), and ENT (59 agency shifts). Notably, Breast Surgery relied entirely on agency cover (50 agency shifts), while several specialties such as Care of the Elderly and Haematology reported minimal or no locum usage.

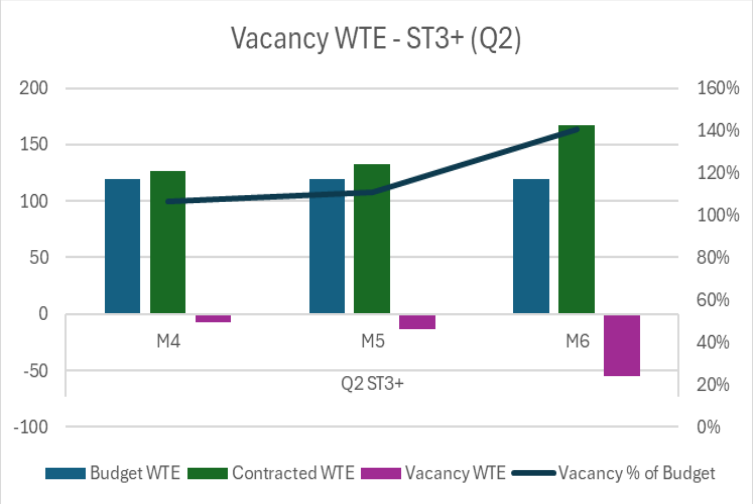
By grade, ST1-2/CT1-2 residents accounted for the majority of locum shifts (2,350 bank and 0 agency), followed by ST3-8 residents (911 bank and 311 agency). The primary reasons for locum bookings included vacancies (1,051 shifts), escalation area support (662), and sickness cover (475). These figures reflect sustained pressure across key departments and highlight the importance of ongoing workforce planning to manage demand and reduce reliance on agency staffing.

Appendix 3: Vacancy WTE for Resident and Locally Employed Doctors Q2

	Q2 FY1-ST2		
	M4	M5	M6
Budget WTE	366.57	366.57	374.2
Contracted WTE	335.71	396.5	382.59
Vacancy WTE	30.86	-29.93	-8.39
Vacancy % of Budget	92%	108%	102%



	Q2 ST3+		
	M4	M5	M6
Budget WTE	119.15	119.15	119.115
Contracted WTE	126.95	132.19	167.33
Vacancy WTE	-7.21	-13.04	-54.73
Vacancy % of Budget	107%	111%	140%



Appendix 4: Budgeted, Contracted, Vacancy (WTE) and Vacancy % of Budget M4-M6 (FY1-ST2)

