The Shrewsbury and Telford Hospital NHS Trust

Hospitals Transformation Programme

SRO Update March 2026

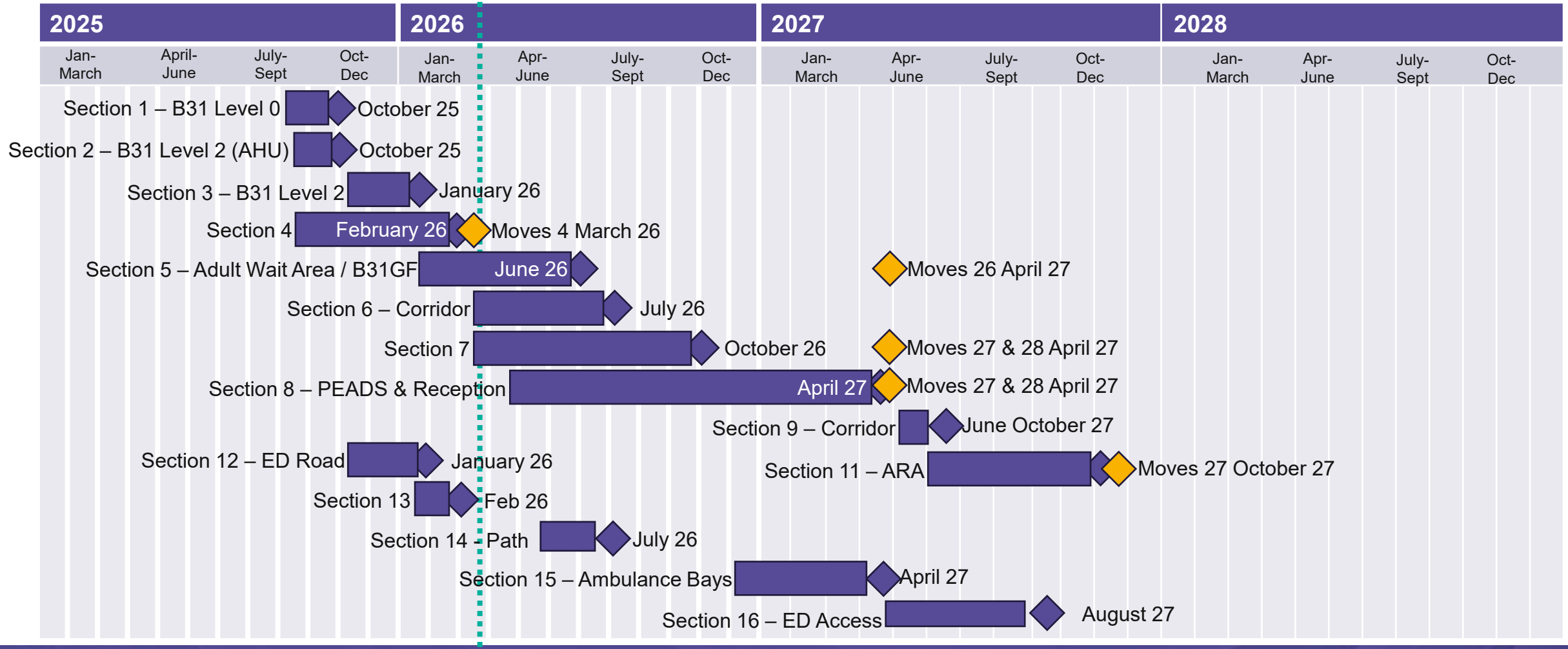
Integrated Care System
Shropshire, Telford and Wrekin

ED2 Critical Path Overview

Report Date

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital
NHS Trust



B60 Critical Path Overview

Integrated Care System
Shropshire, Telford and Wrekin

NHS
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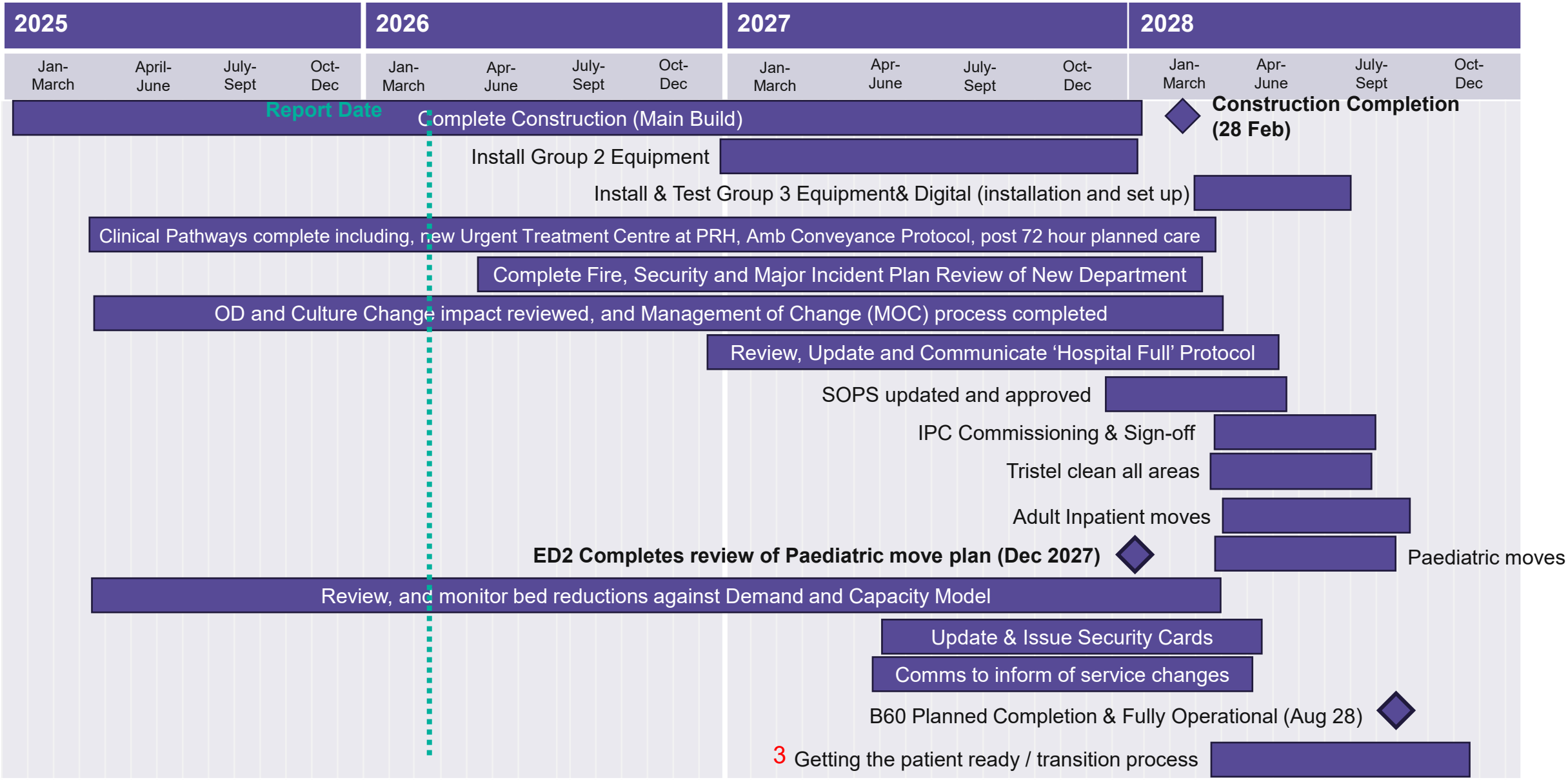
NHS Trust

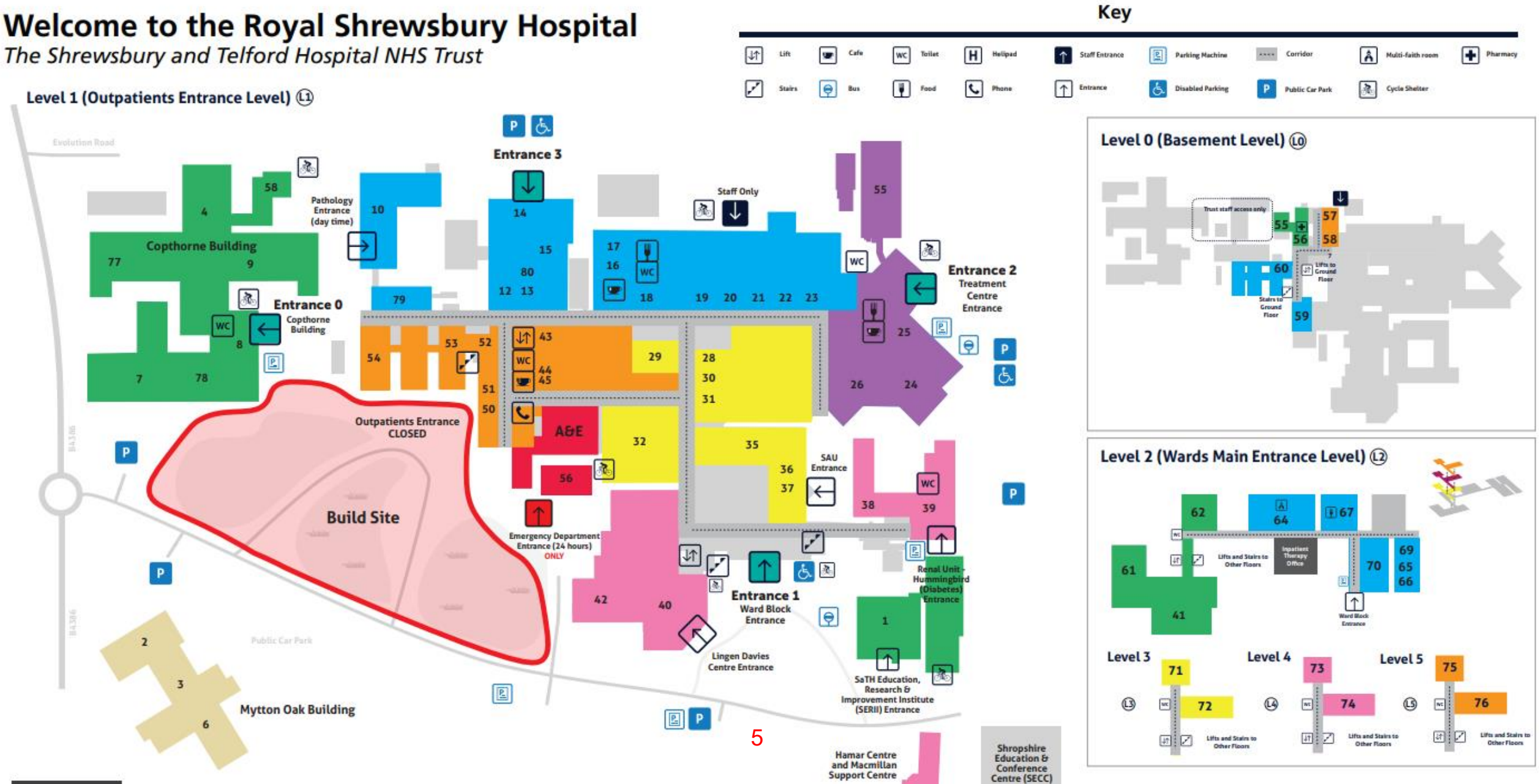


Construction and Estates

Construction area

Integrated Care System

NHS The Shrewsbury and



Latest Drone Image

Integrated Care System
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Works within our Emergency Department

ED2 commenced in August 2025 in non-clinical areas, and September 2025 in clinical areas. These 16 smaller packages of work include:

- Urgent Treatment Centre (UTC) - minor works in department and corridor remains as 10 cubicles.
- Fit to Sit - 6 cubicles, 2 adult crisis rooms a seated waiting area and a plaster room.
- Waiting rooms (adult and paediatric) and 3 adult triage rooms, patient self-check in desks, new public toilets, patient changing spaces room.
- Paediatrics - 3 triage rooms, 6 cubicles, 1 paediatric crisis cubicle and 1 end of life suite.
- Ambulance Receiving Area (ARA) - 6 cubicles.

Work in progress or completed:

- ✓ Section 1 & 2 - completed.
- ✓ Section 3 - B31 Ventilation in Level 2 offices - completed
- ✓ ED road straightening - completed
- Section 4 - Fit to Sit and middle majors, on track to complete February 2026.
- Section 5 – B31 L1, commenced January 2026, on track to complete summer 2026.

- Vanguard Unit to be delivered on March 4th 2026 to support ED patient flow.

