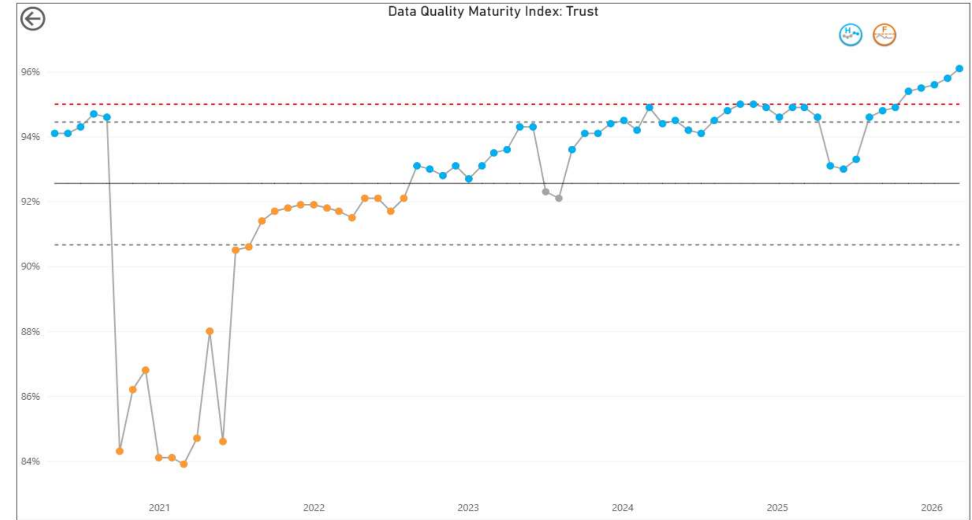
Exception Report - Action Plan

Data Quality Maturity Index

Data Quality Maturity Index as calculated by NHS England. Based on datasets submitted by SCHT



KPI Description	Latest 6 months	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	YTD
DQMI	%	94.9%	95.4%	95.5%	95.6%	95.8%	96.1%	96.1%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Reason for performance gap:	The target for DQMI is 95% and February has seen continued improvement ahead of the planned trajectory and we have met the target with an achievement of 96.1%. The Plan had been to achieve the 95% target by the end of quarter 4 and original individual action plans align to this deadline. The improvement is testament to the action plans that have been developed and the work that has gone into achieving the improving position. The requirement now is to ensure the achievement is maintained in future months and continues to require monitoring of key elements within the indicators. The main elements impacting this metric are compliance with accurately recording ethnicity, spoken language, MIU chief complaint, MIU acuity, MIU discharge and Clinical Coding. Ongoing education efforts emphasise the importance and relevance of these metrics with dedicated areas to target focusing heavily on data capture, clinical coding and MIU. Informatics have supported services in understanding areas that require improvement and the impact to DQMI . There is an ongoing risk to meeting DQMI requirements, especially for recording ethnicity, because primary care no longer provides proformas that previously supplied this vital information for input into RiO following Industrial Action. The below action plans are however designed to mitigate this as much as possible.

		Start Date	End Date	Status	Outcome
	Oversight of improvement plan to 95%: Through Data Quality Sub-Group and Divisional Performance Meetings progress is systematically tracked to assess the effectiveness of the education plan against the trajectory to achieve 95% by January and proactively mitigate risks as they arise, focusing interventions towards specific teams requiring additional support.	Aug-25	Jan-26	Complete	**June 26 Update** Performance has continued to improve to 96.1% in February, which is an improvement of 0.3% on January and this is the 5th month in a row that target has been achieved. This is mainly due to the continued improvement in the MIU Data Quality, which whilst having further to yet go, is in a better position due to actions in this plan. Ethnicity and Spoken Language continue to remain challenged and is seeing fluctuation in improvements vs deteriorations. Further actions and sustained effort from operational teams is required to improve this. Clinical Coding Agency staff being in place has led to dramatic improvements for both March and April 26, which will be seen in future months' DQMI position, but it should be noted that this is only a short term temporary solution to the coding issues within the trust. Further funding explored to support further coding capacity. **May 26 Update** Performance has improved to 95.8% in January, up by 0.2% on the December position. MIU Team leads are now in place at Ludlow and Bridgnorth, so work has commenced to embed below processes. Clinical Coding Agency are now in place and immediate improvement being seen in Coding performance. Ethnicity and Spoken Language performance remains an area of challenge, with continuing fluctuation and requires sustained effort from operational leads to drive performance improvement **April 26 Update** There has been a slight increase to 95.6% for December. Further work to continue with new Teams Leads at Ludlow and Bridgnorth to embed processes. New RiO reports have been developed for Teams to go in and view their own ethnicity and spoken language figures between information report timetables ensuring ownership at team level.
	Area 1 - Clinical Coding: Targeted approach to clinical coding to provide change in KPI performance	Oct-25	Jan-26	Complete	**May 26 Update** Coding compliance has improved dramatically since the introduction of the agency coders. Performance in March is 97%, April 89% and across the rolling 12 months is 40% and provides the evidence of the targeted approach to clinical coding now being in place. **April 26 Update** Agency coding commenced w/c 30.03.26 and they are working on most recent uncoded episodes. Weekly data will be collated to evaluate impact and overall position **March 26 Update** Laptops have been delivered, access, etc, being finalised and then plan will be implemented and 3rd party will begin with most recent uncoded episodes **February 26 Update** Awaiting start date for 3rd party staff and delivery of equipment as per action above. Once this starts, the approach will be in line with this action.

Action Plan					
	Area 2 - Ethnicity: Community Hospital Outpatients Appt Letter currently contains Ethnicity question to patients, which should be populated into RiO at appt check in. Spoken Language will be added to the letter as well, through contact with Rio Configuration Team and message will be re-enforced to reception staff and linking HCA's into process, to check letter when patient arrives at appt and ensure Rio is updated	Oct-25	Feb-26	Complete	**June 26 Update** Comm OP have implemented a new process, await further data to evidence impact, but early sign of improvement at Ludlow and Whitchurch. **May 26 Update** Now SCHT is part of the group model, operational leads will link with SATH colleagues to understand if they have any plans that are supporting their recordng ethnicity that could be transferrable to further expand improvment plan and promote learning across group. **April 26 Update** Improvements of 10% at Bridgnorth and 17% at Ludlow, but deterioration of 10% at Whitchurch, in March 26. Compliance remains not consistent across services. Now SCHT is part of the group model, operational leads will link with SATH colleagues to understand if they have any plans that are supporting their recordng ethnicity that could be transferrable.
	Implement self-check in at reception areas across appropriate Outpatient estate, to include link to Rio and mandating of Ethnicity and Spoken Language population on screen, in line with the 10 year plan to move to Digital where possible. It is key that the self-check in talks to Rio and updates records in real time	Jan-26	Apr-26	Off Track	**June 26 Update** Working with SaTH who are now also following a self check in model re joint roll out and implementation **May 26 Update** Operational teams aligned to priority areas for rollout pending digital capacity and prioritisation to launch. **April 26 Update** Products planned for demonstration and digital team working through planned implementation with current capacity levels
	Urgent Care Division - CSM to ensure cascading of reports through team leads and team members, to drive home the importance of ensuring Ethnicity recording is improved and staff are sighted on the level of monitoring that is happening and the improvements required to get to 90% by April 2026	Dec-25	Apr-26	Off Track	**June 26 Update** Ops lead to meet with CSM's and work to understand the issues that are preventing sustained and consistent improvement for both Ethnicity and Spoken Language **May 26 Update** Service Ops lead will support CSM to create an Audit trial at service level, to understand process and any blockers to improvement as performance continues to fluctuate and not reach levels required overall in UEC. For Spoken Langauge CSM will work to understand processes, in conjunction with above and look at where and if the questions are being asked and embed changes required **April 26 Update** Reports continue to be shared at performance meetings and teams encouraged to improve recording processes. DAART position steady at 70%, further improvement required also in Virtual Ward as currently at 73%
	Service specific review where capture is not improving	Oct-25	Apr-26	Off Track	**New Action** This action is combining the service specific review detail. These remain a key part of the action plan workshop and will be summarised for Committee/Board going forward.

	Action	Start	Due	Status	Update
	Area 3 - MIU: Ludlow MIU - Triage Issue to be urgently solved Staff misunderstanding that using the triage field in Rio to add Acuity and Chief Complaint is populating the Triage timestamp that feeds the 15 minute Triage assessment KPI.	Jan-26	Apr-26	Off Track	**June 26 Update** Performance in Acuity and Chief Complaint has dipped slightly to 63%, new Team Lead has completed induction period and will now pick up actions, with support from CSM on a weekly basis. **May 26 Update** Ludlow Team lead has started in post. Will be trained and exposed to the data quality subgroup meetings in order to understand the issue and requirements. Oswestry team lead will support new team leads and apply same actions that are being progressed to support staff with oversight. Improvement in performance has been seen and April performance is 70.9%, with further expectation of reaching 95% **April 26 Update** Ludlow Team Lead position currently with recruitment. Further new starters coming in over the following 2 months. Training and embedding of need and purpose sessions will be held face to face within 2 weeks of start dates. Inidividual practitioners will be approached with assistance from Information colleagues and reporting.
	Bridgnorth MIU - Acuity and Chief Complaint recording requires further improvement due to slight deterioration in performance	Mar-26	Apr-26	Complete	**June 26 Update** Performance has improved significantly to 76% from 55% in April, this is evidence of the new team lead being in post and picking up actions with support from CSM, further improvement aim towards 90% **May 26 Update** Bridgnorth Team lead has started in post. Will be trained and exposed to the data quality subgroup meetings in order to understand the issue and requirements. Oswestry team lead will support new team leads and apply same actions that are being progressed to support staff with oversight. Improvement in performance has been seen and April performance is 55.8%, with further expectation of reaching 95% **April 26 Update** Team Lead still with recruitment. Once in place, training to be provided within 2 weeks of start date.
	Area 4 - Unoutcomed Appointments Health Visiting and School Nursing unoutomed appointments are showing at a higher level than desired and this has a potential impact upon performance against Core Contact KPI's (i.e. New Birth Visits)	Mar-26	Jun-26	On Track	**June 26 Update** Slight deterioration in May position, 0-19 will also be added to the Performance Agenda for CYP&F as a standing agenda item, due to impact upon Core Contacts KPI's in Health Visiting. Community Nursing issue picked up by ops lead to ensure activity is updated asap. **May 26 Update** Vast improvement being seen to end of March position, 3 quarters less than in previous months. Will continue to monitor in coming months, action to remain open whilst monitoring takes place **April 26 Update** Meeting arranged to discuss reporting options with Information colleagues
	Area 5 - Accomodation Status Continued poor compliance with recording of Accomodation Status in Rio and associated impact upon Health Inequalities Reporting, which has been highlighted by Commissioners as an areas of focus	Jun-26	Sep-26	On Track	**New Action** Agreement at the Data Standardisation T&F Group to review and appropriately alter the options available to staff for selection in the Accomodation Status field within Rio, taking a high level approach but also ensuring relevant granularity available where required. Meeting set for end of June 26 to review.

Author	Alastair Campbell/Helen Cooper/Wendy Hallows/Sam Townsend/Sarah Robinson/Edliz Kelly/Jade Thomas/Sally Stubbs/Beverley Williams	**Date**	09/06/2026	
Accountable Officer Approval	Claire Horsfield	**Date**	15/06/2026	

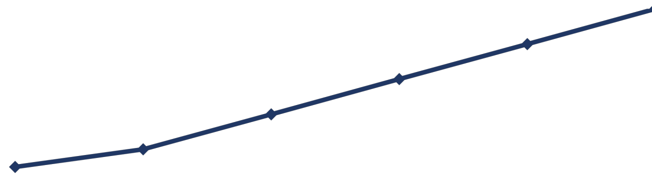
Exception Report - Action Plan

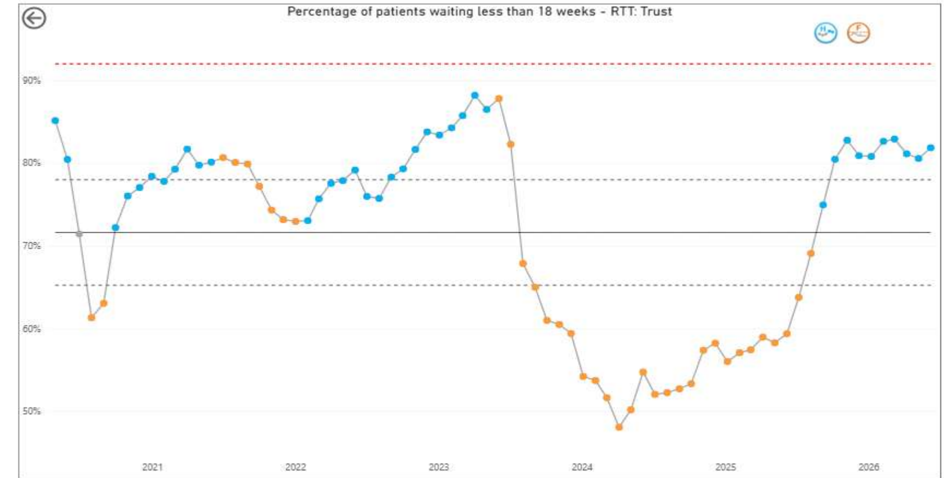
Percentage of Patients waiting less than 18 weeks - RTT

As at the end of the month, the percentage of patients that are still waiting for treatment and are within 18 weeks

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
RTT Incomplete Pathways	%	80.81%	82.64%	82.92%	81.13%	80.56%	81.86*%	81.86*%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	81.5%	82.0%	83.0%	84.0%	85.0%	86.0%





Reason for performance gap:

Following a period of stabilisation, performance increased by 1.3% in month, slightly below the trajectory but demonstrating recovery from March.

Key areas contributing to this improvement include MSST, APCS, and the Bridgnorth and Ludlow Community Outpatient services.

Recovery has been supported by enhanced digital solutions through Doctor Doctor, alongside a targeted focus on validation and clinic utilisation. During May, SaTH also delivered outpatient clinic activity in line with the SLA, helping to stabilise the service for outpatients.

Performance remains well ahead of the national pathway, which aimed for 65% RTT compliance by March 2026 and 92% by March 2029. The trajectory has been updated to reflect the complexity of actions required across multiple providers, with 92% targeted in 2026–27. Further review will be needed as these actions are implemented.

The only remaining RTT risk relates to Oral Surgery, where open clocks have reduced by over 5% but a mismatch between demand and capacity persists. The current level of contracted dental clinics with SaTH remains insufficient to meet demand, with an ongoing monthly shortfall. In addition, inconsistent theatre provision at SaTH has impacted delivery, although early improvements are being made to stabilise access to capacity and support recovery. This position is partially offset through additional activity at RJAH; however, modelling still identifies a gap of approximately eight patients per week that requires resolution at SaTH to maintain progress against the trajectory. Discussions are underway with SaTH colleagues to secure additional capacity and establish a more sustainable forward plan.

The recovery plans have also been assessed against the NHSE May Community Health Services Waiting Times Action Checklists publication to ensure they reflect best practice and address the key domains for improving waiting times.

	Transformation of clinical pathways for MSST, including focus on community appointment days (CAD), superclinics and blitz clinics.	Feb-26	Jun-26	Complete	**June 26 Update** Blitz clinics are now in place across all MSK outpatient departments, generating an additional 100 patient slots. This approach has been embedded as a routine measure to help manage increasing waiting lists. Clinical engagement has been established, supported by standardised templates and clear planning. Following the initial phase, outcomes will be shared with clinicians to assess impact, including changes to new-to-follow-up ratios, and to inform a continuous improvement cycle. This review will be clinically led, with lead clinicians using SPA time to support evaluation and ongoing refinement **May 26 Update** Ongoing operational meetings with a focus on CADs. Engagement sessions with clinical staff planned for May. **April 26 Update** Internal SCHT operational meeting now implemented to help support traction on implementation of the new pathways with particular focus on community appointment days.
	As part of the MSST pathway, SCHT clinic templates have been reviewed and standardised. To maximise patient utilisation, the learning will be shared through the Integration of Therapies programme to align templates across MSST as a parallel service in SaTH.	Jun-26	Oct-26	On Track	**New Action** This month, we are progressing a joint leadership forum and joint huddles to share learning and escalations in readiness for alignment of templates.
	Focus on MSST level 2 to support increased activity with review of templates across SCHT, then SATH and finally RJAH with the aim to improve clinic utilisation and increased activity to drive down recovery.	Feb-26	May-26	Closed	**June 26 Update** There is ongoing engagement with RJAH; however, with governance arrangements and a single line management structure for therapies integration now in place, the focus will shift to aligning with SaTH and sharing learning with RJAH. This will be presented at the face-to-face MSK Board meeting at the end of June for oversight. **May 26 Update** Constant re review of templates to support to increase new patient activity. Utilisation rates have been maintained. **April 26 Update** Internal SCHT operational meeting now implemented to help support traction on supporting improving utilisation. SCHT templates have been reviewed, next step is to make changes to increase number of new appointments. Additionally a large number of SMS have been sent to patients to supporting increasing the booking horizon.

Action Plan	MSST Service reviewing and implementing new ways of working with booking of capacity including use of Dr Doctor, increasing booking horizons and ensuring correct rules with booking order.	Apr-26	Jun-26	Complete	**June 26 Update** Doctor Doctor has now been implemented supporting validation and discharge. Learning taken to support further areas across the Trust. Internal Audit has supported that correct rules with booking order are now standardised, this is further monitored through weekly senior PTL. **May 26 Update** Following the DrDoctor work, bookings for patients over 18 weeks awaiting physio increased by 12%. Bookings horizons have increased by 3 weeks and early evidence shows patients are being booked into the 3-6 week horizon as planned. **New Action** Focus on ensuring correct rules followed throughout booking process to ensure better utilisation imporved data quality
	Workforce Management - Working with finance to review annual turnover and the potential to over recurit to ensure fill capacity throughout the year	Apr-26	Jun-26	Complete	**June 26 Update** This has been completed, with a remaining gap of 1.5 band 6 WTE to meet future demand. This work will now be progressed through the Integration of Therapies programme to model capacity collectively and support productivity and efficiency gains. The service also currently has a 6 WTE vacancy gap, so the plan is to maximise existing capacity, work with SaTH to cover any remaining gap through shared templates and integration work, and develop a productivity plan. **May 26 Update** Working with finance to identify month on month vacancy position for MSST to see possibility of over recruting to ensure required activity levels throughout the year **New Action** Regular reduction in capacity available due to number of vacancies carried throughout year.
	Recruitment to vacancies within MSST (6 WTE Physiotherapists Band 5-7)	Jun-26	Oct-26	On Track	**New Action** Vacancies have been presented at VRF, with executive approval secured for three posts so far. Plans are also in place to work collaboratively across the Group on AHP apprenticeships to address remaining gaps. Exit interviews have been arranged to explore recruitment trends, noting that some vacancies relate to maternity cover and internal promotions
	GPwPER recruitment within APCS to support both Gynae and ENT	Dec-25	Jun-26	On Track	**June 26 Update** Reviewing JD's for new Gynae position with the aim to take via job evaluation. Awaiting start date for new ENT GPwER. **May 26 Update** Awaiting start date for Gynae GPwER. Recruitment checks ongoing for ENT GPwER. **April 26 Update** Still awaiting start date for Gynae GPwER. GPwER ENT interviews were succuesfull with one candidate accepting the role and another to be over recruited to support the longer term transformational plan and recovery of backlog.

	Action	Start	Due	Status	Update
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	Off Track	**June 26 Update** Demand and capacity modelling is complete, identifying a shortfall of approximately eight patients per week. Delivery of the SLA with SaTH would address this gap if implemented consistently. Discussions are underway with SaTH to secure regular, scheduled Loft House slots for SCHT. While additional ad hoc capacity is currently supporting recovery, a more consistent arrangement is required to ensure long-term service stability. In the interim, RJAH sessions are being utilised where available to mitigate the shortfall, albeit at additional cost. **May 26 Update** Double provision has been provided during April. Whilst it is still on ad hoc basis until formally agreed it is supporting reduction of waiting lists to improve RTT performance. **April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists.
	Community outpatients - Regular monthly meetings with SaTH Ops leads to ensure that waits are aligned and transfers occur for those waiting longer on community lists.	Apr-26	Jun-26	Complete	**June 26 Update** Arrangements are in place for all priority services, with escalation routes established where needed. Additional plans are in place to support rapid Duplex scans as a pressure point. Group opportunities and a joint forum are being used to share best practice and support the ongoing expansion of community outpatients. **New Action** Regular meetings now in place to ensure equity of access across STW.
	Robust validation of waiting lists and timely outcoming of clinic appts	Apr-26	Jun-26	Complete	**June 26 Update** Validation across all RTT pathways is now fully embedded within senior PTL governance processes. Community outpatient appointment outcomes has significantly improved and is now meeting KPI standards. **New Action** Increased focus on the admin processes.
	Community Outpatients - Extra clinics for high demand specialities.	Apr-26	Jun-26	On Track	**June 26 Update** Additional clinics have been introduced to support delivery in line with the SLA and trajectory targets; however, further capacity is required to achieve the planned level of activity. This is also necessary to evidence increased outpatient and community activity. Notification has been given regarding high number of unavailable clinics through out summer – request made to SaTH pending for alternative provision or locum support. Greater consistency is needed to ensure equitable access across all areas, alongside timely patient communication. Late notice clinics are contributing to higher DNA rates and increased cancellations. **New Action** Additional clinics agreed with consultants.
Author	Alastair Campbell/Bev Williams/Gemma McIver	**Date**	09/06/2026		
Accountable Officer Approval	Claire Horsfield	**Date**	15/06/2026		

**Please note that the actual performance for the month is subject to change as the validation for the national submission continued at the time of updating the action plan*

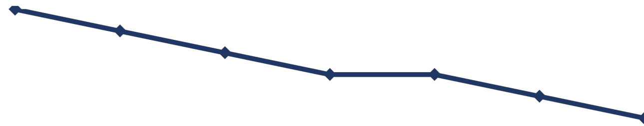
Exception Report - Action Plan

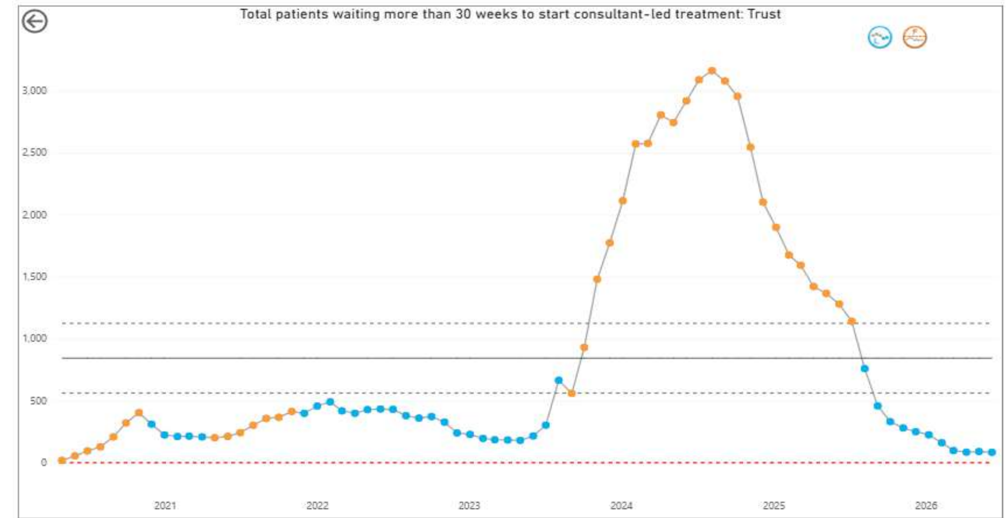
Total patients waiting more than 30 weeks to start consultant-led treatment

As at the end of the month, the number of patients that are still waiting for treatment and are over 30 weeks

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
RTT 30+ week waits	Number	225	161	98	85	90	84*	84*
	Target	0	0	0	0	0	0	0

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
Number	90	80	70	60	60	50	40





Reason for performance gap:

This is a new KPI within the Performance Framework and the SPC chart above shows the significant improvement in high waits over time. The plan is to achieve 0 30 week waits by January 2027 and the current position is on track to achieve this showing consistent decline.

For the last few months, actual numbers have been under 100 and the below contains detail of services with high waits and the actions being taken to improve performance. This is a 63% improvement over the last 6 months.

All RTT Services do still have patients waiting in excess of 30 weeks with Dental and Bridgnorth Outpatients holding the majority. MSST are currently only holding 9 over 30 weeks in their cohort.
A key high week risk relates to Oral Surgery. The current level of contracted dental clinics with SaTH remains insufficient to meet demand, with an ongoing monthly shortfall. In addition, inconsistent theatre provision at SaTH has impacted delivery, although early improvements are being made to stabilise access to capacity and support recovery.

Community outpatient is also an ongoing risk for high week waits, arrangements are in place across all priority services, with escalation routes established where needed. Additional plans are also in place to support rapid Duplex scans as a pressure point but access to diagnostics for other areas is still needing consistency to support long waits.

Ongoing recovery is supported by monthly data validation, performance dashboards, and regular review meetings. SCHT leads are now attending the SATH PTL to ensure equity of access.

The recovery plans have also been stress-tested against the NHSE May Community Health Services Waiting Times Action Checklists publication to ensure they reflect best practice and address the key domains for improving waiting times.

Action Plan		Start Date	End Date	Status	Outcome
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	Off Track	**June 26 Update** Demand and capacity modelling is complete, identifying a shortfall of approximately eight patients per week. Delivery of the SLA with SaTH would address this gap if implemented consistently. Discussions are underway with SaTH to secure regular, scheduled Loft House slots for SCHT. While additional ad hoc capacity is currently supporting recovery, a more consistent arrangement is required to ensure long-term service stability. In the interim, RJAH sessions are being utilised where available to mitigate the shortfall, albeit at additional cost. **May 26 Update** Double provision has been provided during April. Whilst it is still on ad hoc basis until formally agreed it is supporting reduction of waiting lists to improve RTT performance. **April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists.
	Community outpatients - Regular monthly meetings with SaTH Ops leads to ensure that waits are aligned and transfers occur for those waiting longer on community lists.	Apr-26	Jun-26	Complete	**June 26 Update** Arrangements are in place for all priority services, with escalation routes established where needed. Additional plans are in place to support rapid Duplex scans as a pressure point. Group opportunities and a joint forum are being used to share best practice and support the ongoing expansion of community outpatients. **New Action** Regular meetings now in place to ensure equity of access across STW.
	Robust validation of waiting lists and timely outcoming of clinic appts	Apr-26	Jun-26	Complete	**June 26 Update** Validation across all RTT pathways is now fully embedded within senior PTL governance processes. Community outpatient appointment outcomes has significantly improved and is now meeting KPI standards. **New Action** Increased focus on the admin processes.

	Community Outpatients - Extra clinics for high demand specialities.		Apr-26	Jun-26	On Track	**June 26 Update** Additional clinics have been introduced to support delivery in line with the SLA and trajectory targets; however, further capacity is required to achieve the planned level of activity. This is also necessary to evidence increased outpatient and community activity. Notification has been given regarding high number of unavailable clinics through out summer – request made to SaTH pending for alternative provision or locum support. Greater consistency is needed to ensure equitable access across all areas, alongside timely patient communication. Late notice clinics are contributing to higher DNA rates and increased cancellations. **New Action** Additional clinics agreed with consultants.
Author	Alastair Campbell/Bev Williams/Gemma McIver	**Date**	09/06/2026			
Accountable Officer Approval	Claire Horsfield	**Date**	15/06/2026			

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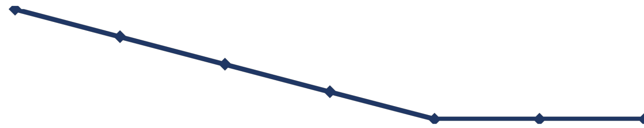
Exception Report - Action Plan

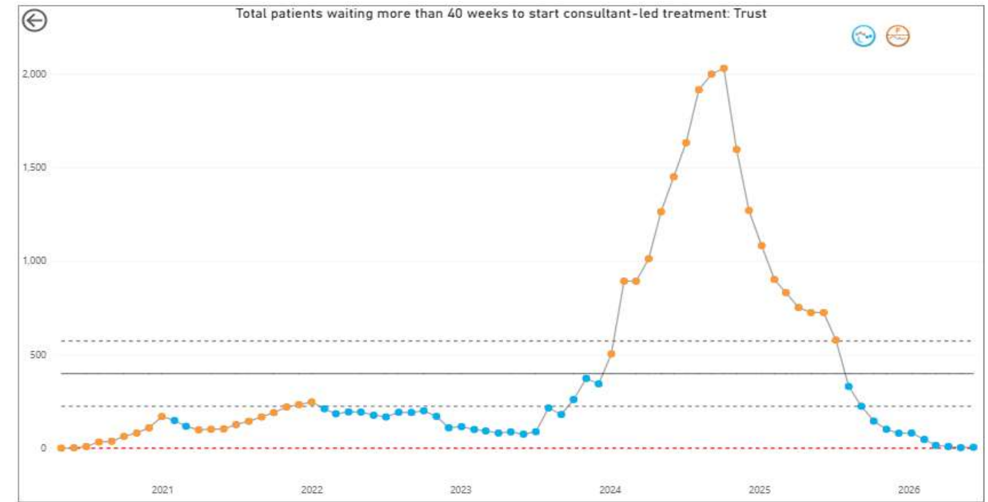
Total patients waiting more than 40 weeks to start consultant-led treatment

As at the end of the month, the number of patients that are still waiting for treatment and are over 40 weeks

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
RTT 40+ week waits	Number	81	47	15	9	3	5*	5*
	Target	0	0	0	0	0	0	0

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
Number	4	3	2	1	0	0	0





Reason for performance gap:

This is a new KPI within the Performance Framework and the SPC chart above shows the significant improvement in high waits over time.

For the last few months, actual numbers have been in single figures and the below contains detail of services with high waits and the actions being taken to improve performance

There were 5 patients across Community Outpatients and Dental

	Start Date	End Date	Status	Outcome
Community outpatients - Regular monthly meetings with SaTH Ops leads to ensure that waits are aligned and transfers occur for those waiting longer on community lists.	Apr-26	Jun-26	Complete	**June 26 Update** Arrangements are in place for all priority services, with escalation routes established where needed. Additional plans are in place to support rapid Duplex scans as a pressure point. Group opportunities and a joint forum are being used to share best practice and support the ongoing expansion of community outpatients. **New Action** Regular meetings now in place to ensure equity of access across STW.

Action Plan	Action	Start	Due	Status	Update
	Robust validation of waiting lists and timely outcoming of clinic appts	Apr-26	Jun-26	Complete	**June 26 Update** Validation across all RTT pathways is now fully embedded within senior PTL governance processes. Community outpatient appointment outcomes has significantly improved and is now meeting KPI standards. **New Action** Increased focus on the admin processes.
	Community Outpatients - Extra clinics now in place for high demand specialities.	Apr-26	Jun-26	On Track	**June 26 Update** Additional clinics have been introduced to support delivery in line with the SLA and trajectory targets; however, further capacity is required to achieve the planned level of activity. This is also necessary to evidence increased outpatient and community activity. Notification has been given regarding high number of unavailable clinics through out summer – request made to SaTH pending for alternative provision or locum support. Greater consistency is needed to ensure equitable access across all areas, alongside timely patient communication. Late notice clinics are contributing to higher DNA rates and increased cancellations. **New Action** Additional clinics agreed with consultants.
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	Off Track	**June 26 Update** Demand and capacity modelling is complete, identifying a shortfall of approximately eight patients per week. Delivery of the SLA with SaTH would address this gap if implemented consistently. Discussions are underway with SaTH to secure regular, scheduled Loft House slots for SCHT. While additional ad hoc capacity is currently supporting recovery, a more consistent arrangement is required to ensure long-term service stability. In the interim, RJAH sessions are being utilised where available to mitigate the shortfall, albeit at additional cost. **May 26 Update** Double provision has been provided during April. Whilst it is still on ad hoc basis until formally agreed it is supporting reduction of waiting lists to improve RTT performance. **April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists.

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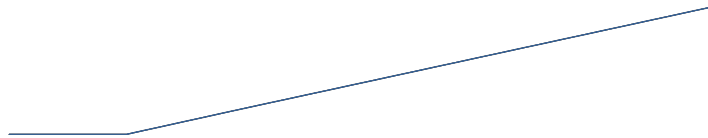
Exception Report - Action Plan

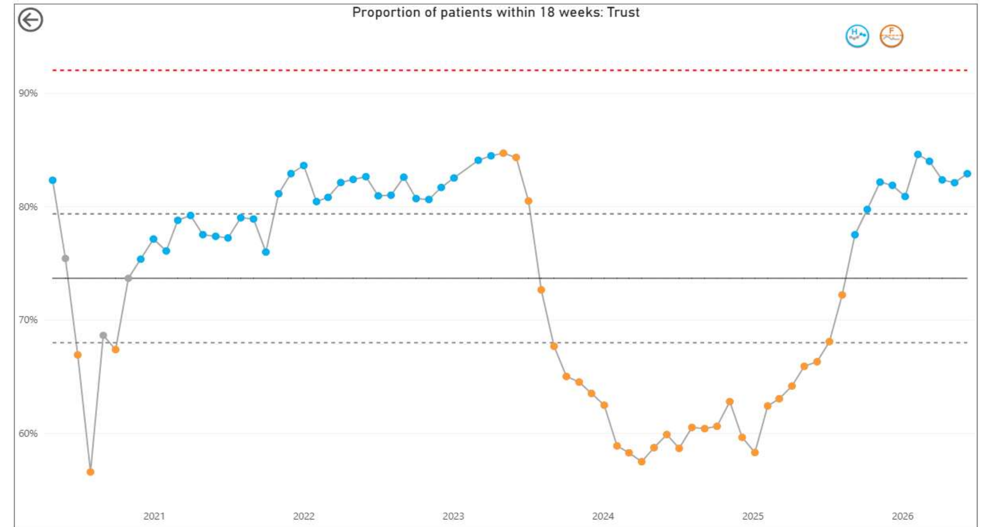
Proportion of patients within 18 weeks

The percentage of patients that are still waiting an appointment and are within 18 weeks

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Proportion of patients within 18 weeks	%	80.87%	84.58%	83.98%	82.33%	82.09%	82.88%	82.88%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
%	82.0%	82.0%	83.0%	84.0%	85.0%	86.0%	87.0%





Reason for performance gap:	Previously performance had stabilised however for May this is starting to improve again by 0.79% continuing to align just above the trajectory. Key Services Impacting Performance •CDC (Children's Development Centre) •Diabetes •Dental •Community Paediatrics •Children's Speech and Language Therapy •MSST (Musculoskeletal Services Shropshire and Telford) •Health Visiting Dudley •Podiatry Revised recovery trajectories have been developed for each service, with progress monitored through action plan workshops and local performance meetings. All services now attend Senior PTL for oversight and shared learning across divisions. Each service, covering both RTT and non-RTT pathways, has a consistent, robust recovery plan in place to support equitable access. This approach has been embedded as standard practice across the Trust over the past 12 months. Following recent NHSE guidance on community waiting times, SCHT is well positioned, having already implemented the required approach. This includes strengthened demand and capacity modelling, pathway redesign, and more structured performance management. The levelling in performance of MSST primarily relates to the level 2 element of the servcie and is due in part to utilisation rates, increased vacancy and sickness absence. Overall results do however remain substantially ahead of the national pathway for achieving 65% RTT compliance by March 2026 and 92% by March 2029. Dudley 0-19 have been performing at 100% for all waits however have seen a reduction in performance the last 2 months. This aligns to senior and admin sickness in the team resulting in data quality and unoutcomed appointments an immediate plan is in place re mutual aid to recover. Speech and Language Therapy 60.42% May, Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of January and maintained since. Additionally, the impact on the referrals rates has seen a reduction to pre covid rates which is a direct correlation to the early help offers. This will take time to work through to impact this metric. Comm Paeds have improved the high week wait position however overall access to first appointment within 18 weeks has stabilised at 62.72% and CDC at 45.66%. SCHT are committed to ensuring RTT and non RTT waits align especially for children so a plan is in place to increase capacity ASAP to accelerate recovery in line with all other services. Diabetes performance have improved this month from 67.13% to 72.4%, through improved waiting list management they continue to have 0 52 week waits. Dental remains an ongoing risk in this areas. The current level of contracted dental clinics with SaTH remains insufficient to meet demand, with an ongoing monthly shortfall. In addition, inconsistent theatre provision at SaTH has impacted delivery, although early improvements are being made to stabilise access to capacity and support recovery. Community outpatient is also an ongoing risk for high week waits, arrangements are in place across all priority services, with escalation routes established where needed. Additional plans are also in place to support rapid Duplex scans as a pressure point but access to diagnostics for other areas is still needing consistency to support long waits. There are other services that contribute to not meeting this target, including APCS, Bridgnorth Hospital - Day Surgery Unit, Children in Care, Community Neuro Rehabilitation Team, Continence Specialist Nursing, Wheelchair Services, Community Outpatients, Pulmonary Rehab.

		Start Date	End Date	Status	Outcome
	Transformation of clinical pathways for MSST, including focus on community appointment days (CAD), superclinics and blitz clinics.	Feb-26	Jun-26	Complete	**June 26 Update** Blitz clinics are now in place across all MSK outpatient departments, generating an additional 100 patient slots. This approach has been embedded as a routine measure to help manage increasing waiting lists. Clinical engagement has been established, supported by standardised templates and clear planning. Following the initial phase, outcomes will be shared with clinicians to assess impact, including changes to new-to-follow-up ratios, and to inform a continuous improvement cycle. This review will be clinically led, with lead clinicians using SPA time to support evaluation and ongoing refinement **May 26 Update** Ongoing operational meetings with a focus on CADs. Engagement sessions with clinical staff planned for May. **April 26 Update** Internal SCHT operational meeting now implemented to help support traction on implementation of the new pathways with particular focus on community appointment days.
	As part of the MSST pathway, SCHT clinic templates have been reviewed and standardised. To maximise patient utilisation, the learning will be shared through the Integration of Therapies programme to align templates across MSST as a parallel service in SaTH.	Jun-26	Oct-26	On Track	**New Action** This month, we are progressing a joint leadership forum and joint huddles to share learning and escalations in readiness for alignment of templates.
	Focus on MSST level 2 to support increased activity with review of templates across SCHT, then SATH and finally RJAH with the aim to improve clinic utilisation and increased activity to drive down recovery.	Feb-26	May-26	Closed	**June 26 Update** There is ongoing engagement with RJAH; however, with governance arrangements and a single line management structure for therapies integration now in place, the focus will shift to aligning with SaTH and sharing learning with RJAH. This will be presented at the face-to-face MSK Board meeting at the end of June for oversight. **May 26 Update** Constant re review of templates to support to increase new patient activity. Utilisation rates have been maintained. **April 26 Update** Internal SCHT operational meeting now implemented to help support traction on supporting improving utilisation. SCHT templates have been reviewed, next step is to make changes to increase number of new appointments. Additionally a large number of SMS have been sent to patients to supporting increasing the booking horizon.

	MSST Service reviewing and implementing new ways of working with booking of capacity including use of Dr Doctor, increasing booking horizons and ensuring correct rules with booking order.	Apr-26	Jun-26	Complete	**June 26 Update** Doctor Doctor has now been implemented supporting validation and discharge. Learning taken to support further areas across the Trust. Internal Audit has supported that correct rules with booking order are now standardised, this is further monitored through weekly senior PTL. **May 26 Update** Following the DrDoctor work, bookings for patients over 18 weeks awaiting physio increased by 12%. Bookings horizons have increased by 3 weeks and early evidence shows patients are being booked into the 3-6 week horizon as planned. **New Action** Focus on ensuring correct rules followed throughout booking process to ensure better utilisation imporved data quality
	Workforce Management - Working with finance to review annual turnover and the potential to over recurit to ensure fill capacity throughout the year	Apr-26	Jun-26	Complete	**June 26 Update** This has been completed, with a remaining gap of 1.5 band 6 WTE to meet future demand. This work will now be progressed through the Integration of Therapies programme to model capacity collectively and support productivity and efficiency gains. The service also currently has a 6 WTE vacancy gap, so the plan is to maximise existing capacity, work with SaTH to cover any remaining gap through shared templates and integration work, and develop a productivity plan. **May 26 Update** Working with finance to identify month on month vacancy position for MSST to see possibility of over recruting to ensure required activity levels throughout the year **New Action** Regular reduction in capacity available due to number of vacancies carried throughout year.
	Recruitment to vacancies within MSST (6 WTE Physiotherapists Band 5-7)	Jun-26	Oct-26	On Track	**New Action** Vacancies have been presented at VRF, with executive approval secured for three posts so far. Plans are also in place to work collaboratively across the Group on AHP apprenticeships to address remaining gaps. Exit interviews have been arranged to explore recruitment trends, noting that some vacancies relate to maternity cover and internal promotions
	Diabetes Nursing - Reviewed admin processes, with support from planned care and identified additional admin capacity was required, being recruited to and expected trajectory of 90% by April	Oct-25	Apr-26	Complete	**June 26 Update** All admin vacancies have now been filled. Peer support and shared improvement plans across the divisions to embed similar improvement plan that was rolled out in MSST and APCS. Service level PTL also established with ongoing improvement Plan overseen at senior PTL. **May 26 Update** New LCM now in post and is planned to undertake a full service review, with aim to release clinical productivity and administrative efficiencies across all specialist services by combining this admin provision to support a consistent resilient approach. **April 26 Update** The group Diatetic appointments have been successful which is demonstrated through the reduction in overall numbers waiting to be seen. This now needs to be implemented within the nursing element of the service. Continue to explore digital solutions for admin efficiencies.
	Diabetes further waiting list management through opt in and opt out process aligning to access policy and roll out of digital applications (Synertec)	Jun-26	Oct-26	On Track	**New Action** Template from APCS opt in and out adopted, admin preparing to send out aligning mutual aid to support admin due to likely increased calls.

Action Plan	Action	Start	End	Status	Update
	Plan to join the Community Paediatrican services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	**June 26 Update** Alignment has commenced. BI have supported with intelligence re other MDT professionals to support re key pathways, plan in place to align senior speech and language therapist to support decision making. **New Action** Teams have just been allocated a new Operational Lead on 5.5.26. Plans to analyse pathways, clinical interventions and workforce will commence following a scoping excerise taking place over next 8 weeks.
	Outsourcing external provision has been used for CDC to increase capacity and support to recover long wait position – plan in place to extend this provision alongside an additional locum Paediatrician for 3 months to support with rapid recover of waiting list access to align with Trust Trajectory for 18 weeks by March 2027 in conjunction with Adults recovery.	Jun-26	Oct-26	On Track	**New Action** Costing additional outsourcing to ensure compliance with procurement rules and temp staffing sourcing paediatric locum CVs for approval by Medical Director.
	Children's Speech and Language Therapy to develop new ways of working	Feb-26	Jun-26	Complete	**June 26 Update** Super Penguin and ELSEC have been implemented, alongside the introduction of multi-agency practitioners to support neurodiversity. Clear care pathways have been established, underpinned by demand and capacity modelling, with recruitment aligned to support delivery. The next phase will focus on embedding these new ways of working following SEND reform, ensuring the service is fully established and ready for future development and transformation. **May 26 Update** Embedding the new pathways and early help interventions have impacted on long waits and referal rates. The impact on recovery to 18 weeks will be ongoing and slower. **April 26 Update** We continue to embed the new clinical pathways and onboard new staff.
	Due to ELSEC roll out there is now risk that there are children on waiting list from historical practice that have been treated within a school setting. Therefore a waiting list validation and opt in/ out process is required.	Jun-26	Oct-26	On Track	**New Action** Partnering with MSST to adopt best practice approach and alignment with safeguarding for children's pathways completed. Letters drafted.
	High levels of maternity and the requirement for SEND expansion as part of reform, service to generate a workforce plan to substantively recruit to manage turnover of short term contracts and proactively recruit ahead of the national SEND ask to secure workforce in county to manage current waiting lists and future demand from September 2026.	Jun-26	Oct-26	On Track	**New Action** Workforce plan commenced and meeting with ICB weekly to plan for provision and financial alignment in readiness for September 2026.
	Additionality over summer to be job planned for drop in clinics and group clinics for Speech and Language Therapy.	Jun-26	Sep-26	On Track	**New Action** Working with childrens admin hub to book ahead to support waiting list.

	Action	Start	End	Status	Update
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	Off Track	**June 26 Update** Demand and capacity modelling is complete, identifying a shortfall of approximately eight patients per week. Delivery of the SLA with SaTH would address this gap if implemented consistently. Discussions are underway with SaTH to secure regular, scheduled Loft House slots for SCHT. While additional ad hoc capacity is currently supporting recovery, a more consistent arrangement is required to ensure long-term service stability. In the interim, RJAH sessions are being utilised where available to mitigate the shortfall, albeit at additional cost. **May 26 Update** Double provision has been provided during April. Whilst it is still on ad hoc basis until formally agreed it is supporting reduction of waiting lists to improve RTT performance. **April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists.
	Podiatry workforce recruitment, immediate support with longer term review planned to ensure standardisation of admin structure/oversight across Planned Care services.	Apr-26	Jun-26	On Track	**June 26 Update** Demand and capacity modelling underway with support from informatics, with aim to complete. **May 26 Update** Recruitment process in progress **New Action** Recruit to vacant administrative roles to support improvement in clinic utilisation and data quality and release additional clinical capacity that supporting some admin tasks currently.
	Work underway to implement Community appointment days within Podiatry.	Jun-26	Sep-26	On Track	**New Action** Alongside the MSST service Podiatry is planning to implement CAD days.
	Community outpatients - Regular monthly meetings with SaTH Ops leads to ensure that waits are aligned and transfers occur for those waiting longer on community lists.	Apr-26	Jun-26	Complete	**June 26 Update** Arrangements are in place for all priority services, with escalation routes established where needed. Additional plans are in place to support rapid Duplex scans as a pressure point. Group opportunities and a joint forum are being used to share best practice and support the ongoing expansion of community outpatients. **New Action** Regular meetings now in place to ensure equity of access across STW.
	Robust validation of waiting lists and timely outcoming of clinic appts	Apr-26	Jun-26	Complete	**June 26 Update** Validation across all RTT pathways is now fully embedded within senior PTL governance processes. Community outpatient appointment outcomes has significantly improved and is now meeting KPI standards. **New Action** Increased focus on the admin processes.