		M4 FY1-ST2				M5 FY1-ST2				M6 FY1-ST2			
Division	Specialty	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of Budget	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of Budget	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of Budget
Clinical Support Services Division	Clinical and Medical Oncology	4	2.73	1.27	68%	3	3	0	100%	3	3	0	100%
Clinical Support Services Division	Clinical Haematology	2	2.8	-0.8	140%	2.8	4.64	-1.84	166%	2.8	3	-0.2	107%
Clinical Support Services Division	Palliative Care	0	0	0	0%	0	1	-1	0%	0	0	0	0%
Clinical Support Services Division	Pathology	4.8	5	-0.2	104%	4.8	2.24	2.56	47%	4.8	3.4	1.4	71%
Clinical Support Services Division	Radiology	0	0	0	0%	0	0	0	0%	0	0	0	0%
Corporate Services	Human Resources	0	0	0	0%	0	0	0	0%	0	0	0	0%
Corporate Services	Medical Directorate	31	28.5	2.5	92%	24	36.93	-12.93	154%	24	35	-11	146%
Medicine and Emergency Care Division	A&E	53	47.37	5.63	89%	53	51.39	1.61	97%	53	50.21	2.79	95%
Medicine and Emergency Care Division	Acute Medicine	25.8	14.6	11.2	57%	25.8	20.02	5.78	78%	25.8	21.2	4.6	82%
Medicine and Emergency Care Division	Cardiology	7	6	1	86%	7	6.7	0.3	96%	7	6	1	86%
Medicine and Emergency Care Division	Care of the Older Adult	30	18.69	11.31	62%	30	20.71	9.29	69%	30	20.55	9.45	69%
Medicine and Emergency Care Division	Diabetes & Endo	10	13	-3	130%	10	10.73	-0.73	107%	10	11	-1	110%
Medicine and Emergency Care Division	General Medicine	36	38.26	-2.26	106%	36	51.99	-15.99	144%	40.2	46.43	-6.23	115%
Medicine and Emergency Care Division	Nephrology	16	12.93	3.07	81%	16	13.46	2.54	84%	16	10.66	5.34	67%
Medicine and Emergency Care Division	Neurology	0	0	0	0%	0	0	0	0%	0	0	0	0%
Medicine and Emergency Care Division	Respiratory	14	17.83	-3.83	127%	14	20.4	-6.4	146%	14	19.76	-5.76	141%
Medicine and Emergency Care Division	Stroke Medicine	1	6.46	-5.46	646%	1	6.91	-5.91	691%	1	6.72	-5.72	672%
Reserves	Reserves	-3.83	0	-3.83	0%	-7.63	0	-7.63	0%	-3.2	0	-3.2	0%
Surgery Anaesthetics and Cancer Division	Anaesthesia	22	14.36	7.64	65%	22	21.58	0.42	98%	22	18.28	3.72	83%
Surgery Anaesthetics and Cancer Division	Breast Surgery	0	0	0	0%	0	0	0	0%	0	0	0	0%
Surgery Anaesthetics and Cancer Division	Colorectal and Upper GI Surgery	21	19	2	90%	22	20.75	1.25	94%	22	21.17	0.83	96%
Surgery Anaesthetics and Cancer Division	ENT	9	9	0	100%	9	12	-3	133%	9	9	0	100%
Surgery Anaesthetics and Cancer Division	Ophthalmology	3	2	1	67%	4	3.99	0.01	100%	4	4	0	100%
Surgery Anaesthetics and Cancer Division	Oral & Maxillo-Facial Surgery	4	5	-1	125%	4	2.72	1.28	68%	4	8	-4	200%
Surgery Anaesthetics and Cancer Division	Orthopaedics and Trauma Surgery	26.8	25	1.8	93%	30.8	31.69	-0.89	103%	30.8	27	3.8	88%
Surgery Anaesthetics and Cancer Division	Urology	5	5	0	100%	5	4.78	0.22	96%	5	5	0	100%
Surgery Anaesthetics and Cancer Division	Vascular Surgery	6	4	2	67%	6	5.02	0.98	84%	5	5	0	100%
Womens & Childrens Division	Gynaecology	15	13.81	1.19	92%	17	15.22	1.78	90%	17	16.38	0.62	96%
Womens & Childrens Division	Neonatology	4	3.87	0.13	97%	6	4.87	1.13	81%	6	6.74	-0.74	112%
Womens & Childrens Division	Paediatrics	20	20.5	-0.5	103%	21	23.76	-2.76	113%	21	25.09	-4.09	119%
		366.57	**335.71**	**30.86**	**92%**	**366.57**	**396.5**	**-29.93**	**108%**	**374.2**	**382.59**	**-8.39**	**102%**

Appendix 5: Budgeted, Contracted, Vacancy (WTE) and Vacancy % of Budget M4-M6 (ST3-ST8)