ED will remain fully operational for our patients throughout the works

Comms and Engagement

Communications Update

- 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:

    - Week commencing 16 March – launch of newsletter, intranet pages
    - Week commencing 13 April – PRH walkabouts across site to amplify campaign

- **Drop-ins across libraires now underway** – with dates added following request of JHOSC
- **Quarterly focus groups and About Health events** scheduled and on track
- **New information booklet** now available in print and online – available here: **Hospitals Transformation Programme - Information Leaflet - 2026 by The Shrewsbury and Telford Hospital NHS Trust - Issuu**
- **Regular content through digital channels** and **local media** to inform audiences of our progress – sharing with system partners to amplify messaging
- Undertaking a **review of engagement with Seldom Heard groups** to understand activity to date, lessons learnt and next steps
- **Filming of sample rooms** to showcase new clinical spaces – includes those with mobility needs
- Supporting with a number of construction related activity including; ED modular building relocation and site roadworks

Recent coverage

- **Library drop-in sessions announced for Hospitals Transformation Programme – SaTH**
- Proactive coverage planned for completion of next phase of ED refurb in March

Communications Update – Social Value

Top headlines

- 33 education activities delivered – benefitting over 700 young people
- 21 community activities delivered – with over £13,500 being invested into Shropshire and Telford communities
- 3 DFN interns now into paid employment (
- 45 score in Considerate Constructions Scheme - 45 is the maximum score that can be achieved
- 514 apprentice weeks, 152 training weeks, and 77 work placement weeks provided

Recent activity includes:

- Harper Adams University, Telford – Sustainability workshops
- Shrewsbury College – T Level careers talk
- Haberdasher Adams, Newport – Careers event
- Telford College – supporting with built environment course and SWAP Scheme placement
- Shrewsbury ARK – donations of materials and labour support
- Hadley Youth Centre, Telford – donations for youth club activities

Recent and upcoming engagement activity

- Wellington Library drop-in– 8 January
- Newport Library drop-in – 13 January
- Public Assurance Forum – 19 January
- Whitchurch Library drop-in – 23 January
- About Health event – 27 January
- RSH neighbour's drop-in – 27 January
- Oswestry Library drop-in – 28 January
- Bridgnorth Library drop-in – 2 February
- Broseley Library drop-in – 6 February
- SALC HTP update – 6 February
- Marden PPG update – 9 February
- Ludlow Library drop-in – 11 February
- LoF Executive Committee update – 16 February

Upcoming

- Newtown Library drop-in – 24 February
- HTP focus group – 5 March
- Live Well Hub, Donnington – 6 March
- Madeley Library drop-in – 12 March
- Bishop's Castle Library drop-in – 20 March
- Welshpool Library drop-in – 23 March

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 to continue to be reviewed in line with committee workplans. The Board agreed both the updated Performance Assurance Committee and Finance Assurance Committee terms of reference at its meeting in January 2026. Recovery Support Programme exit self-assessment considered at February 2026 private Board meeting (pending outcome from NHSE).	**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 & Evidenced**
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**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
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. **Action Complete**	**Complete & Evidenced**
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. Group Accelerator Meeting (grip and control) established February 2026, meeting fortnightly and reporting into the Group Transition Committee.	**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 held on 26 January 2026. Consideration to be given as to what items are for information and what are for decision. **Action Complete**	**Complete & Evidenced**
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. Group Partnership Agreement to be taken to the Board(s) meeting in March 2026, to be in place for 01 April 2026.	**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	Group Chair /Group CEO	01/09/2025	31/3/2026	In progress. Remuneration Committees to consider process and timeline. Plans in place to begin recruitment.	**On track**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
	action to be taken to appoint the Joint Leadership Team and Non-Executive Directors				Remuneration Committees took place and actions agreed. Group Chief Nursing Officer interviews being held on 3 March 2026.	
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 joint Board Development sessions between SaTH and Shropcom, with documented outcomes demonstrating increased cohesion and strengthened collaborative working	Group Chair / Director of Governance	01/09/2025	31/3/2026	A joint Board of Director development day was held on 23rd October 2025. The development meeting scheduled for 26 February 2026 was postponed due to urgent business. However, additional sessions for joint boards have been agreed in place of the postponed meeting (one in March and one in April 2026). With further development sessions scheduled in May, October and January.	**On track**
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	• Group Communications and Engagement plan is in place with milestones and delivery is now complete and the work has transitioned into business as usual. • An engagement event was held on 19 November 2025 at the AFC Telford football group for approximately 130 staff across both organisations. Feedback from the engagement is being used to inform further communications and a Summary Report was shared with the Transition Committee and leads to inform the Medium Plan. • Further engagement activity is being planned for Spring 2026 to strengthen staff involvement in shaping the emerging Group model. • During December 2025, several key communications and engagement actions were completed: • An update on the work of the Transition Committee and the developing approach to	**Complete & Evidenced**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
					Group Identity December 2025. • A stakeholder letter was circulated seeking views on the proposed Group name, ensuring that staff, partners, and wider stakeholders have the opportunity to influence the brand from an early stage. • The latest editions of the 'Better Together' staff newsletters, including the Group Name Survey, were issued, one to SaTH staff and one to ShropCom staff, to maintain consistent messaging across both organisations. • Attended the Public Assurance Forums in January 2026 were used to engage with patient representatives, Healthwatch and other community partners, service users, and members of the publicon key elements of Group development, including the Group name and identity. Further engagement is planned throughout 2026 to seek views on vision and values, culture, and broader organisational direction. • Work continues to optimise shared working across the SaTH and ShropCom Communications teams, with a shared Chief Communications Officer. This will align capacity, expertise, and processes to support the transition to the Group model and ensure consistent, high quality communications. **Action Complete**	
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 and were agreed by the Board on 15 January 2026	**Complete & Evidenced**

Task ID	Task	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	RAG Status
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. The SaTH Risk Management Strategy has been reviewed. It was considered and agreed at Audit & Risk Assurance Committee on 24 November and was agreed by the Board on 15 January 2026. As part of the Group Model development there will be a further review of the Risk Management Strategy in 2026/27.	On track
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 to the Evidence Review Panel meeting with the ICB/NHSE on 14 January 2026 for this action was closed.	**Complete & Evidenced**

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

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

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

Metric 2.1: SaTH workforce delivery plans for 2025/26 and 2026/27 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 & Evidenced**
2.1.2	Review known changes, service changes needed, and business cases approved from 2025/26.	BPs	01/01/2025	31/03/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.3	Outline any assumptions in terms of workforce metrics, turnover absence levels.	SB	01/12/2025	31/03/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.4	Populate Workforce Planning Template.	CM	01/02/2025	31/03/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.5	Calculate the % Change by Staff Group.	CM	01/02/2025	31/03/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.6	Challenge / Sense Check Data.	CM	01/03/2025	28/02/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.7	Review Data with Stakeholders (Divisional teams etc.).	SB	01/03/2025	28/02/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.8	Populate Master Template and Triangulate with Finance and Operations.	SB	01/03/2025	28/02/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.9	Final Sign Off - Board and NHSE.	RB	01/03/2025	31/03/2026	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
2.1.10	Set up and deliver workshops with People and OD team and Divisional reps to identify the priority areas needed that support delivery of our workforce plan in line with HTP.	SK	01/05/2025	31/03/2026	Discussion on progress at Finance committee / and Board Bimonthly HTP workforce report A full programme of workshops with People & OD colleagues and divisional representatives has now been completed, with four sessions delivered to identify the priority workforce actions required to	**Complete & Evidenced**

Metric 2.1: SaTH workforce delivery plans for 2025/26 and 2026/27 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**
					support delivery of the HTP workforce plan. Evidence of completion has been collated (agendas, outputs, and Menti-meter responses). This action is now Completed and Evidenced.	
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 Development of the actions is being finalised having had the follow-up workshops.	**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	Final workforce plan submitted to NHSE 12th February 26	**Complete & Evidenced**
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 and updated within the allocated timescales.	**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 70% with continued progress to improve compliance with West Midlands rates.	**On Track**

Metric 2.1: SaTH workforce delivery plans for 2025/26 and 2026/27 aligned to overall system plans and signed off by the Board of Directors'						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Progress**	**BRAG Status**
STW 2.1.26	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 from 4th February.	**On Track**
STW 2.1.27	Develop fragile services action plan supported by Caroline McIntyre, Head of Workforce Transformation.	Ned Hobbs & John Jones	01/07/2025	31/03/2026	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	Part of operational plan submission.	**Complete & Evidenced**

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**
2.2.6	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**
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. Now in place and module purchased.	**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 & Evidenced**
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 & Evidenced**

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	Oversight of SIIP delivery has been strengthened with monthly progressing reporting submitted to the relevant assurance committees and the Trust Board. The refreshed ward-to-board governance structure	**Completed and Evidenced**

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**
					was approved at the December 2025 Board meeting, providing clear assurance on accountability and delivery.	
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.	**Complete and Evidenced**
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.	**Complete and Evidenced**

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	Three CEO OD Programme events have taken place.	**Complete and Evidenced**
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.	**Complete and Evidenced**
SaTH 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	**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**
					milestones to deliver our vision. Staff Survey: The national embargo on the Staff Survey results remains in place and is expected to be lifted in mid-March 2026. Once the embargo is removed and the Trust has completed its internal quality-assurance process, the results will be shared through the appropriate governance routes.	

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~~ 28/02/2026	5-year plan submitted to NHSE on 12th February 2026 which includes a 3-year financial submission which is complaint with the deficit ceiling in year 3.	**Complete & Evidenced**
	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	Task passed from STW to SaTH as part of 2025-26 refresh and planned ICB exit from NOF4. Sath/Shropcom Group Transition Plan in place.	**Completed & 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**
	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	Rolled over from 2024/25. STW ICS Demand and Capacity Model in place. System Long term plan financial plan in place	**Completed & Evidenced**
	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	Rolled over from 2024/25 This is based on Transformation Programmes. Benchmarking opportunities identified in SaTH and System MTFP detailed in 4A reports.	**Completed & Evidenced**
2025/26 and 2026/27 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	2025/26 and 2026/27 Efficiency plan PIDs signed off by scheme leads and directors.	SaTH 1.2.1	AW	Ongoing	31/03/2026	Rolled over from 2024/25 Financial Planning return FY2026. Full CIP plan is planned to be identified by the end of March 2026.	**Completed & 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**
	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	Activity dashboard. SaTH Data Quality update IPR presented to Board of Directors Meetings.	**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	£5.6m off plan at month 10. Risk identified as well as additional mitigations. Closely monitored through Finance Assurance Committee (FAC) and Board. Aiming for delivery of a break even plan for the year.	**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	AW	Ongoing	31/03/2026	Performance monitored through PAC. Waiting list reduction, however given data limitations detailed monitoring is not currently possible.	**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. The Estates Strategy was approved at the Public Trust Board on 11 September 2024. Evidence submitted to the review panel in January 2026 for the action to be closed. **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	Monitored through the Capital Oversight Group (CPOG) and monthly Capitol Report presented to the monthly CPOG	**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	Completed and monitored through FRG. Included with FRG reports from 24/25 and 25/26. Exec VCP in place, enhanced temporary staffing controls including daily nursing and non-clinical bank panels.	**Complete & Evidenced**
	Follow up review of I&I actions to ensure continued delivery.	SaTH 1.4.4	AW	30/08/2025	30/11/2025	Completed and monitored through FRG.	**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** Completed and monitored through ARAC.	**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	Internal Audit recommendations monitored and implemented timely.	**On Track**
	Individual organisational tracking of timely completion of internal audit actions (Monthly) .	SaTH 1.4.7	AW	Ongoing	31/03/2026	Internal Audit actions reported and monitored at ARAC	**On Track**
	Delivery of individual organisational external audit report recommendations	SaTH 1.4.8	AW	Ongoing	31/03/2026	Delivered individual organisational External Audit recommendations.	**On Track**
	Individual organisational tracking of timely completion of external audit actions (Monthly).	SaTH 1.4.9	AW	Ongoing	31/03/2026	MIAA Audits and actions reported and monitored at ARAC	**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	Monitored at ARAC and Financial Controls Report reported and monitored at ARAC and FRG.	**On Track**
	External audit including VFM to be rated moderate or substantial	SaTH 1.4.12	AW	Ongoing	31/03/2026	VRM Q collated.	**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	Evidence submitted and approved	**Completed & Evidenced**
SaTH 3.1.2	Actively engage with and make a marked contribution to system wide workstreams	Ned Hobbs	01/04/2024	31/03/2026	Evidence submitted and approved	**Completed & Evidenced**

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	Recruitment into UTC GP vacancies continues to help address performance. Additionally, skills gap analysis is underway for the ACPs to support the workforce. Utilisation of UTC was 19% in January 2026. The action is agreed as being at risk and will be carried into the 2026/27 plan.	**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	Evidence submitted and approved	**Completed & Evidenced**
SaTH 3.1.1.4	Implement further GP direct access speciality pathways across surgical services	Andrena Weston	02/04/2025	28/02/2026	Evidence submitted and approved	**Completed & Evidenced**