	Action	Start	End	Status	Update
	Community Outpatients - Extra clinics for high demand specialities.	Apr-26	Jun-26	On Track	**June 26 Update** Additional clinics have been introduced to support delivery in line with the SLA and trajectory targets; however, further capacity is required to achieve the planned level of activity. This is also necessary to evidence increased outpatient and community activity. Notification has been given regarding high number of unavailable clinics through out summer – request made to SaTH pending for alternative provision or locum support. Greater consistency is needed to ensure equitable access across all areas, alongside timely patient communication. Late notice clinics are contributing to higher DNA rates and increased cancellations. **New Action** Additional clinics agreed with consultants.
	Review and update access policy in line with RTT and non RTT services	Jun-26	Aug-26	On Track	**New Action** The policy review has been initiated through PTL engagement, with clinical leads working collaboratively to refine and update the current approach.
	Productivity review and individual action plans across all specialist and children's services created to impliment areas of opportunity re clinic utilisation, clinic templates, new to follow up ratio and PIFU. Improvement plans to be established and overseen through weekly senior PTL.	Jun-26	Jan-27	On Track	**New Action** This has commenced in Diabetes with APCS/MSST peer review. Pulmonary rehab pathway redesign also commenced. Community Peads with additional clinics at Coral House to ensure utilisation.
	Recovery for Dudley admin process re outcome appointments and data quality resulting in a false waiting list picture	Jun-26	Jul-26	On Track	**New Action** Date in place for admin to return from sick leave, mutual aid from Telford and Shropshire aligned

Author	Alastair Campbell/Helen Cooper/Gemma McIver/Sally Stubbs/Sam Townsend/Bev Williams	**Date**	09/06/2026	
Accountable Officer Approval	Claire Horsfield	**Date**	15/06/2026	

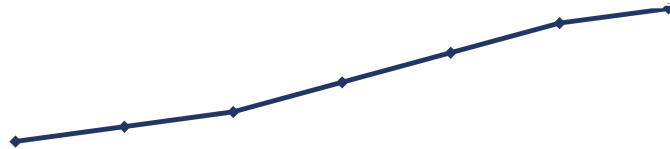
Exception Report - Action Plan

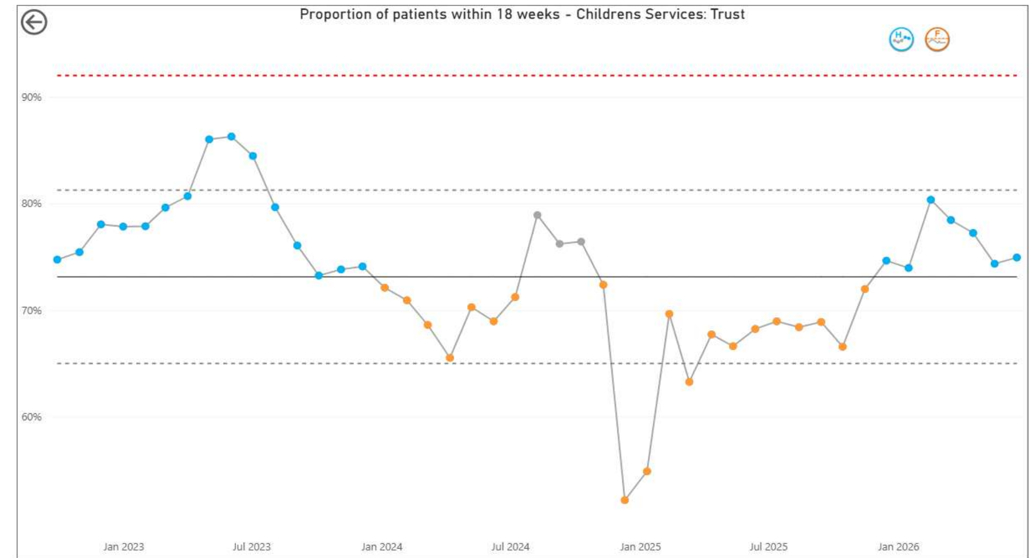
Proportion of patients within 18 weeks - Children's Services

The percentage of patients that are still waiting an appointment and are within 18 weeks - Children's Services including Oral Surgery

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Proportion of patients within 18 weeks - Children's Services	%	73.95%	80.35%	78.45%	77.23%	74.35%	74.93%	74.93%
	Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
%	69.5%	76.0%	77.0%	78.0%	80.0%	82.0%	84.0%	85.0%





Reason for performance gap:	Previously Performance had deteriorated the last few months. However, for May this is starting to improve again by 0.58% and is approx 2% below trajectory. Key Services Impacting Performance •CDC (Children's Development Centre) •Dental •Community Paediatrics •Children's Speech and Language •Health Visiting Dudley Revised recovery trajectories have been developed for each service, with progress monitored through action plan workshops and local performance meetings. All services now attend Senior PTL for oversight and shared learning across divisions. Each service, covering both RTT and non-RTT pathways, has a consistent, robust recovery plan in place to support equitable access. This approach has been embedded as standard practice across the Trust over the past 12 months. Following recent NHSE guidance on community waiting times, SCHT is well positioned, having already implemented the required approach. This includes strengthened demand and capacity modelling, pathway redesign, and more structured performance management. Dudley 0-19 have been performing at 100% for all waits however have seen a reduction in performance the last 2 months. This aligns to senior and admin sickness in the team resulting in data quality and unoutcomed appointments an immediate plan is in place re mutual aid to recover. Speech and Language Therapy 60.42% May, Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of January and maintained since. Additionally, the impact on the referrals rates has seen a reduction to pre covid rates which is a direct correlation to the early help offers. This will take time to work through to impact this metric. Comm Paeds have improved the high week wait position however overall access to first appointment within 18 weeks has stabilised at 62.72% and CDC at 45.66%. SCHT are committed to ensuring RTT and non RTT waits align especially for children so a plan is in place to increase capacity ASAP to accelerate recovery in line with all other services. Dental remains an ongoing risk in this areas. The current level of contracted dental clinics with SaTH remains insufficient to meet demand, with an ongoing monthly shortfall. In addition, inconsistent theatre provision at SaTH has impacted delivery, although early improvements are being made to stabilise access to capacity and support recovery. There are other services that contribute to not meeting this target, including Children in Care, Wheelchair Services The recovery plans have also been stress-tested against the NHSE May Community Health Services Waiting Times Action Checklists publication to ensure they reflect best practice and address the key domains for improving waiting times.

Action Plan		Start Date	End Date	Status	Outcome
	Plan to join the community paediatrican services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	**June 26 Update** Alignment has commenced. BI have supported with intelligence re other MDT professionals to support re key pathways, plan in place to align senior speech and language therapist to support decision making. **New Action** Teams have just been allocated a new Operational Lead on 5.5.26. Plans to analyse pathways, clinical interventions and workforce will commence following a scoping excerise taking place over next 8 weeks.
	Children's Speech and Language Therapy to develop new ways of working	Feb-26	Jun-26	Complete	**June 26 Update** Super Penguin and ELSEC have been implemented, alongside the introduction of multi-agency practitioners to support neurodiversity. Clear care pathways have been established, underpinned by demand and capacity modelling, with recruitment aligned to support delivery. The next phase will focus on embedding these new ways of working following SEND reform, ensuring the service is fully established and ready for future development and transformation. **May 26 Update** Embedding the new pathways and early help interventions have impacted on long waits and referal rates. The impact on recovery to 18 weeks will be ongoing and slower. **April 26 Update** We continue to embed the new clinical pathways and onboard new staff.
	Due to ELSEC roll out there is now risk that there are children on waiting list from historical practice that have been treated within a school setting. Therefore a waiting list validation and opt in/ out process is required.	Jun-26	Oct-26	On Track	**New Action** Partnering with MSST to adopt best practice approach and alignment with safeguarding for children's pathways completed. Letters drafted.
	Additionality over Summer to be job planned for drop in clinics and group clinics for Speech and Language Therapy.	Jun-26	Sep-26	On Track	**New Action** Working with childrens admin hub to book ahead to support waiting list.
	Outsourcing external provision has been used for CDC to increase capacity and support to recover long wait position – plan in place to extend this provision alongside an additional locum Paediatrician for 3 months to support with rapid recover of waiting list access to align with Trust Trajectory for 18 weeks by March 2027 in conjunction with Adults recovery.	Jun-26	Oct-26	On Track	**New Action** Costing additional outsourcing to ensure compliance with procurement rules and temp staffing sourcing paediatric locum CVs for approval by Medical Director.
	High levels of Maternity and the requirement for SEND expansion as part of reform, service to generate a workforce plan to substantively recruit to manage turn over of short term contracts and proactively recruit ahead of the national SEND ask to secure workforce in county to manage current waiting lists and future demand from September 2026.	Jun-26	Oct-26	On Track	**New Action** Workforce plan commenced and meeting with ICB weekly to plan for provision and financial alignment in readiness for September 2026.

	Action	Start	Due	Status	Update
	Review and update access policy in line with RTT and non RTT services	Jun-26	Aug-26	On Track	**New Action** The policy review has been initiated through PTL engagement, with clinical leads working collaboratively to refine and update the current approach.
	Productivity review and individual action plans across all specialist and children's services created to impliment areas of opportunity re clinic utilisation, clinic templates, new to follow up ratio and PIFU. Improvement plans to be established and overseen through weekly senior PTL.	Jun-26	Jan-27	On Track	**New Action** This has commenced in Diabetes with APCS/MSST peer review. Pulmonary rehab pathway redesign also commenced. Community Peads with additional clinics at Coral House to ensure utilisation.
	Recovery for Dudley admin process re outcome appointments and data quality resulting in a false waiting list picture	Jun-26	Jul-26	On Track	**New Action** Date in place for admin to return from sick leave, mutual aid from Telford and Shropshire aligned
	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	Off Track	**June 26 Update** Demand and capacity modelling is complete, identifying a shortfall of approximately eight patients per week. Delivery of the SLA with SaTH would address this gap if implemented consistently. Discussions are underway with SaTH to secure regular, scheduled Loft House slots for SCHT. While additional ad hoc capacity is currently supporting recovery, a more consistent arrangement is required to ensure long-term service stability. In the interim, RJAH sessions are being utilised where available to mitigate the shortfall, albeit at additional cost. **May 26 Update** Double provision has been provided during April. Whilst it is still on ad hoc basis until formally agreed it is supporting reduction of waiting lists to improve RTT performance. **April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists.

Author	Alastair Campbell/Helen Cooper/Gemma McIver	**Date**	09/06/2026	
Accountable Officer Approval	Claire Horsfield		15/06/2026	

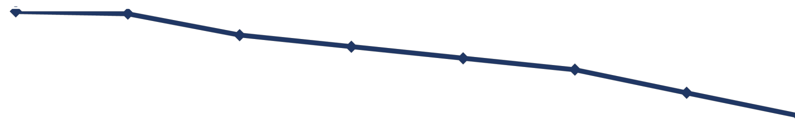
Exception Report - Action Plan

Total patients waiting more than 30 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 30 weeks and over

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
30+ Week waits - All services	Number	716	548	533	546	563	574	574
	Target	0	0	0	0	0	0	0

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	553	543	450	400	350	300	200	100



Reason for performance gap:	This is a new KPI within the Performance Framework and the SPC chart above shows the significant improvement in high waits over time. The below contains detail of services with high waits and the actions being taken to improve performance. Key Services Impacting Performance •CDC (Children's Development Centre) •Children's Speech and Language •Community Paediatrics •Oral Surgery •Pulmonary Rehabilitation •Diabetes •Podiatry •Community Nursing Revised recovery trajectories have been developed for each service, with progress monitored through action plan workshops and local performance meetings. All services now attend Senior PTL for oversight and shared learning across divisions. Each service, covering both RTT and non-RTT pathways, has a consistent, robust recovery plan in place to support equitable access. This approach has been embedded as standard practice across the Trust over the past 12 months. Following recent NHSE guidance on community waiting times, SCHT is well positioned, having already implemented the required approach. This includes strengthened demand and capacity modelling, pathway redesign, and more structured performance management. Speech and Language Therapy 60.42% May, Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of January and maintained since. Additionally, the impact on the referrals rates has seen a reduction to pre covid rates which is a direct correlation to the early help offers. This will take time to work through to impact this metric. Comm Paeds have improved the high week wait position however overall access to first appointment within 18 weeks has stabilised at 62.72% and CDC at 45.66%. SCHT are committed to ensuring RTT and non RTT waits align especially for children so a plan is in place to increase capacity ASAP to accelerate recovery in line with all other services. Diabetes performance have improved this month from 67.13% to 72.4%, through improved waiting list management they continue to have 0 52 week waits. Dental remains an ongoing risk in this areas. The current level of contracted dental clinics with SaTH remains insufficient to meet demand, with an ongoing monthly shortfall. In addition, inconsistent theatre provision at SaTH has impacted delivery, although early improvements are being made to stabilise access to capacity and support recovery. Pulmonary Rehab are a small team with several vacancies across registered, non-registered and admin as well as maternity leave. Performance for May improved to 78.31% and high waits have reduced. There are other services that contribute to not meeting this target, including APCS, Bridgnorth Hospital - Day Surgery Unit, Children in Care, Childrens Continence Service, Community Neuro Rehabilitation Team, Continence Specialist Nursing, MSST, Paediatric Physio, Community Outpatients, Wheelchair Services

		Start Date	End Date	Status	Outcome
	Plan to join the community paediatrican services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	**June 26 Update** Alignment has commenced. BI have supported with intelligence re other MDT professionals to support re key pathways, plan in place to align senior speech and language therapist to support decision making. **New Action** Teams have just been allocated a new Operational Lead on 5.5.26. Plans to analyse pathways, clinical interventions and workforce will commence following a scoping excerise taking place over next 8 weeks.
	Outsourcing external provision has been used for CDC to increase capacity and support to recover long wait position – plan in place to extend this provision alongside an additional locum Paediatrician for 3 months to support with rapid recover of waiting list access to align with Trust Trajectory for 18 weeks by March 2027 in conjunction with Adults recovery.	Jun-26	Oct-26	On Track	**New Action** Costing additional outsourcing to ensure compliance with procurement rules and temp staffing sourcing paediatric locum CVs for approval by Medical Director.
	Children's Speech and Language Therapy to develop new ways of working	Feb-26	Jun-26	Complete	**June 26 Update** Super Penguin and ELSEC have been implemented, alongside the introduction of multi-agency practitioners to support neurodiversity. Clear care pathways have been established, underpinned by demand and capacity modelling, with recruitment aligned to support delivery. The next phase will focus on embedding these new ways of working following SEND reform, ensuring the service is fully established and ready for future development and transformation. **May 26 Update** Embedding the new pathways and early help interventions have impacted on long waits and referal rates. The impact on recovery to 18 weeks will be ongoing and slower. **April 26 Update** We continue to embed the new clinical pathways and onboard new staff.
	Due to ELSEC roll out there is now risk that there are children on waiting list from historical practice that have been treated within a school setting. Therefore a waiting list validation and opt in/ out process is required.	Jun-26	Oct-26	On Track	**New Action** Partnering with MSST to adopt best practice approach and alignment with safeguarding for children’s pathways completed. Letters drafted.
	Additionality over Summer to be job planned for drop in clinics and group clinics for Speech and Language Therapy.	Jun-26	Sep-26	On Track	**New Action** Working with childrens admin hub to book ahead to support waiting list.
	High levels of Maternity and the requirement for SEND expansion as part of reform, service to generate a workforce plan to substantively recruit to manage turn over of short term contracts and proactively recruit ahead of the national SEND ask to secure workforce in county to manage current waiting lists and future demand from September 2026.	Jun-26	Oct-26	On Track	**New Action** Workforce plan commenced and meeting with ICB weekly to plan for provision and financial alignment in readiness for September 2026.

Action Plan	Agree sustainable and consistent Dental theatre provision via SATH.	Feb-26	Apr-26	Off Track	**June 26 Update** Demand and capacity modelling is complete, identifying a shortfall of approximately eight patients per week. Delivery of the SLA with SaTH would address this gap if implemented consistently. Discussions are underway with SaTH to secure regular, scheduled Loft House slots for SCHT. While additional ad hoc capacity is currently supporting recovery, a more consistent arrangement is required to ensure long-term service stability. In the interim, RJAH sessions are being utilised where available to mitigate the shortfall, albeit at additional cost. **May 26 Update** Double provision has been provided during April. Whilst it is still on ad hoc basis until formally agreed it is supporting reduction of waiting lists to improve RTT performance. **April 26 Update** Meeting has taken place with SATH and agreement to work together to ensure equity of access to theatre provision to support the longest waiting patients. SATH have agreed to support improving list efficiency and consistency of lists.
	Diabetes Nursing - Reviewed admin processes, with support from planned care and identified additional admin capacity was required, being recruited to and expected trajectory of 90% by April	Oct-25	Apr-26	Complete	**June 26 Update** All admin vacancies have now been filled. Peer support and shared improvement plans across the divisions to embed similar improvement plan that was rolled out in MSST and APCS. Service level PTL also established with ongoing improvement Plan overseen at senior PTL. **May 26 Update** New LCM now in post and is planned to undertake a full service review, with aim to release clinical productivity and administrative efficiencies across all specialist services by combining this admin provision to support a consistent resilient approach. **April 26 Update** The group Diatetic appointments have been successful which is demonstrated through the reduction in overall numbers waiting to be seen. This now needs to be implemented within the nursing element of the service. Continue to explore digital solutions for admin efficiencies.
	Diabetes further waiting list management through opt in and opt out process aligning to access policy and roll out of digital applications (Synertec)	Jun-26	Oct-26	On Track	**New Action** Template from APCS opt in and out adopted, admin preparing to send out aligning mutual aid to support admin due to likely increased calls.

	Podiatry workforce recruitment, immediate support with longer term review planned to ensure standardisation of admin structure/oversight across Planned Care services.	Apr-26	Jun-26	On Track	**June 26 Update** Demand and capacity modelling underway with support from informatics, with aim to complete. **May 26 Update** Recruitment process in progress **New Action** Recruit to vacant administrative roles to support improvement in clinic utilisation and data quality and release additional clinical capacity that supporting some admin tasks currently.
	Work underway to implement Community appointment days within Podiatry.	Jun-26	Sep-26	On Track	**New Action** Alongside the MSST service Podiatry is planning to implement CAD days.
	Productivity review and individual action plans across all specialist and children's services created to impliment areas of opportunity re clinic utilisation, clinic templates, new to follow up ratio and PIFU. Improvement plans to be established and overseen through weekly senior PTL.	Jun-26	Jan-27	On Track	**New Action** This has commenced in Diabetes with APCS/MSST peer review. Pulmonary rehab pathway redesign also commenced. Community Peads with additional clinics at Coral House to ensure utilisation.
Author	Alastair Campbell/Helen Cooper/Gemma McIver/Sally Stubbs/Sam Townsend/Bev Williams	**Date**	09/06/2026		
Accountable Officer Approval	Claire Horsfield		15/06/2026		

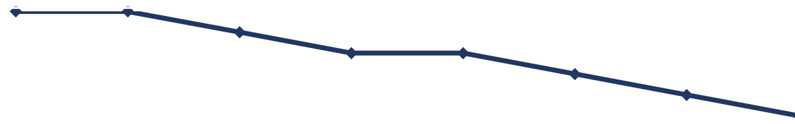
Exception Report - Action Plan

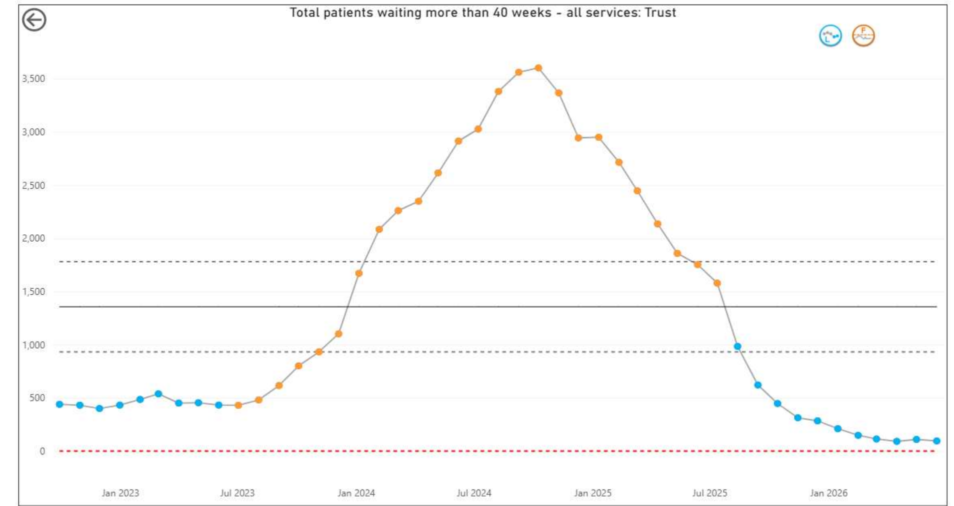
Total patients waiting more than 40 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 40 weeks and over

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
40+ Week waits - All services	Number	210	148	113	91	109	95	95
	Target	0	0	0	0	0	0	0

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	100	100	90	80	80	70	60	50





Reason for performance gap:	This is a new KPI within the Performance Framework and the SPC chart above shows the significant improvement in high waits over time. The below contains detail of services with high waits and the actions being taken to improve performance. Key Services Impacting Performance •CDC (Children's Development Centre) •Children's Speech and Language •Community Paediatrics •Continence Specialist Nursing •Pulmonary Rehabilitation •Diabetes Revised recovery trajectories have been developed for each service, with progress monitored through action plan workshops and local performance meetings. All services now attend Senior PTL for oversight and shared learning across divisions. Each service, covering both RTT and non-RTT pathways, has a consistent, robust recovery plan in place to support equitable access. This approach has been embedded as standard practice across the Trust over the past 12 months. Following recent NHSE guidance on community waiting times, SCHT is well positioned, having already implemented the required approach. This includes strengthened demand and capacity modelling, pathway redesign, and more structured performance management. Speech and Language Therapy 60.42% May, Ongoing improvements have continued, with early intervention and revalidation initiatives reducing the number of children waiting over 52 weeks to zero as of January and maintained since. Additionally, the impact on the referrals rates has seen a reduction to pre covid rates which is a direct correlation to the early help offers. This will take time to work through to impact this metric. Comm Paeds have improved the high week wait position however overall access to first appointment within 18 weeks has stabilised at 62.72% and CDC at 45.66%. SCHT are committed to ensuring RTT and non RTT waits align especially for children so a plan is in place to increase capacity ASAP to accelerate recovery in line with all other services. Diabetes performance have improved this month from 67.13% to 72.4%, through improved waiting list management they continue to have 0 52 week waits. Pulmonary Rehab are a small team with several vacancies across registered, non-registered and admin as well as maternity leave. Performance for May improved to 78.31% and high waits have reduced. There are other services that contribute to not meeting this target, including APCS, Bridgnorth Hospital - Day Surgery Unit, Children in Care, Community Neuro Rehabilitation Team, Community Nursing, MSST, Oral Surgery, Community Outpatients, Podiatry

Action Plan		Start Date	End Date	Status	Outcome
	Plan to join the community paediatrican services with the children's CDC to reduce duplication, streamline clinical pathways and improve capacity to reduce waits.	May-26	Sep-26	On Track	**June 26 Update** Alignment has commenced. BI have supported with intelligence re other MDT professionals to support re key pathways, plan in place to align senior speech and language therapist to support decision making. **New Action** Teams have just been allocated a new Operational Lead on 5.5.26. Plans to analyse pathways, clinical interventions and workforce will commence following a scoping excerise taking place over next 8 weeks.
	Outsourcing external provision has been used for CDC to increase capacity and support to recover long wait position – plan in place to extend this provision alongside an additional locum Paediatrician for 3 months to support with rapid recover of waiting list access to align with Trust Trajectory for 18 weeks by March 2027 in conjunction with Adults recovery.	Jun-26	Oct-26	On Track	**New Action** Costing additional outsourcing to ensure compliance with procurement rules and temp staffing sourcing paediatric locum CVs for approval by Medical Director.
	Children's Speech and Language Therapy to develop new ways of working	Feb-26	Jun-26	Complete	**June 26 Update** Super Penguin and ELSEC have been implemented, alongside the introduction of multi-agency practitioners to support neurodiversity. Clear care pathways have been established, underpinned by demand and capacity modelling, with recruitment aligned to support delivery. The next phase will focus on embedding these new ways of working following SEND reform, ensuring the service is fully established and ready for future development and transformation. **May 26 Update** Embedding the new pathways and early help interventions have impacted on long waits and referal rates. The impact on recovery to 18 weeks will be ongoing and slower. **April 26 Update** We continue to embed the new clinical pathways and onboard new staff.
	Due to ELSEC roll out there is now risk that there are children on waiting list from historical practice that have been treated within a school setting. Therefore a waiting list validation and opt in/ out process is required.	Jun-26	Oct-26	On Track	**New Action** Partnering with MSST to adopt best practice approach and alignment with safeguarding for children's pathways completed. Letters drafted.
	Additionality over Summer to be job planned for drop in clinics and group clinics for Speech and Language Therapy.	Jun-26	Sep-26	On Track	**New Action** Working with childrens admin hub to book ahead to support waiting list.
	High levels of Maternity and the requirement for SEND expansion as part of reform, service to generate a workforce plan to substantively recruit to manage turn over of short term contracts and proactively recruit ahead of the national SEND ask to secure workforce in county to manage current waiting lists and future demand from September 2026.	Jun-26	Oct-26	On Track	**New Action** Workforce plan commenced and meeting with ICB weekly to plan for provision and financial alignment in readiness for September 2026.

	Action	Start	End	Status	Update
	Diabetes Nursing - Reviewed admin processes, with support from planned care and identified additional admin capacity was required, being recruited to and expected trajectory of 90% by April	Oct-25	Apr-26	Complete	**June 26 Update** All admin vacancies have now been filled. Peer support and shared improvement plans across the divisions to embed similar improvement plan that was rolled out in MSST and APCS. Service level PTL also established with ongoing improvement Plan overseen at senior PTL. **May 26 Update** New LCM now in post and is planned to undertake a full service review, with aim to release clinical productivity and administrative efficiencies across all specialist services by combining this admin provision to support a consistent resilient approach. **April 26 Update** The group Diatetic appointments have been successful which is demonstrated through the reduction in overall numbers waiting to be seen. This now needs to be implemented within the nursing element of the service. Continue to explore digital solutions for admin efficiencies.
	Diabetes further waiting list management through opt in and opt out process aligning to access policy and roll out of digital applications (Synertec)	Jun-26	Oct-26	On Track	**New Action** Template from APCS opt in and out adopted, admin preparing to send out aligning mutual aid to support admin due to likely increased calls.
	Productivity review and individual action plans across all specialist and children's services created to impliment areas of opportunity re clinic utilisation, clinic templates, new to follow up ratio and PIFU. Improvement plans to be established and overseen through weekly senior PTL.	Jun-26	Jan-27	On Track	**New Action** This has commenced in Diabetes with APCS/MSST peer review. Pulmonary rehab pathway redesign also commenced. Community Peads with additional clinics at Coral House to ensure utilisation.
	Continence process review	May-26	Jul-26	Complete	**June 26 Update** Review complete with clinic templates and job planning commenced - this work is now overseen through Senior PTL to monitor progress **New Action** New LCM in post and planned to undertake administrative review with closer oversight over processes.

Author	Alastair Campbell/Helen Cooper/Gemma McIver/Sally Stubbs/Sam Townsend/Bev Williams	**Date**	09/06/2026
Accountable Officer Approval	Claire Horsfield		15/06/2026

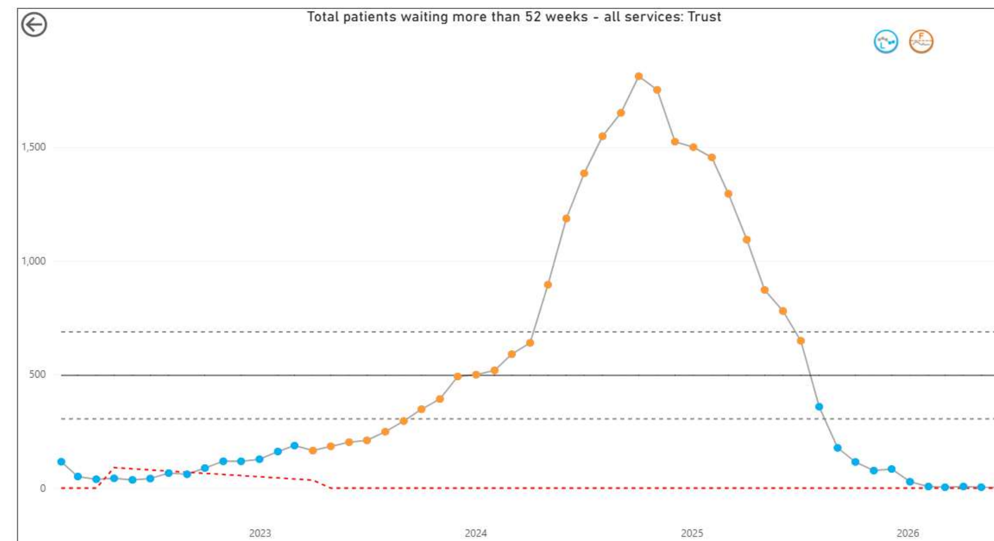
Exception Report - Action Plan

Total patients waiting more than 52 Weeks – All services

The number of patients that are still waiting for an appointment and have been waiting 52 weeks and over

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
52+ Week waits - All services	Number	28	7	4	7	4	3	3
	Target	0	0	0	0	0	0	0

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Number	0	0	0	0	0	0	0



Reason for performance gap:	There has been consistent and significant improvement in reducing 52 weeks over a sustained period, this month recovery has improved slightly but is not meeing the trajectory. Of the 3 patients at 52 weeks, 1 patient was seen before the census period however there was an administrative delay in outcoming appointment, and 1 was aligned to patient choice. For the Adults services there will be an increased focus on validation, data quality and PTL tracking to ensure any data quality issues are highlighted and updated prior to census at month end.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Continence process review	May-26	Jul-26	Complete	**June 26 Update** Review complete with clinic templates and job planning commenced - this work is now overseen through Senior PTL to monitor progress **New Action** New LCM in post and planned to undertake administrative review with closer oversight over processes.
	Through senior PTL all patients across 40 week cohorts are reviewed to support ongoing trajectory of 0 40 by September and mitigate any risk re 52 weeks. A dedicated data submission end of month census check has also been implemented to reduce submission of any unoutcomed or data quality cases.	Jun-26	Sep-26	On Track	**New Action**

Author	Alastair Campbell/Gemma McIver/Sally Stubbs/Sam Townsend	**Date**	09/06/2026
Accountable Officer Approval	Claire Horsfield		15/06/2026

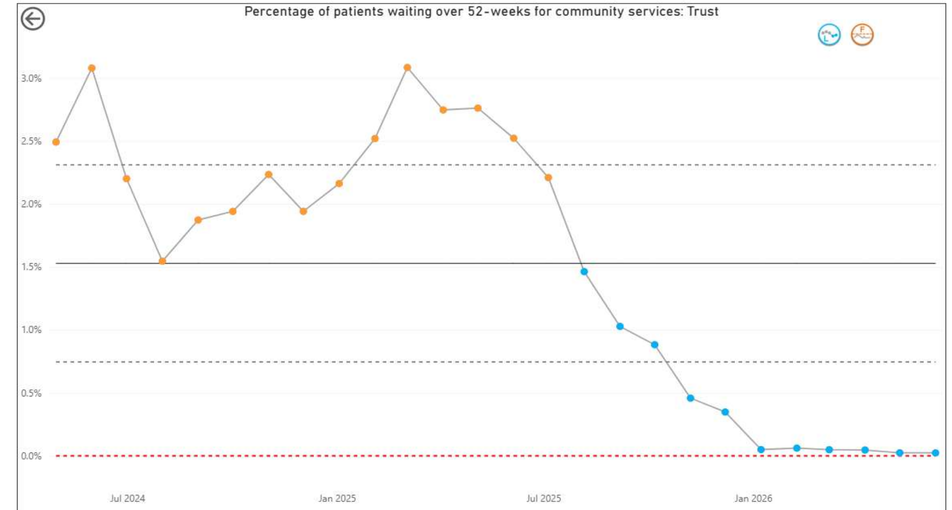
Exception Report - Action Plan

Percentage of patients waiting over 52-weeks for community services

The percentage of patients that are still waiting an appointment and are over 52 weeks

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Percentage of patients waiting over 52-weeks for community services	%	0.05%	0.06%	0.05%	0.05%	0.02%	0.02%	0.02%
	Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trajectory	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%



Reason for performance gap:	There has been consistent and significant improvement in reducing 52 weeks over a sustained period, this month recovery has improved slightly but is not meeing the trajectory. Of the 2 patients at 52 weeks, 1 patient was seen before the census period however there was an administrative delay in outcoming appointment and the final was aligned to patient choice. For the Adults services there will be an increased focus on validation, data quality and PTL tracking to ensure any data quality issues are highlighted and updated prior to census at month end.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Continence process review	May-26	Jul-26	Complete	**June 26 Update** Review complete with clinic templates and job planning commenced - this work is now overseen through Senior PTL to monitor progress **New Action** New LCM in post and planned to undertake administrative review with closer oversight over processes.
	Through senior PTL all patients across 40 week cohorts are reviewed to support ongoing trajectory of 0 40 by September and mitigate any risk re 52 weeks. A dedicated data submission end of month census check has also been implemented to reduce submission of any unoutcomed or data quality cases.	Jun-26	Sep-26	On Track	**New Action**

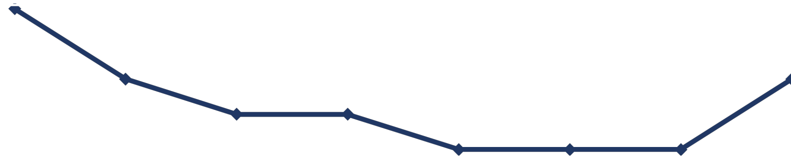
Author	Alastair Campbell/Gemma McIver/Sally Stubbs/Sam Townsend	**Date**	09/06/2026
Accountable Officer Approval	Claire Horsfield		15/06/2026

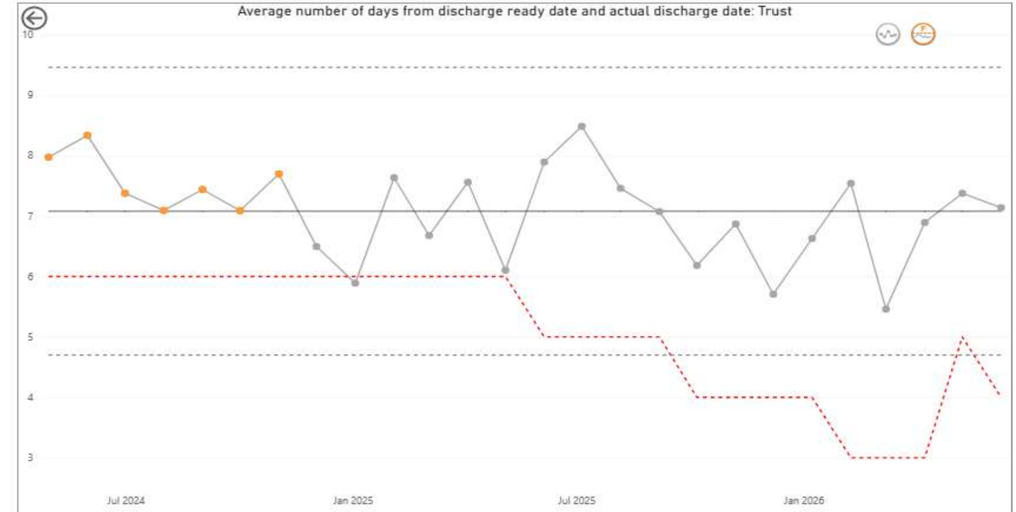
Exception Report - Action Plan

Average number of days from discharge ready date and actual discharge date

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Average number of days from discharge ready date and actual discharge date	Number	6.6	7.5	5.5	6.9	7.4	7.1	7.1
	Target	4.0	4.0	3.0	3.0	5.0	4.0	4.0

Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	5.00	4.00	3.50	3.50	3.00	3.00	3.00	4.00





Reason for performance gap:

NCTR performance is currently below target and is not meeting the improvement trajectory. There has also been an increase in patients admitted to Community hospital Pathway 2 beds with high levels of social complexity which is resulting in longer length of stay. Pathway 3 availability is limited resulting in more patients with NCTR remaining in hospital beds while a placement is found.

The improvement plan is making progress and is being managed by a dedicated task and finish group, with support from the wider system. The new SOP is due to 'go live' in June 2026, which has significant changes in practice to release clinical time and oversight of the NCTR patient cohort. There has been a notable improvement in accountability and actions resulting from the daily NCTR meeting, through the Adults Operational Lead taking on chair, supported by Clinical Service Manager Capacity & Flow as co-chair, this has seen an increase in timely, complex MDTs to facilitate discharge. Oversight of this workstream is provided by the UEC Delivery Group as part of the complex discharge improvement plan. Continued progress depends significantly on engagement from local authorities and ensuring that suitable patients are admitted to community hospitals.

A major risk to sustaining improvement, especially during winter, is the potential for outbreaks. This could increase the risk of patient deconditioning and require more intensive care following discharge, leading to additional delays and longer length of stay. To address this, enhanced infection prevention and control (IPC) measures have been introduced, including daily IPC support, mandatory red mask use, and consolidating ‘red to green’ and ‘no criteria to reside’ meetings into a single daily meeting. This change is designed to free up clinical therapy time and provide more focused rehabilitation support on wards, fostering a stronger rehabilitation culture and minimising unnecessary internal delays.

<table>
<tr><td rowspan="2">Action Plan</td><td colspan="2"></td><td>Start Date</td><td>End Date</td><td>Status</td><td>Outcome</td></tr>
<tr><td colspan="2">Condense the NCTR daily oversight calls at ward level to once a day to reduce duplication, align RIO oversight and release time back to care for therapy staff</td><td>Dec-25</td><td>Apr-26</td><td>Off Track</td><td>June 26 Update
SOP is yet to go live with some clarification required with staff, due to reduced senior operational capacity during May. Complex MDT implementation for NCTR patient through Adults Operational Lead and Clinical Services Manager for Capacity & Flow through consistent daily chair, resulting in clear action plans in place for facilitating discharge, is in place and noticing impact. Improvement has been seen at Ludlow and Whitchurch, but outliers at Bridgnorth and Bishop's Castle have had a detrimental effect on the overall improvement across the trust.

May 26 Update
SOP is in final draft with go live in June 2026. Ward managers & Therapy Leads are engaged with SOP and new ways of working to release clinical capacity and increase senior oversight of NCTR patient cohort. Noted increase in timely, complex MDT implementation for NCTR patient through Adults Operational Lead and Clinical Services Manager for Capacity & Flow through consistent daily chair, resulting in clear action plans in place for facilitating discharge.

April 26 Update
Creation of standard operating procedure for NCTR to standardise practices and release efficiencies across all inpatient units. Adults Operational Lead and Clinical Services Manager now co-chair daily NCTR call.</td></tr>
<tr><td>Author</td><td>Sam Townsend / Sarah Robinson / Sally Stubbs / Gemma McIver</td><td>Date</td><td colspan="2">09/06/2026</td><td colspan="2" rowspan="2"></td></tr>
<tr><td>Accountable Officer Approval</td><td>Claire Horsfield</td><td></td><td colspan="2">15/06/2026</td></tr>
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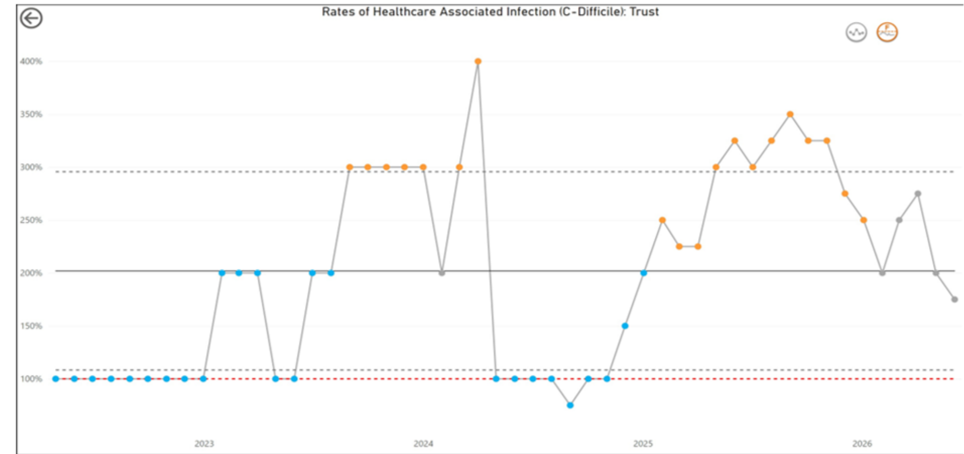
Exception Report - Action Plan

Clostidium difficile infection rate

12-month rolling counts of Clostridioides difficile (C. difficile) infections by NHS organisation and prior trust exposure (from April 2019) in patients aged 2 years and over.

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD (Rolling 12 months)
Clostidium difficile infection rate	Number	10	8	10	11	8	7	7
	Target	4	4	4	4	4	4	4

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	1	0	0	1	0	1	



Narrative/Description:

There have been zero cases of C-Difficile reported in May 2026. The Trust breached it's target for 25/26 with a total of 11 cases against a threshold of 4. Thematic reviews will continue for 26/27 to identify improvements in systems and processes required with actions monitored below and via the IPC Improvement plan. Ribotyping is requested in all cases. A rolling deep clean programme is in place across all Community Hospital sites and there is a continued focus on de-prescribing PPIs and antimicrobial stewardship.

Thresholds for 26/27 have not been set by ICB and are expected in June 2026.

Action Plan

	Start Date	End Date	Status	Outcome
Create visual aids (videos or posters) on how to clean key pieces of equipment (i.e. beds)	Jun-25	~~April-26~~ July 2026	In progress	On recent audit over 10 types of bed in use across all 4 sites. Beds have now been standardised so video on how to clean can be produced. SaTH/SCHT collaborating and producing one video.
Use of AAR template/poster to disseminate and embed learning across Community Hospitals	Sep-25	~~01/12/2025~~ May 2026	Complete	Draft document has been circulated for comment
Ensure Housekeeper roles and responsibilities are mapped to daily/weekly/monthly and are consistent across all sites to support with environmental decontamination	Sep-25	Jun-26	In progress	All roles and responsibilities have been mapped, and shared with all Community Hospitals. Awaiting meeting with Locality Managers to discuss the expectations of the wards against the Job Description.
Mark prescription chart of patients at risk of C. difficile infection to highlight need to select antimicrobials with care.	Apr-26	Jul-26	In progress	

	Using the newly formed template share and disseminate key learning from CDI thematic reviews from 25/26		May-26	Jul-26	In progress	
Author	IPC team	**Date**	16/06/2026			
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	16/06/2026			

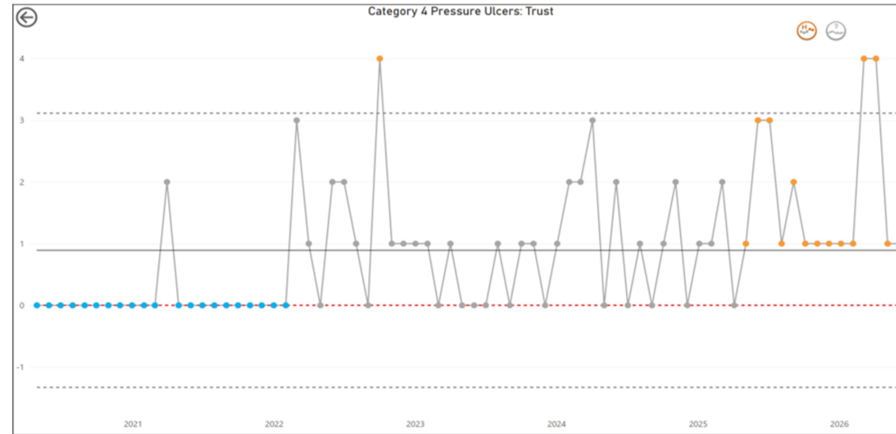
Exception Report - Action Plan

Category 4 Pressure Ulcers

The number of Category 4 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Latest month
Category 4 Pressure Ulcers	Number	1	1	4	4	1	1	1
	Target	0	0	0	0	0	0	0

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	1	1	1	1	1	1	1



Narrative/Description:	In May 2026, on Category 4 pressure ulcer was reported in-service within the South Telford IDT. This incident was discussed at PSIP on 20/5/26. The pressure ulcer was identified as a pressure related injury to the patient's skin. This occurred with an extremely complex patient with extensive medical needs, who even though had capacity and was aware of the risks chose to decline pressure relieving equipment and also to reposition regulary. The IDT were extremely thorough in assessing the patient, escalating any concerns to MDT members and having open discussions with the patient and relatives regarding deterioration in pressure damage. PSIP members felt that this was a good example of outstanding care that should be shared so a case study on the patient is to be written and shared to clinical teams. Following discussion with regional TV Nurse network, local community teams are also seeing increases in pressure ulcer numbers and deterioration and wider thematic review to be planned as a region to establish themes and actions to support.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Further PURPOSE T sessions planned for 2026 to support clinical teams	Jan-26	Dec-26	In Progress	
	Monthly caseload meetings with IDT teams to support complex cases and pressure ulcers	May-25	Dec-25	Complete	This is ongoing throughout the year
	Weekly support for SEIDT from TV Lead Nurse and also TV Clinical Lead to support with clinical oversight for pressure ulcers on the caseload	May-25	Aug-25	In Progress	
	TV sessions added to Core Clinical Skills week throughout 2026 - am - Pressure ulcer prevention and management, PM - Wound assessment/recognising the deteriorating wound	Jan-26	Dec-26	In Progress	
	Overall thematic review to be written for SEIDT pressure ulcers reported and presented back to PSIP	Jun-26	Jul-26	In Progress	
Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	08/06/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	16/06/2026		

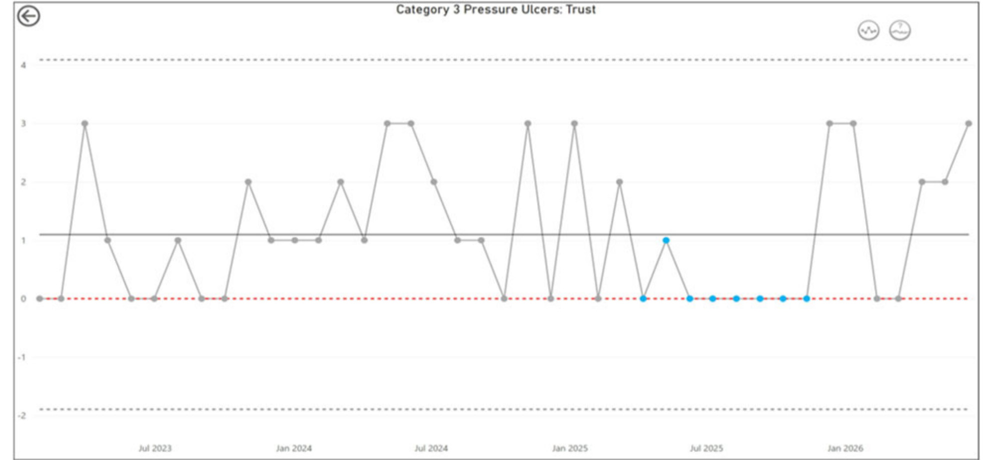
Exception Report - Action Plan

Category 3 Pressure Ulcers

The number of Category 3 Pressure Ulcers developed in service

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Latest Month
Category 3 Pressure Ulcers	Number	3	0	0	2	2	3	3
	Target	0	0	0	0	0	0	0

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	1	1	1	1	1	1	1



Narrative/Description:	In May 2026, there were three category 3 pressure ulcers reported in-service. The first incident relates to the North West team. The patient being extremely complex, with all appropriate pressure relieving equipment in place; however, the patient declined to use this equipment, and ADDER has therefore been completed, following presentation at PSIP it was recommended for incident to be written up as case study to share best practice. The second incident relates to South East team and this was pressure damage to the bridge of the nose due to NIV mask. All appropriate actions had been taken. As part of a wider piece of work, a thematic review will be completed focusing specifically on SEIDT incidents to identify themes and agree actions to address the issues identified. The team is currently experiencing challenges with staff absence and capacity, which is a contributing factor to the number of incidents being reported. The third incident relates to an incident for North Telford team for pressure damage to the elbow, a SWARM huddle was advised to look into learning actions and to share with the team.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	PURPOSE T sessions for clinical staff to attend in 2026	Jan-26	Dec-26	In Progress	
	Monthly caseload meetings with IDT teams to support complex cases and pressure ulcers	Feb-26	Dec-26	Complete	This is ongoing throughout the year
	TV sessions added to Core Clinical Skills Week for 2026 - AM - PU classification and PM - wound assessment and recognising the deteriorating wound	Jan-26	Dec-26	In Progress	

Author	Jodie Jordan - Tissue Viability Service Lead	**Date**	09/06/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	16/06/2026

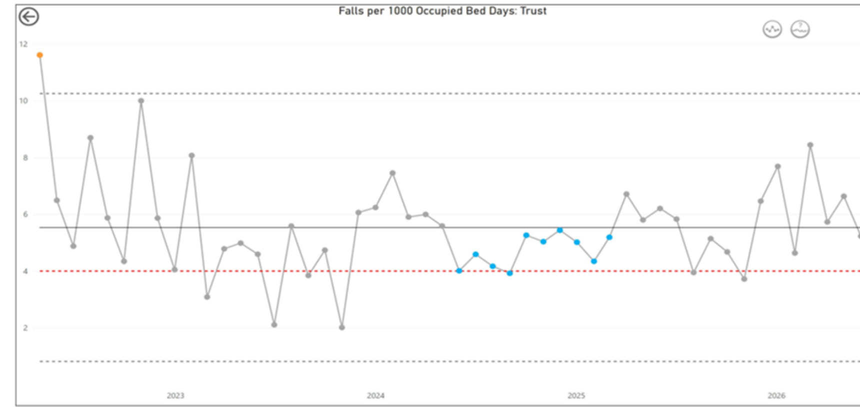
Exception Report - Action Plan

Falls per 1000 occupied bed days

Falls per 1000 occupied bed days

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Latest Month
Falls per 1000 OBDs	Number	7.69	4.64	9.30	5.30	6.48	5.23	5.23
	Target	4	4	4	4	4	4	4

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	4.00	4.00	4.00	4.00	4.00	4.00	4.00



Narrative/Description:

In May 2026 there were 13 inpatient falls reported within our Inpatient Community Hospital wards, this is a decrease of 3 falls from our last monthly report (April 2026 = 16 reported falls). This equates to a Trust rate of 5.23 per 1000 Occupied Bed Days (OBDs) which, is a decrease from 6.48 last month however, it remains above our Trust target of 4.0 falls per 1000 OBD's. Whitchurch Community Hospital achieved only 1 fall for May 2026 and have reduced their falls rate for the 4th consecutive month which is to be celebrated.The range of falls per 1000 OBD's is BCCH 10, an increase from previous month 8.8; BNCH 6.48, a reduction from previous month 15.7; LCH 5.17 an increase from previous month 0 and WCH 1.36, a reduction from previous month 3.6. Two wards had patients who fell multiple times - BNCH two patients and BCCH one patient who fell twice in the month of May 2026. BCCH Ward Manager has updated that mitgating circumstances are that the patient who fell more than once had confusion and ETOC needs. There was additional staffing with ETOC staffing at night but none in the day for 1 of their falls incidents for this specific patient. BNCH Ward Manager has updated that 2 falls were unwitnessed from confused patients whilst staff were with other patients when amber cohort nursing. LCH Ward Manager has updated that of the 2 falls overnight, both were new patients where the Transfer of Care (TOC) stated no confusion however, patients then displayed confusion. WCH Locality Manager is adding their falls number and falls rate reduction to the huddle as a well done and thank you to their staff.