		M4 ST3+				M5 ST3+				M6 ST3+			
Division	Specialty	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of Budget	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of Budget	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy % of Budget
Clinical Support Services Division	Clinical and Medical Oncology	4	1.6	2.4	40%	5	3.28	1.72	66%	5	3.6	1.4	72%
Clinical Support Services Division	Clinical Haematology	1	0	1	0%	0	0	0	0%	0	0	0	0%
Clinical Support Services Division	Radiology	0	0	0	0%	0	0	0	0%	0	0	0	0%
Corporate Services	Finance	0	0	0	0%	0	0	0	0%	0	0	0	0%
Corporate Services	Medical Directorate	7.6	0.8	6.8	11%	7.6	0.4	7.2	5%	7.6	0.9	6.7	12%
Medicine and Emergency Care Division	A&E	4	4.4	-0.4	110%	4	1.85	2.15	46%	4	1.4	2.6	35%
Medicine and Emergency Care Division	Acute Medicine	12	0.6	11.4	5%	12	0	12	0%	12	0	12	0%
Medicine and Emergency Care Division	Cardiology	5	4	1	80%	5	3	2	60%	5	5	0	100%
Medicine and Emergency Care Division	Care of the Older Adult	6	3.57	2.43	60%	6	2.56	3.44	43%	6	4.56	1.44	76%
Medicine and Emergency Care Division	Dermatology	0	0	0	0%	0	0	0	0%	0	0.89	-0.89	0%
Medicine and Emergency Care Division	Diabetes & Endo	3	3	0	100%	3	5.97	-2.97	199%	3	5.02	-2.02	167%
Medicine and Emergency Care Division	General Medicine	8	13.13	-5.13	164%	8	13.38	-5.38	167%	8	33.1	-25.1	414%
Medicine and Emergency Care Division	Nephrology	5	3	2	60%	5	3	2	60%	5	8	-3	160%
Medicine and Emergency Care Division	Respiratory	7	6.86	0.14	98%	7	7.97	-0.97	114%	7	10.61	-3.61	152%
Medicine and Emergency Care Division	Stroke Medicine	0	1	-1	0%	0	1	-1	0%	0	2	-2	0%
Reserves	Reserves	7.55	0	7.55	0%	6.55	0	6.55	0%	0	0	0	0%
Surgery Anaesthetics and Cancer Division	Anaesthesia	9	6.69	2.31	74%	9	6.69	2.31	74%	9	6.69	2.31	74%
Surgery Anaesthetics and Cancer Division	Breast Surgery	0	0	0	0%	0	0	0	0%	0	0	0	0%
Surgery Anaesthetics and Cancer Division	Colorectal and Upper GI Surgery	10	10.51	-0.51	105%	10	10.51	-0.51	105%	11	9.51	1.49	86%
Surgery Anaesthetics and Cancer Division	ENT	3	3	0	100%	3	3	0	100%	3	4	-1	133%
Surgery Anaesthetics and Cancer Division	ITU	0	8.58	-8.58	0%	0	9.79	-9.79	0%	0	9.47	-9.47	0%
Surgery Anaesthetics and Cancer Division	Ophthalmology	3	3.66	-0.66	122%	3	3.26	-0.26	109%	3	3	0	100%
Surgery Anaesthetics and Cancer Division	Oral & Maxillo-Facial Surgery	1	0	1	0%	1	0	1	0%	0	0	0	0%
Surgery Anaesthetics and Cancer Division	Orthopaedics and Trauma Surgery	7	20	-13	286%	7	23.7	-16.7	339%	7	23	-16	329%
Surgery Anaesthetics and Cancer Division	Urology	5	5	0	100%	5	5	0	100%	5	5	0	100%
Surgery Anaesthetics and Cancer Division	Vascular Surgery	3	4	-1	133%	4	4	0	100%	4	4	0	100%
Womens & Childrens Division	Gynaecology	8	10.75	-2.75	134%	8	11.71	-3.71	146%	8	9.14	-1.14	114%
Womens & Childrens Division	Neonatology	0	4.91	-4.91	0%	0	4.82	-4.82	0%	0	7.12	-7.12	0%
Womens & Childrens Division	Paediatrics	0	7.3	-7.3	0%	0	7.3	-7.3	0%	0	11.32	-11.32	0%
		119.15	**126.36**	**-7.21**	**106%**	**119.15**	**132.19**	**-13.04**	**111%**	**112.6**	**167.33**	**-54.73**	**149%**

Appendix 6: Resident Doctor Peer Lead's Comment on the 10-Point Plan

The Trust is strongly supportive of the national 10-Point Plan initiative aimed at improving the working lives of resident doctors. As a Resident Doctor Peer Lead, I have had the privilege of contributing to a task-and-finish group dedicated to implementing this initiative, while also maintaining direct access to the senior leadership team and the Board. Additionally, I have attended regular regional and national meetings to share experiences and learnings.

Recently, we held the first Resident Doctor Committee meeting to gather feedback and suggestions from colleagues. A key theme that emerged was the importance of clear communication—particularly around understanding where feedback sits within the process and ensuring transparency when certain issues cannot be resolved.

To strengthen communication, we plan to establish formal channels through monthly Resident Doctor Committee meetings and forums, including the Guardian of Safe Working forum. It was also noted that resident doctors often face challenges leaving the ward to attend these meetings.

Attendance could be significantly improved if consultants were informed of the scheduled meetings and actively encouraged junior doctors to participate.

While the Trust is initiating improvements at the highest level, some challenges remain within individual clinical areas. We anticipate that these issues will be addressed through strengthened communication channels and ongoing engagement. Ultimately, our goal is to ensure that every resident doctor benefits from this initiative and that high standards are consistently maintained across all areas.