SaTH 3.1.1.5	Improve productivity of Minors	Rebecca Race Rebecca Houlston	3/07/2024	31/03/2026	Evidence submitted and approved	**Completed & Evidenced**
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 continue to be over 60 minutes and this action has been agreed to carry over to 2026/27. An extension of the twilight doctor provision is being scoped as a test in March 2026 in addition to a Rapid Assessment and Treatment model	**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 but early indications suggest that one people promise result has improved in MEC. This action is therefore at risk and will be carried over into the 2026/27 plan with input from People and OD to devise a supporting action plan	**At Risk**
SaTH 3.1.1.9	Reduction in the number of UTC hand backs	Rebecca Houlston	01/07/2025	31/03/2026	Cross site audits are underway to determine not only the uptake of return appointments, designed to minimise handbacks but also any reasons provided by patients for declining or not attending these.	**On Track**
3.1.1.10	Embedding of Initial Assessment clinical model to achieve 75% performance	Emma Harber	01/07/2025	31/03/2026	Overall initial assessment performance reduced slightly in January 2026 to 68.4%, CYP performance improved significantly from 60.4% in December 2025 to 73% in January 2026. Focus on this work continues as the recently introduced process continues to be embedded with some minor amendments recently introduced. A variation has been submitted to the CQC to lift the Section 31	**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	Evidence submitted and approved	**Completed & Evidenced**

SaTH 3.1.1.12	Improvement in UTC 4 hour performance to >90%	Rebecca Houlston	01/07/2025	31/03/2026	Recruitment into the service continues. January 2026 4-hour performance was 86.1% and the action will be carried through to the 2026/27 plan in order to continue the necessary recruitment and support performance	**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 service is currently working with BI to produce a fluid method of tracking response times. Because an improvement cannot be evidenced at this time, the action is at risk and will be carried over into the 2026/27 plan	**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	Significant amount of work completed however now highlighted as off track due to a delay in final estates work to 8 side rooms on Apley ward. These side rooms will be available on 12/02/2026 when the action will move to Completed and Evidenced	**Off Track**
SaTH 3.1.2.4	Recruitment following reconfiguration of Cardiorespiratory to optimise diagnostics.	Nina Moran	31/05/2024	28/02/2026	Evidence submitted and approved	**Completed & Evidenced**
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	The original Therapies stroke pathway business case will not be implemented due to the future HTP workforce configuration; however, associated risks have been fully mitigated through existing service arrangements. Stroke therapy provision continues to be safely delivered and overseen through established governance, with routine performance metrics confirming stable capacity, pathway flow and clinical coverage. The HTP workforce redesign addresses the underlying issues the business case sought to resolve, and no quality or safety risks have been identified from discontinuing the business-case approach.	**Completed & Evidenced**
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	Evidence submitted and approved	**Completed & Evidenced**

SaTH 3.1.2.9	Radiology: 12hr turnaround draft proposal including procedures and SOP	Helen Williams	01/04/2025	31/01/2026	Evidence submitted and approved	**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 improvement in 2025/26.	Imran Hanif	01/07/2025	31/01/2026	Recruitment completed with new recruits in post but is now labelled as “off track” due to the supporting data demonstrating the improvement not being available in time for the delivery date	**Off Track**
SaTH 3.1.2.12	Pathology - Recruitment of additional posts to extend out of hours provision’	Adrian Verdee	01/11/2024	28/02/2026	Evidence submitted and approved	**Completed & Evidenced**
SaTH 3.1.2.15	Increase in patients referred to Medical SDEC of 5%	Liz Slevin	01/07/2025	31/03/2026	Evidence submitted and approved	**Completed & Evidenced**
SaTH 3.1.2.16	Implementation of back pain pathway	Andrew Evans	01/07/2025	31/03/2026	MRI is available until 8pm with 24/7 cover planned to be in place by March 2026. Recruitment is in progress to support and pathway in place with RJAH.	**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	December showed an average of 148 NCTR patients with 218 14 +day LOS patients and 124 21+ day LOS patients. The trust position has not significantly improved and this action will carry over into the 2026/27 plan with the launch of a new Flow Centre model	**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	Evidence submitted and approved	**Completed & Evidenced**
3.1.2.19	Improvement in pre 08:45 Discharge Lounge utilisation.	Alison Vaughan	01/07/2025	31/03/2026	Recruitment continues to support extended Discharge Lounge hours and the action has been agreed as on track and predicted to complete on time	**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	Evidence submitted and approved	**Completed & Evidenced**
SaTH 3.1.3.2	Engagement with ICCC and development of STW integrated urgent care model	Ned Hobbs	01/10/2024	31/03/2026	Evidence submitted and approved	**Completed & Evidenced**
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	Evidence submitted and approved	**Completed & Evidenced**
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	There have been improvements in the data quality but more work is needed to complete the action. Therefore this action is at risk and will be carried into the 2026/27 plan	**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	Evidence submitted and approved	**Completed & Evidenced**
SaTH 3.1.4.12	Frailty intervention team extended hours	Tom Phelps	12/06/2024	28/02/2026	Evidence submitted and approved	**Completed & Evidenced**
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 and approved	**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 Slevin	01/05/2024	31/03/2026	The Section 31 relating to paediatric patients who leave ED without being seen has now been removed. Reports have been submitted to panel as evidence and the action is agreed as on track for delivery on time	**On Track**
SaTH 3.3.2	To reduce initial assessment time exceeding 15 minutes	Liz Slevin	01/05/2024	31/03/2026	The average time to initial assessment in January 2026 was 15 minutes. The work around this process is continuing but the action remains on track for completion	**On Track**
SaTH 3.3.3	Improve Mean ambulance handover time	Susanne Crossly	01/04/2025	31/03/2026	The new Maximum Handover Threshold process has now launched. Mean ambulance handover time in January 2026 was 77.76 minutes	**On Track**
SaTH 3.3.4	Providing additional core and winter bed capacity (RSH)	Susanne Crossly	01/04/2025	31/03/2026	Evidence submitted and approved	**Completed & Evidenced**
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	Coded F10's for inappropriate referrals are increasing and therefore at risk. A new plan is being drafted within the Therapies centre to tackle inappropriate referrals. This action is at risk and will be carried over into the 2026/27 plan	**At Risk**
SaTH 3.4.2	Review and implement assessment area for acute Oncology presentation	Sally Hodson	01/07/2025	31/03/2026	Evidence submitted and approved	**Completed & Evidenced**

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 5: SaTH Integrated Improvement Plan (SIIP): Governance and Leadership Plan 2026/27.

The Shrewsbury and Telford Hospital NHS Trust

Our Moving to Excellence Ambition

Our SaTH Integrated Improvement Plans forms a core part of our 'Moving to Excellence' ambition. Together they reflect strengthened governance, leadership behaviours, financial discipline and systematic improvement, ensuring that our people, our services and our systems are aligned around one shared purpose — delivering safe, high-quality, sustainable care for our communities. These plans provide a clear line of sight between our strategic inte and the actions required to maintain momentum, uphold strong governance, and continue our improvement journey with confidence and credibility.

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
Deliverable: The outputs that you need to produce to demonstrate delivery of exit criteria	**Deliverable: 4.1: Ensure robust governance arrangements are in place in SaTH**					
SaTH 4.1.0	Continue to review and refresh as required the SaTH internal governance structure during 2026/27 to ensure it supports strong oversight and assurance.	Anna Milanec	Already started	31/03/2027	**Evidence will include:** • Updated governance structure diagram • Committee workplans showing alignment • Minutes confirming review discussions • Any revised Terms of Reference approved by Board committees SaTH's internal governance structure to continue to be reviewed in line with committee workplans.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 4.1.15	Deliver and oversee the HTP Improvement Plan, ensuring governance, assurance and reporting via the HTP Assurance Committee.	Matthew Neal	Already started	31/03/2027	**Evidence will include:** • HTP Assurance Committee papers (agendas, minutes, slide packs) confirming regular reporting and oversight • Quarterly HTP progress reports submitted through the Assurance Committee and escalated to QPC/STW Board as required • Updated HTP Improvement Plan tracker showing progress, risks, mitigations, and RAG status • Assurance Committee Key Issues Reports highlighting progress, risks, and decisions • Evidence of internal governance routing, including CE meeting oversight and relevant Board Assurance Committee alignment • Integrated programme dashboards demonstrating progress against milestones and key interdependencies • Correspondence or briefing notes provided to system partners (e.g., ICS, NHSE) demonstrating ongoing assurance • Updated Terms of Reference or governance flow diagrams where relevant, showing the HTP Assurance Committee's role in oversight	
Deliverable: 4.2: Establish the new Group Model						
SaTH 4.2.7a	To recruit and appoint the Group leadership team and Group Non-Executive Directors. (Was previously Task ID 4.2.10)	Group Chair /Group CEO	01/09/2025	30/09/2026	**Evidence will include:** • Remuneration Committee papers confirming process and timelines • Job descriptions and adverts • Announcement or communication confirming appointments In progress. Remuneration Committees to consider process and timeline. Plans in place to begin recruitment.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 4.2.7b	Agree and embed joint membership of Board Committees and update NED portfolios to ensure clear alignment with roles and responsibilities, supporting effective oversight and assurance. (Was previously Task ID 4.2.7)	Anna Milanec	01/09/2025	31/12/2027 (pending confirmation of appointment of group members)	**Evidence will include:** • A short note or minutes showing how membership was agreed • The criteria used (e.g., alignment with portfolios, balance of workload) • The final membership list • The updated Terms of Reference showing the membership • The Evidence • The minutes confirming approval of the Terms of Reference (and therefore the membership). • Group Transition Committee papers (agenda, minutes, packs) The Group Transition Committee (joint with ShropCom) held its initial shadow meeting in July 2025 to review and agree the Terms of Reference, ahead of its formal establishment in August 2025. Agenda, minutes and full meeting packs have been submitted. SaTH's existing Terms of Reference template continues to be used to ensure consistency.	
SaTH 4.2.8	Further develop and embed the workings of the Group People and OD Committee as the first joint committee to unify workforce strategy, culture, and talent development.	Deborah Bryce / Anna Milanec	01/09/2025	31/05/2026	**Evidence will include:** • Minutes and papers from first and second joint committees (24 Nov 2025, 26 Jan 2026) • Forward plan (final version) • Updated ToR when approved 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. Consideration to be given as to what items are for information and what are for decision. Forward plan being finalised.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 4.2.9	Implement an Accountability and Governance Group Framework for setting out shared principles, objectives, and ways of working of the two providers working together (SaTH and ShropCom).	Anna Milanec	01/09/2025	31/03/2027	**Evidence will include:** • Trust Board in Common minutes (23/09/2025) • Group Transition Committee ToR (approved Aug/Sept 2025) • Meeting packs submitted • Framework document (final PDF) Trust Board in Common held between SaTH and SCHT 23/09/2025. Group Transition Committee is in place with Terms of Reference approved by the Board in public on 11 September 2025 (in private: August 2025). Meeting papers submitted as evidence.	
4.2.13	• Develop and implement the Freedom to Speak Up (FTSU) group model. • Promote the FTSU group model through consistent communications so that all staff receive clear and aligned messaging.	Anna Milanec Jenny Fullard	01/04/2026	31/12/2026	**Evidence will include:** • Draft and final FTSU model/approach • Communications plan and staff messages • Screenshots/newsletters confirming roll-out • Minutes from FTSU steering or oversight groups • Updated FTSU policy (when ready) Freedom to Speak Up (FTSU) is already recognised as an essential component of the emerging Group governance framework. FTSU arrangements. The Group Transition Committee documentation confirms that FTSU arrangements are in place across the organisations, including the FTSU Vision and Strategy, the FTSU policy and training in place. These elements are referenced alongside the wider governance and cultural development work required for the new Group Model, demonstrating that FTSU is being treated as a core part of the future Group governance structure.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
4.2.14	Take forward the recommendations from the December 2025 NHSE Freedom to Speak Up (FTSU) report and track delivery through 2026/27.	Anna Milanec	01/12/2025	31/03/2027	**Evidence will include:** • NHSE FTSU review report • Action plan with status updates • Evidence folder (for recommendations) • Quarterly progress update to relevant committee and the Board.	
4.2.15	Further to the review of the SFI's/ Standing Orders/ SoRD at both organisations during 2025, align SaTH and ShropCom Standing Financial Instruction's, Standing Orders and Scheme of Reservation and Delegation.	Anna Milanec Deborah Bryce	01/04/2026	31/03/2027	**Evidence will include:** • Baseline comparison document • Agreed aligned versions (draft & final) • Confirmation of approval in minutes (Audit & Risk or Board)	
Deliverable: 4.3: To ensure the Group identifies and manages risks effectively						
4.3.6	Develop a Group Risk Management Policy and Risk Management Strategy, including an agreed risk appetite statement for SaTH and ShropCom.	Anna Milanec	01/04/2026	01/01/2027	**Evidence will include:** • Draft and final Risk Management Policy • Draft and final Strategy • Jointly agreed Risk Appetite Statement • Minutes from Audit & Risk or Board confirming approval	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

The Shrewsbury and Telford Hospital NHS Trust

Appendix 6: SaTH Integrated Improvement Plan (SIIP): Workforce and Leadership Plan 2026/27.