Overall Trust summary: The majority of falls in May were classified as category Fall from bed / chair / trolley that has increased by 1 this month to 5/13, 38% . Found on floor category was 3/13, 23% (previous month 31%) which, is a consistent reducing pattern. It is be noted BCCH ward is the only ward to report a fall from toilet. The majority of falls were classified as no or low physical harm, 92% 12/13 (100% last month) and there was 1 moderate harm recorded at BCCH ward however upon review this can be downgraded as that specific patient attended A&E but x-rays were NAD and they returned to BCCH ward. There were no serious harms recorded. There were two moderate psychological harms recorded, 1 BNCH ward and 1 LCH ward otherwise 11/13, 85% are no to low psychological harm. This month 73% of falls were unwitnessed which is a significant increase from 63% last month. This month the majority of falls were in the day 10/13, 77% so only 23% at night which has shifted from last month where 56% occured at night. The nighttime falls were on LCH ward, 2 falls and 1 night time fall on BCCH ward. Notably in April for BCCH 3/4 falls, 75% occured at night however, this month it was only 1/4, 25%. For LCH ward 2/3, 75% occured at night which, is pattern to be explored. Of the 13 falls 5 ambulances were called to our inpatient wards, resulting in 2 being sent to an acute hospital, this is a static number of conveyances from last month. Ramblegard was mentioned in 1 Datix as being pro-actively in situ pre-fall however, inconsistent recording of whether ramblegard is skewing data so from 1/6 there will be a question on Datix, "Was ramblegard in situ?". A review of ramblegard impact is due by Q2 26/27 thematic review.

	Start Date	End Date	Status	Outcome
Dementia friendly environment standardisation QI project - Phase 1) Ludlow Phase 2) Bishop's Castle Phase 3) Bridgnorth Phase 4) Whitchurch 5) MIU's	Jun-25	Sep-26	in progress	**June update** - Ludlow installation commenced in first week of June; some issues with quality of walls for the wraps and some of the items potentially to be used not meeting IPEAT standards resulting in some items being adapted to comply and some items now not to be used. Phase 1 now not on track for completion in June 2026 due to pause for estates work on wall surfaces. Learning from Phase 1 will inform implementation for other sites. BCCH ward is the next phase. WCH ward, BNCH ward and MIU's implementation needs to align with Group capital investment in the community estates for which timescales need to be communicated.

Action Plan					
	Moderate falls learning - Improve pro-active learning from moderate falls within inpatient wards Phase 1) Bishop's Castle Ward 2) Whitchurch	Sep-25	Sep-26	In progress	**June Update:** Clinical Quality Lead has established capacity to do a weekly datix review of falls rather than monthly process to support more timely connection with the wards. Governance team to alert Clinical Quality Lead to any falls with moderate harm and are exploring a Quality Dashboard. Clinical Lead for quality attends weekly governance triage of Datix meetings. Clinical Lead for Quality has been allocated 2 PSII to complete, 1 with WCH and 1 with BCCH with view to support review and learning outcomes and correlate with NAIF 2026 audit; WCH PSII has commenced and due to start BCCH with deadline of 2nd week in August 2026. WCH ward are keen for regular falls meetings. Clinical Lead for Quality to meet WCH Ward Manager and LCM re: WCH 4 moderate harm per 2,378 OBD, rate of 1.7 per 1000 OBD which is the highest across the Trust and 1 severe harm per 2,378, a rate of 0.4 severe harms per 1000 OBD's. WCH meeting to be booked for week commening 15/6. BCCH Ward Manager has been contacted as 1 moderate harm fall in May 2026 but no clinical impact of fall, x-rays NAD so potential fo this to be downgraded.
	NICE guidance - SCHT endorse the most recent NICE falls guidance (April 2025) that all inpatients are classed as high risk of falls due to their inpatient needs therefore, there is an expectation to improve implementation of a multifactoral falls assessments for all inpatients which, will require an MDT approach and update to our current assessment documentation.	Sep-25	Sep-26	In progress	**June Update:** SaTH have now completed their Bedside Mobility Assesment tool (BMAT) pilot on 2 wards (W26, W11) and at the end of June 2026 they will commence a whole Trust ward roll out. Our RIO team had already built this BMAT tool within RIO and have now updated it in response to SaTH feedback on changing the wording for level 1. Clinical Lead(s) for Quality will be seeking to complete the SaTH Train the Trainer course in June/July with reps to be identified from In-Patient Ward and UCR nursing and therapy teams to also complete this training and support SCHT pilot. Co-ordination with the Discharge improvement group discharge checklist will occur to ensure BMAT level is to be included in our handovers once roll out commenced. Clinical Lead for Quality have drafted an admission assessment documentation SOP for 6 hours, 24 hours and 72 hours that will be shared with Clinical Documentation group on 10/6. We have on-going meetings with the UCR Team Leads as we see that part of the falls pathway as an area to pilot a new approach to falls screening and assessment, we would aim to pilot this by September 2026.
	Anti-slip Hospital Socks - evidence for and against hospital anti-slip socks shared with Director of Nursing, Deputy Director of Nursing and Head of Quality on 10/12/2025 who are supportive of a QI project to cease use of hospital anti-slip socks across all inpatient wards.	Nov-25	Sep-26	In progress	**June Update:** Jayne Carter, Locality Clinical Manager is the Project Lead and the QI team are facilitating and supporting this project. WCH have already sought to reduce stock ordering and promotion of own shoes as early adopters. We have identified key stakeholders from Nursing and Therapy teams with Therapy representatives from WCH; Care Transfer Hub (CTH) and BNCH and Nursing reps from LCH identified. We await Therapy reps from BCCH and LCH and Nursing reps from WCH, BNCH and BCCH to be identified. Potential QI funding grant source identified from The RCN Foundation Quality Improvement Project was unsuccessful. Discussions with LCM's and Podiatry on-going over supply options of footwear. Regional falls network have shared some alternative footwear options, to be reviewed and funding sourced through charitable funds.
	New confusion datix category and alignment to NEWS2 scores- Within the Q2 PSC Falls Quarterly thematic review it was highlighted that 41% of falls (21 patients) had new confusion category selected within the datix submission. NEWS2 audit QI work has not identified such high levels of new confusion thus, the QI team are interested to correlate NEWS 2 charts to falls datix for specific patients regarding documentation of new confusion to deep dive this finding and share any learning.	Dec-25	Sep-26	In progress	**June update:** on-going reporting area for quarterly thematic review and for Q2 6/27 need to correlate ETOC data with confusion theme for further evidence of context and impact of ETOC project.

	Action	Start	End	Status	Update
	Falls Community service(s) and falls assessment scoping- To undertake a comprehensive review of community falls services across SCHT in order to design and implement a clear, consistent, and proactive falls pathway that aligns with current NICE guidance, improves prevention, assessment and post-fall management, and ensures coordinated care across all services.	Dec-25	Dec-26	In progress	**June update**: The community service process map produced on 5/12/2025 has been shared with Head of Quality. We have scoped data as it appears a large proportion of patients with falls access our Urgent Community Response (UCR) teams- Rapid Response and Virtual Ward. It is clear we do not have internally a clear falls pathway once someone is identified as at risk of falls or post-fall. In alignment set out in the latest NICE guidance for falls it is recommended that we consider a pro-active and preventation approach to falls that encompasses all services and we would recommend it is timely to commence a full service review to internally outline our falls pathway. This will require a Phased QI approach with stakeholder engagement and we have identified UCR as the first services to be reviewed with our support and we have continued engagement with them. Clinical Lead for Quality has mapped the current falls service offer across SCHT and shared with Strategy Development Manager for NHS Shropshire, Telford & Wrekin ICB however, this role has now been lost in the ICB and falls is sittinng within a wider portfoilo of Healthy Aging and Frailty. If no ICB driver of Falls review we may need to focus on internally or across our Group what is within our control or influence to improve.
	PSC new requested action around reporting of timelines of actions taken - i.e. post falls assessment	Feb-26	Sep-26	In progress	**June update:** Clinical Lead for Quality has completed two detailed feedbacks to MDT representatives of 2 SCHT wards (LCH and BCCH), AHP, Nursing and Medical teams as well as Quality and Governance teams, regarding 2 submissions to NAIF for the 2025 audit that have been submitted to date. Comprehensive written feedback has been provided on areas of good practice and opportunities for improvement covering: Multi-factorial Assessment to Assessment to optimise Safe Activity (MASA) – reviewing vision screen; lying and standing BP screen; medication review; delirium screening; mobility screen and continence screen; Post-fall management and Post-fall review. Good practice included: timely Pharmacy reviews; nursing care planning and neurological observations post-fall. There are improvement themes for both inpatient wards regarding: use of RIO documentation rather than paper copy of forms uploaded; lying and standing BP measurements which highlights the priority for e-obs digital solution; the need for the roll out of 4AT delirium screen which, we have piloted with falls task and finish group members and are now ready to launch and timeliness of medical reviews and provision of analgesia post-fall. 2026 audit submissions to now be quarterly rather than annual to provide more timely feedbck on post-fall assessments and areas for improvement. WCH and BCCH NAIF submissions to be completed on Ward with Ward Manager or Deputy Ward Manager by end of June 2026.
	National Audit of Inpatient Falls (NAIF) 2026	Jan-26	Mar-27	Complete and ongoing	**June Update:** To date so far there are 4 confirmed submissions for the 2026 audit: 2 for WCH ward; 1 for LCH ward and 1 for BCCH ward . Submissions will be completed by Clinical Lead for Quality alongside ward staff (TBC) for shared learning.
	Sharing of falls data- QI team to attend WM monthly face to face meeting to share monthly and thematic review	Jan-26	Mar-27	Complete and ongoing	**June update**: Clinical Lead for Quality is contacting Ward Managers, Deputy Ward Manager or Locality Clinical Manager directly about themes within monthly falls report or quarterly thematic review that are priorities for them to focus on.
	Falls education and training	Apr-26	Apr-27	In progress	**June update**: Clinical Lead for Quality has signposted falls task and finish group members to NHSE e-learning frailty training and linked in with SaTH group offer of falls training and established both aligned to ESR link to NHSE e-learning for health offer. Clinical Lead for Quality reviewed survey results and attended Education team away day on 10/4/26 to feedback. Actions are: Currently looking into the possibility of the Admiral nurse team setting up another Dementia Conference this year; There may be funding for 4AT/Delerium training from the CPD Budget; Bitesize sessions are being planned to include NEWS 2 training and lying and standing BP and aim to re-launch Make Every Contact Count; specific training programmes for HCA staff are being developed; AHP leads and staff are to be signposted to ear care workshops available during the year; Clinical skills .net and they have falls information within the MH section but there are no associated competencies available; Education team have a frailty suit available and are also ordering a second suit which is being funded by Bridgnorth LOF. Clinical Lead(s) for Quality are working with SaTH to undertake their Train the Trainer Bedside Mobility Assesment Tool (BMAT) training so we can align and commence our roll out of this assessment tool after June 2026.

	Ambulance callout data for falls by 1000 OBD's	Jun-26	Sep-26	In progress	**June update**: Datix from 1/6/2026 has a new question added "Was an ambulance called?" to give further context and data as to how many ambulances are called out versus ambulance conveyances which are currently captured through the question "Was patient taken to A&E?". Project Lead for I-STUMBLE project to be identified. I-STUMBLE app QI project to be launched which, will pilot the app to support clinical triage of falls by ward staff
	Medication related falls- Ganesh, Mahadeva, Medical Director in Patient Safety Committee (PSC) asked about medication related falls.	May-26	Sep-26	In progress	**June update**: Clinical Lead for Quality completed deep dive into Anti-Cholinergic Burden (ACB) score for those patients who fell and were re-admitted to SaTH within Q4 25/26 post-PSC for 8 patients and included ACB score in updated Table 1 and Table 2 for Q4 thematic review sharing. Forward planning we are looking to integrate the Pharmacy assessment V2 link into the new revised holistic assessment form so the medication section of this and the falls screening and falls assessment form is MDT and includes the specialist Pharmacy reviews for MDT colleagues to cross reference to.

Author	Hayley Grice - Clinical Lead for Quality	**Date**	08/06/2026	
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	16/06/2026	

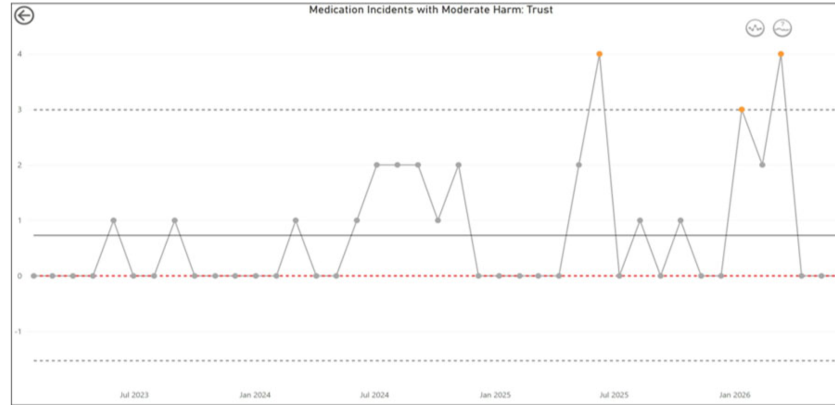
Exception Report - Action Plan

Medication Incidents with Moderate Harm

Number of internal medication incidents per month resulting in moderate harm

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Medication Incidents with Moderate Harm	Number	2	4	4	0	0	0	0
	Target	0	0	0	0	0	0	0

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Number	0	0	0	0	0	0	0



Narrative/Description:	All of these incidents are included in the Patient Safety Incident Response Framework (PSIRF) 6 monthly thematic review. There were 0 moderate psychological/physical harms reported in May 2026.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	MSO to liaise with education team regarding re-implementation of insulin documentation booklet	Sep-24	Jun-26	In progress	Meeting held with Diabetes Specialist Nursing team. Agreed to set up a Diabetes intranet page with links to all relevant resources and guidance that would have been in insulin booklet. JMW / SH 1/5/26 page currently under review. 10.03.26 - meeting taken place with JMW information requested from Datix to understand number of incidents relating to each community team, information then requested from informatics to understand capacity and demand figures vs number of incidents. . 29/4/26 Data now analysed and Insulin incidents less than 2% in relation to number of administrations by community teams. Insulin booklet still not accessable on staff zone escalated for action by am Townsend 20/5/26 at PSGM. New project now commenced with Sarah Gillsepie and michelle Bramble to complete Insulin servcie review
	Review and update of inpatient medicines administration chart	Apr-25	Jul-26	In Progress	SW leading on review of document, multiple changes being made and different professionals involved in review, therefore, deadline extended to July 2026 for approval at Patient Safety Committee
	Discuss mechanism for feeding back concerns re: delays to palliative and end of life patients care out of hours with Health Heros	Feb-26	Feb-26	Complete	DDON met with Health Heros Associate Director of Quality on 12.02.26
Author	Clare Walgrove - Head of Quality Pam Simmons - Interim Medicines Safety Officer	**Date**	02/06/2026		
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community	**Date**	16/06/2026		

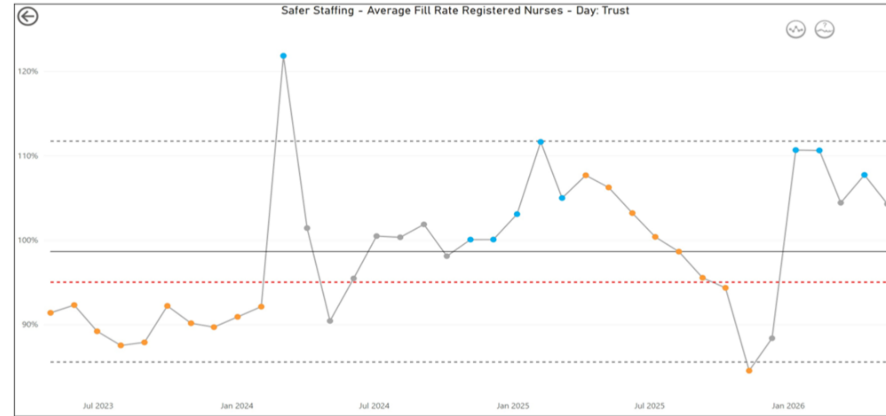
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Registered Nurses - Day: Trust

Safer Staffing - Average Fill Rate Registered Nurses - Day: Trust

KPI Description	Latest 6 months	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD
Safer Staffing	%	88.0%	111.0%	111.0%	104.0%	108.0%	104.0%	104.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description:

Bishops Castle - 116% - 16% due to supervisory shifts
Bridgnorth -111% - 11% due to overestablishment
Ludlow - 104% - 4% due to supernumery shift
Whitchurch - 93%

TES beds closed at Whitchurch on the 13.04.2026 and so staffing was reduced to met the requirement of 25 beds not 29.

Action Plan

Action	Start Date	End Date	Status	Outcome
Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Jun-25	Complete	
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Data submitted to the national team on progress being made
Further education with the ward managers around the health roster and adding additional shifts	Feb-25	Apr-25	Completed and ongoing	Check and Challenge monthly meeting continue to ensure complaince is maintain
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
For the 6 shifts at Whitchurch review whether there were any safer staffing red flags and triangulate with patient safety data	Sep-25	Sep-25	Completed	
Review RN to HCSW ratios for 26/27 as cost pressures	Dec-25	Mar-26	Completed	cost pressure in the 2026/2027 plan for 7.50WTE HCA ageed and recruitment to posts underway
Work with E-Roster team to review whether supervisory shifts can be removed from monthly safer staffing reports	Feb-26	Apr-26	Completed	Discussed with Roster team and we are unable to remove the supernumery shifts

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	06/05/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		20/05/2026

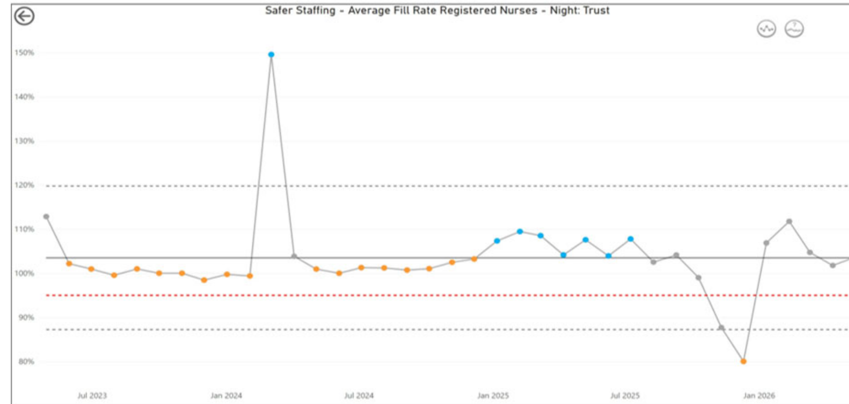
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Registered Nurses - Night: Trust

Safer Staffing - Average Fill Rate Registered Nurses - Night: Trust

KPI Description	Latest 6 months	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD
Safer Staffing	%	88.0%	107.0%	112.0%	105.0%	102.0%	104.0%	104.0%
	Target	95%%	95%%	95%%	95%%	95%%	95%%	95.0%

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description :	Bishops Castle - 102% 2% due to supernumery shift Bridgnorth - 102% 2% due to overestablishment Ludlow - 101% 1% supernumery shift Whitchurch - 101% 1% overestablished RN. When staff are on supervisory shifts they are not included in the establishment numbers but due to their shifts being recorded on E-Roster this pulls through on the monthly safer staffing reports.				
Action Plan		**Start Date**	**End Date**	**Status**	**Outcome**
	Bi-annual safer staffing review to review establishements against SNCT data sets and whether any changes are required	Jan-25	Jun-25	Complete	
	National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	
	Further education with the Ward Managers around the health roster and adding additional shifts	Feb-25	Apr-25	Completed and ongoing	Check and challenge meeting to address this action. weekly data now being received to monitor additional shift code so any discreptencies can be discussed with relevant teams
	ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
	Review RN to HCSW ratios for 26/27 as cost pressures	Dec-25	Mar-26	Completed	cost pressure in the 2026/2027 plan for 7.50WTE HCA ageed and recruitment to posts underway
	Work with E-Roster team to review whether supervisory shifts can be removed from monthly safer staffing reports	Feb-26	Jun-26	In Progress	Discussed with the rostering team

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	**Date**	16/06/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		17/06/2026

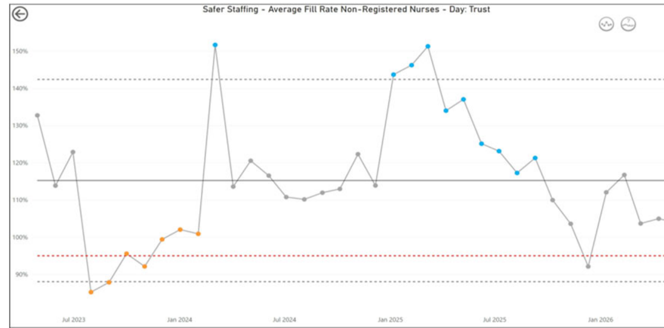
Exception Report - Action Plan

Safer Staffing - Average Fill Rate Non-Registered Nurses - Day: Trust

Safer Staffing - Average Fill Rate Non-Registered Nurses - Day: Trust

KPI Description	Latest 6 months	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD
Safer Staffing	%	104.0%	112.0%	117.0%	104.0%	105.0%	104.0%	104.0%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Narrative/Description :

Bishops Castle - 104% - 4% Due to supenumery shift
Bridgnorth - 104% 4% Due to overestablishment
Ludlow - 111% 11% for Cohorting and 1to 1 nursing
Whitchurch - 114% 14% due to over establishment of HCA due to RRU closure

Action Plan

Action	Start Date	End Date	Status	Outcome
Daily review of patients requiring enhanced supervision at the Red/Amber staffing meeting to ensure parity across all inpatient areas with agreed maximum levels.	Jan-25	Feb-25	Complete	SOP in place
Review of Enhanced Supervison policy and behaviour charts to allow for more timely step down	Mar-25	~~01/09/2025~~ 30/11/2025	Complete	
National ETOC programme application for cohort two and to collect baseline data for submission	Mar-25	Apr-25	Complete	Submitted 2nd set of data to the national team to update on progress
Quality Improvement Project following peer review	Apr-25	Jul-25	Complete and ongoing	Regular meetings held to discuss improvement plans
ICB Peer review of staffing fill rates	Apr-25	Jun-25	Complete	
Review of Memory and Health and Wellbeing worker role to be completed	Apr-25	~~01/08/2025~~ ~~30.10.2025~~ 30.12.2025	Complete	
Review of shift patterns for inpatient areas	Apr-25	Jul-25	Complete	
Paper to JNP regarding changing shift patterns from 3 per day to 2 per day	Aug-25	~~30.01.2026~~ 31.03.2026	Complete	Paper now closed at JNP and it is anticipatied that the change to rotas will be Sept 26
Use of NHSP as national bank to increase number of HCSW available to reduce reliance on agency	Jan-26	Mar-26	Complete	NHSP have started to provide staff to the Trust

Author	Tracie Black, Associate Director of Workforce Education and Professional Standards	Date	17/06/2026
Accountable Officer Approval	Sara Ellis-Anderson, Interim Director of Nursing Community		17/06/2026

Exception Report - Action Plan

Sickness Rate

Percentage of staff absent over a rolling 12-month period

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Sickness Rate	%	5.68%	5.65%	5.68%	5.73%	5.69%	5.68%	5.68%
	Target	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
%	5.30%	5.20%	5.10%	5.10%	5.00%	5.00%	5.00%

Reason for performance gap:

Since March 2025 the rate continues to remain above target. We have seen very slight increases month on month, however, since March 2026 we have continued to see slight decreases each month. The main drivers continue to be stress, anxiety and depression conditions. We continue to see a reduction in long term absence and an increase in short term absence. In terms of long term absence cases we have seen a slight decrease and they continue to remain the lowest number of cases we have seen for a number of months. Support around health and wellbeing, resilience and flexibility are critical to support reduction in absence levels and are being implemented by the People Team. The People Team are continuing to promote the importance of the wellbeing with a monthly health & wellbeing newsletter. At present there continues to be no assurance that short term absence (which has increased) is being managed in line with the Managing Attendance Policy. The People Team continue to send out trigger reports for short term absence to managers with guidance on the triggers and next steps. This is a key action area for our teams to monitor compliance and provide support to managers in maintaining compliance with our policy. A Health and Wellbeing Audit has been completed by our internal auditors on health and wellbeing provision, the audit found substantial assurance with several recommendations which are currently being actioned. An absence audit on absences within Bridgnorth Inpatients and SE Community Nursing have identified the need for actions around absence management and completion of relevant paperwork; these actions are currently being developed for roll out.

Action	Start Date	End Date	Status	Outcome
Conduct an absence masterclass for Bridgnorth Hospital and the South East Community Nursing team, incorporating an audit of absence management practices in accordance with Trust policy. Review the audit results and deliver tailored sessions based on the identified findings. If successful evaluate rolling out to all areas of the Trust. (Audit was completed on 20 May 2026 the results are currently being analysed and themed to inform next steps)	Apr-26	Jun-26	On track	To confirm adherence to Trust policy and deliver tailored support to Team Leaders and Clinical Services Managers
Adult Services - Check and challenge commencing in June with Operational Lead and LCM's supported by HR. Discussion arranged with Operational Leaders in Adults, Associate Director of Professional Standards, Education and Workforce and the People Services team to discuss and agree a governance framework around discussion on people metrics with Line Managers ensuring they add value.	Jun-26	Aug-26	On track	Implement a governance framework that ensures there is oversight of people metrics including absence
Adult Service - Data Analyst to analyse absence data for any trends, hot spots etc **for adult services**	Jun-26	Aug-26	On track	To provide an any intelligence on hot spot areas that require particular focus for absence management and HWB support
Operational leads to receive the annual leave report on a monthly basis to review and ensure annual leave recorded and being taken	Mar-26	Jun-27	On track	To ensure all staff take time away from work to rest and recuperate
Explore digital solutions to support Line Managers in timely management of attendance in line with the Managing Attending policy. This inlcudes a review of eroster to establish absence management capabilities and other digital solutions and also ecplore Goodshape a digital solution that helps manage absence and provides measurable outcomes	May-26	Jul-26	On track	To provide Line Managers with tools to support the timely management of absence
Planned care - Stress anxiety depression 49% for May, Operational Lead to undertake a deep dive into absence focussing on stress and MSK absences due to the increase, Data Analyst to support by providing relevant data	Jun-26	Jul-26	On track	To identify any targetted support for teams

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	312	398	11,771.08	35.3
S12 Other musculoskeletal problems	130	149	3,303.85	9.9
S13 Cold, Cough, Flu - Influenza	634	797	2,778.62	8.3
S25 Gastrointestinal problems	460	602	2,669.09	8.0
S98 Other known causes - not elsewhere classified	172	196	2,621.65	7.9
S11 Back Problems	81	95	1,547.56	4.6
S26 Genitourinary & gynaecological disorders	105	130	1,452.30	4.4

Org L6	Absence FTE	Available FTE	Absence FTE %
825 Dudley CYP&F Management Services	123.00	547.40	22.47%
825 Workforce Systems Service	160.00	851.00	18.80%
825 PCN Pharmacy Service	94.29	565.12	16.69%

Action Plan	A deep dive into MSK absences has highlighted that the main causes for MSK absences relate to neck, shoulder and back pain. Work with the MSK Physio team to develop appropriate videos around prevention with the MSK team initially focussing on these common absence reasons. Launch the Myrecovery app which covers advice, exercise etc for staff experiencing MSK issues instead of developing videos this will be rolled out in the next 3 months. The comms plan will include general communications, targeted comms for staff experiencing MSK issues and those staff absent due to MSK issues, Occupational Health will also raise awareness in appointments and when referring to fast track physio	Feb-25	Jul-26	On Track	To prevent absences around MSK
	Implement the opportunities for improvement identified in the long term absence review of absence cases that was shared with the Executive Team	Nov-25	Mar-26	Complete	Ensure opportunities for improvement are implemented to support the management of long term absence
	UEC - 6.22 % rolling absence, in month 6.02% in month - provide data to Operational Lead to ensure they have oversight of the absences and absence triggers information. Operational Lead to remnind CSM's to ensure relevant paperwork is completed	Jun-26	Jul-26	On track	To ensure appropriate support and management is in place for absence management
	CYP Shropshire & Dudley (both teams are below target for in month absence Dudley 3.83% and Shropshire 3.74%) Continue to oversee management of short term absence to gain assurance this is being managed appropriately and in line with the Managing Attendance Policy.	Jan-26	Jun-26	On track	Increase the uptake of flu vaccinations to protect staff and ensure absence is managed appropriately ensuring staff have the appropriate support in place
	Dudley 0-19 & Stoke Heath Prison - Work with the OD team to provide input into culture which will include reviewing the relevant staff survey results for both teams . Met with OD from SaTH and starting at lock down day - John going in	Mar-26	Dec-26	On track	Create a positive working environment as a supportive and positive workplace can reduce stress and improve job satisfaction, lowering the risk of sickness absence.
	HWB Workshop to understand the offers and what is in place across the Group, working together to develop a collective plan of what can be done as Group (HWB workshop took place on 12 June 2026 actions now being developed)	May-26	Jun-26	On track	Develop a HWB plan that covers the Group model that is fit for purpose
	Implement shared gratitude initiative, encouraging line managers and patients to actively recognise and praise staff contributions, thereby creating a more positive working environment and supporting improved health and wellbeing.	Feb-26	Jul-26	On track	Create a positive working environment as a supportive and positive workplace can reduce stress and improve job satisfaction, lowering the risk of sickness absence.
	Review the health and wellbeing responses, including any free-text comments, from the National Staff Survey. Update the local HWB survey accordingly and distribute it to gain further insights into the national staff survey responses, as well as to inform the HWB action plan for 2026-27.	Feb-26	Jul-26	On track	Tailor interventions to meet the actual needs of teams, ultimately fostering a healthier, more supportive workplace environment where everyone can thrive.
	Undertake a regular flexible campaign to raise awareness of flexible working and the benefits of flexible working	Nov-25	Dec-26	On track	Flexibility can help employees balance work and personal commitments, reducing stress and the likelihood of sickness absence.
	Conduct a health and wellbeing survey to gain a clear understanding of employees' perspectives on health and wellbeing (HWB) initiatives. This survey aims to identify the types of HWB initiatives employees would like to see introduced, assess employees' awareness of the HWB initiatives that are currently available within the Trust, and gather information on which initiatives employees have accessed to date. The findings will help evaluate engagement and utilisation of existing HWB resources and support the development of the 2026-27 HWB action plan	Mar-26	Jun-26	On track	Tailor interventions to meet the actual needs of teams, ultimately fostering a healthier, more supportive workplace environment where everyone can thrive.
	Undertake a deep dive of all absences to establish any themes looking at age profiles, gender, job role etc, once completed work with hot spot teams to ensure provide support	Jan-26	Apr-26	Completed	To understand if there are any underlying themes etc for absences
	Deliver the actions identified in the deep dive of all absences and provide relevant support	Apr-26	Jun-26	On track	Ensure absence is managed appropriately and in line with the Managing Attendance Policy
	Develop and implement a robust flu plan for the 2026-27 flu campaign using the data gathered from the flu survey	Apr-26	Mar-27	On track	To ensure appropriate support is in place.
Author	Fiona MacPherson	**Date**	29.06.2026		
Accountable Officer Approval	Rhia Boyode	**Date**	29.06.2026		

825 Whitchurch Hospital Inpatients Service	2,139.37	14,014.05	15.27%
825 Children's Continence Service	77.70	538.80	14.42%
825 Outpatients Admin Service	313.00	2,289.67	13.67%
825 Enhanced Care Home Service	480.22	3,817.46	12.58%
825 Safeguarding Service	448.20	3,969.93	11.29%
825 Shropshire PHNS Admin Service	335.20	2,988.97	11.21%
825 Single Point of Referral Service	273.73	2,500.40	10.95%

Org L7	Absence FTE	Available FTE	Absence FTE %
825 Compass Health Team	136.20	393.40	34.62%
825 Bridgnorth Hospital Porters Team	88.20	255.50	34.52%
825 CYPF Operational Management Team	123.00	547.40	22.47%
825 Audiology Childrens Admin Team	86.40	401.50	21.52%
825 Workforce Systems Team	160.00	851.00	18.80%
825 Child Development Centre Admin Team	156.61	842.19	18.60%
825 Virtual Wards - Telford Team	676.58	3,714.06	18.22%
825 Enhanced Care Home Team - Shropshire	349.28	1,962.43	17.80%
825 Market Drayton Physiotherapy Clinical Team	135.41	764.35	17.72%
825 PCN Pharmacy Team	94.29	565.12	16.69%

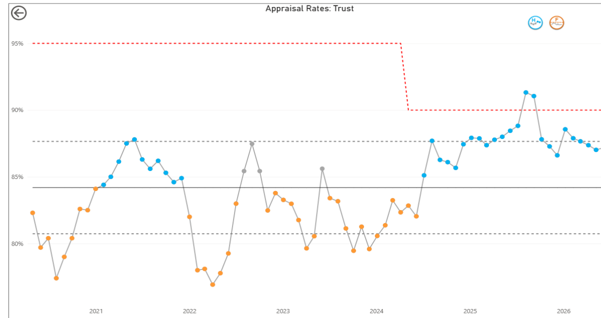
Exception Report - Action Plan

Appraisal Rates

Compliance of substantive staff having had an appraisal in the last 12 months

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Appraisals	%	88.56%	87.89%	87.66%	87.37%	87.02%	87.19%	87.02%
	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
%	89.30%	90.00%	90.00%	90.00%	90.00%	91.00%	91.00%



Reason for performance gap:	In December we saw the highest compliance rate since August 2025, however since then the compliance rate has continued to slightly decreaase month on month until a light increase in May 2025. We continue to send detailed appraisal reports to Managers to ensure they have sight of those appraisals out of date on ESR. The focus is on setting a plan for the services with the lowest completion rates and to set dates for completion by the end of June at the latest except in exceptional circumstances. We are also focussing on ensuring those individuals coming up to the anniversary of their appraisal are appraised within the 12 months so they remain compliant. A process for monitoring progress is in place, with target support for managers and alerts and reminders to ensure completion. Work continues to ensure that all appraisals are inputted correctly on the system to ensure they are included in the overall %.			

Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Adults Community Services Division; South East still a hotspot with 8 outstanding and Diabetes team have 2 outstanding. However overall appriasal compliance has increased to 87.95%. 7 appraisals have been logged incorrectly. All appraisals logged incorrectly to be sent to LCM's. Operational Lead to discuss appraisal complaince in the check and challenge meeting that commences in June (177 appraisals are due in the next 3 months)	Jun-26	Jul-26	On track	To ensure that all appraisals that are non-compliant are undertaken
	ESR to develop a video of how to add appriasals to ESR, this will be communicated via comms and also on the Staff Zone for individuals to review	Jun-26	Sep-26	On track	To ensure that appraisals are logged accurately
	Urgent care Compliance rate has decreased to 74.65% from 81.86% in March, 45 non compliant. Hotspots remain as MIU, Virtual Ward, UCR. 25 due to expire in May. Operations lead to get an update from Team Leads and update shared tracker for oversight.	Jan-26	Jun-26	On track	To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place
	Review of 30 60 90 day compliance and raise awareness of the conversation tools available	Apr-26	Jun-26	On track	To ensure individuals are receiving the relevant support when they commence with the organisation
	Planned Care; 11 non compliant at Stoke Heath, 2 have been completed at Stoke Heath Operational Lead will ensure logged and plan to complete the remianing outstanding appraisals by beginning of August	Jun-26	Aug-26	On track	Ensure appraisals are completed and planned in
	Urgent & Emergency care - 75.70% increasing, second month of tracker being in place and seen an increase with plan to be 90% by no later than end of September	Jun-26	Sep-26	On track	Ensure appraisals are completed and planned in
	Shropshre CYP & Dudley - 7 peoplein Dudley non compliant 95.99%, compliance in Shropshire is 91.40%. No hot spots in Childrens. Admin Service PHNS there are 2 oustanding Divisional Lead pick up with new Line Manager. Dental 10 non compliant - Divisional Lead speak to Clinical Dircetor for Dental Services to ensure they are planned in	Jun-26	Aug-26	On track	Ensure appraisals are completed and planned in

Author	Fiona MacPherson	**Date**	29.06.2026
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Division	Team (hotspot areaas are teams with 10 or more staff members with compliance of less than 81%)	Appraisals Required	Appraisals In-Date	% Compliance
825 Service Delivery Group - Adult Community Services Division	825 South East Shropshire Community Nursing Service	27	19	70.37
825 Service Delivery Group - Adult Community Services Division	825 Specialist Nursing Diabetes Adults Service	10	8	80.00
825 Service Delivery Group - Planned Care Division	825 Dentistry Service	49	39	79.59
825 Service Delivery Group - Planned Care Division	825 Stoke Heath YOI Service	21	10	47.62
825 Service Delivery Group - Urgent Care Division	825 DAART Service	14	8	57.14
825 Service Delivery Group - Urgent Care Division	825 MIU Service	26	15	57.69
825 Service Delivery Group - Urgent Care Division	825 Urgent Community Response Service	44	31	70.45
825 Service Delivery Group - Urgent Care Division	825 Virtual Wards Service	54	41	75.93

SDGs and Divisions	Assignment Count	Reviews Completed	Reviews Completed %	
825 Digital Division	44	42	95.45	↑
825 Finance, Strategy and Estates Division	32	30	93.75	↓
825 Governance Division	19	16	84.21	↓
825 Infection Prevention and Control Division	4	4	100.00	⇔
825 Medical Division	4	3	75.00	⇔
825 Medicines Management Division	16	14	87.50	↓
825 Nursing and Quality Division	13	10	76.92	↓
825 Nursing and Workforce Management Division	4	4	100.00	↑
825 Operations Directorate Management Division	12	11	91.67	↓
825 People and OD Division	26	23	88.46	↓
825 Safeguarding Division	12	12	100.00	⇔
825 Service Delivery Group - Adult Community Services Division	606	533	87.95	↑
825 Service Delivery Group - CYP&F Dudley Services Division	136	130	95.59	↓
825 Service Delivery Group - CYP&F Shropshire Services Division	349	319	91.40	↓
825 Service Delivery Group - Planned Care Division	209	168	80.38	↓
825 Service Delivery Group - Urgent Care Division	214	162	75.70	↑
825 Trust Board Division	9	9	100.00	⇔

Previous month	Assignment Count	Reviews Completed	Reviews Completed %
825 Digital Division	44	41	93.18
825 Finance, Strategy and Estates Division	31	30	96.77
825 Governance Division	20	18	90.00
825 Infection Prevention and Control Division	4	4	100.00
825 Medical Division	4	3	75.00
825 Medicines Management Division	15	13	86.67
825 Nursing and Quality Division	11	11	100.00
825 Nursing and Workforce Management Division	4	3	75.00
825 Operations Directorate Management Division	11	11	100.00
825 People and OD Division	26	24	92.31
825 Safeguarding Division	12	12	100.00
825 Service Delivery Group - Adult Community Services Division	611	529	86.58
825 Service Delivery Group - CYP&F Dudley Services Division	138	131	94.93
825 Service Delivery Group - CYP&F Shropshire Services Division	348	320	91.95
825 Service Delivery Group - Planned Care Division	209	170	81.34
825 Service Delivery Group - Urgent Care Division	213	159	74.65
825 Trust Board Division	9	9	100.00

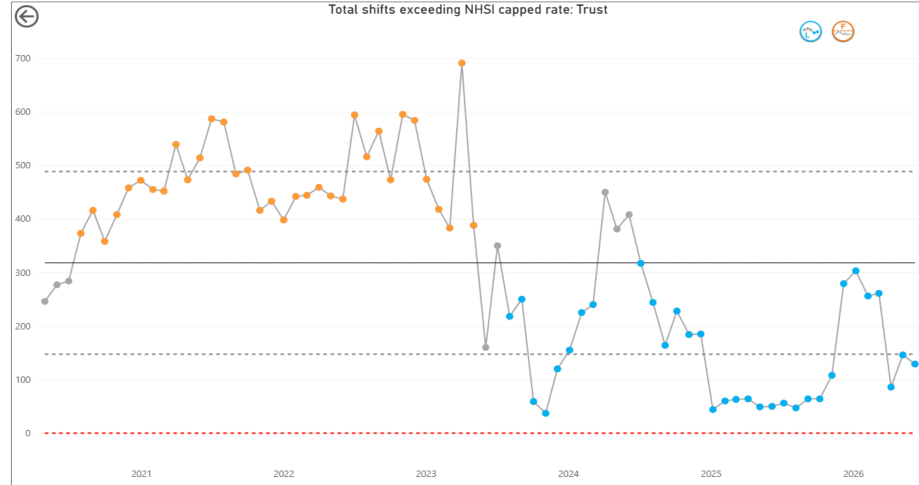
Exception Report - Action Plan

Total shifts exceeding NHSI capped rate

The number of shifts filled by on framework agencies that exceeded the price cap (cap is per shift)

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Shifts	Number	303	256	261	114	146	129	138
	Target	0	0	0	0	0	0	0

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	129	125	125	125	120	120	120



		Start Date	End Date	Status	Outcome
Reason for performance gap:	We are compliant with the West Midlands Region Price Rate card (this is slightly higher than the current NHSE rate). We are currently supplying agency Medical staff to: Virtual Ward, Integrated Front Door, Paeds. Recruitment to the consultant role in UEC has been unsuccessful and review of the medical staffing provision is being undertaken, this may impact on the planned medical roles within UEC.				
Action Plan	Grow our bank and implement the use of centralised bank to support reduction in agency usage. Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-26	Mar-27	On Track	**07/04/2025** Recruitment Lead is arranging a meeting to discuss a rolling bank advert with Operational Lead for adults division. **20/5/26:** Rolling bank advert live on Trac 19/5/26. **09/06** Advert to be reviewed by KT to complete shortlisting. **15/6/26:** There has been a high volume of applicants, shortlisting is in progress but has been delayed due to lack of ops capacity, the lead was recently changed to try and resolve this.
	Expansion of UEC: medical staffing reviewed requirement for Consultant, Speciality Dr and GP.	Oct-25	01/0102026	On Track	**13/04/26** Consultant interviewees withdrew and Med Dir and Ops manager, with SaTH Med Dir to undertake an options appraisal and reviewing next steps. Chased RC as no outcome for the approval of the Specialty Dr jd. **20/5/26** A review of how medical staffing is provided by the service is taking place. Revised date set **09/06/26** pending confirmation on medical model from the group. **15/6/26:** UCR/VW/IFD are reviewing the medical provision in this service with the Medical Directors and ops leads in the Group Model. Medical Agency have been approved until the end of October. Revised date set
	A review to be undertaken of the medical staffing agency in use	Apr-26	Jul-26	On Track	**7/4/26:** Agree plans with relevant ops leads to reduce/remove the agency medical staffing in their areas **20/5/26:** meeting set for 2/6/26 **15/6/26:** Meeting rearranged for 16/6/26 at the request of ops manager.