Our Moving to Excellence Ambition

Our SaTH Integrated Improvement Plans forms a core part of our 'Moving to Excellence' ambition. Together they reflect strengthened governance, leadership behaviours, financial discipline and systematic improvement, ensuring that our people, our services and our systems are aligned around one shared purpose — delivering safe, high-quality, sustainable care for our communities. These plans provide a clear line of sight between our strategic intent and the actions required to maintain momentum, uphold strong governance, and continue our improvement journey with confidence and credibility.

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
Deliverable: The outputs that you need to produce to demonstrate delivery of exit criteria	**Deliverable Metric 2.1: SaTH workforce planning completed ready for 2027/28 sign off by the Trust Board**					
SaTH 2.1.26	E-Rostering implementation – medical workforce.	Laura Carlyon	01/08/2025	31/03/2027	**Evidence will include:** • Medical E-Roster rollout complete based on programme outline • Completion report with % rollout by specialty • Compliance dashboards (job plan linked / rostering KPIs)	
SaTH 2.1.28	5-year Workforce plan to be developed including workforce demand and supply, supporting rightsizing the workforce.	Simon Balderstone	1/2/2026	31/07/2026	**Evidence will include:** • Workforce plan document completed • Board minutes noting approval	
SaTH 2.1.29	Continued work on job planning embedding as part of workforce planning to support productivity and efficiency.	Simon Balderstone	1/2/2026	30/09/2026	**Evidence will include:** • Workforce plan document completed and including job planning elements. • % consultants with approved job plan • Job plan compliance dashboard • Governance minutes from Strategic People Group monitoring	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
SaTH 2.1.30	Staff engagement strategy to be developed and implemented to support preparations for HTP/development of a group model.	Sabeena Khanna	1/2/2026	31/03/2027	**Evidence will include:** • Staff engagement strategy finalised • Board minutes confirming approval of the strategy • Engagement plan and communication materials • Summary of staff feedback	
SaTH 2.1.31	Manage the workforce changes required for the Hospitals Transformation Programme (HTP), including staff consultation, trade union engagement, workforce impact assessment, and meaningful staff involvement to ensure the 2027/28 workforce plan is complete, affordable, and ready for Trust Board sign-off.	Sabeena Khanna	01/04/2026	31/03/2027	**Evidence will include:** • HTP workforce impact assessments • Trade Union engagement logs • Consultation timeline • Workforce modelling for new clinical model • Equality impact documentation	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
2.1.32	Continue to support transformation of services, system alignment and collaboration with STW (Shropshire, Telford and Wrekin) to align to system plans	Ned Hobbs Nigel Lee	1/2/2026	31/03/2027	**Evidence will include:** • Evidence of participation in STW system transformation groups, programme boards, or working groups • Records of joint planning sessions and alignment of organisational plans with STW system priorities • Progress updates on shared transformation projects and delivery milestones • Workforce and leadership involvement in system-wide development or transformation activities • Improvements in service pathways or outcomes linked to system-wide transformation work • Regular reporting through internal governance routes on progress, risks, and impact • Communication and engagement materials demonstrating staff and partner involvement in system transformation	
SaTH 2.1.33	Sickness absence management support programme developed with clear milestones for delivery.	Nick Dowd	1/2/2026	31/03/2027	Evidence will include: • Programme outline developed and implemented. • Reduction in long-term sickness trend • Manager sickness training delivery • Health & Wellbeing interventions • IPR reports	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
SaTH 2.1.34	Temporary staffing strategy is developed to ensure that this managed in alignment with remodelling and rightsizing of the workforce in accordance with workforce plan	Simon Balderstone	1/2/2026	30/09/2026	**Evidence will include:** • Strategy for temp staffing included in workforce plan. • Reduction in agency spend trajectory • Controls framework • Safe staffing modelling alignment	
Deliverable Metric 2.2: Delivery of SaTH People and OD strategy actions for 2026/27						
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. Aligned to strategic workforce plan.	TG/ RA/ SF	01/9/2026	31/03/2027	**Evidence will include:** • Education plans are a feature of the workforce plan. • Minutes of HEI partnership meetings • New role pipelines (ACP, PA, apprenticeships) • Placement capacity changes • Timeline for innovative pathways	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
SaTH 2.2.8	Continue to deliver the cultural and leadership programmes required to support workforce transformation through a rolling framework, including leadership development, OD interventions, health and wellbeing (HWB) initiatives, staff survey actions, reward and recognition, People Pulse reporting and Group-wide communication and engagement plans	DT	01/04/2025	31/03/2027	**Evidence will include:** • Leadership development programme schedules and evaluations • OD intervention reports and outcomes • Health and well-being activity data • Staff Survey action plan progress • Reward and Recognition outputs • Quarterly People Pulse reports and improvements in scores • Papers submitted to Strategic People Group / Group People Committee in Common • Approved Group communication and engagement plan • Staff engagement materials & feedback	
SaTH 2.2.9	Continuing to 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 doctors working hours.	SB	01/04/2026	31/3/2027	**Evidence will include:** • Programme delivered in line with project plan • Manager Self Service adoption data • Flexible working metrics • Medical rostering dashboards • % of teams with redesigned job plans	

Leadership						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
Deliverable Metric 5.3: 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.						
SaTH 5.3.3	Ensure robust monitoring and oversight of delivery of all SaTH's IIP via appropriate governance and operational structures (includes ward to board)	CEO SaTH	In progress	31/03/2027	**Evidence will include:** • Monthly Board SIIP update reports and board minutes • Minutes from Group People Committee in Common monitoring SIIP plans • Escalation logs into STG (System Transformation Group) • Evidence Review Panel output (Governance, Workforce, Leadership, Finance, UEC) • Use of the Integrated Performance Report (IPR) showing workforce metrics • Any assurance mapping linking committees to SIIP tasks/Plans	
Deliverable: *The outputs that you need to produce to demonstrate delivery of exit criteria*	**Deliverable 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.**					
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	31/3/2027	**Evidence will include:** • Attendance logs • Joint leadership expectations pack • Output from STG leadership conversations • Example shared of system decisions demonstrating collaborative leadership	

Leadership						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
SaTH 5.4.5	Analyse NHS Staff Survey and pulse survey results and lead on development and delivery of associated action plan	DT	01/04/2026	31/3/2027	**Evidence will include:** • People Pulse quarterly reports • NHS Staff Survey themes • Divisional action plans • Improvement of metrics year-on-year	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 7: SaTH Integrated Improvement Plan (SIIP): Finance Plan 2026/27.

The Shrewsbury and Telford Hospital NHS Trust

Our Moving to Excellence Ambition

Our SaTH Integrated Improvement Plans forms a core part of our 'Moving to Excellence' ambition. Together they reflect strengthened governance, leadership behaviours, financial discipline and systematic improvement, ensuring that our people, our services and our systems are aligned around one shared purpose — delivering safe, high-quality, sustainable care for our communities. These plans provide a clear line of sight between our strategic inte and the actions required to maintain momentum, uphold strong governance, and continue our improvement journey with confidence and credibility.

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
Deliverable: The outputs that you need to produce to demonstrate delivery of exit criteria **Deliverable 1.1: SaTH has an agreed 3–5 year Medium-Term Financial Plan (MTFP), approved by the Board and agreed with the ICS and NHS England. A triangulation exercise is now required to align the financial plan with the workforce, activity and performance plans, including evidence of testing and review against the HTP model, which will be incorporated into the MTFP for final sign-off.** **In addition, a further high-level 5-year SaTH summary plan is needed to align with HTP timescales and demonstrate the system's trajectory to underlying financial balance. The MTFP should also include a summary of efficiency opportunities informed by benchmarking.**						
SaTH 1.1.2	2026/27 Annual refresh of MTFP and 5-year high level financial plan (including triangulation, cashflow and review against HTP assumptions).	AW	Ongoing	30/09/2026	**Evidence will include:** • Annual refresh and triangulation complete in line with annual planning submission. • Final plan to be submitted 12/02/2026	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
					• Board minutes showing approval of submission of MTFP	
SaTH 1.1.3	Ongoing monitoring of underlying position against MTFP and HTP assumptions.	AW	Ongoing	31/03/2027	**Evidence will include:** • FAC report and minutes	
STW 1.1.6	Develop a revised medium-term planning approach that reflects the introduction of the NHSE Medium-Term Planning Framework. This includes incorporating the statutory elements of the Joint Forward Plan (JFP) into the strategic commissioning 5-year plan, ensuring these requirements are met. In parallel, work collaboratively with provider organisations, both the ICB and Trusts, to produce each organisation's medium-term planning submission. These elements should come together to fulfil the core purpose of maintaining strategic alignment, accountability and responsiveness across the system.	Nigel Lee	Ongoing	30/03/2027	**Evidence will include:** • Strategic Commissioning 5-year plan referencing statutory JFP requirements • NHSE/ICB email confirming statutory JFP elements must be incorporated into the 5-year plan • Provider medium-term planning submissions (SaTH) with evidence of system alignment • Board papers/minutes showing approval of the plan(s)	
SaTH 1.1.8	Signed off LTFP 10-year high level financial plan - SaTH/ICS/NHSE	AW	Ongoing	31/01/2027	**Evidence will include:** • System long term plan • SaTH Board paper confirming approval. • ICS/NHSE sign-off email/letter,	
Deliverable 1.2: 2026/27 and 2027/28 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						
SaTH 1.2.1	2027/28 efficiency plan PIDs signed off by scheme leads and directors.	AW	Ongoing	31/03/2027	**Evidence will include:** • PIDs and FPR submission for 2027/28	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 1.2.11	2026/27 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions.	AW	Ongoing	31/03/2027	**Evidence will include:** • IPR report and minutes	
SaTH 1.2.23	In year monitoring of financial performance against plan, identifying escalation actions where needed (oversight through OPOG, FRG and Finance Assurance Committee).	AW	Ongoing	31/03/2027	**Evidence will include:** • FAC report and minutes • OPOG papers • FRG updates	
SaTH 1.2.24	Monitor ongoing demand & capacity actuals against plan identifying escalation actions where needed (oversight through OPOG and Performance Assurance Committee).	Ned Hobbs	Ongoing	31/03/2027	**Evidence will include:** • IPR report and minutes • PAC report and minutes	
Deliverable: 1.3: Capital plans (aligned to system plans) for 2026/27 signed off (by SaTH and NHSE) and delivered						
SaTH 1.3.8	Support system alignment with and delivery of 2026/27 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPG and CPOG.	AW	Ongoing	31/03/2027	**Evidence will include:** • CPOG report and notes	
Deliverable: 1.4: Delivery of internal and external audit recommendations and actions						
SaTH 1.4.6	Delivery of individual organisational internal audit report recommendations and pro-active management in year (monthly review).	AW	Ongoing	31/03/2027	**Evidence will include:** • Monthly monitoring of internal audit recommendations via governance department and Exec lead updates • HOIA Opinion	
SaTH 1.4.9	Individual organisational tracking of timely completion of external audit actions (Monthly).	AW	Ongoing	31/03/2027	**Evidence will include:** • Monthly External audit tracker • Minutes from Finance Assurance Committee (FAC) where external audit action progress	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
					is reported • Highlight reports showing the month's update	
SaTH 1.4.12	External audit including VFM to be rated moderate or substantial	AW	Ongoing	31/03/2027	**Evidence will include:** • KPMG Year End report to the Audit and Risk Assurance Committee - 2025-26 ISA 260 SaTH Final. • Consistency Opinion SaTH FY26 Final. • Sath Financial Statements Opinion Final. • SaTH Signed Accounts FY26 - 26/05/26. • SaTH Signed Annual Report and Accounts 2025/26. • VRM Q Collated.	
Deliverable: 1.5: Establish a resilient process for data capture, safe data storage and data analysis to meet the Trust's reporting needs and responsibilities, and processes for promoting and optimising data quality						
SaTH 1.5.1	Work with external partners to develop and implement new arrangements for information collection, storage and analysis to support timely and accurate reporting.	Bec Duffy	Ongoing	30/06/2026	**Evidence will include:** • BAU income reporting resumed through FAC • FAC report and minutes • ACM and PLD reporting reinstated with Commissioners	
SaTH 1.5.2	BI to provide data quality assurance on data flows.	Ria Powell	Ongoing	31/03/2027	**Evidence will include:** • Minutes of Data Quality Workgroup	

BRAG Status
Completed and evidenced
On Track
At Risk
Off Track

Appendix 8: SaTH Integrated Improvement Plan (SIIP): UEC Plan 2026/27.

The Shrewsbury and Telford Hospital NHS Trust

Moving to Excellence

We are striving to provide exceptional care for our patients and be a Trust where staff are proud to work

Our Moving to Excellence Ambition

Our SaTH Integrated Improvement Plans forms a core part of our 'Moving to Excellence' ambition. Together they reflect strengthened governance, leadership behaviours, financial discipline and systematic improvement, ensuring that our people, our services and our systems are aligned around one shared purpose — delivering safe, high-quality, sustainable care for our communities. These plans provide a clear line of sight between our strategic inte and the actions required to maintain momentum, uphold strong governance, and continue our improvement journey with confidence and credibility.

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
Deliverable: SaTH 3.1b: Delivery of the SaTH UEC Transformation Programme actions for the MEC Transformation Programme						
SaTH 3.1.1.1	Strengthen UTC workforce and recruit additional GP WTE, implement peak hour rota. **(Task 3.1.1.12 has merged with this task)**	Rebecca Houlston	01/10/2024	31/03/2027	**Evidence will include:** • Recruitment screenshots, • SPC demonstrating – Improvement in UTC utilisation to 25% and	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
					– 4-hour performance to 90% supporting overall ED 4-hour performance towards the local target of >65% by March 2027.	
SaTH 3.1.1.3	Prioritise women's & children's specialties for GP direct access with ICS, including defining referral criteria & diagnostics; update e-RS forms and DoS	Zain Siddiqui	12/05/2024	28/02/2027	**Evidence will include:** • GP direct access specialty pathways, governance minutes, data on pathway usage.	
SaTH 3.1.1.7	Redesign processes and remove inefficiencies within the ED patient journey; monitoring performance via the established working group	Rebecca Race	01/07/2025	31/03/2027	**Evidence will include:** • SPC demonstrating time to be seen by an ED clinician reduced to 60 mins	
SaTH 3.1.1.8	Develop and deliver targeted People Promise action plan focused on wellbeing, culture and retention	Hannah Walpole	01/07/2025	31/03/2027	**Evidence will include:** • Improvements demonstrated in staff survey metrics for the themes of 'We are safe and healthy', 'We work flexibly', and 'We are compassionate and inclusive'	
Deliverable: 3.1.2b: Delivery of the SaTH UEC Transformation Programme actions for the Capacity and Flow Transformation Programme						
SaTH 3.1.2.1	• Publish response SLA for cardiology/ respiratory referrals on AMU and Medical wards (e.g., ≤2h daytime, ≤4h OOH). • Monthly audit of response times with feedback to services.	Tom Phelps	21/05/2024	31.03.2027	**Evidence will include:** • SPC charts demonstrating improved response times for cardiology and respiratory referrals on AMU and medical wards (baseline currently 24 hours). by cardio and respiratory	
SaTH 3.1.2.17	Work with Local Authorities and ICB to develop a flow centre model in 26/27 that will support addressing patients with NCTR and reducing the 14- and	Alison Vaughan	01/07/2025	31/03/2027	**Evidence will include:** • SPC Charts demonstrating a reduction in 14 day / 21-day inpatient length of stay.	

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
	21-day LOS.					
Deliverable: 3.1.4: Improved accuracy and completeness of ECDS data to enable reliable identification of alternative UEC opportunities.						
SaTH 3.1.4.3	Improving the data quality of ECDS to support identification of further alternative opportunities through monthly audit & feedback; publish a data quality dashboard	Rebecca Houlston	01/11/2024	31/03/2027	**Evidence will include:** • Monthly audits show measurable improvements in ECDS data completeness and accuracy, with a live data-quality dashboard in place to support ongoing monitoring.	
Deliverable 3.3: Deliver UEC specific actions as per the Quality Improvement Plan including CQC must/should do's						
SaTH 3.3.2	Continue to embed initial assessment process, whilst ensuring skill mix meets demand. **(Task 3.1.1.10 has merged with this task).**	Liz Slevin	01/05/2024	30/06/2026	**Evidence will include:** • SPC charts demonstrating a reduction in Initial Assessment breaches over 15 minutes and performance over 75%	
SaTH 3.3.3	Implement escalation policy to further improve Mean ambulance handover time	Susanne Crossly	01/04/2025	31/03/2027	**Evidence will include:** • Escalation Policy v1 with joint sign-off; • Governance minutes. • SPC chart demonstrating improved ambulance handover time.	
Deliverable 3.4: Delivery of the SaTH UEC Transformation Programme actions for the CSS Transformation Programme						

Task ID	Task *The tasks you need to complete to produce the deliverables*	Task Owner	Start Date	End Date	Sources of evidence to demonstrate implementation	BRAG Progress Status
SaTH 3.4.1	Implement process to support interventions by physiotherapy/ occupational therapy earlier in the patient journey	Charlotte Jacks	01/07/2025	31/03/2027	**Evidence will include:** • SPC charts demonstrating a reduction in inappropriate physiotherapy / occupational therapy inpatient referrals.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

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

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

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

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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

PROGRESS AS AT 10.02.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital
NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.64	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.	Y	10/12/20	30/04/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	22/04/21	28/02/22	03/02/22	H. Flavell	A. Lawrence	Monday.com
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	03/02/22	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	03/02/22	28/02/22	28/02/22	H. Flavell	A. Lawrence	Monday.com

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

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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

PROGRESS AS AT 10.02.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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PROGRESS AS AT 10.02.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	31/03/21	30/04/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.98	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/09/21	30/06/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.99	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.	Y	10/12/20	31/10/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/01/21	31/10/21	14/09/21	H. Flavell	A.Sizer	Monday.com
4.100	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.	Y	10/12/20	31/05/24	Delivered, Not Yet Evidenced	On Track	This action was approved as Delivered, Not Yet Evidenced at May-24's MTAC. An exception report was presented at Oct-25's MNTAC changing this action's timeframe for assurance from Sep-25 to Jan-26. This will allow for additional work to be completed to further secure honorary contracts allowing for hands on practice in future rotation, following feedback from the already completed rotation.	14/05/24	31/01/26		P. Gardner	A.Sizer	Monday.com

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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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

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FIRST OCKENDEN REPORT ACTION PLAN

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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	Evidenced and Assured	Completed	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. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	10/06/25	31/12/25	13/01/26	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	Evidenced and Assured	Completed	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. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	10/06/25	31/12/25	13/01/26	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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FIRST OCKENDEN REPORT ACTION PLAN

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

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

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

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

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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	Evidenced and Assured	Completed	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. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	13/09/22	28/02/25	13/01/26	P. Gardner	J. Atkinson	Monday.com

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

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

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

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

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

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

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PROGRESS AS AT 10.02.2026

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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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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	Off Track (see exception report)	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'. This action is currently Off Track as a business case is necessary to adress new training requirement published as part of the national framework.	09/01/24	31/05/25		P. Gardner	A. Lawrence	Monday.com
1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	13/06/23	31/03/24	12/09/23	H. Flavell	A. Lawrence	Monday.com
1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	11/07/23	31/03/24	14/12/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com

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1.11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(RCOG and RCP). Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffiecient evidence to allow for any status change according to the programme methodology. Suggestions of appropriate evidence were reviewed at Sep-25's MNTAC and communicated to the national teams.		TBC		J. Jones	H. Flavell	Monday.com

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

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

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

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

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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	Evidenced and Assured	Completed	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. This action was greed as Evidenced and Assured at Jan-26's MNTAC.	08/07/25	31/10/25	14/01/26	P. Gardner	A.Sizer	Monday.com
8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	09/05/23	H. Flavell	A. Sizer	Monday.com
8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	31/08/23	08/08/23	H. Flavell	A. Sizer	Monday.com

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

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

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

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NHS
The Shrewsbury and Telford Hospital NHS Trust

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

Colour	Status	Description
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PROGRESS AS AT 10.02.2026

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 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 Jan-26's MNTAC, where a new timeline for Evidenced and Assured was set for Jul-26.	13/12/22	30/06/26		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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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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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PROGRESS AS AT 10.02.2026

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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PROGRESS AS AT 10.02.2026

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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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	0	25
Total	52	0	1	51
Percentage		0%	2%	98%

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	0	0	0	25	0
Total	52	0	1	0	0	51	0
Percentage		0%	2%	0%	0%	98%	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	2	63
IEA	92	6	4	82
Total	158	7	6	145
Percentage		4%	4%	92%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	66	0	2	0	0	63	1
IEA	92	0	3	0	1	82	6
Total	158	0	5	0	1	145	7
Percentage		0%	3%	0%	1%	92%	4%

Combined actions - Delivery status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	93	1	3	89
IEA	117	6	4	107
Total	210	7	7	196
Percentage		3.33%	3.33%	93.33%

Combined actions- Progress status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	93	0	3	0	0	89	1

Counts

IEA	117	0	3	0	1	107	6
Total	210	0	6	0	1	196	7
Percentage		0.0%	2.9%	0.0%	0.5%	93.3%	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 10.02.2026

APPENDIX TWO

Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR1/I_NEMR2	The service, an LNU, has retained equipment to provide nitric oxide even though changes have been made nationally to focus the provision of nitric oxide within NICUs. The equipment was rarely used and yet associated with anxiety among nursing staff, many of whom were said to lack experience or training in its use. It is therefore recommended that the nitric oxide equipment should be removed from the unit where currently it poses a risk.	Evidenced and Assured	Completed	This action was approved as 'Evidenced and Assured' at Jan-25's MNTAC. Evidence Requirements for Assurance: Letter from the Network Addition to Risk Register Updated Persistent Pulmonary Hypertension of the newborn (PPHN) guideline following nitric oxide removal Engineering services email confirming removal	Immediate (0-3 months)		14/01/2025		14/01/2025	Dr John Jones	CD's	Monday.com
NEMR2/I_NEMR3	The unit should develop a first hour (golden hour) checklist to facilitate delivery and documentation of time critical interventions within the first hour from birth for all infants admitted for intensive care.	Delivered, Not Yet Evidenced	Off Track (see exception report)	An exception report was approved at Jan-25's MNTAC changing the deadline for green to Apr-25 so the audit can be repeated. Initial audit did not show sufficient compliance to ensure the action is fully embedded. A new audit presented through Governance in April still did not show sufficiant compliance. This action was reviewed and agreed as 'Off track' while it is jointly reviewed at the Quality and Safety Workstream of the LMNS so blockers and items requiring support can be identified. Evidence Requirements for Delivery: Golden Hour Guideline - validated at Apr-24 Neonatal Governance Golden Hour Checklist - validated at Apr-24 Neonatal Governance Evidence Requirements for Assurance: Audit of compliance against guideline	Immediate (0-3 months)	30/09/2024	08/10/2024	30/04/2025		Dr John Jones	CD's	Monday.com
NEMR3a/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: a. The unit should collaborate with the ODN to review the number of intensive care days (HRG1) within the unit. The review team observed that for a birth denominator of 4,100, intensive care days appeared to be high, potentially indicating an interventionist approach to neonatal care.	Evidenced and Assured	Completed	This audit has been undertaken further to receipt of the initial letter following the review. This action was accepted as "Delivered, Not yet Evidenced" at Nov-24'MNTAC. Further to this, specific data points were added to the dashboard for ongoing monitoring and form part of the Network monitoring process. This action was accepted as Evidenced and Assured at Mar-25's MNTAC. Evidence Requirements for Delivery: Intensive Care Days Audit - causes Evidence Requirements for Assurance: Surveillance of ITU and HDU care days integrated into Network monitoring processes (Steering Group) Data points added to dashboard for ongoing monitoring	Immediate (0-3 months)	31/12/2024	12/11/2024	28/02/2025	11/03/2025	Dr John Jones	CD's	Monday.com
NEMR3b/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: b. The unit should undertake quarterly audit of all neonatal resuscitations that extend beyond initial inflation breaths, against UK Resuscitation Council Newborn Life Support guidance, with specific focus on timeliness and sequence of interventions, escalations for additional senior help, response, and documentation on advanced resuscitation proforma.	Evidenced and Assured	Completed	Quarterly audit of neonatal resuscitation of all babies requiring more than inflation breaths for 6 months then quarterly for a total of a year completed. Outcome from audit - CD and maternity education team to incorporate neonatal resuscitation education into NLS update teaching. This action was accepted as "Delivered, Not yet Evidenced" at Nov-24'MNTAC and accepted as Evidenced and assured at Mar-25's MNTAC with the integration of the quarterly audit into the Forward Audit Plan. Evidence Requirements for Delivery: Resuscitation Audit Evidence Requirements for Assurance: Listed audits integrated into Forward Audit Plan	Immediate (0-3 months)	30/11/2024	12/11/2024	28/02/2025	11/03/2025	Dr John Jones	CD's	Monday.com
NEMR3c/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: c. The unit should undertake a gap analysis of how its Family Integrated Care provision aligns with national guidelines.	Delivered, Not Yet Evidenced	On Track	This action was approved as 'Delivered, Not Yet Evidenced' at October 2024 MNTAC. 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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PROGRESS AS AT 10.02.2026