Author	Gina Billington	**Date**	29.06.2026
Accountable Officer Approval	Rhia Boyode	**Date**	29.06.2026

Local Action Plans

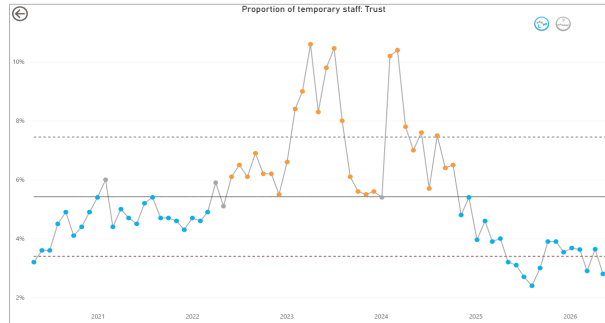
Exception Report - Action Plan

Proportion of temporary staff

Cost of agency and locum as a proportion of total staffing costs for the month expressed as a percentage

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Prop Temporary staff	%	3.7%	3.6%	2.9%	3.6%	2.8%	2.9%	2.8%
	Target	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%



Reason for performance gap: UEC medical staffing recruitment : Recruitment to the consultant role in UEC has been unsuccessful and a review of how medical staffing is provided by the service is in progress. Community Paediatrics have a Locum consultant covering LTS and waiting lists work. To support the costs reduction of our temporary workforce we will be focusing on both volume reductions and price of agency. Price Cap for agency: we are compliant wih the the West Midlands Region Price Rate card for medical and dental staff . Stoke Heath use of agency by booking agency directly and not using TST

Action Plan

Action	Start Date	End Date	Status	Outcome
UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops. JD has been reviewed - may need Royal College approval. Revised target set.	Apr-25	Oct-26	On Track	**13/04/26** Consultant interviewees withdrew and Med Dir and Ops manager, with SaTH Med Dir to undertake an options appraisal and reviewing next steps. Chased RC as no outcome for the approval of the Specialty Dr jd. **20/5/26** A review of how medical staffing is provided by the service is taking place. **09/06/26** pending confirmation on medical model from the group. **15/6/26**: UCR/VW/IFD are reviewing the medical provision in this service with the Medical Directors and ops leads in the Group Model. Medical Agency have been approved until the end of October. REvised target set
Maximise the availability of our workforce through monitoring and improving roster practices. Comms sent to roster approvers regarding use of roster to send unavailable shifts to bank/agency 11/3/25. Programme of continuous improvement workshops in place for roster approvers. Check and Challenge meetings in place with teams to review KPIs and roster efficiencies.	Apr-26	Mar-27	On Track	Improve assignments where the duty's grade type doesn't match the person's qualification / grade. **14-04-2026** 120 teams now live Roster approval lead time: Full Approval = 51- increase by 4 days Partial Approval = 57 Days - increase by 5 days Contract hours unused 2.62% reduction of 0.60% Additional duties 3.61% increase of 1.13% **20/5/26** Currently 127 teams are live on e-roster with a further 12 teams now scheduled up to 30/07/26. Roster approval lead time - Full approval = 45 days, Partial approval 40 days. % contract hours unused 3.2 % hours additional duties 4.2%. **15/6/26** Roster Approvals - Full Approval - 50 days - 7.1 weeks Partial Approval - 56 days - 8 weeks % contracted hours used - 1.33% Additional duties 3.55%
Grow our bank and implement the use of centralised bank to support reduction in agency usage and relieve pressure on teams where covering sickness absence . Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-26	Mar-27	On Track	**07/04/2025** Recruitment Lead is arranging a meeting to discuss a rolling bank advert with Operational Lead for adults division. **20/5/26:** Rolling bank advert live on Trac 19/5/26. **09/06** Advert to be reviewed by KT to complete shortlisting. **15/6/26:** There has been a high volume of applicants, shortlisting is in progress but has been delayed due to lack of ops capacity, the lead was recently changed to try and resolve this.
Roll out e-roster to all clinical staff and non-clinical bank workers. New revised end date.	Sep-25	Jun-26	On-track	Improved staff productivity and reduction of agency usage. Increased goverance and reporting of bank and agency bookings across the Trust. **13/1/26** Implementation plan in place: 103 teams on e-roster with 19 teams planned for implementation until March 2026 - 1 teams planned for April 2026 implementation with further scoping and planning to utilise licences in progress for Q1and Q2 2026/27. **16/3/26** 112 Teams live with a further 10 planned for go live 01-04-2026 with 3 Teams now planned for April **20/5/26:** Implementation plan in place: 23 teams scoped for implementation over the next 2 quarters with further scoping and planning to utilise licences in progress for Q3 and Q4 2026/27. Live Units (11th May roster Period)92(127 Teams on ESR) Planned May 2026 Onwards9(23 Teams on ESR) **15/6/26**: currently 132 teams on roster
Deep dive into the reasons for booking temporary staffing	Oct-25	May-26	On Track	To ensure managers use the correct reason for booking temporary staffing using the roster system to improve the reporting of booking reasons that in turn will enable the resourcing team and ops senior managers to identify any trends with staffing productivity. Meeting arranged 1/4/26 Revised date set **30/4/26:** Meeting with Associate Director for Workforce, Education & Professional Standards to agree reasons for booking. **20/5/26** Meeeting held, resasons being updated and forms amended. **15/6/26:** reviewed forms in draft awaiting ops approval.
Develop manager training and guidance on the use of booking reasons for bank and agency.	Apr-26	Jun-26	On Track	Managers use the correct booking reasons on the system and improves the reporting data **20/5/26:** awaiting updated forms to finalise before launching.
Review of the bank and agency approval request form, booking and cancellation reasons	Apr-26	Jun-26	On Track	Update the form to include reasons from the e-roster system and lock the relevant field in the form so only the correct reason can be selected. Reduce the number of reasons for booking/cancelling and streamline the request and approval process. **20/5/26:** Review of booking reasons with Ops taken place and forms being updated.
Planned Care - Stoke Heath implemenation on E-roster SOP for E-roster use and agency booking to be created and implemented by Ops Lead.	Jun-26	Aug-26	On Track	**09/06** E-roster use and agency booking to follow the Trust process

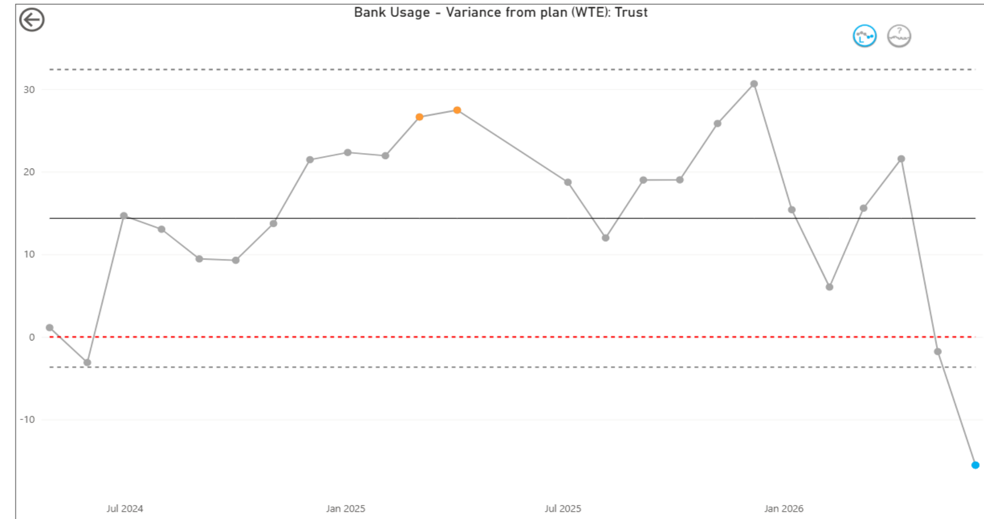
Author	Gina Billington	**Date**	29.06.2026
Accountable Officer Approval	Rhia Boyode	**Date**	29.06.2026

Exception Report - Action Plan

Bank Usage - Variance from plan (WTE)

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Bank Usage - Variance from plan (WTE)	Number	15.40	6.04	15.59	21.57	-1.77	-15.52	-8.65
	Target	62.40	62.40	62.40	55.70	82.04	82.04	82.04

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
	82.04	82.04	82.04	82.04	82.04	82.04	82.04



Reason for performance gap:	This is a new KPI to monitor our bank usage against plan. In month 1 the target bank use was 82.04 WTE with actual use 80.07 WTE - below target.				
Action Plan	**Action**	**Start Date**	**End Date**	**Status**	**Outcome**
	Bank use Hotspots: temporary staffing team to review bank hotspots monthly	May-26	Mar-27	On track	Reasons for use identified in areas of high use and work with ops areas to support actions required to reduce bank reliance
	All remaining bank workers to be on e-roster	May-26	Jul-26	Closed	Visibility of shifts across the Trust and supports monitoring and reporting. Supports opportunity for collaborative bank arrangements.
	Implement centralised bank within SCHT and explore opportunities for collaborative group bank	May-26	Mar-27	On track	Share resources for bank across the group to reduce/eliminate agency reliance. **15/6/26:** meeting with SaTH TST team to review resources scheduled for 24/6/26
	CYP&F - SALT bank used to cover pending backfill for maternity and growth funding.	May-26	Sep-26	On track	Prioritise SALT vacancies in recruitment when advertised.
	Adult Services - Community Nursing to use bank for the next 4 months to cover for new vaccancies (growth money). Community Hospitals increase for 1:1, HCA requirement. Increase in South East Therapies to cover sickness absences.	May-26	Sep-26	On track	Prioritise Community Nursing vacancies in recruitment.
	UEC - UEC, MIU and VW bank usage to be reviewed in June, growth funding for ACP to cover recuitment period.	May-26	Sep-26	On track	Prioritise ACP vacancy in recruitment.
	Planned Care - community therapy outpatients bank usage to cover shared budget, sustained bank usage	Jun-26	Apr-27	On track	Business case to be approved for budget across outpatients

Author	Gina Billington	**Date**	29.06.2026
Accountable Officer Approval	Rhia Boyode	**Date**	29.06.2026

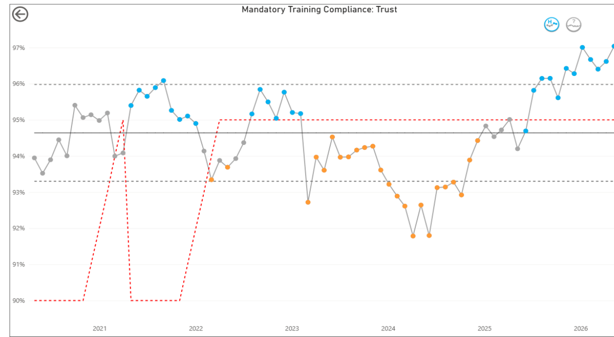
Exception Report - Action Plan

Mandatory Training Compliance

Compliance of staff with Mandatory Training subjects that are mandatory to their role, substantive staff only

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Mandatory Training	%	97.01%	96.67%	96.40%	96.62%	97.04%	96.61%	96.61%
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
%	97.10%	97.10%	97.60%	97.60%	98.10%	98.10%	98.60%



TOPIC	April		May	Variance
Conflict Resolution (England)	98.6%	▼	98.1%	-0.55%
Corporate Induction|	98.5%	▼	98.0%	-0.49%
Equality, Diversity and Human Rights	99.3%	▼	98.9%	-0.39%
Fire Safety - 2 Years|	99.7%	▼	99.6%	-0.17%
Fire Safety - High Risk	91.7%	▲	93.2%	1.44%
Fraud Awareness	98.1%	▼	97.8%	-0.32%
Health, Safety and Welfare	99.1%	▼	98.8%	-0.28%
Infection Prevention and Control - Level 1	99.0%	▼	98.6%	-0.43%
Infection Prevention and Control - Level 2	96.4%	▲	96.8%	0.35%
Information Governance and Data Security	98.0%	▼	97.3%	-0.65%
Moving and Handling - Level 1	98.2%	▼	97.8%	-0.44%
Moving and Handling - Level 2	88.8%	▼	84.2%	-4.62%
Oliver McGowan Mandatory Elearning	89.4%	▲	90.3%	0.95%
Patient Safety - Level 1	99.8%	=	99.8%	0.00%
Patient Safety - Level 2	99.5%	=	99.5%	0.00%
Preventing Radicalisation - Prevent Awareness	98.2%	▼	97.9%	-0.32%
Resuscitation - Level 2 - Adult Basic Life Support	93.9%	▼	93.7%	-0.19%
Resuscitation - Level 2 - Paediatric Basic Life Support	93.9%	▼	93.5%	-0.37%
Resuscitation - Level 3 - Adult Immediate Life Support	88.4%	▼	85.5%	-2.86%
Resuscitation - Level 3 - Paediatric Immediate Life Support	87.9%	▼	85.4%	-2.56%
Safeguarding Adults - Level 1	98.4%	▼	97.8%	-0.60%
Safeguarding Adults - Level 2	98.8%	▼	98.1%	-0.66%
Safeguarding Adults - Level 3	95.4%	▼	94.8%	-0.66%
Safeguarding Children - Level 1	96.8%	▼	96.2%	-0.60%
Safeguarding Children - Level 2	94.5%	▼	93.3%	-1.16%
Safeguarding Children - Level 3	95.3%	▼	94.7%	-0.58%
Safeguarding Children - Level 4	85.7%	=	85.7%	0.00%

Reason for performance gap:

Corporate Updates – Corporate Updates – In May, compliance rates experienced decrease of nearly 0.5%, dropping to 96.61%. Overall we still performing well and still above the 95% target. Over the course of the month, compliance dropped against most topics (21 topics), with reductions ranging from 0.17% (Fire Safety) to -4.62% for Moving and Handling - Level 2.
On the otherside, compliance only improved in 3 topics, increases range from 0.35% (Infection Prevention and Control - Level 2) up to 1.44% (Fire Safety - High Risk).

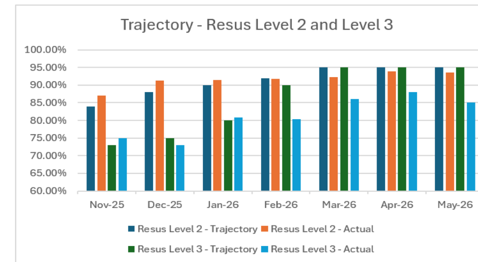
It is important to note that High Risk Fire saw an increase in compliance in May, following training place in various locations throughout the county. We are still below the target 95%, this is still being raised with managers. There are concerns over community staff who are located in community hospitals requiring this training. However, as there is no lead for Fire this cannot be changed currently.

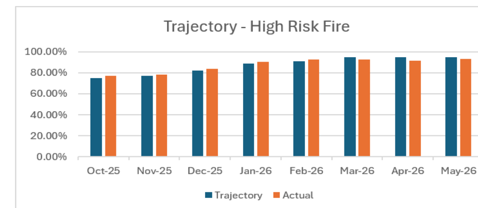
DNA
Resus Level 2 – 11
Resus Level 3 – 7
Moving and Handling Level 2 – 2. Spaces not used 3. There were 2 session cancelled due to the Trainer being Unavailable.

Action Plan

Action	Start Date	End Date	Status	Outcome
Hotspot - Compliance Overview - Ops Teams to focus efforts on improving compliance rates for **Resuscitation Training Level 2**. The ESR Learning Management Team have identified gaps in these topics and provided managers with a detailed breakdown of non-compliance to support targeted interventions. These emails encourage managers to prioritise and allocate time for their staff to complete mandatory training	Mar-25	Jul-26	On Track	Resus Level 2 Adult - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%). Jan 2026 Target 90%. Actual 91% (+1%). Feb 2026 Target 92%. Actual 92% (=0%). Mar 2026 Target 95%. Actual 92% (-3%). Resus Level 2 Paediatric - Nov 2025 - Target 84%. Actual 87% (+3%). Dec 2025 - Target 88%. Actual 91% (+3%). Jan 2026 – Target 90%. Actual 91% (+1%). Feb 2026 – Target 92%. Actual 92% (=0%). Mar 2026 Target 95%. Actual 92% (-3%). During April there was 11 DNA's for Resus Level 2. We cannot monitor the attendance for the Resus Level 2, as there is not the need to book their place through ESR and can turn up to the training. However where staff are booked through ESR, if they don't attend, we have followed the DNA as per any other topic.
Hotspot - Compliance Overview - Ops Teams to focus efforts on improving compliance rates for **Resuscitation Training Level 3**. The ESR Learning Management Team have identified gaps in these topics and provided managers with a detailed breakdown of non-compliance to support targeted interventions. These emails encourage managers to prioritise and allocate time for their staff to complete mandatory training	Apr-25	Jul-26	On Track	Resus Level 3 Adult - Nov 2025 - Target 73%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%). Jan 2026 – Target 80%. Actual 80% (=%). Feb 2026 – Target 90%. Actual 80% (-10%). Mar 2026 – Target 95%. Actual 86% (-9%). Resus Level 3 Paediatric - Nov 2025 - Target 84%. Actual 75% (+2%). Dec 2025 - 75%. Actual 73% (-2%). Jan 2026 – Target 80%. Actual 80% (=%). - Feb 2026 – Target 90%. Actual 80% (-10%). Mar 2026 – Target 95%. Actual 86% (-9%). During April there was 7 DNA's for Resus Level 3. We cannot monitor the attendance for the Resus Level 3 training, as there is not the need to book their place through ESR and can turn up to the training. However where staff are booked through ESR, if they don't attend, we have followed the DNA as per any other topic. We are actively encouring staff and managers to book their place in ESR, due to the course being 4hrs in duration Resus Level 3, managers have been emailed where they have staff who are non-compliant or due to expire within the next 3 months. More planning needs to be done with regard to those who are due to expire.
Hotspot - Compliance Overview - ESRLMS to focus efforts on improving compliance rates for **High Risk Fire**. The Associate Director of Estates has attended Mandatory Training Group with proposal that High Risk Fire is replaced with Fire Warden Training.	Apr-25	Jun-26	On Track	High Risk Fire Trajectory - Oct 2025 - Target 75%. Actual 77%. (+2%). Nov 2025 Target 77%. Actual 78% (+1%), Dec 2025 - Target 82%. Actual 84% (+2%). Jan 2026 – Target 89%. Actual 90% (+1%). Feb 2026 - Target 91%. Actual 93 (+2%). Mar 2026 - Target 95%. Actual 92% (-3%). Mar 2026 - 95%. In April there were no training sessions. Like with Resus Level 3 staff and managers are not booking in training when receiving the 3 month notification, we can see just under 40% of staff who are non-compliant and due within the next 3 months are
Hotspot - Compliance Overview - ESRLMS to focus efforts on improving compliance rates for **Manual Handling Level 2**. Availability of training locations	Apr-26	Dec-26	On Track	The ESRLM lead has linked the locality leads with Clinical Education to ensure Manual Handling Level 2 is available in all community hospitals. The ESRLM has also recommend using SaTH Manual Handling Training rooms in Shrewsbury and Telford also to give more alternative locations to Wem.
Adult Community Services Division - Check and challenge with the Service Lead for Team Leaders.	Apr-26	Sep-26	On Track	To ensure teams with low compliance are supported to increase their compliance rates and senior oversight is in place

Author	Catherine Morris	**Date**	29.06.2026
Accountable Officer Approval	Rhia Boyode	**Date**	29.06.2026





Exception Report - Action Plan

Vacancies - all

Percentage of vacancies (budgeted WTE minus contracted WTE) over budgeted WTE.

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Vacancies	%	7.18%	7.82%	7.68%	7.86%	9.49%	9.14%	9.37%
	Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Trajectory	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
%	9.1%	8.6%	8.6%	8.3%	8.0%	8.0%	8.0%

Reason for performance gap:

Corporate Updates - Focus on the areas with vacancies that are creating demand for temporary staffing which will be across inpatient areas. Recruitment team is holding a B3 1.00 WTE vacancy.
Operational Updates - UEC are continuing to expand their services and vacancies are being recruited to - this is ongoing until establishment is complete. UEC consultant recruitment has been reviewed and a review of the medical staffing is now being undertaken to determine needs. Dudley C&YP Services holding vacancies whilst undertaking review of structures for management of change . Dental service is holding vacancies due to contract reviews. **10/03/2026** Secondments to Children in care and MASH holding vacancies for staff to return to.
Vacancy rate increase in month 1 is due to additional investment into services being reflected in the 2026/27 workforce establishment (UCR Expansion, HCA investment for the Community Inpatient Wards and Children in Care and Children Psychology business cases).

Month 1 hotspots: HV Dudley (On hold), Ludlow CH, BCCH, VW management (budget in review) UCR NW, Children in Care, DN NE

Action Plan

Action	Start Date	End Date	Status	Outcome/Update
UEC Consultant: Advert closed - not able to shortlist - UEC to review options of recruitment with medical director and director of ops. JD has been reviewed - may need Royal College approval. Revised target set	Apr-25	Mar-26	On Track	**13/04/26** Consultant interviewees withdrew and Med Dir and Ops manager, with SaTH Med Dir to undertake an options appraisal and reviewing next steps. Chased RC as no outcome for the approval of the Specialty Dr jd. **09/06/26** pending confirmation on medical model from the group
Resourcing to undertake a deep dive into vacancy hotspots.	May-25	Mar-27	On Track	**Month 2 Hotspots:** LCH (6.06 WTE) •Emergency Practitioner: 2.39 WTE o 0.59 WTE – Offered pending check o 0.88 WTE – Starting on 03/08/2026 o 0.92 WTE – Starting 01/09/2026 •Combined HCA advert for Ludlow, BCCH and Whitchurch: 7.8 WTE – Shortlisting in progress •Receptionist / Ward Clerk – Started on 10/06/2026 •Staff Nurse: 1 WTE – Offered pending checks •Cook: 0.68 WTE – Starting on 06/07/2026 BCCH: (5.46 WTE) •Staff Nurse: 0.6WTE - Shortlisting in progress following readvertisement. VW Management (5.39 WTE) / UCR NW (4.82 WTE) 09/06 - VW management line includes Dr budget, needs reviewing •UCR HCSW Bridgnorth: 1 WTE – Starting 29/06/2026 •UCR Senior Nurse Bridgnorth: 1 WTE – Interview stage •UCR Staff Nurse Bridgnorth: 1 WTE – Longlisting (advertising) •UCR Staff Nurse Telford: 1 WTE – Offered pending checks •UCR Team Lead Whitchurch: 0.96 WTE – Starting 21/09/2026 •UCR HCSW Oswestry: 2 WTE o 1 WTE - Offered pending checks o 1 WTE - Starting 01/10/2026 •UCR Staff Nurse Oswestry: 1 WTE – Offered pending checks •UCR HCSW Church Stretton: 1 WTE – Starting on 06/07/2026 •UCR Physiotherapist Church Stretton – Started on 08/06/2026 Children in Care (4.8 WTE) •Children in Care Nurse: 3.60 WTE o 1.2 WTE – Authorisation in progress o 2.40 WTE – Started/starting on 11/05/2026, 18/2026 and 22/06/2026 •Administration Co-ordinator: 1 WTE – Starting on 06/07/2026 DN SE (4.53 WTE) •Nurse Associate: 0.8 WTE – Starting 24/06/2026 •Community Staff Nurse: 1 WTE – Offered pending checks
Resourcing team to work with operational managers and recruitment team to plan recruitment events and rolling bank adverts to be held over the next 12 months.	Apr-26	May-27	On Track	**07/04/2025** Recruitment Lead is arranging a meeting to discuss a rolling bank advert with Operational Lead for adults division. **20/5/26:** Rolling bank advert live on Trac 19/5/26. **09/06** Advert to be reviewed by KT to complete shortlisting. **15/6/26:** There has been a high volume of applicants, shortlisting is in progress but has been delayed due to lack of ops capacity, the lead was recently changed to try and resolve this.
Review all outstanding HCA vacancies in CHs and UEC and recruitment to prioritise HCA.	Apr-26	May-26	On Track	Meeting with Ops managers for areas and a plan agreed. Meeting: 28/4/26. **15/6/26:** Advert closed on 22/05 due to a high volume of applicants, shortlisting is in progress but has been delayed due to lack of ops capacity, the lead was recently changed by ops to try and resolve this. **16/6/26:** Shortlisting for the CH HCA vacancies resulted in non suitable for interview, awaiting confirmation from ops if we should readvertise. UCR HCA's: 1.7 WTE - NW, 1 WTE - Whitchurch, 1 WTE - Church Stretton in authorisation.

Author	Gina Billington	Date	29.06.2026
Accountable Officer Approval	Rhia Boyode	Date	29.06.2026

Division	Column1	Column2	Budget WTE	Vacancy WTE	% vacancy
Chief Operating Officer			26.07	1.69	6.5
Urgent Care (Adults)			263.04	35.57	13.5
Community Services (Adults)			612.48	43.53	7.1
Planned Care SDG			213.82	24.14	11.3
Children and Families Division			471	36.67	7.8
Chief Executive			10.64	2.00	18.8
Director of Finance and IM&T			80.5	8.49	10.5
Director of Governance			21.7	0.90	4.1
Director of People			29.86	5.80	19.4
Director of Nursing and AHPs			34.5	1.52	4.4
Medical Directorate			5.88	1.40	23.8
Total			**1,769.49**	**161.71**	**9.1**

Urgent Care (Adults)	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Single Point of Referral		TT001	8.02	2.52	31.4
Virtual Wards- Management		YA250	19.56	4.45	22.8
Virtual Wards- Central		YA251	9	0.08	0.9
Virtual Wards- North East		YA252	5.36	0.24	4.5
Virtual Wards- North West		YA253	9.88	2.12	21.5
Virtual Wards- South East		YA254	8.6	3.43	39.9
Virtual Wards- South West		YA256	7.23	1.73	23.9
Virtual Wards- Telford		YA257	9.94	0.03	0.3
OPAT		YA255	5.29	0.69	13.0
Urgent Community Response- Telford		TT700	18.24	-0.55	(3.0)
Urgent Community Response- Central		TT701	13.8	-0.11	(0.8)
Urgent Community Response- North East		TT702	9.4	3.48	37.0
Urgent Community Response- North West		TT703	9.02	3.82	42.4
Urgent Community Response- South East		TT704	8	0.1	1.3
Urgent Community Response- South West		TT706	9	2.9	32.2
Care Transfer Hub		TW402	32.24	0.54	1.7
Integrated Front Door		TW403	8.01	3.05	38.1
Total			**190.59**	**28.52**	**15.0**

Minor Injuries Units	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Whitchurch Hospital Minor Injuries Unit		TN120	3.03	0.22	7.3
Oswestry HC Minor Injuries Unit		TN200	7.1	0.01	0.1
Bridgnorth Hospital Minor Injuries Unit		TT120	12.77	3.04	23.8
Ludlow Hospital Minor Injuries Unit		TW220	6.59	-0.34	(5.2)
Total			**29.49**	**2.93**	**9.9**

Inpatient Wards	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Bishops Castle Hospital Ward		TW130	24.14	4.04	16.7
Ludlow Hospital Ward		TW230	37.75	5.66	15.0
Whitchurch Hospital Ward		TN130	42.26	1.12	2.7
Bridgnorth Hospital Ward		TT130	40.35	0.49	1.2
Total			**144.5**	**11.31**	**7.8**

Community Nursing	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Community Nursing - Telford North		TT530	33.75	2.36	7.0
Community Nursing - Telford South		TT500	33.07	-0.09	(0.3)
Community Nursing - Shrewsbury North		TC300	31.78	2.15	6.8
Community Nursing - Shrewsbury South		TC301	30.97	2.53	8.2
Community Nursing - North East		TN300	30.07	4.64	15.4
Community Nursing - North West		TN400	30.83	3.79	12.3
Community Nursing - South East		TW301	31.38	5.1	16.3
Community Nursing - South West		TW300	27.11	0.22	0.8
Total			**248.96**	**20.70**	**8.3**

Community Therapy Services	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Adult Community Therapy Central		TA001	16.25	-0.51	(3.1)
Adult Community Therapy North East		TA003	17.05	-0.06	(0.4)
Adult Community Therapy North West		TA004	11.9	0.00	(0.0)
Adult Community Therapy South East		TA005	14.18	-0.02	(0.1)
Adult Community Therapy South West		TA006	15.35	1.83	11.9
Total			**74.73**	**1.24**	**1.7**

Children, Young People & Families	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Shropshire PHNS Admin		WP125	8.39	0.7	8.3
Shropshire Health Visiting		WP135	43.95	1.33	3.0
Family Nurse Partnership Shropshire		WP601	5.07	0	0.0
Telford PHNS Admin Service		WP127	4.6	0	0.0
Health Visiting Telford Service		WP136	32.24	1.73	5.4
Family Nurse Partnership Telford		WP603	3.05	0.05	1.6
Dudley Health Visiting Admin Service		WP126	11.54	1.94	16.8
Health Visiting Dudley Service		WP205	79	11.31	14.3
Family Nurse Partnership Dudley Service		WP602	10.05	-0.15	(1.5)
5-19 School Nursing Dudley Service		WP200	32.42	3.1	9.6
5-19 School Nursing Shropshire		WP210	23.01	0.53	2.3
5-19 School Nursing Telford		WP220	13.79	1	7.3
Total			**267.11**	**21.54**	**8.1**

Paediatric Therapies	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Paediatric Psychology		WC090	8.07	2.49	30.9
Paediatric Psychology Admin		WC095	1.2	0.4	33.3
Paediatric Physiotherapy		WT110	11.92	0.31	2.6
Specialist Nursing Diabetes Children		WD105	6.51	-0.31	(4.8)
Total			**27.7**	**2.89**	**10.4**

Paediatric Diabetes	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Specialist Nursing Diabetes Children		WD105	6.51	-0.31	(4.8)
Total			**6.51**	**(0.31)**	**(4.8)**

Dental in Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Dental Central Admin		WM900	3.3	0.04	1.2
Dental Special Care and Access		WM910	30	2.77	9.2
Dental Market Drayton		WM920	3.56	0.96	27.0
Dental Craven Arms		WM930	2.01	0.94	46.8
Oral Health Improvement		WM960	9.82	3.22	32.8
Total			**48.69**	**7.93**	**16.3**

Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
MSK MDT Clinic		TC232	4.47	4.44089E-16	0.0
MSK Podiatry		TC235	1	0.15	15.0
TeMS Admin		TC240	18.62	0.9	4.8
Total			**24.09**	**1.05**	**4.4**

Planned Care	Column1	Cost Centre	Budget WTE	Vacancy WTE	% vacancy
Prison Healthcare		WH200	26.82	0.88	3.3
Total			**26.82**	**0.88**	**3.3**

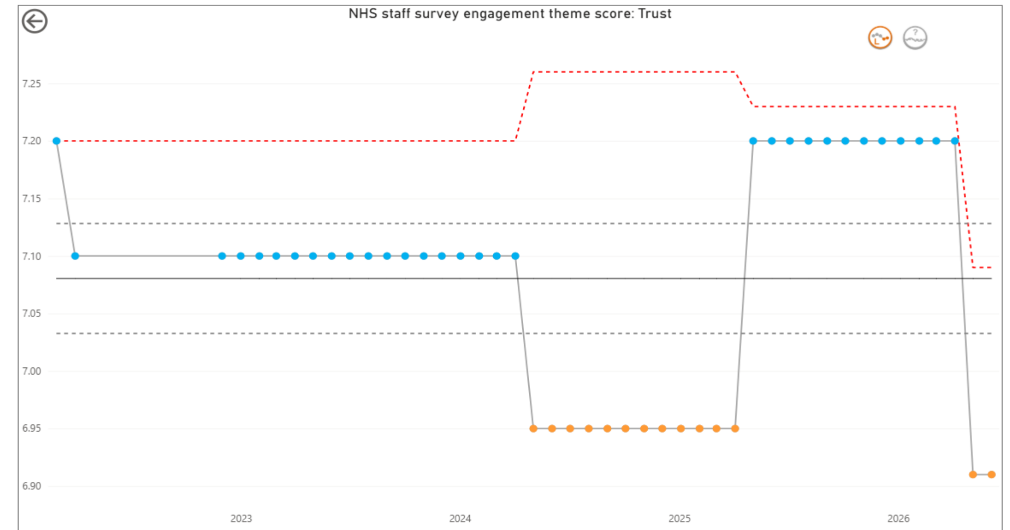
Yearly Reported KPIs

Exception Report - Action Plan

NHS Staff survey engagement theme score

KPI Description	Latest 6 months	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Staff survey engagement theme score	Number	7.2	7.2	7.2	7.2	6.91	6.91	6.91
	Target	7.23	7.23	7.23	7.23	7.09	7.09	7.09

Trajectory	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
%	7.2	7.2	7.2	7.2	7.2	7.2	7.2



Reason for performance gap:	Work is continuing around staff engagement particualrly with the move to Group				
Action Plan	Action	Start Date	End Date	Status	Outcome
	Commission and commence work with Aqua and Tim Keogh A kind Life	Apr-25	Mar-26	On track	Create an open, kind and compassionate culture

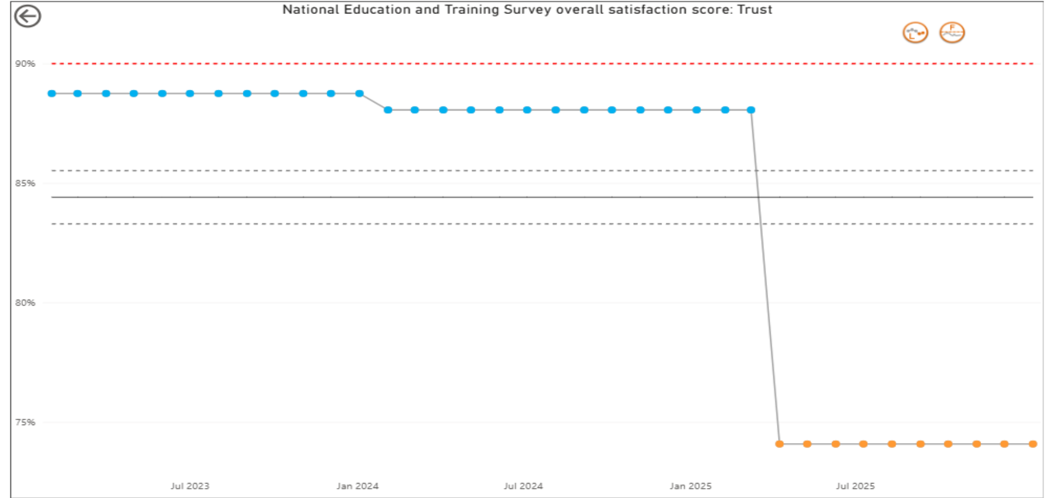
Author	Fiona MacPherson	Date	29.06.2026
Accountable Officer Approval	Rhia Boyode	Date	29.06.2026

Exception Report - Action Plan

National Education and Training Survey overall satisfaction score

KPI Description	Latest 6 months	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
National Education and Training Survey	Number	74.08%	74.08%	74.08%	74.08%	74.08%	74.08%	74.08%
	Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Trajectory	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
%	74.08%	74.08%	74.08%	74.08%	74.08%	74.08%	74.08%



Reason for performance gap:					
Action Plan	Action	Start Date	End Date	Status	Outcome
Author		Date			
Accountable Officer Approval		Date			

Appendix 1 SaTH Integrated Improvement Plan (SIIP): Governance and Leadership Plan 2026/27.

NHS
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. **Evidence will include:** • Updated governance structure diagram	Anna Milanec	Already started	31/03/2027	SaTH's internal governance structure to continue to be reviewed in line with committee workplans. HTP Assurance Committee terms of reference (ToR) reviewed in March to April 2026 and were considered at the May HTPAC meeting. The ToR have been circulated for further comments ahead of the next HTPAC meeting in July 2026, ahead of approval by the Board of Directors.	

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
	• Committee workplans showing alignment. • Minutes confirming review discussions. • Any revised Terms of Reference approved by Board committees.				A Local Care Transformation Assurance Committee was established in June 2026, with terms of reference agreed at June 2026 private Board. Its first meeting was held on 26 June 2026.	
SaTH 4.1.15	Deliver and oversee the HTP Improvement Plan, ensuring governance, assurance and reporting via the HTP Assurance Committee. 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.,	Matthew Neal	Already started	31/03/2027	The Hospitals Transformation Programme continues to be overseen through established governance and assurance arrangements. Recent progress includes ongoing workforce engagement activity, development of HTP workforce timescales for inclusion within the Master Programme, and continued alignment of HTP activity with wider Shropshire, Telford and Wrekin system transformation priorities.	

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
	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) **Evidence will include:** • Remuneration Committee papers confirming process and timelines. • Job descriptions and adverts • Announcement or communication confirming appointments	Group Chair /Group CEO	01/09/2025	30/09/2026	In progress. Remuneration Committees to consider process and timeline. Plans in place to begin recruitment.	
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) **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.	Anna Milanec	01/09/2025	31/12/2027 (pending confirmation of appointment of group members)	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.	

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
	• The minutes confirming approval of the Terms of Reference (and therefore the membership). • Group Transition Committee papers (agenda, minutes, packs)					
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. **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	Deborah Bryce / Anna Milanec	01/09/2025	31/05/2026	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. The People Committee forward workplan has received a further review in June 2026 with the Chief People Officer and team and continues to be developed. To be considered at the September 2026 meeting.	
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). **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)	Anna Milanec	01/09/2025	31/03/2027	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.	Anna Milanec	01/04/2026	31/12/2026	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	

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
	• Promote the FTSU group model through consistent communications so that all staff receive clear and aligned messaging. **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)	Jenny Fullard			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.	
4.2.14	Take forward the recommendations from the December 2025 NHSE Freedom to Speak Up (FTSU) report and track delivery through 2026/27. **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.	Anna Milanec	01/12/2025	31/03/2027	• In progress	
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	• In 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
	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. **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.	Anna Milanec	01/04/2026	01/01/2027	Work to develop a Group Risk Management Policy, Risk Management Strategy and shared risk appetite statement for SaTH and ShropCom is scheduled for consideration.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

Appendix 2: SaTH Integrated Improvement Plan (SIIP): Workforce 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 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**	**Updates**	**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. **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)	Laura Carlyon	01/08/2025	31/03/2027	• 95% of resident doctors are now in place with e-roster. Activity Manager module purchased and preparations underway for consultant rotas. Project resource has been secured commencing in June 26.	
SaTH 2.1.28	5-year Workforce plan to be developed including workforce demand and supply, supporting rightsizing the workforce. **Evidence will include:** • Workforce plan document completed Board minutes noting approval	Simon Balderstone	1/2/2026	31/07/2026	• CSU have been commissioned to undertake 5 year plan – completed and now being socialized across Trust.	.
SaTH 2.1.29	Continued work on job planning embedding as part of workforce planning to support productivity and efficiency. **Evidence will include:** • Workforce plan document completed and including job planning elements. • % consultants with approved job plan • Job plan compliance dashboard	Simon Balderstone	1/2/2026	30/09/2026	• Job planning programme for 26/27 launched with workshop and launch event.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Updates**	**RAG Progress Status**
	• Governance minutes from Strategic People Group monitoring					
SaTH 2.1.30	Staff engagement strategy to be developed and implemented to support preparations for HTP/development of a group model. **Evidence will include:** • Staff engagement strategy finalised • Board minutes confirming approval of the strategy • Engagement plan and communication materials Summary of staff feedback	Sabeena Khanna	1/2/2026	31/03/2027	• HTP workforce engagement activity, including emphasis on early engagement, communication and confidence-building with staff at an HTP workforce workshop held in February 2026.	
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. **Evidence will include:** • HTP workforce impact assessments • Trade Union engagement logs • Consultation timeline • Workforce modelling for new clinical model Equality impact documentation	Sabeena Khanna	01/04/2026	31/03/2027	• Working with the PMO support team to develop workforce HTP timescales and these will be added to the Master Programme.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Updates**	**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 **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	Ned Hobbs Nigel Lee	1/2/2026	31/03/2027	• The Trust continues to actively support service transformation and system alignment through sustained collaboration with STW partners. This includes engagement in STW system governance and transformation forums, alignment of HTP, UEC and workforce activity to STW system plans, and contribution to shared services and system improvement programmes. Progress is monitored through SIIP and system assurance frameworks.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Updates**	**RAG Progress Status**
SaTH 2.1.33	Sickness absence management support programme developed with clear milestones for delivery. Evidence will include: • Programme outline developed and implemented. • Reduction in long-term sickness trend • Manager sickness training delivery • Health & Wellbeing interventions IPR reports	Nick Dowd	1/2/2026	31/03/2027	• Programme is being developed and is progressing.	
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 **Evidence will include:** • Strategy for temp staffing included in workforce plan. • Reduction in agency spend trajectory • Controls framework Safe staffing modelling alignment	Simon Balderstone	1/2/2026	30/09/2026	• Governance actions will remain in place for 26/27 – further areas to include bank rate proposal as part of strategy. Task and finish group in place across Group to support development of bank strategy / approach including rates review.	.
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	The Trust is working with Higher Education Institutions to strengthen education pathways and develop new clinical and vocational roles, including ACP and apprenticeships. HEI	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Updates**	**RAG Progress Status**
	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				engagement, apprenticeship expansion and innovative role development are being progressed through the People & OD programme and reflected within the strategic workforce plan and forthcoming 2026/27 delivery milestones	
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 **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	DT	01/04/2025	31/03/2027	Cultural transformation, focusing on group, Poppy's promise planning sessions for launch as a brand and movement for cultural change, plan being developed. Conversations have taken place with AQUA and Kind of Life. Group Leaders forum on 30th April 2026. Further planning meetings with AQUA in May 2026. Board development day 21st May 2026. Leadership Framework - programmes and masterclasses can be accessed by the Group.	

Workforce						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Updates**	**RAG Progress Status**
	• 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. **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	SB	01/04/2026	31/3/2027	• Manager Self-Service ESR now fully deployed across the Trust, giving greater autonomy for managers.	

<table>
<tr><th colspan="7">Leadership</th></tr>
<tr><th>Task ID</th><th>Task</th><th>Task Owner</th><th>Start Date</th><th>End Date</th><th>Sources of evidence to demonstrate implementation</th><th>RAG Progress Status</th></tr>
<tr><td colspan="7">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.</td></tr>
<tr><td>SaTH 5.3.3</td><td>Ensure robust monitoring and oversight of delivery of all SaTH's IIP via appropriate governance and operational structures (includes ward to board)

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</td><td>CEO SaTH</td><td>In progress</td><td>31/03/2027</td><td>Robust monitoring and oversight of SaTH's Integrated Improvement Plan (SIIP) is in place through a clearly defined governance framework, with delivery monitored via Board Assurance Committees and escalated to the Board of Directors through regular reporting. Ward-to-Board assurance is strengthened through PMO scrutiny, M2E transformation oversight, executive escalation routes and alignment with bi-monthly NHSE/PRM assurance processes.</td><td></td></tr>
<tr><td colspan="2">Deliverable:
The outputs that you need to produce to demonstrate delivery of exit criteria</td><td colspan="5">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.</td></tr>
</table>

Leadership						
Task ID	**Task**	**Task Owner**	**Start Date**	**End Date**	**Sources of evidence to demonstrate implementation**	**RAG Progress Status**
SaTH 5.4.2	Ensure Executive participation in the Executive Directors Development programme including initiating dialogue on shared expectations and collaborative leadership through STG. **Evidence will include:** • Attendance logs • Joint leadership expectations pack • Output from STG leadership conversations Example shared of system decisions demonstrating collaborative leadership	CEO, SaTH	29/01/2025	31/3/2027	• Executive Directors have actively participated in the Executive Directors 12 month Development Programme, with structured sessions initiating dialogue on shared expectations and collaborative leadership through the System Transformation Group (STG). This has been formally delivered and signed off through the People Committee and Board governance, with the approach rolled forward into 2026/27 to sustain system-wide collaborative leadership	
SaTH 5.4.5	Analyse NHS Staff Survey and pulse survey results and lead on development and delivery of associated action plan **Evidence will include:** • People Pulse quarterly reports • NHS Staff Survey themes • Divisional action plans • Improvement of metrics year-on-year	DT	01/04/2026	31/3/2027	• The latest people pulse survey concludes 30th April. Results in early May and report to SPG by June 26. Staff survey – results published, staff briefings held, dashboard created so that managers can view their own results and work on action plans. Group paper scheduled for Board in May 26.	

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

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

Our Moving to Excellence Ambition

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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, demand and capacity modelling aligned to system plans, cashflow and review against HTP	AW	Ongoing	30/09/2026	**Evidence will include:** • Annual refresh and triangulation complete in line with annual planning submission. • Final plan 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
	assumptions). (Incorporating former SaTH 1.1.4 – demand and capacity modelling and former SaTH 1.1.5 – cashflow requirements).				• Realignment plan submitted 18/03/2026 • 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 • PAF to be implemented in 2026/27	
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:** • CSG 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:** • 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 review).	AW	Ongoing	31/03/2027	**Evidence will include:** • Monthly external audit tracker • Minutes from Audit Risk Assurance Committee (ARAC) where external audit	

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
					action progress 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 2025/26 Final • Sath Financial Statements Opinion Final • SaTH Signed Accounts 2025/26 - 26/05/26 • SaTH Signed Annual Report and Accounts 2025/26 • VRM Q Collated	
Deliverable: 1.5: Establish a resilient process for data capture, safdata 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.	Helen Ainsbury	Ongoing	~~30/06/2026~~ 31/08/2026	**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 1: SaTH Integrated Improvement Plan (SIIP): UEC Plan 2026/27.

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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	Type 3 4 hour performance reduced to 90.7% in May 2026 compared to 91.8% in April 2026. 17.8% of attendances were streamed to UTC. Streaming performance is to be addressed at an upcoming initial assessment workshop which aims to build confidence and consistency in streaming decisions.	**On Track**
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 **(Carried over from 2025/26)**	Jay Atkinson	12/05/2024	28/02/2027	**Evidence will include:** • GP direct access specialty pathways, governance minutes, data on pathway usage.	**On Track**

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 3.1.1.7	Redesign processes and remove inefficiencies within the ED patient journey; monitoring performance via the established working group **(Carried over from 2025/26)**	Syed Asad	01/07/2025	31/03/2027	Non-Admitted ED 4 hour performance in May 2026 reduced to 63.5% compared with 68% in April 2026. The average wait to be seen time increased to 129 minutes. The Non-Admitted working group is incorporating feedback from Nexus Consulting on key drivers impacting ED performance which will help inform the group's work.	**At Risk**
SaTH 3.1.1.8	Develop and deliver targeted People Promise action plan focused on wellbeing, culture and retention **(Carried over from 2025/26)**	Hannah Walpole	01/07/2025	31/03/2027	The Culture workstream is forming a sub-group to address the staff survey feedback relating to race discrimination. This is being worked on in collaboration with the Group Chief People Officer	**At Risk**
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. **(Carried over from 2025/26)**	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	**At Risk**
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 21-day LOS. **(Carried over from 2025/26)**	Alison Vaughan	01/07/2025	31/03/2027	• Complex NCTR patients increased in May 2026 to 136 compared to 124 in April 2026. 14+ day LOS patients reduced slightly to 177 as did 21+ day patients to 100.	**On Track**
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 **(Carried over from 2025/26)**	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.	**At Risk**

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 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	Initial assessment performance reduced slightly in May 2026 to 72.2% compared to 76% in April 2026. The average time to initial assessment remained at 12 minutes. The performance has shown special cause improvement for 12 months.	**On Track**
SaTH 3.3.3	Implement escalation policy to further improve Mean ambulance handover time **(Carried over from 2025/26)**	Susanne Crossley	01/04/2025	31/03/2027	Mean ambulance handover time in May 2026 was 28.1 minutes against an operational target of 55 minutes. 90.8% of patients were handed over within 60 minutes of arrival.	**On Track**
Deliverable 3.4: Delivery of the SaTH UEC Transformation Programme actions for the CSS Transformation Programme						
SaTH 3.4.1	Implement process to support interventions by physiotherapy/ occupational therapy earlier in the patient journey **(Carried over from 2025/26)**	Charlotte Jacks	01/07/2025	31/03/2027	The Therapy in-patient team in Medicine at RSH have combined their referrals with the intention of triaging referrals according to therapy needs and the best professional to assess and treat the patients as opposed to triaging OT and PT referrals individually which can lead to duplication and delays. The response time of referral to triage time has significantly improved since this has started. Performance remains in special cause improvement	**On Track**

BRAG Status
Completed and Evidenced
On Track
At Risk
Off Track

SaTH 2026/27 Revised Undertakings – UEC

Section	Requirement/Action	Parties Involved	Key Focus/Emphasis	Reporting/Review
1.1	Ensure robust UEC improvement plan is in place	Licensee, NHS England, NHS England Midlands Region	Admitted, transferred or discharged within four hours, ambulance handovers; patients spending more than 12 hours in Emergency Department	SaTH are participating in the STW plan. The internal plan has been created with workstreams to support improvements has now launched and will commence reporting into UECTAC in June 2026. As a result of the ongoing work, 4 hour, 12 hour and ambulance handover performance continue to show sustained improvement
1.2	Include actions to monitor impact on quality, leadership, culture, trajectories, risks, milestones, KPIs	Licensee, STW ICB, WMAS and wider system partners	Monitor quality, leadership effectiveness, cultural/ behavioural issues, risks, milestones, KPIs	The 2026/27 UEC programme focuses primarily on 4 hour/12 hour/ambulance handover performance with more granular metrics underpinning these. Work is underway to develop leadership and engagement, recognising the importance of this to overall improvement. Risks, milestones and KPIs continue to be monitored through governance channels including the Divisions and UECTAC
1.3	Keep UEC plan under continuous review and update as required	Licensee, system providers, ICB, NHS England		The internal UEC plan for 2026/27 remains under continuous review and will be updated in response to requirements with any changes being approved via the appropriate channels. The

Section	Requirement/Action	Parties Involved	Key Focus/Emphasis	Reporting/Review
				recent input from Nexus Consulting will feed into key workstreams and help direct future improvements
1.4	Deliver UEC Plan and provide monthly report on delivery of improvement priorities	Licensee, NHSE		Reports submitted in writing, reviewed at monthly Provider Review Meetings; more regular/ad hoc updates if requested
1.5	Notify NHS England of matters affecting ability to deliver UEC Plan; update plan promptly	Licensee, NHSE		Submit updated UEC Plan within five working days; changes subject to approval by NHS England
1.6	Ensure UEC Plan implementation does not compromise financial position	Licensee, NHSE, STW ICB		Work is underway to ensure that the programme is sighted on and does not interfere with the organisation's financial recovery plan. A financial UEC group is being led by the ICB to ensure that costs are kept under control
2.1	Programme Management and governance to be sufficient to enable delivery	Licensee, NHSE		The UEC Plan is fully supported by the Programme Management Office and remains a key priority within their portfolio. The PMO work closely with the stakeholders and provide support to workstreams at a level they feel is suitable
3.1-3.3	Licensee must attend appropriate NHSE meetings or conference calls	Licensee, NHSE		Provision of reports as requested by NHSE and attend monthly oversight and assurance meetings

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

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

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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

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PROGRESS AS AT 09.06.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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FIRST OCKENDEN REPORT ACTION PLAN

The Shrewsbury and Telford Hospital NHS Trust

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

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PROGRESS AS AT 09.06.2026

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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

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

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Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	31/03/21	30/04/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.98	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/09/21	30/06/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
4.99	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.	Y	10/12/20	31/10/21	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	12/01/21	31/10/21	14/09/21	H. Flavell	A.Sizer	Monday.com
4.100	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.	Y	10/12/20	31/05/24	Evidenced and Assured	Completed	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. This action was accepted as Evidenced and Assured at mar-26's MNTAC following completion of the work on honorary contracts that will allow more hands on practice for ANNPs going forward.	14/05/24	31/01/26	10/03/26	P. Gardner	A.Sizer	Monday.com

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NHS
The Shrewsbury and Telford Hospital NHS Trust

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	Not Yet Delivered	Descoped (see exception report)	External dependent action on NHSEI. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as the MNISA who is in post cannot start working with families until the greenlight from NHSEI has been received. We currently have no information as to when that greenlight is expected. Progressing this action with NHSEI sits with the LMNS. All other evidence requirements for this action have been met and it will be proposed for "Delivered, Not yet Evidenced" as soon as NHSEI enable the MNISA to start their work with families. A new timeline for "Evidenced and Assured" will be proposed at the same time. 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. With the national MNISA programme not being renewed, this action has reverted back to red and was agreed as Descoped at May-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	Not Yet Delivered	Descoped (see exception report)	External dependent action on NHSEI. Linked to IEA 2.1. An exception report was presented and accepted at Apr-25's MNTAC changing the status of this action to "Off Track" as this action is dependant on IEA 2.1. Until progress can be made with the above action, realistic new timelines cannot be estimated. 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. With the national MNISA programme not being renewed, this action has reverted back to red and was agreed as Descoped at May-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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(green)	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

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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NHS
The Shrewsbury and Telford Hospital
NHS Trust

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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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FIRST OCKENDEN REPORT ACTION PLAN

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

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

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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

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

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

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

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

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

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FINAL OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital NHS Trust

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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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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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 09.06.2026

APPENDIX ONE

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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 Mar-26's MNTAC with a new timeframe for assurance at Dec-27 which aligns the timeframes agreed as part of CNST.	13/12/22	31/12/27		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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(yellow)	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
(green)	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

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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	Evidenced and Assured	Completed	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. This action was agreed as Evidenced and Assured at May-26's MNTAC. Staff survey results have shown improvements against bullying and harassment questions year on year since 2022. Additionally, while there have been more grievances recorded, this shows improved reporting and appropriate management through HR channels as there were none recorded in years prior to the transformation programme.	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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NHS
The Shrewsbury and Telford Hospital NHS Trust

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	Delivered, Not Yet Evidenced	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. This action was agreed as Delivered not yet Evidenced at Mar-26's MNTAC following the publication of the Indepedent Review of birthrate+. This action however remains decsoped.	10/03/26	TBC		J. Jones	H. Flavell	Monday.com
1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	08/11/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	28/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Y	30/03/22	TBC	Delivered, Not Yet Evidenced	On Track	Action 'rescoped' at the Jan-24 MTAC; as the programme has been approved Nationally. An exception report was presented and accepted at May-24's MTAC setting the new deadline for Evidenced and Assured at May-25. This action is no longer 'At Risk'. This action was agreed back on Track at Jun-26's MNTAC as information was recieved from the regional team regarding training requirements. Evidence is being validated by the team and will be submitted to the commitee by Jul-26.	09/01/24	31/6		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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

The Shrewsbury and Telford Hospital NHS Trust

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
1.11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(RCOG and RCP). Thereby this action lies fully outside the scope of work of the MTP. This action was reviewed as at Aug-25's MNTAC against updates from the national teams. those updates however did not provide suffecient 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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FINAL OCKENDEN REPORT ACTION PLAN

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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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FINAL OCKENDEN REPORT ACTION PLAN

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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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FINAL OCKENDEN REPORT ACTION PLAN

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Immediate and Essential Action 4: Clinical Governance - 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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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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)

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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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FINAL OCKENDEN REPORT ACTION PLAN

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

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.