APPENDIX TWO

Neonatal External Mortality Review Action Plan

The Shrewsbury and Telford Hospital NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
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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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
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	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. 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	13/01/2026	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	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 Jan-26's MNTAC 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)		13/01/2026	31/07/2026		Paula Gardner	Julie Plant	Monday.com
NEMR6g/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Safeguarding Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. This action was agreed as 'Delivered, Not yet Evidenced' at Jul-25's MNTAC. Following the resignation of the member of staff holding the role, this action has reverted to Not Yet Delivered. The team presented an execption report with new timelines for recruitment bringing the new amber date to Jun-26 and green date to Nov-26. 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)	30/06/2026		30/11/2026		Paula Gardner	Julie Plant	Monday.com

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PROGRESS AS AT 10.02.2026

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Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
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	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. Evidence Requirements for Delivery: IPC Leads in post - job sharing - 2 band 7s Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	28/02/2026	13/01/2026	30/06/2026		Paula Gardner	Julie Plant	Monday.com
NEMR6i/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Breavement Lead	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including dedicated quality lead posts). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in March 2025. An exception report was presented and accepted at Apr-25's MNTAC proposing the subdivision of NEMR6 into 9 actions for each of the quality roles required as part of national frameworks with timelines allocated to reflect the recruitment schedule. Evidence Requirements for Delivery: Bereavement Lead Job Description Bereavement Lead in post Evidence Requirements for Assurance: Rosters demonstrating protected time - 3 months	Short Term (0-6 months)	31/03/2026		31/07/2026		Paula Gardner	Julie Plant	Monday.com
NEMR7	There should be protected time for bereavement quality roles in the neonatal service to work alongside the bereavement midwives.	Not Yet Delivered	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards (including a dedicated bereavement lead post). This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. An exception re[ort was presented and accepted at Feb-25's MNTAC adjusting the delivery and evidence timescales to Jan-26 and Apr-26 respectively to adhere to the current trajectory for recruitment. Evidence Requirements for Delivery: Backfill in place to cover for quality roles duties Bereavement lead in post Evidence Requirements for Assurance: Evidence of delivery withing the roles Roster demonstrating protected time - 3 months	Short Term (0-6 months)	31/01/2026		30/04/2026		Paula Gardner	Julie Plant	Monday.com
NEMR8/I_NEMR4	ANNPs should receive 20% protected time to ensure they complete all four pillars of advanced practice and must be able to access their allocated time to update their skills on a NICU.	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

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APPENDIX TWO

Neonatal External Mortality Review Action Plan

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NEMR9	Team building should be undertaken to reflect on this review and enable the multidisciplinary team to identify actions. This should provide the following opportunities: a. For more junior nursing staff to develop effective working relationships with senior doctors on the unit and collaborate in projects to take the unit forward. b. To ensure debriefs, learning events, meetings, teaching and education aim for a multidisciplinary and multiprofessional theme to reflect the work environment and how care is delivered. c. To encourage psychological safety in ways of working, events, education and training, to ensure a safe space for colleagues to flag any concerns and worries.	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.	Evidenced and Assured	Completed	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. This action was agreed as 'Evidencedand Assured ' at Feb-26's MNTAC. Evidence Requirements for Delivery: PMRT Business Case including PMRT resources PMRT ToRs inc. externality requirement Agendas and Minutes from Quarterly Network Mortality meetings Evidence Requirements for Assurance: Evidence of regular reporting of PMRTs and actions to the LMNS CNST year 7 - Safety action 1 compliance	Short Term (0-6 months)	31/01/2025	11/02/2025	31/03/2026	10/02/2026	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

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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

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

APPENDIX 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
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.	Delivered, Not Yet Evidenced	Descoped (see exception report)	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. This action was agreed as 'Delivered, Not Yet Evidenced' at Feb-26's MNTAC with evidence of engagement with the network regarding the cot locator services. It was also agreed as descoped as it is not within the Trust power to secure a new and/or improved service. The team will continue to engage with the Network and is commited to implement any new system that is selcted by the network in future, at which time the action would be rescoped. Evidence Requirements for Delivery: Evidence of Engagement with network regarding cot locator provision (minutes and email exchanges) Evidence Requirements for Assurance:	Medium Term (6-12 months)	TBC	10/02/2026	TBC		Dr John Jones	Mr Andrew Sizer	Monday.com
NEMR19	The trust should engage the neonatal network in the findings of this review, and specifically: a. Questions raised by the review team over the functioning of the network, with the LNU at times left caring for extremely sick premature babies for longer than it ought to. b. The impact of instances when the NICU appeared reluctant to accept patients for transfer from the LNU (section 6.1.4) on the likelihood or readiness for staff at the LNU to make a referral, and on timely transfer. questions raised during interviews over whether escalation to NICUs happened sufficiently early and 'assertively enough' (section 6.2.2).	Evidenced and Assured	Completed	The team has continued to engage with the Network and to provide exception reports ensuring care continues to be delivered within pathway. The team will conduct a review of transfer cases and discuss the findings with the network to ensure transfers are happening appropriately. Those exception reports are regularly discussed at netwrok and LMNS meetings. This action was agreed as 'Delivered, Not yet Evidenced' at Jun-25 MNTAC. This action was approved as 'Evidenced and Assured' at Oct-25's MNTAC. Evidence Requirements for Delivery: Network exception reports - quarterly overview Evidence Requirements for Assurance: Review of Transfer cases Evidence of discussion with ODN - LMNS agenda and minutes	No Timeline Allocated	TBC	10/06/2025	31/10/2025	14/10/2025	Dr John Jones	Mr Andrew Sizer	Monday.com
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	Off Track (see exception report)	Further to receipt of the final report, the clinical team have identified a series of actions required to demonstrate compliance with this recommendation. This action has been agreed as Off Track at jan-26's MNTAC as absence within the team has delayed the delivery of this work. The new Interim clinical director is conducting a review and an update will be presented at Feb-26's MNTAC.	Short Term (0-6 months)	30/09/2025		31/01/2026		Dr John Jones & Paula Gardner	Mr Andrew Sizer & Julie Plant	Monday.com

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

PROGRESS AS AT 10.02.2026

APPENDIX TWO

Neonatal External Mortality Review Action Plan

The Shrewsbury and Telford Hospital NHS Trust

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
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
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	8	11	16
Total	35	8	11	16
Percentage		22.9%	31.4%	45.7%

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	34	0	16	0	2	16	1
Total	34	0	16	0	2	16	1
Percentage		0.00%	47.06%	0.00%	5.88%	47.06%	2.9%

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

The Shrewsbury and Telford Hospital NHS Trust

Phase 2 Updates

Progress

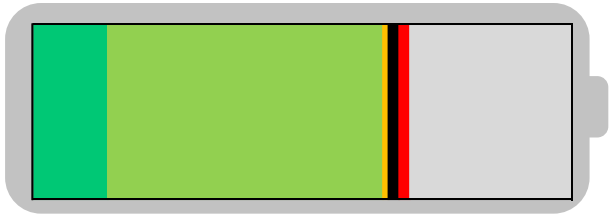
Phase 2 batteries – Post Nov-25 MNTAC

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

Phase 2 batteries – Post Jan-26 MNTAC

The Shrewsbury and Telford Hospital NHS Trust

Overall Delivery

768% (166) Not Yet Delivered
16% (38) Delivered, Not Yet Evidenced
16% (38) Evidence & Assured

Overall Progress

16% (38) Complete
49% (119) On Track
2% (6) Descoped
2% (5) Off track
1% (1) At Risk
30% (73) 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) | 17% (5) | 7% (2)	7% (2) | 37% (111) | 57% (17)
LMNS 3 Year Delivery Plan	32% (9) | 29% (8) | 39% (11)	39% (11) | 43% (11) | 4% (2) | 11% (3)
Cultural Improvement Plan	92% (34) | 5% (2) | 3% (1)	3% (1) | 49% (18) | 48% (18)
CQC Neonates Action Plan	10% (1) | 30% (3) | 60% (6)	50% (5) | 20% (2) | 20% (2) | 10% (1)
Neonatal External Mortality Review	23% (8) | 34% (12) | 43% (15)	43% (15) | 46% (16) | 3% (1) | 6% (2) | 3% (1)
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

Board of Directors' Meeting – 12th March 2026

Agenda item		054/26 Appendix 4		
Report Title		CNST MIS Year 7 – Completion Report		
Executive Lead		Paula Gardner, Interim Director of Nursing		
Report Author		Jacqui Bolton, Interim Head of Midwifery		
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		N/a		
Executive summary:		To note completion for Year 7 of the Maternity Incentive Scheme measured against the 10 Safety Actions. SaTH have delivered all 10 Safety Action. Validation and sign off from the Board and a representive of the ICB held on 12th February 2026. Full official submission to Maternity Incentive Scheme completed as of 23rd February 2026.		
Recommendations for the Board:		The Board is asked to: Accept this paper as March update for the Integrated Maternity and Neonatal Report		
Appendices:				

1. 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.

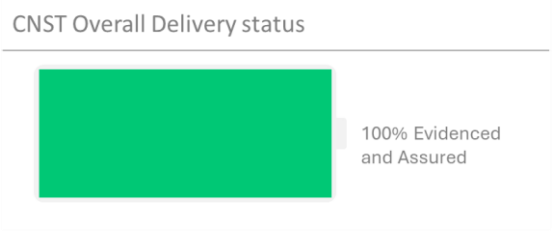
1.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.3 Year 7 guidance was published in April 2025 and references a relevant time period (depending on the safety action) of either *1 December 2024 until 30 November 2025* or *2 April 2025 until 30 November 2025* for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **12 noon on 3 March 2026.**

1.5 The purpose of this paper is to provide Board with assurance of delivery against the standards set out in Year of CNST for each Safety Action.

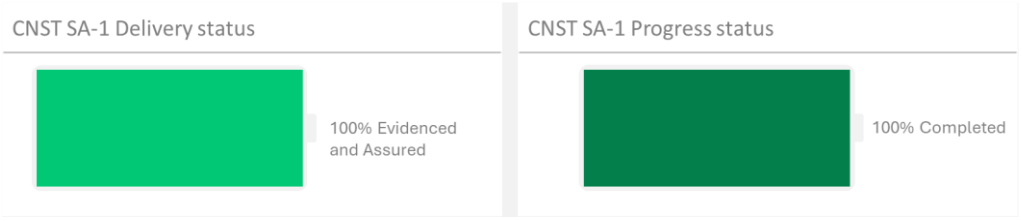
1.6 The overall delivery status of the scheme is presented in the battery below and shows full compliance with all 10 Safety Actions.



1.7 Detailed assurance for each Safety action is provided below:

2. Detailed position on Safety Actions

2.1 **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?



2.1.1 Safety Action Standards

- SA1a - All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.
- SA1b - 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.

- SA1c - 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 multidisciplinary 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.
- SA1d - 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.

2.1.2 **Minimum Audit Requirements:**

- SA1.1 - Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?
- SA1.2 - For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?
- SA1.3 - Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.
- SA1.4 - Were 75% of all reports completed and published within 6 months of death?
- SA1.5 - For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT?
- SA1.6 - Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.
- SA 1.7 - Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?

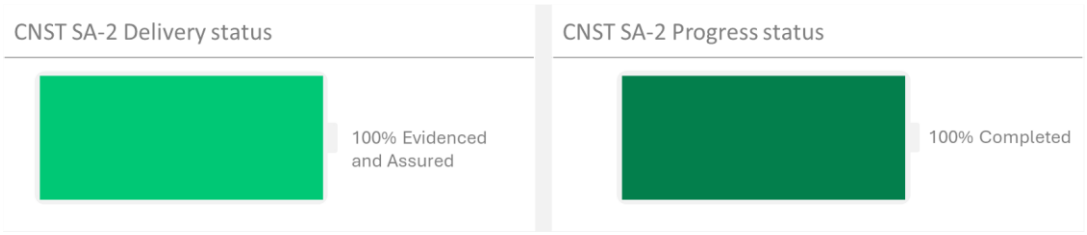
2.1.3 **Trust Position**

- The Trust is compliant to date with reporting to the MBRRACE-UK website
- All families were contacted and given an opportunity to provide feedback and ask question.
- 100% of published reports were done so within 6 months.

- An external panel member of appropriate seniority and expertise was present for 66% of PMRT reviews.
- The Board of Directors, LMNS and Safety Champions have received a report each quarter since December 2024. This includes details of the deaths reviewed and the consequent action plans.
- Quarterly reports were filed as evidence along with agendas and minutes demonstrating they have been received by the Trust Executive Board. Quarterly reports contain evidence of compliance with all requirements.
- A closure report demonstrating that the standard has been maintained throughout the entirety has been presented to Board in January 2025.