FINAL OCKENDEN REPORT ACTION PLAN

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

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

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
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 09.06.2026

APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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 Mar-26's MNTAC, where a new timeline for Evidenced and Assured was set for Dec-26.	13/12/22	31/12/26		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

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.

FINAL OCKENDEN REPORT ACTION PLAN

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

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
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	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

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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FINAL OCKENDEN REPORT ACTION PLAN

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

Colour	Status	Description
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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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

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
15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com
15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com
15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - Evidenced and Assured.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	Monday.com

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

Ockenden 1

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	0	0	27
IEA	25	2	0	23
Total	52	2	0	50
Percentage		4%	0%	96%

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	0	0	0	27	0
IEA	25	0	0	0	0	23	2
Total	52	0	0	0	0	50	2
Percentage		0%	0%	0%	0%	96%	4%

Ockenden 2

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	66	1	1	64
IEA	92	5	5	82
Total	158	6	6	146
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	1	0	0	64	1
IEA	92	0	4	0	0	82	6
Total	158	0	5	0	0	146	7
Percentage		0%	3.2%	0%	0%	92.4%	4.4%

Combined actions - Delivery status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	93	1	1	91
IEA	117	7	5	105
Total	210	8	6	196
Percentage		3.81%	2.86%	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	1	0	0	91	1

Counts

IEA	117	0	4	0	0	105	8
Total	210	0	5	0	0	196	9
Percentage		0.0%	2.4%	0.0%	0.0%	93.3%	4.3%

NHS
The Shrewsbury and Telford Hospital NHS Trust

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

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

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

PROGRESS AS AT 09.06.2026

APPENDIX TWO

Neonatal External Mortality Review Action Plan

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NEMR3d/I_NEMR5	There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: d. The unit should review National Neonatal Audit Programme (NNAP) quality outcome trends, particularly bronchopulmonary dysplasia, brain injury, non-invasive ventilation rates, and create quality improvement projects to address any issues identified.	Delivered, Not Yet Evidenced	On Track	The clinical team have undertaken a review of NNAP data for 2022/23 and is in the process of reviewing the outcome of the 2023 data, evidence to demonstrate this will be presented to MNTAC in December 2023. Further evidence of any amended practice or dissemination of learning will be presented to MNTAC in due course to provide evidence of embedded practice. An exception report was presented and accepted at Mar-26's MNTAC follwoing delays in the implementation of Badgernet for neonates, changing the timframe for green tot Mar-27. 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 Implementation of Badgernet EPR allowing better reporting	Immediate (0-3 months)	31/12/2024	10/12/2024	01/03/2027		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

NHS
The Shrewsbury and Telford Hospital NHS Trust

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NEMR6b/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. Governance Lead	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. 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: Lead in post for 6 months - completed probation	Short Term (0-6 months)	30/08/2025	09/09/2026	31/12/2025	14/06/2026	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. An exception report amneding the timframes to Aug-26 for amber and Feb-27 for green was agreed at mar-26' MNTAC to account for delays in the recruitment process. 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)	31/08/2026		28/02/2027		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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Neonatal External Mortality Review Action Plan

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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	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. This action was agreed as Delivered, Not yet Evidenced at Jan-26's MNTAC This action was agreed as Evidenced and assured at May-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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Neonatal External Mortality Review Action Plan

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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NEMR6h/I_NEMR4	Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles. IPC Lead	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	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. Following a review of the bereavement support requirements for the neonatal unit, it was agreed that this would be provided by the bereavement midwives team, already in place and running. This action was agreed as Evidenced and Assured at May-26's MNTAC. Evidence Requirements for Assurance: Agreement for Midwifery bereavement team to provide support on the Neonatal Unit.	Short Term (0-6 months)	31/03/2026	14/05/2026	31/07/2026	14/05/2026	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.	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 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. Following a review of the bereavement support requirements for the neonatal unit, it was agreed that this would be provided by the bereavement midwives team, already in place and running. This action was agreed as Evidenced and Assured at May-26's MNTAC. Evidence Requirements for Assurance: Agreement for Midwifery bereavement team to provide support on the Neonatal Unit.	Short Term (0-6 months)	31/01/2026	14/05/2026	30/04/2026	14/05/2026	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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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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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
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

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

Neonatal External Mortality Review Action Plan

Ref	Action required	Delivery Status	Progress Status	Status Commentary (This Period)	Timeline set out in Report	Delivery Due Date (Amber)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
NEMR15	The service should ensure compliance with the medical and nursing standards as listed in BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022.	Delivered, Not Yet Evidenced	On Track	Further to a benchmarking exercise comparing the establishment for the neonatal unit against BAPM standards, a business case was submitted requesting funding for the required posts to achieve best practice compliance with BAPM standards. This business case has been approved and is in the process of implementation. A balanced approach to recruitment is required to mitigate the risk of depleting the units core clinical workforce, consequently, there is a recruitment plan in place over a 12 month period, delivery of this is overseen by the Divisional Director of Nursing. Evidence of delivery of this action will be presented to MNTAC in June 2025 to allow time for recruitment into the new posts identified. This action was accepted as 'Delivered, Not Yet Evidenced' at Aug-25's MNTAC with new timeframes for green to jan-27. Evidence Requirements for Delivery: CNST SA4 compliance for Years 4, 5, 6 Refreshed QIS trajectory - Jun-25 Staffinf papers demonstration QIS cover on shifts Evidence Requirements for Assurance: CNST year 7 compliance QIS compliance reached	Short Term (0-6 months)	31/06/2025	12/08/2025	31/01/2027		Dr John Jones & Paula Gardner	Dr Andrew Sizer & Julie Plant	Monday.com
NEMR16	The neonatal service should review its 'golden hour' care practices for preterm infants and sick term infants born within the service, with a focus on implementing evidence-based care practices around resuscitation, stabilisation, surfactant administration and other supportive measures in the first few hours after birth.	Delivered, Not Yet Evidenced	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. This action was agreed as Delivered, Not yet Evidenced at May-26's MNTAC. 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	14/05/2026	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". An exception report was presented and accepted at Mar-26's MNTAC follwoing delays in the implementation, changing the timframe for green tot Mar-27. 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	31/03/2027		Ned Hobbs	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.

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.	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. 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. Progress against this action was presented at May-26's MNTAC where it was agreed as Delivered, Not Yet Evidenced. A new timeframe for green at Dec-26 was also agreed. Evidence Requirements for Delivery: Review of 18 cases completed Additional learning and QI plans presented at neonatal Governace Evidence Requirements for Assurance: Evidence of completed QI	Short Term (0-6 months)	30/09/2025	14/05/2026	31/12/2026		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 09.06.2026

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
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.	Evidenced and Assured	Completed	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. This action was agreed as Evidenced and Assured at Jun-26's MNTAC. Evidence Requirements for Delivery: Forward audit plan in place Quality Improvement plan in place Monthly dashboard with review of trends and themes Evidence Requirements for Assurance: Monthly Audit Paper (Neonatal Governance) Quarterly Neonatal QI Paper (Neonatal Governance)	Short Term (0-6 months)	31/05/2025	10/06/2025	30/04/2026	09/06/2026	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 Mar-26's MNTAC, amending the Delivery date to Oct-26 to allow for the recruitement of the FICare lead who will be essential to the embedding of this action. the assurance date has been removed and will be reallocated once the lead has had a chance to conduct a review of the service's position and devise an action plan. Evidence Requirements for Delivery: Patient Experience Group - Neonates Nurse Specialist in post MNVP surveys and meetings Local Parent Advisor 'Champion' Benchmark against BAPM PIC standard - Gap Analysis Evidence Requirements for Assurance: Evidence of Nurse Specialist delivering in role Compliance with BAPM OIC standards Evidence of deliverables from PEG meetings and survey findings	Medium Term (6-12 months)	31/10/2026				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.

NEMR

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
Actions	35	4	10	21
Total	35	4	10	21
Percentage		11.4%	28.6%	60.0%

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
Action	35	0	12	0	1	21	1
Total	35	0	12	0	1	21	1
Percentage		0.00%	34.29%	0.00%	2.86%	60.00%	2.9%

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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

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Women & Children's Transformation Programmes

Jun-26 Batteries

Post Assurance Committees

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Maternity and Neonatal Transformation

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Ockenden Reports

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Assurance - Actual Delivery since 2022

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Month	Not yet delivered	Delivered, not yet evidenced	Evidenced and assured
Apr-22	146	24	40
May-22	146	23	41
Jun-22	146	5	59
Jul-22	130	9	71
Aug-22	122	13	75
Sep-22	107	17	86
Oct-22	102	16	92
Nov-22	87	26	97
Dec-22	70	35	105
Jan-23	66	34	110
Feb-23	48	32	130
Mar-23	48	32	130
Apr-23	39	32	139
May-23	38	24	148
Jun-23	34	28	148
Jul-23	30	28	152
Aug-23	26	28	156
Sep-23	25	21	164
Oct-23	21	25	164
Nov-23	19	22	169
Dec-23	19	17	174
Jan-24	18	17	175
Feb-24	18	17	175
Mar-24	18	14	178
Apr-24	18	14	178
May-24	16	16	178
Jun-24	16	15	179
Jul-24	15	14	181
Aug-24	14	14	182
Sep-24	14	14	182
Oct-24	14	14	182
Nov-24	12	15	183
Dec-24	12	15	183
Jan-25	10	14	186
Feb-25	11	13	186
Mar-25	11	9	190
Apr-25	11	9	190
Jun-25	9	11	190
Jul-25	7	12	191
Aug-25	7	11	192
Sep-25	7	11	192
Oct-25	7	11	192
Nov-25	7	11	192
Dec-25	7	11	192
Jan-26	7	7	196
Feb-26	7	7	196
Mar-26	6	7	197
Apr-26	6	7	197
May-26	8	6	196
Jun-26	8	6	196

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Ockenden Reports – Overall Status
First Report

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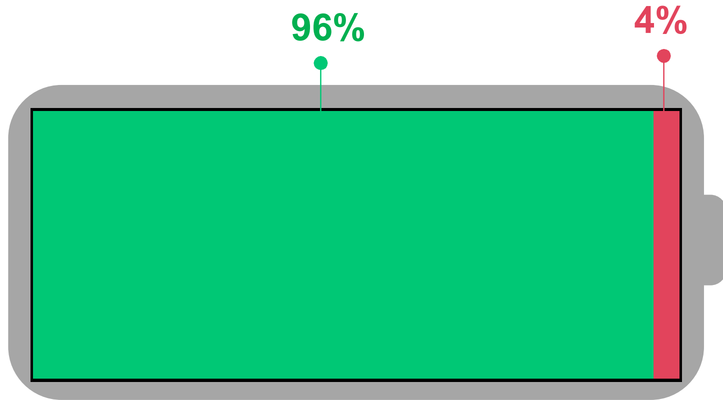
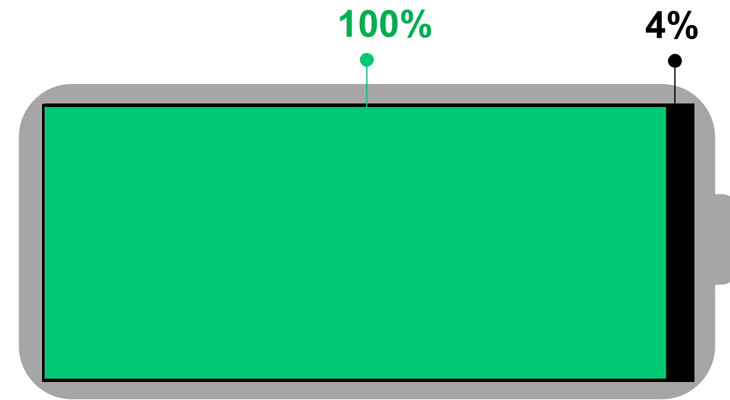
First Report - Delivery Battery



50/52 (96%) actions implemented

- 50 actions (100%) 'Evidenced & Assured'
- 2 actions (4%) 'Not yet Delivered'

First Report – Progress Battery



- 50 actions (96%) 'Complete'
- 2 actions (4%) **'Descoped'**

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Ockenden Reports – Overall Status Final Report

Shropshire, Telford and Wrekin Community and Hospitals
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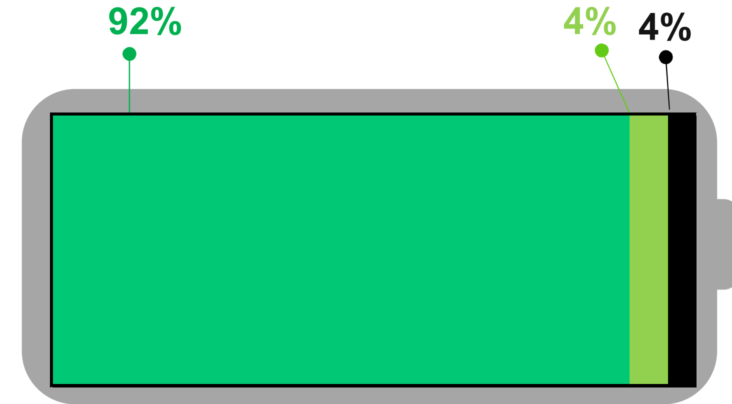
Final Report - Delivery Battery

152/158 (96%) actions implemented

- 146 actions (92%) 'Evidenced and Assured'
- 6 actions (4%) 'Delivered, Not Yet Evidenced'
- 6 actions (4%) 'Not Yet Delivered'

Final Report – Progress Battery



- 146 actions (92%) 'Complete'
- 5 actions (4%) 'On Track'
- 7 actions (4%) 'Descoped/On Hold'

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Neonatal Mortality Review

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Assurance - Actual Delivery since 2024

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Month on Month Progress

Month	Not yet delivered	Delivered, not yet evidenced	Evidenced and assured
Oct-24	21	6	
Nov-24	19	8	
Dec-24	17	9	1
Jan-25	15	10	2
Feb-25	14	11	2
Mar-25	14	9	4
Apr-25	19	10	6
Jun-25	17	10	8
Jul-25	13	14	8
Aug-25	12	14	9
Sep-25	11	15	9
Oct-25	11	9	15
Nov-25	11	9	15
Dec-25	11	9	15
Jan-26	8	12	15
Feb-26	8	11	16
Mar-26	8	11	16
Apr-26	8	11	16
May-26	4	11	20
Jun-26	4	10	21

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Neonatal Mortality Review Status

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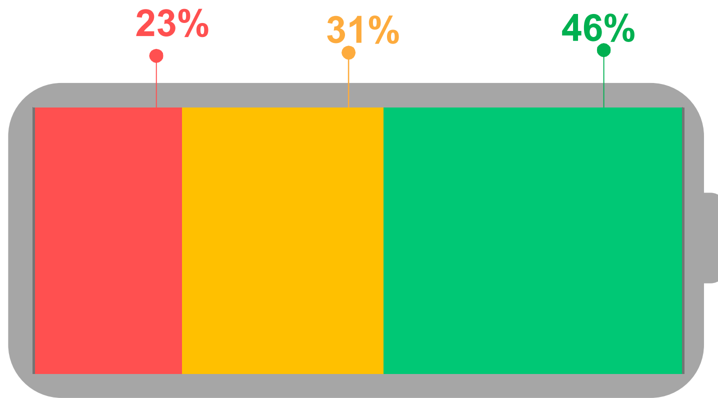
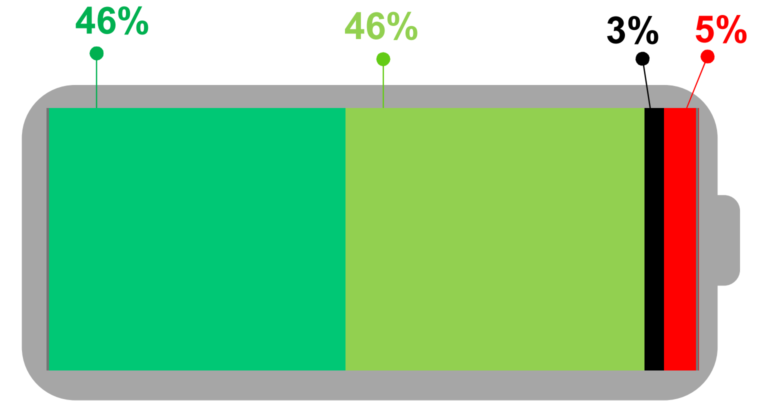
Delivery Battery



27/35 (77%) actions implemented

- 21 actions (46%) 'Evidenced and Assured'
- 10 actions (31%) 'Delivered, Not Yet Evidenced'
- 4 actions (23%) 'Not Yet Delivered'

Progress Battery



- 16 actions (46%) 'Complete'
- 16 actions (46%) 'On Track'
- 2 action (5%) 'Off Track'
- 1 actions (3%) 'Descoped'

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Phase 2

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Phase 2 batteries – Post Jun-26 MNTAC

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Overall Delivery

63% (152) Not Yet Delivered
15% (37) Delivered, Not Yet Evidenced
22% (53) Evidence & Assured

Overall Progress

22% (53) Complete
45% (110) On Track
3% (7) Descoped
1% (2) Off track
29% (70) 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	70% (21); 20% (6); 10% (3)	10% (3); 30% (9); 60% (18)
LMNS 3 Year Delivery Plan	7% (2); 43% (12); 50% (14)	50% (14); 46% (13); 4% (1)
Cultural Improvement Plan	92% (34); 5% (2); 3% (1)	3% (1); 49% (18); 48% (18)
CQC Neonates Action Plan	10% (1); 20% (2); 70% (7)	70% (7); 20% (2); 10% (1)
Neonatal External Mortality Review	11% (4); 29% (10); 60% (21)	60% (21); 34% (12); 3% (1); 3% (1)
Neonatal Unit Implementation Plan	91% (43%); 3% (1); 6% (3)	2% (1); 83% (39); 4% (2); 11% (5)
CQC National Review	25% (1); 50% (2); 25% (1)	25% (1); 75% (3)
Phase 2 Internal Actions	80% (4); 20% (1)	20% (1); 20% (1); 60% (3)

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Thank You.

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Maternity Governance: 19 June 2026

<table>
<tr><td>Agenda item</td><td colspan="4"></td></tr>
<tr><td>Report Title</td><td colspan="4">CNST MIS Year 8 - Progress Updates – June 2026</td></tr>
<tr><td>Executive Lead</td><td colspan="4">Martina Morris – Group Chief Nursing Officer</td></tr>
<tr><td>Report Author</td><td colspan="4">Lauren Taylor – Interim Head of Midwifery
Cecile Pollitt – Project Manager</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="2">CQC Domain:</td><td colspan="2">Link to Strategic Goal:</td><td>Link to BAF / risk:</td></tr>
<tr><td>Safe</td><td>√</td><td>Our patients and community</td><td>√</td><td rowspan="2">BAF1, BAF4,</td></tr>
<tr><td>Effective</td><td>√</td><td>Our people</td><td>√</td></tr>
<tr><td>Caring</td><td>√</td><td>Our service delivery</td><td>√</td><td>Trust Risk Register id:</td></tr>
<tr><td>Responsive</td><td>√</td><td>Our governance</td><td>√</td><td rowspan="2"></td></tr>
<tr><td>Well Led</td><td>√</td><td>Our partners</td><td></td></tr>
<tr><td colspan="2">Consultation Communication</td><td colspan="3">Maternity Governance Committee
Neonatal Governance Committee
Divisional Committee
Quality & Safety Assurance Committee
Maternity & Neonatal Safety Champions
LMNS PQSG
Board of Directors</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="2">Executive summary:</td><td colspan="3">This paper evidences progress against Year 8 of the CNST Maternity Incentive Scheme as of June 2026.

Work on evidencing compliance with Year 8 of the Maternity Incentive Scheme is underway. This paper provides assurance of progress against each Safety Action and note a compliance risk to Safet Action E, linked to the implemenation of the Maternal Care Bundle, which requires system partners collaboration (section 3.5.2).</td></tr>
<tr><td colspan="2">Recommendations for the Committee:</td><td colspan="3">Review and discuss this paper and its appendices and advise the Head of Midwifery of any further detail required.</td></tr>
<tr><td colspan="2">Appendices:</td><td colspan="3">Appendix 1 – MIS Audit Tool – June 2026</td></tr>
</table>

1. Introduction

1.1. The Scheme

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

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

1.2. Year 8 Guidance

1.2.1. Year 8 guidance was published on 31st March 2026, with version 1.0 and references a relevant time period of 1 April 2026 until 30 November 2026 though the expectation is for Trusts to maintain the standards year round.

1.2.2. Safety Actions were significantly revised for Year 8 with the previous ten safety actions condensed into six actions.

1.2.3. Self-declaration deadline is 2 March 2027, before which the Board will need to have attended a presentation on progress against all Safety Actions from the Perinatal Leadership Team.

1.3. This report

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

- An update on progress against delivery of Year 8 of the scheme.
- Any risks to the delivery of the scheme under the new safety actions technical guidance.

1.3.2. Included with this paper as an appendix is a detailed tracker against all Safety actions and their subitems, along with the evidence the service has identified and will be collating throughout the reporting period to support its compliance with the requirements.

2. Overall Progress Status

The below table summarises progress against each Safety Action and their subitems. Of the 27 subitems, 23 are In progress and On Track, 3 are Not Started and not yet due and 1 has been flagged a compliance Risk (See details in section 3.5.2 of this paper).

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully Evidenced	Total subitems
A	2	0	5	0	0	7
B	0	0	5	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	0	1	2	0	0	3
F	1	0	3	0	0	4
Total	**3**	**1**	**23**	**0**	**0**	

3. Safety Actions Status

3.1. Safety Action A: Workforce and Capacity

3.1.1. A1 – Consultant Attendance

- **Status:** Not Started
- Evidence of the processes in place to ensure consultant attendance is being collated for robustness. An audit will be conducted to check compliance but is not yet due.

3.1.2. A2 - Short-term locum certification (obstetric workforce)

- **Status:** Not Started
- Processes are in place to ensure the requirements of this action are met and evidence of those will be collated. An audit will be conducted to ensure compliance.

3.1.3. A3 – Neonatal Workforce Establishment (nursing & medical)

- **Status:** In Progress & On Track
- The neonatal monthly staffing report is being adapted jointly with Maternity to reflect the updated requirements.

3.1.4. A4 – Midwifery Workforce Establishment

- **Status:** In Progress & On Track
- The Maternity monthly staffing report is being adapted jointly with Neonatal Services to reflect the updated requirements. The most recent Birthrate+ report has been reviewed and staffing adjusted accordingly. A paper detailing the findings and changes is in circulation.

3.1.5. A5 – Anaesthetic Workforce

- **Status:** In Progress & On Track
- A closure paper, similar to the one produced in previous years, will be requested from the Anaesthetic Obstetric lead along with additional evidence to cover the added requirement linked to the anaesthetic assistant. Further evidence linked to the supplementary guidance will be sought as well.

3.1.6. A6 - Planned Caesarean birth capacity mapping

- **Status:** In Progress & On Track
- The service has already completed a demand-capacity review of its planned elective section activity but will conduct a second one taking into account SitRep data from other Trusts. The service itself doesn't appear within the regional data as it has not been impacted by delays in its elective section lists.

3.1.7. A7 – Board and Governance Oversight

- **Status:** In Progress & On Track
- Neonatal Staffing will be integrated into the existing Maternity Safe Staffing report to provide oversight of Perinatal Safe Staffing to Board.

3.2. Safety Action B – Training

3.2.1. B1 – Obstetric Emergency Training

- **Status:** In Progress & On Track

- PROMPT training is well embedded within the service. Content has been amended to reflect the new requirement for a scenario including Impacted Fetal Head.
- The new guidance required a mid-point compliance check where the service would meet 90% ahead of the end of the reporting period. This will be done using July's training compliance data, which will be available in August.
- Full compliance will only be achieved once November's training compliance has been compiled.

3.2.2. **B2 – Neonatal Resuscitation**

- **Status:** In Progress & On Track
- Neonatal Resuscitation (NLS) forms part of the annual mandatory curriculum delivered on "Day 3". The course includes the assessment and any staff who doesn't qualify at the end of that course has to repeat the day until competency is compliant with the standard. Any non-compliant staff cannot work clinically until they have passed the assessment.
- Additionally, the Neonatal Unit has been assessing competency against the BAPM Airway Standards and gaps will be addressed through training.

3.2.3. **B3 – Fetal Monitoring Training**

- **Status:** In Progress & On Track
- Fetal Monitoring is well embedded within the service and forms part of the programme for annual mandatory training.
- Training compliance will continue to be monitored and included in the quarterly Education paper for the service with any gaps escalated.

3.2.4. **B4 - In situ multi-professional perinatal emergencies simulations**

- **Status:** In Progress & On Track
- Simulation plans will be collated as evidence for this action, indicating the appropriate scenarios were conducted along with evidence of collaboration with other services and the MNVP.

3.2.5. **B5 - Training compliance oversight**

- **Status:** In Progress & On Track
- Training compliance forms part of the reports routinely provided to Board for Oversight. This will continue with any gaps escalated appropriately.

3.3. Safety Action C - Learning from reviews and investigations

3.3.1. **C1 – Notify all qualifying events**

- **Status:** In Progress & On Track
- PMRT is an embedded process within the service with regular reporting already part of the cycle of business. Guidelines and processes are being reviewed to ensure compliance with the SPEN system.

3.3.2. **C2 – Seek parents' views of care**

- **Status:** In Progress & On Track
- Seeking feedback within the PMRT process has been well embedded as part of previous years of CNST. Anonymised evidence will be collated additional to regular reporting to demonstrate good compliance.

3.3.3. **C3 – External multi-disciplinary reviewers**

- **Status:** In Progress & On Track

- Appropriate externality has been achieved in previous years and arrangements are in place to continue toward a target of 100% externality provided. This is monitored continuously and any downward trend will be escalated.

3.3.4. **C4 – Provide relevant information**

- **Status:** In Progress & On Track
- Process surrounding information provided to families are well embedded with PMRT and Duty of Candour. Examples will be collated as evidence. Work has been started with families to further improve language used to provide information on Duty of Candour, evidence of that work will be collated.

3.3.5. **C5 – Offer parents a meeting with relevant specialists**

- **Status:** In Progress & On Track
- Processes regarding meetings offered to families as part of the incidents and PMRT process are embedded within the service and subject to continuous improvement depending on feedback received from families. Evidence will be collated within the reporting period.

3.3.6. **C6 - Thematic reports of learning and actions**

- **Status:** In Progress & On Track
- Triangulation of thematic learning is now well embedded within the service along with sharing of learning. To further strengthen the process, a section will be added to the quarterly PMRT report, ensuring this is properly escalated through all relevant meetings.

3.4. Safety Action D - Service-user voice and equityA1 – Consultant Attendance

3.4.1. **D1 - Communication equity, language support and accessible information**

- **Status:** In Progress & On Track
- Interpretation services, including video translation when an in-person interpretor cannot be present are available within the service. Progress continues to improve the provision of leaflets in the languages spoken within the local community.

3.4.2. **D2 - Service-user voice driving safety and quality improvement**

- **Status:** In Progress & On Track
- Maternity and Neonatal Services now hold a joint Patient Experience Group in which feedback from Surveys, 15 steps and other engagement events will be reviewed and improvement actions will be devised collaboratively. Evidence will be collated throughout the reporting period.

3.5. Safety Action E – Care Bundles

3.5.1. **E1 – Saving Babies' Lives Care Bundle (SBLCBv3.2)**

- **Status:** In Progress & On Track
- The service fully implemented Saving Babies Lives in March 2024 and continues to report on compliance against the target set out in the tool. Those reports will continue to be provided to Board.

3.5.2. **E2 – Maternal Care Bundle Implementation Plan**

- **Status:** Compliance Risk
- A gap analysis of our current position has been completed and is currently being reviewed against the recently published implementation tool. Once completed, this will be provided to Board with an action plan for oversight and sign off.

- To note, the implementation of one element of the bundle will require system collaboration, notably with local GPs, to properly implement and is therefore not entirely within the Trust's control, so this item has been flagged as a compliance risk whilst further review is underway.

3.5.3. **E3 – Neonatal pulse oximetry testing**

- **Status:** In Progress & On Track
- A guideline including Neonatal Pulse Oximetry was ratified previously and is currently being reviewed to ensure it fully complies with the requirement before this item is marked as compliant.

3.6. Safety Action F - Board oversight, governance, culture and leadership

3.6.1. **F1 – Board Oversight of Maternity and Neonatal Quality and Safety**

- **Status:** In Progress & On Track
- Reports are routinely provided to QSAC along with Trust Board to provide oversight of Perinatal quality and Safety. The service is currently reviewing a new template to further improve the quality of the information provided to Board. Whilst this is being developed, current reporting will continue.

3.6.2. **F2 – Maternity Outcomes Signal System**

- **Status:** Not Started
- The service has never has a MOSS signal triggered and is reviewing how to proceed with a drill to provide assurance that should one be triggered, a timely and appropriate response will be completed. The appropriate sign off for this process will be sought.

3.6.3. **F3 - Maternity and Neonatal Board Safety Champions**

- **Status:** In Progress & On Track
- Maternity Nad Neonatal Safety Champions are well embedded within the service and appropriate challenge, dialogue and support continues to be provided. Evidence will be collated through the reporting period.

3.6.4. **F4 - Perinatal Culture Improvement Plan**

- **Status:** In Progress & On Track
- A Divisional Culture workstream is in place, which includes improvements to the Perinatal Culture. Improvements on reporting against progress for this plan are needed and a new reporting format is under consideration to include progress within the workstream, but also triangulate actions linked to culture within other forums.

4. Actions requested of the Board

- Review and discuss this paper.
- Receive the paper for assurance.

Maternity Governance- June 2026

<table>
<tr><td>Agenda item</td><td colspan="4">2026/258</td></tr>
<tr><td>Report</td><td colspan="4">Maternity Care Bundle- Gap Analysis</td></tr>
<tr><td>Executive Lead</td><td colspan="4">Martina Morris, Group Chief Nursing Officer</td></tr>
<tr><td rowspan="6"></td><td colspan="2">Link to strategic pillar:</td><td colspan="2">Link to CQC domain:</td></tr>
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<tr><td>For assurance</td><td>√</td><td colspan="2">BAF 1204</td></tr>
<tr><td>For decision / approval</td><td></td><td colspan="2">Link to risk register:</td></tr>
<tr><td>For review / discussion</td><td></td><td colspan="2" rowspan="4"></td></tr>
<tr><td>For noting</td><td></td></tr>
<tr><td>For information</td><td>√</td></tr>
<tr><td>For consent</td><td></td></tr>
<tr><td>Presented to:</td><td colspan="4">Maternity Governance – June 2026</td></tr>
<tr><td>Dependent upon:</td><td colspan="4">NA</td></tr>
<tr><td>Executive summary:</td><td colspan="4">This report presents the findings of a gap analysis undertaken to assess the implementation of the Maternity Care Bundle within The Shrewsbury and Telford Hospital NHS Trust (SaTH). The Maternity Care Bundle sets out a series of evidence-based interventions designed to improve safety, reduce variation in care, and enhance outcomes for women and babies. Its effective implementation is essential to delivering high-quality, consistent maternity services aligned with national standards.</td></tr>
<tr><td>Appendices</td><td colspan="4">• Appendix 1- Gap Analysis of the Care Bundle</td></tr>
</table>

1.0 Introduction

The Maternity Care Bundle is a nationally recognised framework designed to improve the quality, safety, and outcomes of maternity services. It brings together a set of evidence-based practices and interventions aimed at reducing variation in care, enhancing clinical consistency, and ensuring that women and babies receive safe, personalised, and effective care throughout the maternity pathway.

The bundle supports multidisciplinary collaboration and aligns with national priorities to reduce maternal and neonatal morbidity and mortality.

This report focuses on the implementation of the Maternity Care Bundle within The Shrewsbury and Telford Hospital NHS Trust (SaTH). Through a structured gap analysis, the report will assess current practice against the standards and expectations outlined within the bundle. The aim is to identify areas of strength as well as gaps in compliance, processes, or outcomes, thereby highlighting opportunities for improvement.

The findings will inform recommendations to support continuous quality improvement and the delivery of high-quality, evidence-based maternity care across SaTH.

2.0 Elements

This section provides a detailed narrative analysis of each core element within the NHS England Maternity Care Bundle (MCB). Highlighting the systemic and cross boundary nature of these clinical mandates, full implementation cannot be achieved by the Shrewsbury and Telford Hospital Trust in isolation. The following breakdown outlines the specific strategic, operational and financial support SaTH requires from external healthcare partners, commissioners and regional networks to achieve compliance by the national March 2027 deadline.

Element 1- Venous Thromboembolism

Element 1 completely shifts the timeline for VTE risk identification away from traditional hospital "booking" appointments and pushes it to the very first contact of pregnancy, a trust cannot deliver this internally within a standard maternity unit alone.

1. **Primary Care and Community Integration (GPs and Pharmacies)**

The care bundle mandates a universal early VTE risk assessment at the first NHS care contact with a positive pregnancy test. Since this interaction almost always happens in the community before a formal midwife booking, massive external support is required from:

- **General Practitioners (GPs):** To incorporate the early screening tool into their initial pregnancy confirmation consultations.
- **Community Pharmacies & Urgent Care Centres:** Clear pathways must be established so that if a woman presents here early in pregnancy, the screening is triggered immediately.

2. Integrated Care Boards (ICBs) and Local Maternity and Neonatal Systems (LMNS)

Regional healthcare commissioners and oversight bodies provide the critical operational scaffolding:

- **Cross-Provider Protocols:** The LMNS is responsible for leading the co-production and maintenance of clinical protocols that span across different organisations. They ensure that if a woman is screened in a community hub, her risk profile transfers to the secondary care trust.
- **System-Wide Funding and Resourcing**: ICBs must review and allocate adequate funding across regional networks to support the increased demand for Low Molecular Weight Heparin (LMWH) prescriptions and administrative tracking.

3. Co-Production of National Standardised Screening Tools

SaTH require validated, resources from external clinical and charitable bodies to avoid regional variation:

- **Thrombosis UK Support:** Alongside national expert working groups and NHS England, Thrombosis UK has developed a brief, targeted self-assessment questionnaire specifically designed to identify high-risk individuals in early pregnancy. Trusts require direct adoption or integration of this specific tool into their existing digital and paper medical questionnaires.

4. Specialised External Clinical Sectors (Cross-Boundary Services)

Because VTE risk exists independently of live birth outcomes, integration with external clinical specialists is explicitly required:

- **Abortion Care Providers:** External independent and NHS abortion services must embed the national VTE risk assessment into their medical questionnaires. If a woman screens positive, these external providers are required to prescribe and distribute a 1-week post-procedure course of LMWH.
- **Emergency Departments (ED) and Early Pregnancy Assessment Units (EPAUs):** Frontline urgent care services require specific clinical pathways to trigger VTE screening immediately upon a pregnant patient's attendance for related complications (e.g., hyperemesis gravidarum causing severe dehydration).

5. Secondary Care Specialist Links

To handle the downstream impact of early screening, SaTH will require immediate, structured escalation pathways to:

- **Obstetric Haematology Specialists**: For rapid consultation on complex cases or women with a history of recurrent VTE.

- **Pharmacy Supply Chains:** Ensuring immediate, unhindered access to LMWH within 72 hours of identification without waiting for ultrasound confirmation of a viable pregnancy.

Element 2 – Pre Hospital and Acute Care

Shrewsbury and Telford Hospital must bridge the gap between emergency frontline services and specialist maternity care. The core objective of Element 2 is ensuring that acutely unwell pregnant or postpartum women receive the right care at the right time, preventing delays in identifying clinical deterioration. Because this element directly interfaces with emergency medicine, ambulance services, and hospital estates, the implementation requires a highly coordinated, cross-departmental approach.

1. **Governance and Board-Level Planning**

   Implementation must be driven from the top down to ensure cross-directorate cooperation between Maternity, Emergency Medicine, and Acute Medical Units (AMU).

- **Board-Approved Implementation Plan:** SaTH must secure formal Board approval for a localised plan that explicitly loops in all overlapping services (maternity, anaesthetics, emergency medicine, critical care, and facilities).
- **Quarterly Progress Audits:** Progress against Element 2, implementation gaps, and risk mitigation must be documented and reviewed quarterly through existing maternity and neonatal safety governance routes.

2. **Standardisation of MEWS (Maternal Early Warning Score)**

To eliminate variation in how a deteriorating patient is spotted, trusts are required to embed a unified, common approach to clinical monitoring.

- **Trust-Wide Alignment:** Trusts must transition to a standardised Maternal Early Warning Score (MEWS) system that operates seamlessly across all clinical settings where a pregnant woman might present—not just on the labour ward, but within the Emergency Department (ED), Intensive Care, and Urgent Treatment Centres.
- **Implementation Themes:** Starting in April 2026, national support frameworks focus on preparing trusts across four core pillars: leadership and staff readiness, digital systems integration (ensuring electronic patient records trigger MEWS correctly), guideline alignment, and standard metrics collection.

3. **Local Maternity Medicine Network Integration**

Trusts cannot operate in isolation; they must align directly with their regional Maternal Medicine Network (MMN) to standardise pathways for non-obstetric medical emergencies in pregnancy (such as acute cardiac, respiratory, or neurological issues).

- **Co-Produced Referral Protocols:** SaTH must comply with and integrate the MMN's regional protocol for the management, escalation, and rapid referral of complex medical conditions.
- **Escalation Pathways:** Clear, operational pathways must exist to escalate clinical issues fluidly between non-specialist acute medical teams, local maternity services, and regional specialised maternal medicine centres.

4. **Estates, Signage, and Physical Access for Ambulance Services**

A highly practical but critical intervention in Element 2 focuses on removing the physical barriers that regional ambulance crews face when transferring critically ill obstetric patients into the hospital.

- **Standardised Visual Signage:** SaTH must collaborate with their Estates/Facilities management and regional Ambulance Services to overhaul physical hospital signage. Signs must be highly visible to arriving vehicles, coloured in red, and explicitly state "Maternity ambulances".
- **Dedicated Access Pathways:** The designated ambulance parking area must lead directly to the labour ward via a clear, unobstructed route fully suitable for heavy stretchers. Swipe-card barriers, secure doors, and lift clearances must be physically reviewed, audited, and tested by external clinicians who do not routinely work within the trust's maternity unit to ensure zero delays during an active emergency drop-off.

Element 3- Epilepsy in Pregnancy.

Element 3 addresses a critical area of indirect maternal mortality by standardising and accelerating access to specialist multidisciplinary care for pregnant and postpartum individuals with epilepsy. Because anti-seizure medication (ASM) clearance rates alter rapidly due to pregnancy physiology, and because uncontrolled seizures present severe risks to both maternal and fetal safety, this element mandates immediate risk stratification and structured, cross-specialty clinical management.
Achieving this standard requires a highly combined operational link between acute secondary care maternity services, community medicine, and specialised adult neurology networks.

1. **Required External Support and Interventions**

To build a resilient, compliant pathway that meets national standards, SaTH requires targeted support from external systems and regional providers:

- **Adult Neurology and Epilepsy Specialist Integration:** SaTH requires formal workforce and scheduling agreements with regional acute neurology services to establish and sustain a local Joint Obstetric-Neurology Multi-Disciplinary Team (MDT) clinic. This must include dedicated, contracted sessions from an external Epilepsy Nurse Specialist or Consultant Neurologist to work directly alongside SaTH's Maternal Medicine Obstetricians.
- **Maternal Medicine Network (MMN) Pathways:** Clear governance and tertiary escalation pathways must be formalised by the regional MMN. This ensures that complex epilepsy cases—particularly those involving drug-resistant epilepsy or patients requiring complex polytherapy adjustments—can be rapidly reviewed or transferred to a specialised regional maternal medicine centre without delay.
- **Primary Care (GP) Safety-Netting Protocols**: Direct external alignment with regional General Practitioners is required to optimise pre-conception care and early pregnancy signalling. GPs must be supported to universally trigger high-dose folic acid (5mg) prescribing and immediate secondary care referrals the moment an epilepsy diagnosis is disclosed at pregnancy confirmation.
- **National Evidence-Based Educational Frameworks:** SaTH requires co-produced clinical tools and communication toolkits from national bodies (such as SUDEP Action and relevant Royal Colleges). This support ensures that frontline midwives can deliver consistent, evidence-based, and empathetic counselling regarding Sudden Unexpected Death in Epilepsy (SUDEP) risks and lifestyle safety modifications without causing undue maternal anxiety.
- **Integrated Care Board (ICB) Digital Infrastructure Investment:** Capital and digital development support from the ICB to enhance SaTH's Electronic Patient Record (EPR) workflows. This is required to configure automated "safety-netting" flags that automatically alert the multidisciplinary team if a high-risk epilepsy patient misses an appointment or requires third-trimester fetal growth surveillance due to specific ASM exposures.

Element 4- Maternal Mental Health.

1. Clinical Objectives & Governance Framework

Mental health concerns remain a leading cause of indirect maternal deaths in the UK, particularly within the first postpartum year. The objective of Element 4 is to establish a standardised pathway for the early identification, tracking, and rapid referral of perinatal mental health concerns across SaTH's maternity footprint. SaTH will align this strategy directly with NICE Guideline CG192 (Antenatal and Postnatal Mental

Health) and monitor implementation progress through quarterly reports to the trust's Quality Assurance and Safety Committees.

2. Implementation Methodology

- **Stage 1: Universal Screening & EPR Mandatory Fields**

To eliminate regional variation in how maternal distress is identified, SaTH will embed standardised screening protocols across all entry points:

The Whooley Questions & GAD-2: Frontline midwives will universally administer the Whooley questions (for depression screening) and the GAD-2 scale (for anxiety screening) at initial booking, at 28 weeks gestation, and during the immediate postnatal contact.

EPR Hard-Stops: SaTH's Electronic Patient Record (EPR) system will be updated to include mandatory fields for these screening scores. A midwife will be unable to progress or close an antenatal consultation entry without completing the mental health assessment block, mitigating the risk of missed assessments.

- **Stage 2: Enhancing the Specialist Midwifery Footprint**

Perinatal Mental Health Specialist Midwives: SaTH will secure and deploy dedicated Specialist Midwives to oversee the local caseload. These specialists will act as the operational bridge between routine community midwifery teams and acute psychiatric services.

Triage: Any positive screen generated in the community or triage units will route directly to SaTH's specialist midwifery team for secondary clinical triage within 48 hours, ensuring no woman "falls through the gaps" between primary and secondary care.

- **Stage 3: Integrated Cross-Boundary Pathways and Escalation**

For women identified with moderate-to-severe mental health conditions (or a past history of severe psychosis/bipolar disorder), SaTH will establish direct rapid-access pathways:

Joint Perinatal MDT Clinics: SaTH will host joint multidisciplinary clinics bringing together Obstetricians, Obstetric Physicians, Specialist Midwives, and the external Midlands Partnership University NHS Foundation Trust (MPFT) Specialist Perinatal Mental Health Team.

Fast-Track Emergency Escalation: Clear clinical triggers will be updated within the Maternity Triage Unit for emergency psychiatric escalation. If a woman presents with signs of rapid postpartum deterioration or suspected postpartum psychosis, a direct, immediate referral protocol to the regional Mother and Baby Unit (MBU) will bypass standard acute medical admission routes.

3. Workforce Education and Competency Tiered Training Framework: All frontline maternity staff, including obstetricians, sonographers, and maternity support workers (MSWs), will complete mandatory, tiered perinatal mental health training via the e-Learning for Healthcare (e-LfH) platform.
Trauma-Informed Care: Staff working within the inpatient areas will receive specialised training in trauma-informed care to effectively support women presenting with severe tokophobia (fear of childbirth) or previous birth-related post-traumatic stress disorder (PTSD).

4. Patient Information and Co-Production
Culturally Sensitive Resources: SaTH will partner with the local Maternity Voices Partnership (MVP) to co-produce and distribute multilingual digital and paper information packs. These materials will explicitly de-stigmatise mental health reporting and provide clear, local self-referral contact numbers for talking therapies (Shropshire Digital NHS Talking Therapies) and crisis helplines.

Element 5 – Postnatal Care and Prevention of Future Maternal Mortality

This element mandates a structured, personalised approach to the transition of care from secondary obstetric services to community-based primary care. It ensures that critical risk factors identified during pregnancy or birth are proactively communicated, monitored, and mitigated, rather than being lost during discharge.

Required External Support and Interventions

- **Primary Care (GPs and Primary Care Networks)**: Direct operational collaboration is required to standardise the handover process for the mandatory 6-to-8-week maternal postnatal GP consultation. SaTH requires GPs to utilise a unified clinical template that prioritises maternal physical and psychological recovery.
- **Integrated Care Board (ICB) Digital and Data Alignment**: SaTH requires ICB-led digital infrastructure support to implement a robust, automated electronic discharge summary system. This IT infrastructure must ensure that complex intrapartum data (e.g., gestational diabetes, new-onset gestational hypertension, or severe postpartum haemorrhage) triggers immediate, high-priority actions within primary care clinical systems (such as EMIS or SystmOne) without manual administrative delays.
- **Specialist Community Services and Health Visiting Networks**: Formalised pathways must be established with external health visiting providers (such as Shropshire Community Health NHS Trust and neighbouring provider networks). This ensures that clinical alerts are shared bi-directional, allowing community health visitors to provide targeted home-surveillance that complements the midwifery discharge plan.
- **Public Health and Local Authority Commissioning:** SaTH requires aligned public health commissioning to support postpartum health optimisation. This includes securing direct, fast-track referral routes for vulnerable or high-risk

postpartum women into external, community-funded public health programs, including smoking cessation services, gestational diabetes follow-up clinics, and weight-management or metabolic health pathways.

- **National and Charitable Resource Co-Production:**
  Provision of standardised, multilingual, and highly accessible patient education toolkits from national bodies (such as the Royal College of Obstetricians and Gynaecologists and relevant maternal charities). These resources are required to ensure that women discharged from SaTH receive consistent, evidence-based guidance on postpartum "red flag" symptoms (e.g., signs of late-onset pre-eclampsia, deep vein thrombosis, or severe infection) and clear instructions on how to access emergency services.

3.0- Gap Analysis

Appendix 1 outlines a detailed breakdown of the components within the gap analysis form, providing the committee with a clear understanding of the baseline position.

4.0 Conclusion/ Next steps

In conclusion, this report highlights the current position of SaTH in relation to the Maternity Care Bundle. An updated progress report on the implementation of the Maternity Care Bundle will be presented on a monthly basis at Maternity Governance, Safety Champions, QSAC, and Board meetings.

Appendix 1- Gap Analysis

Care Bundle Element	Care Bundle Recommendation	Local Policy / Practice Evidence	Recommendation Met?	Gap Identified	Actions Required
Element 1: Venous Thromboembolism	1.1 Women should be offered the national self-assessment questionnaire on VTE risk at first NHS care contact with a positive pregnancy test. Those identified as being at high risk of VTE should be offered low molecular weight heparin (LMWH) and receive it within 72 hours*.	Clinical Risk Assessment and Referral guideline: urgent referral made for ANC "within 1 week"	Partial	Women don't get offered the questionnaire. Referral aims at within week not 72 hours	* ?Provide women with self-assessment questionnaire when registering pregnancy via any method of referral. *? Refer to Emergency ANC for quicker face to face consultation and prescription. *Information made available on internet
	1.2 The ICB has arrangements in place for LMWH to be prescribed in early pregnancy (that is, before antenatal booking) within 72 hours, and for a follow-up consultation to take place within 4 weeks in secondary care*.	Clinical Risk Assessment and Referral guideline: urgent referral made for ANC "within 1 week"	Partial	Women don't get offered the questionnaire. Referral aims at within week not 72 hours	*? Provide women with self-assessment questionnaire when registering pregnancy. *? Refer to Emergency ANC for quicker face to face consultation and prescription.
	1.3 Women identified as being at high risk of VTE and not already taking clot preventing medication should be offered a standardised dose of LMWH	Thromboprophylaxis in Pregnancy and Puerperium Guideline	Partial	Local standardise dose differs	*? Review doses

Element 2: Pre-hospital and acute care	2.1 Implement the national maternity early warning score (MEWS) tool across all settings for women who are or have been pregnant in the past 4 weeks. This means ensuring timely obstetric team and/or obstetric physician review in line with the MEWS escalation timeframes, according to the total score identified and relevant additional concerns.	In progress Care of women on Critical Care SOP	Partial	National MEWS not rolled out locally	*Update local guidance *Implement national MEWS. *Badgernet integration *HDU charts *All areas including ED/Critical Care have updated MEWS charts
	2.2 Implement a standardised pre-alert communication system between the ambulance service and labour ward and ensure adequate signage for all labour wards so that ambulance services can convey women with an obstetric emergency or red flags promptly and appropriately.		Partial	Red phone - SOP / signage	Signage - WMAS / Contact to confirm SOP
	2.3 Establish acute referral pathways from local services to the maternal medicine centre (MMC) for acutely unwell pregnant or recently pregnant women presenting with symptoms or diagnostic uncertainty necessitating maternal medicine expertise. Maternity services and the maternity medicine network (MMN) should review these pathways annually.	Referral to MMN policy	Partial	To review pathway	

Element 3: Epilepsy in Pregnancy	3.1 Every pregnant woman with epilepsy has access to a local epilepsy in pregnancy team who will ordinarily lead the early pregnancy, intrapartum and postnatal care plans in line with the local maternal medicine network's (MMN) management and escalation protocol. The local team will consist of, at a minimum: * epilepsy nurse specialist or neurologist * Maternal medicine obstetrician * obstetric physician	Local Epilepsy in Pregnancy Guideline: "WWE who are pregnant will be seen in the joint epilepsy obstetric clinic by the designated epilepsy care team comprising an epilepsy specialist nurse, obstetrician with a maternal medicine interest and midwives (RCOG 2016) whilst continuing their community care with their community midwife. "	Partial	Service provision/ Guideline review / operations input	
	3.2 Women requiring more complex epilepsy care should be referred by the local epilepsy in pregnancy team to a maternal medicine network (MMN) multidisciplinary team (MDT) who can oversee and – where necessary – lead the provision of care.	Referral to MMN policy Epilepsy in Pregnancy Guideline	Yes		
Element 4: Maternal Mental Health	4.1 As part of routine emotional wellbeing screening, women should be invited to **self-administer** the Whooley questions ahead of the: Booking, 25-28 week and 31-34 week antenatal appointments and the 10-14 day postnatal appointment		No	Women not advised to self-administer question/ Contact system C	*Design simple patient leaflet with these questions *Auto push reminders at 6-8 weeks/ 25 weeks/ 31 weeks and 1 week PN *Information to be uploaded to the publicly accessible internet

	4.2 When a woman responds positively to either of the Whooley questions or there is concern, she should be invited to complete a further assessment using the Edinburgh Postnatal Depression Scale (EPDS). Where appropriate, this could be by self-administration		No	Edinburgh Postnatal Depression Scale not utilised in local guidance	*Guideline update to include this additional assessment
	4.3 If a woman screens positive using EPDS (scores 13 or above in total or 2 or above on self-harm) or there is clinical concern, allow sufficient time in the same appointment to offer the woman a compassionate conversation to explore needs, discuss care options, agree next steps and receive referral to appropriate services if indicated.	Referral process in place for PMHT, IWH, Health visitor or GP dependent on situation as per local "Mental Health - Antenatal & Postnatal" guideline	Partial	Edinburgh Postnatal Depression Scale not utilised in local guidance	*Guideline update to include this additional assessment/ reviewing to extend appointment times
Element 5: Obstetric Haemorrhage	5.1 Measure cumulative blood loss for all births in community and secondary care settings. This includes ensuring access to key resources including: * scales – available at all births with swab weight chart to record and assess blood loss accurately * under-buttock blood collection drapes for assisted vaginal births * access to an obstetric haemorrhage emergency kit – that is, a trolley or grab bag for all births and postnatal settings * documentation tool for individual patient records to be updated in real time	Postpartum Obstetric Haemorrhage guideline. Assisted vaginal birth guideline Obs UK proforma Scales included in home birth equipment checklist PPH trolley on del suite and PNW	Yes		

	5.2 Standardised definition and reporting of postpartum haemorrhage (PPH) and points of escalation by cumulative measured blood loss: * by 500mL loss* and ongoing bleeding: - for community births, escalation and help sought, with plans made for immediate transfer to secondary care. - in secondary care, midwife in charge and the first-line obstetric and anaesthetic staff should be alerted * by 1,000mL loss,* senior midwife, obstetrician (ST3 equivalent or above) and anaesthetist should all be present and managing as an obstetric emergency * by 1,500mL loss,* consultant obstetricians should be informed, with attendance required if bleeding ongoing, unstable or deteriorating standardising reporting of PPH at 1,500mL* *** Clinical judgement should be used to escalate earlier if required, taking into consideration the woman's individual risk factors that may lead to an earlier deterioration and the skill mix of the clinical team attending.**	Postpartum Obstetric Haemorrhage guideline.	Yes		
	5.3 Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month.	Postpartum Obstetric Haemorrhage guideline. Datix trigger list being updated	Yes	Cryoprecipitate and Fibrinogen use not current trigger for review but would occur with MOH datix in general	Cryoprecipitate and Fibrinogen use to be reviewed monthly as MDT. And added to PPH governance report

The Shrewsbury and Telford Hospital NHS Trust

Divisional Committee Meeting
May 2026

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<tr><td>Executive Lead</td><td colspan="4">Paula Gardner Interim Chief Nursing Officer</td></tr>
<tr><td>Report Author</td><td colspan="4">Jacqueline Bolton- Interim Head of Midwifery
Lauren Taylor – Deputy Head of Midwifery</td></tr>
<tr><td rowspan="6"></td><td colspan="2">Link to strategic goal:</td><td colspan="2">Link to CQC domain:</td></tr>
<tr><td>Our patients and community</td><td></td><td>Safe</td><td>√</td></tr>
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<tr><td>For information</td><td>√</td></tr>
<tr><td>For consent</td><td></td></tr>
<tr><td>Presented to:</td><td colspan="4">Maternity Governance</td></tr>
<tr><td>Executive summary:</td><td colspan="4">Birthrate Plus® (BR+) is a framework for workforce planning consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings endorsed by the RCM and RCOG.

The Independent Review of the Birthrate Plus® Methodology published in February 2026 concluded that the tools remains an appropriate and credible foundation for midwifery workforce planning.

The Maternity Incentive Scheme (MIS) Year 8 Safety Action A requires that Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate.

The total clinical establishment as produced from Birthrate Plus® is 206.83wte and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.</td></tr>
<tr><td>Appendices</td><td colspan="4">Appendix 1: Birthrate Plus® report.
Appendix 2: Independent Review of the Birthrate Plus® Methodology</td></tr>
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Executive Lead	Paula Gardner Interim Chief Nursing Officer

1. Introduction

1.1 Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published

1.2 It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

1.3 The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

1.4 The Birthrate methodology aligns with the NICE safe staffing guideline for maternity settings and is endorsed by both the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG). The RCM recommends Birthrate Plus® as the only recognised national tool for systematically assessing midwifery staffing needs. While birth outcomes depend on more than staffing levels alone, applying a validated, widely used tool is essential to ensure safe staffing and one-to-one intrapartum care (NICE 1.1.3).

1.5 The Independent Review of the Birthrate Plus® Methodology published in February 2026 concluded that the tool remains an appropriate and credible foundation for midwifery workforce planning. However, highlights identified recommendations from the review of short term and medium-long term development of the Birthrate Plus® tool, which ill further strengthen the recognition of the increase medical and social complexity of the birthing population.

1.6 As a maternity service with the Hospital Transformation Programme (HTP) relocation of the services in the next few years will have an impact on potential retirements.

1.7 Furthermore, we have seen a significant shift in the age demographic of the midwifery workforce and the impact on increasing unavailability for parenting leave.

2. Assessment

2.1 The assessment took place in 2025 and the results are based on casemix data obtained during the months April, July and September 2025.

The annual activity period used was 2025 Annual births decreased from 4439 in 2022 to 4070 in 2025. Casemix acuity has risen, with a shift from lower-risk Categories I–III to higher-risk Categories IV–V, driven by factors like diabetes, mental health, high BMI, and increased induction and operative deliveries. Additional intrapartum activity includes antenatal cases needing 1:1 care, postnatal readmissions, escorted transfers, high-risk inductions of labour, and non-viable pregnancies.

2.2 Table 1 shows there has been an increase in the acuity of women with 69.6% of women being in the 2 higher categories. The 2022 generic casemix shows the % in Categories I to III was 37.5% and has reduced to 30.4%. This reduction results in the increase in IV and V and as before, the highest % is in Category V. Factors impacting upon the Casemix include more co-morbidities such as diabetes, mental health, high BMI, increased induction rates usually in line with national clinical guidance, increase in operative deliveries, neonatal factors are some of the contributing reasons.

Table 1

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
Delivery suite & Wrekin MLU - 2025	2.8	7.9	19.7	28.8	40.8
		30.4%			**69.6%**
Delivery suite & Wrekin MLU – 2022	*3.0*	*10.4*	*24.1*	*30.8*	*31.7*
		37.5%			**62.5%**

2.3 The casemix is unique to each service as reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines.

3. Findings

3.1 Maternity wards 21 and 22 show significant antenatal and postnatal activity, including 60 ward attenders and medical outliers being seen by staff from ward 22. Ward 21 have seen an increase in extra care babies from the 2022 report from 192 reported cases to 301 reported cases in 2025, this is an increase of 109 cases.

3.2 The 2025 Birthrate Plus assessment recommends a WTE of 206.83wte RM's & PN MSWs.

3.3 Table 2 shows the breakdown of the clinical staffing.

Table 2

Breakdown of Birthrate Plus® Clinical Staffing **Shrewsbury and Telford Hospitals NHS Trust**

Intrapartum Services	59.80wte RMs
Triage and Advice Line	18.52wte RMs
Antenatal Ward 22	16.67wte RMs
Postnatal Ward 21 including TCU	45.33wte RMs and PN MSWs
Outpatient Services	12.06wte RMs
Day Unit	2.08wte RMs
Total for Shrewsbury & Telford Hospital services	154.46wte RMs and PN MSWs
Community WTE	
Community (Home births, antenatal and/or postnatal care, attrition and safeguarding)	52.37wte RMs and PN MSWs
Total Clinical WTE	**206.83wte RMs and PN MSWs**

3.4 The current budget for midwifery staffing is aligned to the recommendations of 2025 Birthrate Plus assessment however this is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care.

3.5 While there are no changes required to the funded establishment, there is a requirement to apply professional judgement to the staffing recommendations for the postnatal ward in line with the casemix findings.

3.6 The establishment for delivery suite and postnatal ward has been updated to reflect this which is in keeping with the requirements to provide safe staffing to these areas.

3.7 The service currently exceeds this establishment as there are some roles which are externally funded in order to progress with the quality improvements required to deliver against Ockenden etc.

BirthratePlus Working.

BR+ Recommended

Total Clinical WTE: 206.8
Of above MSWs: 16.3
Of above RMs: 190.5

This includes all ward management and includes unavailability (24% and 21.5%) including 4% sickness (bank), this is the WTE for bands 3-7.

Comprises

	RMs	MSWs	Total
BR+ Recommended Total Substantive WTE:	184.3	15.8	**200.1**
BR+ Recommended Total Bank WTE:	6.1	0.5	**6.7**
	190.5	**16.3**	**206.8**

Staff in Post M12

	RMs	MSWs	
M12 Total Worked Substantive WTE:	181.5	19.8	**201.3**
M12 Total Worked Bank WTE:	15.2	1.3	**16.5**
	196.7	**21.1**	**217.8**

Difference Actual

	RMs	MSWs	
Substantive Difference WTE:	2.9	- 4.0	- **1.2**
Bank Difference WTE:	-9.1	-0.7	- **9.8**
	-6.2	**-4.8**	- **11.0**

Substantive is almost exactly in line with recommended numbers, bank is over the recommended, but we have schemes to reduce this and have higher sickness unavailability than 4%.

Recurrent Budget M12

	RMs	MSWs	
M12 Total Budget Substantive WTE:	182.7	17.2	**199.9**
M12 Total Budget Bank WTE:	5.8	0.6	**6.4**
	188.5	**17.8**	**206.3**

Difference Budget

	RMs	MSWs	
Substantive Difference WTE:	1.7	-1.4	
Bank Difference WTE:	0.3	0.0	
	2.0	**-1.4**	**0.6**

Budget is almost exactly correct, our mix of budget between MSW and RM is slightly different to the report.

Specialist Midwives Management
BR+ recommended Specialist and Management posts: 24.28wte

M12 Total work substantive WTE – 24.7
M12 Difference Substantive WTE- 0.1

To note The BR+ report assumes that the Specialists Midwives contribute to 10.68WTE to clinical rosters however, Specialist Midwife Clinical time is in clinics, hence there is no contributions to the roster.

There is no nationally recognised uplift required for midwifery workforce in Specialist Midwifery roles, however, a number of national incentives require organisations to ensure a Specialist is in role to meet national requirements, for example, Pelvic Health Programme, Birth Trauma Report, National Bereavement Pathway, MBRRACE, Education and Training.

As shown above our budgets and actual wte match the BR+ report, the only difference is bank, which we are actively managing through CIP schemes.

4. Recommendations

Women and Children's Divisional Committee are asked to:

4.1 Take assurance from the content of this paper.

4.2 Advise if any next steps are required.

Board of Directors' Meeting in Common – 9 July 2026

Agenda item	Board Information Pack Item
Report Title	Shropshire Community Health NHS Trust (SCHT) Annual Infection Prevention and Control Report 2025/26
Executive Lead	Martina Morris, Group Chief Nursing Officer
Report Author	Sara Ellis-Anderson, Director of Nursing – Community (Interim)

Prior Consultation:	CQC Domain:		Link to (SATH) BAF id(s)
SCHT Infection Prevention and Control Committee 18th June 2026 and SCHT Quality and Safety Committee 29th June 2026	Safe	√	
	Effective	√	
	Caring	√	**(SaTH) Risk Register id(s):**
	Responsive	√	
	Well Led	√	

Executive Summary	The IPC Annual Report is a statutory requirement demonstrating compliance with the Health and Social Care Act 2008 and provides assurance on the Trust's arrangements for Infection Prevention and Control. **Assure** • Zero MRSA bacteraemias and a reduced number of outbreaks demonstrate strong infection control performance. • Antimicrobial stewardship is embedded across services, with routine pharmacy review, audit and challenge of prescribing noted. • IPC training compliance of 98% overall and organisational processes to complete annual hand hygiene assessments for all staff provide strong assurance of workforce capability and safe practice. • Delivery of IPC strategic ambitions, focused on integrated working, strengthening education and workforce capability, enhancing digital reporting and communication, and improving engagement achieved. **Advise** • Continued focus is required on reducing Clostridioides difficile (C. difficile) incidence, improving MRSA screening compliance and sustaining delivery of the IPC improvement plan. • For 2026/27, priorities include strengthening vaccination uptake, enhancing IPC training and skills in high-risk areas, embedding digital solutions to improve surveillance and reporting, and continuing collaborative quality improvement programmes to standardise practice and reduce variation.

	Alert • Clostridioides difficile (C. difficile) cases totalled 11 in 2025/26 against a threshold of 4. This requires continued focus on prevention, early identification and management, while recognising that the increase reflects wider regional and national trends.
Recommendations for the Boards	The Boards are asked to **note** this report for information and assurance.
Appendices:	Appendix 1: Shropshire Community Health NHS Trust Annual IPC Report 2025/26.

Shropshire Community Health NHS Trust

INFECTION PREVENTION AND CONTROL

ANNUAL REPORT 2025-26

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The Criteria of the Health and Social Care Act (2008: revised 2022) 7

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them 8

Criterion 2 – The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections 14

Criterion 3 – Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance 16

Criterion 4 – The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion 26

Criterion 5 – That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people 27

Criterion 6 – Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection 28

Criterion 7 – The provision or ability to secure adequate isolation facilities 29

Criterion 8 – The ability to secure adequate access to laboratory support as appropriate 29

Criterion 9 – That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections 29

Criterion 10 – That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control 30

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Foreword by Sara Ellis-Anderson, Interim Director of Community and Deputy Director of IPC

As Interim Director of Nursing for Community Services, I am pleased to present the Infection Prevention and Control Annual Report for 2025/26.

This report reflects the continued commitment of Shropshire Community Health NHS Trust to delivering safe, high-quality care, with infection prevention remaining central to patient safety across all services.

During the year, we have maintained strong performance in key areas, including zero MRSA bacteraemia cases and effective management of outbreaks, demonstrating organisational resilience and robust IPC practices. The Infection Prevention, Education and Advisory Team (IPEAT) have driven progress through our four strategic ambitions, strengthening system collaboration, enhancing education, enhancing digital capability and supporting quality improvement across the organisation.

We have also strengthened our multidisciplinary approach to infection prevention, working closely with pharmacy colleagues to embed antimicrobial stewardship across services, ensuring safe and effective use of antimicrobials and contributing to the reduction of antimicrobial resistance.

Partnership working has continued to be a key strength, including collaboration with Occupational Health to support staff health and vaccination programmes, and with Estates teams to maintain safe environments, including water safety and ventilation systems, providing assurance of safe care environments for patients and staff.

I would like to take this opportunity to thank colleagues across the Trust for their continued commitment to infection prevention and control. The work described in this report reflects the everyday efforts of staff in all roles, who consistently support safe practice and high standards of care.

I would also like to recognise the contribution of the Infection Prevention, Education and Advisory Team, whose support, advice and leadership have been central to the progress made this year.

Sara Ellis-Anderson, Interim Director of Nursing Community and Deputy Director of IPC

Introduction

Who We Are and What We Do

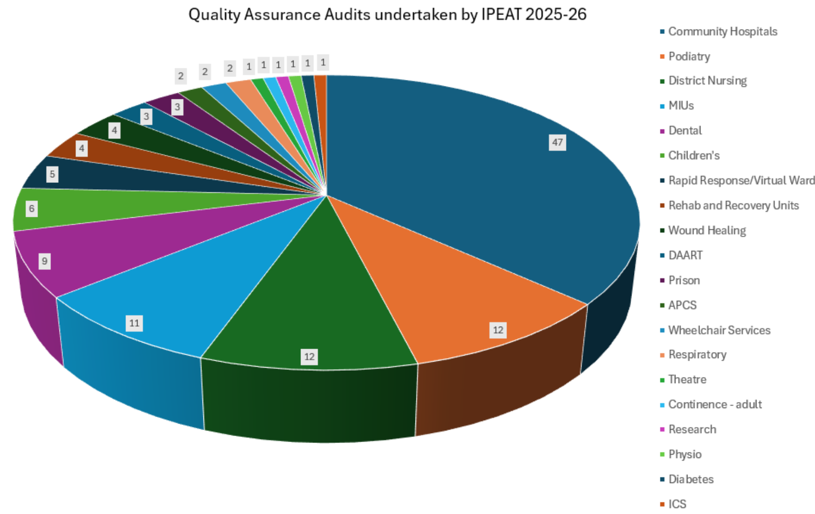
Shropshire Community Health NHS Trust (SCHT) provides a range of community and community hospital services for the people of Shropshire, Telford and Wrekin, serving a population of around between 500,000 and 528,000 people and, additionally, some services to people in surrounding areas, including Dudley's Family Nurse Partnership, School Nursing and Health Visiting Services.

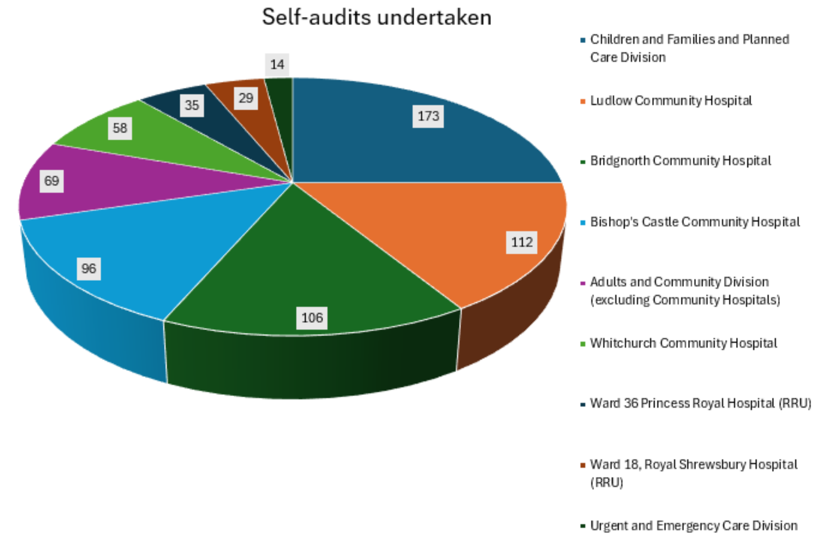
Shropshire is a mostly rural, diverse county with over a third of the population living in villages, hamlets and dispersed dwellings, a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. By contrast, Telford & Wrekin is predominantly urban with more than a quarter of its population living in some of the most deprived areas in England. As over a third of our population live rurally, our services are on the main organised geographically to enable us to be as responsive as possible to meet the needs of our service users, their carers and families. SCHT serves its population throughout life, with a wide range of services including but not limited to; 0-19s Services, Community Therapy and Nursing, Urgent Care such as Minor Injury Units and Virtual Ward, Outpatients and Community Inpatient Wards. As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to transform the provision of our services by working in partnership with others to meet the needs of those served.

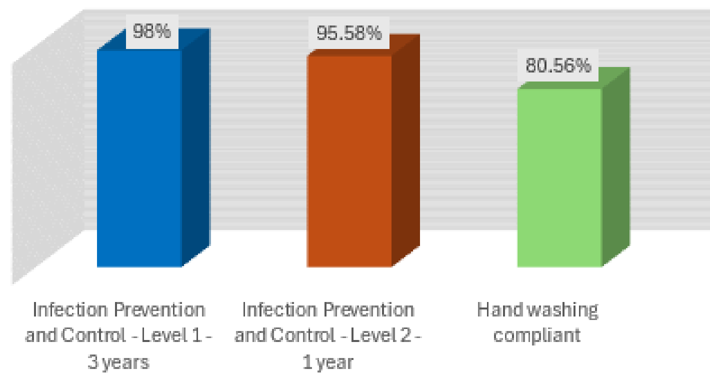
This annual report outlines the activities of SCHT relating to Infection Prevention and Control (IPC) for the year from April 2025 to March 2026 and discusses the arrangements SCHT have in place to reduce the spread of infections. It also reviews governance arrangements, policies and procedures relating to monitoring and surveillance, the environment, cleaning, audit and education. The report fulfils its statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised December 2022), which sets out 10 criteria of which a registered provider must be compliant. This sets the framework on which we base our annual programme that is monitored at SCHT's Quality and Safety Committee and IPC Committee (IPCC). The prevention and management of infection is the responsibility of all staff working in SCHT and is an integral element of patient safety programmes. The aim of the Infection Prevention, Education and Advisory Team is to maintain organisational focus and collaborative working to ensure continued compliance with IPC practices, and to actively contribute to quality improvement and safer patient care.

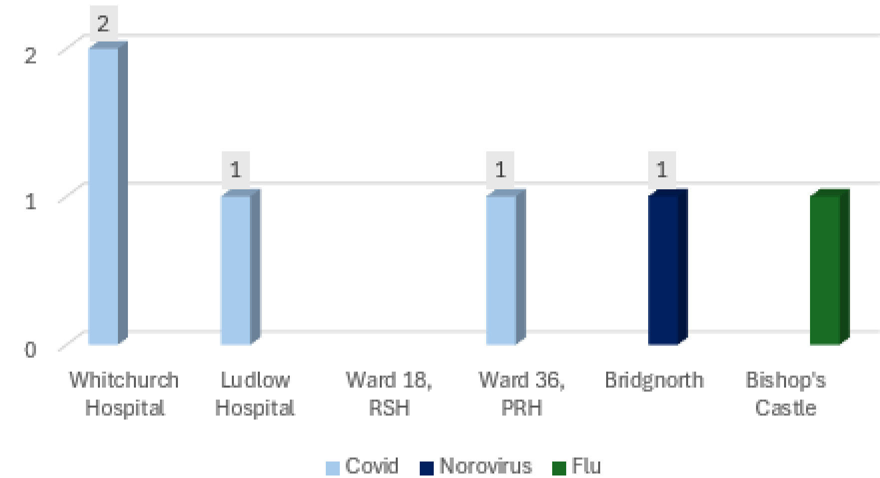
Key Achievements of 2025/26

Our year in numbers









MRSA Bacteraemia and *Clostridioides difficile* cases in SCHT in 2025/26

KEY: Green – below threshold Red – above threshold

Current Year	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	Threshold
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium difficile	3	1	0	1	1	0	0	0	1	0	2	2	11	4

MRSA Screening on admission to SCHT inpatient areas 2025/26

Percentage of inpatients screened for MRSA on admission to Community Hospitals – KEY: Green – above 97% Red – below 97%

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-25	Feb-26	Mar-26	Total	Threshold
Average over Trust	95.7%	94.9%	96.8%	97.4%	98.4%	97.5%	95.4%	98.4%	96.0%	97.9%	99.0%	94.1%	96.7%	97%

Key Achievements

The Trust launched their first IPC strategy in January 2023 and IPEAT have continued to deliver against the four ambitions set out; integrated working, education and training, digital technology and enhanced engagement.

Our key achievements against the four ambitions for 2025/26 were:

Ambition 1: Integrated Working	
Collaboration with providers to continue with particular focus on CDI and AMR for next 12 months	• IPEAT have attended and contributed to Shropshire, Telford and Wrekin (STW) system IPC and Antimicrobial Resistance (AMR) group regularly throughout 25/26. • Active organisational CDI multi-disciplinary review meetings involving microbiology, pharmacy, ward teams and IPEAT. • CDI thematic reviews and improvement actions reviewed quarterly at IPC Committee. • AMR programme integration across pharmacy, IPC, and clinical teams, including prescribing oversight and audit feedback evidenced through AMR presentation. • IPEAT collective input and feedback into Regional CDI strategy development.
Support and contribute to Emergency Preparedness, Resilience and Response (EPRR) exercises and Pandemic planning	• Development and review of Pandemic Plan aligned to NHS England EPRR Standards. • Leadership and participation in pandemic preparedness workshop and exercise by DDIPC and IPEAT. • IPEAT contribution to multi-agency exercises evidenced throughout the year.

Ambition 2: Education and Training	
Develop scenario-based teaching for IPC	• IPEAT have developed and deliver IPC education sessions at core clinical skills week as part of clinical induction. • Introduction of Supportive Visits - intended to provide support and advice to services and teams rather than be a formal audit. Areas of good practice are highlighted as well as advice on areas where improvements to infection prevention practices could be considered with opportunities to do training sessions in practice. • Winter Ready Campaign delivered to build confidence in managing outbreaks, IPEAT delivered realistic scenario-based training informed by previous experiences.
Corporate student placements to be offered	• Community Nursing SPQ students have spent time with IPEAT as part of their leadership course.
Develop IPC educational resources that are accessible such as videos to support bite-size learning	• Winter ready campaign - offered support, answered questions, and provided reassurance around outbreak management. All teams received guidance on completing outbreak documentation to support consistent and efficient reporting across sites. To build confidence in managing outbreaks, IPEAT delivered realistic scenario-based training informed by previous experiences.

Ambition 3: Digital Technology	
Contribute to development of digital quality dashboard to display key IPC metrics at ward/department level	• My Audit software module has been purchased and designed for IPC Quality Assurance Audits in Community Hospital inpatient wards. • My Audit data used in reports to IPC Committee highlighting key areas of focus.
IPC reports to develop use of SPC charts to enable overview of themes and trends	• CDI reported as SPC chart through monthly Integrated Performance Report.
Enhance digital communications for dissemination of key messages	• Several bitesize videos available on Staffzone. • WhatsApp Group for key leaders and IP link staff used for key messages and updates. • Teams channel created for IPEAT and Capacity Hub for quick decision making to support safe patient admissions into our Community Hospitals. • Four IPEAT Hot Topic Newsletters disseminated throughout 25/26

Ambition 4: Enhanced Engagement and Involvement	
Continue collaboration with QI team with specific focus on: • Catheter Care • Mouth Care	• SCHT/SaTH QI project led by Continence lead and supported by Clinical Lead for Quality and IPEAT colleagues improved the discharge process for patients with catheters demonstrating a reduction in related incidents • The Quality team and IPEAT implemented the Mouth Care Matters campaign across inpatient wards to strengthen oral health as a core component of patient safety and reducing hospital acquired pneumonia. Using the NHSE toolkit, baseline audits identified variation in assessment, documentation and escalation. In response, standardised SOPs, staff training, mouth care champions and improved digital documentation on Rio have been introduced to drive consistent practice and sustained improvement. • IPEAT were instrumental in delivering a Quality Improvement project to standardise community nursing bags, introducing IPC-compliant, compartmentalised designs to improve safety and efficiency. The programme achieved a 17% reduction in clinical stock spend (£198k saving), maintained zero IPC incidents, and improved staff experience through better organisation, releasing time back to patient care and supporting safer practice. • Central venous access device (CVAD) QI work led by IPEAT has focused on improving safe insertion, maintenance and documentation of vascular access devices to reduce infection risk. Using audit, education and standardised care processes aligned to national guidance, the project strengthens compliance with best practice, supports staff competency, and aims to minimise device-related bloodstream infections and improve patient safety.

Develop method for reward and recognition of excellent IPC practices	• Certificate of Excellence in Infection Prevention issued quarterly to individuals or teams recognising excellent practice
Re-design brand of IPC team to focus on education and advise.	• Successful re-brand of team name from IPC to Infection Prevention Education and Advisory Team (IPEAT) including new logo to reflect our core purpose, which is to help educate and advise teams across the Trust on matters relating to Infection Prevention.

The Criteria of the Health and Social Care Act (2008: revised 2022)

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

NHS England (NHSE)'s Health and Social Care Act (H&SCA) guidance, builds on the previous H&SCA code of practice and contains statutory guidance about compliance with the registration requirement relating to IPC, including cleanliness. The H&SCA and regulations are law and must be complied with. The Care Quality Commission (CQC) has enforcement powers that it may use if registered providers do not comply with the law.

Any gaps in compliance and actions to address these are captured on the overarching Trust IPC Improvement Plan.

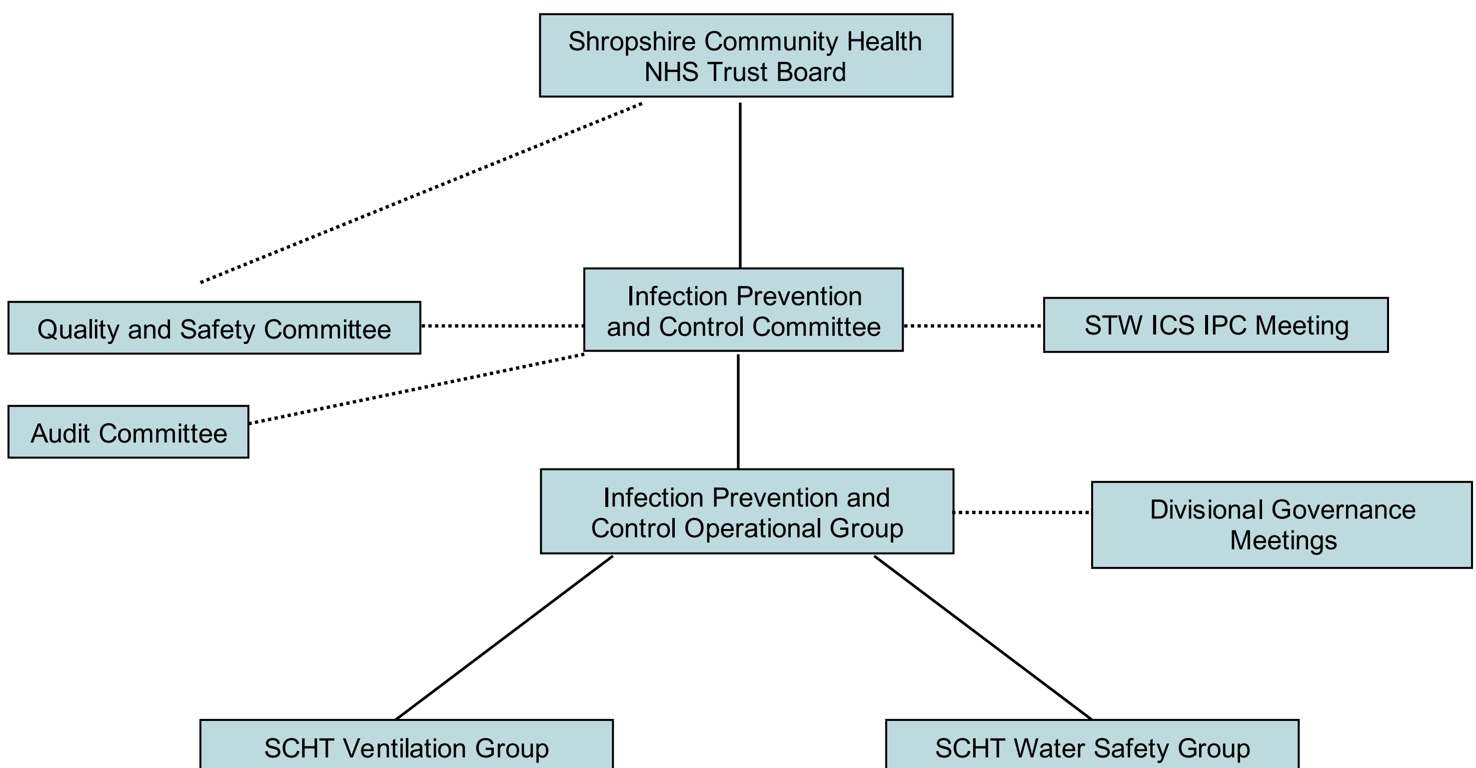
Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

Duties, arrangements and assurance

The SCHT Board and ultimately the Chief Executive carries responsibility for ensuring that systems and resources are available to implement and monitor compliance with IPC and is a vital component of Quality and Safety. The Director of IPC (DIPC) provides oversight and assesses assurances on IPC (including cleanliness), the built environment and antimicrobial stewardship reported to the Trust Board. The responsibilities of the DIPC are discharged by the Deputy Director for IPC who is responsible and manages IPC for the Trust. All managers and clinicians must ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff is expected to demonstrate commitment to reducing the risk of Healthcare Associated Infections (HAI) through the application of standard IPC measures aligned to the National IPC Manual. IPEAT provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC. Reports on all IPC activity are submitted through a series of operational Groups, Committees and to Private and Public Board for oversight and assurance purposes.

Governance and Assurance Arrangements for 2025/26

Shropshire Community Health NHS Trust
Infection Prevention and Control Governance Framework



The Infection Prevention and Control Team

The Trust's DIPC was Clair Hobbs until March 2026, who was also Director of Nursing, Quality and Clinical Delivery, and reported directly to the Chief Executive. When she left the Trust, Sara Ellis-Anderson was appointed as Interim Director of Nursing – Community and continued in her role as Deputy DIPC with the Group Chief Nursing Officer assuming the DIPC role.

Sharon Toland is the Clinical Lead Nurse for IPC. Ian McCabe, Eve Morris and Holly Grainger are IPEAT Nurses. Admin Support is provided by Alison Davies.
SCHT's committed Infection Prevention Team are very clear on the actions necessary to deliver and maintain patient safety and quality of care. Equally, it is recognised IPC is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. IPEAT utilises a proactive approach to engage with staff to develop systems and processes that lead to sustainable and reliable improvements in applying IPC practices.

Infection Prevention and Control Service for 2025/26

- Director of IPC (also Director of Nursing, Quality and Clinical Delivery) (1.0 WTE)
- Deputy Director of IPC (also Deputy Director of Nursing) (1.0 WTE)
- Clinical Lead Nurse, IPC (1.0 WTE)
- IPC Nurse (1 WTE)
- IPC Nurse (1 WTE)
- IPC Nurse (0.6 WTE)
- IPC Secretary (0.8 WTE)

SCHT has a Service Level Agreement for specialist support from a Consultant Microbiologist at Shrewsbury and Telford NHS Trust (SaTH) to act as SCHT's IPC Doctor. Medical microbiology support is provided 24 hours a day, 365 days a year through on-call arrangement. SCHT also seek advice from the UK Health Security Agency (UKHSA) and NHSE when required.

Trust Board – SCHT's performance against the MRSA Bacteraemia, Clostridioides Difficile Infection (CDI) national reduction thresholds are included in the monthly Integrated Quality Report. The IPC Board Assurance Framework (IPC BAF) is completed and presented at the SCHT Public Board Meetings bi-annually and this IPC Annual Report is presented annually at the Public Board.

Infection Prevention and Control Committee (IPCC) – Membership is multi-disciplinary and includes representation from the Operational and Quality Directorates, Estates Department, Medicines Management, Integrated Care Board (ICB) IPC Nurse, IPC Nurse and SaTH IPC Doctor. The meeting is chaired by the DIPC or the DDIPC. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

Quality and Safety Committee (QSC) – SCHT's performance against the MRSA Bacteraemia, CDI national reduction thresholds are included in the Integrated Quality report. IPCC Chair reports, the IPC Board Assurance Framework and the IPC Annual report are presented to Quality and Safety Committee meetings.

Infection Prevention and Control Operational Group (IPCOG) Meeting – Primary membership is from higher risk areas within the Trust, such as Community Hospitals, dental services and podiatry as well as Health and Safety, Quality Improvement, EPRR and Estates

representatives. Team leaders from other services are invited to join if they have any IPC issues to discuss and/or address or where IPC audits fall below expected standards and improvement plans are required. The meeting is chaired by the Deputy DIPC and meets monthly. The TOR and membership are reviewed every year to ensure responsibility for IPC continues to be embedded across the organisation.

Outbreak/infections review – Chaired by either DIPC or Deputy DIPC, this is a monthly meeting to discuss any alert organisms or outbreaks to establish whether there were any lapses in care or lessons to be learned and shared. Attendance is by invitation and may include Ward Manager or representative, SaTH IPC Doctor, prescribing Doctor, pharmacist and ICB IPC Nurse. PIRs or after-action reviews are prepared and discussed and actions and findings disseminated.

Learning from Deaths Meeting – The membership is multi-disciplinary and includes representation from the operations and quality directorates, IPC and medical directorate.

SCHT Water Safety Group – The membership is multi-disciplinary and has representatives from Midlands Partnership Foundation NHS Trust (MPFT) and an Authorising Engineer and to the end of March 2026 was chaired by the Deputy DIPC. The TOR and governance structure is reviewed every two years. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, Automated Endoscope Reprocessor (AER) and capital developments and reports to the IPC Committee. The annual SCHT Water Safety audit was undertaken in October 2025. The Deputy Director of IPC has also been a member of the MPFT Operational Water Safety Group for Shropshire chaired by MPFT to oversee operational delivery of Water Safety.

SCHT Ventilation Group – The membership is multi-disciplinary and has representatives from Midlands Partnership Foundation NHS Trust (MPFT) and an Authorising Engineer and is chaired by the Deputy DIPC. The TOR and governance structure is reviewed every two years. The Group continues to monitor ventilation risk assessments and reports to the IPC Committee.

Integrated Care System IPC Meeting/IPC and Anti-Microbial Resistance Group – These System groups aim to ensure a strategic overview across the local health economy and SCHT is represented by the Clinical Lead Nurse for IPC.

In addition to the meetings mentioned above, IPEAT also attend other regular and ad hoc meetings where specialist IPC knowledge is required.

Infection Prevention and Control Link Staff – All IPC link staff and their line managers are asked to sign a Roles and Responsibilities agreement. Our IPC link staff support the operational delivery of IPC practice ensuring high standards of quality and patient safety in relation to IPC. Our IPC link staff are also responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

Divisional Clinical Managers, Locality Clinical Managers, Ward Managers, Sisters, Charge Nurses and Team Leaders – Locality Clinical Managers, Ward Managers, Sisters, Charge Nurses and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Our leaders are responsible for ensuring the IPC link staff are supported in performing their role and have appropriate time and resources to do this effectively.

Organisational Development Team – Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which include IPC. Training compliance is reported to the IPC Committee. IPEAT participates in Core Clinical Skills weeks, providing clinical staff with a general overview of infection prevention and

control, encompassing the importance of embedding standard IPC precautions into practice to prevent the transmission of infection.

Roles and Responsibilities of all Staff – All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow standard IPC precautions at all times and are familiar with IPC policies, procedures and guidance relevant to their area of work and this responsibility is included in all SCHT job descriptions.

Alert Organism Surveillance and Management and Healthcare Associated Infection (HAI)

All organisms of IPC significance are monitored by IPEAT and are termed Alert Organisms. The local Acute Trust, whose microbiology laboratory process specimens from SCHT patients, submit data on SCHT's behalf on MRSA Bacteraemia, MSSA Bacteraemia, Escherichia coli (E.coli) Bacteraemia infections and CDI to UKHSA, as part of the national mandatory surveillance programme for HAIs.

SCHT does not have nationally set thresholds for reducing HAIs. These thresholds are set for Acute Trusts and ICBs. However, SCHT recognises it does have a responsibility in contributing to the overall reduction thresholds of Shropshire and Telford & Wrekin ICB and therefore agree local infection thresholds.

Healthcare Associated Infections in SCHT 2025/26

2025/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-25	Feb-26	Mar-26	Total	Threshold
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium difficile	3	1	0	1	1	0	0	0	1	0	2	2	11	4
Bacteraemia:														
• E-coli	0	0	0	0	0	0	0	0	0	0	0	0	0	0
• *P. Aeruginosa*	0	0	0	0	0	0	0	0	0	0	0	0	0	0
• *Klebsiella spp*	0	0	0	0	0	0	0	0	0	0	0	0	0	0
• MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
• CPE	0	0	0	0	0	0	0	0	0	0	0	0	0	0
• VRE	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Consultant Microbiologist at SaTH monitors the local health economy CDI mortality data which includes patients in SCHT. There were no deaths attributed to CDI at our Community Hospitals in 2025/26.

Periods of Increased Incidence (PII)

Since April 2010, all Trusts have been asked to report PII of infections on the Trust's electronic incident reporting system, Datix. SCHT reported no PII during 2025/26.

Other Alert Organism Surveillance and Management

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia.

Mandatory reporting of all MSSA bacteraemia commenced in January 2011. There is currently no target associated with MSSA bacteraemia incidence. SCHT continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance scheme.

Carbapenemase-producing Enterobacteriaceae (CPE)

CPE are Gram negative bacteria which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics, are ineffective. CPE continues to be included in the SCHT revised Prevention and Control of Multi-Resistant Gram-Negative Bacteria policy and

advice is included in the Guide to Multi Resistant Gram-Negative Bacteria information leaflets available to all staff, patients and visitors.

Glycopeptide-Resistant Enterococci (GRE) also known as Vancomycin-Resistant Enterococci (VRE)

In all cases of GRE/VRE, IPC recommend source isolation for all Community Hospital patients as prevention of transmission is through effective transmission-based precautions.

Extended Spectrum Beta-Lactamase (ESBL) including Escherichia *coli.* and *Klebsiella/AmpC Beta-Lactamase*

Within the Community Hospitals the most common site for these bacteria is in patients' urine. Upon notification of a positive result, IPEAT contact the ward to discuss isolation, other precautions and if treatment is required.

SCHT recorded no incidences of patients contracting E.coli bacteraemia whilst inpatients in the Community Hospitals.

Outbreaks

An outbreak of infection is described as two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample and are linked through a common exposure, personal characteristics, time or location.

The table below summarises the outbreaks declared in SCHT community hospitals during 2025/26.

Total outbreaks declared in SCHT in 2025/26

Hospital/Team	Date	Causative Organism
Ludlow	April 2025	COVID-19
Bridgnorth	May 2025	COVID-19
Ward 36	August 2025	COVID-19
Whitchurch	September 2025	COVID-19
Whitchurch	November 2025	COVID-19
Bishop's Castle	January 2026	Flu
Bridgnorth	March 2026	Norovirus

There has been a reduction in outbreaks across SCHT in 2025/26, with seven outbreaks reported compared to eleven in 2024/25. This reflects strengthened outbreak prevention, early identification and effective management arrangements. Despite ongoing seasonal challenges, including COVID-19, influenza and norovirus, outbreaks were contained with minimal disruption, demonstrating improved organisational resilience and IPC practice.

SCHT has continued to follow and adhere to National Guidance regarding COVID-19. In each of the outbreaks, whether for COVID-19, flu or Norovirus, IPEAT conducted Quality Ward Walks to offer guidance on patient management and placement, adherence to control measures and advised the use of a range of tools designed to assist in the care and monitoring of affected patients. Daily discussions were conducted with operational

colleagues and ward teams. Close monitoring in this way meant that the disruption to patients and SCHT services and teams was kept to a minimum.

Internal outbreak meetings were held on declaration of an outbreak with the ICB, and NHSE UKHSA and the Care Quality Commission were notified of any disruption of services.

Auditing Programme

Auditing is the mainstay of the systems we use to manage and monitor the prevention and control of infection and a summary of our audits is provided below.

Hand Hygiene Assessments

Effective and timely hand decontamination is acknowledged as the most important way of preventing and controlling infections. IPEAT continued its concerted efforts to ensure that hand hygiene compliance remained a high priority.

Training on the importance of hand hygiene, being “bare below the elbow” and the World Health Organisation (WHO) “5 moments for hand hygiene”, was provided locally to new clinical staff on induction and was reinforced by members of IPEAT at all IPC training events, during clinical visits and whilst auditing.

Assessments to monitor effective hand washing are undertaken by all new staff within one week of commencement of employment, and annual assessments undertaken for existing staff, including students on placement. Hand washing assessments are included in clinical areas’ reports to the IPCC meeting.

IPC Quality Assurance Audits

In total 128 audits were undertaken by IPEAT. The objectives of the audits were to inform services of their level of compliance to the National Infection Prevention and Control Manual (NIPCM), local policy and procedures and allow improvements to be made based upon the findings. It also identified target areas for IPC training.

IPC Quality Assurance Audits undertaken during 2025/26 have provided consistent assurance regarding the Trust’s ability to identify themes, escalate risks and target improvement activity. The most common findings related to missed hand hygiene opportunities, PPE and glove use, documentation quality, and equipment cleanliness. These recurrent themes have informed focused action plans, supportive visits, training and QI work, supporting continuous improvement in IPC practice across services.

As well as audits undertaken by IPEAT, IPC have encouraged the use of the self-audit/checklist by ward staff and community staff to monitor ongoing IPC compliance. Any issues identified are addressed immediately to ensure safety for the individual patient, other patients, and staff, and for assurance as all self-audits are reported through IPC Committee meetings.

372 self-audits were undertaken at the Community Hospitals by ward staff – 106 at Bridgnorth Community Hospital, 96 at Bishop’s Castle Community Hospital, 112 at Ludlow Community Hospital and 58 at Whitchurch Community Hospital. A total of 64 self-audits were undertaken at the two Rehabilitation and Recovery Units (RRUs) – 35 at Ward 36, PRH and 29 at Ward 18, RSH.

Self-audits were also undertaken in non-inpatient areas. These monitored areas such as the environment, cleaning standards and the condition and cleanliness of equipment, 69 such self-audits were undertaken in the Adults and Community Division, 14 in Urgent and Emergency Care Division and 173 in Children and Families and Planned Care Division.

External Audit

An external joint quality visit was undertaken at Whitchurch Community Hospital in December 2025, involving the ICB Clinical Quality Lead and the ICB Infection Prevention and Control Nurse Specialist. The review identified strong compliance with key IPC practices, including hand hygiene, PPE use and effective outbreak management. Good patient and visitor communication was observed, alongside visible IPC team support, providing assurance of safe and consistent IPC practice.

Criterion 2 – The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The 2025 cleaning standards encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results. The 2025 standards reflect modern methods of cleaning, IPC and other changes since the last review and important considerations for cleaning services during a pandemic; and emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

All hospital wards have a hospital cleaning schedule and charter specific to the ward clearly displayed. Key policies for this criterion are in place.

- Quality reviews and IPC audits are undertaken in all areas that include general cleanliness.
- Monthly cleaning scores for sites maintained by MPFT are reported to the IPCC meeting.
- Formal assessments using Patient Led Assessment of the Care Environment were re-established and were reported through the Patient Experience Group.
- IPC Team continue to advise on refurbishment or redevelopment and new build projects to ensure IPC is adequately considered at all stages in line with Health Technical Memorandum and Health Building Notes.
- All laundry is reprocessed at Elis Laundry Services via a contract agreement with Mid Cheshire Hospitals NHS Foundation Trust. Compliance evidence against the contract specifics is reviewed by the Trust and auditing of the laundry facilities is shared with colleagues from RJAH.
- The Central Sterilising Services Department (CSSD) in Telford, operated by SaTH, undertakes most of the decontamination of reusable instruments for SCHT.
- The SCHT dental service is compliant with the “essential quality” requirements contained in the Health Technical Memorandum 01-05 – Decontamination in Primary Care Dental Practices and use the NHSE Dental Audit tool to monitor IPC.
- An automated audit reporting system is now used for completion and monitoring of cleaning audits at the Community Hospitals.

Water Safety and Ventilation Groups

Both Groups meets quarterly with representatives from MPFT and NHS Property Services (NHS PS) and report through IPCC. The Trust employs an Authorised Engineer for each area.

The AE for water conducts an annual audit, and an action plan is developed to address any issues arising. The Water Safety Group monitors and manages water risks, especially around Legionella and Pseudomonas, flushing regimens, annual disinfection and capital developments. The Trust received substantial assurance from the annual independent audit undertaken by the Authorising Engineer (Water), confirming that effective systems and governance arrangements are in place to manage water safety risks. The review identified that water safety management aligns with national guidance (HTM 04-01), with robust controls in place to mitigate risk from waterborne pathogens, providing assurance of safe water systems for patients, staff and visitors

The purpose of the ventilation group is to raise the level of awareness and accountability for the use of ventilation and endeavour to ensure that all policies, procedures and relevant guidelines are complied with and related standards are met.