2.1.4 **Progress status: Requirement Met**

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



2.2.1 **Safety Action Standards**

- SA2a - July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405).
- SA2b - July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101).

2.2.2 **Minimum Audit Requirements:**

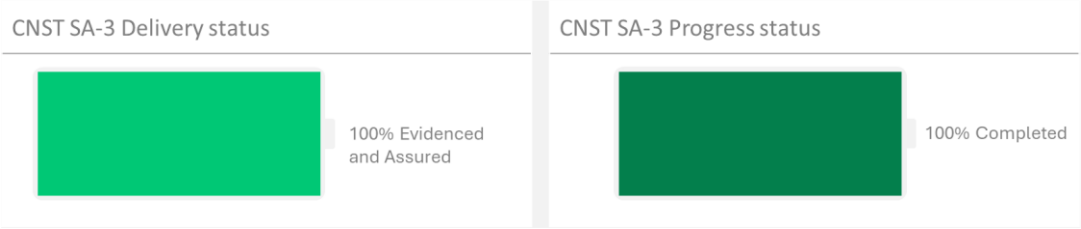
- SA2.1 - Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)
- SA2.2 - Did July's 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

2.2.3 **Trust Position**

- NHS Digital who oversee this Safety Action have confirmed that SaTH have uploaded all required data points to the Maternity Services Data Set (including metrics referenced for this safety action) at the required standard of data quality, for the month of July 2025 (which was the month against which the standard is tested).

2.2.4 **Progress status: Requirement Met**

2.3 **Safety Action 3:** Can you demonstrate that you have Transitional Care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?



2.3.1 **Safety Action Standards**

- SA3a - Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice
  Or
  Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM)Transitional Care Framework for Practice and submit this to your Trust and the neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.

- SA3b - Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safety Champions and LMNS.

2.3.2 **Minimum Audit Requirements:**

- SA3.1 - Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?
  Or
  Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.

- SA3.2 Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality

improvement initiative to decrease admissions and/or length of infant/mother separation.

For units commencing a QI project

- By 2 September 2025, register the QI project with local Trust quality/service improvement team.
- By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.

For units continuing a QI project from the previous year

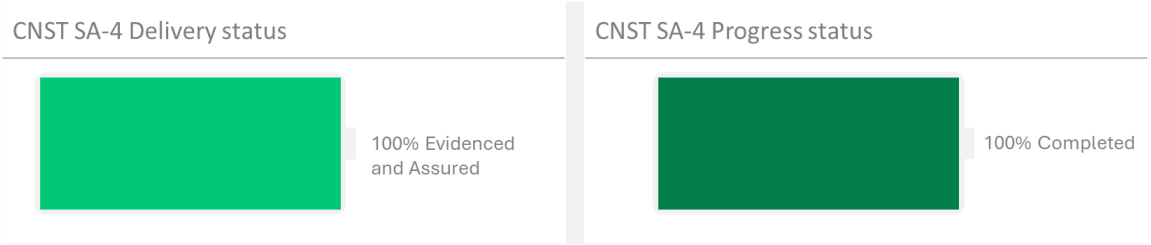
- Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.
- By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period

2.3.3 **Trust Position**

- Transitional care policy with admission criteria and pathway based on BAPM transitional care framework which includes an explicit staffing model in place. This policy was approved by both Maternity and Neonatal teams and includes auditable standards.
- Additionally, an action plan has been co-produced to further improve the Transitional Care provision, including NG tube feeding.
- Quarterly audits for compliance are undertaken, and agendas and minutes of committees and boards have been collated demonstrating those audits have been received.
- As per the required standard in Year 6, a quality improvement project aimed at reducing term admissions (Reducing Term Admissions to NNU due to respiratory causes & Early recognition of Chorioamnionitis) was registered in July 2024. It was ratified by the LMNS and Safety Champions. This project was concluded during year 7 and a report was provided to the LMNS and Safety Champions.
- To ensure full compliance with the Year 7 scheme, a new project was started and presented to the LMNS and Safety Champions, aimed at reducing term admissions linked to Jaundice.
- Agendas and minutes demonstrating those reports have been received by the appropriate committees have been collated.

2.3.4 **Progress status: Requirement Met**

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



2.4.1 Safety Action Standards

- Obstetric Medical Workforce
- SA4.1 - 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:
    - currently work in their unit on the tier 2 or 3 rota
      or
    - 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 Annual Review of Competency Progressions (ARCP)
      or
    - hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums
- SA4.2 - 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.
- SA4.3 - 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.
- SA4.4 - Trusts should ensure they are compliant with 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 roles-responsibilities-consultant-report.pdf
- Anaesthetic Medical Workforce
- SA4.5 - A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric

patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

- Neonatal Medical Workforce
- SA4.6 - 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.
  Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
- Neonatal Nursing Workforce
- SA4.7 - 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.
  Any action plans should be shared with the LMNS and Neonatal ODN.

2.4.2 **Minimum Audit Requirements:**

- Obstetric medical Workforce
- SA4.1 - Locum currently works in their unit on the tier 2 or 3 rota?
- SA4.2 - OR
  They 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 Annual review of Competency Progression (ARCP)?"
- SA4.3 - OR
  They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?"
- SA4.4 – Has the Trust implemented the RCOG guidance on engagement of long-term locums in full? Trusts should demonstrate compliance though audit of any 6 months period from February 2025 to November 2025.
- SA4.5 - Have you met, or are working towards full 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?
- SA4.6 - Is the Trust compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document: ‘Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology’ into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.

- SA4.7 - Do you have evidence that the Trust position with the above has been shared with Trust Board?
- SA4.8 - Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?
- SA4.9 - Do you have evidence that the Trust position with the above has been shared with the LMNS?
- Anaesthetic Medical Workforce
- SA4.10- "Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.
- Neonatal Medical Workforce
- SA4.11 - Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?
- SA4.12 - Is this formally recorded in Trust Board minutes?
- SA4.13 - If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.
- SA4.14 - Was the above action plan shared with the LMNS?
- SA4.15 - Was the above action plan shared with the ODN?
- Neonatal Nursing Workforce
- SA4.16 - Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?
- SA4.17 - Is this formally recorded in Trust Board minutes?
- SA4.18 - If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.
- SA4.19 - Was the above action plan shared with the LMNS?
- SA4.20 - Was the above action plan shared with the ODN?

2.4.3 **Trust Position**

- Obstetric Medical Workforce

- An audit was conducted of shifts that required Tier 2 locums for 6 months of activity between February 1st – August 1st, 2025.

  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. Therefore, this standard was met.

- 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 (Mar-Nov 25) we did not employ any long-term middle grade locums therefore the standard has been met.

- In SaTH all consultant cover of Delivery Suite is resident. As we do not do any non-resident on call evidence requirements for SA4.4 are not applicable.

- An audit showed excellent compliance with the RCOG standard for consultant attendance for clinical situations listed in the RCOG "Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology" document.

  Situations where the consultant MUST attend were all at 100% with the exception of Caesarean birth for women with a BMI >50 which was 93% (13/14 cases).

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

  All cases have been reviewed by the CD and an action plan has been written and started. The results of the audit and the action plan were shared at the Obstetric Governance Feedback meeting on the 9th January 2026.

- <u>Anaesthetics Medical Workforce</u>

- A paper and Anaesthetics rotas have been provided as evidence that this requirement is met in full.

- <u>Neonatal Medical Workforce</u>

- The evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce is contained within the CNST Neonatal Workforce 2025 paper. This has previously been evidenced since Year 4 and was included again as part of the CNST papers presented to Board in January 2026.

- <u>Neonatal Nursing Workforce</u>

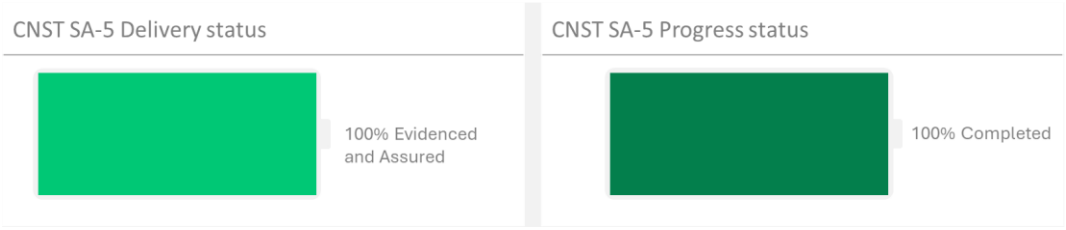
- The Trust does not currently meet this standard however there is progress on the agreed action plan. That is reflected in the Neonatal Nursing Workforce Paper presented to Board in January 2026. Acceptance of the plan is reflected in the minutes of this meeting.

- Progress on the action plan have been shared with the LMNS with minutes collated as evidence along with confirmation from the ODN being in receipt of the plan.

- Quarterly reports on staffing are submitted to the LMNS and to the network.

2.4.4 **Progress status: Requirement Met**

2.5 **Safety Action 5:** Can you demonstrate an effective system of workforce planning to the required standard?



2.5.1 **Safety action Standard**

- SA5a - A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.
- SA5b - Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- SA5c - The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
- SA5d - All women in active labour receive one-to-one midwifery care
- SA5e - Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year seven reporting period.

2.5.2 **Minimum Audit Requirements**

- SA5.1 - Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.)
- SA5.2 – Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis.

- Every report should include an update on all of the points below:

  ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall.
  ● The midwife to birth ratio
  ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift.
  ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour
  ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?

  We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated,

  This includes:
  - Redeployment of staff to other services/sites/wards based on acuity.
  - Delayed or cancelled time critical activity.
  - Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).
  - Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
  - Delay of more than 30 minutes in providing pain relief.
  - Delay of 30 minutes or more between presentation and triage.
  - Full clinical examination not carried out when presenting in labour.
  - Delay of two hours or more between admission for induction and beginning of process.
  - Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
  - Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

  Other midwifery red flags may be agreed locally.

- SA5.3 - Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated?

  Evidence should include:

  - Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
  - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives."

- SA5.4 - Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale

for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- SA5.5 - Where deficits in staffing levels have been identified must be shared with the local commissioners.

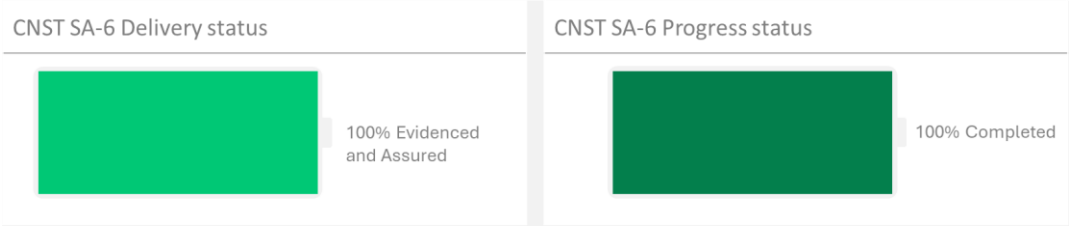
2.5.3 **Trust Position**

- A Birthrate+ review was conducted in November 2022. The service has been engaging with Birthrate+ in 2025 to undertake a new review. The draft of the new review is expected end of January 2026. The service remains compliant with the 2022 review.

- This action requires two papers covering midwifery staffing be sent to Trust Board.
  - The first was provided in July 2025.
  - The second was provided in November 2025
- The Head of Midwifery papers were also shared with Divisional Committee, QSAC and LMNS.
- These papers included:
  - Staffing budget compliance
  - Details of planned vs actual midwifery staffing levels
  - Evidence of 1to1 care in labour (1 to 1 care in Labour)
  - 100% compliance with supernumerary coordinator status

2.5.4 **Progress status: Requirement Met**

2.6 **Safety Action 6:** Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?



2.6.1 **Safety action Standard**

- SA6 - Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of the current version of SBLCB v3 through quarterly quality improvement discussions with the ICB.

2.6.2 **Minimum Audit Requirements**

- SA6.1 - Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment?
  Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.
- SA6.2 - Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle?
  These meetings must include:
    - Agreement of a local improvement trajectory against these metrics for 25/26 and subsequently reviews of progress against the trajectory.
    - Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
    - Evidence of sustained improvement where high levels of reliability have already been achieved.
    - Regular review of local themes and trends with regard to potential harms in each of the six elements.
    - Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.
- SA6.3 - Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?
- SA6.4 - If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.