Criterion 3 – Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance

Medicines Management Report

Shropshire Community Health trust follows local and national prescribing guidelines and uses the online antimicrobial formulary, Eola's, which aligns with national guidance and reflects local resistance patterns. All non-medical prescribers receive pharmacist-led induction training that includes antimicrobial stewardship.

In community hospitals, pharmacists and pharmacy technicians review all antimicrobial prescriptions and provide stewardship advice. Prescribing outside guidelines is challenged, and any interventions are recorded in the patient's RiO record.

A Lead Pharmacy Technician for AMS (Antimicrobial Stewardship) oversees antimicrobial use across the trust. They contribute to a range of workstreams to support compliance with national standards for the safe use of antimicrobials and to help reduce antimicrobial resistance.

The Lead Pharmacy Technician for AMS attends meetings with ICS colleagues and reports antimicrobial stewardship activity back to the team through Medicines Management and Medicines Governance and Safety meetings.

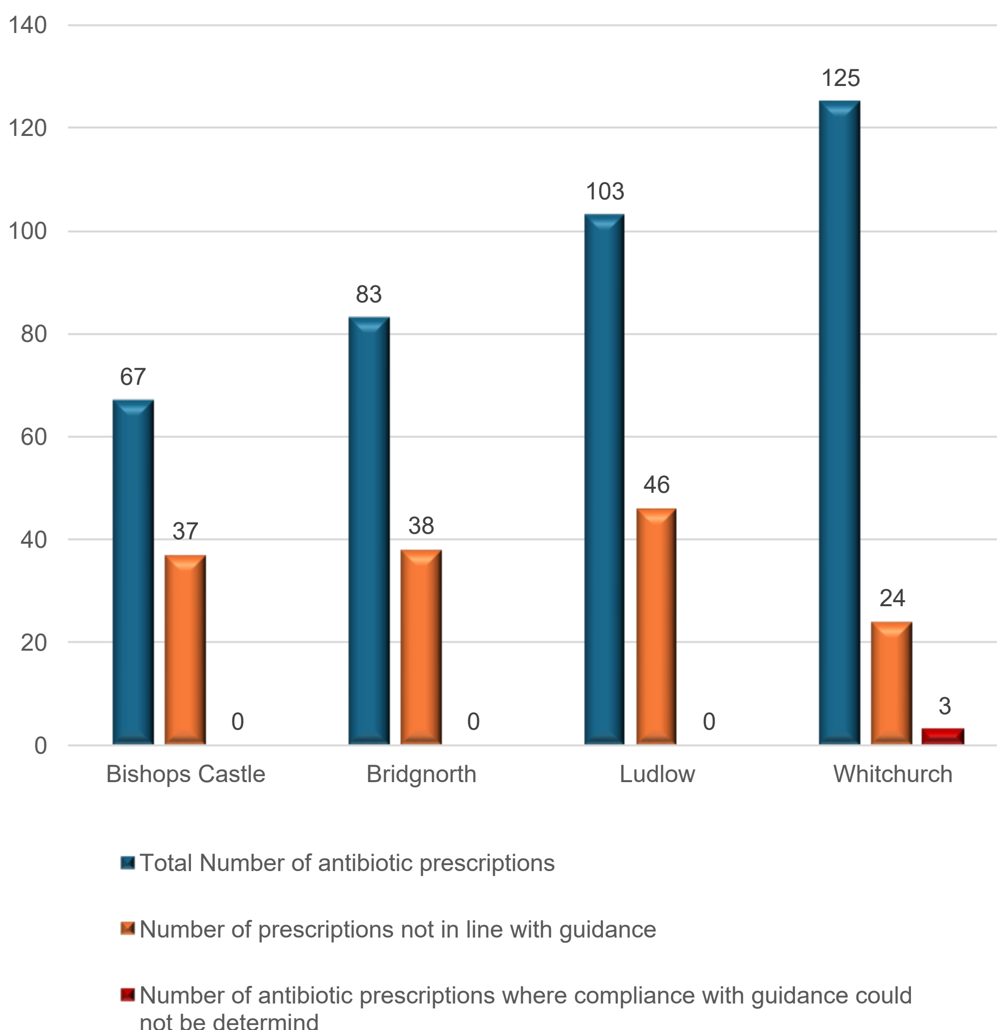
Antimicrobial prescribing and administration occur across various services within Shropshire Community Health Trust including Prison Services, Community Hospitals, Dental, Virtual Ward, Non-medical prescribers and Minor Injuries (Whitchurch, Bridgnorth, Oswestry, Ludlow) among others.

Community Hospitals

- A designated member of the Medicines Management Team electronically monitors antimicrobial prescribing. This information is shared securely with the Quality Team via their Microsoft Teams channel to support quality improvement projects, reduce duplication, and enable collaborative work to improve patient care and antimicrobial stewardship.
- The Lead Pharmacy Technician for AMS oversees antimicrobial stewardship (AMS) in the Community Hospitals, monitoring prescribing practices and supporting compliance with guidelines. They review prescribing data regularly and submit quarterly reports to the Infection Prevention and Control (IPC) Committee to support optimisation of antimicrobial use and improve patient outcomes.
- The Lead Pharmacist for Community Hospitals holds daily huddles with pharmacy staff. During these huddles, the importance of reviewing antimicrobial prescriptions is reinforced. The AMS Pharmacy Technician attends when updates to AMS practice need to be communicated. The pharmacy team are reminded to review each patient's drug chart daily and to highlight any antimicrobial prescribing for further clinical review.
- Ward Pharmacists review antimicrobial prescriptions for compliance with local guidelines. Where prescribing falls outside guidance, they challenge it and record the outcome in the patient's notes, including any changes made or the prescriber's rationale for continuing the original treatment.
- The Lead Pharmacist for Community Hospitals and Minor Injury Units (MIU's) is the designated member of the medicines management team that audits antimicrobial use. The data is recorded on a spreadsheet (shared with the Quality team). The

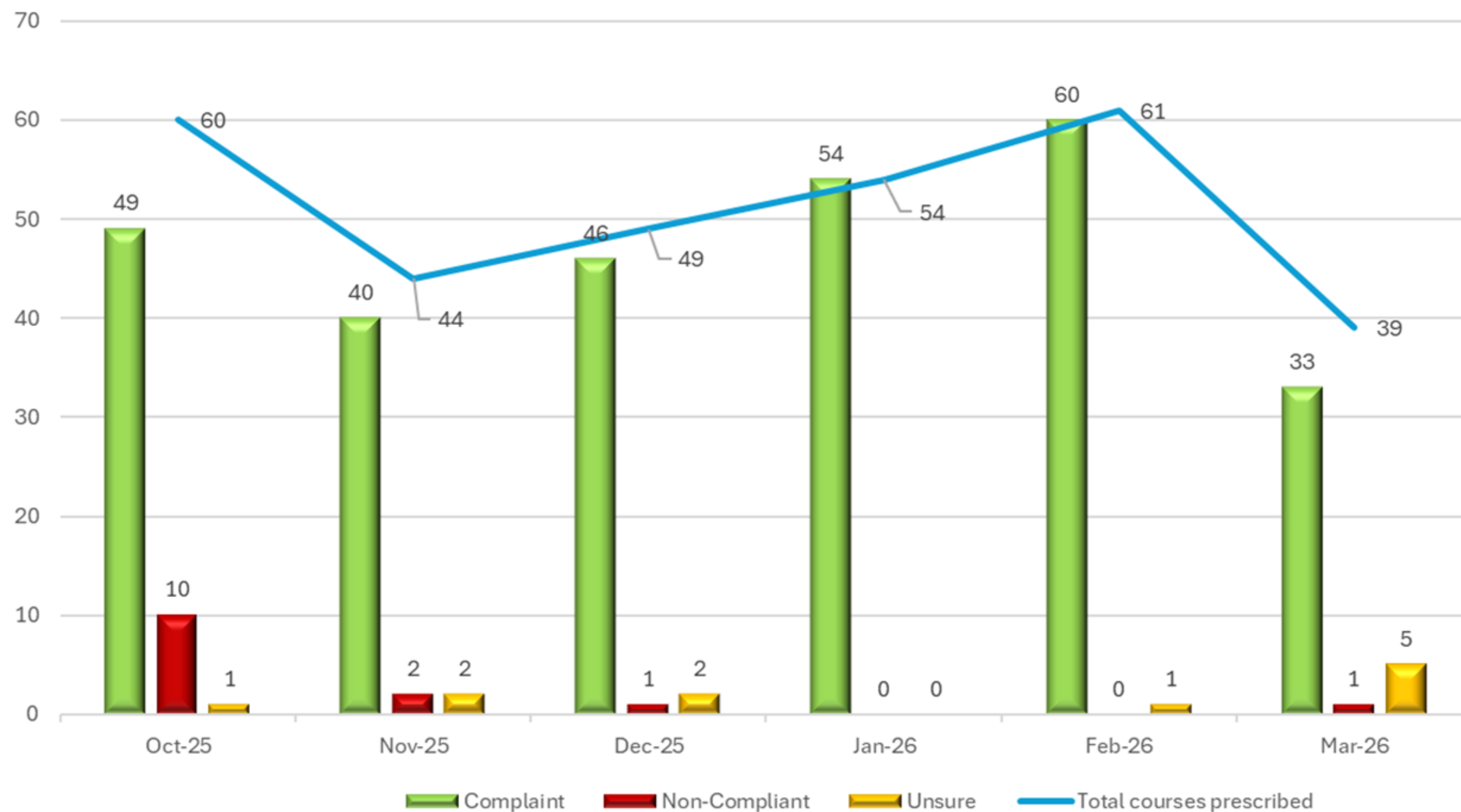
audits are shared at the Medicines Management Team meetings which are held quarterly and used by the Lead Pharmacy Technician for AMS in the quarterly report to IPCC. In the interim, any queries are referred to the relevant hospital team.

- All prescribed antibiotic courses are documented in each patient's RiO record, including the indication, prescriber details, length of course and any relevant microbiology results. This supports audit activity, helps identify and address poor prescribing practice, and ensures prescribing decisions are aligned with clinical guidelines.
- Most of the antimicrobial prescribing is for oral antimicrobials within our community hospitals. A very small amount of IV antimicrobials is used within Whitchurch Community Hospital when oral options are not appropriate.
- The graph below shows the quantity of antimicrobial courses prescribed in our community hospitals and of those prescribed how many were outside of guidelines.
- Where non-compliance is identified, the community hospital pharmacy teams challenge the prescribing and document the outcome in the patient's RiO notes. The pharmacy team are also asked to submit a Datix report where non-compliance appears unjustified.



Prison Healthcare

- SystmOne is the electronic patient record used in prison. All antimicrobial prescribing is scrutinised and clinically checked by a pharmacist.
- SystmOne can be accessed remotely and has an audit functionality which allows for antimicrobial prescribing to be audited by the Lead Pharmacy Technician for AMS.
- Antimicrobial prescribing within HMP Stoke Heath averages 46 acute prescriptions per month with most of the prescribing for indications associated with skin/soft tissue and chest infections.
- Antimicrobial use for acne treatment remains low at 1-2 prescriptions per month due to an NHS England initiative aimed at educating prisoners on the risks of long-term antimicrobial use.
- The prison GP has a strong understanding of antimicrobial stewardship. The electronic prescribing system supports formulary compliance by automatically populating the recommended dose and course length.
- Audit findings are reported to the prison service through the bi-monthly Prison Medicines Governance Meeting and shared with staff via an Excel spreadsheet. Good practice and any areas of poor prescribing are fed back to the team.
- Antimicrobial audit findings are also reported to the Infection Prevention and Control (IPC) Committee, providing assurance to the Director of Infection Prevention and Control (DIPC) and supporting oversight of prescribing practice and guideline compliance.
- The bar chart on the next page shows the quantity of antimicrobial courses prescribed between October 2025 and March 2026 and the quantity of antimicrobial courses prescribed that are compliant with local antimicrobials guidelines, non-complaint or unsure if compliant. A course was marked unsure if the indication couldn't be found as the compliance cannot be checked without this.
- Non-compliance most commonly relates to an incorrect course length. Where this is identified, feedback is provided through prison governance meetings. Longer courses may be justified if the infection is not resolving as expected; in these cases, prescribers are asked to document the rationale for deviating from the guideline.
- A newly appointed prison GP has been attending prison governance meetings and is committed to further improving compliance.


Prison Compliance with local antimicrobial guidelines (Eolas)
70
60
50
40
30
20
10
0
60
44
49
54
61
39
49
10
1
40
2
2
46
1
2
54
0
0
60
0
1
33
1
5
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Complaint
Non-Compliant
Unsure
Total courses prescribed

Dental Services

- Antimicrobial prescribing within dental services is reviewed by the Lead Pharmacy Technician for antimicrobial services. Data is supplied electronically in the form of an excel spreadsheet.
- Antimicrobial prescribing generally takes place during working hours. Emergency clinics have the highest rates of antibiotic prescribing, where antibiotics may account for up to 50% of all prescribing activity.
- Antimicrobials are only prescribed within dental services for infections that are severe, with systemic symptoms or prophylactically to prevent risk of complications.
- Most antimicrobials prescriptions are for amoxicillin or metronidazole which follows our local antimicrobial guideline (Eolas).
- Dental antimicrobial prescribing audit findings indicate high compliance with the Eolas prescribing guidelines, with the shortest effective course prescribed for the majority of patients.

Patient Group Directions

- Patient Group Directions (PGDs) are used to supply antimicrobials to patients who meet defined clinical criteria, for example in Minor Injury Units.
- When reviewed, PGDs are checked against evidence-based sources, including NICE guidance and the Shropshire, Telford and Wrekin local antimicrobial guidelines (Eolas).
- All PGDs for the supply of antimicrobials receive microbiology approval prior to publication and go through a strict approval process.

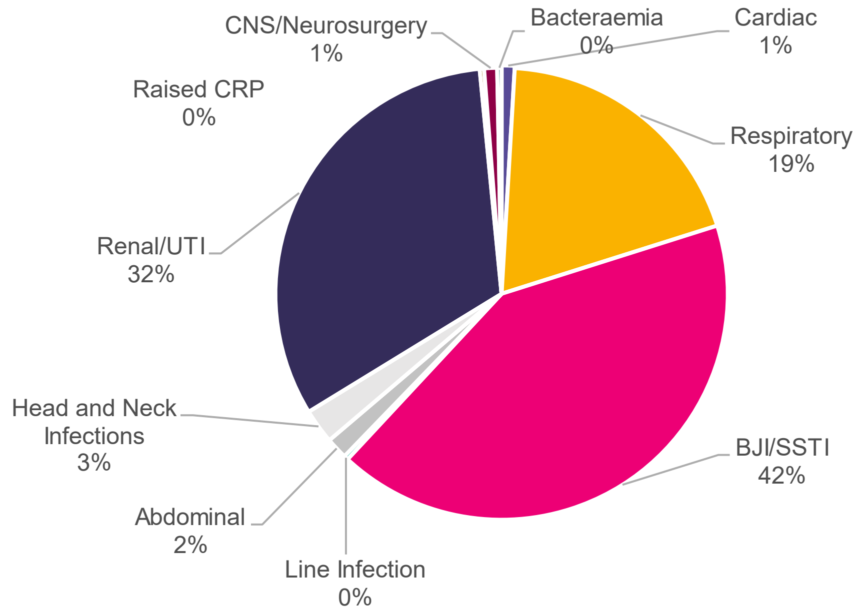
OPAT

- Outpatient Parenteral Antimicrobial Therapy (OPAT) enables medically stable adult patients, who's only ongoing requirement for inpatient care is the administration of intravenous antimicrobials, to receive safe and effective treatment in an outpatient or community setting
- The OPAT service is delivered as a joint arrangement between Shrewsbury and Telford Hospital NHS Trust (SaTH) and Shropshire Community Health NHS Trust (SCHT). Referring clinicians retain overall responsibility for patient care, while the OPAT team provides clinical oversight. Weekly multidisciplinary team (MDT) meetings support best practice and the maintenance of effective antimicrobial stewardship.
- Intravenous antimicrobials are administered either through daily attendance at the RSH Hub, currently based within DAART, or via home visits undertaken by the specialist community nursing team. All antimicrobials are supplied by the SaTH Pharmacy Team, either as patient-specific supplies or from stock held at community locations.
- The main antimicrobials prescribed within the OPAT service are ceftazidime, ceftriaxone, ertapenem and teicoplanin, largely due to their once- or twice-daily dosing regimens, which are more practical for service delivery. These are prescribed by the OPAT team using either a Patient Specific Direction (PSD) or an authorisation to administer form.
- OPAT pathways include
  - Bronchiectasis
  - Skin and Soft tissue infection
  - Bone and joint infection

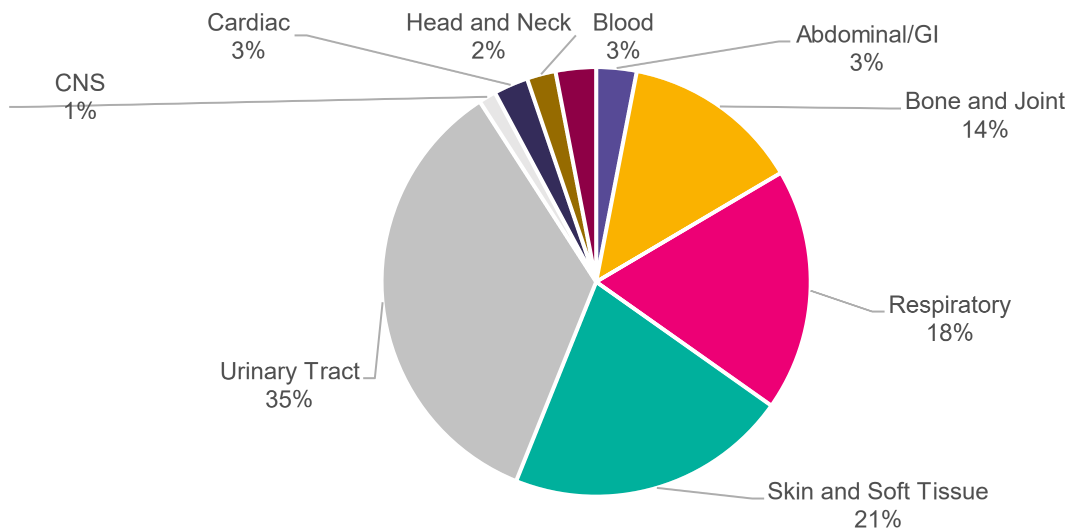
- Complex UTI.

- Since the service was created in Nov 2023, over **7325** bed days have been saved.
- From launch to March 2026 referrals into the service are predominately from Shrewsbury and Telford Hospital NHS Trust (SaTH) and these equate to **66.1%, 22.2%** from GP,**11.7%** from another hospital.

OPAT Indications for treatment launch to March 2025



OPAT Indications for treatment March 2025- 2026

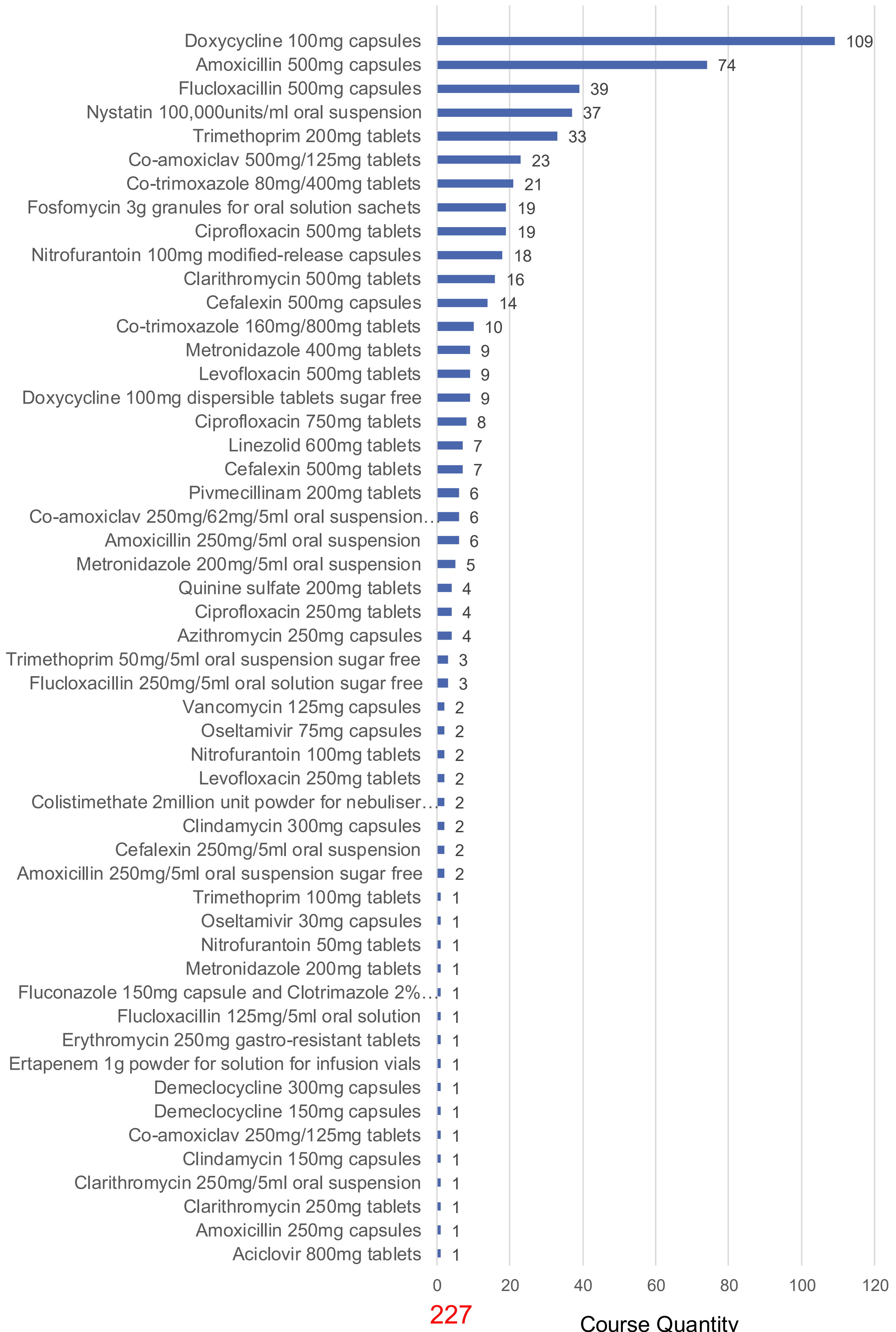


Virtual Ward

- The Virtual Ward (VW) enables patients to receive hospital-level care safely in their own homes, supporting recovery in a familiar environment while releasing hospital beds for patients with greater clinical need.
- The service is delivered by a multidisciplinary team of pharmacy staff, nurses, non-medical prescribers (NMPs), GP's and Consultants. Intravenous antibiotics are supplied through OPAT, while oral antimicrobials are prescribed the Electronic

Prescription Service (EPS), and the virtual ward have access to pre-packed over-labelled stock.

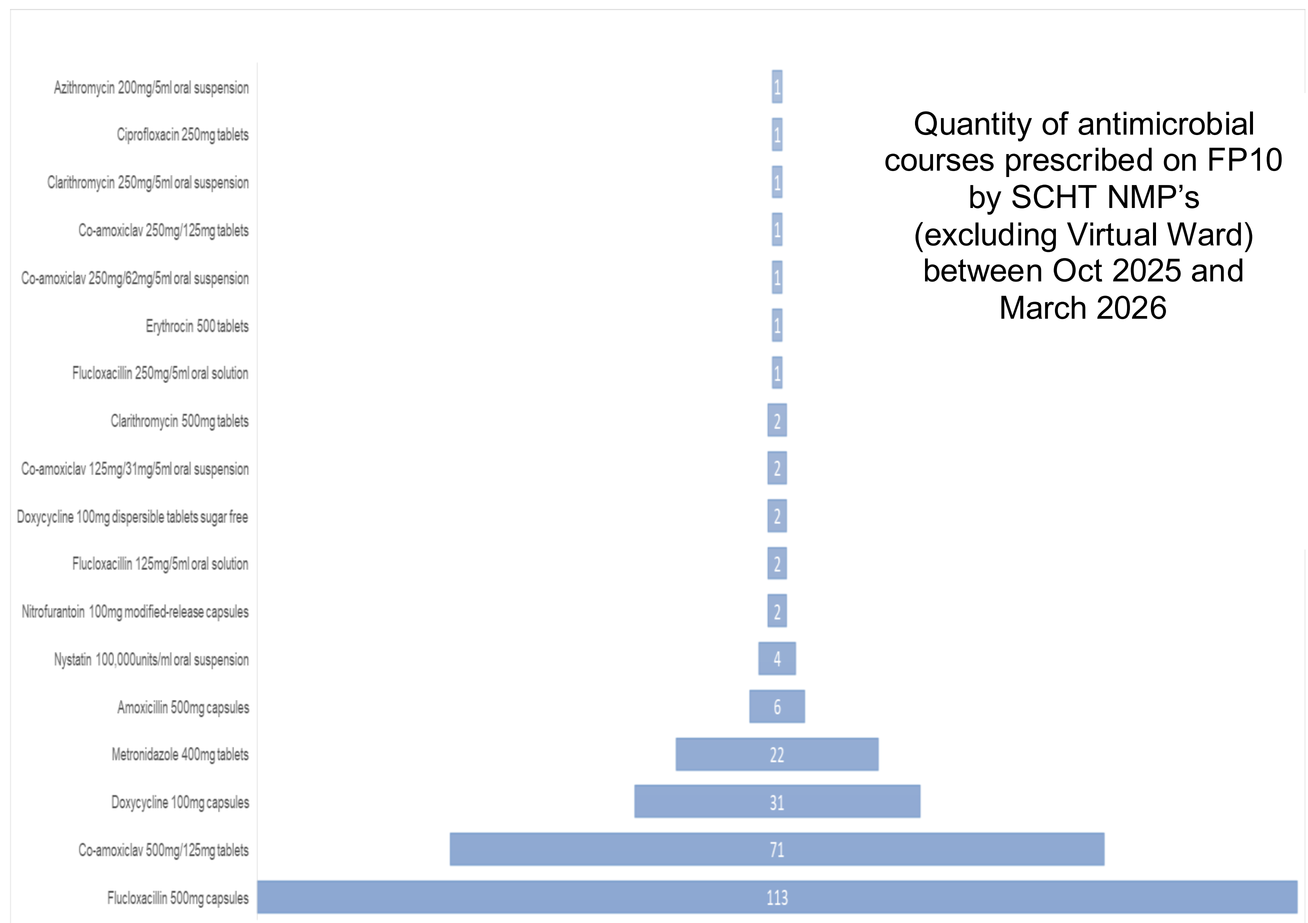
- Pre-packed over-labelled antibiotics were introduced into the Virtual Ward during quarter 1 of 2026. This ensures patients can commence treatment promptly, helping to prevent deterioration and reduce the risk of hospital admission.
- Most antimicrobial prescribing is for oral treatment, with around one patient per month receiving intravenous therapy.
- Antimicrobials are prescribed under the direction of microbiology, the Virtual Ward Consultant or Virtual Ward doctors.
- The Principal Pharmacist for the Virtual Ward clinically reviews prescribed antimicrobials to ensure antimicrobial prescribing is in line with local guidance, where possible.
- The service is progressing towards full implementation of EPS, which will improve documentation of treatment indications and enhance the ability to audit compliance with prescribing standards.
- Following the safety alert on fluoroquinolone antibiotics, reducing inappropriate use of this antibiotic class is a priority. To support this, the Lead Pharmacy Technician for AMS with the support of the VW team runs a daily report to identify fluroquinolone prescriptions promptly. Where the reason for prescribing is not clear from the patient notes, the prescriber is contacted to provide justification for its use instead of a safer alternative.



Virtual Ward Antimicrobial courses prescribed
Oct 2025 to March 2026
Doxycycline 100mg capsules 109
Amoxicillin 500mg capsules 74
Flucloxacillin 500mg capsules 39
Nystatin 100,000units/ml oral suspension 37
Trimethoprim 200mg tablets 33
Co-amoxiclav 500mg/125mg tablets 23
Co-trimoxazole 80mg/400mg tablets 21
Fosfomycin 3g granules for oral solution sachets 19
Ciprofloxacin 500mg tablets 19
Nitrofurantoin 100mg modified-release capsules 18
Clarithromycin 500mg tablets 16
Cefalexin 500mg capsules 14
Co-trimoxazole 160mg/800mg tablets 10
Metronidazole 400mg tablets 9
Levofloxacin 500mg tablets 9
Doxycycline 100mg dispersible tablets sugar free 9
Ciprofloxacin 750mg tablets 8
Linezolid 600mg tablets 7
Cefalexin 500mg tablets 7
Pivmecillinam 200mg tablets 6
Co-amoxiclav 250mg/62mg/5ml oral suspension… 6
Amoxicillin 250mg/5ml oral suspension 6
Metronidazole 200mg/5ml oral suspension 5
Quinine sulfate 200mg tablets 4
Ciprofloxacin 250mg tablets 4
Azithromycin 250mg capsules 4
Trimethoprim 50mg/5ml oral suspension sugar free 3
Flucloxacillin 250mg/5ml oral solution sugar free 3
Vancomycin 125mg capsules 2
Oseltamivir 75mg capsules 2
Nitrofurantoin 100mg tablets 2
Levofloxacin 250mg tablets 2
Colistimethate 2million unit powder for nebuliser… 2
Clindamycin 300mg capsules 2
Cefalexin 250mg/5ml oral suspension 2
Amoxicillin 250mg/5ml oral suspension sugar free 2
Trimethoprim 100mg tablets 1
Oseltamivir 30mg capsules 1
Nitrofurantoin 50mg tablets 1
Metronidazole 200mg tablets 1
Fluconazole 150mg capsule and Clotrimazole 2%… 1
Flucloxacillin 125mg/5ml oral solution 1
Erythromycin 250mg gastro-resistant tablets 1
Ertapenem 1g powder for solution for infusion vials 1
Demeclocycline 300mg capsules 1
Demeclocycline 150mg capsules 1
Co-amoxiclav 250mg/125mg tablets 1
Clindamycin 150mg capsules 1
Clarithromycin 250mg/5ml oral suspension 1
Clarithromycin 250mg tablets 1
Amoxicillin 250mg capsules 1
Aciclovir 800mg tablets 1
0
20
40
60
80
100
120
Course Quantity

Community Nursing/Non-Medical Prescribers

- SCHT currently employs 187 non-medical prescribers (NMPs), representing an increase of 18 since the previous annual report. This group comprises nurses, health visitors, paramedics, physiotherapists, pharmacists and one podiatrist.
- Indications for prescribed antimicrobials routinely present as UTI, respiratory, wound infections and cellulitis / bites.
- Since the introduction of OPAT and the Virtual Ward, the number of intravenous antimicrobials prescribed by Community Nurses, who comprise part of the non-medical prescriber workforce, has reduced.
- Non-medical prescribing is monitored via ePACT2 data by the Lead Pharmacy Technician for AMS and the Integrated Care Board.
- Data is reported back in the IPC committee meeting within a medicines management report to provide assurance to the IPC board.
- Where appropriate, clinical justification is sought for antimicrobial prescribing, with scrutiny given to the overprescribing of broad-spectrum antibiotics and the use of fluoroquinolones in response to the UKHSA drug safety alert.
- Fluoroquinolone use is very low with only one course prescribed in 6 months.
- Broad-spectrum antimicrobial use appears high, with 71 courses of co-amoxiclav prescribed. However, these prescriptions were issued by non-medical prescribers working in Minor Injury Units, where co-amoxiclav is indicated for the treatment of animal and human bites. A temporary procurement issue with over-labelled stock also led to increased use of FP10 prescriptions which has shown in this data.



Summary

- Antimicrobial stewardship is embedded across Shropshire Community Health NHS Trust through clear governance arrangements, use of local and national prescribing guidance, and routine pharmacy oversight of antimicrobial prescribing in a range of services.
- Pharmacy teams provide regular review, audit and challenge of antimicrobial prescribing across community hospitals, prison healthcare, dental services, OPAT, the Virtual Ward and non-medical prescribing services, with findings reported through governance structures including Medicines Management meetings and the IPC Committee.
- Overall, the report provides assurance that antimicrobial stewardship arrangements are well established and continuing to develop, with targeted workstreams in place to address audit findings, patient safety priorities and national expectations for safe, effective antimicrobial use.

Lisa Pascall
Lead Pharmacy Technician

Criterion 4 – The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion

Communication regarding appropriate guidelines has continued to be a key requirement in the provision of care, the instigation of IPC initiatives as well as public and visitor safety as we moved to "business as usual" introducing a traffic light system for wearing masks and face coverings in our hospitals, visits and clinics.

The Communications Team are invited to attend IPC outbreak meetings if these may result in media interest because of the nature or impact of the outbreak. The Communications Team also provides the support and guidance and to prepare proactive and reactive media statements where required.

IPEAT Secretary is responsible for updating IPEAT intranet site and for the production of staff and visitors' leaflets. IPC updates are also provided to Team leads and an IPC newsletter is designed, sent to all staff and published on the intranet. There is also an "opt-in" WhatsApp group which provides members with immediate important updates direct to their phone.

As in Criteria One, SCHT report on all Alert Organism monitoring and surveillance through IPCC meetings and Quality and Safety Committees. Our IPC Annual Report is a public document and available to view or download on our Trust website. Details of Alert Organism cases and MRSA screening compliance are also published on the intranet and the public website.

Criterion 5 – That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people

IPEAT perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of IPC; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organism surveillance and managing outbreaks of infection.

MRSA Screening

In addition to the local infection thresholds, a compliance threshold of 97% for MRSA screening for in-patients on admission was agreed with the ICB. Compliance results are reported monthly to the Quality and Safety Committee and IPC Committee with oversight by the DIPC to ensure good practice is shared and action plans are completed and show improvement.

MRSA Screening Compliance for in-patient areas

We aim to screen at least 97% of patients on admission for MRSA each month. For 2025/26, our MRSA screening compliance score was 96.7%, just below the 97% target. Work continues to ensure that this figure is maintained or improved for 2026/27 which includes supporting our clinical teams with digital solutions to form filling and helping reduce the amount of paperwork on admission to our Community Hospitals.

Month	Bishops Castle	Bridgnorth	Ludlow	Whitchurch	PRH	RSH	Overall Trust
Apr-25	86.96%	100.00%	87.50%	93.48%	100.00%	100.00%	95.69%
May-25	96.15%	98.00%	90.32%	89.19%	100.00%	95.35%	94.88%
Jun-25	95.65%	100.00%	88.89%	94.74%	100.00%	97.37%	96.76%
Jul-25	100.00%	100.00%	86.96%	97.73%	96.30%	100.00%	97.44%
Aug-25	96.43%	97.22%	100.00%	100.00%	96.88%	100.00%	98.38%
Sep-25	94.29%	100.00%	93.10%	97.14%	100.00%	100.00%	97.46%
Oct-25	94.74%	100.00%	94.12%	90.91%	Not open	97.30%	95.43%
Nov-25	100.00%	100.00%	96.88%	96.77%	Not open	100.00%	98.43%
Dec-25	95.45%	100.00%	100.00%	88.89%	Not open	Not open	96.00%
Jan-26	100.00%	100.00%	93.94%	97.37%	Not open	Not open	97.93%
Feb-26	95.65%	100.00%	100.00%	100.00%	Not open	Not open	99.04%
Mar-26	93.75%	100.00%	100.00%	86.36%	Not open	Not open	94.07%
Year End	95.76%	99.57%	94.30%	94.12%	98.84%	98.58%	96.72%

Criterion 6 – Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

The Trust has information and processes in place to ensure that its staff, including agency staff, contractors, and volunteers, are able to meet the requirements of this criterion.

All clinical staff receive induction and updated training and education in current IPC practices. IPC mandatory training for clinical staff was delivered via e-learning and 98% of clinical staff were up to date with mandatory Level 2 IPC training as of March 2026.

IPEAT have been engaging with the Clinical Education team and have a regular 2-hour training session being delivered to SCHT staff as part of the clinical induction week programme. IPEAT also support the Shropshire Telford and Wrekin (STW) Healthcare Support Worker (HCSW) academy by delivering IPC training to new HCSW staff that have been recruited.

Other systems in place include:

- SCHT job descriptions include IPC compliance alongside mandatory training to show that responsibility for IPC is delegated to every member of staff.
- "IPC working with patients in community hospitals" information booklet developed with the Feedback Information Group, provides IPC advice and information for all volunteers working with SCHT.
- An IPC information leaflet for health professional staff is available for use as part of local induction.
- IPC Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in the Community Hospitals.
- Information leaflet for contractors working in Community Hospitals.
- Monthly hand hygiene observational audits tools include volunteers and students.

It is important that the Trust can demonstrate that responsibility for IPC is effectively devolved to all groups involved with delivering care and that we have the arrangements in place to inform relevant authorities and System partners of outbreaks or incidents relating to infection. Surveillance of Alert Organisms is covered under Criteria 1.

- Our IPC Arrangements and Responsibilities policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC from Board to floor, demonstrating that responsibility is disseminated to all staff in the organisation.
- Responsibilities of groups and of staff are included in all SCHT IPC policies.
- IPC Link Staff Roles and Responsibilities for both community and Community Hospitals has been revised and updated. The IPC link staff receive additional training in IPC and act as a resource and role model and liaise between their clinical area and IPEAT.
- The IPC Self-audit programme encourages teams to own IPC practices and compliance as part of their day-to-day work.
- IPC Team access SaTH Laboratory IT systems to allow enhanced alert organism surveillance and on notification, IPEAT report all outbreaks and incidents of infection to the CQC, ICB, UKHSA and NHSE.

SCHT IPC Ambitions were launched in January 2023 and a report on progress against the milestones has been updated through the IPC report received at IPCC and the IPC annual report.

Figure: SCHT IPC Ambitions

IPEAT have maintained 100% compliance with their own mandatory training programme and personal development reviews that support increasing knowledge and skills to assist in the delivery of improved quality of care. IPC Nurses have revalidated with the Nursing and Midwifery Council.

Criterion 7 – The provision or ability to secure adequate isolation facilities

The Trust has robust isolation policies in place and has single room accommodation available to isolate patients when this is required. The Trust is also able to implement cohort isolation processes within the current estate and this process has been assured by NHSE Deputy Director of IPC. The Isolation policy includes an Isolation Risk Assessment Tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case-by-case basis.

Criterion 8 – The ability to secure adequate access to laboratory support as appropriate

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. IPEAT have a good working relationship with our IPC Doctor who is the Consultant Microbiologist at SaTH. Medical microbiology support is provided by SaTH 24 hours a day, 365 days a year and the Trust is currently fully compliant with this criterion.

Criterion 9 – That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections

The Trust has many policies and Standard Operating Procedures (SOPs) in place to ensure it meets the requirements of this criterion. IPEAT have a rolling programme to update and review policies and compliance with the programme is monitored through IPCC. In addition, policies are updated prior to review date if national guidance changes to ensure they reflect up to date, evidence based, best practice. All policies are ratified and approved through SCHT governance arrangements.

Criterion 10 – That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

Occupational Health Report 2025/26

Occupational Health have had another busy year in offering support and advise to Trust staff and managers, delivering Health and Wellbeing sessions and ensuring that all staff have the required vaccines and blood testing on commencement in post.

Work has also been undertaken to review staff measles and pertussis vaccination status. The county-wide measles programme has now been completed, and plans are in place to visit the Dudley team to review their records in relation to both measles and pertussis.

During the year Occupational Health has met with the Health and Safety Team to cross check all needlestick/Splash/Scratch incidents to ensure they have been managed successfully and recorded on both Datix and OH records.

Both Health and Safety and Occupational Health have worked with IPEAT to look at how we might best carry out and record all Skin Questionnaires and Skin Assessments on staff that have patient contact or contact with anything that could be considered an irritant – so including Hotel Services and Kitchen Staff.

Health and Wellbeing days were held at three of the community hospitals and several bigger trust sites offering Blood Pressure and Cholesterol checks and Flu vaccines as well as lots of other useful information and a small complimentary therapy such as a head or hand massage. Smaller sites were visited and offered ‘Know your Numbers’ which included Blood Pressure and Cholesterol testing with Flu vaccines.

Flu vaccinations for the season 2025/26 was not as hoped but was still successful looking at both national and regional data and saw 892 Flu vaccines administered equating to 53.3% of staff being vaccinated

Helen Russell
Occupational Health Team Lead

Looking Forward to 2026/27

An Overview of Infection Prevention and Control Programme

The key aim in 2026/27 will be to continue to prevent HAI and to provide education and support to SCHT staff to enable prompt management and control of infections. This will include meeting thresholds and to evidence compliance with the Health and Social Care Act through completing the IPC BAF. In addition, we will strive to achieve the IPC objectives and four ambitions in our IPC Strategy.

Our focus will be to:

Ambition 1: Integrated Working

- Strengthened IPEAT and Occupational Health work to support delivery of seasonal flu vaccination programme, including expansion of peer vaccinators to improve uptake and workforce protection
- Formalise mechanisms to share IPC learning, QI outputs and innovation across the Group

Ambition 2: Education and Training

- Joint work with the Clinical Education Team to support skills updates in high-risk areas
- Implementation of SureWash technology to provide objective hand hygiene assessment, real-time feedback and measurable improvement in compliance and technique

Ambition 3: Digital Technology

- Strengthen use of RiO patient record system to support surveillance and improve visibility of infection status and risks
- Introduce digital IPC prevention messaging across main SCHT sites through use of screens

Ambition 4: Enhanced Engagement and Involvement

- Continued close working with the Quality team to deliver identified priorities
- Support and contribute to mock inspections and service readiness activity in preparation for external assurance (CQC readiness)

Conclusion

This report provides assurance that Shropshire Community Health NHS Trust has robust systems and processes in place to prevent and control infection, supported by strong governance framework.

Across 2025/26, the Trust has demonstrated sustained focus on patient safety and quality, with positive performance in key areas including zero MRSA bacteraemia cases and a reduction in outbreaks, reflecting strengthened prevention, early identification and effective management arrangements. Significant progress has been made in delivering the IPC strategy ambitions, including strengthened system collaboration, enhanced digital capability, and improved staff engagement and recognition. These developments, alongside continued partnership working with pharmacy, occupational health, estates and quality improvement teams, provide a strong foundation for sustained improvement.

Whilst challenges remain, particularly in relation to Clostridioides difficile infection thresholds and maintaining consistently high compliance in some areas, the Trust has clear improvement plans in place, supported by multidisciplinary review and robust governance oversight.

Overall, this report demonstrates that infection prevention and control arrangements within the Trust are effective, continually improving and aligned to national standards. The Trust remains committed to delivering its IPC strategy ambitions for 2026/27, ensuring that patients, staff and the public are protected through safe, high-quality care.

Glossary of Terms

AMR	Antimicrobial Resistance
Bacteraemia	A bloodstream infection
CDI	*Clostridioides difficile* infection. *Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
COVID-19	Coronavirus disease
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
E.coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ePACT2	Prescription database for authorised users
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HAI	Healthcare Associated Infection
H&SCA	Health and Social Care Act
ICB	Integrated Care Board. Previously known as the Clinical Commissioning Group.
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPEAT	Infection Prevention Education Advisory Team
MPFT	Midlands Partnership NHS Foundation Trust
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NHSE	NHS England
NMP	Non Medical Prescriber
NICE	National Institute for Health and Care Excellence
OPAT	Outpatient Parenteral Antimicrobial Therapy

Outbreak	Two or more persons with the same signs, symptoms in time place and space.
PGD	Patient Group Direction
PII	Period of Increased Incidence
PPE	Personal Protective Equipment e.g. gloves, aprons and goggles
PRH	Princess Royal Hospital
PSD	Patient Specific Direction
QI	Quality Improvement
QSC	Quality and Safety Committee
RRU	Rehab and Recovery Unit
RSH	Royal Shrewsbury Hospital
SaTH	Shrewsbury and Telford Hospital NHS Trust
SBAR	Situation, Background, Assessment, and Recommendation
SCHT	Shropshire Community Health NHS Trust
TOR	Terms of Reference
UKHSA	United Kingdom Health Security Agency

Acknowledgements and Further Information

Thank you for reading the IPC Annual Report for 2025/26.

If you require any further information about IPC in SCHT please email the team at Shropcom.IPCTeam@nhs.net or visit our webpage at https://www.shropscommunityhealth.nhs.uk/safehands

This report was prepared by SCHT's IPC team:

Sara Ellis-Anderson – Interim Director of Infection Prevention and Control
Sharon Toland – Clinical Lead Nurse, Infection Prevention and Control
Ian McCabe – Infection Prevention, Education and Advisory Team Nurse
Holly Grainger - Infection Prevention and Control Nurse
Alison Davies – Infection Prevention and Control Team Secretary

In conjunction with:

Susan Watkins – Chief Pharmacist,
Lisa Pascall, Lead Pharmacy Technician – AMS and Vaccination Services
Helen Russell – Occupational Health Advisor

References

Department of Health: The Health and Social Care Act 2008

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)

NHSE: National Infection Prevention and Control Manual

NHS England » National infection prevention and control manual (NIPCM) for England

National Standards of Healthcare Cleanliness 2021

B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

The Shrewsbury and Telford Hospital NHS Trust

Boards of Directors' Meeting in Common: 09 July 2026

Agenda item	Board Information Pack Item			
Report Title	SaTH Audit and Risk Assurance Committee Chair's Annual Report 2025-26			
Lead	ARAC Chair, Prof Trevor Purt			
Report Author	Anna Milanec, Group Chief Governance Officer (GCGO)			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		BAF13
Effective	√	Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led	√	Our partners		
Consultation / Communication	Report written in consultation with ARAC Chair.			
Executive summary:	All SATH board assurance committees' Terms of Reference (agreed by committees and approved by the Board) include a duty to provide an annual Chair's report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year. For NHS trusts and NHS foundation trusts, paragraph 2.1 of the *Code of Governance for NHS provider trusts* sets out that 'the board of directors should establish an audit committee of independent non-executive directors.' As in this case, "Audit and Risk Assurance Committee" usually infers that this type of committee takes a more active role in looking at the management of risks and the effectiveness of risk control and the sources of assurances, as compared with the traditional 'Audit Committee' which focuses on audit (internal and external) and uses the work of the auditors to assist in its oversight.			
Recommendations for the Board:	The Board is asked to **note** and take assurance from this report as to its required duties and activities undertaken during the 2025/6 financial year as indicated by its Terms of Reference.			
Appendices:	None			

1.0 Introduction

1.1 The terms of reference for the Trust's board assurance committees were updated to include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities, on this occasion, during the 2025/26 financial year.

1.2 As set out by the Institute of Chartered Accountants in England and Wales (ICAEW) , "intellectual curiosity and professional scepticism are necessary attributes in an audit committee member. It's not enough to request confirmation from the external auditors and the executive team, as this can provide a false sense of comfort. Members of the modern audit committee must understand the business and ask the right questions".

1.3 This is the report of the Board's Audit and Risk Assurance Committee (ARAC / 'the Committee').

2.0 Committee membership and meetings

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

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

2.3 The Committee was chaired throughout the year by Professor Trevor Purt, a Non-Executive Director with relevant financial experience. Three of the Trust's Non-Executive Directors are members of the ARAC, all of whom are independent.

2.4 As required, the Trust's (Joint) Chair is neither the Chair nor a member of the Committee.

2.5 The Director of Finance, and Director of Governance / Company Secretary, attended each meeting, as do members of the Governance, Risk and Compliance teams. In addition, other executives or senior managers attend meetings as required for agenda items. Once a year, the Chief Executive, as Accounting Officer, attends the meeting where the annual financial statements are presented.

2.6 During 2025/6, the Committee met on seven occasions, to discharge its responsibilities.

Audit and Risk Assurance Committee Attendance Matrix 2025/26	Committee Meetings					
Committee Members:	14 April 2025	19 May 2025	23 June 2025	1 Sept 2025	24 Nov 2025	16 Feb 2026
Trevor Purt (Committee Chair and NED)	√	√	√	√	√	√
Teresa Boughey (NED)	√	√	x	√	√	√
Raj Dhaliwal (NED)	√	√	√	√	√	√
Jonathan Sargeant (Associate NED)		*x*	*x*	√	√	√

2.7 External Auditors, Internal Auditors and Anti-Fraud attend each meeting.

2.8 The Non-Executive Director members of the Committee meet on a regular basis with the auditors (usually before formal meetings) without regular Committee attendees.

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

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

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

a. The Committee reviewed relevant disclosure statements, particularly the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit Report and Value for Money report, and other appropriate independent assurances.
b. The Board Assurance Framework (BAF) was reviewed by the Committee on a quarterly basis throughout the financial year.
c. Reporting of the Operational Risk Register, and Corporate Risk register was reported to the Committee.
d. The adequacy and effectiveness of the organisation's financial control systems have been reviewed by the Committee throughout the year through the receipt of regular reports; competition waiver reports, procurement waiver reports, contract award reports, losses and special payment reports.
e. Annual review of the Trust's Standing Financial Instructions, Scheme of Delegation and Standing Orders.
f. Trust's Risk Appetite review was undertaken.
g. Work was undertaken during the year relating to the Trust's systems for recording conflicts of interest, gifts and hospitality.
h. And, in addition, the work of Internal Audit relating to financial control systems and the work of External Audit relating to the financial statements.
i. Data quality remained a key priority for the Committee in 2025/26, particularly as the organisation transitioned into business as usual following the implementation of Careflow and the migration of its data warehousing infrastructure into the Federated Data Platform (FDP) environment.
j. Matters may arise at the ARAC that were either directed to the Committee to discuss (for instance the results of some form of external assurance), or where the ARAC may wish to direct a matter to another committee (for instance assurance on the oversight of particular risks or e.g. an internal audit review on patient safety to the Quality and Safety Assurance Committee).

3.2 *Internal Audit - MIAA*

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

A report is presented to the ARAC at each meeting providing updates on the number of internal audit recommendations closed / remaining open each month. During the year, 34 audit recommendations, all accepted by the organisation, were raised relating to the risk-based internal audits

Internal audit reports received during the year were:

Opinion provided	Title of core and risk-based reviews issued
1 **high** assurance opinion:	1. Risk Management Core Controls
4 **substantial** assurance opinions:	1. Key Financial Controls. 2. Patient Safety Incident Response Framework (PSIRF) (*carry forward from 24-25*). 3. (Financial) Grip & Control Review 4. Fit & Proper Persons Regulations
2 **moderate** assurance opinions:	1. Data Quality - Waiting List & Performance Review. 2. E Rostering / Roster Management
1 **limited** assurance opinions:	1. Waiting List Initiatives & Consultant Job Planning
Nil **no** assurance opinions	
Nil reviews without an assurance rating	

3.3. *External Audit - KPMG*

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

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

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

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

3.4 *Other Assurance Functions*

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

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

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

The Assurance Framework (AF) internal audit opinion for the period 1st April 2025 to 31st March 2026 was as follows:

"The structure of the AF meets the NHS requirements. Processes in place to update the AF robust. The AF was visibly reviewed by the organisation."

3.5 *Anti-Fraud - MIAA*

The aim of all anti-fraud work is to support improved NHS services and to ensure that, through awareness raising and local proactive work, fraud within the NHS is seen as unacceptable, and that the loss to taxpayers is minimal. Nevertheless, several incidents were reported throughout the year to the Trust's Anti-Fraud specialist, which have been investigated and appropriate actions taken where required.

Fraud prevention checks continued throughout the year with additional training and awareness materials being especially in view of the introduction of the "Failure to Prevent Fraud" offence, introduced under the Economic Crime and Corporate Transparency Act 2023, effective from 1 September 2025.

On 19 June 2025, representatives from NHSCFA Fraud Hub, conducted an engagement visit to the Trust, followed by a virtual meeting on 23 June 2025. This visit was prompted by the Trust's stated performance in fraud risk assessments (Requirement 3) and detection activity (Requirement 10) as part of the Government Functional Standard 013 for Counter Fraud (CFFSR). The engagement was largely positive with the NHSCFSA recognising the Trust's approach to undertaking fraud risk assessments as being an example of good practice. Some observations were made in respect of the timing of recording detection activity on the CFA's Clue crime recording system. A full action plan formally addressing the CFA's recommendations was actioned and completed during the year with the CFFSR 2025 annual self-assessment was submitted in quarter 1 by the AFS. The Trust received a 'Green' rating overall.

3.6. *Financial Reporting*

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

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

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

4.0 Conclusion

4.1 It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2025/26.

Report prepared by Anna Milanec, Director of Governance

On behalf of Professor Trevor Purt, Chair of ARAC
May 2026

Board of Directors Meeting in common – 09 July 2026

Agenda item	Board Information Pack Item		
Report Title	**SaTH QSAC Chair's Annual Report, 2025/26**		
Executive Lead	Sarah Dunnett, Non-Executive Director		
Report Author	Sarah Dunnett, Non-Executive Director; and Deborah Bryce, Head of Corporate Governance & Compliance		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
QSAC Chair and Head of Corporate Governance & Compliance	Safe		BAF risk 13
	Effective		
	Caring		**(SaTH) Risk Register id(s):**
	Responsive		N/A
	Well Led	✓	
Executive Summary	1. The terms of reference of the Trust's Board assurance committees outlines that an annual review of its effectiveness will be undertaken and an annual report provided to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference 2. This is the Quality & Safety Assurance Committee's annual report for the 2025/26 financial year.		
Recommendations to the Board	The Board is asked to **note** the content of the Quality and Safety Assurance Committee Chair's annual report 2025/26		
Appendices:	-		

1.0 Introduction

1.1 The terms of reference of the Trust's Board assurance committees outlines that an annual review of its effectiveness will be undertaken and an annual report provided to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference.

2.0 Purpose

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

3.0 Committee membership, meetings and terms of reference

3.1 The membership of the SaTH Quality and Safety Assurance Committee (QSAC) was appointed by the Board of Directors and consists of not less than five members, as follows:

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

3.2 Non-Executive Director, Sarah Dunnett has been the Chair of QSAC throughout 2025/26.

3.3 QSAC met 10 times in 2025/2026. The meeting attendance table for members of the committee for 2025/26 is provided below and is included within the 2025/26 Trust Annual Report:

Quality and Safety Assurance Committee Attendance 2025/26

Members:			2025/26									
Name	**Title**	**Role**	**April**	**May**	**June**	**July**	**Sept**	**Oct**	**Nov**	**Jan**	**Feb**	**Mar**
Sarah Dunnett [chair]	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rosi Edwards	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Heidi Fuller	Associate Non-Executive Director	Member		✓	✓	✓	✓	✓	✓	✓	✓	✓
Wendy Nicholson MBE	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paula Gardner	Interim Chief Nursing Officer	Member	✓	✓	X	✓	✓	✓	X	✓	✓	✓
John Jones	Executive Medical Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: there was no meeting held in August and December 2025.

3.4 During the year there has been attendance at meetings by observers from NHS England.

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

3.6 Agenda setting meetings are held in advance of each meeting to agree the agenda, based on the cycle of business and other important matters, as part of a continuing process of focussing the agenda on assurance in support of the Board.

3.7 The QSAC terms of reference were last approved by the Board in May 2025 and are due for their annual review. Consideration is currently underway of the potential for QSAC to meet as a committee in common with SCHT.

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

4.1 At its meetings during the year (from April 2025 to March 2026), QSAC considered a wide range of reports, including:

- Antibiotic Stewardship Group overview report
- Antimicrobial resistance – call to action
- Board Assurance Framework (BAF) - quarterly
- Clinical Audit Plan – Bi-annual Progress Reports
- CQC Inspection Visits March 2026
- CQC Quarterly Update Reports
- Decision to delivery in category 1 & 2 caesarean sections and equality issues with delays
- Emergency Department (ED) mortality audit (and update) and fit-to-sit case update
- ED Report – Patient Experience
- Getting to Good/ Moving to Excellence Quarterly Report
- Guidance for presenting to committees
- Health, Safety, Security and Fire Annual Report and in-year update
- Health & Safety Management Policy
- Incident Management Overview Report
- IPC – Antimicrobial Resistance
- IPC – Deep Clean action plans
- IPC Annual and quarterly reports
- Learning from Deaths quarterly reports
- Medical Examiner/Bereavement Service reports, including annual report 2024/25
- Legal reports - quarterly
- Levelling Up report
- Martha's Rule update
- Maternity & Neonatal Transformation Assurance Committee - items for escalation and key issues reports
- Maternity Dashboard and key issues report
- Maternity Neonatal Safety Champions reports
- Maternity Survey
- Maxillo Facial service provision update
- MBRRACE Report
- Medical Regulatory Group reports
- Medication Safety Annual Report
- National surveys: Adult Inpatient, Cancer Patient Experience, Children and Young People Survey
- Nursing and Midwifery Staffing Bi-annual Report
- Paediatric Transformation Assurance Committee Report and annual report
- PALS, Complaints, Patient Experience & PACE Reports
- Palliative and End of Life Care Update Report
- Quality Priorities proposed for the coming year and mid-year update
- PSIRF quarterly update

- Quality Operational Committee key issues reports
- Quality Operational Committee Terms of Reference (approval)
- QSAC Chair's Annual Report 2024/25
- Quality Indicators Integrated Performance (IPR) Report and Exception Report
- Regulation 28 case update
- Report into the benefits of the diabetic podiatry service being brought into SaTH
- Safeguarding quarterly and annual report
- Safeguarding Children and Young People Policy
- Stroke Therapies and aftercare deep dive
- Tuberculosis Call to Action Letter and TB business case
- The Royal Wolverhampton NHS Trust - elective work update
- Urgent and Emergency Care System Integrated Improvement Plan (SIIP) Key Issues Report
- Update on the Amos Review
- Urgent & Emergency Care Transformation Assurance Committee (UECTAC) Reports
- Bi-annual Nursing & Midwifery Staffing Reports
- Draft Quality Account 2024/25
- Paediatric & Adult Pathway Update
- Themes for Complaints (clinical care)
- UEC review of paediatric and adult pathways

4.2 Chair's Reports to the Board

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

- To continue improving the effectiveness of QSAC, a meeting is to be arranged with NEDs and the medical director and chief nurse to look at how the committee spends its time. (April 2025)
- A deep dive into the diabetic foot service was agreed which will provide an update on the service since the podiatry service was brought in house. (May 2025)
- Work to be undertaken to align meetings to ensure timely receipt of papers at QSAC. (June 2025)
- QSAC requested clarity for the governance processes for business cases that need ICB approval. (Nov 2025)
- Review of rhythm of meetings next year to support papers being available for QSAC in a timely way. (Nov 2025)
- Consider the addition of dates to the project updates in Moving to Excellence. (Nov 2025)
- As the Trust has now achieved University status, there was a discussion of what this means for the Trust. An action was agreed that there should be a meeting to discuss next steps between the Trust and the University. (Jan 2026)
- A request for Moving to Excellence, and all reports to focus on what the impact is on patients. (Jan 2026)
- Medical Director to share findings from the PTAC walkabout in CYP ED with Ops colleagues to check that all findings are addressed in capital plans. (Mar 2026)
- A report on how the Trust is applying Martha's Rule is coming to QSAC in July. (Mar 2026)

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

There was one matter that was escalated to the ARAC chair for information from QSAC in 2025/2026. This was to share the alert raised by Quality Operational Committee that the information governance committee had not met since December 2024.

4.4 QSAC's review of its performance/effectiveness

QSAC reviews each meeting as a standard agenda item at the end of each meeting. Reviews have considered/raised such items as:

- the large number of agenda items and balancing this;
- timings of agenda items;
- adequate time for Non-Executive Directors to provide challenge during the meeting;
- the quality of reports submitted;
- deep-dives being presented at the beginning of a meeting;
- having concise summary papers;
- improvement in the action log;
- the meeting now being more solution focussed and forward looking;
- good chairing of the meeting;
- cross cutting themes emerging with reports interconnecting; and
- members observed an improvement in both the clarity and focus of papers presented.

All forms of feedback are welcomed by the QSAC Chair in relation to the committee's continuous improvement and effectiveness, and this continues to be a topic of discussion with QSAC members. This will be an important mechanism as we move to joint committees.

5.0 Conclusion

It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2025/2026.

Sarah Dunnett, Non-Executive Director/ Chair of Quality & Safety Assurance Committee

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting in Common: 09 July 2026

Agenda item	**Board Information Pack Item**			
Report Title	**SaTH PAC Chair's Annual Report, 2025-26**			
Non-Executive Lead	Rosi Edwards, Non-Executive Director			
Report Author	Rosi Edwards, Non-Executive Director			

CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		BAF13
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	N/A
Well Led	√	Our partners		

Consultation Communication	PAC Chair and Head of Corporate Governance & Compliance
Executive summary:	1. The terms of reference of the Trust's Board assurance committees outlines that an annual review of its effectiveness will be undertaken and an annual report provided to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference 2. This is the Performance Assurance Committee's annual report for the 2025-26 financial year.
Recommendations to the Board:	The Board is asked to **note** the content of the Performance Assurance Committee Chair's annual report 2025/26.
Appendices:	-

1.0 Introduction

1.1 The terms of reference of the Trust's Board assurance committees outlines that an annual review of its effectiveness will be undertaken and an annual report provided to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference.

2.0 Purpose

2.1 The purpose of the Performance Assurance Committee (PAC) is to provide assurance to the Board of Directors on the performance of the Trust across a range of performance indicators within the Integrated Performance Report, including on access standards, quality, and workforce. The Committee will also ensure that the Trust has an appropriate Estates Strategy and Digital Strategy. It also has oversight of the development of a long-term strategy that addresses all identified operational business risks and opportunities, including those deriving from partnership work.

3.0 Committee membership, meetings and terms of reference

3.1 The membership of the SaTH Performance Assurance Committee (PAC) was appointed by the Board of Directors and consists of not less than five members, as follows:

Committee Chair: a nominated Non-Executive Director
Two Further nominated Non-Executive Directors or Associate Non-Executive Directors
Chief Operating Officer (lead executive for the committee)
Assistant Chief Executive.

3.2 Non-Executive Director, Rosi Edwards has been the Chair of Performance Assurance Committee throughout 2025-26.

3.3 PAC met 10 times in 2025-2026 (there was no meeting held in August and December 2025). The meeting attendance table for members for 2025-26 is provided below and will be included within the 2025/26 Trust Annual Report:

Performance Assurance Committee Attendance 2025/26

Members:			**2025/26**									
Name	**Title**	**Role**	**April**	**May**	**June**	**July**	**Sept**	**Oct**	**Nov**	**Jan**	**Feb**	**Mar**
Rosi Edwards [committee chair]	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Dunnett	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rajindar Dhaliwal	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ned Hobbs	Chief Operating Officer	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inese Robotham	Assistant Chief Executive	Member	✓	✓	✓	✓	✓	✓	✓	x	x	x

Note: There was no meeting held during August or December 2025.

3.4 During the year there has been attendance at meetings by observers from NHS England.

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

3.6 Agenda setting meetings are held in advance of each meeting to agree the agenda, based on the cycle of business and other important matters, as part of a continuing process of focussing the agenda on assurance in support of the Board.

3.7 PAC considered the annual review of its terms of reference at its meeting in November 2025, and these were approved by the Board of Directors in January 2026.

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

4.1 At its meetings during the year PAC reports received have included:

- Performance Highlights and the Integrated Performance Report.
- Workforce Performance Impact & Plan
- Strategy & Partnerships update
- Data Warehouse Update
- Digital Programme Update
- Health & Inequalities Update
- Board Assurance Framework update
- Climate Change 4A Key Issues Report
- Estates Annual & Operational Plan
- Review of Winter Plan
- Estates Strategy
- Fire Safety/Risk Report
- Fire Audit Strategy & Action Plan
- Annual Review of terms of reference
- Annual Review of Reporting Cycle
- Green Plan
- Effectiveness Annual Review
- UEC System Integrated Improvement Plan (SIIP) Key Issues Report
- Premises Assurance Model
- Deep Dive on actions being taken to avoid corridor care
- Digital - Windows 11 Project update
- Update on Switchboard position at PRH
- Cancer Improvement Programme work on pathways - update
- Update Reports on UTC & UEC
- Productivity data and workforce analysis focusing on SaTH as a whole
- Type 3 4-hour performance update
- Withdrawal of Enforcement Notice 348
- Hospital of the Future
- Neighbourhoods
- Agree a way to triangulate and report the financial risks and impacts within the UEC transformation programme.

4.2 Chair's Reports to the Board

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

- Inquiry into what might have caused the sharp rise in ED attendances in March 2025.
- Follow-up report on PIFU to cover progress with action plan and also how we know if the right patients are put on PIFU, and whether there are health inequalities arising from it, indicated by categories of patients not initiating contact.
- Follow up report on PRH switchboard.
- Report on Cancer Improvement Programme work on pathways.
- Report on Winter Plan.
- Reports on UTC and UEC.
- PAC asked for a report to review a sample of patients on the PIFU pathway to gain assurance that the right patients are being put on this pathway and are gaining benefits.
- A paper to come to PAC/FAC on work on productivity. (Being developed specialism by specialism).
- Chair to speak to Director of Strategy and Partnerships about the score for BAF risk 7b.
- N Hobbs (COO) and T Cotterill to agree a way to triangulate and report the financial risks and impacts within the UEC transformation programme.
- N Hobbs to present data on long waits in ED, so that PAC can see trends and progress and also the impact on those with protected characteristics.
- Report on care pathways for patients with alcohol dependency to come to January 2026 PAC.
- BAF Q4 to consider whether to reduce the score for BAF Risk 9 Elective Care.
- Paper to come to QSAC and PAC on the health outcomes and harm arising from the spike in NCTR over Christmas and New Year.
- Further data on UEC long waits separating admitted and non-admitted to be included in the Performance Highlights report.
- Paper comparing SaTH's digital maturity with that of other trusts to come to PAC in April/May.
- Paper to come to PAC on ways to provide an effective Alcohol and Drug care team.
- Action plan in response to Shropshire Fire and Rescue Service Notices and Authorised Engineer Annual Report to come to PAC in April 2026.
- Training in Fire Safety: chair to inform co-chair of Group People Committee of issues raised by SFRS and AE.
- Chair to write to Chief People Officer and Co-chair of Group People Committee about "owed hours" asking how these have accrued and how they are being managed.

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

PAC considered at each meeting whether there were matters that should be sent to the ARAC chair for information, but there were none in 2025/2026.

On behalf of PAC, the chair raised with the Chair of People & OD Assurance Committee/Joint chair of Group People Committee the issues of training in fire safety and of rostering and hours owed by staff.

With the Chair of Finance Assurance Committee the chair raised on PAC's behalf a response from HR to a query from PAC about enablers which would allow SaTH to reduce its workforce.

The following Internal Audit Reports gave assurance to PAC and were referenced in the SaTH meetings during the year:

- Internal Audit Report – Waiting List Management PIFU (April 2025)

4.4 PAC's review of its performance/effectiveness

PAC reviewed each meeting as a standard agenda item. PAC also carried out an anonymised review of its performance using an electronic questionnaire format provided by the Corporate Governance Team, which was issued during October 2025, with seven responses. The results of the survey, compiled by Corporate Governance Team and discussed at PAC in November 2025, were very positive overall, with only three uncertain responses.

Regarding one comment, on whether the committee should merge with Finance Assurance Committee, PAC members considered that combined Finance and Performance committees were the norm (though the ICB has a combined Quality and Performance Committee) though the reasons for splitting performance from finance - to ensure that each was given sufficient time and focus in meetings - were considered valid and to have been successful. Longer term in view of closer working with Shropshire Community Trust, PAC considered it will be necessary to review the need for separation - while bearing in mind the need for enough time at any combined meeting for performance and finance to get adequate attention, and for a suitable committee home to be found for digital, estates and equalities issues.

How to improve committee effectiveness continues to be a topic of discussion with PAC members.

5.0 Conclusion

It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2025-2026.

Rosi Edwards, Non-Executive Director and Chair of Performance Assurance Committee

Shropshire, Telford and Wrekin Community and Hospitals
NHS Group

Moving to EXCELLENCE

Board of Directors' Meeting in Common 9 July 2026

Agenda item	Board Information Pack Item		
Report Title	SaTH FAC Chair's Annual Report, 2025-26		
Executive Lead	Adam Winstanley, Acting Chief Finance Officer		
Report Author	Richard Miner, Non-Executive Director and Deborah Bryce, Head of Corporate Governance & Compliance		
Prior Consultation:	**CQC Domain:**		**Link to (SATH) BAF id(s)**
Finance Assurance Committee	Safe		BAF 13
	Effective		
	Caring		**(SaTH) Risk Register id(s):**
	Responsive		N/E
	Well Led	√	
Executive Summary	1. The terms of reference of the Trust's Board assurance committees outlines that an annual review of its effectiveness will be undertaken and an annual report provided to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference 2. This is the Finance Assurance Committee's annual report for the 2025-26 financial year.		
Recommendations for the Board	The Board is asked to **note** the content of the SaTH Finance Assurance Committee Chair's Annual Report 2025/26		
Appendices:	N/A		

1.0 Introduction

1.1 The terms of reference of the Trust's Board assurance committees outlines that an annual review of its effectiveness will be undertaken and an annual report provided to the Board on its work in discharging its duties, delivering its objectives and complying with its terms of reference.

2.0 Purpose

2.1 The purpose of the Finance Assurance Committee (FAC) is to undertake on behalf of the Board of Directors objective scrutiny and seek evidence of assurance of the Trust's financial performance plans, major investment decisions, capital plans and relevant regulatory compliance.

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

2.3 It also considers processes for the preparation and the content of strategic and operational financial plans, including annual revenue, capital and workforce budgets, and test the key assumptions and risks underpinning such plans.

3.0 Committee membership, meetings and terms of reference

3.1 The membership of the SaTH Finance Assurance Committee (FAC) was appointed by the Board of Directors and consists of not less than six members, as follows:

- Committee Chair: a nominated Non-Executive or Associate Non-Executive Director
- Two further nominated Non-Executive or Associate Non-Executive Directors
- Director of Finance (lead executive for the Committee)
- Director of Nursing
- Chief Operating Officer, or Deputy COO – Membership currently review

3.2 Non-Executive Director, Richard Miner has been the Chair of Finance Assurance Committee throughout 2025-26.

3.3 FAC met 15 times in 2025-2026. The meeting attendance table for members of the committee for 2025-26 is provided below.

Finance Assurance Committee - Attendance 2025/26

		2025										2026				
Name	Role	Apr	May	Jun (extra 16.06.2025)	Jun	Jul	02.09.2025	Sept	Oct	Nov	Dec (extra 02.12.2025)	Dec	Jan	Feb (Extra 02.02.2026)	Feb	Mar
Richard Miner [Chair]	Member	✓	✓	x	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Simon Crowther	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓ (Chair)	✓	✓	✓	✓	✓	✓
Adam Winstanley	Member	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trevor Purt	Member			✓ (Chair)												
Paula Gardner	Member	✓	✓	x	x	✓	✓	✓	✓	x	x	✓	✓	✓	✓	✓
Jonathan Sargeant	Member		✓		x	✓	x	✓	✓	✓	✓	✓	✓	x	✓	✓

3.4 During the year there has been attendance at meetings by observers from NHS England and the Committee has been conscious of the heightened levels of scrutiny throughout the year. The Trust's Interim Director of Financial Recovery has also attended as well as members of the people/workforce team.

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

3.6 Agenda setting meetings are held in advance of each meeting to agree the agenda, based on the cycle of business and other important matters, as part of a continuing process of focusing the agenda on assurance in support of the Board.

3.7 FAC considered the annual review of its terms of reference at its meeting in November 2025, and these terms of reference were approved by the Board of Directors in January 2026.

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

4.1 At its meetings during the year, FAC has received a number of reports, including:

- Monthly financial reports and forward look
- Key issues reports from Capital Planning Group, Efficiency & Sustainability Group, Operational Performance Oversight Group and Financial Recovery Group
- Finance System Integrated Improvement Plan (SIIP) Report
- Efficiency & Financial Recovery monthly report
- 25/26 Operating Plan
- National Costs Collection Submission
- National Planning Framework
- Operational Performance Oversight Group reports
- Workforce Plan and Financial Impact
- Quarterly Board Assurance Framework (BAF)
- Quarterly Contract Award Reports
- Cash Committee Financial Matters
- Datawarehouse/SLaM update
- Integrated Operating Plan 2026-27
- Annual Budget
- Annual review of FAC Terms of Reference and business cycle
- Draft Chair's Annual Committee Report
- Financial Recovery Group and Integrated Planning Meeting Terms of Reference
- System Operational Plan
- Medium Term Planning Submission 2026-31
- STW Medium Term Financial Plan update
- STW Finance Strategy
- Next Year's Operating Plan assumptions and baseline
- 5-Year Capital Plan
- Mutually Agreed Redundancy Scheme (MARS)
- 2026-27 draft and final Budget

- Reinforced Autoclaved Aerated Concrete (RAAC)
- SDEC and Catheter Lab business cases
- Service Review Programme - Key Messages
- West Midlands Imaging Network Outline Business Case
- Modular Theatre Options Appraisal, Grip & Control and HFMA Sustainability Framework
- Deep Dives – Run Rate; and Productivity
- HTP contracts and related issues
- Energy, Security and Decarbonisation contract variation
- Trauma floor expansion
- LED lighting bids
- Demolition blocks 3 & 4 at RSH case
- Corporate Benchmarking Report
- Financial Governance Report update

4.2 Chair's Reports to the Board

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

- The development of enhanced reporting to embellish the controls necessary.
- Budgets as devolved out to budget holders.
- More work was required to determine the "who, what, how" aspects of the Medium-Term Financial Plan and Finance Strategy; a timeline; the HTP "triangulation" with STW; more details on activity; the starting point for year 2 (which does not appear to be the same as the end of year 1); more work on the drivers of the deficit; more work to understand the base case, upside and downside; more work on the drivers of the deficit.
- The Financial Recovery Group (FRG) is still in operation with a far more strategic view and the Committee Chair, and the other NEDs attend as observers at various points throughout the year as part of the assurance process.
- Further work to ensure we are accurately tracking both workforce numbers and costs and can take the necessary actions.
- NHSE have issued some guidance highlighting the need for strong financial governance, challenge and accountability, run rates and Board focus. The Committee continues to make progress. (Sept 2025).
- Executive feedback and measures, impact and timing to deal with the current unmitigated £9.7m of risk. (Sept 2025).
- As a consequence of run rate analysis presented at the October 2025 meeting, the Committee asked for further assurance around underlying run rates and to satisfy itself that the underlying cost base was reducing.
- The Committee recognises the current workload and challenges of hitting financial targets by the year-end particularly the pressure from workforce costs including current NHSE observations on bank costs and the need to balance safety considerations (staff ratios, fill rates, roles not filled, etc) and proposed a more detailed Board discussion. (Oct 2025).
- Cash planning: formalise scenario planning for cash management, including the impact of any delay or withdrawal of Q4 deficit support. (Nov 2025).

- Bank usage analysis: produce a triangulated report on bank and how that works with workforce vacancies and bank/locum usage across all staff groups. (Nov 2025).
- Accounting treatment: Director of Finance confirmed, with external audit, the accounting treatment for modular building reuse to avoid impairment risk. (Nov 2025).
- Data warehouse / SLAM: Director of Finance provided a position paper with timeline and risk analysis at the next meeting. (Nov 2025).
- Capex is behind plan but is being pushed notwithstanding that some deferral has been agreed. (Dec 2025).
- The Committee to keep under review the effectiveness and trajectories of cost mitigations in Q4 such that the outturn for 25/26 becomes as accurate as possible. (Jan 2026).
- The Committee noted that while no contracts had been awarded between the beginning of November 2025 and 31 January 2026, the reporting felt incomplete, and the Committee considered that it would be helpful if a list of wavers came to the Committee together with a forward list of expected contracts. (Feb 2026).
- A more transparent financial quantification of excess workforce costs (albeit acknowledged as difficult) would be helpful in identifying trends. (Feb 2026)
- The cycle of reporting remains a work in progress with further items to be added including Data Warehouse updates, divisional deep dives and a “report back” on previous business case approvals. (Feb 2026).
- The efficiency programme for 2026/27 is very much predicated on transformational workforce shifts including digital initiatives. (March 2026).
- The Data Quality Report highlighted work still to be done but with growing confidence from regulators. Completion of the necessary work is expected in Q1 2026.27. (March 2026).

In setting out the above, it should be noted that the work of FAC has developed over the course of year towards a more structured oversight role with increased emphasis on assuring itself around the deliverability of key transformational initiatives which are vital to the longer-term financial sustainability of the Trust.

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

There were no matters that were escalated to the ARAC chair for information from FAC in 2025/2026. There is a link between FAC and ARAC with certain matters, such as the Quarterly Contract Award Report which is considered by FAC and ARAC.

The Chair of Finance Assurance Committee received a communication from the Chair of Performance Assurance Committee (PAC - on PAC's behalf), a response from HR to a query from PAC about enablers which would allow SaTH to reduce its workforce as both committees share concerns.

4.4 FAC’s review of its performance/effectiveness

FAC reviews the effectiveness of each meeting as a standard agenda item at the end of each meeting. Reviews have considered such items as the balance of the agenda, timing of items, the importance of accurate information, along with positive developments and challenges.

All forms of feedback are welcomed by the FAC Chair, including those of third-party observers during the course of the year, in relation to the committee’s continuous improvement and effectiveness, and this continues to be a topic of discussion with FAC members.

5.0 Conclusion

It is considered that the Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2025-2026.

Richard Miner, Non-Executive Director/ Chair of Finance Assurance Committee

Shropshire, Telford and Wrekin Community and Hospitals NHS Group

Moving to EXCELLENCE

Board of Directors' Meeting in common – 09 July 2026

<table>
<tr><td>Agenda item</td><td colspan="3">Board Information Pack Item</td></tr>
<tr><td>Report Title</td><td colspan="3">Group People Committee Chairs' Annual Report 2025-26</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Anna Milanec, Group Director of Governance</td></tr>
<tr><td>Report Authors</td><td colspan="3">Deborah Bryce, Head of Corporate Governance & Compliance (SaTH); Shelley Ramtuhul, Director of Governance (SCHT); Teresa Boughey, Non-Executive Director; Cathy Purt, Non-Executive Director.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Prior Consultation:</td><td colspan="2">CQC Domain:</td><td>Link to BAF id(s)</td></tr>
<tr><td rowspan="5">Committee chairs and members (via email)</td><td>Safe</td><td>√</td><td rowspan="2">BAF risk 13 (SaTH)</td></tr>
<tr><td>Effective</td><td>√</td></tr>
<tr><td>Caring</td><td>√</td><td>Risk Register id(s):</td></tr>
<tr><td>Responsive</td><td>√</td><td rowspan="2">-</td></tr>
<tr><td>Well Led</td><td>√</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Executive Summary</td><td colspan="3">1. The terms of reference of both Trusts' Board assurance committees include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year.

2. The SaTH People & OD Assurance Committee and SCHT People Committee have held their meetings in common since November 2025 (Group People Committee). This is the joint annual report of those committees for the 2025-26 financial year.</td></tr>
<tr><td>Recommendations to the Board</td><td colspan="3">The Board is asked to note the content of the Chair's Annual Report and to take assurance that the Committee(s) has effectively discharged its role and responsibilities during the 2025/26 financial year.</td></tr>
<tr><td>Appendices:</td><td colspan="3"></td></tr>
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1.0 Introduction

1.1 The terms of reference of the Board assurance committees for both Shrewsbury & Telford Hospital NHS Trust and Shropshire Community Health NHS Trust include a duty to provide an annual report to the Board providing assurance as to how they have discharged their role and responsibilities during the financial year.

1.2 The SaTH People & OD Assurance Committee (PODAC) and Shropshire Community Health NHS Trust (SCHT) People Committee have held their meetings in common (at the same time) since November 2025 (named the Group People Committee), meeting bi-monthly during 2025-26. Prior to this, the SaTH PODAC met bi-monthly and the SCHT People Committee met monthly until moving to bi-monthly from November 2025 onwards.

2.0 Purpose

2.1 The key role of the SaTH and SCHT People Committees is to receive assurances that staffing processes are safe, sustainable, and effective and that the NHS People Promises are being delivered.

3.0 Committee membership, meetings and terms of reference

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

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

3.2 The membership of the SCHT People Committee was appointed by the Board of Directors and consists of the following:

- Committee Chair: a nominated Non-Executive Director
- One further nominated Non-Executive Director
- Chief People Officer (who is a non-voting Director of the Board) – Lead Executive for the Committee
- Director of Operations and Chief AHP
- Director of Governance

3.3 Teresa Boughey, Non-Executive Director is the chair of SaTH PODAC. Cathy Purt, Non-Executive Director is the chair of SCHT People Committee. Since the establishment of the Group People Committee (committees meeting in common), the chair of each meeting is rotated between Teresa Boughey and Cathy Purt.

3.4 SaTH PODAC/People Committee met bi-monthly and met eight times during 2025-2026 (three of the meetings in 2025-26 were meetings held in common with SCHT). The SATH meeting attendance table is below:

SATH People & OD Assurance Committee Attendance

Name	Title	Role	Apr	Jun	Aug	Oct	Nov (SaTH only)	Nov*	Jan*	Mar*
					2025-2026					
Teresa Boughey (Chair)	Non-Executive Director	Member	x	✓	✓	✓	✓	✓	✓	✓
Trevor Purt	Non-Executive Director	Member	✓							
Rosi Edwards	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓
Wendy Nicholson MBE	Non-Executive Director	Member	✓	x	✓	✓	✓	✓	✓	✓
Heidi Fuller	Associate Non-Executive Director	Member		✓	✓	✓	x	x	✓	✓
Rhia Boyode	Chief People Officer	Member	✓	x	✓	✓	✓	✓	✓	✓
Nigel Lee	Director of Strategy and Partnerships	Member	✓	✓	✓	✓	✓	✓	✓	✓

* denotes meeting held in common with Shropshire Community Health NHS Trust

3.5 The SCHT People Committee met 9 times during 2025-26 (three of the meetings in 2025-26 were meetings held in common with SaTH). The committee met monthly until October 2025 and then bi-monthly from November 2025, when meetings in common were established. The SCHT meeting attendance is below:

Membership & Attendance for 2025/26:

- Cathy Purt (Chair) (8 of 9)
  Non-Executive Director
- Jill Barker (6 of 9)
  Non-Executive Director
  Rhia Boyode (7of 9)
  Chief People Officer
- Claire Horsfield (8 of 9)
  Director of Operations and Chief AHP
- Shelley Ramtuhul (7 of 9)
  Director of Governance

3.6 Reports are typically presented to People Committee by the authors, who can answer questions raised by the committee.

3.7 The cycle of business of the committee is kept up to date and is used to plan the agenda for each meeting. The cycle of business of the Group People Committee is currently being further updated for 2026/27.

3.8 SaTH PODAC last reviewed and agreed its terms of reference at its meeting in December 2024, and these were approved by the Board of Directors in January 2025. SCHT People Committee last reviewed and agreed its terms of reference in March 2025, and these were approved by the Board in April 2025. Both Boards approved amendments to the terms of reference in the latter part of 2025 to allow for meetings in common across the Group and it is intended that a single Group People Committee terms of reference will be developed in early 2026-27.

3.9 The People Committees of both Trusts were selected to be the first Board committees to work as committees in common, based on both committees' willingness to join together, as well as recognition that focus on our workforce as we form and develop the Group will be paramount. The committees in common have shared their learning and will therefore inform implementation on other committees in common as part of the 2026/27 transition year for the Group.

4.0 Principal Areas of Review

4.1 At its meetings during 2025/26 SaTH PODAC considered and received assurances on the following:

- People & OD Assurance Report (including culture)
- Workforce & Leadership System Integrated Improvement Plan (SIIP) Key Issues Report
- Risk Report People Risks
- Nursing & Midwifery Staffing Report
- Audit recommendations – Bank and Agency review
- Board Assurance Framework
- Equality, Diversity & Inclusion update reports
- Annual Staff Survey Results and staff survey updates
- Education Annual Report 2024-25
- Updated polices including Employee Wellbeing and Attendance Management Policy and Disciplinary Policy.
- Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) update report
- Employee Relations update
- Assurance Committee items (items that pass between committees)
- Financial Recovery Planning 2025/26
- Annual Committee Effectiveness Survey Results
- Workforce plan assurance paper
- HTP and Neighbourhood updates
- Flu vaccine programme update
- People communications update
- Draft Joint People Strategy update
- Integrated Performance Report
- Strategic Resourcing Report
- People Health, Safety and Wellbeing Report
- Strategic People Group Terms of Reference
- Chief People Officer updates
- National Education and Training Survey and GMC Survey Report
- Progress on 10 Point Plan to improve resident doctors' working lives
- Nursing & Midwifery job evaluation project
- Graduation guarantee for newly qualified nurses and midwives
- Proposal to Change Disclosure and Barring Service (DBS) Checks Policy.

4.2 At its meetings during 2025/26 SCHT People Committee considered and received assurances on the following:

- Chief People Officer Report
- Integrated Performance Report
- Performance Framework Update
- People Assurance Report
- Workforce Plan Delivery Reports
- Flu Programme Updates
- Board Assurance Framework
- Clinical Education Activity Reports
- Culture Updates
- Employee Relations Reports
- Annual Staff Survey Results and staff survey updates including People Promise updates

- ESR Annual Assessment Report
- Armed Forces Covenant Update
- Strategic Resourcing and Digital Transformation Update
- Trade Union Facility Time Report
- Freedom to Speak Up Guardian Reports
- NHSE Education Contract Self-Assessment 2024/25 Performance
- Internal Audit Reports: Mandatory Training
- People Strategies: Clinical Education Strategy 2025
- Schwartz Rounds Annual Report
- Policy Tracker
- Updated polices including Neurodiversity Guidance, Maternity / Adoption Leave Policy, Long Service Award Policies, SAS Pay Progression Policy, On Call Policy, Lease Car Policy, Fixed Term Contracts Policy, Job Planning Policy, Maintaining High Professional Standards Policy
- Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) update report, Smoking in the Workplace Policy, Multi-professional Preceptorship Policy

4.3 At its meetings held in common SCHT and SaTH, via the Group People Committee, have considered and received assurances on the following:

- How to work as a committee in common
- People risks
- Board Assurance Framework
- Workforce integrated performance reports
- Policy tracker and relevant policies for approval
- Staff Survey updates
- Clinical Education update
- Practice Education Facilitator NHSE Education Contract Self-Assessment 2024-25
- Hospitals Transformation Programme (HTP) and Neighbourhood updates
- 2025-26 SIIP Workforce and Leadership plan
- Employee relations report
- Nursing and Midwifery staffing updates
- Equality Delivery System review, prior to publication
- Culture and leadership updates
- Gender Pay Gap reports
- Integrated Strategic Workforce Plan updated 2025/26 and 2026/27
- Staff Story
- Guardian of Safe Working report
- Armed Forces update
- Stress-related sickness deep dive report

4.4 Chair's Reports to the Board

The Committee Chairs for SaTH meetings and Group People Committee meetings submitted a report to the Board of Directors after each meeting in the 4A format (Alert, Assure, Advise, Action). In addition, SCHT reported to Board via a Chairs Assurance Report and following the meetings being held in common a joint report was submitted using the 4A format referenced above. Actions raised for significant follow up included:-

a) **SaTH items (from PODAC April 2025 to October 2025):**

- The Chief Nursing Officer to take forward improvement to the safe staffing report (complete).
- Financial recovery slides to be shared with all Non-Executive Directors.
- The evaluation of Clinical Support Worker role profiles and the quantification of the associated financial provision and impact for SaTH.
- The executives will now move forward and reflect on the draft Joint People Strategy feedback from PODAC.
- Following the industrial action, and in relation to improving the lives of resident doctors, a forum will be established and the Medical Director invited to future PODAC meetings (complete).
- The Chief People Officer agreed to review the risk register outside of the meeting (August 2025) in relation to:- some risks being quite old; further possible detail on head count reduction being required; and the re-banding of Clinical Support Workers being more of a financial risk rather than a people risk.
- The Improvement Director to review the detail of BAF risks 2, 3 and 4 to support the work of the Board Assurance Framework (BAF).
- To bring the DBS checks policy back to a future meeting for further discussion (October 2025).
- The Chief People Officer was asked to provide clarity regarding workforce numbers and associated reporting.

b) **SCHT items (from People Committee April 2025 to October 2025):**

- The Deputy Director of Workforce was asked to ensure the Trust Board's objectives were set and in place with the six high impact requirements
- The Chief People Officer was asked to link with the Medical Director to include SCHT research details in the joint People Strategy and ensure wider inclusion of support services beyond AHPs
- The Deputy Director of Workforce was asked to provide a trajectory for mandatory training
- The Director of Nursing and Director of operations were asked to link up to provide a future update on Oliver McGowan Training
- The Chief People Officer was asked to ensure an MSK Specialist to be invited to the Health and Wellbeing / Staff Sickness roundtable discussion
- The Deputy Director of Workforce Operations was asked to provide a breakdown of long term and short term sickness and to triangulate the data with manual handling training compliance
- The Director of Operations was asked to discuss the RESUS online training with the Director of Nursing
- The Associate Director of Workforce was asked to provide a deep dive into mandatory training at a future meeting
- Deputy Director of Workforce was asked to verify the workforce reduction figures for consistency
- Deputy Director of Workforce was asked to review the health and wellbeing plan around men's health initiatives
- The Director of Governance and Chief People Officer were asked to look at the risk relating to managing organisational change, including policy alignment and staff engagement to be reflected in the BAF
- The Deputy Director of Workforce to make required changes to the Terms of Reference and submit them to the Trust Board

c) **Group People Committee items (from November 2025 to March 2026):**

- Consider how to present staff experiences in a way that is sustainable for both organisations.
- An update on the Recovery Support Programme (RSP) funding for the workforce planning tool is scheduled for the January (2026) meeting. (SaTH) Mandatory training and wellbeing themes (including sickness, absence, mental health and carers) were highlighted, with deeper analysis to be undertaken.
- The Committee agreed to explore a joint review of training needs across both organisations, reflecting the shift from hospital to community.
- The Committee agreed that, alongside seeking assurance from available data, it must maintain a strong forward-looking focus, anticipating emerging people issues.
- Armed Forces covenant update to be provided at the March 2026 Group People Committee meeting.
- Policy alignment work will continue as part of the Group Transition programme.
- An update on the sickness levels relating to stress and the round table discussion to be provided to the Group People Committee (complete).
- Focus on mandatory training compliance relating to Fire Safety and Resuscitation for SCHT.

4.5 Reviewing Effectiveness

As part of its commitment to continuous improvement, SaTH PODAC, SCHT People Committee and the Group People Committee include a standing agenda item at each meeting for members to provide feedback on the effectiveness of each meeting.

The committees also routinely consider the cycle of business which is reviewed and used to plan the agendas of forthcoming meetings. All meeting agendas are agreed with the Group Chief People Officer.

The committees met as a Group People Committee (meeting in common between SCHT and SATH People Committees) from November 2025. The Group People Committee's fourth meeting in common will be held on 1 June 2026. The content of the agenda and format has continued to evolve since the initial in-common meetings. Members have now become more familiar with the in-common approach and more of the papers considered are now joint papers, rather than separate SCHT and SaTH papers/items. It is planned that later in the year an effectiveness survey will be undertaken across the Group People Committee to gain intelligence and look to further improve the functioning of the committee.

5.0 Conclusion

It is considered that each Committee has undertaken its duties and responsibilities appropriately and in full during the financial year 2025-2026.

Teresa Boughey, Chair of SaTH PODAC and joint chair of the Group People Committee

Cathy Purt, Chair of SCHT People Committee and joint chair of the Group People Committee

Appendix 1

Would You Speak Up Again	Please Explain Your Answer
Yes	I must admit that I was very hesitant to speak up about the treatment I was facing at work, mostly because I felt I might be blowing things out of proportion. But after speaking with FTSUG, she reassured me and made me feel safe. She provided me with the support I desperately needed at the time and put my wishes at the centre of every action. Above all, she has assured me that even though I do not feel prepared to escalate my concerns at this time, it is okay to tell my story whenever I am ready and to use my experience to support others. I am very grateful to have felt as empowered as I did with the support of FTSUG and the FTSU service.
Yes	The trust encourages staff to speak up, as I have previously spoken up
Yes	It was very well dealt with by the team but was a situation that no one had an answer for, without putting CCTV everywhere!
Yes	Thank you for the brilliant support you gave to me. Thanks to you and your service I have a workable solution
Yes	I am now utilising the flexible working policy many thanks for all your help.
Yes	I would encourage my colleagues to use FTSU if needed as they were very supportive, and I am so thankful that the FTSUG was on the ward. I knew I had done the right thing, and I would speak up again.
Yes	There is still a plethora of opportunities to rectify any wrongs such as lack of awareness in the NHS environment. From when I last spoke up about the lack of awareness toward deafness, hard of hearing and speech difficulties. I've since seen more engagement and enthusiasm from other colleagues who were interested in practicing sign language.
Yes	I feel that we should be treated fairly whist at work, whilst being treat treated with dignity and respect. I could not say much in the corridor, but with regards to my award, it would have been nice to have been presented it, by an Executive, rather than having to collect it from their PA. Hopefully some lessons will be learnt, for the next set of awards.
Yes	It is important that we speak up especially if it affects our family life. We have to be sensitive in each other journey in life. People working in our institution are hard workers and they do it for their families. It is important that we protect what matters to them so that they will be feel valued
Yes	I felt comfortable with the process and would do it again if ever required.
Yes	In speaking up I was given the support I needed to enable me to address a number of issues within my department. Advice was impartial and non-judgemental.
Yes	Was grateful for the safe space to talk about my concerns
Yes	The response to my query was very quick and i felt welcoming. However, i was not totally satisfied with the clarification given since Tier 2 Visa Thornbury nurses are still doing shifts in your trust since i was stopped from booking since September when the government guidelines on restricted hours were announced on November 10th, 2022.
Yes	Ther independent investigation was completed and everyone including myself have decided to move on thank you for your advice.
Yes	Thanks for checking in while this was being addressed, everything is much better thank you
Maybe	Would depend on the scenario and the reasons
Maybe	I do not know if I would speak up again. However, I appreciate that we have a FTSU channel, and I also appreciate the support that you gave me when I raised the issue I had. The reason for my answer being that I do not feel that the issue I raised was really met with any care about me as an individual person from the people who make decisions within the trust when you raised it with them.

No	It has been sometime since our FTSU experience, and I would like to give you some feedback about the process. My experience (and I know others agree with me on this) of the FTSU process is that it was NOT very good and probably did more harm to the people trying to raise concerns than good. I am happy to talk to you about why this was the case and what can be done to improve the process but not in writing. We could maybe meet or discuss over Teams if you feel this would help. The culture in our department is gradually improving but this is more to do with our new head of department implementing changes rather than the FTSU process.
No	"I spoke up about a culture in a team and our working practices, it was very difficult, and it took 4.5 years to come to a solution. Following the outcome, I was relieved of my managerial duties and was told "you will never manage in this Trust again." I believe the reason for this was because I spoke up and although I had made an error following process this was used as an excuse to relieve me of my duties. I find this shocking when I have seen colleagues do much worse. At SaTH there is a culture in middle management that is impenetrable and holds back those trying to change the culture and instil good working practices. Although I have suffered detriment because of speaking up I am not prepared to have this escalated and looked at because of fear of further repercussions. I know now that further advancement at SaTH is out of my reach because of the culture that prevails."
No	As I feel that the higher managers don't care and that we are just a number and easily replaceable. I feel that after nearly 17 years working for SATH I feel disillusioned and very disappointed and I would not recommend this a place to work for anyone if asked.
Yes	I would not hesitate to contact your team in the future if required. Without your support I genuinely feel I would have gone off sick. The support and guidance I was given has been invaluable to me mentally and allowed me to continue to come into work. I was given time to talk and listened to without being judged. The signposting and information gave me the strength to do the right thing. Mentally. It was so comforting knowing someone would guide me through this incident and follow things up. Your help has been truly invaluable at a time when I felt vulnerable. Thank you
Yes	Really helpful, kind and supportive
Yes	I have found the service really helpful. It was a difficult situation in that the patient did not want to raise their concern but I felt it needed to be raised. I wanted to remain anonymous. FTSUG was brilliant at keeping the situation confidential. I was able to raise the concern on behalf of the patient without it leading to any animosity. The situation was looked into and answers were found.
Yes	It was easy to contact someone and explain my concerns. I was given good advice and sign posting and received regular follow up contact.
Yes	FTSUG could have refused to listen to my concerns due to me working for another trust and advised me to speak to the FTSU team within MPFT. However, she listened to my concerns and provided me with a suggestion for a solution to my problem. She was helpful and I felt valued and was given the time I needed.
Yes	The support I've had from yourself and my trade union has been amazing, however at local level this hasn't been the case. I was meant to have a review meeting with the manager who chaired the meeting back in the summer, this hasn't happened, this was meant to happen in September. The XX said he wanted to have a weekly check in with me and this never happened. The lack of support from my managers has meant that I went external with my concerns recently and raised these with the XX who are now working with me to try and resolve these issues.
Yes	FTSUG dealt with my FTSU issue in a timely manner and kept me up to date with developments. Many thanks for your help.
Yes	At a time when I was finding it hard in my workplace to the point I did not feel psychologically safe FTSUG allowed me to talk through my feelings. She took the time to understand me and sign posted me to other support services. She understood my perspective and validated my feelings which was very important at the time.
Yes	I found it very helpful to raise concerns in a safe space.
Yes	Helpful and good advice and appreciated the chance to speak to someone.
Yes	I wanted to let you know that I have now joined the XX team, and I would like to sincerely thank you all for your help and support throughout my hard time.