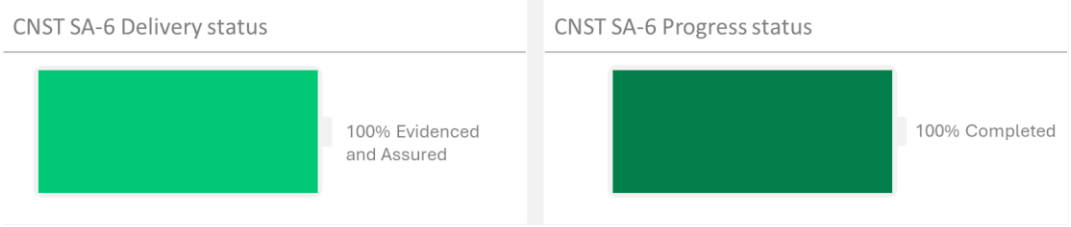
2.6.3 **Trust Position**

- SBLv3 was fully implemented in March 2024 and a signed declaration by Executive Medical Director was obtained in October 2024
- Version 3.2 of the care bundle has since been published and the service has continued its implementation. Progress has been monitored with the ICB using the national Implementation tool.
- As required by the standard, quarterly quality improvement meetings with the ICB have been held in January, July and October 2025.Minutes have been collated as evidence.

- Quarterly SBL papers are produced and presented at governance meetings, to the LMNS and to Board. Papers and minutes from those meetings are collated as evidence.

2.6.4 **Progress status: Requirement Met**

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



2.7.1 **Safety action Standard**

- SA7a - Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:
  - a) Engagement and listening to families
  - b) Strategic influence and decision-making
  - c) Infrastructure
- SA7b - Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

2.7.2 **Minimum Audit Requirements**

- SA7.1 – Evidence of an actual plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.
  Has progress on the coproduced action above been shared with Safety Champions?
  Has progress on the coproduced action above been shared with the LMNS?
- SA7.2 - Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:
  - Job description for MNVP Lead
  - Contracts for service or grant agreements
  - Budget with allocated funds for IT, comms, engagement, training and administrative support
  - Local service user volunteer expenses policy including out of pocket expenses and childcare cost
- SA7.3 - If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been

escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.
If evidence for 7.2 cannot be provided, then the escalation route must be followed as stated above.
Evidence requirements for 7.4 and 7.5 are only required if evidence has been provided for 7.2
In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS for this safety action.

- SA 7.4 - Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following:
    - Safety champion meetings
    - Maternity business and governance
    - Neonatal business and governance
    - PMRT review meeting
    - Patient safety meeting
    - Guideline committee
- SA 7.5 - Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

2.7.3 **Trust Position**

- The MNVP has provided evidence of the following:
    - Summary of engagements
    - Quarterly reports of activity
    - Current infrastructure in place
    - MNVP lead job description
    - Adequate funding
    - Volunteer Expense Policy
- Terms of Reference for the following meetings have been collated as evidence of the MNVP being part of the membership:
    - Safety Champions
    - Maternity Governance
    - Neonatal Governance
    - Patient Experience Group
    - Patient & Carer Experience Panel
    - PMRT

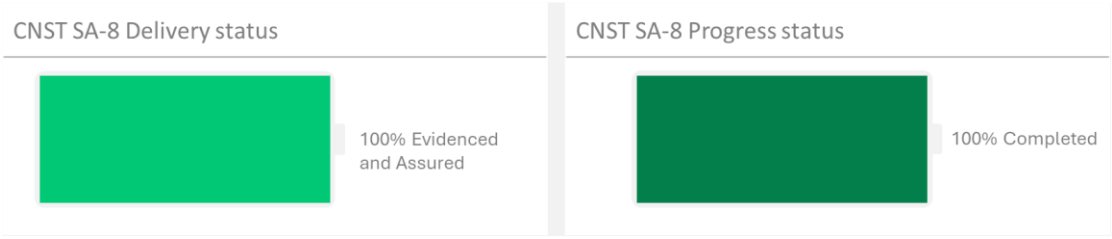
The MNVP is not yet a quorate member of those meetings as there is only one lead. This was escalated to Safety Champions, the LMNS and Board as per the PQSM and an action plan has been developed to enable volunteers to attend the meetings and for the MNVP to become quorate members.

An action plan following the CQC Maternity Survey was co-produced in February 2025 and ratified by Safety Champions and the LMNS who also received an

update on progress. Results of the 2025 CQC maternity Survey showed improvement from the previous year with all questions scoring about the same (47), somewhat better (5) or better (6) than other trusts.

2.7.4 **Progress status: Requirement Met**

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



2.8.1 **Safety action Standard**

- SA8 - 90% of attendance in each relevant staff group at:
    - Fetal monitoring training
    - Multi-professional maternity emergencies training
    - Neonatal Life Support Training
    - ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS.
    - For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.
    - It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

2.8.2 **Minimum Audit Requirements**

<u>Fetal monitoring and surveillance (in the antenatal and intrapartum period) training</u>

- SA8.1 - 90% of obstetric consultants
- SA8.2 - 90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)
- SA8.3 - For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?

- SA8.4 - 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres

Maternity emergencies and multiprofessional training -

- SA8.5 - 90% of obstetric consultants
- SA8.6 - 90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota
- SA8.7 - For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?
- SA8.8 - 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives
- SA8.9 - 90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).
- SA8.10 - 90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors
- SA8.11 - 90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.
- SA8.12 - For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?
- SA8.13 - Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?

Neonatal basic life support -

- SA8.15* - 90% of neonatal Consultants or Paediatric consultants covering neonatal units
- SA8.16 - 90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births

*No item 8.14 in audit tool

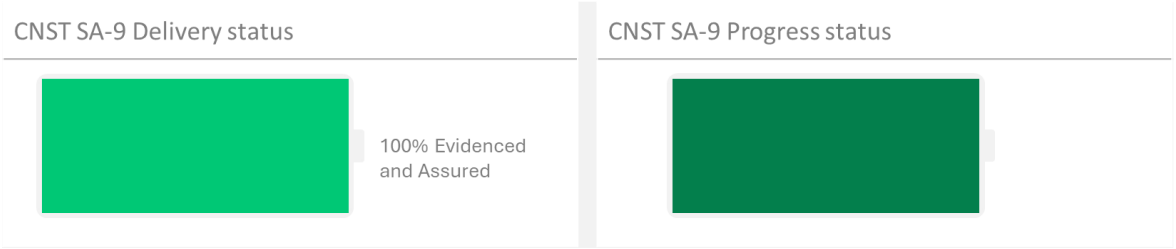
- SA8.17 - For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?
- SA8.18 - 90% of neonatal nurses (Band 5 and above who attend any births)
- SA8.19 - 90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.
- SA8.20 - 90% of advanced Neonatal Nurse Practitioner (ANNP)
- SA8.21 - 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)
- SA8.22 - In addition to the above Neonatal basic life support (NBLS) training, is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance by year 7 of MIS and ongoing?

2.8.3 **Trust Position**

- A closure paper for this safety action has been presented to Board in January 2026 to assure the Board of the following:
  - 90% compliance has been achieved with the relevant training and staff groups
  - At least one scenario/drill was conducted in a clinical area ensuring attendance from the wider professional team

2.8.4 **Progress status: Requirement Met**

2.9 **Safety Action 9:** Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?



2.9.1 **Safety action Standard**

- SA9a – All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) must be fully embedded with evidence of Trusts working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.
- SA9b - The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends, with evidence of reporting/escalation to the LMNS/ODN/ICB/ Local & Regional Learning System meetings.
- SA9c - All Trusts must have Maternity and Neonatal Board Safety Champions (BSC) who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.

2.9.2 **Minimum Audit Requirements**

- SA9.1 - Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025? (including the following)
- SA9.2 - Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?
- SA9.3 - Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly and presented by a member of the perinatal leadership team to provide supporting context.
- SA9.4 - Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.
- SA9.5 - Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.
- SA9.6 - Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.
- SA9.7 - Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level

Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?

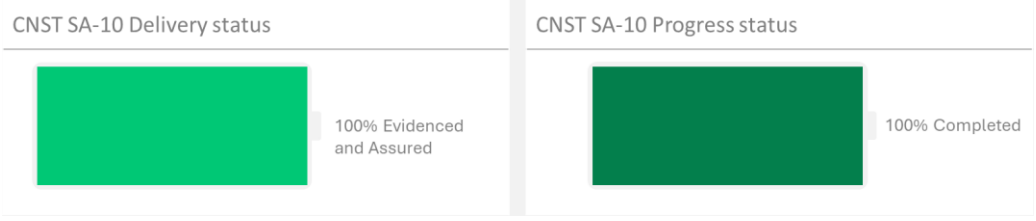
- SA9.8 - Evidence in the Trust Board minutes that Board Safety Champion(s) and the MNVP lead (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.
- SA9.9 - Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

2.9.3 **Trust Position**

- All PQSM requirements are fully embedded within the Trust:
  - A Non-Executive Director has been appointed for Safety Champions.
  - A Safety intelligence Dashboard is reviewed on a monthly basis. The Dashboards have been collated as evidence along with relevant agendas and minutes.
  - The dashboards are presented and discussed at every QSAC and LMNS Board meeting.
  - 'You Said, We Listened' posters are provided as evidence of engagement with staff.
- Evidence of the Claims Scorecard being presented and discussed quarterly has been collated with agenda and minutes of relevant meetings provided. The evidence covers two quarters of the reporting period.
- Minutes from the safety Champions meeting with the Quadrumvirate have been provided as evidence. The evidence covers the required minimum of 3 meetings within the reporting period.
- An update is provided to the Board on the progress of the Maternity and Neonatal Culture Plan through the Integrated Maternity and Neonatal report.

2.9.4 **Progress status: Requirement Met**

2.10 **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?



2.10.1 **Safety action Standard**

- SA10a - Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025.
- SA10b – Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025.
- SA10c - For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that
    - the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and
    - 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.

2.10.2 **Minimum Audit Requirements**

- SA10.1 - Have you reported of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025.
- SA10.2 - Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025.
- SA10.3 - Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme
- SA10.4 - For any occasions where it has not been possible to provide a format that is accessible for eligible families, has a SMART plan been developed to address this for the future.
- SA10.5 - Has 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.
- SA10.6 - Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.
- SA10.7 - Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?
- SA10.8 - Has Trust Board had sight of evidence of compliance with the statutory duty of candour?
- SA10.9 - Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.

2.10.3 **Trust Position**

- As with Safety Action 1, the need to report appropriately to the HSIB/MNSI and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action is never 'completed'.
- This action was presented to Board as complete in a closure report in January 2026 detailing compliance with all the requirements within the reporting timeframe.

2.10.4 **Progress status: Requirement Met**

3. Summary

3.1 SaTH has now met all requirements from the 10 Safety Actions of CNST Maternity Incentive Scheme Year 7.

3.2 A summary of evidence against each action and its minimum evidence requirements has been shared with board as part of a presentation held on February 12th 2026. (Appendix 1)

3.3 Evidence against each minimum requirement has been collated into Monday.com for assurance.

4. Actions requested of the Board*

4.1 Review and accept this paper, advising the Head of Midwifery of any further detail required

4.2 Provide Assurance, in the minutes of this meeting, of the following:

For Safety Action 1

4.2.1 A quarterly report has been received by the Trust Executive Board each quarter from 1 April 2025 that includes details of the deaths reviewed from 1 December 2024, any themes identified and the consequent action plans.

For Safety Action 4

4.2.2 A closure paper has been received by the Trust Executive Board providing assurance of compliance with:

- RCOG guidance on the engagement of long-term locums.
- Consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'

4.2.3 A paper has been received by the Trust Executive Board providing assurance of compliance with BAPM recommendations for the Neonatal Medical Workforce

4.2.4 A paper has been received by the Trust Executive Board providing evidence of progress against an action plan to meet BAPM recommendations for the Neonatal Nursing Workforce and this action plan was agreed by the Board

For Safety Action 5

4.2.5 A midwifery staffing oversight report that covers staffing/safety issues has been received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

4.2.6 Midwifery Staffing reports, providing assurance of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations, has been received by the Trust Board and with evidence recorded in the minutes.

For safety Action 6

4.2.7 A signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully in place as agreed with the ICB has been provided to the Trust Executive Board.

For Safety Action 7

4.2.8 Evidence that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC) has been provided to the Trust Executive Board.

4.2.9 Evidence of a monthly review of maternity and neonatal quality and safety using a minimum data set has been presented to the Trust Executive Board by a member of the perinatal leadership team to provide supporting context. This included a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.

4.2.10 A quarterly review the Trust's claims scorecard alongside incident and complaint data was provided and discussed by the maternity, neonatal and Trust Board level Safety Champions at least twice within the reporting period.

4.2.11 Evidence of a bi-monthly meeting between the Board safety Champion and Perinatal Leadership team was provided Trust

Executive Board demonstrating a minimum of three meetings within the reporting period.

4.2.12 Progress against the maternity and neonatal culture improvement plan has been presented to Board, and any identified support being considered and implemented.

For Safety Action 10

4.2.13 A closure paper has been received by the Trust Executive Board providing assurance of:

- Compliance with Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.
- Compliance with requirement that families receive information on the role of MNSI and NHS Resolution's EN scheme
- Compliance with the statutory duty of candour

4.3 Empower CEO for declaration